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# "Show Me the Money"

*Labor and the Bottom Line of National Health Insurance*

**Marie Gottschalk**

**A** WELL-KNOWN political scientist once declared that the definition of the alternatives is the supreme instrument of power. The simple question—single-payer or not—conceals major differences over whether to frame the health care issue primarily as an economic question or a moral one. Economic considerations are critical to propelling the cause of universal health care. But advocates of universal health care should not cast the economic competitiveness of U.S. business as the central economic issue at stake in the debate over health care reform.

If we are to finally achieve a fair, affordable, and truly universal health care system, other economic considerations need to frame the debate. These include: How efficient is the U.S. health system? How is the health care cost burden distributed between business, government, and the public? What are the trends in health care cost shifting? What is (and what should be) the role of insurance companies in the U.S. health system and the wider political economy? To their credit, single-payer supporters have been some of the loudest and most articulate voices raising these important questions.

In bringing up these issues, advocates of universal health care need to be wary about emphasizing the economic rationale for health care reform at the cost of the moral rationale. The two cannot be disentangled. All of these economic issues in some way touch on how to redivide the economic pie—and that raises basic questions about economic and social justice.

Organized labor has enormous potential to be the pivotal player in raising these economic and moral questions and anchoring a reform

coalition that fundamentally reshapes the health care debate. For well over a century now, labor has been instrumental in the development of the U.S. health system. It established some of the first prepaid group practices and health maintenance organizations, was the leading voice for national health insurance up until the mid-1970s, and was decisive in the establishment of Medicare and in the expansion of other major social programs, like Social Security and the Great Society. The employment-based system of health benefits is largely the product of a collective-bargaining regime established during and immediately after the Second World War. That system is under siege today. Without unions to act as a brake, today's downward spiral in health benefits for union and nonunion workers would be even faster.

Divided and hemorrhaging members, organized labor still has formidable resources to influence the course of health care reform. The membership rolls and resources of the major unions dwarf those of most public interest groups. Labor's lobbying capacity has expanded dramatically as the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO), other labor groups, and individual unions have invested more heavily in lobbyists, enlarged their research departments, and developed grassroots lobbying networks. Labor's financial resources have not contracted significantly despite its dwindling membership base.

Today the Democratic Party is more dependent than ever on labor's money, votes, and electoral apparatus. Although money and members are important, they are not decisive in determining the political influence of organized labor. As Douglas A. Fraser, the late former president of the United Auto Workers, once said, the strength of the union movement also depends "on the agenda, the sense of commitment and the manner in which the labor move-

ment allocates resources.”

As we stand at the brink of another major attempt to overhaul the U.S. health care system, organized labor is divided about how to define the alternatives. At one pole is Andrew Stern, president of the Service Employees International Union (SEIU), the nation's largest union, and arguably the best known labor leader today. He stridently contends that health care reform must be pitched primarily as an economic competitiveness issue, not a moral one. Stern also has indicated that the single-payer approach, for all its virtues, is a political nonstarter. At the other pole is the growing number of national unions, locals, labor councils, and rank-and-file members pledged to the single-payer solution. Somewhere in between is the AFL-CIO, the nation's largest labor federation, which in March 2007 endorsed the idea of “Medicare for All” but carefully avoided mentioning the “s” word, that is, single-payer.

So far, Stern has garnered a disproportionate amount of media and popular attention. His business-friendly stance on health care reform, which stresses how the U.S. health care system is fundamentally hurting the country's economic competitiveness, helps explain why. But his economic competitiveness argument is not convincing and could undermine efforts to forge a successful coalition or movement on behalf of affordable, high-quality care for all.

### **Economic Competitiveness**

In breaking away from the AFL-CIO in 2005 to form the Change to Win federation, which represents about six million workers, Stern implored organized labor to radically reposition itself on organizing new members and other issues. Yet his position on health care reform is remarkably similar to the pro-business stance that John Sweeney, currently president of the nine-million-member AFL-CIO, maneuvered the federation into as chairman of its health care committee in the lead-up to the battle over the Clinton plan in the early 1990s. Like Sweeney years ago, Stern has focused on courting the business sector. In his view, no fundamental change in health care will “arrive until American business leaders make the call for change.”

