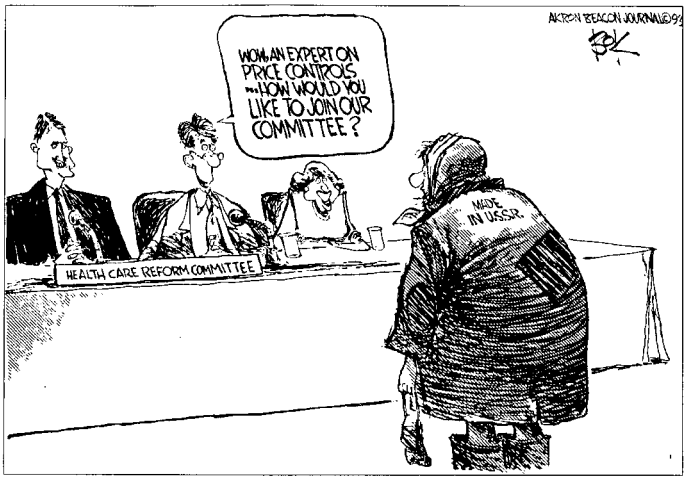
California Scheming

By Steven Hayward and Michael Lynch

A referendum on single-payer health care



WITH ALL EYES FIXED on the growing deadlock in Washington, D.C., the biggest health-care story of 1994 may be emerging a continent away. In California, a sweeping, Canadian-style "single payer" initiative that gathered more than 1 million signatures has qualified for the November ballot. More breathtaking than anything the Clintons dare propose, the California initiative will be a battleground to test both the "health-care crisis" mentality and the voters' eagerness to have a government takeover of health care.

The initiative's ballot qualification coincided with the launching of a national effort by single-payer advocates that features TV spots and full-page newspaper ads. If this long-shot initiative somehow passes in November, Congress and the president may well change their minds about the political feasibility of a federal takeover of the complete health-care system, without the patina of private insurance. The initiative would abolish private health insurance in California and replace it with a state-run "time tested single payer system" to be known as the "California Health Security System."

It is not necessary to reopen the arguments about the performance of Canada's single-payer system (waiting lists, rationing, fudged cost numbers, and so forth) to get at the defects of this initiative, because the most dramatic feature of the measure is not the single-payer system itself but the creation of an elected state health commissioner with immense, even ominous, powers. To label this prospective officer a "health czar" would be an understatement. The health commissioner would have complete authority, with little legislative oversight, to control the estimated $108-billion budget the system would set up (twice the size of California's present state budget). The health commissioner would be granted "any and all powers necessary to implement this Act."

"These broad powers include," the initiative continues, "the power to set rates and promulgate generally binding regulation on any and all matters relating to the implementation of this Act and its purposes." The commissioner will determine how many doctors there shall be, in what specialties, and where they are located. Section 25275 (b) sets as goals "achieving the number, geographic, discipline and specialty distribution of professional providers...needed by the state" and "adjusting, over a period of years to be determined by the Commissioner, the number, geographic and specialty distribution of professional providers to staff underserved areas and communities."

These and other coercive measures can be enforced through the global budgeting and price-fixing powers of the health commissioner, whose powers over the prospective $108-billion health-care budget would be far greater than the governor's powers over the regular $50-billion state budget. The global budgeting power extends not only to operating expenditures for each category of medical specialty but to capital budgets as well. No medical facility may make a capital improvement or establish a new procedure worth more than $500,000 without approval from the health commissioner. The commissioner would regulate the development and implementation of new technology through these capital controls.

THE HEALTH COMMISSIONER'S OFFICE would be complemented by a phalanx of regional administrators and regional consumer advocates, an expert Health Care Policy Advisory Board, and an ostensibly grass-roots Health Care Consumer Council that would really serve as the political base for the elected commissioner. The system would be funded through a new payroll tax, a personal income-tax surcharge, and a $1.00-a-pack levy on cigarettes. These new taxes would amount to about $48 billion; the balance of the health budget would come from consolidating existing federal and state health programs such as Medicare Part B and Medicaid. Global budgets, price controls, a constitutional declaration that health care is a "right," and a generous list of benefits, including mental-health and drug treatment, are all part of the package.

A consortium of left-leaning organizations, including labor, churches, seniors, nurses, a few doctors and pharmacists, Naderite consumer groups, and even the California Teachers Association, is backing the initiative. Out-of-state money has gone to support the California initiative, including $25,000 from a New York City

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hospital workers' union. Labor union financial support—estimated at more than $500,000 for the signature-gathering drive—was crucial.

