

US HEALTH REFORM AND THE STOCKHOLM SYNDROME

MARIE GOTTSCHALK

The US healthcare system is exceptional in many ways compared to other developed countries. On average, the United States spends more than twice as much per capita on health care, yet nearly 50 million people are uninsured, and tens of millions more are grossly underinsured. The US ranks near the bottom in major health indicators like life expectancy and infant mortality, and public satisfaction with the healthcare system is extremely low. Heartbreaking stories of people scrambling to find affordable and adequate healthcare coverage while facing down serious, even life threatening, illnesses are common in the media.

In the face of these remarkable problems, the leading solution proposed by the Obama administration, top Democrats in Congress, and their supporters is remarkably modest. Time and again, major attempts to reform the US health system fall victim to the ‘Stockholm syndrome’ – like the famous Swedish bank hostages who became emotionally attached to their captors and even defended them after they were released. Held captive for so long by neoliberal ideas about how best to organise the US economy and society, many advocates of universal health care have put competition and consumer choice at the centre of the latest major push for health reform. Dozens of major organisations close to the Democratic Party, including the AFL-CIO (the country’s pre-eminent labour organisation), Moveon.org, and the Children’s Defense Fund, have mobilised over the last year or so on behalf of a breathtakingly modest solution: creation of a public health plan – essentially a nonprofit insurance company – to compete with the commercial health insurers. They have largely abandoned the call for a ‘single-payer’ health system modelled after Canada’s that many progressives have rallied around since the demise of the Clinton administration’s Health Security Act. This push for a competitive public insurance plan indicates that faith in market-led solutions for health reform remains largely unshaken

despite the recent financial collapse, which has prompted even former Fed chairman Alan Greenspan to publicly question the market *über alles*.

As the problems of the US health system have mounted over the last four decades, the vision of what is possible in healthcare reform continues to shrink. The current enthusiasm for creating a nonprofit health insurance company to relieve the country's healthcare malaise is but the latest example. A closer look at the origins, development, and shortcomings of the Democrats' competitive public plan solution helps explain why many advocates of universal, affordable, high-quality health care continue to bite off less than they can chew.

THE COMPETITIVE PUBLIC PLAN PROPOSAL

The focus of the latest health reform debate has been creation of a new public insurance option for Americans under age 65 who lack employment-based health coverage. This group would be able to choose between a standard package of benefits offered by the public plan, or a comparable one provided by private insurers. Employers who do not offer insurance to their employees would pay a penalty tax to help cover the uninsured ('play-or-pay'). Lower-income Americans would receive subsidies or tax credits based on a sliding scale to buy into the public plan or one of the private ones. Those who remained uninsured would likely be fined (the so-called individual mandate). The expectation is that the public plan would win hands down in a fair competition because commercial health insurers are so bloated by administrative waste, huge underwriting and marketing costs, and excessive executive compensation and profits. Tens of millions of consumers would vote with their feet, choosing the less costly yet also higher-quality public plan. This would force the commercial insurers to reduce costs and improve benefits and service, slowing the galloping rate of healthcare inflation.

Private insurers raised alarms that a public plan would not be competing on a level playing field and thus would ultimately drive them out of business. This subtly recast the debate over health reform. The focus shifted to how to make the public plan a 'fair' competitor and away from the enormous inequities of the under-regulated private insurance market in the United States that have contributed so significantly to the country's healthcare crisis. In order to neutralise charges of unfair advantage, some supporters of the public plan have watered down the original proposal or bargained away (or shunned) key reforms needed to rein in insurers and providers. For example, one popular 'neutered' version of the public plan would require the new public programme to abide by identical rules and standards that apply to

private insurers.¹ It would deny the new programme access to Medicare's purchasing clout to bargain with providers or impose uniform reimbursement rates, two proven mechanisms for containing the costs of the decades-old government-run health programme for all elderly Americans.

Supporters of this 'hybrid' approach to reform created highly stylised versions of the relative strengths and weaknesses of the public and private sectors in the delivery of health care.² They extolled the public sector for its reported ability to contain costs and to pursue innovations that improve the quality of care. Meanwhile, they applauded the private sector for offering a range of insurance products and nimbly adjusting benefit packages to meet shifts in consumer demand. Glossed over were the enormous variations in how the public and private sectors actually deliver health care in the United States and abroad.

The highly stylised version of what public plans are best at doing was based on a select and idiosyncratic reading of the origins and development of Medicare, the public healthcare programme for senior citizens established in 1965. Under Medicare, the US government directly pays providers to care for people over 65 primarily from funds collected from a designated payroll tax, general revenues, and health premiums charged to the over-65s themselves. Medicare is heralded for its superior ability to retain wide access while containing healthcare expenditures through cost-saving innovations like the prospective payment systems introduced in 1983 and national fee schedules for physicians introduced in the 1990s. Left out of the story is that these innovations took decades to enact. The quid pro quo to get physicians and hospitals to end their jihad against Medicare was an agreement to reimburse them on a fee-for-service basis and to eschew imposing serious cost or budget controls. It was well understood at the time that this was a massive financial concession in aid of reaching a compromise. By the early 1970s, talk was already widespread about the runaway costs of Medicare and of a crisis in financing health care. In recent years, spending per enrollee in private plans has generally grown faster than in Medicare. But for much of its history Medicare has been a largely unregulated cash cow for providers.

