

CRICKET, RUGBY, AND U.S. HEALTH REFORM THREE SPORTS, IN INCREASING ORDER OF VIOLENCE

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When Adam Oliver invited me, just under a year ago, to talk about health reform in the United States, he probably thought that matters would be settled by now. I surely did. How wrong we were. The process goes on. The outcome is still in doubt. I feel like a critic asked to review a three-act play at the second interval. The hope is growing that we are watching a gripping drama with an uplifting denouement, but many remain concerned that it may turn out to be a bizarre mix of tragedy and farce.

The origins of this political theater go back a long way—nearly a century, in fact. Theodore Roosevelt, running unsuccessfully for president in 1912 as an independent, advocated a limited form of national health insurance. The next Roosevelt, Franklin this time, considered including health insurance along with unemployment and old-age benefits and poor relief in the Social Security Act, but decided against it, fearing that including health insurance would rouse opposition from physicians and doom the whole bill. At about the time you were setting up the National Health Service, president Harry Truman tried and humiliatingly failed to get Congress even to hold hearings on a plan to provide limited health benefits to all Americans.

The reasons for his failure are instructive. The chairmen of the Congressional committees through which health insurance would have to move were Southern-state politicians. They understood that national health insurance would end formal racial segregation of American hospitals. Sure enough, just under twenty years later, when Lyndon Johnson's landslide victory in 1964 gave non-Southerners enough clout to push through nationally-mandated health insurance for the elderly and disabled, formal segregation in American hospitals ended. This episode illustrates an important feature of

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U.S. debate on health care policy: how seemingly extraneous considerations can frustrate reform efforts.

Later, presidents Nixon, Ford, Carter, and, most recently, Clinton all tried and failed to get Congress seriously to consider national health plans. As this list indicates, such failure has been bipartisan. Still, polls consistently report that the American public generally trusts Democrats more than Republicans on health care policy.

During the 2008 presidential campaign, the tone of the intra-Democratic Party debate could be summarized in five words: ‘mine is bigger than yours.’ John Edwards had the most sweeping proposal. Hilary Clinton had the most carefully detailed plan. Both embraced universal coverage. Both drew the same lesson from Bill Clinton’s failure—that it was important to persuade insured Americans that if they wished to keep the coverage they had, they could. Most did. Both embraced the same strategy for extending coverage. Public coverage of the poor and near-poor would be extended. All but the smallest employers would be required to offer insurance to their employees or pay a tax instead. People not insured at work or by a public program would be required to buy insurance. Those who needed financial assistance to make insurance affordable would receive it. During the primary election campaign, Barack Obama was the odd-man-out. Health insurance should be mandatory only for children, he said. Others should receive financial assistance to buy it, but should not be required to do so.

Only one fringe candidate called for a government-run, tax-financed plan, and he won little support. Most Americans oppose that approach for two reasons. First, about 85 percent of Americans have health insurance. In general, it is good insurance. For two-thirds, it is privately managed. Most of that private coverage comes as a fringe benefit of employment and employers pay most of the cost. Economists may think that workers really pay for such coverage because employers will reduce other compensation by about what insurance costs. But few others really believe it. Furthermore, the tax system encourages U.S. businesses to buy health insurance for their employees. If workers buy insurance themselves, they must first pay income and payroll taxes on the income. If employers pay for it, workers are spared these taxes. In addition, the administrative cost of insuring

groups is lower than that of insuring individuals. Switching to a government run plan would upset all of these arrangements.

The second reason why Americans react negatively to government-run health insurance is even more fundamental. The United States, as you doubtless recall, was founded through rebellion against a remote government that wanted to tax them. For many, Washington is quite remote enough. And tax phobia is alive and well. Comedians use the phrase “I am from the government and I am here to help you” as a laugh line. Describing something as ‘government-run and tax-financed’ is just not a good way to win votes in the United States.

Back to the elections. No Democratic primary candidate gained a significant advantage on health policy—or, indeed, on any other issue. The positions of the candidates were just too similar.

Not so in the general election. An ideological abyss separated the health care policies of the two major-party candidates. While Democrats wanted to require that large employers sponsor and pay for most of the cost of health insurance for their employees, to extend public coverage of those with low incomes, to compel others to buy insurance, and to give publicly funded subsidies to help them do so, Republicans opposed each of these steps. Republicans wanted instead to break the link between employment and health insurance. Whatever employers spend to pay for health insurance for their workers, they argued, should be included in each worker’s taxable income thereby sharply reducing the incentives to link health insurance and work. In return, everyone should receive a refundable tax credit—the same amount for everyone—to help pay for health insurance wherever each person chose to buy it.

