Whitney for Governor 2006

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How We Can Win Health Care for All

A Position Paper by Rich Whitney, Green Party Candidate for Governor

The United States is the only industrialized country in the world that does not guarantee health coverage for its population.

The U.S. spends far more on health care per person than any other country in the world – in fact more than twice as much as the average for other rich countries. We have the best technology and certainly among the finest physicians. Yet we are not getting our money's worth in terms of good health.

The United States ranks near the bottom of the industrialized world in life expectancy, infant mortality, and other standard measures of health. The World Health Organization ranks the United States 37th in overall quality of health-care performance. No wonder, since so many don't have health-care coverage at all and millions more have inadequate coverage.

The situation is growing worse. Double-digit increases in health care costs are leading more employers to drop health insurance coverage for workers or their family members, and to raise costs for those who keep coverage. According to one recent report, "health insurance premiums for workers are rising around three times faster than their wages, and health costs eat up a quarter of earnings for more than 14 million Americans." This survey of 35 states found that health insurance premiums rose by nearly 36 percent between 2000 and 2004, while average earnings rose only 12 percent. It added that "Family health premiums paid by employers and workers rose from $7,028 in 2000 to $9,320 in 2004. The average amount paid by workers for this coverage rose from $1,433 to $1,947 during that period."

Thus it's no surprise that the number of people without insurance or with inadequate insurance is rising rapidly. Here in Illinois, we have about 1.7 million uninsured, and about twice that number, 3.5 million, are uninsured during some part of the year. Eighty percent of the uninsured are working people and their dependents.

Even those who have insurance are feeling the impact of rising costs. Employers across the country are passing on rising health care costs by forcing workers to accept pay cuts to keep their health care coverage and to pick up more of the cost of their health insurance. Millions of workers have to pay much of the cost of their insurance premium out of their own pocket, and often have to pay the entire cost of insuring their spouse or children. Increasingly, they have large co-payments and deductibles that still leave them stuck with big medical bills. With out-of-pocket expenses already averaging almost $1,000 per person each year (and, as just shown, nearing $2,000 per worker per year), it should come as no surprise that health care expenses are the number one cause of skyrocketing personal bankruptcy rates in this country.

With health care costs projected to more than double over the next decade:

Unless something is done, the number of uninsured is also expected to grow rapidly.

Unless something is done, those who have insurance will have to devote an ever-larger portion of their pay to health care costs.

Unless something is done, even workers with decent insurance will live in constant fear that if they lose their job, they will lose their insurance. Studies show that when workers lose their jobs, the prospect of getting another job with comparable health insurance is bleak – especially for the tens of millions of workers with preexisting health conditions. And in a system in which health-care coverage depends upon employment, the rising cost of health care will encourage more companies to use part-time and temporary workers to avoid having to provide benefits.

Why is this happening? And what can be done about it?

As to why, health care is the most profitable industry in the nation and it is perhaps the most shameless example of unbridled corporate greed in the United States. In the guise of cost-containment, it redistributes resources from sick people and their care-givers to wealthy businessmen and shareholders.

Our health care system is also enormously wasteful. Every year, hundreds of billions of dollars of health spending gets wasted paying the administrative costs of a fragmented and inefficient private health insurance system. Most private insurers are run for profit. In addition, the top executives in the insurance industry often pull down annual salaries that run into the millions, or even tens of millions. The private profits and the huge CEO salaries necessarily comes out of the pocket of patients and/or employers.

In addition, the web of private insurers creates a huge amount of unnecessary paperwork and bureaucracy. Insurers make money by not paying bills. Their profits rise when they can find ways to avoid paying bills, passing them on to either the government, other insurers, or to you, the patients. As a result, the administrative costs of the private health insurance system are almost ten times as great (per dollar amount of health-care payouts) as the administrative costs of the Medicare system. Or, to use another point of comparison, our nation spends over 31 cents of every health-care dollar on administrative costs, while Canada – which provides high quality health care to all of its citizens, through a single-payer, government-insured system – spends only 16.7 cents per dollar on such costs.

The huge gap in administrative costs between the U.S. and Canada arises from their differing mechanisms of paying for health care. While Canada has a single insurance plan, or "single-payer", in each province, that pays the bills for everyone, the U.S. has a complex and fragmented payment structure built around thousands of different insurance plans, each with its own regulations on coverage, eligibility, and documentation.