Medicare is so politically and fiscally attractive because it is a very particular kind of public plan. Medicare has been able to spread risks broadly and maintain wide access for the simple reason that the government bluntly requires it to do so. Nearly everyone qualifies for Medicare upon reaching age 65, regardless of health status or income level. This has created at least some sense of social solidarity, given older Americans across the board a stake in defending a public healthcare system for the aged, and, until recently, avoided incentives to cherry pick healthier (and presumably

cheaper) subscribers.

For public programmes, the devil is in the details. Medicaid, the means-tested healthcare programme for low-income Americans established alongside Medicare in 1965, has had a strikingly different trajectory. It has been far easier to starve Medicaid for funding because lower-income Americans do not enjoy the political clout of the elderly, all of whom fall under Medicare's protective umbrella. Despite improvements in Medicaid in recent years, it is still widely viewed as an expensive public programme that dispenses second-class medical care. When healthcare reformers talk about the superiority of the public approach, it is no wonder they talk mostly about Medicare, not Medicaid.³

The competitive public plan that reformers envisioned differs from Medicare in key ways that could reinforce the current pathologies of the US health system and introduce new ones. First, supporters talk about the need for competition and choice. Yet the estimated 160 million American workers and their dependents who rely on employment-sponsored health benefits would probably not be free to choose the public plan. These captive consumers would likely only have the option to go public if their employers decided to move over to the public plan or gave up providing benefits altogether and paid the penalty tax. Even if the public plan turns out to be cheaper and better, employers will not necessarily make the switch. In the history of the development of US social policy, business leaders have often allowed their visceral ideological opposition to government programmes to trump their immediate bottom-line calculations. The fear is that permitting an expansion of the public sector in one area opens the door for government expansion in other areas. A number of large employers walked away from the Clintons' Health Security Act in 1993-94 for precisely this reason.

Another crucial factor is that some employers are, not surprisingly, large manufacturers of lucrative medical devices and other medical products. Is General Electric, whose second most important division is health care, ready to funnel its employees into a government-sponsored plan with potentially enormous power to, say, reduce the costs and utilisation of MRI and x-ray machines, a multi-billion dollar business each year for the company? And how about the pharmaceutical companies? Furthermore, as much as employers begrudge how much they pay for healthcare coverage for their workers, many of them do not want to relinquish the paternalistic control that employment-based benefits give them over their workers. Welfare capitalism has deep roots in the evolution of labour-management relations in the United States. Even in the darkest days of the Depression, employers were loath to abandon job-based benefits and the power over workers they

conveyed.⁴

In competing with private plans, the public plan should, in theory, be able to provide better benefits and services at lower costs because it presumably would not be saddled with high administrative, marketing, and executive compensation expenses and would not need to turn a profit for shareholders. But the public programme, with its superior benefits and initially lower costs, could end up becoming a magnet for sicker patients in need of costlier care. This would drive up its costs, prompting healthier people to flock to the less expensive private insurance options. Furthermore, private insurers are quite ingenious when it comes to tailoring their benefit packages, premium costs, and provider networks to discourage less healthy people from enrolling. The private Medicare Advantage plans introduced in 2003, which tend to attract healthier elderly Americans, are a stark reminder of this. Moreover, doctors and hospitals might balk at participating in the new public plan and might demand costly inducements to sign up, just as they did 45 years ago as a *quid pro quo* to support Medicare.

It is not obvious that the public plan could compete primarily on costs, quality, and service alone if insurance companies in the United States remain free to market and advertise their products with few restrictions.⁵ One can imagine driving down the highway and seeing massive billboards paid for by private insurers with slogans like: ‘Should Uncle Sam’s plan tell your doctor what to do?’ This could erode the public’s confidence in the government’s ability to solve the health system’s pressing problems.

The competitive public plan option could also undermine public support for government intervention in social policy in other ways. It might end up pitting the captive consumers of employment-based private insurance against people enrolled in the public plan. It would be politically explosive if employees covered by private health insurance came to believe that they were providing huge subsidies to a superior public plan that they were not permitted to enrol in. For years, physicians and hospitals have compensated for lower Medicare and Medicaid reimbursement rates by shifting some of their costs onto patients covered by private insurance. Presumably private insurers would frame their marketing and political strategies around allegations of unfair cost shifting, putting the public plan on the defensive. Instead of cultivating a shared sense of social responsibility, as supporters had hoped, the public plan might end up fostering a zero-sum view of health reform. Advances in the public provision of health care would appear to be coming at the cost of unfairly squeezing people covered by private insurance. This would put the public plan on the defensive. The crucial role of private insurers in creating and sustaining such an inequitable health system would

recede further to the margins of the public debate.

