U2K EDUCATION HANDBOOK

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INTRODUCTION

America's health care costs too much, covers too little, and excludes too many. The market-based system of the 1990s is failing to solve these problems. It is time for a change. Yet to visualize the shape fundamental health care reform might take, it is critical to have an understanding of the major building blocks of modern American health care.

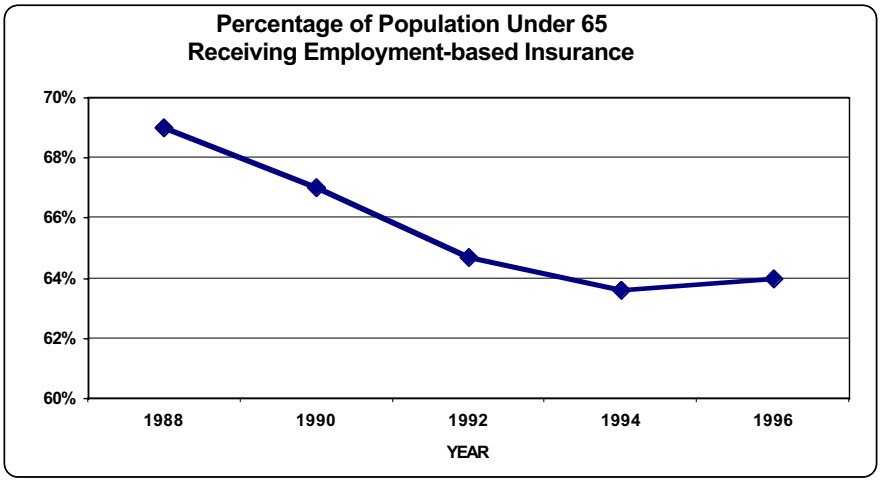
The three major payers for health services in the United States are employment-based private insurance, Medicare and Medicaid. The history, current trends, and current policy issues of each are outlined below.

EMPLOYMENT-BASED PRIVATE INSURANCE

History

Private insurance began in the early 1930s. The formation of Blue Cross was spurred during the Depression because, at that time of economic hardship, few people had money to pay their hospital bills. Hospital insurance, guaranteeing money for hospitals, ensured hospitals' survival. Originally Blue Cross hospital insurance rates were "community rated" - all members of a community shared equally in the costs of care.

During World War II, wages were controlled, but employers could add or raise fringe benefits to attract workers. Therefore, employer-based private health insurance became widespread. In the 1950s, private insurance companies moved in to take business away from Blue Cross by charging lower rates for companies with younger and healthier workers. This system, known as "experience rating," gradually undermined community rating.



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As the technology of health care has advanced and care has become more expensive, there has been a steady decline in the percentage of workers insured through their jobs.

Current Trends

As private insurance corporations have come to dominate health care, there has been a decline in the number of Americans who have health insurance. For a variety of reasons, employer-based health insurance is failing to provide coverage for many Americans. The majority of dollars that are spent on health insurance are public dollars. Private sector employers were the only source of insurance for merely 46% of the population in 1996.

Percentage of uninsured workers by firm size, 1995:

Fewer than 10 employees:	33%
10-24 employees	28%
Self-employed	25%
25-99 employees	20%
100-499 employees	15%
500-999 employees	13%
More than 1000 employees	12%

Percentage of uninsured workers, by industry, 1995:

Agriculture	36%
Personal services	32%
Construction	31%
Business and repair services	27%
Retail	26%
Entertainment	20%
Wholesale	15%
Transportation	13%
Manufacturing	13%
Professional services	12%
Mining	10%
Finance	8%
Government	7%