The Republican position needed two important changes to make it workable. First, to assure equal access to insurance coverage, the credits should have been inversely related to income. Second, given the heavy reliance on private insurers, aggressive regulation was essential—first, to hold down administrative costs and, second, to discourage private companies from competing by trying to enroll people expected *not* to use health care services.

There was, however, no political way that John McCain, the standard bearer of a Republican party long opposed to most government regulation, could endorse heavy regulation, even if he believed in it—and there is no sign that he did. Even worse from a political standpoint, the proposal to end the exclusion of employer-financed health insurance from income tax was open to the devastating charge that it would massively raise taxes on working people. Yes, there would be a tax credit to replace it, but the credit would cover much less than half of the cost of standard health insurance and workers didn't really understand that they paid—albeit indirectly—for the health insurance their employers provided.

Obama pounced. He charged McCain with endorsing a regressive tax increase and with exposing people to the rapacity of profit-oriented private insurance companies. The attack was analytically unfair, but highly effective. It was, however, a Faustian bargain. It was unfair because the exclusion of employer-financed health insurance from income tax is more regressive than the credit that McCain proposed. And the deduction is worth less than the credit would have been to most people. It was a Faustian bargain because it limited Obama's own options for how to pay for extending coverage that he was determined to seek when, as was becoming increasingly likely, he won the election.

Which, of course, he did. Democrats won not only the presidency, but also large majorities in both houses of Congress. Two quotations encapsulate the significance of those majorities. One is: 'I've been rich and I've been poor, and rich is better.' The other is humorist Will Rogers' remark "I belong to no organized political party; I am a Democrat."

Without large majorities, Obama's attempt at health system reform would have been quixotic. Even with them, the odds were long. To see why, consider this fact: Democrats enjoyed Congressional majorities almost as large when Bill Clinton became president as when Barack Obama was sworn in. Clinton's health reform plans nonetheless failed utterly and contributed to the 1994 electoral flood that swept Republicans to twelve years of national electoral dominance.

Obama knew he had to do something different from Clinton—and he did. Like Clinton, he made health reform a top priority. It was, he said, vital for the nation's health,

fiscal as well as somatic. In his first budget he proposed tax increases and spending cuts totaling \$635 billion over ten years as a ‘reserve’ for health reform. But unlike Clinton, who had set up a huge task force to design a plan and draft legislative language, which he then asked members of Congress to approve, Obama sent up no legislative language.

Instead, he asked Congress to do the drafting. He did lay down certain general health reform objectives. Specifically the legislation should correct the three major shortcomings of the U.S. health care system, known—perhaps too cutely—as the ‘three Cs’: coverage, cost, and quality. The administration hoped that this approach would cause members of Congress to see the resulting bill not as something thrust upon them but as their own handiwork.

This diagnosis of Congressional psychology was probably correct, but solving one problem created another: delay. Five separate committees of Congress, two in the Senate and three in the House, worked independently and drafted separate and different bills. The three in the House had to be merged, and were—not, however until November 7 and then only narrowly. Although Democrats hold 258 of 435 seats, the margin was narrow—220 to 215. All Republicans but one opposed passage. Most Democratic defectors were conservatives elected from normally Republican districts Democrats could win in 2006 and 2008 because revulsion against George Bush’s administration was wide and deep. A minority of Democratic opponents believed the bill was too timid, including that fringe presidential candidate who had embraced a nationally-administered, tax-financed health plan.

It is revealing to note that Republicans probably could have defeated the bill but chose not to do so. The device would have been another of those extraneous issues—in this case, abortion. Just before the final vote, the House adopted an amendment limiting the funding of abortions. The amendment was adopted with the support of all 177 Republicans and 63 Democrats elected from districts strongly opposed to allowing federal money to be used to pay for abortions under any circumstances. If the amendment limiting abortions had failed, enough Democrats would have joined Republican opponents to defeat the health reform bill.

So, the question arises: why didn't the Republican leadership instruct a sufficient number from their ranks to vote against the abortion-limiting amendment to defeat it? The answer, pretty clearly is that they wanted to force Democrats from conservative districts to take a stand supporting the health legislation in the belief that such a vote would hurt the Democrats in the 2010 election and increase the chances that Republicans will regain a majority. And, of course, they knew that they would have another shot at the health bill later on.

The health reform drama then shifted to the Senate, where the obstacles differed from those in the House of Representatives because of the Senate's peculiar voting rules. The Senate permits 41 of its 100 members to prevent a final vote on any bill by talking endlessly. Republicans hold 40 seats. Although formal party discipline does not exist in the U.S. Congress, not one Republican broke the ranks to support health reform legislation. Republican unity meant that all 58 Democrats and two independents who caucus with them had to vote to end debate and for passage of the reform bill. It also meant that each and every Democratic Senator could demand ransom for his or her vote and that the leadership had to—and did—pay. Come Christmas eve, the political stockings were hung by the chimney with care, in the hopes that St. Nicholas soon would be there...and he was.

