Strategic National Health Care Initiatives:
Influences of U.S. Political Forces and International Experience on Future U.S. Policy

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While the United States spends much more on health care than any other nation, it nevertheless fails to provide health care coverage for many millions of its citizens.[1] In fact, one non-elderly person out of six has no insurance at any given time.[2] Insurance companies are increasingly hard to deal with, while many people are uninsured or uninsurable. To complicate matters, costs are already high and rising out of control here. To solve these problems, universal, national health care programs have been instituted in other countries experiencing similar problems and having varying degrees of success. In keeping with the U.S. government's strategic missions to "promote the general welfare" and "insure the domestic tranquility" as declared in the preamble to the U.S. Constitution, lawmakers and interested parties have proposed several realistic proposals for universal health coverage in this country. This paper examines the relative merits of foreign health systems and prominent domestic proposals, and historical and current political forces influencing and, some may say, obstructing, the national health care reform movement which seeks to provide universal health care and contain costs at the same time.

This health movement is not a particularly new one in the U.S. In 1912, the Progressive Party, led by Theodore Roosevelt, included a health insurance plank in its campaign platform.[3] In the 1930s, President Franklin D. Roosevelt charged a committee with creating proposals for health care to be a part of the Social Security Act.[4] This committee worked largely in secret, removed from public debate and input.[5] Their

concern for attacks from the medical profession and business led to cautious proposals for health reform that recommended systems of subsidies to states instead of a national system.[6] Because their cautious proposals did not appeal to the grassroots of the U.S. and Roosevelt was afraid of losing the support of the influential American Medical Association (AMA), he dropped health coverage from his New Deal agenda.[7]

However, from 1935 to 1947, the U.S. Department of Agriculture's Farm Security Administration (FSA) sponsored an extensive civilian medical care program, which was the largest government-sponsored program for providing medical care to a civilian group until Medicare and Medicaid.[8] This program emphasized free choice of physician and voluntary participation.[9] While the AMA had steadfastly opposed federal involvement in medical care delivery previously, the FSA enjoyed substantial support from the medical community.[10] Strategically, farmers, at that time, were a large and important group to the country and politically it was important to please them.

During this same period, organized labor joined health care reformers and, in 1943, they backed the Wagner-Murray-Dingell bill, the major health insurance legislation of the Truman era, which Truman supported strongly.[11] Unfortunately, reformers failed to enlist grassroots support while the AMA, steadfastly against the bill, waged a grassroots television, radio, telegram and letter-writing campaign (as well as lobbying legislators), that unseated many of the congressional supporters of the bill.[12]

Of course, during the 1960s, Medicare[13] and Medicaid[14] were proposed and enacted. This time, the AMA's efforts to obstruct the proposals were thwarted by that tool so necessary to health care reform: grassroots support.[15] Seniors, in particular, garnered the sympathy of the 1964 Democratic Convention.[16] Unfortunately, many of

the poor being served by Medicaid have difficulty accessing care while those that do, find it of poor quality.[17] That brings us up to nearer the day when President and Mrs. Clinton made their proposals for a universal national health care system.

The landscape is different today, with AIDS activists and women advocating national health systems.[18] Indeed, even the medical profession is coming around, with the Physicians for a National Health Program forming in 1987 to promote a single-payer health system.[19] In 1992, President Clinton proposed his universal health care plan that would attempt to fulfill the qualities of being universal, standardized, community-rated, and managed.[20] Relying on elitist decision-making[21], Clinton's program failed to win approval and was abandoned in 1994.[22]

Finally, at the state level, several states have attempted to provide universal coverage, very notably Massachusetts.[23] Massachusetts succeeded in lowering the number of uninsured in that state from 680,000 in 1995 down to 365,000 in the year 2000 using Medicaid, called Mass Health there.[24] They found that unity within the broad health care community was essential for success.[25]

Clearly, there are many political forces at work here. The AMA has always been a powerful force against national health insurance, but that is changing. Labor unions once fought hard for national health care, but their numbers and powers are dwindling. Farmers once were so powerful that they commanded a health plan of their own, but are relatively few in number today. Senior citizens are largely taken care of with Medicare, but still strongly support national health care out of concern for others around them. Karen Davis states in her article *Inequities to Access to Health Services,* "Individuals least able to bear the cost of poor health are most likely to be ill and uninsured."[26] The

poor, women, AIDS patients, the self-employed, and young adults are the groups most in need of national health care, although the argument is strong that all would benefit from it, but many of them are the least able to work towards those political ends. Add to that group all of those who have ever suffered through COBRA or went without health insurance and one has a large, but disparate base of support for national health care. Unfortunately, those that oppose it, especially doctors, business, and insurance companies, are often powerful and moneyed.[27]

