



FACTS & ISSUES

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League of Women Voters of the Houston Area

HEALTH CARE

Our top domestic concern today is health care. The combination of spiraling costs, declining employer coverage and growing numbers of Americans without health insurance has prompted consumers, employers, lawyers, and the medical industry to call for change.¹

THE PROBLEM

Rising Costs: Health care coverage costs rose 6.1 percent this year, reports the *Houston Chronicle* 12 September 2007,² an increase more than double the rate of inflation and greater than wage increases. Indeed, Americans spend more on health care per person than anyone else, \$6,102 in 2004, according to Anderson, Frogner, and Reinhart in *Health Affairs*.³ These authors note this is 15.3 percent of gross domestic product. Only seven other countries spent more than 10 percent of their GDP on health care.⁴

Paul Krugman argues that the US health system is extremely inefficient, and this inefficiency becomes more costly as the health care sector becomes a larger fraction of the economy.⁵ Inefficiency is not to be desired for any reason, but the inefficiency of our health care system exacerbates a second problem: our health care system makes irrational choices, and rising costs exacerbate these irrationalities. American health care divides the population into insiders and outsiders. Insiders with good insurance receive the very best of care. Outsiders with no or poor insurance receive very little. For example, Krugman reports one study that found among Americans diagnosed with colorectal cancer, those without insurance were 70 percent more likely than those with insurance to die over the next three years.⁶ Nearly one-third of adults and more than half of all children do not have a primary care "medical home."⁷ As Gail Shearer puts it, "the record is clear: uninsured people get inadequate care."⁸

We may be spending more but our citizenry collectively are getting less. Not only are we quantitatively failing to provide health care for Americans, qualitatively the care provided leaves something to be desired. Anderson and Hussey compared health system performance in twenty-nine industrialized countries in 1998, finding that on most indicators the U.S. relative performance declined since 1960.⁹ The United States showed the greatest relative decline in life expectancy at birth for females, life expectancy at age sixty for females, and in infant mortality. Life expectancy at birth and at age sixty remained in the mid-range of the study countries. In a similar study using a new scorecard, Schoen, Davis, How,

and Schoenbaum conclude that the United States has broad opportunities to improve: "Cost and coverage, vital signs, are moving in the wrong direction. To assure a healthy, productive nation, transformation of the health system is of great urgency"¹⁰

Declining Employer Coverage: Krugman reports in 2003, only 16 percent of health care spending consisted of out-of-pocket expenditures by consumers with the balance paid by private or public insurance.¹¹ Insurance is the only way modern medical care can be made available to anyone other than the very rich. It is difficult for the private sector to provide insurance because health insurance suffers from a particularly acute case of a well-known economic problem known as adverse selection. If an insurer offered policies to anyone with the annual premium set to cover the average person's health expenditures, the pool would be heavily weighted toward those who are unhealthy. Very healthy individuals would seek a cheaper policy because they expect low medical bills. Only if the risk pool included everyone could the insurer charge a premium to cover the average person's health insurance. In 2004 the Census Bureau estimated that 63.1 percent of Americans less than sixty-five years of age received health insurance through their employers or family member's employers, down from 67.7 percent in 2000.¹²

Rising Tide of the Uninsured: The Census Bureau reports that in 2006, while the poverty rate fell, and median income rose, the number of Americans without health insurance rose to an unprecedented 47 million, including 8.7 million children.¹³ Texas had the highest three-year average uninsured rate of 24.1 while in Harris county 30 percent or almost one in three persons are uninsured.¹⁴

POSSIBLE SOLUTIONS

No other industrialized nation delivers health care in a manner similar to the US. In Great Britain and Spain health care is delivered through "socialized medicine."¹⁵ Socialized medicine is a system in which physicians and hospitals are employed by the government and draw salaries from the government. In Great Britain, however, individuals who wish to use private practitioners are free to do so, but no reimbursement is provided. In most European countries, Canada, Australia, and Japan, health

care is financed by government but delivered in the private (mostly not-for-profit) sector.

