

**MYTHS AS BARRIERS TO HEALTH CARE REFORM
IN THE UNITED STATES**

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The U.S. health care system is deteriorating in terms of decreasing access, increased costs, unacceptable quality, and poor system performance compared with health care systems in many other industrialized Western countries. Reform efforts to establish universal insurance coverage have been defeated on five occasions over the last century, largely through successful opposition by pro-market stakeholders in the status quo. Reform attempts have repeatedly been thwarted by myths perpetuated by stakeholders without regard for the public interest. Six myths are identified here and defused by evidence: (1) "Everyone gets care anyhow;" (2) "We don't ration care in the United States"; (3) "The free market can resolve our problems in health care"; (4) "The U.S. health care system is basically healthy, so incremental change will address its problems;" (5) "The United States has the best health care system in the world"; and (6) "National health insurance is so unfeasible for political reasons that it should not be given serious consideration as a policy alternative." Incremental changes of the existing health care system have failed to resolve its underlying problems. Pressure is building again for system reform, which may become more feasible if a national debate can be focused on the public interest without distortion by myths and disinformation fueled by defending stakeholders.

As on many occasions over the last century in the United States, the issue of health care reform is again moving toward center stage on the nation's agenda. There is growing recognition that the present system is sick, and many feel that structural reform is required. If one has any doubts about how critical is this juncture in U.S. health care, the Appendix (pp. 324–326) lists examples of some of its serious problems with respect to access, cost, quality, and overall performance of the current system (1–27).

There have been five well-motivated and serious attempts to enact a system of universal coverage in the United States over the last 100 years. On each occasion, health care stakeholders have pulled no punches in using disinformation and obfuscation to confuse and mislead the public. Thus, the American Medical Association (AMA) has repeatedly fought national health insurance by labeling it “socialized medicine” (instead of socialized insurance), while the insurance industry distorted the debate in 1994 by raising fears of decreased choice of physicians and the role of government in health care. Since disinformation and intentional misrepresentation of the real issues will certainly occur again as new reforms are debated, this article briefly examines six myths concerning U.S. health care, which are recurrently used to cloud the debate, maintain the status quo, and defeat systemic efforts to reform our health care system.

MYTHS OF U.S. HEALTH CARE

These six well-worn myths have been perpetuated over the years by stakeholders in our present market-based system.

1. *“Everyone gets care anyhow”*

Purveyors of this myth assume that the uninsured and underinsured are able to access health care within an extensive safety net of community health centers; emergency rooms and outpatient clinics of public hospitals and not-for-profit community hospitals; local health departments; or other public sector clinics and hospitals, such as the Veterans Administration or National Health Service Corps. While this belief may absolve their guilt about serious access problems within the present system, it is a total misperception on many counts. Access to health care is more complex than it may appear, even for the insured. Eisenberg and Power (28) have drawn the analogy between access to health care and electrical current passing through resistance—even for the insured, access suffers with each voltage drop, whether their needed services are actually covered, their choice is informed and available, or primary and specialty services are available.

How should acceptable access be measured? Access to medical and surgical services is one measure, but how about preventive care, prescription drugs, glasses, mental health care, and dental care? Does a visit to an overwhelmed emergency room for a nonemergent problem, or to an urgent care clinic where the physician “sees” 60 or more patients during a 12-hour shift without continuity (and often without access to their medical records), compensate for the lack of primary care?

While the plight of the uninsured is more obvious, there are many misperceptions here as well. For example, 80 percent of the uninsured live in working families, and still cannot qualify for or afford health insurance (29). Whether insured, underinsured, or uninsured, people suffer serious outcomes of lack of

access to primary care. Three examples make the point. A 1997 study of low-income patients hospitalized for preventable or avoidable conditions found, for example, that 60 percent reported receiving no care before admission, while only 17 percent had been seen in an emergency room (30). A 2001 study by Baker and colleagues (31) of 7,500 adults aged 51 to 61 who lacked continuous health insurance found that almost three times as many persons experienced a decline in their health or functional status if continuously uninsured than if insured. In another recent study of 1,900 Medicare beneficiaries, only 4 percent without prescription drug coverage were receiving statins, compared with an estimated 60 percent who could benefit from their use (32).

