PNHP Newsletter Fall 2016

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM ▪ 29 E. MADISON ST., STE. 1412, CHICAGO, IL ▪ WWW.PNHP.ORG

PNHP, NNU leaders testify before Democratic Party's platform committee

PNHP co-founder Dr. Steffie Woolhandler and Rose Ann DeMoro, executive director of National Nurses United (NNU), testified in support of single-payer Medicare for All before the Democratic National Committee's platform drafting committee in Phoenix in June (see Woolhandler testimony, p. 18). While the drafting committee endorsed health care as "a right," it voted 7-6 against "fighting for Medicare for All," prompting committee member Cornel West to comment that health care "is not a right, it's still a privilege if 29 million fellow citizens do not have access to it."

PNHPer Dr. Pam Gronemeyer and NNU Policy Director Michael Lighty were among those who took the fight for Medicare for All to the full DNC platform committee in Orlando, Fla., but who lost in a 66-92 vote. Lighty reminded the committee that "if it is controversial in this room, it is the only room of Democrats in which it is controversial," alluding to a recent Kaiser poll showing 81 percent of Democrats support Medicare for All. For background on several presidential candidates' health care planks, see page 9.

Wealthy now get more care than (sicker) poor

Between 2004 and 2012, health spending on wealthy and middle-income Americans under age 65 rose by 20 percent and 10 percent, respectively, while health expenditures on the poor declined, reversing a 50-year trend, according to a new study in Health Affairs (reprinted on p. 52). The study by a Harvard-based team of PNHPers led by Dr. Samuel Dickman (now an intern at the University of California, San Francisco) found no such trend in the elderly. The findings suggest that the Great Recession was accompanied by a redistribution of care toward wealthier Americans that was mitigated in the elderly by Medicare.

Pulmonary, ICU doctors call for single payer

Drs. Adam Gaffney, Philip Verhoef, and Jesse Hall make an evidence-based case for single payer in their recent article titled "Should pulmonary/ICU physicians support single-payer healthcare reform? Yes" in Chest, the journal of the American College of Chest Physicians (see p. 26).

PNHPers in other specialties are encouraged to start a dialogue about single payer in their field's journals and/or to promote speakers for meetings. Dr. Susan Rogers recently spoke to 500 oncologists at the annual meeting of the American Society of Clinical Oncology (see p. 48).

Annual Meeting: Nov. 19, Washington, D.C.

PNHPers are invited to attend PNHP's 2016 Annual Meeting, "Post-election opportunities and challenges for single payer," on Saturday, Nov. 19, in Washington, D.C., at the Westin City Center (1400 M St. NW). Confirmed speakers include Dr. Marcia Angell, former editor of the New England Journal of Medicine, Dr. Mary Bassett, New York City Health Commissioner, PNHP co-founders Drs. David Himmelstein and Steffie Woolhandler, and activist Seattle City Council Member Kshama Sawant. Sen. Bernie Sanders is invited. The meeting will be preceded by two events on Friday, Nov. 18: a public rally in Lafayette Square (directly in front of the White House) and PNHP's popular Leadership Training. Members will also be encouraged to lobby their representatives while they are in D.C. For details and to RSVP, see **www.pnhp.org/meeting** or call (312) 782-6006.

Dr. Mary Bassett

In this issue

Health care crisis by the numbers . . . 3
Doctors' single-payer prescription for health care reform . . . 10
Obamacare is flawed, but there is a solution . . . 11
Doctors agree with Sanders on universal health care . . . 12
Why American doctors are calling for Canadian-style medicare . . . 14
Medical student prescribes remedy our sick system needs . . . 15
Bernie Sanders easily wins the policy debate . . . 16
Woolhandler testifies on single payer at DNC panel . . . 18
Trump on immigrants and health costs: just plain wrong . . . 21
Saving the NHS – the junior doctors' strike . . . 22
The future of the Veterans Health Administration . . . 24
Should pulmonary/ICU physicians support single payer? . . . 26
Single-payer essential to controlling health care costs . . . 29
Medical school: An invitation for activism for single payer . . . 30
Doctors unveil single-payer plan at National Press Club . . . 32
The Urban Institute's flawed attack on single payer . . . 34
Doctor-Workers: Unite! . . . 35
Faulty proposals for measuring physician 'value' . . . 38
Is the path to racial health equity paved with 'reparations'? . . . 40
New research on income and health; access problems . . . 49-60
Chapter reports . . . 61

PNHP Board of Directors, 2016

Officers
Robert Zarr, M.D., M.P.H. (DC), **President**
Andrew Coates, M.D. (NY), **Immediate Past President**
Gordon Schiff, M.D. (MA), **Secretary**
Claudia Fegan, M.D. (IL), **Treasurer, National Coordinator**

Regional and At-Large Delegates
Pippa C. Abston, M.D., Ph.D. (AL), Philip Caper, M.D., M.S. (ME),
Olveen Carrasquillo, M.D., M.P.H. (FL), Paul Hochfeld, M.D. (OR)
Danny McCormick, M.D., M.P.H. (MA), Mary E. O'Brien, M.D. (NY)
Carol A. Paris, M.D. (TN), Ann Settgast, M.D., D.T.M&H (MN)
Diljeet K. Singh, M.D., Dr.P.H. (DC), Paul Y. Song, M.D. (CA)
Steffie Woolhandler, M.D., M.P.H. (NY/MA)

Medical Student and Resident Delegates
Emily Kirchner (M4, Temple University)
Janine Petito (M4, Boston University)
Anand Saha (MS3, East Tennessee State University)
Bryant Shuey (M3, University of New Mexico)
Vanessa Van Doren (MS3, Case Western Reserve)

Past Presidents
Garrett Adams, M.D., M.P.H. (KY); Carolyn Clancy, M.D. (MD)
Claudia Fegan, M.D. (IL); Oliver Fein, M.D. (NY)
John Geyman, M.D. (WA); Robert LeBow, M.D. (deceased, ID)
Ana Malinow, M.D. (PA); Don McCanne, M.D. (CA)
Glenn Pearson, M.D. (CO); Deb Richter, M.D. (VT)
Cecile Rose, M.D., M.P.H. (CO); Johnathon Ross, M.D., M.P.H. (OH)
Jeffrey Scavron, M.D. (MA); Gordon Schiff, M.D. (MA)
Susan Steigerwalt, M.D. (MI); Isaac Taylor, M.D. (deceased, MA)
Quentin D. Young, M.D. (deceased, IL)

Honorary Board Member
RoseAnn DeMoro, National Nurses United

Board Advisers
Henry L. Abrons, M.D., M.P.H., (CA), Danielle Alexander, M.D., M.Sc. (CA)
John Bower, M.D. (MS), Richard Bruno, M.D., M.P.H. (MD)
Harvey Fernbach, M.D., M.P.H. (DC), Margaret Flowers, M.D. (MD)
Adam Gaffney, M.D. (MA), Scott Goldberg, M.D. (CA)
Jawad Husain (M4, Boston University, MA)
C. Bree Johnston, M.D., M.P.H. (WA), Stephen B. Kemble, M.D. (HI)
David McLanahan, M.D. (WA), Karen Palmer, M.P.H. (Canada)
Susan Rogers, M.D. (IL), Jessica Schorr Saxe, M.D. (NC)
Greg Silver, M.D. (FL), Robert C. Stone, M.D. (IN)
Arthur J. Sutherland III, M.D. (TN), Kay Tillow (KY)
Walter Tsou, M.D., M.P.H. (PA), Philip Verhoef, M.D., Ph.D. (IL)

Editors: Dr. David Himmelstein, Dr. Steffie Woolhandler, Dr. Ida Hellander, and Mark Almberg.
National Office Staff: PNHP's headquarters in Chicago is staffed by Matthew Petty, executive director; Dr. Ida Hellander, director of health policy and programs; Mark Almberg, communications director; Angela Fegan, membership associate; Dixon Galvez-Searle, communications specialist; and Emily Henkels, national organizer.
Local chapter staff include Katie Robbins (New York Metro).
Contact information:
29 E. Madison St., Ste 1412, Chicago, IL 60602-4410
P. 312-782-6006 ~ F. 312-782-6007
www.pnhp.org ~ info@pnhp.org

Membership drive update

Welcome to 645 physicians and medical students who have joined PNHP in the past year, bringing our total membership to 20,539. We invite new (and longtime) PNHP members to participate in our activities and to take the lead on behalf of PNHP in their communities. Need help getting started? Drop a note to PNHP National Organizer Emily Henkels at **e.henkels@pnhp.org**.

Updates from the states

The New York State Assembly overwhelmingly passed state-based single-payer legislation (A. 5062), introduced by Assemblyman Richard Gottfried, in June. The "New York Health Act" is backed by a large coalition of groups, including PNHP, NYS Nurses Association, American Academy of Family Physicians, American Academy of Pediatrics, and the Public Health Association of New York City.

In Oregon, activists are awaiting the results of a state-funded study by RAND of different health care reform options, including single payer. The study is due out this fall.

Meanwhile, a ballot initiative in Colorado to create a health insurance cooperative for the non-elderly is being viewed (incorrectly) as a referendum on single payer. Unfortunately the initiative received a misleading and negative title from the Colorado Title Board that begins "Shall state taxes be increased $25 billion annually…" creating an uphill battle despite polling data showing that a majority of Coloradans currently support ColoradoCare. The opposition, funded primarily by large insurers, has already spent $3 million to defeat the measure. Stay tuned.

SNaHP's fall action plans

Students for a National Health Program (SNaHP) has created an organizing committee to plan a national fall student action on Monday, Oct. 31. The action will target candidates and elected officials just prior to the November election with the goal of elevating single payer on candidates' platforms. A coalition-building Health Justice Education month will precede the action, which is planned at the more than 50 institutions around the country with active SNaHP chapters. The activities are being planned in conjunction with the Latino Medical Student Association, White Coats for Black Lives, the American Medical Student Association, and others. It continues a tradition started last year when SNaHP students organized a nationwide vigil on 10/01/15 ("TenOne"). To learn more, contact Emily Henkels at **e.henkels@pnhp.org**.

AMA votes to study financing models

The American Medical Association passed a resolution for an "updated study on health care payment models" at its House of Delegates meeting in June. The resolution, which initially (before it was amended) called for a study of single-payer financing, was shepherded through the Chicago and Illinois branches of the AMA by James Curry, a fourth-year medical student at the University of Illinois at Chicago who is active in PNHP's student affiliate, Students for a National Health Program, and longtime PNHPer Dr. Peter Orris.

Health care crisis by the numbers:
Data update from the PNHP newsletter editors

UNINSURED AND UNDERINSURED

• 28.6 million Americans (9.1 percent) were uninsured in 2015, a drop of 7.4 million from 2014. States that expanded Medicaid under the Affordable Care Act (ACA) had a lower proportion of uninsured working age adults (9.8 percent) than non-expansion states (17.5 percent). People aged 25-34 had the highest uninsured rate of any age group, 17.9 percent. The proportion of uninsured children dropped from 5.5 percent in 2014 to 4.5 percent in 2015. Despite gains in coverage, 27.7 percent of Hispanic and 14.4 percent of black working age adults were uninsured in 2015, compared with 8.7 percent of white and 7.9 percent of Asian adults ("Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2015," National Center for Health Statistics, May 2016. Note: "uninsured" is defined here as uninsured at time of interview.)

24 million Americans aged 19-64 (12.7 percent) were uninsured in early 2016, according to a survey by the Commonwealth Fund. The number of uninsured adults declined by 13 million between mid-2013 and the spring of 2016. But after a steep decline in 2014, there has been little progress in covering more low- and moderate-income Americans. They remain uninsured at rates as much as 10 times higher than for adults with higher incomes. 25.2 percent of the poor are uninsured, along with 22.1 percent of people with incomes between 100 percent and 138 percent of the federal poverty level (FPL), compared with 2.4 percent of people earning more than 400 percent of FPL (Collins, "Americans' experiences with ACA marketplace and Medicaid coverage," Commonwealth Fund, 5/25/16).

• Although coverage for adults under age 65 experiencing serious psychological distress (SPD) improved significantly between 2012 and 2015, adults with SPD are still more likely to be uninsured (19.5 percent) than their counterparts without SPD (12.3 percent), according to the National Center for Health Statistics. The cost of medical care is also still a barrier: 24.4 percent of adults with SPD had not received needed medical care due to cost, compared with 6.1 percent of adults without serious psychological distress. Additionally, by at least one important measure – a visit to a mental health professional in the past year – access to care for people with SPD has deteriorated. Among adults aged 18-64 with SPD in the past 30 days, the percentage who had seen or talked to a mental health professional in the past 12 months decreased significantly ($p < 0.05$) between 2012 and 2015, from 41.8 percent to 34.2 percent, while it remained stable, around 7 percent, for people without SPD (Cohen et al., "Access to Care Among Adults Aged 18-64 With Serious Psychological Distress: Early Release of Estimates From the National Health Interview Survey, 2012–September 2015," National Center for Health Statistics, May 2016).

• 11.1 million people are enrolled in ACA plans this year, up from 9.1 million at the end of 2015. 12.7 million people signed up for coverage, but 1.6 million (13 percent) dropped out or failed to pay their first premium ("About 1.6M drop-outs from health law coverage this year," Associated Press, 6/30/16).

There were 5.9 million uninsured mothers (defined as women living with dependent children under age 19) in the U.S. in 2014, down from 7.5 million in 2013. Despite gains from the ACA, 1 in 6 mothers in the U.S. remained uninsured, including about 1 in 5 mothers who reported having moderate or severe psychological stress or being in less than very good health. Major reasons for uninsurance included the high cost of coverage (reported by 41.5 percent); coverage ending after pregnancy (18.7 percent); and losing coverage after they or a household member had lost or changed jobs (18 percent) (Karpman et al., "How are moms faring under the Affordable Care Act?" Urban Institute, May 2016).

• An estimated 106 million Americans are uninsured for dental care, including about 70 percent of seniors (Medicare does not cover dental care). On average, 1 in 4 adults has untreated dental caries, but the rate is nearly twice as high among blacks. Dental coverage for adults on Medicaid varies from state to state: 12 states provide comprehensive coverage; 20 provide limited coverage (e.g. up to a cap of $1,000 a year); 15 provide emergency care; and four provide no coverage at all. The situation for children is only slightly better: Medicaid and ACA plans must cover dental care for children, but 19 states have not expanded their Medicaid programs and private ACA plans may require hefty cost sharing. Coverage also does not equal care, since many dentists don't accept Medicaid (Sered, "Why, in heaven's name, aren't teeth considered part of our health?" Time, 4/27/16; Congressional Black Caucus, "2015 Kelly Report: Health Disparities in America," p. 121-122).

COSTS

In 2016 national health expenditures are estimated to total $3.4 trillion, 18.1 percent of GDP or $10,346 per capita. Over the next decade costs are projected to rise by an average rate of 5.8 percent annually, to 20.1 percent of GDP in 2025 (Keehan et al., "National Health Expenditure Projections 2015-2025," Health Affairs, July 2016).

• U.S. health care costs increased by 6.5 percent in 2015, 50 percent more rapidly than 2014's rate of 4.3 percent. Spending on medical services increased by 4.3 percent while drug costs increased by 15.8 percent (19.2 percent for brand name drugs and 6.6 percent for generics). The cost of health insurance plans in the individual market rose by 23 percent in 2015. Per member per month costs reached $525.33 in the individual market in December, surpassing costs in the employer-provided market (large group and self-insured) for the first time ("S&P Healthcare Claims Index Monthly Report," May 2016).

• The Milliman Medical Index (MMI) tracks the cost of health care for a typical family of four covered by an employer-sponsored preferred provider plan, or PPO. In 2016, the MMI rose by 4.7 percent to $25,826, triple the 2001 figure. Spending on prescription drugs rose to $4,270 annually (17 percent of total spending), quadrupling spending on drugs since 2001. Employers paid 57 percent of employee health costs, down from 61 percent in 2001 (Mangan, "Average family healthcare costs have tripled since 2001," CNBC Business, 5/24/16).

AFFORDABLE CARE ACT

• In 2016, there were 1,121 U.S. counties (36 percent) with two or fewer insurers offering ACA plans. UnitedHealthcare, the nation's largest insurer, will pull out of all but a few of the 34 states in which it sells ACA plans next year. UnitedHealthcare's exit will leave at least 10 entire states in the South and Midwest with only one or two insurers. Humana has also announced its intentions to pull out of 8 of the 19 states where it sells ACA plans on the exchange (Demko, "Anthem links Obamacare expansion with approval of Cigna acquisition," Politico Pro, 7/27/16).

