

A Plan for Universal Health Care

PDA Health Care Working Group

For more than a decade health care policy in the United States has languished under misguided principles. The result has seen a decade of increasing costs, lagging quality, and rising numbers of uninsured. Fewer Americans are able to receive needed health care. American businesses are straining under the burden of double-digit health benefit cost increases each year.

The mission of the Universal Health Care Task Force, a committee within the Progressive Democrats of America, is to provide information about basic health policy and economics.

This policy paper offers a health care plan that is responsible and conservative, meaning:

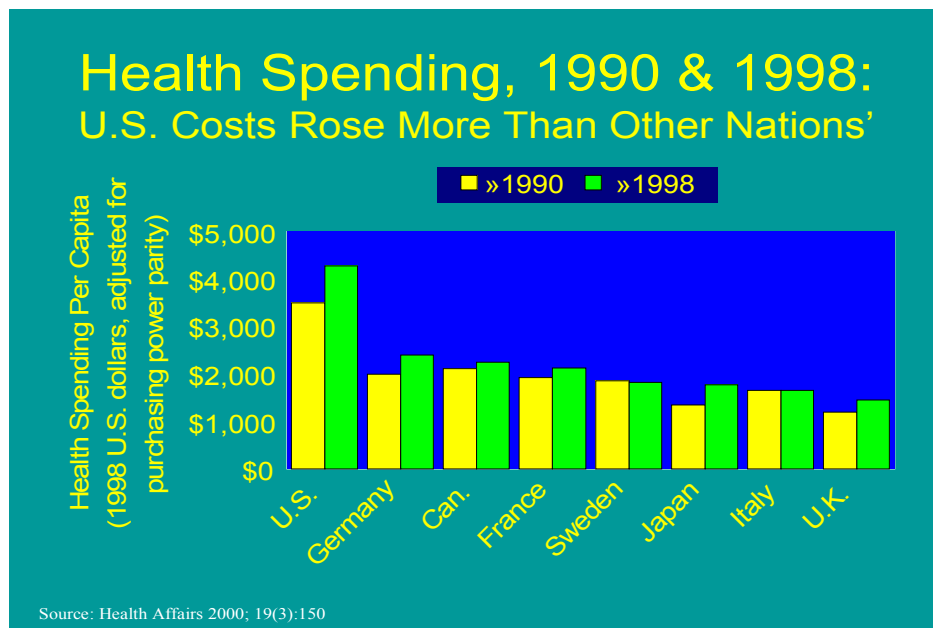
- 1) It is a plan that requires no net increase in per capita revenues for health care to fund it;
- 2) It is a business-friendly proposal that will relieve businesses in the US from double-digit annual increases in the cost of health benefits;
- 3) It is a patient-centered proposal; all medically necessary care and the unrestricted choice of physicians is guaranteed;
- 4) It preserves the American tradition of non-profit, community-based, private hospitals and health care delivery;
- 5) It would protect fee-for-service medicine.

A HEALTH POLICY BRIEFING: AN OPPORTUNITY FOR A UNIVERSAL HEALTH POLICY

Our premise is quite simply that the citizens of the United States deserve better health care and a better health care policy.

