National Health Insurance or Incremental Reform: Aim High, or at Our Feet?

Single-payer national health insurance could cover the uninsured and upgrade coverage for most Americans without increasing costs; savings on insurance overhead and other bureaucracy would fully offset the costs of improved care. In contrast, proposed incremental reforms are projected to cover a fraction of the uninsured, at great cost.

Moreover, even these projections are suspect; reforms of the past quarter century have not stemmed the erosion of coverage. Despite incrementalists' claims of pragmatism, they have proven unable to shepherd meaningful reform through the political system.

While national health insurance is often dismissed as ultra left by the policy community, it is dead center in public opinion. Polls have consistently shown that at least 40%, and perhaps 60%, of Americans favor such reform. (*Am J Public Health.* 2003;93: 102–105)

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WE ADVOCATE SINGLE-PAYER national health insurance (NHI) (Table 1) because it would work and lesser reforms would not. The policy establishment often portrays NHI as an impossible dream: an ultra-left, utopian vision. Yet, most other wealthy capitalist nations have implemented NHI, and it enjoys wide, even majority, public support in the United States.

Most would agree that our health care system is deeply troubled. At least 41 million people residing in the United States have no health insurance, and millions more have inadequate coverage. Medical care costs are soaring, and job-based coverage is eroding. Public resources of enormous worth—hospitals, visiting nurse agencies, even hospices—built over decades by taxes, charity, and devoted volunteers, are being taken over by companies attentive to profits but indifferent to suffering.

TABLE 1—Key Features of Single-Payer National Health Insurance

1. *Universal, comprehensive coverage:* Only such coverage ensures access, avoids a "2-class" system, and minimizes administrative expense
2. *No out-of-pocket payments:* Copayments and deductibles are barriers to access, administratively unwieldy, and unnecessary for cost containment
3. *A single insurance plan in each region, administered by a public or quasi-public agency:* A fragmentary payment system that entrusts private firms with administration ensures the waste of billions of dollars on useless paper pushing and profits. Private insurance duplicating public coverage fosters 2-class care and drives up costs; such duplication should be prohibited
4. *Global operating budgets for hospitals, nursing homes, HMOs, and other providers, with separate allocation of capital funds:* Billing on a per-patient basis creates unnecessary administrative complexity and expense. Allowing diversion of operating funds for capital investments or profits undermines health planning and intensifies incentives for unnecessary care (under fee for service) or undertreatment (in HMOs)
5. *Free choice of providers:* Patients should be free to seek care from any licensed health care provider, without financial incentives or penalties
6. *Public accountability, not corporate dictates:* The public has an absolute right to democratically set overall health policies and priorities, but medical decisions must be made by patients and providers rather than dictated from afar. Market mechanisms principally empower employers and insurance bureaucrats pursuing narrow financial interests
7. *Ban on for-profit health care providers:* Profit seeking inevitably distorts care and diverts resources from patients to investors
8. *Protection of the rights of health care and insurance workers:* A single-payer reform would eliminate the jobs of hundreds of thousands of people who currently perform billing, advertising, eligibility determination, and other superfluous tasks. These workers must be guaranteed retraining and placement in meaningful jobs

Since the defeat of the Clintons' Rube Goldberg scheme for universal coverage, reform debate has been muted. But the fast developing medical care crisis—business grappling with soaring premiums, workers and unions fighting cutbacks in coverage, governments confronting deficits, and a sharp upturn in the number of individuals who are unemployed and uninsured—ensures a reopening of health policy debate.

THE LIMITS OF INCREMENTALISM

Since the passage of Medicare and Medicaid, a welter of incremental reforms have been attempted—and have failed. Health maintenance organizations (HMOs) and diagnosis-related groups promised to contain costs and free up funds to expand coverage. Billions have been allocated to expanding Medicaid, the State Children's Health Insurance Program, and similar state-based insurance programs for poor and near-poor citizens. Medicare and Medicaid have pushed managed care. Oregon essayed rationing; Massachusetts and Hawaii passed laws requiring all employers to cover their workers; Tennessee promised nearly universal coverage; and several states implemented risk pools to insure high-cost individuals and insurance regulations to protect consumers.[1] Senators Kennedy and Kassebaum lent their names to insurance market reform legislation. And for-profit firms pledged

that market discipline and businesslike efficiency would fix health care.

Fans of incrementalism dismiss NHI as a hopeless home run swing when a bunt—small steps toward universal coverage—would do. Despite incrementalists' claims of pragmatism, however, they have proven unable to shepherd meaningful reform through our political system. Over the past quarter century, incrementalists have trumpeted victories such as those detailed above. Meanwhile, the number of uninsured individuals has increased by 18 million, health care's share of the gross domestic product has risen from 7.9% to 13.2%, and more and more seniors have been forced to choose between food and medicine. How many more strikes before incrementalism is out?