Nonprofit CO-OPS ("consumer oriented and operated plans") selling plans on the exchanges in Connecticut, Oregon, and Illinois have shut down recently. Only seven out of the initial 23 CO-OP plans remain. Illinois' Land of Lincoln Health lost more than $100 million in two years. Its problems started when CMS failed to pay the firm $70 million in risk corridors funding (compensation to plans that enrolled a disproportionate share of high-cost patients) that it was owed for 2014, then demanded a $31.8 million payment for risk adjustment for 2015. The plan's nearly 50,000 enrollees will have 60 days to enroll in an alternative ACA plan, with no guarantee they'll be able to continue treatment with current doctors and hospitals (Demko, "Land of Lincoln Health will become the 16th Obamacare co-op to collapse," Politico, 7/12/16).

• Alaska is setting up a $55 million fund to subsidize care for expensively ill enrollees in its lone-surviving ACA insurer, Blue Cross and Blue Shield. The fund, financed by an industry-wide tax, will keep 23,000 Alaskans from losing ACA coverage as the only other insurer in the market, Moda, pulls out. The lowest-cost silver plan in Alaska cost $956 a month in 2016, up 40 percent since 2015, and the most costly in the nation (Pradhan, "Alaska scrambles to prevent Obamacare collapse," Politico, 6/10/16).

A greater share of people with ACA plans feel vulnerable to high medical bills (45 percent) than those with employer-based coverage (36 percent) in 2016, although financial vulnerability has risen significantly – by 10 percentage points – in both groups since 2014. In addition, more than half (54 percent) of those with ACA coverage in 2016 now rate the value of their coverage as "fair" or "poor," compared with 40 percent of those with employer-based coverage (Hamel et al., "Survey of Non-group Health Insurance Enrollees, Wave 3," Kaiser Family Foundation, 5/20/16).

• A lawsuit making its way through the federal court system, House of Representatives vs. Burwell, will determine if the government may, without an annual appropriation by Congress, continue to subsidize cost sharing (e.g. deductibles and copayments) in marketplace silver plans for an estimated 7 million Americans in households earning below 250 percent of the federal poverty limit (FPL), as specified in the ACA. The Congressional Budget Office projects that federal outlays on cost-sharing subsidies will total $7 billion this year and $130 billion over the next decade. The House Republicans who brought the suit say that Congress never authorized the expenditures and that the Department of Health and Human Services lacks the authority to do so on its own. A Federal District Court judge agreed; the administration is appealing the decision (Hulse, "Judge backs house challenge to a key part of health law," New York Times, 5/12/16; "Federal subsidies for health insurance coverage for people under age 65: Tables from CBO's March 2016 baseline," CBO).

Lower-income Americans with high health care needs in ACA plans still face unaffordable medical costs, even with cost-sharing subsidies. For example, an individual earning $17,000 (less than 150 percent of the FPL) is responsible for $650 in costs before reaching their out-of-pocket maximum, while someone earning $20,000 (between 150 percent and 200 percent of the FPL) faces out-of-pocket health costs of $1,850. Charges for uncovered services and out-of-network charges are not included in the out-of-pocket maximum, adding to the unaffordability of care for lower-income Americans ("How will the ACA's cost-sharing reductions affect consumers' out of pocket costs in 2016?" Commonwealth Fund, March 2016).

• Premiums for ACA plans are projected to increase by an average of 10 percent in 2017, based on an analysis of insurers' rate requests for the benchmark – or second-lowest-cost silver plan, which is used by the federal government to determine subsidy levels – in 14 cities, according to the Kaiser Family Foundation. But many insurers are seeking much larger increases from state regulators. Texas Blue Cross and Blue Shield, which covers 600,000 individuals, has requested rate hikes of nearly 60 percent. Aetna wants to raise premiums by an average of 24.5 percent on its 130,000 members in North Carolina. Highmark is seeking an average increase of 38.4 percent on its remaining 123,000 ACA plan

members in Pennsylvania, on top of a 20 percent premium increase last year. Humana is seeking a 65.2 percent average rate increase on its plans in Georgia. In New York, UnitedHealth Group has requested a rate increase of 45.6 percent (Tracer, "Health-law plans in New York seek to raise premiums by 17 percent," Bloomberg, 5/18/16; Demko, "Texas Blue wants rate hikes of nearly 60 percent," Politico Pro, 5/26/16; Demko, "Double-digit rate hikes for North Carolina exchange plans," Politico, 6/2/16; Radnofsky, "Insurers Seek Big Premium Boosts," Wall Street Journal, 5/26/16; Cox, "Analysis of 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces," Kaiser Family Foundation, 6/15/16).

The three largest insurers participating in the exchange in Washington, D.C., limit access to psychiatric care, according to the American Psychiatric Association. Eighty-six percent of listed psychiatrists were either unreachable or not taking new patients, and only 7 percent were able to schedule a new appointment within two weeks. The average wait time was nearly three weeks (19.1 days). Twenty-three percent of the phone numbers listed were non-working, and half (49 percent) of psychiatrists were no longer at the number listed (American Psychiatric Association news release, 5/16/16).

• Blue Cross and Blue Shield of Minnesota is dropping its ACA health plans with broad networks after losing $280 million in 2015. Instead, the firm is promoting its narrow network option, Blue Plus, hoping to offload some of its sicker beneficiaries (who are less willing to change doctors) to other insurers. Blues plans in Illinois, Oklahoma, Montana and Texas also dropped broad-network plans (Herman, "Minnesota Blues' decision to alter ACA plans mirrors stampede to narrow networks," Modern Healthcare, 6/24/16).

MEDICAID

• 72.4 million Americans have Medicaid coverage, up from 56.4 in 2013, an increase of 16 million (27 percent) since the ACA was implemented. Total Medicaid spending is projected to grow to $890 billion by 2024 from $496 billion in 2014. Private managed care insurers served as middlemen for one-third of all Medicaid spending in 2014. Although a new Centers for Medicare and Medicaid Services (CMS) rule proposes that Medicaid managed care firms be required to maintain a medical loss ratio (MLR) of at least 85 percent, there is currently no penalty if overhead and profit consume more than 15 percent. And at least four private insurers – Aetna, Anthem, Humana, and UnitedHealth – do not even disclose a separate MLR for Medicaid. UnitedHealthcare took in $28.9 billion in Medicaid revenues in 2015.

The new CMS rule also would require states to audit their Medicaid managed care plans, but only once every three years. The cost of an audit, about $240,000, is minor compared to the potential savings to taxpayers, but only a few states currently have auditing programs. Rhode Island uncovered a $208 million overpayment (8 percent of the state's total Medicaid budget) to UnitedHealthcare and another insurance plan in an audit last year. Massachusetts discovered $500 million in erroneous payments to private managed care insurers between 2009 and 2014 (Herman, "Medicaid's unmanaged managed care" Modern Healthcare, 5/2/16).

• Ohio is seeking a federal Medicaid waiver that would require its 1.3 million non-disabled Medicaid beneficiaries to pay premiums of 2 percent of income, up to $99 annually. Pregnant women would be exempt, but not the "medically frail." Adult beneficiaries who miss two premium payments would be locked out of the program until they made back payments and re-enrolled. The state's Republican administration is also seeking to eliminate 90-day retroactive coverage for Medicaid beneficiaries, and to include a health savings account-like feature which would track "points" enrollees earn with "healthy behaviors" and by paying premiums electronically (Patton, "Healthy Ohio plan is bad medicine," Policy Matters Ohio, January 2016; Sanner, "Proposal to charge Medicaid enrollees draws critics in Ohio," AP, 5/8/16).

Medicaid coverage has a beneficial financial impact, according to a study comparing credit report data in states that expanded Medicaid to those that did not. Medicaid expansion reduced the amount of non-medical debt sent to third-party collection agencies by $600 to $1,000 per person who obtained Medicaid coverage, according to a study by researchers with the National Bureau of Economic Research (Hu, "The effect of the PPACA Medicaid expansions on financial well-being," NBER paper No. 22170, April 2016).

MEDICARE

• Employer- and union-sponsored retiree health benefits have filled the gaps in Medicare coverage for many seniors, but the number of companies providing such benefits is plummeting. Between 1988 and 2015 the share of large employers (more than 200 employees) offering retiree health coverage fell from 66 percent to 23 percent. The share of seniors with any supplemental retiree coverage declined from 24 percent in 2005 to 16 percent in 2014 (Neuman and Damico, "Fading Fast: Fewer seniors have retiree health coverage," Kaiser Family Foundation, 5/5/16).

• In 2016, the Medicare premium for Part B physician and medical services is $1,249, with a $166 deductible and 20 percent co-insurance. There is also a $1,288 deductible for each hospital stay and $161/day co-pay for skilled nursing facility care after the first 20 days. Medicare has no out-of-pocket limit, and there is no coverage for dental, hearing, or longer-term care (Schoen, "On Medicare but at risk," Commonwealth Fund, 5/10/16).

Nearly a quarter (23 percent) of Medicare beneficiaries (11.5 million) were underinsured in 2014, meaning that their out-of-pocket medical bills (excluding premiums) exceeded 10 percent of their income, or 5 percent if they were low-income (under 200 percent of the FPL). Nearly 41 percent of low-income beneficiaries were underinsured. Including premiums, 16 percent of beneficiaries (8 million) spent more than 20 percent of their incomes on insurance plus care. Forty percent of all Medicare beneficiaries have annual incomes below 200 percent of poverty (less than $23,760 for a single person and $32,000 for a couple this year) (Schoen, "On Medicare but at risk," Commonwealth Fund, 5/10/16).

• A recently unsealed whistleblower case against a Humana Medicare Advantage plan and a medical practice in southern Florida alleges that upcoding (adding diagnostic codes that make a patient seem sicker than they really are) not only inflated payments, but also put patients at risk of medical harm. Humana, which is up for sale to Aetna, has more than 3 million patients in Medicare Advantage plans. One of the clinic's physicians was convicted of fraudulently billing Medicare for $4.8 million. False information entered in patients' medical records to justify upcoding could hurt patients, according to whistleblower Dr. Mario Baez. Baez wrote to the presiding judge that treating elderly patients with multiple problems is hard enough, but "when medical records are poisoned with misleading data, [medical treatment] becomes Russian roulette" (Schulte, "Yet another whistleblower alleges Medicare Advantage fraud," Center for Public Integrity, 3/4/16).

Medicare Advantage (MA) plans continue to be overpaid relative to traditional, fee-for-service Medicare. MA plans will be paid 102 percent of what the cost of care would be in traditional Medicare in 2016, according to the Medicare Payment Advisory Commission. There are 16.7 million MA plan enrollees (30 percent of all beneficiaries), up 6 percent from 2015. A majority, 11 million enrollees, are in HMOs. Consolidation in the program is continuing: Last year, 54 percent of enrollees were in just four insurers, up from 45 percent in 2007 ("Fact Sheet, MedPAC Report to the Congress," July 2016).

An obscure section of the newly passed Medicare physician payment reform (described below) will drive even more Medicare beneficiaries into MA plans. The provision outlaws Medigap policies that cover the Part B deductible ($166 in 2016) for newly eligible Medicare beneficiaries starting in 2020. Ninety-five percent of traditional Medicare enrollees have supplemental insurance that covers the deductible. The only way for future beneficiaries to avoid the deductible will be to join a private Medicare Advantage plan (Herman, "Changes loom as most-popular Medigap plans face extinction," Modern Healthcare, 6/27/16).

• Medicare's new physician payment system, MACRA (Medicare Access and CHIP Reauthorization Act of 2015, aka the "doc fix" bill), is expected to drive even greater consolidation among physician practices. MACRA's complex algorithm favors large group practices, including "virtual" ones, over small and independent practices. According to CMS projections, a majority of practices with fewer than 25 doctors (and 70 percent of practices with fewer than 10 physicians) will be financially penalized under the new merit-based incentive payment system (MIPS), while 80 percent of practices with 100 doctors or more will receive financial bonuses. The potential penalties and rewards start at up to 4 percent and rise as high as 27 percent of Medicare reimbursement in subsequent years. The law allows small practices to form "virtual groups" to spread performance evaluation across a larger number of physicians.

Physicians may opt-out of MIPS if they join an organization that qualifies as an "Alternative Payment Model" (APM) by bearing "downside risk," i.e. the organization is at risk of financial penalties if health care costs are too high. But few existing organizations qualify as APMs. Ninety-five percent of the 433 ACOs participating in Medicare's Shared Savings Program don't qualify because they have only signed up to receive bonuses if costs are low, not to be penalized if costs are high (Kutscher, "Physicians face stark choices under new Medicare pay proposal," 5/2/16).

A study of Medicare's hospital value-based purchasing (HVBP) program – the pay for performance program for Medicare – found it had no significant impact on 30-day mortality for acute myocardial infarction, heart failure, or pneumonia. The study included data on 2,430,618 patients admitted to 4,267 hospitals from 2008 through 2013 (before and after the HVBP began in 2011). It concluded that "nations considering similar pay-for-performance programs may want to consider alternative models to achieve improved patient outcomes" (Figueroa, "Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals," BMJ, 5/9/16).

GALLOPING TOWARD OLIGOPOLY

• Sutter Health, a giant nonprofit health system with more than 5,000 doctors, 24 hospitals, and 34 surgery centers in Northern California, is the subject of a lawsuit by the United Food and Commercial Workers and its Employers Benefits Trust accusing the giant health system of imposing anticompetitive terms and illegally inflated prices for health care. The joint union-employer health plan, administered by Blue Shield, represents more than 60,000 employees, dependents, and retirees. The lawsuit alleges that Sutter has used its market power to charge up to 56 percent more for hospital care in San Francisco than local competitors (Terhune, "Big California firms take on health care giant over cost of care," NPR Health News, 4/7/16).

• Anthem is creating another giant insurer-provider alliance, this time in Wisconsin. In 2014 Anthem's California branch partnered with seven Southern California health systems, including Cedars-Sinai and UCLA, to create an HMO, Vivity, to compete with Kaiser. Now Anthem is partnering with Aurora, a 15-hospital system based in Milwaukee, to create Wisconsin Collaborative Insurance Co. Aurora won't be the only provider in the network, but only Au-

rora and Anthem will split the profits 50-50. Aurora had revenue of $4.9 billion in 2015, with $462 million in operating income (Herman, "Anthem hatches another hospital joint venture, this time in Wisconsin," Modern Healthcare, 4/20/16).

Health care industry mergers and acquisitions jumped 14 percent in 2015, to a record 1,498 transactions. There were 112 hospital mergers in 2015, a 70 percent increase over 2010. The largest merger, of California-based St. Joseph Health and Washington-based Providence Health and Services, will create a nonprofit system with 50 hospitals and annual revenue of $18 billion. Hospitals and insurers both claim they need to get bigger to match the expanding size of the other – the "sumo wrestler theory" – and say consolidation is promoted by the ACA (Hiltzik, "Mergers in the healthcare sector: why you'll pay more," Los Angeles Times, 5/27/16).

• The Department of Justice (DOJ) has filed lawsuits to block Anthem's $54 billion purchase of Cigna and Aetna's $37 billion deal to buy Humana. The DOJ says the deals would hurt consumers by reducing competition in the Medicare Advantage market (particularly the Aetna-Humana merger) and in the ACA marketplaces, and reduce to three the number of companies with national networks big enough to serve the largest employers. Aetna and Humana said they plan to "vigorously defend" their merger to create a combined firm with more than 33 million enrollees and $115 billion in revenues.

Former Senate Majority Leader Tom Daschle registered as a lobbyist for Aetna earlier this year. The insurance giant, which needs approval from the Justice Department for its pending takeover of Humana, employed 25 former federal officials and spent $4.1 million lobbying the federal government last year. Aetna has also signed up five outside lobbying firms since mid-2015 with at least 15 more former federal officials, many with legal and antitrust experience (Sirota and Mindock, "Aetna hires Tom Daschle, other former government officials, as feds consider its merger with Humana," International Business Times, 4/11/16; Merle, "Justice Department sues to block two healthcare mega-mergers," Washington Post, 7/21/16).

Connecticut is supposed to lead states' anti-trust review of the Anthem-Cigna merger. But Connecticut Gov. Daniel Malloy is doing everything possible to push the merger though without public scrutiny. He appointed Katharine Wade – a former longtime Cigna executive who is married to a Cigna official – to be the state's Insurance Commissioner and recently signed legislation prohibiting the public release of insurance documents reviewed by the state. Anthem, Cigna, and the Connecticut Association of Health Plans spent more than $213,000 lobbying for the secrecy measure, which passed near midnight in the final moments of the 2016 legislative session (Sirota, "Cigna-Anthem Deal: Connecticut Gov. Malloy Signs Secrecy Bill," International Business Times, 6/13/16).

