The Case for Universal Health Insurance

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After nearly a decade of quiescence, the debate over the need for fundamental reform of the American health care system re-emerged rapidly in 1989. Dr Arnold Relman of the *New England Journal of Medicine* staged a journalistic debate between the advocates of a procompetitive private pluralistic model of health coverage[1] and the supporters of a single system public model.[2] He entitled his accompanying editorial: "Universal Health Insurance: Its Time Has Come." A month later a widely quoted Harris poll reported that fully 89% of Americans feels our health care system needs a major overhaul; 61% preferred the Canadian health care model to our own.[3]

As family physicians we take an interest in systems. In looking at the crisis in the health care system, we have to ask our usual questions: (1) Why is this crisis emerging now? (2) How do our beliefs about our system need to be changed? (3) How does the system need to be restructured to work better?

Our History

Like families, health care systems undergo evolution over time. A mere two generations ago, during the Depression, the traditional personal payment of the physician model was disrupted for the first time with the emergence of Blue Cross-Blue Shield third-party payment. (Interestingly and significantly, this change took place almost two generations after the introduction of health insurance in Europe.) Employer-based third-party payment spread rapidly in the post–World War II prosperity when the United States was the world's unchallenged economic power. Public third-party payments took a quantum leap in the mid 1960s, when the federal government agreed to support the care of most, but not all, of those left out in an employer-based health insurance system—the elderly through Medicare and the poor through Medicaid.

The landmark health insurance legislation of 1965, legitimizing government's role in paying directly for care, was clearly the last fundamental health care reform in the United States. Health care policy debate shifted from how to make reform to how to contain, control, and limit reforms already made. Within 9 years of the enactment of Medicare and Medicaid, government spending on health rose to around 40% of all health care dollars and has remained there. In contrast, the evolution of the health care systems of the other advanced industrialized countries over the past two decades has included an increase from 60% to 80% in the public share of health services financing.[4]

By the early 1970s it had become apparent that a major cause of the rapidly escalating cost of health care was that insurance programs unquestioningly paid any bill presented to them—whether for services, procedures, or depreciation of new capital expenditures. Simultaneously, technical advances in medicine have made many more interventions possible. At the time Medicare was passed, none of the following procedures was being done—coronary artery bypass graft (now 200,000 a year), carotid endarterectomy (100,000 a year), intraocular lens implant (900,000 eyes a year), total joint replacement (200,000 a year), and renal dialysis (95,000 a year), among others. The expansion in capability and the rise in price has led to an increase in the percentage share of the gross national product going to health care, from 4.5% in 1950 to 5.9% in 1965 and now to 11.2% in 1988.

Why Now?

A rising percentage of our national income going to health care need not in and of itself provoke a crisis. Many argue that as we become a more affluent society, in which most people's basic food and shelter needs are easily met, it is appropriate to spend more of our wealth on health care. Three phenomena, however, explain why health care inflation has become a major issue.

First, the United States is no longer the world's premier economic power. It is an interesting coincidence that

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1971, a year when health inflation concerns were first awakening, was the first year in the 20th century in which the United States ran a trade deficit. With heightened international economic competition, American business leaders are eyeing with envy the 25% to 50% lower health insurance costs their overseas counterparts are paying.

Second, alone among advanced industrialized countries, United States health care relies on patient decision making to restrain demand. Raising copayments and deductibles has been one of the major strategies of traditional indemnity insurers throughout the 1980s to limit their expenses. Unions that in the 1960s and 1970s easily obtained increases in their health insurance coverage are now often forced to go on strike to prevent health insurance give-backs, and all too often patients opt not to carry out the parts of their treatment plan they will have to pay for out of pocket.

Finally, structural changes in the economy—such as the loss of high-paying productive industrial jobs and their replacement with low-paying service sector jobs—have led to high levels of uninsurance (nearly 20% of the population aged under 65 years) and underinsurance. Despite a prolonged economic recovery and relatively low unemployment rates, the forthcoming recession will only make this problem worse.

Reshaping Our Beliefs

When a system is in a deep crisis, it is necessary not only to reshape the behavior of the individual members of the system but also to rethink its operating principles or ideology. One old belief, which amazingly has still not expired after two generations of slow decay, is that health care should be seen as a private personal commodity and should be distributed, like cars, to those with the means and desire to pay. The alternative formulation is that health care is a social or public commodity to be distributed in a population on the basis of need. The United States insurance systems do indeed redistribute health care dollars from the healthy to the unhealthy, especially after serious illness has occurred. Yet, strikingly, in the ambulatory sector where family physicians work, the out-of-pocket payment system for primary care and preventive services continues the personal commodity approach to health care. As a consequence, the implicit health care rationing is irrational; lower income people are allowed to neglect their health until they become so sick that health insurance redistribution mechanisms come into play.

