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## If Clinton wins

### *Little chance of major reforms of health care*

If the smart money is right the world will awake on Wednesday to find a Democrat preparing to move into the American White House for the first time in 12 years. And if voters decide that Mr Bill Clinton should live in Washington one of his greatest tasks will be the reformation of the American medical system—a task he has promised to take on within his first 100 days in office.

Mr Clinton has broadly sketched what he plans to do with American medicine but has said nothing on how he plans to do it. His aims are fairly clear. Firstly, he would create a National Health Board, comprising “consumers, providers and representatives from business, labor and government,”<sup>1</sup> though he has not said how they would be chosen. The board would set a global medical budget for the nation, set basic benefits that every insurance plan would have to offer, and oversee research into the effectiveness of various diagnostic tests and treatments. He would also set up a “pay or play” system: employers would either provide insurance for workers or else pay about 7% extra in payroll taxes to support public insurance plans. Like Mr Bush, he would create incentives to shift Americans into managed care groups (which operate rather like small versions of the NHS), promote preventive and primary care medicine, demand reform of malpractice, and streamline billing and patient records through electronic technology.<sup>1,2</sup>

How Mr Clinton would pay for his plan to insure 37 million more Americans he has not actually said. He has implied that legal and administrative reforms would eventually save at least a quarter of the \$808 billion spent this year on health care and that this would be more than enough to cover the 16% of Americans now uninsured. Numerous economists have criticised Mr Clinton for not being more specific about costs, but few have declared outright that his plan is unworkable.<sup>1,4</sup>

Difficult as it is, the economic means will prove easier to deal with than the political means. A mile down the street from the White House stands the Capitol, Congress’s home. Congress, through nine presidents, has failed to pass a comprehensive medical reform plan. It passed Medicare (for elderly people) and Medicaid (for poor people) in the 1960s, after arm twisting by Senate leader turned president Lyndon Johnson. But it ignored national health plans proposed by presidents Truman, Nixon, and Ford.

Right now Congress has at least 36 health care plans of its own. And even though Congress is—and no doubt will be next year—controlled by the very same Democratic party that nominated Mr Clinton, there is no evidence that he will be able to push through his initiatives. Like Mr Clinton, Jimmy Carter, the last Democratic governor to assume the presidency, was a stranger to Washington and a moderate in a

liberal party, and he was virtually ignored by the liberal Democratic leadership. Congress is not a parliament, so the leader of the United States cannot exert party discipline other than through personal friendships.

Even if Congress was inclined to go along with Mr Clinton’s reforms more—and richer—obstacles exist. Since 1979 the number of medical lobbying organisations that circle Washington has grown from 117 to 741.<sup>5</sup> The richest among them, the American Medical Association, doles out about \$4m each election year to congressional candidates, an average of about \$8500 per seat.<sup>6</sup> Total contributions from health industry lobbyists are expected to exceed \$22m this election.<sup>7</sup> The cost of running for re-election is now so high that congress men and women must each gather about \$2000 a day in contributions just to keep their seats. The implications for wealthy lobbying groups that oppose Mr Clinton’s plans, such as the American Medical Association, the American Hospital Association, and the 1700 insurance companies, are obvious to each of the 435 members of the house and 100 senators.

Of course, not all of the 600 000 doctors in the United States are against the Clinton proposal. In September the 77 000 member American College of Physicians put forward a comprehensive reform plan very similar to Mr Clinton’s,<sup>8</sup> joining the 74 000 member American Academy of Family Physicians. The strengths of their lobbying attempts remain to be seen.

Congress and lobbyists will be barriers for Mr Clinton, but his greatest obstacle may be the American people. Mr Clinton says that his plan will pay for itself within four years, but its immediate costs will be great. In some form the money will come from the people, either through lower wages (as employers contribute more into health insurance to cover all their workers), government borrowing (which means increasing the \$4 trillion federal deficit), or some kind of tax (proposals have included a federal value added tax,<sup>9</sup> higher payroll taxes, higher alcohol and cigarette taxes, and higher insurance premiums for the rich<sup>8</sup>). As George Bush has learnt all too well in this campaign, any increase in taxes will surely incur the wrath of voters.