Functions essential to private insurance but absent in public programs – such as underwriting, marketing, and corporate services – account for about two-thirds of private insurers' overhead. In addition, private insurers have incentives to erect administrative hurdles – by complicating and stalling payment they can hold premiums longer, boosting their interest income. Such hurdles also discourage some patients and providers from pursuing claims.

The waste that results from the system of private insurers is even larger than just the difference in administrative costs. The efforts of private insurers to avoid paying claims force hospitals, doctors' offices, and other health care providers to spend hundreds of billions of dollars dealing with paperwork from the insurance industry.

A fragmented payment structure is inherently more expensive than a single payer system. For insurers, it means the duplication of claims processing facilities and reduced insured-group size, which increases overhead. Fragmentation also raises costs for providers, who deal with multitudes of different insurance plans -- one study pointed out that there are at least 755 insurance plans in the City of Seattle alone. This means providers must determine each patient's insurance coverage and eligibility for a particular service, and keep track of varying co-payments, referral networks, approval requirements and formulas. In contrast, Canadian physicians send virtually all bills to a single insurer using a simple billing form or computer program, and may refer patients to any colleague or hospital.

The multiplicity of insurers also precludes paying hospitals on a lump sum, or global-budgeted basis as in Canada. Global budgets eliminate most billing, and simplify internal accounting since costs and charges need not be attributed to individual patients and insurers.

Little wonder, then, that the Canadian single-payer health system is better at controlling health-care inflation. Health expenditures in the U.S. are currently rising three times as rapidly as the U.S. Gross National Product; in Canada they are rising at a rate only slightly greater than growth in the Gross National Product.

In sum, a poorly regulated, corporate-dominated for-profit health care system eliminates choice, erodes care, increasingly sticks you with the bill anyway, and inflates administrative costs while boosting profits and CEO compensation.

While the costly administration of the insurance industry is one of the biggest single sources of waste in the U.S. health care system, it is not the only one. The United States also spends far more on drugs each year – more than $200 billion in 2004 – than any other country in the world. Drug prices are the most rapidly growing health care expense. Drugs are
projected to cost the country almost $520 billion annually by 2013, more than $1,700 per person.

There is no reason that drugs have to cost this much. With few exceptions, drugs are cheap to produce and would sell for a low price in a competitive market. Drugs are only expensive because the U.S. government grants the pharmaceutical industry unrestricted patent
monopolies. These patent monopolies allow drug companies to charge as much as they want,
without fear that competitors in the market will undercut their prices. The United States is the
only country in the world that gives the industry unrestricted patent monopolies. As a result of these unrestricted patent monopolies, people in the United States pay twice as much for their drugs as do people in Canada or other rich counties. Some drugs sell for prices in the United States that are three or four times as high as the price that the same drug – subject to the same quality and safety standards – sells for in other rich countries.

This, unfortunately, is a problem, or failure, of national policy that will mostly have to be solved at the national level, notwithstanding our Governor's current attempts to challenge the federal government on it. So there's not much I can propose on that account, except to say that the we could improve our ability to use our State government to negotiate a price with the industry if we had a single-payer system.

Clearly, a single-payer health-care system would seem to have tremendous advantages over the present system. But I'm sure most of us have heard common objections to this idea:

1) This is "socialized medicine." Do we really want the government in charge of health care?

2) People in Canada have rationing and have long waiting periods. Some Canadians come to the U.S. to get faster treatment, so their system can't be all that good.

3) Maybe this would be a good idea on a national scale but it will not be feasible for a single state like Illinois to adopt such a plan; and

4) This will drive our taxes up.

Let's address these in turn.

First, a single-payer health care plan is not the same as "socialized medicine." Government is not going to be delivering the care. It's going to pay for it. Your doctors, other health professionals and hospitals will remain private, just as now. The medical decisions are left to the doctor and patient, and you have your choice of doctors, unlike the lack of choice that many people have now. A government health-care agency will perform functions of health planning, creating an overall budget, making budgetary decisions and negotiating reimbursement rates with doctors and hospitals. It will be like any other agency

that oversees a public service. Because it is a public agency, problems will be aired in public. Nothing will be hidden or swept under the rug. The agency will be accountable to the people, in contrast to the lack of accountability in our health care now.

