Health care reform in the 2008 US presidential election

As in Canada, the challenges of health care reform are a constant political refrain in electoral battles in the United States. Since the 1940s, in fact, successive presidential elections have been marked by the issues of health care access, cost, and coverage. The failure of Harry Truman’s fair deal proposals and the success of Lyndon Johnson’s great society project both had core visions for health reform, while the more recent challenges faced during Bill Clinton’s first term in office underscore the persistent problems in addressing health care issues in the US.¹

The 2008 election year lived up to its promise of political spectacle, with a showdown between Hillary Clinton and Barack Obama for the Democratic

nomination, and the fresh image of Sarah Palin recasting the Republican ticket with John McCain. In the vortex of the personality politics that dominated the campaign, it remained important not to lose perspective on the real political issues of the contest. The policy stakes between the parties were real and salient for voters and candidates alike. And although the economic crises of the fall 2008 would dominate headlines, health care reform remained a main ballot box issue in the November election.

HEALTH CARE IN THE 2008 CAMPAIGN

In most US political contests, “pocketbook” issues tend to dominate voter concerns, particularly in worsening economic times. Members of the baby-boom generation have become increasingly insecure about their health-care future as costs soar and even middle-income Americans remain worried about being able to afford health care.

The stakes also are high for businesses grappling with how to insure workers in an economic downturn and how to compete with firms in other countries—including Canada—that don’t have to shoulder that burden directly. Yet even though a good number of business leaders recognize the need for health reform, the business community remains divided on the nature of needed change and has been unable to sustain or support concerted legislative efforts.2

Moreover, the persistent problem of the uninsured—47 million at last count—haunts every political candidate.3 Why the US can spend so much on health care and yet have so many residents uninsured has led to a lively scholarly debate, but the question of the uninsured is of key practical concern as well.4 This is because access to health care in the US depends on insurance coverage, not citizenship, as is the case in practically every other industrialized country.

In fact, in the United States today, in sharp contrast to Canada, access to care is not guaranteed. Instead, access to care depends on one’s insurance coverage, which varies widely between individuals and is determined by state

4 See, for example, Jill Quadagno, One Nation Uninsured: Why the US Has No National Health Insurance (New York: Oxford University Press, 2005).
of residence, employment status, financial capacity, age, and disability. Most Americans (and their dependents) are covered through voluntary employment-based health insurance, in which they share in paying the costs of premiums with their employer. A small minority carry individual private insurance.

So, while Canadians bemoan rising taxes and politicians fret about increases in health care budgets, our concerns are largely about the collective impact of rising health care costs. In the US, meanwhile, those costs are felt directly in people’s wallets. As the economy tightens and the potential for unemployment rises, so too does the possibility of losing coverage. But financial squeezes also come into play for the employed, since many low-wage workers cannot afford to pay health-insurance premiums, while most part-time workers are not offered those benefits at all.

As in Canada, health-care reform in the US is also about government programs, public spending, and fiscal federalism. This is because government involvement in health care is substantial, through major federal legislation instated in the 1960s, through tax subsidies for health insurance for employees and the self-employed, and through extensive regulations of insurers and health maintenance organizations.

Almost one-third of the population is eligible in some form for government-funded health insurance, including coverage of federal employees, the military, and veterans, and through publicly-funded health insurance programs. About half of the total spending on health care in the US is public, and while there are some cost-control mechanisms in place, they are not as robust as in the Canadian system. Over 40 million elderly (over 65) and disabled Americans are covered by Medicare, which involves a contributory plan (part A) for hospital insurance, and a supplemental premium (part B) for medical insurance. The Bush administration’s legacy in health care includes the Medicare prescription drug, improvement, and modernization act of 2003, which added prescription drug coverage to Medicare benefits, and was hotly contested by Democrats in congress who were thwarted in their attempts to include guarantees for lower drug prices.

Meanwhile, Medicaid now covers almost 60 million low-income Americans through joint federal-state programs, which provide the largest federal transfers to the states to help cover hospital, medical, and long-term care services. Unlike the Canadian block funding arrangements, in the US, these federal transfers are matching grants and are thus open ended, with the states having considerable leeway on eligibility and financing.
Medicaid has become the fastest-growing public spending item in the US, mainly due to the passage of the 1997 state children’s health insurance program. While most health reformers have thought, since the 1960s, that Medicare expansion via federal government efforts held the key to covering the uninsured, over the past decade it has in fact been the reform efforts of the states that have led to more access for care.\(^5\) The state children’s health insurance program provides additional federal funds to states for children in mainly working poor families who would otherwise ineligible for Medicaid. In the fall of 2007, congress passed a bipartisan measure to expand the program through increased spending and eligibility. President Bush’s other health care legacy is that he vetoed that legislation, despite its popularity in congress, including among Republicans.

