The third reason that the United States has been unable to rely on market forces to provide universal coverage is cultural. The commitment in America to expanding the supply of health care that is technologically sophisticated promotes individualism and social divisiveness, focusing attention on the personal costs of universal coverage rather than on the benefits to the community.[2]

Another approach to providing health care is based on ideals of voluntarism, community, and cooperation. This approach would limit government intervention but, being based on community ideals, it would solve the problems of uninsurance and underinsurance. In practice, however, it has not worked. A nation that spends 14% of its gross national product on health care while leaving so many of its citizens without health coverage, and millions more with inadequate coverage, may safely conclude that voluntarism has not met the challenge of providing insurance to everyone.[3]

The last option is to work through the government, which other advanced nations have chosen to do. It is now both desirable and possible for the government to insure all Americans. It is desirable because there are increasing pressures on hospital revenues, which means that many hospitals will no longer be able to rely on "cross subsidies," the overcharging of insured patients to help pay for the care of the uninsured. It is estimated that if disproportionate share payments by Medicare and Medicaid (the additional funds given to hospitals that care for the uninsured) were eliminated, would experience a 7% decline in their operational margins.[4] Controls on spending on health care jeopardize even the limited access to care that uninsured people have.

Providing national health insurance is possible: the total share of governmental funding at the federal and state levels for our health service was about $650 billion in 1999 (including the federal tax subsidy of more than $100 billion available to the providers and beneficiaries of private group health insurance benefits). All of the governmental funding required to fund national health insurance is, therefore, being raised although not all of this sum could be reallocated to cover its costs.

The introduction of national health insurance would encourage discussions that would clarify the responsibilities of the government, employers, and the individual to fund the costs of health care. It would also open up discussion of the issue of rationing. We must provide universal coverage of essential care. But what are the essential healthcare costs that should be covered by national health insurance? It will not be easy for Congress and voters to agree on the fiscal responsibility that the federal and state governments should assume when they commit to providing essential medical care under the proposed plan. But the difficulties should also not be exaggerated. The federal government has set the terms for coverage for both Medicare and Medicaid since their implementation in 1966 and in the case of Medicare the public has responded positively. The federal government can reassure the people of its commitment to national health insurance by increasing funding for the program as the gross national product rises (which would allow access to new treatments) and by not reducing funding should the gross national product fall. Those people who want more and better coverage than the federal government will provide can either pay for it themselves or negotiate with their employer for additional health benefits. The government could offer new diagnostic and therapeutic techniques to all, after thorough evaluation.

Universal coverage has eluded the United States for a long time. The government should not miss this opportunity to introduce something so desirable and practical.

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Why health care is failing in a booming economy

Public health is a national investment, not a business

John C Baldwin

Office of the Dean
Dartmouth Medical School
Hanover, NH 03755-3833

Correspondence to:
Dr Baldwin
John.C.Baldwin@Dartmouth.edu

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The health care business is failing because it is not a business. Warning signs are ominous: 44 million Americans have no health insurance, and many more have inadequate protection; percentage increases in premiums will be in double digits. Many of our elected officials remain dogged in their belief that conventional business models can correct the shortcomings of our health care system. In frustration, politicians across the spectrum pursue the notion that legislative tinkering will solve the problems. However, we have a grave situation that the "businessification" of health care will not resolve.

We have been lulled into a false sense of confidence

that the crisis in American health care can somehow be reversed by reforms based on such euphemisms as gatekeepers, pathways, preexisting conditions, and risk pools. These "reforms" are essentially impediments to access, disguised as tools of efficient management. Those susceptible to this opiate point to the success of managed care in reducing costs to employers and to the salutary effect of this trend on the American economy.

Yes, health care costs have risen too rapidly in the past 20 years. Highly paid providers and administrators and exceedingly profitable health care corporations played a role, although less so than the effects of an aging population and the infusion of new technology arising from our commitment to scientific advancement. Nevertheless, our inability as a society to grapple with the decisions necessary to restrain the growth of health care costs should not prompt us to abrogate our responsibility to make difficult choices, hoping that a free-market, profit-based system will somehow resolve the problems.

