Sometime this fall, the Clinton administration will announce its plan to overhaul America's $900 billion-a-year health care system. For 20 years, this magazine has urged the adoption of a national health insurance plan in which everyone is covered and the government strictly controls costs. Such a system works in Canada, and with careful adaptation, this is a worthy starting point for U.S. health care reform. Yet Washington is paralyzed, unable to consider, let alone adopt, models which require a drastically reduced role for private insurers. In the following section, we explain why the capital's insider culture pays so little attention to Canada's experience, which we remain convinced points the way to real reform. Then we offer dramatic solutions that will work whether we keep or reform the present system: First, how to quickly move doctors out of expensive specialities and int general practice, and second, how to efficiently reform Medicare to cost less and work better.

Dead On Arrival

Why Washington's power elites won't consider single payer health reform

by Tom Hamburger and Ted Marmor

In February, Dr. Quentin Young flew to Washington from his home in Chicago, pleased to have been asked to consult with top White House officials on health care. Young, the past president of Physicians for a National Health Program, was looking forward to plumping for his organization's favorite cause: Adapting Canada's national health insurance system to the United States.

Young had an attractive case to make: Canada, where provincial governments act as single insurers, annually spends 30 percent less per capita than we do for health care, providing universal coverage, cost controls, and choice of physician. The U.S. fails to insure 37 million people and has no control over rising costs, and a Harvard University survey of 10 nations found that Canadians were the most satisfied with their health-care system; Americans were the least.

But Young's enthusiasm quickly withered within the White House gates. It turned out, in Young's words, that he had been invited for "pseudo consultation." White House staff made it clear that single payer was off the table. "Why?" Young asked, amazed. A senior White House health adviser, Walter Zelman, put it bluntly: "Single payer is not politically feasible."

In a separate session with Hillary Rodham Clinton, Dr. David Himmelstein of Harvard Medical School (a close colleague of Young's), also pressed the single-payer point. Canada's solution, he said, made sense for the United States. Himmelstein's studies, published in *The New England Journal of Medicine* since 1986, show that the U.S. could save as much as $67 billion in administrative costs alone by cutting out the 1,500 private insurers and going to a single government insurer in each state—easily enough to pay to cover every uninsured American.

Hillary Clinton had heard it all before. How, she asked Himmelstein, do you defeat the multi-billion dollar insurance industry? "With presidential leadership and polls showing that 70 percent of Americans favor

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[the features of] a single-payer system," Himmelstein recalls telling Mrs. Clinton. The First Lady replied: "Tell me something interesting, David."

So by February, fewer than six weeks into the Clinton presidency, the White House had made its key policy decision: Before the Health Care Task Force wrote a single page of its 22-volume report to the President, the single payer idea was written off, and "managed competition" was in. But why should an intelligent First Lady and her 500 health care advisers *not* want to debate every option, especially examples available from nations that have combined universal access and cost control?

Because in Washington's political culture, incremental change is the coin of the realm, and a move to single payer is seen as anything but incremental. (Though in fact, managed competition proposes a more drastic shift in health care delivery for most Americans than single payer does.) "I've been in so many meetings in Washington where people say, 'We've got to fashion something that's acceptable to the interest groups,'" says Minnesota Senator Paul Wellstone, one of the few single payer champions. "And I know what groups they put at the top of the list—the health care and insurance lobbies." But there's more to the failure to discuss single payer than lobbyists and their clout. Some politicians fear being caricatured as advocates of "big government" in an age of sound bite politics. And some fear being dismissed as irrelevant for supporting a cause that's thought to be outside the mainstream. What constitutes the mainstream? To understand that, consider how the capital's three established tribes—the politicians, the press, and the experts—slid single payer off the table without allowing people to decide for themselves whether it should be adopted:

- First, politicians like Mrs. Clinton fear the bitter, unique opposition of the health insurance industry to single payer. Doctors, hospitals, and health insurers will oppose elements of any reform, but only a single payer plan means the virtual abolition of an entire industry as we know it. Politicians who are reluctant to take on established interests in Washington ($60 million in medical and insurance PAC contributions since 1980) and back home (insurance agents in every Rotary Club in every district) are terrified by the anger that would result from putting health insurers out of business. Combining this with the normal opposition any reform provokes and with a political process that discourages full debate, politicians duck the merits of the issue and dismiss single payer as not feasible.

