

The Middle Class and National Health Reform

Paul Starr

With the recent flurry of proposals for universal health insurance, including a new plan submitted on June 5 by Majority Leader George Mitchell on behalf of the Senate Democratic leadership, a struggle that began three-quarters of a century ago in the United States entered another phase. Four times—in the Progressive Era, during the New Deal, under President Truman, and again in the 1970s—reformers believed passage of legislation was close at hand. Yet on each occasion the movement failed and receded.

Should we expect anything different this time? And, bearing in mind the dénouement of previous campaigns, what sort of legislation should we favor—a comprehensive reform of health care finance or a measure that would achieve universal insurance with the minimum disturbance to established institutions?

These are the general questions animating a pair of articles in this issue. Departing from the conventional wisdom in Congress, Senator Robert Kerrey of Nebraska argues that America is ready for a comprehensive change to a single-payer system of national health insurance. Ronald Pollack and Phyllis Torda, in contrast, call for an approach that builds on current arrangements. While similar to the Mitchell plan in requiring employers to provide private coverage or to pay a tax into a public program for the uninsured, Pollack and Torda's proposal is more ambitious in regulating health costs and the practices of private insurers. With health care now widely recognized as perhaps the leading domestic concern of the 1990s—and cer-

tainly the most expensive—the choice among these alternative approaches along the spectrum from incremental to comprehensive reform will be critical.

Standing in the way of any action are formidable political obstacles: the lack of presidential leadership or even interest in health policy, the Democrats' inability to set the national agenda, and the seemingly endless fiscal blockade of domestic initiatives. Yet the underlying pressures for adoption of national health reform in the 1990s, while perhaps not yet strong enough to achieve a genuine breakthrough, are stronger than they have been for decades. That fundamental change is necessary in health insurance, almost everyone agrees. Whether change is possible, nearly everyone wonders. In this respect, health care suffers from the chronic fatigue syndrome that generally afflicts domestic policy under the current administration. (The President's hyperactivity, linked to his thyroid, seems to be triggered only by international affairs and sports.) But consider the following developments.

Thanks to the uncontrollable escalation of health costs and unraveling of private insurance, reform of the nation's health insurance system is being transformed, for the first time in recent decades, into a serious political concern for the middle class. The economic pain caused by the rising cost of health care has become so great, moreover, that it is obliging America's business and political leaders to do something rare and difficult: rethink their assumptions. Both private-sector and

government leaders have long clung to the assumption that they could control health costs within the existing framework of health care finance. Those who had doubts saw little choice; challenging the framework seemed hopeless. It no longer does. Years of tinkering with the framework, all to little avail, have broken down confidence that anything short of structural change will work. And as the pressure develops for structural change to control costs, it reopens and recasts the debate over national health insurance that seemed closed, or at least suspended, in the 1980s.

This linkage may puzzle many people, who have firmly fixed in their minds the idea that national health insurance is a way of spending more money on medical care. That was certainly the case years ago, when a national health insurance program would have represented a sudden surge in finance available for health care. But now the United States has far higher health costs than do other Western countries; we spend over 12 percent of gross national product on health care, compared to only 8 to 9 percent in Canada and Western Europe. Why higher costs here—the one country without universal coverage? Almost certainly because we did *not* enact national health insurance years ago. What Americans have feared as too costly has elsewhere evolved into a system for controlling costs. It could here, too: the additional expense of covering the uninsured is now far outweighed by the additional leverage for cost containment and potential for administrative simplification that a national program could provide. But no one familiar with the system underestimates the difficulties of fashioning and enacting such a program.

One factor raising the chances for comprehensive reform is the increasing jeopardy of the middle class. In retrospect, it is now clear that the growth of employee health plans after the Second World War and passage of Medicare and Medicaid in the 1960s created a virtually insuperable political problem for

advocates of universal insurance. For while the remaining uninsured numbered in the millions, they had no organization or even any clear identity. Scattered across the society, composed disproportionately of children, the uninsured are a population that can be measured but not mobilized. In a social or political sense, they scarcely form a group at all; they experience the same problems but have no voice and make no demands.