So how will Mr Clinton win his comprehensive plan to “control rising health care costs, covering every American with at least a basic health benefits package, and maintain consumer choice in coverage and care”?<sup>1</sup> Most likely, he cannot. More likely, small reforms will be made to encourage primary care and discourage malpractice lawsuits. Meanwhile, more states will continue to grow impatient and will join Hawaii, Oregon, Minnesota, Vermont, Massachusetts, and others in experimenting with medical reforms. The federal government, which now controls 41% of medical

spending, is likely to continue ratcheting down how much it pays doctors, with insurers following suit. The prospect for major federal reform of medical care during the next four years, whether under Mr Clinton or Mr Bush, is poor.

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## Australia's national health strategy

### *Medicare under the microscope*

Two years ago Australia embarked on an ambitious review of all aspects of its health care system. On its packed agenda are the distribution of health care costs and their impact on individual people and families, factors creating demand for medical services, and options to contain costs while maintaining quality and access, particularly in public hospitals. The review has also to consider the role of the private sector and ways of better integrating community and preventive services with the rest of the health care system. Its terms of reference also list the effects of financial and organisational arrangements on the delivery of health care, and the supply of and demand for health workers. Once decided, a formal strategy will presumably form part of the federal Labor party's health policy.

Whatever the outcome of the review it has been assumed that at least part of Australia's system of universal health insurance (Medicare) will stay. Medicare is funded out of general revenue and meets half the costs of free public hospital care, with states and territories providing the other half. By directly reimbursing doctors Medicare also finances most general and specialist medical services outside hospital. Spending on "hospital Medicare" is under government control and hence capped. "Medical Medicare" is not, the only limit on spending being agreed levels of government reimbursement for individual services with no controls on their volume.

Two out of five Australians have private health insurance, which allows them greater choice of doctor and pays for better hotel services in public hospitals and much of the cost of care in private hospitals. (These usually offer less technically sophisticated services than public hospitals.) This variety of funding sources—federal, state, and private—complicates the financial management of health care and makes integrating services more difficult. It also encourages cost shifting: hospital managers, responsible to their state or territory, tend to encourage doctors to get patients out of hospitals into the community, where the commonwealth pays for services (such as those provided by family practitioners).

How much progress has been made in setting Australia's "national health strategy?" So far options are being explored: the review has published 10 background papers and four issues papers<sup>1-14</sup> and interest groups have been consulted widely. The effects of the review may be clearly seen in current proposals for renegotiating the next Medicare agreement, to run from 1993 to 1998. It conflates the 26 separate agreements between the commonwealth and the states now governing health care and the care of elderly people into six "broad band" programmes: public hospitals, pharmaceuticals, non-inpatient medical specialist and diagnostic services,

primary health and community care, mental health, and small rural communities.

The new Medicare agreement requires future health services to be geared to achieve explicit health outcomes. Current initiatives in several states, including the largest (New South Wales), will fit well with this, as will a national review of goals and targets for Australia's health, which builds on earlier work by the Better Health Commission and the National Better Health Programme.<sup>15, 16</sup>

In Australia fiscal power is concentrated at the centre (the federal government). Political changes there can result in considerable changes in medical practice more easily than, say, in Canada.<sup>17</sup> With health care so politicised and its financing so centralised, the new strategy, originated by a Labor minister, has its best chance of success if endorsed by the current Labor government. What would happen after a change of government is uncertain. The draft health policy published last year by the conservative opposition made no specific reference to the strategy. Instead its solutions to the dilemmas of health care policy depended on substantial government encouragement (subsidy) of private health insurance.

Political concerns aside, the strategy documents are a leap forward in seeking public discussion about how Australia spends the 8% of its gross domestic product allocated to health care. Asking the questions and stimulating the debate can only be good for the health of the public.

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