I shall presently speculate on where things are likely to go from here. But, substantively, what is being proposed?

For background, roughly 85 percent of Americans—about 255 million people—are insured at any given time. Of this total, roughly 200 million are covered by private insurance, 175 million through work, 25 million through individual purchase. Public programs—Medicare for the elderly and disabled, Medicaid for the poor, and Military health care for members of the armed services and their families cover nearly 90 million. And, as those of you who have been totaling things in your heads recognize, there is some double counting as many people are covered under two or even three categories. I, for example, have private insurance through my employer and am eligible for Medicare. Had I served in the armed services, I would also be eligible for veterans coverage.

Federal and state governments directly pay for nearly half of U.S. health care. If one adds in the revenues foregone because of tax breaks for employer-financed insurance, governments pay for more than half of all U.S. health care. Contrary to common perception abroad, the uninsured are not bereft of health care. Many can afford whatever care they may need. And, if they can't, federal law requires every hospital to treat and stabilize all patients who come in, regardless of their ability to pay. Many physicians also provide uncompensated care or work part time in free clinics. The best estimates are that the uninsured consume, on average, about half as much health care per person as they would if insured, which, in the United States is quite a lot.

From an administrative standpoint, the system is a mess. A recent book on the U.S. system quoted a health economist who wrote: 'I look at the U.S. health care program and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggeringly complex public systems with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird.' That statement may be a tad florid, but I feel free saying so, as I am the economist who was being quoted.

We spend more per capita—by far!—than does any other country. Just why is a bit of a mystery. We do use a lot of advanced technology, much more than in most other countries, but not uniformly so. Partly for that reason, our hospital lengths of stay are among the shortest in the world. We have few queues. Much of the added spending comes from higher prices, not from more hospital days or visits to the doctor. We pay doctors more relative to average earnings than does any other country for which the OECD reports data. The waste entailed in administering our fee-for-service payment system makes pyramid building seem the height of utilitarian parsimony. In general, our prices for almost any specific service you can think of are higher than in other developed nations. Some of that cost probably goes for superior quality, but how much is hard to tell. At its best, U.S. health care is superlative.

But quality, alas, is uneven. One of the most widely cited studies of recent years, reported that U.S. patients on average received only a bit over half of recommended care

during an average contact with a hospital or physician. Rather surprisingly, treatment gaps were almost the same for men or women, old or young, rich or poor, blacks and whites. Interestingly, the group that scored highest was the Veterans Administration health service, a group organized—and I am not pandering to my audience—much like the National Health Service, operating on a fixed budget with salaried physicians.

The bills passed by the House and Senate differ in important details, but share a common structure. All would expand, rather than replace, the prevailing mix of private and public coverage. All would extend the reach of Medicaid to cover all poor and near-poor Americans not insured at work. All would require businesses, except the smallest, to offer and pay for insurance for their employees or to pay a penalty tax. All would require individuals not insured through work or a public program to buy insurance themselves or pay a penalty charge. All would subsidize those with low- and moderate incomes to prevent the cost of health insurance, including premiums and anticipated out-of-pocket spending, from exceeding specified fractions of income.

All would create so-called insurance exchanges—publicly managed organizations that would regulate the sale of insurance to individuals and small businesses. The exchanges would enforce standards requiring insurers to pay out at least a stipulated fraction of premiums in benefits. They would prohibit insurers from denying or terminating coverage because of a person's actual or anticipated use of services. Eventually, larger businesses and even beneficiaries of federally financed programs, may be allowed to buy insurance for their employees through the exchanges. At that point, the exchanges could become just what both American conservatives and liberals dream about. For conservatives, the exchanges would be a place where individuals could freely choose among competing, if regulated, health plans. For liberals, the exchanges could become powerful, public organizations that guarantee coverage to all, provide subsidies to those who need them, and enforce delivery system changes no organization can now effect because none has sufficient market power.

In addition to provisions extending coverage, all plans contain numerous measures designed to improve the quality of care and to slow the growth of health care spending. These measures include reforms to replace payments for individual services with payments

for whole episodes of illness or even to create so-called ‘accountable health organizations’ that would aspire to become something like the NHS primary care trusts. The bills would authorize a new commission empowered to propose changes in Medicare and other health reform legislation on which Congress would commit to vote on without amendment. The bills would speed introduction of health information technology. They would also foster comparative effectiveness analysis, but not—Congress forbend!—cost effectiveness analysis. Bringing cost into evaluations conjures the still-unthinkable notion that some medical treatments and the benefits they produce cost more than they are worth.