Incrementalism founders on a simple problem: expansion of coverage must increase costs unless resources are diverted from elsewhere in the system. US health costs are already nearly double those of any other nation and are rising rapidly.[2] The economic climate is cool. Yet, an incrementalist strategy implausibly posits massive infusions of new money, funds that would go mostly to the poor and near poor, who wield little political power. For instance, proposals to offer tax credits for the purchase of coverage would cost about $3000 annually per newly insured person.[3] Employer mandate proposals in California would boost public spending by between $4000 and $10 000 per newly insured person while also increasing employers' costs.[4]

Absent new money, patchwork reforms can expand coverage only by siphoning resources from existing clinical care. Advocates of managed care and market competition once argued that their strategy could accomplish this end by trimming clinical fat. Unfortunately, new layers of corporate bureaucrats have invariably overseen the managed care "diet" prescribed for clinicians and patients. Such cost management bureaucracies have devoured virtually all of the existing clinical savings and antagonized huge swaths of middle-class patients as well as the medical profession.

THE FISCAL CASE FOR NHI

The fiscal case for NHI arises from the observation that bureaucracy now consumes nearly 30% of our health care budget,[5–7] as well as the fact that this enormous bureaucratic burden is a peculiarly American phenomenon. Our biggest HMOs keep 20%, even 25%, of premiums for their overhead and profit[8]; Canada's NHI has 1% overhead,[2] and even US Medicare takes less than 4%.[9] HMOs also inflict mountains of paperwork on clinicians and institutional providers. The average US hospital spends one quarter of its budget on billing and administration, nearly twice the average in Canada.[7] American physicians spend far more time and money on paperwork and billing than their Canadian colleagues.[5] Administration consumes 35% of home care agency budgets in the United States, as opposed to 15.8% in Ontario (S. Woolhandler, T. Campbell, D.U. Himmelstein, unpublished data, 1999–2000).

Reducing our bureaucratic spending to Canadian levels would save at least $140 billion annually, enough to fully cover the uninsured and upgrade coverage among those now underinsured. Proponents of NHI,[10] disinterested civil servants,[11,12] and even skeptics[13] all agree on this point. NHI would require new taxes, but these taxes would be fully offset by a fall in insurance premiums and out-of-pocket costs. Moreover, the additional tax burden would be smaller than is usually appreciated, because nearly 60% of health spending is already tax supported[14] (vs roughly 70% in Canada).

Unfortunately, incremental tinkering cannot achieve significant bureaucratic savings. The key to administrative simplicity in Canada (and other nations) is single-source payment through a public insurer. Canadian hospitals have a global annual budget to cover all costs—much as a health department is funded in the United States—virtually eliminating billing. Physicians bill a single insurer using a simple form, and fee schedules are negotiated annually between provincial medical associations and governments. In contrast, US providers face a welter of plans—at least 755 in Seattle alone[15]—each with its own rules and paperwork.

Even a step from 1 to 2 insurers raises providers' administrative costs. Fragmented coverage necessitates eligibility determination and internal cost accounting to attribute costs to individual patients and insurers and undermines global budgeting and health planning efforts. Although many assumed that computerization of billing would cut administrative costs, savings have not materialized.[16] While all nations with NHI have lower health administration costs than the United States, multipayer systems sacrifice part of this advantage. Thus, Germany's health care providers employ far more administrators and clerks than Canada's.[17] In the United Kingdom, the implementation of "internal markets" (in effect, a multipayer structure superimposed on the National Health Service) doubled administrative costs.[18]

For insurers, a multipayer structure requires duplication of claims processing facilities and reduces the size of the group that is insured, which increases overhead[19,20]; insurance overhead in the multipayer NHI systems of Germany and the Netherlands is at least double that in Canada.[2] Any degree of participation by private insurers also raises administrative costs.[21] Private insurers in Australia, Germany, and the Netherlands all have high overheads: 15.8%, 20.4%, and 10.4%, respectively.[2] Functions essential to private insurance but absent in public programs (e.g., underwriting and marketing) account for about two thirds of private insurers' overhead.[22]

THE POLITICAL CASE FOR NHI

The political case for NHI arises from the fact that it would improve care for most Americans, not just the poor: solidarity is stronger than charity, a formulation we first heard from Vicente Navarro. NHI would not just expand current insurance arrangements; it would upgrade coverage for many in the middle class, assuage clinicians' and communities' concerns over the growing corporate dominance of care, and provide a framework for addressing the myriad problems exacerbated by our current irrational financing structure. These problems include the overuse of technology and neglect of caring, the extortionate profits of

our drug industry, the imbalance between curative and preventive resources, the mismatch between health investments and need, and the multitude of quality problems that plague us (why is it that virtually every hospital in the United States has a complex computer billing system yet almost none have computerized order-entry systems that would prevent millions of medication errors?).

