The Movement for Universal Health Insurance: Finding Common Ground

Before 1971, all proposals for universal health insurance were based on private sector financing and administration. After 1971, universal health insurance plans relying on the private sector complicated efforts of the universal health insurance movement.

To forge as broad a movement for universal health insurance as possible, it may be worthwhile for universal health insurance advocates of different persuasions to seek common ground on the basis of a set of goals for a new health care system. The goals can serve as a measuring stick to determine which health insurance plans are worthy of support. (Am J Public Health, 2003;93:112–115)

FROM 1912 TO 1971, THE movement for universal health insurance in the United States advocated a publicly administered system, supported by social security or taxes and drawing on concepts widely accepted in other developed nations. Three major periods of activity—the American Association for Labor Legislation efforts from 1912 to 1919, the efforts to pass the Wagner–Murray–Dingell bill championed by President Truman (1943–1949), and the Kennedy–Griffiths Health Security Act of 1970—characterized this era. The drive for universal health insurance generally featured a united movement of reformers clashing with powerful opposition—in particular the American Medical Association and the private insurance industry.

In the past 30 years, the character of the drive for universal health insurance experienced a fundamental change. Opponents of the Kennedy–Griffiths legislation changed their strategy. Rather than simply kill the legislation, they offered their own alternative, President Nixon’s proposal for an employer mandate in 1971. Under this proposal, the government would require employers to purchase private insurance for their employees. For the first time, universal health insurance was conceived as a program of the private insurance industry, with government subsidies to help people without the means to buy private insurance policies.1

As a result of this sea change in the conception of universal health insurance, the health insurance reform movement fragmented beyond recognition. In contrast to the clarity of the pre-1971 era, when proponents and opponents of publicly administered universal health insurance squared off, the complexity of the current situation poses daunting strategic problems. In 2003, almost no one overtly opposes the idea of universal health insurance, but virtually everyone disagrees with everyone else on how universal health insurance should be constructed.

The American public is now faced with a bewildering array of proposals—employer mandates, individual mandates, voluntary subsidies to employers or to individuals, tax credit plans, Medicaid expansion, Medicare expansion, and publicly administered plans, each with its academic and political supporters. The proposal that continues the pre-1971 idea of a public insurance program supported by social security or taxes is the “single-payer” plan, which I shall call the “public solution.”

My point of view is that the public solution is the best way to implement universal health insurance, but achieving universal health insurance will be easier if advocates of the public solution and well-intentioned supporters of solutions that contain some private or quasi-private elements seek common ground. Most proposals that are not fully in the public realm are a mix of public and private mechanisms; in a vast oversimplification, I will call these proposals the “private solution.”

BUILDING COMMON GROUND

Antagonism between those who advocate the public solution and adherents of the private solution is common. Bridging the chasm between the 2 may improve the prospects for universal health insurance. On the other hand, the chasm is real, based on disagreements about how health care, and society in general, should be organized. The challenge is to distinguish between irreconcilable differences and areas of potential unity.

There are several categories of private-solution advocates. A first step is to separate those who oppose the public solution on the basis of political disagreement from those who privately support the public solution but publicly favor private-based plans for reasons of political feasibility. Members of the latter group are allies of public-solution proponents; rather than being attacked as sell-outs, they should be approached by public-solution advocates to discuss their concerns and look for common ground.

The former group—those who truly believe in a private solution—are not a homogeneous entity (Figure 1). Some are employed or paid by insurance companies, pharmaceutical firms, the private hospital industry, the money-motivated (in contrast to the professionally motivated) sector of organized
A vision for a new health system

The following set of principles, each addressing more than 1 of 5 intertwined goals—universal access, reasonable cost, high quality, caregiver-friendliness, and equality—suggests a vision for a new health care system. By no means is this the only formulation of goals; it is offered as an example of how people supporting a variety of specific universal health insurance plans can unite on a vision for health care.