• Aetna's proposed takeover of Humana has run into opposition in Missouri, where the state's Department of Insurance prohibited the merged firm from competing in the individual, small group, and Medicare Advantage group markets. In addition, the insurer was barred from selling individual Medicaid Advantage plans in 65 of Missouri's 115 counties. A merged Aetna-Humana would control more than 70 percent of the Medicare Advantage market in 33 counties, according to state regulators (Demko, "Missouri's rebuke of Aetna-Humana deal could have nationwide reverberations," Politico Pro, 5/25/16).

VETERANS ADMINISTRATION

• Veterans' groups supported by the Koch brothers have been critical of the VA health system for not reducing wait times more quickly, and are pushing privatization. According to online wait times data, in October 2014 there were 355,396 veterans who waited more than 30 days for an appointment, 6 percent of the total number of veterans who sought care. In May 2016 there were 494,690 veterans waiting more than 30 days, 7.4 percent of the total. However, during that period the number of visits scheduled by the VA increased by nearly 800,000 per month, to 6.7 million. Despite this surge in patient demand, average wait times for primary care visits (6.8 days) and mental health care (4.3 days) remained stable. The average wait for specialty care rose slightly to 9.9 days, but there is no evidence that wait times are any lower in the private sector ("Pending appointments as of July 1, 2016," United States Department of Veterans Affairs).

CORPORATE MONEY AND CARE

• In the first half of 2016, the health care sector spent $266 million on lobbying, more than any other sector of the economy. The next four top spenders were business ($253 million), financial services ($240 million), communications ($187 million) and energy ($154 million) ("Lobbying by sector," Center for Responsive Politics (opensecrets.org), accessed 7/28/16).

• Indianapolis-based Anthem, which owns for-profit Blue Cross and Blue Shield plans in Colorado and 14 other states, gave $1 million to defeat ColoradoCare, a ballot initiative for universal (although not single-payer) coverage. Other major contributors to the $3.2 million opposition fund include two insurance companies, UnitedHealth ($450,000) and KP Financial Services ($500,000), as well as the lobbying group PhRMA ($100,000) and health system HealthOne ($100,000). Anthem's donation is higher than the entire amount raised by the ColoradoCare Yes campaign as of July, $636,000 ("Colorado State Health Care System Initiative, Amendment 69," Ballotpedia.org, accessed on 7/29/16).

• A dialysis firm is being sued for billing fraud. American Renal Associates, a chain of 200 for-profit dialysis facilities, persuaded Medicaid patients on dialysis in Florida and Ohio to sign up for UnitedHealthcare coverage because it reimbursed more for care, according to a suit brought by the giant insurer. Florida Medic-

aid pays around $200 for each dialysis treatment, while American Renal Associates billed UnitedHealthcare up to $4,000 per treatment for "out-of-network" care. The American Kidney Fund, a nonprofit "patient advocacy" group funded by dialysis companies, even paid the patients' private premiums. UnitedHealthcare says it was overbilled by millions of dollars and patients were exposed to unnecessary medical costs in the form of co-pays (Abelson and Thomas, "UnitedHealthcare sues dialysis chain over billing," New York Times, 7/1/16).

PHARMA

- Pfizer will pay $784.6 million, including $371 million to state Medicaid programs, to settle allegations of Medicaid fraud by its subsidiary Wyeth, which it purchased in 2009. Wyeth allegedly bundled discounts on its proton pump inhibitor drugs, Protonix Oral and Protonix IV, to encourage hospitals to use Protonix Oral, without reporting those discounts to Medicaid (Schencker, "Pfizer finalizes $784 million settlement over Medicaid rebates," Modern Healthcare, 4/27/16).

- An Oxford, Miss., consultant to the pharmaceutical industry, Mick Kolassa of Medical Marketing Economics, is credited with the strategy of pricing drugs according to the "value" they provide society, rather than the cost to produce them, thereby justifying swift and dramatic price increases. Kolassa wrote in "The Strategic Pricing of Pharmaceuticals" that "It is theoretically possible to set a price that is too high. We have yet to identify such a situation in the U.S. market" (Langreth, "The Blues Singer who created America's hated drug pricing model," Bloomberg, 5/3/16).

- Many patients skip doses of insulin to save money. Between 2013 and 2016 the retail price of three popular forms of insulin, Sanofi's Lantus, Novo Nordisk's Novolog, and Eli Lilly's Humulin R, increased by about 60 percent, to $381, $466, and $139 per month, respectively. In Europe, where governments negotiate prices with drug companies, insulin costs a small fraction of what it does in the U.S. There is no generic for insulin. Lilly's biosimilar for Lantus (insulin glargine), Blasagar, was approved earlier this year but is only expected to cost about 15 percent less. Three giant pharmacy benefit managers – Express Scripts, CVS Health, and Optum Rx – negotiate drug prices for over half of Americans. Industry analysts estimate that "rebates" from drug manufacturers, and other backroom deals, amount to as much as 50 percent of the list price of insulin (Lipska, "Break up the insulin racket," New York Times, 2/20/16; goodrx.com/insulins accessed on 8/2/16).

- Californians will vote on a ballot initiative this November requiring state agencies to pay the same low prices as the U.S. Department of Veterans Affairs for prescription drugs. The California Drug Price Relief Initiative, Prop. 61, was put on the ballot by a citizen initiative drive supported by the AIDS Healthcare Foundation. The VA pays about 42 percent of the market price for drugs, while Medi-Cal currently pays about 51 percent. As of July 6, supporters had raised $9.5 million, primarily from the AIDS Healthcare Foundation and the California Nurses Association, while opponents had raised $69.4 million, almost entirely from 10 giant pharmaceutical companies ("California Drug Price Relief Initiative, 2016," Ballotpedia.org, accessed on 7/13/16).

In 2015, just as California began debating an aid-in-dying law, Valeant Pharmaceuticals acquired secobarbital, the drug most commonly used in physician-assisted death, and immediately doubled its price to $3,000 for a lethal dose of 100 capsules. In 2009 a lethal dose of the drug cost less than $200. Secobarbital was originally developed in the 1930s and is simple to manufacture (Dembrosky, "Pharmaceutical companies hiked price on aid in dying drug," KQED, 3/22/16).

INTERNATIONAL

- Private insurance exists in Europe, but pays for only a small share of health expenditures. According to a new study, private "voluntary health insurance" accounts for less than 5 percent of total spending in 42 out of 53 nations in the European region. In the U.K., about 9 percent of the population has private insurance that supplements their coverage by the National Health Service, but it accounts for only 3.4 percent of total health spending. Germans earning over about $65,000 annually are allowed to opt-out of their public system. In Germany, about 11 percent of people have private coverage, mostly as a substitute for the public system, but it accounts for just 8.9 percent of total spending. In France, 90 percent of the population has supplementary private insurance (which is publicly subsidized for people with low incomes), mostly to cover co-pays, but private insurance only accounts for 13.3 percent of total health spending. The former Soviet republic of Georgia has the highest share of total spending channeled through private insurance, 19.2 percent (Sagan and Thompson, "Voluntary health insurance in Europe: role and regulation," European Observatory on Health Systems and Policies, 2016).

- The U.S. pressured the South American nation of Colombia not to issue a compulsory license to manufacture imatinib, a generic version of Novartis' Gleevac cancer medicine. Everett Eissenstat, an aide to the U.S. Senate Finance Committee, and staff from the United States Trade Representative's office warned Colombian officials that issuing a compulsory license (allowing a generic manufacturer to make a brand name medicine without the consent of the patent holder) might jeopardize $450 million in U.S. funding for a peace effort as well as backing for a free-trade agreement. Novartis, a Swiss firm, also refused to negotiate a lower price, so Colombian regulators plan to make a "public interest declaration" and set one unilaterally (Jilani, "Leaks show Senate aide threat," The Intercept, 5/14/16; Goodman and Johnson, "Colombia battles world's biggest drugmaker over cancer drug," AP, 5/18/16; Cobb and Acosta, "Colombia to set new price for Novartis cancer drug: minister," Reuters, 6/9/16).

GALLUP POLL FINDS 58% OF AMERICANS SUPPORT SINGLE PAYER

A new Gallup poll finds that 58 percent of Americans favor replacing the ACA with a "federally funded healthcare program providing insurance for all Americans," including 73 percent of Democrats and 41 percent of Republicans. The overall support for a federally funded health care program was higher than support for keeping the ACA in place (48 percent) or repealing the ACA (51 percent). A federally funded program was also favored by a 2:1 ratio over keeping the ACA, 64 percent to 32 percent, when supporters of both were asked to choose. **Strikingly, more than twice as many Republicans favored replacing the ACA with a federal health care program as keeping the ACA in place (16 percent).** The poll found broad support for single payer among ACA supporters: 72 percent of Americans who approve of the ACA would also favor replacing it with a federally funded program. But there is significant support for single payer among those who favor repealing the ACA too: 27 percent of Americans who favor repealing the ACA say they favor replacing it with a federally funded program. The "bottom line" according to Gallup: "Americans express considerable support for the idea of replacing the ACA with a federally run national healthcare system, which is similar to the proposal championed by presidential candidate Sanders" (Newport, "Majority in U.S. support idea of fed-funded healthcare system," Gallup, 5/16/16).

SELECTED PRESIDENTIAL CANDIDATES' HEALTH PROPOSALS

- Hillary Clinton (Democrat) supports "building on" the ACA and expanding access to care by doubling funding for community health centers to $40 billion over 10 years, funding 100 percent of the cost of expanding Medicaid for the first three years in non-expansion states, and investing $500 million in Medicaid enrollment outreach. She would also mitigate some of the ACA's gaps by providing a $5,000 refundable tax credit to offset out-of-pocket costs exceeding 5 percent of household income, requiring insurers to cover three doctor visits a year before applying the deductible, fixing the "family glitch" so the uninsured can get subsidized ACA family coverage when their employer's plan is too expensive, and using Medicare's bargaining power to negotiate lower prices for some high-cost drugs. In sum, her policies would expand coverage, particularly to some of the 5 million uninsured, low-income people in states that haven't expanded Medicaid coverage, and assist some of the underinsured with out-of-pocket costs, but would fall far short of affordable, universal coverage. Two of her proposals, allowing people over 55 to buy into Medicare, and giving states permission to set up "public options" on their exchanges, might give some of the uninsured an additional choice but would not make health care more affordable or expand coverage.

- Donald Trump (Republican) proposes to repeal the ACA and adopt "free market" approaches to health care, such as expanding the use of health savings accounts, increasing "competition" by allowing the sale of insurance plans across state lines (something insurers can already do), and making health insurance tax-deductible for individuals. He would also block-grant Medicaid, allowing states to charge premiums and put up other barriers to access, such as running mate Gov. Mike Pence did with the Medicaid expansion in Indiana. In sum, Trump's policies would increase the number of uninsured by 20 million people and exacerbate the health care crisis. In addition, Pence, senior Trump campaign staffer Sam Clovis, and House Republicans led by Paul Ryan, R-Wis., have all called for turning Medicare into a "premium support" or voucher program, paving the way for Trump to sign on after the election. Pence also favors banning abortion and defunding Planned Parenthood, measures that would severely restrict access to safe reproductive health care for women, especially the poor.

- Dr. Jill Stein (Green) supports single-payer national health insurance and negotiating drug prices with pharmaceutical companies. Her proposal, similar to PNHP's Physicians Proposal for Single-Payer Health Reform, would provide affordable, universal coverage and control health care costs.

- Gary Johnson (Libertarian) favors repealing the ACA and Medicare Part D, along with block-granting Medicare and Medicare to the states while cutting their funding by 43 percent. His policies would raise the number of uninsured by 20 million and jeopardize access to care for Medicaid and Medicare recipients nationwide.

PNHP note: The above proposals were drawn from the candidates' websites, public statements, and news accounts.

Physicians for a National Health Program (PNHP) is a nonpartisan educational and research organization. It neither supports nor opposes any candidate for public office or any political party.

MAY 12, 2016

Doctors' single-payer prescription for health care reform

By Steffie Woolhandler, M.D., M.P.H. & David U. Himmelstein, M.D.

Many months before Bernie Sanders entered the presidential race, we (along with Dr. Adam Gaffney, an energetic younger colleague, and Dr. Marcia Angell, the former editor of the New England Journal of Medicine) convened a nonpartisan group of 39 leading physicians to envision health care reforms that would fix the glaring problems that remain despite the Affordable Care Act (ACA).

After the Supreme Court removed the final roadblock to the law in 2015, President Obama declared that at last "in America, health care is not a privilege for a few, but a right for all." Yet doctors on the ground knew that wasn't entirely true. We continue to see patients who dangerously delay their care because of cost concerns or insurance obstacles.

At least 27 million Americans remain uninsured, and for tens of millions with insurance, sky-high copayments and deductibles (which average $5,300 in the bronze plans sold on the ACA exchanges) mean they'd be bankrupted by a serious illness. Many more people have narrow network coverage that won't pay for care at top cancer centers or academic hospitals.

Meanwhile, giant insurers and hospital conglomerates with a single-minded focus on their bottom line increasingly dominate health care. And doctors and nurses contend with insurers' growing demands for mind-numbing electronic documentation. These trends predated the ACA, but the law accelerated them. The ACA has also fueled medical merger-mania and the health system's administrative complexity and cost.

The alternative we and our colleagues developed (which has now been endorsed by 2,227 other physician colleagues) appears in the current issue of the American Journal of Public Health. It calls for radical change: a single-payer national health program, essentially an expanded and improved version of Medicare for all, much along the lines that Bernie Sanders has advocated.

The single-payer plan we propose would cover everyone for all medically necessary care – including dental care, prescription drugs and long-term care – without copayments or deductibles. In contrast to private insurers' narrow networks that restrict patients' choice of doctors and hospitals, the single payer would cover care from any doctor or hospital.

Our nation can readily afford such expanded and improved coverage if we replace the current wasteful patchwork of insurers with a streamlined single-payer system. At present, private insurers' take 12.3 percent of total premiums for their overhead; only 88 cents of every premium dollar ever reaches a doctor, hospital or pharmacy. And insurers inflict massive paperwork on doctors and hospitals, which spend about one-quarter of their revenues on billing and administration.

In contrast, insurance overhead is only 1.8 percent in Canada's single-payer system, about the same overhead as in our Medicare program. And Canadian hospitals have administrative costs less than half those of their U.S. counterparts. That's because Canadian hospitals are paid annual global budgets, like U.S. fire departments, instead of billing separately for each Band-Aid and aspirin tablet. Billing is also simple and inexpensive for Canadian physicians.

Overall, a single payer would save about $500 billion annually by trimming administrative spending to Canadian levels. Moreover, as in other nations, the single payer could use its purchasing power to lower drug prices, saving tens of billions more each year. These savings could fully cover the new costs of the coverage expansions we propose, a conclusion in keeping with past estimates by the Government Accountability Office, the Congressional Budget Office, and private consulting groups (including one that's owned by an insurance company).

Our nation can readily afford such expanded and improved coverage if we replace the current wasteful patchwork of insurers with a streamlined single-payer system.

Contrary claims, including those contained in a report published by the Urban Institute this week, are fraught with flawed assumptions and grossly underestimate the savings a single-payer system would assure.

We and our colleagues recognize that, despite widespread public support for Medicare for all, passage of our proposal is unlikely absent sweeping changes in the makeup of Congress. But the same can be said about any salutary health reform; Congress has resisted even modest tweaks to the ACA.

Yet as physicians we feel obliged to offer our best advice. Our health care crisis can be solved. We have the resources needed to provide excellent care for all Americans; an abundance of hospitals and sophisticated equipment; superbly trained doctors and nurses; prodigious research output; and generous health care funding. Yet only thoroughgoing single-payer reform can realize the healing potential that is currently thwarted by our dysfunctional health care financing system.

The authors are internists who teach at the City University of New York at Hunter College and Harvard Medical School. They co-founded Physicians for a National Health Program, a nonpartisan organization that advocates single-payer reform.

The Charlotte Observer

MAY 5, 2016

Obamacare is flawed, but there is a solution

By Jessica Schorr Saxe, M.D.

Why, in the age of the Affordable Care Act, would a large, respected group of physicians develop A Physicians' Proposal for Single-Payer Health Care Reform? On Thursday, this document was released by a panel at the National Press Club and published online in the American Journal of Public Health.

Are you or someone you know forgoing medical care for financial reasons, having trouble with medical bills, being forced to change providers due to network problems, or reeling from arbitrary increases in premiums or deductibles? If so, you know the ACA has drawbacks.

While the ACA has increased access to health care, it falls short in achieving the goals of making care available and affordable to all and controlling costs.

Dr. Jessica Schorr Saxe

Although millions have gained insurance, the Congressional Budget Office estimates 28 million Americans will remain uninsured in 10 years when the law is fully operational.

Additionally, underinsurance is an increasing, often overlooked problem. The underinsured are those who, despite coverage, are not able to afford their deductibles or out-of-pocket costs. According to the Commonwealth Fund, this included 21 percent of adults below Medicare age in 2014. More than one-third of Americans did not get needed care due to financial barriers, and more than one-third have trouble paying a medical bill.