The US system is, by most accounts, a patchwork of plans, and yet an exceedingly expensive one, well above the average of other industrialized countries. Although the pace of growth has slowed since 2007, health care now accounts for 16.2 percent of GDP, and the US averages per capita health costs of $7,421.\(^6\) Economists suggest that the reasons for these cost differences have to do with the structure of the US economy (a higher GDP per capita overall) and the impact of this on the costs of health care services and the ability to pay for them. Prices for health care professionals, infrastructure, equipment, technology, and prescription drugs tend to be much higher in the US than elsewhere. The market power of doctors, hospitals, and pharmaceutical companies exacerbates this situation. Because of the multiple payers and purchasers of health care in the US, costs are not controlled to the same extent as in other countries. The complexities in payment for both private and public spending in the US have been shown to have an impact on costs as well, through higher administrative overhead. Others have pointed to the impact of malpractice litigation and the practice of “defensive medicine.”\(^7\)

HEALTH CARE IN THE PRIMARY SEASON

Despite the divisive primary battles, particularly among Democrats, the leading candidates within each party had similar approaches to health care. In short, Democrats favoured reform to expand coverage subsidized by government and employers, while Republicans favoured free-market, consumer-based approaches. Still, the primary battles did give an indication of the nuances that reside within each party and the type of concessions that the chosen candidates had to make on health care reform.9

Early on in the campaign, Barack Obama, in distinguishing and distancing himself from his main rival, made children his priority, with education as the bedrock of his vision. As such, he was criticized for not being up to speed on the health care issues that most concerned his party’s faithful. As it emerged, his position on health care was to advocate subsidies and tax credits to help the uninsured acquire coverage, while at the same time requiring that all children have health insurance. Like most Democrats, Obama’s policy team thought that the money for these initiatives could be found by rolling back Bush’s tax cuts for higher-income households. But throughout the primary season, Obama shied away from the idea of forcing people to purchase insurance they may not be able to afford.

Hillary Clinton, in contrast, made health care the central point of her platform from the beginning, making no bones about where she stood on health reform. In so doing, she was handling a double-edged political sword. While Clinton was seen by the public as having the strongest platform in health reform, she was also saddled with her past efforts in this regard.10 As first lady, she had been in charge of the ill-fated health task force whose proposals failed miserably in congress. Bill Clinton swept to power in 1992 promising affordable health insurance for every American; by 1994, his policy was in shambles and many observers regard the right-wing backlash in that year’s mid-term elections as fallout from the health reform fiasco.11

The central component of the Clintons’ earlier approach was the idea of employer mandates, in which employers would assume responsibility for insuring employees and their dependants. By 2008, Hillary Clinton was focused on individual mandates that would require everyone to purchase health insurance. This, in turn, would be made affordable by subsidies from employers and government. Unlike the persuasion principle at work in Obama’s original plan, the battle-scarred Clinton was not about to leave this up to voluntary choice or business largesse. Instead, she fought for a legal framework to compel all Americans to be covered by health insurance, just as they are legally obliged to have auto insurance.

John McCain, like all Republican contenders in the primaries, refused to entertain the idea of any kind of mandate or tax increase in the name of health reform. Even Mitt Romney, who as governor of Massachusetts introduced a major reform based on individual mandates in that state, refused to support an expansion of his model nationwide. McCain, like Romney, Mike Huckabee, and even Rudolph Giuliani, continued to pledge support for a free-market, consumer-based health-care system.

Nevertheless, the two Democratic candidates’ positions differed little in comparison with the gulf that separates them from the Republicans. Given the complexity and the devilish details, most people who tuned in to the primary debates probably couldn’t figure out exactly how any of the plans would work.

Still, the health-care issue did provide all of the candidates with the chance to display their remarkable rhetorical abilities. Especially for Clinton and Obama, the opportunity to focus on this issue in a cool and composed manner helped the two opponents move away from the strategy of mutually assured destruction that was threatening the Democrats’ ability to present a united front in November. The extensive interest in the issue also gave the candidates the ability—Democrats and Republicans alike—to attract considerable campaign contributions from the health and insurance sectors. In this regard, in fact, Obama and Clinton each outstripped McCain and his Republican rivals in contributions from the health sector.12

12 For detailed data on campaign contributions from various sectors and industries, see the Center for Responsive Politics, www.opensecrets.org.
HEALTH CARE IN THE FALL ELECTION CAMPAIGN

Despite the heavy attention on the economy and the war in Iraq during the party conventions, health care was still evidently on voter’s minds across the US as middle-class issues took the fore-front in the fall campaign. Unlike previous recent campaigns in which Medicare was a central feature, health care in this election campaign has become an issue of personal economic import, part of the “pocketbook” issues that tend to preoccupy voters in tense economic times. In this respect, policy analysts and political pundits alike suggested that both Barack Obama and John McCain had to get a clearer grasp on health care reform in order to sell their respective plans to the American people.

The gulf between the candidates was enormous. As the Democratic candidate, Obama morphed his child-centred social program into a “plan for a healthy America.” Echoing decades of previous Democratic candidates for the presidency, it involved a national health plan for Americans, but one in which flexibility and diversity of choice remain key features. Apart from specific coverage for children, the proposal did not “mandate” coverage, but rather advocated a new plan under which the uninsured can get access to affordable insurance coverage. Employers and individuals would still be able to choose the insurance plans of their choice, but employers would be obligated to cover employees or pay into the national plan, and insurers would be subject to new regulations to help control costs and broaden access to care.

