



## THE RIGHT TO HEALTH CARE AND THE ROLE OF GOVERNMENT IN HEALTH POLICY

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### I: Is Health Care a Fundamental Right?

Is the provision of health care a fundamental right in the United States? Does government have an obligation to provide health care for all citizens – or at least, to make sure the systems and financing are in place, in or out of government, for them to get it? Many countries include the right to health care in their constitutions. Indeed, the World Health Organization, in its Constitution, attests to a right to the “highest attainable standard” of health.<sup>1</sup> But what does it mean to have a “right” to “health care?” In order to answer that question we need to define what we mean by “right” and what we mean by “health care,” and how they are related.

At the most basic level, “right” means that government guarantees something to everyone. It can mean individual freedoms like freedom of speech, or, more expansively, it can mean guaranteeing a population-based outcome like an entitlement to public education for everyone in a society. In the U.S. our notion of rights leans more toward the narrower definition, toward personal freedoms, drawn from our country’s earliest beginnings in reaction to the oppressive political regimes of Europe. This stands in sharp contrast to other democratic nations who view the delineation of “rights” as social entitlements in order to fulfill a larger social purpose. In these countries, certain benefits, like education and health care, are guaranteed as a right to their citizens because they promote social welfare. From this perspective, the definition of “rights” embraces the more expansive affirmative duty of a government to intervene to support the larger social good, thus shifting the locus of attention and responsibility from the individual to the larger community and the government.<sup>2</sup>

By extension, health care as a “right” may also be viewed differently in the U.S., and suggests that there may be a more limited protection in ensuring a “right to health care” in the U.S. The right to health care is distinct from the right to health, which is much broader and includes social predictors of health such as level of education and income, and is influenced by a variety of factors, including lifestyle choices and behaviors. In order for government to guarantee “health” to its citizens it would have to be empowered to prohibit unhealthy behaviors like smoking or eating junk food, require healthy activities like getting enough exercise, and eliminate economic inequality since personal income is positively associated with overall health.<sup>3</sup> When most countries express a “right to health” they generally mean a right to health care, a more limited right.

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<sup>1</sup> As referenced in Yamin, A.E., “The Right to Health Under International Law and Its Relevance to the United States,” *American Journal of Public Health* 2005, Vol. 95(7): 1156-1161.

<sup>2</sup> Yamin, A.E., 2005, op cit

<sup>3</sup> S.L. Isaacs and S.A. Schroeder, “Class- the Ignored Determinant of the Nation’s Health,” *NEJM* 2004, Vol. 351(11): 1137-1142.

The belief in a right to health care has its basis in two moral principles: 1) the “social justice” argument that health care maintains an individual’s normal functioning and therefore preserves the ability to participate in the social and economic life of society; and 2) the “utilitarian” view that guaranteeing health services increases the welfare of the greatest number of people.<sup>4</sup> The first principle is advanced by John Rawls who argued that a just society would guarantee personal freedoms as long as they did not limit the freedom of others and would promote equality of opportunity. The social justice model benefits the least advantaged in society because it advocates keeping people close to normal functioning in order to allow them a “fair share” in the full participation in society. Viewed in this way, access to health, broadly speaking, and by extension, to health services, preserves for people the ability to participate in the political, social, and economic life of their society.<sup>5</sup>

Utilitarianism is an [ethical](#) doctrine that supports actions according to the balance of their positive and negative consequences, and advocates that a society ought to always produce the optimal positive value. Utilitarian philosophers argue that certain positive values in society, like health, should be guaranteed because they increase the welfare of the greatest number of people.<sup>6</sup> While the social justice model supports individual health in order to protect normal functioning, utilitarianism primarily protects the aggregate welfare of the larger society. Countries that promote a right to health care often combine the two moral principles by creating an entitlement to a basic level of health services, to enhance normal functioning, and then organize the delivery of health services through a compulsory social insurance model with set limits in order to be affordable. According to Daniel Callahan, early on these countries realized the “economic iron law of universal health care plans: to be affordable they must be limited.”<sup>7</sup>

Setting limits based on finite resources to support the moral principles of social justice and social utility requires that countries employ explicit rationing as a necessary step in providing a right to basic health care to all. This type of moral framework is an awkward fit with the American preference for pluralism, individual freedoms, and limited government. Rather than rely on an explicit mechanism to limit the supply of health services in order to ensure universal coverage and affordability, the American system relies instead on an implicit rationing structure based on individual preferences and ability to pay, which attempts to curtail demand for health services but currently leaves 47 million people without health coverage.

## II: U.S. Health Care Caught Between Liberals and Conservatives

As outlined above, the majority of the developed world uses public financing and administration - or a combination of that with compulsory private spending and administration, as in Germany or Japan - to insure its population. However, we in the U.S. have stopped short of this because we are different. Simply put, we do not have a Canadian or German or Australian health care system because we are not Canadian, German, or Australian. The Canadian credo is

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<sup>4</sup> This is discussed in greater detail in Thomas Bodenheimer’s article, “The Political Divide in Health Care: A Liberal Perspective,” *Health Affairs* 2005 Vol. 24(6): 1426-1435.

<sup>5</sup> Norman Daniels, “Justice, Health, and Healthcare,” *The American Journal of Bioethics* 2001, Vol. 1 (2):2-16.

<sup>6</sup> For an in-depth discussion of utilitarianism see T. Beauchamp and J. Childress, *Principles of Biomedical Ethics*, 4<sup>th</sup> Edition, New York: Oxford University Press, 1994.

<sup>7</sup> See Daniel Callahan, “Symbols, Rationality, and Justice: Rationing Health Care,” *American Journal of Law & Medicine* 1992, Vol. XVIII (1-2): 1-13.

“peace, order, and good government,”<sup>8</sup> and that doctrine is reflected in their health financing system, which is dominated by public payers at the federal and provincial level. Our American credo stands in sharp contrast: “life, liberty, and the pursuit of happiness,” is about freedom and individualism. When we speak of government, we are quick to think of “the consent of the governed,” rather than “good government.” So, who are we? It is important to ask that question because who we are as Americans and, indeed, how America functions, will ultimately determine the structure and principles that guide the development of our health care system. Any exploration of who we are begins with an examination of certain key characteristics that reflect our uniquely American beliefs and values.<sup>9</sup>

### *Who Are We?*

Although Americans are full of contradictions, there traditionally has been a strong thread running through American society of “rugged individualism.” The classic American “rags to riches” story is set in the national self-image of idealism, opportunity, and sacrifice, with origins in the “Wild West” and the Depression, in which one “pulled oneself up by the bootstraps” to get wealthy. The emphasis was on individual effort and responsibility in order to “make it.” Such individualism extends to problem solving: “I don’t need you to tell me what to do. I create my approach to solving problems, recognizing there may be a number of different ways to solve it. No reason we can’t do all do our own thing. I am a rugged individual.”

“Rugged individualism” means different things to different people: in today’s world, “making it” for a large number of people is not achieving wealth, but simply finding a paying job. Those who insist that “everyone can make it the way I did” might be surprised to know that 83 percent of the uninsured live in families headed by workers, have to put bread on the table and a roof over their head, and the vast majority cannot afford health insurance despite working hard. But the myth lives on: “I’m not going to help you because you shouldn’t need my help either.”<sup>10</sup>

This strong philosophical belief in individual responsibility directly affects how Americans view government’s role in providing health care to its citizens, or making certain they can obtain it through public or private means. Since we think everyone should be able to “make it,” many often voice reluctance to provide our tax dollars to support someone else’s health care<sup>11</sup> – even though governments at all levels are now paying roughly half of all U.S. health care bills, through programs ranging from Medicare and Medicaid to military and veterans’ health care. We are charitable as individuals to individuals; we will help our neighbors and will take a sick, uninsured co-worker to the emergency room and might even pay for the visit. We perform amazing acts of kindness and humanitarian assistance in the face of natural disasters like

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<sup>8</sup> “What Does Canadian Citizenship Mean?” <http://www.cic.gc.ca/english/citizen/look>. This government website says that Canadians value Equality, Cultural Differences, Freedom, Peace, and Law and Order. The phrase “peace, order, and good government” called POGG for short, is often used to describe the principles of the Canadian Confederation.

<sup>9</sup> This section and the following section is taken in large part from the authors’ recent publication, *Health Care Half-Truths: Too Many Myths, Not Enough Reality*, published in 2007 by Rowman & Littlefield Publishers.

<sup>10</sup> Mongan, James J. and Thomas H. Lee, “Do We Really Want Broad Access to Health Care?” *NEJM* 352.12 (2005): 1260-1263. The authors describe how Americans sacrifice in times of national crisis, but forget about their fellow Americans day in and day out, because they are “self-centered in the name of rugged individualism.”

