Single-payer health care plan is no solution to medical crisis

by Linda Everett

Among the plethora of health care reform proposals inundating Washington, the single-payer, Canadian-style health care plan is one of the least known. Originally proposed by Rep. Jim McDermott (D-Wash.)—and Paul D. Wellstone (D-Minn.) in the Senate—H.R. 1200 has over 91 co-sponsors in the House. A slightly altered version (H.R. 3960) was introduced into the House Education and Labor subcommittee on Labor Management by Rep. George Miller (D-Calif.) in March. The bill would replace the health insurance industry with the federal government as the sole provider of health insurance for Americans, although insurers could still be utilized as fiscal intermediaries or administrators of the national program.

It's obvious why the health insurance industry doesn't care for this bill. And, since insurers are providing representatives of the media with honoraria into the tens of thousands of dollars for speaking engagements on health care reform, it's no wonder the media failed to notice that the McDermott-Miller bill passed by voice vote in the subcommittee on June 9 and will now go before the full committee. But despite the media blackout, a movement for establishing single-payer plans on the state level has erupted among health care providers over the recent months, almost as a backlash against the horrors inflicted by the insurance industry's managed care takeover.

In April, over 112 House Democrats sent a letter to President Clinton asking that he retain a provision in his reform plan to allow states to establish their own single-payer systems. It was later reported that the President said he would sign the single-payer plan if Congress passed it. Advocates of the Canadian-style approach see it as the answer to the managed care menace and to the inadequate health policies of the status quo. But that's not likely to be the case.

According to McDermott, the American Health Security Act would provide the most generous health care benefit package among the reform proposals, including preventive care, hospital services, prescription drugs, and substance abuse and mental health benefits for every citizen and lawful resident alien, no matter where they live or work. H.R. 3960 would shift the approximately $100 billion now wasted on paperwork and administration of the country's more than 1,500 different health insurance policies into the expanded delivery of health care services. Under the plan, 85% of health care would be federally financed, based mainly on revenues from an 8.4% payroll tax on employers with more than 75 full-time employees earning more than $24,000 a year, a 4% payroll tax on employers with less than 75 full-time employees earning less than $24,000 a year, a 2.1% employee payroll tax, a 2.1% non-wage/non-salary income tax, a $2 per pack tax on cigarettes, and a 50% excise tax on handgun ammunition.

The original bill's levy of a $65 a month premium for long-term care/health insurance on elderly citizens caused concern among the American Association of Retired Persons. Under the amended provision, payment for home- or community-based long-term care services are subject to a co-insurance fee of 20%. Social Security cost-of-living increases were factored into the 35% co-insurance fee required of elderly citizens for nursing home services.

Unsustainable health care

McDermott boasts that a fundamental component of H.R. 3960 is its "enforceable cost-containment mechanisms," or global budgets, which are set by a single financing agency, the American Health Security Standards Board. Under the bill, the national health care budget would be *arbitrarily* limited to the prior year's health expenditures plus an increase in step with changes in the Gross Domestic Product. In other words, instead of evaluating what is needed to reestablish public health standards in a country faced with a crumbling public hospital and health care infrastructure, and faced with full-blown epidemics of the AIDS virus, tuberculosis, and hosts of new communicable diseases, this bill, like most reform efforts, ties the delivery of health care to our depression-level budget. You could call it "sustainable" health care. Only those health care services that the shrinking budget provides for are allowed. The federal global health budget would be divided into quality assessment, professional education, administrative, and operating components.

The American Health Security Standards Board, whose six members would be selected by the President, would allocate funds to the states based on a national average per capita cost of covered services, adjusted for differences in state costs, demographics, and the population's health sta-

tus. Individual states would plan their own program and allocate funds among providers according to the state's needs. States would negotiate fees annually with hospitals, community health centers, and doctors, who must accept fees as payment in full. They cannot bill patients beyond the negotiated fee.