As a result, advocates of universal insurance, like advocates of so many other liberal policies since the 1960s, found themselves in recent decades appealing to middle-class voters to support change, not for their own good, but for the benefit of a minority—and a hazily defined, politically inaudible minority at that. As health expenditures grew under both private insurance and government programs, the prospective budgetary impact of national health insurance seemed more and more forbidding. In short, while earlier reforms were reducing the number of people who expected to benefit from universal coverage, they were increasing the perceived cost. To the middle-class taxpayer, even the family of the unionized worker, or the elderly protected by Medicare, national health insurance seemed to promise too little for too much.

With so many Americans more or less protected against the costs of illness, advocates of national health insurance could not easily answer an inevitable question: Why change the system for everyone if it was only failing a minority? Of course, the case could be made—I made it myself—that only a general reform could remedy the deeper pathologies of the system, which are all too apparent today. But for a long time the insulated majority had no compelling reason to take an interest in such arguments. Health insurance generally seemed to be someone else's problem.

That has been changing, particularly during the past decade. In response to rising health costs, employers have modified their insurance plans every which way: they have switched insurers, self-insured,

promoted health maintenance organizations and other plans limiting choice of doctor, required second opinions for surgery and other utilization controls, imposed greater employee cost-sharing in premiums and higher copayments and deductibles. Advocates of "pro-competitive," market-oriented reform have cheered on these measures, and in the mid-1980s, when there was a brief pause in health care inflation, some announced that faith in the market had been rewarded once again. But while one or another measure may have provided some employers partial or temporary relief from double-digit increases in insurance premiums, they have been unable to hold back the tide. At best, firms have managed to get costs shifted to someone else; at worst, they have simply abandoned providing health insurance altogether. The net result is that after years of cost containment efforts, managers are frustrated, and many employees are angry and fearful as they see their health benefits rolled back.

Furthermore, as private insurance companies have refined their methods for rating groups and avoiding the highest health risks, they have put in jeopardy the security of many people who once thought the system protected them. Groups with older employees, particularly small businesses, and even whole industries and occupations find today that they have been red-lined as uninsurable. Millions of people, even with insurance, discover they have no coverage for pre-existing conditions, and others are reluctant to change jobs for fear of losing coverage. In principle, insurance is supposed to spread the costs of sickness among the healthy, but the practices of the insurance industry now run in the opposite direction: concentrating the costs of sickness among those most at risk.

This "desocialization" of health insurance increasingly exposes the middle class to the insecurity of the uninsured poor. Few people under age sixty-five can be entirely confident today that they and their families will continue at all times to be

protected by health insurance. They may be conservative and prudent, even vote Republican; still, if they develop a serious illness and lose their jobs or change employers, the private insurance system cannot be counted on to protect them. In effect, the market-driven responses of employers and private insurers are undoing some of the middle-class insulation from health costs that made it so difficult to construct an alliance for health insurance reform across class lines.

Objectively, middle-class voters have other reasons to support comprehensive reform. One of the major reasons why take-home pay has stagnated in real terms since the early 1970s is the increasing cost of health benefits as well as the share of taxes now taken by health programs. In this respect, however, many still do not sense how much health costs are hurting them, since the costs are partly hidden in employer contributions to health plans, indirect tax subsidies, and complex public budgets. Yet hardly anyone, least of all the business and political leaders who see total costs most clearly, disagrees that the system is dangerously out of control.

This growing recognition of the need for system-wide reforms fundamentally alters the politics of universal insurance. During the 1980s, with national health insurance off the agenda, many advocates of universal coverage concluded that rather than change the system, they would only try to extend it. They defined their objective as the ways and means of inclusion: how to fill in the gaps in health insurance at the least political cost. Consequently, they came to support a variety of incremental steps: requiring firms to provide insurance to their employees; broadening eligibility for Medicaid; creating risk pools to enable those turned away by insurance companies to buy state-subsidized coverage; offering tax credits for individuals and subsidies for small firms to enable them to purchase insurance.