THE BASIC FACTS

Table 1

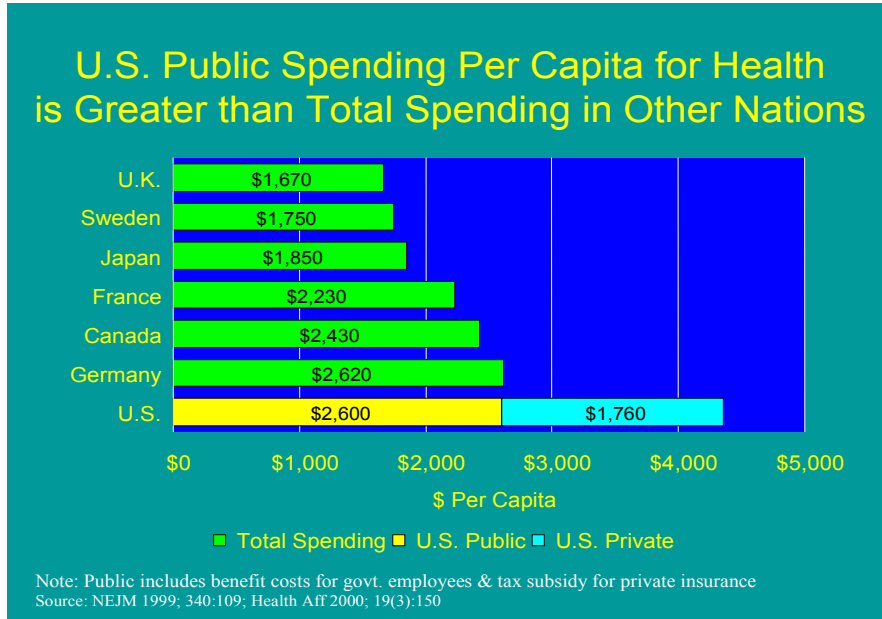


Per capita health spending in the United States is twice as high as the amount spent in other industrialized countries, and spending is rising faster in the US than anywhere else in the world. The US Department of Health and Human Services estimates that per capita health spending in 2004 will exceed \$6000.

BASIC POLICY FACT: Americans have generously funded health care; no more per capita spending should be needed to cover all US citizens.

Table 2

Per capita spending on health care by the US taxpayer (represented by the yellow bar) is greater than

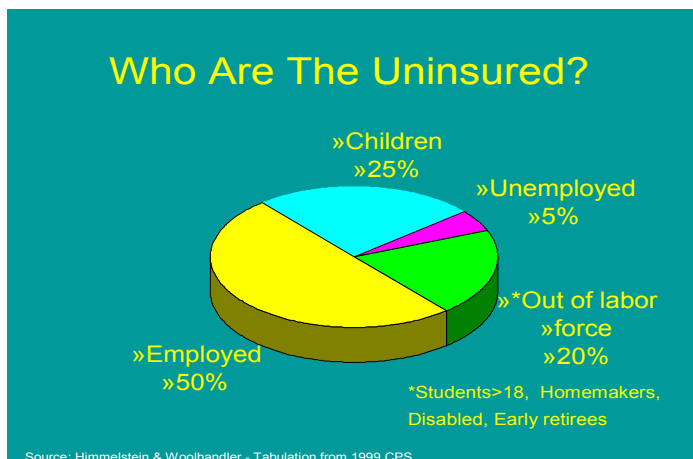


similar spending by the taxpayers of any other country (represented by the green bars). Unlike the citizens of any other country, however, after bearing the world's greatest burden for health care taxes, the US citizen then spends an additional 40% more on health care (represented by the light blue bar). About half of this additional 40% is paid by private employers for employee health

benefits, while the remaining half of the additional 40% is paid out of pocket by private citizens for premiums, co-payments, deductibles, and point of service costs.

BASIC POLICY FACTS: 1) American taxpayers pay the world's largest tax burden for health care; 2) the American health care system is primarily a tax-based system, not a system mostly paid by private employers; 3) Individual out-of-pocket expenses for health care are in aggregate as large as the share paid by private employers, with individual out-of-pocket expenses growing faster.

Table 3



People with no health insurance in the United States are either employed or dependent upon someone who is employed (with few exceptions).

BASIC POLICY FACT: Because uninsured Americans are virtually all members of working households, they are contributing to the payment of the world's greatest health care tax burden, but have no financial support when they need health care. This could be the most unfair tax policy in our society.

Table 4

The non-profit, non-partisan Institute of Medicine found that more than 18,000 adults ages 25-65 die

18,314 Adult Deaths Annually Due to Uninsurance

Age Group	Deaths
25-34	1,930
35-44	3,431
45-54	4,734
55-64	8,219
Total	18,314

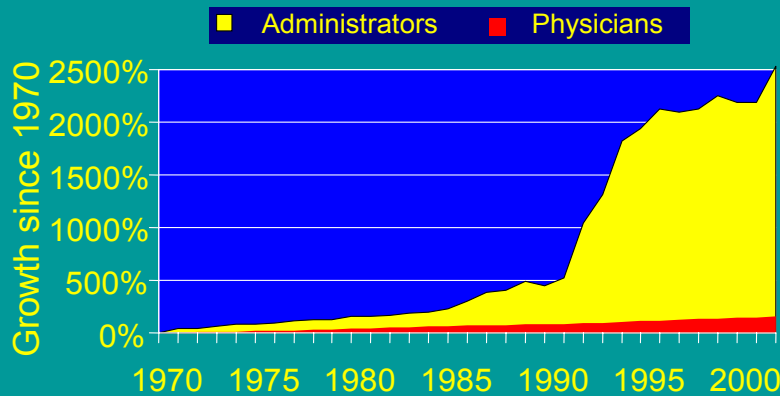
Source: Care Without Coverage. Institute of Medicine, 2002

annually due to lack of health insurance. This observation qualifies lack of health insurance as one of the most important causes of preventable premature death in the United States. No other developed country has an epidemic of adult death due to lack of health insurance.