2. *“We don’t ration care in the United States”*

This is a common notion, often used as a put-down for those countries with national health systems without full coverage for every conceivable health care service (e.g., chronic renal dialysis for elderly patients, cosmetic surgery). This myth flourishes while the prevailing public attitude (fueled by powerful stakeholders in the present system) is outright denial that rationing is common, necessary, or moral. Consider these examples of ways in which health care services are rationed in everyday practice:

- Either by self-referral or through a gatekeeper, sick HMO patients have about twice as much difficulty in seeking needed care as do healthy patients in HMOs, PPOs (preferred provider organizations), or point-of-service programs (33).
- Many managed mental health programs have overly restrictive admission policies for detoxification, such as requiring delirium tremens to occur before hospital admission is approved (34).
- Comparative rates of preventable hospitalization between those in affluent and poor zip codes are much higher in U.S. cities than in Canadian cities (e.g., more than twice as prevalent in San Francisco and New York than in Ottawa or Toronto) (35).
- Use of essential drugs decreased by 9 percent in elderly persons and by 14 percent in welfare recipients after cost-sharing was introduced, resulting in a doubling of the rates of serious adverse reactions in both groups (36).

It is an often overlooked given that our market-based health care economy implicitly denies services to those who can’t pay for them. Another type of rationing—denial of services to those who can pay for them—also is common (and highly contentious). Thus, there is a growing field of litigation challenging the prerogatives of HMOs to deny services. Some may be inappropriate denials, while others (e.g., coverage of autologous bone marrow transplants for women with metastatic breast cancer) may be well grounded in evidence-based clinical

science (37). What is typically missing in public attitudes in the United States, however, is a societal (vs. individual) perspective on what services can be made available to those who can pay without compromising basic health services for those who cannot.

3. *“The free market can resolve our problems in health care”*

This myth continues to underpin pro-market health care policies of both major political parties, with the belief that the marketplace can effectively resolve access, cost, and quality problems in delivery of health care services. Touted as the “American way,” this view reflects the belief that a private, competitive market exists in health care. Yet there is incontrovertible evidence that health care markets do not behave in a freely competitive way. Robert Evans (38), health care economist at the University of British Columbia, has pointed out how market mechanisms in health care yield distributional advantages for particular groups, including providers, suppliers, insurers, and more affluent and healthier people. He calls attention to the natural alliance between providers, suppliers, and higher-income citizens in support of private financing of health care, leaving the burden of financing care for the sick and uninsured to the public sector. As a result, the farther such privatization goes, the more difficult it is to finance basic health care services for sick and lower-income people through a smaller risk pool.

It is well documented that the public interest is not well served by an unfettered private health care market, as reflected by these examples:

- An overriding goal of for-profit health care corporations is to maximize return on investment to shareholders; thus, even during our current recession, some for-profit hospital chains have reported profits of 45 percent or more (16).
- The extent of for-profit ownership of health care organizations is higher than many realize, including (in 1998) 85 percent of dialysis centers, 70 percent of nursing homes and home care agencies, and 64 percent of HMOs (39).
- Investor-owned health care organizations provide lower quality care than do nonprofit organizations (e.g., investor-owned HMOs scored worse in a 1999 study on all 14 quality indicators reported to the National Committee for Quality Assurance, such as 27 percent lower rate of eye examinations for patients with diabetes) (26).
- The overhead of investor-owned HMOs is 25 to 33 percent higher for some of the largest HMOs than for nonprofit HMOs (40).
- Market-oriented HMOs commonly use many strategies designed more to manage costs than to manage care (e.g., “deselection” (firing) of high-utilizing physicians, attempts to enroll healthier enrollees rather than sicker ones) (41).

