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The Forgotten Domestic Crisis

By MARCIA ANGELL

CAMBRIDGE, Mass. — If it weren't for the steady beat of war drums, health care would be front and center in this fall's political debate. And war or no war, politicians will not be able to avoid it much longer. As John Breaux of Louisiana, long one of the most conservative Senate Democrats, recently told the press, "The system is collapsing around us."

That is not hyperbole. Private health insurance premiums are rising at an unsustainable average of about 13 percent per year — and as much as 25 percent in some areas of the country. Coverage is shrinking, as more employers decide to cap their contributions to health insurance plans and workers find they cannot pay their rapidly expanding share. And with the rise in unemployment, more people are losing what limited coverage they had. Last month, the Census Bureau reported that nearly 1.5 million Americans lost their insurance in 2001.

The fatal flaw in the system is that we treat health care as a commodity. That has been the case for a long time, but the effects were masked during the economic boom of the 1990's. Now, with the recession, the irrationality of that approach is exposed.

When health care becomes a commodity, the criterion for receiving it is ability to pay, not medical need. Private insurers and providers compete with one another to avoid getting stuck with high-cost patients, so they can keep more of their revenues. But this game of hot potato takes a lot of oversight and paperwork. In fact, the hallmark of the system is the extent to which health funds are diverted to overhead and profits.

Look at what happens to the health-care dollar as it wends its way from employers to the doctors and hospitals that provide medical services. Private insurers regularly skim off the top 10 percent to 25 percent of premiums for administrative costs, marketing and profits. The remainder is passed along a gantlet of satellite businesses — insurance brokers, disease-management and utilization-review companies, lawyers, consultants, billing agencies, information management firms and so on. Their function is often to limit services in one way or another. They, too, take a cut, including enough for their own administrative costs, marketing and profits. As much as half the health-care dollar never reaches doctors and hospitals — who themselves face high overhead costs in dealing with multiple insurers.

One more absurdity of our market-based system: the pressure is to increase total health-care expenditures, not reduce them. Presumably, as a nation we want to constrain the growth of health costs. But that's simply not what health-care businesses do. Like all businesses, they want more, not fewer, customers — but only if they can pay.

All piecemeal attempts to improve the system — while keeping it market-based — have run into the following dilemma: if access to services is expanded, costs rise; if costs are lowered, access is cut. That's the way it is. The only way to avoid this dilemma is to change the system entirely.

What we need is a national single-payer system that would eliminate unnecessary administrative costs, duplication and profits. In many ways, this would be tantamount to extending Medicare to the entire population. Medicare is, after all, a government-financed single-payer system embedded within our private, market-based system. It's by far the most efficient part of our health-care system, with overhead costs of less than 3 percent, and it covers virtually everyone over the age of 65. Medicare is not perfect, but it's the most popular part of the American health-care system.

Many people believe a single-payer system is a good idea, but that we can't afford it. The truth is that we can no longer afford not to have such a system. We now spend more than $5,000 a year on health care for each American — more than twice the average of other advanced countries. But nearly half that amount is wasted. We now pay for health care in multiple ways — through our paychecks, the prices of goods and services, taxes at all levels of government, and out-of-pocket fees. It makes more sense to pay only once, perhaps through a new tax on income earmarked for health care (in the same way Medicare is financed through payroll taxes).

It is sometimes argued that innovative technologies would be scarce in a national single-payer system, so we would have long waiting lists. This misconception is based on the fact that there are indeed waits for elective procedures in some countries with national health systems like Great Britain and Canada. But that's because they spend far less on health care than we do. If they were to put the same amount of money as we do into their systems, there would be no waits. For them, the problem is not the system; it's the money. For us, it's not the money; it's the system. We already spend enough for an excellent universal system.

A single-payer system is not socialized medicine. Although a new national program — like Medicare — would be publicly financed, the doctors and hospitals would not work for the government, but would remain private. Some fear onerous government regulations from a national payment system, but surely nothing could be more onerous for patients and providers than the multiple, intrusive regulations imposed on them by the private insurance industry today.

We live in a country that tolerates enormous disparities in income, material possessions and social privilege. That may be inevitable in a free-market economy. But those disparities should not extend to essential services like education, clean water and air and protection from crime, all of which we already acknowledge are public responsibilities. The same should be true for medical care — particularly since we can well afford to provide it for everyone if we end the waste and profiteering of our market-based system.

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