Why Single Payer is Still Our Best Bet

Elaine Bernard

Elaine Bernard is executive director of the Harvard Trade Union Program.

A month before the 1992 Presidential election, the *New York Times* declared, "the debate over health care is over." According to the *Times*, "managed competition won."

Yet, today, in spite of many months of promotion by the *Times* and other media, the campaign for managed competition and the President's health-care plan has stalled, proving to be a hard sell with the public. At least part of the reason is that managed competition is far from the "blueprint" the *Times* explained it to be in October 1992—simply a matter of letting Congress "dot the i's and send it to the President."

The problem is that managed competition was devised, in essence, as a way to preserve the place of the largest firms in the private health-insurance industry. The plan would provide a multi-tier health-care system that would force most Americans into cut-rate health maintenance organizations offering "a standard minimum-benefit package."

Office Worker, New York City - George Cohen/Impact Visuals

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The wealthy, of course, would continue to be able to purchase additional insurance with wider choice and superior access to care.

Managed competition is an awkward, expensive, timid reform that makes sense only when a central goal of health-care reform is to maintain private insurance rather than to assure quality health care for all at reasonable costs.

In spite of pronouncements that it is politically "not feasible," many Americans are continuing to campaign for a universal, single-payer, Canadian-type system. Calling them "the guerrilla fighters of the health-care debate," the *New York Times* described single-payer supporters as "outfinanced by the industry groups, outmuscled by the policy gurus in the White House, viewed by most of the pundits as hopeless idealists." Viewed as marginal by the politicians and media alike, the *Times* nevertheless warned that these advocates still constitute "a force to be reckoned with in the coming struggle on Capitol Hill."

Managed competition is more tightly linked to the single-payer issue than most people realize. No, it is not the half step in the direction of single payer, as has been argued by some advocates of managed competition. Rather, it is designed to appear to do what we know single payer can do: hold down costs, assure universal coverage, and eliminate administrative waste and duplication. But it does so by leaving private insurance, which caused many of these problems in the first place, in the driver's seat.

What's So Radical about Single Payer?

In order to sell managed competition, advocates have promoted it as "the only reform that has a realistic chance to control costs as coverage is extended to millions of uninsured Americans." Since managed competition provides inferior coverage at greater cost than a publicly administered single-payer system, its advocates have clearly concluded that people will only find it acceptable if they are convinced that no other solution is possible.

As a result, we've seen a widespread attack on the single-payer model. The most frequent attack simply dismisses single payer by declaring it "utterly unrealistic," and "too radical for American politics to digest," as a *Times* article put it on May 4, 1993. This tack has been very successful to date, and, unfortunately for the public, it has become a self-fulfilling prophesy. Permitting a rather paltry reform—such as adoption of a single-payer insurance system—to be pegged as the outer extreme of radical reform in the health-care debate greatly limits the discussion of options.

What, after all, is so radical about a Canadian-type single-payer health-care system? To begin with, let's be clear. What we're talk-

ing about is not actually health-care reform, it's merely health *insurance* reform. An irony of the current discussion is that what is being touted as the great US health-care debate hardly mentions health *care* at all.

The main difference between the Canadian and American health-care systems comes down to how each pays for health-care *insurance*. The majority of doctors in both countries are private, for-profit, independent business people, charging patients on a fee-for-service basis. In the US, patients pay their bills through a patchwork of varying levels of insurance coverage and a variety of additional out-of-pocket payments. In Canada, health care is paid by universal, comprehensive insurance coverage from a public insurance agency, which is financed by general tax revenues. Canadians simply eliminated the role of private insurance companies in basic health-care coverage and replaced them with publicly administered provincial insurance agencies.

Single payer, in fact, is not a radical alternative to the free market in medicine. Rather it is a compromise between a genuinely radical alternative to for-profit medicine (socialized medicine) and the United States' current costly, discriminatory, inefficient system of private insurance.

Although it is a compromise, however, single payer can readily deliver much what most Americans they say they want: freedom of choice of doctor, no bills, no premiums, no co-pays, no lifetime maximum, no managed care by an insurance clerk, and lifelong security with "insurance that can not be taken way." And it can do so at a cheaper total price than the US currently pays for health care.

So why is single payer called "politically unfeasible"? Because it is not what the insurance, pharmaceutical, hospital and medical-equipment industries want. What concerns them about single payer is the tremendous bargaining power the public insurance agency would hold.

Canada: False Problems...

Increasingly, as the single-payer "guerrilla fighters" continue their campaign with the grassroots, opponents of a single-payer system have used a second prong of attack—to write "exposés" of the Canadian single-payer system showing that it too is in crisis. Adopting a similar system in the US, they argue, would not solve the health-care crisis; indeed, it might result in simply inheriting an additional set of problems.

