# Universal Health Insurance—Let the Debate Resume

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The article by The Physicians' Working Group for Single-Payer National Health Insurance[1] in this issue of THE JOURNAL should re-energize the much needed debate on universal health insurance. More than 40 million Americans lack health insurance[2] and nearly 60 million are without health insurance for a portion of the year.[3] Employers face rising health insurance premiums, and their employees face increasing cost-sharing. There are ongoing and increasing disagreements about health benefits coverage. Physicians, hospital administrators, home health agency financial officers, and others are increasingly frustrated with the confusion and inefficiencies of the current multiple payment mechanisms. In these fiscally troubled times, state legislators are having difficulty finding funds to support Medicaid and free-care pools. Clearly, there must be a "simpler and better way."

Proposals for and debates surrounding universal health insurance certainly are not new. It has now been a decade since President Clinton put forth his Health Security Plan for universal insurance, some 30 years since President Nixon proposed his Comprehensive Health Insurance Program, and more than 5 decades since President Truman failed to get his proposed program enacted.[4]

Today, the issue of universal health insurance remains on the agenda because policymakers have been unable to reach agreement on what that "simpler and better way" is, and consequently have failed to act. Some might deny the dimensions of the problem, arguing that the uninsured receive free care at US hospitals and charity care from many of the nation's physicians. They know the proportion of US citizens who lack health insurance or are underinsured but cannot believe that translates into less care.[5] Furthermore, some might argue that "the others" (ie, the uninsured) brought health problems on themselves by their lifestyles: if "they" would eat less, smoke less, drink less, and exercise more, they would need less medical care.

Nevertheless, most Americans agree that the various reports documenting disparities in access and in health care, ie, those disparities related to insurance status, are compelling. Most Americans agree that they would not want to be uninsured or underinsured. Furthermore, most Americans are disturbed when they read that their physicians are pressed to work harder and faster even as their incomes decline, and most Americans believe that something has to be done about health care.[6]

Failure of the Clinton Administration's effort to reform the health care system served to virtually eliminate discussion of universal health insurance from the US public policy agenda. This attempt to expand insurance was quite different from the debate about Medicare. That effort was sustained over almost a 10-year period (1957-1965) during which the American public and its legislators came to understand the "problem" and the various ways that persons across the political spectrum, from Senator Taft to Senator Anderson, preferred to solve it. The bill that was finally enacted represented a major improvement over the measure that was first submitted. That improvement was, in part, the result of educational efforts that engaged all protagonists and the public at large and, in part, because of agreement that elderly persons faced real problems in obtaining health insurance and that government had to find a solution—either through the public sector, the private sector, or, as it turned out, some combination of the two.

Conversely, when the Clinton effort failed, there was no agreement that government was required to find an answer and skepticism that it was wise enough to do so. There were no sustained educational efforts that continue into the present. Yet, from the perspective of the uninsured and the insured with higher cost-sharing, employers and governments with severe budgetary obligations, and physicians and other health care professionals, the problems have worsened and the valuable dollars spent trying to administer the dysfunctional system have increased.

For these reasons, the article by the Physicians' Working Group is particularly important. Whether one agrees or disagrees with the approach that nearly 8000 physicians and medical students have endorsed, this group has provided a considerable service by fanning the almost extinguished spark called universal health insurance. Perhaps the most noteworthy aspect of this article is that by offering its approach, the Physicians' Working Group issues a challenge: those who reject its "solution" are challenged to present its own, better and stronger one as a replacement. Thus, it will not suffice simply to dismiss the Physicians' Working Group solution as unworkable. The American health care system and American society face a real problem and are compelled to search for an answer.

The Physicians' Working Group proposal has the virtue of simplicity. For instance, Louise, from the well-known "Harry and Louise" advertisements against the Clinton proposal, might still say that there is a better way, but she could not complain that she cannot understand how the single-payer proposal would work. Indeed, she and tens of millions of Americans need only refer to Medicare to get the broad picture of the proposed "single-payer national health insurance," an expanded and strengthened "Medicare-for-all" system.

