

## PATIENTS AND PROFITS

I'm delighted to be here and particularly delighted to be able to help celebrate Quentin Young's 90<sup>th</sup> birthday. We all know that Quentin is a fearless and indefatigable champion of the sick and downtrodden. But what some of you may not fully appreciate is his historical role in the front lines of the struggle for a better health system, and indeed for a more decent and saner world. I recently read his memoir, and was astonished at how he managed to be nearly everywhere the good fight was being fought in the last half of the 20<sup>th</sup> century – not just as a witness, sort of Zelig-like, but as a participant and leader. I won't list his many contributions to important social changes, but I want to mention one.

I recently read Quentin's testimony before the infamous House Un-American Activities Committee in October of 1968. A few words of background: This was in the wake of the horrific police violence unleashed by Chicago Mayor Richard Daley against thousands of anti-Vietnam war protestors in Grant Park, while the 1968

Democratic Convention was underway right across the street. The brutal beatings were witnessed live on television by the entire country. Not surprisingly, Quentin was right there in the middle of it as chairman of the Medical Committee for Human Rights, which was trying to minister to the injured despite considerable risks to themselves. Afterwards, the House Un-American Activities Committee, known as HUAC, held hearings to try to pin responsibility for the violence on a communist plot. HUAC had terrorized leftists since its founding in 1938, often destroying people's reputations and livelihood. Many who were summoned to appear before it were reluctant to stand up for themselves, often taking the 5<sup>th</sup> Amendment to avoid answering questions.

HUAC sure didn't count on Quentin! When he was summoned, and they set out to link him to the Communist Party and discredit the Medical Committee for Human Rights, he refused to hide behind the 5<sup>th</sup> Amendment, but instead appealed to the 1<sup>st</sup> Amendment, saying it gave him the right to say and believe anything he wanted and associate with whomever he wanted. He then led HUAC on a merry

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chase during two days of testimony, outmaneuvering them at every turn. Crafty, really. It was great reading, and I recommend it to all of you. I never thought I'd feel sorry for HUAC, but I almost did. Incidentally, HUAC changed its name the following year.

So it's a real pleasure to wish this great and good man a very happy 90<sup>th</sup> birthday.

This year also marks the 10<sup>th</sup> anniversary of the publication in JAMA of the Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. (In the spirit of full disclosure I should mention that I was on the writing committee, which was led by Steffie Woolhandler, David Himmelstein, and Quentin.) In the proposal, PNHP laid out the details of how a single-payer system could work in the United States, how it could provide universal care for the same cost as the current system, without the rapid inflation, and how the transition might be accomplished. That proposal became the template for HR 676, introduced by Representative John Conyers the same year, and re-introduced regularly since then.

I recently re-read the JAMA article to see if there were any changes I would make – ten years and hundreds of billions of dollars later, with tens more millions of Americans uninsured or underinsured. I decided it's just as relevant now as it was then, maybe more so. The formal title of HR 676 is The Expanded and Improved Medicare for All Act, which, although clunky as a title, is descriptive. As you know, it essentially calls for extending Medicare to everyone, within a nonprofit delivery system.

This morning, we've heard excellent talks on health policy, including an update on the Massachusetts plan, which explains a lot of pot holes in our roads as health care crowds out all other state responsibilities. And we've heard about the more hopeful Vermont effort to establish a single-payer system. So I'll try not to spend much time duplicating in detail what's already been said. Instead, I'd like to say just a few words about a couple of general points I think are particularly important and worth emphasizing.

First, it's necessary to say again and again that the fundamental

problem with our health system is its staggering and uncontrollable costs. Problems with access and coverage stem from that. After all, if money were no object, everyone could have all the health care they wanted. To work long-term, any reform must target costs. But to target costs, we need to know why they're so high, and there are two quite simple reasons: the investor-owned private insurance industry, and the profit-oriented delivery system.