Large firms, often having incredible financial and political resources at their disposal, compete with smaller, up-and-coming firms having smaller resources, for employees. Thus, being able to offer health coverage when others cannot is a strategic advantage to large employers. Large businesses are usually more able to pay for employee health care and are therefore more able to compete for employees than small companies. Consequently, coverage options are more plentiful in large firms than small ones.[28] Only 6% of firms having 25 or fewer employees could offer multiple plans to their employees and only 29% of those were involved in managed care, as of 1991.[29] Contrast that with 63% of large firms having 1000 or more employees offering multiple plans and 57% being enrolled in managed care.[30] This is indicative of the greater power large firms, and their employees, experience in health care. Another influence of firm size on health care availability is that the larger the number insured in a group, the lower the administration costs per insured.[31] Therefore, large employers are more likely to offer health coverage than small ones.[32]

Likewise, the proportion of the employee's compensation paid as insurance premiums increases as the level of compensation decreases.[33] Boaz states that:

> Employers with a predominantly low-wage workforce are, therefore, less likely to offer insurance than firms with a considerable number of high-earning employees. Thus, a non-negligible number of employed and self-employed individuals do not have insurance coverage through employment. Individually purchased insurance is much more expensive than group insurance; hence, many persons who do not have employer-based insurance remain uninsured.[34]

At the heart of the matter is the group health insurance system itself because it discourages individual coverage. Insurance carriers prefer group insurance because most employed individuals are low risk.[35] Employers prefer group insurance because they get a tax break from it.[36] Unfortunately, this causes employers to prefer hiring and retaining low-risk people to keep premiums low.[37] Unemployed people and those having no labor-market connection are usually excluded from this arrangement.[38] Important to understand, however, is that those who do not have insurance are not always denied care; the care can be delivered, but the charges result in higher premiums for the insured.[39]

A very striking example of the U.S. failure to fulfill its "general welfare" mission is the lack of health care among contingent workers. Says David M. Cutler in his article *Cutting Costs and Improving Health*, "Anecdotal evidence suggests that employers are increasingly switching from full-time employment to part-time workers, temporary workers, and contract service workers, in part because they need not provide contingent workers with health benefits."[40] To remedy this and the aforementioned problems, Boaz stipulates that any program to provide universal health coverage would have to:

> 1) substitute risk-blind for risk-based (experience-rated) health insurance
> 2) sever the link between employment status and health insurance coverage
> 3) stipulate uniform and comprehensive benefits
> 4) specify an income-based ceiling on out-of-pocket expenses
> 5) eliminate cost-shifting
> 6) minimize non-medical expenses.[41]

Other segments of the population fare in different ways, also. Governments and non-profits are treated just like businesses of similar size by health insurance companies and their employees have the resultant levels of benefits and options. However, the elderly and the poor have other programs available to them: Medicare and Medicaid. In fact, many people are both elderly and poor and receive coverage from both systems.[42]

People aged 65 and above, roughly 12% of our population, account for one full third of our annual health care expenditures, as of 1993.[43] Since the elderly are expected to comprise 23% of our population by the year 2040, health care costs potentially could become an unsustainable burden on our national resources.[44] Governments financed about 66% of the costs for the elderly as of 1994.[45] Medicare provides about 45% of the total cost.[46] Other issues besides cost are being considered: 1) old-age-based rationing, where limits are set on acute health care for the elderly, and 2) the expansion of long-term care for the elderly and those having chronic diseases and disabilities.[47] Nevertheless, Robert H. Binstock finds that "If the population aging has a major impact on U.S. health care costs, it will not be felt strongly until after 2015 when the Baby Boom population cohort joins the ranks of persons aged 65 and older; and even this is not at all certain."[48] While Medicare also lacks a prescription drug benefit, there seem to be few other serious complaints about the system.[49]

However, Medicaid does not compare favorably to Medicare in either cost or coverage. Wrote Martin de Alteriis:

