US health care. III: The reform problem

Jennifer Dixon

This is the final part in the series. Part II appeared in last week's issue

America: a country that spends more on health care than any other nation but where one in five of the population is not guaranteed access to basic care . . . a country with a \$666 billion health care industry whose members have competing interests and significant political lobbying power . . . a country whose citizens want to consume more health care but pay less for it . . . a country with numerous proposals for health care reform, none satisfying all the key players . . . a country with a tradition of market solutions to policy problems, a low profile role for government, and an inclination towards incremental rather than radical change . . . a country where the presidential administration and Congress are of a different political stripe, each needing the other's support to pass legislation on health care reform . . . a country with a federal budget deficit of over \$300 billion and currently a president who will veto any legislation requiring higher taxes. . . All this adds up to a country with health care policy "gridlock."

In this, the final article in the series on health care in the United States we examine how far health care reform is a priority, the reform proposals on offer, and how acceptable they are to the key players in the health care arena. We also examine the action taken by the states and consider the likely course of reform in the future.

Is reform a priority?

The position of health care reform on the political agenda in the United States depends, as elsewhere, on who wants reform and how badly they want it. Though most Americans are worried about the costs and future access to care,^{1,2} it is less clear how far reform is a priority. Exit polls at the last presidential election in 1988 showed that health care, though an important concern, was not a key issue which influenced the election outcome.³ Two clues suggest that things may be different in 1992. The first was the surprise victory of Democrat Harris Wofford over the Republican incumbent in the Senate election in Pennsylvania last November. Wofford's main election message was the need for national health insurance. The second was a recent national survey where the public ranked health care as a political issue second only to the economy and ahead of taxes, jobs, and education.² However, public opinion surveys on health care remain notoriously difficult to interpret.^{4,5}

More obvious is the high level of concern among American businesses⁶ which foot the health insurance bill for their workers. Concern is evidenced by increasing business involvement in health policy making at state and federal level⁷ and vigorous efforts to contain health care costs. But reform is less of an issue for small businesses (with fewer than 25 employees) since only 36% offered health insurance to their workers in 1990⁸ and many of the rest show no interest in offering cover in future.⁹ Reform is even a priority for the insurance industry. High costs of care have put health insurance out of reach of many businesses. To keep premium prices affordable, insurers have invested heavily in managed care (such as in health maintenance organisations), expanded the use of utilisation review to reduce inappropriate insurance claims, and led efforts to

reform their industry to make insurance more accessible to small businesses.¹⁰ Anxious to preserve the existing health system based on insurance, insurers have worked to expand access to care for vulnerable groups. In 1990 the Health Insurance Association of America worked on no fewer than 522 pieces of state legislation to improve access and led an unlikely coalition of interest groups to lobby Congress to expand Medicaid to poor children.^{11,12}

Health care reform is also high on the agenda of organised medicine and provider organisations.¹³ Hospitals are concerned with an increasing financial burden for care of uninsured people.¹⁴ Physicians are frustrated with the increasing paperwork required to claim payments from insurers and with utilisation review encroaching into patient management. A plethora of advocacy groups with a high national profile, such as the Children's Defense Fund, continue to lobby hard for reform, and the media have devoted an unprecedented amount of column inches and broadcast time to the need for reform.

Proposals for reform

How far reform is a priority also depends on the alternatives. There is no shortage of proposals—most favouring incremental rather than wholesale change. Most aim to plug the gaps in access by extending private insurance, public insurance, or both, to those currently uninsured and plan to curb costs in a range of ways. The proposals fall into four broad groups and concern employer mandates, tax incentives, expansion of Medicaid, and national health insurance.

EMPLOYER MANDATES

Employer mandates would require all employers to offer health insurance to their workers or pay a tax to the state for each uninsured employee—the so called "pay or play" proposal. The idea is that the employee tax is used by the state to subsidise health insurance for the uninsured through a new public health programme or through Medicaid or Medicare.¹⁵ Because health insurance costs would be steep for small businesses, pay or play proposals are usually combined with tax incentives to small employers and insurance reform to make premiums more affordable and available.

Supporters point out that a pay or play reform could dramatically reduce the number of uninsured people since roughly half of them are employed, that it preserves the traditional system of employer based health insurance, and that the costs are borne largely outside federal and state governments. Critics worry that generous tax incentives would be required to protect small businesses from crippling insurance bills—adding to the \$50 billion federal tax subsidy already given to employers for this purpose. Also, depending on the level of tax, businesses may opt to "pay" rather than "play," leading to a reduction in employer based health insurance—the opposite of what is intended.

