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**A History of Modern American Health Care Policy**

Issues of National Health Insurance up to 2008

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**2010**

# **1. The aims and relevance of the dissertation**

Health care reform is again a very relevant issue, especially since the 2007-2008 presidential campaign. Senator Barack Obama campaigned on promising to enact universal health care for all Americans by the end of his first term in office. Indeed, the Democrats' victory in November 2008 has widely been interpreted as a 'mandate for change', including a mandate for health care reform. The window of opportunity to meaningfully address the American health care crisis has reopened for the first time in 14 years. Democrats have been given a majority in both Houses of Congress, as well as a Democrat in charge of the executive branch. Those who are familiar with 20<sup>th</sup> century American history and health care policy, however, know that even such a favorable constellation for health reform is not enough to successfully overcome the many legislative hurdles that it takes to enact universal health care in the USA.

This dissertation investigates the causes underlying the failure of health reform proposals throughout the 20<sup>th</sup> century in the United States, together with analyzing the nature and some of the possible solutions for the present health care crisis in America.

Health care is the largest industry in the United States with total medical expenditure reaching the psychologically critical figure of \$2.5 trillion in 2009.<sup>1</sup> America has the most expensive health care system in the world, spending more on health care as a proportion of its GDP (up from 16.2% in 2008 to 17.3% in 2009),<sup>2</sup> as well as per capita (\$8,047 per person)<sup>3</sup> than any other country. In fact, medical spending has been growing considerably faster than the economy for decades, which essentially means that health care consumes more and more of the economy, leaving less money available for other areas of national spending.<sup>4</sup>

During the 2008 presidential campaign, the most widely used figure when referring to those without any health insurance in America was 47 million. That is one out of every 6 persons living in the USA today.<sup>5</sup> According to a recent study released by Lewin and Associates, however, "as many as 90 million people under the age of 65 years lacked health insurance for at least 1 month or more during 2006–2007".<sup>6</sup> "Since the

recession began in 2007, more than 7.2 million jobs have been lost in the US.<sup>7</sup> (In 2009 alone, the economy lost 4.2 million jobs.)”<sup>8</sup> If we add to the 47 million those who have lost their jobs and with it their and their family members’ medical coverage,<sup>9</sup> then the total number of the uninsured is well above 60 million.

In addition to the millions of uninsured, there are those who in their hour of biggest need discover that, even though they have health insurance, they are still severely ‘under-insured.’ The first such in-depth study carried out in the US was done by Harvard Law School in conjunction with Harvard Medical School in 2005 and it claims that every year there are over 700,000 people (or well over 2 million, if we include their children and spouses) who go bankrupt in the US because they cannot pay their medical bills.<sup>10</sup> What is astonishing for Europeans is that more than 75% of these people do have health insurance coverage at the start of their illness, but are shocked to find that their policy does not cover their specific treatment or medication for one reason or another.<sup>11</sup> For nearly all of these families it is only a matter of weeks before their utilities are turned off, and eventually most have to sell their homes to be able to pay their hospital bills, or simply to buy their cancer medications - which tend to cost two to three times more than the same products in Canada or in European countries.

Why and how do other market economies manage to cover everybody in their respective country and pay only half as much per capita for health care as people in the States? What explains the fact that practically nobody goes bankrupt because of medical bills in Germany, Canada, the UK, Japan, or France? How is it that the same MRI exam that costs \$1200 in the States costs a mere \$98 in Japan,<sup>12</sup> or the sicker the people are, the less money they have to pay in France (that is until somebody is diagnosed with cancer or a chronic condition, at which point the *Sécurité Sociale* will take over and cover everything)? Then, there is the United Kingdom where there are no bills at any point for any patient. Hospitals are non-profit, government owned, doctors are employed by the National Health Service, and yet the British hospitals compete for the patients. What is more, the Brits have even better statistics with regards to all the major measures of health outcomes.<sup>13</sup>

Perhaps we can posit that "comprehensive health insurance is an idea whose time has come in America. There has long been a need to assure every American financial access to high quality health care. As medical costs go up, that need grows more pressing." This quote could very well be from the campaign trail of Senator Barack Obama, the Democratic Party's candidate for president for the 2008 general election, but it is not. Instead, the previous lines belong to a former Republican President, Richard M. Nixon, who said these words in his special message to Congress arguing for his "Comprehensive Health Insurance Plan," on February 6, 1974. Sadly, neither the 1974 plan, nor those preceding or following it, which called for universal health insurance for all Americans, came to fruition.

