

# Affordable Health Care for All Turning a Dream into a Reality

by

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**H**ealth is an indicator of social class. When the Labor Government established Britain's long-needed National Health Service after World War II, the move had the unanticipated consequence of removing the most visible distinction separating working men and women from their upper class betters: bad teeth. As expected, NHS provision of ready access to virtually free care drastically increased workers' longevity by sparking a drop-off in deaths from opportunistic and easy-to-spot-and-treat illnesses. But the real physical distinctions between the classes – not just the elite myth of a working class “smell” that George Orwell isolated and satirized – were also eliminated by positive government intervention to end a social problem.

The class divide in health care is not much less visible in America today than it was in pre-war Britain. The public sector in general and all forms of social welfare policy are under the privatizing gun. 45 million Americans go without any health care coverage. Many of the elderly choose between medicine and food. Malnutrition is prevalent among new immigrants. The poor are undiagnosed and primary care doctors are still scarce in rural areas and inner city neighborhoods. Undetected lead poisoning harms children's ability to compete for a place even on the lower rungs of the social ladder. Poor health is still the mark of Cain.

Unlike Europe, where socialists succeeded in having health care judged as a human right, core elements of the U.S. public accept it as a purchasable commodity, and public discourse revolves around how to pay for it. And unlike in the Scandinavian countries, whose conservatives were frustrated in efforts to privatize the system, the U.S. takes private health care as a fact of life. Only in a few states such as New York are private for-profit hospitals even disallowed, though the non-profit university and other hospitals are frequently operated along market lines as cash cows for their parent institutions and private boards.

Nationwide, private chains such as Humana are growing and research aims at treating the ills of the rich and the needs of corporations. Only public education is still prized, and even there, voucher supporters and charter school advocates are making inroads and attempting to drain public dollars into private hands.

Instead of government subsidies to private insurers, DSA supports a single-payer system, similar to the Canadian model and to legislation introduced more than 10 years ago by the late Senator Paul Wellstone and Rep. James McDermott. Their initiative—needed more than ever—would offer continuous coverage funded through progressive tax levies. With far fewer administrators than are required by the myriad private plans, with less paperwork leading to cost containment and with corporate influence over diagnosis and treatment blunted, hospitals and doctors could focus on medical delivery. Doctors would still operate private practices, but lower rates would be set by the government as the sole purchaser.

Frisof helps demystify and unravel the complex issue of how health care developed in the United States and what the prospects are for universal health care today.

## Introduction

Imagine the U.S. health care system as a big, complicated machine, full of nuts and bolts and cogs and wheels and motors. There are thousands of pieces - an intricate jumble of law, policy, tradition, technology, bureaucracy, and practice - transforming what we put into the machine (money, time, energy) into what comes out: health care. Our health-care producing machine was assembled slowly over the last 150 years, pieced together from a variety of laws and traditions that weren't designed or intended to work together. Our machine has been patched up a number of times as we've added new cogs or tightened some screws and filled in some gaps, and new and changing technologies have improved some of the machine's parts, but this machine has never received a complete overhaul.

This machine - the U.S. health care system - is breaking down. It still works - very well for some, so-so for most, and barely at all for far too many. The machine consumes one-seventh of the national economy, an input so great that it will never suffer a total breakdown. But it is certainly the least efficient machine of its class, consuming far more and producing considerably less than the health care systems constructed by other industrialized democracies.

This DSA pamphlet will:

- Describe the current problems in U.S. health care;
- Provide a brief history of the political economics of American health care;
- Explore the economic and political roots of the problems;
- Delineate how to make change happen.

## The Current Problems in U.S. Health Care

The central dynamic causing the current crisis in U.S. health care, leading to the breakdown of our health care machine, is escalating cost. As costs rise, health care becomes less and less affordable for more and more people.

The access problems in American health care are a consequence of the cost problems. Health insurance premiums

are rising, so fewer employers are offering health insurance. Fewer workers can afford to pay their share of the premium, so they elect not to carry health insurance. They gamble that no one in their family will get seriously ill. Others have insurance policies, but the policies have such high deductibles and copayments that families delay seeking care to avoid the expense until they feel absolutely compelled. They go for care and do not pick up all the prescriptions written for them, or they pick up prescriptions for medicines needed every day but take them every other day to save money.