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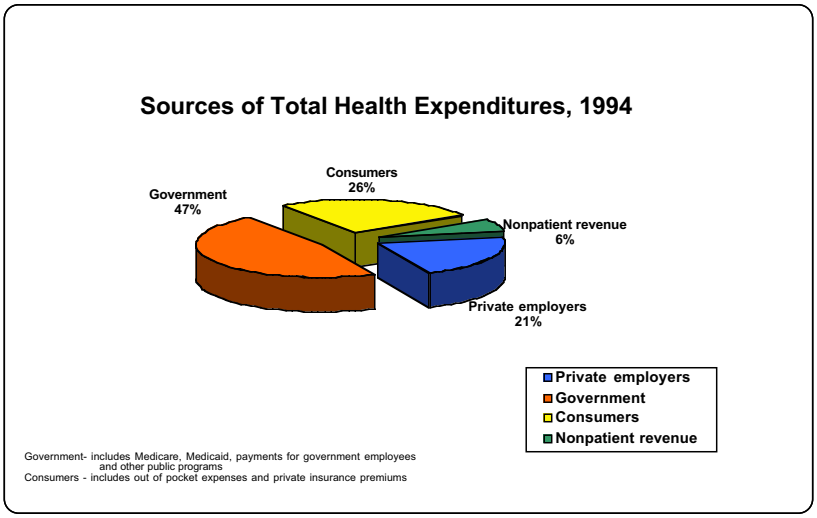

Despite the perception that most health benefits are provided by employers, the actual dollars are coming from individual employees and citizens.

(3)

Average cost of premiums for medium and large employers, 1997:

	Single	Family
Conventional	$2311	$6033
HMO	$1920	$5157
PPO	$2028	$5325
POS	$2021	$5572

(See the section on managed care for more information.)

Proportion of premium paid by employee, by firm size 1996:

	Small (<200 employees)	Medium/Large
Single coverage	33%	22%
Family coverage	44%	30%

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Current Policy Issues

Employers in high wage industries don't want to give up employment-based insurance because they feel it gives them the ability to control health care costs. They have been the main forces promoting managed care and moving their employees into managed care plans. Employers of low-wage workers often do not provide health insurance for their employees, making them "free riders" in economic terms. The slight upward income expansion of Medicaid eligibility is providing some help to these workers. However, private insurers don't want Medicaid eligibility to reach too high income levels out of fear that it will cut into their business.

TALKING POINTS

- THE LINK BETWEEN EMPLOYMENT AND HEALTH CARE is an accident of history unique to the U.S. Health insurance tied to jobs inevitably leaves some people without coverage.
- MIDDLE-INCOME WORKERS ARE OFTEN "UNDERINSURED" – they do not receive services they need because their co-payments or deductibles cost too much, or their managed care companies do not cover specialized services they need.