- Once this political fact has been established in the hearts and minds of politicians, the people who might be expected to raise out-of-the-mainstream questions—reporters—are generally too focused on politics, not on substance, to do anything more than reflect prevailing opinion rather than informing it.

- Finally, the experts who might be expected to rise above the political currents resist seriously appraising Canada for fear of being dismissed as cranks or out-of-touch with *realpolitik*. Those experts who *do* argue for single payer are penalized by having to chase research dollars with more difficulty at foundations where insurance executives are a presence. And so it is that an industry which employs 140,000 agents in the U.S. helps kill reform that would help 250 million Americans.

There's the human drama, too, of watching these tribes operate in unhealthy symbiosis. Once something is thought to be off the agenda—as single payer has appeared to be—then it's death for a Washington player, no matter how established, to keep banging away. Take Rep. Jim McDermott, a Seattle Democrat, who despite years of talking up single payer still feels the sharp dismissiveness of his colleagues and understands why so few people challenge the status quo. A few months ago, McDermott and the rest of his state's congressional delegation won the coveted invitation to fly with Clinton on Air Force One to the Pacific Northwest's Timber Summit. In that collegial atmosphere, at the center of power, the politicians congregated around the President in his cabin.

McDermott raised his hand, and everyone groaned. "He's going to ask about single payer again," they muttered. He wasn't, but it didn't matter. "You get stereotyped and people act like they know what you're thinking and they become dismissive without listening to what you have to say," says McDermott, a psychiatrist who came to Congress in 1988. "You have to put up with a certain amount of ridicule. This is an issue on which everybody has an opinion. And if you choose the wrong solution, you can be defeated."

The word is out among Democrats in the capital: Positions like McDermott's, which appear to

contradict the Clintons' approach, are considered disloyal to the new President. More to the point, the conventional wisdom goes, *why* would any halfway savvy Washingtonian want to fool with something that's off the table? Among the politicians and the press, where does this conventional wisdom begin to form?

Welcome to the world of the Sperling breakfast group. In the understated elegance of the Sheraton Carlton Hotel, two blocks from the White House, Washington print reporters meet several times a week with prominent news sources. The event, hosted by *The Christian Science Monitor*'s Godfrey Sperling Jr., recalls an older, more genteel era in Washington. Old in style, the setting reflects the continuing nature of most Washington journalism: Reporters transcribing the thoughts and words of highly placed sources.

When Bobby Rush, a newly elected congressman, got to Washington, he initially balked at backing the single payer system he had advocated during his campaign. He told one group that "important supporters"—health care lobbies gave him $13,750 during his campaign—might not understand.

Senate Majority Leader George Mitchell dropped by one of these gatherings in July. Even before the waiters brought out the bacon and eggs, the questions turned to health care: Do you favor consideration of Canadian style health reform, the most popular solution among your constituents in Maine?

"No," Mitchell said bluntly. Canada's system may be good for Canada, but "it will not be enacted" in Washington. Americans want an American solution. (A phrase Mrs. Clinton would also use during her working July holiday in Hawaii, sitting poolside with reporters.) A couple of months before, when Mitchell met with *The Wall Street Journal*'s lunch group at the same hotel, he outlined the key elements he would like to see in a reformed American health system. His answer was crisp and precise: insurance coverage for all; controlled costs; consumer choice of physician and hospital; renewed emphasis on primary over specialized care; and flexibility for states to tailor the plan for their own needs. (All of which perfectly describe the Canadian plan.)

When pressed on the point, Mitchell said, "I respect the Canadian system. . . But we ought to select the system that's based on the practices and standards of our country. When very wealthy people—kings and prime ministers and others of means—in other countries get sick, they don't go to Canada. They don't go to Germany. They don't go to Japan. They come to the United States." Reporters at the Sheraton dutifully recorded Mitchell's words. Never mind that foreign leaders regularly use their own systems in Germany, Japan, Canada, and elsewhere. Never mind that just a few years ago, Mitchell's Senate colleague, the late Spark Matsunaga of Hawaii, went to Canada for new, high-tech cancer treatments that were unavailable in the U.S.

With such broad agreement on what health reform should provide, why don't the Canadian or the German or the Australian systems get more seriously considered? The short answer is fear. For politicians, this means mostly fear of political attack, fear of taking on powerful American myths, and fear of incurring the wrath of the well-endowed health care and insurance industries. And politicians fear being left out of the game. That means they talk the prevailing talk, and think the prevailing thoughts, instead of realistically appraising proposed reforms or genuinely evaluating foreign experience.

