Can We Get There from Here?
The Fight for Universal Access in the States
Since its inception in 1968, the Health Policy Advisory Center—known as Health/PAC—has served as a unique progressive voice for changing consciousness on domestic and international health priorities. Through the Health/PAC Bulletin and the books Prognosis Negative and The American Health Empire, and in its outreach to a national network of grassroots activist groups, Health/PAC continues to challenge a "medical-industrial complex" which has yet to provide decent, affordable care.

### IN THIS ISSUE

#### California Dreaming: Universal Health Insurance in One State?
Kevin Grumbach chronicles the unique California approach to developing a state-based universal health care plan .................................................. 6

#### Campaigning for Health Care Reform
David West recounts the ongoing efforts in Washington State to achieve major change in the health care system .................................................. 12

#### The Universal Health Care Law in Action
Rob Restuccia evaluates the initial phase of the nation's first health-care-for-all legislation in light of Massachusetts's fiscal crisis .................................................. 16

#### Patchwork Not Perestroika: The Promise and Problems of UNYCare
David Himmelstein and Steffie Woolhandler analyze the recent New York State proposal to improve access to care by revamping the health insurance system .................................................. 22

#### Importing Health Care Reform? Issues in Transposing Canada's Health Care System to the United States
Samuel Wolfe presents the truth about the Canadian national health insurance program and the possibility of adopting such a system here .................................................. 27

#### Media Scan
Two reviews examine the ideology behind disease prevention policy and the dangers lurking in diagnostic testing .................................................. 34

---

**Health Policy Advisory Center**

17 Murray Street New York, New York 10007 212/267-8890

Health/PAC Bulletin

Volume 20, Number 2 Summer 1990


**Acting Editor** Ellen Bilofsky

**Assistant Editor** Caren Teitelbaum

---

© 1990 Health/PAC. The Health/PAC Bulletin (ISSN 0017-9051) is published quarterly in the spring, summer, fall, and winter. Second Class postage paid at New York, N.Y. Postmaster: Send address changes to Health/PAC Bulletin, 17 Murray St., New York, NY 10007. The Health/PAC Bulletin is distributed to bookstores by Ubiquity Distributors, 607 Degraw St., Brooklyn, NY 11217. Articles in the Bulletin are indexed in the Health Planning and Administration data base of the National Library of Medicine and on the Alternative Press Index. Microforms of the Bulletin are available from University Microfilms International, 300 Zeeb Road, Dept. T.R., Ann Arbor, MI 48106. MANUSCRIPTS, COMMENTS, LETTERS TO THE EDITOR, AND SUBSCRIPTION ORDERS should be addressed to Health/PAC, 17 Murray St., New York, NY, 10007. Subscriptions are by $35 membership for individuals. Institutional subscriptions are $45.
The Debate is in the States

DANA HUGHES AND ZOE CLAYSON

Great Republic Insurance Co. of Santa Barbara is canceling a health insurance plan that covers 14,000 Californians, many of them ill with cancer, AIDS, and other catastrophic diseases. In a letter sent to insurance agents last month, Great Republic said that it is dropping the entire block of business, which accounts for $25 million in annual premiums, because unlike the company's other health plans, it "is not producing a profit." The move...will leave many policy holders who have contracted major illnesses without affordable health-care coverage and with no hope of being picked up by another carrier. —San Francisco Chronicle, May 1990

The phenomenon described in this newspaper report—of insurance companies cold-bloodedly divesting needy individuals of their access to medical care—is neither new nor unique to California. As long as people's ability to obtain and pay for health care in this country has depended on an insurance system, the profitability of health insurance companies has come before people's needs. What is new is the attention that state legislatures are paying to this issue in response to a variety of concerns, including runaway health care costs; growing pressure for states to assume these costs; and political pressure from employers, providers, and consumers. A number of state legislatures over the last few years have debated and passed a range of health care initiatives. More recently, the focus of debate in several states has shifted from initiatives targeted to specific populations (such as pregnant women and infants and persons with catastrophic medical expenses) to what are dubbed "universal health care plans"—proposals intended to provide health insurance to all who currently lack it.

This issue of the Health/PAC Bulletin examines efforts in four states—New York, California, Massachusetts, and Washington—to reform the health care system. David Himmelstein and Steffie Woolhandler critique New York State Health Commissioner David Axelrod's proposed UNY*Care, a plan to provide health insurance coverage to uninsured New Yorkers. Kevin Grumbach provides a perspective on efforts by Health Access to enact a comprehensive "universal" health care program in California. Rob Restuccia, along with Debbie Socolar and Alan Sager, present their views on the issues influencing Massachusetts's so-called Universal Health Care Law, the nation's most comprehensive health insurance statute to date. David West of Washington describes efforts in that state to organize around a health reform package. To round out the issue, Sam Wolfe analyzes the prospects of the United States adopting a Canadian-style health care system on a national basis.

The four states covered in this Bulletin each represent different stages of development in political organization, the design of proposals, the enactment of initiatives, and the implementation of laws. Of these, only Massachusetts has actually passed a comprehensive reform act, although other states appear on the verge of adopting some measure. For example, Sacramento watchers in California are confident that, given the momentum that has built around the issue of health care, one of the six or more major health reform bills introduced thus far will be approved this fall. Whether a source of funding will be identified to finance whatever measure is approved is far less predictable.

New York's UNY*Care proposal was crafted by the administration, at least in part in response to the mounting pressure from external forces to enact some reform. In the case of California, the original impetus for a "universal" state health proposal was generated by a broad-based coalition of consumers, advocates for low-income families, labor, and public health providers. Since then, special interests such as the California Medical Association have countered with their own proposals. This pattern was repeated in Washington State, where the Washington State Medical Association proposed an alternative to the progressive proposal developed by state Representative Dennis Braddock, within weeks of its introduction.

These articles provide insight into the unique conditions and circumstances in each state that give shape to the different proposals, strategies, and outcomes. Yet, these experiences provide common lessons from which state and national efforts can benefit.

- State activism has been successful in moving the health care debate along in large part because of the coalitions that have been created around health care reforms,
HEALTH INSURANCE
AND YOU

Age, race, and employment play a large role in determining who has health insurance, reports the Bureau of the Census in a report released in April. Young people, African Americans, Latinos, and part-time workers are most likely to lack coverage (see “Radical Surgery,” October 1989).

The Bureau of Census examined health insurance coverage over a 28-month period from the first quarter of 1986 to the fourth quarter of 1988, using data from the Survey of Income and Program Participation.

The study found that losing health insurance for short periods of time is common for many people. Researchers found that, when they did spot checks during any particular month, 13% to 14% of the populations lacked health insurance, but when they studied the full 28-month period, 28% of the population lacked insurance for one or more months.

Persons under the age of 25 comprised one-half of those without continuous health insurance, while accounting for 37% of the population. Sixty-five percent of those under age 18 had coverage, but less than half of those between the ages of 18-and-24 did. Of all age groups, 18 to 24 year olds were the most likely to lack insurance for at least one month. After age 24, the percentage of people continuously covered by insurance rises with each age group. By age 65, when Medicare kicks in, continuous coverage was at 99%.

Employers frequently did not provide health insurance to younger full-time workers who worked the entire 28-month cycle. Twenty-nine percent of 18 to 24 year olds working full-time spent one or more months without health insurance.

Among the racial groups the Bureau of the Census studied, Latinos and blacks were more likely to lack insurance than whites. Over half of Latinos and a third of blacks spent at least one month without health insurance. In comparison, the rate for whites was 25%. Whites are also more likely to be insured privately than through the government. Ninety percent of all whites with health insurance were covered by private health insurance, while only around 75% of blacks and Latinos were.

Part-time workers also have difficulty maintaining health insurance. Of those who worked the full 28 months, 14% of all full-time workers lacked continuous coverage, while one-quarter of part-time workers did. Most part-time workers who had continuous health coverage received their health insurance as a dependent on someone else’s plan.


Reprinted from Dollars & Sense, June 1990. Introductory subscriptions are $14.95 from Dollars & Sense, One Summer Street, Somerville, MA 02143.
• On the other hand, it is no coincidence that some of the greatest momentum for state health programs has been generated in the wealthier states. California, New York, Massachusetts, and Washington are not only relatively affluent, but each is already committed to financing care for a segment of the uninsured (usually by taking advantage of Medicaid options and supplementing Medicaid with state programs). The costs of making additional investments in these states, even with their large populations, are not as great as they would be in other states that do not have that preexisting commitment, such as Alabama, Nevada, or Maine. The fact that a number of states have neither the means nor the will to ever pursue state health plans to cover the uninsured is one of many reasons why state-level health plans must be perceived as incremental steps toward a national health plan.

• Because the organization and delivery of health care in this country is driven by economic considerations, the crisis on the state level (as well as the national level) tends to be defined exclusively in financial terms. Depending on one's point of view, the issue is either uncompensated care (the view of doctors and hospitals), lack of health care (the view of consumers), or rising costs (the view of employers). Despite the on-going efforts by many people involved in health care movements at the state level to seek broad reform, few proposals emphasize primary and preventive care, attempt to strengthen planning, or invoke accountability on the part of health care providers and insurers.

One of the few modest, though important, exceptions in the state health plans discussed in this issue is Massachusetts’s Centercare program, which continues long-standing support for community health centers as a component of the Universal Health Care Law. As experience with Medicaid and other health programs for low-income people demonstrates, the need to ensure an ample supply of health care providers and a full complement of primary care and social services does not evaporate when people are provided with insurance. And yet most state-level (as well as federal) proposals either rely on “market forces” to redistribute the supply of health care providers or ignore the issue altogether.

• Although cost containment is a primary motivation for employers and some providers involved in state-level reform efforts, most proposals build on the very administrative and insurance systems that promote (and consume) escalating costs. The New York State UNY*Care proposal is among the most explicit in its attempt to integrate a cost-containment provision, but its “single-payer” system may actually duplicate administrative functions by establishing a state agency as the middle person between insurance companies and providers. As Himmelstein and Woolhandler point out, this approach is actually likely to cost more than the existing system.

Failure to address cost containment in state-level plans has the potential to slow, if not altogether collapse, the building momentum for comprehensive reforms by creating political and practical barriers to making the initial new expenditures that are required to ensure an equitable distribution of health services countrywide. Of more immediate concern is the likelihood that powerful provider groups and employers involved in shaping state health proposals will seek cost savings not through single-payer systems or regulatory control over providers but by restricting benefits to the newly insured and excluding coverage of others altogether.

The prospects for federal leadership in addressing the nation’s health care crisis are dim. With the exception of a few notable leaders—such as California Congressman Ron Dellums, who has promoted a comprehensive health care plan for the nation every year since 1975—Congress and the administration appear impotent on the question of health care reform. By default, therefore, states are now, and will continue to be, the centers of the debate.

(Continued on page 21)
California has always been a study in political contradictions. The state that biannually re-elects Ron Dellums, Congress's most avid advocate of a national health service, and Fortney "Pete" Stark, the representative at the top of the American Medical Association's "hit list," also thrust Richard Nixon and Ronald Reagan on the country. Clearly, anyone writing about California politics has some explaining to do.

Despite its often contradictory political tendencies, California is a leading contender among the states attempting to implement public, universal health insurance plans at the state level. The nation's most populous state, it also has one of the highest proportions of people who lack health insurance. Nearly one out of every seven uninsured U.S. citizens resides in California. Although health care problems loom large in the state, California also has a sufficiently strong state economy to consider going it alone with a state-based insurance program. If Californians ever developed Baltic inclinations about their national sovereignty, California would register sixth in the world in terms of gross domestic product.

And, while state government is regularly paralyzed by a Democratic legislature at odds with the fiercely conservative Republican Governor George Deukmejian, as well as by some of the most stultifying (and on occasion, criminal) special-interest lobbying in the nation, California has one of the country's most open ballot initiative processes. Californians are placing bold ballot measures before the electorate with increasing regularity. A memorable triple play of progressive initiatives passed in November 1988: restoration of the state Occupational Safety and Health Agency, previously eliminated by Deukmejian; a cigarette tax; and, most hearteningly for advocates of health insurance reform, an insurance measure calling for strict regulation of and cuts in automobile and other liability insurance. All measures won on the basis of grass-roots organizing in the face of multimillion dollar opposition campaigns.

The progressive health care movement in California has recently found its most visible embodiment in the Health Access coalition. As a member of the Health Access Steering Committee, I will provide a somewhat parochial view of events in California centering around the work of this coalition.

Health Access originated in 1987 out of groups working to implement stricter penalties against "dumping" of uninsured patients by private hospital emergency rooms. Member organizations included minority groups, associations of interns and residents, public interest law firms, unions, religious groups, senior citizen advocates, and consumer organizations. With the assistance of sympathetic media, which dramatized a number of especially heinous dumping stories, the campaign succeeded in enacting a strict anti-dumping bill in the state legislature over the formidable opposition of the California Medical Association.

With this incremental reform in hand, participating groups sought to develop a wider and more sustained coalition to address the larger crisis in access to care in the state. In the year after Health Access first coalesced around the dumping issue, the nation's attention shifted to the

Kevin Grumbach is a family physician in San Francisco. He is co-chair of the California Physicians' Alliance and serves on the Steering Committee of Health Access.
broader question of universal health insurance. The coalition now had two tasks: designing a policy agenda and developing a political strategy to put the policy into action.

Formulating a Health Plan Policy
Late in 1987, Health Access convened a committee of "policy experts" to develop a program to, as stated in a Health Access memo at the time, "move the California health agenda forward toward more sweeping, fundamental reforms." By and large, the policy committee mem-

bers did not officially represent groups in the coalition, but were drawn from academic circles, health services, consulting firms, and legislative staffs.

One of the committee's working premises was that to be viable, a program for equitable and universal coverage had to be able to hold down costs. In designing a model plan for the state, the committee almost immediately reached consensus that the plan should be a universal, tax-financed program administered by a public agency. It would have to include all California residents and provide comprehensive benefits, including long-term care. There was less agreement about exactly how the public agency should go about administering the program.