4. *“The U.S. health care system is basically healthy,
so incremental change will address its problems”*

Incrementalism has been the prevailing approach to health care reform for at least 30 years in the United States, and is still the most politically popular. Strongly supported by influential stakeholders in the present system, incremental changes are periodically put in place, which fail to address the more fundamental problems of the system. Examples include the attempt to contain rising hospital costs by the DRG (diagnosis related groups) prospective payment system (costs soared again 11 years later) (42) and the State Children’s Health Insurance Program (SCHIP) enacted in 1997 (but by 2000 up to 21 million American children were still estimated to have significant access problems) (43).

Incrementalism best serves advocates of privatizing health care, reflecting values often diametrically opposed to the public interest. If incrementalism as the dominant health policy instrument over the last 30 years was effective, a 1998 RAND analysis of many studies would not give the following findings: 50 percent of people receive recommended preventive care; 60 percent receive recommended chronic care; 70 percent receive recommended acute care; 30 percent receive contraindicated acute care; and 20 percent receive contraindicated chronic care (44). Under the banner of incrementalism and increased consumer choice, there is now a vigorous effort by pro-market interests, supported by government, to shift more and more costs of health care to consumers, thereby discriminating against lower-income people and the sick.

The “invisible hand” deserves special comment, for much of the lobbying by the stakeholders in the pro-market system is almost transparent behind the scenes. Consider these examples:

- Insurance companies and their allies spent \$60 million (an average of \$112,000 per lawmaker) in lobbying against a Patients’ Bill of Rights during the first six months of 1998 (45).
- The pharmaceutical industry spent \$80 million during the 2000 election campaign supporting candidates opposed to a Medicare prescription drug benefit (46); of the 22 candidates backed by the drug industry, 18 were elected to Congress (47).
- A revolving door exists between stakeholder corporations and the government, as well illustrated by this recent exchange: two former Health Care Financing Administration (HCFA) administrators have joined the board of the for-profit dialysis company Da Vita (which receives 60 percent of its revenue from Medicare and Medicaid), while a former board member at Da Vita became the new chair of the HCFA (now the Centers for Medicare and Medicaid Services) (48).

5. *“The United States has the best health care system in the world”*

How can one look at the list in the Appendix and still believe that we have the best health care system in the world? Yet this remains a widespread view, which again is nurtured by the stakeholders in the present system. That such a view is not only untenable but also arrogant toward countries with better-performing health care systems is demonstrated by these examples:

- The average ranking for the United States on 16 health indicators in a 1998 comparative study of 13 countries by Starfield (24) was twelfth, second from the bottom. The top five, in decreasing order, were Japan, Sweden, Canada, France, and Australia.
- In another study by Starfield (27, 49) of 11 Western countries, the United States was ranked last with respect to its primary care base and its per capita health care expenditures (the highest), while ranking poorly on public satisfaction, health indicators, and use of medication.
- A 2000 study by the World Health Organization based on various indicators (including disability-adjusted life expectancy, child survival to five years of age, social disparities in care, experiences with the health care system, and out-of-pocket health care expenditures) found the average ranking of the United States to be fifteenth out of 25 countries (50).
- A 1998 meta-analysis of 39 prospective studies in U.S. hospitals estimated that more than 2.2 million patients had serious adverse drug reactions in 1994, resulting in 106,000 deaths (51).
- A 2000 report on the epidemiology of medical error estimated that about 1 million preventable injuries occur to U.S. patients each year (52); these include transfusion errors, adverse drug events, surgery on the wrong side, and mistaken identity (53).

6. *“National health insurance is so unfeasible for political reasons that it should not be given serious consideration as a policy alternative”*

Since national health insurance (NHI) would require fundamental restructuring of the health care system, it poses a threat to the stakeholders in the present system. For many reasons, when NHI is raised as a policy alternative, it therefore becomes a target of opportunity for interests vested in the status quo. Each time this occurs it obscures a national debate on the real issues, which should focus on which of the policy alternatives best serves the public interest.

