Confusion and Controversy On the Road to Healthcare Reform

BY JANE H. WHITE

Any enterprise that costs more than $2 billion a day is necessarily complex and laden with divisive special interests. Such is the case with healthcare in the United States. Government leaders and the public agree reform is necessary. Considerable confusion and controversy exist, however, over precisely what reforms are needed and how to go about implementing them.

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Differing Perceptions

The Public Versus the Leaders A study released April 6, 1992, reports that the gulf between the perceptions of the public and the healthcare experts suggests that "the national debate on health care is badly off course."[1] "Among political, business, and healthcare leadership, a debate of some focus and precision has indeed begun," the study reports. "But among the public, confusion, misunderstanding, fear, frustration, scapegoating, and wishful thinking characterize an issue poised to go nowhere." This study by the New York–based Public Agenda Foundation analyzes existing polling data, the results of 15 focus groups of U.S. citizens convened from spring 1991 to winter 1992, and a two-part national survey fielded by Public Agenda, the Employee Benefit Research Institute (EBRI), and the Gallup Organization in June 1991 and January 1992.

Healthcare Costs The views of the public and the experts diverge on a range of questions, according to the report. On the cost of healthcare, the problem for the healthcare leaders is the total U.S. healthcare bill—pushing an estimated $750 billion for 1991. The public, on the other hand, are concerned that their own out-of-pocket costs are too high, and they seriously underestimate the size of the nation's healthcare bill. They blame the rising cost on greed, epitomized by "unnecessary tests, overpaid doctors, wasteful hospitals, profiteering drug companies, and greedy malpractice lawyers. For the public, it all adds up to a *profits* problem, not a *costs* problem," explains the report. For the healthcare leaders, the costs problem is "complex and multifaceted, including factors such as duplication of technology and services, defensive medicine, the health costs associated with crime and drug use, an aging population, and the development of new technology."

The Uninsured A perception gap emerges in defining who are the uninsured, what to do about the elderly, and what to do about technology. Both the public and the experts cite the number of uninsured as a critical symptom of the healthcare crisis. However, while healthcare leaders have moved beyond the Medicare and Medicaid populations and are currently debating how to insure the working poor, the Public Agenda–EBRI survey shows that 54 percent of the public believe that "many people over 65 have no health care coverage at all," and 64 percent think that "many people on welfare have no health care coverage at all."

The Elderly Healthcare leaders point to the aging U.S. population as one of the key factors in rising healthcare costs. The public, on the other hand, is reluctant to accept or address this issue. The survey found that 54 percent of those aged 14 to 34 believe that "older people are no more responsible for growing health care costs than any other part of the population. Many of the most expensive medical problems happen most frequently to younger people." In focus groups, Public Agenda found that:

> Not only do people underestimate the amount of health care older people need, most completely fail to understand why the phenomenon of more older people living longer will drive up health care costs for the nation as a whole. Moreover, since many people believe that each patient actually pays most of the cost for his own health care treatment, they don't understand why an older person's illness would increase their own health care burden—or be of any concern to society.

Technology Both the public and the experts are concerned about inappropriate and unnecessary use of technology. The experts, however, are also concerned about the high cost of new, but potentially useful, technology. The public is reluctant to "ration" any new technology given the "greed and waste" they see remaining in the healthcare system. The Public Agenda Foundation report cites a 1987 Louis Harris survey to illuminate the different perceptions: "While less than a quarter of the political leaders (23%) agree that 'health insurance should pay for any treatment which will save lives, even if it costs one million dollars to save a life,' more than seven out of ten (71%) of the public endorses this statement."