Pinpointing and analyzing the historical and political reasons behind the failure of health reform proposals in the past can serve as a starting point for current policymakers and for all those who shape public opinion. Diagnosing the ills of the present market-oriented health care system, in turn, will assist all those who want to have a better understanding and a more critical view of the various options 'on the table' before the United States at this point in life.

## **2) Sources and Methods**

For several years I have been following the daily US news with the help of the Washington Post and the New York Times, both of which I receive in my email-box every day. I have also registered to several mailing lists focused on US health policy from both ends of the political spectrum, among them the Health Care Policy and Marketplace Review, Council for Affordable Health Insurance, FactCheck.org, KevinMD.com, the Cato Institute's News, Michael Moore's circulars on health policy, and the McKinsey Quarterly.

Concerning the primers on US health policy, I have relied chiefly on the following books throughout my research for Part II, on *America's Health Care Policy in the 20<sup>th</sup> Century*; and for some of Part III, on the *Factors Blamed for Skyrocketing Health Care Costs*:

- Cohn, Jonathan. *Sick, The Untold Story of America's Health Care Crisis – And the People Who Pay the Price*. Harper Collins, New York, 2007
- Corning, Peter A. *The Evolution of Medicare...from idea to law*. 1969
- Hacker, Jacob. *The Road to Nowhere*. Princeton University, 1999
- Kooijman, Jaap. *And the Pursuit of National Health. The Incremental Strategy Toward National Health Insurance in the United States of America*. Rodopi, Atlanta, 1999
- Marmor, Theodore R. *The Politics of Medicare*. New York, 2000
- Mayes, Rick. *Universal Coverage: The Elusive Quest for National Health Insurance*. University of Michigan, 2004
- Moon, Marilyn. *Medicare: A Policy Primer*. Urban Institute Press, 2006
- Oberlander, Jonathan. *Medicare and the Modern State: The Politics of Federal Health Insurance, 1965-1995*. Yale University. 1995
- Patel, Kant and Rushefsky, Mark E. *Health Care Politics and Policy in America*. M.E. Sharpe, 2006
- Quadagno, Jill. *One Nation, Uninsured*. Oxford University Press, 2005
- Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 1982
- Starr Sered, Susan and Fernandopulle, Rushika. *Uninsured in America*. University of California Press, 2007
- Stevens, Rosemary et al. *History and Health Policy in the United States*. Rutgers State University, 2006

I have used the Internet to access invaluable primary sources to support my arguments throughout the dissertation, such as the databases of the US Census Bureau, opinion polls, Congressional records of committee hearings, speeches of the presidents, acts passed by Congress, bills that were introduced but never made it to the desk of the President,

interviews with people who played an important role in defining American, Canadian, British or German health care reform, as well as original news footage from throughout the 20<sup>th</sup> century and into the 21<sup>st</sup> century. A number of the chief findings in Part III, *Diagnosis of the Present American Health Care Crisis*, have been illustrated through graphs and tables (some used as retrieved from archives, while others have had to be updated, extended and/or graphically enhanced).

There are a number of documentaries closely related to the topic of my research which have been of particular interest and inspiration, such as Maggie Mahar's *Money Driven Medicine* (2009); T.R. Reid's *Sick Around the World* (2008), PBS' *Health Care Update* (2009), Michael Moore's *Sicko* (2007), as well as Frontline's *Sick Around America* (2009).