Stern has aggressively identified the inter-

ests of the SEIU with the interests of the business sector. In July 2006, he sent a letter to every Fortune 500 CEO asking them to make health care their national priority. In January 2007, Stern's union launched a new health care coalition with two organizations that have checkered pasts on universal health care—the Business Roundtable, the elite business organization of top CEOs that helped torpedo the Clinton plan, and the AARP, the country's largest organization for senior citizens, which gave critical support to the controversial Medicare prescription drug bill in 2003. In December 2006, Stern joined Safeway's chief executive, Steve Burd, and Senator Ron Wyden (D-OR) in support of the Healthy Americans Act. The bill is modeled on the individual-mandate solution lionized in the Massachusetts reform effort. But it also includes a radical proposal to end employer-sponsored health insurance altogether.

Stern's most controversial public dalliance is with H. Lee Scott, Jr., chief executive officer of Wal-Mart. In February 2007, Stern joined Scott and other business executives to announce the creation of “Better Health Care Together,” a business-labor coalition. Despite Wal-Mart's dismal record on health benefits and other labor issues, Stern appears confident that the bottom line provides compelling reasons for Wal-Mart and other large employers to be constructive allies in health reform. “Obviously, we have a huge problem for American business because it is pretty hard to compete in a global economy when the price of your health care is put on the cost of goods, while in other countries, it is shared among society,” he contends.

In tapping big business as a key ally in the health care debate beginning in the 1980s, much of organized labor took a stance remarkably similar to Stern's position today. Labor leaders largely accepted the Fortune 500's definition of what was ailing the American economy and hence the American worker. Many of them jumped on the competitiveness bandwagon. In their public statements, labor and business leaders regularly sang off the same song sheet. Their refrain was a simple one—higher medical costs were making American products less competitive in the interna-

tional marketplace, which was severely hurting the U.S. economy and the American worker.

Health care economists have raised numerous objections to the claim that escalating health care costs imperil the economic competitiveness of the United States and the overall health of the U.S. economy. Their analyses, however, have made little headway against what Princeton professor Uwe Reinhardt calls the “shared folklore” that higher health care costs are pricing U.S. products out of the market.

It is true that employer spending on health care, measured as a percentage of after-tax profits, did jump in the late 1990s. But the rise in health care costs as a percentage of profits was due partly to a drop overall in corporate profits as the dot-com and high technology sectors went bust in the late 1990s. Spending on health care measured as a percentage of after-tax corporate profits declined steadily from 1986 to 2004, except during the 1998–2001 period. More significantly, employer spending on wages and salaries and on total compensation as a percentage of after-tax profits has dropped precipitously since 1986, except during the 1998–2001 period.\* While health care costs continue to escalate, employers have had great success at squeezing wages and other forms of compensation and shifting more health care costs onto their employees. Wages and salaries make up the smallest portion of the country’s gross domestic product since the government began collecting such data in 1947. In 2006, on the eve of the subprime crisis and the recession, corporate profits were at their highest level in four decades.

To underscore the exceptional severity of the health care cost crunch, Stern and some business leaders stress (as they did in the late 1980s and early 1990s) what U.S. employers pay directly for health care compared to their foreign competitors. Once again, the auto industry is the designated poster child as auto executives and labor leaders bemoan how crippling

medical expenses add \$1,500 to the cost of each car manufactured by General Motors, while some of its competitors pay as little as \$200 per vehicle.

The focus on comparing what U.S. companies pay *directly* for health care relative to what their foreign competitors pay directly ignores the higher indirect costs that many European and Japanese firms and individuals shoulder due to higher corporate and personal income taxes to support more extensive public welfare states. This amount generally exceeds what even the most generous U.S. firms spend on health care for their employees. “The cost of employment-related health benefits as a percentage of payroll is nearly 50 percent greater in Germany than in the United States, but little is heard about this,” according to health care economist Mark Pauly. The fact is that many European and Japanese firms are highly competitive even though their workers enjoy more generous health, vacation, maternity, and other benefits.

