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Toward Universal and Less Costly Healthcare

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In a rich nation such as the U.S., everyone should have health insurance. We also should do better at controlling healthcare costs; while we won't go bankrupt spending 18% of our GDP on health, or even more, the fact that every other rich democratic country achieves equivalent or better health outcomes while spending far less suggests that we have considerable room for improvement. How can we achieve these two goals?

The most straightforward path would be to expand coverage through Medicare, Medicaid, and a "public option", lower the age at which Americans can get Medicare, raise the income limit for Medicaid eligibility, and add a Medicare-like program that individuals and families can purchase on health insurance exchanges and that firms can purchase for their employees. Or simply allow any employer or individual to buy into Medicaid or Medicare, with subsidies for those who need them.

Eventually, a large portion of the population would be covered by these public programs. This would achieve universal coverage, and the government, as the dominant payer, would be in a strong position to control healthcare costs.

Lane Kenworthy

Canada's experience suggests that this type of arrangement can function quite effectively. Every Canadian has health insurance, and, over the past half century life expectancy has increased more in Canada than in the U.S. despite a far smaller rise in healthcare expenditures.

Such a system wouldn't eliminate private insurers. There would be a market among the affluent for insurance plans better than the one(s) offered by the government. And employers and individuals might choose to supplement the basic health insurance plan with an additional one, as many elderly Americans who have Medicare currently do.

Over time, government has gradually increased its role in promoting access to health insurance in the United States. The Veterans Administration was created in 1865 and significantly reformed in 1930 and 1994. In the 1940s and 1950s the federal government created and expanded a tax deduction for firms that contribute to health insurance for their employees. Medicare was created in 1965 and extended to cover prescription drugs in 2004. Medicaid too was created in 1965, and the share of the population it covers was expanded in the 1980s, in 1999 with the S-CHIP program, and in 2010 via the Affordable Care Act . Together, these two programs now cover about 40 percent of the U.S. population. The 2010 ACA also requires that medium-size and large firms offer health insurance to their employees, it provides subsidies for persons and families with modest incomes, it requires that health insurers

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allow people to remain on their parents' plan through age 25, and it forbids insurers from denying insurance to persons with preexisting conditions. (Its mandate that individuals have health insurance was removed in 2017.)

Why not instead expand employer-based health insurance? America's employer-centered health insurance system was a historical accident. It originated during World War II, when wage controls made it difficult for firms to offer higher pay in order to attract and retain good employees. Some decided to offer health insurance instead. After the war, encouraged by a new tax break, this practice proliferated, and it has remained in place ever since. But in a society where people switch jobs frequently, it makes little sense for insurance against a potentially major and very costly risk to be tied to one's employer. Moreover, providing health insurance is expensive for firms, putting them at a disadvantage relative to small firms and foreign competitors. And it likely acts as a brake on wage increases.

Why does employer-based health insurance work well in some other countries, such as Germany and Japan? The reason is that if people quit or lose their job, they are automatically switched into a government ("community") health insurance plan. And the cost of health care is contained, so it's less of a burden for employers. This happens in part because health insurance firms and funds aren't for-profit, so they aren't inserting additional costs into the system, and partly via cost controls set by centralized agreements between insurers and providers, with government stepping in if that fails.

Do Americans like government health insurance? Most say they do. About two-thirds of Americans think Medicare and Medicaid are working well for the groups they serve. In 2015, Gallup asked a representative sample of U.S. adults "Are you satisfied or dissatisfied with how the healthcare system is working for you?" Satisfaction was higher among those getting their health insurance via the military, the VA, Medicare, or Medicaid than among those getting it via an employer or purchasing it directly themselves.

Should government not only pay for health insurance and oversee it but also be the provider? That's how countries such as the UK, Sweden, Finland, and some others do it, and it tends to work well. Indeed, the UK got top ranking in a recent Commonwealth Fund assessment of healthcare quality in 11 affluent nations. But these might be isolated examples; there is no systematic evidence to support a conclusion that government provision is superior to mixed public and private provision. In any event, it's extremely unlikely that the US will replace its existing array of private for-profit and nonprofit medical providers with a fully government-run physician and hospital system.

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How much would a single-payer healthcare system cost, and where would the money come from? In 2015, the U.S. spent $3.2 trillion, 18 percent of the country's GDP, on health care. The government's share is a little less than half of this total. The tax benefit to employers costs about $250 billion, Medicare $650 billion, Medicaid $560 billion, health care for veterans $65 billion, and health care for current military personnel and their families $40 billion.