Throughout 2007 and 2008, I followed the campaign trail of Senators Barack Obama, Hillary Clinton, John Edwards, John McCain, Representative Dennis Kucinich, as well as of Former Governors Mike Huckabee and Mitt Romney, with special attention to their health care proposals.

### **3) Results**

#### **The Basic Health-Care Systems of the World**

Part One of the dissertation provides a short historical overview and an introduction to the four basic health care systems in the world. Each of the four systems is represented by the country where the particular health care model was first implemented. The Bismarck model is introduced through the German system, the Beveridge model through the English National Health Service, the national health insurance model through the Canadian Medicare system, whereas the market driven health care model is represented by the American health system.<sup>14</sup>

There are numerous characteristics of the US market-driven health care model which set it completely apart from the three other models. The primary difference is that in the United States access to comprehensive health care is not a basic human right.<sup>15</sup> Risk spreading in America is

unlike that in any other industrialized nation.<sup>16</sup> Instead of pooling everyone, rich and poor, young and old, sick and healthy into a single pool, or to several large pools, the American system allows private profit-driven insurance companies to select those who are healthy enough to hold a job, and tends to leave the rest of the population to the government to cover (if it can). Thus, the elderly, the disabled, the children of the working poor and certain populations of the very poor receive government assistance, while working adults pay into the private commercial plans. ‘Privatize profit, nationalize loss’ - could be a fitting motto for the American ‘market-driven’ model. “Although America leads the world in spending on health care, it is the only wealthy, industrialized nation that does not ensure that all her citizens have coverage.”<sup>17</sup>

Though the US already spends what a high-quality universal health care system would cost,<sup>18</sup> in fact almost twice as much, they are still far from covering everybody for even basic health care services. The United States does not have a single organized health care system, instead there is a non-system patchwork pieced together from public (non-profit, tax-funded) providers (covering 27% of those insured) and private, for-profit providers (covering 68% of those insured),<sup>19</sup> where care is rationed according to ability to pay.<sup>20</sup>

The basic purpose of health insurance would be to reduce the financial barriers to needed care and to do it in a way that will protect prospective and already suffering patients against financial hardship. The current health care system in America, however, is not designed to meet the health needs of the American population, instead it is primarily geared to insure and increase the profit of the private medical insurance companies, drug companies and that of organized medicine.<sup>21</sup> Until fairly recently, the American middle class was secure and satisfied with their employer-sponsored health insurance and, as a consequence, did not support any reform initiative that would destabilize the status quo. Their situation, however, has changed considerably for the worse since the Clinton years when PPOs and HMOs replaced traditional indemnity health insurance, and with it the people’s freedom of choice of health care providers, specialists, hospitals and even of prescription medications. As a result of the 2008 and 2009 job losses, and the associated loss of health

insurance of millions of middle-class (acceptable, deserving) Americans, people are increasingly becoming open to the idea of a government public option.

Chapter 2 of Part One, titled *Ideological Issues at Play in Health Care Policy*, explains why Republicans and Democrats are divided over the issue whether the provision of comprehensive health care is a public or private responsibility. Democrats commonly hold the view that the government is a suited institution for protecting and providing for the basic health care rights of individuals. They believe that there are certain human needs which even the freest market will not provide in a dependable and safe manner to every member of our society, therefore the government needs to step in and assume that role (to one degree or another). Conversely, if we hold the view, as do many conservatives in America<sup>22</sup>, that health care is merely another market commodity, instead of a basic human need, then two deductions logically follow. One, that it should not be recognized as a fundamental human right. Two, that the roles of the government in health care should be limited to ensuring individual liberties and protecting the freedom of the market. Conservatives generally agree that the most efficient way to answer nearly all societal needs is through a free market. Anything that the free market will not provide for can and should be met through a safety net, provided by public assistance and voluntary charity programs on a means tested basis.<sup>23</sup>

