Chapter II

Introduction: In the previous chapter we learned that what we are accustomed to thinking of as our health care in fact depends on something called a health care infrastructure. The infrastructure is all the medical services in Vermont and their professional staffs. It is the same in other nations, except they have organized their infrastructure into a system that assumes full responsibility to finance the health care services, maintain quality, moderate cost increases and make health care available to all citizens. On average their quality is better, their costs are much less, and their citizens are highly supportive of the systems. From this we conclude they are doing something right and we are not.

1. What can we do?

We might want to consider a health care system for Vermont. Where systems exist – in all other industrialized nations around the world – they see to it that needed health care is available to all citizens and paid for. They serve three primary constituencies—(a) patients, (b) taxpaying citizens, and (c) doctors/medical providers. They adhere to basic principles:

a. Universal coverage: Everyone is included in the health care system, because inclusion, literally, is a matter of life and death.
b. Public financing: The health care infrastructure is largely publicly financed. This is the most efficient and reliable way to guarantee adequate financing for the health care infrastructure. Private insurers cannot be counted on for a simple reason: their way to make a profit – which they are entitled to – is to sell policies to the healthy, not the sick or probable sick. Public financing mechanisms respond to needs of the population, not profit motives. Their challenge is to guarantee there will be enough money to fund the health care infrastructure.
c. Global budgeting: Other advanced industrial countries talk about health care in the context of a global budget that is financed by and accountable to the entire population. By contrast we have separate operating budgets for medical institutions, like hospitals and nursing homes, and public oversight of certain aspects of those budgets. But we do not have a global budget that lays out for all to see how much is needed to pay the fixed costs of the health care system or that explains how the bottom line is arrived at. With a global health budget, people are assured that the fixed costs of the health system are paid for. If they aren't, citizens experience shortages that compromise the quality of care.
d. Public accountability: This is simple: institutions that serve the public must be accountable to the public. Public accountability means each individual has a stake in the health care system and in the process that funds it. If everyone is in the game, so to speak, on an equal footing—rich and poor, employed and unemployed, healthy and sick—every citizen has an incentive to make sure nothing is done by those elected or appointed to serve them that compromises his or her medical care. Public accountability, therefore, is also the best way to protect society from medical under-funding or excessive spending.
e. Public stewardship: Health care systems financed mainly with public tax dollars are managed by individuals in the public sector with (or with easy access to) expertise in health care, administration and financing, public health, community- and family-based systems of care, and medical technology. Stewardship can be by a public agency, a quasi-public agency or even a private agency as long as the management adheres to the rules and regulations of the system.

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2. Who would oversee this system?

An agency operating under legislated rules and regulations would do health planning, negotiate prices with providers, and pay for health care. This agency could coordinate and contract with private sources, including perhaps hiring an insurance company to process claims, as is done now for Medicare.

Your choice of doctor, however, in this system would still be your own, and decisions about your care would remain between you and you doctor. The public agency would finance the care, but the care itself would remain private.

The concept of government overseeing health care makes people very nervous. You hear things like, "You wouldn't want them to run health care like they do the post office, would you?" Well, let's think about it first. The post office, like any public service, is not perfect, and it changes over time. It is easy to complain about it. But consider this. Supported by tax dollars and other revenues, it delivers mail to a country of nearly 300 million people without violating their privacy, and it is fundamental to the operation of America's economy. It also oversees international operations.

Whatever our gripes, the postal service delivers letters, packages and goods as promised most days and at a reasonable rate. It must be organized as a public trust, because we can't do on our own what it does for us. Sure, some can afford to hire UPS or FedEx on a regular basis, but most of us don't have the money to rely on private mail sources regularly. We don't like it when stamps go up in price, but we like knowing that our mail is coming consistently on the same days and that the mailbox at the end of the street is going to be emptied and its contents delivered to the addresses on them no matter the weather. We put our faith in the postal infrastructure, for better or worse, and that faith is generally rewarded.