In short, under these conditions public plans may not necessarily be superior when it comes to developing cost-saving innovations. The real question is: under what conditions do the political stars line up to the point where both the government and the public are willing to use their considerable powers as the prime purchasers of health care to control the providers and insurers? The new public plan could look like the largely unregulated Medicare programme in 1965, or the semi-regulated Medicare programme in 2009, or today's underfunded Medicaid programme, or the healthcare equivalent of Fannie Mae and Freddie Mac, the quasi-public mortgage companies that were leading culprits in the subprime fiasco and the foreclosure crisis.

THE SINGLE-PAYER ALTERNATIVE

The competitive public plan option has split organised labour and other key groups. Just as was the case in the early 1990s, supporters of a single-payer plan continue to be some of the fiercest opponents of a minimalist approach to health reform. They essentially advocate vaporising the US health insurance industry and replacing it with a government-run programme modelled after Canada's system.⁶ The government would pay most medical bills directly; doctors, hospitals, and other providers would operate within global budgets but remain in the private sector; and everyone would be entitled to a basic package of health benefits. The single-payer message has not changed much from the early 1990s, though supporters have been investing more effort this time around in mobilising organised labour and other groups to endorse their position. Hundreds of union locals and dozens of central labour councils and state labour federations have passed symbolic resolutions in favour of single-payer legislation, as have the international chapters of many major unions.

A single-payer system has much to recommend it. When the Congressional Budget Office analysed all the major health reform proposals then under consideration in 1993-94, it concluded that a single-payer plan was the only one likely to achieve universal coverage while saving money.

Earlier in his political career Obama spoke strongly in favour of a single-payer system. Today he acknowledges that if he were starting from scratch, a single-payer plan would be preferable but that the best option now is to build on the current system. In the opening months of the health reform debate, Obama, Senator Max Baucus (Democrat – Montana) – chairman of the pivotal Senate Finance Committee – and other leading political players sought to delegitimise single-payer advocates, or even exclude them from the debate. At the healthcare summit in March 2009 and other leading forums, they surrounded themselves with the 'men and women who made their

careers killing healthcare reform', in the words of *The Washington Post*.⁷ This strategy backfired. Baucus's move to arrest single-payers supporters (many of them doctors and nurses) demanding admission to a Senate roundtable on health reform created an uproar, as did Obama's initial guest list for his summit, which did not include any single-payer advocates.

Some key labour leaders publicly made polite noises about a single-payer system while disparaging it behind the scenes. Most national labour leaders put their energy and resources behind Obama's prescription early on, even though the president was stunningly vague on key issues. Some rallied around the public plan after convincing themselves that it really is a Trojan horse that will ultimately unleash a single-payer plan after enfeebling the private insurance industry. Others signed up because they consider themselves political realists and view the single-payer option as politically dead on arrival.

To their credit, single-payer advocates have drawn public attention to the extraordinary pathologies of the US health system, notably its gross lapses in care and coverage, excessive costs, and the billions of dollars squandered on administrative costs. They also have offered the most progressive tax proposals to finance universal health care. Held hostage for so long by a health system that is dysfunctional and cruel in many respects, it is not surprising that single-payer advocates want to essentially blow up the private insurance industry. But the fixation on the Canadian solution over the years may have come at the cost of ignoring the scandal of inadequate regulation of providers and insurers in the US healthcare system.

THE PROBLEM OF REGULATION

What fundamentally distinguishes the US healthcare system is the price of care not the amount of care.⁸ President Obama and other would-be reformers have attempted to skirt an axiom of medical economics that is at the heart of the politics of health care: 'A dollar spent on medical care is a dollar of income for someone'.⁹ Health reform to achieve universal, high-quality, affordable care is fundamentally a redistributive issue with high political and economic stakes. Meaningful cost control will require strong government leadership that sets targets or caps on medical spending. Competition is a weak, indirect way to contain costs. This is especially so in the absence of strong regulatory institutions.

Historically the United States has been shockingly unwilling to seriously regulate its private insurance industry. US health insurance companies have not just been under-regulated compared to private insurers overseas, but also compared to many other major industries in the United States. A

hodgepodge of loose regulations at the state level enforced by ineffectual and sometimes corrupt state insurance departments govern the health insurance industry. On the eve of the last major burst for health reform, the US House of Representatives issued a scathing report in the late 1980s denouncing the greed, incompetence, and profiteering of the health insurance industry and the lax state regulators who repeatedly looked the other way.¹⁰