<sup>11</sup> “New AEI Public Opinion Study on Taxes,” American Enterprise Institute, April 13, 2006. This press release issued just before tax day in 2006 reported on surveys by major U.S. pollsters on the topic of taxes. Most Americans believe the amount of taxes they pay is too high; only one in ten Americans would be willing to pay the extra \$2,470 per person in taxes to balance the federal budget deficit.

Hurricane Katrina. But, at the same time, we may also say that we have no interest in supporting large groups of “faceless” people, such as the uninsured, over the long-term.

Because of our strong belief in the rights of individuals, we Americans say we hate top-down governmental oversight.<sup>12</sup> This traditional “I can do it myself” philosophy, and by extension, “So should you,” is reflected in today’s emphasis on consumer-directed health care. Under the consumer-directed philosophy, individuals are “empowered” to “take ownership” of their lives, exercising individual responsibility and accountability rather than taking into account how those decisions might affect the larger community.<sup>13</sup> With regard to our health care, an example of this preference for individual choice is reflected in what we call the “freedom to choose” - and keep - our own doctors. This societal orientation toward the individual extends to a more generalized view that is tolerant of, and even supports, multiple approaches to health care, which in turn permits (and reinforces) an extremely uncoordinated system.

In addition to our allegiance to individualism, a second uniquely American characteristic is the great faith we hold in the power of entrepreneurialism, even when it backfires, such as in the current sub-prime mortgage fallout. Americans take pride in being able to make money doing virtually anything. We believe in and value capitalism and the power of economic markets. We define success in monetary terms and as “the bottom line,” whether an organization is called “for-profit” or “not-for-profit.”

Like other industries, the business of health care values making money. Because of this strong capitalistic underpinning, our system of health care will in all likelihood continue to have insurance companies, as well as drug and device manufacturers, that are in the Fortune 500. Because profit is a measure of success, we will continue to have for-profit hospitals, for-profit doctors and for-profit lawyers, and not-for-profit organizations that look more and more like for-profit entities. Just like their for-profit counterparts, executives in the not-for-profit sector will be rewarded monetarily for their achievements. As a case in point, currently, CEOs at the six largest non-profit, tax-exempt hospital systems all make more than \$1.2 million per year. We make a lot more money than our worldwide counterparts and it shows; it is the main reason our medical care is so expensive.

Thirdly, Americans are robust consumers and very susceptible to marketing and media messages.<sup>14</sup> The media is very powerful in “priming” us for certain messages and in creating demand for certain products. The focus is on the individual consumer. Most marketing communications are written to make it seem like the message is “speaking to me directly,” and the language is carefully chosen to give a short and simple “personalized message.” Often, the fifteen-second “sound bite” is all that is needed to buy into the message, and this subtle (and sometimes not so subtle) manipulation connects us, personally, to whatever the message represents.

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<sup>12</sup> This is discussed in more detail in Theda Skocpol’s book, *Boomerang: Clinton's Health Security Effort and the Turn against Government in U.S. Politics*, New York: WW Norton & Company, 1996.

<sup>13</sup> Boaz, David, “Defining an Ownership Society,” [http://www.cato.org/cgi-bin/scripts/printtech.cgi/special/ownership\\_society/boaz.html](http://www.cato.org/cgi-bin/scripts/printtech.cgi/special/ownership_society/boaz.html). This article, from the Cato Institute, addresses calls for an “ownership society,” in which individual private ownership makes people more responsible and more involved. This type of philosophy extends into social programs in the form of school vouchers, private retirement accounts, and wider use of Health Savings Accounts in purchasing medical care.

<sup>14</sup> Schudson, Michael, “The News Media as Political Institutions,” *Annual Review of Political Science* (2002)5: 249-69. Investigators in sociology, communications, and political science have studied the role of the media from different perspectives. This review article discusses media and their role in shaping public opinion and in influencing belief systems, assumptions, and values.

When it comes to understanding complex medical information, Americans also want a simple message. For example, the concept of “quality medical care” is extremely complicated, and so Americans prefer instead to use the simpler, more familiar “fix my car for the cheapest price” or “get the best deal” analogy when shopping for health insurance or medical care coverage. This is also true when Americans choose a physician - they tend to resort to the easiest way to make a decision. Rather than rely on expert information about which physician ranks highly in providing quality care, we most often take the recommendation of a family member or neighbor.

Americans also hate restrictions if they think it will limit their choices or impede their path toward something they desire. Remember, we live in a country founded on “the pursuit of happiness.” This translates into, “I can have everything – white teeth (probably even white straight teeth), and a fancy automobile, and I can have it all now. I don’t take no for an answer.” This “right” to whatever makes us happy is easily translated into our desire for health care; we have a “right” to health care, all that we want. Americans as individuals feel entitled to any available medical service, regardless of its direct benefit. We will not wait for a physician visit and will become angry if we do not receive a return phone call within minutes. Waiting lines? Absurd. Rationing? No way.

This type of “right” to health care and the desire to receive information in short, simple sound bites reinforces the American sense of exceptionalism. When it comes to medical outcomes, our expectation is “I can beat the odds. I will live through this.” Americans and their loved ones are always the exception. Statistics that suggest the contrary are, in the minds of many Americans, too complicated and generally apply to “someone else.”

This plays out in the health care system every day. A number of years ago a system was created that predicted with 95 percent certainty whether an individual would leave an intensive care unit alive. It performed perfectly but was never accepted. Why? It failed because the patients’ families were all convinced that their relative was in the 5 percent who would live.<sup>15</sup> This is why we spend so much in the last 12 months of life. In many Americans’ minds, death is not an option.

Finally, how Americans feel about their own personal finances as well as the economy of the country drives our views in so many areas, and health care is no exception. In a good economy with high employment, fewer people are uninsured (because more employers are able to offer insurance, and workers have more money to purchase it), and the issue of health insurance coverage disappears from the headlines. In a poor economy, levels of unemployment and uninsurance increase. As the economy continues to worsen, employers reduce the amount they are willing to pay for health insurance, either dropping coverage entirely or shifting more payment to the employee who is less able to pay the premiums. These actions increase the growing numbers of the uninsured.

### *The 30-50 Year Liberal – Conservative Cycle*

The attitudes of Americans cycle every 30-50 years from liberal to conservative and back again. In a conservative world, private ownership is “king,” taxes are low, government is small, individual freedom and responsibility reign, and there is a deep belief in “traditional values.”

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<sup>15</sup> Truog, Robert D., et al, “Rationing in the Intensive Care Unit,” *Critical Care Medicine* 34.4 (2006): 958-963. Efforts to ration care in intensive care units (ICUs) have failed because many patients and families believe they are entitled to any available service (regardless of its benefit), and many clinicians believe they must, in the name of professional duty to the patient, offer any service that yields even minimal benefit.

Conversely, liberalism chooses the collective welfare of a society over the needs of the individual, and looks to government to protect the disadvantaged (usually through public programs paid for by taxing the “advantaged”), to curb capitalism, and to promote social justice.<sup>16</sup>

It is clear from history that overall social and economic conditions have a highly significant effect on how we feel about our health care system at any given time. This is also true with regard to our willingness to tolerate the number of people without insurance in this country and how much we challenge the status quo. Over the last decade, the prevailing view of health care insurance favored continued involvement of the employer and supported only very slight incremental changes in our “system,” if any at all, suggesting we have been in a more conservative mode. However, there have been times in the past when America’s views were more liberal, such as in the early 1960s when two sweeping social programs occurred – Medicare and Medicaid. This suggests the possibility for major change will occur about as often as the political merry-go-round passes the liberal brass ring.

Additionally, where we are in the liberal-conservative cycle reflects the deep philosophical differences in this country as to how health care services should be distributed. Advocates of a competitive, free market model believe that like other societal goods and services, health care should be allocated within a voluntary system based on individual preference and ability to pay. The contrasting more liberal view is based on a social justice model, in which the allocation of goods and services are based on individual need. Social justice models rest on a principle of shared responsibility with government ensuring fairness as part of a larger social contract.<sup>17</sup>

Market advocates<sup>18</sup> argue that health care is a market just like all other commodities. In their view, the problem with the current system is that consumers don’t get enough information about the price or quality of health services, have allowed those who provide the services to shift costs, accumulate bargaining power, and reduce competition, which in turn reduces the value of the service. Supporters of a free market in health care delivery contend that our health care crisis could be resolved if doctors and hospitals were forced to compete on the quality and cost of care they provide, just as in other industries whose goods are distributed through a competitive market.