There is regular public discussion about the problems of the uninsured. Their number has increased by 5 million over the past four years, to 45 million in 2003, more than one in six Americans under the age of 65 (virtually every-

one over 65 has publicly financed insurance through Medicare). But this is not a stable group. As people lose jobs or get new ones, they go through episodes of health insecurity when they lose their insurance. Over the last two years, nearly one in three Americans under the age of 65 was without insurance for one or more months.

But uninsurance is only part of the problem. Underinsurance, insurance which leaves such big financial burdens on patients as to hinder their access to care, is harder to estimate exactly, but is at least as large a problem. Conservative

estimates place the number of underinsured in the U.S. at 50-70 million. In fact, underinsurance (i.e., excessive financial strain as a consequence of costs associated with illness) is a major contributor to half of the personal bankruptcies in this country.

Not surprisingly, uninsurance and underinsurance are almost exclusively problems of low and middle income workers.

## A Brief History of the Political Economy of Health Care in America

From 1776 through the early twentieth century, the vast majority of payment for health care came directly from the pockets of patients - sometimes in cash, sometimes in goods, sometimes immediately, sometimes later. Doctors made house calls. For the poor, local governments and reli-



gious institutions set up charity care in which providers volunteered their services.

In the early decades of the twentieth century, hospitals rose in importance and medicine was institutionalized. Advances in medical technology, hard times during the Great Depression, the growing influence of organized labor, and the political recognition of the importance of security issues led to the initiation of private insurance in America. Employment-based insurance was an unintentional side-effect of wage and price controls during World War II. Employers could compete for scarce labor through benefits to their workers (e.g., health insurance) but not through higher wages.

After Medicare and Medicaid were added to the Social Security Act in 1965, publicly financed health insurance has become the largest health care payer. Expanded and modified since their inception, these programs increased the role of federal and state governments in making health care accessible for specific populations. Also, they have contributed to portions of our health care system that facilitate everyone's care, such as medical education and research.

Cost containment became a hot issue within five years after the implementation of Medicare and Medicaid. The Johnson Administration, afraid of strong opposition from physicians, had devised reimbursement techniques that

included no cost-containment measures. As a consequence, federal health care spending grew much more rapidly than anticipated.

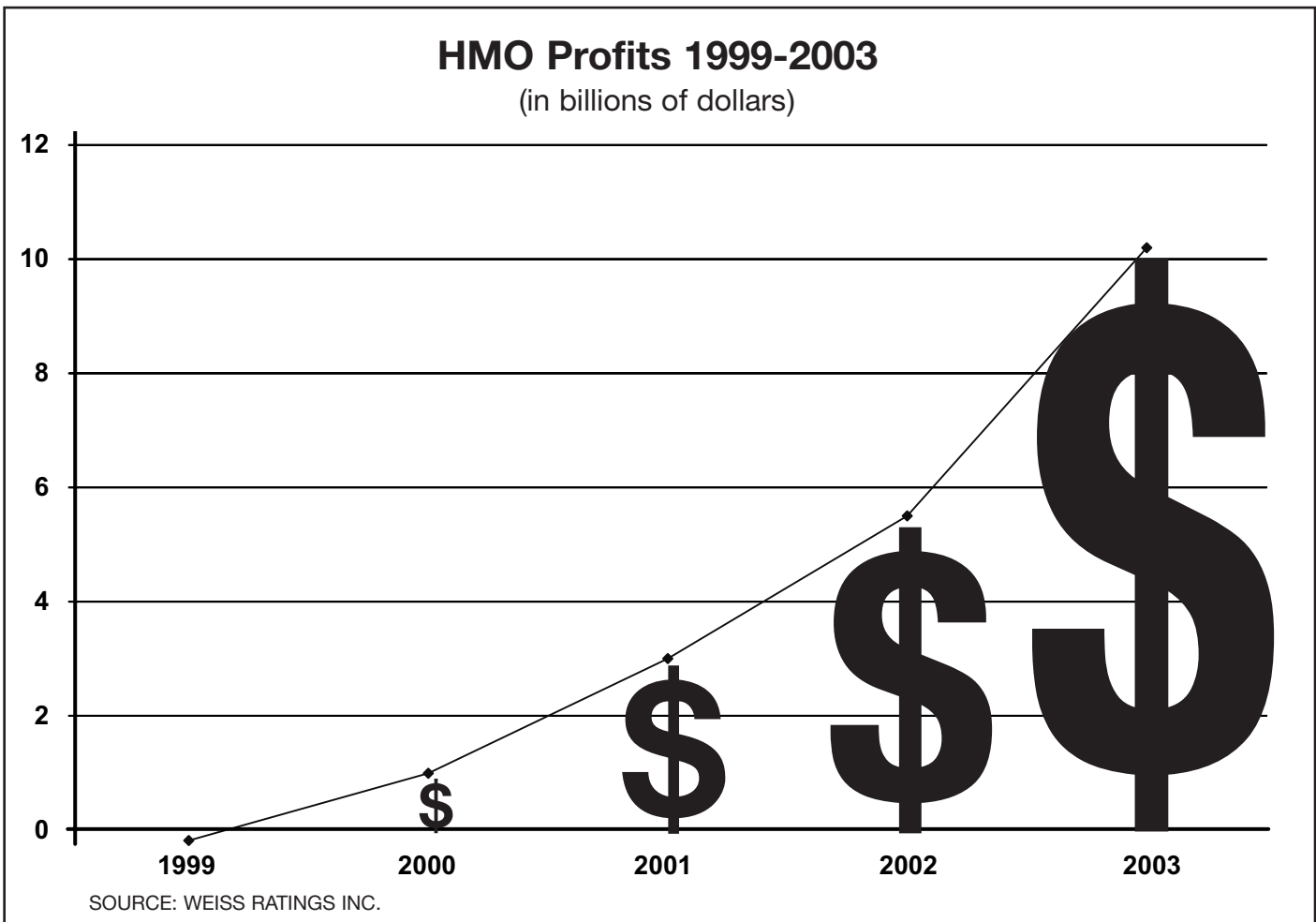
In the 1980s, the federal government introduced by administrative regulation two new methods to control costs.