MEDICARE

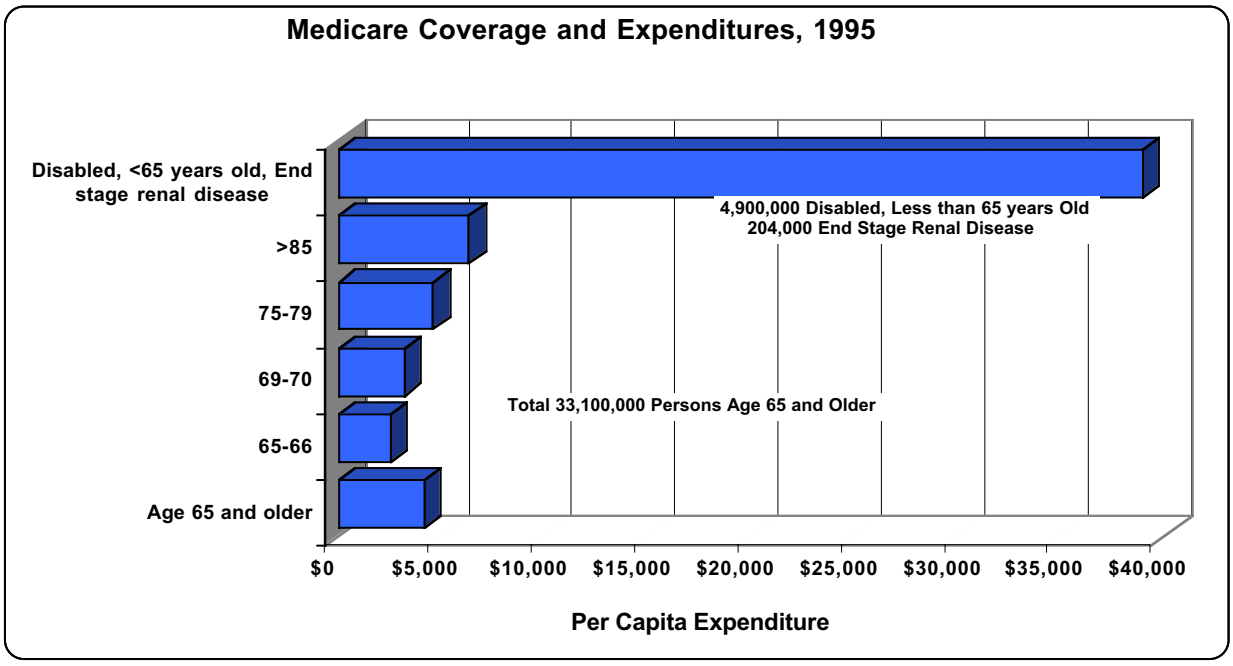
History

Medicare was enacted in 1965 as part of President Johnson's Great Society program. Leaders of the failed attempt to obtain national health insurance in 1949 created the Medicare strategy. Unable to get coverage for everyone, they started with the most needy and vulnerable group. Medicare provides coverage to all people over 65, regardless of income. It was expanded in the 1970s to include some people with disabilities.

The benefit plan created in 1966 mirrored private insurance, including co-payments and deductibles. As care became more expensive, more and more people obtained insurance to pay these costs through supplemental insurance often called "Medigap." This is sometimes provided by former employers as a retirement benefit, sometimes purchased individually and sometimes provided to the those with the lowest income through Medicaid.

Current Trends

Originally Medicare paid hospitals and doctors as private insurers did, paying individually for each item or procedure. As technology made health care more expensive, in the 1980s Medicare switched to prospective payment, paying a fixed price per diagnosis regardless of individual costs (the DRG system). This controlled the Medicare hospital expenditures, but led insurers, hospitals and physicians to "cost-shift" to private insurers and employers. This led to the double-digit health inflation of the late 80s and early 90s. Government intervention controlled costs temporarily, but soon health care industry stakeholders found ways to shift costs onto other parts of the system.



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Medicare spending as a % of total spending by sector, 1995:

	$	% of total $
Hospitals	$110.6 billion	32%
Doctors	$ 39.7 billion	20%
Nursing homes	$ 7.8 billion	10% ⑥

TALKING POINTS

- MEDICARE IS A SOCIAL INSURANCE PROGRAM that covers everyone under one set of rules. Its 3% administrative overhead is a fraction of the cost of private insurers.
- CHANGING MEDICARE to a voucher to purchase private insurance will weaken the program as insurance companies will try to "cherry pick" healthy patients who use fewer services. Programs using taxpayer dollars will be left to serve those with the most expensive health care needs.
- THREE OUT OF FIVE SENIORS LACK COVERAGE FOR PRESCRIPTION DRUGS. Medicare coverage of prescription drugs has become a big issue as newer medicines play a bigger role in maintaining and improving health and prices rise faster than inflation.
- MEDICARE IS A UNIVERSAL HEALTH CARE PROGRAM for everyone 65 years and older . It could be the basis for expanding health care to all, by lowering the age people are eligible for benefits and/or extending coverage to all

Current Policy Issues

Medicare is America's largest, most important and most successful health insurance program, yet it is under constant cost pressure from advances in care and the graying of the population.

There is a recent trend, encouraged by the insurance industry, to force more Medicare recipients into HMO's. Evidence has shown that this doesn't work because healthier patients choose HMO's and sicker patients prefer the freedom of choice in traditional Medicare. Many HMO's were being paid more by the government than they needed to spend for individual enrollees. In 1998, when the government tried to address this by reducing payment rates, 41 managed care plans quit Medicare, and another 58 reduced areas of coverage, cuts that affected some 327,000 people.

In the 1960s, when the Medicare benefit package was designed on the model of private insurance, it did not include pharmaceuticals. Scientific advances have led to the availability of new drugs to control chronic disease and improve function and quality of life, making access to prescription drugs an increasingly important aspect of health care for older people.