Opponents to this view argue just as loudly that in order for markets to work there must be adequate information about price and quality, and that such information is not currently available in today’s health care system. They also argue, with data, that the majority of Americans don’t want all that data – they just want to be told what to do by their doctor, just like taking their car to the mechanic. Paul Ellwood, MD, best known as the “father of managed care,” concurs. In an open letter to President Bush published in Stanford University’s *Managed Care Magazine*, Ellwood wrote, “Until recently I was convinced that consumers, given adequate

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<sup>16</sup> Bodenheimer, Thomas, *Health Affairs* 2005, op cit. U.S. health policy rests between conservative and liberal viewpoints, which basically part along lines of whether health care coverage is a basic right or not.

<sup>17</sup> Two recent *JAMA* articles discuss markets and health care. For a greater discussion of how markets in health care are distorted, see David A. Wells, et al, “What Is Different About the Market in Health Care?” *JAMA* 298(23): 2785-2787; and Budetti, P., “Market Justice and U.S. Health Care,” *JAMA* 299(1): 92-94 for discussion about the differences between market justice and social justice in the allocation of health care services in the U.S.

<sup>18</sup> For an in-depth discussion about the virtues of market-based health care financing, see Regina Hertzlinger’s *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service*, Addison-Wesley Pub., 1997; and Michel E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, 2006.

information about their choices, could effectively influence both the cost of health insurance and the quality of health care....I was wrong....Studies show that despite the greater public access to sound health information, market forces...do not exert sufficient influence over the quality of health services.”<sup>19</sup>

These two disparate conservative versus liberal philosophical views about the organization, financing, and delivery of health care in the U.S. has been articulated for decades and has plagued health reform efforts for just as long. Therefore, any enduring health care system reform in the U.S. will have to balance the two views and reflect both the underlying values and the realities of the politics that make us who we are. This is not easy, partially because the interests are so varied and may be, at times, contradictory. Accordingly then, at a minimum, any “reformed” U.S. health care system will need to be acceptable to lobbyists; agreeable to private insurance companies; able to accommodate for-profit businesses and professions like drug and device industry, doctors, and lawyers; provide choice of providers and plans; have little or no waiting for services; and require no explicit rationing. Depending upon where we find ourselves in the liberal-conservative cycle, Americans’ tolerance for government mandates, continuation of employer-sponsored health care, and support of minimal new taxes will depend in large part on how we feel about whether there is (at least a limited) right to health care for everyone.

Returning, then, to the question that opened this paper, “Do Americans have a fundamental right to health care, and it is the obligation of government to secure that right?” the answer would seem to be, “Depends upon whom you ask and when you ask it.”

### III: What Can We Learn from Past Failures?

In recent years, proposals to make major reforms in the U.S. health care system have surfaced during the term of almost every U.S. president. This has been true since President Franklin Roosevelt considered universal health care as part of the Social Security Act, and Presidents Truman, Nixon, Carter, and most recently, Clinton, all unsuccessfully included a national plan to make basic medical care available to all.<sup>20</sup> However, health care’s reinvention in the U.S. is stymied time and time again because entrenched interests ultimately convince the public that they will lose more than they will gain in the effort. Since 1994, the last attempt at national health care reform, U.S. health policy has been largely governed by inaction. The two major issues that historically drive reform – the disproportionate growth in health care spending and (a distant second as a driver) the number of uninsured Americans – have now reached the highest levels in history.

What can we learn from these past attempts to reconfigure a good share of one-sixth of our economy? First of all, despite the lofty ideals of Americans regarding reforming our health care system, 85 percent of Americans are insured and may fear change. Americans idealize a

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<sup>19</sup> Reported in Maggie Mahar, “Why Market Competition Will Not Mend Our Health Care System,” *Managed Care Magazine*, February 2007, <http://www.managedcaremag.com/archives/0702/0702.collaboration.html>.

<sup>20</sup> Steinmo, Sven and Jon Watts, “Why Comprehensive National Health Insurance Always Fails in America,” *Journal of Health Politics, Policy and Law* 20.2 (1995). This article discusses why national health reform is so difficult to achieve in the United States because of a bias against comprehensive reform. Reasons for the failure to enact a national program were the same in 1994 (the last attempt) as they were in 1948, 1965, 1974 and 1978. They include the role of interest groups, a weak executive branch, a fragmented political party system, an American distaste for a large government, and a system of checks and balances. As a result, incremental reforms are more possible and more popular.

fully insured America on public opinion polls but their voting habits suggest otherwise. A compendium of public opinion polls summarized and reported in *Health Affairs* in 2006<sup>21</sup> suggests that health care continues to be a second-tier issue at the polls, behind the economy, and more recently, national security issues. When Americans react with concern about health care costs they are talking about *their* costs, not society's, and larger national health care issues rarely motivate individual voters to vote for change if the change will result in reduced health coverage for them and their families or in higher taxes to cover more Americans.<sup>22</sup>

Secondly, entrenched vested interests, like those of doctors and hospitals, the pharmaceutical industry, health insurers, and consumer advocates, each have a stake in any governmental action, whether it is shoring up the current employment-based system for workers or financing a national system through taxes. Each prefers the status quo to the alternatives,<sup>23</sup> which makes moving toward a national consensus very difficult. In addition, comprehensive change is easier to block in the federal arena than to advance given the structure of our political institutions that foster divisions in Congress and limit presidential power. In the end, no one wins, no one loses, and nothing changes very much.<sup>24</sup>

Finally, how to pay for health care reform remains a challenge. Large-scale financing reform may require income redistribution, something Americans are loath to consider, at least explicitly. If overall health spending is to be held constant, increasing spending for some groups like the low-income uninsured will mean decreased spending for others. If it is not held constant, it will require identifying new financing sources, such as higher taxes or mandatory contributions from individuals and employers. The Clinton Plan failed in part because of the call for employers to offer health coverage for their workers. This prompted a negative reaction from many in the small business community, who accused the President of levying burdensome taxation on their shoulders and threatening their viability. Some analysts argue that the United States' persistent anti-tax politics disadvantage health care reform efforts,<sup>25</sup> and, along with the current budget deficit and economic slowdown, negate any support for comprehensive action.

The ultimate lesson in these past attempts at health care reform can be summarized as follows: no matter how much momentum a current election cycle seems to generate, no matter how much public support there seems to be for health reform, no matter how rational the economic and social justice causes may be to recommend a shift in policy, there is nothing

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<sup>21</sup>Robert J. Blendon, Kelly Hunt, John M. Benson, Chanttal Fleischfresser, and Tami Buhr, "Understanding the American Public's Health Priorities: A 2006 Perspective," *Health Affairs*, November/December 2006; 25(6): w508-w515.

<sup>22</sup>For a greater discussion about the dissonance between pre- and post-election public opinion regarding the need for comprehensive health care reform, and about what Americans think health care cost means, see Engelhard, C. and Garson, A., "In the Shadow of Cost Containment: Americans, Affordability, and Health Reform," *American Heart Hospital Journal*, Winter 2007, 5:6-9.

<sup>23</sup>This is often referred to as "Machiavelli's Law of Reform," as reflected in a much quoted excerpt from *The Prince*: "The reformer has enemies in all those who profit from the old order and only lukewarm defenders in all those who would profit from the new order." This quote is referenced and an overall discussion of the "fear of loss" being stronger than the "hope of gain" as an obstacle in enacting health care reform can be found in more detail in Victor Fuchs' article "What are the Prospects for Enduring Comprehensive Health Care Reform," in November/December 2007 *Health Affairs*, 26(6): 1542-1544.

<sup>24</sup>A recent editorial by Henry Aaron discusses this in more detail; see: "Why Has Healthcare Reform Failed?" *Los Angeles Times*, November 6, 2007, <http://www.latimes.com/news/printedition/asection/la-oe-aaron6nov06.1.6764374.story?ctrack=1&cset=true>.