Hospitals were reimbursed by a "prospective payment" system through which they receive a flat rate for patients with similar problems (Diagnosis Related Groups or DRGs).

Physician payment changed to a Resource Based Relative Value System (RBRVS) in which fees were set by calculations of complexity, time involved, and training needed.

Under these arrangements, hospitals finally had financial incentives to be efficient. There was a lever to reduce grossly excessive historical physician fees. The rate of health care inflation for the government fell sharply. But the health industry, always seeking "greener pastures," recouped its money by raising charges to private payers. This led to major private sector inflation of the late 1980s and early 1990s and the push for managed care.

What is now known as managed care started as "pre-paid group practice," a progressive reform in the middle of the twentieth century that offered workers organized, integrated, comprehensive care with little to no copayments. Ideologically reluctant to support national health insurance



during the cost crisis of the early 70s, the Nixon Administration enacted HMO legislation, primarily with an eye to controlling health care spending. But HMOs did not really take off until the late 80s, when U.S. corporations embraced them as a way of containing costs and forced workers into using them. Starting in the mid 90s, state governments forced Medicaid patients into managed care, while the federal government tried to entice seniors into Medicare HMOs.

In theory, managed care could save money by:

*Managing costs:* Lowering prices through strong negotiations with providers and threatening to take business elsewhere.

*Improving care:* Providing financial incentives and bureaucratic mechanisms that promote less wasteful practice patterns, reducing the quantities of services actually delivered.

Most analysts agree that in the mid-90s, managed care reduced health spending, primarily through strong negotiations that lowered provider prices. But the attempt to reduce quantities of service led to a backlash that undermined its political legitimacy. Beginning with political opposition to particular medical procedures, i.e. state bans on “drive-through deliveries,” the backlash expanded to patient “bills of rights.” Moreover, because they preferentially recruit healthier patients, HMOs do not reduce overall