Medicaid

History

Medicaid was enacted in 1965, as part of President Johnson's Great Society. Unlike Medicare, it was not the subject of prolonged political advocacy and discussion. It was added to the Medicare package near the end of the legislative debate in order to provide care to people who are medically indigent. Prior to Medicaid, this care was mostly financed at the local level by counties, with some assistance from states. Medicaid became a shared federal-state program, unlike Medicare, which is a purely federal program.

Also, unlike Medicare, which provides universal coverage to elderly Americans regardless of income, Medicaid eligibility does depend on income. It is a means-tested program, meaning that applicants are required to pass a number of eligibility requirements, including income verification, before they can enroll in the program. During the 1980s, Congress passed legislation requiring increases in eligibility by age through childhood and adolescence. In 1997, Congress encouraged the states to increase income eligibility for children through CHIP (the Child Health Insurance Program).

Medicaid covers care for low-income families with children, people with disabilities and the impoverished elderly, particularly those with expensive nursing home bills.

1. 1996 Medicaid coverage and expenditures:

	#covered	$ total expend	$ per capita
Children	21,270,000	$24.2 billion	$1115
Adults	9,210,000	$16.9 billion	$1837
People with disabilities	6,690,000	$56.9 billion	$8505
Elderly	4,089,000	$42.1 billion	$10,296

2. Percentage of nonelderly covered under Medicaid, 1988-1996:

1988	8.7%
1990	10.2%
1992	11.8%
1994	12.5%
1996	12.1%

3. Medicaid spending as a % of total spending, by sector, 1995:

Hospitals	$51 billion	14.7%
Doctors	$14.5 billion	7.4%
Nursing homes	$35.5 billion	47.2%

4. Federal share of Medicaid expenditures (1996):

• **Average**: 56.9%

• **Low federal share, 50 to 51%:** Alaska, California, Connecticut, Delaware, DC, Hawaii, Illinois, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, New York, Washington

• **Mid range share, 55-60%:** Florida, Kansas, Michigan, Nebraska,Wisconsin, Wyoming

• **High range share, 70-78%:** Arkansas, Kentucky, Louisiana, New Mexico, South Carolina, Utah, West Virginia ⑦

Current Policy Issues

Before welfare reform in 1996, all families receiving cash assistance automatically qualified for Medicaid, though the programs are actually separate. Presently, many that qualify for Medicaid but not cash benefits, are losing their health care when cash assistance ends. In many states, administrative confusion in welfare agencies has hindered enrollment in Medicaid or CHIP programs. Outreach to enroll children in CHIP has fallen far short of expectations.

Citing the potential for cost savings and improved health outcomes, many states mandated Medicaid recipients enroll in HMO's in the mid-1990s. In some states, many Medicaid HMOs have gone out of business - due to managerial incompetence, fraud or the inability to make a profit. Although Medicaid spending by individual states has recently declined, it is mostly because of lower enrollment related to changes in welfare. There is little evidence of improved health outcomes as a result of these changes.

Some justice groups across the country are working to expand Medicaid eligibility levels to include working families who do not qualify for Medicaid, but who work in low-wage jobs that do not provide affordable, quality health insurance.

TALKING POINTS

- MEDICAID IS A MEANS-TESTED SAFETY NET PROGRAM that requires a great deal of administrative overhead. Because Medicaid only covers those with the lowest income, the program often lacks broad public support and is more vulnerable to attack.
- WELFARE REFORM HAS LEFT MANY FAMILIES WITHOUT HEALTH INSURANCE as they make the transition from welfare to work.
- FORCING MEDICAID PATIENTS INTO MANAGED CARE HASN'T SAVED MONEY OR IMPROVED HEALTH OUTCOMES. It has angered and frustrated health care providers who are often faced with administrative and financial barriers to providing patients with needed care.
- RAISING INCOME ELIGIBILITY CAN ENSURE THAT MORE WORKING FAMILIES HAVE ACCESS TO HEALTH CARE. However, these incremental reforms are limited in that they are means-tested programs, in which public dollars are spent on private insurance that is not publicly accountable.

