The Deficits of U.S. Democracy and the Implications for Health and Social Policy

THE POLITICS OF HEALTH CARE REFORMS IN U.S. PRESIDENTIAL ELECTIONS

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This article analyzes why people in the United States have major problems in accessing medical care that are due to financial constraints. The author suggests that the cause of these problems is the way in which medical care and elections are funded in the United States, with private sources being the largest component in the funding of both activities. The article includes a comparison of funding of the electoral process in the United States with similar electoral processes in the countries of the European Union, and postulates that privatization of the funding of U.S. elections (primary and general) is responsible for privatization of the funding of medical care—the root of people's problem in paying for their medical care. Privatization of election funding gives undue power to the economic, financial, and professional groups that dominate medicine in the United States.

THE U.S. AND EUROPEAN POLITICAL CULTURES ARE VERY DIFFERENT

I appreciate the invitation from the *Harvard Health Policy Review* to discuss the relationship between national health care systems and the policy process. One cannot analyze this relationship without analyzing the political context in which it occurs, and since the United States is now in the midst of a very important political process—the presidential primaries of 2008—it may be of special interest to readers of the *Review* to focus on the impact of the political process on the health care reform proposals put forward by the presidential candidates in this and past elections.[1]

[1] See *Note* on p. 606.

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The invitation from the senior editor of the *Review* left open the possibility of presenting a comparison of the political context of health policy formation in the United States with that in other countries. Rather than making such comparisons, however, I am going to focus on the United States, but with a few notes on how this country compares with other developed democratic countries at levels of economic development similar to that of the United States—specifically, the countries of the European Union.

I use the E.U. countries for reference because I know them well. I was born in Spain and received a degree in medicine there. I then had to leave Spain because of my participation in the anti-fascist underground in the 1950s. I went first to Sweden and studied economics, and was much influenced by my intellectual mentor, Gunnar Myrdal, from whom I learned everything I know about economics. I have always been a great admirer of the Swedish welfare state, although I am not oblivious to some of its weaknesses. (I described this in my book *The National Health Planning in Sweden*, published by the Fogarty Center of the National Institutes of Health in 1974.) I then studied social policy at the London School of Economics, under another great influence in my intellectual life, Richard Titmus, and later studied health policy and management at Edinburgh University, Scotland. I admired Britain's National Health Service, the jewel of the British welfare state (as Churchill once called it), but again was aware of some of its faults (as expressed in my book *Class Struggle, the State and Medicine: An Historical and Contemporary Analysis of the Medical Sector in Great Britain*, published in 1978). In 1965 I arrived in the United States and joined the Johns Hopkins University, where I have worked ever since. My early analysis of the U.S. health care system was published as *Medicine under Capitalism* (1976), which described the greatness but also the miseries of the U.S. house of medicine. Much has changed since then, yet much has remained the same.

Before focusing on the United States, with some comparative notes on the European situation, let me make several observations that are necessary to a better understanding of health policy on both sides of the Atlantic. The U.S. and E.U. political cultures are very different. Just one example: red is the color of the conservative forces (the Republican Party) in the United States, and blue is the color of the progressive forces (the Democratic Party). The reverse is true in the European Union: red is the color of the left and center-left parties, and blue the color of the right and center-right parties. In Europe, a "red region" is a region such as Barcelona, which has always been governed by left-wing parties during Spain's democratic period. In the United States, a "red state" is one governed by the Republican Party. This difference may seem a minor point, but it isn't. It shows how even the symbols of the political cultures differ. Such differences also appear in the political discourse. A "liberal" in the United States is a politician, such as Jesse Jackson Sr., who is in favor of a larger role for the state (or, in popular language, the "government") in society, supporting higher public expenditures for social ends and encouraging redistributive policies backed up by

more progressive taxation. A liberal in the European Union is precisely the opposite—someone who favors reducing the role of government in society, advocates lower taxation, is against redistributive policies, and supports a reduction of public expenditures. These opposite meanings of "liberal" explain the enormous confusion created in Europe when the media there translate the term "liberal" literally. In Europe, the parties that advocate the types of policies called "liberal" in the United States are referred to as social democratic. Liberals in the European Union are small parties that usually have limited influence in the political representative institutions

THE NATURE OF THE MEDICAL PROBLEM IN THE UNITED STATES

Let's now turn to the United States. One of the major problems faced by large sectors of the population is their limited access to medical services in time of need, their insufficient health benefits coverage if they do have health insurance, and their difficulties in paying premiums to the health insurance companies and paying the medical bills they receive. None of these problems, experienced in the United States, are found in the publicly funded health services of the European Union (or in Canada for that matter).