A number of committee members advocated a system of competing prepaid health plan intermediaries. While the state would act as a "single payer" on the financing side, it would use these public funds to enroll Californians in the prepaid plan of their choice rather than directly reimbursing hospitals, physicians, and other providers. Its advocates saw this system as being in tune with health care policy "California style." HMO's, particularly the giant Kaiser plans, are well-entrenched in the state. California government has a tradition of eschewing regulatory policies, such as certificate of need programs to approve hospitals' capital projects and hospital rate setting. Rather, in the past decade the state has promoted such pro-competition policies as health plans bargaining with hospitals for discounted rates and competitive hospital bidding for MediCal contracts. The "managed competition" philosophy of Stanford Professor Alain Enthoven, which emphasizes consumers acting as cost-conscious purchasers of competing health insurance plans, holds considerable sway in parts west (although the competition pervading the California health care scene isn't always of a particularly "managed" variety).

Other participants on the committee argued for a more traditional single-payer system, with the state reimbursing providers directly without relying on private HMO intermediaries. What was coming to be known as the "Canadian model" was gaining notice at the time and figured prominently in the national proposal under development by Physicians for a National Health Program (PNHP). Groups such as PNHP stressed the administrative savings of the Canadian system and viewed private intermediaries as a likely obstacle to an equitable and economical system.

Over the ensuing months, the policy committee moved toward agreement on a plan that would incorporate both models. True to the spirit of consumer choice, Californians would be free to enroll in either a plan administered directly by the state (a la Canada), or in prepaid plans under contract with the state. In other words, a Californian could elect either to have the state act directly as the "insurance company," paying the individual's doctor and hospital bills, or to have the state simply pay a lump sum to a health plan intermediary to provide all the individual's necessary care.

The plan would differ from Enthoven's approach in two key ways. First, the Health Access proposal would be a social insurance plan financed exclusively through taxes, rather than preserving enrollment based on insurance premiums and linked to employment. If not a classic single-payer structure, the plan would at least constitute a "single-financer" system. Second, there would be no price competition between prepaid plans. The state would set a fixed, risk-adjusted capitation rate that all participating plans would be required to accept as payment in full for the designated benefit package. Prepaid plans could com-

petition on the basis of quality of services for the given package of benefits, or they could compete on the basis of efficiencies that might allow them to expand benefits beyond the minimum (but relatively comprehensive) package or to eliminate small co-payments at the time of service. But plans wouldn't be able to segregate the market based on individuals' ability and willingness to pay extra enrollment fees for standard benefits. The final model plan was seen as striking a balance between a regulated and a competitive system.

Our task involves making the health care crisis personal not just for the uninsured, but for the majority of middle-class voters.

The coalition had two tasks: designing a policy agenda and developing a political agenda and developing a political strategy to put the policy into action.
Questions of Strategy

How was Health Access to go about enacting such an ambitious plan? One option was a legislative route, working with sympathetic legislators to sponsor it. Even as Health Access was working to design a plan for "sweeping, fundamental reform," the coalition had remained active in the Sacramento legislative arena in support of a number of less ambitious measures. A Health Access proposal for comprehensive insurance for all pregnant women and children had been a factor in the state's decision to expand perinatal coverage under the state's MediCal program. One option was therefore to build on this established modus operandi in Sacramento.

Health Access conferred with Assemblyman Burt Margolin, one of the legislature's most active members in health care reform and co-author of the state's tough antidumping bill. Margolin, however, was willing only to introduce legislation that relied on a "play-or-pay" structure, rather than the fully public insurance design that characterized the Health Access plan. Margolin's proposal, like Massachusetts's Dukakis plan, allowed employers the choice of "playing"—providing insurance benefits—or paying a payroll tax into a public pool for those without private insurance. Cost containment would rest with a commissioner to regulate insurance premiums. (The Margolin bill also excluded long-term care coverage).

The Margolin bill stood as the more liberal alternative to a measure calling for mandated employer coverage that was being introduced at the time by the influential speaker of the Assembly, Democrat Willie Brown, with the backing of the California Medical Association. Sacramento prognosticators gave the Brown bill a better chance of passage, although both were considered long shots in a legislature known for its inactivity on insurance reform and its inability to override gubernatorial vetoes of measures that threatened business interests.

Many coalition members pushed the alternative of placing a Health Access plan initiative on the November 1990 ballot. The coalition would at least then be able to control its own policy, if not entirely its own political destiny. But costs for an initiative campaign were daunting—an estimated $750,000 to $1 million just to collect the one million signatures needed to qualify for the ballot. (The measure would be an amendment to the state constitution, requiring a particularly large number of signatures for qualification.) How could Health Access raise the required sum, particularly with labor unions, the coalition's major organizational contributor, making the 1990 gubernatorial race a priority of their political activities and funding? And, despite the generally optimistic poll results, would Californians vote for a complicated measure that radically overhauled the way in which they paid for and received their health insurance? The recently victorious auto insurance initiative, in contrast, had simply promised a 20 percent cut in their car insurance premiums.

Health Access set out to negotiate with some "deep-pocket" interests to co-sponsor a ballot measure. One of the few groups seriously willing to talk about possibly

---

**Coming to Terms with the Proposals: Some Definitions**

Three main types of approaches are currently advocated in the United States for broadening health insurance coverage. Under the employer-mandate approach, government requires businesses to provide private health insurance benefits to their employees. (Approximately three-quarters of the uninsured are employed or dependents in families with a working member.) Government's role is limited to regulating and enforcing the mandate (what one economist has referred to as a "pseudo-tax"), and, usually, subsidizing some of the costs of insurance for lower-income businesses and workers. The proposed Kennedy-Waxman bill is an example of the employer-mandate approach.

Play-or-pay proposals are a variation of employer mandates. Employers are given a choice: they either have to enroll their employees in private insurance plans ("play") or pay a payroll tax for the government to use in setting up a public program to cover uninsured employees. Employers receive a tax credit for the amount they spend on health insurance benefits, up to the limits of the health insurance payroll tax level. Massachusetts is currently attempting to phase in a play-or-pay program.

The third approach divorces health insurance financing from employment altogether. Under the public or social insurance model, everyone is covered under a unitary public insurance program, and financing is primarily through the tax system, rather than through premiums paid by individuals or employers to private insurance companies. Under this single-payer system, the government is directly responsible for financing and administering health insurance. The provincial health plans in Canada exemplify this approach, as does the U.S. Medicare program to a more limited degree.

—K.G.
backing a measure was the hospital lobby. Not unexpectedly, negotiations led the initiative further and further away from Health Access's model plan before the hospitals decided to drop out of negotiations altogether.

Both the legislative and hospital-lobby forays compelled Health Access to come to terms with what it was willing to settle for. Was the universal health program embodied in the model plan a real commitment, or was it just a model set up to provoke political compromise? The difficulty in coming to consensus on this question was understandable. To begin with, the plan's authors were predominantly drawn from academic or consulting circles, rather than representing defined constituencies within Health Access. Not all groups came to Health Access already sold on the merits of a public insurance program, as opposed to other models such as "play or pay." Some groups, including several senior citizen organizations and the California Physicians' Alliance (a California affiliate of FNHP), were wedded to the tax-financed public structure embodied in the model plan. Other groups had less clearly delineated policy positions, either because of political judgments that they should not fully commit to any one proposal or because they were less familiar with the policy details under debate. Understanding the different policy implications of employer mandates, play-or-pay schemes, and social insurance models was no easy matter.

Whether due to the San Francisco earthquake, or to some other shift in the elements, a greater singularity of purpose began to take hold among coalition members during the fall of 1989. Members began to re-group around the original model plan. There was greater recognition that truly progressive health reform would have to hitch its prospects to the hard work of grass-roots organizing and strengthening of a health advocacy movement from the bottom up. Organizations appeared more ready to dig in for a sustained two-year effort to build toward an initiative campaign in 1992, rather than looking for quick money and a frantic go at it in 1990.

A Bevy of Bills

Events of early 1990 seem to have validated Health Access's strategy of sticking with its program, demonstrating just how far the health care debate has come in California. Willie Brown's employer-mandate bill of 1989 passed the legislature in an amended form, calling for a "study" of the access crisis. (This phenomenon—bills designed to enact plans emerging from legislatures as bills to "study" the problem—is not unique to California, as recent events in Washington State attest.)

The Brown bill called for the heads of the California Departments of Health and Human Services and of Transportation and Commerce to chair a task force to produce a non-binding recommendation to the governor for a plan to address the health insurance problem. Of the 18 task force members, Health Access was the only consumer representative.

Although the task force included such diverse constituencies that no consensus was reached, the chairs drafted a proposal for mandated employer-sponsored health insurance coverage. What made the proposal surprising was, first, that it encompassed many more workers and dependents than would have been covered in the employer-mandate bill proposed by Democratic Speaker
of the Assembly Brown a year earlier and, second, that it issued from a Republican administration that in past years had virtually refused to acknowledge the very existence of a problem in access to health care. There could not be two more diametrically opposed California politicians than Congressman Henry Waxman and Governor George Deukmejian, but now here was the Deukmejian administration (albeit in the form of his less-conservative appointees) proposing a measure not too dissimilar from the Kennedy-Waxman bill in Congress!

Governor Deukmejian, who was attending the National Governors Association conference in Washington, D.C., at the time the draft of the plan hit the California newspapers, didn’t even wait to return home to hold a press conference distancing himself from any personal endorsement of the draft. Democrats Margolin and Brown (whose bill had created the task force) retooled the draft into a bill that they jointly introduced in the Assembly (although, adding to the peculiarity of this proposal, they have refrained from actually endorsing it, not wishing to antagonize the medical lobby). In sum, everybody in Sacramento wants to support the “process” of the task force, but almost no one wants to go on record as endorsing the specific proposal.

Not to be left behind, the California Medical Association found a legislative sponsor for its own version of an employer-mandate proposal with a more favorable reimbursement scheme for providers (the Brown-Margolin, née Deukmejian, proposal has some clauses the physicians’ lobby finds especially onerous).

By this time, Health Access had also found a credible sponsor, Oakland Senator Nick Petris, to introduce a bill for a universal, tax-financed plan closely drawn from the Health Access model plan. Although prospects for passage of the Petris bill are dim, the introduction of a bold public insurance proposal in the legislature has served to advance Health Access’s long-range goals in several ways. First, the sponsorship of a highly regarded senator has added legitimacy to the Health Access plan. Second, it has accentuated the health care debate in the media and compelled many organizations, such as unions, to take a formal, public position on the plan. Finally, it has provided a rallying point for community organizers while they build toward the more distant 1992 initiative campaign.

The introduction of the Petris bill brought the tally of insurance proposals before the legislature to four, including the still-active Margolin play-or-pay bill. While no one is optimistic that any of the four bills will pass this session, the debate in California is certainly on a different order than before. Health Access’s call for sweeping, fundamental reforms is gaining greater political legitimacy.

States can be the testing ground for a variety of alternative approaches to universal health coverage.

The Road Ahead

Are there lessons to be gleaned from these at times difficult but by and large promising experiences in California? Most important, the presence of a strong, consumer-based movement such as Health Access, promoting fundamental restructuring of health insurance, has proven to be a catalyst for much more dynamic health care reform activity in California. Without the threat of Health Access placing a social insurance plan on the ballot, employer-mandate and play-or-pay proposals would not be generating such serious legislative consideration. Defining and rallying around a progressive public plan provides ample opportunities for more traditional political interests to offer less ambitious programs.

In terms of organizing strategies, getting a coalition (much less an electorate or legislature) to agree on a universal public insurance plan is a task of a different order than getting people to agree to penalize physicians for patient dumping or to enroll a few more pregnant women and children in Medicaid. Part of the task involves making the health care crisis personal not just for the minority of uninsured persons, but for the majority of middle-class voters. They must experience a sense of collective vulnerability to the “takebacks” of medical benefits at the workplace, to the growing burdens of long-term expenses for working families, to the insurance industry’s insidious practices of experience-rating and exclusionary underwriting, and to the unrelenting inflation of health care and insurance costs.

Educational efforts must also clarify the distinctions between a complicated array of alternative “solutions.” A successful example was Health Access’s timely analysis pointing out the weaknesses of a mandate approach by publicizing the projected costs of the Deukmejian administration’s employer-mandate draft proposal. While working on internal analyses of the costs of the Health Access model plan, Health Access had also estimated the costs of an employer-mandate scheme. We were fortuitously able to use these cost projections to flesh out the state’s own belated cost estimates for the mandate proposal, generating considerable media attention about the high public and private costs of a mandated-benefit approach.

Experiences in California also suggest that major health insurance reform will be contingent on strengthening a new populist consumer movement. Mobilization of stal-
wart, grass-roots health care advocates, such as the Gray Panthers and the well-established Vote Health consumer coalition in Alameda county, in conjunction with newer groups such as AIDS activist organizations, is emerging as the key to the prospects of a Health Access ballot initiative. Organized labor stands to be a crucial ally, and unions such as the American Federation of State, County and Municipal Employees (AFSCME) have been supportive. The Petris bill garnered impressive union backing, including, AFSCME, the Service Employees International Union (SEIU), the California State Employees Association, and the California Labor Federation (AFL-CIO).

Assertions that a tax-financed program will be fairer than a flat mandating of premiums have done little to lessen opposition from business to compulsory insurance of any variety in California. And, as advocates in other states have learned, getting involved in negotiations on insurance plans with vested-interest groups of health care providers seems to be just asking for trouble. On the other hand, the participation of groups such as PNHP and the California Physicians' Alliance has added considerable legitimacy to the plan and made a strategic dent in the traditional opposition of organized medicine.

While an all-encompassing national health program is ultimately necessary, there is much to be said for commencing with one or a few state-based programs. States can be the testing ground for a variety of alternative approaches to universal health coverage, providing valuable experience about the merits and liabilities of competing plans. States may also devise plans that are in tune with regional styles and idiosyncrasies. It only took the institution of a public program in one province—Saskatchewan—for the idea to catch on throughout Canada. Who is to say it can't happen here?

