U.S. Health Care Needs The Glass-Steagall Principle

by Mary Burdman and Marcia Merry Baker

Jan. 17—The extremely low rankings of health conditions in the United States, compared with 15 other OECD nations, reported in *U.S. Health in International Perspective: Shorter Lives, Poorer Health*, focuses attention on problems which cry out for reinstatement of the Glass-Steagall law. Glass-Steagall would make possible the credit needed to rebuild the physical health-care delivery system in the United States, by restoring the commitment to the public good, and providing health care for all. This outlook was codified in the U.S. in the 1940s, under the Hill-Burton Act; but by the 1980s, the commitment was taken down, to the point that today, under President Obama's killer-policies, as summarized below, health care in the U.S. is at a nadir.

The terrible devolution is shown in the dramatic, detailed comparisons of poor health parameters in the U.S., contrasted with those in other advanced industrial nations, such as Japan, Australia, Canada, France, Britain, and ten others.

However, the rapidity of the financial and economic collapse internationally, and the imposition of barbaric austerity as the "solution"—especially in the trans-Atlantic region—is causing terrible rates of sickness and death in Europe.

In Britain, the subversion of its nation-serving, 60-plus-year-old National Health System (NHS), has reached the stage of a program—the Liverpool Care Pathway—to hasten death for designated victims, in order to "save money"—exactly the Hitler T-4 principle of eliminating lives deemed not worthy to support.

These instances all show that fascism is coming back full-fledged, unless this gateway to hell is defeated, and fast.

U.S. Health Care Compared

The 378-page report, *Shorter Lives, Poorer Health*, released in January, is based on a study by a panel of experts convened by the National Research Council and the Institute of Medicine, and covers the period from to the 1980s to the present.

U.S. health-care spending per capita is far beyond any other nation, at about $9,000, as of 2012. This is 2.5 times the OECD average, twice that of France or Germany, and about three times that of Japan. Spending as a percentage of GDP, at over 17.6%, is also much higher. The OECD includes not only Europe and the U.S., but also South Korea, Turkey, and Mexico.

Yet, at the same time, the U.S. has fewer practicing physicians per 1,000 population, at 2.4, lower than the OECD median of 3.3. Americans make fewer physician visits per year, 4 compared to the OECD average of 6.4, and have fewer and shorter hospital stays, although these cost much more. The short hospital stays also mean that ill Americans, including the elderly, are being sent home from hospitals to be nursed by relatives or friends—if they are available—or to make do on their own.

Prescription drugs in the U.S. are also much more expensive. In Germany or Great Britain, prescriptions for insured patients, i.e., all citizens and residents, are either free, or cost the equivalent of $10-20.

The International Federation of Health Plans comparative price report for 2011, documents that U.S. fees for doctor and hospital visits, as well as just about every clinical test or procedure, are double or even more than those of other developed nations. Costs in Canada were closer to the U.S., but still significantly lower. For office visits, Americans paid two to five times as much. Charges for hospital stays, averaging almost $16,000, are three times those of Germany, and almost four times those in France, although hospital stays are longer in both those countries.

In sharp contrast to the United States, where the heavy financial burden of health-care costs imposes personal bankruptcy, or falling deeply into debt due to medical expenses, in western Europe or Japan this is both impossible and inconceivable, because the coverage under there is comprehensive. In the U.S., medical costs are the cause for 62% of bankruptcy filings, ac-

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Too many Americans, lacking health insurance, go to a hospital emergency room when they are sick, when their illness often could have been treated much earlier, if they had had access to a primary care physician.

cording to a 2009 study by the *American Journal of Medicine*. Some 75% of those bankrupted by medical costs had at the time of their illness, or had previously had, medical insurance.

The reasons for the big differences in the costs for health care in the U.S., and in nations with regulated systems, are simple. They include assured mega-profits for the private insurers, administration costs which are at least 30% of the expenditure, advertising (!), and the cost of delivering extremely expensive emergency or hospital care to the un- or under-insured, for many illnesses or conditions which, as the report *Shorter Lives, Poorer Health* emphasized, could have been detected, and either cured, or at least effectively treated much earlier, if the patient had had access to primary care.