1. Everyone should have access to the care they need when they need it, without financial hardship (access, equality).
2. The cost of the entire system should not be excessive because everyone pays more when costs increase; costs should be controlled by eliminating waste, not by restricting effective services. Cost and access are related because when costs go up, access often goes down (cost, access).
3. Everyone should receive all the care that is effective in preventing illness and improving health, and no one should receive care that is ineffective or harmful (quality, equality).
4. Caregivers’ work should be organized so that caregivers can serve the public to the best of their abilities under conditions that do not create undue job stress or burnout (caregiver-friendliness, quality).
5. Health care should be delivered and paid for in an equitable way. People with more money should pay the same proportion of their wealth for health care (or a higher proportion) as people with less money, and everyone should be afforded equal access and quality (equality, access, quality).

Vision versus reality

Higher levels of agreement between proponents of the public and private solutions may be achievable through discussions that compare the vision embodied in the 5 goals with the reality of our present system.

1. Access. At least 3 problems should be confronted in striving for the goal of universal access: uninsurance, underinsurance, and difficulty in getting care promptly. Agreement abounds that everyone must have health insurance, but disagreement regarding underinsurance is widespread. Best exemplified by the failure of Medicare to cover prescription drugs, the issue of underinsurance is on the verge of exploding into a devastating problem. While health maintenance organizations (HMOs) have provided broad benefit packages with low out-of-pocket costs, the emerging era features preferred provider plans with, for example, $2500 deductibles and 25% coinsurance. One prominent HMO offers a product with a $1500 deductible for hospital admissions plus 20% of daily hospital charges. Medical savings accounts may require $10000 yearly deductibles, and the most generous proposed tax credit plan would make the average family pay almost $4000 of its insurance premium out of pocket. Any universal health insurance plan, including a “single-payer” plan, can offer limited benefits that leave individuals to bear large out-of-pocket costs—an inequitable solution that is unacceptable to those who embrace the 5 goals above.

The third element of the access goal is timely access to care. In 2001, 33% of people interviewed reported that they were unable to get medical appointments when they needed them, up from 23% in 1997. Same-day scheduling systems are being developed that guarantee patients an appointment on the day they call. These “open access” systems represent microlevel changes that, together with the macrolevel reform of universal health insurance, are an important aspect of a vision for the future.

2. Cost. Health care costs are rising again. The average HMO premium rose by 15.3% in 2002 and is expected to jump by 22% in 2003. To reach the goal of reasonable cost, the public solution has clear advantages over solutions involving private insurance. Several studies have shown that a “single payer” has the potential to provide universal access and cost containment simultaneously. Most recently the Lewin Group, analyzing 9 California health coverage expansion proposals, found that costs increased under the private proposals but decreased under the public plans. By itself, however, even a public insurance mechanism is in-
sufficient to guarantee cost containment. Reimbursement models are needed that encourage cost savings, and low-cost primary care and home care programs are needed to take the place of high-cost and often unnecessary hospital and other institutional care.3

3. Quality. While the goal of quality is not a fundamental attribute of universal health insurance, it is a crucial plank in the larger platform envisioning a new health care system. The issues of underuse, overuse, and misuse of medical services must be addressed, both at the macro (system) level, by reimbursement methods that reward quality, and at the micro level, by change within institutions.9

4. Caregiver-friendliness. A high volume and intensity of medical need and demand confronts many caregivers; the lack of time to provide services in a satisfying manner for patients and caregivers, and the stress produced by this mismatch, are serious problems. No system is sustainable without improving the work environment for the people who provide health care services.9 A caregiver-friendly system improves access and quality and requires both macrolevel change in reimbursement systems and microlevel change within health care institutions.11