> Medicaid is very costly. When the program was initiated in 1966, total annual federal and state costs were $1.5 billion; by 1990 total costs had reached $75 billion. Preliminary data for 1991 suggest that total costs rose by more than 30 percent to $98 billion; total costs for 1992 are projected to reach $129 billion. Despite the program's costs, Medicaid eligibles have difficulty accessing care. One reason is that Medicaid fees for

> private physicians, even in the most generous states, are usually far lower than those allowed by private insurers and the Medicare program. Low fees have led to low physician participation rates. Access to physicians is also limited by the fact that many mainstream providers are reluctant to treat Medicaid recipients for a whole host of nonmonetary reasons: excessive paperwork, reported delays in payment, bureaucratic interference and the low status of recipients. One study even found that a large proportion of private physicians refused to treat Medicaid recipients because of their ideological opposition to government involvement in health care provision.[50]

Furthermore, prescription drug coverage and long-term care are both excluded from Medicaid coverage.[51] To make matters worse, Medicaid is not one program but a name for a complicated set of 50 individual state administered, federally subsidized programs.[52] Boaz relates further:

> During budget crunches, the federal and state governments have repeatedly limited their reimbursements to physicians, hospitals, nursing homes, and other providers. In addition, states have lowered the limits of coverage for mandated services and eliminated many optional ones, thereby leaving the poor and impoverished to fend for themselves.[53]

Thus, it is clear that, although many have some level of coverage, only those who work for large organizations (or the families of those who work), the elderly, or those who can afford individual coverage, have satisfactory coverage in this country.

By contrast, all other industrialized countries have embraced some form of universal health coverage and have had varying degrees of success with it.[54] The experiences of Canada, Great Britain, and France are widely documented and especially suitable for comparison to the United States.

Proponents of the Canadian system of universal health coverage emphasize that there are differences in hospital care by income and insurance in the U.S., while detractors claim that the Canadian system has created unacceptable delays in obtaining treatment.[55] However, there is little evidence that these delays affect concrete clinical

outcomes.[56] In Hamilton's, et.al., surgery research indicates that delay does not increase the mortality rate.[57] Interestingly, income does not seem to influence the chance of death when in the hospital in either country.[58] Also, higher income patients in both countries leave surgery more quickly than lower income patients.[59] Furthermore, postsurgery length of stay in Quebec is roughly twice that of Massachusetts, likely due to different methods of reimbursement.[60] Past research indicates that length of stay has dropped 42% in the U.S. since the institutionalization of Diagnostic Related Groups (DRGs) for reimbursement.[61] (DRGs would make a good subject for further research.) Finally, Hamilton's, et.al., research indicates that "… Canada has a higher inpatient mortality rate than the United States" which they attribute to longer lengths of stay in Quebec.[62] To be clear, this means that more people die in the hospital in Canada than in the U.S., but more people die at home after surgery in the U.S. than in Canada.

Likewise, few drawbacks to universal health coverage are mentioned by Donald W. Light, Ph.D., in his article "Universal Health Care: Lessons From the British Experience." He argues that:

> The United States is the only remaining industrialized country without some form of universal access to medical services, in part because policy debates are driven by false, self-defeating beliefs. One such belief is that the United States cannot afford to cover the uninsured, when in fact a coordinated system is *the* key tool for holding costs down, and there are affordable ways to do it…
>
> A second belief, held by the medical profession, is that they would lose still more power than they have already under corporate managed care. Yet universal health care systems elsewhere give the profession greater institutional powers.
>
> Third, many believe that the only alternative to voluntary, market-based health insurance is a single-payer system financed by tax revenues, when there are a number of options.

> Fourth, many believe that the United States is so large and diverse that any lessons one might learn from smaller and less diverse countries do not apply here, so why bother with possible lessons from anywhere else?
>
> Finally, conservative policy-makers and providers imagine that a universal health care system would mean low salaries, rundown facilities, poor quality, and endless waits to see a doctor, as with the British National Health Service (NHS). In US policy debates, the NHS serves as a dreary image of everything we want to avoid and might get if we actually developed a universal system that was equitable and efficient. US journalists almost never describe its remarkable achievements or its innovative and instructive reforms.[63]