Free clinics, which expected declining numbers after the ACA, are seeing an influx of insured patients who cannot afford copays or deductibles.

Though health care inflation was relatively low for a few years, it is now rising. Currently at about 18 percent of gross domestic product (about twice that of most other developed countries), health care is projected to reach almost 20 percent by 2024.

The Congressional Budget Office estimates 28 million Americans will remain uninsured in 10 years when the Affordable Care Act is fully operational.

Administrative costs consume an inordinate amount of our health care budget. Bureaucracy plagues providers and patients. If the forms now contained in the electronic record were hard copies, physicians would be crushed under their weight.

Surely we can agree that Americans are entitled to better care. The Physicians Proposal outlines a better course.

A single-payer health care system, sometimes referred to as Expanded and Improved Medicare for All, would provide comprehensive health care with no deductibles or co-pays. Financing would be federal, much like current Medicare, and paid for largely through progressive taxes. Even those who consider raising taxes anathema would likely be pleasantly surprised to find these taxes are more than offset by reductions in premiums, copays and other medical expenses.

Expanded (covering more people) and Improved (more comprehensive) services would be made possible by savings in many areas. Administrative costs would plummet by eliminating private insurance companies, the expensive middle men that siphon off dollars that could otherwise be spent on actual health care. Cutting administrative costs to the level of Canada would save about $500 billion annually.

The National Health Plan would negotiate pharmaceutical prices, as do other countries, yielding further and extensive savings. For-profit hospitals and clinics, documented to be of poorer quality and more expensive, would be prohibited.

Single-payer health care is a financing mechanism. Current private hospitals and practices would continue to deliver health care, much as they do now, except that they would submit bills to a single entity. With a unified system, there would be no more separate networks. The opportunity to choose providers and relief from financial barriers would strengthen the currently endangered physician-patient relationship.

Critics insist widespread opposition is an obstacle. In fact, polls show rising support. In 2008, a national survey showed that 59 percent of physicians supported a national health insurance plan, and in December 2015, a Kaiser poll indicated that 58 percent of Americans support Medicare for All. As both physicians and patients feel more beleaguered by our current system, expect those numbers to rise.

Can we afford it? Yes. And, given current trends, we cannot afford to delay its implementation.

If you are or know an individual suffering from lack of access, oppressive medical bills, unbearable bureaucracy, or fear of your own rising medical costs or the collective burden on the U.S. economy, you, too, should support a single-payer health care system.

Dr. Jessica Schorr Saxe is chair of Health Care Justice-NC, a chapter of Physicians for a National Health Program. Email: ***HCJusticeNC@gmail.com****. The Physicians Proposal is available at:* ***pnhp.org/nhi****.*

may 7, 2016

Doctors agree with Sanders on universal health care: Dr. Adam Gaffney on the Physicians' Proposal for Single-Payer Reform

By Viji Sundaram

Presidential hopefuls have their own ideas on what to do with the Affordable Care Act (ACA), President Obama's signature legislation, when they move into the White House.

Sen. Bernie Sanders thinks it should be replaced with a single-payer health plan of the kind Europe and Canada have. This federally administered universal health care program would eliminate copays and deductibles. There's currently a move afoot in Colorado to have such a plan. Secretary Hillary Clinton would like to keep the ACA, with a few fixes.

Dr. Adam Gaffney

Donald Trump says he will uproot the ACA, get Congress to allow the sale of health insurance across state lines and allow individuals to take tax deductions for insurance premium payments. But that would not help low-income Americans because they do not pay much in income taxes.

This week, the American Journal of Public Health carried a proposal by a working group of more than 2,000 physicians nationwide titled: Moving Forward from the Affordable Care Act to a Single-Payer system. The physicans warn that the risks of continuing the ACA will leave millions uninsured indefinitely.

NAM health editor Viji Sundaram interviewed Dr. Adam Gaffney, a co-chair of the working group.

Your proposal calls for a single-payer health care plan for the United States. Obamacare has helped 16.9 million people become newly insured. Would it not be less disruptive to expand the provisions in the ACA instead of repealing the law and replacing it?

The U.S. health system is highly disruptive as things stand now. You're liable to lose your insurance at any time – for instance, if you change your job or get divorced. Similarly, those purchasing plans on the "marketplaces" may find that they can keep down premium increases by changing plans on an annual basis. Every time your insurance plan changes, you may need to change all of your doctors and hospitals in order to stay "in network." This is enormously disruptive to people's health care. In contrast, in a single-payer system, everyone has free choice of doctors and hospitals.

Your proposal promises health coverage for all. Does this include undocumented U.S. residents?

Yes, it would. The single-payer national health program we envision would include everyone regardless of country of origin, including undocumented residents. If we believe that health care is truly a human right, then this is the right thing to do. At the same time, it is also financially achievable. Immigrants, on average, have lower health care spending as compared to those born in the United States. One study demonstrated that immigrants actually pay more into Medicare than what they use in terms of health care. Everyone would be included in the national health program we envision.

Why do you think there would be no additional government spending if the United States has a single-payer health care plan? Countries such as Canada and the England run their national health program on the backs of taxpayers. Will that happen in the United States as well? Can it be done without raising taxes?

There would be additional government spending with a single-payer plan, but this would be offset by the elimination of spending by individuals and employers on premiums, co-payments, and deductibles. We can expand coverage to everyone in the country and eliminate co-payments and deductibles, and at the same time keep overall current health care spending roughly unchanged.

Some providers criticize single-payer plan as one that will force them to contract with the one payer available. Currently, providers have some choice of insurers. They can even opt out of Medicare and Medicaid.

There are many benefits for practices to have to contract with only one payer: it's much simpler and is less costly from an administrative perspective.

How would you respond to the criticism of the single payer program as having the capacity to get doctors to sign in with fairly attractive reimbursement rates, but once in, those rates can come down, leaving providers helpless?

Because the vast majority of the nation's doctors would participate in the national health program, there would be a powerful lobby fighting to ensure that reimbursements remain fair.

In countries that have a single-payer health care system, there seems to be a long waiting period before a patient can see a doctor. How can we keep that from happening in this country?

The problem of waiting times for care in other nations is often exaggerated. Moreover, where there are excessive waiting times for elective procedures, it is often due to underinvestment. We spend much more than other countries on health care, and have the resources to ensure that waiting times for elective procedures are reasonable. It's also worth noting that we have waiting times in the United States also, though they are not as visible. Indeed, if you have the wrong insurance plan [currently], the waiting time for some providers may, so to speak, be infinite.

The UK allows people to be in both the national health plan as well as subscribe to a private insurance plan, which they can fall back on for expedited care. But your plan calls for an

(continued on next page)

MAY 10, 2016

Why some doctors want the government to handle all health insurance

By Baylee Pulliam

There are a lot of ways to get health insurance – but not everyone does.

Right now, there are multiple payers, including private companies and the federal government. But a new proposal from the Physicians for a National Health Program advocacy group suggests there should be only one.

Proponents in Louisville rallied Tuesday near the University of Louisville School of Medicine to discuss the proposal, which calls for all health insurance to be administered by the federal government – the "single-payer" – as Medicare is now.

So far, the proposal so far has signatures from more than 2,200 physicians and 149 students across the country.

Under the proposal, everyone would get a National Health Program (NHP) card, which they could use to get care at any doctor's office or hospital, with no bills or co-pays for covered services. (Democratic presidential candidate Bernie Sanders also has supported a similar payer plan.)

PNHP also says a single-payer system would reduce overhead for health care providers, who now have to employ additional staff and spend more time filling out paper work and tracking down insurance information from multiple sources.

Because the providers would spend less to provide care, they could charge less, which would make it more affordable for the federal government to provide coverage, according to PNHP.

PNHP says that if the U.S. had the same level of per capita health care spending as Canada, which uses a similar system, it would free up about $500 billion per year toward the cost of providing that care.

But, of course, if the government is the single payer, there's the question of what happens to private insurers such as Louisville's Humana Inc.

That's still not clear, but Dr. Barbara Casper, professor at the U of L School of Medicine and a supporter of the PNHP proposal, said there are a few possibilities. One is that they go away entirely, and their employees could be retrained for new jobs or go to work for the government.

Another possibility is that they continue to exist, but offer optional, additional coverage for those who choose to buy it.

The idea behind the plan is to give everyone access to the same basic health care coverage, Casper said.

Casper, who has practiced medicine for 34 years, said more people have coverage since the Affordable Care Act was passed. "But I've still admitted three patients today who had no insurance."

A national health plan also would lessen the burden on employers, some of which are opting to pay the $2,000 penalty for not providing coverage to their workforces because that costs less.

"Businesses don't provide car insurance," said Dr. Syed Quadri, a private practice internist from Elizabethtown and supporter of PNHP. "Why should they provide health insurance? When businesses are free from this task, they can focus on business."

Baylee Pulliam covers these beats: health care, health insurance, media/marketing and technology.

(***Gaffney interview,*** *continued from previous page)*

end to commercial insurance.

First, if providers must bill and contend with multiple different insurance plans, we lose the efficiency savings that come with a single universal system. Second, if we give the rich preferential access to superior and expedited care while relegating everyone else to an inferior tier, we make a mockery of the idea of an equal right to health care. Third, the best way to ensure that the quality of health care is superb is having everybody – whether rich or poor – in the same system together.

Medicaid and Medicare depend on the cost shift from private payers. Some providers say the only way doctors are willing to get into the Medicare network is because they get higher payment from commercial insurers.

Doctors would continue to do well under a Medicare-for-All system. The transition to a single-payer system would eliminate the need to bill and contend with a multiplicity of payers, producing substantial savings for practices (and hospitals).

How much could the United States save by switching to a single-payer health plan? What does it currently spend?

It is estimated that upwards of $400 billion a year could be saved from reduced spending on administration and billing that would occur through the transition to a single-payer plan. Additional money could be saved when the national health program enters into direct negotiations with pharmaceutical companies over drug prices. These savings could then be used to cover everybody in the country, while at the same time eliminating copayments and deductibles. Overall health care spending, at the end of the day, would be approximately the same as it is now, but nobody would ever again have to worry about losing insurance, about paying a big deductible if they got sick, or about not having access to the doctor or hospital of their choice.

Dr. Adam Gaffney, M.D. is in the Pulmonary and Critical Care Fellowship Program at Massachusetts General Hospital.

MAY 15, 2016

Why American doctors are calling for Canadian-style medicare

By Karen Palmer

In a dramatic show of physician support for deep health care reform in the U.S., more than 2,200 physician leaders have signed a "Physician's Proposal" calling for sweeping change.

The proposal, published May 5, 2016, in the American Journal of Public Health, calls for the creation of a publicly financed, single-payer, national health program to cover all Americans for all medically necessary care.

If that sounds familiar, it should. These American doctors are calling for Canadian-style medicare. They want a decisive break from the expensive and inefficient private insurance industry at the heart of the U.S. health care system.

Karen Palmer

How ironic that at the same time U.S. physicians are calling for a single-payer health system like ours, Canada is in the midst of a legal battle threatening to pave the way for a multi-payer system resembling what has failed Americans.

What's at stake? A trial about to begin in British Columbia threatens to make the Canada Health Act unenforceable.

The Canada Health Act is federal legislation that guides our health care system. It strongly discourages private payment for medically necessary hospital and physician services covered under our publicly funded medicare plans. This includes out-of-pocket payments in the form of extra billing or other user charges. Legislation in most provinces further prohibits private insurance that duplicates what is already covered under provincial plans.

If patients are billed for medically necessary hospital and physician care, the federal government is mandated to withhold an equivalent amount from federal cash transfers to provinces or territories violating the Act.

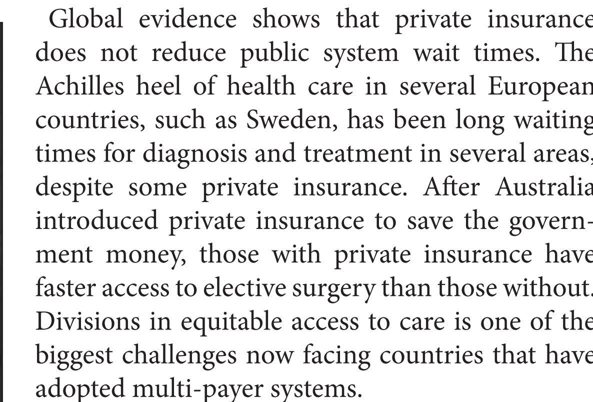
At least that's what supposed to happen.

Unfortunately, the last decade saw a proliferation of extra billing in several provinces, and few instances of government clawing back fiscal transfers. Perhaps, things will change. Health Minister Jane Philpott recently said the government will "absolutely uphold the Canada Health Act."

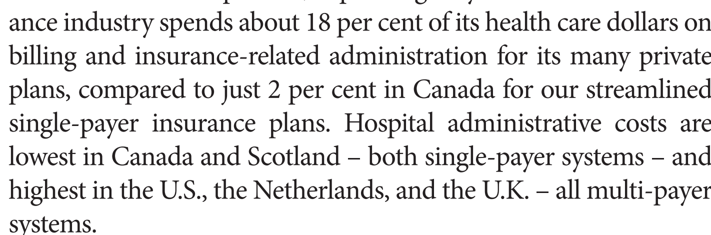
In B.C.'s upcoming trial, the plaintiffs – including two for-profit investor-owned facilities, Cambie Surgery Centre and the Specialist Referral Clinic – are attempting to have the court strike down limits on private payment. They support the creation of a constitutionally protected right for physicians to bill patients, either out-of-pocket or through private insurance, for medically necessary care, while also billing the public plan.

In other words, the plaintiffs want to undo our elegantly simple single-payer system for hospital and physician care, creating instead a multi-payer system like the U.S. If their constitutional challenge is successful, the door will swing wide open in BC – and across Canada – for insurers to sell what will amount to "private queue jumping insurance" for those who can afford it, potentially harming the rest of us who can't.

The outcome of this trial could be that those who can pay for care would jump the queue, drawing doctors and other resources out of the public system. Those who can't pay would likely wait longer. Rather than a solution for wait times, private payment in the Canadian context would make them worse.



Global evidence shows that private insurance does not reduce public system wait times. The Achilles heel of health care in several European countries, such as Sweden, has been long waiting times for diagnosis and treatment in several areas, despite some private insurance. After Australia introduced private insurance to save the government money, those with private insurance have faster access to elective surgery than those without. Divisions in equitable access to care is one of the biggest challenges now facing countries that have adopted multi-payer systems.



Multi-payer systems are administratively complex and expensive, explaining why the U.S. health insurance industry spends about 18 per cent of its health care dollars on billing and insurance-related administration for its many private plans, compared to just 2 per cent in Canada for our streamlined single-payer insurance plans. Hospital administrative costs are lowest in Canada and Scotland – both single-payer systems – and highest in the U.S., the Netherlands, and the U.K. – all multi-payer systems.

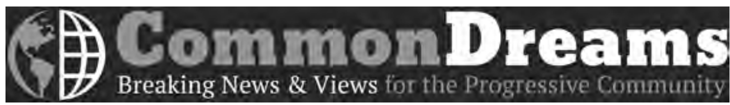
For all of its warts in how we deliver health care in Canada, the way in which we pay for care – a single public payer in each province or territory – avoids the high administrative costs of multi-payer systems.

Abundant evidence shows private insurance is at the root of what ails the U.S. system. Dr. Marcia Angell, co-author of the Physicians' Proposal, Harvard Medical School faculty and former editor-in-chief of the New England Journal of Medicine, sums it up: "We can no longer afford to waste the vast resources we do on the administrative costs, executive salaries, and profiteering of the private insurance system."

A Canadian-style single-payer financing system would save the U.S. about $500 billion annually.

Meanwhile, in Canada, abandoning our single-payer health care system for a U.S.-style multi-payer system would be the worst possible outcome for Canadians. Let's hope the evidence convinces the judge. The trial begins in September.

Karen Palmer is an advisor with EvidenceNetwork.ca, a health policy analyst, and adjunct professor in the Faculty of Health Sciences at Simon Fraser University.



MAY 15, 2016

Medical student prescribes remedy our sick system needs

By Emily Kirchner

I am a fourth-year medical student. I've dreamed about being a physician since I was in sixth grade. For a long time, my deepest hopes were to get into college, be accepted by a medical school, and maintain the grades and test scores needed to keep me there. My clinical rotations have taken me to hospitals across the state of Pennsylvania – from Pittsburgh's North Side to North Philadelphia with stops in rural and suburban communities in between. Now I'm less than a year away from obtaining my medical degree.

Despite many hours of study and months on the hospital wards, I don't feel any closer to practicing the kind of medicine I've always dreamed about than when I watched my first episode of "ER."