Today the US insurance industry is gung-ho to be the stick to prod doctors and hospitals to get in shape with pay-for-performance standards and other cost-cutting and quality control measures. Insurers are outspoken advocates of greater transparency for physicians and hospitals so that the public is better able to scrutinise their performance and costs. But insurance companies stridently defend their rights to keep vital information about their own operations confidential. This has permitted them to strategically shape debates over health and other social policies by selectively making claims about costs and performance that are difficult to verify. As long as the private insurance industry is allowed to hide behind the cloak that these are business trade secrets, informed consumer choice – a key ingredient of market competition to contain costs – is a myth.¹¹

Beginning in late 2008, US health insurers made what many commentators have billed as sweeping concessions on regulation. They signalled their willingness to accept all individual applicants, regardless of pre-existing health conditions. They also expressed their willingness to discontinue setting premium rates that are based on health status or gender, but only if the US Congress mandated that all Americans must carry health insurance – i.e., if all Americans were forced to buy their products. But US insurers included some whopping caveats. First, they would retain the option of setting rates based on age, geography, and family size in the individual market. This means that premium rates would continue to vary enormously, pricing many people out of the market. Insurers would also remain free to use their extensive marketing budgets and experience to attract healthier subscribers and discourage sicker people from seeking coverage. Insurers also made no promises to forego considering health status and other key factors in setting rates for small employers, one of the most profitable segments of the health insurance market.¹²

The proposed competitive public plan is supposed to force insurers to be more aggressive with providers in order to hold down costs and prices or else risk losing customers to the public plan. Obama repeatedly talked about the need to use the market to discipline insurers but did not make a strong case for tightly regulating them in the opening months of his Presidency. The administration even hailed the vague and largely unenforceable voluntary

promises to cut costs that the US insurance industry and medical providers announced in May 2009 as a watershed in health reform. Obama's message was inconsistent. As healthcare reform was floundering in Congress by midsummer, the administration became more openly critical of the insurance industry after months of portraying it as a key ally.

Obama has attempted to finesse the politically explosive issue of real cost containment by focusing on what one critic has called 'faith-based savings'.¹³ The flagship proposal the president unveiled at his healthcare summit in March 2009 was the national adoption of electronic health records, which Obama said could save \$80 billion annually. But medical experts dispute that electronic health records will yield sizable savings.¹⁴ So does Peter Orzag. Or at least he did when he headed the Congressional Budget Office before becoming Obama's budget czar. Experts generally agree that preventive care and better disease-management programmes – two other cornerstones of the Obama effort – are good ideas that will improve the quality of life for many people. But most experts also agree that these measures are not likely to save much money any time soon – and might even drive medical expenditures up.

Supporters of the competitive public plan solution did concede that the insurance industry needs to be regulated more tightly, but this was not their main focus initially. Their emphasis on competition reinforced the idea that health care should be treated primarily as a private consumer good distributed by market principles. This displaced the idea that health care is a social good that needs to be organised around underlying principles of social solidarity, not market competition.

Advocates of the public plan risked squandering enormous political capital to get so little. They bent over backwards to convince the public and critics in the insurance industry that they will create a level playing field. This fostered the impression that the insurance industry has been playing fair and square all along. The terms of the debate shifted to the imaginary injustices that a mammoth public plan would inflict on a Lilliputian insurance industry that has historically been too weak and fragmented or too disinterested to put the cost-containment screws on providers. This is a revisionist portrait completely at odds with the real role of the insurance industry in the US healthcare crisis, past and present.

The US insurance industry has been a shrewd behind-the-scenes political operator for well over a century. Each time healthcare reform has moved to centre stage, cries for more federal action have repeatedly ended up further entrenching the private insurance industry.¹⁵ Fearing that the United States might copy Europe's burst of social insurance programmes

during the Progressive era, US commercial insurers and business executives aggressively sought to develop corporate welfare schemes to blunt calls for more government action. Once the New Deal put security at the centre of American economic and political life, commercial insurers set out to redefine what security meant in ways that served their interests. They also sought to ensure that the private sector would be the main provider of that security – not public welfare programmes or nonmarket alternatives like union-backed healthcare centres or community health cooperatives.¹⁶

Three years ago, the industry's leading Washington lobbyist predicted that health care would top the domestic agenda in 2009 and that insurers needed a strategy based on more than just saying no. As head of America's Health Insurance Plans, Karen M. Ignagni positioned the industry as an ally of health reform, not its enemy, without making any serious concessions or revealing what the industry would do if Congress produced a bill it opposes. Ignagni was so successful that '[n]ot only are health insurers at the table, they're sometimes driving the debate'.¹⁷ This is a remarkable accomplishment. After all, relatively few Americans have a favourable view of the health insurance industry, and profits at the ten largest publicly traded health insurance companies more than quadrupled between 2000 and 2007 while health insurance premiums soared and millions lost coverage.¹⁸