Mitchell is well aware of the power of advertising to defeat single payer advocates. His Republican colleague from Maine, Senator William Cohen, beat a Democratic challenger in 1990 in the nation's first election to turn almost entirely on health reform. Cohen's opponent, Neil Rolde, openly championed the Canadian-style system, but Cohen's campaign was guided by Republican pollster Bill McInturff, a clever conservative with an uncanny knack for packaging effective attacks.

"We trashed the hell out of the Canadian system," McInturff recalled. Foreshadowing the tack Bush took in his own re-election campaign, McInturff described how he planned ads attacking national health insurance with footage of a crowded department-of-motor-vehicles waiting line. The ominous voiceover? "This is your

health care system if we go to a national plan." McInturff's GOP strategy rightly assumed that voters associate Democrats with big government, high taxes, and bureaucratic hassles. So McInturff shrewdly responded to a Democratic national health proposal by raising the specter of big government run amok, linking Canada with this dismal image. And McInturff was among those who recommended a line that Bush would later use in 1992: Universal health insurance, the President said, would operate "with the efficiency of the U.S. Postal Service and the compassion of the KGB."

But Clinton, as usual, was a step ahead of Bush—and, by extension, of McInturff. In the Democratic primary campaign, Clinton regularly referred to what we could learn from the experience of other nations. But in the general election campaign, Clinton suddenly adopted the phrase "managed competition" to define his variant of health insurance reform. Few understood then or now what he meant, but no one—especially political or industry opponents—could accuse him of foisting "failed" foreign ideas on the good old U.S. of A.

The institutional pressure on politicians to play it safe is powerfully dramatized in the cautious attitude of a reformer elected with Clinton: Rep. Bobby Rush of Chicago. In 1992, Rush, a former Black Panther, campaigned as an advocate of Canadian style reform. But once introduced to the pressures of Washington, his former supporters claim he became skittish about co-sponsoring a single payer solution. Rush shocked Quentin Young and others by refusing to co-sponsor Jim McDermott's single payer bill in the House. Rush told supporters, including Young, that as part of leadership (House Speaker Tom Foley had made Rush a freshman whip) it would be difficult for him to support a non-administration bill, and that important supporters (medical, hospital, and insurance PACs donated $13,750 to Rush's campaign) would also not understand if he went along with the single payers. Outraged Chicago health activists who had supported Rush pressed him hard, and eventually he signed on. A Rush spokesperson says that Rush was just being "deliberate" as he considered a complex subject and did not delay because of other pressures. But when the tribal need to be accepted as part of the system is so strong that someone like Rush hesitates, it's little wonder that politicians of lesser proven conviction slip so readily into complacency.

No, Canada

So if politicians fear treading in the single-payer arena, why aren't journalists learning and talking about Canada and other foreign experience? Why are discussions of these matters relegated to largely arcane academic journals and occasional features? To be sure, there are thoughtful mainstream pieces from time to time. This July, *The New York Times* ran a detailed article explaining the advantages of Ontario's system of caring for the elderly. The *Philadelphia Inquirer* ran an extensive three-part series in April comparing Canadian, German, and American patient care.

But most of the time, almost any news story in Canada about waiting lists, a disappointed physician, or the lack of funds for doctors or hospitals finds its way into congressional testimony and into American news stories. Medical pressure groups do the digging and journalists do the disseminating. Because America's journalistic ethic of quoting both sides gives equal space to those who praise Canada and those who criticize it, articles repeat myths about Canada without analyzing them.

For example, in March, *The New York Times* ran a major front page piece headlined: "Patients Footing the Bill Amid Canadian Cutbacks: Spending Outstrips Government's Ability to Pay." Read beyond that alarming head and there was quite different news: The Canadian system is widely popular and 95 percent of all Canadians reported receiving the care they needed within 24 hours. The cutbacks? The Canadian government had decided not to reimburse its citizens any longer for electrolysis removal of unwanted hair.