Government Responsibility With these broad perception gaps about the fundamental issues of healthcare reform, reaching the consensus and understanding necessary to achieve change will be difficult. A new Louis Harris poll commissioned by the Kaiser Family Foundation and the Commonwealth Fund underscores the public's confusion.[2] The poll found that healthcare still ranks number two, after the economy, as a politically important issue among the American people. However, "in spite of the great importance to voters of health care as an issue, neither major party nor any of the candidates has a health reform strategy that has captured the public's attention." When asked, "Can you think of any political leader or candidate whose proposals for health care reform you support?" 80 percent responded "no one," 5 percent cited President George Bush, and Democratic candidate Bill Clinton garnered a 2 percent response.

Even though most Americans do not support or identify with any of the presidential candidates' healthcare proposals, 60 percent of the respondents told Harris pollsters that the government should have the primary role in "assuring access and controlling costs"; 34 percent thought the private sector should. Not only does the majority of the public believe these healthcare problems are government's responsibility, 62 percent believe the federal government should take the lead, versus the state government (30 percent).

Among policy and healthcare experts, on the other hand, dissension exists regarding whether healthcare reform is a public or private responsibility and whether states or federal government should take the lead. In April, yet another state took action on the healthcare front, while federal policymakers remained mired in political debate. Minnesota passed a modified version of its "HealthRight" legislation to begin subsidizing insurance for the state's uninsured citizens. A tax on hospitals and other providers will finance the program.

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Division among the Experts

Healthcare policymakers and analysts are divided on the direction reform should take. Broadly categorized, the three main proposals that have emerged are defined as "play-or-pay"; "single payer," or the Canadian model; and "managed competition," or market reform. These categories are overgeneralizations, and many hybrid variations have emerged. Nevertheless, they do show the divisions and controversies that have erupted in the debate over healthcare reform.

Play-or-Pay This plan would require employers either to provide health insurance to their employees who work more than a certain number of hours a week ("play") or pay a tax that funds a public insurance pool to cover the uninsured ("pay"). Versions of this proposal are supported by the Pepper Commission; the Senate Democratic leadership, which proposed the HealthAmerica Act (S. 1227); Democratic healthcare leaders in the House, such as Rep. Dan Rostenkowski, D-IL, who proposed the Health Insurance Coverage and Cost Containment Act (H.R. 3205); and some business and labor leaders, as represented by the National Leadership Coalition for Health Care Reform.

The American Hospital Association (AHA) proposed a play-or-pay system in May 1991. At its January 1992 annual meeting, AHA broadened its proposal to focus reform on the delivery side. It proposed "community care networks" to link together hospitals, physicians, and other providers. The services of these networks of providers would be offered as a package. The networks would be paid a set fee per enrolled patient, and payments from the networks to providers would be based on negotiated rates.

The Bush administration is adamantly opposed to play-or-pay and perceives the plan as a back door to national health insurance. In his 1992 State of the Union address, Bush said: "Now some pretend we can have it both ways. They call it 'play-or-pay'—but that expensive approach is unstable. It will mean higher taxes, fewer jobs, and eventually, a system under complete government control."

An Urban Institute study recently became the controversial focal point for the different views regarding play-or-pay.[3] The Labor Department commissioned the Washington, DC–based research group, which is highly regarded for its cost-simulation modeling, to estimate the poten-

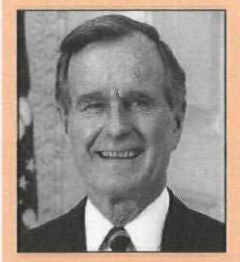
tial costs and effects of a play-or-pay plan. Labor Secretary Lynn Martin, Department of Health and Human Services Secretary Louis Sullivan, and other opponents of play-or-pay interpreted the study's results to say that the plan would result in a large number of Americans being "dumped" into the public-sector health insurance program and would present an undue burden for small business. Advocates of play-or-pay interpreted the study's results as confirming the belief that the plan would provide universal access to healthcare while capping employers' health insurance costs.