Even though American culture emphasizes the rights of the individual over the interest of the community, there are still some powerful values embraced by the majority of Americans, the emphasis of which could help affect the necessary change regarding the basic ideology underpinning the current American health care system – namely that universal access to comprehensive health care is *not* among basic human necessities like food and shelter. These values are justice and efficiency. While the first of these two might be too elusive and abstract for many, the latter one is certainly concrete and pragmatic. In fact, it seems that “budgets may reflect American values and priorities more than shouted political discourse. We don’t, after all, have a Congressional Justice and Fairness Office “scoring” health legislation. We have a Congressional



Budget Office.”<sup>24</sup> Denying access to basic and affordable health care goes against cold and rational considerations of cost-effectiveness. People who put off seeking timely treatment for their health problems most of the time end up in emergency care where their treatment costs far more to the American system (ultimately to the taxpayer) than it would have at an earlier stage of the condition. Most people agree that it would make a lot of financial sense to give every person the right and access to timely comprehensive health care in the first place, rather than continue Ronald Reagan’s highly expensive, demeaning and irrational approach to securing the medical safety net for everyone in the form of guaranteeing emergency intensive care.

## **Health Care Policy in America in the 20<sup>th</sup> Century**

There are a number of factors why the US took a different course than Germany, which was the first country to introduce compulsory health coverage in the 19<sup>th</sup> century; or, in fact, each of the industrialized democratic nations throughout the 20<sup>th</sup> century, including Switzerland (1994), Taiwan (1995) and Israel (1995), the three newcomers in the ‘world of universal healthcare’. These factors are discussed in detail in part two of the dissertation, titled *Health Care Policy in America in the 20<sup>th</sup> Century*. In Part Two, it is argued that disunity (either owing to a lack of respect for the person of the president, or to a series of personal scandals diverting national attention from the health care reform agenda within the ranks of the Democratic Party) was largely responsible for the inability of various Presidents and Congress to successfully introduce national health insurance in the US. The second argument in Part Two is that fiscal conservatives (most Republicans and Blue Dog Democrats) will call any health care reform that Democrats propose "socialized medicine". Indeed, threatening Americans with socialized medicine and the lack of party discipline has been very effective at derailing meaningful reform at least 6 times throughout the 20<sup>th</sup> century. These instances were:

1. In 1935, President **Franklin D. Roosevelt** decided to remove provisions for health insurance from the Social Security bill. FDR had been lobbied by the American Medical Association (AMA), and was heavily influenced by the fears of his personal physician, as well as of his wife from a possible enactment of national health insurance. They believed that “national health insurance would undermine the quality of American medical care”.<sup>25</sup> (Mrs. Roosevelt later changed her position and became an activist for the cause of universal medical care under President Truman’s administration).

Efforts to amend the Social Security Act by introducing compulsory health insurance failed in 1939 and again in 1943 (Wagner-Murray-Dingell Bill). In fact, time after time Roosevelt had decided to withhold his support and influence from the various health care reform initiatives during his 12 years in office. He had regularly paid lip service to the importance and urgency of providing government health insurance cradle to grave to Americans, but would never venture into the political arena to back his words up with action. In 1944, President Roosevelt called on Congress to draw up a plan to give every American citizen health care. FDR also advocated an ‘Economic Bill of Rights’ for the American people, including "the right to adequate medical care and the opportunity to achieve and enjoy good health" and "the right to adequate protection from the economic fears of old age, sickness, accident, and unemployment." In January 1945, he called for an "extended social security, including medical care."

The lessons were obvious. Health care activists would either have to secure the full support of the president (which they obviously could not), or find a new strategy. If the Wagner-Murray-Dingell Bill was too comprehensive to pass in one piece, then it had to be scaled back and broken up into pieces and introduced incrementally, custom tailored to fit the new political realities, and coupled with the right amount of lobbying from civil organizations.

