Commentary

Who Shall Pay? Politics, Money, And Health Care Reform
by Lawrence D. Brown

Politics is how society manages conflicts about values and interests. The United States, a large, heterogeneous society with complex cross-cutting divisions by race, ethnicity, class, region, and more, naturally presents many such conflicts to manage. Health care, an arena of high popular expectations, settled professional prerogatives, and expenses that now total nearly one trillion dollars per year, piles on further problems of its own. The conflict management that is politics, therefore, is not some nonrational and inefficient sideshow that threatens the reformist visions of the best and the brightest but rather a challenge central to making health reform come out for the better—indeed, come out at all. And no issues trigger battles over values and interests more quickly and acutely than do the source and use of money in health reform proposals.

Different extractions and allocation mechanisms have their theoretical pros and cons, but successful politics of health reform financing will correspond closely to the three basic reasons why health care became intensely politicized in the early 1990s. First, a sizable portion of the public grew upset over the uncertain availability and affordability of health insurance coverage. Second, a range of interested parties—business, labor, providers, and even insurers—discovered that the weak government involvement upon which they had always insisted permitted each to shift costs to and otherwise prey upon others and began seeking selective and self-serving solutions from policymakers. Third, political leaders themselves increasingly deplored the strong standing claims of health care on public budgets that they wanted to use for a broad range of ameliorative projects. To leaders such as Ronald Reagan and George Bush, determined to check liberal activism, any deficit-enhancing excuse would do. But to more activist-type leaders (including Bill Clinton, arguably the nation’s first post-Medicare activist president, and many governors), this extravagant grab not only was unfair, but also took much of the fun out of public leadership. In short, the public wants health care that is more secure and

Larry Brown is a professor and head of the Division of Health Policy and Management at the Columbia University School of Public Health in New York City.
more affordable but expects to pay or sacrifice little or nothing to get it. Groups take reform to mean arrangements that protect them from incursions by others and thus secure their incomes and revenues without disrupting their core operations. Policymakers seek reforms that slow the growth of health care spending without offending anyone very much in the process. Each of these three images may or may not be internally contradictory, but each surely conflicts with others in important ways, and therefore all are themselves difficult to manage politically.

Bill Clinton’s Excellent Adventure

The plan proposed by the Clinton administration tackles three broad goals—universal coverage, delivery system reform, and cost containment—in one fine-grained legislative package. The sweep and integration of the plan no doubt partly reflect the thrill of the intellectual chase among its highly intelligent designers, but these features also reflect a quest to steer within tight political constraints by ensuring universal coverage without calling forth Big Government or major new taxing and spending measures. The plan would use delivery system reform to get the cost containment that yields the savings that fund the universal coverage.

This approach is politically implausible for three main reasons. First, the times are hardly so ripe for reform that they admit simultaneous achievement, in one fell swoop, of three goals that have eluded the United States for decades. Second, the scheme seeks to “score” sizable short-term savings by means of delivery system changes that demand a medium or long time horizon, if they can be realized at all. (In principle, caps on health insurance premiums would force health alliances and plans to enforce savings if market forces falter, but none of the major players is likely to welcome so heavy a federal foot on the fiscal brakes.)

Third, the plan rests on a number of strategic non sequiturs (meaning practical aspirations problematically inferred from “truths” too casually held to be self-evident). Boiled down to basics, the Clinton program seems to rest on the propositions that the public demands fundamental change in the health care system; that the system contains much wasteful and inappropriate care waiting to be squeezed out; and that the unfolding managed care “revolution” points the way toward more efficient markets, better health delivery, and constrained costs. Working from these premises, the administration designed a systems analytic tour de force that uses reorganized markets to squeeze out waste and channel the savings into universal coverage. But it is far from clear that what the public means by “fundamental change” bears much resemblance to the Clintons’ vision. That 30–40 percent of the system’s facilities and services could be in some sense waste-
ful and unnecessary does not mean that there is a constituency for eliminating concrete inefficiencies—which are tied to jobs, incomes, peace of mind, cherished community institutions, and more. And it is equally doubtful that consumers are ready to extend their embrace of managed care—the growth of which has so far centered mainly on such relatively toothless forms as preferred provider organizations (PPOs) and individual practice associations (IPAs)—to more aggressively managed group- and staff-model health maintenance organizations (HMOs) that might save significant sums of money. To date, managed care seems to be most acceptable when it declines to do what its aficionados insist upon: depart substantially from the norms of third-party payment and fee-for-service practice.

