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Statement of Dr. Marcia Angell introducing the U.S. National Health Insurance Act

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Concurrent with the publication of the Physicians' Proposal for National Health Insurance in the *JAMA*, the proposal was adapted into legislative form by Congressmen John Conyers (D-MI), Dennis Kucinich (D-OH) and Jim McDermott (D-WA).

The U.S. National Health Insurance Act (also known as the Expanded and Improved Medicare for All Act), HR 676, was introduced on February 4, 2003. The following is the statement made at the introduction ceremony by Physicians' Working Group member and former *NEJM* editor Dr. Marcia Angell.

(A printable handout of this document is available by clicking here)

February 4, 2003
Washington D.C.

We are here today to introduce a national health insurance program. Such a program is no longer optional; it's necessary.

Americans have the most expensive health care system in the world. We spend about twice as much per person as other developed nations, and that gap is growing. That's not because we are sicker or more demanding (Canadians, for example, see their doctors more often and spend more time in the hospital). And it's not because we get better results. By the usual measures of health (life expectancy, infant mortality, immunization rates), we do worse than most other developed countries. Furthermore, we are the only developed nation that does not provide comprehensive health care to all its citizens. Some 42 million Americans are uninsured — disproportionately the sick, the poor, and minorities — and most of the rest of us are underinsured. In sum, our health care system is outrageously expensive, yet inadequate. Why? The only plausible explanation is that there's something about our system — about the way we finance and deliver health care — that's enormously inefficient. The failures of the system were partly masked during the economic boom of the 1990's, but now they stand starkly exposed. There is no question that with the deepening recession and rising unemployment, in the words of John Breaux,

"The system is collapsing around us."

The underlying problem is that we treat health care like a market commodity instead of a social service. Health care is targeted not to medical need, but to the ability to pay. Markets are good for many things, but they are not a good way to distribute health care. To understand what's happening, let's look at how the health care market works. Most Americans receive tax-free health benefits from their employers, who pay insurers a portion of the premiums for health coverage. But not all employers offer benefits, and when they do, the benefits may not be comprehensive. It's; entirely voluntary. When employers are competing for workers, they offer good benefits; when unemployment rises, they drop them.

The insurers with whom employers do business are mostly investor-owned, for-profit managed care businesses. They try to keep premiums down and profits up by stinting on medical services. In fact, the best way for insurers to compete is by not insuring high-risk patients at all; limiting the coverage of those they do insure (for example, by excluding expensive services, such as heart transplantation); and by passing costs back to patients by denying claims or as deductibles and co-payments. We are the only nation in the world with a health care system based on dodging sick people. These practices add greatly to overhead costs because they require a mountain of paperwork. They also require creative marketing to attract the affluent and healthy and avoid the poor and sick. Not surprisingly, the U. S. has by far the highest overhead costs in the world.

It's instructive to follow the health care dollar as it wends its way from employers toward the doctors and nurses and hospitals that actually provide medical services. First, private insurers regularly skim off the top a substantial fraction of the premiums — anywhere from 10 to 25 percent — for their administrative costs, marketing, and profits. The remainder is then passed along a veritable gauntlet of satellite businesses that feed on the health care industry, including brokers to cut deals, disease-management and utilization review companies, drug-management companies, legal services, marketing consultants, billing agencies, information management firms, and so on 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. I would estimate that no more than 50 cents of the health care dollar actually reaches the providers — who themselves face high overhead costs in dealing with multiple insurers.

What are the signs of the imminent collapse of this system? Private health insurance premiums are now rising at an unsustainable rate 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 and workers find they cannot pay their rapidly growing share. And finally, with the rise in unemployment, more people are losing what limited coverage they had. This is not a system that can be tinkered with. It needs to change.

The program we are introducing today is the very soul of simplicity and efficiency, compared with our private health care system. It is a single-payer system, that is, health care funds would be distributed by a single, public entity, so that health care could be coordinated to eliminate both gaps and overlap. In many ways, our program 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, not just some of them. Medicare is not perfect, but it is by far the most popular part of the U. S. health care system, and in my opinion its problems would be relatively easy to remedy — but that is another subject.

What are the usual objections to the sort of national program we are calling for today? They are mostly based on a number of myths.

Myth #1 is that we can't afford a national health care system, and if we try it, we will have to ration care. My answer is that we can't afford not to have a national health care system. A single-payer system would be far more efficient, since it would eliminate excess administrative costs, profits, cost-shifting and unnecessary duplication. Furthermore, it would permit the establishment of an overall budget and the fair and rational distribution of resources. We should remember that 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. It makes more sense to pay just once.

According to Myth #2, innovative technologies would be scarce under a single-payer system, we would have long waiting lists for operations and procedures, and in general, medical care would be threadbare and less available. This misconception is based on the fact that there are indeed waits for elective procedures in some countries with national health systems, such as the U. K. and Canada. But that's because they spend far less on health care than we do. (The U. K. spends about a third of what we do per person.) If they were to put the same amount of money as we do into their systems, there would be no waits and all their citizens would have immediate access to all the care they need. For them, the problem is not the system; it's the money. For us, it's not the money; it's the system.

Myth #3 is that a single-payer system amounts to socialized medicine, which would subject doctors and other providers to onerous, bureaucratic regulations. But in fact, although a national program would be publicly funded, providers would not work for the government. That's currently the case with Medicare, which is publicly funded, but privately delivered.

As for onerous regulations, nothing could be more onerous both to patients and providers than the multiple, intrusive regulations imposed on them by the private insurance industry. Indeed, many doctors who once opposed a single-payer system are now coming to see it as a far preferable option.

Myth #4 says that the government can't do anything right. Some Americans like to say that, without thinking of all the ways in which government functions very well indeed, and without considering the alternatives. I would not want to see, for example, the NIH, the National Park Service, or the IRS privatized. We should remember that the government is elected by the public and we are responsible for it. An investor-owned insurance company reports to its owners, not to the public.

Some people say that a single-payer system is a good idea, but politically unrealistic. That is a self-fulfilling prophecy. In my opinion, the medical profession and the public would be enthusiastic about a single-payer system if the facts were known and the myths dispelled. Yes, there would be powerful special interests opposing it and I don't underestimate them, but with courageous leadership, such as Representative Conyers is providing, and the

support of the medical profession and public, I believe there is nothing unrealistic about a National Health Insurance Program.

I want to mention one final and very important reason for enacting a national health program. We live in a country that tolerates enormous disparities in income, material possessions, and social privilege. That may be an inevitable consequence of a free market economy. But those disparities should not extend to denying some of our citizens certain essential services because of their income or social status. One of those services is health care. Others are education, clean water and air, equal justice, and protection from crime, all of which we already acknowledge are public responsibilities. We need to acknowledge the same thing for health care. Providing these essential services to all Americans, regardless of who they are, helps ensure that we remain a cohesive and optimistic country. It says that when it comes to vital needs, we are one community, not 280 million individuals competing with one another. In seeking to ensure adequate health care for all our citizens, we have an opportunity today to reassert that we are indeed a single nation.

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