That's because I now understand that I won't be able to take care of patients the way they – or I – would like.

How so? Although we're living in a time and place where we have more ways than ever before to treat illness, our health care system is broken. It's clear to me that the current system is set up to make profits for corporate shareholders, not to keep people healthy.

Right now, we are paying exorbitantly – the highest per capita expenditure in the world – for a health care system that leaves too many people out. Even after the Affordable Care Act is fully implemented, 28 million people will still be uninsured in 2026, according to the Congressional Budget Office.

Further, the specter of under-insurance, where insured individuals' out-of-pocket medical costs are more than 10 percent of their income, is rising. Premiums, deductibles and co-pays are going up, deterring people from seeking needed care and exposing them to the danger of medical bankruptcy.

This very expensive system is also ineffective. I met a patient who first lost her energy, then her appetite, then her hair, and then her insurance in the middle of cancer treatment. She finally lost her oncologist because the latter did not accept Medicaid.

This is the only way to keep everyone healthy, and to do it efficiently.

I've met parents who guiltily admit they can't afford their own medicine and use their children's inhalers when they can't breathe. I'm trained to ask if patients are taking their medicines and then to follow up: "Do you ever have trouble affording your medications?"

I've watched the extent of insurance coverage determine treatment decisions for patients injured in car accidents. Or whether a patient with mental health problems gets treated at all.

So today I'm pouring my energy into a new dream: to practice medicine in a health care system where everyone gets covered for all medically necessary care. I want to help bring about a single-payer, national health insurance program.

This is not pie in the sky. Last month, the nonprofit Physicians for a National Health Program released "Beyond the Affordable Care Act: A Physicians' Proposal for Single-Payer Health Care Reform" in the pages of the American Journal of Public Health. The proposal is endorsed by more than 2,200 physicians in all specialties.

Emily Kirchner

Under the proposal, everyone will be covered by a publicly financed, nonprofit national health program, or NHP, for both outpatient and inpatient care, as well as rehabilitation, mental health services, long-term care, dental care, and prescriptions.

And it's affordable. By replacing our redundant, complex private insurance bureaucracy with a single, nonprofit, streamlined program, we'll reap savings of roughly $500 billion a year. That's enough to improve and expand coverage to all – i.e. to eliminate the problems of uninsurance and under-insurance, and eliminate all co-pays and deductibles – without any increase in total health care spending.

The new system will be able to rein in costs. Much like we currently fund fire departments, the NHP will pay global, lump-sum budgets to hospitals, clinics, and nursing homes, rather than charging for each aspirin tablet.

Physicians will be paid based on a fee-for-service schedule covering all patients or by salary. The NHP, as a single buyer, will negotiate prices with drug companies, just like other countries already do, reaping additional savings.

We can finance this program by combining all current sources of government health spending, which already accounts for 64.3 percent of the country's health bill, with modest new taxes based on ability to pay. Ninety-five percent of all households would save money, according to one study.

This is not a government takeover; this is the people reclaiming control over their own health care. This is the only way to keep everyone healthy, and to do it efficiently.

This is the plan I want for my patients, for my family, for myself. Based on recent polls showing solid majority support for "Medicare for All," I'm obviously not alone. We should implement this remedy without delay.

Emily Kirchner is a medical student at Lewis Katz School of Medicine at Temple University. She is a student member of the Board of Directors of Physicians for a National Health Program, and is also active in Students for a National Health Program.

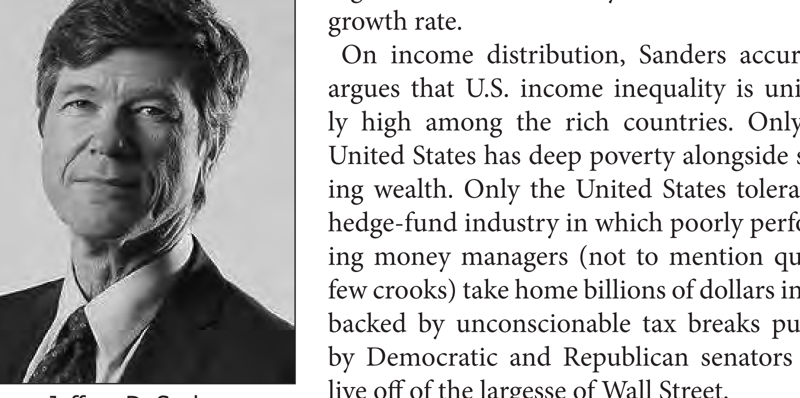
The Washington Post

MAY 25, 2016

Bernie Sanders easily wins the policy debate

By Jeffrey D. Sachs

Mainstream U.S. economists have criticized Democratic presidential candidate Bernie Sanders's proposals as unworkable, but these economists betray the status quo bias of their economic models and professional experience. It's been decades since the United States had a progressive economic strategy, and mainstream economists have forgotten what one can deliver. In fact, Sanders's recipes are supported by overwhelming evidence – notably from countries that already follow the policies he advocates. On health care, growth and income inequality, Sanders wins the policy debate hands down.


Jeffrey D. Sachs

On health care, Sanders's proposal for a single-payer system has been roundly attacked as too expensive. His campaign (for which I briefly served as a foreign policy adviser) is told that his plan will raise taxes and burst the budget. But this attack misses the whole point of his health proposals. While health spending by the government would go up in the Sanders health plan, private insurance payments would disappear, generating huge net savings for the American people.

Countries such as Canada, Germany, Sweden and Britain all follow something like a single-payer approach and pay much less for health care than the United States does. While the United States spent 16.4 percent of gross domestic product on health care in 2013, Canada paid only 10.2 percent; Germany, 11 percent; Sweden, 11 percent; and Britain, 8.5 percent. U.S. overspending is about 5 percent of GDP, or nearly $1 trillion as of 2016, mainly because of the excessive market power of private health insurers and big drug companies. An authoritative study by the U.S. Institute of Medicine confirms this extent of excess costs, finding losses of about 5 percent of GDP in 2009. Critics of Sanders's health plan have failed to recognize or acknowledge the huge savings and cost reductions that would accompany a single-payer system.

On economic growth, Sanders also easily wins the debate. While President Obama opted for a short-term stimulus that peaked after two years and disappeared by the end of his first term, and Hillary Clinton has proposed a modest infrastructure program over five years, Sanders calls for a much bolder public investment program directed at the skills of young people (through free college tuition) and at modernizing and upgrading America's infrastructure, with a focus on renewable energy, high-speed rail, safe drinking water and urban public transport. Sanders's growth strategy would get back to fundamentals: a long-overdue increase in productive investments to underpin good jobs and rising worker productivity.

Sanders's mainstream critics are mostly Keynesians. Their focus is on total spending, whether it's consumption or investment. Sanders, instead, focuses on investment because long-term growth depends on more rapid capital accumulation (including in skills and technology). America's slow growth is no mystery. The U.S. net investment rate has declined to about 5 percent of GDP, down from about 10 percent of GDP during the 1960s and 1970s. Sanders's plan would restore a high-investment economy and, with it, a higher growth rate.

On income distribution, Sanders accurately argues that U.S. income inequality is uniquely high among the rich countries. Only the United States has deep poverty alongside soaring wealth. Only the United States tolerates a hedge-fund industry in which poorly performing money managers (not to mention quite a few crooks) take home billions of dollars in pay, backed by unconscionable tax breaks pushed by Democratic and Republican senators who live off of the largesse of Wall Street.

Consider the most basic measure of income inequality, the Gini coefficient. This measures the inequality of income among households, with zero signifying complete equality and 1 complete inequality. For high-income countries, a Gini coefficient below 0.3 reflects a low degree of income inequality; between 0.3 and 0.4, a moderate degree; and at 0.4 or above, a high degree. According to the most recent data from the Organization for Economic Cooperation and Development, the U.S. Gini coefficient stood at 0.40, with Canada at 0.32; Germany, 0.29; Sweden, 0.27; and Britain, 0.35.

What accounts for this striking difference? Most important, U.S. inequality has soared in the past 35 years, since the start of the Reagan era. The U.S. Gini coefficient stood at 0.31 in 1980. All countries have faced market pressures pushing toward more inequality – especially increased trade with low-wage countries such as China and automation that has claimed the jobs and wages of workers with only high school educations. Yet only in the United States have these pressures turned into massive inequality of income.

The reasons are clear. The United States unleashed the power of CEOs to enrich themselves with mega-salaries, weakened trade unions and gave massive tax breaks to the super-rich. Sanders's policies would go after all of these unconscionable moves, bringing the United States back into line with the rest of the high-income world. He would, in short, end the age of impunity in which the rich and the powerful get their way, while the

(continued on next page)

Single Payer News

JUNE 20, 2016

Thousands rally as 22,000 miners face cutoff of health benefits

LEXINGTON, Ky. – Over 5,000 miners rallied here last Tuesday to protest health benefit cuts threatened to happen before the end of the year. Responding to the call of their union, United Mine Workers of America (UMWA), miners came from seven states to gather at the convention center. Some arrived with walkers, canes, wheel chairs, and oxygen tanks, giving tangible evidence of the toll on human health inflicted by the mining industry.

The UMWA reports that 22,000 retired union miners, widows or dependents would lose health care benefits at the end of the year if federal legislation they are backing isn't enacted this year. Retirement benefits are also at risk.

UMWA President Cecil Roberts told those assembled that union miners had spent their lives working in dangerous places to provide America's electricity and steel and make it the most prosperous nation on earth.

"We have stood up for America, and it's time America stood up for us!" said Roberts. "America owes us, and we will collect on that debt!"

Union miners said the promise of good health care and pensions dates to 1946, when the federal government promised benefits in resolving a labor dispute.

Miners protest pending health care cuts in Lexington, Ky., June 15. Photo: UWMA/Phil Smith

Roberts calls for march on Washington with civil disobedience

Roberts announced at the rally that union members will march on Washington, D.C., later this year and risk being arrested if that's what it takes. He told miners to go home and find at least five others that would be willing to rally at the nation's capital.

The UMWA is calling for passage of legislation in Congress, Senate Bill 1714 and House Resolution 2403, which would redirect existing appropriations to ensure health care benefits for retirees whose companies have gone bankrupt in the last four years, as well as prevent the UMWA pension fund from collapsing. The Lexington Herald-Leader endorsed the proposed bills.

Solidarity action

Contact your two senators and ask them to support S 1714 and your representative and ask him/her to support HR 2403. Call the U.S. Capitol Switchboard (202) 224-3121 and ask for your lawmakers.

This coal miners' crisis is further testimony that collective bargaining power alone is insufficient to resolve the health care problem for unions and workers. Workers and the nation must have a legislative solution. If we are to protect and improve health care for workers, the labor movement must lead the battle for national single payer health care.

Endorse HR 676

HR 676, a national single payer bill, would improve Medicare and expand it to everyone. It includes all medically necessary care including dental and drugs with no co-pays and no deductibles. It was introduced by Congressman John Conyers (D-MI) and has 62 co-sponsors. If your union has not yet endorsed this bill, please do so! The sample resolution is here:

unionsforsinglepayer.org/tools/sample_resolution.

Build the movement to make it happen!

Issued by: All Unions Committee for Single Payer Health Care
Email: ***nursenpo@aol.com*** *Website:* ***unionsforsinglepayer.org***

(***Sanders wins policy debate,*** *continued from previous page*)

rest suffer. Sanders's policies include higher taxes on the rich, strengthening unions, raising the minimum wage, supporting families, providing free tuition at public universities and cracking down on financial crimes.

There is nothing magical or utopian about Sanders's recommendations. He is advocating policies of decency long ago adopted by other prosperous high-income countries. Our own neighbor, Canada, is a case in point. Canada has lower-cost health care, a life expectancy two years higher than in the United States, much lower college tuition, far lower poverty rates and, not surprisingly, more happiness (ranking sixth in the world in life satisfaction, behind Scandinavia and well ahead of the United States, which is 12th).

Mainstream economists long ago lost the melody line. Their models are oriented to the status quo and underemphasize the benefits of public investment. They take America's bloated health care costs as a given, not as the result of the influence of the U.S. private health lobby. They treat low growth as natural ("secular stagnation") rather than as the result of chronic underinvestment. They have come to accept cruelly rising income inequality and rampant impunity for financial crimes. Sanders knows better, based on worldwide experience, an abiding sense of decency and a strong and accurate vision for a brighter economic future.

Jeffrey D. Sachs is director of the Earth Institute and a professor at Columbia University.

JUNE 17, 2016

Testimony in support of single-payer national health insurance before the Democratic Platform Drafting Committee

By Steffie Woolhandler, M.D., M.P.H.

I am a primary care doctor and professor of medicine and health policy. In 1986, I co-founded the nonpartisan organization Physicians for a National Health Program, whose 20,000 members advocate for single-payer reform.

Our proposals for single-payer reform have appeared in the New England Journal of Medicine, The Journal of the American Medical Association, and most recently in the American Journal of Public Health. That proposal and references for my statements appear in my written testimony.

1. The ACA has not solved the health care crisis. About 30 million Americans are uninsured today. And 25 million would remain uninsured even if all states were to accept the Medicaid expansion.

2. Millions more have such hollowed-out coverage that they can't afford care. Deductibles on employer-sponsored plans increased 255 percent between 2006 and 2015. Deductibles in the ACA's exchange silver plans average $3,064.

My research with Elizabeth Warren, when we were both professors at Harvard, found that medical problems were a cause of 62 percent of all personal bankruptcies. The majority of the medically bankrupt had private insurance that failed to protect them. This year, the Consumer Financial Protection Bureau reported that unpaid medical bills are by far the most common debts sent to collection agencies.

3. Many Americans have been forced into insurance that limits their choice of doctors and hospitals, often excluding leading cancer centers and teaching hospitals. Medicare for All would assure everyone a free choice of doctor and hospital.

4. Health inequality is on the rise. Today, the wealthiest American men live, on average, 15 years longer than the poorest. Meanwhile, the life expectancy gap has fallen in Canada. Overall, Canadians and Europeans now live 2 to 3 years longer than Americans.

5. Single-payer systems in these nations provide first-dollar coverage, while spending about half as much per person as we do.

6. The economic numbers on single payer add up. At the outset, government health spending would rise, but would be fully offset by reductions in premiums and out-of-pocket costs. Over the longer term, single-payer reform would be less inflationary than our current market-based system. (Markets are designed to expand, and they do, especially when they're heavily subsidized.)

Single payer would save about $3.3 trillion on insurance overhead over the next decade by replacing private health insurers, whose overhead averages 12 percent, with a single public insurer with overhead of 2-3 percent, as in the traditional Medicare program or Canada's single payer.

Single-payer reform would also slash the paperwork that insurers inflict on doctors and hospitals, saving another $2.75 trillion over 10 years. Doctors would send all bills to one place using a simple billing form, and hospitals would stop sending bills. Instead, they'd be paid negotiated lump-sum budgets – much as we pay fire departments. Administration consumes 25 percent of hospital budgets in the U.S., vs. 12 percent in Canada and Scotland.

Overall, a single-payer reform would save more than $6 trillion on paperwork over the next decade, enough money to cover all of the uninsured, and to upgrade coverage for those of us with insurance.

7. A single-payer reform could save an additional $2 trillion over 10 years by using its leverage as a monopsony buyer to drive down drug prices. This strategy has allowed Europeans and Canadians (as well as the VA) to get drugs at half–price.

Dr. Steffie Woolhandler testifies to the health and economic benefits of single-payer national health insurance.

8. A Medicare buy-in or public option will not work. It would improve choices for some Americans but fail to garner most of the administrative or drug savings available through single payer. Moreover, as in the Medicare Advantage program, overall costs would go up because private insurers would cherry-pick the healthiest patients, shunting expensive and unprofitable patients to the public option. We have already seen this dynamic at work in the collapse of the nonprofit insurance coops under the ACA. In insurance competition, good guys finish last.

9. Single payer is popular. Most doctors, like other Americans, now favor national health insurance, and according a recent Gallup survey, the public now greatly prefers it to Obamacare.

10. In summary, single-payer reform is the only route to affordable and sustainable universal coverage. The Democratic Party cannot pretend that minor tweaks to our failing health care system will fix it.

Additional written testimony and documentation for the Democratic Party Platform Committee

1. The full text of the recent physicians' proposal for single-payer health care reform is available at **www.pnhp.org/nhi**.

2. My estimates of single-payer savings on insurance overhead are based on the following sources. According to the National Health Expenditure Accounts, private insurers' overhead in 2016 was 12.5 percent of total premium (see: **go.cms.gov/2aOxRdd**). In contrast, according to the Medicare Trustees, overhead in the traditional Medicare program is less than 3 percent (see: **go.cms.gov/2aNLB7L**), and overhead in Canada's single-payer program, which streamlines administration by paying hospitals global budgets, is 1.8 percent (see: **bit.ly/1PTbUqO**).