These non sequiturs and the fragile policy solutions built on them mean that the politics of financing reforms have so far been viewed through a glass darkly. Yet the political economy of the matter is as analytically straightforward as it is practically convoluted. There are two sources of money for reforms—public and private—and two ways to tap them—by raising new monies and by redistributing existing funds. The two dimensions combined yield four cells, each a site of politically painful choices. Cell one (new public money) means new taxes, anathema to new Democrats and their old Republican antagonists alike. Cell two (new private money) requires mandates or some other way of getting funds from private-sector purchasers (employers and families) that have not anted up before. Cell three (redistributed public money) entails cuts in Medicare and Medicaid, duly proposed by the Clinton plan to the tune of $238 billion. Cell four (redistributed private funds) looks to savings by means of managed care and reorganized markets. To the degree that one cell fails to deliver, fiscal weight must shift to the others—or coverage goals must be curtailed. An artful politics of financing requires a “just” extraction of revenues across the four cells, putting on each as much weight as, but no more than, it can bear politically. If the critique of the Clinton plan sketched above is accurate, financing politics will probably be obliged to shift emphasis considerably from cells three and four onto the treacherous terrain of cells one and two. What, then, are the major options for doing so?

### Three Funding Strategies

**Individual mandate.** One approach would require that all citizens buy health insurance for themselves and their families, with government subsidies for lower-income households that need help. This proposal has several appeals. It gets everyone covered, eliminates free riders, avoids the conflicts and possible economic dislocations of an employer mandate, severs the illogical link between employment and health insurance, and demands no
heroic transformations of the delivery system. It also has several potential political liabilities. Designing subsidies that are equitable but not costly may be difficult. If the scheme looks like a bad economic bargain for the middle-income insured—and it was their anxieties, not those of the uninsured, that politicized the issue in the first place—then the core reform constituency may be alienated. Adjusting subsidies upward to keep pace with costs over time may be tricky for a plan that largely entrusts cost containment to the nebulous dynamics of prudent consumer shopping in a little-reformed marketplace. And although proponents contend that the plan would have negligible effect on the willingness of employers to maintain existing coverage, others fear that new public subsidies might encourage employers to withdraw contributions to the coverage of many workers, especially in low-wage jobs. If so, government (meaning the taxpayer) would pay more.

Arguably, then, the individual mandate is less a freestanding alternative than a distinct mechanism for apportioning costs among employers and taxpayers. What employers decline to cover goes onto the tab of a government that has been promising the electorate that health reform will mean no new taxes. If many higher taxbearers simultaneously face increased out-of-pocket costs without benefit of the new subsidies they help to underwrite, the political result could be a reprise of the reaction to the catastrophic benefits affixed to Medicare in 1988 and then stripped from it a year later, but on a much larger scale. The individual mandate’s elegant simplicity could cut through stalemates dogging employer mandates and single-payer proposals. It also could make millions of voters very angry by fashioning a highly visible allocation of benefits and costs whose equity eludes citizens who eagerly await something very different.

Employer mandate. Some—including the Clinton administration—would require that all employers buy or contribute to the purchase of health insurance coverage for all of their workers. Prima facie, this approach is highly attractive. Most of the nonaged population now gets coverage in the workplace, so an employer mandate can wear the halo of incrementalism. (Admittedly, the Clinton scheme, which obliges most employers to make payments to regional health alliances that present a menu of health plan options to workers, stretches this term severely.) Moreover, most of the uninsured either work or are dependents of workers, so an employer mandate would meet the needs of the vast majority of that 15 percent or so of nonelderly Americans who now lack coverage.