Health Access may be reached at 1535 Mission Street, San Francisco, CA 94103, (415) 431-7430. The California Physicians Alliance is at 230 Bosworth Street, San Francisco, CA 94112, (415) 695-9532.
Washington State has a long history of innovation in health care. It was the first state to adopt a no-fault insurance program for injured workers. A hospital cost-containment program was established in 1973 (and killed in 1989). Washington is one of only 15 states with a high-risk health insurance pool run by the state, and it has a long tradition of strong support for health maintenance organizations (HMO's), led by the 360,000-member Group Health Co-op. Most important, with the 1987 Basic Health Care Plan, Washington launched the nation's first pilot program to provide HMO-style health coverage for the uninsured.

As even their supporters recognize, however, these and many other innovations are piecemeal attempts at reform that have failed to address the fundamental problems of cost containment and equal access to health care. Until recently, though, the political climate was not ripe for systemic change.

Several major trends have affected Washington, as they have most other states. The first and perhaps most visible of these is the rising cost of health care. According to state estimates, over $8 billion is spent in Washington State on health care, and the figure will reach $22 billion by the year 2000 if national trends are followed.

These rising costs have pushed both business and labor to seek new answers to the old question of cost controls (see "Labor Confronts the Health Care Crisis," by Laura McClure, Spring 1990 issue). Nearly every major union in Washington has seen health care costs become the toughest issue in bargaining. Unions, service sector unions in particular, are discovering that there is not enough negotiating room between them and employers to absorb 20 to 40 percent annual increases in health care costs, and health care is moving rapidly to the top of their agenda.

Business in Washington is split on the health care issue. Boeing, the state's largest employer, with over 120,000 workers, has not been hit as hard as many industrial companies because of its strong market position and bargaining power, as a self-insured entity, with providers. Boeing lobbyists did help push legislators to act this year, particularly on the cost issue, but Boeing and other large companies have not played a major public role in the health care debate.

However, the response of one small business group, the Washington Federation of Independent Businesses, has been to call for the elimination of benefits that are already mandated for insurance plans, believing that cutting back on state-mandated benefits such as coverage for mammograms and chiropractic care will somehow stop the spiral of health costs.

The second major trend has been the rise in the number of both the uninsured and underinsured. Washington has 780,000 residents without health insurance—17 percent of the state's population, according to state and Washington State Medical Association estimates. This number rose dramatically in the 1980's and is up 50,000 in the last three years alone.

A third trend is the move by insurers in Washington, like those elsewhere, to reduce health coverage for small business employees and the self-insured by screening out people with pre-existing conditions. This move away from community rating has gone beyond commercial insurers to HMO's and Blue Cross/Blue Shield plans.

The Politics of Health Care

The rise in the number of people without adequate health insurance has caught the attention of Washington's media in a major way, and scarcely a month passes without some media coverage of the issue. The media's focus on the issue has in turn caught the attention of the legislature and the governor.

Governor Booth Gardner, a Democrat, will become chair of the National Governors Association (NGA) this summer, and he will make health care his "issue" for the association in the coming year. Naturally, he is interested in making Washington State a leader in health care reform. Among his concerns, however, is the fact that health care now makes up 14 percent of the state budget and will be
23 percent of the budget in 10 years unless things change.

Another major player on health issues is House Health Care Committee Chair Dennis Braddock, a Democrat with a reputation in the capitol as a neo-liberal on budget issues. Over the past two years, as he has grappled with cost issues on his committee, he became convinced that Washington should follow the example of the Canadian provinces on health care. He was on one of six different teams of state health care professionals, lawmakers, and researchers who made visits to British Columbia in early 1989.

Rep. Braddock introduced the outline of a state health care plan in September 1989, evoking howls from insurers and the Washington State Medical Association. His proposal, dubbed the Washington Universal Health Access Plan (WUHAP), provided for comprehensive universal coverage, an overall state health care budget, and a single-payer system (replacing the 241 entities now licensed to underwrite health coverage in Washington). Legislative staff estimated that under this plan, overall health care spending in Washington State would be no more than is currently spent under a multiple-payer system.

The experience in Washington has been that major changes in state policy are accomplished most successfully through a process involving the creation of a commission that builds in participation and, hopefully, support from a wide variety of interest groups. Thus, Braddock's proposal called for a 17-member commission to include representatives of business, labor, providers, consumers, and state government. The commission would develop an implementation plan, based on the principles of the Canadian system.

---

**Quality of health care, as well as access and cost, is important to voters.**

While it was unlikely that such a proposal would pass the legislature in the short pre-election 1990 session, given Republican control of the state Senate, supporters hoped for a victory in the House to build pressure for the next session in 1991.

### Organizing the Health Care Campaign

While Rep. Braddock was formulating his plan in the summer of 1989, health care advocates began to organize. Washington Fair Share, the Citizen Action affiliate in Washington State, began discussions about forming a new coalition with the new progressive health care providers group, Health Care for All, as well as with senior citizen, labor, and church groups.

Together, they organized the Washington Health Care Campaign to develop an ongoing campaign for universal access to health care and strong cost controls. The initial focus for the campaign was Braddock's proposal, but it will also address national health care issues.

Groups that participate in the campaign, either formally or informally, include the Washington Association of Churches, the State Catholic Conference, the Washington State Labor Council, the American Federation of State, County and Municipal Employees (AFSCME), Service Employees International Union, Communications Workers of America, Health Care for All, the State Council of Senior Citizens, the Retired Federal Employees, the Neurological Alliance, welfare rights groups, and some primary care clinics. Staffing for the campaign has been provided by Fair Share (now Washington Citizen Action).

The organization had its first meeting in December 1989 to plan its campaign. In the next few months, the group successfully organized a number of activities. It put together legislator accountability meetings in Seattle, Tacoma, and Spokane involving over 200 people and turned out 150 people for a major hearing on the Braddock bill in Olympia. The Washington Health Care Campaign commissioned a statewide poll that found strong support among Washington voters for a Canadian-style universal access and cost-control plan in Washington. Activists held meetings with editorial boards of a number of newspapers and spoke on radio shows in Seattle, Everett, Tacoma, Vancouver, and Spokane. The Washington Health Care Survivors, a grass-roots effort to organize families without
health care insurance, was formed to advocate for better health insurance in Washington. Finally, the campaign formulated plans for an organization directed to small businesses to organize support for legislation on health care cost and access.

Debating the Braddock Bill

The Braddock plan (HB 2252) was the subject of numerous public hearings and debates. Doctors took it so seriously that the Washington State Medical Association responded within two weeks with their own proposal. They recommended a universal access plan similar to the recently enacted Oregon legislation calling for employer-mandated insurance and an expanded Medicaid program.

In Washington, the Oregon plan was dubbed "medical apartheid" by advocates of a Canadian-style system. The doctors' plan would not control rising medical costs; nor would it do anything about the inefficiency built into a multiple-payer insurance industry. The Oregon plan would also limit Medicaid services, setting up a two-tier system of unlimited care for those with good insurance and rationed care for the less fortunate on Medicaid. Washington Health Care Campaign members have taken the position that waste and inefficiency in health care should be eliminated before rationing is used to try to hold down costs. Should the "Oregon Plan" be adopted in Washington, the fear is that it would be seen as the "Northwest plan" and could then become the model for the rest of the country.

In January 1990, the House Health Care Committee took action. The hearings featured members of the Washington Health Care Campaign and other health care advocates on one side, and the Washington State Medical Association and insurance companies on the other.

The Washington State Medical Association attacked the Canadian system as not being "high-quality." This they defined as not having enough high-tech equipment like CAT scanners, having waiting lists for some kinds of surgery, and not having as much capacity for operations such as open-heart surgery as the United States.

These arguments can and must be countered, because quality of health care, as well as access and cost, is important to voters. Washington Health Care Campaign's response is that a state-run system in the United States can set whatever budget it chooses, and consumers here will not accept a funding level that produces long waiting lines. In addition, there is no evidence that our emphasis on high-tech health care has any impact on the overall health of our citizens or that Canadians are less healthy as a result of their system. The final argument, of course, is that we already have waiting lines here for low-income people, and the 37 million who lack insurance aren't even fortunate enough to be in line for care.

The insurance companies, led by Blue Shield Plans of Washington, attacked Braddock's plan as eliminating consumers' "choice" of insurance companies and plans and setting up a "totalitarian" system. However, the Washington Health Care Campaign's poll, like others, demonstrated that voters cared less about who their insurance company is, but they do care about having a choice of providers—a choice that is increasingly denied by HMO's and other managed-care plans. Moreover, the campaign countered, universal access will never become a reality without effective cost controls, and only a single-payer system and an overall state health budget could slow the rising costs of health care.

The Commission Compromise

Unfortunately for Braddock, one of the votes he needed to get HB 2252 out of his committee belonged to Democrat Art Sprenkle, who also happened to be a Washington State Medical Association member. To get Sprenkle's vote, Braddock softened the language of the bill slightly to allow the commission to study other health care models in addition to Canada's and made a single-payer system an element to be studied, not required.

Thus amended, the bill withstood intense lobbying from the insurance industry and passed the House in February 1990, with over a two-thirds majority. As passed, the plan's elements included universal access, choice of providers, and an overall state health services budget to control costs. The legislation created a commission and guided its investigation with a series of principles, including universal comprehensive coverage for all residents; consumer choice of health care providers; a single entity with control over all services provided by the plan; funding by state revenue, employer contributions, and individual contributions (which could be paid by providers); integration of long-term care services into the
The compromise House plan met with further resistance in the Republican-controlled Senate. After many more weeks of intensive lobbying, the final Health Care Resolution passed by both houses called for the creation of a commission to recommend a universal access and cost-control plan by 1991-92. The very general goals for this final compromise commission were to identify methods to reduce and control health care costs; identify appropriate and effective health services; recommend changes relating to medical malpractice and liability insurance; and recommend plans for ensuring access to health care for all people.

Whether the commission will come up with a real health care reform plan without the strong guidelines of the Braddock plan remains to be seen. Once the legislative process was started, however, the Washington Health Care Campaign found it difficult to back away from supporting an open-ended commission as a final compromise, especially when it appears that reform advocates will have a strong voice on the commission.

Governor Gardner made the appointments to the commission in late May. His selections were notable for who was missing—the Washington State Medical Association (although two of the legislators are physicians), Blue Cross/Blue Shield, the major HMO's, and the Washington Hospital Association. Instead, health care providers are represented only by a nurse from the Seattle/King County Health Department and a hospital administrator from Southwest Washington who was not the choice of the Hospital Association. Insurers are represented only by an independent HMO consultant rather than by the industry giants. Overall, the commission looks to be independent, pro-universal access, and undecided on cost controls.

A major concern of health care providers during the commission's deliberations will be shifting the debate away from cost controls and insurance reform. They want to focus instead on the idea of rationing of health care, along the lines of the Oregon plan to set priorities for different health care procedures.

The passage late in the session of a bill backed by business and insurance allowing insurers to drop state-mandated benefits for employers with less than 25 employees will spur more debate over what benefits should be covered with a universal bill. Business will push to expand this "stripped-down" coverage to other employees and to state plans in the future, including Medicaid and public employees.

Developing a solution for Washington is not only a challenge for health advocates, but a political challenge for Governor Gardner as well. He must manage the issue in Washington while projecting a national message from his position as chair of the National Governors Association.

Voters could care less about who their insurance company is, but they do care about having a choice of providers.

Gardner has played a key role not only through his appointments to the commission, but in his public statements about health care. In recent months he has told the Medical Association that while the Canadian plan wasn't the only option, it was fundamentally acceptable to his administration. His aides have also talked about the West German all-payer system as a possible model, which does include a limited role for private insurers.

Opportunities for the Future

The message of the Washington Health Care Campaign's poll should be at the heart of any health care reform strategy. Voters want three major elements from a health care system—access, quality, and reasonable costs—and any progressive strategy has to address all three issues. While there is strong voter support (88 percent in our poll) for a universal access system, it is strongest with Democrats. A better message with independent voters and Republicans is the cost issue, namely, that the health care industry has failed to hold down costs, and it is time for the state to control costs directly.

Since the appointment of the commission, the Washington Health Care Campaign is focusing on education and organizing constituencies before the 1991-92 state legislative session. The campaign will also work to influence the commission, the governor, and the legislature through public hearings, media work, and research in support of a Canadian-style system.

The Washington Health Care Campaign has come a long way in a few months. The key elements in its strategy were establishing a strong coalition, conducting a credible poll to establish public support, and building the Washington Health Care Survivors group to highlight the stories of the uninsured. With this experience and a strong message, we believe reform advocates can overcome almost any defense of our current system by the health care industry. □
The passage of the Universal Health Care Law was an important victory for the uninsured of Massachusetts, but the law is not a panacea. It is not a fundamental reform of the state's health care system, but rather the product of political compromise supported by generous state contributions to its hospitals. The business community supported the legislation because the law limited its liability for the uninsured by shifting some of the costs to the state. Chapter 23 succeeded because it gave something to each of the major players in the system. (See "The Massacre of MASSCARE," by David A. Danielson and Susan Abrams, Winter 1987 issue.)

The political environment has changed radically since the law's enactment. A regional recession and the ballooning state deficit have limited the state contributions and eroded the law's political support. Most of the major interest groups that were represented on the podium with...
Access Programs of the Massachusetts Universal Health Care Law

Chapter 23 of the Act of 1988, "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing," was signed into law on April 21, 1988. By enacting this Universal Health Care Law, the Commonwealth of Massachusetts committed itself to significantly expanding access to health care and health insurance through the gradual implementation of the following programs and initiatives over a four-year period.

Programs in Place

1. **CommonHealth** consists of three new programs that address the needs of former welfare recipients, working disabled adults, and disabled children. All are administered by the Massachusetts Department of Public Welfare. A total of 17,500 people are currently enrolled, 2,500 in the disability programs.

   **CommonHealth for disabled adults** allows seriously disabled people who are employed to buy health insurance on a sliding-scale basis. Without CommonHealth, many disabled people would not be able to maintain employment because health insurance would be either unavailable or inadequate.

   **CommonHealth for disabled children** allows families with disabled children to buy health insurance on a sliding-scale basis. Many members of families with disabled children could not afford to take jobs because their wages would make them ineligible for Medicaid, but their earnings would be too low to afford necessary health care. CommonHealth helps make health insurance affordable to these families.