But the prime mover behind the effort is Neighbor-to-Neighbor, a grass-roots activist group formed in the 1980s to agitate about Central America. With the waning of the Cold War and the ferment over Nicaragua and El Salvador subsiding, Neighbor-to-Neighbor needed to find a new issue. It settled on health care. One goal is to reinvigorate the fortunes of a single-payer plan on the national level. "Our hope is to provide ballast to the left of Clinton," says Glen Schneider, executive director of Neighbor-to-Neighbor. "This will be a real wake-up call. This will start a true health-care debate with the real options front and center."

THE GRAND STRATEGY OF THE INITIATIVE is clear: bash insurance companies. "If we cut out the insurance industry," says Schneider, "there will be plenty of money for everybody." The initiative's backers assert that a state takeover would save as much as $20 billion a year in administrative costs. These savings would enable the extension of coverage to California's uninsured population, which they claim to be as large as 6 million. Insurance companies, they say, eat up as much as 27 cents of every heath-care dollar in overhead and administrative costs (and high CEO salaries, they usually mention), while Medicare—their chosen comparison—takes only about 2.5 cents of every dollar for administration. The initiative would supposedly cap administrative costs for its system at 4 percent.

Comparing insurance administrative costs—whatever the true figure is (insurance groups claim lower administrative costs than government)—with Medicare administrative costs is a clear case of comparing rotten apples to oranges. One ironic reason that Medicare's administrative cost is so seemingly low is that it has been completely unsuccessful at any kind of cost control. The cost of Medicare has risen at double-digit rates for all but two years. That's one reason why the program, originally estimated to cost just $12 billion in 1990, cost $107 billion instead. With soaring expenditures, administrative costs are bound to be a small ratio, especially since Medicare is essentially a check-writing program and doesn't face the same kind of underwriting and other costs that private insurers do. (See "The Medicare Monster," January 1993.)

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Holding up Medicare as the model of administrative efficiency is not the only whopper the backers of the initiative tell. Consider this passage from the preamble to the initiative: "Since people always need health care services, prices for those services often do not respond to normal supply-and-demand market forces.... Price control is therefore necessary to achieve cost control and to make quality health care accessible to all." Such a claim would be dismissed with a hoot if it named a necessity such as food, housing, or clothing instead of health care. Perhaps it is a measure of how mysterious health care has become in the public mind after 30-plus years of heavy government distortion of the medical marketplace that such a claim can be made without a blush.

DONALD COHEN, ANOTHER NEIGHBOR-to-Neighbor spokesman, goes even further: "Single-payer has been portrayed as Big Government, but it is a very free-market, pro-competition system." Although Cohen admits there won't be price competition, "there will continue to be competition in quality of care."

It is not necessary to unpack a homily about "price competition" being at the heart of the very idea of a competitive marketplace to explode this soothing claim. The details of the initiative turn out on close inspection to refute the claims of its supporters. Backers attempt to allay potential fears by claiming that people will still be able to choose their own doctor and that health care will remain predominantly private, including even fee-for-service medicine.

But the initiative provides that the health commissioner may require all fee-for-service care to be coordinated through a designated primary care giver. To get around the problem of fee-for-service doctors adopting assembly-line practices such as are common in Japan (where doctors may see dozens of patients a day in visits that last about two minutes), the initiative gives the health commissioner power to set "a limit on the aggregate annual payments to an individual professional provider."

What this really means—besides a way to set pay scales for the medical profession—is that many ill consumers will find "The Doctor Is Out" signs as physicians achieve their quotas and take extended holidays. Although the initiative's backers claim that medicine will remain private and competitive (on non-price grounds), there is extensive anti-private and anti-profit bias built into the initiative. All capital improvements made through the system's capital-improvements account "shall remain the property of the state of California," thereby giving the system the means slowly to take over private hospitals and clinics. Public health facilities are given priority for capital spending for the first three years of the system, and preferential treatment for "academic medical centers" is built into the initiative.

Other indicators of anti-private bias are more explicit. Any person employed by a for-profit health-care entity or insurance company (or any person with a family member who works for such an entity) is

ineligible to serve on any of the advisory boards created by the initiative.

Finally, the initiative prescribes that for-profit health-care providers "shall have their profits restricted to a fair rate of return to be negotiated with the commissioner and are subject to the same restrictions on capital expansion that apply to all other health facilities." In other words, private, for-profit health providers will be transformed into public utilities.