PNHP has always emphasized the problems created by multiple private insurance companies – hence the term “single-payer.” And those problems are certainly worth emphasizing. The existence of hundreds of for-profit insurance companies vying to cover the healthy and avoid the sick has created a gigantic game of hot potato. We're the only country in the world with a health system designed to avoid sick people, and when insurers try to do that without explicitly admitting it, it creates enormous overhead costs. That point is made wonderfully in the cartoon at the back of the recent PNHP Newsletter that shows a doctor saying to his hapless patient, “Uh-oh, your coverage doesn't seem to include illness.” This cost-shifting,

along with the profits and corporate perks of the industry, is probably wasting around a half trillion dollars this year, although there's no way to calculate health expenditures very precisely. Suffice it to say, it wastes hundreds of billions of dollars a year.

But this refers only to the financing system – the costs of not having a single government payer. What about the delivery system – the hospitals, clinics, and doctors who actually provide the care? I think we don't say enough about the delivery system, which in my view is even more culpable than the financing system. Here again, we're unique among advanced countries in that we've left the delivery system largely in the hands of profit-maximizing providers. Even institutions that are technically nonprofit behave the same way because they're swimming in the same money-saturated sea. Doctors are paid fee-for-service, and the fees are heavily skewed toward specialist procedures, which is why we have so many specialists doing so many unnecessary and duplicative procedures, often in investor-owned facilities.

It's probably even harder to say how much is wasted in our delivery system, compared with the financing system, but I believe it's probably at least as much – maybe even twice as much. That's why Medicare, for all its virtues, is almost as costly and inflationary as the private system. It uses the same delivery system. The key is to prohibit profits in the delivery of health care. In the 2003 PNHP proposal, that point was made, but I believe it receives too little emphasis. Medicare for all is not enough.

The problem with the Affordable Care Act, which the President is happy to call Obamacare for the time being, is that it doesn't really deal with either of the two underlying reasons for the ever-rising costs and consequent poor quality of our health system – namely, the existence of private insurers, and the profiteering of providers.

Under Obamacare, private insurance companies will *still* be able to set their own premiums, and since the legislation will pour more money and customers into the industry, that's a recipe for inflation. Most of the regulations to prohibit abuses are fairly easily circumvented, and as the president of the health insurers' trade

association once told me, any adverse effect on the companies' bottom line can always be offset by increasing premiums. As for the delivery system, care will *still* be provided in for-profit facilities, and doctors will *still* be paid fee-for-service, and the fees will *still* be skewed to reward highly-paid specialists for doing as many procedures as possible. There is some language in the legislation about determining cost-effective practice and setting up demonstration projects that would pay doctors differently, but nothing specific. It's a promissory note. Moreover, the law actually forbids tying fees to findings from comparative effectiveness research.

Despite all the hype that Obamacare is the most important piece of social legislation since Medicare, I doubt very much that it will ever be fully implemented as written. It's just too inflationary and also too Byzantine. I'm no techie, but it strikes me that the failure of the healthcare.gov website has more to do with the mind-boggling complexity of the law than with technological challenges per se. And I don't believe there's any way to make it work by further



tinkering.

In recent years, I've grown increasingly sympathetic to a completely nationalized health system in which there is no insurance of any kind. In essence, that would mean extending the Veterans Affairs system to everyone, with hospitals and clinics owned by the federal government, which would pay salaries to doctors. This would be like the UK's original National Health Service. Of course, that would be even harder to achieve than an expanded and improved Medicare system, but it strikes me that it is the simplest system, and it completely separates health care from payment.

In my view, health care is fundamentally a moral issue, not an economic one. Why should people who are sick or injured have to pay for the privilege? Yet that is what we make them do – as though illness were some consumer product that patients are keen to have. So they pay twice – once in the suffering caused by the illness itself, and then again in the financial costs. To me, that is immoral, a sort of piling on. People who are sick or injured should be able to get the

care they need, and money should have nothing to do with it.

My fervent hope is that as the ACA unravels and costs go up, the U.S. will finally be ready to embrace a nonprofit single-payer system that covers everyone, from the President on down. My fear, however, is that Americans will instead conclude that providing universal health care is simply too expensive, and give up on it. The tragedy in that case would be that the country was too insular and too much in the pocket of the health industry to recognize that universal care can be provided relatively cheaply, as other countries have shown.