   **CommonHealth's “welfare-to-work” program** provides health insurance for people who become ineligible for Medicaid as a result of increased income from employment. Many people who lose Medicaid after they begin a job do not receive health insurance from their employer or cannot afford the premiums if insurance is available. Under the “welfare-to-work” rules, eligible people can receive health coverage offered by the Department of Public Welfare or qualify for financial assistance to purchase employer-sponsored health insurance. Eligibility continues for up to two years after Medicaid is stopped, as long as the family's income remains below 185 percent of the federal poverty line.

2. **Expanded Medicaid eligibility** for pregnant women, young children, and teens.

   **Medicaid for pregnant women and infants under age 1** is now available for those whose income is below 185 percent of the federal poverty level, with no limit on assets.

   **Medicaid for children between ages 1 and 5** was expanded by increasing the income eligibility limit to the federal poverty level, also with no limit on assets.

   **Medicaid for pregnant teens** now allows teens to qualify for Medicaid when their parents are not contributing toward their medical expenses. Prior rules counted parental income, even when the parent did not know about the pregnancy or knew but refused to pay for medical care.

3. **Healthy Start**, a state-funded program that pays for pregnancy-related care for low-income women who are not eligible for Medicaid, existed prior to the Universal Health Care Law. It is now a permanent state program administered by the Department of Public Health. Healthy Start also helps pregnant women make their way through the Medicaid application process.

4. **The free care pool**, which pays for hospital bills for persons who cannot afford to pay them, also existed prior to the Universal Health Care Law. The pool is now regulated by the newly created Department of Medical Security. All persons with incomes below 200 percent of the federal poverty level are eligible for free care. Persons with income over this amount may be eligible for full or partial free care, depending on their income, expenses, and individual circumstances. The Universal Health Care Law shifted some of the responsibility for funding the free care pool from business to the state.

5. **Student health insurance** requires three-quarters to full-time students to participate in a qualified health program.

6. **Certain employees of small businesses**, which often cannot afford to offer health insurance, as well as individuals not offered health insurance by their employer can now obtain health insurance coverage through “phase-in” demonstration programs required by the Department of Medical Security. The plans will provide coverage for about 14,000 persons. This program was delayed one year; 400 people are currently enrolled, with a projected total of 7,500 by the end of 1990. A low-cost insurance product is being developed for marketing next year.

7. **Mandated well-children coverage**. All insurance programs in the state are now required to cover well-child visits for children under 6.

8. **Center Care**. This is a program to provide primary care services to patients at independent (not operated by hospitals) neighborhood health centers.

9. **Persons receiving unemployment insurance compensation and their families** who are without health insurance will now be offered coverage by the Department of Medical Security. Approximately 20,000 to 30,000 people will be served under this program.

Programs To Be Implemented

1. **General Relief recipients** (indigent citizens not covered by Medicaid) will be provided with a “comprehensive program of managed health care,” beginning January 1, 1991. Currently, General Relief recipients receive some health care coverage through the General Relief Medical program, but their hospital-based care is paid for by the free care pool. The new requirement should provide the same or better coverage for General Relief recipients and decrease the amount paid by the free care pool. There are currently 30,000 people on General Relief.

2. **All employees and their families** who are not offered health insurance at their jobs and who do not otherwise have health insurance must be provided coverage by the Department of Medical Security as of April 1, 1992. The Department of Medical Security will establish a schedule of premium contributions, copayments, deductibles, or co-insurance amounts, which are to be paid by the employee-participants, based on family size and family income. This program is to be funded in part by employers who do not offer health care coverage to their workers, beginning January 1, 1992.

3. **All other residents of the Commonwealth** who do not have health insurance coverage are to be offered coverage through the Department of Medical Security effective April 1, 1992. This will complete the mandates of the Universal Health Care Law, ensuring that all citizens of Massachusetts have access to health care services.

—R. R.
Governor Dukakis when he signed the law are no longer publicly supportive. At the same time, the small business community is energetically working for repeal of the requirement (known as the “employer mandate” or “play or pay”) that by 1992 employers of six or more workers must provide health insurance for their employees or pay a surcharge on their state unemployment insurance.

Despite these warning signals, the recent reports of the Universal Health Care Law’s demise are exaggerated. All access programs are moving forward, and polling data, such as the Mass Insight survey conducted for the business community, reveal overwhelming public support. Attempts to delay or repeal the 1992 “play-or-pay” requirement have been defeated. Still, the ultimate future of the law depends on the mobilization of those who benefit from its provisions, as well as on the resolution of the state’s fiscal crisis.

Rocky Road Ahead

The road toward universal access is a rocky one, pitted with many political obstacles. The fragmentation of the coalition that once supported the Universal Health Care Law publicly provides its critics with a convenient opportunity to delay or repeal it. Left without any significant political leadership, consumers alone remain committed advocates for universal access, albeit with stronger labor support than before. The business, hospital, and insurance company interests now feel they can do better without the law. And, for the past year, small business lobbyists have taken advantage of the political vacuum in the legislature to mount a strong campaign to repeal the employer-mandate provision. A majority in the Massachusetts House of Representatives currently supports delayed implementation, and it is likely that a one-year delay will pass in the next few months. Underfunding of phase-in programs has also slowed the pace of implementation, and certain postponements are likely within the next year.

Although the legislature is in the process of raising taxes, the initiative petition by Citizens for Limited Taxation to limit all state revenues will be on the ballot in the fall. Passage of this bill would wreak havoc with state finances and specifically with the funding of Universal Health Care programs. The state’s fiscal crisis puts all of the Universal Health Care programs in jeopardy. Many of these programs are already underfunded and face further cuts. This predicament also puts tremendous pressure on other important access programs, such as Medicaid. Even if the Universal Health Care Law survives the repeal attempt, the services that it provides will be in dire jeopardy if the fiscal situation is not improved. The proposed cutbacks in these programs make the Universal Health Care Law’s promise of health care for all a hollow one.

Unanswered Questions

The Universal Health Care Law leaves unanswered many key questions concerning the shape of our health care system. Massachusetts has the most expensive health care system of any state, in the country with the most expensive health care system in the world. However, the cost-containment provisions in the Universal Health Care Law are weak. (See sidebar.) The law’s very generous hospital reimbursement formula allows hospitals to raise their charges, thus increasing health insurance premiums and further straining the ability of workers, employers, and government to pay. A solution to health care costs is vital if these access programs are to be affordable and truly accessible.

At the same time, guaranteeing access to health care is not just a matter of providing insurance coverage. The resources to provide the needed services must also be in place. Health care institutions in low-income areas are suffering from increased competition in the hospital sector. Entitling people to health care will not protect inner-city health delivery systems from collapse.

The high cost of health insurance will make it difficult to implement the “play-or-pay” employer mandate. Given the skyrocketing cost of health insurance, the yearly surcharge of $1,680 per worker (the sum that most employers who do not provide health benefits must pay to the state after March 1992) will be less than the average cost of providing health insurance for an individual employee. Employers will thus have an incentive to drop health coverage for their employees, and providing or arranging health benefits will increasingly become a state responsibility. This could further strain an already overburdened budget, unless the state’s benefit package is made less than adequate or there is additional funding.

Reform of insurance practices to guarantee equity in coverage is another critical issue. The continued erosion of the small-group insurance market and the skyrocketing cost of Medigap coverage (to supplement Medicare) are of particular concern. Insurance reform is important to all consumers deemed by insurance companies to be in high-risk categories, especially people whose pre-existing conditions currently exclude them from the insurance market. The Universal Health Care Law left insurance reform to a study commission that lay dormant this past year. However, consumers are beginning to pressure the legisl-
While the 1988 Massachusetts Universal Health Care Law linked hospital finance and universal access to health care in its title (it is formally known as “An Act to Make Health Security Available to All Citizens of the Commonwealth and Improve Hospital Financing”), it did not do so in substance. It promised to provide new money for each, rather than squeeze current spending and redirect it to improve access. But, contrary to popular impression, the vast majority of new spending in the first four years of the law goes to pay hospitals more money for care of their already-insured patients, rather than to expand access to health care for those who lack it. These added funds for business-as-usual care were a key ingredient in the financial “glue” that, as the accompanying article indicates, holds the compromise law together. In fact, passage of the universal insurance provisions hinged on their connection to hospital finance legislation that was urgently needed to replace expiring rate-setting policies.

Reflecting the political power of hospitals in Massachusetts, Chapter 23 permitted hospitals to substantially raise their charges for privately insured patients and does not channel any of these funds toward improving access for the uninsured. The costs of these hospital rate increases were greatly underestimated when the law passed, and little attention has been given to this hidden tax that drives up premium costs for everyone who buys or receives health insurance. In contrast, the early programs designed to expand access to (Continued on page 20)

The Future of Universal Health Care

The future of the Universal Health Care Law is not clear. Like many other human services programs, its fate will depend on how the state responds to the current fiscal crisis. If the law is to survive, the attacks of the small business lobbyists must be thwarted, unresolved issues must
To Those Who Have, continued from p. 19

care depend largely on state appropriations, which are uncertain even in the best of times. These have been cut substantially from promised levels, worsening the discrepancy between new spending on access and on hospitals. Hospitals have received almost every dollar promised, through higher charges and the resulting higher insurance premiums for employers and workers, while appropriations for access programs have been only one-third to one-half the promised levels for the law’s first two years. The ratio of new spending on hospitals to new spending on access programs thus may prove to be as high as ten to one in the period before 1992 (when the employer-mandate and universal access provisions take effect).

Furthermore, Chapter 23 lacks genuine cost controls. This weakness, as Restuccia notes, as well as the increased hospital funding, is boosting healthcare costs and making care less affordable. High costs jeopardize the availability of insurance both for people who have had coverage until now and for those whom the new law aims to insure. Increased spending on hospitals is a serious misallocation of funds and is pushing costs to unsustainable levels in a health care system that spends more per capita overall, and more on hospitals, than any other state or nation. Other states looking to Massachusetts’s example must recognize both the central role of hospital financing in the Universal Health Care Law and the particular difficulties of expanding healthcare spending any further in such a high-cost state.

Despite the claims of conservative politicians and some business representatives, steps taken to promote universal access in Massachusetts have not been the cause of the state’s budget crisis, soaring health insurance premiums, or hospitals’ worsening financial situation. In fact, though the state contributed $87 million from general revenues to improve the hospitals’ bottom lines in the first two years under the law, access provisions received only about half that much from general revenue appropriations.

The financial margins of hospitals in Massachusetts have indeed been narrowing, and some institutions are in bad shape; in a serious recession, we may find many hospitals bankrupt because of rising costs they can’t cover. But a number have been stockpiling millions, sometimes in less-visible parent corporations. Today, hospitals are again seeking to increase revenues, the one thing they imagine they can control. There is no need, however, to pump even more revenue into the hospital system. The problem in the system is not insufficient overall revenues; it is primarily excess hospital costs, as well as revenues that are unfairly distributed among hospitals.

State regulations capping hospital revenues succeeded in slowing cost increases during the mid-1980’s, but the 1988 law’s cost-control provisions will probably be ineffective—even counterproductive. In the negotiations on Chapter 23, business and state government each sought to shift some of their existing costs to the other rather than to control total health spending—a key reason the law’s financial compromise has proven so unstable. The resulting law relies on managed care, competition, and closing hospitals to contain costs. There is little evidence, though, that managed care saves money—and real concern that it can harm many of the populations now uninsured. Under competition and pressure to close hospitals, institutions with greater financial reserves will benefit. Teaching hospitals are generally less vulnerable to closure than lower-cost community hospitals. Thus, besides raising barriers to access, hospital closings may actually cost the system more if they shift patients into expensive teaching facilities. Even worse, the law introduces rewards for hospitals that increase admissions, replacing prior financial incentives that were neutral about the volume of patients.

Hospital administrators cannot control their costs alone, because most spending is determined by physicians’ treatment decisions. In many other countries (including Canada), hospitals receive annual budgets and are obligated to serve all. Physicians then play a key role, making clinical trade-offs so that funds that now go to buy only marginally or not at all useful care for those who happen to be well insured can instead be redistributed to buy care for people who are currently unprotected.

Massachusetts passed what is in many ways a very traditional law, despite its pathbreaking goals for access to health care. Along with its business-as-usual approach toward hospitals, the law relies on purchase of traditional insurance policies as the means of achieving universal access to care. Stresses in the present system are likely to require much more work from consumers, providers, business, government, and others to shape a health care system we can all afford in years to come. A major new battle is looming as hospitals, lured by hopes of higher revenue, seek total deregulation of the prices they can charge. Access advocates oppose deregulation because it would permit hospital rates to soar, rapidly increase spending on already insured patients, undermine the system that reimburses hospitals serving the uninsured, and bankrupt facilities with limited financial reserves or large numbers of Medicare, Medicaid, and uninsured patients.

The promise of Massachusetts’s Universal Health Care Law can be fulfilled, though new approaches will be needed to link genuine cost controls with funding for universal access. With health care spending per capita in Massachusetts already 20 to 25 percent above the U.S. average, redistribution of these funds should enable us to provide needed care to all who live in our state, while sustaining all essential hospitals.

—Debbie Socolar and Alan Sager

Alan Sager and Debbie Socolar work on the Access and Affordability Monitoring Project at the Boston University School of Public Health. To receive the Project’s monitoring reports on the Massachusetts Universal Health Care Law, Chapter 23, call (617) 638-5042.
be addressed, and the state must provide adequate funding.

The Universal Health Care Law will not cure our ailing health care system, but it is a significant step forward. It marks the first time that the issue of access to health care was made a priority on a state's agenda. In the era of Reagan and Bush, the law has given a much-needed shot in the arm to all concerned with universal access to care. Failure of Chapter 23 would be a major setback for the health care reform movement.

There is a growing discontent with our health care system. The short-term challenge for activists will be to fend off the right-wing small business forces. But the long-range strategy must have a national component. Political support for national efforts will be bolstered by success in the states. While continuing to fight for improvements in Massachusetts's access programs, Health Care For All will work toward a national health care solution.