THE FISCAL LINCHPIN OF THE CALIFORNIA initiative is a payroll tax. The proposed payroll tax, which would operate on a progressive scale of 4.4 percent for firms with fewer than 10 employees, 6 percent for firms with 10 to 24 employees, 7 percent for firms with 24 to 49 employees, and 8.9 percent for firms with more than 50 employees, would raise about $40 billion a year in new revenue.

The proponents argue that most companies will pay less in payroll tax than they spend currently for health insurance, though data from the U.S. Department of Commerce suggest the average cost of employer-provided health insurance in California is 7.5 percent of payroll, less than the 8.9-percent rate that larger companies would pay.

But even if the proponents are right that the payroll tax would cost less than existing private health insurance, it would still be a job killer. First, for the 15 percent of California employers who do not currently provide health insurance, the system would impose an absolute tax increase. Many of these jobs are entry-level positions (especially restaurant jobs) with per-employee operating margins less than the payroll tax rate. These jobs would tend to disappear entirely, or go underground.

Second, there is no exemption or threshold for part-time employees. So the payroll tax will be a significant barrier to part-time employment opportunities, especially within small companies that will be reluctant to add the next employee who will bump them into the higher payroll-tax bracket.

The initiative supposedly guarantees that rationing of health services will not take place and that the health system budget will grow each year only at the rate of inflation and population growth. When expenditures begin to exceed the budget, "mandatory cost controls" kick in, at which time "the Commissioner may request that the Legislature increase appropriations for the Health Security System." At this point, the health commissioner may begin to "establish restrictions or copayments on elective services."

The health commissioner will set "a limit on the aggregate annual payments to an individual professional provider." As a result, many patients will find "The Doctor Is Out" signs.

Nearly every page of the initiative's text offers an eye-popping or budget-busting feature of one kind or another. Benefits include long-term care and free prescription drugs. Doctors and other health-care workers are encouraged, and may eventually be compelled, to unionize and engage in collective bargaining with the health commissioner.

SO WHAT ARE THE PROSPECTS FOR SUCH AN initiative? California voters seem increasingly suspicious of complicated initiatives. Two years ago, California voters rejected by a 2-to-1 margin a far milder "pay or play" initiative that would have required all employers to provide health insurance to full-time employees or pay a payroll tax to a state-run system. That measure was backed by the formidable California Medical Association, which for the moment is sitting out the single-payer initiative.

While national polls have shown more than 30 percent in favor of the single-payer concept, more-recent national surveys, such as a Gallup poll and a *Los Angeles Times* poll (both conducted in mid-April) report a majority against a "government-run" health system. An early poll emphasizing the tax-increase features of the California initiative found that 65 percent of voters reject the single-payer idea, with only 26 percent in support. "This is as close to 'dead on arrival' as a proposition gets," said Robert Nelson, the Republican-oriented Sacramento political consultant who conducted the poll. "It will only get worse once voters really focus on how much it will cost them."

Perhaps. But unlike the "pay or play" initiative, the proponents of the single-payer plan have targeted one of the most unpopular interests in California: insurance companies. There is some precedent for the success of such a strategy. In 1988, a Ralph Nader–inspired grass-roots campaign defeated several well-funded insurance-industry initiatives with the simple slogan, "Another insurance company trick," and passed a monstrous measure, Proposition 103, that created an elected insurance commissioner and attempted to roll back insurance prices by decree.

The single-payer initiative is an attempt at a rerun of Prop. 103. A large infusion of labor-union cash might turn it into a close contest. By the same token, a big loss for the initiative would likely be a major setback for a single-payer system on the national level.

But would a loss also be a setback for other health-care reforms, such as the Clinton or Cooper plans? Or would these become the "moderate" fallback positions? The question that will be raised in the campaign to come is whether the usual sound bites about higher taxes and massive bureaucracy will lead voters to ponder how the supposedly more reasonable reforms will do the same thing, and whether such a controversy has any prospect of awakening among the public an awareness that even for the mysterious world of health care, re-establishing the proper market signals is the right fix. ®

Contributing Editor Steven Hayward is research and editorial director for the Pacific Research Institute in San Francisco. Michael Lynch is a public policy fellow at PRI.

