



Healing Our Sicko Health Care System

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There is a scene in *Sicko* — Michael Moore’s controversial new film about U.S. health care — that captures both the power and the limits of Moore’s cinematic polemic. A mother is speaking

about her 18-month-old daughter, Mychelle, who became ill one evening with vomiting, diarrhea, and a high fever. At the nearest emergency room, Mychelle is treated by a physician who suspects, rightly, that she has a life-threatening bacterial infection. But rather than give her antibiotics, the doctor calls her insurer, whose physician-gatekeeper tells him that Mychelle is not covered at the hospital and must be taken to another facility. The doctor repeatedly says that Mychelle needs care, and he is repeatedly told that she must be transferred first. Finally, nearly 3 hours after arriving at the hospital, wracked by seizures, Mychelle is taken to the approved facility. She dies 15 minutes later.

As Mychelle’s mother, Dawnelle Keys, recounts this awful sequence

of events, a swing hangs empty in the background. Even if we had not witnessed multiple tragedies already — a woman seriously injured in a car crash whose insurer denies payment because she doesn’t obtain “prior authorization” to visit the emergency room, an elderly couple who move into their daughter’s storage room because they cannot afford their medicine, an uninsured man forced to choose which of his two fingers to have reattached after an accident — we’d know how the story ends. And yet, when the moment comes, and Dawnelle Keys’s voice cracks as she describes losing her daughter, the effect is still devastating. We can’t but wonder how our rich, powerful country can let so many citizens face such unnecessary pain and loss. How could a

government “of, by, and for the people” fail so miserably to protect the people from such vast and preventable tragedies?

We do not find the answer in Moore’s movie — and that is its great limitation. The golden age of documentary has demonstrated the medium’s clout. Along with Al Gore’s global-warming warning, *An Inconvenient Truth*, *Sicko* may well be remembered as our generation’s *Silent Spring* or *The Jungle* — propaganda, in the best sense of the word, that pricks our collective conscience about problems that are hidden in plain sight. The first half of Moore’s movie is ruthlessly effective. With little commentary, the film moves from one outrage to the next. With the exception of two people in opening vignettes, everyone featured in the film has insurance. But we learn that insurance is not always enough. Insurers erect obstacles to care, hassle patients and doctors, or just fail to provide sufficient protection to keep fam-

ilies out of financial trouble. No wonder insurance companies have decried the film. “Moore wants a government takeover,” Karen Ignagni, head of America’s Health Insurance Plans, recently blustered in *USA Today*. “To make his case, he relies on one-sided anecdotes — some dating back to the 1980s — that grossly distort the role of health insurance plans in providing access to care to more than 200 million people.”¹

It is certainly true that *Sicko* is not a careful accounting of the pros and cons of the U.S. insurance system. But the basic truth of Moore’s indictment is undeniable. A recent survey by *Consumer Reports* found that nearly half of adults younger than 65 — most of them

insured — say they are “somewhat” or “completely” unprepared to cope with a costly medical emergency in the coming year.² A substantial share of the more than 1 million personal bankruptcies in the United States each year — perhaps as many as half — are due in part to medical costs and crises.³ In no other rich country are people even remotely as likely to report having trouble with paying medical bills or going without care because of the cost.⁴ These problems are longstanding — yes, “dating back to the 1980s” — and worsening. And they are largely due to our reliance on employment-based, voluntary private health insurance.

The question is why we let these problems fester and what we can do to address them. Here, perhaps inevitably, is where Moore’s indictment falls short. Mychelle Keys died in 1993 — the same year that President Bill Clinton went before Congress

and declared, “This health care system of ours is badly broken, and it is time to fix it.” Moore takes us back to the Clinton reform saga. But he does not convincingly explain why President Clinton and First Lady Hillary Clinton — now, of course, the leading Democratic candidate for President — failed so miserably. To Moore, the answer is simple:



Michael Moore, in *Sicko*, Talking with a Physician from Britain’s National Health Service.

health industry lobbyists and right-wing nut jobs. But the lobbyists that descended on Washington in 1993 were not the ultimate reason for the failure of the Clinton plan. And though conservative critics had a bigger impact, they, like the lobbyists, were swimming with a powerful tide at their backs — the public ambivalence, divided interests, and budgetary barriers created by our crazy quilt of health coverage.