Debate, continued from p. 5

The question for many people is whether activity at the state level contributes to the national political impasse by deflecting pressure away from Washington. On the other hand, one could argue that state health initiatives push us closer to a national health plan, and that each state-based program reduces the overall political and financial cost of a national system. This is much like the strategy that has been used to raise federal Medicaid eligibility and benefit floors for pregnant women and children: When enough states have exercised federal Medicaid options, the process of transforming the options into mandates is more feasible, politically and financially.

And yet, just as the Medicaid expansions have been built on an overly complex, burdensome, and inefficient system of administrative and health service delivery, state health initiatives run the risk of perpetuating and strengthening the most regressive qualities of the current system. Thus, in addition to evaluating whether state health initiatives undermine or support a movement toward a national health plan, a number of other questions must be raised. The first is whether a state health plan actually produces some social benefit, such as providing health care to individuals who otherwise would go without. Some of the plans under consideration at the state level propose to provide coverage for new groups of uninsured people, but at the expense of others who are only marginally covered at present.

Related to the question of social good is social harm: Does the state health plan reinforce and bolster the most insidious features of the current system, such as wasteful administration? In fact, most state (as well as federal) proposals recommend maintaining the current insurance system, which promotes waste and serves more as an insurance system for providers (that is, a guarantee of payment) than a means of financing needed health care.

In addition, we must examine who the principal beneficiaries of each program are, how the system will be financed, whether attention is paid to issues of planning and resource allocation, and the extent to which the proposal promotes prevention and primary care. Whatever one's position is on the tactic of state health initiatives as a step toward a national health program, the fact remains that the debate is underway in the state capitols. Unless progressives make ourselves heard on these issues, they will neither be addressed nor even raised.
A new proposal to overhaul New York State’s financing of health care was recently floated by the New York State Department of Health, headed by Commissioner David Axelrod. Known as UNY*Care—Universal New York Health Care—it purports to extend health coverage to many of those who currently lack insurance by mandating that employers insure their workers. The New York State proposal shares this “employer-mandate” approach with several other programs to improve access to health care, including Massachusetts’s universal health care bill, federal legislation sponsored by Senator Edward Kennedy and Representative Henry Waxman, and the program offered by the National Leadership Commission on Health Care. While these other proposals have been criticized for their lack of realistic cost controls, UNY*Care’s authors aver that their program can simultaneously control costs and improve access through a novel reform of the system of reimbursing health care providers. This claim has attracted wide attention within the health policy community, and UNY*Care is likely to serve as a model for similar proposals elsewhere. We fear, however, that such sanguine views of UNY*Care are unwarranted.

UNY*Care’s unique feature is the interpolation of a new state agency between providers (hospitals, physicians, clinics, etc.) and bill payers (insurance companies, government insurance plans, and individual patients). Providers would send all bills for insured services to this state agency, which would pay a uniform fee for a covered service regardless of the patient’s insurance. The agency would in turn bill the appropriate insurer and then bill the patient directly for any co-payment or deductible. Published descriptions of UNY*Care don’t specify what would happen when a patient received one of the many services not covered by their insurance. Presumably, the provider would bill the patient directly.

In addition, UNY*Care would set all hospital rates; negotiate a fee schedule for services that would be binding on physicians, as well as make assignment—acceptance of payment from the insurance carrier—mandatory; foster competition among insurance carriers; and encourage health maintenance organizations and other capitated systems of care, in which one flat fee is charged for each individual. Every New Yorker would receive an electronically coded plastic UNY*Care card. This card would contain information for the provider on covered services, which would vary from patient to patient, depending on their coverage. In addition, the card would be used for all billing.

UNY*Care, like other employer-mandate plans, would force employers to either contribute to health insurance for their employees or pay a penalty—in UNY*Care’s case, an unemployment insurance surcharge. New York’s Medicaid program would continue to cover everyone with incomes below the poverty line, and Medicare for the elderly would remain largely unchanged. Those not covered through Medicaid, Medicare, or their workplace would be offered a plan through a private insurer at an estimated cost of $1,200 for an individual and $2,700 for family coverage—considerably less than current costs for non-group coverage. These lower rates would presumably be possible because the state would act as the broker and could use its clout as a “wholesale” buyer of insurance. The state would subsidize this coverage for people with incomes between 100 percent and 200 percent of the poverty line and would also offer tax credits for low-income workers who contributed more than $250 (for an individual policy) or $500 (for a family policy) to an employer-provided plan. In addition, during UNY*Care’s first four years, the state would subsidize employers that were offering coverage for the first time.

All policies would provide at least the mandated minimum coverage, which would be similar to the current Medicare benefit package. Coverage would also include preventive care for all children and pregnant women as well as for all adults with incomes below 200 percent of the
poverty line. There would be no co-payments or deductibles for any covered services for those below the poverty line, and deductibles on a sliding scale, rising to $1,000 per year for those with incomes between 100 and 200 percent of the poverty line. Those with higher incomes would see little change in their current policies, though the state would pay any hospital bills in excess of $25,000 each year. A similar stop-loss provision would apply to doctors' bills (for a total of $50,000). Thus, neither insurance companies nor individuals would be liable for these “catastrophic” costs. Through this “stop-loss” provision, UNY*Care’s authors hope to halt “risk selection”—the insurance industry’s ubiquitous practice of vigorously avoiding high-risk, and hence unprofitable, subscribers.

The Promise of UNY*Care

UNY*Care would extend coverage to many (its authors claim all) of the uninsured. Setting Medicaid fees for providers at the same level as those of other insurers would significantly improve access to care for Medicaid patients. The establishment of a single payer for all health care bills (the newly created state payment agency) would allow the state to control the flow of money into the health care system and, at least theoretically, to control costs.

Dr. Axelrod and his colleagues claim that the new payment system would engender substantial administrative savings, despite the continued participation of private insurance carriers. They recognize that a system fully financed through taxes is “the fairest and the most efficient way to finance universal coverage.” Yet they reject a publicly financed program for fear of antagonizing taxpayers and imply that the insurance industry is too powerful to throw overboard.

The Problems of UNY*Care

Despite the laudable goals of UNY*Care’s authors, the program’s flaws deeply undermine its ability to improve access or contain costs. UNY*Care avoids confronting the private insurance industry, which by itself consumes billions of health care dollars and engenders waste in hospitals and doctors’ offices costing tens of billions more. Since UNY*Care eschews savings at the expense of the insurance
industry and health bureaucracy and includes no mechanisms to improve health planning, if cost containment is to occur at all, it can only come at the expense of clinical care.

There is little reason to believe that UNY*Care would streamline administration of health insurance. At present, private insurance companies keep 12 percent of premiums for “overhead” costs, four times as much as the overhead of the Canadian provincial health programs or the U.S. Medicare and Medicaid programs. UNY*Care’s authors claim that insurance companies’ overhead would decrease under their plan and seem to believe that private insurance would quietly wither away as its role became redundant. While the private insurance plans would play a diminished role in claims processing, the insurance companies’ other wasteful and expensive activities would continue or intensify. There is little evidence that the $50,000 total stop-loss provision would in fact deter insurers from vigorous and expensive efforts to avoid high-risk individuals. Moreover, UNY*Care would nurture competition among insurers, thereby fostering expansion of risk-selection, marketing, and cost-shifting activities. Indeed, since the state would purchase its new coverage for the uninsured from private insurance companies, the total spent for insurance overhead might actually increase. UNY*Care would perpetuate the current profligate arrangements and add yet another layer of bureaucracy—the state payment agency—without subtracting any of the old ones. The pattern familiar from each attempted reform of the health insurance system over the past quarter-century seems likely to recur. New bureaucrats will join rather than replace their predecessors.

UNY*Care’s creators also assert that the program would generate substantial savings by reducing hospitals’ billing costs. Currently, U.S. hospitals spend fully 18 percent of their total revenues for billing and administration. Canadian hospitals, which receive their budgets for all operating expenses in a lump-sum and do not bill for individual patients, spend less than half that amount. Unfortunately, UNY*Care would not establish lump-sum hospital budgets. By maintaining the per-case reimbursement system with patients having varying coverage, UNY*Care perpetuates the large-scale internal accounting apparatus hospitals need to apportion costs to individual patients. Some savings would accrue because most bills would be sent to the state agency as the single payer, and the many different forms now used for submitting bills would be eliminated (although hospitals would still bill patients directly for services that are not covered). But in the absence of other changes, these administrative savings would likely be modest—perhaps 10 percent of what could be realized by a more thorough reform.

Since UNY*Care is unlikely to achieve substantial savings by streamlining bureaucracy or improving health planning, it cannot reconcile the goals of expanding access and containing costs. As a result, the proposal aspires to only a relatively modest expansion in access to care and would leave many New Yorkers severely underinsured and probably some still uninsured.

While UNY*Care addresses the problems of the uninsured by requiring employers and the uninsured themselves to buy coverage, it does almost nothing for the millions who are currently underinsured. For instance, there would be little change for senior citizens, who currently pay more than half their medical bills out of pocket, spending an average of 18.1 percent of their total income, despite Medicare coverage. Disturbingly, the proposal cites the inadequate Medicare benefit package as the model for coverage under UNY*Care.

Access to care (as well as its quality) may be further compromised because UNY*Care’s only viable provision for cost containment is the power of the state agency to squeeze the incomes and budgets of health care providers. Hospitals in New York have operated under a similar cost-containment policy for some years, with dubious results. Indeed, the pitfalls of cost containment based on rigid budgetary constraints, without streamlining the bureaucracy and improving health planning, are illustrated by the current crisis in New York’s hospital system. Queues of patients on gurneys line emergency department corridors, often waiting days for an inpatient bed. Hospital pharmacies that were virtually the only source of medications for hundreds of thousands of Medicaid and uninsured outpatients have been closed. Patients followed for decades in private hospital outpatient clinics have been shunted to already overburdened public facilities. Hospitals renowned for clinical excellence are drowning in a sea of red ink.

UNY*Care would aggravate this unfortunate state of affairs; the powerful leverage of single-source (monopsony) payment would be exercised in the absence of the other key features of a Canadian-style program. In essence, UNY*Care is an effort to construct a monopsony payment system that can coexist with the inefficient and inequitable patchwork system of private insurance and even no insur-
ance. Although UNY*Care's authors propose coupling this cost-containment structure with provisions that would extend access to care, there is no necessary link between the two—the UNY*Care payment structure is fully compatible with profound inequalities in coverage and access.

Disturbingly, the largely undocumented cost estimates in the UNY*Care proposal seem wildly optimistic. The authors assert that less than $100 million in new tax dollars will be needed to supplement the $1.1 billion now spent by New York State and New York City for uncompensated care. This $1.2 billion is expected to subsidize private coverage for 1.32 million near-poor individuals who are currently uninsured; pay part of the premiums of all of the near poor who now have insurance but will become eligible for subsidies; boost Medicaid reimbursement rates; assist small businesses in purchasing coverage; and continue to pay hospitals for uncompensated care given to out-of-state residents and illegal aliens. Moreover, the estimates assume the continuation of the longest economic expansion in modern history. Any rise in unemployment would cause a rapid escalation in the public costs of the program at the same time that tax revenues fall.

### Health Care Reform on New York's Agenda

The UNY*Care plan developed by the New York State Department of Health is not the only proposal for universal health care coverage currently circulating in the state. The New York State Health Care Campaign, a coalition of health care advocates including unions, have developed their own plan, an enhanced version of UNY*Care known as UNY*Care Plus. Alternative plans to increase health care coverage in the state have also been put forward by the Hospital Trustees of New York; the New York Business Council and the Hospital Association of New York State; and Richard Gottfried, chair of the state Assembly Health Committee.

Each of these proposals is a patchwork of existing mechanisms. Most try to expand coverage through employer-based coverage and buy-ins to the Medicaid program encouraged and supported by state subsidies. Because of their patchwork nature, each proposal almost surely overlooks some population that will be left without coverage. The range of proposed benefit packages runs the gamut, from special benefits for preventive, primary, prenatal, and maternity care, to catastrophic coverage only, to the elimination of state-mandated benefits altogether.

The plethora of plans indicates that organizations all along the spectrum, from the most liberal to the traditionally conservative, have come to recognize the need for government intervention to expand health care coverage. While there was no dearth of proposals, however, the political climate, exacerbated by the state's fiscal crisis, precluded any action by the New York State legislature on a universal health insurance plan this year.

Anjean Carter is Director of Health Research at the Community Service Society in New York City and a member of the Health/PAC Board.

Even health care advocates modified their goals and decided to spend their energy on getting legislators to commit the state to the concept of health care coverage for all. Labor unions, spearheaded by the hospital workers' Local 1199, recently joined with the New York State Health Care Campaign to form the Health Care for All New York Campaign. On June 13 the coalition held a massive rally at the state capitol. They were successful in getting the chairs of both the Senate and Assembly Health Committees to introduce legislation calling for a commission charged with recommending a package of universal basic benefits and reforms to control health care costs. This legislation did not pass.

However, included in the hospital reimbursement bill that passed both houses in June are provisions for a child health insurance program. Children under 13 who live in families with incomes under 133 percent of the poverty level would be covered for preventive, primary, and selected ambulatory care services at no cost to their parents. In-hospital care is not included. Whether Governor Cuomo will sign the bill, however, is still in question.

This is essentially the Healthy Start plan that was proposed earlier in the session by Speaker of the House Melvin Miller and Assembly Health Committee Chair Gottfried. It was only one of several proposals that would expand coverage for children only, including the governor's own NYCHILD, apparently taking advantage of Cuomo's proclaimed "Decade of the Child."

Targeting children for improved health care might be financially and politically astute, since they are less expensive to cover and more appealing to the public at large. But the politicians have conveniently forgotten the majority of the state's two million uninsured, who are left without even a promise.
Finally, UNY*Care, like other employer-mandate proposals, relies on a transparent semantic device to circumvent anti-tax sentiment. While the proposal scrupulously avoids the word "taxes," it nevertheless mandates payments for health insurance. These payments are taxes by another name, and those forced to pay will certainly recognize them as such. Thus, employers will be required to pay either health insurance premiums or a surcharge on unemployment insurance. The self-employed and unemployed will have to pay for health insurance themselves, with subsidies for those with incomes between 100 and 200 percent of the poverty line. (Those below the poverty line would be covered by New York's Medicaid program, as they are today.) It's unclear from the proposal whether this coverage for the unemployed and self-employed will be mandatory or voluntary. If mandatory, this is in reality a tax, and an extremely regressive one at that. If voluntary, hundreds of thousands would undoubtedly remain without insurance since the premium alone would amount to as much as 15 percent of gross income.

