Becoming Australian? Two different approaches to health care reform in the United States

Jessica K Roydhouse

THE “SUBSTANTIAL PRIVATE SECTOR”\textsuperscript{1} ROLE in Australian health care has sometimes given rise to fears of “Americanisation” of the Australian health care system, particularly in the media. For example, in 2000 Kenneth Davidson wrote, “The US-style health financing route being taken by the Howard Government is mad and bad.”\textsuperscript{2} The US system is the “leading example” of “inferior system performance”\textsuperscript{3} and is often viewed as a system to be feared and avoided.

Despite spending far more per capita than any other country on health care, the United States nonetheless fails to provide equitable health care for everyone. The system is “a paradox of excess and deprivation”,\textsuperscript{4} spending far more than other systems without providing adequate care and treatment for all.

Although the US system is seen as frightening in Australia, broad historical and political similarities such as the “strong”\textsuperscript{5} role and “long history”\textsuperscript{5} of private insurance and powerful, vocal physicians’ groups\textsuperscript{1,5} make the Australian experience a useful comparative one for US policymakers. As Altman and Jackson note, the US system will probably not develop into a fully public system, but a system combining private and public aspects along the lines of the Australian model is possible.\textsuperscript{5}

Furthermore, while politicians in the US at the state and local levels have attempted to address the issue of universal or near-universal coverage for some time, previous efforts sought to expand coverage using existing programs instead of establishing a new system.\textsuperscript{6} More recently, the state of Massachusetts and the county (municipality) of San Francisco have introduced near-universal health care programs. Although introduced nearly simultaneously, their development processes and structures differ. In addition, the Massachusetts plan in particular was viewed as a potential model for future sub-national and possibly national health reforms.

Thus, this short paper examines the two plans as two different approaches to health care reform in the US and compares them to the Australian system, asking the question whether or not current reform efforts in the US make the system more like that in Australia, or are likely to do so in the future.

What is known about the topic?
There is substantial information covered in the literature and media regarding the inequity of health care and the lack of universal coverage in the US health care system. National attempts at health care reform such as former President Clinton’s are also found in the literature.

What does this paper add?
This paper analyses two recent sub-national developments in US health care reform together rather than in isolation and compares them to aspects of the Australian system.

What are the implications for practitioners?
This will provide practitioners with a better understanding of these current developments and allow comparative analysis with the Australian system.

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The US health care system
Unlike other industrialised nations, the US lacks universal health coverage for its population. In
In 2007, 45.7 million people, or 15.3% of the population, were uninsured. A series of studies commissioned by a major national health advisory body highlighted the problems and costs of the current health care situation in the US, including the fact that the uninsured have worse health outcomes. Uninsurance also affects access to health care services and treatment. For example, cost was the main reason for over one third of uninsured adults failing to fill drug prescriptions, and not taking recommended medical tests or treatments. A recent Centers for Disease Control and Prevention (CDC) survey found that over 40 million adults failed to seek needed care, including medical care, dental care and drug prescriptions, because they were unable to afford it.

The US system is characterised by a strong reliance on employer-based private insurance, with public coverage for particular groups such as children and the elderly rather than the entire population. Individually purchased private insurance plays only a small role in the system. Therefore, lack of employer-based insurance coverage, due to unemployment or because it is either not offered or not affordable if offered, combined with eligibility for public programs puts an individual at high risk for uninsurance. Uninsured individuals are typically low-income working adults.

**Health care reforms**

Despite the system’s failure to cover a significant percentage of the population, it is extraordinarily expensive, consuming about 2 trillion US dollars in 2005. The high cost of health care in the US is of significant concern to US families and policy makers, particularly in light of the projections of a 25% spending increase by 2030 as the population ages. As health care costs continue to increase, the numbers of the uninsured do as well. Nonetheless, for some time comprehensive national health care reform has not seemed imminent. In 2006, with a major federal overhaul of the health system unlikely, individual states and municipalities began experimenting with various methods to achieve universal health care.

Two recent reform efforts are the Massachusetts plan and the San Francisco plan. The Massachusetts plan garnered significant national press coverage due, at least in part, to the mandatory individual insurance purchasing requirement. The then-governor Mitt Romney declared that, “We insist that everybody who drives a car has insurance ... And cars are a lot less expensive than people.”