The second long-cherished belief of American physicians, and American society in general, is that only private enterprise can acceptably reward individual initiative and thereby promote economic efficiency. (This notion lay behind the American Medical Association's relabeling of Harry Truman's national health insurance plan as "socialized medicine" and its ultimate defeat.[5]) In contrast, most economic analysts credit the strong postwar economic growth of many European and Asian nations to a level of overt private sector–public sector cooperation rarely seen in this country.[6] John Maynard Keynes noted in 1925 that "The political problem of mankind is to combine these three things: social justice, individual liberty and economic efficiency." Our current privately dominated health care system is failing on all three counts. As we will see, a strengthening of the public role in health care has the potential to improve the system on all three values.

Reshaping The System

Any proposals for revamping the health care system need to meet the needs of its three family members:

1. Patients, who need access to care without financial barriers
2. Physicians, who need to maintain or increase professional satisfaction
3. Payers for care (government and business), who need to hold down costs by avoiding wasteful expenditures

What kind of system can best meet these needs? The answer of Physicians for a National Health Program, a 3-year-old organization with over 2500 members in 48 states, is a single comprehensive public insurance program modeled after the Canadian system. All patients would receive a health insurance card entitling them to necessary medical care from any physician or institution without copayments or deductibles. Physicians could freely choose their mode of practice—fee-for-service, salaried, or capitated. Reimbursement rates would be set by negotiations between institutions such as hospitals, provider groups, and a state medical insurance board. The government would be the sole payer for necessary health care; this "monopsony" buying power would allow it to control costs effectively. The new forms of public revenue that would have to be raised to replace private insurance premiums could be through payroll taxes, an income tax, or even premiums. In our pluralistic system, states could raise revenues in different ways and spend different per capita amounts on health care, as long as appropriations met minimum federal standards. Private insurance could be sold for "luxury" services not covered by public insurance—eg, private rooms, cosmetic surgery—but could not replace public benefits.

How would this system meet the needs of the three parties?

Patients would see an elimination of financial barriers to care. Universal access would make care available to

the 37 million people currently without insurance and to the millions more with inadequate insurance who improperly ration their own care. The primary impact of universal coverage would be to increase the amount of ambulatory care people receive, a quantity that, for low-income people, has actually fallen in the 1980s.

Physicians would benefit from the simplification of paperwork because all patients would have the same eligibility for the same services at the same reimbursement rates. In the current fragmented pluralistic system many physicians are burdened with creating, maintaining, and modifying multiple fee schedules, figuring out how to maximize reimbursement from some payers to cover time caring for those for whom they are undercompensated.

One component of professional satisfaction is income, a component more important for some physicians than others. Freedom to set one's own fees according to how valuable one thinks one's services are is rapidly becoming a relic of a bygone era. The support of major medical organizations for the resource-based relative value system and its variants is an implicit recognition of the need for a rational reimbursement schema. This schema would most likely serve as a framework for the negotiations between physicians and state medical insurance boards.

Finally, as health economists have pointed out,[8] control of health care costs centrally at a macro level eliminates the administrative micromanagement that has become so characteristic of American medicine over the past decade. The erosion of clinical freedom could be halted, if not reversed.

Payers for care would benefit from a reduction in administrative waste of health care dollars. The American health care system costs at least twice as much to administrate as the Canadian and other single-payer systems.[7,8] The costs of determining insurance eligibility, attributing costs to individual patients, billing the right insurance company, collecting the copayment, and so on, amount to approximately 10% of health care expenditures,[7] over $55 billion in 1988. If this hidden source of waste of health care dollars were eliminated, a lot of needed clinical care could be afforded.

A single, universal, computerized system would also facilitate the kind of outcome management studies proposed by Ellwood[9] and already performed on the Medicare database by the Health Care Financing Administration[10] that are needed to help determine what interventions are most beneficial. A single system could more easily uncover outlier providers with practice patterns that are unduly expensive or dangerous. Finally, a single-payer system, through reimbursing experimental procedures at a limited number of sites, could prevent the premature diffusion of unproven technologies and interventions that many observers feel to be a significant cause of America's high health bill.

Conclusions

The winds of change are blowing on the health care system with ever-increasing strength. Many feel that the time for patchwork reform is past.[11] Most of the plenary speeches at the 1989 Society of Teachers of Family Medicine Annual Meeting called on the audience to get involved in reshaping the health care system to reverse the increasing burden of illness imposed on the poor by our legacy from the Reagan era. The gatekeeper role, enthusiastically welcomed only a decade ago as increasing family physicians' strength in the health care system, has now come under attack for undermining physicians' time-honored ethical position as patient advocate.

Despite the growing enthusiasm for change, it will not come easily. The insurance industry is rich and powerful and, though occasionally beaten as in the 1988 California auto insurance struggle, it is likely to use a lot of muscle to block health insurance reform. Partially out of expedience and partially out of ideology, some will support reforms that allow private insurance companies to participate in an expanded multiple-insurer system as exemplified by the proposal of Enthoven and Kronick.[1] As the political debate on this issue grows, I am convinced that more and more physicians will conclude that it is in both society's and their own best interest to support a single public universal health care system.

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