In addition, physicians outside the United States do not have to pay the super-high costs of higher education that they do in the U.S., leaving doctors deep in debt as they begin their practices; nor are they subjected to the insanity of excessive malpractice litigation, a plague traceable at least in part to the excess of lawyers in the U.S.

The 'Solidarity Principle' System

One outstanding difference between health care delivered in the U.S., and that in the 15 other nations studied, is that the U.S. today is the only country that does not even require, let alone attempt to ensure, universal access to health care for all citizens and residents. A look at some relevant history of the principle of government regulation involved in providing access to care, tells the story.

The German system, for example, dating back to the Bismarck era of the late 19th Century, is based on private *Krankenkasse* insurance funds, and is the model for most of the public-private cooperative systems used in continental Europe and Japan, or the single-payer National Health Service in Great Britain. An essential element of these varying systems, is that they are all strictly *regulated* by state and/or national governments, in cooperation with the insurance funds themselves. The health insurance funds exist, as the public utilities in U.S. once did (and not that long ago!), to deliver an essential service, not to make a profit, and are regulated accordingly. In the Hill-Burton era in the United States, most of the health insurance was private—for example Blue-Cross/Blue Shield—but non-profit and regulated.

The *Krankenkasse* health-care systems are based on what Germans call the "solidarity principle." They were established as part of Bismarck's general welfare program, and included old-age and disability pensions. Under this system, everyone pays a regulated percentage of earnings (about 8%, matched by your employer), which provides the same comprehensive health care for everyone, regardless of income, age, existing health problems, or anything else. You keep the same insurance your entire life: If you are unemployed, disabled, or retired, the insurance is covered by government funding, so no one ever loses health care. Fully private health insurance is also available throughout western Europe, but, because it is also strictly regulated, it delivers far more comprehensive benefits for the premiums paid than U.S. plans do.

The Hill-Burton Build-Up; Then the Takedown

In the United States, the principle of universal access to care, and the commitment to provide the physical system to deliver that care, was respected and codified in the 1940s Hill-Burton Act. The "Hill-Burton Principle," as it came to be known, set forth in merely nine pages the authorization to provide a network of hospitals throughout the country, with specified ratios of modern beds and services per 1,000 citizens in each county, and networks of accompanying services. Hill-Burton also required that hospitals built with Federal

funds provide free or low-cost care to those who could not afford to pay.

With the still-sound financial and credit system—notably secured under the 1933 Glass-Steagall Act—there was an extensive expansion of medical facilities, funded by states, localities, and the Federal government, which allowed for the commitment to provide treatment for all. For example, public-health measures were taken to roll back tuberculosis, and to conduct and apply R&D for other diseases—for example, universal inoculation to defeat polio, etc. This continued up through the 1960s.

Then, this very commitment of care-for-all, and delivery systems to provide it, were undercut drastically, at two key turning-points. First, beginning in the 1970s, the onset of the casino-economy era, which included, in particular, the passage of the 1973 HMO (health maintenance organization) Act. Over the ensuing decades, U.S. health-care infrastructure contracted, while privatized, for-profit insurance increased its percent of rake-off.

The level of general health in the United States began deteriorating in key ways, including that, by 2000, for the first time in a century, the U.S. saw a measurable increase in the rate of infectious disease.

Next, in response to the general economic decline, came still more extreme degradations in the U.S. health-care system, following the lead of the 1997-2007 period of Prime Minister Tony Blair's initiatives against the British National Health Care System. In 1999, Blair put in the NICE (National Institute for Health and Clinical Excellence) death panel, to decree what treatments would be denied for whom; and by 2003, he began a wholesale subversion of the NHS physical delivery system, through for-profit privatization.

This was pushed hard in the United States in 2000-10, and implemented under President Obama's Affordable Care Act (Obamacare). In fact, Blair's very NICE originator, Simon Stevens, came to the United States to lead the UnitedHealth insurance firm (he is president, Global Health, UnitedHealth Group), which now is the biggest profiteer insurance operation in the U.S., with over 75 million policies. Thanks to this subversion process, the U.S. has the highest health-care costs in the world, and a plunging quality of health.

The United States needs the Glass-Steagall standard system of regulation for its vital health care as much as it does for its banks!