2. President **Harry Truman** called for the establishment of a federal, single-payer, compulsory health insurance under Social Security (Wagner-Murray-Dingell Bill of 1946), and quite unlike his predecessor, Truman

gave the bill his full support. The bill, however, fell prey a) to the Southern Democrats in Congress, who were unhappy with Truman's anti-segregationist proposals, b) to the antagonism of labor unions that put pressure on their Democrat Congressmen to withhold support from Truman's health care reform, and c) to the anti-Communist rhetoric of an influential Republican senator (Senator Taft from Ohio).

In 1949, Truman's second health bill (part of his Fair Deal program) died in committee owing to a) the second red scare, b) the antagonism of the Southern Democrats, and c) to the enormous lobbying work of the AMA.

3. In 1961, President **John F. Kennedy**'s New Frontier program promised hospital insurance and nursing home care for America's senior citizens (Medicare). The AMA launched a massive campaign against Medicare, called "Operation Coffee Cup" featuring Ronald Reagan's 11-minute LP recording. (Reagan warned Americans that their freedom was at stake.) The Ways and Means Committee voted against reporting the bill to the House for a vote. (The decisive vote was actually cast by the Southern Democrat chairman of the committee, Wilbur Mills.)

4. Following the landslide electoral victory of **Lyndon B. Johnson** and the Democratic Party in 1964, Medicare and Medicaid successfully passed all the legislative hurdles, and were signed into law in 1965 as parts of Johnson's Great Society program.

Medicare started operations on July 1, 1966. Nineteen million elderly Americans and disabled qualified automatically for hospital benefits (Part A), while eighteen million signed up for the voluntary physician services (Part B) by the deadline (March 1966).

5. In 1974, in order to pre-empt an imminent single-payer national health insurance act, the **Nixon** administration came forward with a health insurance plan,<sup>26</sup> called the Comprehensive Health Insurance Act. It would essentially have provided universal coverage to all Americans. The two absolute breakthroughs in the bill were that employers would have been under a *mandate* to provide their workers with health insurance,<sup>27</sup> as

well as it would have established a *federal health plan* (today referred to as a public option) open to any American, with premiums determined on a sliding scale based on income. Two high profile scandals in 1974 (the Watergate Affair, and Mills' sex scandal), however, foiled effective health care reform, and thus robbed Americans of their rare chance to have universal healthcare finally enacted in their nation.

6. In 1993, President **Bill Clinton** introduced his health care reform plan, named Health Security (the namesake of Jimmy Carter's plan from 1976). The core concept of the Clinton plan was providing universal health care through "guaranteeing private insurance for every American".<sup>28</sup> The bill explicitly stated that health care was (to become) a fundamental right of Americans. Universal coverage was to be achieved through enacting an individual mandate to carry health insurance, an employer mandate requiring employers to provide health insurance, prohibitions against dropping consumers from coverage or denying coverage based on pre-existing conditions, as well as guaranteeing affordable coverage (community rating) and financial subsidies to the needy.

Cost control was envisioned to take place through the implementation of reforms in three strategic areas: 1) by changing the dominant health care delivery system (from the long-established fee-for-service model to a managed care model with in-network doctors and hospitals), 2) by reducing the administrative overhead, (create standard rules and administrative forms for the reimbursement of hospitals, clinics, labs, doctors, etc. through the 1,200 insurance companies, almost all of which have widely different administrative forms and sets of rules) and 3) by capping the inflation of premiums, and 4) by creating large risk pools and guaranteeing community rating (with everybody "in", costs could be spread).

On account of numerous domestic scandals and foreign crises in Somalia, Haiti and Russia, health care reform was time and again 'placed on the backburner'. Attacks on Clinton's character and honesty had started to eat away at his authority, and Republicans in Congress, sensing the importance of killing the bill if they wanted to win in the upcoming mid-term elections, had become resolute to obstruct any measure.<sup>29</sup> The Health

Security Act (proposal) never received enough support for a floor vote in either the House or the Senate, despite the fact that both chambers had a Democratic majority. Thus the proposal was abandoned in September 1994.<sup>30</sup> A month and a half later, at the 1994 mid-term elections voters duly punished Democrats, as Republicans took control of both the House and the Senate.