Another example of government working for the common good is its support for police and fire departments. Both public services are paid for through our taxes, and while we would prefer not to use them, we want them available should we need them.

There is a critical distinction, though, between how services are delivered in health care and how they are provided by the postal service, local and state police, and fire departments.

Unlike the latter three, we don't actually need the government to deliver health care, just to pay for it adequately and fairly.

Commitment to efficiency and technological innovation, well-trained staff, cost transparency, privacy protections, local service delivery systems with connections to national and international delivery operations, public oversight, accessibility and accountability—these are the guiding principles of the postal service, and our police, fire and public works departments. And our armed forces. And our civil defense. And our state and federal bureaucracies. Life as we know if would not be possible without the services of government.

So why isn't health care on the list of services and civic protections financed through public tax dollars and managed as a public trust? Especially given that we already depend on government to foot 60% of the national medical bill. Remember, universal health care systems exist in many other countries, and their medical outcomes are no worse and, in some cases, better than ours. There is a positive and constructive role for government to play to ensure that all Americans have access to good health care. A universal health care system, at the national or state level, would be responsible for the following:

1. Protecting our choice of doctors and our medical privacy.
2. Managing and allocating public revenues to finance the health care infrastructure.
3. Administering or overseeing the administration of claims.

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4. Setting and managing a global health care budget.
5. Negotiating reimbursement rates with providers.
6. Educating citizens about their rights and responsibilities under such a system.
7. Regulating the licensing and oversight of medical providers.
8. Helping to collect, analyze and disseminate data on health care outcomes and best practices.
9. Launching public health initiatives and wellness programs.

3. How do we ensure public accountability over such a system?

Public accountability is achieved in two ways: (1) fair representation of all involved parties—in particular, taxpayers, patients and providers—at the local, state and national level in the operation and oversight of the health care system; (2) the people we entrust with the management and oversight of our health care system should be subjected to the same health benefits and responsibilities as everyone else. If each individual has a stake in the system, if it "belongs" to all of us equally, with no special favors for some groups and not others, we will have every incentive to make sure it is well financed and effectively managed.

4. How do we keep taxes from soaring if we make access to health care universal and continuous for every citizen?

The notion that taxes will soar if we enact a universal health care system is often used to scare people and derail reform efforts. If we look at every other advanced industrial nation, all have universal health care systems, which are largely financed by taxes. **All these countries pay lower per capita taxes than we do toward health care.** The main reason for this is that they manage to control overall health costs through global budgeting and other measures, without compromising the quality of care.

Universal access to health care does not mean automatically that our taxes will skyrocket. Not if we distribute the costs of the health care infrastructure equitably across society, implement progressive tax law measures to protect small businesses and those of less means, and carefully tailor the amount of medical services we can afford to meet the needs of the population. Further, if we invest in public health and wellness programs in a serious and extensive way, and take strong measures to protect the population from unnecessary health and environmental risks, we will save costs to our health care system in the long run.

5. Won't there be rationing?

There is rationing now, and there always has been rationing. It appears under different names and in some cases other guises. Rationing is a necessary acknowledgment that our resources are finite, and not only in medicine of course. Everyone from individuals to families to towns to cities, states, the federal government and businesses of all sizes up to the largest corporations must learn to distribute their resources sensibly if they do not wish to perish financially or otherwise.

Allocation of resources is perhaps a better term. Rationing implies desperation, a last-ditch solution to extreme circumstances. Allocation of resources is a rational choice, not out of desperation, but as a planning or budgeting tool, a sensible acknowledgement that there must be a limit to what can be expected.

Rationing as it now exists in the health care infrastructure has its genesis in the individual's ability to pay, or not, directly for care or for health insurance. Vermont is in better shape than most states in this regard. Even those of us who cannot afford it receive care, but possibly not all the

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care we need or all we need in a timely way. Little comfort is to be taken from our comparative status, however, because there are signs that it is eroding. Charity care may be waning.