In the early 1990s, much of labor’s political energy went into forging an elite-level deal between labor, business, and the government over health care. The failed Clinton plan, which caused such an uproar with much of the business sector, called for larger employers to contribute a modest 7.9 percent of their payroll to help pay for employees’ health coverage. According to Drew Altman, president of the Henry J. Kaiser Family Foundation, “You couldn’t have done more to pay off corporate America than they did with the Clinton plan, but in the end, companies turned on it because it was viewed as a big government plan.” When business walked away from the table, there was no sustained grassroots pressure to bring it back. The ingredients for that mobilization had been squandered by promises that business would do right by workers on health care even as it was engaged in a massive assault on workers in other areas, such as the right to unionize and passage of the North American Free Trade Agreement (NAFTA) in late 1993. Labor leaders repeatedly portrayed employers as ready to do the right thing on health care—until they weren’t.

The persistent faith that business will somehow unlock the door to universal, afford-

\*Marie Gottschalk, “Back to the Future? Health Benefits, Organized Labor, and Universal Health Care,” *Journal of Health Politics, Policy and Law*, 32 no. 5 (December 2007), pp. 946-47, Figures 1 and 2.

able health care flies in the face of the experience of other countries. While analysts may disagree about precisely why universal and near-universal health care took root in Western Europe and Canada, they concur that business was at best a passive player and at worst an obstructionist. Studies of the politics of health policy in other countries reveal that the medical providers, the business sector, and other conservative political forces often fiercely opposed the establishment of universal health care.

### **The Bottom Line**

As we gear up for another major debate over universal health care, what economic factors should be stressed? First, the focus needs to stay squarely on the question of who bears the greatest burden of rising health care costs. There is a health care crisis in the United States, but it is a health care crisis with wrenching economic consequences for individuals and households, not employers. Emphasizing what U.S. employers pay out directly for health insurance obscures the question of who really shoulders the U.S. health care bill. Government expenditures account for about 36 percent of the tab. Household spending comes in next at 33 percent, and employers are in third place at 27 percent. The burden on households is even greater than these figures suggest because of hidden costs in taxes, lower wages, and higher prices for goods and services.

The economic competitiveness framework obscures the fact that employers and insurers have been remarkably successful at shifting health care costs onto employees, their families, and other individuals through higher copays, higher deductibles, restrictions on coverage, and other measures. Since the demise of the Clinton health plan fifteen years ago, the benefits of unionized workers have come under attack from many directions. The erosion of benefits in unionized jobs has hastened the erosion of benefits for workers in nonunion jobs. Some employers are eliminating benefits altogether; others are whittling away at them. Companies are creatively using bankruptcy proceedings to wiggle out of contract obligations to unionized workers. They also have been suing their retirees in an effort

to renege on earlier promises made to retired workers. New national accounting standards for private and public employers threaten to hollow out retiree benefits further. In the public sector, the new standards pit taxpayers against state and municipal employees. The U.S. government has been remarkably complicit in this assault on employee benefits. For example, the U.S. Labor Department has not taken up the cause of retired workers denied promised health benefits, arguing that they "aren't our constituents anymore."

Another important economic question has to do with economic efficiency. The United States has the most expensive, inefficient health care system in the world with great variations in quality. The country spends over 15 percent of its GDP on health care, yet has forty-seven million people who are uninsured and millions more who are underinsured. By comparison, other industrialized countries have been able to achieve universal care while spending on average about 9 percent of their GDP on health care. The United States spends so much more, yet has fewer hospital beds, doctors, and nurses per capita than many other industrialized countries. No wonder that only 40 percent of Americans describe themselves as satisfied with the U.S. medical system, making the United States nearly last in public satisfaction (and dead last among public health experts polled).

