

Universal Health Care: Columbia Nursing's SOLUTION

“Essential health care is eminently affordable, and the business case, as well as the social one, demands that we take action.” So ends a novel proposal for universal health care crafted three years ago by policy experts at the School of Nursing. The “essential health benefit plan” is notable for its affordability, its focus on preventive and evidence-based services, and its inclusiveness, covering all Americans currently without health insurance. Ahead of its time and roundly ignored, the plan remains as pertinent as ever, and thus worthy of reconsideration as the nation searches for a solution to one of the great crises of our time.

by Gary
Goldenberg

As the 2008 presidential campaign unfolds, health care reform has once again moved to the top of the national agenda, second only perhaps, to the war in Iraq. While a few candidates have proposed detailed solutions for making health care accessible and affordable for all, debate about the issue has rarely risen above the level of platitudes and sound bites.

For inspiration, the candidates and their policy advisers would do well to take a look at a privately administered, network plan for universal health care devised by School of Nursing faculty during the last presidential campaign. (See “Essential Health Care: Affordable for All?” *Nursing Economics*, September-October 2004, Vol. 22, No.5.) Though the plan’s numbers are a bit dated, the general thesis still holds: It is possible to provide “essential” health care services to all uninsured Americans at a reasonable annual cost — about \$2,100* per enrollee, plus copays and out-of-pocket expenses limited to \$1,500 per year.

** 2003 dollars, used throughout.*

“There is a need for a fresh approach to health care plans — one that recognizes the changes in health care, particularly the aging of America’s population and the increased emphasis on prevention and treatment of chronic disease,” explains Mary O’Neil Munding, DrPH, Dean and Centennial Professor in Health Policy, and lead author of the plan. “Because nursing has often been ahead of the curve in understanding and planning for these developments, we thought it was time for us to provide a blueprint that would help others to better understand and plan for the future.”

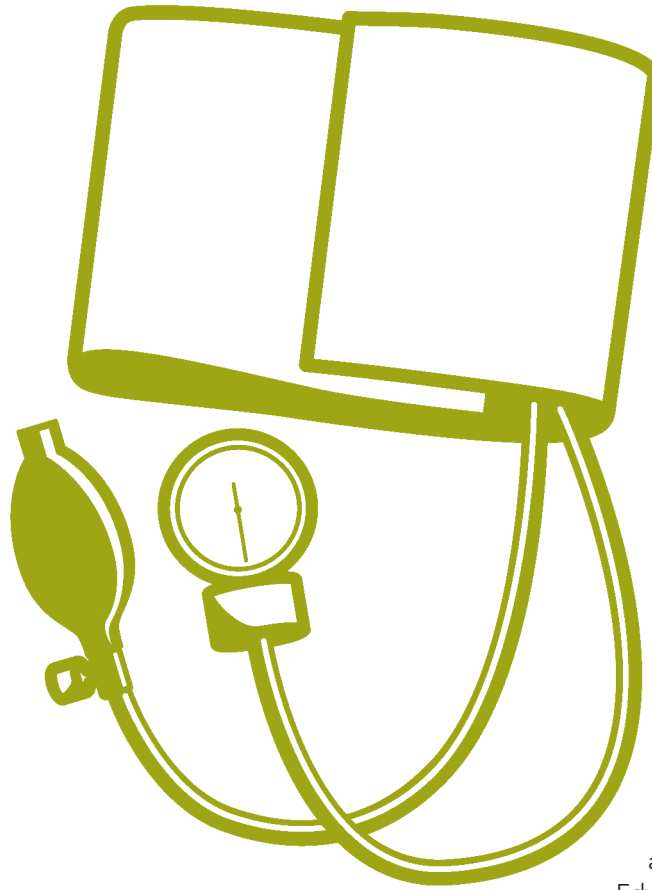
The Columbia Nursing plan, apparently the first to be offered by nurses, is based on the experience of a group of nurse practitioners with (at the time) a ten-year history of practicing independent primary care in New York City, with Medicaid, Medicare and commercially insured populations. This includes the pioneering CAPNA (Columbia Advanced Practice Nurse Associates) practice, located in midtown Manhattan.

