
A National Health Insurance System/Program: A Review Of US History And Current Debate

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Abstract

A national health insurance system or program has been a heated debate throughout the history of the United States. As a country, the United States has the best medical system in the world. However, it also has the highest costs and least insured citizens in the developed world.

The purpose of this paper is to understand the current plan proposed by the Physicians for a National Health Insurance Program. The purpose is to also identify positive and negative concerns in the development or use of a single payer National Health Insurance Program. Financial concerns of a single payer National Health Insurance Program were also explored.

INTRODUCTION

The United States health care system is one that boasts many resources. The system has personnel, which are the best trained in the world. Facilities boast the most sophisticated, up-to-date and state of art equipment. It is considered by many to be one of the best health care entities in the world today. Foreign diplomats, the wealthy and many others, from outside the United States flock to its medical care systems.

Despite all the advances in medicine, personnel and equipment, health care access for Americans can be described as irrational and burdensome for those that need the care. "More than 41 million Americans have no health insurance, including 33% of all Hispanics, 19% of African Americans, and 10% of non-Hispanics whites. Many more ... are underinsured" (1, p. 798). This can be considered and by some is considered a national tragedy. "Even the well-insured may find care compromised when health maintenance organizations (HMOs) deny expensive medications and therapies" (1, p. 798).

The uninsured or underinsured patient has contributed to the health disparities seen in the United States. Why then, a country that "spends more than twice as much of health care as the average of other developed nations" (1, p. 798) could have such a problem with access to care?

Nations that have seen drastic rises in health care costs have

combated the issue by enacting a national health insurance plan. In the United States, we treat "health care as a commodity distributed according to the ability to pay, rather than as a social service to be distributed according to the medical need" (1, p. 798). This has created an atmosphere in which market forces dictate the access to care. This creates a paradox of a health care system when profits to insurance company stockholders, executives, etc. are more important than helping the sick that need care the most. It is based on the premise of avoidance of the sick is the best approach to ensure returns to investors.

The purpose of this study is to outline what a national health plan or insurance would look like. It will also look at the costs associated with the proposal and how to pay for those costs.

REVIEW OF THE LITERATURE

WHAT IS NATIONAL HEALTH INSURANCE?

To change the health care coverage in the United States, we must first change how we feel about health care. According to the Physicians for a National Health Program, "four principles are need for health care reform:

1. Access to comprehensive health care is a human right.
2. The right to choose and change one's physician is

fundamental to patient autonomy.

3. Pursuit of corporate profit and personal fortune has no place in care giving.
4. In a democracy, the public should set health policies and budgets.” (1, p. 799)

Until these principles are widely adopted, access to care will also be confrontational.

A national health insurance plan has been suggested by a group of physicians in the United States. This plan was published in the *Journal of the American Medical Association*. A summary of their plan will be used as a template for the current National Health Insurance debate.

A National Health Insurance Plan would be one that is open to all United States citizens and those United State Territories. The plan would cover all necessary medical services, including primary care, outpatient care, emergency care, prescription drugs, allied health testing, etc. (2). The plan would allow patients to access medical care, to include hospitals, physicians, clinics, etc., at those locations they choose, not have the plan choose for them.

There can be some limitations to the plan for example non-medically necessary procedures, which will allow private insurance companies to still exist. A good example would be the Medicare Supplemental Insurance offered to those currently on Medicare. As a rule, Medicare does not provide for all health care in the United States. However, it does provide enough coverage to ensure the good health of the participants. By not including every health care option in this plan, the risk of abuses in the insurance plan benefit would be reduced significantly (1).

Cost containment of the program would be accomplished by the United States National Health Insurance program setting reimbursement rates annually. These rates would be negotiated for physicians, health care providers and prescription drugs. Administration of the reimbursement could be accomplished in the same fashion as the current Medicare program (1).

The conversion to this program, according to the Physician Working Group, would be up to a 15-year process. It was suggested that a fast, decisive move would adversely effect the United State economy due to the number of insurance companies leaving the field. Additionally, this 15-year conversion would allow insurance companies to decide if

they wanted to remain in the new health insurance market and make appropriate changes to their business structure (1).