Second, as to rationing and waiting periods in Canada, "single payer" does not mean that our system would have to emulate Canada's system in every respect. Notions of rationing in Canada are highly exaggerated. There are problems with some services in Canada, depending on which province you live in. For example, some shortages exist in radiation treatments for some cancers. However, Canadians with end-stage renal disease, for example, receive more kidney transplants on average than U.S. citizens do. U.S. citizens receive more procedures than Canadians, but Canadians receive more overall care -- more testing, more evaluation by physicians, more overall health services than Americans do. (JAMA, 1996;275:1410.)

Also, keep in mind Canada spends one half what we spend per person. A single-payer system does not dictate how much we spend. And if we kept spending twice as much as Canada (on actual health-care services, not waste) we would not experience the same shortages.

In other words, it's a matter of public will, or you get what you pay for. What is actually happening in some provinces of Canada is a systematic attack by the right wing to underfund public health care in order to let the forces of privatization and corporate greed get their foot in the door – much like the right wing in this country has systematically underfunded public education in order to push their agenda of cutting taxes for the rich and push privatization in education. First they cut the budget, then they turn around and say, "Aha! See, government programs don't work – we need to turn this over to private business." And unfortunately, some voters, some of the time, fall for it. And then you end up with the worst of both worlds, publicly subsidized profiteering.

But it doesn't have to be that way. The experience of other nations – not just Canada – proves that when you keep progressive-minded people in office, single-payer health care can work, and work well.

If comparisons with Canada are troubling, think of Medicare instead. Despite some recent controversial tinkering with Medicare, most objective observers would have to agree that Medicare has been a successful positive example of a government program that works and works rather well. The administrative overhead for Medicare is literally nearly 10 times cheaper, per health-care dollar, than the administrative overhead of private insurance plans. A single-payer system is like Medicare for everyone, which does kind of make sense, since the elderly are not the only people in our society who get sick.

Well, then, if we can't wait for universal health care in the United States, is it feasible to have a single-payer plan in Illinois?

Assuming that our states can be as efficient at administering health-care as the Canadian provinces, one recent study in the International Journal of Health Services showed that states like Illinois would save more than enough to fund universal coverage without any increase in total health spending.

In Illinois, for example, the administrative savings alone – about $12.3 billion – would be equivalent to $7,362 per year per uninsured resident, clearly more than enough to cover their health-care costs.

What does this mean? We could provide quality health-care for all Illinois residents – better than what the overwhelming majority are getting now – and the amount of tax revenue needed to cover it would be less than what most insured residents are paying now in insurance premiums, not to mention co-pays and deductibles.

The details of how it would work in Illinois have not yet been worked out because our government has not yet seen fit to commission a study on single-payer in Illinois. However, the State of Vermont did a study on how it could work in that state and the findings were very eye-opening.

Under the Vermont proposal, public funds now used for government programs (Medicare, Medicaid, etc.) would be folded into the unified system. A payroll tax and an income tax would replace all insurance premiums and deductibles. A payroll tax of 5.8 percent and an income tax of 2.9 percent would be adequate to fund the system. The annual cost to employers would be about $1,450 per worker, far less than the cost of insurance premiums.

Under the model studied, there would be no premiums or deductibles to collect and administer except for a $10 co-pay for most services. Any benefits provided under Medicaid not covered under the plan would continue.

Families earning under $75,000 would pay less than they currently do while getting full health coverage. Businesses with fewer than 25 employees also would save, between $225 and $995 per worker. Employer costs for retiree benefits would drop substantially, saving employers another $30 million, because many covered services would be part of the universal plan. Physicians practices and hospitals would see no net loss in revenue.

Every Vermonter would receive comprehensive healthcare with free choice of provider. Providers could spend more time with patients and less on administration and paperwork. Savings could go to prevention and public health improvement, further reducing long-term costs.

Under the Vermont plan, the total savings to the people of Vermont would be $118 million in the first year. Single-payer in Illinois would obviously have a much bigger payoff because of the advantages of economies of scale. So, yes, obviously our taxes would go up because any publicly funded system would obviously have to be funded with tax dollars. But the increase in taxes would be far less than the savings we would realize by not having to pay health-insurance premiums and our overall cost of living would go down. There would be big savings to businesses, especially small to medium businesses that struggle to pay for health care, and this, in turn, would stimulate spending in other areas and be good for our business climate and our economy.

The wealthiest nation in the world clearly ought to be able to deliver quality health care to all its citizens, no less than Canada and other industrialized nations. Health care is a critical social good that demands that collective interests prevail over private gain. It should be viewed as a right, not a privilege. Accordingly, I support, and will fight for universal health-care in Illinois if elected – because it clearly would serve the public good.

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