He further asserts that much of what one associates with the NHS – rundown hospitals, shortages of specialists, and long waiting lists – are due to being underfunded, while the U.S., by contrast, is well-funded but extremely wasteful and inefficient in health care delivery.[64] While universal health care is sometimes considered to be "socialist" in the U.S., in every other industrialized country, the conservatives value universal access to health care because it acts to "maximize the ability to exercise individual freedom and responsibility by enabling people to take care of themselves and be productive."[65] What a powerful argument that such a system would be a fulfillment of the U.S. government's mission to "promote the general welfare!" British universal health care is founded on the premises of: 1) "*individuals* having a right to health care", and 2) the idea that "*society* has an obligation to look after the health of its *people*."[66] Light proposes several basic lessons to be learned from the United Kingdom:

> 1) Health care should be "free at the point of service," a founding principle of the NHS.
> 2) Fund health care from income taxes.
> 3) Establish a strong primary care base for a health care system.
> 4) Pay GPs extra for treating patients with deprivations or from deprived areas.
> 5) Reduce inequalities in historic funding that usually favor the affluent.
> 6) Devise a set of bonuses for GP practices that reach population-based targets for prevention.

7) Pay all subspecialists on the same salary scale.
8) Control prescription drug prices while rewarding basic research for breakthrough drugs.[67]

This universal system costs the British about on third, per capita, what similar health coverage does in the U.S.[68] Even with this low level of funding, everyone can choose their own primary care physician and be seen promptly.[69] Urgent cases are addressed quickly and thoroughly.[70] However, elective procedures are handled through infamous "waiting lists", which, for hospital-based care, are 46 days, on average.[71] For this reason, 11.5% of the population takes out private health insurance policies for elective services.[72]

The French have had even more success with national, universal health coverage than the British. In fact, the French system was ranked first by the World Health Organization in the year 2000.[73] The French see their national health insurance (NHI) as lying between the extremes of "solidarity and liberalism", meaning between the "nationalism" of the British system and the "competitiveness" of the United States system.[74] Some analysts argue that the French system needs to reform its centralization of decision-making and its chronic deficits.[75] However, the system provides universal coverage using a public-private mix at a cost of 9.5% of its Gross Domestic Product versus the higher 13% of GDP spent in the U.S. Rodwin relates that:

> The health system in France is dominated by solo-based, fee-for-service private practice for ambulatory care and public hospitals for acute institutional care, among which patients are free to navigate and be reimbursed under NHI. All residents are automatically enrolled with an insurance fund based on their occupational status. In addition, 90% of the population subscribes to supplementary health insurance to cover other benefits not covered under NHI. Another distinguishing feature of the French health system is its proprietary hospital sector, the largest in Europe, which is accessible to all insured patients. Finally, there are no gatekeepers regulating access to specialists and hospitals.[76]

Appendix, Table 1, shows the relative satisfaction rates in industrialized countries and clearly demonstrates the superior levels of satisfaction enjoyed by the French.[77] Note that the U.S. is a distant last place on this scale.[78] Tables 2 and 3 in the Appendix show that the French use their health care system much more than the U.S. does, yet the U.S. pays much more for it, even on an absolute basis not a per use basis.[79] Added to this low cost level for the French is their abundance of health system delivery options that produce a high level of population health status.[80] Critics, however, still have some points to make:

> First, despite the achievement of universal coverage under NHI, there are still striking disparities in the geographic distribution of health resources and inequalities of health outcomes by social class…
>
> Second, there is a newly perceived problem of uneven quality in the distribution of health services…
>
> Third, although, compared with the United States, France appears to have controlled expenditures, within Europe, France is still among the higher spenders.[81]

Consequently, France has instituted price controls along the same lines as Medicare has done in the U.S.[82] However, France has enjoyed greater levels of cost containment from such actions.[83] As a national, universal health coverage success story, France has some important lessons to teach the U.S., as delineated by Rodwin:

> First, the French experience demonstrates that is it possible to achieve universal coverage without a "single-payer" system. To do this, however, will still require a statutory framework and an active state that requires NHI financing and provider reimbursement…
>
> Second, the evolution of French NHI demonstrates that it is possible to achieve universal coverage without a "big bang" reform, since this was accomplished in incremental stages beginning in 1928, with big extensions in 1945, 1961, 1966, 1978, and finally in 2000…

> Third, French experience demonstrates that universal coverage can be achieved without excluding private insurers from the supplementary insurance market…
>
> Fourth, coverage of the remaining 1% of the uninsured in France suggests that national responsibility for entitlement is more equitable than delegating these decisions to local authorities…
>
> Finally, and perhaps most important for the United States, the French experience suggests that it is possible to solve the problem of financing universal coverage before meeting the challenge of modernizing and reorganizing the health care system for the 21st century.[84]

Clearly, the industrialized world has some powerful lessons to teach the U.S., but the U.S., in typical, isolationist fashion, is intent on doing things its own way. Indeed, its own way may be better characterized as unconscious, chaotic drift on this issue. The political forces of stagnation seem to rule on this issue, yet some proposals have been made in the U.S. in recent years.