On the other side of the political ledger, however, lies a potent triple threat: ideology, economics, and influence. Many business groups oppose an employer mandate on principle. Such opposition comes predictably from companies that do not now offer coverage, but many firms, large and
small, that do offer insurance would prefer to “pay twice” (that is, meet the health care costs of the uninsured as well as those of their own covered employees) rather than to endorse new federal rules and regulations. The economic consequences of a mandate raise further troubling questions. Economists may insist that “business” rarely pays for health coverage (that is, costs are generally shifted along to consumers in higher prices or back to workers in slower wage growth), but many small employers swear that a mandate will drive them out of business, slash their precarious profits, force them to lay off workers, or inflict other adversities. These complaints register heavily with political leaders, few of whom expect that a steady parade of foreign automotive plants descending into their districts will assure prosperity. Most value small business, want to see it thrive and prosper, and resist policy measures that might depress it.

Political influence reinforces ideological and economic calculi. Small business is a ubiquitous presence in most districts; wears the legitimacy that accompanies capital accumulation, job creation, and tax generation; and is represented politically by organizations that are well-heeled, well-staffed, vigilant, vehement, and vindictive.

Facing these obstacles, policymakers have three options. First, they can draw the proverbial line in the sand and seek to force a mandate on employers. Second, they can consecrate small business as an economic class so vulnerable and valuable as to warrant special exemption from duties binding on other private purchasers and cover their workers with public funds. That strategy might buy peace with small business but could antagonize taxpayers, who hold the quaint conviction that all employers should contribute their fair share. Third, they could, as the Clinton plan does, insist on a universal employer mandate but sweeten it with subsidies and contribution caps that offset economic hardship for marginal firms. This may be the most politic approach, but to date it has not won over many opponents within the business community, and analysts deplore the generosity of subsidies to firms that (they say) shift costs to individual employees who should, therefore, be the primary objects of public support. Unfortunately for those who favor an employer mandate because it eases the bite on public funds, the strategy may end up posing as many problems as it solves: Assuaging business antagonism seems to require a steady enlargement of the public monies the strategy was supposed to relieve.

Single-payer system. The United States could adopt a system that funds care mainly with public revenues and in which providers get paid by the government without the intermediation of insurance plans. Such an arrangement, often called the “Canadian system,” offers several advantages. It plainly identifies the health care system as a democratic construct: How much it spends, how, and on what are decided by political leaders who
answer directly to the electorate. In manipulating public budgets that necessarily set health spending in the larger context of other public priorities, policymakers must ponder the relative value of the services they fund. Eliminating private insurance ends difficulties in monitoring and regulating the behavior of an industry with no evident social rationale. All citizens can seek care from any provider they please simply by presenting their health care card; “lock-ins” and other controversial measures entailed by efforts to manage care in complex organizations are not needed. A single-payer model gets high marks for equity, simplicity, and accountability.

The American political setting, however, turns each of these virtues into a vice. Managed care enthusiasts (and investors) fear that a “retreat” to broad freedom of choice between patients and providers will spoil their efforts to control utilization and to discipline providers. There may be no convincing, normative reasons for retaining a private health insurance industry, but there are millions of potent political reasons—jobs—for sparing its sorry life. Providers have not warmed to the prospect of direct bilateral bargaining between themselves and government agencies over fee schedules and payment levels, nor would they relish participation in the budgetary competition among social arenas for scarce public dollars that sets the context for such bargaining. Consumers used to demanding and getting the most and the best medical care at readily accessible facilities may reject government “planning” and “rationing” to extract value for money. And looming above these points of contention is of course the issue of taxes, with which the system would largely be funded. A single-payer, Canadian-style system would shift the 7 percent or so of gross domestic product (GDP) now spent in the private sector on health to public budgets, and taxes would supplant private insurance premiums. This approach stands at the opposite strategic pole from the Clinton plan, which assures the electorate that universal coverage demands no new general taxes.

Single-payer proponents object, reasonably enough, that money is money; whether one talks of a “tax,” a “premium,” a “contribution,” or a horse of some other color, the costs of care must be met, and ultimately households pay (albeit more or less progressively, depending on the financing method selected). Politically, however, a “tax” connotes not merely money but money that is collected, controlled, and allocated by government. Therein lies the rub: The United States seems to be a nation most similar to Canada in all respects save that most important for the adoption of a single-payer system, namely, attitudes toward the role of the State. Canadians are, on the whole, far more willing to accept a positive role for government in addressing social problems and allocating collective resources than are their neighbors to the south.