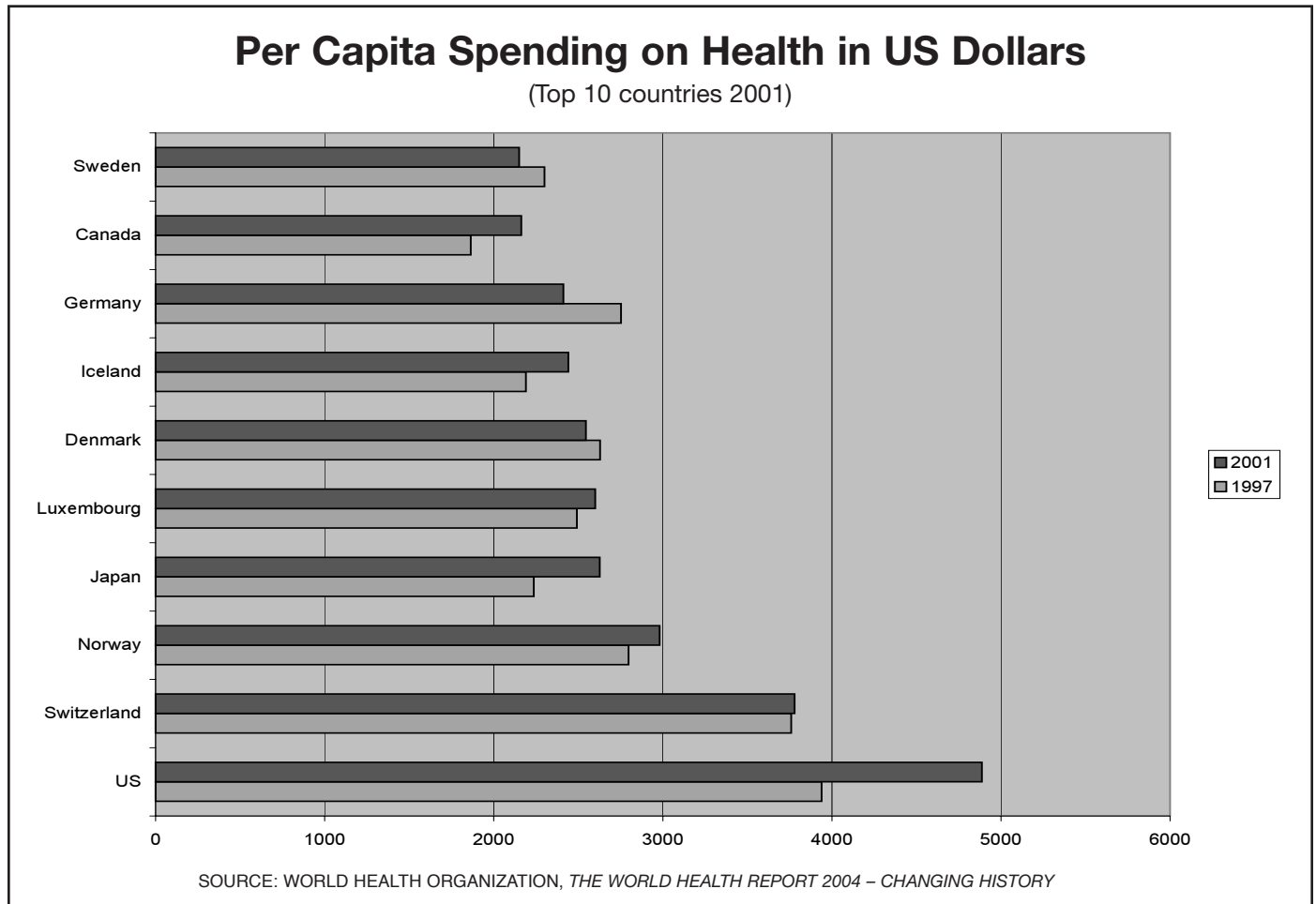
spending. Finally, hospitals in many metropolitan areas have consolidated into for-profit “chains” or not for profit “systems,” increasing their strength at the bargaining table.

## Roots of the Problems in U.S. Health Care

The best way to understand the roots of the problems in American health care is through comparison with other long-standing democracies. The World Health Organization’s *World Health Report 2000: Health Systems: Improving Performance* is the most widely quoted international comparative study.

It offered two main quantitative conclusions. First, the United States ranks first in health care spending. American health care costs twice the average of other industrialized nations, and is a third more expensive than the second nation, Switzerland.

Second, the U.S. ranks 37th in the world in the efficiency of our health care system. In other words, for the dollars we spend, we are obtaining much worse results than other nations. For example, the U.S. ranks 16th in the world in female life expectancy, 17th in the world in male life expectancy. We rate 21st in the world in infant mortality. We have the third lowest rate of childhood vaccination in the western hemisphere.



## Why does the U.S. rank so poorly in health care outcomes and efficiency?

First and foremost, it is because we don't have a national commitment to health care for all.