Table 5

American health care costs are twice the median per capita spending of other developed nations not

Growth of Physicians and Administrators 1970-2002



Source: Bureau of Labor Statistics & NCHS

because Americans receive more hospital care, visit physicians more often, or have more high tech medical devices, but because America leads the world in health care bureaucracy. Over the last thirty years of the 20th century, the number of physicians doubled in the US (red wedge) while the number of health care bureaucrats increased 2,500% (yellow area). These bureaucrats are largely in the private sector, staffing the benefit denial

activities of health insurance and managed care companies, or the billing departments of hospitals and doctors offices.

BASIC POLICY FACT: By reducing bureaucratic staff and red tape, Americans would save close to \$300 billion each year, enough to pay for medically necessary care for all citizens without increasing overall per capita costs.

BUSINESS INTERESTS IN HEALTH CARE REFORM

Less than a year ago, while preparing for another round of labor negotiations dominated by health care issues, William Clay Ford, Jr., chairman of Ford Motor Co., said that the rising costs of health benefits is the “biggest issue” that American businesses can’t solve. “Health care is just out of control, it’s a system that’s broke.”¹ He noted that the US is the only industrialized country with employer-based health care, putting US businesses at a competitive disadvantage in a global economy. Ford called for a national solution to the American health care crisis. Without such a solution, all North American cars may someday be manufactured in Canada, where labor costs are significantly cheaper primarily because health care financing is much more efficient.² Wall Street analysts have already begun referring to the Big Three American automakers as HMOs with wheels that only incidentally make cars to finance health care.³ American businesses, pay 8 times more internal costs for arranging health benefits than do Canadian businesses.⁴

SIX PRINCIPLES OF HEALTH CARE REFORM

1st Principle: Finance medically necessary care for all American residents.

All health professional organizations have called for some form of universal health care financing. Four in five Americans, polled repeatedly over many years, have called for universal health care. This consensus exists because we all know the devastating consequences that occur when people cannot afford health care. The Institute of Medicine, or IOM, estimates that more than 18,000 American adults die prematurely each year because they lacked health care financing. A Harvard Law School study estimated that nearly half of all personal bankruptcies are caused by costs associated with illness or injury in the family.⁵ Costs for employee health benefits have been rising with double-digit annual inflation for four years. Church and community charities are depleted by medical welfare needs. Because Americans pay a higher tax burden for health care than do the taxpayers of any other country, the working uninsured in the US are paying the highest health care taxes in the world without receiving any benefit when they need medical care. Relief from all these problems can only occur when every citizen has financing for all medical services determined necessary by their own doctor.

2nd Principle: Patients should be able to make an unrestricted choice of any willing, licensed provider of health services. Doctors should have no greater obligation than the one owed to their patients.

Without a protected relationship between doctor and patient, the trust needed for full patient disclosure cannot develop; no doctor can offer the best care when only part of the patient history is known. Patient care is not an assembly line process with quality control imposed by supervision from outside the therapeutic alliance. The intimate doctor-patient relationship, protected from invasion by business interests, is the guarantor of quality health care. Americans lag behind other developed countries in assessment of health care quality, ranking 37th in the world while outspending any other country 2:1. Americans are least able among first world citizens to maintain long-term continuity with their chosen physicians. Business interests increasingly rob the patient of unrestricted choice of doctor while doctors find themselves subject to contractual obligations for increased patient caseloads, gag orders, and financial risk for patient referral. Bureaucratic hassle is toxic to quality health care. The only health care decision a patient can make unassisted is choice of doctor; all other decisions are best made together with a trusted

¹ Morris, K. “Ford: Health costs ‘out of control’”. The Detroit News and Free Press. May 31, 2003.

² Joint letter on publicly funded health care to the Canadian Government, from the Canadian CEOs of Ford, GM, and Daimler-Chrysler and the National President of CAW, November 2002.

³ Hakim, D. “Health Costs Soaring, Automakers Are to Begin Labor Talks”. The New York Times. July 15, 2003.

⁴ Woolhandler S, Campbell T, and Himmelstein DU. “Costs of Health Care Administration in the United States and Canada”. New England Journal of Medicine 349:768-75. August 21, 2003.

⁵ Norton’s Bankruptcy Advisor, May 2000.

physician. A cancer patient desiring a second opinion should have no financial barrier in seeking that service.

3rd Principle: Finance all medically necessary care and allow patients an unrestricted choice among licensed and willing physicians without increasing per capita health care expenditures.