NHI proposals in the United States have been attacked by their critics in past years on many counts, including alleged lack of affordability, overly intrusive roles of government, questions of quality, threat to the physician-patient relationship, and lack of political acceptance. The closer that NHI comes to serious

consideration, the harder its opponents battle to denigrate such a proposal or distort the issues.

Despite the constant pressure by stakeholders in the pro-market status quo to keep single-payer NHI off the table of policy alternatives for health care reform, the myth of its alleged lack of feasibility can be well countered by the facts. In California, for example, where 22 percent of the population is uninsured, nine alternative reform proposals have been carefully studied under the California Health Care Options Project (HCOP). These include public program expansions, individual and employer tax credits, employer and individual mandates, single-payer models, and combination approaches. These options were analyzed and compared using a micro-simulation model developed by the Lewin Group. Most of the options are incremental proposals, all of which would increase health care costs without providing universal coverage. Only the single-payer proposals would provide comprehensive care for the state's entire population while reducing costs by \$8 billion (54). In terms of affordability of NHI at the national level, the \$1.4 trillion now being spent on health care (about \$5,000 for every adult and child in the United States) could easily fund universal coverage of comprehensive care, if the wasteful for-profit insurance industry were replaced by a single, publicly administered insurance program.

DISCUSSION

The United States is alone among developed Western industrialized nations in still not having some form of national health insurance. Some have suggested that this is because the American public has not wanted it (55, 56). Vicente Navarro makes a convincing case for another explanation—that the power and influence of the labor movement is the single most important factor in establishing national health insurance in any country. With a low rate of unionization (only about 13 percent of the workforce today; 57) and without a strong and cohesive political party representing labor, the capitalist and management class in the United States has so far effectively thwarted any populist movement toward NHI (58). A recent position paper developed for the Wisconsin State AFL-CIO further contends that a class-based struggle has been fought by the right against labor since the 1930s, with the right persistently promoting its own economic interests and unlimited corporate power as an overall anti-worker agenda (59).

Although opponents of NHI have discounted the level of popular support for NHI on many occasions over the years, there is good evidence that a majority or plurality of Americans have expressed support for it, as early as the 1940s and even at a cost of higher taxes (60). Growing evidence in recent years indicates that the public is increasingly dissatisfied with the health care system and more supportive of an expanded role of government in assuring access to care. There is now widespread support, even in the conservative South, for government regulation of HMOs (61). The most recent national poll by Harris Interactive

(August 2002) found that one-half of respondents (physicians, employers, hospital managers, health plan managers, and public citizens) now favor radical reform, not incremental change. Only 19 percent of physicians and smaller percentages of the other four groups felt that “on the whole the health care system works pretty well and only minor changes are necessary” (62).

As editor of the *New England Journal of Medicine*, Relman (63) warned in 1980 of the corrosive effects of the medical-industrial complex in medicine and health care. The ensuing years have fully demonstrated these effects. In 1990, Coddington and colleagues (64), in their book *The Crisis in Health Care: Costs, Choices, and Strategies*, predicted these outcomes under our market-based system:

- More than 40 million uninsured
- Continued gaps in safety net coverage
- Double-digit health plan rate increases
- Smaller employers cutting coverage or even dropping health plans
- Increased copayments and deductibles for employees
- Large rate increases for private insurers in shrinking markets
- Numerous failures of HMOs and withdrawal from the market by larger insurance companies
- Continued cost shifting in an increasingly fragmented market
- Continued inflation of health care costs

Twelve years later, every one of these outcomes has taken place, precisely as predicted.