PHYSICIANS AS POTENTIAL ALLIES

The emphasis on insurers and the competitive public plan to police providers and bring down costs implies that US physicians and the US medical community are single-mindedly rapacious and are best controlled by the brute force of competition and market power. But the US medical community has the potential to be a constructive and creative force in healthcare reform. Nurses have been some of the feistiest advocates of a single-payer plan. And while physicians do not want to see their earnings cut, they also have other interests. It is no secret that there is no love lost today between physicians and insurance companies in the United States. Physicians simmer as they watch healthcare dollars eaten up by high administrative costs and as they deal with multiple private insurers second-guessing and micro-managing them at every turn. A 2009 study calculated that dealing with health plans costs physicians and their staffs \$31 billion each year in lost hours – or about \$68,000 on average per physician.¹⁹ Doctors might be more willing to accept cuts in their incomes and fee schedules if they were assured that the savings did not flow into insurers' pockets but rather went to expand access, enhance healthcare quality, and improve the quality of life for doctors.

The alleged monumental shifts in the US health insurance industry on

the question of health reform have overshadowed important real shifts in physician sentiment. Nearly 60 per cent of physicians recently surveyed now favour switching to a national health plan, up from fewer than half in 2002. 'Across the board, more physicians feel that our fragmented insurance system is obstructing good patient care, and a majority now support governmental legislation to establish national insurance as the remedy', according to one of the authors of the study.²⁰ Physicians for a National Health Program, one of the most outspoken organisations in favour of a single-player plan, has more than 15,000 physician members. Marcia Angell, former editor of the *New England Journal of Medicine*, a premier medical journal, is a leading voice on behalf of a single-payer plan. In January 2008, the American College of Physicians, the second largest physician organisation in the country, published a position paper recommending a single-payer plan as one viable option for reform. Furthermore, the historically conservative AMA is no longer the pre-eminent voice in health policy that it once was. The medical profession has splintered into a myriad of specialty associations. Today barely one-quarter of the country's physicians belong to the AMA, and younger doctors are shunning the association in record numbers. Furthermore, the medical profession is no longer the all-white male army of white coats it once was as women and minorities increasingly fill its ranks.

Physicians, who were largely invisible in the healthcare battle 15 years ago, have slowly become more outspoken about the ills of the private insurance industry. Recently doctors turned the tables on private insurers and began rating health insurance plans. The AMA has focused public attention on the troubling consequences of the insurance industry's massive consolidation over the last decade or so. As of 2007, the top two insurance companies, WellPoint and UnitedHealth, together covered 67 million people, or 36 per cent of the national market for commercial health insurance. Thanks in part to the lax enforcement of anti-trust laws, most metropolitan areas are now dominated by two – and often just one – health insurers.²¹ According to the AMA, the 'physician's role is being systematically undermined as dominant insurers are able to impose take-it-or-leave-it contracts that directly affect the provision of patient care and the patient-physician relationship'.²²

The US hospital and insurance industries have been undergoing major consolidations, but doctors remain one of the least-consolidated sectors of the US health system. Indeed, most doctors belong to practices with four or fewer physicians and with no clout to bargain with insurers. But there are a significant number of physician groups in the United States that are potentially large enough to own and operate their own health plans independently of insurers. Paving the way for them to do so by fostering self-

regulatory associations of physicians or by modifying anti-trust legislation so physicians have more leverage vis-à-vis insurers may be important carrots to lure US physicians to accept uniform fee schedules, budget targets, and the like. Notably, physicians employed by California's Kaiser Permanente are the most satisfied doctors in California, according to survey data. Their satisfaction undoubtedly stems from having to deal with a single, non-profit insurance plan 'that is answerable to the medical group'.²³

The AMA is widely blamed (not entirely justifiably) for single-handedly killing national health insurance in the 1930s, and again in the immediate postwar decades. This may help explain why some reformers are unable to envision a constructive and leading role for physicians in health reform. But this is a period of disarray and uncertainty among US doctors at a time when physicians' legitimacy with the public is plummeting because of their questionable ties to pharmaceutical companies and manufacturers of medical devices. Furthermore, physician impotence vis-à-vis insurance companies is growing. More doctors are realising that if they do not find a way to restore their public image and police their own members, someone else may take up the task, with less favourable results.

HEALTH CARE AND ECONOMIC HEALTH

The political agility of the insurance industry and the neoliberal cloud that has dogged US public policy for decades do not entirely explain why many advocates of universal health care have lined up behind such modest proposals in such extraordinary times. Another key factor is the persistently unshaken belief that the healthcare issue needs to be framed primarily as an economic issue and that doing so will attract the allegedly crucial support from the business sector.

We are in the midst of an economic meltdown widely understood to be the result of breathtaking malfeasance by the financial sector and its political patrons. Yet President Obama and key advisers repeatedly single out healthcare costs as the leading threat to the country's long-term economic health.²⁴ Characterising health care as primarily an economic issue is costly. It fosters an exaggerated faith in the possibility of forging productive coalitions with business leaders and the insurance sector and a diminished interest in cultivating a wider social movement on behalf of universal health care. This is exactly what happened in 1993-94. It also distracts political and public attention away from arguably more dire threats to the economy, including the opaque bailout of the financial sector, the gargantuan military budget, and the grossly inequitable tax system. It also stokes public hysteria over the costs of Medicare and Social Security, paving the way for major retrenchments in

these two central pillars of the US welfare state.