Health care reform should be budget neutral, which means that there would be no increase in the aggregate amount of money spent on health care. More than \$6,000 was spent per person in 2005 for health care in the US. We are the world's leaders in health care expenditures by a wide margin. On average, 60% of health care revenues in the US are from taxpayers, making Americans the most taxed citizenry in the world for health care. Because Americans have been so generous with health care budgets, it cannot be argued that inadequate coverage and quality are due to stinginess. We do not have a revenue problem in our health care system; we already are paying enough to fund universal care of high quality with unlimited choice of provider.

4th Principle: Finance universal care and unlimited choice of provider without raising per capita health care revenues by reducing administrative waste.

Americans on average do not have the best health care in the world, but we do have the most profitable and the most bureaucratic health care system. Increasingly, our health care institutions, many originally built with Hill-Burton tax funds or through the generosity of donations, are being purchased by investors. The for-profit motive in health care is demonstrably more expensive while providing lower quality care. Investor-owned interests in health care are also responsible for an increasing rate of medical fraud on an immense scale. US hospitals and doctors' offices are forced into benefit denial paper chase, which raises American provider administrative costs to a level five times higher than Canadian providers' experience. Up to 30% of the premium dollar given to US health insurance/managed care companies is not used on patient care. Many studies of the US health care system have documented that vast administrative savings are available. The NEJM in August 2003⁶ documented nearly \$300 billion in savings available nationwide. The administrative waste problem in the US is primarily a private sector problem, where administrative costs are 2.5 times higher than in the public health sector.⁷

5th Principle: Health care is best delivered when hospitals, doctors, health departments, and other institutions cooperate together to assure patients are matched to the services they need.

The United States, which has the most competitive health care sector in the developed world, also has the least efficient health care sector in the developed world. A product of fierce competition in the health care sector is the medical arms race, which has all hospitals vying to be all things to all patients, even in catchment areas not large enough to sustain a single high-level intensive care unit. These competitions inevitably lead to inflated prices and higher morbidity and mortality. Another example of useless competition in health care is the nauseatingly frequent use of commercial speech to advertise health care products. No community health benefit is achieved by a hospital repeatedly claiming pre-eminence in heart care, or integrated care, or by a pharmaceutical firm assuring that we all have heard of some new purple pill. Demand for health services is not dependant on price. People do not decide to have heart surgery because it is on sale this week. Nor do the parents of a leukemic child forgo needed chemotherapy because they cannot afford it. Sellers of health services, like doctors and nurses, cannot enter the market with their own selfish interests at heart. The ultimate users of these services are not shoppers, they are patients. They do not have the special knowledge to be customers in a health care market, nor do they have the time, energy, or judgment to find the lowest price or best value. In health care, the buyer cannot beware. Unlike a real commodity, with health care, factors outside of medicine come into play. This means that it matters to each of us whether all of our community members receive timely and necessary health care. Each case of communicable disease undetected and untreated represents a risk to others. Each baby born without

⁶ See reference 12.

⁷ Reinhardt UE, Hussey PS, and Anderson FG. "US Health Care Spending in an International Context". Health Affairs 23(3):10-25, 5/4/04.

adequate prenatal care is a risk to society for high cost developmental and educational services as well as poor lifetime productivity. Each time a financial barrier keeps a surgical patient from care, our doctors and nurses are that less well practiced for the time we need their help. Any health care reform proposal that begins by assuming that competition is good is ignoring the last decade of market-based health reform efforts, which have failed to register a single significant improvement in cost, access, or quality.

6th Principle: Health care should be publicly funded, privately delivered.

Managed competition, the Clinton proposal, was soundly rejected only a decade ago, because it worsens the health benefits obligations of businesses through employer mandates and it increases administrative waste by locking in private sector health bureaucracies. What is needed is a system that allows public funding of health care, and private sector health care delivery. Public funding of health care is essentially already occurring; most health care revenues are tax dollars. A private board can administer a non-profit trust fund created to receive and spend public sector revenues intended for health care in a publicly accountable manner. Health care delivery would remain in the private sector. Hospitals would be funded with two methods: 1) an operating budget for each institution could be negotiated reflecting the true costs of hospital function, with payments made at regular intervals; *expensive and wasteful hospital billing practices would be eliminated*; 2) a capital budget could be held in reserve for use in maintaining pace with developing technology and population shifts; *the medical arms race would be over*. Doctors would be primarily fee-for-service providers. A panel representing more than 50% of the doctors would negotiate compensation, fee schedules and contract terms with the representatives on the administrative board of the private, non-profit trust fund.