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Health Care Reform: Beyond Ideology

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of the future, especially if Medicare plays a larger role in insurance. Surprisingly, in the political maneuvering to date, the hospitals and physician organizations have decided not to ally themselves with the insurers. Indeed, the 2 groups played off each other last year in the debate over Medicare Advantage funding.[14]

Conclusion

Reform proposals based on twinning Medicare expansions with connector-based oversight of the individual and small-group markets suggest an incremental approach to reform that does not abandon market competition, and hence may be more politically viable than fundamental reform has been in the past. But the reform's passage is not imminent and indeed will be challenging. Because the goal is to cover more individuals while spending less, reform will involve losses for some, sparking resistance.[15] Moreover, many who share the goal of universal access are nonetheless committed to market efficiencies and innovations and will fear these will be lost in a government-dominated approach. This philosophical/political difference will be the critical basis for debate even for an apparently incremental reform plan.

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Health Care Reform
Beyond Ideology

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FOR THE FIRST TIME SINCE 1994, THERE APPEARS TO BE A real window of opportunity to enact universal health care coverage. President Obama and leading members of Congress have made health care reform a top priority. With 45 million individuals uninsured,[1] and millions more finding their health care insurance inadequate,[2] the United States may finally join the ranks of other industrialized countries and guarantee coverage for all of its citizens.

Proposed reforms take many forms and run a broad range in terms of their underlying philosophy, sources of financing, and role for the government. Many advocates want to rely more on competition and the market, whereas others believe greater government intervention is essential. Some call for more patient responsibility, while others focus on reform of physician practices.

Many of the arguments are familiar. Market proponents claim that government intervention will stifle innovation, lower quality, and drive up costs. Supporters of a bigger role for the government respond that health care markets are dysfunctional. According to this view, competition in health care does not work as it does in other sectors of the economy, but instead generates high costs and wasteful spending.

This Commentary considers the history of public welfare programs in the United States to identify proposals that actually can achieve universal coverage. Universal coverage is not the only goal of health care reform; reforms also should improve quality and contain costs. Nevertheless, universal coverage is a key goal, and it is essential to identify the viable options for reaching it.

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A variety of approaches could in theory ensure coverage for everyone, and in practice have done so in many countries. But only a few approaches could do so in the United States, where social values and the structure of political power set important limits on the kinds of public programs that can succeed. Specifically, to achieve universal coverage, a government plan should include 3 basic components.

Coverage Should Be Funded by Payroll Taxes

The United States values individual initiative and personal responsibility. Individuals in the United States worry that when the government provides food, shelter, or health care, it will discourage recipients from seeking work to support themselves.[3] Accordingly, governmental programs that are seen as earned are much more popular than governmental programs viewed as handouts.[4]

Consider the earned income tax credit, which is a tax credit for low-income workers. It also is refundable. A working family that has an annual income so low that it does not pay federal income taxes will still receive the credit in the form of a tax refund. The earned income tax credit operates as an income supplement for the poor who are gainfully employed, as a reward for their effort. This is a popular program—the earned income tax credit has always enjoyed broad congressional support, with major program expansions even during Republican administrations.[5]

In contrast, the federal welfare program (now called Temporary Assistance for Needy Families) has received far less support from the public and from Congress.[5] This was particularly the case before 1996, when welfare recipients were under no obligation to work to qualify for the program, as they are today. Welfare was frequently criticized before the 1996 reforms, and its beneficiaries demonized, as in the pejorative term "welfare queens."

The preference for earned over unearned benefits also is reflected in the February 2009 economic stimulus package. President Obama included a 2-year reduction in payroll taxes for low- to middle-income families and dubbed it the "Making Work Pay" tax credit.[6]

If the United States decides to provide health care coverage for everyone, how can it be seen as an earned benefit? Social Security and Medicare offer an important model. These programs are viewed as supplying earned benefits because they are funded in large part through payroll deductions. As with private pension plans and private insurance plans, individuals pay for their Social Security and Medicare Part A benefits by making regular contributions out of their salaries. A new health care plan could be funded in the same way.

With alternative funding mechanisms, health care reform would be perceived negatively as entailing a government handout. Thus, proposals to use general tax revenues, higher taxes on wealthy individuals, or tobacco taxes could easily discourage broad public support for an initiative to expand health care coverage.

A New Program Should Be Run by the Federal Government

The Medicaid program, welfare, and other benefit programs operate as federal-state partnerships. As one element of health care reform, Congress might be tempted to expand Medicaid to reach more of the uninsured.[7] However, federal-state partnership programs are far less successful than federal-only programs.[5] Food stamps, for example, were not offered in every county in the United States until the federal government eliminated state authority to set eligibility standards.[8] With reimbursement rates under Medicaid well below those under Medicare, Medicaid recipients experience much greater difficulty than Medicare recipients in finding a physician to provide care.[9] While Medicare provides coverage for virtually all seniors, Medicaid reaches less than half of the indigent.