Physicians are in private practice and are paid on a fee for service basis from government funds.¹⁶ One country, Holland, has a system first proposed three decades ago by Alain Enthoven called “managed competition.” Holland’s system adopted in 2006 features two rules: all adults must buy health insurance and all insurers must offer a policy to anyone who applies. Funds from tax revenues aid those who cannot afford to pay premiums. The real test of the Dutch approach is yet to come reported Gautam Naik in *The Wall Street Journal*.¹⁷

The US health system is more privatized than any of the other industrialized countries, but Paul Krugman reminds us that nearly half of total health care spending still comes from government.¹⁸ Medical care for the armed services and veterans is indeed socialized medicine; here physicians of the Veterans Administration and the Armed Services are employed by government. Two large social insurance programs, Medicare and Medicaid, however, account for most of government spending. In 2004 Medicaid covered almost as many people as Medicare—37.5 million compared to 39.7 million. CHIP represents the newest social insurance program for children. While Medicare is a federal program, both Medicaid and CHIP are federal-state matching programs. Krugman notes that the complex structure of these federal-state matching programs makes these programs particularly vulnerable to the political system. ¹⁹ The recent SCHIP veto and subsequent curtailment is but one example of how difficult it is to expand the social safety net.

The “Consumer-Directed” Solution. The view that Americans consume too much health care because insurers pay the bills is currently being termed the “consumer directed” approach to health care reform. Defining features of these plans tend to be high deductible policies (e.g. \$5,000) combined with a contribution by the employer to a health care savings account, at a level that leaves the consumer exposed to some out-of-pocket costs before the high deductible is met. Gail Shearer argues that “consumer-directed” health care is better termed “defined contribution” health care. ²⁰ Cogan, Hubbard, and Kessler in *Healthy, Wealthy, and Wise* call for making all out-of-pocket medical spending tax-deductible, a proposal the Congressional Budget Office deems unenforceable.²¹

Other proposals in this vein are “health savings account,” termed by Krugman as tax breaks for the wealthy. ²² Health savings accounts have not been embraced wholeheartedly. According to Hewitt Associates 94 percent of companies offer health savings accounts, but only 23 percent of employees sign up.²³ *The Wall Street Journal* reports **Rudy Giuliani** would offer a new tax break to buy insurance on the open market and suggests voucher or tax refunds to help low income families. ²⁴ Some policy makers have advocated tax credits to help the uninsured purchase coverage. To see the effect a \$1,000 tax credit would mean for low-income uninsured people,

Families USA analyzed information about insurance plans offered in 50 states and the District of Columbia. They found that \$1,000 health plans are not available or are substandard.²³ The landmark Community Tracking Study for nine years conducted periodic interviews in sixty communities with 60,000 households and 12,000 physicians, and additional surveys of employers and insurers. Their most recent findings show deep skepticism about the ability of market-based reforms to produce urgently needed improvements in the efficiency and quality of the nation’s health care system.²⁶

The Insurance Mandate Solution: Others advocate mandating that individuals purchase insurance and/or that employers offer insurance or pay a special tax. Massachusetts is one state that is experimenting with this system. *The Wall Street Journal* now reports **Mitt Romney** rejects the individual and employer mandates that he supported as Massachusetts governor and advocates tax breaks for individuals to buy insurance, boost flexibility for states, and encourage states to ease insurance regulations such as those mandating certain benefits.²⁷ *The Journal* reports **Hillary Rodham Clinton** wants to require all Americans to get health insurance, bar insurers from denying coverage and provide subsidies for low-income people. Large employers would have to provide insurance or help pay for it. **John Edwards** would require all Americans to have insurance, with lower-income subsidies for lower-income families, require companies to provide insurance or pay into a government fund, and create a new federal plan that could be the basis of national health insurance. **Barack Obama** would require employers to provide coverage or face a penalty, provide subsidies for lower-income families; let people buy coverage through new exchanges or from a new government-run plan modeled after Medicare.²⁸