Two main competing bills were proposed to the 103rd Congress: the Clinton plan and the McDermott plan.[85] A third proposal, called Equitable Risk Insurance (ERI), has merit and was proposed during the famous health care debates of 1993. The Clinton Health Plan (The Health Security Act) is the most remembered of these plans, both for its audacity and its failure. Nevertheless, it had some worthwhile points. It mandated universal coverage, its chief benefit.[86] It also proposed the "uniform claims form" for simplifying reimbursement of providers.[87] It attempted to contain costs through "managed competition" of government-created alliances of health insurance in each health care market.[88] This is a quite controversial system. While it possibly could curb medical costs, non-medical costs would probably increase under such a system because it would create large new bureaucracies.[89] In fact, the bill proposed four layers of new administration: 1) the health plans, 2) the alliances, 3) the states, and 4) the National

Health Board.[90] Hence, Boaz concludes "… the administration of the restructured delivery system is vastly more extensive and costly than the administration of the current system – itself quite costly."[91]

Additionally, the Clinton plan had some interesting specifics. Employers would have to withhold premiums like they withhold taxes.[92] The employer would be obligated to pay 80% of the premiums, which would be tax-exempt income for the employees.[93] This would clearly create a higher burden on small employers than large employers since many small employers do not provide coverage today or only provide inexpensive coverage. In fact, it would create another barrier for new firms entering the market and increase costs for those attempting to compete with larger companies. The plan also stipulated a "cost-sharing" amount of $1500 per individual or $3000 per family that would be like a deductible.[94] Unfortunately, this burdens poorer people more than more wealthy people.[95]

By contrast, the McDermott plan is administratively less costly and is simpler.[96] It does not restructure the health care deliver system, nor does it require spending funds on open-enrollment seasons and on determining qualifications for subsidies.[97] Unlike the Clinton plan, the McDermott plan requires only two layers of administration: 1) the states, and 2) the American Health Security Standards Board.[98] States would receive funds from this board and would negotiate fees and budgets with providers, much like Clinton's alliances would.[99] Providers would be reimbursed by the states directly, not by the patients.[100] Furthermore, as the controller of the national funds, the board would allocate and control financial outlays to the states in order to restrict the growth of medical expenditures.[101]

The Clinton and McDermott proposals have some similarities as well as important differences. Boaz sees these as follows:

> First, in both cases, high-risk persons would no longer be excluded from insurance, and would no longer be required to pay risk-based premiums. Second, availability of health-insurance coverage would not depend on employment status. Third, preventive clinical services would be exempt from any out-of-pocket (cost-sharing) expenses. Fourth, a uniform claims form would simplify the paperwork of providers. Beyond these attributes, the bills differ in their prescribed solutions to the inequities in out-of-pocket payments, free-ridership and cost-shifting, administrative complexity, and unintended consequences.[102]

Specifically, the McDermott plan equalizes out-of-pocket payments by eliminating cost-sharing and including Medicare enrollees.[103] Being a single-payer system, it would spend fewer dollars on administration than any multi-payer system including the Clinton plan.[104] Two important by-products would be that health plan administrators (utilization review) would be eliminated and consumers could switch providers at any time, thus raising patient satisfaction.[105]

By contrast, the subsidies that the Clinton plan proposes to remove the inequities for low and moderate income people would create “notch” problems and require a bureaucracy to decide who gets what subsidy.[106] Furthermore, the $1500/$3000 ceiling does not apply to Medicare enrollees in the Clinton plan.[107] The Clinton plan would also introduce two new inequities: 1) special premium-based subsidies for early retirees, and 2) different tax rules for those having a labor-market connection than otherwise.[108]

Unlike the McDermott and Clinton plans, Equitable Risk Insurance is what is termed a “last-dollar” approach because it is designed to provide catastrophic insurance to all people rather than attempting to pay for every health care bill one might incur.[109] The reasoning behind this approach is the premise that only the well-insured presently

fully utilize the health care system in the U.S. and that universal coverage would raise utilization and hence raise health care expenditures.[110] As seen in the French experience, this may not necessarily be so. It is also possible that it is so in this country and that ERI would be a more worthwhile approach to universal coverage in this country.