## **Diagnosis of the Present American Health Care Crisis**

The third part of the dissertation provides a diagnosis of the present American health system through addressing the two most widely discussed issues that contribute to the current health care crisis: 1) the case of the 45-60 million, or so, uninsured Americans, and 2) the five factors which are blamed for skyrocketing health care costs, hampering American businesses, overburdening family budgets, and contributing to the spiraling national deficit.

While the number 47 million has been one of the most dominant features of discussions, debates, and political speeches on health care reform during the 2008 general elections, it has almost always been used as if the figure stood for a homogeneous group of people, all of whom were helpless Americans with no access to any health care services whatsoever due to either their dire financial situation or because they had a chronic condition which rendered them basically uninsurable. The reality, however, is much more nuanced than that. In fact, before America can begin to pragmatically address the issue of the uninsured, they first need to have more substantive information about who these people are, for what reason(s) they are uninsured, and just how much medical care is available to them already.

In fact, a study by Keith Hennessey (2009)<sup>31</sup> breaks this group into 6 categories, as shown on Figure 1. The first subpopulation, 6.4 million people are the so-called *Medicare Undercount* group, who are actually covered by a public plan, but forgot to tell the Census taker and therefore should not be included in the statistics on uninsured Americans (45.7 or 47 million) in the first place. Even though the Medicare Undercount has

been published by several renowned researchers and health policy analysts and even the Census Bureau has admitted to the inaccuracy, the mainstream media seems to ignore this flaw and thus becomes an accomplice of the politicians in spreading misinformation by citing bigger numbers as if those were accurate and truthful.

The second group with 4.3 million people is comprised of people who are eligible for existing government health care coverage (like Medicaid for the poor, or Medicare for the disabled or elderly, or SCHIP for children), but choose not to enroll for some reason.<sup>32</sup> A study carried out by the Health Policy Institute of Georgetown University (2008)<sup>33</sup> confirmed that 70% of uninsured children are qualified for Medicaid or SCHIP coverage. Their parents would only need to do the paperwork. Should anyone from this group need to be hospitalized, the hospital staff would actually do the paperwork for them, and that way most of their expenses would be covered by either the state or the federal government.

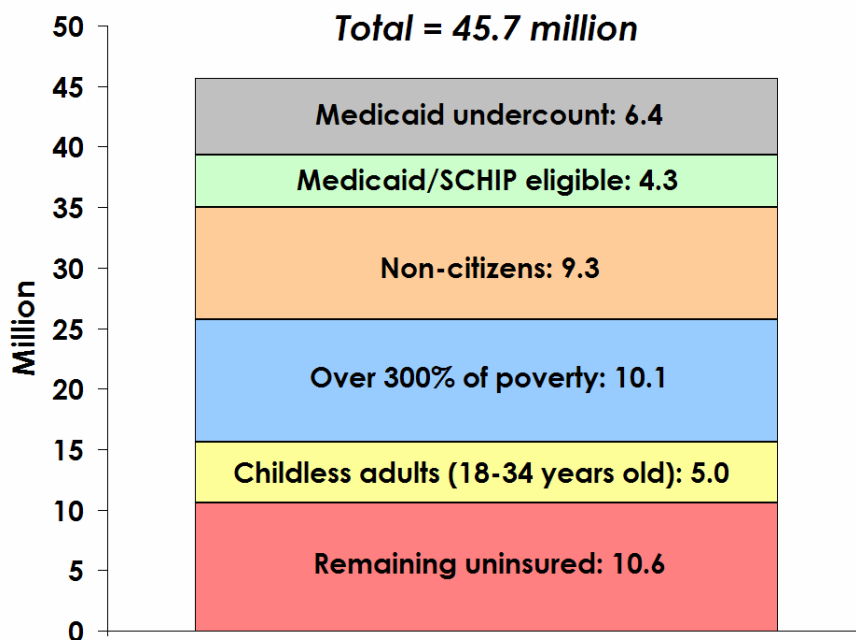
The third category represents 9.7 million immigrants out of the estimated 12 million present in the country.<sup>34</sup> They account for over 20% of the “commonly accepted figure of the uninsured in America”. Recent immigrants (2000-2006) made up over 90% of the expansion in the number of uninsured people living in the USA between 1998 and 2003.<sup>35</sup> Many Americans feel adamant about ending the subsidization of the healthcare costs of the uninsured illegal immigrants, be it in the form of Emergency Room care, Medicaid, SCHIP or charity hospitals. These costs amount to an additional “hidden tax burden” of \$1,100 per every medically insured person in the US.<sup>36</sup> From their point of view, anger and frustration is understandable when the President’s Council of Economic Advisers (CEA) continually claims in the news media that “Perhaps the most visible sign of the need for health care reform is the 46 million Americans currently without health insurance, and CEA projections suggest that this number will rise to about 72 million in 2040 in the absence of reform.”<sup>37</sup>