**Patchwork or Perestroika?**

A Canadian-style system covering everyone equally under a single comprehensive public plan would be far more efficient and equitable than the UNY*Care proposal. UNY*Care's authors avoid this "radical" restructuring for fear of antagonizing insurance companies and other powerful interests. But in so doing they fracture the potential coalition for health policy "perestroika." Most of those who are currently insured would gain little from UNY*Care. Businesses now offering health benefits would see little decrease in their outlays, and those not presently providing coverage would face a steep increase. Hospitals, physicians, and other health workers would see scant change in their bureaucratic burden, and they need little prescience to foresee that without administrative streamlining, cost savings would come only from their incomes.

In contrast, a universal, comprehensive public program would unite the interests of most Americans: the affluent, the middle class, and the poor. Such a national health program would insure all of the uninsured; improve the coverage of those who are currently underinsured; reduce costs for most businesses that currently provide health benefits; and preferentially squeeze savings out of bureaucracy. Such broad-based support is vital to both the initial passage of reform legislation and its continued survival. Universal entitlement programs such as Social Security have proven far more durable than welfare-style legislation like Medicaid that segregates the poor programatically and politically.

After decades of failed solutions and a vast accumulation of useless apparatchiks, it will require more than UNY*Care's patchwork reforms to overcome bureaucratic power and obsolete tradition. America's health care perestroika is long overdue. □

---

**References**

5. Himmelstein and Woolhandler, op. cit.
Importing Health Care Reform?

Issues in Transposing Canada’s Health Care System to the United States

SAMUEL WOLFE

We are especially pleased to be publishing this article by Samuel Wolfe, a Canadian who has spent a majority of his professional life in the United States. Before coming south of the border, Wolfe helped preside over the implementation of North America’s first universal publicly funded medical care insurance program in Saskatchewan province. This program was to serve as the prototype for national health insurance in Canada—a scheme that a growing number of experts advocate for the United States.

Having survived (but not unscathed) the famed Saskatchewan doctors’ strike and the battles over consumer-controlled community clinics, Wolfe went to the United States, finally coming to rest at Columbia University School of Public Health. He served there as Division Chair of Health Administration until 1980 and then as professor until his retirement this past spring. Given his varied professional experiences on both sides of the border—including practice as a rural family physician, additional training in psychiatry, and then a career encompassing public health practice, governance, and research—Wolfe is able to provide especially unique insights into why Canada’s health care system may neither be as readily transferable to the United States as some would hope, nor as trouble free as some would have us believe.

Many of us have known Sam Wolfe in at least one or more of his roles as teacher, advocate, analyst, researcher, mentor, loyal supporter of Health/PAC, and friend. As he gets ready to depart for British Columbia, we want to publicly thank him for his untiring dedication over many decades to the struggle for social justice and health care for all and to let him know he will be missed.

Many of us have known Sam Wolfe in at least one or more of his roles as teacher, advocate, analyst, researcher, mentor, loyal supporter of Health/PAC, and friend. As he gets ready to depart for British Columbia, we want to publicly thank him for his untiring dedication over many decades to the struggle for social justice and health care for all and to let him know he will be missed.

Equality before the health care system is a political principle in Canada.

In discussing the Canadian health care system, I start with the assumption that even though Canada and the United States share an unarmed and generally friendly border, Canadians don’t know much about the United States, and U.S. citizens don’t know much about Canada. This applies with special emphasis in the fields of politics and health care, because even though we share democratic systems and parallel systems of medical education, medical practice, and hospitals (although not of financing), the differences are great. So, I’m going to describe the Canadian system of health care, with special reference to financing, emphasize what makes it different from the experience in the United States, and conclude with issues to be faced if attempts are made to transpose the Canadian system to the United States.

The Canadian Difference

A headline in the New York Times Week in Review section for March 25, 1990, read, “Canada, Where Officers Halt All Cars and Drivers Cheer.” The article describes flying roadblocks, where groups of police officers halt every car, shine their lights inside, and have brief conversations with the drivers to find the slightest signs of impairment. The campaign is highly popular in Canada, and few drivers complain, but such roadblocks would have been illegal in the United States (at least until the recent Supreme Court decision). It illustrates the difference between the Canadian emphasis on the group and the emphasis in the United States on the individual. The Canadian courts ruled that brief roadside stops by police officers who were looking for drunken drivers were not an invasion of the rights of all the non-drinking drivers. In the United States, authorities needed a probable cause, a reason to be suspicious about a particular car. In Canada, the momentary inconvenience is weighed against the safety of the larger society. Similarly, Canadians wait in line more willingly than do Americans, and it is illegal in Canada to carry handguns. We are by and large a Royal Canadian Mounted Police law-and-order society.

Canada is a parliamentary, not a republican, democracy, and there is no sharp separation of powers between the executive and the legislative branches of government. The prime minister is elected only by the voters in his own geo-

Sam Wolfe is a physician and Professor of Public Health at the Columbia University School of Public Health and a Canadian citizen. From 1962 to 1966 he was a commissioner of health insurance in Saskatchewan, Canada. An earlier version of this article was presented at a joint meeting of the Northeast Group on Student Affairs and the Northeast Association of Advisers to the Health Professions, Toronto, Canada, April 18, 1990.
graphic district and holds his position by virtue of the fact that he is the leader of the party that holds the majority of the seats in the House of Commons in the Canadian parliament. In the parliamentary democracies, elected members rarely vote against their own party platform. This means that if the party with a majority proposes a major piece of legislation, it is almost certain to become the law of the land.

Furthermore, since the 1930's Canada has had a major third force, a social democratic party that has played a significant role in the Canadian parliament and has held at various times the majority power in Saskatchewan, in Manitoba, and in British Columbia. Thus, there has been some pressure from the left as a Canadian reality for over 50 years, and in this respect, Canada is much more like Britain or Scandinavia than like the United States.

Participation in or partial ownership of natural monopolies such as radio, television, railways, airlines, telephones, and electric power by the federal or provincial government is accepted as normal by most Canadians. Canadians appear more trusting of these arrangements, and of government in general, than do Americans.

**Pioneering Provinces**

In Canada, the provinces and not the federal government in Ottawa have most powers relating to health, education, and welfare. Federal participation involves agreements between the ten provinces and two territories and Ottawa. The responsibility for and administration of health insurance plans in Canada are therefore at the provincial level, with federal participation in planning, development, and financing. The pattern has been that individual provinces develop and implement plans, these are picked up by other provinces, and then Ottawa passes legislation spelling out the conditions under which the federal government will participate in federal-provincial sharing arrangements, including financing.¹

As of July 1990, it has been 43 years since Saskatchewan, a Canadian prairie province with less than a million people in an area of about 250,000 square miles, implemented acute care hospital insurance for all residents. By the end of 1990, it will have been 29 years that all residents of Canada have been protected against the costs of acute care in hospitals, as well as for the costs of outpatient ancillary services. Again, as of July, it has been 28 years since Saskatchewan once again pioneered with its medical care insurance plan, under which all physician services and certain other services were paid for universally through the public purse. By the end of this year, all Canadians will have been covered by medical care insurance for 19 years. Both the hospital and medical care plans are operated and administered by the provinces with federal-provincial cost-sharing arrangements.

---

Long-established class disparities in the amount and types of care received still characterize the use of health services.
We Canadians cannot be accused of being too hasty. It took from 1919, when it was first a major plank in the platform of a political party, to 1961—42 years—to achieve universal entitlement to acute-care hospital insurance, and 52 years, until 1971, to achieve universal entitlement to medical care insurance. These two programs are the centerpieces of the Canadian national health insurance system.

The Canadian System
To get federal dollars, the provincial plans must provide universal access to care with equal terms and conditions for all, must cover all services determined medically necessary by physicians, must provide province-to-province portability benefits and must be publicly administered on a nonprofit basis. Insured hospital services include all inpatient services provided at a standard ward level and all necessary drugs, biologicals, supplies, and diagnostic tests, as well as a broad range of outpatient services. The services of psychiatrists and mental hospitals are fully covered. There are no upper limits to the care provided, as long as it is medically necessary.

The insured services of physicians, who by and large are paid on a fee-for-service basis, include all medically required services provided by licensed medical practitioners, regardless of whether they are provided in hospitals, clinics, doctors' offices, or elsewhere. Fees are negotiated by each province with its provincial medical association.

Acute care hospitals are paid on a prospective payment system based on global budgeting. At a given time of year, each hospital negotiates its global budget for the coming year with the provincial government, based on historical trends and actual use and cost data for the most recent full year. Once the overall budget is set, the hospital, starting on January 1, receives 1/26th of its budget every two weeks, thus assuring an adequate cash flow. It is unheard of for a Canadian hospital to declare bankruptcy. This is a prospective payment system, but without the use of diagnosis-related groups (DRG's). Once the global budget is set, the hospital cannot exceed it unless there are very extenuating circumstances. But a hospital can change categories within its budget, thus giving it a small measure of flexibility. Capital costs for hospitals are borne in general by the provinces and not shared by Ottawa.

Residency training is built into the global budgeting. I might point out that 52 percent of Canadian doctors are family doctors (compared to about 30 percent in the United States, including general internists, general pediatricians, and family practitioners), and that all Canadian teaching hospitals and many community hospitals have major training programs in family medicine. In Canada we have a large and growing supply of family doctors serving people of all ages in the population. Remember also that Canadian medical school tuition averages about $1,500, so graduates are not faced with the mountains of debt that U.S. medical school graduates confront.

Blue Cross and Blue Shield as well as other commercial insurers in Canada are prohibited by law from selling insurance or paying for care already covered by the provincial plans. They can sell amenity services, such as private duty nursing, private room coverage, and other services not covered by the public plans. Of the 1,243 hospitals in Canada, all but 9 are not-for-profit institutions. Only in the field of nursing home services is there a sizable component of investor ownership. Canada, as described recently by the well-known Canadian economist Robert Evans, has a deep-rooted suspicion of class-based systems of any kind. Private schools are a rarity in Canada, and private universities do not exist. Equality before the health care system is a political principle in Canada; in fact, in Canada the issues surrounding national health insurance have become apolitical because all political parties strongly favor the plans and support their expansion. In the field of health, at least, Canadians have become their brothers' and sisters' keepers.

The poor all over Canada are in the mainstream of health care services.

The Bottom Line
The plans across the country are operated and financed primarily through the public purse. In the United States in 1990, 40 percent of national health expenditures will be publicly financed. In Canada, public funds will make up at least 75 percent of national health expenditures. At the federal level, the dollars come from the consolidated revenues of the country, primarily from the graduated income tax; at the provincial level, the money comes from the provincial income tax and sales taxes. Only two provinces still require premiums to be paid—Alberta and British Columbia. Most people appreciate the fact that still another public bureaucracy was avoided. The poor all over Canada fall into the mainstream of health care services because they are protected in the same fashion as all residents of Canada.

This year, 1990, it is estimated that Canada's national health expenditures will consume just under 9 percent of the gross national product, with everyone protected by a comprehensive system for paying hospital, medical, and certain other bills. In the United States this year, the best estimates are that just under 12 percent of the gross national product will be spent on health care, with at least 35 million persons totally uninsured and a further 20 million persons so scantily covered that they may be said to be severely underinsured in the face of serious illness.
Trends in health care spending in the United States and Canada paralleled each other until the early 1960’s when Canada’s hospital plans were firmly in place. The gap has been widening ever since and currently stands at 3 percent of gross national product. For example, in Canada in 1985 just over 0.1 percent of the gross national product was spent on administrative costs of health insurance; in the United States in that same year, 0.655 percent of the gross national product was spent—a difference of 22 billion U.S. dollars for that item alone.4

As before national health insurance, ill-health and disability remain more prevalent among the poor.

The reasons for the difference in spending in both countries are worth elaborating on. In the Canadian system, insurance overhead is low because of the administrative simplicity of the provincial plans, and because all funding for covered services runs through the provincial plans, which are virtually the sole source for buying health care services. In the United States, in contrast, health insurance overhead is higher because of the hundreds of companies that sell coverage (the “Blues,” the commercial insurers, the HMO’s, the PPO’s, etc., etc.), and health care dollars run through hundreds or thousands of pipes. The Canadian system has only a few pipes through which the money runs. Moreover, the Canadian system controls payments to physicians and hospitals through toughly and tightly negotiated fees and global budgeting.

An additional reason for the proportionately lower amount spent on health care in both countries may be its restraint on the distribution of some forms of technology. There is a noticeable separation in Canada between hospital operating expenses and capital spending. In addition to approving overall hospital budgets, the provinces must also approve the funding of new capital acquisitions. By controlling both capital and operating budgets, the provinces have effectively limited the growth of outlays for labor, supplies, and equipment. There have been sharp constraints on duplication of costly medical technologies. It is impossible in Canada to have a private magnetic resonance imaging (MRI) unit around the corner from an MRI unit based in a teaching hospital.

