National Health Insurance or Incremental Reform: Aim High, or at Our Feet?

Single-payer national health insurance could cover the uninsured and upgrade coverage for most Americans without increasing costs; savings on insurance overhead and other bureaucracy would fully offset the costs of improved care. In contrast, proposed incremental reforms are projected to cover a fraction of the uninsured, at great cost. Moreover, even these projections are suspect; reforms of the past quarter century have not stemmed the erosion of coverage. Despite incrementalists’ claims of pragmatism, they have proven unable to shepherd meaningful reform through the political system.

While national health insurance is often dismissed as ultra left by the policy community, it is dead center in public opinion. Polls have consistently shown that at least 40%, and perhaps 60%, of Americans favor such reform. (Am J Public Health. 2003;93:102–105)

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WE ADVOCATE SINGLE-PAYER national health insurance (NHI) (Table 1) because it would work and lesser reforms would not. The policy establishment often portrays NHI as an impossible dream: an ultra-left, utopian vision. Yet, most other wealthy capitalist nations have implemented NHI, and it enjoys wide, even majority, public support in the United States. Most would agree that our health care system is deeply troubled. At least 41 million people residing in the United States have no health insurance, and millions more have inadequate coverage. Medical care costs are soaring, and job-based coverage is eroding. Public resources of enormous worth—hospitals, visiting nurse agencies, even hospices—built over decades by taxes, charity, and devoted volunteers, are being taken over by companies attentive to profits but indifferent to suffering.

Since the defeat of the Clinto%27s Rube Goldberg scheme for universal coverage, reform debate has been muted. But the fast developing medical care crisis—business grappling with soaring premiums, workers and unions fighting cutbacks in coverage, governments confronting deficits, and a sharp upturn in the number of individuals who are unemployed and uninsured—ensures a reopening of health policy debate.

THE LIMITS OF INCREMENTALISM

Since the passage of Medicare and Medicaid, a welter of incremental reforms have been attempted—and have failed. Health maintenance organizations (HMOs) and diagnosis-related groups promised to contain costs and free up funds to expand coverage. Billions have been allocated to expanding Medicaid, the State Children’s Health Insurance Program, and similar state-based insurance programs for poor and near-poor citizens. Medicare and Medicaid have pushed managed care. Oregon essayed rationing; Massachusetts and Hawaii passed laws requiring all employers to cover their workers; Tennessee promised nearly universal coverage; and several states implemented risk pools to insure high-cost individuals and insurance regulations to protect consumers. Senators Kennedy and Kassebaum lent their names to insurance market reform legislation. And for-profit firms pledged...
that market discipline and businesslike efficiency would fix health care.

Fans of incrementalism dismiss NHI as a hopeless home run swing when a bunt—small steps toward universal coverage—would do. Despite incrementalists’ claims of pragmatism, however, they have proven unable to shepherd meaningful reform through our political system. Over the past quarter century, incrementalists have trumpeted victories such as those detailed above. Meanwhile, the number of uninsured individuals has increased by 18 million, health care’s share of the gross domestic product has risen from 7.9% to 13.2%, and more and more seniors have been forced to choose between food and medicine. How many more strikes before incrementalism is out?

Incrementalism founders on a simple problem: expansion of coverage must increase costs unless resources are diverted from elsewhere in the system. US health costs are already nearly double those of any other nation and are rising rapidly.2 The economic climate is cool. Yet, an incrementalist strategy implausibly posits massive infusions of new money, funds that would go mostly to the poor and near poor, who wield little political power. For instance, proposals to offer tax credits for the purchase of coverage would cost about $3000 annually per newly insured person.3 Employer mandate proposals in California would boost public spending by between $4000 and $10,000 per newly insured person while also increasing employers’ costs.4 Absent new money, patchwork reforms can expand coverage only by siphoning resources from existing clinical care. Advocates of managed care and market competition once argued that their strategy could accomplish this end by trimming clinical fat. Unfortunately, new layers of corporate bureaucracies have invariably overseen the managed care “diet” prescribed for clinicians and patients. Such cost management bureaucracies have devoured virtually all of the existing clinical savings and antagonized huge swaths of middle-class patients as well as the medical profession.

**THE POLITICAL CASE FOR NHI**

The political case for NHI arises from the fact that it would improve care for most Americans, not just the poor: solidarity is stronger than charity, a formulation we first heard from Vincente Navarro. NHI would not just expand current insurance arrangements; it would upgrade coverage for many in the middle class, assuage clinicians’ and communities’ concerns over the growing corporate dominance of health care, and provide a framework for addressing the myriad problems exacerbated by our current irrational financing structure.