One reason the U.S. health care system is so expensive is because it is so highly regulated by the private insurance industry. The main difference between here and other countries is that the commercial insurers—not the government—are the prime regulators. They determine, with little public input, who is fit to be insured and who is not; which medical bills to pay and which to deny; and which treatments are "experimental" and which are not. These regulations are expensive and have created what Henry Aaron characterizes as "an administrative monstrosity." In 2006, Wellpoint, the country's largest for-profit insurer, spent nearly \$9 billion in marketing and administrative costs, many of which involved "regulating" the insurance market. Even with these high marketing and administrative costs, the health insurers are incredibly profitable. In

2006, the six largest health insurance companies had combined profits of more than \$10 billion. Ironically, the costs of administering the U.S. health system roughly equal what employers pay out directly for health care—or about one-quarter of total spending on health care in the United States. And these calculations for administrative costs do not include all the time wasted as patients chase down referrals, wade through piles of incomprehensible medical bills, and navigate phone trees that take them nowhere. Streamlining U.S. administrative costs to levels comparable to those of Canada would reduce the U.S. health tab by an estimated 17 percent.

Another important economic question is where to assign blame for health care inflation. The recent stampede to enact health care legislation based on an individual mandate that penalizes people without insurance is shifting the wider understanding of who is to blame for rising medical costs. Somehow the uninsured have become the prime culprits. Fingers are pointed at the sickly uninsured who rely on expensive emergency room care and rack up unpaid hospital and doctors' bills that have to be shifted onto someone else. They also are directed at the young and healthy who forgo insurance because they cannot imagine falling ill and needing expensive medical care. As one analyst remarked, attempting to solve the problem of the uninsured by mandating they buy insurance is akin to attempting to solve world hunger by ordering the hungry to buy food. Blaming individuals for medical inflation shifts attention away from the more significant culprits, such as the expansive for-profit health care system with its high administrative and marketing costs; the perverse incentives to perform high-cost medical procedures and not invest in primary care, preventive care, and public health; and the enormous economic clout of the pharmaceutical companies and other health care industries, which buys them enormous political clout.


The bottom line is that to achieve universal health care, the country needs to have real cost containment and to reallocate its health care resources. If we are truly committed to creating a high-quality, affordable universal health care system, someone will have to give

something up, and some will have to give up more than others. The call for health care reform in the name of economic competitiveness holds out the chimera that a bloodless win-win solution is possible for all the stakeholders in the health care system—insurers, medical providers, and the general population.

### A Dose of Political Realism

The economic rationales for national health insurance are considerable. But we need to resist the temptation to reduce this mainly to a question of dollars and cents. As Uwe Reinhardt recently said, the health care debate really boils down to one question: "Should the child of a gas station attendant have the same chance of staying healthy or getting cured, if sick, as the child of a corporate executive?" Reinhardt notes that it would cost about \$100 billion in additional government spending to provide health care coverage for every man, woman, and child in the United States—or about what the country spends every nine months to fund the war in Iraq.

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Successful reform movements in the United States—the abolitionist movement, the New Deal, the civil rights movement—have always had strong moral overtones. President Franklin D. Roosevelt did not invoke the dollars-and-cents language of an accountant to spur the country to support the landmark social insurance programs that became known as the second New Deal.

The New Deal example is relevant in another respect. In the 1930s, the popular Townsend movement of older Americans took the country by storm. This movement induced FDR and business to support Social Security and other social welfare protections so as to neutralize growing public sentiment for more radical pension proposals. Facing not only ruinous economic competition at the time but also a burgeoning and threatening social movement, employers decided to accept some legislated solution.

It is reasonable to raise the question whether the pursuit of a single-payer strategy is realistic given how politically and economically entrenched the drug and insurance industries are and how entrenched the for-profit medical system is. But Stern of the SEIU is wrong to claim that single-payer is a dead end because Americans deeply mistrust the government, are basically satisfied with

their health care system, and don't like anyone else's system. Recent public opinion data show strong public support for a government guarantee of health care. Moreover, a revealing new study of voter discontent by the Democracy Corps found the most commonly chosen phrase to characterize what's wrong with the country was, "Big business gets whatever they want in Washington." Instead of attempting to ride what *New York Times* columnist Paul Krugman has characterized as the "strong populist tide running in America right now," Stern is flying against it. As the famous German sociologist Max Weber once said, "Successful politics is always the art of the possible. It is no less true, however, that the possible is often achieved only by reaching out towards the impossible which lies beyond it." ●

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