Assuming a 9 percent payroll tax, the study estimated that 39 percent of the population would be enrolled in the public insurance plan, assuming premium costs are similar to current levels. This includes 64 percent of the currently uninsured and 21 percent of those who currently receive private insurance from their own employer. At a 7 percent payroll tax, these percentages increase to 52 percent of the total population in the public program (78 percent of the currently uninsured and 35 percent of those whose employer currently provided private insurance).

Not only is there deep division among interest groups regarding the potential effects of play-or-pay, there is division *within* such groups. Small business and some big business interests, as represented by the National Association of Manufacturers, oppose play-or-pay, whereas other business leaders support the plan as a way to hold down their insurance costs. One provider group, the Federation of American Health Systems, recently changed its mind regarding play-or-pay. A former supporter of the plan, the for-profit hospital group voted at its spring 1992 meeting in Las Vegas to shift its support toward market-oriented reforms.

Single Payer Single-payer advocates look to Canada's provincial healthcare systems and other models where government is the sole payer and sets a global healthcare budget in negotiation with healthcare leaders. The delivery of care remains private, but the financing is public. This type of plan is supported by a number of Democratic leaders, including Rep. Fortney H. (Pete) Stark, D-CA, who proposed the Mediplan Health Care Act (H.R. 650); former presidential candidate Sen. Bob Kerrey, D-NE, who proposed the Health USA Act (S. 1446); and the physician group Physicians for National Health Insurance.

Comparisons of healthcare in Canada and the United States have produced fervent debate and disagreement among health policy analysts.



Opponents of a single-payer system, like President Bush, point to long waiting periods for certain surgeries and the specter of rationing.

Proponents of the plan point to lower costs, administrative efficiency, and Canadians' higher level of satisfaction with their healthcare system. The measurement of administrative cost savings, however, has aroused considerable controversy. Estimates of administrative savings for the U.S. healthcare system under a Canadian-style system range from $100 billion in 1991, proposed by Harvard physicians Steffie Woolhandler and David Himmelstein,[4] to just $3 billion if one accounts for the increased number of people gaining access to healthcare.[5] A new study by the Washington, DC–based consulting firm Lewin/ICF, Inc., estimates that the costs resulting from increased use of the healthcare system under a Canadian-type plan would, in fact, overshadow the administrative savings by $31.4 billion.[6]

Opponents of a single-payer system point to long waiting periods for certain surgeries and the specter of rationing. Bush pointed to such issues when he released his Comprehensive Health Reform proposal. He cited a study comparing health and surgical outcomes in New England and Manitoba to support his view that Canada does not provide adequate care for certain health conditions, compared with the U.S. health insurance market. The authors of the study took umbrage and called the president's comments "a distortion of our previous work."[7]

Canadian economists Morris L. Barer and Robert G. Evans of the University of British Columbia recently commented on this "predilection for misrepresentation and mudslinging, most recently displayed by George Bush." They predicted that "this difficult process of comparing alternatives will continue to be hampered by the creation of disinformation by 'experts,' because there are too many players and not enough umpires. . . . This is particularly true when the issues are inherently very complex and charged with personal values, and when the different alternatives represent very different distributions of gains and losses."[8]

Market Reform A number of healthcare proposals take a more incremental approach to reform, maintaining the private, flexible system of choice that Americans have come to expect, while reforming the most glaring problems. Such proposals promote managed care to control costs, small-group market reform to help small businesses afford insurance for their employees, other insurance reforms to provide stability and increase access, changes in the tax code to provide incentives to buy insurance, and malpractice tort reform, among other options. The primary proposal here is Bush's Comprehensive Health

Reform plan (see "President Bush Joins the Healthcare Reform Debate," *Health Progress*, May 1992, pp. 12-15). Other supporters include Republican congressional leaders, health insurance industry leaders, and small business groups.