3. The large administrative savings for doctors and hospitals under single payer have been well documented (see, for instance, my studies in the New England Journal of Medicine at: **bit.ly/2avbdbe**, and in BMC Health Services Research at: **bit.ly/2aiBvfB**). Every serious analyst of single-payer reform has acknowledged these savings (for a summary of studies of the cost of single-payer reform see: **pnhp.org/facts/single-payer-system-cost**), including the Congressional Budget Office, the Government Accountability Office, the Lewin Group (a consulting firm owned by UnitedHealth Group).

As my international research team found, U.S. hospitals spend one-quarter of their total budgets on billing and administration, more than twice as much as hospitals spend in single-payer systems like Canada's or Scotland's (see: **bit.ly/WGamHK**). Similarly, U.S. physicians, who must bill hundreds of different insurance plans with varying payment and coverage rules, spend two to three times as much as our Canadian colleagues on billing (see: **bit.ly/1hCSZ1z**).

4. Nations with national health insurance programs that negotiate drug prices pay about half as much for prescription drugs as Americans (see: **bit.ly/2aJddcU**).

5. Implementing a single-payer program would disrupt the private insurance industry, but would not disrupt the smooth functioning of hospitals, clinics, doctors' offices and other medical providers. The rollout of Medicare in 1965 caused no disruption, contrary to predictions of disaster (see: **huff.to/2aOCrYI**), and the start-up of single-payer systems in Canada and Taiwan went smoothly. Interestingly, when Medicare started up, there was little society-wide increase in the utilization of medical services. Between 1964 (before Medicare) and 1966 (the year when Medicare was fully functioning) there was no increase in the total number of doctor visit in the U.S.; Americans averaged 4.3 visits per person in 1964 and 4.3 visits per person in 1966. Instead, the number of visits by poor seniors went up, while the number of visits by healthy and wealthy patients went down slightly. The same thing happened in hospitals. There were no waiting lists, just a reduction in the utilization of unneeded elective care by wealthier patients, and the delivery of more care to sick people who needed it. A similar phenomenon occurred in Canada (see: **bit.ly/2aSj3LE**).

6. According to a 2016 Gallup survey (available at: **bit.ly/2aNSnKH**), 58 percent of Americans favor (and only 37 percent oppose) "replacing the ACA with federally funded healthcare system." Among those who favor either keeping the ACA or replacing it with a federally funded system, 64 percent prefer single payer vs. 32 percent who prefer the ACA – a 2:1 margin. Moreover, 27 percent of those who want to repeal the ACA and say they favor replacing it with a federally funded system. Strikingly, while only 16 percent of Republicans support keeping the ACA in place, 41 percent favor a federally funded health care system.

*Dr. Woolhandler's verbal testimony (and subsequent dialogue with members of the drafting committee) can also be viewed at **cs.pn/2ayG18H**.*

PNHP note: Physicians for a National Health Program is a nonpartisan educational organization. It neither supports nor opposes any candidate for public office or any political party.

Single payer at the DNC

National Nurses United co-hosted a forum on "Medcare for All" at the Democratic National Convention in Philadelphia on July 24, where Michael Lighty, NNU's public policy director, left, was among the speakers. To view NNU executive director Rose Ann DeMoro's earlier testimony in support of single payer before the platform committee, visit **bit.ly/2blLrCf**. Photo: NNU

MAY 20, 2016

The business case for single payer

By Bennett Hall

CORVALLIS, Ore. – As the owner of MCS Industries, a Pennsylvania manufacturer of home décor products with 160 employees, Richard Master has firsthand experience with the relentlessly rising cost of health care, for both companies and workers.

Last year, he said, it cost his company $18,000 for each employee with a family health plan. This year that figure rose by more than 14 percent — the latest in a string of double-digit annual increases that have pushed MCS Industries' bill for employee health coverage to $1.5 million a year.

Costs keep going up for his workers, as well.

"Insurance comes with deductibles, co-pays and out-of-pocket expenses that make it not such a good deal," he said in an interview this week. "And it doesn't really have to be that way."

Master is a convert to the cause of single-payer health care, a government-sponsored system that would eliminate the multipayer welter of private insurance carriers we have now and replace it with a single health plan for every American, a proposal sometimes known as Medicare for All.

He's become so passionate about single payer that he's produced a documentary on the subject called "Fix It: Healthcare at the Tipping Point," and he's been traveling the country screening the film and speaking to business people about a health care system he believes is crippling the economy.

Now he's teamed up with Health Care for All-Oregon and the state chapters of Physicians for a National Health Program and the Main Street Alliance for a six-city swing through Oregon, including a stop next week in Corvallis.

On Wednesday, Master will meet for lunch with a group of local business leaders and elected officials, then host free public screenings of "Fix It" at 6 and 7:30 p.m. at the Darkside Cinema, 215 S.W. Fourth St. Each showing of the film will be followed by a discussion.

A single-payer system as envisioned by Master would use individual and employer taxes to cover all medically necessary care through the current private delivery system. By eliminating the administrative burden of multipayer billing and allowing the government to negotiate drug prices with pharmaceutical companies, he argues, Americans could slash about $500 billion a year from a national health care bill that currently runs to $3 trillion annually.

It's an approach that's already providing better outcomes at much lower costs in other developed nations such as Canada, Germany and France.

"The U.S. really is the anomaly," he said. "We are the outlier, and the rest of the industrialized world is following a different model, a much more efficient model, and that is single payer."

By focusing on issues of cost and inefficiency, Master is hoping to persuade other business leaders to back the movement to bring single-payer health care to the United States.

"What we say to them is that single payer costs less," he said. "It costs less for the company in basic care, and it will take away from the company the requirement that they are responsible for

(continued on next page)

LAS VEGAS SUN

DECEMBER 10, 2015

Single-payer health insurance option is needed

By Joanne Leovy, M.D.

As a physician, I applaud Bruce Gilbert's plea for Nevadans without health insurance to use the Silver State Exchange to seek insurance and subsidies ("Too many Nevadans remain uninsured," Las Vegas Sun, Nov. 18). Unfortunately, Mr. Gilbert glosses over the health care elephant in the room: It's still too expensive, and we don't get value for our money!

In the U.S., we spend nearly twice as much per person as other advanced countries, yet we have a greater chronic disease burden and are more likely to die in infancy and as young and middle-aged adults. Obamacare did not help control excessive costs of medical tests, hospital care or medications. It certainly did not help to relieve your doctor of excessive administrative burdens. I and my staff still spend hours each week begging insurance companies to cover drugs and tests. It did not put an end to obscene profit-seeking in the industry.

Now that the Nevada Health Co-op is closing, consumers will be forced to enroll in a for-profit insurance plan. Did you know insurance companies ensured the failure of nonprofit health cooperatives around the country by inserting language into the Affordable Care Act to prohibit the co-ops from starting with enough capital and to prohibit them from advertising? Backroom deals have rigged Obamacare from the start. Now Americans are paying with their lives: More than 30,000 still die annually because of a lack of health insurance.

It's time we stand up to this corporate kleptocracy and demand robust public options that control costs and administrative expenses. I urge readers to consider a single-payer health insurance option introduced in the House of Representatives, H.R. 676.

THE HUFFINGTON POST

MAY 26, 2016

Trump on immigrants and health care costs: just plain wrong

By Leah Zallman, M.D., M.P.H., and Steffie Woolhandler, M.D., M.P.H.

Throughout the primary season, leading Republican presidential candidates vied over who could bash immigrants the hardest. And they were promising more than border walls. Donald Trump is the most extreme immigrant-blamer; according to his website, "Providing healthcare to illegal immigrants costs us some $11 billion annually. If we were to simply enforce the current immigration laws and restrict the unbridled granting of visas to this country, we could relieve healthcare cost pressures on state and local governments."

As with many of Trump's claims, this one is wrong. But unlike some of his other falsehoods, the media has left this one unchallenged. Trump's $11 billion figure comes from an obviously biased study that's based on outlandish assumptions.

For instance, it counts as "immigrants" millions of U.S. citizens – children who were born in the U.S. of immigrant parents. It also assumes that immigrant families have high health care costs, ignoring a raft of data showing that immigrants use little care. For instance, nearly half (48 percent) of noncitizen immigrant children never see the doctor in the course of a year.

Dr. Leah Zallman

Finally, Trump's source assumes that every penny of immigrant kids' health care costs are borne by the taxpayers. Yet a recent study in the respected journal Health Affairs found that unauthorized immigrants families pay the vast majority of their own health care bills, either out-of-pocket, or by buying private insurance. Indeed, 40 percent of newly arrived immigrants have private insurance.

Trump's numbers don't just exaggerate taxpayers' costs for immigrants' care, they ignore the billions that immigrants pay in taxes. Compared to other Americans, immigrants are younger, healthier and more likely to be male and part of the workforce. That means that an outsized share of immigrants pay the payroll taxes that support Medicare and Social Security, while few are eligible to draw benefits from these programs.

Employers are required to check a Social Security card when hiring a new worker. But they don't have to check that it's valid. The IRS happily accepts (and passes on to Medicare and Social Security) payments made under invalid Social Security numbers.

Consequently, millions of undocumented immigrants work and pay taxes under fake or borrowed Social Security numbers. The Social Security Administration estimates that undocumented immigrants pay $13 billion annually into the Social Security trust funds. And, in studies we did at Harvard and the City University of New York, we found that undocumented immigrants contribute billions more to Medicare.

Without immigrants – and especially unauthorized immigrants – Medicare's Trust Fund would be broke. Each year, immigrants pay about $11 billion more in Medicare taxes than Medicare pays for their care. And undocumented immigrants contribute the lion's share of this subsidy.

And, just like everyone else, unauthorized immigrants pay sales taxes every time they shop and property taxes (indirectly) when they pay their rent, contributing $11 billion annually in state and local taxes.

While unauthorized immigrants contribute billions in taxes, they use shockingly little health care. Most of the federal health programs they help pay for (like Medicare, Medicaid and the ACA's plans) exclude them. And those who pay for private coverage use very little care, so their premiums effectively subsidize other enrollees with private insurance.

As physicians, we believe that medical care must be available to everyone residing in the U.S. However, if Trump and other politicians are concerned about "relieving healthcare cost pressures on state and local governments" they should champion fair immigration policies that assure a steady flow of immigrants who come here wanting to work and willing to pay taxes, and don't need much medical care.

Leah Zallman, M.D., M.P.H., is a research scientist at the Institute for Community Health, a primary care doctor at Cambridge Health Alliance, and an instructor of medicine at the Harvard Medical School. Steffie Woolhandler, M.D., M.P.H., is an internist in the South Bronx, professor at the City University of New York School of Public Health at Hunter College, and lecturer in medicine at Harvard Medical School. She co-founded Physicians for a National Health Program. The opinions expressed here do not necessarily reflect the views of the authors' institutions.

PNHP note: Physicians for a National Health Program (PNHP) is a nonpartisan educational and research organization. It neither supports nor opposes any candidate for public office.

(***Business case,*** *continued from previous page*)

providing medical care for employees."

Removing that burden from U.S. businesses, he said, would make them more competitive in the global marketplace. In the meantime, American firms — and American workers — are struggling under health care costs that are much higher than they need to be.

"This is 18 percent of our entire economy right now. In other countries, it's generally 9 to 11 percent," Master said. "We've got to get it under control."

April 26, 2016

Saving the NHS

Britain's junior doctors' strike isn't just about pay – it's about preserving a health system based on need, not profit

By Adam Gaffney

Today in England, "junior doctors" – post-graduate physicians akin to residents and fellows in the United States – are walking out. This two-day strike represents a major intensification of actions that began in January. It was precipitated by last year's breakdown in negotiations over a contract that the Conservative government of David Cameron has now proclaimed it will impose come hell or high water. But the stakes of the junior doctors' strike are much higher.

Physicians' strikes, it's worth acknowledging, do not always seek progressive ends. The 1962 Saskatchewan Doctors' Strike aimed to torpedo the province's milestone single-payer legislation. But the current action in England, endorsed by a near-unanimous vote last year, is something different. Fundamentally, it's aimed at the preservation – not the derailment – of universal health care.

Junior doctors protest cuts to the NHS. Photo: Rohin Francis/Flickr

The travails of the junior doctors are one part of a much larger campaign. Against austerity, of course. But also for the perseverance of the United Kingdom's unique health care system – in substance, not merely in name – in the twenty-first century.

A Cracked Foundation

Every nation's health system is split along a rights-commodity axis, ranging from a public system that provides a universal right to health care according to need, to a private enterprise that profitably provides care according to means. When the National Health Service was founded, notes scholar Rudolf Klein in "The New Politics of the NHS," it was the first system that universalized government-provided care, and it thereby skewed health care toward the "rights" side of that axis. As he puts it,

> *It [the NHS] was . . . the first comprehensive system to be based . . . on the national provision of services available to everyone. It thus offered free and universal entitlement to State-provided medical care. At the time of its creation it was a unique example of the collectivist provision of health care in a market society.*

In the 1980s, however, Margaret Thatcher's government began an attack on the principles of the NHS that has not yet subsided. As public health doctor and scholar Allyson Pollock describes in "NHS Plc: The Privatisation of our Health Care," Thatcher's government imposed intermittent austerity funding and the incremental imposition of market-based reforms such as the "internal market" and the "private finance initiative," signaling a retreat from the NHS's initial collectivist provisions and a partial move toward commodification.

The Labour government of Tony Blair, as she notes, continued down the road first paved by Thatcher. However, Blair's government did eventually initiate a much-needed increase in funding: to just under 7 percent a year, almost twice the historical average of 4 percent. This overdue boost, however, would not survive the Great Recession.

In 2010, David Cameron's Conservative-led government was elected and destabilized the NHS through two great upheavals. First, the government reorganized the NHS through the passage of the 2012 Health and Social Care Act; second, it instituted a period of funding austerity the likes of which the NHS had never seen.

The changes wrought by the 2012 law are complex, and the full ramifications not yet entirely clear. Health policy scholar John Lister described the law in a phone interview as a "massive top-down reorganization of the NHS" that pushes it further onto the free market, effectively displacing (some) care provision into the private sector.

And as Pollock and lawyer Peter Roderick – both supporters and advocates for a fully public NHS – wrote in the British Medical Journal last year, the law calls for a number of "reductions and restrictions [of health care that] pave the way for mixed funding arrangements and a gradual shift to private insurance and charges to patients."

Essentially, they argue, the law "marked the end of the NHS in England" not only by encouraging further privatization and fragmentation, but by effectively ending the health secretary's legal duty to provide comprehensive health services throughout the nation.

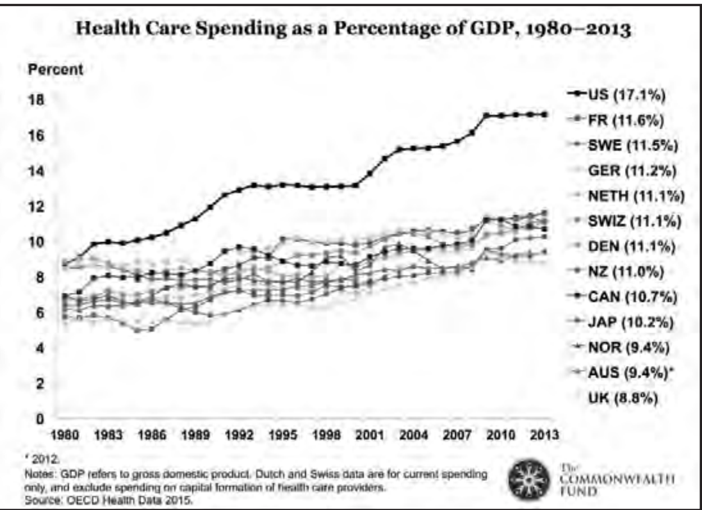
The Scrooge Model

Whether the law will fully undo the NHS or simply prove to be another incremental step remains to be seen. The more immediately harmful trend – and the one largely responsible for the junior doctors' strike – has been the draconian austerity that

the service now faces.

In the United States, discussions around health policy generally revolve on how best to reduce excessive spending (especially the public variety). Globally, however, and particularly in low-income countries, insufficient public spending is frequently the larger problem. This is now also the case with the NHS, which was already quite efficient before the Cameron government came to power.

As a percentage of GDP, the United Kingdom currently has the cheapest health system among thirteen other high-income peer countries:



Moreover, health spending in the UK as a percentage of GDP has actually fallen since 2009. As Klein wrote in an article last year, while historically NHS funding had grown at an average rate of almost 4 percent yearly, it is currently growing at a bit under 1 percent. Given population growth, he notes, such a rate of "increase" is in fact a per capita reduction.