Medicare and Medicaid limit the amount they will pay to healthcare providers, and they have relatively low administrative costs, even though they've been covering more and more of the population. The share of GDP spent on these two programs has been rising at about the same pace as the rest of the healthcare system. Their cost will continue to rise going forward, owing partly to population aging and expansion of Medicaid coverage and partly to the general rise in healthcare costs, but the projected increases are fairly small.

A key obstacle facing proposals for a single-payer system is that taxes would have to increase significantly in order to pay for it. But this isn't insurmountable. A single-payer system likely would reduce total spending on health care. According to one estimate, adding coverage for the roughly 9 percent of Americans who now lack it and improving coverage for the 35 percent who currently are underinsured would increase costs by about 10 percent. But single-payer would reduce overall healthcare costs by approximately 18 percent: 7 percent from reduction in administrative costs, 3 percent from lower pharmaceutical prices, 3 percent from paying Medicare rates to healthcare providers, and 5 percent

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from improved service delivery (reduction in unnecessary services, inefficiently delivered services, missed prevention opportunities, and fraud). If correct, this estimate suggests a single-payer healthcare system would cost roughly 90 percent of the current spending total, or about 16 percent of GDP. That means government expenditures on health would rise by about 8 percent of GDP.

Of current health spending, 45 percent is by government (federal, state, and local). The other 55 percent is private: 27 percent by households, 20 percent by private firms, and 8 percent by other private sources. The cost of a single-payer system would need to come from taxes that replace these private expenditures. There are many possibilities, from a payroll tax paid by employers to an income tax and/or consumption tax on households. While the dollar figure will scare some Americans, such a system won't mean additional payments for health care; it will simply mean a different form of payment — public instead of private.

So is single-payer the solution for the US? In the long run, probably yes. In the short run, it may be more sensible to focus on making health insurance universal and making sure all Americans have insurance that is minimally adequate. The most straightforward way to do this is by expanding access to Medicaid and/or Medicare, in one or more of the ways described earlier. According to one estimate, this would increase government health care expenditures by approximately 10 percent, or about 1.75 percent of GDP. The benefits would easily outweigh the costs.

Adapted from a chapter of Kenworthy's latest book, Social Democratic Capitalism *(forthcoming, Oxford University Press).*

Remembering Elizabeth Barrett-Conner

By Henry C. Powell, Professor Emeritus of Pathology, and Marguerite Jackson, Associate Clinical Professor Emerita

Elizabeth Barrett-Conner †

Dr. Elizabeth Barrett-Connor joined our Department of Community Medicine in 1970, at the same time as her husband, **Dr. Jim Connor**, a virologist, came to head the Division of Infectious Disease in the Department of Pediatrics. The success of the Health Sciences program and the high reputation of the School of Medicine are in no small measure the legacy of founding faculty like her, who came with a vision and leaves a cohort of colleagues, many of them her trainees. The eminent medical historian **Roy Foster** liked to quote the saying of **Hippocrates** that the art of medicine has three factors, "the patient, the doctor, and the disease." Elizabeth was a master of that triad.

After college, Elizabeth thought of becoming a nurse but decided to study medicine and entered the profession at a time when women were less than warmly welcomed. Characteristically, she turned that neglect into opportunity, becoming a forceful advocate for women's education and a dedicated student of women's health issues. Throughout her career she also invited many young PhDs, a number of them women, to join her research teams. She was also especially mindful of the role nurses play in health care and opened research opportunities to them at a time when the prevailing view was that "doctors give orders and nurses take them." In the 1970s she showed how important nurses could be in the emerging field of the epidemiology of infection prevention and control. For that purpose, she was a key developer of the first certificate program through UCSD Extension designed to educate these new practitioners (of whom MJ was one) and in 1978 co -authored the first book on the subject, *Epidemiology for the Infection Control Nurse.*

Over more than four decades, beginning in 1972, she and her colleagues established one of the best-known longitudinal research programs in community public health, the Rancho Bernardo Heart and Chronic Disease Study. She mentored many investigators and successfully engaged public participation. At first the study focused on cholesterol and heart disease, but it was expanded to cover broader issues, such as the significance of early indicators like fasting blood sugar levels in the pathogenesis and onset of cardiac disease. Her findings on the epidemiology of heart disease and other chronic conditions have helped both doctors and patients, as have her forays into related fields such as neurovascular illness and its connections to cognitive and intel

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