MANAGED CARE

History

In the 1940s and 50s, several pioneering "prepaid group practices" were developed. These groups collected a single charge for all care to a group of patients, rather than individual fees for individual services. In the early 1970s, President Nixon encouraged the expansion of this type of practice organization, renamed **Health Maintenance Organizations *(HMOs)***, as an alternative to the national health insurance plans being promoted by Democrats.

HMO enrollment grew slowly until the late 1980s, when large corporations began forcing their employees into them. Corporations also convinced governments to encourage or require them for recipients of Medicaid and Medicare.

HMOs restrict choice of physicians and hospitals to those in their plan. Resistance to this feature led the insurance industry to create new insurance products that allow a wider degree of choice. The two broad types are **PPOs or Preferred Provider Organizations** and **POS or Point of Service plans**. PPOs enlist a panel of health care providers; a patient may choose a non-panel provider, though the co-payments will be more. A POS plan allows patients to see anyone who will accept the plan's reimbursement rate. The initial prepaid plans, such as Kaiser and Group Health Associations, were non-profit. In recent years, for-profit insurance company chains have become dominant.

Employer-sponsored health insurance, medium and large firms, by plan type:

	1988	1992	1996	1998
Conventional	71%	45%	26%	14%
HMOs	18%	22%	33%	30%
PPOs	11%	26%	25%	34%
POS	0	8%	16%	22%

Percentage of publicly insured patients enrolled in managed care:

	Medicaid	Medicare
1989	9%	5%
1991	10%	6%
1993	14%	7%
1995	29%	10%
1997	48%	14%

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Distribution of HMO enrollment by ownership status:

	Nonprofit	For profit
1981	88%	12%
1985	74%	26%
1989	54%	46%
1993	48%	52%
1997	37%	63%

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Range of Managed Care Penetration in States, 1996
Managed Care = HMO + PPO + POS

HIGH (more than 80%): Arizona (89%), California (93%), Colorado (82%), District of Columbia (91%), Florida (84%), Maryland (83%), Missouri (80%), Nevada (88%), Oregon (87%), Rhode Island (81%), Tennessee (81%), Utah (88%), Washington (87%)

LOW (less than 60%): Idaho (45%), Iowa (59%), Maine (56%), Montana (46%), North Dakota (54%), South Dakota (51%), Vermont (56%), Wyoming (42%)

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Current Policy Issues

Over the last decade, managed care has become the dominant force in American health care. Many say that it has fundamentally transformed the health care system. It is not only a way of paying for care, but a way of organizing and delivering care. Prior to the advent of managed care, insurers, whether public or private, paid the bills submitted by health care providers with little questioning. Managed care organizations actively manage their budgets, determining practice patterns and reimbursement rates. The payers are no longer taking a back seat; they are now driving the health care system.

TALKING POINTS

- Managed care lowered costs only temporarily.
- Managed care has not increased the number of people with access to health care.
- Passing a strong Patients' Bill of Rights is an important step towards achieving public accountability of our health care system. Yet these legislative proposals only serve people who have health insurance. A real "bill of rights" for patients must address the fundamental right to health care for all.

The rapidly emerging power of the managed care industry has led to a backlash. **Patients** react to cost-cutting moves that limit services. **Physicians** are angry at administrative hassles to obtain permission for patient care and are worried about threats to their income. These groups have combined to pass legislation in every state during the last five years that regulates managed care companies, preventing some of the worst abuses, such as "drive-through deliveries" or gag clauses on physicians. Federal patient protection legislation is a hot button political issue in the current Congress.

A major impetus for managed care was to control health care costs, especially for business. Others included politically cautious reactions by the industry to the health care reform activity of 1993-1994 and increases in copayments deterring patients from seeking care. In 1999, insurance rates once again began to rise rapidly. The assumption that controlling health care costs would lead to declines in the number of people without health insurance certainly has not been borne out. In fact, managed care companies now lobby against regulation on the grounds that increased costs will raise the number of those without coverage.