Americans do not always implacably oppose higher taxes or a larger
public role in problem solving and may welcome such expansions when and if they believe that the cause is worthy, no plausible alternative to state action exists, and government’s suspect hand will not botch the enterprise. One could argue persuasively that the first and possibly the second of these criteria now hold in the case of health reform, but it can hardly escape political notice that conservative Republicans won the White House three times straight in the 1980s by blasting taxes, government, bureaucracy, and related bugbears that terrify “new” Democrats like Bill Clinton. A single-payer system evokes bitter opposition among insurers, providers, and most of the business community, so the administration is surely not wrong to fear that sentiment in favor of a single-payer system might be handily exterminated by heavy propaganda barrages against any formal initiative that embraces it. The United States might in time evolve toward such a system, but probably not without many intervening trials and errors.

**Health Financing Politics: New Dawn Or Dead Ends?**

None of the three “pure” financing strategies reviewed here is likely to be politically acceptable as it stands. Each requires modification and meshing with others into some impure (and perhaps inefficient) package if funding sources are to be varied, and costs diffused, enough to sustain a coalition. But this will not be achieved easily. Health financing politics is tough because it demands contributions from people who are not convinced that they should make them, so massaging and mixing strategies that are individually unpalatable will not necessarily yield a higher political synthesis. The nation may be unwilling to make the financial commitment to sustain universal coverage after all. Three steps would help policymakers find out.

First, the Clinton plan badly needs deconstruction, meaning the decoupling of delivery system reform and (to a lesser degree) cost containment from what should be the top priority, universal coverage. By proposing to fund new entitlements with savings wrung from delivery system reform (backed up by tough insurance premium regulation), the plan not only embraces an unrealistic vision of the potential and pace of system reorganization but also diverts the electorate’s attention from fundamental to extraneous worries. The issues surrounding aggressive promotion of managed care plans with teeth sharp enough to yield sizable short-term savings—menus constructed by new health alliances, fiscal pressure to join plans that may discourage easy access to “any willing provider,” and the end of the employer’s role in selecting plans—make the public nervous, defy plain explanation, and hand potent ammunition to groups eager to discredit the plan. The conceptual foundations and administrative architecture of this portion of the plan are largely speculative, anyway, so it is all the
more unreasonable to hold universal coverage hostage to them.

Second, the cost containment provisions of the plan would benefit not so much from deconstruction as from reconstruction. Universal coverage should obviously be affordable. Affordability has many dimensions—cultural, demographic, technological, fiscal, and more. Some of these variables are basically givens (demographics), some we may not want to change significantly (technology), and some change slowly at best (consumer expectations). But this also applies to societies that have done better by affordable universal coverage than the United States has done. The main difference between us and them that invites sustained short-term policy manipulation is the level of payments to providers, which is exceptionally high here and must come down (or rise more slowly) if costs are to be contained.

Other comparable nations create by one means or another a sense among providers (and consumers) that health resources have opportunity costs, and so should we. But these societies achieved their relatively favorable spending records not by a sudden U-turn after years of indulgence, but rather by the application over many years of discipline made possible by a coherent public policy framework—precisely what the United States lacks. Building a foundation for cost containment is indeed an urgent calling, but it will require subtle, patient political preparation. The expectation of massive waste-squeezing and money-rechanneling in the short term is implausible and, worse, counterproductive, for universal coverage could be stymied if savings are made too firm a precondition of it.

It is not likely that system reorganization will generate large savings quickly or that society will accept firm premium caps as a regulatory backstop should market forces fail to work fast enough. Federal policymakers should return to the drawing board and try to fashion negotiating machinery to engage affected parties—physicians, hospitals, business, labor, and perhaps insurers—in generating voluntary cost targets within which all would agree to live under the threat of triggering mandatory caps (on prices, premiums, or some other variation on global budgets) if sectoral leadership failed to find a sufficient following. This threat, and the pressure it applies to negotiate in good faith and to work to enforce agreements, will be only the greater in the (otherwise) cost-increasing context of universal coverage.