The *New York Times'* front-page feature story, "The Bill Comes Due: Canada's Health Care Costs" (March 7, 1993), was a typical example of this genre. The main point of the story was to explain that "like the United States, Canada, with a radically different system...faces exploding medical costs...and spending outstrips Government's ability to pay." The article contends that while "no one wants to dismantle the most popular Canadian social program...there is talk of changing some of the ground rules." It then details some cost-cutting measures under consideration by a few provincial governments.

Unfortunately, the *Times* article is typical in that it does not offer readers a description of these "ground rules" that provide a necessary context for understanding the health-care discussion in Canada—where the focus is on seeking cost savings with periodic adjustments within the existing system rather than signifi-

cant change to the overall system. Nor does it mention that no one in Canada has suggested that Canadians switch to the American model.

While, at first glance, the cost concerns sound similar to the debate in the US, the Canadian health-care discussion starts from a very different base. Most importantly, Canadians can focus on the cost issues because they have for the most part resolved the access and quality issues. Canadians have made important gains in establishing health care as a right of all residents based on five principles. The Canadian health-care system is 1) universal (it covers all residents), 2) comprehensive (it covers all medically necessary services), 3) accessible (it provides access to everyone with no spending ceiling), 4) portable (it is not linked to employment and coverage in one province is recognized in all other provinces), and 5) publicly administered (in each province it must be run by a public, nonprofit agency). Doctors, as in the US, are private entrepreneurs and are reimbursed on a fee-for-service basis according to periodically negotiated fee schedules. Hospitals, which are private, nonprofit corporations overseen by community trustees, receive an annual global budget. Would public institutions of this sort be unprecedented in the US? A rather similar system is used in the US to finance police and fire departments—and few would argue that those services should be provided on a fee-for-service basis.

...and Real Ones

Despite the Canadian system's success in providing quality health care for all, it has not completely eliminated pressures from powerful groups, including hospital administrators, physicians, health-care worker unions, and, to a lesser extent, private insurance companies (which can offer insurance for services and items not covered by the public plans). All of these players are jockeying for greater power, resources and control within the system. But issues of resource allocation in health care are public issues in Canada, open for public debate and scrutiny. Governments are elected—and rejected—based

Health Care Demonstration, New York City - Christopher Smith/Impact Visuals

on their management of the health issue.

In Canada, it is widely recognized that an important part of a publicly administered system is open and ongoing public debate over allocation of resources and level of service. The *Times* notes, for example, "despite the financial constraints," that Ontario and British Columbia have both quickly expanded their open-heart surgery capacity—in response to public pressure over delays.

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While the *Times* admits that the Canadian system "provides good medical care to all its citizens at a lower cost than in the United States—averaging 1,915 American dollars per person in 1991...compared with $2,868 in the United States," it nevertheless maintains that the Canadian system is in a crisis where "spending in recent years has grown nearly as fast as in the United States, and is outstripping the ability of the public sector to pay."

Yet, while some readers may have envisioned Canadians paying exorbitant taxes to pay for this system, in fact they pay only three percent higher taxes than their counterparts in the US—and in return receive not only comprehensive health coverage, but also a far more generous overall social-benefits package.

Protesting Too Much?

If the evidence is clear about the costs savings of a single-payer system, why has the campaign against it been so virulent?

Some companies one would expect to oppose the single-payer option: insurance companies (who risk being eliminated from a very lucrative market), doctors (who would be forced to negotiate a fee schedule with the single-payer agency), and pharmaceutical companies and for-profit hospitals (which similarly fear a cut in their profits).

Other companies, however, one would expect to see supporting significant health-insurance reform. These include the majority of large employers, for example, who are already providing health-care insurance for their employees, and who currently pay approximately 10 percent or more of their payroll on health care. This ought to be a major constituency for reform—though not necessarily for the single-payer option. It is this group that the Clinton plan was particularly geared to court, agreeing as it does to have the public foot the bill for health insurance of early retirees, and assuring that the health-care costs for large employers would be capped at 7.9 percent of payroll.

These are tremendous bonuses for some businesses. At Bell Atlantic, for example, a 7.9 percent cap on health-care expenditure would save the company $52 million annually (based on 1992 payroll figures). For these large employers, any reform that controls costs and forces their competition to pay into a universal health-care insurance system would both reduce their expenses, and increase expenses for their free-loading competition.

One would thus expect at least the large employers who already provide health care to

support any system that shared out the cost of health care among all employers. Yet, the large employers balked at supporting universal health-care reform—even though it would mean increased profits for their companies. Apparently, they were worried about the frightening precedent of permitting the government to regulate one-seventh of the national economy (total health-care expenditure is currently 14 percent of the gross domestic product). In the face of such corporate class-consciousness, one only wishes that the progressive community had as clear a sense of social mission and representation.

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What Happened to Progressives?