Finally, as an oversight to the program, a Health Advisory Board needs to be convened. This board would be comprised of health care professionals, public health professionals, health care advocacy organizations, governmental officials and the public. This board would review policies and procedures, denial of care complaints and other various duties to ensure the proper access to care for every person in the program. It would also set policies on the recommended procedures and medical treatments to be covered in the program. This would ensure new medical advances be given due consideration for medical conditions. It would also ensure that costs versus benefits would be taken into consideration as well (2).

A BRIEF HISTORY OF UNIVERSAL HEALTH CARE EFFORT IN THE UNITED STATES

The United States in the Progressive Era (1883 – 1912), took little or no action to create a National Health Insurance system. The social conditions of the working class did have reformers trying to improve health care concerns. Most of these attempts did end with little or no success.

President Theodore Roosevelt (1901-1909) did support a health insurance plan. He believed that “no country could be strong whose people were sick and poor” (3, p. 2). However, he too did not feel it was the government's place to mandate reforms. Thus most of the reforms were placed outside the government in the private sector and failed to respond to the need of society.

In 1906, the American Association of Labor Legislation led the campaign for national health insurance. However, their plan came under opposition from several groups including the American Federation of Lead and the private insurance industry. The American Medical Association was one of the only groups to support the measure. (3).

President Franklin D. Roosevelt (1933 – 1945) made several attempts to create a national health insurance system. In Roosevelt's second attempt, the Wagner Bill (National Health Act of 1939) grew into a strong movement. Although by the time the bill was introduced into Congress, the bill never had Roosevelt's full support. “The movement for national health insurance in the 1930's ran into the declining fortunes of the New Deal and WWII [World War II]” (3, p. 5).

After the death of Roosevelt, Truman became president (1945-1953). President Truman believed strongly in a national health insurance program. “The health care issue finally moved into the center arena of national politics and received the unreserved support of an American president” (3, p. 6).

The opponents to national health insurance had an unwilling ally, the Communists. The opposition to the plan spoke of the plan looking a lot like socialism. “Compulsory health insurance became entangled in the Cold War and its opponents were able to make “socialized medicine” a symbolic issue in the growing crusade against Communist influence in America” (3, p. 6). Truman's Plan was defeated.

Other American presidents have taken up the cause such as President Nixon's Comprehensive Health Insurance Program and President Clinton's Health Security Plan (4). In fact, failure of President Clinton's Health Security Plan almost removed the idea of a national health insurance from the United State's public policy agenda (5). “Nevertheless, most Americans agree that the various reports documenting disparities in access and in health care, i.e. those disparities related to insurance status, are compelling. Most Americans agree that they would not want to be uninsured or underinsured” (5).

UNIVERSAL HEALTH INSURANCE – THE CURRENT DEBATE

The debate on a national health insurance continues today. In 2003, senior citizens received a prescription benefit as part of their Medicare package. Although the plan has not been as successful as hoped, some prescriptions cost are covered.

Today, the idea of a national health insurance remains part of the American agenda because policy makers have not found a simpler and more effective way to reform healthcare. One of the most outspoken groups is the Physicians for a National Health Program based in Chicago, Illinois.

They have stated healthcare is “a mounting crisis [that] threatens medical care in our nation. A decade of managed care constraints and pro-market public policies have now clearly failed” (6). They recognized that “reopening of [the] health reform debate is imminent after a decade of quiescence” (6).

According to their website, the group has created the Physicians' Proposal of a Single-Payer National Health

Insurance plan. “The NHI [Physicians' Proposal of a Single-Payer National Health Insurance] proposal was crafted by a distinguished panel at the invitation of some 125 members of Congress” (6, p. 1). This proposal has received the endorsement of over 12,000 physician and health care providers in the United States. “Perhaps the most noteworthy aspect of this article [the Physicians' Proposal of a Single-Payer National Health Insurance proposal] is that by offering its approach, the Physicians' Working Group issues a challenge: those who reject its “solution” are challenged to present their own, better and stronger one as a replacement” (5, p. 819). This challenge to the opponents will not allow them to simply dismiss the proposal. To do so without an alternative would be to admit no plan exists.

American society faces an ever-growing problem with healthcare. Society should be compelled to search for a solution (5). Many have suggested that now is the time to begin the debate on a national health insurance system. The Physicians' Working Group has offered a solution to the problem. “Those who like their proposal should join with them. Those who do not should develop and propose something better, more effective and with fewer untoward side effects” (5, p 820).