This was a strategy aimed at minimizing

opposition, but it did so with little regard for overall health costs. All these proposed changes are additive: they would add new people to the ranks of the insured and new benefits for some currently underinsured, while taking nothing away from the doctors, hospitals, and insurance industry. Indeed, they achieve universal insurance by some of the most expensive means conceivable. Under present conditions, the administrative costs of insurers for small-business policies run extremely high; the smaller the group, the higher the percentage of the premium costs that go into overhead. Of every dollar in premiums paid by an employer for a group of under fifty workers, for example, only 75 cents get paid out for health care; for a group with fewer than five workers, only 60 cents. From a social standpoint, it is hard to imagine a more inefficient way to cover the uninsured than mandating coverage by small business in the current insurance market. Although public subsidies may enable small businesses to afford the benefits, they merely shift part of a burden that a more rational system would greatly reduce.

While economically inefficient, such an approach has the political virtue of minimizing the tax cost of universal insurance. And since most public discussion of the issue confuses tax costs with total social costs, the supporters of incremental reform reasonably expect that most people will think the approach to be cheaper than national health insurance, which it almost certainly is not. Besides, by increasing the stream of revenue flowing into health care, incremental reforms actually benefit health care providers, who are among the most enthusiastic supporters of such measures. After all, from the standpoint of the doctors and hospitals, the problems of uncompensated care and the uninsured are an inconvenience, an embarrassment, and a source of real losses. What more appealing a way to gain moral standing than to support a praiseworthy reform that will likely increase your income.

These political considerations are shap-

ing the current debate about health reform among Democrats. The Mitchell plan takes the path of incremental reform, with an additional step (or is it a bow?) in the direction of cost containment. By requiring employers to provide coverage or pay into a public program for the uninsured that would replace Medicaid, the plan both minimizes tax costs and places the burden of new taxes on a seemingly culpable party (cheap and irresponsible employers). And by setting voluntary expenditure targets, this approach moves toward cost containment without actually enforcing limits and thereby antagonizing health care providers.

The short-term political logic here is powerful. Frustrated in previous campaigns by the opposition of organized physicians, proponents of universal insurance now see an opportunity to win their support and to avoid arousing the resistance of the insurance and pharmaceutical industries. But precisely because of its accommodation of health care interests, the Mitchell plan does little to repair the problems that generated high health costs in the first place. Some will support the program anyway to get universal insurance coverage; others will support it to get rid of the *issue* of universal insurance. The legislation may just pass, particularly if the Democrats, through some magic not yet apparent, can convince the Bush administration that by accepting some version of this approach it will deprive the opposition of its best campaign issue in the nineties.

However, failure to control health costs or to change insurance industry practices almost certainly guarantees a continuation of current problems for the middle class, business, and the economy at large. Even the currently uninsured who gain coverage under this program will see its value erode unless there is real control of health costs. In the past, when confidence in the current framework of insurance was still strong, it may have made sense to accept the political necessity to build on it. But to build on it

today, when its failures are manifest, is to underestimate the potential and need for change. Perhaps the best that may be said of the Mitchell proposal is that, if it passes, it will advance the point at which comprehensive reform becomes unavoidable.

Comprehensive reform, as I understand it, does not necessarily mean a governmental insurance plan. The key question is not who operates the insurance system, but under what rules it operates. As Pollack and Torda show in this issue, it is possible to combine the pay-or-play model with a unitary framework of rules for insurers to approach, if not altogether to achieve, the advantages of a Canadian-style, single-payer system. In the European countries that insure their entire populations at a cost significantly lower than what America pays for health care, the governments do not necessarily own the hospitals, employ the doctors, or run the insurance plans. But nearly all the governments set limits on health spending and common rules that apply across their health care systems. They often set ceilings on total budgets for hospitals and doctors (a system called "global budgeting"). They limit and regulate capital spending, which shapes the long-run growth curve of the system. If they have multiple insurance plans, they regulate the rates they charge. And they insist that insurance payments to providers constitute payment in full, thereby preventing the providers from using the insurance system as a floor for ever higher charges.

The key elements here are, first of all, a "hard" budget constraint on the health system, forcing decision makers, from physicians to managers, to develop styles of practice and plans of investment that make conservative use of the nation's resources; and, second, a framework for insurance that blocks the segregation of the poor in a second-rate public plan and that prevents insurers from sorting the public according to risk and dumping the highest risks on the public sector.