Indeed, as John Appleby, chief economist of the Kings Fund noted in a blog post, spending increases under the Cameron government are the lowest of any government since the end of World War II. At that point, however, Great Britain was essentially penniless and in virtual ruins. Today, Ebenezer Scrooge–level miserliness has replaced frugal funding as a matter of choice.

What is obvious is that while the United Kingdom ostensibly maintains a social right to health care, the foundation of that promise is cracking.

The First Cut

It was amid all this tumult, Lister notes, that the government decided to move to what it called a "seven-day NHS," extending the availability of (non-emergency) clinical services throughout the week. While not necessarily a bad idea – though there has been considerable controversy regarding the actual benefits of such a transformation – the change requires more money, not less. That is, unless you have junior doctors around to pick up the slack.

Increasing weekend staffing means "you either over stress the staff who are currently doing it or you actually reduce the cover during the week as a result," Lister says. Although the government's proposed contract would increase junior doctors' base pay, it would also reduce existing premiums for night and weekend work. "Ministers have promised to protect the pay of existing doctors for the first three years," the BBC notes, but at the same time "new doctors starting their career in the NHS under this contract may be worse off."

Contract negotiations between the government and the British Medical Association (BMA) collapsed late last year over these issues, leading to a November strike vote with 76.2 percent turnout and 98 percent support. The first strike took place January 12 and the last was April 6. Today and tomorrow's actions, however, raise the bar considerably: they are full walkout strikes, with emergency care provided by covering consulting physicians, some of whom have loudly expressed solidarity with their striking junior colleagues.

Like their American counterparts, junior doctors work hard and long hours. "I regularly work weekends and nights," one said in a series of interviews published by the Mirror. "So far in the last 7 days I have worked over 80 hours, I will work at least another 10 hours tomorrow before I get a day off. I am absolutely shattered."

Among strike supporters interviewed by the Mirror, a concern over pay was not prominent (indeed, one said he would financially benefit under the new contract). Instead, they emphasized patient safety, quality of care, and the potential for greater workforce strain caused by the changes.

The broader point, as Lister emphasizes, is that the move against the junior doctors may be the first stage in a larger campaign to save money by squeezing the health care workforce. "[B]ehind the junior doctors' dispute," he notes, "is the much bigger apple that they're after which is to strip away the weekend enhancement payments and out-of-hours payments for over a million other health workers." In other words, in the quest for NHS austerity, junior doctors may only be the first on the chopping block.

Which leads to another question: can the junior doctors' strike advance the larger campaign to preserve and restore a fully funded, fully public NHS, or will it remain an isolated battle?

A Bigger Fight

Perhaps the most critical factor that will shape the battle over the NHS in coming months and years is the human impact of continued NHS austerity, which could produce grassroots protest.

A February report from the Kings Fund gives a clear sense of the service's dire fiscal straits and some of its ramifications:

- The report estimates that NHS trusts (provider organizations like hospitals) will be in the red by £2.3 billion by the end of the financial year;

- It reports a rising sense that patient care is worsening: for the first time, a majority of trust finance directors surveyed believed that patient care in their region had deteriorated over the past year;

- It notes a failure to meet targets for waiting time for care, including for cancer treatment.

(continued on next page)

APRIL 29, 2016

The future of the Veterans Health Administration

By Suzanne Gordon

By the end of this year, the US will have a new president as well some new members of Congress. The results of the 2016 election will not only effect the further implementation of the Affordable Care Act (Obamacare), but the future of the country's largest healthcare system – the Veterans Health Administration. That's because most of the Conservative Republicans running for President – as well as many of those running for or already serving in Congress – are not only determined to repeal Obamacare. They are also committed to dismantling the largest and only publicly funded, fully integrated healthcare system in the US – the Veterans Health Administration (VHA). Even many Democrats are not fully supportive of the VHA. While Hillary Clinton says she does not support privatization of the VHA, only Bernie Sanders (D. VT) has demonstrated a deep understanding of what the VHA does and how it actually works.

The Veterans Health Administration grew out of Abraham Lincoln's Civil War pledge: "To care for him who shall have borne the battle and for his widow, and his orphan." Since World War Two, the VHA has become the largest and only fully integrated, publicly funded healthcare system in the United States. Its 1700 sites of care include more than 150 medical centers, 1000 community based outpatient clinics (CBOCs), and other mental health, nursing home facilities, and in and outpatient facilities.

The VHA has over 260,000 employees, over a third of whom are veterans. Its tripartite mission includes the delivery of clinical care, research, and teaching. Since 1946, the VHA has affiliated with major academic teaching hospitals and now trains

(continued on next page)

(***Saving the NHS,*** *continued from previous page)*

None of this, of course, is particularly surprising: it's the all-but-inevitable consequence of trying to squeeze more money out of an already lean health care system. The NHS's current budget crisis and declining quality of care don't reflect the flaws of a public approach to health care, but rather the penny-pinching prerogatives of a government committed to the preservation of concentrated wealth above good health.

In order to deal with the massive projected deficit, Lister emphasizes that at least some cuts in services will take place, as indicated by discussions to close A&Es (ERs) in the rural county of Lancashire.

Such reductions may become critical focal points for local grassroots movements: "[T]hese types of cuts," he notes, "when they are made, they do have the power to mobilize all kinds of people who would never normally engage in any kind of political activity at all."

Even though local battles against reductions in services or hospital closures may serve as important loci of resistance, action on the national level will be necessary to reverse course on NHS.

The election of Jeremy Corbyn to the leadership of the Labour Party could be a game changer in this regard. His campaign website calls for a "fully-funded NHS, integrated with social care, with an end to privatisation in health." But Lister suggests that Labour, even under Corbyn, has been disappointingly tepid in its support of the NHS.

He notes that the party did not champion a bill drafted by Pollock and Roderick, the NHS Reinstatement Bill, which aimed to "fully restore the NHS as an accountable public service by reversing 25 years of marketization in the NHS." (Corbyn, however, has supported it as an individual.)

Looking forward, Lister hopes to press Labour to adopt the bill's principles, whatever they want to label it. More broadly, he hopes to see a coalition of NHS activists, labor unions and, one day, the Labour Party joined together in a "united campaign to challenge the Tory offensive."

Defending the health care work force, restoring previous levels of health funding, rolling back privatization, and ejecting the powerful corporate health care sector from the NHS will clearly be a formidable feat. No doubt it will require a coalition of health workers, activists, politicians, parties, and unions to achieve it.

Like the fight for a single-payer health care system in the United States, health care activism necessitates a multifocal yet united movement. Neither campaign is impossible, but neither will be easy.

Finally, cooperation and solidarity among activists across national borders may provide yet another source of support: health care capital operates transnationally, and so too must like-minded health care workers, activists, and scholars.

The British NHS can only survive insofar as it can continue to provide, universally, the highest quality health care. But austerity makes that increasingly untenable. The junior doctors' strike rejects this neoliberal squeeze. If successful, it might help lead the way to something more: the end of a series of setbacks for the NHS, and the first of many victories for those who believe in its basic principles.

Adam Gaffney is a physician whose work has appeared in Salon, Dissent, and In These Times. He blogs at ***theprogressivephysician.org****.*

over 70 percent of American physicians as well as students and trainees in 40 other healthcare professions. It's vast research arm has produced innovations that have improved the health of veterans suffering from illnesses like Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), as well as spinal cord injury. VHA research has also produced innovations that help all patients. To name only a few, the VHA developed the first implantable cardiac pacemaker, performed the first successful liver transplant, helped to test the Shingles vaccine and develop the nicotine patch.

Suzanne Gordon

Republicans have consistently refused to adequately fund the VHA and have resisted expanding its services to all veterans. The VHA only serves veterans who have some form of honorable discharge and who have service related disabilities and/or low incomes. The result is that the system takes care of the oldest, sickest, and poorest veterans. The average VHA patient is 62 years old, has multiple physical co-morbidities and a higher percentage of mental health problems than the average patient in the private sector. In spite of this significant challenge, an Independent Assessment of the VHA's record on care delivery, mandated by the 2014 Choice Act, documents that the VHA outperforms the private sector on many measures, is equivalent on some, and marginally worse on only a few. Despite variability in the VHA system, the Independent Assessment repeatedly reports that the private sector healthcare system provides care with even more variability than the VHA. The Association of VA Psychologist Leaders recently posted yet another review of the scientific studies on VHA care which document similar outcomes.

Republicans have consistently refused to adequately fund the VHA and have resisted expanding its services to all veterans. The result is that the system takes care of the oldest, sickest, and poorest veterans.

Ignoring the VHA's record of care delivery, congressional conservatives are exploiting the wait time problems and delays uncovered in 2014 in Phoenix and some other VHA facilities to argue that the entire VHA system is broken and that the VHA should no longer pay for and provide healthcare services. They want to eliminate the VHA and transfer veterans to the private sector healthcare system, with the government serving as payer, rather than also the provider of care.

Needless to say, this would be a huge boon to private sector hospitals, which is why many support this plan. It is also favored by large pharmaceutical and medical equipment companies. Big Pharma has long chafed at the fact that the VHA – unlike say Medicare or other US health plans – negotiates lower pharmaceutical prices through its drug formularies. Since VHA physicians and other staff are on salary, they have little financial incentive to either over or undertreat their patients and thus use medical equipment and treatments much more judiciously than their counterparts in the private sector. They have also developed more integrated mental health, primary care, geriatric and palliative care services than other US health plans.

Finally, the VHA has long been anathema to conservatives. As Alicia Mundy has recently reported in an article in The Washington Monthly, the Koch brothers have funded a group called the Concerned Veterans of America – a veterans' service organization that has no veteran members and provides no veteran services.

The CVA has been lobbying for partial and ultimately full privatization of the VHA. The mainstream media have been filled with stories about VHA dysfunction. Media outlets have promoted this narrative and ignored continuing evidence that the VHA – in spite of wait time delays and top heavy management – continues to deliver high quality care to veterans.

As a result Congress is now considering two bills that could pave the way for the privatization of the VHA. At the same time, a congressionally mandated Commission on Care tasked with strategizing about the future of the VHA, is also dominated by discussions of VHA privatization.

Seven of the commission's members have written a proposal entitled "The Strawman Document" recommending the total elimination of the VHA. The Strawman document has produced an outcry from veterans' service organizations (VSOs). Eight of the nation's largest veterans' services organizations – including the American Legion, Disabled American Veterans, and Paralyzed Veterans of America – have written a formal letter to the commission to express their concern about the report. These groups support proposals, like that put forth by VA Undersecretary of Health David Shulkin, that would strengthen the VHA, give veterans the choice to see outside providers if necessary, but maintain the VHA as provider and coordinator of healthcare services.

The fate of VHA will affect more than America's 24 million veterans and their families. With its research, teaching, and innovative models of team-based integrated care, the VHA serves as a model for quality healthcare delivery that should be emulated rather than dismantled.

Suzanne Gordon is a healthcare journalist and co-editor of The Culture and Politics of Healthcare Work Series at Cornell University Press. Her latest book is "Collaborative Caring: Stories and Reflections on Teamwork in Healthcare," which she co-edited. She is co-author of "Beyond the Checklist: What Else Healthcare Can Learn from Aviation Teamwork and Safety." Most importantly, she is a patient.

Competing interests: Ms. Gordon is currently writing a book about the VHA.

POINT: Should Pulmonary/ICU Physicians Support Single-payer Health-care Reform? Yes

Adam W. Gaffney, MD
Boston, MA
Philip A. Verhoef, MD, PhD
Jesse B. Hall, MD, FCCP
Chicago, IL

ABBREVIATIONS: ACA = Patient Protection and Affordable Care Act; NHP = national health program

Has the Patient Protection and Affordable Care Act (ACA) finally ensured the longstanding goal of universal health care? Although the ACA helps many people, in several crucial respects it falls well short of a universal system. Rather than comprehensively cover all individuals in a single public program (eg, Medicare for those aged > 65 years), the ACA broadens coverage through a patchwork of provisions predicated on a continued major role for the private health insurance industry. Together, the provisions of the ACA significantly expand insurance coverage.[1] However, even with the law fully implemented, the most serious shortcomings of our health-care system persist. Here we outline why the ACA falls short (with a focus on issues pertinent to pulmonary and critical care medicine) and propose an alternative, truly universal approach to health care in the United States.

AFFILIATIONS: From the Division of Pulmonary and Critical Care Medicine (Dr Gaffney), Massachusetts General Hospital; and the Section of Pulmonary and Critical Care Medicine (Drs Verhoef and Hall), University of Chicago.

FINANCIAL/NONFINANCIAL DISCLOSURES: The authors have reported to *CHEST* the following: A.G. has received a National Institutes of Health grant [T32 HL116275]. None declared: (P. A. V., J. B. H.).

CORRESPONDENCE TO: Philip A. Verhoef, MD, PhD, Department of Medicine, Section of Pulmonary and Critical Care, 5841 S Maryland Ave, MC 6076, University of Chicago, Chicago, IL 60637; e-mail: philip.verhoef@uchospitals.edu

Copyright © 2016 American College of Chest Physicians. Published by Elsevier Inc. All rights reserved.

DOI: http://dx.doi.org/10.1016/j.chest.2016.02.660

Persistent Insurance Disparities

Despite the expansion in access under the ACA, ~27 million individuals are projected to remain uninsured under the law.[1] Uninsurance has grave implications for patients with lung disease and critical illness. For patients with cystic fibrosis, uninsurance has been associated with increased mortality.[2] Similarly, a retrospective evaluation of critically injured pediatric trauma patients revealed that those without insurance were 4.6 times more likely to die compared with the privately insured.[3]

In addition to the problem of uninsurance, disparities among patients with different types of insurance will persist. Much of the expansion of insurance under the ACA is through Medicaid. However, Medicaid—compared with Medicare or private insurance—has been associated with inferior processes of care and outcomes for patients with lung cancer.[4] Nonelderly adults both without insurance or with only Medicaid coverage are also more likely to die during a hospitalization for sepsis.[5] Although these types of studies can be susceptible to residual confounding, Medicaid participants clearly face disparities in access to care, thereby limiting the capacity of the ACA to eliminate insurance-related inequalities.[6] For example, children covered by Medicaid are more likely to be denied appointments to see pediatric specialists.[7]

To summarize, both uninsurance and insurance-related disparities in care will persist under the ACA.

Patients Don't Need More Lung in the Game

Equally problematic, however, is the problem of increased cost-shifting to patients. High out-of-pocket expenses or exposure in the form of copayments, deductibles, or coinsurance has left an increasing number of Americans (almost one-quarter of insured, nonelderly adults) "underinsured" in 2014.[8] These individuals, although insured, still struggle with medical bills and avoid needed care. Underinsurance, unfortunately, is "built into" the ACA. Plans purchased on the ACA exchanges, for instance, leave families responsible for as much as $13,200 a year in out-of-pocket payments after premiums are paid (depending on income).

Such cost sharing can be particularly burdensome for patients with pulmonary issues. High cost-sharing plans

for inhaled medications used by patients with COPD or asthma have been associated with a 41% increase in emergency hospitalizations as well as reduced medication adherence.[9,10] Similarly, high-deductible health plans deter those of low socioeconomic status from seeking emergency care even for "high-severity" conditions such as acute asthma.[11]

Overall, the ACA perpetuates the misguided notion that more "skin in the game" (or in our case, "lung in the game") is a wise or just means to control health-care usage and costs.

Failure to Engage Evidence-based Measures for Controlling Costs

The economic burden of lung disease in the United States is high. By one estimate, $67.7 billion was spent in direct costs for asthma, COPD, and pneumonia in 2008.[12] The ACA, however, lacks potent cost-control mechanisms.

In recent years, prices for many medications have soared. However, Medicare is still prohibited under the ACA from using its purchasing power to negotiate with pharmaceutical companies for lower prices, and drugs are generally priced at what the "market will bear." This approach can result in extraordinarily high drug prices in the United States, such as the $373,000 reported annual price of ivacaftor (for cystic fibrosis).[13] Unfortunately, this problem is not limited to new or innovative medications: rising prices for newly patented albuterol inhalers have contributed to spiraling medication costs for patients and an increase of $1.2 billion annually in health-care expenditures in the United States by one estimate.[14]

In contrast with direct negotiation over drug prices, many of the ACA's cost-saving initiatives have little basis in evidence. For example, under the ACA, Medicare will penalize hospitals that have excessive readmissions for certain conditions, including COPD. However, there is no clear evidence that any specific currently available interventions prevent COPD readmissions.[15] Moreover, penalizing resource-poor safety-net hospitals that care for low socioeconomic status patients may potentially worsen COPD health disparities.[16]

Our current system has also done poorly with respect to the control, planning, and regionalization of ICU infrastructure. Despite decreasing numbers of total hospital beds, the number of ICU beds continues to rise.[17] Because ICU bed supply likely drives ICU bed use, excesses in ICU infrastructure may be driving increased costs without clear benefits, underscoring the importance of a more rational system of ICU capital planning.[18]

Finally, the ACA does not address what may be the most wasteful aspect of the US health-care system: the massive administrative costs that are unavoidable in a fragmented multipayer system. Compared with Canada, the United States spends much more on health-care administration and has a much greater percentage of the health-care workforce engaged in administrative work.[19] This large and unnecessary burden of excessive health-care administration—in the private insurance industry, the hospital billing office, or the outpatient practice—is by no means diminished, and indeed may grow, under the ACA.