From a health systems perspective, even more interesting is the emphasis that Obama places on organizational reform. As in Canada and in health care systems across the world, the US faces huge organizational challenges in proper disease management and integration of care, as well as the need for more investment in electronic health records and the assessment of effectiveness of drugs and medical procedures.

Still, the real resonance for voters remains the affordability of and access to health care, and this is what John McCain emphasized as the Republican presidential candidate. As with his attempts to emphasize change as the leitmotiv of the GOP campaign, his “call to action” altered the scope of health insurance in the US. The centrepiece was a “guaranteed access plan” involving innovative tax reform to encourage Americans to buy coverage in

the private health insurance market. Although McCain insisted that this would be accompanied by guarantees of affordable plans (including “insurers of last resort”), better choice, and opportunities for health savings accounts, the plan would have replaced the decades-old reliance of workers on their employers with a brave new world of individual markets in health care. The central point in McCain’s health care stance was an emphasis on individuals, choice, and flexibility. State autonomy was also a recurring theme for the GOP nominee, as was individual responsibility. The addition of Alaskan governor Sarah Palin to the ticket brought these themes forward even more emphatically. Palin had been an aggressive advocate of more competition in the health care sector, as well as more “personal responsibility” for wellness.

THE ELECTION’S OUTCOME AND ITS AFTERMATH FOR HEALTH CARE

Americans were faced with a real choice between two very different positions on health care reform in the 2008 election. While the details of the Obama and McCain plans were complex, the main messages were clear: for Democrats, the goal is to achieve—somehow—universal coverage; for Republicans, the objective is to avoid any new government foray into health care.

It looks likely that, in 2009, some movement toward health reform will be contemplated in Washington. This is due both to the victory of Barack Obama in the presidential race and, perhaps even more compelling, the stability garnered by the Democratic party in congressional contests. With the White House and congress dominated by Democrats, the time should be ripe for health reform. The first indication of this has come rapidly: an expansion and extension of the state children’s health insurance program is already making its way through the senate, on the heels of Obama’s promise that, as president, he would immediately support and approve of legislation that would turn back Bush’s veto of this measure.

The nomination of Tom Daschle as health and human resources secretary and as head of the new White House Office of Health Reform confirmed the resolve of the president to move forward in this area. A former senator from South Dakota, Daschle was known for his heavily liberal voting record in congress and for his difficult challenges in leading the Democratic minority in the senate during Clinton’s first term in office, when health

reform became a partisan debacle. His main message so far has been to temper expectations on the pace of health reform and to promise to engage members of congress and interest groups in an inclusive process toward reform.\textsuperscript{15}

The worsening economic climate is another sign that health care reform is possible. Exit polls on 4 November 2008 suggested that economic concerns became the ballot box question for the majority of Americans, but that worries about health care access and cost were nearly as salient in voter choice.\textsuperscript{16} In effect, the economy and health care are inextricably linked in US politics, since employment status is a key predictor of health care coverage and access. Health care reform initiatives are likely to be packaged, in this context, as necessary for economic recovery.

LESSONS FOR CANADA
If the history of the emergence of universal health insurance in Canada had as much to do with politics as its absence in the United States, so too do the pressures for health reform in the two countries today. The story of health care in the 2008 US presidential election year does have some lessons for Canada. First, many of the concerns voiced about health by all presidential candidates echoed concerns heard on this side of the border: the containment of costs, the pressures of an ageing population, the management of chronic disease, the need for more health care professionals, the problems of primary care, and the interest in modernizing technology such as electronic records are but a few of the themes that resonated across the border. But the context remains different: In Canada, concerns tend to be expressed about how care is rationed as a public good and the problems associated with equity based on needs-based prioritizing. In the US, concerns are contextualized within the broader issue of being able to access affordable health care—that is to say, the problems associated with health care as a commodity rather than as a public good, and the lack of equity in the US health care system.

A second lesson is the way in which policy solutions are framed and choices between alternative scenarios are made. In the US, the scope for health care reform is at once broader and more narrow than in Canada. It is


broader in the sense of the larger terrain of policy solutions that abound in the US, ranging from single-payer arrangements, to employer or individual mandates, to health savings account and tax reform, to large federal interventions, to state-led reform, and to more incremental changes. The essential questions are how can we ensure access to a wider set of people and how can we control costs for everyone? In Canada, despite the debates about sustainability and crisis in our health care system, most discussions about health care reform are bounded by the premise of universality—i.e., that every legal resident should have access to a provincial health system—and then build from there on the way in which we should guarantee access, navigate the system, and share in the costs of care.

The narrower scope of health reform refers to the types of institutional constraints that have been faced time and again over the past decades. Despite much effort, health reform remains, politically speaking, a divisive issue and an elusive goal. Regardless of the amount of political energy or capital that Barack Obama is willing to expend on this endeavour, the new president is well aware of the kinds of trench warfare and tradeoffs that are needed to inch the game forward in congress, among powerful lobbies, and before the court of public opinion.