In 2006, 47 million Americans did not have any form of health benefits coverage, and 108 million had insufficient coverage. And people die because of this. Estimates of the number of preventable deaths vary, from 18,000 per year (estimated by the conservative Institute of Medicine) to a more realistic level of more than 100,000 (calculated by Professor David Himmelstein of Harvard University). The number depends on how one defines "preventable deaths." But even the conservative figure of 18,000 deaths per year is six times the number of people killed in the World Trade Center on 9/11. That event outraged people (as it should), but the deaths resulting from lack of health care seem to go unnoticed; these deaths are not reported on the front pages, or even on the back pages, of the *New York Times*, *Washington Post*, *Los Angeles Times*, or any other U.S. newspaper. These deaths are so much a part of our everyday reality that they are not news.

But besides the problem of the uninsured, the United States has another major problem: the underinsured. Most people believe that because they have health insurance, they will never face the problem of being unable to pay their medical bills. They eventually find out the truth, however—that their insurance is dramatically insufficient. Even for families with the best health benefits coverage available, the benefits are much less comprehensive than those provided as entitlements in Canada and in most E.U. countries. Paying medical bills in the United States is a serious difficulty for many people. In fact, inability to pay medical bills is the primary cause of family bankruptcy, and most of these families have health insurance. Furthermore, 20 percent of families spend more

than 10 percent of their disposable income on insurance premiums and medical bills (the percentage is even higher for those with individual insurance: 53%). In 2006, one of every four Americans lived in families that had problems with paying medical bills. And most of them had health insurance. None of the E.U. countries face this dramatic situation.

CAN THE UNITED STATES AFFORD A COMPREHENSIVE UNIVERSAL HEALTH CARE PROGRAM?

The roots of this human and economic problem cannot be lack of resources. The United States spends 16 percent of its GNP (gross national product) on medical care, almost double the percentage spent by Canada and most E.U. countries on providing their populations with universal, comprehensive health care coverage. We in the United States spend $2.1 trillion annually on medical care, making the medical care sector one of the largest economies in the world (if the medical care sector were a country, rather than a massive sector within a country). And it has been estimated that this spending will reach 20 percent of GNP in a few years (7 years according to some, 12 years according to others). Lack of money is not the root of the medical care problem in the United States. We spend far, far more than any other developed country, and far more than we would need to spend to provide comprehensive health care coverage for everyone. The frequently heard argument that the United States cannot afford universal, comprehensive care has no credibility. It is a poor rationale for keeping the situation as it is.

If lack of resources is not the problem, then what is? The answer is fairly easy to see. The root of the problem is the channels through which the money is managed and spent. The United States is the only country where medical care is predominantly private (although if we include the tax exemptions for private insurers, most of the funding in the United States is public). And the health insurers play a critical role in the funding and management of medical care in the United States. The current system of funding and managing medical care is based on an employers-insurers alliance that was established in 1948 in the Taft-Hartley Act. Immediately after World War II, a pact was established between the major employers associations and the insurance companies and was crystallized in the Act (initially vetoed by President Truman). The health benefits coverage of the working population was to be provided, not through the state (as in the majority of European countries), but through people's place of employment by a process of negotiation between trade unions and employers that takes place in a highly decentralized collective-bargaining process. Employers and employees pay the insurance premiums for health benefits coverage, coverage that varies enormously depending on the strength of the labor unions. Wherever trade unions are strong (as in manufacturing) the health benefits coverage has been good, although never as good as in the publicly funded medical care systems in the European Union. Wherever trade unions are weak or absent, the health benefits