TAX INCENTIVES

Tax incentives would entail granting tax credits to people with low incomes to help purchase health insurance individually¹⁶ or with the help of a public

Health Services Research Unit, London School of Hygiene and Tropical Medicine, London WC1E 7HT
Jennifer Dixon, *honorary lecturer in public health medicine*

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broker to negotiate lower premiums.¹⁷ Supporters claim that uninsured people would be able to enter the health care market and would stimulate competition among providers and that the plan offers an individual based and free choice approach to solving the access and cost problem. Critics claim that significant subsidies would be required before the poor could afford insurance.

EXPANSION OF MEDICAID

Proposals simply to expand Medicaid would be aimed at covering more of the uninsured poor and allowing the near poor or special groups (such as people who have retired early or unemployed people) to buy cover in the Medicaid or Medicare programme. Advantages are that expanding Medicaid is a less regressive use of tax dollars than providing tax breaks for employers¹⁸ and is a simple move which would not disrupt the structure of the current system. The main disadvantage is that the plan could be hugely expensive for shaky state budgets.¹⁹

NATIONAL HEALTH INSURANCE

The plan concerning national health insurance aims at a complete overhaul in the way health care is currently financed and organised in the United States and would result in a health system similar to that in Canada. It proposes a single, comprehensive health insurance programme for all Americans which is federally administered and financed through general taxation.²⁰ Services would be free at the point of use and private insurance eliminated. Costs would be controlled by applying a fixed national expenditure cap indexed to changes in the gross national product, by requiring hospitals to work within fixed budgets, and by regulating the fees charged by physicians. Supporters claim that universal cover would be achieved, administrative costs would be reduced, and cost control would be more effective. Critics point out that expenditure caps would result in queues for care (as in Canada), there are few incentives for innovation or improving quality, and the plans run counter to the American penchant for pluralism, individual choice, and a minimal role for government.

Many proposals borrow features from all the above groups and add methods to contain costs. Some favour greater government regulation of hospital charges and physicians' fees in both the private and the public sector and more extensive use of managed care. Others argue that less regulation would stimulate the market to keep prices competitive. More radical proposals suggest that all payments for health care should be

made by or through a single payer—that is, state²¹ or federal government²⁰—which would set a fixed annual ceiling for health spending.

How acceptable are the proposals and to whom?

As far as the public mind can be read, there seems to be support for federal government to take the lead to control costs and expand access but less consensus on the specifics of reform or the extra tax (if any) Americans are prepared to pay for it. Americans seem to favour the Canadian health system over their own but may not fully realise what such a system would mean in the United States.⁴

Employers remain against national health insurance and pay or play proposals but favour tax incentives to help small businesses provide health benefits. Insurers have lobbied against proposals which regulate their activities¹² or threaten their existence. Physicians have strongly resisted proposals which break the impressive upward trend in their income,²² and hospitals dislike plans which regulate the prices they charge. States are reluctant to take on any proposal which threatens their fragile economies or requires a tax increase.

Bush, Clinton, and Congress: proposals

To find an acceptable solution is the stuff of politics. Both candidates for the presidency have settled on different plans.

THE BUSH PLAN

Unveiled in January, the Bush plan would phase in tax credits of up to \$3750 per year to help people with low incomes (up to \$20 000 per year for a family of four) purchase private insurance. This should help roughly half of uninsured people. The plan would increase funding to community health centres which provide cheap primary care for the poor and reform the insurance market to help small businesses to purchase cover for employees. The main cost containment proposal is to encourage growth of managed care. Critics say the tax credits are not nearly enough to help the poor buy insurance, that generous incentives would be needed to encourage small businesses to participate voluntarily,²³ and that encouraging managed care will not control costs. With an estimated price tag of \$30 billion, and given the "no new taxes" pledge, it is unclear how the Bush plan will be financed.

THE CLINTON PLAN

The Clinton camp is pushing a pay or play proposal in which employers must purchase a defined package of benefits or participate in a public programme and insurers must offer one premium price for healthy or sick workers.²⁴ The main thrust to contain costs is to set annual health budget targets at a national and state level to guide health spending and to encourage the development of group networks of insurers and providers (essentially health maintenance organisations), which must operate within a fixed budget. This proposal is estimated to cost \$66 billion.²⁵ As with the Bush plan the source of funding is unclear.