The technical details of health system financing and delivery in the thirty-six nations that are more efficient than us vary widely, but all differ from ours in the fact that they have real systems that include everyone. Unlike the U.S., with its steadily growing population of the uninsured and underinsured, all persons in these nations have affordable access to comprehensive care.

## The Market Fallacy in health care

Other nations understand that health care is a social good, a public good - a good that benefits all people, like fire departments, police departments, and clean water. The United States stands alone in continuing to treat health care primarily as a market commodity purchased by individuals for their "personal" use.

While the ideology of the market dominates American political and economic discussion today, it is particularly inappropriate in health care. Health care is not a "pure" market for several reasons:

In classical markets, if one cannot afford a commodity,

he does not get it. In health care, even though we do not guarantee affordable access to comprehensive health care to all, we do not want people to die on the streets. There is a legally enforceable right to emergency room access and subsequent hospitalization if needed. So it is not that the uninsured get no health care. In the words of the Institute of Medicine, the care they get is "too little, too late" - and, consequently, less effective and more expensive.

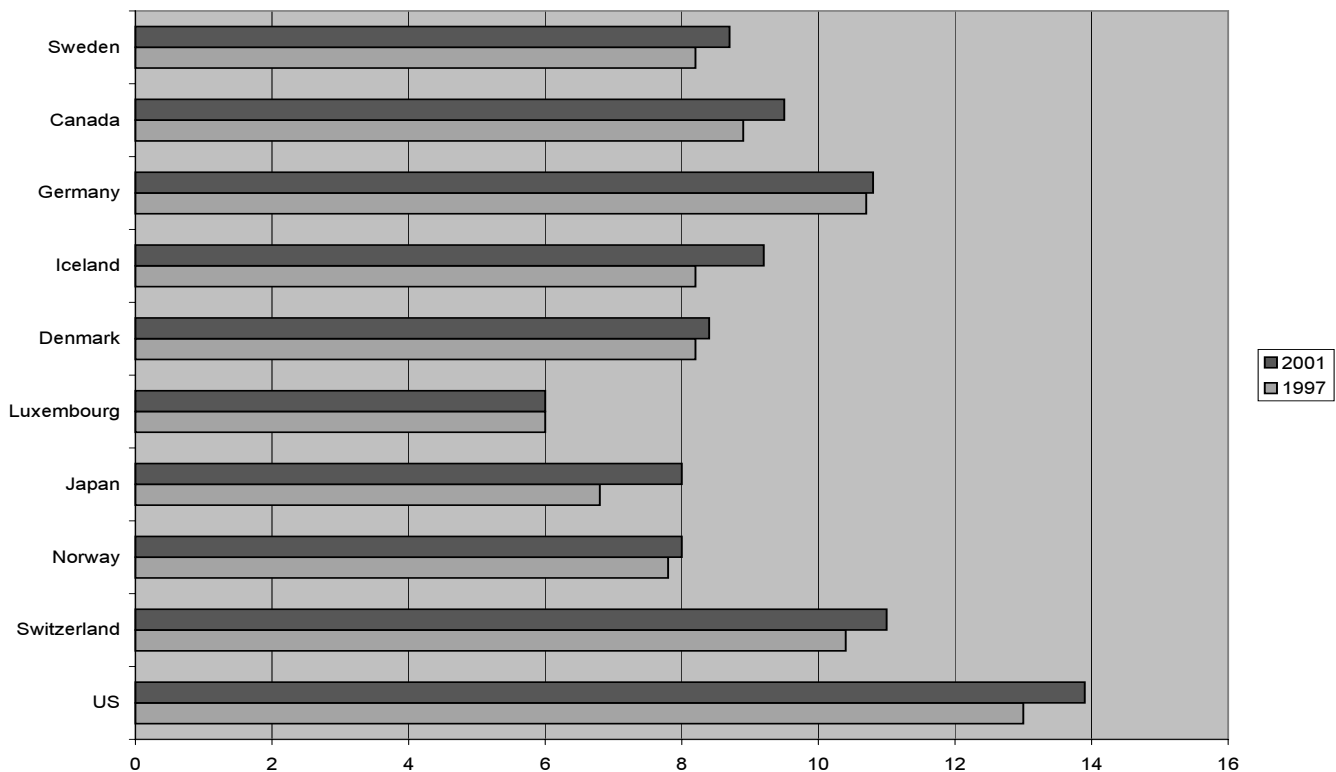
In classical markets, rational consumers make thoughtful decisions on purchases based on price and quality. In health care, patients are rarely totally rational; they are in pain, fearful about their symptoms, anxious. Prices are rarely known. Information on quality is hard to come by.