<sup>25</sup>T. Skocpal, 1996, op cit.

inevitable about health care reform in the U.S. In fact, there is much to suggest that comprehensive change is difficult if not impossible to enact, let alone implement.<sup>26</sup>

#### IV: Where We Are Now?

Private, voluntary, employer-based coverage worked well until very recently. However, over the last six years, the number of workers receiving health coverage at their workplace has steadily declined: Almost 60% of Americans received employment-based health coverage in 2006 compared to 64.2 percent in 2000.<sup>27</sup> This represents a drop of 4.5 percentage points, or 2.3 million Americans. When one factors in the population growth during the same period, however, the erosion of employment-based insurance becomes clearer: as many as thirteen million more people would have had employer-provided health insurance in 2006 if coverage had remained at the 64.2% 2000 level.<sup>28</sup> The percentage of businesses offering health insurance has steadily declined as well, with 60 percent of employers offering coverage, down from 69 percent in 2000.<sup>29</sup>

The major reason for the erosion in employer-sponsored health benefits is cost. Growth in the cost of providing health coverage to workers continues to run double the growth in earnings and also inflation. This has a direct influence on the growth in the number of Americans who become uninsured because for each one percent increase in health spending over personal income, 246,000 people will lose private health insurance coverage. At the current rate of health spending, the number of the uninsured in this country will grow to 56 million by 2013.<sup>30</sup> This is particularly true in small firms, which offer health coverage less often, have fewer workers eligible for coverage, and whose workers buy less employer-sponsored health insurance. Two in five lower-wage workers in small firms are uninsured, more than twice the rate of higher-wage workers.<sup>31</sup>

Small employers face higher insurance premiums and administrative costs – sometimes as much as 18 percent higher - than large employers, and insurance premiums vary widely across the country.<sup>32</sup> However, as rising health costs and premiums are making it more difficult for employers, particularly small businesses, to provide affordable health coverage for their employees, increasing numbers of Americans under the age of 65 are finding themselves without access to employer-based health insurance and are also ineligible for benefits through public insurance programs because they make too much.

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<sup>26</sup> This is eloquently discussed in Jonathan Oberlander's recent *NEJM Perspectives*, "[Presidential Politics and the Resurgence of Health Care Reform](#)," *NEJM* 357:2101, November 22, 2007 and "[Learning from Failure in Health Care Reform](#)," *NEJM* 357:1677, October 25, 2007.

<sup>27</sup> Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey* (Washington: Kaiser Family Foundation, September 2007).

<sup>28</sup> Taken from, "The Erosion of Employment-Based Insurance: More Working Families Left Uninsured," *EPI Briefing Paper #203*, Economic Policy Institute, [www.epi.org](http://www.epi.org).

<sup>29</sup> Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey*, op. cit.

<sup>30</sup> Gilmer, Todd and Richard Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs*, April 2005: w5-143-151.

<sup>31</sup> Collins, S.R., et al, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance*, Commonwealth Fund Publication No. 1059, September 2007.

<sup>32</sup> Collins, S.R., et al. 2007, op cit.

The increase in the number of uninsured over the last six years affected all categories of workers and their families. Full-time workers, workers with a college degree, and workers in the highest wage quintile experienced declines in coverage between 2000 and 2006, and childrens' coverage fell six percentage points during that time, from 65.9 percent to 59.7 percent. Public insurance is no longer offsetting these losses and for the second year in a row, the rate of uninsured children has increased.<sup>33</sup>

In addition to the 47 million Americans without health insurance, there are many who have high health care burdens despite having private health insurance. These individuals and families are considered “underinsured” because they spend a disproportionate amount of their income on health care. Americans are considered “underinsured” when they meet any one of three criteria: (1) medical expenses amount to ten percent of income or more; (2) among low-income adults (below 200 percent of the Federal Poverty Level — 200 percent is about \$20,000 for an individual and \$40,000 for a family of four), medical expenses amount to at least five percent of income; and (3) health plan deductibles equaled or exceeded five percent of income.<sup>34</sup> According to a recent study, 45 million people live in families that spend more than ten percent of *after-tax* income on health care.<sup>35</sup> Of these individuals, most are privately insured with employer-sponsored coverage. This suggests that private health insurance coverage may no longer provide adequate financial protection for an increasing number of Americans.

### *Effects of Being Uninsured*

The widening gap in our health insurance system is costly for society as well as for individual Americans. Three Institute of Medicine studies reported that the most important determinant of access to health care is adequate insurance coverage,<sup>36</sup> that people who lack health insurance have fundamentally different life experiences than do those who are insured,<sup>37</sup> and that even geographic areas with a robust safety net care system fail to provide access to health services to the same extent as having health insurance.<sup>38</sup> Having health insurance is important because coverage helps people receive timely medical care. Those without continuous health coverage are sicker and more apt to die prematurely. According to the IOM studies, death risk is 25 percent higher for uninsured people with chronic conditions and 18,000 extra deaths per year may be attributed to lack of health insurance.

Three recent studies extend the IOM's findings. One found that the uninsured near-elderly got sicker at a faster rate than comparable people with health coverage and that the disparities between the two groups sharply diminished once the uninsured became eligible for Medicare at age 65. Those who previously had insurance showed no significant change in their health status after they transitioned to Medicare, but the value for those who lacked health insurance prior to age 65 was significant, particularly for those suffering from heart disease,

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<sup>33</sup> EPI Briefing Paper #203, Economic Policy Institute, op cit.

<sup>34</sup> Schoen, Cathy, Michelle M. Doty, Sara R. Collins, and Alyssa L. Holmgren, “Insured but Not Protected: How Many Adults Are Underinsured?” *Health Affairs* 2005 Web Exclusive, June 14, 2005: w5-289-302.

<sup>35</sup> Banthin, J.S., et al, “Financial Burden of Health Care, 2001-2004,” *Health Affairs*, January/February 2008:188-195.

<sup>36</sup> Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, June 2003)

<sup>37</sup> Institute of Medicine, Committee on the Consequences of Uninsurance, *Care without Coverage: Too Little, Too Late* (Washington, D.C.: National Academies Press, 2002).

<sup>38</sup> Institute of Medicine, *Coverage Matters: Insurance and Health Care* (Washington D.C.: National Academies Press, 2002).

stroke, high blood pressure, or diabetes.<sup>39</sup> Being uninsured is a long-term problem for three out of five older adults. More than one in five of uninsured 50- to 64-year-olds never had insurance, and more than two in five had been without it for at least three years.<sup>40</sup> The second study, by researchers at the American Cancer Society, found substantial evidence that lack of adequate health insurance was associated with less access to needed medical care and poorer outcomes for cancer patients. The uninsured were less likely to receive recommended cancer screening tests, more likely to have their cancers diagnosed at a later stage, and had lower survival rates after the cancer was detected.<sup>41</sup> The third study, just issued in January 2008 by the Urban Institute, looked at the impact of uninsurance on mortality. Based on the IOM's methodology and subsequent Census Bureau estimates of health insurance coverage, 137,000 people died from 2000 to 2006 because they lacked health insurance, including 22,000 in 2006.<sup>42</sup>

### *High Cost – What Do We Get?*

A McKinsey Global Institute analysis found that the U.S. spends more than \$500 billion per year more on health care than peer OECD countries after adjusting for wealth, population mix, and higher levels of some disease.<sup>43</sup> Health care spending comprises the largest part of our economy - sixteen percent and one out of every five dollars of the gross domestic product - yet our population has poorer health outcomes in terms of life expectancy, disease prevention, and infant mortality than many countries that spend far less per capita.<sup>44</sup> In a recent study<sup>45</sup> comparing the health of nations as measured by the decline in preventable deaths, the U.S. ranked last among nineteen nations. While most countries surveyed saw preventable deaths decline by an average of sixteen percent, the U.S. saw only a four percent reduction. A country's ability to reduce the rate of preventable deaths is seen as a measure of health care performance. Like the other countries in the study, the U.S. started from a relatively high level of potentially preventable deaths, but it experienced smaller reductions than the other eighteen countries.

This in part may reflect the importance other countries place on nonmedical determinants of health such as poverty, level of education, or lifestyle choices, all of which have a direct effect on health status and longevity. In the U.S. there are large variations in health status based on geography, race, and insurance coverage. A recent study suggests that there is up to a two-fold

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<sup>39</sup> McWilliams, J.M., et al, "Health of Previously Uninsured Adults after Acquiring Medicare Coverage," *JAMA* 2007, 298(24): 2886-2894.

<sup>40</sup> This is from the National Health Interview Survey 2006 (CDC 2006) as reported in AARP Data Digest #155, May 2007, "Health Coverage Among 50- to 64-Year-Olds," AARP Public Policy Institute.

<sup>41</sup> Ward, E., et al, "Association of Insurance with Cancer Care Utilization and Outcomes," *CA: A Cancer Journal for Clinicians*, Vol. 58 (1): 9-31.

<sup>42</sup> Dorn, Stan, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality," Urban Institute, <http://www.urban.org/publications/411588.html>.

<sup>43</sup> C. Angrisano, et al, "Accounting for the Cost of Health Care in the United States," January 2007, [http://www.mckinsey.com/mgi/rp/healthcare/accounting\\_cost\\_healthcare.asp](http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp). This refers to the \$526 billion of U.S. spending above Estimated Spending According to Wealth (ESAW). This is the figure before it is adjusted for U.S. spending below ESAW in long-term care, which would result in a net figure of \$477 billion.