The San Francisco plan was unique for two reasons, both of which helped it gain media coverage. The first reason was that it was the first US city to ever pass such legislation. The second reason, which differentiated the plan from its Massachusetts counterpart, was its emphasis on access, rather than insurance. Mayor Gavin Newsom’s spokeswoman Jennifer Petrucione described the plan as “an actual system, whereby people have everything from primary care to pharmaceuticals.” A newspaper article described the San Francisco plan as the “rejection of an insurance program in favor of expanded access to healthcare.” Despite these differences, both plans were said to be constructed around a sense of shared/collective responsibility, requiring employer, governmental and individual involvement. Furthermore, while both were sometimes described as “universal” care plans in the press, both contained significant exemptions and were thus more near-universal rather than truly universal care plans.

**The Massachusetts and San Francisco plans**

Beyond the obvious distinction that the Massachusetts plan is a state-level program and the Healthy San Francisco Plan (HSFP) is a county-level program, there are other important distinctions between the two plans. Bodenheimer, drawing on the work of Bodenheimer and Grumbach, argues that there are essentially three
broad types of universal health insurance: government-based (eg, single-payer), employer-based and individual-based. Using this classification, the Massachusetts plan builds on the current employer-based system widespread in the US, but mandates individual insurance for those outside the employer-based system. By contrast, the HSFP utilises the existing employer-based system but moves closer to a government-based system with its publicly funded and implemented plan.

In essence, the very philosophies of the two plans differ. The Massachusetts plan, especially the emphasis on individual purchase of private insurance, is closer in political spirit to former presidential candidate McCain’s proposed health care plan. McCain’s plan also shares similarities with plans proposed by ex-President Bush, particularly the tax inducement for individual insurance and the loss of the tax break for employer-based insurance. These positions are conceptually grounded in the idea of uninsured individuals taking responsibility by purchasing individual insurance, with the implication that those who don’t are free-riding. As noted by Glied, the “free-rider problem” is a core conceptual component of an individual mandate.

The HSFP, on the other hand, emphasises changing the current method of health care delivery to the uninsured. Its focus is therefore on a better system for health care access and delivery, rather than the individual purchase of private insurance. In addition, the HSFP is almost a system within a system: it may be seen as developing a new health care delivery system for the uninsured within the constraints of the existing framework.

The details of the plans, as well as the pre-plan situations, are contrasted in Box 1 and Box 2.

In part, differences in the uninsurance rate stem from Massachusetts’ high rate of employer-based insurance. By contrast, San Francisco’s uninsurance rate is similar to the national uninsurance rate (about 15%) (Box 1).

The two plans have different emphases, with the Massachusetts plan focusing on the purchase of individual insurance with some employer involvement and the San Francisco plan concentrating on employer contributions and some individual involvement. Also, the “choice” in both plans ends up on different sides. Massachusetts employers can decide which part of the provision of coverage/payment of penalties trade-off is most appropriate for them. San Francisco individuals can decide whether or not to participate in a program offering them access to care.

Another significant difference is the overall focus of the two plans. The Massachusetts plan is focused on expanding insurance coverage, while the HSFP does not emphasise insurance — the Universal Healthcare Council, when creating the plan, described it as “an affordable alternative to health insurance.” The stated goal of the HSFP is to provide a primary care “medical home” for uninsured residents, and another objective is to make access to care easier. In San Francisco, there are some nineteen health coverage programs for varying groups of people, and then several free clinics throughout the county for those ineligible for the aforementioned programs. The provision of one “medical home” is thus an effort to simplify this complex and challenging system.

Furthermore, overall care has the potential to be much more coordinated under the HSFP. The Universal Healthcare Council agreed on a package of services that will be provided to uninsured individuals under the new plan. By contrast, despite the “minimum creditable coverage” provision that commences in 2009, the Massachusetts plan has a much more individualised focus. For example, there are several new insurance

<table>
<thead>
<tr>
<th>Pre-plan uninsurance statistics</th>
<th>Massachusetts</th>
<th>San Francisco</th>
</tr>
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<tbody>
<tr>
<td>Number of uninsured residents</td>
<td>550 000</td>
<td>82 000 (adults; children covered under a prior program)</td>
</tr>
<tr>
<td>Uninsured as proportion of population</td>
<td>10%</td>
<td>15%</td>
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products as part of the Massachusetts plan, including special policies for people between the ages of 19 and 26.\textsuperscript{42} Approved plans are sorted into “tiers” which vary by the cost and services provided.\textsuperscript{42}