Entry into the medical field is restricted. No one can simply hang up a shingle and begin treating patients.

Physicians are not perfect substitutes for each other. The doctor-patient relationship requires time to cultivate.

In economics, when a particular market deviates from the characteristics of a "pure" market, attempts to make it perform according to pure market principles will have uncertain effects on overall economic efficiency - and may produce perverse outcomes. This market mentality is the root cause of the three components of the economic problems of American health care: high prices, waste, and excessive fragmentation. But since all economics is fundamentally political economics, the reason these problems persist is

## Spending on Health as Percentage of Gross Domestic Product



SOURCE: WORLD HEALTH ORGANIZATION, *THE WORLD HEALTH REPORT 2004 - CHANGING HISTORY*

the power of vested interests to influence the debate on how to fix American health care.

## Economic Problems in U.S. health care: High costs and waste

High costs and waste impede reform by making it seem as though expanding access is prohibitively expensive. Based on the misconception that overall costs can only be controlled by reducing use of health care services, this illusion has long hampered reform efforts.

High costs are caused by more than merely high utilization. Some causes of high costs include:

- high prices for goods and services, demonstrated most vividly in drug prices;
- high administrative costs due to the enormous complexity of American health care financing (fragmentation) - huge numbers of insurance companies and insurance products, frequent gaps in coverage and changes in plans. (A 2000 study in Seattle already showed that 2277 people were covered by 755 different policies linked to 189 different health plans!)
- economic incentives and cultural expectations that promote clinical practice that excessively utilizes high cost treatments and inadequately reward prevention, chronic care, and information sharing.

## Fragmentation of health care finance and delivery

Unlike health care systems in other western democracies - all of which more or less guarantee comprehensive health care to all residents - American health care lacks

clear lines of authority and responsibility. It is less a "system" than an assortment of haphazard arrangements, with thousands of small players vying for a good spot in the game.

This contributes to the high cost of American health care by making administration, communication, and coordination more difficult and more expensive. Effective solutions will have to "defragment" American health care and simplify it.

## The role of vested interests

Many key players have a vested interest in seeing the fragmentation that characterizes the status quo continue indefinitely. In health care, because the services clinicians, hospitals, pharmaceutical manufacturers, and others provide are seen as so essential, the balance of power is widely skewed in their favor. Even seemingly monolithic government-sponsored insurance is in reality divided into a number of smaller groups.

This has direct consequences for the politics of policy change. Many of those comfortable with the status quo are able to spend a lot of money defending those interests. While the activities of lobbyists and campaign donors may not always determine how politicians vote, they certainly influence how legislation is framed.

## Moving forward: making reform happen

In January 2004, the Institute of Medicine of the National Academy of Sciences issued a report entitled *Insuring America's Health: Principles and Recommendations* that contains five principles to guide and evaluate reform. The United States needs health insurance that is:

- Universal
- Continuous
- Affordable to individuals and families
- Affordable and sustainable for society
- Able to enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable. (IOM: 8-9)

The IOM emphasizes high-quality care because it would be very easy and completely meaningless to expand insurance coverage by leaving patients with complex, expensive, and limited insurance. The ultimate goal of health care reform is to improve health. Expanding coverage is merely a means to that end.

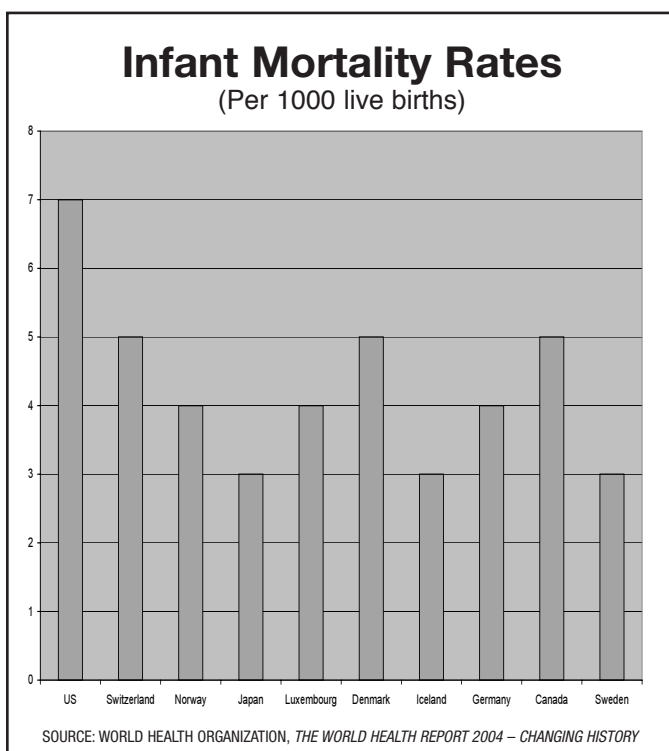
However, providing everyone with access to comprehensive health care has to be undertaken at the same time as we tackle the political barrier of cost control.