In the early 1990s, Mark Peterson (65), well-known policy analyst and scholar in government affairs, noted that the “iron triangle” of closely allied stakeholders in the pro-market health care system (business, the insurance industry, and the medical profession) was starting to break down into competition among themselves. That even more disunity among stakeholders has occurred since then is shown by these examples:

- Business is now supporting state regulation over health insurance premiums, as is already the case for automobile and commercial insurance (66).
- The interests of small and mid-size employers are often at odds with those of large employers, and most that offer health benefits to their employees are looking for ways to decrease their expense and responsibility by passing along more costs to employees.
- Some business leaders have joined the National Coalition on Health Care in support of these principles—health insurance for all, cost containment, improved quality of care, equitable financing, and simplified administration (67).

- Only about 30 percent of U.S. physicians are members of the AMA, which has lost much of its influence over health policy over the last 50 years; although the AMA still opposes NHI (as it did Medicare and Medicaid during the 1960s), many physicians now support a system of social health insurance.

A battle is raging over the future of U.S. health care, much of it behind the scenes. In their defense against growing pressure by stake challengers for effective change, the corporate class will promulgate the myths described here in well-funded campaigns of disinformation. However, a fresh proposal for fundamental reform of the health care system could well succeed the next time around if these six myths are seen as such and a national debate can be sharply focused on the public interest. The middle class, not just the lower class, is affected by the increasing unaffordability of health care. The length and depth of the current recession will broaden the constituency adversely affected by the present system and increase the influence of grassroots activism for reform. The aftermath of the September 11 tragedy will stretch the nation's resources and call into question the value being returned on the country's already huge investment in health care.

Assuming that the political will for serious health care reform will increase over the next few years and that these six myths can be exposed as such by a broad coalition of defenders of the public interest and by responsible media coverage, the following developments would appear to favor fundamental reform, even to the point of a national health insurance program:

- More emphasis than in the past on campaign finance reform
- Fallout from the Enron and World Com scandals that will focus public attention on the damage to the public interest by corporate greed
- Need for improved health care while maximizing potential cost savings (e.g., about \$150 billion could be saved each year by eliminating administrative costs and profits of an enormous insurance industry—more than enough to fund NHI) (68)
- Recent studies in several states showing projected cost savings of single-payer plans—such as annual savings of \$8 billion in California (54) and \$118 million in Vermont (69)
- Support of a single-payer system by 64 percent of members of the American Medical Women's Association (70)
- Growing activist influence of Physicians for a National Health Program (PNHP), with over 9,500 members
- Preference for a single-payer health care system by 57 percent of respondents in a 1999 study of more than 2,100 medical students, residents, faculty, and deans in U.S. medical schools (80 percent response rate) (71)
- Single-payer proposals moving forward in several states, including Massachusetts, Vermont, Maine, Florida, and Oregon

- Recent bipartisan support for passage in the U.S. Senate (by a vote of 78 to 21) of the Greater Access to Affordable Pharmaceuticals Act against a well-financed campaign by the drug industry (72)
- Growing support behind House Concurrent Resolution 99 that would require enactment of legislation by October 2004 assuring universal health care for all Americans meeting 14 explicit criteria (73)

Americans want, and deserve, a system assuring them of access to health care, free choice of physician, affordable care of high quality, trust and respect. What many now get is a disorganized, failing, and nonsustainable system with increasingly serious problems of access, cost, quality, and equity. The most unfortunate aspect of previous reform efforts is how successful their opponents have been in purveying myths in order to change the subject, distort the debate, and promote hopes that tinkering around the edges of the current system will succeed. Neither of the two major political parties is yet prepared to address fundamental reform, still subscribing to an incrementalism that has been a complete failure for more than 25 years. The current experiment with consumerism conveys a cruel illusion of “progress,” is unfair, and won’t resolve system problems.