The Canadian argument is that costly new technologies should be regionally based and require doctors to judge carefully which patients can profit from their use; highly sophisticated tertiary technologies are exclusively diffused only in teaching hospitals. Such technologies as MRI’s, lithotripsy, cardiac catherization, and open-heart surgery are far more available on a per capita basis in the United States than in Canada. A recent study showed no evidence that substantial numbers of Canadians are seeking care at American medical centers; those that do travel to American medical centers—for example, from Windsor to Detroit—do so by agreement with the provincial health insurance plan.5

The original formula by which the provinces created their plans was based on federal-provincial cost-sharing arrangements on a 50-50 basis, with more dollars going to the poorer provinces—Newfoundland, Prince Edward Island, New Brunswick, and Nova Scotia. These formulas were built into the original hospital and medical care acts. Even though the poorer provinces receive far more than 50 percent, they do not have the fiscal resources to provide extra services beyond meeting the conditions for receiving federal dollars for the required coverages under the federal-provincial cost-sharing agreements. As a colleague and I wrote previously:

Over the years, the Ottawa formulas to the provinces have not adequately compensated for lower provincial per capita incomes. For example, Alberta spends 39 percent of its gross domestic product for basic insured health services, Saskatchewan spends 51 percent, and Newfoundland and Prince Edward Island spend over 9 percent respectively. Poorer provinces have to spend a greater proportion of their domestic product to achieve a basic threshold of benefits under national health insurance. For example, as long ago as 1981, the federal per capita transfer to the provinces ranged from $541 for Alberta to $1,300 for Prince Edward Island; in turn, the federal transfers made up 12 percent of provincial revenues in Alberta and 56 percent of the provincial revenues in Prince Edward Island. Federal transfers have accounted for more than 50 percent of provincial revenues in all four maritime provinces. The poorer provinces have been less able to provide additional benefits, for example, pharmaceutical programs, dental programs, and alternatives to care in hospitals. These observations, of course, do not control for the philosophy and ideology of either provincial or federal governments in Canada.6

Thus, the poorer provinces spend far more of their gross domestic product on health care than do the wealthier provinces. There are wide disparities in per capita incomes in Canada, as there are all over the world.

As health care costs have escalated, Ottawa has stopped sharing equally with the provinces. Commencing with the 1977 Federal-Provincial Fiscal Arrangements and Established Programs Act, provincial programs and governments have been at greater risk of being hit with increases in the cost of medical care. The 1977 act linked the federal contribution to the provinces to the growth of gross national product, requiring the provinces to pick up more of the costs when their aggregate outlays for health care as a proportion of the provincial budgets were greater than that of their economies as a whole. Revisions of the act in 1987 and 1989 further restricted federal funding for health care to the provinces. In 1980, Ottawa provided 44.6 percent of provincial health care financing; the estimate for 1990 is 36.7 percent. By the year 2000, the federal contribution may be down to as low as 30 percent as a proportion
of provincial health expenditures, leaving the provinces to make up the difference.7

During the same period in which health care costs were being shifted to the provinces, the Canada Health Act of 1984 was passed unanimously by the Canadian parliament to safeguard unlimited access to health care by patients. The provinces were forced to ban the practice of extra billing by doctors in excess of the amounts allowed by the provincial fee schedules as well as hospitals’ insidious practice of charging for certain services to inpatients. Although there was a 25-day doctors’ strike in Ontario, court challenges, and outrages from the Canadian Medical Association, every province has gone along with the ban on extra billing and user charges, because failure to do so means loss of federal dollars in proportion to the amounts of extra billing and user fees imposed on patients by both doctors and hospitals.

The Balance Sheet for NHI

We can draw several conclusions about the implementation of national health insurance in Canada. It has led to sharp narrowing of regional differences in distribution of hospitals, doctors, and other categories of health workers. Clear gains have been made in making primary care services uniformly available across the country. Accompanying this, infant mortality rates and longevity have leveled out regionally across the country. However, disparities have continued to exist in per capita spending on health. Poorer regions have poorer differential access, particularly to highly specialized tertiary care services.8

Most Canadians have made extensive use of hospital and medical care benefits under national health insurance, and access to services without opening your wallet has been a major step forward. But low-income groups have generated much less spending on health services than have higher-income groups, and long-established class disparities in the amount and types of health care received still characterize the use of health services. Lower-income families spend more of the total family income in out-of-pocket expenses for uninsured and other health services than do families with higher incomes. As before national health insurance, ill-health and disability remain more prevalent among the poor; those who are not poor also live longer, and that disparity is worsening.

The supply of Canadian doctors is ever increasing, and the number of Canadian graduates migrating to the United States is decreasing. For academic year 1988-89, there were four applications for every place in a medical school in Canada, compared to 1.6 for every place in a medical school in the United States. Fully 44.4 percent of Canadian medical students in that same year were women. In 1970 there was one practicing doctor to every 870 Canadians, compared to one to every 525 in 1988. These figures exclude residents in training programs. Although, as noted, Canada has an expanding supply of family practitioners, there are shortages in general surgery, in psychiatry, in oncology, and in the pediatric subspecialties. Medicine remains a highly attractive profession in Canada, and doctors are still highly regarded. They are by far the best-paid professionals in Canada. Doctors netted $84,700 in 1987, compared to $70,800 for dentists, $63,500 for lawyers, and $49,300 for accountants.9 The net earnings of doctors in the early to the

While all in Canada have gained, pre-existing class-related disparities remain unaltered at the aggregate level.
mid-1970's were at least four times the net earnings of other taxable Canadian workers. I doubt if these figures have changed much in the intervening years.

While all in Canada have gained, pre-existing class-related disparities remain unaltered at the aggregate level. The Canadian experience tells us what we already know: that a single measure like national health insurance is insufficient to redistribute the inequitable allocation of services whose roots lie in the social and class structures of every country in the world.

Implications for the United States

To transpose the Canadian system to the United States, there has to be agreement on several key principles. First, everyone has to be covered. The United States has the technical ability to do this, but to date it lacks the political will. You have to agree once and for all that the right of access to needed health services applies to all residents of the country as a basic human right, like the right to public education or to police and fire department protection.

A single measure cannot redistribute the inequitable allocation of services whose roots lie in the social and class structures of every country.

An analysis of the Canadian system in the 1970's by a group of experts from both the United States and Canada agreed that the application of the Canadian system in the United States would in most essential respects have the same effects. However, the assumptions made by this group are not so easy to assume: that insurance payers and institutional and professional providers of services exercise more self-discipline, that government is willing to act in a manner consistent with protecting the public interest, not special interest groups. Legislators in the United States often appear to be partners with the insurance companies and the lobbyists for institutional and professional providers.

The second principle you have to agree on is to stop determining individuals' eligibility for benefits through means tests that create various bureaucracies of insensitive persons who try to block people from having access to sorely needed services. Third, you have to create a fund or funds to pay for services for everyone. The Canadian experience shows that public control of the payment process—and by that is meant not just regulatory control, but the actual responsibility for paying all the bills vested in a virtually sole-source funding mechanism—is sufficient to provide both universal and comprehensive coverage as well as control of costs. The 3 percent differential between proportions of gross national product devoted to health care in the two countries is testimony to that essential fact.

The only viable current proposal in the United States that takes at least some of these principles into account is the UNYCare proposal of the New York State Department of Health, which is likely dead in the water anyway. All the other current proposals—with the exception of California Congressman Ronald Dellums's perennial proposal to enact a U.S. national health service—will simply perpetuate the inadequacies and abuses associated with Medicare and Medicaid and with partly uninsured and inadequately insured populations. Any proposal that works properly has to remove the crushing tax burden from the backs of counties and cities with high levels of high-risk, poorly insured populations.

There are no ideal ways to pay doctors. The prevailing system in Canada, as in the United States, is payment by fee for service, which emphasizes procedures and downgrades counseling and talking, careful history taking, and thorough physical examinations. Fee-for-service leaves the problem of utilization-driven income untouched. The options are capitation payment (one-time flat fees, as in health maintenance organizations) and salaries for physicians, which also have their limitations. For example, in Saskatchewan, expenses for physician services increased by 153 percent between 1978 and 1986. Close to 100 percent of this increase was due to increases in physicians' fees, and less than 1 percent was accounted for by increases in population growth.

Freezing or reducing payment levels to doctors is not an effective cost control, because doctors respond by increasing the quantity and complexity of their services. Fee controls that are not backed up by global caps on payments will not control costs. To maintain adequate cost controls, you have to address fee levels, rates and patterns of services provided per physician, and the number of physicians in the system. In Canada today there is still professional control over the specifics of providing services, but public control over the total resources used, with, as I have pointed out, very little use of direct charges to patients and other market mechanisms. This has been satisfactory to date, but there have been escalating frictions, primarily due to the great expansion of the pool of doctors drawing money from the public purse, which leads to greater costs of the system or smaller incomes for doctors. In neither country have we faced up to the great expansion in the pool of doctors of the past two decades, and to the thousands each year that are still in the pipeline.

I am not optimistic that even such a minor social reform as universal financing for essential health services is imminent in the United States. The plans were enacted in Canada when there was a social democratic ferment across the country, and that moment has passed in Canada, at least at the present time; such a ferment does not exist in the United States.

But there are other indicators as well as causes for cautious optimism. First, the mass of uninsured and underinsured is not going to go away, and their numbers are increasing. Second, the middle class is being squeezed in health care, with increasing premiums, greater employee contributions, greater deductibles, and greater coinsurance. Third, in the face of the demographics of aging in the
years ahead, the spectre of financing for long-term care is not going to disappear. Whether new coalitions can be mobilized to address these issues in a comprehensive rather than a piecemeal fashion remains to be seen.

7. Iglehart, op. cit.
A s an occupational health educator, I receive dozens of ads for publications, posters, and educational materials designed to motivate workers to quit smoking, wear respirators, stop abusing drugs, and generally correct their careless health habits, in the misguided belief that once these problems are corrected, the work environment will be safe and healthy. Bad choices and unhealthy life-style, it is claimed, take the greatest toll on health.

Recently, a lobbying consortium of asbestos industries calling itself the Safe Building Alliance paraded its favorite scientists before the media to announce that asbestos isn’t quite as bad as we once thought, prompting the New York Times to publish a November 1989 editorial urging us to reconsider our penchant for overregulating asbestos.

A government environmental protection officer recently complained to me that environmental regulations are burdensome and unnecessary, saying, "We’re finding out every day that even hazardous waste has much less effect on the environment than we thought."

These examples illustrate how public health activities often seem to subvert attempts to arrive at the true causes of disease. The first assumes, incorrectly, that workers are at fault for their own burden of death and disease. In the second, asbestos is seen not as a public health problem, but as an economic burden unfairly shouldered by business. Finally, a government worker implies that environmental protection should not be the responsibility of government. Each of these views diverts attention, deliberately or not, from the real and complex causes of disease and disability.

In Hidden Arguments—Political Ideology and Disease Prevention Policy, Sylvia Noble Tesh, professor of public health and political science at Yale University, explores how and why these victim-blaming and anti-regulatory approaches have come to dominate the debate over what measures should be taken to prevent disease.

Tesh argues that individually and collectively held assumptions about what causes disease underlie the development and adoption of policies intended to prevent disease. These assumptions, influenced by politics, economics, and individually held values are not static, but fluid, and together comprise the political ideologies about which she writes.

Theories of Disease Causality

The book begins with a description of the history of theories of disease causality in the 19th century. Among them are the contagion theory, which held that diseases are spread from close and direct personal contact, and the supernatural theory, that disease is caused by demons and sin and that cure is occasioned by divine intervention.

The contagion theory guided most disease prevention activity in the early 19th century. It held that isolating the sick from the well would prevent the spread of disease. Though insufficient to explain the worst epidemics—cholera, for example, whose spread does not require human contact—the contagion theory fell out of favor only when its policy implications of isolating individuals and communities from one another threatened to cut off communication and trade necessary for industrial development. Tesh shows that the rejection of contagion theory as wholly explanatory of disease causation came from the political and economic mandates of industrialization, not from scientific rationale.

Supernatural theories of disease causation were also espoused during the 19th century. Ascribing disease and poverty to the will of the gods helped exonerate society of responsibility. As science and industry advanced, blaming disease on demons and the like became less tenable. But even the most absurd of explanations dies slowly. Supernatural explanations for disease still influence the tenor and content of more modern discussions. The early association of AIDS with sinfulness by reactionary clergy and lawmakers, for example, helped justify a delay in governmental research and treatment. And, despite its inappropriateness to AIDS, even the contagion theory is still invoked to support quarantining HIV-seropositive people.

Tesh’s chapter on 20th century debates on the causes of chronic diseases shows that the question of causality is still politically charged.
and unresolved. Today, Tesh argues, at least two theories vie for acceptance. The first, which Tesh calls the life-style theory, holds that it is what people do to themselves (e.g., diet, stress, smoking), not what is done to them, which causes chronic illness. In just a few pages, Tesh lucidly reveals the ideological underpinnings of this theory, which lays all blame and responsibility for change on the individual. It excuses government from its responsibility to address social inequities, environmental preservation, and overall prevention, while absolving industry of its contribution to the toll on individual health from pollution and occupational exposures.

An alternative to the life-style theory is the growing recognition that a lot of disease may be caused by environmental toxins. Tesh’s critique of this environmental theory is fascinating. She describes an ideological battle between proponents of environmental causation over whether environment means the air or workplace itself (as Barry Commoner, for example, argues), or the individual chemicals that inhabit them (as EPA and OSHA would have it).

If the difference seems semantic, consider their policy implications. The latter approach assumes that a problem arises when a given substance is discovered to be harmful. If it is, then a rather conservative prescription is indicated: conduct more research, regulate a product or two, file a few lawsuits, or simply counsel people to avoid the substance. If, however, we view the environment in its totality, then we must recognize that we are harmed not just by exposure to certain substances, but as a consequence of social phenomena, such as overconsumption, waste accumulation, and over-use of non-renewable resources. The problem seen in this way requires more far-reaching solutions, no longer calling for the regulation of individual chemicals, but for the elimination of whole categories of substances, subsidization of new technologies, and even an outright ban of whole industries.

Analyzing Ideology

Reading *Hidden Arguments*’s analysis of ideology is challenging on several levels. The first has to do with how we perceive ideology. For many, “ideology” is an ugly term usually invoked to dismiss ideas, not to expand on them. Innovative ideas are accused of being “ideological,” their proponents, “ideologues.” But to engage in an analysis of ideology, one must accept, a priori, that it is a meaningful, explanatory construct. Those unaccustomed to seeing scientific inquiry as guided by more than the pursuit of fact may stumble.

Also, picking apart ideology so it becomes understandable requires an ongoing, albeit silent, dialogue between the reader and the text’s author. Tesh knows this; at each turn in her line of argument, she predicts the reader’s objection, answers it, and steers the reader in a new direction. Finally, it is a challenge to keep from continually asking oneself, “But how does this apply to my work and to the struggle for progressive health policies?” But the value of most sociological inquiry is measured by its analytical and predictive quality, not its prescriptive potential. On these terms, *Hidden Arguments* succeeds.