A large number of policy solutions have been advanced in recent decades to reform health care. These are best understood as consisting of three broad categories:

*Conservative solutions:* seeing health care as an individual responsibility;

*Liberal solutions:* Expansions of group coverage through employers or public systems;

*Hybrid models.*



## Health Care as an individual responsibility

In this model, individuals are responsible for purchasing their own health insurance. Called the individual mandate, it parallels state requirements for motorists to purchase auto insurance.

**Tax credits.** For those whose incomes are too low, tax credits can be made available. Tax credits can go either to individuals to help them buy private insurance or to companies with low-wage workers to help them purchase insurance. In some of the more sweeping versions of the individual mandate approach, the employer tax deduction for paying for health insurance is eliminated and the funds redistributed as tax credits.

**Health Savings Accounts.** Another approach for holding individuals responsible for making financial choices as consumers about how much care they can afford is the establishment of Health Savings accounts (formerly called Medical Savings Accounts). Individuals purchase a “high deductible” form of catastrophic health insurance. If they stay healthy and don’t spend all their deductible, they can bank it for future use and/or spend it for non-health related purposes.

## Expansions of group coverage: Employer-based

Since most people who are uninsured are workers, one approach is to increase the number of companies offering health insurance. This is known as the employer mandate. One widely used model is called pay or play. In this approach, a company may either purchase health insurance from a private company or pay a payroll tax on its employees to enroll them in a publicly designed and accountable insurance plan.

## Expansion of public insurance

Two models of expanding public financing arise from the two major public programs in the U.S. – Medicare and Medicaid – while a third is based on Canada’s system of public finance.

**Medicare.** Medicare is social insurance, covering all in certain categories of age and disability regardless of their ability to pay. Some proposals build on this social insurance model, putting everyone under Medicare because of the administrative efficiencies of this “single-payer model.” Other proposals pick certain age ranges – children or pre-retirement adults – for Medicare program insurance expansions.

**Medicaid.** A second model of expansion of public financing is targeted to people with low incomes. Enacted in 1965, Medicaid is a means tested program that covers low-income individuals of all ages. The State Children’s Health Insurance Program (S-CHIP), passed in 1997, is an addition that makes children at higher income levels eligible for publicly supported coverage. Some proposals focus on increasing the income eligibility for these programs.

Public financing also can be targeted to assist community health centers to improve access in poor neighborhoods.

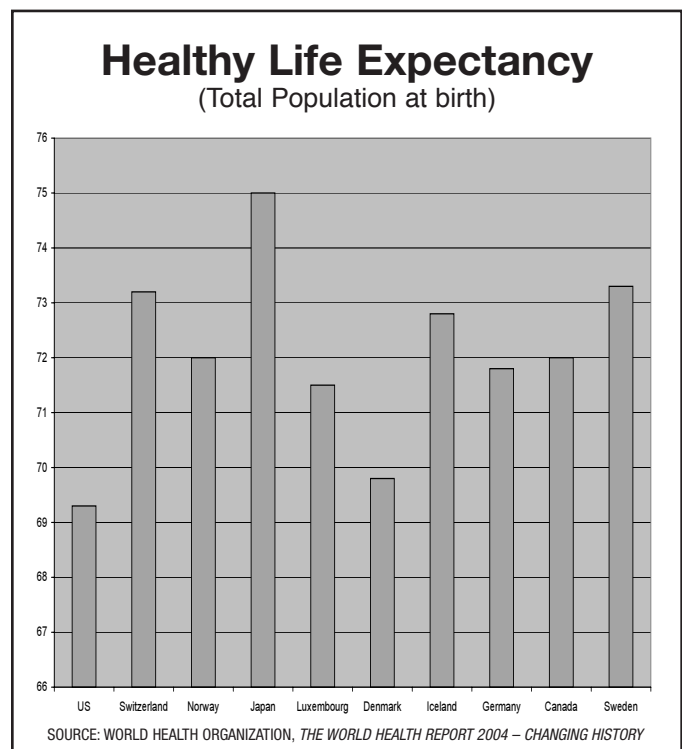
**Single-payer.** Single-payer or “Canadian style” health care means that the government becomes the exclusive insurer and financier of health care. All Canadians pay taxes – some of which are earmarked for health insurance – and all Canadians are automatically enrolled in the provincially run insurance programs. Costs in the Canadian system are lower because of much lower administrative costs, the ability to bargain for lower prices from providers and suppliers, organized planning and sharing of major capital expenditures, and an emphasis on preventive, chronic, and primary care.