Top labour leaders – most notably Andrew Stern, president of the Service Employees International Union (SEIU), the nation's largest union – have echoed the administration's highly economic view of healthcare reform. Stern's stance is quite similar to the pro-business position that John Sweeney (who stepped down as president of the AFL-CIO in September) manoeuvred the labour federation into when he was chairman of its healthcare committee in the lead-up to the battle over the Clinton plan in the early 1990s. Stern contends that no fundamental change in health care will 'arrive until American business leaders make the call for change'.²⁵

Stern has been aggressively identifying the interests of the SEIU with the interests of the business sector in many high-profile business-labour coalitions and other activities. One of Stern's most controversial public dalliances was with H. Lee Scott, Jr. when he was chief executive officer of Wal-Mart. Despite Wal-Mart's dismal record on health benefits and its virulently anti-labour history, Stern argued that the bottom line provides compelling reasons for Wal-Mart and other large employers to be constructive allies in health reform.

In tapping big business as a key ally in the healthcare debate beginning in the late 1980s, much of organised labour took a stance quite similar to Stern's position today.²⁶ Labour 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, labour 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 international marketplace, which was severely hurting the US economy and the American worker.

Economists have raised numerous objections to the contention that escalating healthcare costs are imperilling US economic competitiveness and the overall health of the US economy. But their analyses have made little headway against the 'shared folklore' that employees' healthcare costs are pricing US products out of the market.²⁷ In his eagerness to woo business on the healthcare issue, Stern has been a leading purveyor of this simplistic folklore. He has promoted alarmist claims that the average Fortune 500 company is at risk of spending more on health care than it earns in profits.

Left out of the story is that spending on health care measured as a percentage of after-tax corporate profits declined steadily from 1986 to 2004 (except for the late 1990s due to a drop overall in corporate profits as the dot-com and high technology sectors went bust). 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 for the 1998–2001 period.²⁸ Although healthcare costs continue to escalate, employers have had great success at squeezing wages and other forms of compensation and shifting more healthcare 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 economic meltdown, corporate profits were at their highest level in four decades.

To underscore the alleged severity of the healthcare cost crunch, Stern and some business leaders stress (as they did in the late 1980s and early 1990s), what US employers are paying out in direct costs for health care as compared with their foreign competitors. Over the years, the auto industry has been the designated poster child as auto executives and labour leaders bemoan how crippling medical expenses add \$1,500 to the cost of each car manufactured by GM, while some of its competitors pay as little as \$200 per vehicle.

But the focus on comparing what US companies pay *directly* for health care relative to their foreign competitors is often misleading. It ignores the higher indirect costs that many overseas 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 US firms spend on health care for their employees. The fact is that many firms in Europe and elsewhere have been highly competitive even though their workers have enjoyed more generous health, vacation, maternity, and other benefits. Moreover, in a number of countries, the direct healthcare costs paid for by corporations have been considerable.²⁹

In the early 1990s, much of labour's political energy went into forging an elite-level deal between labour, business, and the government over health care. The defeated Clinton plan, which caused such an uproar with much of the business sector, called for larger employers to contribute a modest 7.9 per cent 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'.³⁰

When business walked away from the table, there was no sustained grass-roots pressure to bring it back. The ingredients for that mobilisation 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, like the right to unionise and passage of the North American

Free-Trade Agreement (NAFTA) in late 1993. Labour leaders repeatedly portrayed business leaders as ready to do the right thing on health care – until they weren't. There is a parallel here with the current situation. The latest healthcare debate has unfolded simultaneously with the business sector's vitriolic mobilisation against the Employee Free Choice Act, the most important piece of US labour legislation in decades.

HARRY AND LOUISE GET ANGRY

The competitive public plan solution emerged out of the doldrums of the vanquished Clinton plan and out of a very particular reading of what went wrong 15 years ago. In the revisionist account, the Health Security Act was not defeated because Clinton came into office with a weak mandate, elected with only 43 per cent of the vote. Nor because of strategic mistakes his administration made and divisions within the Congressional Democratic leadership. Nor because powerful interest groups, notably organised labour, were at war with one another. Nor because Newt Gingrich and the new ascendant conservative wing of the Republican Party had committed themselves to the defeat of 'Hillarycare' at all costs. Nor because the tepid support within the business community rapidly evaporated once Clinton began looking like a one-term president due to missteps over gays in the military, Somalia, etc.