Medicine has the opportunity to take a leadership role in promoting a broad consensus supporting what should be unassailable principles of reform against which reform alternatives can be assessed. These principles could well include (a) guaranteed universal coverage; (b) free choice of physicians; (c) continuity of primary care; (d) a comprehensive, basic set of clinically effective benefits; (e) cost containment with affordability, and (f) commitment to continuous quality improvement. Hopefully, the time for much needed structural reform of the nation’s ailing health care system will soon be at hand.

APPENDIX

Problems with the U.S. Health Care System

Decreasing access to care

- More than 40 million Americans are uninsured (17% of the population less than 65 years of age (1), more than the combined population of Texas, Florida, and Connecticut) (2).
- The number of uninsured under age 65 has increased by almost one-third since 1987 (3).
- Twenty percent of the uninsured cannot afford health insurance if offered by their employers (4).
- One-quarter of all nonelderly Americans are uninsured for at least one month per year (5).
- Of health care personnel less than 65 years of age, 12.2% were without health insurance in 1999 for themselves and their families (up from 8.4% in 1988) (6).

- In 32 states, a parent working full-time at the minimum wage of \$5.15 per hour is ineligible for Medicaid and can't afford insurance (7).
- Only 64% of U.S. workers are covered by employer-based insurance (8).
- Consolidation and decreasing choice are occurring for employer-based insurance (e.g., American Express dropped 164 HMOs nationwide in the last two years, retaining 48) (5).
- In 2001, 37% of applicants for insurance in the individual insurance market were turned down, even with a \$500 deductible and \$20 co-pay for physicians' visits; only 10% were approved without restrictions or higher premiums (9).
- In the event of recession, the number of uninsured is projected to increase to 61 million by 2009 (10).

Increasing costs of care

- Health spending is projected to increase to 16.2% of GDP by 2008, almost doubling to \$2.2 trillion (11).
- Compared with a Consumer Price Index of 1.6% for the 12 months ending December 2001, medical care was up 4.7% (12).
- Employer-based insurance premiums increased an average of 14% in 2002 (13).
- Prescription drug costs increased 17.3% in 2000 (12).
- Average family health insurance premiums are now \$7,053 (19).
- Nongroup insurance for a typical family is now estimated to cost \$10,000 per year (14) (so a tax credit of \$2,000 won't help much).
- HMO profits were up 16% in the second quarter of 2001 (15).
- For-profit hospital chains reported huge profits in the third quarter of 2001 (e.g., HCA at 47%; Tenet, 45%) (16).
- Corporate greed burgeons while access declines and costs go up (e.g., 23 top executives of investor-owned HMOs were paid more than \$63 million in salary in 2000, plus \$109 million in stock options) (17).
- Administrative costs account for about 26% of the nation's health care expenditures (18).

Variable and often poor quality of care

- Many factors lead to poor quality of care, including denial of services (18), lack of primary care and continuity (19), unnecessary procedures/surgery (20), and neglect of psychosocial and quality-of-life issues (21).
- Documented regional variations in care cannot be justified by clinical evidence or population differences (e.g., 20-fold differences in carotid endarterectomy rates in 16 large communities in four states) (22).
- Ten of 28 evaluations by the Technology Evaluation Center of the national Blue Cross and Blue Shield Association showed drugs, devices, or procedures to be either lacking or uncertain in their effectiveness (23).

- The U.S. ranks last among 13 industrialized Western countries for low birthweight percentage, neonatal and overall infant mortality, and years of potential life lost (24).

Nonsustainable, overly complex, inefficient system with poor performance

- The more than 1,200 insurers have an increasing burden of paperwork and bureaucracy (25).
- The insurance industry, largely investor-owned, is pursuing profits and returns to shareholders while discriminating against the sick.
- The chronic problems of inadequate access, rising costs, and unacceptable quality of care are refractory to all attempted incremental remedies.
- The market-driven private sector is often in conflict with public interest (26).
- A weak primary care base ranks the United States last among 11 industrialized nations based on 11 criteria (27).
- There is a growing need for the increasingly fragile public safety net.

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