<sup>44</sup> Banks, J., et al, "Disease and Disadvantage in the U.S. and in England," *JAMA* 295 (17): 2037-2045.

<sup>45</sup> This study, appearing in the January/February 2008 issue of *Health Affairs*, was written by researchers from the London School of Hygiene and Tropical Medicine, and looked at death rates in subjects younger than 75 that could have been prevented by timely and effective health care. Results of the survey among nineteen developed countries indicate that the U.S. ranks last in providing timely and effective health care to its citizens. See Nolte, E. and C. M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs* 27(1): 58-70.

difference in health outcomes across the fifty states and the District of Columbia.<sup>46</sup> While the U.S. provides effective medical care once people get sick – there has been a fifty percent reduction in age-adjusted mortality from coronary heart disease over the past four decades – it falls short on preventing disease or promoting health for those who are well.<sup>47</sup> If the U.S. had performed as well as any of the top three industrialized countries in the study looking at the decline of preventable deaths, there would have been more than 100,000 fewer deaths per year.<sup>48</sup>

Increasingly, health care providers can no longer explain or defend the disconnect between cost and quality. A 2003 study<sup>49</sup> looking at the quality of health care delivered in the U.S. demonstrated that only 55 percent of adult Americans get recommended health care, suggesting poor value for the large amount of dollars expended. This combination of unequal and often inadequate health coverage for Americans, poorer health outcomes and health experiences compared to other countries, and the unrelenting health care expenditure growth that has continued to fuel higher health insurance premiums,<sup>50</sup> is once again bringing health reform to the national agenda. With more than 40 million U.S. residents saying they cannot afford adequate health care,<sup>51</sup> purchasers tired of absorbing annual health insurance increases, and national health care expenditures continuing to outpace overall economic growth and general inflation,<sup>52</sup> many fear that health care spending will cripple our future economy. The Congressional Budget Office in December of 2007 presented a long-range budget forecast warning that projected health care spending in the Medicare and Medicaid programs would place the federal budget on an “unsustainable path.”<sup>53</sup> Analysts, pundits, and ordinary citizens fear that entitlement spending, driven by the rate at which health costs will grow because of the supply of and demand for services, will crowd out other national priorities, straddle future generations of Americans with economic hardship, and threaten our national security as foreign

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<sup>46</sup> A recent Commonwealth Fund report revealed a two-fold difference across the fifty states and District of Columbia on the measure of preventable deaths in 2002. See *Aiming Higher: Results from a State Scoreboard on Health System Performance*, 2007.

<sup>47</sup> Engelhard and Garson, op cit.

<sup>48</sup> Nolte and McKee, op cit.

<sup>49</sup> McGlynn, Elizabeth A., et al, “The Quality of Health Care Delivered to Adults in the United States,” *NEJM* 348.26 (2003): 2635-2645. Individuals in this study were asked about their health care experiences in order to evaluate if their care was consistent with basic quality standards regarding the use of preventive, chronic, and acute medical care. “Recommended care” was decided by a panel of experts based on national guidelines taken from the medical literature. Examples of conditions surveyed included alcohol dependence, asthma, breast cancer, colorectal cancer, and coronary artery (heart) disease. The study found that a little more than half of the participants (54.9%) received care felt by the experts to be appropriate, or “recommended care.”

<sup>50</sup> Two recent studies by Hewitt Associates and Towers Perrin reported that employer-sponsored health insurance premiums increased by more than twice the rate of inflation in 2007 and that costs are expected to continue to rise in 2008. See Kaiser Daily Health Policy Report, September 25, 2007 for a summary of the two studies: [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=47738](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=47738), accessed September 25, 2007.

<sup>51</sup> National Center for Health Statistics, News Release, December 3, 2007, accessed December 5, 2007, <http://www.cdc.gov/nchs/pressroom/07newsreleases/hus07.htm>.

<sup>52</sup> Each year analysts at the Centers for Medicare and Medicaid (CMS) issue a report of the nation’s health care spending. The study found that health spending totaled \$2.1 trillion in 2006, or \$7,026 per capita. Because of the new Medicare drug program, Medicare spending increased 19%, the fastest pace since 1981. Although health care spending growth has slowed in recent years, the rate of 6.7 percent in 2006 still continues to outpace overall economic growth and general inflation, which grew 6.1 percent and 3.2 percent, respectively, in 2006. For more information, see Catlin, A., et al, “National Health Spending in 2006: A Year of Change for Prescription Drugs,” *Health Affairs* 27(1): 14-28.

<sup>53</sup> Congressional Budget Office, Statement of Peter R. Orszag, “The Long-Term Budget Outlook,” before the Committee on the Budget, U.S. House of Representatives, December 13, 2007.

countries fund our growing national deficit. Because budget experts increasingly view health care as a significant risk to America's economic and national security future,<sup>54</sup> health reform has landed squarely in the laps of the 2008 presidential candidates.

## V: Health Reform 2008: State Action and the National Agenda

There is much to suggest that now may be the time for health system reform in this country. The U.S. spends twice as much per capita on health care as the average of the richest countries in the world, and more than one person in six under the age of 65 in the U.S. is uninsured. Many businesses, which traditionally have provided the scaffold for our voluntary private health insurance system, are worried that inflationary health insurance premiums are cutting into their global competitiveness, and workers, who pay for those inflationary premiums with less generous wage increases, are finding health care less and less affordable.

Public opinion polls measuring views of employers, employees, and opinion leaders suggest that expanded access to affordable health insurance is a critical domestic policy challenge. The Commonwealth Fund reported in 2005<sup>55</sup> that almost eight out of ten Americans (78 percent) believed that employers should either provide health insurance to their workers or pay into a fund that would help cover uninsured workers. In a later survey, a majority of employers agreed with this sentiment. Even a majority of employers who do not currently offer health benefits said that companies have some responsibility to contribute to their employees' health coverage.<sup>56</sup>

When the Democrats took control of Congress in the November 2006 midterm elections, the expectation was that Congress and the President would make some headway on resolving these pressing issues in health care. Instead, lawmakers continued the partisan rhetoric and gridlock, and could not even agree on how to structure the continuation of the popular health insurance program for children that was up for renewal.

### *State Reform*

As a result of persistent federal inaction, many states have attempted to enact health care reform.<sup>57</sup> Massachusetts, with the most far-reaching state plan and one of a handful of states to actually enact broad reforms in recent years, uses a combination of Medicaid expansions, state subsidies for the purchase of private group coverage, reorganization of the health insurance market, and an individual mandate to ensure universal coverage. After eighteen months, the experience is mixed: 216,000 people are newly insured under the program, but it is running \$147 million over budget. The lack of "affordable" insurance plans for the uninsured middle class relieves them of the mandated requirement to purchase health insurance, thereby potentially compromising the universality of the new law. Many of the previously uninsured that signed up

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<sup>54</sup> Schaeffer, L.D., "The New Architects of Health Care Reform," *Health Affairs* November/December 2007, 26(6): 1557-1559.

<sup>55</sup> As reported in Collins, S.R., et al, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance*, Commonwealth Fund, op cit.

<sup>56</sup> Whitmore, H., et al, "Employers' Views on Incremental Measures to Expand Health Insurance Coverage," *Health Affairs*, November/December 2006 25(6): 1668-78.

<sup>57</sup> For an overall discussion on state reform efforts, the future of state-based health reforms, and the role of the federal government in partnering with states, see J. McDonough, et al, "A Progress Report on State Health Access Reform," *Health Affairs* 27, no. 2 (2008): w105-w115.

for insurance are those who met eligibility requirements to get coverage for free; many of those who are ineligible for the subsidized insurance have yet to purchase it. In an attempt to address the budgetary impact, Massachusetts in year two will raise premiums and reduce health care provider payments. Some believe this action will diminish any further coverage expansion as health insurance plans become less affordable and health care providers become reluctant to treat those whose health plan's reimbursement rates are not sufficient to cover the costs of care.<sup>58</sup> Nevertheless, despite these initial roll-out problems, Massachusetts' health plan remains a model of how states can succeed in implementing significant reforms when federal action is lacking, and may point to a continuing role for state health reform efforts.<sup>59</sup>

Although Massachusetts is heralded as the premier example of bipartisan success in enacting state-based health reform, most states will not be able to closely emulate the Massachusetts model because most states have larger numbers of uninsured and underinsured citizens, fewer employers who offer higher wages and generous employment benefits, and less generous state health programs. The tax base in most states is lower than in Massachusetts, which means there are fewer resources from which to build new health programs.<sup>60</sup>