COST-SAVING MEASURES

Several aspects of the plan would keep costs manageable. First, enrollment would be mandatory. Everyone without health insurance



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would be required to obtain basic coverage, either individually or through their employers. This would ensure that the risk pool would mirror the general population, a prerequisite for any financially viable health plan. In this way, high-cost chronically ill patients would be counterbalanced by the inclusion of healthy young adults, who often choose to forgo coverage.

"This mandatory coverage approach, similar to a requirement that drivers carry car insurance, is certainly not without significant social, financial, and policy implications," admit the authors, who include

Edwidge Thomas, DrNP, Assist-

ant Professor of Clinical Nursing; Janice Smolowitz, DrNP, EdD, Associate Professor of Clinical Nursing; and Judy Honig, DrNP, EdD, Associate Professor of Clinical Nursing. "It will, however, make universal insurance affordable... This issue will arise in any strategy to cover 100% of the population."

A cornerstone of the plan is its emphasis on prevention, which promises to save money in various ways. "The uninsured more often present with health crises that are costly to themselves, as well as to the system," the authors contend. "Many, if not most, of these crises could be prevented with early detection of new problems or effective management of existing ones."

The benefits of universal coverage and prevention would reverberate around the entire health care system. "Preventive care and effective chronic illness management can be quite expensive to provide," the authors note. "Because patients change insurers often, there is a financial deterrent for any insurer to cover these services unless all insurers do so. If everyone were covered for prevention, chronic illness management, and early detection of potentially costly illnesses, then insurers would be less likely to limit coverage for these services. The benefits, universally provided, would accrue to all benefit plans regardless of patients switching between insurers. Individuals would bring with them the health benefits from earlier prevention/management/detection, and the aggregate costs to the system would decrease, perhaps dramatically. This is true for all populations, most of all the uninsured."

Low co-pays for preventive care (e.g., screening, counseling, education, and immunizations) and high co-pays for emergency services would provide further incentive for enrollees to get timely and appropriate care.

EVIDENCE-BASED CARE

The plan also calls for participating clinicians to provide care within established evidence-based guidelines, a recipe for limiting the amount of futile or unnecessary services. This would require a cultural change in health care, however. "Clinicians ... still find it difficult to say no to patients' demands for care, drugs, testing, or new technology deemed (by the patients) as a health care right... In the current environment of expanded choice and litigation triggered by denial of care, clinicians all too often defer to patient demands even though they may be fully aware that the treatment or tests have little chance of helping the patient or course of care," the authors acknowledge.

"With the growth of evidence-based practice guidelines, and a growing awareness in the public that not all care is beneficial, this is more possible today than even a few years ago," the proposal continues.

It has already been demonstrated that it's possible to modify even the most entrenched clinician and patient behaviors. "In pediatrics, we've had this problem for a long time, for example, with parents demanding antibiotics for every child with a runny nose," says Dr. Honig, a pediatric nurse practitioner. "In the 1990s, our field took on this issue by educating providers and the public, significantly reducing antibiotic use. It's complicated but doable. This is what nurses are so good at."

Evidence-based guidelines would also figure in the plan's prescription drug benefit, which would cover only generic medications, except in the few instances when a brand-name medication is demonstrably more effective, or when there is no generic substitute.

WHAT'S NOT COVERED

The plan would not cover such a variety of services, including several the authors consider "beneficial," a necessary compromise for achieving broad coverage. "Many uncovered services are either utilized primarily by the Medicare population (podiatry, hearing aids, durable medical equipment) and are therefore already covered for those individuals, or are needed by a minority of beneficiaries (transplant, the newest generation of drugs), or are of questionable medical value (cosmetic surgery)," according to the proposal.

"Everybody's scared of the idea of rationing health care," says Dr. Mundinger. "But we have to ration what is a scarce resource. It won't be a thoughtless process. It will come down to

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evidence-based medicine, considering how much a person would benefit from a particular intervention, and how many years of life it would be adding.”