**Cuba, PATCO, and the VA**

The second part of *Hidden Arguments* consists of case studies of ideology in action. Tesh published earlier versions of each of these in peer-review journals in the mid-1980s. Though time may have robbed the subjects of some of their urgency, they make for interesting reading.

The first case study contrasts health promotion policies in Cuba with those in the United States. By most ideological measures, Cuba and the United States are poles apart politically, socially, and economically. We would expect that the countries’ respective policies on how to prevent chronic disease should fundamentally differ. In fact, according to Tesh, they are remarkably similar. In Cuba, as in the United States, prevention of chronic disease depends largely on the responsiveness of individuals to programs exalting the benefits of dietary change, regular exercise, stress-relief, and smoking cessation.

Compared to the rest of the book, Tesh’s writing on Cuba is the most personal, and its conclusions, the most tentative. In it, Tesh recounts her interviews with Cuban health personnel, during which she looks for some explanation for why Cuban policies rely so heavily on personal and life-style change just as in the United States, despite such differing political and health care systems. To explain, she touches on two fundamental distinctions between the countries: (1) the dominant relationships between the state and the individual (separate and in conflict in the United States, interdependent and coexistent in Cuba); and (2) socioeconomic class differences (glaring and largely deterministic of health status in the United States, while largely absent in Cuba).

The first distinction suggests that in Cuba, individual responsibility is, by definition, social responsibility. Therefore, Tesh believes, relying on a life-style theory and promoting personal change really asks society to change. The second distinction, that Cuba, unlike the United States, is a classless society, implies that asking Cubans to change their life-style is less dishonest than asking all U.S. citizens to change theirs, since the former have, more or less, equal abilities to do so. Maybe all this is so, but the reality is that neither in the United States nor in Cuba will these strategies actually improve health in any significant way.

Earlier in *Hidden Arguments* we learned that laying responsibility on an individual is not necessarily rational, but pragmatic, as it helps maintain the status quo and diverts attention from broader political issues. As for Tesh’s second distinction, we have learned that it is affluence, not just the absence of class differences, that largely predicts “healthiness” and one’s ability to alter one’s life-style to be more “healthful.” When writing about Cuba, Tesh does the book an unintentional service. This section shows that her analysis of the importance of political ideology in disease prevention policy crosses geopolitical boundaries.

The second case study, on air traffic control and stress, is the book’s most original and absorbing. In 1981, the Professional Air Traffic Controllers Union (PATCO) illegally walked out and were subsequently fired and replaced, in the first of many attacks on organized labor by the new Reagan administration. The walkout followed frustrating congressional hearings on the merits of the controllers’ claim that the unusual stress
of their work entitled them to improvements in wages and schedules. At these hearings, PATCO enlisted the support of social epidemiologists and physicians to argue their case.

Hidden Arguments offers a learned and sobering account of how the best intentions of social theorists can be subverted by scientists who serve, knowingly or not, an oppositional ideological master. PATCO was prepared to do battle against the Federal Aviation Administration (FAA), but not against scientists who argued on the FAA's behalf. The FAA was able to present study after study supporting the idea that stress is a phenomenon that is individually experienced and mediated. If there was a stress problem, Congress concluded, it was with the controllers, not with the profession. Air traffic controllers soon learned that unemployment, too, is one form of work stress.

The third case study explores Vietnam veterans' fight against the Veterans Administration over Agent Orange. The concluding chapters look to the role personal values play in scientific inquiry. This last portion of Hidden Arguments shows how general beliefs about the nature of people and the world affect the hypotheses made in scientific studies, what methodological choices are made, and especially what policy recommendations scientists will make. But rather than bemoan the inclusion of personal and political values in science, Tesh argues that it is unavoidable. Her answer, simple as it may sound, is to openly accept and encourage the bringing of values to science, so long as they support egalitarian policies.

Espousing Our Own Values

Hidden Arguments rejects the myth of science as an objective search for facts with which Truth may be ascertained. Alternatively, it argues that scientific disputes over the meaning and substance of the evidence of the causes of disease, whether Agent Orange, stress, or environmental causes, are best explained in the context of cultural, societal, and ideological tensions and arguments.

This should come as no surprise to readers of the Health/PAC Bulletin. As activists, we weave progressive politics into the fabric of public health activities, and public health into the fabric of progressive politics. Hidden Arguments looks to the context in which this weaving occurs. There is but one fabric, argues Tesh, and ideology and its hidden arguments govern its form and texture. Formulating and implementing disease prevention policy free from the influences of ideology is therefore impossible. Tesh's concluding prescription is that we expose the hidden arguments of others and openly espouse our own egalitarian values and ideology. This work does an able job of just that.

Daniel Kass is coordinator of the Hunter-Montefiore Health and Safety Training Program, a labor-oriented occupational health education program in New York City.

The Power to Test


by Eric Holtzman

The message of Dangerous Diagnostics can be paraphrased as "the power to test is the power to destroy." Nelkin and Tancredi are alarmed at the expanding reliance on medical and biological tests by employers, the educational and legal systems, insurance companies, hospitals, and HMO's. The book deals in greatest detail with genetic screening and related molecular biological procedures and with emerging "imaging" and neurobiological approaches (CAT and PET scans and EEG's). However, the authors are also concerned with drug and HIV testing and even standardized school examinations.

Dorothy Nelkin is a sociologist at New York University who has published extensively on the interplay between science and society. Laurence Tancredi heads a health law program at the University of Texas. Accordingly, the book's greatest strengths are in outlining the potential negative social ramifications of the testing frenzy in this country and in examining the entrepreneurial and adversarial atmosphere—including the responses of the courts and trade unions. Though full of facts and ideas, the book is compact and well written, more journalistic in tone than scholarly.

Nelkin and Tancredi begin by outlining bits of pertinent history and laying out their analytic threads. They mention the importance of the eugenics movement in helping to strengthen belief in biological perfectibility and point to ongoing trends toward medicalizing social problems. And they establish the foundation for their conclusion that, by defining categories and establishing hierarchical rankings in terms that appear objective, tests are powerful means for social and economic institutions to reinforce their own standards of normalcy and to pressure or stigmatize those people who deviate. Tests also help shift responsibility (as well as the locus of proposed remedies) to the tested individual.

Two of Nelson and Tancredi's core arguments are particularly important for their book. First, they suggest that we are predisposed to welcome testing by a number of factors, including society's preoccupation with actuarial efforts to predict and control liability and risk; current medical concern with prevention of illness; long-standing habits of construing social problems in simplified biological terms that strip away the developmental and environmental contexts; and addiction to "scientific" devices and language. Second, they contend that testing programs often create severe tension between the interests and rights of the tested individual—his or her overall individuality or physical, social, and economic well-being—and the interests and desires of institutions that promote and administer the tests, such as economic efficiency or conformity to behavioral norms.

The opening segments of Danger-
ous Diagnostics also outline some of
the testing technologies, emphasizing
layperson's language capsules of the
sorts of information that can be
gained from the procedures. They
describe commercial pressures for
developing testing technology, the
extent of testing, and problems of test
interpretation, such as the crucial fact
that, when used to screen populations,
even highly reliable procedures
can generate uncomfortably high
numbers of false positives.

Testing in Context

In its middle chapters, Dangerous
Diagnostics deals with testing in spe-
cific contexts, such as health care,
employment, schools, and courts. The
medical system—hospitals, HMO's,
insurance companies, and the
like—looks to sensitive (and inexpen-
sive) procedures as means, for exam-
ple, to discriminate potentially prof-
itable clients from those whose access
should be limited because they are
likely to get too sick for the financial
comfort of the institutions. The ability
to detect is running far ahead of the
capacity to understand precisely what
is being detected or, in many cases, to
do much about the condition identi-
fied. Meanwhile, however, the genetic
markers or statistical predispositions
identified in the tests come to be
regarded almost as though they were
themselves manifest disorders. And
conscientious physicians find them-

The court system, seeking greater
efficiency, needs reliable tests, like
those that now unambiguously estab-
lish paternity, to replace opinions—
those of psychiatrists about "sanity,"
for example—with biological "facts."
Defense lawyers look for grounds on
which to make plausible competency
arguments. But Nelkin and Tancredi
also note cases in which courts have
blocked the introduction of seemingly
unambiguous scientific evidence for
fear that the strong impact of "science-
tific facts" would spread beyond the
specific and limited matters with
which the evidence was concerned,
unduly weakening the opportunities
for defense.

Historical and Political Questions

Perhaps because the book's tone is
so matter-of-fact and its subject matter
increasingly familiar in our daily
lives, much of this is quite depressing.
From time to time, Nelkin and
Tancredi do take care to mention ben-
efits of improved diagnostic capabili-
ties. But these mentions are over-
whelmed by the specters of Ritalin
prescribed for children diagnosed as
"hyperactive" and the creation of ever
broader classes of genetically unem-
ployable men and women, and by the
threats posed to the shreds of humane
concern with the whole person that
still persist in the medical and educa-
tional system. From this negative
tone, and from their stated purpose
demystification and the opening of
debate), I suspect that the authors are
ultimately after renewed interest in at
least the two types of difficult ques-
tions that kept recurring to me as I
read Dangerous Diagnostics—the his-
torical and the political.

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-

The historical questions have to do
with technological progress. Ad-
The political questions are equally familiar and many sided. In their final chapter, Nelkin and Tancredi specify immediate responses needed in the face of the flood of testing, such as better regulations to protect privacy and clarification of the responsibilities of medical personnel employed by corporations or by the school system. I think that, to be fully effective in confronting testing and screening, we will also have to remember or recraft the arguments and strategies we use to deal with such realities trumpeted by the Right, such as that risk can rarely be made to disappear altogether and that individuals must indeed take care of themselves and of their behavior. Dangerous Diagnostics calls, by implication, for resolute resistance to the shifting of too much of the burden from social and economic institutions to the individual. Given the ceaseless and cynical propaganda about personal responsibility in the current political and economic environment, such insistence surely is appropriate: Denial of access to health care, health insurance, or employment for those most likely to get sick is barbaric; the idea of selecting workers who can survive best in given working conditions has remarkably ugly resonances; schools are more in need of reform than are students.

But this resistance is largely defensive, and one value of strong books like Dangerous Diagnostics is in spurring us to escape our shell-shocked state and pursue deeper solutions. Here, as in many other contemporary arenas, we need to attack the familiar, paralyzing “free-market” illusion that technologies emerge from the neutral efforts of objective scientists, to take on a life largely of their own, driving social change as quasi-independent forces. Given that so much of the research on which the new testing technologies depend was publicly funded but has been appropriated by private institutions, a first step for scientists and medical personnel is to encourage open scrutiny of the nation’s research and application agendas—the agendas that shape technologies from their birth.

Eric Holtzman is a Professor in the Department of Biological Sciences at Columbia University.

---

**If You Care about Health Care...**

...you know that our health care system is beyond sick. It’s in crisis. The policies of Ronald Reagan and George Bush have created the greatest inequities in health care this nation has ever known. Epidemics bred of poverty—AIDS, drugs, homelessness—are overwhelming hospitals and health care providers. If you know our system is sick, but you don’t know what to do about it...

...you should be reading the Health/PAC Bulletin!

---

**Yes,** I want to become a member of the Health Policy Advisory Center and receive the Health/PAC Bulletin.

- Individuals $35
- Institutions $45
- 2 years $70
- Student/low income $22.50

I want to help Health/PAC support the fight for health rights.

Enclosed is my tax-deductible contribution of

- $15
- $25
- $50
- $100
- Other [ ]

Name ____________________________
Address ____________________________
City/State/Zip ____________________________
Charge: [ ] Visa [ ] MasterCard
Signature ____________________________
No. ____________________________ Exp. Date ____________________________

Health/PAC, 17 Murray Street, New York, NY 10007

---

**ACID RAIN**

**DON’T GET MAD**

**OIL SPILLS**

**TOXIC WASTES**

**GET E**

**PESTICIDES**

**GLOBAL WARMING**

**OVERPOPULATION**

**ANIMAL ABUSE**

**FOREST FIRES**

**OZONE DAMAGE**

**DEFORESTATION**

**GARBAGE CRISIS**

**THE ENVIRONMENTAL MAGAZINE**

Now, a new magazine marks the dawn of the 1990s—the Decade of the Environment! E is an independent publication for concerned people—the growing thousands of grassroots activists and veteran environmentalists—who want to clean up our environment and improve their relationship with the natural world.

E Magazine is your connection to a movement that is sweeping the world. It is your “clearinghouse” of environmental information—on the issues and trends—on the campaigns of key organizations—on what you can do to help preserve and restore our imperiled environment. Subscribe today!

FOR FAST ACTION CALL 1-800-825-0061 (Mon-Fri, 9am-5pm, E.S.T.)

---

[ ] 1 year/$20  [ ] 2 years/$36  [ ] 3 years/$50  (Canada/Mexico, add $5/year. Overseas add $10/year)

Name ____________________________
Address ____________________________ State ____________________________ Zip ____________________________

[ ] Payment enclosed  [ ] Please bill me

Please mail to: E Subscriptions, P.O. Box 6667, Syracuse, NY 13217
The Hospital Crisis:

New York City's hospital system is experiencing a crisis of unprecedented proportions. Policy analysts examine what's unique about the situation there compared to other cities across the country. Are there viable, equitable solutions at hand? The authors—drawn from labor, the municipal hospital system, and the consumer movement—explore these issues and the reciprocal relationship between hospital ills and the social ills of the city, the state, and the country. Illustrated by Timothy McCarthy.

Health Rights Abuses in the West Bank and Gaza

Health/PAC presents a ground-breaking eyewitness report of the Palestinian uprising by Physicians for Human Rights. Plus, efforts by Palestinian and Israeli health workers to break the cycle of violence plaguing their communities.

Women and AIDS

Why are women neglected in defining, diagnosing, and treating AIDS? Physicians on the front lines report on the missing women in the AIDS epidemic. Plus, living with AIDS: women talk about their lives with HIV disease; a grandmother's story of hope. Includes photo essay by Catherine Smith.