**THE FISCAL CASE FOR NHI**

The fiscal case for NHI arises from the observation that bureaucracy now consumes nearly 30% of our health care budget,5–7 as well as the fact that this enormous bureaucratic burden is a peculiarly American phenomenon. Our biggest HMOs keep 20%, even 25%, of premiums for their overhead and profit8; Canada’s NHI has 1% overhead,2 and even US Medicare takes less than 4%;9 HMOs also inflict mountains of paperwork on clinicians and institutional providers. The average US hospital spends one quarter of its budget on billing and administration, nearly twice the average in Canada.7 American physicians spend far more time and money on paperwork and billing than their Canadian colleagues.5 Administration consumes 35% of home care agency budgets in the United States, as opposed to 15.8% in Ontario (S. Woolhandler, T. Campbell, D.U. Himmelstein, unpublished data, 1999–2000).

Reducing our bureaucratic spending to Canadian levels would save at least $140 billion annually, enough to fully cover the uninsured and upgrade coverage among those now underinsured. Proponents of NHI,10 disinterested civil servants,11,12 and even skeptics13 all agree on this point. NHI would require new taxes, but these taxes would be fully offset by a fall in insurance premiums and out-of-pocket costs. Moreover, the additional tax burden would be smaller than is usually appreciated, because nearly 60% of health spending is already tax supported14 (vs roughly 70% in Canada).

Unfortunately, incremental tinkering cannot achieve significant bureaucratic savings. The key to administrative simplicity in Canada (and other nations) is single-source payment through a public insurer. Canadian hospitals have a global annual budget to cover all costs—much as a health department is funded in the United States—virtually eliminating billing. Physicians bill a single insurer using a simple form, and fee schedules are negotiated annually between provincial medical associations and governments. In contrast, US providers face a welter of plans—at least 755 in Seattle alone15—each with its own rules and paperwork.

Even a step from 1 to 2 insurers raises providers’ administrative costs. Fragmented coverage necessitates eligibility determination and internal cost accounting to attribute costs to individual patients and insurers and undermines global budgeting and health planning efforts. Although many assumed that computerization of billing would cut administrative costs, savings have not materialized.16 While all nations with NHI have lower health administration costs than the United States, multipayer systems sacrifice part of this advantage. Thus, Germany’s health care providers employ far more administrators and clerks than Canada’s.17 In the United Kingdom, the implementation of “internal markets” (in effect, a multipayer structure superimposed on the National Health Service) doubled administrative costs.18

For insurers, a multipayer structure requires duplication of claims processing facilities and reduces the size of the group that is insured, which increases overhead19,20; insurance overhead in the multipayer NHI systems of Germany and the Netherlands is at least double that in Canada.2 Any degree of participation by private insurers also raises administrative costs.21 Private insurers in Australia, Germany, and the Netherlands all have high overheads: 15.8%, 20.4%, and 10.4%, respectively.2 Functions essential to private insurance but absent in public programs (e.g., underwriting and marketing) account for about two thirds of private insurers’ overhead.22
our drug industry, the imbalance between curative and preventive resources, the mismatch between health investments and need, and the multitude of quality problems that plague us (why is it that virtually every hospital in the United States has a complex computer billing system yet almost none have computerized order-entry systems that would prevent millions of medication errors?).

Among those who already have coverage, NHI would eliminate the fear that today’s coverage will subsequently become unaffordable or disappear as a result of a strike, layoff, disabling illness, or college graduation. It would afford them a free choice of providers, a top priority for many Americans according to polls (hence the right-wing appropriation of terms such as “consumer choice health reform”) but rare in today’s managed care environment. It would encompass many services that are excluded from current coverage—notably long-term care, as well as prescription drugs for the elderly.

Among health workers, NHI can reduce the aggravation of bureaucratic hassles, dampen market-induced gyrations in the financial health of institutions and practices, and refocus the attention of health leaders from the micromanagement of providers, a top priority for many Americans according to polls (hence the right-wing appropriation of terms such as “consumer choice health reform”) but rare in today’s managed care environment. It would encompass many services that are excluded from current coverage—notably long-term care, as well as prescription drugs for the elderly.

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discussion of health care’s future. For generations, the moral stance of the public health community has helped spark social movements, often against dauntingly powerful foes: the crusade against tobacco and fights for clean water, a sustainable environment, workplace safety, and reproductive rights. Our professions’ voices gain extraordinary resonance when we speak courageously in the public interest. A time to raise our cry is again at hand.

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