“On this campus, we’re doing transplants on people over the age of 70,” she continues. “There’s something wrong with that, from a cost-benefit perspective. On the other hand, people in their 90s are getting joint replacements. If that keeps them active and independent and out of a nursing home, it is well worth it. It has to come down to evidence.”

“The plan may not be ideal for everybody, but we would not be leaving anyone out,” adds Dr. Honig. “Beyond that, that is where the American way comes in” — meaning that employers or individuals could choose to enhance the coverage with outside plans.

PRIVATELY ADMINISTERED

According to the authors, the plan should be privately administered, allowing market forces to assure that it “remains competitive and flexible within the major health insurance market.”

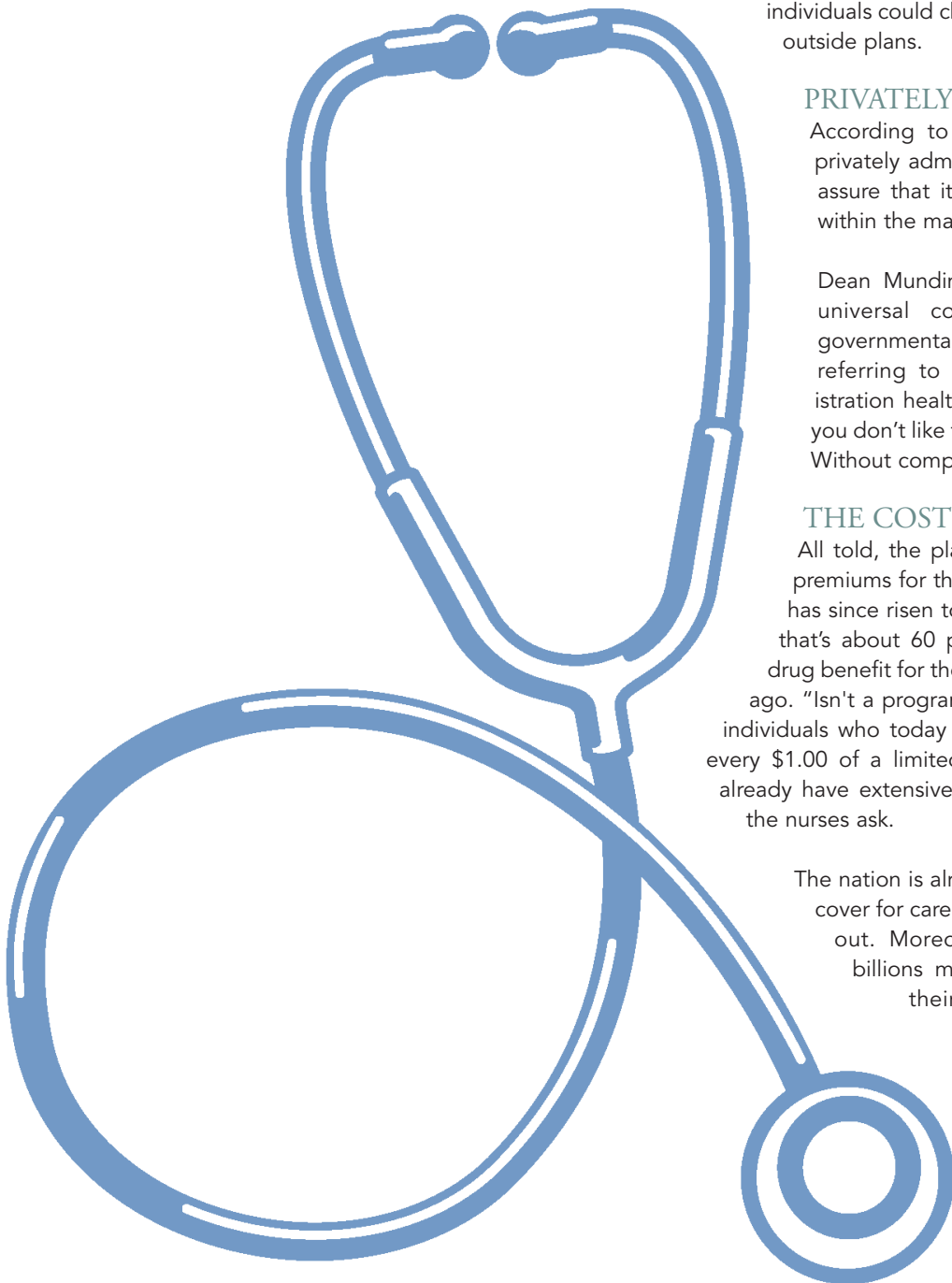
Dean Munding, for one, is against achieving universal coverage through a single-payer governmental system. “Look at the VA,” she says, referring to the oft-derided Veteran’s Administration health system. “Or the Postal System. If you don’t like the service, you don’t have a choice. Without competition, accountability is at risk.”