WHY THE UNITED STATES NEEDS A SINGLE PAYER HEALTH SYSTEM

More and more, a few larger companies in the United States control the healthcare market nationally. Additionally, groups of companies or groups of hospitals are controlling the healthcare market at the local level. The result is that “hospital chains and managed care plans will soon corner the market, leaving physicians and patients with few options” (7, p. 1).

On average, private healthcare insurers take 13% - 15% of each premium dollar on overhead or administrative expenses. As can be expected, larger firms take a higher percentage, about 30% of each premium dollar for overhead and profits to investors. In contrast, Medicare takes on average 2% of each premium dollar for overhead (7). Much of the cost consumers are paying for health care does not go toward the care itself.

Physicians face even more costs. In one study, “the average office-based American doctor employs 1.5 clerical and managerial staff, spends 44% of gross income on overhead and devotes 134 hours of his/her own time annually to billing” (7, p. 3). Another study shows that nearly one-third of health care [physician] spending goes to overhead (8,

2003, p. 768). “In private practice, we waste countless hours billing and bureaucracy” (1, p. 798).

According to the United States Congress' General Accounting Office, administrative savings realized from a single-payer reform would reduce the amount of overall health care spending by 10%, or \$100 billion dollars annually (6). There have been differences in the spending of this savings, from reducing the need for co-pays, deductibles, etc. to increasing health promotion programs. Although these disagreements on spending exist, there would be money to spend.

The current market structure of health care denies access. “Healthcare and other investor-owned managed care plans are inserting “gag” clauses in physician's contracts” (7, p. 3). These clauses have “preempted the physician's independence and exercise of medical judgment” (5, p. 819). Thus, disparities in health care run rampant in the United States.

FUNDING A NATIONAL HEALTH INSURANCE PROGRAM

Before implementing a new system, cost is always a factor to be considered. Not only the fixed costs but also those intangible costs that hide in the details of many health insurance financial reports. Determining the variables of the program will also have discrepancies, but these should be manageable.

Some of the intangibles to be considered differ from the current structure in health care today. First, most underinsured and all uninsured would have full access to health care. Second, reductions in costs would lead to increased usage by those that have insurance but could not afford the procedures, due to cost. Third, administrative costs would fall dramatically (10, 11). Finally, cost containment procedures would contain the growth of health care costs (10, 12).

All Americans are already paying for health insurance whether they have coverage or not. It is estimated that 60% of governmental expenditures already go to private insurance companies in the form of tax subsidies and payments for public employees' private health coverage (13). The premise would be that all the public money now being funded to private insurance companies would be used to fund the national health insurance. (1).

Other avenues of funding, which could also be explored, are taxes or requiring employer contribution, as required by

Social Security. It is suggested by Rassel that “for the average, middle-income household the increase [in taxes] would average less than \$731” (14, p. 186) annually. Further “in exchange for a tax increase, premiums and out-of-pocket spending would be eliminated” (14, p. 186), thus reducing the health care costs burdening the majority of Americans.

The Physicians Working Group has suggested that their proposal would cost \$1.86 Trillion dollars per year. Their suggestion is that there would be little, if any, changes in the tax structure, thus making this proposal equitable for all Americans. They suggest the following, as a funding possibility:

1. A payroll tax on all employers of 3.3%
2. Maintain current Medicare payroll taxes of 1.45% per employee
3. Implement a method to ensure lower and middle income families are not paying the bulk of the insurance costs
4. Implement a small tax on stocks and bonds
5. Close the ability for corporation to have tax shelters
6. Repeal the Bush tax cut of 2001 (2)

They suggest these measures would greatly reduce the average cost currently being paid for health insurance.

QUALITY OF CARE UTILIZING A NATIONAL HEALTH INSURANCE PROGRAM

Would a national health insurance program increase the quality of health care in the United States? Most would say, “Yes.” According to Don R. McClanne, MD, “It would relieve businesses of administrative hassles and expenses of maintaining a health benefits program. It would remove from the health care equation the middleman - the insurance/managed care industry - that has wreaked havoc on the traditional patient-physician relationship, while diverting outrageous amounts of patient-care dollars to their own coffers” (15, p 1). The program would control health care inflation through constructive mechanisms of cost containment. These cost containment measures would improve allocation of our health care resources, rather than controlling costs through an impersonal business ethic that strips patients of care to improve the bottom line (15).