The distribution of needs for health care in a population like Vermont's follows approximate patterns. The trick is to distribute the health care services to conform as nearly as possible to the distribution of these needs. Because these needs, or patterns of disease, originate in the whole population, Vermonters as a whole must ask themselves two questions. How much health care do we want? And how much are we willing to pay for?

Now the first covers a myriad of options such as, Do we want just enough to treat basics needs, or far more to treat all the latest high-tech procedures, or even more than that to treat basically unnecessary but maybe desirable procedures? The point to remember is that no matter what the choice is, it is connected to the size of the health care infrastructure. It bears little relationship to whether one individual or another has the wealth or the high-grade insurance to pay for treatment. The health care infrastructure basically reflects what the whole population appears to need and, moreover, wants.

This brings us to the nub of allocation of resources, or if you wish, rationing. We recognize that what we need and want must be paid for some how, some way. It is simply unrealistic to think that medical procedures emerge like the Good Genie because all of a sudden we need them. Someone had to be paying for them all along. That someone is all of us, whether it is cash out of our pockets, cash to insurance companies, or cash to taxing entities like the state and municipalities, or cash diverted from hospitals or physicians' practices for charity care. As to the second crucial question - How much are we willing to pay for? - this is now to be understood not as, How much can I or my insurance afford, but How much are we prepared to invest in the health care infrastructure, in the health care services we all share?

A question like that, of course, is a societal question. The population as a whole, our society, must decide however roughly how much it is prepared to invest. If we invest too little, a curtailment of resources will follow. In other words, rationing. If we, on the other hand, invest too much, we will have unneeded health care services, and costs will go higher. It is a difficult balance. It should be obvious that it is a balance that cannot be achieved on an individual, laissez-faire basis. The best approach, as it is with all other decisions affecting society as a whole, is at the population level, in other words, at the societal level. Which means at a representative level taking into account all Vermonters, which in turn means a system of some kind overseeing health care.

Allocation decisions then become part of health care policy, not last resorts of fiscal panic. Decisions then affect all citizens on an equal basis, not on the basis of wealth only.

To a lesser or greater extent, these crucial decisions will always be with us. They will arise as a concern, no matter what kind of medical system we have, because we must always match available resources and expertise to the ever-changing needs and expectations of society and to advancements in medical science. Allocation at the societal level, however, is not only more fair to us all, it helps to ensure the financial viability of our health care services.

6. How would we pay for such a system?

Right now, we have no comprehensive and integrated financing policy for our health care services. Yet, as we discussed above, we end up paying the whole bill anyway. There are a number of different systems internationally that provide universal access to health care, and we can learn from them as reform efforts unfold. <u>Fundamentally, however, all share in common a public-financing mechanism.</u> Doesn't this make sense? If health care is a public good, a shared trust of vital services and medical expertise, shouldn't public dollars be used to make sure each of us has access to it?

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How might a **public-financed system** of health care—one that preserved and strengthened private health care—be structured? There are many choices. <u>But all involve some sort of tax or a combination of taxes.</u>

One system that is talked about frequently is called the single-payer model, which sets and collects taxes to pay for universal health care, as determined by a global health care budget, through an accountable governmental body.

This particular model, which was studied for Vermont in a 2001 report from the Lewin Foundation, and which exists in Canada and some Western European societies, not only guarantees universal coverage, but brings the added benefit of streamlining health care administrative functions and reducing their costs dramatically. It does the latter by standardizing medical claims forms and processing them through a central billing system, as is done now with Medicare. (Medicare's administrative costs, by the way, are about 4%.)

Currently, health care providers and hospitals carry the burden of reconciling their billing procedures with, literally, thousands of policies and regulations from private insurance carriers. This has created a very expensive and labor-intensive bureaucracy that is entirely unnecessary and a massive drain on social resources that would be better directed at expanding and improving medical care.