While the public debate in America is

opening up to more fundamental reforms than Senator Mitchell is proposing, the debate is constricted by a virtually unshakable conviction that any solution will be costly. That is certainly true of the incremental and additive reforms. But it is not true of structural reforms aimed at recasting the framework. With by far the most expensive medical system in the industrialized world, America does not need to put more of its national income into health care. Some other countries, like Germany, that spend less than we do have standards of medical care as high as ours and, according to various measures, better health.

Americans have heard most about the Canadian system. Yet conservatives and health-industry critics have had considerable success in discrediting the Canadian model by pointing to limits in the availability of various high technologies in Canada, implying that national health insurance necessarily results in compromised medical care. But, as Theodore Marmor and Jerry Mashaw wrote in these pages ("Canada's Health Care and Ours: The Real Lessons, the Big Choices," *TAP*, Fall, 1990), a careful analysis shows that the difference between Canadian and American health spending arises in roughly equal degree from three causes: America's drastically higher administrative costs for health care and health insurance, our sharply higher payments to physicians (despite a lower volume of physicians' services in the United States), and our higher capital spending on hospitals. Real benefits to patients can be found only in the latter category, and even there much of our higher cost results from excess capacity and underused technology. By focusing on a few high technologies, conservatives have distorted the larger picture and diverted attention from our bloated private insurance bureaucracy, high physicians' fees, and other excessive costs (such as drug prices that are 50 percent higher in the United States than in Europe).

The lesson of Canada, Germany, and other countries is not that costs can be con-

trolled only by rationing beneficial care. The chief savings are to be found in a reconstruction of health insurance on administratively simpler and less costly lines and in the overall discipline of provider incomes that a unified system affords. But, of course, to secure these savings requires confronting entrenched financial interests. Ultimately, the real determinant of the cost of any health care reform is not the technical details of the proposal, but the political support behind it. A political leadership capable of mobilizing the middle class and American business on the basis of their real interests could use national health insurance to achieve the results that other countries have seen: universal coverage at a moderate and stable percentage of national income. But while the nation's leadership has begun to rethink its assumptions about health care, it has not yet broken loose from a skittish solicitude for established interests that fixes the current system of health care finance in place. ♦

The Private Use of Public Life

Robert Kuttner

Last December, a public interest group called the Center for Public Integrity published a unique analysis of the Office of the U.S. Trade Representative (USTR), titled "America's Frontline Trade Officials."* The center used a wide variety of government documents, newsletters, press clips, directories, and other sources to piece together the career paths of mid-level and senior USTR officials. It found that roughly half of recent

* 201 pages; available from the Center for Public Integrity, 1910 K Street, Washington D.C. 20006.

senior officials subsequently worked as agents of foreign firms or governments. The fraction that left USTR to pursue careers representing other private interests was over 80 percent.

Those with major foreign clients included former trade ambassadors of both parties, including Democrat Robert Strauss, whose law firm has represented the People's Republic of China, Fujitsu, and many others, and Republican William Brock, a long-time paid advocate for Toyota. Deputy Trade Representative Julius Katz was simultaneously a paid consultant to USTR and to French, German, Japanese, British, and Canadian clients with trade policy concerns. Deputy Representative Harald Malmgren's clients have included Korean, Peruvian, and Japanese firms as well as the Japanese External Trade Organization (JETRO).

The story about key trade officials working for foreign interests has been told before in Pat Choate's book *Agents of Influence* and in *New Republic* articles by David Osborne and John Judis. What is new about the center's report is the documentation of a pattern that pervades the entire agency. It isn't just top-ranking officials who put in time at USTR and then represent companies such as Toyota and Toshiba. The more startling finding is that this revolving door is virtually the normal career pattern. For example, the 24 top ranking officials who left USTR during the 1980s served there an average of just 3.27 years, down from just under five years for officials who left during the 1970s. One very senior career official whom I have interviewed on several occasions, Geza Fekatekuty, stands out as an almost unique exception to the norm. Fekatekuty, a highly regarded Hungarian-born civil servant, has unaccountably decided to stay at USTR for his entire career, where he is now senior policy adviser, although he could doubtless cash in his knowledge and double or treble his income tomorrow.

Charles Lewis, the former television producer who founded the Center for