In short, McClanne believes a national health insurance program would provide access to health care for the ones that need health care the most. Additionally, the quality of health care and health care outcomes would increase because everyone has equal access. It would make “available to everyone preventive and public health services would significantly improve the level of health of our entire nation” (15, page 2).

A national health insurance program would reduce the number of communicable diseases and chronic diseases. A decrease in the number of chronic diseases would, in part, reduce the higher costs of untreated chronic disease. The reduction in health care treatment costs would help society in general (15). “Healthy individuals make for a healthier work force, with less lost time at work, greater productivity, and a more positive work environment” (15, p 2).

ALTERNATIVES SUGGESTED TO THE NATIONAL HEALTH INSURANCE

The mounting health care insurance and health care disparity crisis has created several alternatives to a National Health Insurance proposal. Critics state that “all [these proposals] share one critical liability: because they would retain the role of private insurers, they would perpetuate administrative waste, making universal coverage unaffordable” (1, p. 803).

CONTRIBUTION SCHEMES AND OTHER MECHANISMS TO INCREASE PATIENTS' PRICE SENSITIVITY

This proposal places a cap on the employers' premium contribution at a specified fixed amount. This would cause employers to look for low cost options in health care insurance and health care treatment. Identified problems would be that the increasing cost of health insurance would be re-directed from the employer to the employee. Additionally, lower-income workers would need to choose between a higher priced insurance plan and other personal expenses or a lower-priced health insurance plan with little or no benefit to the employee (1).

TAX SUBSIDIES

This proposal would offer tax credits to low and middle income families that purchase private health insurance. Identified problems would be the amount of tax credit given and the rise in the cost of health insurance. The current proposal has an annual credit of \$3,000.00 per family under President Bush's Plan. This amount falls far short of the annual amount of adequate health insurance paid in the

United States (1).

EXPANSION MEDICAID AND OTHER PUBLIC PROGRAM

These proposals would expand the eligibility requirement for public programs. One obvious problem would be that these programs are already considered to “offer second-class coverage” (1, p. 803) to enrollees. Another identified problem is that the payment by Medicaid and other public programs are slow. This may cause financial difficulties for health care providers if the number of enrollees is high (1). This already has been realized in some of the public hospital closures recently in the United States.

EMPLOYER MANDATES

These proposals would mandate that all employers pay for health insurance for their employees. This would include a mandate that employers pay all or a major part of the premium. The identified problems would be the effect on the economy and small businesses. The businesses in the United States would begin to lower wages or increase prices to compensate for this mandate. Thus, the problem has not been solved. The employee would not have the ability to pay for the health insurance because of personal expenses versus the cost of insurance (1).

METHODOLOGY

Research for this project included a review of literature on the proposal for a National Health Insurance plan. Review of the literature focused on three areas. First, the research focused on the proposals by a president or governmental agency of a National Health Insurance system and the debate surrounding these proposals. Second, the research focused on the current proposal drafted by a group in the medical community in the United States. Third, the research focused on the ability to fund such a program.

The goals of this project were: 1) to identify articles and describe the current health care issues associated with the lack of insurance coverage or underinsurance coverage in the United States, 2) to identify articles and describe the past issues and debates surrounding a reform in health care or health care insurance and 3) identify governmental articles and studies and research articles on the funding of such a program in the United States. Review of literature included search of PubMed database: Medline, PreMedline and HealthStar, and publisher supplied citations using keyword including “national health insurance”, “Clinton health security plan”, “Nixon comprehensive health insurance”,

“Truman health insurance”, and “Funding National Health”, both alone and in several combinations. A search of the Internet with publisher supplies citations using keyword “national health insurance” and “health insurance debate”, both alone and in combinations. I also reviewed the references of the articles selected using this search method to identify other publications not already identified in this process. Only those publications and Internet sites that specifically identified and described the goals stated above were included in the final review of the topic.

RESULTS

Health care disparities in the United States and the ability to afford health insurance are problems that need to be addressed. The United States has attempted to offer solutions to this problem since Harry Truman was president. Every attempt to date has failed.

A National Health Insurance Plan is one solution to the problem. It is also a solution that has been used in several countries across the globe from Canada to the European Continent. While there are some inherent dangers in the current proposal from the Physicians for a National Health Program, most of these dangers can be met by the exercise of democracy.