The net cost of these provisions would be not more than \$900 billion over ten years, a limit set by president Obama. In addition, and of critical importance in light of current and anticipated budget deficits, the bill would have to be fully paid for with tax increases or specific spending cuts. Implementation in all bills is delayed for several years, largely because of these financial constraints. Delay both limits the cost of subsidies over the next decade—the period used in official budget accounting—and gives more time for the delivery-system reforms to slow spending growth.

Divisive issues teem within this framework. Each is sufficient to cause members of Congress to oppose the whole bill. I have already mentioned abortion. The treatment of illegal aliens is equally fraught. The Senate bill would prohibit illegal aliens from buying health insurance through the health exchanges, even with their own money. Inclusion of such a provision in the House bill would have guaranteed its defeat. The single most intense debate revolved around whether the exchanges should offer one publicly-managed health plan along with many private insurance plans. Some members of Congress believe passionately, if (in my view) irrationally, that a bill that lacks a public plan is no reform at all. Because others, including some of those indispensable Senate Democrats, flatly refuse to support a bill that includes a public plan, the idea is dead. Other issues concern where on the income scale subsidy funds should be concentrated, what sort of penalty should be imposed on businesses that fail to provide their employees with insurance, and what sort of penalty should be imposed on people who refuse to buy insurance.

One other element of the U.S. health reform debate must be mentioned—the dishonesty and sheer nastiness of some of its participants. Early bills proposed to pay physicians and others for time spent counseling the elderly regarding options for end-of-life care. That provision was attacked as creating ‘death panels’ and ‘teaching people how to die.’ A somewhat senior administration official, whose career as a medical ethicist had led him to write about the tragic choices that scarcity forces society to confront, was labeled ‘Dr. Death’ and was singled out as an example of the administration’s willingness to ration care. Critics, including the Republican leader in the House of Representatives, have described a plan that aims to extend the reach of private insurance as a ‘government take-over.’

A well-regarded organization that evaluates the accuracy of statements by public figures labeled the death-panel libel as the ‘lie of the year.’ But the damage to civility and good sense has been, and continues to be, done. Elected officials displaying more gutlessness than good sense, struck end-of-life counseling from all bills on which a vote has been taken.

Such attacks though mendacious reflect a sound political insight. Should health reform fail, president Obama’s domestic agenda and his presidency would be badly wounded. If it succeeds and is implemented, the political and policy environment will never again be the same. The first of what will doubtless be many steps to modify the health care system will have been taken. The debate will change from ‘*should* the federal government act?’ to ‘*what* should the federal government do next?’ If you belong to a party that opposes active government intervention in domestic policy, that is not a shift you want to see.

The House and Senate bills now go to a conference committee consisting of members of both the Senate and House. Their job is to craft a blended bill on which both Houses will vote. There is no guarantee that a bill agreed to in conference will pass both houses of Congress. The bills each house has passed differ on the sensitive matters I have already described. Even small changes might offend one or two members and cause them to turn from supporters into opponents. Because the initial margins of approval were so narrow, a shift of just one or two votes could block passage.

Even if health reform is approved in Congress and the president signs it into law, the saga will not end. To hold down expenditures in the ten year budget ‘window,’ key provisions of the bill will not be implemented until 2013 or 2014. At least one and perhaps two elections will be held before then. Republican opponents will continue to attack the bill’s shortcomings and—rest assured—mistakes will be made. The U.S. health care system is just too big and complicated and the nation is too diverse for mortal human beings to get everything right. Opponents will also identify those who lose from reform. And—rest assured—there will be losers. Some people will have to spend more than is comfortable to buy insurance or will suffer reductions in coverage. Some providers will find their incomes cut. Opponents of reform will try to mobilize the losers to win elections and repeal the bill. The debate after health reform is enacted will remain just as intense and nasty as it is today for at least three more years.

I know that many of you are wondering why a large, rich country has so much trouble doing what other countries did so long ago and what they embrace today. But, keep in mind two key facts. First, the U.S. system of government was carefully crafted to prevent bold action by narrow majorities. Large changes require broad consensus. Americans, most of whom are well insured and happy with what they have, must agree not only that change is necessary but what form of change is best. Second, U.S. health care spending in 2010 is projected to be \$2.6 trillion. The GDP of the United Kingdom in 2008 was \$2.7 trillion. What the president and Congress are trying to do is reform an entity the size of your entire country with one law. So, I beg you, cut us a little slack!