The proposal also has the (not unrelated) advantage of administrative efficiency. Enrollment would no longer be related to employment (as with most private insurance) or income status (as with Medicaid). Similar to Medicare for those older than 65 years, the plan would reflect a "once enrolled, always enrolled" approach. Similarly, on the payment side of the ledger, a single rather than a set of multiple payers would reduce the administrative load on individual practitioners and hospitals. All patients would have the same broad coverage, and all payments would come from a single source. Not surprisingly, even as President Clinton rejected this approach, he indicated that this (Canadian-like) way of doing things would save millions of dollars.[7]

The proposal has numerous other features, one of which, although extraordinarily difficult to attain, would help return medicine to its earlier honored status—the elimination of for-profit institutions and the corporatization of medicine and return to the broad-based not-for-profit community hospital and prepaid group practice. America's physicians have never looked to government as their savior. However, while they were guarding their flanks against "big government" and its power, they were blind-sided by employers who discovered they could bargain with insurers over benefits and premiums, by insurers who—responding to employers—exercised control over issues of productivity, requiring more "output" at lower reimbursement, and by managed care organizations who organized delivery systems that tried to preempt the physician's independence and exercise of clinical judgment. Although American medicine may fear government's exercise of arbitrary power, government is accountable. The real danger lies in the faceless, inexorable, profit-motivated market, an institution from which there is no appeal.

Yet, the single-payer approach was rejected by President Clinton even as he spoke about its advantages. Similarly, others who believe that this "Medicare for all" system is the most efficient and most equitable answer have sought and moved to other alternatives. Why have they done so? Is it because there is a yet unmentioned weakness in the Physicians' Working Group proposal? Is it because some other alternative is inherently better?

While some "dangers" are inherent in the proposal, these dangers most likely can be met by the exercise of democracy. If the money that fuels the system flows through government, it means that government may choose to spend too little and then try to compensate for that shortfall by reducing reimbursements, classifying drugs and procedures as "experimental" and not reimbursable, and engaging in other "shenanigans" designed to shift responsibility to others for the queues for appointments, decline in quality of nursing care, lack of capital investment, and so forth that may occur. That outcome is as true in medicine as it is in every facet of US society, including education, highways, national parks, bioterrorism defense, and the like. The ballot box is the answer. Given the dollars that now enter into election campaigns and the low voter turnout, that may not be an especially strong rod. Even so, it is a stronger rod to lean on and is likely to be more effective than an appeal to the kindness and generosity of the market that, in a quest for profits, may also "underspend."

A second "problem" with the proposal is that it calls for a massive restructuring of the flow of dollars in the system. There is little doubt that this would affect labor-management negotiations and long-existing arrangements by which the money entering the system now flows. These matters can be managed, but there is no way around a single-payer approach requiring an increase in taxes. Although these taxes would substitute for existing premiums and out-of-pocket payments, they would be new and visible. It is clear, therefore, that such a proposal would require sustained efforts at education, strong leadership, and patience.

Thus, the compelling reason this Medicare-like approach (which was taken very seriously in the late 1960s and early 1970s) has failed to receive political support in recent years does not lie in its analytical strengths or weaknesses, but elsewhere. The rejection comes because of a widely held view that the single-payer approach is too radical in that it simply is too much for the political system to handle, and therefore would never pass.

This is not a position that can be dismissed lightly. In recent years the US political system has provided little evidence of its ability to handle major comprehensive legislation. The electorate and the Congress are closely divided, and the days of true bipartisanship that operated under a slogan of "come let us reason together" seem to have been replaced (at least, temporarily) by a certain mean spiritedness that does not search for compromise, but advantage. There is little agreement that government has to find (or be part of) an answer to the health insurance problem. It hardly seems to be a time for more than incrementalism (at best) and, most assuredly, that is not what a single-payer system is.

But Medicare took almost a decade to be enacted into law, and it is reasonable to argue that any comprehensive reform not only will, but should, take time—time for the nation to be educated, time for improvements in specifications to be offered, time for alternatives to be discussed, and time for defensible cost estimates and financing implications to be developed. Time is also needed to examine the principles, aims, and objectives of the single-payer proposal and consider whether those goals are attainable through other methods that trade off efficiency for political acceptability.

Now is the time to reopen that discussion. The members of the Physicians' Working Group have done their job by raising the issue of national health insurance once again. Those who like their proposal should join with them. Those who do not should develop and propose something better, more effective, and with fewer untoward side effects. No one should sit back and bemoan the existing state of affairs. The "health care mess" is too real for anyone to ignore it.

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