California, Illinois, and Pennsylvania each proposed wide-ranging health care proposals, but none ended 2007 with signed bills. In each state, the initiatives confronted entrenched opposition from insurance and other business lobbies that made it far more difficult to build a consensus for change than in Massachusetts and therefore stalled progress. California's actions to overhaul the state's health care financing and delivery system garnered a lot of national attention. Not only is California the most populous state, it has the highest proportion of uninsured residents—about one in five Californians do not have health coverage. Success in California would send a signal that health reform is viable at the state level. But building a consensus and finding the financing was difficult, and ultimately failed, early in 2008. Despite the successfully negotiated plan between Governor Arnold Schwarzenegger and state Assembly speaker Fabian Nunez in late 2007, the \$14.9 billion health care proposal was defeated by California lawmakers who, staring at a \$14.5 billion state budget gap, “couldn't justify the paradox of voting for an ambitious expansion of medical coverage while, separately, approving massive cuts in existing state healthy care programs to balance the budget.”<sup>61</sup> Like Massachusetts, California's plan would have required most state residents to obtain health coverage and most employers to participate, but would have relied on a significantly increased cigarette tax and a tax on hospital revenues in addition to the employer payroll tax. Even before its apparent demise in late January, many observers had expressed concern about the plan's viability because of the cost of the plan at a time when the state faced a massive budget shortfall.<sup>62</sup>

Other states have attempted smaller, more incremental programs to expand health coverage to its citizens, particularly children. Maryland and Texas joined the fifteen states that

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<sup>58</sup> See Community Catalyst, Inc., “Revisiting Massachusetts Health Reform: 18 Months Later,” published December 2007; and Alice Dembner, “Mass. Panel Approves Changes to Subsidized Residents Health Plan,” *The Boston Globe*, December 14, 2007.

<sup>59</sup> McDonough, et al, *Health Affairs* 2008, op cit.

<sup>60</sup> For a more detailed analysis of state ability and variability in developing health reforms, see Peter J. Cunningham, *Overburdened and Overwhelmed: The Struggles of Communities with High Medical Cost Burdens*, The Commonwealth Fund, publication 1073, November 2007.

<sup>61</sup> See George Skelton, “Healthcare Plan's Death Shows the System Works,” *Los Angeles Times*, January 31, 2008.

<sup>62</sup> Kaiser Daily Health Policy Report, “Schwarzenegger, Nunez Submit Ballot Initiative for Health Care Reform Proposal,” January 2, 2008, [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=49621](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=49621).

have created programs to subsidize insurance for small businesses and individuals, and four states effectively guaranteed that all children could be insured through expanded eligibility for [Medicaid](#) and the [State Children's Health Insurance Program](#) (SCHIP). An additional thirteen states passed more modest expansions for children. Any continuation of that trend in 2008 would likely depend on Congress and President Bush settling their considerable differences over financing an expanded SCHIP, which the Congress passed and the President twice vetoed in 2007.<sup>63</sup> The experiences and struggles of states like Massachusetts and California to enact and implement meaningful health reform highlight the difficulties of states overcoming their own political divisions and financial struggles within a darkening national economy and a state requirement for a balanced budget. Robert Blendon, a Harvard professor of health policy and political analysis, concurs: "It remains incredibly difficult for states by themselves to get all the uninsured covered," he said in a recent *New York Times* article. "There just is not a consensus on who should pay."<sup>64</sup> The legacy of these states' attempts at health reform may suggest that a national solution is needed, or at least greater federal assistance to assist states. Legislation recently introduced into the U.S. Senate and House, "the Health Partnership Act," may pave the way for federal government grants to states to help fund innovative approaches to coverage, cost and quality.<sup>65</sup>

### *National Reform*

Despite the difficulties of state reform efforts, the actions of Massachusetts and California demonstrate that a bipartisan effort to define basic principles of health reform is not impossible. Their actions in part paved the way for the current national conversation about health reform as part of the 2008 presidential election. Each of the major candidates has fashioned plans to improve coverage and control costs in our current health care system. The plans tend to fall along partisan lines and ideologies, with the Democrats endorsing new government mandates and taxes to capture the 47 million who currently go without comprehensive coverage, while the Republicans propose more modest market-based solutions to control costs. To pay for the reforms, Democrats generally suggest allowing President Bush's tax cuts for the highest-income earners to expire on schedule as planned, and ending the war in Iraq. Republicans focus on more competition in insurance markets, economic efficiencies, and increased consumer cost-sharing, as well as relying on tax benefits to encourage the voluntary purchase of health coverage. Some analysts<sup>66</sup> believe that the Republican preference for market solutions will have little effect on increased coverage rates because, as shown in Massachusetts, unless the government or the employer pays most of the premium, individuals will not buy health insurance. Alternately, opponents of government-regulated health reforms contend that

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<sup>63</sup> Ibid

<sup>64</sup> For a discussion of recent actions in California and overall state health expansion attempts in 2007, see Kevin Sack, "States' Widening of Health Care Hits Roadblocks," *New York Times*, December 25, 2007, accessed at: [http://www.nytimes.com/2007/12/25/us/25health.html?\\_r=1&adxnnl=1&oref=login&adxnnlx=1200244635-7gpm0xBQPzu+4oifnymm3w#](http://www.nytimes.com/2007/12/25/us/25health.html?_r=1&adxnnl=1&oref=login&adxnnlx=1200244635-7gpm0xBQPzu+4oifnymm3w#).

<sup>65</sup> For information about the federal bill, go to: <http://thomas.loc.gov/cgi-bin/query/z?c109:s.2772>.

<sup>66</sup> This statement is attributed to David Grande, a senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania. See article, "Presidential Candidates Push Health Care Reform, but Who Will Pay?" Published in the on-line newsletter, *Knowledge @ Wharton*, From: Knowledge@Wharton Article, October 17, 2007, <http://knowledge.wharton.upenn.edu/article.cfm?articleid=1827> accessed January 5, 2008.

individual mandates and increased taxes on businesses will create a too costly, “one size fits all” health system that hampers individual choice, raises prices, and suppresses market competition.<sup>67</sup>

### *Dimensions for the Discussion of Health Care Reform*

Is it possible to define then, for the country as a whole, basic dimensions for the discussion of health reform in this country? Perhaps we could begin with five basic dimensions. First of all is the question of whether it is important that all or almost all Americans have some form of health coverage, whether financed privately, publicly or in combination. This does not mean “socialized medicine,” since it is extremely unlikely that the U.S. government will ever engage directly in the provision of health care to most Americans as they do now, for example, for veterans. Nor does it mean that we need to adopt the approach taken by any particular country, such as Canada, in financing the provision of health care largely through the public sector. Liberals would advocate for universal coverage with government mandates – in effect, requiring streams of funding for health coverage to come either from individuals, employers, government or some combination of these. Conservatives would advocate mainly for expanded private coverage through private markets, with any government financing coming in the form of tax breaks to offset the cost of private purchases of insurance, and overall a more limited role for government. No doubt there would be disagreement about how this complex financing system would be structured. Some might even quarrel with the notion that everyone should have basic health coverage (remember the twin values of “rugged individualism” and “individual responsibility” cited earlier). Learning from state programs may well give us information about what works (and what doesn’t), and some will argue that states are the most appropriate governmental body to promote innovative service delivery. Others will counter that the federal government must at least take the lead in health reform, even if a portion of the work is delegated to states; otherwise, without a stated national commitment to universal coverage, more than one in five Americans may be uninsured within the next two presidential elections.<sup>68</sup> Despite these stark differences, areas of agreement do exist between these approaches. All would likely agree that coverage must be affordable, pay for a set of minimally acceptable services, and be portable from job to job.

Secondly, should the U.S. system have both a public and a private component? Currently, there are pure single-payer advocates as well as those who are in favor of purely private sector insurance. Others will point to the fact that the current system has a combination of the two, and argue that the goal is to stretch both forms of coverage – public and private – to cover more people. This could be accomplished either by keeping employer-sponsored health care and expanding it, or by creating a new system in which private insurance is provided through large risk pools outside of the work place. Whatever the structure, its viability will depend on the inclusion of two important features: choice (a time-honored American preference) and understandability. Any proposal that expects the poor, less educated, and the elderly to know how to take advantage of a tax deduction or tax credit without a system that provides personalized education will never be adopted. To achieve these goals, liberals advocate

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<sup>67</sup> Turner, Grace-Marie, “Toward Free-Market Health Care,” Heritage Lectures, The Heritage Foundation, May 4, 2007; see also a recent January 11, 2008, *Wall Street Journal* letter to the editor from Kate Campaigne, Legislative Specialist at the Heartland Institute, Chicago, IL, where she argues against universal coverage and government mandates.