5. Equality. Voucher-like “defined contribution” schemes are poised to flood the private health insurance market and to threaten the entire Medicare program. Already, the 10% of families with the lowest incomes pay a far greater percentage of income for health care (about 20% on average) than the 10% with the highest incomes (who pay about 8% on average).12 Under “defined contribution” proposals, and with the large deductibles and copayments offered by the new generation of insurance products,2 inequality will rise markedly. People with lower incomes and poorer health will pay an even greater proportion of their income for health care than they do now, while the healthy and wealthy will pay less. The public solution has the potential to lessen inequality in health care payment; for example, single-payer proposals in both Vermont and California would reduce total health care payments for families with incomes of less than $75,000 to $100,000 while increasing payments for those above these income levels.7,13

Discussion of the vision and its gap with reality will sort out which advocates of the private solution are potential allies of public-solution supporters. For example, it is unlikely that for-profit private insurance can fit with the goal of equality because for-profit insurance segments the population into higher and lower risk “buckets,” with higher-risk (i.e., older and less healthy) people paying more. On the other hand, quasi-private, nonprofit, community-rated, strictly regulated insurance mechanisms that more closely resemble insurance mechanisms in Germany and Japan may be compatible with the equality goal.

This brief and incomplete presentation of the gap between vision and reality is offered as an example of how universal health insurance advocates of different stripes can use a discussion of goals, including discussion of the vision–reality gap, to increase areas of agreement or sharpen topics of disagreement. Focusing on goals rather than specific universal health insurance plans could be an important unifying step. “Single-payer,” for example, is not a goal; it is a means to implement the access, cost, and equality goals described above.

**HOW TO PROCEED**

Focusing on goals may be a soothing and nonconfrontational activity, but eventually a specific universal health insurance plan is needed. The goals can be used as measuring sticks to determine whether or not a specific plan deserves support. But what happens to the unity generated around goals when it is time to decide on specifics?

We may never achieve one specific unifying plan. Public-solution advocates, of whom I am one, have a specific plan. Supporters of solutions with a mix of public and private elements have specific plans. Members of these 2 groups are unlikely to let go of their specific plans, but they should commit themselves to building on whatever common ground is possible. This can be done by reaching unity on a set of goals and popularizing those goals. It can be done by supporting legislative efforts that strive to enact a list of goals. For example, the Health Care Access Resolution (House Concurrent Resolution 99) proposes a series of goals and directs Congress to pass universal health insurance legislation consistent with those goals.

A strategy that postpones the need to pick a specific health insurance plan is the “federal-state partnership” model, which proposes to enact universal health insurance in 2 giant steps.14,15 First would be the enactment of a federal law creating potent financial incentives for states to legislate universal health insurance based on a set of goals. Second, specific implementation of universal coverage would take place at the state level. In 2000, legislation embodying the federal-state partnership approach was introduced as the Health Security for All Americans Act by Representatives Baldwin and Obey and the late Senator Wellstone.

Supporters of the public solution and the private solution can also work together on proactive strategies to make partial improvements in insurance coverage (e.g., a public program to cover prescription drugs under Medicare) and on defensive strategies to stop bad things from happening (e.g., defeating the privatization and voucherization of the Medicare program supported by Republicans and a number of Democrats).

As advocates of the public and the private solutions work together on formulating a set of goals and in offensive and defensive campaigns, the discussions that take place regarding a specific universal health insurance plan will, I hope, result in a larger and—after 95 years of failure—successful movement for universal health insurance in the United States.

Should advocates of the public solution (the single-payer movement) abandon our enthusiasm for our proposal? Absolutely not. I firmly believe that the public solution is the best solution. However, I differ from some single-payer advocates in that, although I find the public solution to be the best solution, I am not sure that it is the only solution. It may be possible to construct a public–private proposal that approaches the goals listed above.

Am I championing the same tepid incrementalism that has failed us for the past decades? Strategy-wise, what I propose is incremental—an attempt to build a stronger voice for universal
health insurance in steps. Goalwise, it is not incremental—the vision of a future health system must project health care as a service rather than a business, creating a new entity that lies galaxies apart from what we have now.

References

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