## Hybrid models

Recognizing the long-term political deadlock on comprehensive health reform, some proposals mix reform elements popular with different constituencies.

**Public program expansions and tax credits.** Commonly, hybrid proposals at the federal level include both public program expansions and tax credits. Medicare, Medicaid, and possibly S-CHIP would cover more categories of patients. Tax credits would be offered to businesses who insured their employees and private individuals who chose to purchase insurance.

**Federalist Model.** A second hybrid approach uses states as “laboratories of democracy.” In the federalist model of comprehensive health care reform, national legislation offers federal financial support to states implementing universal health care plans that meet federally established standards of affordability, comprehensiveness, cost containment and public accountability. States could choose any



one of a variety of models consistent with their local political cultures and institutional structures.

## Fixing American Health Care

Fixing American health care is not “rocket science,” but “political science.” We may or may not need more money for health care. We certainly need more health care for our money.

We offer three broad suggestions to make the health care justice movement more strategic and savvy.

Making change involves recognizing what needs to change and who needs to be involved. In the U.S., the first part of the prescription means honestly assessing and planning for cultural and institutional resistance to change. The activist should be equipped with arguments for universal, comprehensive health care that speak to everyone across the political spectrum. The second part of this prescription, recognizing who needs to be involved, means that activists should identify and target key players in the health care politics game. In particular, this entails appreciating the power of health care special interests and learning to work with them or to undermine them at key points.

Fixing health care isn't just a question of “may the best plan win.” There are no plans that are best for everybody. Instead, there are plans that do a reasonable job of balancing competing interests, plans that better reflect the financial interests of interested parties, and plans that better reflect the health needs of individuals and communities. There are plans that are focused on providing a bare minimum or changing as little as possible, plans that aim for truly comprehensive care, and plans that aim to change as much as possible. All plans involve some compromises between competing interests. For us, the best plans will be those that build effective coalitions that are compatible with the ideals of justice in health care - comprehensive

care, fair financing, and accessible delivery.

There is a dialectic between the long-term goal of achieving universal health care and the short-term goal of improving access and affordability. Many health care justice activists believe that only a federally funded and regulated health care system will solve the problems of access, quality, and cost currently facing us. Others believe that the current health care system is such a mess that any legislation improving access or controlling costs is better than the status quo. The challenge for health care justice advocates is to strike a balance between working for long-term change and supporting short-term fixes, between holding fast to ideals of equality and justice and finding practical paths to improving access and quality. This task is daunting but not impossible. Equipped with a basic understanding of the health care system, a working map of the political system, and the conviction that health care justice is possible and worth striving for, we can make change happen.

We need to be loud, constant, and articulate advocates for including everyone, spreading costs fairly, and using limited resources in a way that best improves the health of the largest number of people. While working in broader coalitions to achieve modest but immediate improvements in the health care system, we must keep our eyes on the prize: universal health care. We must remind our fellow citizens that no nation ever achieved universal health care through pure market mechanisms. As the United Nations recognized in its Universal Declaration of Human Rights over 50 years ago, health care is a human right, not a commodity.

*This pamphlet has been adapted from Seeking Justice in Health Care: A Guide for Advocates, produced by UHCAN, the Universal Health Care Action Network. Individual or bulk copies of the Guide can be purchased from UHCAN by going to [www.ubcan.org](http://www.ubcan.org) or by calling 216 241-8422.*

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