A search of 100 health care articles in *The Washington Post* since April found that only 10 percent dealt substantially with Canada; 70 percent focused on leaks from the Health Care Task Force and on the political implications of the Clinton plan. Only three focused critically on managed competition. A cover story in the *Post*'s health supplement in June trumpeted a financial crunch hitting Canada's system. The

cover art? Bill and Hillary as Adam and Eve in a health care Garden of Eden looking at a half-eaten Canadian apple. The headline? "The Model is Tempting, But. . . ." The lead? Canadians "know well how expensive it is to run a national system with universal coverage: They have one and evidence is mounting that they can't afford it." This makes little sense. Costs have risen over the past decade in Canada but nowhere near the rate U.S. costs have. So if we have non-universal coverage and spend 14 percent of GNP, how can a system with universal coverage that costs 9 percent of GNP illustrate the point that Canadians "know well how expensive it is to run a system with universal coverage?" Viewing the U.S. from Canada reveals exactly the opposite: It shows how expensive it is *not* to have universal coverage and cost constraints.

Why do things like this get into print? First, there's the matter of sophistication. Few American journalists spend enough time studying the health systems of other developed democracies to know that the lessons thought peculiar to Canada are in fact quite general. Germany, France, Japan, Australia, and Canada all combine universal coverage with budget limits and considerable bargaining power in the hands of payers. Second, there's the matter of drama. (In mainstream journalism, bad news is always more interesting than good news.) So for dramatic reasons, even when stories explaining the benefits of Canadian or European systems do appear, they tend to be underplayed. For example, when the Congressional Budget Office (CBO) reported in May that a single payer system could provide universal health care and still cut costs by $14 billion a year, the *Post* ran a single column story inside the paper that never referred to Canada. A second CBO report in July saying that a Canadian style plan would save more money than any other proposal—including managed competition—ran on page A15.

There are other factors at work here, too. Even after Watergate and Iran-*contra*, journalists are still reluctant to challenge the statements of public officials. During the 1992 campaign, for example, Paul Tsongas flatly dismissed the idea of national health insurance. Dramatically, Tsongas said he might be dead today if he had been living in Canada because the medical technology that saved his life from cancer was unavailable there. But it was not true. In fact, the treatment Tsongas needed was developed by Toronto doctors and is available to Canadians with little or no delay from the surgeons who helped invent it. At the time, most reporters never bothered to check whether Tsongas' remark were true; *The New Yorker* and *The Chicago Tribune* followed up and told readers that a major presidential aspirant didn't know what he was talking about.

Why aren't more reporters and news organizations up there examining the system for themselves? Why do they fail to investigate exaggerated complaints and underplay positive reports? They aren't corrupt or bought off by the insurance industry. The more compelling explanation is less scandalous, but more serious. Over and over again, reporters hear that the Canadian system "is not politically feasible." Over and over again, they hear that Canada is not the perfect system advocates make it out to be. These messages do not come solely from the spoonfeeding at lunch and breakfast meetings. Most importantly, once health care becomes a political issue, it is assigned to *political* reporters, not medical reporters, and the politicos naturally judge everything through a "can-this-pass" filter. And reporters, confronting a complicated subject, are generally afraid of asking questions when they think the answers must be obvious to everybody else. Politicians and interest group spokesmen can therefore spin like tops, using statistics and scenarios that the reporters don't know enough to challenge.

Even the "MacNeil-Lehrer NewsHour," which makes unusual efforts to air the full range of health care opinion, dramatizes the problems. In May, health reporter Stuart Schear arranged a four-guest debate on single payer versus managed competition. One of the managed competition critics mysteriously dropped his opposition on the air, leaving only Dr. Steffie Woolhandler, a Harvard colleague of David Himmelstein's, to make the Canadian case. At the end of the interview, MacNeil noted that Woolhandler was in the minority and then asked: "If this [managed competition] is the program that has political consensus and the other one that you advocate [single payer] is considered impossible politically at the moment, why are you then against the one that is viable and would produce a large amount of reform?"

While Woolhandler rejected the assumption that managed competition would produce meaningful reform, MacNeil's question—designed as it may have been to elicit an interesting response—reinforced the impression that single payer was simply not feasible.

Health snare

If most politicians dwell in fear of insurance industry enmity and political irrelevance, and if most reporters ingest that view without thinking, then where are we? Where can reporters and moderate and liberal politicians turn in the health care debate? Quick—to the Rolodex. How about the outside experts?