The fourth category consists of those 10 million uninsured Americans who live in a household earning around or over 300% of the poverty level. They are surely not the people who can count on public support for getting

insurance through the government. Yet many of them are too sick to be able to find an affordable policy, even if they do make a lot of money.

The fifth group is comprised of the 5 million uninsured young adults between 18 and 34 about whom a nation-wide survey on consumer expenditure has found that they “spend more than four times as much on alcohol, tobacco, entertainment and dining out as they do for out-of-pocket spending on health care”.<sup>38</sup> Judging alone by the implications of this survey, one would not expect support for universal healthcare out of sympathy for these “reckless invincibles” from the tax-payer middle-class.

The sixth category corresponds to those who are deemed<sup>39</sup> truly uninsured: some 11 million *Americans*.



**Figure 1.** Key subpopulations of uninsured (2007)<sup>40</sup>

Increasingly more Americans believe that illegal immigrants should not be counted among the uninsured Americans, similarly to those US citizens who live in households with a net 300% above the poverty line, or to the 5 million young people (ages 18 to 34) many of whom could afford health coverage but choose not to, or the 11 million people who are already insured or eligible for heavily subsidized or free government health care.

Once people add these four numbers they might arrive at the same conclusion that millions of the opponents of Obamacare have arrived at: in reality there are only some 10.6 million uninsured Americans (2007) who

are truly in need of government assistance because they cannot afford medical insurance.

The five factors analyzed in Part III, Chapter 2, which help explain why healthcare is significantly (and mostly unnecessarily) more expensive in the United States than in all other OECD countries, as well as the reason why costs continue to grow faster than the economy are the following:

- A. The multiple–payer system
- B. Chronic care
- C. New medical technology
- D. The physician payment system
- E. Pharmaceutical prices

## **Solutions Offered by the Two Presidential Candidates of 2008**

Part Four of this paper provides a critical analysis of the solutions offered by the two presidential candidates of 2008, Senator Barack Obama and Senator John McCain, to the American health care crisis. Beginning in Part Three and continuing in Part Four as well as in the concluding chapter, it is claimed that truly meaningful reform of the American health care system, based on sound social and economic principles benefiting the overwhelming majority of the people, is a political taboo in America.