Third, if delivery reform and cost containment were redefined as long-term and medium-range goals, respectively, policymakers could then concentrate on the top instant priority: figuring out how to fund universal coverage. They might start by getting back to basics. Thorough going reform of current health insurance practices is both indispensable to a better system and probably the only element of the reform agenda that is both readily comprehensible and acceptable to the average citizen and the object
of broad moral consensus across the range of interest groups. The assault on preferred risk selection—redlining of industries and firms, exclusions and limitations on coverage for preexisting conditions, premium differentials tailored to use and risk, and lack of portable coverage for individuals and groups—should top the action agenda. Political leaders then would need to explain, however, that insurance reform is necessary but not sufficient to answer the concerns that have so politicized health care in the 1990s. Such reform may make coverage more widely available but not more affordable.

At this point policymakers face a leap of faith from the bedrock of insurance reform into universalist vapors. They should explain clearly why coverage is unlikely to remain secure and affordable over time unless it is universal—for example, because cost shifting wreaks havoc in a system that does not cover everyone, and because community rating does not work unless contributions are pooled and risks spread over whole communities. They should insist, too, that it is morally indefensible for government to stabilize rates and coverage for the “haves” while ignoring the “have nots.” In this context it may be possible to open public discussion of an unhappy truth: If short-term cost containment mechanisms will not cover the price tag for universal coverage, new funds will be needed from a combination of out-of-pocket payments, employer contributions, and public revenues. The hard question is, what combination?

This is not news for which political leaders have been preparing the electorate; quite the contrary. But if one cannot get this far, perhaps policymakers should infer that the nation is not in fact ready to insure all its citizens and give crime, welfare, or other pressing concerns their fifteen months of fame. Financing doth make cowards of us all. But if leaders can close the sale with public opinion on this much of the reform agenda, the rest may prove to be manageable.

If there were good answers, they would presumably have been instituted by now, but a few guidelines might prove useful. After so many gilded promises of health reform, the willingness of individual citizens to pay more out of pocket is probably limited (though not necessarily nil), the explicitly crafted subsidy scales of an individual mandate may be too lucid to avoid dividing income classes, and schemes that ask the middle and upper classes to pay more to fund benefits of doubtful value to themselves are probably doomed. Employer mandates may be worth insisting on both to protect the principle that everyone capable of contributing to coverage should do so in proportion to ability and to ease the visible bite on public revenues. But an 80 percent share of premiums may be too high, and even at lower percentages, large subsidies will be needed—preferably to lower-wage individuals instead of to firms that will offset “their” share by suppressing the growth of wages. Finally, the public should be told candidly that if the savings and
fiscal redistributions that should ideally fund coverage for all cannot be achieved without excessive conflict and untenable assumptions in the short term, then while cost containment and delivery reform are put incrementally in place, new general revenues—taxes—will have to support some of the cost of health insurance for some citizens. These guidelines might point toward a synthesis of the leading strategic contenders. For instance, policy makers might retain an employer mandate but scale back the required contribution to below 80 percent while fashioning income-related public subsidies for workers whose now-higher share would be burdensome. Or, if talk about taxes is no longer strictly taboo, they might even revisit the case for payroll tax financing, a more progressive strategy that has worked well in Social Security and Medicare.

These public subsidies would require new tax-supported dollars, and some view any such departure from the administration’s line as a shameful defeat by a wasteful status quo. Windows of opportunity for “real” change rarely open, say proponents of an integrated systemic approach; to install universal coverage without simultaneously curbing costs would squander an uncommon chance to discipline a hitherto uncontrollable system. But the window of opportunity for steady change in health policy will probably stay open, propped up by nearly $1 trillion annually (and rising fast). The window began to open a decade ago—the antigovernmental Reagan and Bush administrations presided over major reforms in the Medicare payment system for hospitals and physicians, for example—and has widened further with accelerating state reforms since 1989. The rhetoric and rhythm of the pushing process, and the scope and content of what gets pushed will differ with political party and ideology, but cost pressures have now grown too great to allow the window to be shut for long. In this respect the United States will be—already is—similar to other Western nations with broad third-party payment: Canada, France, Germany, and others are back every year or two debating significant legislative revisions in their health care systems. So will the United States, and for the same reason: The forces of demography, technology, consumer expectations, personnel costs, and the like are inherently explosive and resistant to a final resolution or easy management. The additional costs of universal coverage in the United States will push the window of opportunity more firmly open, accelerating a quest for cost containment that is best pursued with coverage for all as backdrop and precondition, not as fiscal offset and political hostage.