coverage has been very limited or nonexistent. This is the reason for the enormous variability in health benefits coverage in the United States. One reason why employers supported this arrangement was that this system of funding is one of the most powerful ways of controlling employees. The United States is the only country where, when workers are fired, they lose not only their salary but also their health benefits coverage for their family. This is one reason for the United States being the country with the fewest working days lost due to strikes: workers think twice before striking. Today, the high costs of health insurance premiums are weakening employers' support for this employer-based insurance. But the majority of large employers (major components of the "corporate class") still favor this system. Individuals who don't receive health insurance through their place of employment must buy their own, or they have no insurance. If a person has a chronic illness or disability, the price of the premium may be prohibitive, or the person is not accepted by an insurer because of a "preexisting condition."

The other side of this employers-insurers alliance is that the health insurance industry is one of the most profitable in the United States. The insurance industry and other sectors of the medical-industrial complex enjoy the highest rates of profit in the country. Just last year, insurance industry profits reached $12 billion, and pharmaceutical industry profits $49 billion, the highest in the United States and in the world. According to *Fortune* magazine, health-related industries are among the most profitable industries in the United States. A lot of money is being made from people's suffering. This scandalous situation is easy to document. For example, Lanzoprasol, a gastric-secretion-reducing medicine widely used in the United States, costs $329 in Baltimore, Maryland; the same medicine (same number of doses) costs $9 in Barcelona, Spain! And the current Bush administration signed legislation for a program that, in theory, covers drug costs for elderly people, but in practice this is an enormous rip-off. It forbids the government to negotiate with drug companies on the cost of drugs—that is, the price of their products. What this means is that the federal government pays the prices dictated by the pharmaceutical industry.

WHY HAVE U.S. GOVERNMENTS CONSISTENTLY FAILED TO RESOLVE THIS SITUATION?

Why does this continue? Why hasn't the U.S. government done something about it? Is it that the government could not provide comprehensive health benefits coverage? It certainly could. All E.U. governments do so. All provide publicly funded, comprehensive health care coverage to their entire population. And on this side of the Atlantic, Canada (which once had a system identical to ours, health insurers included) also provides this entitlement to all its citizens. In Canada in the 1960s, a social democratic government in Saskatchewan did a very logical thing. My good friend Dr. Samuel Wolfe, who was then Chief Health Officer of Saskatchewan, proposed to the province's social democratic

government that rather than paying premiums to insurance companies, people would pay earmarked taxes to a public trust fund, controlled by their representatives. This trust fund would negotiate with doctors and hospitals for the payments they receive for the care they provide. This saved a lot of money by bypassing the insurance companies. The Saskatchewan Health Plan provided comprehensive care to everyone in the province at a much lower cost than before. Soon, the other provinces adopted similar plans, eventually establishing Canada's nationwide health plan that now covers everyone. The overhead for the public system in Canada is only 4 percent, compared with 30 percent in the U.S. insurance industry—30 percent that goes to marketing, administration (a lot of paper shuffling goes on in U.S. health care), and the salaries of extremely well-paid executives and insurance lobbyists. One of the best-paid individuals in the United States is William McGuire, CEO of an insurance company—UnitedHealth. He makes $37 million a year, plus $1.7 billion in stock options. And all of this money comes from premiums paid by people, many of whom have insufficient coverage.

THE POLITICAL CONTEXT: IT'S NOT JUST THE MEDICAL SECTOR THAT IS PRIVATIZED— THE ELECTORAL PROCESS IS ALSO PRIVATIZED

The United States is also the only country where the electoral process is privatized. This means that most of the money for candidates' political campaigns is private money. And we are speaking of big money. The idealized version of the U.S. electoral process, in which candidates are funded by a conglomeration of small contributions from ordinary citizens, is plain wrong. According to Common Cause, the most credible center for the study of elections in the United States, most of the funding for candidates comes from large economic interests (insurance companies, drug companies, professional associations, banking, construction industries, and a long list of others) and from the 30 percent of the population with highest incomes. Candidates need this money for, among other things, buying media space in the private broadcasting industry that sells airtime to the highest bidder. The more money your campaign takes in, the greater is your chance of winning the election. According to Common Cause, 94 percent of the best-funded candidates won in the last Congressional election, in 2006.