One of the dangers is that if the money flows through the government, spending of those funds can become entangled in political sub-divisions. It may mean that the government will spend the money at a slow rate, effecting health care providers ability to pay bills associated with a business, such as payroll and payments to the National Health Insurance Plan.

During the changes in political control of the Congress and the White House, unforeseen changes in the policy coverage and funding may become an issue. The government may compensate the lack of funding by re-classifying some procedure or drugs as experimental and determining those as non-covered.

Additionally the make-up oversight panel, as with the Supreme Court, changes due to political appointments. The ability to have a consistent insurance plan could be compromised if a drastic change in the members of the oversight panel occurs. Again, the problem would not be solved.

The National Health Insurance Plan would require a massive overhaul of the flow of insurance dollars in the United States

from private, commercial entities to the government. This change in the flow of money would effect other issues outside of health care, such as contract negotiations with labor unions, possible increase in a governmental agency, etc.

All of these dangers can be managed in our political system. What is not being managed is the uninsured and underinsured health care problem. This proposal offered by the Physicians for a National Health Program would take several years to implement and many more years to see if the program actually works.

CONCLUSION

Health care reform is again in the political eye of the country. Health care costs continue to rise at an unprecedented rate and show no signs this trend will change. The number of Americans who were uninsured or lacked adequate insurance to cover medical needs continues to increase at a rapid pace. Medicare and Medicaid are being threatened by funding changes and overuse. The American people are actively taking part in the debate of health care reform in the United States.

Other countries have made universal health care an option. Most of their problems around universal health care are funding. In the United States the problem seems systemic to the system itself. The current private, market driven insurance plans are not protecting the economy and the health of the public. The public programs are under-funded, overused and have their resources stretched to capacity. Reliance on either or both systems as they are currently working, will only create more problem than will it solve. What needs to change is the system of health care delivery and payment in the United States.

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References

1. Woolhandler, S. Proposal of the Physicians' Working Group for Single-Payer National Health Insurance [Cited 2003]. Available from http://www.physicianproposal.org/proposal_group.htm
2. Physicians for a National Health Insurance Program. What is National Health Insurance? [Cited 2003]. Available from http://www.phnp.org/facts/what_is_national_health_insurance.php
3. Litman, T.J. Health Politics and Policy. Albany, NY: Delmar Publishers; 1997.

4. Palmer, K (2003). A Brief History: Universal Health Care Efforts in the US [Cited 2003]. Available from http://www.pnhp.org/facts/a_brief_history_universal_health_care_efforts_in_us.php
5. Fein, R. Universal Health Insurance - Let the Debate Resume. *Journal of the American Medical Association* 2003; 290(6), 818 - 820.
6. Physicians for a National Health Program. Invitation to Endorse. [Cited 2003]. Available from <http://www.physicianproposal.org/proposal/invtie.pdf>
7. Woolhandler S & Himmelstein D. Why the US Needs a Single Payer Health System? [Cited 1995]. Available from http://www.php.org/facts/why_the_us_needs_a_single_payer_health_system.php
8. Woolhandler S, Campbell T, Himmelstein D. Costs of Health Care Administration in the United States and Canada. *New England Journal of Medicine* 2003; 349(8), 768 - 775.
9. United States General Accounting Office. Health Care Spending Control: The Experience of France, Germany and Japan. Washington, DC: GAO Report; 1991
10. United States General Accounting Office. Health Care Spending Control: The Experience of France, Germany and Japan. Washington, DC: GAO Report; 1991
11. Woolhandler S & Himmelstein D. The Deteriorating Administrative Efficiency of the U.S. Health Care System. *New England Journal of Medicine* 1991; 324, 1253-1258.
12. Rogal D, Gauthier A., Barrand, N. Managing the Health System Under a Global Expenditure Limit: A Workshop Summary. *Inquiry* 30 1993; 318-322
13. Woolhandler S & Himmelstein D. Paying for National Health Insurance - And Not Getting It: Taxes Pay for a Larger Share of US Healthcare Than Most Americans Think They Do. *Health Affairs* 2002; 21, 88-89
14. Rassel, E. An Equitable Way to Pay for Universal Coverage. *International Journal of Health Services* 1999; 29(1), 179-188.
15. McCanne, D Would single payer be good for America? [Cited 2002] Available from http://www.pnhp.org/publications/wold_single_payer_be_good_for_america.php

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