Among those who already have coverage, NHI would eliminate the fear that today's coverage will subsequently become unaffordable or disappear as a result of a strike, layoff, disabling illness, or college graduation. It would afford them a free choice of providers, a top priority for many Americans according to polls (hence the right-wing appropriation of terms such as "consumer choice health reform") but rare in today's managed care environment. It would encompass many services that are excluded from current coverage—notably long-term care, as well as prescription drugs for the elderly.

Among health workers, NHI can reduce the aggravation of bureaucratic hassles, dampen market-induced gyrations in the financial health of institutions and practices, and refocus the attention of health leaders from profits to health improvement. NHI offers reassurance for health workers and communities now fearful that a distant corporate board may discontinue vital but unprofitable services.

In contrast, incremental reforms divide our potential supporters, proposing fixes for the problems of the uninsured, seniors, disgruntled HMO members, and unhappy physicians and nurses in separate pieces of legislation that compete for resources. And the fundamental problem of corporate control of our health care system remains unaddressed.

Paradoxically, despite the shift from a Democratic to a Republican administration and the recent assault on social spending and civil liberties, the political climate may be favorable to NHI. The recent spate of corporate scandals has spread appreciation of the corruption and inefficiency of private firms.

Moreover, the corporate class is confused and divided over what should be done about health care, opening space for debate. Between 2000 and 2002, the percentage of employers who thought the health care system was working "pretty well" declined by 37%.[23] Some within business are drawn to voucher schemes (e.g., the defined-contribution program that our own university recently implemented and President Bush's "premium support" proposal for Medicare) that are thinly veiled mechanisms to cut care. Others, however, recognize that such schemes cannot stabilize the health care system or provide sufficient care to ensure workers' productivity and labor peace. NHI is attractive to some corporate leaders because it would socialize the costs of employee benefits (improving their competitive position vis-à-vis firms in other countries), although this would deprive employers of some of their bargaining leverage. Forty percent of small business owners now favor single-payer NHI.[24]

Predictably, these corporate divisions will soon be reflected in an uptick in media attention to NHI. For a decade the virtual media blackout on NHI has been broken only for occasional assaults on Canada's program. Many of these stories trumpeted the lunatic assertions of right-wing fringe groups (e.g., a recent claim that Canada's health care system was comparable to Turkey's[25]). Others dramatized the real problems that emerged in Canada during the early 1990s, a period during which health care was starved of funds by governments responsive to pressure from the wealthy, who sought to avoid cross-subsidizing care for the sick and poor.

Whereas once Canadian and US health spending were comparable, today Canada spends barely half (per capita) what we do.[2] Shortages of expensive, high-technology care have resulted. Yet, Canada's health outcomes remain better than ours (e.g., life expectancy in Canada is 2 years longer[2]), and most quality comparisons indicate that Canadians enjoy care equivalent to that for insured Americans; few Canadians cross the border seeking care.[26] Few if any reporters have noted that a system structured in a manner similar to Canada's, but with double the funding, could deliver high-quality care without the waits or shortages that Canadians have experienced.

The media and policy wonks' dismissal of NHI is remarkable in the face of polls that have consistently shown wide popular support for such reform. While NHI may seem ultra left in the policy milieu, it is dead center in public opinion and even in the opinion of physicians. Even the most negatively phrased surveys reveal that 40% of Americans are in favor of single-payer NHI; more sympathetic phrasing elicits support from about 60%,[27] polling numbers that have not changed since Richard Nixon was advocating policies that have since become Ted Kennedy's. The Democrats' abandonment of NHI reflects an ideological shift in the party, not in the populace. Indeed, today 62% of Massachusetts physicians favor single-payer NHI.[28] Is any other policy position that enjoys so much support treated so dismissively? Only 17% of Americans want to see abortion outlawed![29]

In the name of pragmatism, some public health leaders and many politicians counsel us to abandon, or indefinitely delay, the fight for NHI. To them, corporate power appears unchallengeable and politics so polluted that decent public policy is unthinkable. From this perspective, one would advise Rosa Parks to forgo her futile gesture given the dismal political milieu of 1955.

Rosa Parks understood that even apparently stable systems can change dramatically and unexpectedly, a point also made repeatedly by evolutionary biologist Stephen Jay Gould. The months ahead will see rising pressure for change in our medical care system. Predictably, employers will attempt to shift costs to workers, and governments will attempt to balance budgets on the backs of the poor and the sick. Our tottering medical care system need not veer in that direction, however; a lurch toward NHI is also possible.

In the coming months, our task is to break the iron curtain of media and political silence on NHI. We urge colleagues to publicly endorse NHI (see http://www.physiciansproposal.org) and to enlist other individuals and organizations in the fight for NHI. We are convinced that a striking show of support for NHI among health professionals would uniquely capture public attention, setting in motion vital public

discussion of health care's future. For generations, the moral stance of the public health community has helped spark social movements, often against dauntingly powerful foes: the crusade against tobacco and fights for clean water, a sustainable environment, workplace safety, and reproductive rights. Our professions' voices gain extraordinary resonance when we speak courageously in the public interest. A time to raise our cry is again at hand. ■

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