PLANS IN CONGRESS

In the meantime Congress is awash with at least three dozen bills relating to health care reform. These range from the radical Russo bill, which proposes Canadian style national health insurance, to the Mitchell bill, proposing pay or play employer mandates, to bills which reform the insurance market. The more radical bills have little chance of passing into law, not least because any bill passed by the Democrat dominated Congress needs a two thirds majority vote

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Health reforms are of smaller relevance for small businesses, which are less concerned with offering health insurance to employees

to override a presidential veto—a tall order considering the vested interest groups with a voice on Capitol Hill.

Action by the states

Meanwhile, in the absence of federal leadership the states have been busy with reforms of their own. There have been diverse public and public-private initiatives in states over the past decade to tackle the twin problems of costs and access. Most states offer some assistance to the uninsured—for example, by granting direct subsidies to providers the uninsured use the most or by offering tax incentives to help the poor buy basic health insurance.²⁶ Others have targeted state tax dollars to subsidise health care for special groups such as low income uninsured children, the disabled, and the medically uninsurable. To reduce costs many have encouraged growth of managed care or, like New York, mandated that Medicaid recipients should enrol in health maintenance organisations. A few states, such as Maryland and California, determine the prices that hospitals can charge insurers (public or private) for services, but there is debate whether this “all payer rate setting” has effectively contained costs.²⁷ Vermont is the only state which has passed a law which sets a fixed budget for total health spending, but is still deciding how the law should be implemented.

Other states have combined several approaches to improve access. Minnesota passed a law in April 1992 which extends low cost basic health benefits in a public plan called HealthRight to low income families without insurance.²⁸ It is a voluntary enrolment programme which plans to cover 157 000 of the state's 400 000 uninsured by 1995. The law also increases the Medicaid reimbursement rates payable to providers to improve access for Medicaid recipients and requires insurers to make insurance policies more affordable for small businesses. These plans are financed by a tax on cigarettes and the income of health care providers.

In 1987 Washington state began to offer subsidised health insurance to the low income uninsured through the Basic Health Plan. This programme is administered by an independent state agency which contracts with managed care organisations. It is a popular voluntary scheme: by April 1992 over 22 000 people had enrolled and 29 000 were waiting to join.²⁹

Earlier this year (1992) Florida passed a pay or play law where employers must offer basic health insurance by 1995 or pay a tax for each uninsured employee. Hawaii passed a similar law as far back as 1974 and backed this with the State Health Insurance Plan in 1989, which covers basic health benefits for those without insurance and who are not eligible for Medicaid. By 1990 only 9.2% of non-elderly people were uninsured compared with 16.6% nationally.³⁰

Some states have taken heart from events in Massachusetts. In 1988 Governor Dukakis signed the Health Security Act into law, the main thrust of which was a pay or play requirement for employers. Massachusetts showed that it was possible to build a political coalition between the state and private interest groups around substantive health care reform³¹ and to afford to expand access in a recession. However, since 1988 the political coalition has weakened and the political complexion of the Senate has changed. As a result the pay or play implementation has been delayed until 1995.

In 1989 Oregon passed the Basic Health Care Act, which helped small businesses purchase health cover for their workers, extended health benefits to the uninsurable, and expanded the Medicaid programme to more of the uninsured poor. To help finance the Medicaid expansion Oregon planned to curtail low priority Medicaid services and used a unique and controversial method to decide health care priorities.³²

But Oregon requires federal approval to do this—which was denied in August but may be granted in the future. Nevertheless, Oregon's experiment has stimulated much debate in the United States and beyond about rationing. The states are proving that, although reform is difficult in the present economic climate, the problems of costs and access are too important to ignore. But many, like Oregon, will require federal approval to implement state laws on reform, otherwise action will stall.

Likely course of reform

Despite the concern, health care has not been a major issue in the presidential campaign.³³ The reason relates to the complexity of the problem, the fear of alienating powerful interest groups, and the signs that public discontent is still not high enough for politicians to take on the risky business of reform.³⁴ Some point out that reform requires strong presidential leadership,³⁵ and American economist Victor Fuchs commented recently that short of a major change in the political climate that “often accompanies a war, a depression or large-scale civil unrest” national health insurance is unlikely.³⁶ Either way a radical federal solution looks unlikely in the short term.