The plan is highly decentralized, allowing states to almost exclusively administer their own programs as long as they meet federal qualifications and guarantee individuals free choice of private fee-for-service physician or health maintenance organization (HMO). This last provision is indicative of the single-payer advocates' fierce opposition to forced participation in HMOs and other managed care plans, which deny patients free choice of doctors and which heavily influence doctors to restrict patient services. The bill's focus on free choice of doctors is a marked departure from reform proposals built on managed care or managed competition formulas which allow insurance companies or HMO cartels to dictate how and when treatment or specialist referrals are allowed beyond the assumed guarantee of primary or preventive care benefits.

But all this focus on "choice" is deceptive, because nearly every aspect of health care delivery would be dictated under this bill by five different federal boards overseeing everything, including national and state funding levels, cost containment, benefits, approved prescription drugs, state programs, medical education, and medical practice guidelines. Should systematic reviews of physicians' practice patterns reveal that doctors are compromising care, such "outliers," as they are called, face "reeducation." There are a score of professional, technical, and temporary advisory committees operating on national and state levels as well.

Nevertheless, it is lawful that health care providers and patients alike would endorse a single-payer system, especially given the insurance cartel's ruthless takeover of medical delivery systems. Consider California's experience, where for-profit HMOs and managed care groups contract with the state to deliver health care services for the uninsured population. The HMOs essentially lied about their ability to provide services. They signed up large numbers of patients but few physicians, and never bothered to provide indigent families with a single doctor visit. The families were forced to obtain care at hospital emergency rooms. In effect, the state paid twice for their care! Insurers such as Blue Cross of California manage to wring nearly 30% in profits and administration costs out of their managed care plans, while enforcing totalitarian "utilization review" over doctors' medical care decisions in order to cut their costs of delivering services. California is expected to approve a voters' initiative on the November ballot to establish a single-payer health care system in the state.

Several states have also launched campaigns for single-payer plans. An example is Tennessee's new managed care system for the poor and uninsured, called TennCare. According to Larry Gage, president of the National Association of Public Hospitals, managed care organizations and insurers who contracted for TennCare beneficiaries engaged in illegal marketing practices to enroll large numbers of patients quickly. Prospective enrollees were offered life insurance policies and secured credit cards as inducements. Agents were paid on commission, new enrollees were given turkeys, hams, and even cash for signing up. The more patients they enrolled, the more profits and control for the HMO or managed care organization—while hospitals and doctors are being reimbursed at only 40% of their costs. While the public hospitals and facilities dedicated to providing the public health needs of the poorest population are forced out of existence, insurers rework the delivery of health care to their own ends.

The Canadian model

But the single-payer plan would wipe out all utilization review programs except the federal government's. Will the delivery of medical care defined by the nation's plummeting economy be any different? Consider Canada's single-payer system, where the federal government used to fund about 40% of the cost of the basic package of services for its 10 provinces. But eroding tax revenues have radically reduced Canada's budget for the provinces to about 25%, forcing hospital closings, cuts in services and hospital beds, and long waiting lists. In March, the Quebec government mandated that the province must, by law, reduce the total employment level of their health system by 12.6% within two years. The directive called for a 20% reduction in executives and a 12% reduction of employees—an overall reduction of 21,000 full-time jobs, or 12.6% of the total employment level of the health care system of the province.

Last year, one survey found that residents in all 10 provinces wait at least two months for hospital procedures. The average wait for hip replacement in Manitoba is more than a year. In Prince Edward Island, it takes 27 weeks just to see an ophthalmologist. In Ontario, ophthalmology patients wait 4.3-51 weeks; elective orthopedic surgery patients wait 8.5-51 weeks. Patients needing cardiac bypass surgery wait a year, which forced the British Columbia government to contract with Washington State hospitals to perform the surgery on 200 Canadians—demonstrating how the United States is covering for the Canadian system. The number of patients waiting for procedures is also increasing, while the total number of operations performed has decreased. In 1967, patients on hospital waiting lists in British Columbia exceeded 12,000; by 1992, it was 32,671. Besides such rationing of services, triage of elderly and cancer patients is increasingly the rule.

Are well-intentioned supporters of the single-payer plan willing to shut down whole wards or operating rooms when the budget runs out, as hospitals now do in Canada? The solution lies in expanding our tax base, not collapsing health care to whatever the budget can "sustain."