Moore wants to do away with it all. His “prescription for change,” available on the *Sicko* Web site, calls for giving every U.S. resident “free, universal health care for life,” abolishing “all health insurance companies,” and strictly regulating pharmaceutical companies “like a public utility.” Moore clearly does not think much of the health plans being offered by Democratic presidential candidates Barack Obama and John Edwards. The *Sicko* site directs us to a new vehicle for “netroots” or-

ganizing sponsored by Physicians for a National Health Program, www.sickocure.org, which warns, “Beware of Phony Universal Coverage: Many political candidates say they support ‘universal health care,’ but usually this just means making more Americans insurance company customers. Real universal coverage means evicting insurance companies and establishing a national health program instead.”

It is an appealing vision, in many ways. We could use more populism and less caution in our health care debate. But it is also unrealistic. The Clinton plan failed in part because it combined the ideals of Social Security with the instruments of Aetna — tightly managed private health plans in which people would be financially pressured to enroll. And yes, it also failed because of conservative and health industry attacks. Above all, however, it failed because it tried to remake a deeply entrenched framework of insurance on which millions have come to rely, often quite happily despite the costs and hassles. Sadly, most Americans — even the underinsured and soon-to-be-uninsured, the potentially uninsurable and the one-illness-from-bankrupt — can be frightened into believing that changing this entrenched and inadequate system means paying more for less. This is the legacy of an insurance structure that lulls many into believing they are secure when they are not, that hides vast costs in quiet deductions from workers’ pay, that leaves government paying the tab for the most vulnerable and the least well, and that so fragments the purchase of care that no one

can bargain for lower prices or judge the value of what is being bought. This is the catch-22 of health care reform: it is the very failings of our insurance system that make dealing with those failings so devilishly hard.

To get around this catch-22, we will need populist anger but also political foresight. Moore heads abroad to show us that a single public insurer is the only hope. But one need not travel to Canada, the United Kingdom, or France (much less Cuba — Moore's most dubious destination) to see the virtues of combining universality with public cost control. Medicare, our country's most popular and successful public insurance plan, covers everyone older than 65 and people with disabilities — groups with great need for coverage and little ability to obtain it privately. Yet it has controlled expenses better than the private sector, spends little on administration, and allows patients to seek care from nearly every doctor and hospital. For some reason, Moore ignores Medicare. He talks about the post office, the fire department, public education — but not the one public program that most resembles the “free universal health care” he extols.

That's too bad, because the Medicare model is the not-so-secret weapon in the campaign for affordable health care for all. Today, many advocates of national health insurance have wisely started calling for “Medicare for All” rather than their old rallying cry, “Single Payer.” But moving to a national insurance plan overnight, whatever the label, means threatening the private coverage on which so many Americans rely and requiring our cash-strapped government to raise the highly

visible taxes necessary to fund a system now financed largely by the hidden drain on workers' paychecks. We may be moving toward the day when we are ready to clear these hurdles in one leap, but we are not there yet.

For now, the best step may be to require employers either to provide their workers with good private coverage or to enroll them, at a modest cost, in a new public program modeled after Medicare. Workers enrolled in this new public framework could be asked to pay a modest premium on top of employers' contributions, based on their income, and they could be allowed to enroll in qualified private plans — as people with Medicare coverage can today. No doubt many employers would seize the opportunity to obtain inexpensive coverage for their workers, which would give the new public insurance plan a large, diverse enrollment and a great deal of leverage to contain costs and improve care. But employers could also implement their own cost-control and quality-enhancement strategies, without having to bear the burden of uncompensated charity care for the uninsured and underinsured. This approach is easy to describe, its elements are familiar, and it will also almost certainly evolve toward increasingly broad public coverage over time. Employers today are rushing to shed or shred insurance. This strategy would ensure that their retreat results not in greater dislocation and insecurity but in increasing numbers of Americans gaining access to a national, Medicare-like plan that guarantees affordable, high-quality care.⁵

This blueprint for reform may not be as evocative as “evicting insurance companies and estab-

lishing a national health program instead.” But it does stand a real chance of becoming law. It will happen, however, only if Americans demand that their leaders finally do something and if health care reformers make the public a willing ally, rather than a wary opponent, of change. Moore's exposure of the rot at the core of U.S. health insurance drives home the pressing need for action. But reform will not be easy, and it will require many midwives. At the close of *Sicko*, a quote from Alexis de Tocqueville appears: “The greatness of America lies not in being more enlightened than any other nation, but rather in her ability to repair her faults.” To this should be added another of de Tocqueville's timeless observations: “The people reign over the American political world as does God over the universe. They are the cause and the end of all things.” Let it be so.

An interview with Dr. Hacker can be heard at www.nejm.org.

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