In the revisionist account, Harry and Louise killed healthcare reform. Harry and Louise were a white, middle-class – dare I say yuppie – couple that starred in a series of commercials funded by the insurance industry. The fictional Harry and Louise became famous – or infamous – as they sat around their kitchen table fretting that the Clinton plan would force them to change their current health benefits and maybe even switch doctors. The hold that the ghosts of Harry and Louise have had on the current health reform debate is striking. The mantra from President Obama, the SEIU's Andy Stern, Senator Baucus, and other would-be reformers is that most Americans are basically content with their health coverage and seek a uniquely American solution that keeps the current system of employment-sponsored benefits largely untouched. The biggest impact of the ad campaign then and now appears to have been on elite policy and opinion makers, who have persistently overestimated how much Harry and Louise represented heartfelt popular sentiment and how satisfied Americans are with the healthcare coverage they have.³¹

Evidence continues to mount that Americans are profoundly dissatisfied with their health system and are ready for major changes. In terms of public satisfaction with its medical system, the United States is nearly last compared

with other developed countries (and dead last among public health experts polled).³² No wonder. Since the demise of the Clinton plan, the wheels have come off job-based benefits. Some employers have eliminated health benefits altogether while others are persistently whittling them away. In 2008, only 60 per cent of all workers – or barely half of the total US population – were covered by employment-based health benefits. Those employers who do offer benefits have been offloading more of the costs onto employees through higher co-pays, deductibles, out-of-pocket expenses, and insurance premium costs.

It is no longer possible for most Americans to be six degrees of separation from the uninsured. With the official unemployment rate surpassing 8 per cent in February 2009, a Kaiser Family Foundation survey found that 52 per cent of people with employment-sponsored coverage were worried about losing it. Nearly 87 million Americans experienced a spell of being uninsured in the last two years. In California, nearly 40 per cent of residents under age 65 did. The foreclosure crisis has also riveted public attention on the enormous number of Americans – many of them middle-class people who had health insurance at the start of their illness – who go bankrupt and risk losing their homes because of medical debts. On the eve of the historic November 2008 election, a Commonwealth Fund survey found that four out of five US residents believe the nation's health system needs to be completely rebuilt or fundamentally changed. Asked whether they support national health insurance and a government guarantee of health care, overwhelming numbers of Americans routinely tell pollsters yes. One of the most surprising poll results came from a 2008 Harvard School of Public Health survey that directly asked whether a 'socialised medical system' would be better than the current one. Among those who said they had some understanding of this historically inflammatory phrase (82 per cent), a stunning plurality (45 per cent) said socialised medicine was preferable (39 per cent said it wasn't).

The minimalist approach to health reform does not tap into this smoldering public anger over the health system or into the explosive public outrage at the financial industry, the business sector, and their political patrons in Congress in the wake of the economic meltdown. The political futures of several Democratic barons in Congress, including Senator Christopher Dodd, Senator Charles Schumer, and Representative Charles Rangel, are clouded because of their close, see-no-evil ties to the banking and insurance industries nourished over the years by enormous campaign donations from these sectors. The healthcare sector spent nearly \$1 billion in lobbying in 2007 and 2008 alone and has long ranked as one of the most powerful political forces, alongside the financial and energy sectors. Over the last four

years, Senator Max Baucus, who became the most important member of Congress on health reform after Senator Edward Kennedy became gravely ill, was the top recipient of campaign contributions from health insurers and drug makers. Notably, Baucus proudly co-authored the controversial 2001 tax cuts, the Bush administration's signature 'trickle-up' legislation.

These conflicts of interest run deep. UnitedHealth, one of the nation's largest insurers, now owns the Lewin Group, which once was considered a reliable independent analyst of trends in healthcare benefits and costs. David E. Nexon, who for two decades was Senator Kennedy's key staffer on health policy, became a top executive at Advanced Medical Technology, a leading trade association for the medical industry. Karen M. Ignagni, president of the main trade group for the insurance industry, ran labour's healthcare reform effort at the AFL-CIO in the early 1990s.

The time is ripe for an ambitious healthcare plan that fundamentally challenges these special interests. The economic meltdown has made legislators on both sides of the aisle in Congress particularly vulnerable to charges of shilling for the business sector. A revealing study of voter discontent conducted in 2007 by Democracy Corps on the eve of the financial crisis found that the most commonly chosen phrase to characterise what's wrong with the country was: 'Big business gets whatever they want in Washington'.³³ Obama's decision to seed his administration with many free-market protégés of Citigroup's Robert Rubin made him vulnerable on this score. So did the choice of Nancy-Ann DeParle, who served as director of many large healthcare companies, as his health czar.