When states assume a role in the implementation of a governmental program, benefits vary widely from state to state. In Mississippi, families can earn no more than 32% of the federal poverty level to qualify for Medicaid; in New Jersey, families can earn up to 133% of the federal poverty level and still qualify for Medicaid.[10] In early 2009, some governors threatened to reject federal stimulus dollars for the unemployed, which would leave their residents without a critical source of support.

The history of public housing also illustrates the problems that arise when the federal government delegates authority to the states for benefit programs. In the 1930s and early 1940s, federal officials favored inexpensive, vacant lots at the periphery of cities and low-density, scattered-site units for housing for the poor.[11] That allowed for healthier, safer, and less costly housing. It also increased the chances that urban ghettos could be eliminated rather than re-created. However, responsibility for site selection shifted to local housing agencies. This ensured that public housing was built in inner-city settings as middle- and upper-income residents exercised their political strength to prevent the building of public housing in their neighborhoods.[12] The working poor with dreams and prospects of upward mobility avoided the new housing, leaving behind a high concentration of the poorest of the poor, who had no place else to go.[12] Ultimately, inner-city public housing projects had to be torn down. In sum, experience in the United States with federal-state partnerships indicates that the federal government should assume full responsibility for a new health care plan.

All US Individuals Should Receive Their Coverage in the Same Way

Many policy makers believe that universal coverage can be achieved by maintaining private, employer-based insurance for most individuals, with public subsidies for those who do not receive coverage through their job and are too poor to afford the costs of coverage on their own. But if the subsidies go only to the poor, they likely will not be adequate to meet the needs of their recipients.

When governmental programs in the United States serve only the poor, they generally do not generate sufficient political support to ensure appropriate funding. For the most part, individuals with political influence will not back adequate funding for programs when they pay for the programs but do not benefit directly from them.[13] Thus, for example, programs like Social Security and Medicare that serve recipients at all income levels are far more successful than programs like Medicaid that are targeted to the indigent.

Or consider funding for housing. The federal government spends about $200 billion on housing subsidies each year.[14] Nearly 80% of those dollars fund tax deductions for homeowners at all income levels, particularly at the highest income levels. The remaining dollars provide rent subsidies for low-income families at a level insufficient to meet the housing needs of the poor.

Some programs targeting only the poor have elicited strong political backing. However, these programs have relatively small budgets. The earned income tax credit and the food stamps program each cost less than $40 billion per year. Health care coverage for all of the poor, including existing spending for Medicaid, would run into the hundreds of billions per year.

Moreover, even the most successful programs targeted at the poor do not achieve universal coverage. Among those eligible for food stamps, only two-thirds sign up for the benefit. Many qualified persons are unaware of their eligibility or find it difficult to navigate the application process.[8] Targeted benefit programs have to screen applicants for eligibility, and the screening process can be daunting, especially for poorly educated persons. Universal programs do not need to screen applicants, and thus have much simpler application processes.

Some persons eligible for public programs wish to avoid the embarrassment of being a recipient.[8] Having to rely on governmental benefits can be demeaning, and some individuals prefer to maintain their dignity, even at the cost of forgoing important services. Universal programs, on the other hand, do not carry the problem of stigma. If everyone receives health care through the same program, poor individuals do not need to feel that participation in the program automatically identifies them as being poor.

Reforms That Can Achieve Universal Coverage

With these 3 elements—a federal program funded by payroll taxes for all US individuals—there are 3 main options for achieving universal access to health care.

First, the federal government could choose to employ or contract with hospitals, physicians, and other professionals to treat patients who need medical care. Under this model, the government acts not simply as an insurer but as a provider of health care. The Veterans Affairs health care system takes this approach.

In the other 2 options for universal coverage, the federal government acts as insurer, but not as a provider, of health care. In one option, the government would provide health care coverage to everyone, paying hospital, physician, and pharmacy bills, but leaving it to individuals to choose their physicians and other health care professionals, who may be privately or publicly employed. Medicare follows this model.

Alternatively, the government could provide a voucher to everyone for the purchase of health care insurance, and each person would then find a private plan for coverage. The private plans would be required to accept the voucher as payment in full. While such a program does not exist in the United States, it has been proposed by Emanuel and Fuchs.[15]

Other approaches simply will not achieve full health care coverage. For example, the German/Dutch/Massachusetts model of requiring everyone to purchase insurance requires government subsidies for the poor and others who cannot afford coverage. Because those subsidies are provided only to the poor, it is highly unlikely that they will be adequately funded over time.

Ideology can suggest potential paths to universal coverage. Social and political realities can indicate which paths will work, and that is where efforts should begin.

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