Health care is an essential and increasingly costly service. Health care is not a business. If it were, it would be a strange one, indeed—one in which so many sectors of the market could never be profitable. People with AIDS; most children with congenital, chronic, or catastrophic illness; poor people; old people; and most truly sick people could never pay enough to make caring for them profitable. Nor is health care a right, although many think that access to it should be. As the civil rights movement taught us, rights must be set down explicitly if they are to be enjoyed by those who lack them.

"Health care is like any other product; you buy what you can afford." Sensing the large moral pitfall around the next corner, proponents of this tenet quickly add, "Basic health care, of course, should be provided." "Basic" is an important and difficult term. Suppose that two children, one in an uninsured family and one in a well-insured family, both developed leukemia, which is treatable and often curable. How would basic care be defined for the uninsured child? How would the basic cure differ from the more affluent, market-based cure? Cure must be the goal in both cases, and cure is expensive.

Executives of health maintenance organizations define their responsibility in terms of profit and stock prices to shareholders. The result, inevitably, is the restriction of access and the withholding of care. Both may be necessary to enhance efficiency and reduce costs. But do we want to relegate these decisions to health care analysts, or should we assert the public interest in these crucial ethical, societal, and medical issues?

We knowingly nod when told that the portion of our gross national product spent on health care is too high and that inefficiency, the "fat," results in a system that provides less effective care than in other industrialized nations, which spend a lower percentage of their gross national product. This argument is largely specious. American medicine engenders enormous respect worldwide. The dramatic decline in deaths from heart disease is salient evidence for the phenomenal success of technologically advanced American medical care, for those who can afford it.

Like education—also, in key ways, not a business—public health is a national investment. Could we justify a privatized educational system that denied access to slower learners unable to pay, the children who most need help? Would we acquiesce in such a self-destructive national policy? When we spend more on leisure than on health care, is the absolute current percentage of the gross national product for health care so inappropriate? We spend 22% more on just recreation, restaurant meals, tobacco, and foreign travel than we do on health care—50% more, if clothing is included (*Statistical abstract of the United States,* US Department of Commerce, Bureau of the Census, 1998). Our indignation should focus on eliminating real inefficiencies, defining and controlling excessive profits, and broadening access to our remarkable biomedical knowledge.

Our system is not a failure. Our problem is a failure of distribution—to extend care to all of those who need it and to recognize the importance of applying scientific research into outcomes to the broad-based delivery of health care. If citizens were offered state-of-the art American medicine in a comprehensive way, our public health outcomes would, without doubt, be unexcelled. The failure is the product of our notion that health care access depends on the ability to pay, a tacit acquiescence that has become, for many, a point of ideologic zeal. Payments to hospitals and physicians through the drive to enhance corporate profits or through government regulation will be restricted, and the need to improve the efficiency of our practice patterns and delivery system is critical. So, broad-based access to health care will still be an exceedingly expensive proposition. We must rid ourselves of the delusion that health care is a business like any other.

Awakening and coalescing public consensus is a mighty and politically perilous challenge. It will require leadership and rare courage to acknowledge that adequate health care is, in an age of verifiable efficacy, an appropriate goal for this nation. What we can afford may have to be redefined based on a thoughtful consideration of priorities; access to and withholding of care should be properly discussed in the public domain. These are, indeed, treacherous waters.

We should stop deluding ourselves and tinkering at the margins with bills for patient rights or drug benefits that apply only to those with insurance. We can create a system (perhaps incrementally) committed to universal access, decision making that is based on evidence, and innovative management that reflects an informed public consensus. We should couple our commitment to the advancement of biomedical science for the public good with the organizational skills that have generated our vibrant, competitive economy to a national policy of investment in health.