Money is indeed the major motor behind politics. This is what gives the insurance companies their enormous power, both in Washington, DC, and in most state legislatures. In Maryland, for example, a former governor arranged for candidates for Insurance Commissioner to be interviewed by the insurance associations before he made his final selection. But insurance industry influence is strongest in Washington. The insurance companies pay a lot of money to candidates. According to the Center for Responsive Politics, as of February 12, 2008, the insurance industry had contributed $525,188 to Hillary Clinton,

$414,863 to Barack Obama, and $274,724 to John McCain. As a consequence, not one of the candidates is asking for a publicly funded health care system. The major players in medical care in the United States—insurance companies, drug companies, professional associations, and so on, as noted above—have given a lot of money to the candidates. The splendid document called the U.S. Constitution, which begins "We the people," should have a footnote: "and the insurance companies, the drug companies, . . ." The U.S. Congress is indeed the best Congress money can buy—for a further discussion of how money corrupts the electoral system, see my article "How to Read the U.S. Primaries: Guide for Europeans" (*CounterPunch*, February 13, 2008). Privatization of the electoral process corrupts the democratic process. I am not implying that politicians are corrupt (although some are). I am willing to admit that most are honorable persons. But the need to constantly raise funds for their campaigns (for election and reelection) corrupts the democratic process. And the unwillingness of most members of Congress to change this situation makes them accomplices in that corruption. Such practices are illegal in most democratic countries. Many ministers of European governments have had to resign when it came to light that they had received private funds for the electoral process.

And people know all about this. In surveys, 68 percent of people believe the U.S. Congress does not represent their interests, but represents the interests of the financial and economic groups that fund political campaigns. But the establishments, including the political, media, and academic establishments, want everyone to believe that the reason we don't have a universal health program is that people don't want it. They would like people to believe that Congress legislates what people actually want. Meanwhile, the long list of public policies that people want but do not get from their government is growing: 65 percent of people want a publicly funded health care system similar to that in Canada, a single-payer system. In a single-payer system, the government, rather than the insurance companies, negotiates with providers—doctors, hospitals, nurses, and so on—for the provision of medical care. We already have a system of this type in Medicare (with an administrative overhead of only 4 percent, compared with the 30 percent overhead in the insurance system). By eliminating the huge administrative expenses, we could provide comprehensive health care coverage for everyone without spending an extra penny. Let me add that according to *Annals of Internal Medicine*, 59 percent of physicians across the United States "support government legislation to establish a national health insurance."

THE POLITICAL RESPONSE: THE PROPOSALS FOR HEALTH CARE REFORM

These enormous problems in obtaining medical care in the United States explain why medical care reform has become—along with the economy and Iraq—a top issue in this year's presidential election. For this reason, candidates in the

presidential primaries (the Democrats more often than the Republicans) have been recounting stories about the health-related tragedies they have encountered in meetings with ordinary people around the country (an exercise conducted in the United States every four years, at presidential election time). These stories tell of the enormous difficulties and suffering faced by many people in their attempts to get the medical care they need. I have been around long enough—I was senior health advisor to Jesse Jackson in the Democratic primaries of 1984 and 1988—to know how frequently Democratic candidates, over the years, have referred to such cases. The only things that change are the names and faces in these human tragedies. Otherwise, the stories, year after year, are almost the same.

In the Democratic Party primaries of 1988, for example, candidate Michael Dukakis talked about a young single mother who had two jobs and still could not afford medical insurance for herself and her children. In 1992, Bill Clinton did the same, changing the story only slightly. This time it was the case of a woman with diabetes who could not get health insurance because of her chronic condition. And now, in the 2008 primaries, Hillary Clinton (whom I worked with on the White House Health Care Reform Task Force in 1993) describes a similar case. This time it's a single woman, with two daughters, who cannot pay her medical bills because her congenital heart defect makes it impossible for her to get insurance coverage. And Barack Obama describes similar cases, with the eloquence that characterizes all of his speeches. He frequently refers to his own mother, who had cancer and had to worry not only about her illness but about paying her medical bills. Republican candidates rarely make references to such situations.