THE HEALTH CARE CRISIS IN THE UNITED STATES

America's Health Care Costs Too Much

Health care in the United States costs more than in other industrialized nations, and has since World War II. In the 1990s, market forces were supposed to control costs, yet health expenditures are still rising faster here than in comparable nations and faster than inflation.

Percent of Gross Domestic Product (GDP) spent on health:

	1960	**1990**	**1997**
United States	5.2%	12.6%	13.5%
OECD* mean	3.8%	7.2%	7.5%
Ratio: U.S. / OECD	1.37	1.75	1.8

OECD: Organization of Economic Cooperation and Development (29 industrialized nations)

Why?

1. **Higher prices for the same goods and services.** Recent attention in this area has focused especially on pharmaceuticals. U.S. consumers pay 25% to 100% more than customers elsewhere for medications that are produced by the same multinational pharmaceutical companies. Coronary artery "stents," a brand new medical device to prevent heart attacks cost $500 per stent more in the United States than in Canada.

2. **Administrative waste.** Approximately 25% of the costs of health care are spent on non-clinical administration related to eligibility determinations, billing procedures and marketing expenses. Other industrialized nations spend half this amount.

3. **A technology-intensive style of medical practice.** The United States has more than three times the number of CT scanners and five times the number of MRI units per million people than other industrialized nations. This technology-intensive style is particularly striking in hospital care. In 1996, the average cost per day in American hospital was $1,128; Denmark was next at $632 per day, followed by Canada at $489 per day. The other twenty countries spent less than $350 per day. Despite this use of technology, the U.S. still lags behind other nations in its health outcomes.

America's Health Care Covers Too Little

About $1 out of every $6 spent for U.S. health care comes out of patients' pockets for individual products and services. In some instances, this money is a co-payment and insurance pays the rest. Other times, the out-of-pocket payment is the full payment because the patient has no insurance, or insurance does not cover the service. The burdens of out-of-pocket care are the highest on the sickest people.

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Managed care tends to be not so much about managing care as about managing costs. Companies manage costs by making it harder for patients to receive care they need, either through administrative barriers or by making patients pay more for them. The backlash to these practices has spurred national and state legislative action.

America's Health Care Excludes too Many

The percentage of the uninsured is increasing every year, despite a booming economy.

Percentage of the non-elderly without health insurance:

1988	15.5%
1990	16.1%
1992	17.0%
1994	17.1%
1996	17.7%

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In March 1998, 44.3 million Americans were without health insurance. These numbers underestimate the problem. 1997 data show that over a two-year period, one-third of non-elderly adults had a gap of one or more months in health coverage.

Lack of insurance is a big problem for low-income workers. The majority of Americans who lack health insurance are white, but **the risk of being uninsured is about twice as high for African-Americans and Hispanics.** Seventy-two percent of uninsured workers earn less than $20,000 annually.

Income and the Risk of Being Uninsured, 1995:

< 100% of poverty	23%
100-199%	27%
200-299%	18%
300-399%	11%
> 400%	7%

Family Work Status of the Uninsured, 1995:

One full-time worker	50%
Two or more full-time workers	29%
Only part-time workers	11%
No workers	10%

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How does not being insured affect people's health?

People without health insurance do receive some health care, but often too little and too late. Sometimes the neglect of chronic conditions in their early state leads to more expensive care later on.

- The uninsured are **three times as likely to lack a usual source of care** than insured.
- Children without insurance are **nearly twice as likely not to receive medical care for acute conditions** such as asthma and ear infections.
- The uninsured are **twice as likely to have not seen a doctor** even once in a year.
- The uninsured are only **two-thirds as likely to receive preventive examinations** such as mammograms, pap smears, prostate exams and physical exams.
- The uninsured are **four times more likely to postpone care due to costs.**

THE AMERICAN POLITICAL SYSTEM AND FUNDAMENTAL HEALTH CARE REFORM

Every democratic industrialized nation has found a way to guarantee health care for all of its citizens, except the U. S. A chronology reveals how badly the U.S. is out of step:

Health Care for All: An International Timeline

Year in which elected representatives enacted universal health care:

Germany	**1883**
Switzerland	**1911**
New Zealand	**1938**
Belgium	**1945**
United Kingdom	**1946**
Sweden	**1947**
Greece	**1961**
Japan	**1961**
Canada	**1966**
Denmark	**1973**
Australia	**1974**
Italy	**1978**
Portugal	**1979**
Spain	**1986**
South Africa	**1996**

Despite comprehensive proposals by presidents in 1948 and 1994 and strong popular support, the U. S. failed in its recent attempts to achieve health care for all.