In a split with the Democratic congressional leadership, a group of conservative and moderate Democrats, the Conservative Democratic Forum, introduced a plan in April that relies on private-sector reforms. The plan would encourage providers and insurers to form community health partnerships via incentives in the tax code. It would also shift the acute care portion of Medicaid to the federal government, while states would pick up coverage for long-term care, expand coverage for people earning less than the federal poverty level, increase Medicaid payments to the Medicare level, reform the small-group market for insurance, and simplify administrative tasks and paperwork. The plan's proponents tout it as a more pragmatic, and enactable, approach toward healthcare reform.

Unitary Financing, Plural Delivery

Beyond the three general reform models, many groups have set out variations that range the full length of the reform continuum. One of the newest "hybrid" plans to emerge is the Catholic Health Association's (CHA's) *Working Proposal for Systemic Healthcare Reform*, released in April.[9] The CHA proposal aims to blend regulatory and competitive approaches by combining a unitary financing system with multiple payers and a pluralistic delivery system. Sources of financing would include federal and state healthcare spending, payroll taxes on employers and employees, and targeted taxes such as alcohol and tobacco excise taxes.

On the delivery side, CHA proposes integrated delivery networks (IDNs) that are privately organized and provide the full continuum of care from prevention to acute care to long-term, home health, and hospice care. These IDNs would compete for patients on the basis of quality and services, not price, and would assume the financial risk for providing services.

The CHA proposal offers three significant contributions to the healthcare reform debate. First, the proposal is rooted in an emphasis on values such as human dignity, the common good, social justice, responsible stewardship, and the role of healthcare for the poor. Second, the proposal starts with delivery reform, rather than the more common focus of financial reform. Third, the proposal adds to the debate regarding the appropriate role of the government.

"If government is going to play a role, then it's incumbent on us [as providers] to help define that role," said CHA lobbyist Jack Bresch.

"It's unrealistic to think that the government, which puts in approximately 42 percent of all healthcare spending, is not going to play a role in the healthcare system," said CHA lobbyist Jack Bresch. "If government is going to play a role, then it's incumbent on us [as providers] to help define that role. We think government should bring order to the system by (1) guaranteeing universal access, (2) establishing and defining a basic benefit package, and (3) establishing national expenditure levels."

A Long Way to Go

Given this wide array of proposals and political viewpoints, surely some plan would emerge to capture the support of the American people. Yet, as the Kaiser-Commonwealth poll showed, only 16 percent of the public answered yes when asked, "Do you see any real difference between the two major parties on health care reform?"[10] And four out of five surveyed could find no presidential candidate whose proposal for healthcare reform they supported. Clearly the reform debate has a long way to go to increase public understanding of the issues involved and to forge some consensus on the appropriate course of action. □

NOTES

1. John Immerwahr, Jean Johnson, and Adam Kernan-Schloss, *Faulty Diagnosis: Public Misconceptions about Health Care Reform*, Public Agenda Foundation, New York City, 1992.
2. Mark D. Smith et al., "Americans and Their Health Insurance: Experiences and Political Prospects," *Health Affairs*, Summer 1992.
3. Sheila Zedlewski et al., "Play or Pay Employer Mandates: Potential Effects," *Health Affairs*, Spring 1992, pp. 62-83.
4. Steffie Woolhandler and David Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *New England Journal of Medicine*, May 2, 1991, pp. 1,253-1,258.
5. U.S. General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, Washington, DC, June 1991.
6. John F. Sheils, Gary J. Young, and Robert J. Rubin, "O Canada: Do We Expect Too Much from Its Health System?" *Health Affairs*, Spring 1992, pp. 7-20.
7. Leslie L. Roos et al., "Health and Surgical Outcomes in Canada and the United States," *Health Affairs*, Summer 1992.
8. Morris L. Barer and Robert G. Evans, "Interpreting Canada: Models, Mindsets, and Myths," *Health Affairs*, Spring 1992, pp. 44-61.
9. Catholic Health Association, *Setting Relationships Right: A Working Proposal for Systemic Healthcare Reform*, St. Louis, April 1992.
10. Smith et al.