All these cases are tragic and are representative of a situation faced by millions of people in the United States every year. But, I am afraid that unless the winning Democratic candidate, once elected president (and I hope he or she will be), develops a more comprehensive health care proposal than any of those put forward in the primaries so far, we will see the same situation continue. Democratic candidates in the 2012 primaries, and in the 2016 primaries, will still be referring to single mothers with chronic health conditions who cannot pay their medical bills. The proposals put forward by Obama and Clinton (not to speak of McCain) underestimate the gravity of the problem in the U.S. medical care sector. The situation is bad and is getting worse: the number of people who are uninsured and underinsured has been growing since 1978. There were 21 million uninsured people in the United States in 1972. By 2006, that number had more than doubled to 47 million. And this increase has occurred independent of economic cycles. The number of uninsured grew by 3.4 million from 2004 to 2006, even as a resurgent economy raised incomes and lowered poverty rates. Meanwhile, during those years, the Republican establishment ignored the situation altogether and the Democratic establishment distanced itself from any commitment to resolving these problems. Even though the 1976, 1980, 1984, 1988, and 1992 Democratic platforms included calls for health care benefits

coverage for everyone (or "universal health care"), that call was usually made without much conviction. In the primaries of 1988, when I was involved in preparing the Democratic platform, Dukakis (the winner of the primaries) resisted including universal health care in the party platform. He was afraid of being perceived as "too radical." He had to accept it, however, because Jesse Jackson agreed to support Dukakis (Jackson had 40% of the Democratic delegates at the Atlanta convention) only if the platform included this call for universal care.

Then, in 1992, Bill Clinton (who borrowed extensively from Jackson's 1988 proposals) put the call for universal health care at the center of his program. But, once president, his closeness to Wall Street and his intellectual dependence on Robert Rubin of Wall Street (who became his Secretary of the Treasury) made him leery of antagonizing the insurance industry. It was President Clinton's unwillingness to confront the insurance companies that led to his failure to honor his commitment to work toward a universal health care program—see my article "Why HillaryCare Failed" (*CounterPunch*, November 12, 2007). The type of reform President Clinton called for was a health-insurance-based model called "managed care," in which insurance companies remain at the center of health care. An alternative approach could have been to establish a publicly funded health care program (which was favored by the majority of the population) that would cover everyone, providing medical care as an entitlement for all citizens and residents. This could have been achieved, such as by expanding the federal Medicare program to cover everyone. To do so, however, would have required neutralizing the enormous power of the insurance companies with a massive mobilization of the population against them and in favor of a comprehensive and universal health care program.

But President Clinton's loyalty to Wall Street prevailed. His administration's top priorities were reduction of the federal deficit (at the cost of reduced public social expenditures) and approval of NAFTA, the North American Free Trade Agreement (without amending President George H. W. Bush's proposal, which Clinton had inherited, and refusing to address the concerns of the labor and environmental movements). These actions antagonized and demoralized the grassroots of the Democratic Party. Clinton lost any power to mobilize people for the establishment of a universal health care program. This frustration of the grassroots, and especially the working class, also led to the huge abstention by the Democratic Party base in the 1994 congressional elections and the consequent loss of the Democratic majority in the House, the Senate, and many state legislatures. At the root of this disenchantment with the Clinton administration was its unwillingness to confront the insurance companies and Wall Street. Could that happen again? The answer is yes. Regardless of who wins the coming presidential election, we are likely to face a similar situation. I doubt that the Republican candidate would dare carry out proposals that might antagonize the powerful forces that shape the funding and organization of medicine in the United States. But, the same could occur with the Democratic candidate. Unless there is a

profound change in the way the United States funds the electoral process, we are not going to see major reforms in the health sector. It is as plain as that.

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