Unfortunately, the cultural imperatives that shut down political and journalistic inquiry are also at work in think tanks and universities. Experts fear being labeled as out of touch as much as the politicians and the press. Take Henry Aaron, the highly-regarded senior economist at the Brookings Institution, whose 1991 book on health care, *Serious and Unstable Condition*, was widely noted in Washington. Aaron's book painstakingly reviews our troubled "condition," reports the experience of other industrial democracies, and then outlines a solution which in fact reflects principles applied abroad. But he devotes just one paragraph to Canada, and his proposed solution builds on private insurance. Intellectually honest, Aaron almost apologetically explains his surrender to presumed political constraint: "Although a wholly public plan probably could achieve some additional savings. . . [my plan] is predicated on the unwillingness of Congress to shift the bulk of currently private health care arrangements for most Americans." No one wants to be left out.

And some say there appears a financial price to be paid if one goes too far beyond what is regarded as the conventional wisdom. Consider the case of David Himmelstein, an authority on the costs of bureaucracy in the American and Canadian health systems. His studies, conducted with Woolhandler, appear regularly in *The New England Journal of Medicine* and, though controversial, have been used by the General Accounting Office, journalists, and congressional committees to compare health systems. Yet their research has been done on a shoestring: The two doctors actually had to pool their academic salaries to pay research expenses. (And though the research is cited, it's not generally understood and runs into the journalistic he said/she said confusion.)

Private funding for research on single payer systems is far more difficult to find than money for other kinds of health care research, Himmelstein says, unless you make clear that conclusions will be negative. "Our personal experience is that research that may show the superiority of a single payer system is somewhere between difficult and impossible to fund," Himmelstein said. In 11 years, their only funded project was "only indirectly related to single payer work." Himmelstein has been complaining of bias for years. One foundation vice president told him, in confidence, that his work would never be funded. "There is a person on our board," the foundation official said, "who will veto any proposal that would lead to the abolition of the health insurance industry. A specific piece of research that leads to the implication that the health insurance industry should be done away with is completely unfundable." Himmelstein looked around and saw that most of the foundation boards he was applying to had members connected to the insurance industry.

Of course, serious students of single-payer systems *can* be funded (full disclosure: both authors of this article have been); it's just harder, and that's important. Inside Washington, experts tend to play the game as it's played by the politicians and the press: Focus on the possibilities of the moment. For that reason, both Brookings and the Urban Institute, the respectable left-of-center think tanks, now largely ignore single payer plans. So there is an imbalance with important implications: Reformers suck up to the "feasible," and the forces for the status quo spread the myths and exacerbate the problem.

The upshot of this systematic relationship between journalists, politicians, and experts is confusion about Canada, not clarification of its enduring strengths and weaknesses. Sound bite journalism—electronic and print, featuring snippets of contradictory claims—has obscured the fact that Canada, although recently suffering from recession, has managed to satisfy most of its citizens in ways we should marvel at and learn from rather than dismiss. □

Scalpel, Please

Start cutting away at the salaries and the numbers of specialists out there, or whatever health care system we have will cost too much

by Christopher Georges

"Everyone told me it was the wrong thing to do," recalls Dr. Jennifer Weyler, explaining her decision two years ago as a medical student to become a family doctor. "My teachers discouraged me; administrators discouraged me. They told me I was too smart to go into primary care or that the job wouldn't be enough of a challenge." And sure enough, Weyler, now a resident in family medicine at the University of Massachusetts School of Medicine, is frustrated—but not by her job, which she loves. "It frustrates me," she explains, "to have to continually explain to people what a primary care practitioner is."

It was only 50 years ago, after all, that no one had to be told what a family doctor was, mainly because that's about all there was. Eighty-seven percent of all doctors in the thirties were general practitioners—namely internists, pediatricians, and family doctors. Today that figure has dropped to 30 percent.

That might appear, at first glance, like good news: As researchers become more sophisticated about what causes diseases and how to treat them, we need physicians who can focus on complex subfields of medicine. As medical technology evolves from stethoscopes to x-rays to CAT scans, we need doctors who can make the most of high-tech advances.

But it's also true that, despite the media's obsession with heart-warming stories about ice-packed kidneys air-lifted across America, the vast majority of medical treatments require little more than a visit to a generalist, where a check up, a prescription, or some simple medical advice will do the trick. More than three-fourths of all symptoms for which people seek treatment, studies show, can be fully treated by primary care doctors.

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