Pre-Paid Plans: Several hundred doctors across the country offer flat rate, pay-in advance plans. A clinic in West Virginia has a monthly fee of \$83 per individual or \$125 per family for unlimited primary and urgent care. Those who enroll get office visits, lab work, X-rays and as many generic drugs as the clinic can provide.²⁹ Another in Sugar Land has a \$1,800 yearly fee.³⁰ Some plans, known as concierge medicine cost \$5,000 to \$10,000 annually. *The Houston Chronicle* quotes Dr. Clarence Braddock, III, an internist and ethicist at the Sanford Center for Biomedical Ethics, “Despite all the ethical difficulties I have with concierge medicine, it’s hard to disagree with where a lot of physicians are coming from. More than anything, I think, the rise of concierge medicine is an indictment of the current health care system.”³¹

The Single-Payer System. Paul Krugman and others argue that the main reason US health care costs so much is the unique degree to which the US system relies on private rather than public health insurance.³² The cost advantage of public health insurance arises from two main sources: lower administrative costs and the ability to bargain with suppliers, especially drug companies for lower prices.

Medicare's overhead is 1.5 percent compared with 13 to 16 percent in the private sector. Jane Bryant Quinn in *Newsweek* cites John Shields of the Lewin Group, a health-care consultant who argues that health insurers' overhead came to \$120 billion in 2006, of which \$40 billion was profit and by comparison it would cost \$54 billion to cover all the uninsured. 33

Woolhandler, Campbell, and Himmelstein examined health administration costs in the United States and Canada in 1999.³⁴ They found administration accounted for 31.0 percent of health care expenditures in the United States and 16.7 percent in Canada. Canada's national health insurance program had overhead of 1.3 percent. Providers' administrative costs were far lower in Canada. They conclude, "the difference in the costs of health care administration between the United States and Canada is clearly large and growing. Is \$294.3 billion annually U.S. health care administration money well spent?"³⁵

Woolhandler and Himmelstein of Harvard Medical School argue that we are already paying for national health insurance and not getting it.³⁶ They argue that the current tax-financed share of health spending is far higher than most people think, 59.8 percent. The figure includes health care-related tax subsidies and public employees health benefits. These authors argue "the *sub rosa* character of much tax financed health spending in the United States obscures its regressivity. Public spending for care of the poor, elderly, and disabled is hotly debated and intensely scrutinized. But tax subsidies that accrue mostly to the affluent and middle-class government workers are mostly below the radar screen."³⁷

Physicians for a National Health Program advocate a single payer system. 38 Their proposal would leave intact the public financing for Medicare and Medicaid. The gap needed for a universal health care system would be financed by a payroll tax on employers (7 percent), and an

income tax on individuals (2 percent). The payroll tax would replace all other employer expenses for employee's health care. The income tax would replace all current insurance premiums, co-payments, deductibles and other out-of-pocket payments. They argue that in a publicly financed, universal health care system, medical decisions are left to the patient and doctor.

The American Cancer Society argues, "Winning the war on cancer depends on expanding access to health care. "Individuals and families who lack meaningful insurance often go without preventive care despite research showing that early detection and timely treatment are effective in improving outcomes....Cancer patients having no insurance or inadequate insurance have higher medical costs, poorer outcomes, and higher rates of death." 39 The American Cancer Society in conjunction with the American Cancer Action Network says that meaningful access to health care includes **adequate, available, affordable, and administratively simple** health insurance that **limits "cherry picking."**⁴⁰

League of Women Voters. In 1990 the LWVUS undertook a two-year study of the funding and delivery of health care in the United States. In April 1992 the League's position called for a national health insurance plan financed through general taxes, commonly known as the "single-payer" system.⁴¹ The final position released in April 1993 reads in part "The League favors a national health insurance plan financed through general taxes in place of individual insurance premiums. As the United States moves toward a national health insurance plan, an employer-based system of health care reform that provides universal access is acceptable to the League. The League supports administration of the U.S. health care system either by a combination of the private and public sectors or by a combination of federal, state and/or regional government agencies."⁴²

Endnotes

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