Why did national health care reform stall in 1993-1994?

Paul Starr, *Pulitzer Prize winning author of* ***The Social Transformation of American Medicine*** *and high-ranking Clinton health care advisor; from: "What Happened to Health Care Reform?" in The American Prospect, Winter 1995, p. 25*

"To say these judgements about strategy were mistaken is an understatement; they proved to be a disaster. Despite the comprehensive benefit package and the extras such as prescription drug coverage for the elderly, we did not receive passionate support from the groups we were counting on. We did succeed, however, in mobilizing the opposition.

"The scale of the program and its regulatory features caused sympathetic groups in the business community and opinion leaders in the media to think twice about support.

"Because we failed to edit the plan down to its essentials and find familiar ways to convey it, many people couldn't understand what we were proposing. There were too many parts, too many new ideas, even for many policy experts to keep straight."

***'Daniel Yankelovich**, prominent polling expert, from "The Debate That Wasn't: The Public and the Clinton Plan," Health Affairs, Spring 1995 , pps 8-9:*

"The nation's leadership and the public are carrying out a bizarre dialogue of the deaf. The nation's elites have little trouble conversing with one another, but when it comes to engaging the public, there is an astonishing lack of dialogue. Public relations, punditry, advertising, speechifying, spin-doctoring, and so-called public education - these mechanisms of top-down communication abound. The absence of plain give-and-take between leaders and the public is striking.

"President Clinton's reform plan was not shaped by discussion with citizens about rising health care costs and what to do about them… The plan was the product of experts and experts alone. Technical experts designed it, special interests argued it, political leaders sold it, journalists more interested in its political ramifications than its content kibitzed it, advertising attacked it. There was no way for average Americans to understand what it meant for them."

TALKING POINTS

- In order to facilitate a national dialogue about ways to achieve universal health care - the dialogue that never occurred in the early 1990's - health care justice activists must first build a broad movement around the need for fundamental health care reform. We must educate the public on the urgency of reform, and involve the public in discussion about ways to achieve health care for all.
- Letting candidates in the 2000 elections know that their stand on universal health care and fundamental health care reform affects how we'll vote can help move America towards finally achieving universal health care.

***Haynes Johnson and David Broder**, Pulitzer Prize winning journalists, from: **The System: the American Way of Politics at the Breaking Point**, Little, Brown and Company, 1996, pp. 628-9*

"In many respects, the story of the life and death of health care reform is the story of how to manufacture and manipulate public opinion. A fundamental question that emerges from this story is, Why did the anticipated, and needed, great public debate about what kind of health care Americans want never occur?

"The answer is that 'public opinion' was largely an artifact of the groups that mobilized to defeat reform. They created opinion with their grassroots and media efforts. Then they invoked that public opinion to convince, or provide a rationale for, the members of Congress who for reasons of self-interest wanted to vote no."

The Power of Money in Health Care Politics

TALKING POINTS

- The struggle for universal health care is inseparably linked to the struggle for campaign finance reform. Since the health care industry spends so much money lobbying Congress, we must fight their influence through a broad-based and well-organized movement for universal health care, in 2000 and beyond.
- Health care justice activists can link the twin struggles for campaign finance reform and universal health care by exposing the campaign contributions of the health care industry, and how this affects Congress people's stance on fundamental health care reform.
- It takes big numbers to overcome the influence of big money. We must build a broad movement of new allies in order to finally win health care for all.

"Those without health insurance - who disproportionately include working women and children - are not only marginalized from the health care delivery system, they are marginalized from the political process."