<sup>68</sup> Gilmer, Todd and Richard Kronick, “It’s the Premiums, Stupid: Projections of the Uninsured Through 2013,” *Health Affairs*, op cit.

expansion of government safety net programs like Medicaid and SCHIP, with a regulated insurance industry that leans more toward consumer information and eligibility protections for those with higher health risks. Conservatives, on the other hand, would first and foremost advance a policy that maintained individual, not societal, responsibility for their own health and the health of their children, even with the help of subsidies and tax breaks. In their view, this would best be accomplished by less, not more, insurance regulation, and would allow individuals to choose policies that may cover less but are less expensive as well. The philosophical difference between the two views rests on what and how much health coverage should be obtained and who is responsible for making the decision. Although the differences are vast, there is some common ground in the area of affordability. Liberals prefer safeguards such as a cap on the percentage of a family's income that can go toward the purchase of health services, while conservatives believe more in the creation of an efficient and affordable private health insurance marketplace that encourages individual choice and competition. But both approaches are cognizant of the need to control costs, although few if any workable proposals have been advanced to do so.

Third, we can all agree that a reformed health system should assure the highest possible level of quality while controlling costs. It is essential to link the two. Both liberals and conservatives believe that a reformed health care system must include electronic health records that improve care, reduce errors and lower cost, which can be achieved by public/private "carrots" or "sticks," or both. Cost must be addressed in a number of ways, beginning with elimination of waste, whether it is in the form of administrative paperwork, overuse of services because of payment incentives to physicians and hospitals to do more, or overuse and/or overpayment for new drugs and new technology that offer little improvement. The underuse of preventive services also must be corrected, and disparities in access to health care or in health outcomes on the basis of race, geography or economic factors must be addressed. Both liberals and conservatives agree, generally, in this principle, but whether taxes and mandates are used or competition and incentives to innovate are used to achieve the ends separates the two policy directions. One area in which both liberals and conservatives agree is that competition among health care providers, if based on quality and access, can be a positive force.<sup>69</sup>

Fourth, another area of agreement in principle: people must take more responsibility for their health. How broadly this statement applies is open to debate. It is likely that all would agree that personal responsibility should be in partnership with people's own health care practitioner by actively working to maintain their own health (starting with obesity and smoking) and managing their chronic illnesses. However, how far? Would personal responsibility extend to the idea that, as a matter of personal responsibility, all Americans should be required to have health coverage, and pay their fair share, with the poorest offered either a government program or a subsidy to buy insurance? To this end, some liberals would support a governmentally enforced individual mandate, provided enough financing was available to make coverage affordable to individuals. Although not every conservative today believes in an individual mandate to obtain health coverage, it is instructive to remember that it was part of some Republican health reform efforts in the early 1990s and an essential aspect of Governor Mitt Romney's state-based universal coverage plan in Massachusetts. While liberals now emphasize building on the employer-based system and public programs, and the conservatives prefer an approach in which people purchase insurance themselves in the individual market, both agree

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<sup>69</sup> Bodenheimer, 2005 *Health Affairs*, op cit.

that designing a system of “shared responsibility” bridges some of the disagreements between the two approaches.

Lastly, all would agree that mechanisms for funding the system must be explicit, attainable and accountable. Prevention is essential but we can’t count on it to save money to pay for the uninsured. Think about it: in the extreme, we prevent disease so we can all get to 85 when half will develop Alzheimer’s. We invest in preventive care because it improves our quality of life, not because it saves money.<sup>70</sup> By the same token, modern information technology may save money for doctors, hospitals, patients and insurers, but the government won’t necessarily see those savings. In a shared responsibility model, individuals would be expected to pay for a part of their coverage and businesses would have a responsibility to provide health care coverage for their employees or pay their fair share, with exemptions for the smallest businesses. The conservatives would choose less comprehensive goals and coverage options, with catastrophic protection coupled with tax preferred savings accounts for routine care in order to encourage prudent use of health services. Liberals favor more comprehensive proposals emphasizing prevention and financial protection against illness. Although both sides agree that funding mechanisms must be more transparent and fairer, they do not agree on the coverage-cost trade-off to bring everyone into the current system. The cost of covering the uninsured is between \$80 to \$120 billion per year — this is new money that must be identified if universal coverage is accomplished.<sup>71</sup>

#### *Proposals of Current Presidential Candidates*

Given our principles, how do we evaluate the current menu of plans laid out by the presidential candidates? Republican Senator John McCain’s plan echoes the conservative sentiment and President Bush’s proposal, laid out in his 2008 budget, to restructure the so-called tax exclusion on employer-paid health insurance, and use the proceeds to pay for tax incentives for people to purchase health insurance on their own. In order to control costs, the Republican plan advocates deregulation of state-based insurance markets (thus allowing small businesses to purchase health insurance outside of state lines), reform of the medical malpractice system (mostly in the form of caps on punitive and noneconomic damage awards), and expansion of health savings accounts (making Americans more price sensitive as they purchase more health services with money in tax-advantaged accounts).

The Democratic plans differ. Senator Hillary Rodham Clinton includes individual mandates to purchase health insurance and substantial subsidies to small businesses to offer coverage for their workers. Senator Barack Obama shuns a broad individual mandate, only requiring parents to provide insurance for their children. Both plans include regulation of private insurance companies to protect those with chronic illnesses and high health risks. Both support the establishment of new insurance purchasing pools for individuals and businesses that include a new public “Medicare-like” coverage plan. Both provide government subsidies based on income to purchase insurance, and both expand Medicaid and SCHIP to cover more of the low-income. Cost-saving measures in the two Democratic plans include new payment models that foster development of electronic medical records and reward providers for cost-effective, appropriate care, including preventive care and disease management. No presidential candidate in either party has put forth a comprehensive plan for paying for health reform, but Democrats do

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<sup>70</sup> See J. T. Cohen, P. J. Neumann, and M. C. Weinstein, “[Does Preventive Care Save Money? Health Economics and the Presidential Candidates](#),” *NEJM*, Volume 358(7): 661-663.

<sup>71</sup> See Garson and Engelhard, op cit.

say they would finance reforms in part by allowing President Bush's tax cuts for high-income citizens to expire on schedule and dedicating that revenue to health coverage, and through administrative efficiencies.<sup>72</sup>

At the end of the day, Democrats and Republicans can perhaps agree on a few of the principles surrounding improved access to services, insurance coverage, cost control, and quality improvement, but they differ markedly in how they see Americans and America. At one extreme, the most left-leaning Democrats would like to shore up the social contract with a more European-style system that ensures equity through income redistribution and slows the dissemination of some expensive new technologies. However, many more right-leaning Americans embrace values that are distinctly non-European, such as antipathy for centralized government tax increases and a similarly strong desire for access to every new health and beauty aid.<sup>73</sup> The Republicans prefer a more decentralized approach with state experimentation, insurance deregulation, and cost control measures at the individual level. This matches the value of "rugged individualism," but places many in the individual health insurance market, which utilizes medical underwriting and may decline to insure those with chronic illnesses and high health risks. In short, the individual health insurance market as currently constituted works reasonably well, if expensively, for the healthy; it doesn't work at all for the sick. That is why the leading alternative for decades has been group health insurance, in which medical underwriting is unnecessary because costs are spread across the healthy and sick alike.

What they may also agree upon is that expanded coverage will require new monies, even with administrative efficiencies and other kinds of cost controls.<sup>74</sup> This is because those who gain health coverage will use more than they did before, and ensuring overall improvements in health across the population will require many Americans to use more, not fewer, health services. How much more this will cost society depends upon the size of administrative savings, identification of which health benefits can be eliminated or reduced, and the net cost and savings of improvements in efficiency and quality. Current estimates are between \$80-120 billion per year.

## VI: Are We There Yet?

With all the national attention and societal pressures, it is tempting to believe that the moment for true health care reform has arrived in this country—right? Americans are worried about losing their health coverage and dissatisfaction with the U.S. health system is widespread. In the 2007 Health Confidence Survey, almost one in four Americans stated that there is so much wrong with our health care system that it needs to be completely overhauled, and sixty percent ranked the current system as fair or poor. More than eight in ten responded that they were

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<sup>72</sup> Oberlander, "Presidential Politics and the Resurgence of Health Care Reform," *NEJM*, op cit.

<sup>73</sup> The notion of a social contract and the distinctly American version of what it means is covered in David Brooks, "The New Social Contract," *The New York Times*, September 7, 2007. In this op-ed, Brooks features the work of Stuart Butler of the Heritage Foundation, who lays out the specifics of a hybrid, but conservative leaning, health reform built on restoring the American social contract. For more information, go to: <http://www.heritage.org/Research/Family/hl1039.cfm>.