Catastrophic health coverage potentially could provide all Americans with protection against medical bills that are large relative to their incomes.[111] It could do this within the current health care system that provides such a high quality of care.[112] Treatments that require expensive and sophisticated technology would not be denied.[113] ERI would cover a broad range of services for the entire population and would cover out-of-pocket expenses on a sliding scale based on ability to pay. Thus, the poor would still have access to complete health care, the administration would be relatively simple, it would be single-payer from the government but allow private insurance companies to continue to offer both group and individual coverage for more incidental amounts, costs would be partially borne by the patients who would learn to appreciate the cost of the care, and government expenditures would not be overwhelming.[114] As presently proposed, it does have a major drawback, namely, that payments would be made through tax deductions from the IRS.[115] While this would be a relatively simple thing to administer, two problems occur with it: 1) relief is not felt until the end of the year, and 2) if the medical bills are so catastrophic that the bills exceed taxes paid, there is no provision made for the government to fully cover the medical bills.[116] Therefore, a workable system might provide for a credit card against a tax account.[117] That would fix #1 above, but #2 would require some additional insurance on the part of the government.

Unfortunately, only the Health Security Act (the Clinton plan) addresses a root cause of high health care costs in the extremely litigious United States of America. Here, not only are physicians sued, but sued punitively, for many millions of dollars. These costs are borne by the physicians and hospitals who pay higher malpractice insurance premiums, then pass those costs off in the form of higher prices, which the health insurance companies then pay. While awards clearly have to be made to victims, the extremely high awards are made, not to award the victim, but to deter these and others from making such errors and crimes, and are out of proportion to the needs of the victims, thereby punishing every member of society that has health insurance rather than the perpetrator.

Consequently, physicians also feel obliged to overtreat patients to assure that the physicians are not sued.[118] Also, attorneys collect contingency fees that are based on the amount of the award.[119] Canada, for instance, does not have contingency-fee based law suits for medical malpractice.[120] Lee, Soffel, and Luft concluded that "… 30% of professional liability costs went to the direct payment of malpractice premiums, whereas 70% was attributable to practicing defensive medicine.[121] Lundberg states:

> The costs of malpractice coverage and defensive medicine are unknown but very large – perhaps in excess of $20 billion per year. Defensive medicine probably benefits no one except those with the health care jobs that are generated by this practice. Only about half of the total fiscal resources placed into the malpractice insurance pool ever find their way to truly injured patients. The remainder is consumed by "friction costs" of investigators, administrators, insurance companies, expert witnesses, lawyers, and courts. This grossly unfair and inefficient situation must be solved as part of the health care reform.[122]

Limits on both contingency fees and on punitive award settlements would do much to ameliorate this problem. Such tort reform could be enacted with any health plan or on its own.

Thus, constructive programs have been proposed here in the United States and when the political forces are so aligned and an excellent program is proposed, we may someday see universal coverage of, at least, the most devastating medical bills. While there are many proposals, there are almost too many and some are not good, yet have considerable support. The Clinton plan enjoyed some support but was arguably not one of the best proposals made. He may have done more harm than good to the movement by proposing an ill-conceived plan rather than proposing nothing, which would have left the door open for a better plan to succeed either then or at a later date. The plan seemed to propose just what Americans hate and fear: bloated bureaucracy. It both would add several new layers of government bureaucracy and would keep insurers acting in a primary role.

Nonetheless, the goal of universal coverage and simultaneous cost containment is a worthy one. Experiences in other nations have been positive and their lessons applicable to the U.S.   The British and French experiences indicate the biggest lesson is that each country can find its own approach that suits its own history and yields to its own political forces. Specifically, universality, cost containment, prescription drug coverage with incentives for companies to develop new ones, low bureaucracy, and the keeping of private insurers for supplemental coverage, but not primary coverage, seem to be the keys to universal health care in industrialized countries outside the U.S.

Simplicity, however, seems to be the primary key and the more complex the system the less effective the system. Also, international experience indicates that containing administration costs is more important than containing medical costs, since the Canadians, British, and French all enjoy lower overall costs while having higher utilization of medical services. Arguably, however, higher medical malpractice litigation, and the resultant costs, in the U.S. factors in here as well and it may serve our country well to lower those costs before attempting to change any other part of the system. Having those costs clouds the issues and the assessment of cost structures. Of course, lowering those costs would be beneficial immediately and would be the simplest thing the country could do to control runaway medical costs.