Finally, another difference between the two plans is the manner in which they were developed. The Massachusetts plan incorporated philosophies from both the US political right and left.\textsuperscript{31} Altman and Doonan also note that critical to the plan’s passage was the “active engagement of businesses, hospitals, insurers and a sophisticated advocacy community.”\textsuperscript{31} Similarly, Hager also notes the “unprecedented involvement of the interfaith community” in developing the Massachusetts plan,\textsuperscript{41} although the extent and means of engagement from these different groups is not clearly spelt out. By contrast, this was much clearer in the HSFPs case, as the Universal Healthcare Council was designed to be a collaboration and it included representatives from hospitals, business groups, various advocacy groups and labour unions.\textsuperscript{32}

There are several factors to consider in the links between political process and outcome. First, and possibly foremost, at the time of legislation Massachusetts was led by a Republican governor (Romney) with a primarily Democratic legislature, in contrast to the San Francisco government,

### 2 Comparison of the two plans

<table>
<thead>
<tr>
<th>Category</th>
<th>Massachusetts Plan\textsuperscript{29-31,38,39}</th>
<th>San Francisco Plan\textsuperscript{32-37}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key date</td>
<td>July 1, 2007 (individual mandate begins)</td>
<td>July 1, 2007 (enrolment into the HSFP begins)</td>
</tr>
<tr>
<td>Mandate/core of plan</td>
<td>Individual insurance mandate — all individuals required to purchase insurance, and penalised for not doing so if it is “affordable”</td>
<td>Combination employer expenditure mandate and individual enrolment option — focus on affordable access to care, not insurance</td>
</tr>
<tr>
<td>Method(s) of achieving affordability</td>
<td>“Insurance market reform”</td>
<td>Income-based sliding scale for premiums, copayments</td>
</tr>
<tr>
<td>Eligibility requirements</td>
<td>Subsidies only for those ineligible for other programs</td>
<td>Ineligible for other public programs</td>
</tr>
<tr>
<td>Individual’s role</td>
<td>Must purchase insurance if able to afford it, or face taxation penalty</td>
<td>Earn below 500% of the federal poverty level</td>
</tr>
<tr>
<td>Employer’s role</td>
<td>Annual “assessment” if not providing insurance “Free rider surcharge” if not providing insurance and employees use state-provided “free care” beyond certain threshold Employers with 11 or more workers must offer plans letting workers buy insurance with pre-tax money</td>
<td>Aged 18–64 years</td>
</tr>
<tr>
<td>(Local) government management role</td>
<td>Enforce individual mandate using tax returns Creation of the Connector, a state authority serving as “intermediary” between individuals and insurers Authority can set policies, eg, “minimum creditable coverage”</td>
<td>Encouraged to participate but no penalty for non-participation</td>
</tr>
<tr>
<td>Major exemptions</td>
<td>Businesses with 11 or fewer employees Individuals who cannot afford insurance or have religious objections to it</td>
<td>Businesses with 20 or fewer employees, or non-profit organisations with 50 or fewer employees Employees working less than a minimum number of hours per week</td>
</tr>
</tbody>
</table>
which had a Democratic mayor (Newsom) and a largely Democratic legislature. The Massachusetts plan was thus more likely to be a compromise between Republican and Democratic health care approaches, and the San Francisco one was not. Second, San Francisco’s municipality status and comparatively smaller size made undertaking a more community-based approach much more feasible. It was thus always very likely that the plans could substantially diverge in terms of final design due to both structural and process differences during their development.

Current status
Both plans were implemented as scheduled, and both have encountered challenges after implementation. Though it is too early to fully investigate success or failure, some brief summaries of the situation can be undertaken.

San Francisco
The employer spending requirement was quickly challenged in court by the local restaurant association. Although the restaurant association initially won in local court, enrolments continued during appeal and a higher court ultimately struck down the earlier ruling favouring the restaurant association in October 2008. How ever, further legal challenges cannot be ruled out.