Vermont (or the U.S.) could pay for a single-payer model through a combination of income taxes already used to fund Medicaid and Medicare, a payroll tax on employers and an income on earned and unearned income. This would allow us, we believe, to replace insurance premiums and most out-of-pocket payments for health care, and reduce costs for businesses and workers.

Most large business would benefit handsomely from a public-financed arrangement like single payer, because they are paying upwards of 15% of payroll now for health insurance. Also, for average citizens, property taxes and income taxes that presently pay for health insurance for public employees should decline as new tax-funded sources of revenues are generated specifically to pay for universal health care and the infrastructure that provides it.

There will be more discussion in the future about taxes and health care reform. Whatever we decide, the taxes we rely on to pay for health care in the future, under a single-payer system or some variation, must be fair and progressively calibrated for individuals and businesses, especially for small business owners and folks of lesser means. And it is well to remember that taxes financing a universal health care system are **replacement taxes.** They take the place of most taxes we now pay toward health care and insurance premiums. The issue is not the new tax, whatever it is, but the net effect on the individual and businesses and the economy in general.

7. What about total costs in the future?

Let's be honest. Medical costs will continue to rise into the future, but by how much is the real issue. We are aging, we are developing more expensive technology, and we expect the very best from our health care system. The same is true for our schools, police, fire fighters and for all public services, in fact. Nothing is getting cheaper.

But medical costs cannot continue to rise at a rate 3 to 4 times greater than our gross domestic product, which is what is happening now. Businesses, government programs, retirement systems—all our complaining that they can't maintain current benefits and stay economically competitive unless health care costs stop rising so sharply.

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There is an urgent need for a long-term cost-management model in health care that doesn't compromise care, rewards innovation in care, and extends that care to everyone on an equal basis. This is not impossible to do, if the political will is mustered to do it.

The United States—or Vermont—needs to do what other countries do: evaluate what we need medically based on the best information, set a global health budget, make choices within that budget, and suffer the political consequences if we don't fund that budget sufficiently.

Will the system operate perfectly all the time? No. There will never be enough beds in a severe flu epidemic, just as there aren't enough plows during a massive blizzard. But look at what we are dealing with now. Tens of thousands Vermonters without health insurance, yearly rollbacks in health benefits for active and retired employees, many millions in cost shifts, obscenely high administrative overhead, unsustainable economic costs to business and government, threats to the fiscal solvency of entitlement programs like Medicare, the closing of hospitals and emergency facilities in other states, nursing and primary care physician shortages, lack of funding for public health programs.

We know from the experience of other countries that fiscal and medical accountability mechanisms can protect people from abuse and inadequate care. Governments that provide universal health care access and benefits are generally more accountable and responsive to public pressures for preserving something or changing it. That is because, in part, the influential and powerful in society are strong advocates for adequate health care funding. They, like everyone else, are dependent on its services. When no one stands outside a publicly financed, universal health-care system, everyone has a big stake in making sure the system works well.

It's no accident that the call for health-care reform is heating up now in the United States at a time when the ranks of the uninsured include a growing number of Americans with annual incomes of $75,000 or more and businesses are facing the prospect of laying off workers and cutting back retirement health benefits. Many of us never thought we'd see the day when Vermont's IBM workers would be protesting loudly in public about cutbacks in their pensions and retiree health care benefits. Well, that day has come, and it should worry all of us. Their future is our future, unless we act.

Affordable health care is no longer just a problem for the poor and unemployed or the very sick and socially marginalized. It is a problem for all of us, and so the solution must be one that protects all of us from cradle to grave and depends on our life-long support, financial and political.

Summary:

What we have outlined above corresponds to a universal health care system. Every other advanced nation has one. They adhere to the basic general principles but in details they differ greatly. If you have read this far, you also are in a position to begin to assess and analyze the many different kinds of health care reform proposals.

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