Finding political alignment will be difficult. Those in power have good health insurance, as individuals, and the large organizations whose support and mobilization are so crucial to pushing through a health plan have little or no strategic interest in national universal health coverage. The coalition of those who would benefit most from such a plan (the poor, mentally-ill, self-employed, small employers, etc.) is too weak to succeed without a grassroots mobilization that too often fragments into small groups seeking band-aid solutions. Historically, this has been the case in the U.S. and is the reason for the patchwork of medical systems that include Medicare, Medicaid, and a host of special subsidized programs such as the Maryland Health Insurance Plan (MHIP – a plan for high-risk individuals).

Finally, of the three plans offered here, both the McDermott plan and the ERI plan have merit. Both would curb the worst problems of the present system. Both would "insure the general welfare" by ensuring that no one is destroyed by medical expenses

that are large relative to their income. Both offer simplicity in their own way and limit bureaucracy. Given the American propensity towards conservatism, the ERI plan may be more appealing to the U.S. public and to lawmakers because it uses government systems that already exist, namely, the IRS. Its shortcomings are not insurmountable. Moreover, any plan should include tort reform. Regardless of the strategic commitment to "insuring the general welfare" in the preamble to the U.S. constitution which is so necessary to the success of our nation, without the alignment of political forces powerful enough to rise against not only those who oppose it, against the morass of confusion surrounding the issues and competing plans, and against the frustration of failure from past attempts, the U.S. will doubtlessly suffer the lack of national universal health coverage system for a considerable time to come.

Appendix

TABLE 1—Health Status and Consumer Satisfaction Measures: France, United States, Germany, United Kingdom, Japan, and Italy

	France	US	Germany	UK	Japan	Italy
Health status						
Infant mortality (deaths/1000 live births), 1999[a]	4.3	7.2[b]	4.6	5.8	3.4	5.1
LEB (female), 1998[a]	82.2	79.4	80.5	79.7	84.0	81.6[c]
LEB (male), 1998[a]	74.6	73.9	74.5	74.8	77.2	75.3[c]
LE at 65 (female), 1997[a]	20.8	19.2	18.9	18.5	21.8	20.2
LE at 65 (male), 1997[a]	16.3	15.9	15.2	15.0	17.0	15.8
Severe disability-free life expectancy (female), 1990/1991[d]	14.8	NA	NA	13.6	14.9	NA
Severe disability-free life expectancy (male), 1990/1991[d]	18.1	NA	NA	16.9	17.3	NA
Potential years of life lost per 100 000 population (female), 1993[e]	2262	3222	2713	2642	1914	2136
Potential years of life lost per 100 000 population (male), 1993[e]	5832	6522	5752	4688	4003	4873
Consumer satisfaction, %						
Only minor changes needed, 1990[f]	41	10	41	27	29	12
Very satisfied, 1996[g]	10	NA	12.8	7.6	NA	0.08
Fairly satisfied, 1996[g]	55.1	NA	53.2	40.5	NA	15.5

Note. US = United States; UK = United Kingdom; LEB = life expectancy at birth; LE = life expectancy; NA = not available.
[a]*Source.* Organization for Economic Cooperation and Development.[6(p27)]
[b]1998.
[c]1997.
[d]Defined as life expectancy with the ability "to perform those activities essential for everyday life without significant help."[6(p27,31)]
[e]*Source.* Organization for Economic Cooperation and Development.[6(p30)]
[f]*Source.* Harvard-Louis Harris Interactive 1990 Ten-Nation Survey, cited by Blendon et al.[7]
[g]*Source.* Eurobarometer Survey, 1996, cited in Mossialos.[8]

TABLE 2—Health Care Resources: France and United States, 1997–2000

Resources	France	US
Active physicians per 1000 population	3.3[a] (1998)	2.8[a] (1999)
Active physicians in private, office-based practice per 1000 population	1.9[b] (2002)	1.7[c] (1999)
General/family practice, %	53.3[b] (2002)	22.5[c] (1999)
Obstetricians, pediatricians, and internists, %	7.5[b] (2002)	35.6[c] (1999)
Other specialists, %	39.2[b] (2002)	41.0[c] (1999)
Nonphysician personnel per acute hospital bed[d]	1.9 (2001)[e]	5.7 (2000/01)[f]
Total inpatient hospital beds per 1000 population[g] (1998)	8.5[a]	3.7[a]
Short-stay hospital beds per 1000 population	4.0[h] (2000)	3.0[i] (1998)
Share of public beds, %	64.2[h] (2000)	19.2[i] (1999)
Share of private beds, %	35.8[h] (2000)	80.8[i] (1999)
Proprietary beds as percentage of private beds (1999), %	56[j]	12[j]
Nonprofit beds as percentage of private beds (1999), %	44[j]	88[j]
Share of proprietary beds, %	27[k] (1998)	10.7[i] (1999)