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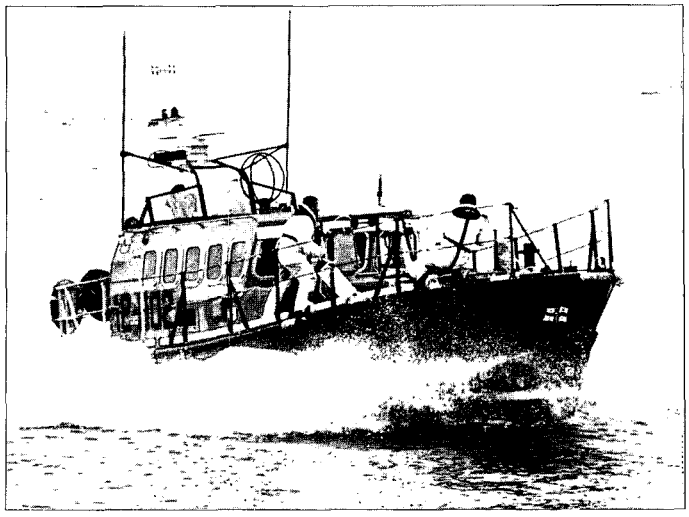
Life Savings

By James L. Payne

For 170 years, a private British organization has been rescuing people at sea.



A British lifeboat: The Royal National Lifeboat Institution saved an average of three lives a day in 1993. It is supported "entirely by voluntary contributions."

IN MAY 1993 THE RACING yacht *Heptarchy*, with a crew of 10, fouled its propeller in a fishing net while trying to get into port in Cornwall, England. Gale winds of more than 60 knots blew the yacht out to sea and knocked it down. Using its VHF direction-finder, the lifeboat *David Robinson* located the *Heptarchy* and connected a line. After a five-hour struggle in turbulent seas, it managed to tow the 56-foot yacht to safety in Falmouth.

The *David Robinson* is one of 272 lifeboats assigned to 210 stations in the British Isles run by the Royal National Lifeboat Institution. The lifeboats are called out some 5,000 times every year to offer assistance in marine mishaps. According to its records, the service saved an average of three lives a day in 1993 and has saved more than 124,000 since its founding in 1824.

But running the lifeboats and paying the thousands of rescue workers does not cost British taxpayers a penny. The Royal National Lifeboat Institution is a private organization, supported, as it proudly says on its letterhead, "entirely by voluntary contributions" and managed by its own trustees and staff. The RNLI will rescue you whether you are rich or poor, whether you have donated to it or not.

Most of the RNLI's rescues these days involve pleasure craft such as the *Heptarchy*. But the service has wide experience. In the north of Scotland, the *Wick* lifeboat was called out in April 1993 to save the cargo freighter *Eilean MoGrhidh* after its engines had failed and the tide was sweeping it out to sea. The tow was quite a feat, since the freighter was 20 times the size of the lifeboat. At Aberdeen, Scotland, in October 1993, an inshore inflatable lifeboat was called out to a trailer park that was under 10 feet of water because of flash flooding. According to the service report, the lifeboat crew rescued 12 residents, three cats, and one American visitor.

THE LIFEBOAT SERVICE WAS BORN IN the days when Britons believed in independent, voluntary action. In 1789, a ship foundered in a storm in the mouth of the river Tyne. Spectators on shore watched in horror as crewmen fell into the sea and drowned; no one was able to rescue them. Moved by the tragedy, local philanthropists offered a two-guinea prize for a lifeboat designed to withstand heavy seas. Several inventors came forth with ideas, and the result was a long rowboat pointed at both ends and buoyed by 700 pounds of cork. One by one, local lifeboat stations were established along the coast.

In 1823, Sir William Hillary, himself a lifeboatman on the Isle of Man with 305 rescues to his credit, wrote an "Appeal to the Nation" calling for the establishment of a national lifeboat organization supported by voluntary subscriptions. London merchants took up the idea and organized the Royal National Lifeboat Institution in 1824. The RNLI eventually set up stations all around the British Isles, including Ireland and Northern Ireland.

The RNLI is unusual among British charities in the loyalty and affection it inspires. It has some 2,000 fund-raising branches led by volunteers who organize a multitude of events, from penny races, bike rides, and tugs of war to golf tournaments and garden shows. The donors feel the RNLI is special. In a pub in Lympstone, Devon, I struck up a conversation with Ian Smith, a computer programmer for an insurance company and an amateur yachtsman. When I told him I was in England studying voluntary groups, he wrinkled his nose.

"There's only one charity I respect," he declared. "As a matter of fact, it's already in my will." I'd been around the nonprofit scene in Britain long enough to know before he said it that Smith was talking about the RNLI, which is known for its probity. Most other national charities in Britain are partially funded by the government—though they try to hide this fact—and many lobby the government for more money.

THE IDEALISM ASSOCIATED WITH BEING "entirely voluntary" helps motivate volunteers for the lifeboat crews. At Exmouth, a town on the Southwest coast,