Early on, progressive support for a single-payer plan seemed clear. But as some of the key players were wooed by the Clinton camp, progressives seem to have quickly collapsed into support for the Clinton plan as the best we can get. Unfortunately, as the Clinton plan comes under attack from both single-payer advocates and right-wing advocates of the status quo, it is clear that progressives have made a tactical error. By sliding into the President's pocket too quickly, they have helped the administration to politically write off single payer—a far easier system to explain than managed competition, and one the Clintons and most Americans seem to have had some real affinity for in the early stages.

Today, progressives find themselves on the defensive, trying to hold onto key elements in a much weaker and more-difficult-to-explain program—one even the President has said is open for amendment. Had major progressive forces, most especially the labor movement, been united in support for single payer, the dynamics of the debate within Congress and around the country would be very different today. Too many in the progressive community bargained themselves down to what they thought "Congress would go for" long before the bargaining had even begun.

The most important principle lost in the current debate is universality. While the President has said he will not sign a health-care reform bill that does not provide for universal coverage, he has moved the goal posts from universality meaning everyone getting quality, comprehensive coverage, to universality meaning a multi-tier system—quality care for those who can afford it, basic care for those who cannot.

Universality could have been the building block for a new, politically unifying strategy for progressives—and could help demonstrate the positive role of public enterprise and regulation. In the US, social programs have tended to be targeted to specific groups, and end up causing resentment among people who feel that they must pay for these programs but cannot receive any benefits from them. This explains at least part of the "tax revolt" phenomenon in the US. Also, the target group receiving the benefit is usually relatively pow-

erless and not able to mount a campaign to maintain the quality of the service they are receiving. This is clearly the case in welfare, Medicaid and other targeted programs.

The question is not whether there will be reform, but what type of reform we will have and who will pay the bill.

Universal programs, such as a single-payer health-care system, are better able to assure quality for all by extending the service to socially powerful groupings. The poor and disadvantaged are included in the system with no social stigma of "special programs" attached to their rightful entitlement. Working people pay for the service with their taxes, but they also garner the benefits personally and directly. Canadian progressives are adamantly opposed to a two-tier system, with a private system paralleling the public one, because it would allow the wealthy and powerful to buy superior care and reduce the pressure to maintain quality for all. They recognize that universality is a useful political strategy that builds social solidarity.

While President Clinton uses the term "universal" to describe his health-care reform, the unfortunate reality is that it is a multi-tier program that is universal only in the limited sense that everyone will have some form of health care. Under it, Americans will get care according to their ability to pay—not according to their health-care needs.

Increasingly, single-payer advocates are being told that they must abandon their campaign, and come over to the Clinton plan (a rapidly moving target at best) as the only realistic reform possible at this time. The threat is made that if we do not go along with the Clinton plan, we will lose the opportunity, possibly for decades, of significant health-care reform.

This is the age-old promise of reformers that half a loaf is better than none. But this argument is false on two points. First, with health-care spending currently at 14 percent of the US gross domestic product—significantly higher than any other country in the world and rapidly rising—there will be health-care reform. With predictions that, unchecked, costs will rise to an astonishing 17 percent of the GDP by the turn of the century, reform will have to be sooner rather than later. The question is not whether there will be reform, but what type of reform we will have and who will pay the bill.

Second, single-payer advocates need to consider that, if we support a half-measure that is *seen as* government-regulated health care but in fact leaves private insurance in control, we will be blamed for all of the faults of the new system without getting any of the control that single payer provides.

The Good News: HR 1200

There a realistic alternative: H.R. 1200, sponsored by Jim McDermott and Paul Wellstone. H.R. 1200 proposes a Canadian-style single-payer plan, and is sponsored by 92 Representatives and six Senators. It is endorsed by Consumers Union, Public Citizen, the American College of Surgeons, the New England Journal of Medicine, the National Medical Association, the American Medical Women's Association, the American Public Health Association, Physicians for a National

Health Program, and thousands of others who see single payer as the way out of the current health-care crisis.

At the state level, single-payer advocates in California have succeeded in collecting over a million names to put a single-payer referendum on the ballot in this fall's election. Such state initiatives can play a very useful role in the health-care debate. First, they provide an opportunity to place single payer at the center of health-care reform proposals. Second, they provide the opening for doing the important educational work on what single payer is and how it works. Finally, they are a very concrete way of showing that single payer is not only politically feasible, but is preferable for millions of people in the US. While it will be necessary in the long run for single payer to be a national system, in the short run, the state-by-state campaigns can help to revise the political agenda on single payer.

Does a national single-payer plan stand a chance? To quote Yogi Berra, "It ain't over 'til it's over." Ultimately, health-care reform is about building a political constituency that demands quality health care as a right. The conservative agenda in the US is aimed at lowering expectations, convincing us that change is not possible, and demonstrating that there is no role for government in providing social services. The current debate on health-care reform is exciting in that, on this essential social service, millions of Americans are prepared to challenge the rule of the market and health care for profit. They are rejecting conservative arguments and coming to the conclusion that health care is a right, not a privilege only for those who can afford it. The health-care debate needs the single-payer campaign—that is the only plan under discussion that advocates a real universal health-care system.