

Health Policy Placebos

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We don't administer useless nostrums for curable cancer--even when effective treatment is arduous. Yet Hillary Clinton and Barack Obama prescribe the health policy equivalent of placebos. (John McCain suggests arsenic, but more about him another time.)

The Democratic contenders proffer a superficially plausible reform model that has a long record of failure. Their proposals trace back to Nixon's 1971 employer mandate scheme, concocted to woo moderate Republicans away from Ted Kennedy's single-payer plan. Like mandate reforms subsequently passed (and failed) in Massachusetts (1988), Oregon (1989) and Washington (1993), Clinton's and Obama's plans would couple subsidies for the poor with a requirement that large employers foot part of the bill for employee coverage. These earlier reforms also required the self-employed to buy coverage, an individual mandate that Clinton (like the 2006 Massachusetts reform) would expand to virtually all; Obama limits his mandate to children. In both versions, a federal agency would serve as insurance broker, selling a new public plan and a menu of private ones--reprising the format of Medicare's ongoing privatization, implemented through competition rigged to favor private plans [see Trudy Lieberman, "The Medicare Privatization Scam," July 16/23, 2007].

The earlier state reforms foundered on the shoals of cost. As health spending soared, employers rebelled and legislators rescinded the mandates and subsidies. Massachusetts looks set to replay this experience; only 7 percent of those required to buy unsubsidized coverage have yet to sign up, while the state wrestles with massive cost overruns for subsidies.

Proposals that rely on private insurers can add coverage only by adding costs. Both Democrats promise savings from computerization, prevention and chronic disease-care management. Yet medical computing hasn't yielded savings, despite thirty years of rosy promises. As for prevention, a raft of studies show that it saves lives but not money. And the Medicare Health Support program recently abandoned its care management project because it yielded no savings.

Both Democrats' proposals forgo the administrative savings possible under single-payer national health insurance (NHI) such as that proposed by the Conyers/Kucinich bill (HR 676) and by Ralph Nader. Bureaucracy consumes 31 percent of US health spending, versus 17 percent in Canada. The difference translates into \$350 billion frittered away annually here, where a million healthcare workers, as well as hundreds of thousands in the insurance industry, spend their days on useless paperwork.

This waste is a natural byproduct of private insurance. Private plan overhead is eleven times that of Canada's NHI program. Each dollar spent on private premiums buys only 88 cents of care; the rest pays for insurers' marketing, underwriting, utilization reviewers and profits--and for the billions paid to their CEOs. Fragmented coverage also means duplication of claims-processing facilities and mountains of paperwork for doctors and hospitals, which must deal with multiple insurance products each with its

own eligibility rules, co-payments, referral networks, etc.--tasks that are absent in Canada. Our multiplicity of insurers also precludes the payment to hospitals of a global, lump-sum budget. In Canada global budgets obviate the need for most hospital billing and much of the internal accounting needed to attribute costs to individual patients and payers.

Clinton's and Obama's plans also lack credible means to redirect the hundreds of billions now wasted on overtreatment. Hospitals, doctors and equipment firms profit from investments in expensive high-tech care, encouraging the overuse of interventions that help some patients but harm others--for example, spine surgery, cardiac stents and CAT scans (which often deliver radiation equivalent to 500 chest X-rays). Insurers limit their outlays through intrusive case-by-case reviews or by raising co-payments. But they have little interest in systemwide cost control, so their efforts have mainly shifted costs to patients or other payers--the economic equivalent of squeezing a balloon. In contrast, NHI would allow explicit public decision-making about today's capital investments that shape tomorrow's care, and straightforward mechanisms to limit profit.

Without savings, the tax increases Obama and Clinton propose would be eaten up by subsidies for the uninsured, leaving nothing for the majority of Americans already covered but often unable to afford care. As we found in a 2005 study with Elizabeth Warren and Deborah Thorne, three-quarters of the 750,000 families driven to bankruptcy each year by illness or medical bills had coverage, though with unaffordable co-payments, deductibles and uncovered services. NHI would eliminate these gaps.

Private insurers caused the healthcare crisis. Yet both Democratic contenders advocate reforms that would fortify private plans, making government their debt collector. Their proposals, while palatable to the health industry--which supplies the Democrats with huge donations as well as key officials (DNC credentials committee co-chair James Roosevelt moonlights as an insurance company CEO)--cannot cure our healthcare crisis.

Nonetheless, we're optimistic about the prognosis for healthcare reform. If you turn up the volume on C-SPAN you can hear the audience cheering whenever Clinton or Obama lets the words "single payer" slip out--a reflection of the fact that three-fifths of the general public, as well as the 124,000-member American College of Physicians, support NHI. As in the JFK era, a charismatic, if only tepidly liberal, candidate can help raise hopes and expectations, igniting a mass movement that pushes a progressive agenda further and faster than the candidate intends.

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