The Obama-Biden Plan for a Healthy America (2008) claims that it can tackle both of the two most urgent health care issues in America simultaneously without introducing system-wide reforms that would upset the status-quo. The plan promises to ensure access to affordable medical coverage to every American through a robust public option, also referred to as a Medicare-like national health insurance. At the same time, the Obama-Biden plan pledges (if enacted) to lower prices by “reducing unnecessary and wasteful spending, improving prevention and management of chronic conditions, increasing insurance industry competition, as well as by reining in the abusive practices of monopoly insurance and drug companies”<sup>41</sup>. The plan, however, lacks reform that



would meaningfully address the deep structural defects of the American health care system, which (to repeat) are the following:

1. It is a specialty-dominated, rather than primary care-dominated system, which promotes more expensive care at later stages of medical conditions.
2. The fee-for-service reimbursement system is still dominant in which health care providers are overwhelmingly paid based on volume of care instead of quality of care provided.
3. The public health care programs (Medicare, Medicaid, SCHIP) are already financially unsustainable.

## **Conclusion**

The concluding chapter of this paper is titled '*A New American Success Story*', in which it is argued that America could provide comprehensive, cradle-to-grave coverage to all her citizens with national health insurance, for the same amount they are spending now, and end the cruelty of financially overburdening families when they fall ill.<sup>42</sup> The Veterans Health Administration, an American single payer health system, has become an amazing success story in a matter of less than 5 years. America could greatly benefit from implementing the VA's model on a nationwide basis, if only policy makers in Congress were well informed and were free from the shackles of special interest groups.

Introducing single-payer health care in the US however, remains an unrealistic aim for now; therefore a second best solution has had to be offered. The one put forward by the Obama team in 2007-8 comes close, but is off-target. The 'Obama-Biden Plan for a Healthy America' neither entails a system-wide reform of physician reimbursement, nor the reorientation of health care from a specialty-dominated, rather than primary care focused system.

Meaningful reform of the American health care system, based on sound social and economic principles, benefiting the overwhelming majority of the people, remains a political taboo in America – largely

owing to the so-called “iron triangle”, the politicians, bureaucrats and special interest groups, paid by the stakeholders of the private health care industry, that “perpetuate the status quo”<sup>43</sup>. This iron triangle consistently misrepresents the possible solutions and the immense amount of international experience in support of national health insurance. However, once mainstream, middle-class America understands the ramifications of the elemental flaws imbedded in their market-oriented system, the road will be far easier to a system-wide change. Change, which currently most Americans are taught to vehemently fear, will then be demanded.

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## References

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<sup>4</sup> Claxton, Gary. “Health Spending Consumes More Of U.S. Economy, Will Tip Toward Government”. *Medical News Today*. Feb. 5, 2010. Web. Feb. 10, 2010.

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<sup>5</sup> The Employee Benefit Research Institute, in a report released on October 5, 2007, found that the number of uninsured U.S. residents younger than 65 rose to 46.4 million or 17.9% of that population. More than 25% of self-employed workers are uninsured, while almost 20% of all workers lacked insurance. Self-employed people and workers at private sector firms with fewer than 100 employees made up 63% of the working uninsured. About 33% of the uninsured were in families with annual incomes less than \$20,000, compared with about 7% of people in families with annual incomes of \$75,000 or more. (The Employee Benefit Research Institute. “Uninsured Nonelderly U.S. Residents Up 17.9% in 2006” California Healthline. Oct. 5, 2007. Web. Oct. 23, 2009. <http://www.californiahealthline.org/articles/2007/10/5/Uninsured-Nonelderly-US-Resident-Up-179-in-2006.aspx>.)

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<sup>8</sup> Ibid.

<sup>9</sup> Losing one’s job is a double blow in America, because it also entails losing one’s (or often case the entire family’s) health coverage. According to the latest statistics, published in December 2009, the lack of health insurance causes at least 44,800 unnecessary deaths every year in the United States. (Wilper, Andrew; Woolhandler, Steffie; et al. “Health Insurance and Mortality in US Adults.” *American Journal of Public Health*. Dec. 2009, vol 99, No. 12 Web. Jan. 10, 2010. <http://ajph.aphapublications.org/cgi/content/short/99/12/2289>)

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<sup>12</sup> Reid, T.R. *Sick Around the World*. Frontline, PBS. 2007. Documentary, WEB Dec, 29. 2008. <http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/interviews/reinhardt.html>

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