During the campaign, Obama said, 'It's time to let the drug and insurance industries know that while they'll get a seat at the table, they don't get to buy every chair'.³⁴ He also promised that if the insurance industry sought to block reform with another Harry and Louise blitzkrieg, he would go on the offensive. But in the formative months of the healthcare debate, Obama and his key advisers gave no public indication of their readiness to defend certain first principles – or even to define what those first principles might be.³⁵ To the consternation of some Congressional Democrats and healthcare reformers, they appeared willing to accept a grossly watered down public plan or maybe even to abandon the public plan altogether as a concession to conservatives. They did not proclaim universal coverage as a fundamental goal and were noncommittal on a mandate requiring employers to pay for a portion of their employees' health benefits. The administration quickly retreated from proposals to fund health reform by levying higher taxes on upper-income earners. Instead, it began talking favourably about taxing employees' health benefits to raise money for health reform. This was a

key feature of Senator John McCain's healthcare platform that Obama had denounced during the 2008 campaign as an unfair tax on middle-class Americans. During the presidential campaign, Obama promised to 'take on' the pharmaceutical industry. But his concessions to drug companies as the health reform battle unfolded surprised and alarmed some leading Democrats in Congress.³⁶

The Obama administration and much of the leadership of the Democratic Party have responded to the healthcare crisis much as they have responded to the financial crisis. They have taken extreme care not to upset the basic interests of the powerful insurance industry and segments of the medical industry and not to raise fundamental questions about the political and economic interests that have perpetuated such a dysfunctional health system. The biggest surprise is how the leadership of organised labour and many supposedly progressive groups have unquestioningly followed Obama and Congressional Democrats on health care. As a consequence, they may be squandering an exceptional political moment. If the Obama administration can get away with such a massive government role in the bailout of General Motors, Chrysler, and Citibank, garnering public support to bring about the demise of the for-profit health insurance industry should not be impossible.

There are not many times in American history when the previous administration and ruling party have been so thoroughly discredited, as were former President George W. Bush and the Republican Party. Or when the princes of the financial sector have been 'stripped naked as leaders and strategists', in the words of Simon Johnson, a former chief economist at the International Monetary Fund.³⁷ The Depression was one of them. This is another. As the billionaire financier Warren Buffet said a couple of years ago: 'There's class warfare, all right, but it's my class, the rich class, that's making war, and we're winning'.³⁸

President Franklin D. Roosevelt came into office at an exceptional moment in 1933. Four years into the Depression, the Hoover administration was thoroughly discredited, as was the business sector. FDR recognised that the country was ready for a break with the past as he symbolically and substantively cultivated that sentiment. But the break did not come from FDR alone. Massive numbers of Americans mobilised in unions, women's organisations, veterans' groups, senior citizen associations, and civil rights organisations to push FDR to switch course. Faced with deep public mistrust and contempt of business after the 1929 stock market crash, leading American corporations invested heavily in winning back the public trust. Over the next few decades, they spent lavishly on public relations and company-based propaganda campaigns directed at their employees to

reassure America that capitalism was indeed good and that too much of the state was, well, socialism.

The Obama administration and leading Democrats have sought a minimalist solution rather than seizing the exceptional political moment to strike out in a bold new direction in health policy. If they calculated that the political conditions were not fortuitous to secure a single-payer plan, at least they might have pushed for a seriously regulated insurance system. Failure to attempt even that is perilous for the cause of universal health care and for their political futures. The president and the Democrats risk looking in a couple of years like Herbert Hoover and the Republicans on the eve of their historic 1932 defeat rather than FDR and the Democrats on their march to a triumphant re-election in 1936.

Would-be reformers who have fought so doggedly to essentially create a nonprofit health insurance company do not recognise the potential of this political moment. It is not 1993-94 all over again. These would-be reformers remain under the spell of the Stockholm syndrome and identify too closely with insurers, the medical industry, and their political patrons. Identifying too closely with one's captors is risky. The window opens, but you don't make a run for it. Indeed, you do not even see the opening.

NOTES

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- 3 One notable exception is Michael Sparer, 'Medicaid and the US path to national health insurance', *New England Journal of Medicine* 360(4), 22 January 2009, pp. 323-25.
- 4 Jennifer Klein, *For All These Rights: Business, Labour, and the Shaping of America's Public-Private Welfare State*, Princeton: Princeton University Press, 2003; and Sanford M. Jacoby, ed., *Masters to Managers: Historical and Comparative Perspectives on American Employers*, New York: Columbia University Press, 1991.
- 5 Although private insurers play a significant role in many European countries, they have been restricted in their promotional advertising, and

direct-to-consumer advertising of prescription drugs has been banned in the European Union. Lawrence D. Brown and Volker E. Amelung, “Manacled competition”: market reforms in German health care’, *Health Affairs* 18(3), May/June 1999, p. 82; and Uwe E. Reinhardt, “Mangled competition” and “managed whatever”, *Health Affairs*, 18(3), May/June 1999, p. 93. As the clout of multinational insurance companies, for-profit hospital chains, pharmaceutical companies, and much of the medical industry have increased worldwide, these and other regulations are increasingly under threat by a strident push for more market competition. See Christoph Hermann’s essay in this volume.

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- 15 Quadagno, *One Nation Uninsured*, p. 75; and Klein, *For All These*

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- 16 Klein, *For All These Rights*, pp. 3–6.
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