<sup>74</sup> Aaron, H. in "Budget Crisis, Entitlement Crisis, Health Care Financing Problem – Which Is It?" *Health Affairs* November/December 2007, 26(6): 1622-1633.

dissatisfied with the cost of health insurance or with costs not covered by insurance.<sup>75</sup> The National Federation of Independent Businesses, the trade association for many small employers in America, is on record as saying that it believes our current system of health insurance and health care is financially unsustainable and threatens the health and financial security of the American people.<sup>76</sup> At a forum sponsored by the General Accountability Office (GAO) in September 2007, health policy experts, business leaders, and public officials were in agreement that the federal government should ensure all Americans are covered for basic and essential health services and that the federal government should take the lead in developing indicators to measure the U.S. health system's outcomes and performance.<sup>77</sup>

Henry Aaron of the Brookings Institution concurs and further suggests that the cost-coverage problems are linked: that control in the growth in health spending will only come with some form of universal coverage.<sup>78</sup> This is because control of public spending will be ineffective if private-sector spending is not also controlled, and some form of universal coverage with spending limits is the only way to effectively control the growth of overall health costs. Aaron goes on to suggest that viewing universal coverage in this way is inherently nonpartisan, as the mechanism to implement a program that promotes coverage for all Americans can be through either market-based strategies or through government-program expansions. A recent study from the Commonwealth Fund came up with a similar conclusion and outlines fifteen federal policy options that incorporate universal coverage with the potential for lower spending and improved health.<sup>79</sup>

All of this suggests that the time for health reform in this country may have finally come. Yet, we know, as demonstrated by the multiple times health care reform has been attempted over the last one hundred years, just because health reform is on the national agenda and there seems to be substantial support for it, actually getting reform through our political institutions and accepted by powerful interest groups is extremely difficult. And American voters are fickle: they respond in polls that they are very worried about health care costs but the issue rarely seems to make it into the voting booth. Historically, public opinion polls suggest that health care is a second tier issue behind the economy and, since 2001, national security issues.<sup>80</sup> More recent surveys<sup>81</sup> demonstrate the long-standing conflict that has dogged every health reform overhaul dating back to President Truman: Americans support the principle of extending coverage to millions of people but only if they don't pay more taxes for others and have the same access to physicians. The demise of the last attempt under President Clinton speaks to the extreme difficulty of moving our country toward comprehensive health care reform.<sup>82</sup>

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<sup>75</sup> Employee Benefit Research Institute, *2007 Health Confidence Survey*, as reported in EBRI Notes, Vol. 28, No. 11, November 2007, [http://www.ebri.org/pdf/notespdf/EBRI\\_Notes\\_11a-20071.pdf](http://www.ebri.org/pdf/notespdf/EBRI_Notes_11a-20071.pdf).

<sup>76</sup> NFIB, *Small Business Principles for Health Care Reform*, [http://www.nfib.com/object/IO\\_35533?\\_templateID=315](http://www.nfib.com/object/IO_35533?_templateID=315).

<sup>77</sup> GAO Highlights, September 2007, *Health Care 20 Years from Now: Taking Steps Today to Meet Tomorrow's Challenges*, [www.gao.gov/cgi-bin/getrpt?GAO-07-1155SP](http://www.gao.gov/cgi-bin/getrpt?GAO-07-1155SP).

<sup>78</sup> Aaron, H. in "Budget Crisis, Entitlement Crisis, Health Care Financing Problem – Which Is It?" November/December 2007, *Health Affairs*, op cit.

<sup>79</sup> See Schoen, C., et al, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, The Commonwealth Fund, December 2007.

<sup>80</sup> Blendon, R.J. et al, "Understanding the American Public's Health Priorities: a 2006 Perspective," *Health Affairs*, op cit.

<sup>81</sup> Kevin Freking, "Healthcare: It's Hard to Figure Out Voters," *Miami Herald*, December 11, 2007, [www.miamiherald.com/campaign08/story/340159.html](http://www.miamiherald.com/campaign08/story/340159.html).

<sup>82</sup> Oberlander, "Learning from Failure in Health Care Reform," *NEJM*, op cit.

Are there signs that this moment in history is different? The public has clearly rejected using pure market principles since they support public health programs like Medicare, and yet the public has not yet expressed a collective demand for a larger role of government to allocate health benefits to everyone.

Although government mandates to purchase health insurance are typically seen as a liberal-leaning solution to the problems of the U.S. health system, mandates also satisfy many more market-driven people because mandates address the “free rider” problem in which those who are young and healthy choose not to pay for health coverage even if they have the money. But implementing mandates can be tricky, and some experts contend that individual mandates may, but don’t always, increase coverage. This is because a high compliance rate requires that mandates be easy and relatively inexpensive, that penalties for noncompliance be stiff but not excessive, and that enforcement be routine and frequent.<sup>83</sup> As we have seen in Massachusetts, implementing individual mandates may be difficult because of the balance point between what is affordable to an individual household and the cost of basic but adequate health coverage. Therefore, as rational and potentially bipartisan as individual mandates initially sound, providing adequate subsidies to Americans to make required health coverage affordable and then monitoring compliance will be expensive. This begs the question of where the money will come from and how any new program’s funding will be balanced with the anticipated budget shortfalls in the Medicare and Medicaid programs.

At its core then, the current national conversation about health care reform is starting to look like a replay of the past, a reflection that goes beyond simple political partisanship and requires a debate about the thorny issue of the role of government in the lives of Americans. Unlike other developed countries where health care is considered a “merit good,” where every person has a right to health care regardless of ability to pay, those in the U.S. who fear government involvement continue to believe that, if only we could change the information flow and how providers are paid, health care would become like other societal goods and services and the market would work without a government role.

If history is our guide, incrementalism will prevail,<sup>84,85</sup> and for the near future we will continue to chip away at health reform.<sup>86</sup> The kind of sacrifice and social obligation that occurred after the Second World War and that helped create Medicare and Medicaid despite opposition from an assortment of special interests is hard to imagine today.<sup>87</sup> Not even the World Trade Center bombing on September 11, 2001 or the humanitarian devastation of Hurricane Katrina four years later was severe enough to prod us toward a spirit of shared sacrifice in the form of comprehensive health policies.

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<sup>83</sup> Sherry Glied, et al, “Consider It Done? The Likely Efficacy of Mandates for Health Insurance,” *Health Affairs*, Vol. 26(6): 1612-1621; Glied suggests that the effectiveness of individual mandates depends on the cost of compliance, the penalties for noncompliance, and timely enforcement of compliance.

<sup>84</sup> Steinmo, Sven and Jon Watts, “Why Comprehensive National Health Insurance Always Fails in America,” *Journal of Health Politics, Policy and Law* 20.2 (1995), op cit.

<sup>85</sup> Oberlander, Jonathan, “The Politics of Health Reform: Why Do Bad Things Happen to Good Plans?” *Health Affairs* 27: 433-446. The author discusses the various unsuccessful attempts at comprehensive health reform over the last fifty years, and suggests that one reason for the lack of major reform is that incremental changes are more attractive to most Americans, notably in the form of either tax credits or expansion of public programs.

<sup>86</sup> Victor Fuchs has argued this for over 25 years, but most recently in a *Health Affairs* perspective, “What Are the Prospects for Enduring Comprehensive Health Care Reform?” op cit.

<sup>87</sup> Bloche, M.G., “Health Care for All?” *NEJM* 357(12): 1173-1175.

Over time, as new generations of Americans begin to think more about themselves and their families, it is possible that they will begin to “talk over the back fence” with their neighbors and develop more of a sense of community. Perhaps this will lead to a stronger sense of a social contract based on what a just and compassionate society would offer. Perhaps the unrelenting cost of medical innovation coupled with the demand for more medical services will force us to temper our unbridled trust in the power of economic markets and lead us to consider the more European utilitarian concept of “rational” rationing in the name of fairness and cost control. Maybe then, finally, the health care reform “merry-go-round” will simply get to the “right place” in history, and public pressure will move politics. Americans may decide that providing basic health care for all (and helping to pay for it) is the right thing to do after all, and a majority will vote for it. Whether it will be because Americans believe they have an intrinsic moral right to health care, and that government has a moral imperative to provide it, or because economic self-interest paradoxically requires government to “set the rules” and determine limits, remains to be seen. If the time is right and the interests align, voters will respond, likely around a presidential campaign. Whether 2008 will be the year for significant health reform will depend on whether the voters, the lobbyists, the President, and the Congress can align the universe of varied interests and pressures. Only then will we move toward a relatively rational, uniquely American, health care system.