THE COSTS

All told, the plan would cost \$89 billion a year in premiums for the 43 million uninsured (a figure that has since risen to 45 million). For some perspective, that’s about 60 percent more than the prescription drug benefit for the elderly passed into law a few years ago. “Isn’t a program of broad essential health care for individuals who today have no insurance worth \$1.60 for every \$1.00 of a limited drug benefit for individuals who already have extensive comprehensive health coverage?” the nurses ask.

The nation is already paying this much and more to cover for care for the uninsured, the authors point out. Moreover, the uninsured incur tens of billions more in other economic costs from their lack of coverage, including disability and lost work.

“Hidden in the premiums of the insured is the cost of care of the uninsured,” the authors add.



“This subsidy would no longer be needed if everyone were covered. The savings, therefore, would accrue to the currently insured, to employers who carry much of the cost, and to all the uninsured who today suffer from avoidable illness and disability.”

The authors do not specify who would bear the cost of the premiums. A good portion would be born directly by employers or individuals. People at the lower end of the socioeconomic stratum would probably need assistance in the form of public subsidies or tax breaks.

A SYSTEM TO BUCK

Dean Mundinger is hopeful that fundamental health reform is around the corner, no matter who becomes president. “I know the war [in Iraq] is overwhelming,” she says. “But health reform is crucial. And not just in the payment structure. We have a whole system to buck.”

As the authors write, the health of all Americans, not only the uninsured, depends on healing our ailing system of care: “The miracles of modern American medicine have raised the hopes of every citizen for a healthier, longer life. The promise of the continuing cascade of scientific breakthroughs is real, but better health still relies primarily on the low-tech system of care that prevents crises, protects against the ravages of poorly managed chronic illness, and advances health through assisting individuals to adopt healthier lifestyles. Optimally everyone would have access to this valuable generalist care, and to sophisticated technologies when their use has a reliable chance of adding benefit. Not only can this country afford to engage in developing such a system, but it cannot afford not to. A catastrophic benefit plan may be appropriate for extensive care in a crisis, but preventing expensive, debilitating outcomes depends on the availability of essential health care services.”





If a health plan FALLS in the forest...

Except for a brief article on the *CBS MarketWatch* website, the School of Nursing's proposal for universal health care received no coverage in the mainstream media.

One organization that picked up on this oversight was the Center for Nursing Advocacy, which questioned why a “striking” proposal was ignored at the height of a president campaign in which health care was a major issue. In an unsigned piece, cheekily titled, “Maybe I wrote in invisible ink,” the center wrote, “It is not a paucity of space in the nation’s periodicals; without naming names, we think it is fair to say that a great deal of marginally important health news has been published in the last nine days. It is difficult to avoid the conclusion that the Columbia plan was largely ignored because of the professional status of those who created it...”

The plan also received coverage on NurseZone.com, where E’Louise Ondash, RN, commented, “If anyone thinks that designing a health insurance program should be left to the business folks, think again.”

No one else seemed to notice. The question remains, why not?

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