However, there may be incremental federal action to improve access by encouraging small businesses to provide health benefits, reforming insurance, expanding Medicaid, and helping the poor afford insurance. There may also be greater federal intervention to control costs by regulating prices in both public and private health sectors.³⁷ In the meantime, substantial action is more likely to come from the laboratory of the states, and some believe successful experiments from a critical mass of states might tip the balance to nationwide health care reform.³⁸

Conclusion

There is a link between universal health coverage and effective cost control. Though the United States is far from both, incremental reform is slowly but surely taking place. Attempts to patch up the current system may delay but not obviate the need for a national health insurance system. How soon that occurs depends on the level of discontent among interest groups who count with politicians on Capitol Hill and their willingness to work together towards one solution.

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Sexual harassment at work

Peter Forster

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In a recent survey of 132 employers almost half said that cases of sexual harassment had been reported by employees during the previous year. In most cases the complaints had been upheld.¹ Although affecting both sexes most cases of harassment at work affect women. Earlier surveys in Britain support the view that a substantial proportion of women have been sexually harassed at some time during their working lives. Similar findings have been reported by researchers in other European countries.²

In the United States a survey of 25 000 federal employees produced a remarkable 85% response rate and showed that 42% of women (and 14% of men) had experienced some form of uninvited and unwanted sexual attention at work.³ Sexual harassment allegations increased by 40% in the three months after Anita Hill's charges against Supreme Court nominee Clarence Carter in October 1991. In June navy secretary Laurence Garrett resigned amid a furore of publicity over claims that at least 26 female naval officers were sexually assaulted by drunken male pilots and navigators during a conference in Las Vegas. Such findings as these have led one commentator to conclude "sexual harassment is a problem in virtually every organisation and that a substantial proportion of working women are the recipients of unwanted sexual attention at work."⁴

The real question seems to be not whether sexual harassment is a problem but how much of a problem it is. Among medical staff anecdotal evidence of harassment exists in the hospital service as well as in general practice. At their conference in Cardiff this year the pressure group Women in Medicine launched a national survey to discover the extent of sexual harassment in the NHS (western Europe's largest employer of women). This coincided with the introduction in March of an enabling agreement between NHS management and unions seeking to outlaw sexual (and racial) harassment.

What is sexual harassment?

Sexual harassment is a particularly antisocial and unacceptable form of behaviour which until 15 years ago was largely unrecognised. Although a commonplace experience for working women, sexual harass-

ment was considered a trivial issue and of only peripheral concern to employers.

The term emerged in the United States during the 1970s and in the intervening years has become recognised both in the United States and Britain as an important industrial relations and legal issue. The recently adopted European Commission code of practice on the subject defined sexual harassment as "unwanted conduct of a sexual nature or other conduct based on sex affecting the dignity of women and men at work."⁵

The European Commission's definition encapsulates the subjective character of sexual harassment whereas the definition adopted in the NHS Whitley agreement is more specific. Harassment is defined here as "action, behaviour, comment or physical contact which is found objectionable or which causes offence. It can result in the recipient feeling threatened, humiliated or patronised and it can create an intimidating work environment."⁶

Many misconceptions are held by both men and women about what constitutes sexual harassment. Its essential characteristic is that it is unwanted by and unwelcome to the recipient and needs to be distinguished from acts of mutual flattery, flirtation, or harmless romantic behaviour. The *Industrial Relations Review and Report* survey lists a range of actions which most respondents said they would define as acts of sexual harassment if an employee were to complain about them (box 1). It is often an employer's failure to recognise the unwelcome and unwanted aspects of a harasser's behaviour which leads to harassment being trivialised and not taken seriously.

Consequences of sexual harassment

Introducing the new NHS agreement in March on harassment at work, Virginia Bottomley said "Many do not know how to cope with harassment. Some eventually leave the workforce and this is a tragedy both for the individual and for the health service. Every employee, male as well as female, has the right to respect and dignity at work." Only in recent years have the consequences of sexual harassment at work become apparent. Most literature on the subject refers to costs—direct and indirect—to recipient and employer.

**BMA North Western
Regional Office, Didsbury,
Manchester M20 8RX**
Peter Forster, *industrial
relations officer*

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