[a]*Source.* Organization for Economic Cooperation and Development.[17]
[b]*Source.* CNAMTS.[18]
[c]*Source.* National Center for Health Statistics.[19] (These figures exclude federally employed physicians as well as all anesthesiologists, pathologists, and radiologists.)
[d]Nonphysician personnel include all hospital employees—administrative, technical, and clinical—excluding physicians. Among the category of physicians in the United States, we included chiropractors and podiatrists.
[e]*Source.* CREDES.[20]
[f]*Source.* Acute care beds: American Hospital Association[21]; nonphysician personnel: Bureau of Labor Statistics.[22]
[g]These differences reflect the use of long-term care beds in French hospitals—public and private nonprofit—as nursing homes.
[h]*Source.* DRESS.[23]
[i]*Source.* American Hospital Association.[21]
[j]Source: DRESS.[24]
[k]*Source.* DRESS.[25]

TABLE 3—Use of Health Services: France and United States, 1997–2000

Use	France	US
Physician office visits per capita[a] (1999)	6.0[b]	2.8[c]
Specialist visits per capita (1999)	1.9[b]	1.4[c]
Hospital days per capita (1999)	2.4[d]	0.9[d]
Short-stay hospital days per capita (1999)	1.1[d]	0.7[d]
Admission rate for short-stay hospital services per 1000 population	170.1[e] (2000)	118.0[f] (1998)
Average length of stay for all inpatient hospital services (1999)	10.6[b]	7.0[g]
Average length of stay in short-stay beds (1999)	6.2[e]	5.9[f]
Per capita spending on pharmaceuticals, PPP, $ (1999)	484[h]	478[h]
MRIs per million population	2.5[i] (1997)	7.6[i] (1998)

Note. $PPP–purchasing power parity; MRI–magnetic resonance imaging unit.

[a]Organization for Economic Cooperation and Development (OECD) Health Data has traditionally published a figure of around 6 physician consultations per capita for the United States. According to the 2002 edition, this figure is based on the National Health Interview Survey of the National Center for Health Statistics. This source, however, includes telephone contacts with physicians, as well as contacts with physicians in hospital outpatient departments and emergency rooms (ERs). The French figure includes consultations with all physicians in private practice including health centers (5.4) and home visits by physicians (0.6). It excludes all telephone contacts and hospital outpatient and ER consultations. Thus, to obtain comparable data, the US figure is taken from the National Ambulatory Medical Care Survey (NAMCS), a survey of visits to physicians' offices, hospital outpatient departments, and ERs. According to the 1995 NAMCS, visits to physician offices account for 81% of ambulatory care use, and visits to emergency rooms and hospital outpatient departments account, respectively, for 11.2% and 7.8% of ambulatory care use. Taking these proportions into account, as well as the fact that patients are seen by physicians in only 71% of outpatient department visits, the 1999 per capita rate of physician visits would only increase to 3.04.

[b]*Source.* CREDES.[20]

[c]*Source.* National Center for Health Statistics.[19] (These figures exclude federally employed physicians as well as all anesthesiologists, pathologists, and radiologists.)

[d]*Source.* OECD.[27]

[e]*Source.* Ministry of Health and Social Affairs.[28]

[f]*Source.* National Center for Health Statistics.[29]

[g]*Source.* National Center for Health Statistics.[30]

[h]These figures, cited in Reinhardt et al,[31] understate differences in the per capita volume of prescription drugs sold because increases in drug prices have been significantly higher in France than in the United States since 1980. When expenditure data on prescription drugs in France and the United States are adjusted by the OECD index of pharmaceutical price inflation in both nations, the volume of prescription drug purchases in France exceeds that in the United States by a factor of 2. Source: OECD Health Data 1999, cited in S. Chambaretaud.[26]

[i]*Source.* OECD Health Data 2001.

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End Notes

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