Enrolment into the plan continued: by December 2007, 7400 people were enrolled and over 31,000 (or over 37% of the uninsured) had enrolled by October 2008. However, about 6% had left the program, with a significant minority (42%) doing so because of the program fee. Although some had left to join other programs, this “enrollment” indicates that coverage of all uninsured residents may not occur. The eligibility criteria were expanded in February 2009 and enrolments have continued to increase steadily, with 36,622 enrolled by late February 2009. However, the plan’s exemptions (for example, small businesses and non-profits) make universality unlikely.

In summary, the plan has had some successes but also encountered serious obstacles and it ultimately seems likely to provide near-universal, though probably not fully universal, care.

Massachusetts
Massachusetts similarly experienced a fairly high and rapid enrolment, with 440,000 previously uninsured people getting coverage by June 2008, leading to a 6% decrease in the adult uninsured rate. However, the majority signed up for subsidised coverage, so expenditure has been higher than projected. These costs, partially due to an underestimate of the true number of uninsured, remain a significant challenge.

A related issue is that of affordability. While “affordability standards” have been set, premium increases pose a challenge to making coverage truly affordable for Massachusetts residents. Furthermore, there have been concerns about the cost of insurance for “lower-middle-income families” who are ineligible for subsidies. In particular, such families may be required to spend significant amounts to purchase limited service packages that will leave them “underinsured.”

A survey of Massachusetts employers indicating that “affordability” issues were inhibiting employee insurance participation highlighted this problem.

Although there were initial concerns that the “token penalties” for employers would lead to a decrease in employer-sponsored coverage, thus far a majority of employers appear to support the plan and employer-sponsored coverage seems to have increased.

Additionally, there are exemptions, including one for religious beliefs. Furthermore, the stated aim of the program is “to provide near-universal coverage”, so universality seems unlikely.

In summary, like the San Francisco effort the Massachusetts plan has also had some successes but also faces serious challenges, although the challenges in this case are mostly financial rather than legal. Furthermore, the Massachusetts plan also seems likely to achieve near-universal rather than universal care.

Conclusion
Both the San Francisco and the Massachusetts health reform efforts are currently underway, and have both encountered significant challenges. In
addition, though both plans have had high, rapid enrolment, both are unlikely to achieve fully universal coverage (despite press and journal article headlines). The successes of the plans, as well as their challenges and limitations, highlight the difficult path ahead for reform in the US health care system, as well as the need for more comprehensive, national-level reform if true universality is to be achieved.

In terms of national reform, the plan that was proposed by President Barack Obama during his candidacy appears to lie closest to the Massachusetts plan. Similar to Massachusetts, Obama proposed a national Connector-type “exchange” and regulation of plan benefits. However, there is no individual mandate, except for children, and a public plan would be available as an option for the uninsured as well as those “want[ing] new health insurance.” While the details are not entirely clear, this appears to contrast with the San Francisco plan, which is not available to insured individuals, and the Massachusetts plan, which has no “public option” except government subsidies to assist low-income individuals in purchasing private insurance.

The Obama plan resembles the framework set forth by Schoen et al., which also draws on the Massachusetts model. Again, a Connector-like mechanism is utilised, as is an individual mandate. Like the Obama plan and unlike the Massachusetts plan, the Schoen plan proposes “new options for the insured.” This is a broader-based approach than both the Massachusetts and San Francisco plans, which are explicitly targeted at the uninsured. Because of this broader outlook, approaches like that of Obama and Schoen et al could be more able to lead to larger changes in the system, such as a shift away from employer-based insurance towards a public plan, than the San Francisco and Massachusetts approaches.

Finally, the Obama plan, compared with the San Francisco and Massachusetts plans, has the potential to be a step closer towards universal coverage within a mixed public/private system. The plan proposed during Obama’s candidacy may be able to produce a mixed public/private system with some similarities but also some substantial differences to the Australian system, particularly because employer-based insurance is likely to continue to play a significant role. Applying Bodenheimer’s classification to mixed public/private systems, Australia would fall closer to the government-based end of the classification while a successful Obama plan would be closer to the employer-based end. By contrast, the Massachusetts plans would be in between the employer- and individual-based ends and the San Francisco plan would be between the employer- and government-based ends. Finally, neither the San Francisco plan nor the Massachusetts plan is likely to provide either fully universal care or a system with a strong public component resembling the one in Australia.

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**Competing interests**

The author declares she has no competing interests.

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