Father Michael Place, CEO, Catholic Health Association, April 1999

The Big Spenders

Money takes two roads to influence political decisions - campaign contributions and lobbying. In 1997-98, over $4 billion was spent to gain access to and influence the opinions of federal officeholders and candidates - $1.56 billion to finance campaigns, $2.68 billion for lobbying. **The vast majority of this money comes from the wealthiest 2% of individuals and corporations in the U.S.**

Campaign Contributions

Congressional candidates	**$781.3 million**
Contributions to National Party Committees - *hard money*	**$445 million**
Contributions to National Party Committees - *soft money*	**$224.4 million**
Issue advertising (est. - Annenburg Public Policy Center)	**$100 million**
Independent expenditures	**$ 11.7 million**
Grand Total	**$1.56 BILLION**

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Over the last several election cycles, contributions from businesses and professionals have exceeded contributions from labor by a ratio of 7 to 1, and contributions from single issue groups by a ratio of 13 to 1.

Lobbying

Following are the 1997-98 lobbying expenditures of the top thirty lobbies. Together they account for $2.045 billion in lobbying expenditures, which is 76% of the total. Six of these thirty have a significant interest in health policy issues. The campaign contributions of these six are also given.

	Lobbying	Campaign Contributions
1.Pharmaceuticals / health products	$148.6 million	$13 million
2. Insurance	$141.3 million	$31.2 million
3. Telephone utilities	$130.2 million	
4. Oil & Gas	$120 million	
5. Electric utilities	$118.4 million	
6. Tobacco	$105.6 million	
7. Health professionals	$89 million	$31.5 million
8. Business Associations	$82.6 million	$ 2.5 million
9. Miscellaneous issues	$77.1 million	
10 Automotive	$76.9 million	
11. Misc. manufacturing & distributing	$73.7 million	
12. Air transport	$72.4 million	
13. Government agencies	$64 million	
14. Computer equipment & services	$63.9 million	
15. Commercial banks	$62.9 million	
16. Securities & investment	$59.1 million	
17. TV / music / movies	$57.3 million	
18. Defense aerospace	$56.1 million	
19. Education	$55.4 million	
20. Chemical & related manufacturing	$51.7 million	
21. Hospitals / nursing homes	$49.6 million	$ 7.8 million
22. Real estate	$48.9 million	
23. Telecom services & equipment	$43.7 million	
24. Railroads	$34.5 million	
25. Agricultural services / products	$33.2 million	
26. Finance / credit companies	$31.1 million	
27. Health services	$30.1 million	$ 5.5 million
28. Lawyers / law firms	$25.1 million	
29. Printing & publishing	$22 million	
30. Casinos / gambling	$20.4 million	

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Total lobbying expenses for unions: $44.4 million
Total lobbying expenses for clergy and religious organizations: $2 million.

How Money Affects Health Care Politics

Monied interests sometimes get what they want. More frequently they make sure they don't get what they don't want. There is no more convincing evidence of this than in the arena of universal health care. Over the past fifty years - a half century in which the vast majority of the democracies of the world enacted coverage for all - there has not been a single vote on the floor of the U.S. House or Senate on this issue.

Despite the billions invested to influence the political system, it is not always easy to see its impact, because most of it is behind the scenes. Sometimes it is possible to predict which way politicians will vote on the floor based on the sources of their contributions and intensity of a lobbying campaign. More commonly, money affects which bills politicians will sponsor, which bills will be given hearings in committees, which bills will be voted out of committee, which amendments will be bundled together on the floor. Most importantly, money influences what bills will not go forward in Congress.

Sources and Bibliography

Please contact the U2K office or check the U2K web site for the sources designated by number in the text of this handbook and for an additional bibliography (available after April 15, 2000).

**THE GOAL OF THE U2K CAMPAIGN IS TO BRING ABOUT,
THROUGH A DEMOCRATIC PROCESS,
A NATIONAL GUARANTEE OF
COMPREHENSIVE, ACCESSIBLE, QUALITY, AFFORDABLE AND
PUBLICLY ACCOUNTABLE HEALTH CARE FOR ALL.**

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