The National Health Program Alternative

A single-payer national health program (NHP) system would address the numerous problems that we have outlined thus far. A proposal for such a program has been published previously and is briefly summarized here as follows.[20]

Unlike the ACA, the NHP would provide coverage for the entire US population, replacing existing public and private insurance plans. Benefits would be comprehensive and would include medical care, dental care, prescription drugs, long-term care, and mental health care. Such a system would eliminate disparities on the basis of insurance status and eliminate financial barriers to care in the form of cost sharing.

This expansion of care would be funded in a cost-neutral manner through powerful cost-control mechanisms. First, as discussed earlier, a single-payer reform would dramatically lower spending on health-care administration, in part through the "global budgeting" of hospitals. Second, a NHP would directly negotiate with pharmaceutical companies over drug prices. Third, operating expenses would be separated from capital expenditures, facilitating the rational, planned expansion of health-care infrastructure such as ICUs.

There could be additional benefits from such a comprehensive reform. Physicians, for instance, although still paid through various currently existing modes of payment, could expect dramatic reductions in the clerical work required of billing. For investigators, a centralized single-payer system might facilitate population-level research, which is currently impeded by the current, multipayer environment. A single-payer system would also allow health-care administrators to focus on optimizing system performance, shifting the

emphasis away from business activities such as advertising and acquisitions.

Most importantly, for patients and their families, an NHP would mean that sickness and health would be entirely divorced from financial concerns. Our health-care system would again be centered on the mission of health.

As pulmonary and critical care physicians, we aim to utilize the highest quality evidence, in conjunction with our understanding of the pathophysiologic and social determinants of health, to provide the best care for patients. By taking such an evidence-based approach to the realm of policy, we conclude that only a single-payer system can address the problem of rising health-care costs, while simultaneously ending the grave inequalities that continue to plague our critically ill health-care system.

Acknowledgments

Other contributions: The authors acknowledge Mark Almberg, BA, David Himmelstein, MD, and Steffie Woolhandler, MD, MPH, for their careful review of this manuscript.

References

1. Congressional Budget Office. Insurance coverage provisions of the Affordable Care Act-CBO's March 2015 Baseline. https://www.cbo.gov/sites/default/files/51298-2015-03-ACA.pdf. Accessed May 6, 2015.
2. Curtis JR, Burke W, Kassner AW, Aitken ML. Absence of health insurance is associated with decreased life expectancy in patients with cystic fibrosis. *Am J Respir Crit Care Med*. 1997;155(6): 1921-1924.
3. Cassidy LD, Lambropoulos D, Enters J, Gourlay D, Farahzad M, Lal DR. Health disparities analysis of critically ill pediatric trauma patients in Milwaukee, Wisconsin. *J Am Coll Surg*. 2013;217(2): 233-239.
4. Slatore CG, Au DH, Gould MK. An official American Thoracic Society systematic review: insurance status and disparities in lung cancer practices and outcomes. *Am J Respir Crit Care Med*. 2010;182(9):1195-1205.
5. O'Brien JM Jr, Lu B, Ali NA, Levine DA, Aberegg SK, Lemeshow S. Insurance type and sepsis-associated hospitalizations and sepsis-associated mortality among US adults: a retrospective cohort study. *Crit Care*. 2011;15(3):R130.
6. Lyon SM, Douglas IS, Cooke CR. Medicaid Expansion under the Affordable Care Act. Implications for insurance-related disparities in pulmonary, critical care, and sleep. *Ann Am Thorac Soc*. 2014;11(4): 661-667.
7. Bisgaier J, Rhodes KV. Auditing access to specialty care for children with public insurance. *N Engl J Med*. 2011;364(24):2324-2333.
8. Collins SR, Rasmussen PW, Beutel S, Doty MM. The Problem of Underinsurance and How Rising Deductibles Will Make It Worse—Findings from the Commonwealth Fund Biennial Health Insurance Survey. *The Commonwealth Fund*. 2015.
9. Dormuth CR, Maclure M, Glynn RJ, Neumann P, Brookhart AM, Schneeweiss S. Emergency hospital admissions after income-based deductibles and prescription copayments in older users of inhaled medications. *Clin Ther*. 2008;30(pt 1):1038-1050.
10. Dormuth CR, Glynn RJ, Neumann P, Maclure M, Brookhart AM, Schneeweiss S. Impact of two sequential drug cost-sharing policies on the use of inhaled medications in older patients with chronic obstructive pulmonary disease or asthma. *Clin Ther*. 2006;28(6): 964-978.
11. Wharam JF, Zhang F, Landon BE, Soumerai SB, Ross-Degnan D. Low-socioeconomic-status enrollees in high-deductible plans reduced high-severity emergency care. *Health Aff (Millwood)*. 2013;32(8):1398-1406.
12. National Heart, Lung and Blood Institute. Morbidity and mortality: 2012 chart book on cardiovascular, lung, and blood diseases. National Institutes of Health website. http://www.nhlbi.nih.gov/files/docs/research/2012_ChartBook.pdf. Accessed March 3, 2015.
13. O'Sullivan BP, Orenstein DM, Milla CE. Pricing for orphan drugs: will the market bear what society cannot? *JAMA*. 2013;310(13): 1343-1344.
14. Hendeles L, Colice GL, Meyer RJ. Withdrawal of albuterol inhalers containing chlorofluorocarbon propellants. *N Engl J Med*. 2007;356(13):1344-1351.
15. Prieto-Centurion V, Markos MA, Ramey NI, et al. Interventions to reduce rehospitalizations after chronic obstructive pulmonary disease exacerbations. A systematic review. *Ann Am Thorac Soc*. 2014;11(3):417-424.
16. Sjoding MW, Cooke CR. Readmission penalties for chronic obstructive pulmonary disease will further stress hospitals caring for vulnerable patient populations. *Am J Respir Crit Car Med*. 2014;190(9):1072-1074.
17. Halpern NA, Pastores SM. Critical care medicine in the United States 2000-2005: an analysis of bed numbers, occupancy rates, payer mix, and costs. *Crit Care Med*. 2010;38(1):65-71.
18. Gooch RA, Kahn JM. ICU bed supply, utilization, and health care spending: an example of demand elasticity. *JAMA*. 2014;311(6): 567-568.
19. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med*. 2003;349(8):768-775.
20. Woolhandler S, Himmelstein DU, Angell M, Young QD. Physicians' Working Group for Single-Payer National Health Insurance. Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. *JAMA*. 2003;290(6):798-805.

The Philadelphia Inquirer

May 17, 2016

Single-payer essential to controlling health-care costs

By David Woods

One hears these days mutterings by disaffected Americans that if Donald Trump becomes president, they will pack their bags and leave for Canada. One assumes, of course, that no wall will be built along the border to thwart their exit.

I made the reverse trip. Having emigrated from Britain to Canada, where I became the editor in chief of the Canadian Medical Association Journal, I opted to come to the United States in 1988 for personal reasons.

But I was also taken with American rugged individualism and a health-care system focused on market forces and competition. I wrote articles for the Economist Intelligence Unit and other periodicals on the wonders of the American system. In print, I debated longtime advocates of single-payer national health insurance, extolling the virtues of the health-care market that others abhorred.

David Woods

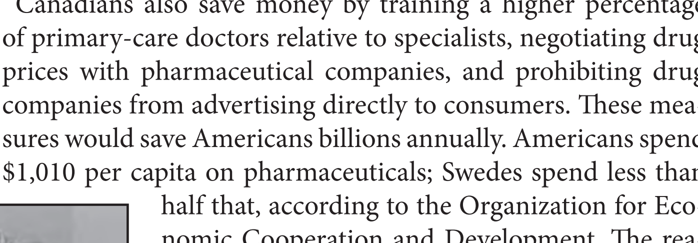
Gradually, though, I too began to have doubts about market-driven health care. Over the 25 years that I've lived on the U.S. side of the border, I've come to the view that the American health-care system – which still leaves 11 percent of the population uninsured, despite the Affordable Care Act – is inferior to the health systems in Canada and the United Kingdom.

One of the ACA's architects, Dr. Ezekiel Emanuel, describes the U.S. health system as a "terribly complex, blatantly unjust, outrageously expensive, grossly inefficient, error-prone system." Unfortunately, that's still true, six years after the ACA's passage.

The reform didn't address the fundamental problem in U.S. health care: It's more about profit than patients.

Controlling health-care costs is essential to the long-term financial health of the United States. A single-payer system would make truly universal coverage affordable, costing no more than we already spend on health care. Of the $3.1 trillion the United States will spend on health care this year, 63 percent is taxpayer-financed, funding Medicare, Medicaid, and Veterans Affairs, along with private coverage for government employees and tax subsidies for employers.

Because of its fragmented, profit-driven system, the United States spends 18.1 percent of gross domestic product on health care, compared with about 8 percent in Britain and 11 percent in Canada. Much of U.S. health spending is simply wasted. For example, 25.3 percent of hospital expenditures go to administrative costs, compared with 12.4 percent in Canada, where there is a single payer in each province and hospitals are mainly funded on a global or lump-sum basis.



Canadians also save money by training a higher percentage of primary-care doctors relative to specialists, negotiating drug prices with pharmaceutical companies, and prohibiting drug companies from advertising directly to consumers. These measures would save Americans billions annually. Americans spend $1,010 per capita on pharmaceuticals; Swedes spend less than half that, according to the Organization for Economic Cooperation and Development. The reason? Sweden doesn't pay the list price.

Lobbying and influence-peddling by the pharmaceutical and insurance industries keeps the United States from adopting a single-payer health system. Several presidential candidates this season seemed completely under their hypnotic sway. The private insurance industry brazenly tells me, now a U.S. voter, which doctors I can see, charges me astronomical premiums, not to mention co-pays and deductibles, and then wants me to believe that having publicly funded health care that would allow me to go to any doctor in the United States without a $5,000 deductible would be "socialism."

And don't believe the widely held U.S. notion that Canadians suffer long waits for care. That's a canard. We are not going to cut U.S. health spending to Canadian levels. With our much higher level of spending, waits would not be an issue, even with the population aging. Japan and many countries in Europe already have higher percentages of elderly citizens than the graying of the baby boomers is projected to produce.

In his book "In Search of the Perfect Health System," British economist Mark Britnell notes that the British love their single-payer National Health Service because of its fairness; it's available to everyone. He even quotes a former U.K. finance minister who said that the NHS is the closest thing the English have to a religion. Their single-payer system keeps quality indexes up and costs down for the population at large. This enables the British to invest additional funds in education and economic stimulation, areas that also contribute to health and well-being.

The United States should take a lesson from the example of nations with single-payer systems. They offer a measure of hope and optimism that high-quality health care can be the right of all Americans, if they demand it.

David Woods is a former editor in chief of the Canadian Medical Association Journal. He can be reached at ***hmi3000@comcast.net***

Medical school: An invitation for activism toward single payer

By Josh Faucher

I've been a part of SNaHP since the beginning, watching our annual gathering grow from a few dozen people in a small conference room in 2012, to the massive turnout we had this spring with representatives from around the country.

Each year, I'm impressed with the reality that many of our most enthusiastic and active members are students early in their medical school journeys, many of whom haven't had much contact with patients yet.

When I first began medical school, it was easy to get caught up in the praise and aggrandizement that was heaped upon us – the constant congratulations for joining a profession as well-respected and impactful as medicine. It is true that physicians can have a profound impact on the lives of our patients, curing terrible diseases and lessening the suffering caused by chronic ailments.

Josh Faucher

In looking at the nature of the health care system as a whole, however, I have seen clear examples of how access is rationed based on a patient's financial resources, and how seeking health care can leave patients vulnerable to harm that affects their livelihoods and economic security.

As a new resident, when I look back on medical school, there were many things that left me less confident in my ability to avoid doing harm as a physician.

Take, for instance, the guest speaker we had during my second year of medical school, a young woman in her 20s (let's call her Sarah) who recounted her battle with acute lymphocytic leukemia, a cancer that strikes suddenly and can be fatal in a matter of hours.

Sarah described to us the physical challenges she faced while receiving chemotherapy, and the fantastic care she had received from her physicians. As I listened to her story, I wondered whether, as a young person who had just entered the workforce, she had the financial resources to pay for her care. At the end of her presentation, I asked her, and it turned out that cancer devastated more than just her body.

Sarah's illness prevented her from working and when she eventually lost her job, she lost her insurance, too. The hospital bills that followed quickly depleted her savings until she was forced to go on Medicaid. She described this as an extremely difficult experience that caused her considerable shame.

For some reason, to this patient and others who told us stories of illness, the consistent assumption seemed to be that future doctors didn't need to hear about, or wouldn't be interested in, the financial problems caused by our health care system.

I strongly believe that no one should experience shame or financial ruin just because they get sick. I think many of my classmates would agree, but if patients aren't given a chance to share that side of their experience, we can't expect their physicians to become aware of the problem solely through intuition.

There was also the middle-aged man – I'll call him Bill – who I met during one of my clinical rotations. Bill had a chronic mental illness and an unstable, intermittent employment status, but nevertheless was surviving on his own in the community. He presented to the clinic with shortness of breath after a temporary construction job had been halted because of the discovery that he and his co-workers had been exposed to asbestos.

It took multiple visits for us to explain to him that asbestos causes disease many years after exposure, and that, instead, he was experiencing symptoms related to longstanding COPD. Worker's comp, of course, would not pay to manage this chronic preexisting disease, and Bill experienced considerable distress until we were able to enroll him in Medicare because of his new disability.

With a universal, comprehensive insurance system his disease might have been detected earlier, or smoking cessation therapy could have been emphasized when he was young. Instead, he'll live with COPD for the rest of his life, and will probably die from it.

Then there's me. I was born with a serious heart defect that required surgery when I was a toddler, and again when I was 13 years old.

Despite facing health challenges during my own life, I consider myself privileged. I'm privileged to have had a better outcome than many others in the same situation; I'm privileged to have never missed one of the annual cardiologist visits that will determine when I need to have my next operation; and I'm privileged because I happened to have the best hospital in the country in-network on my insurance while attending medical school.

The Affordable Care Act has not done nearly enough to address the barriers to health care that exist due to our broken insurance system.

Nevertheless, despite having insurance, I have to pay hundreds or thousands of dollars in deductibles and copayments out-of-pocket every year to monitor a health condition I have through no fault of my own.

If I was like millions of working Americans living paycheck-to-paycheck, unable to save money let alone pay thousands of dollars for medical bills, I might have to skip yearly checkups to take

care of other necessities first. If I were truly poor and on Medicaid, I might have to travel long distances or wait many weeks to find a physician who would take me for an appointment. In either case, I might not get the care I need until I deteriorate to a point that would cause me permanent harm.

The Affordable Care Act has not done nearly enough to address the barriers to health care that exist due to our broken insurance system. Under Obamacare, the United States remains the only industrialized capitalist democracy on the planet that does not provide universal health care access to its entire population.

Indeed, even if it works as well as it possibly can, Obamacare will leave over 30 million people uninsured and without access to basic care. Those benefiting from the law are forced into a relationship with private insurers, the same companies that previously denied people for preexisting conditions and cut policies when people got sick until those practices were outlawed by Congress.

Now, the insurance companies have a different approach to maximizing their revenue: they lure buyers on the exchange with low premiums, and then slam them with high deductibles. An annual deductible of thousands of dollars before insurance kicks in can quickly empty a family's savings account, and does little to protect them from health care costs.

As a member of SNaHP and PNHP, I advocate for an alternative along with other medical students and physician: an improved version of Medicare that would apply to the entire population; a universal, single-payer, publicly financed and administered insurance system.

By its very nature, such a system would apply to the entire citizenry from birth to death, and would reduce or eliminate out-of-pocket costs for medical care. It could be progressively financed while providing universal, equitable access.

Unlike the hodgepodge of secretive private companies providing insurance right now, Medicare-for-all would be transparently financed and publicly accountable through the democratic process. With the entire population invested in the program, the adequacy of reimbursement for medical expenses would be a top priority.

Most importantly, a Medicare-for-all program would reduce our out-of-proportion spending on health care while at the same time expanding coverage and access to everyone. It would greatly reduce the need for providers to maintain complicated administrative structures for billing multiple insurers, and would act as a strong negotiator to prevent unfair profiteering by pharmaceutical and device manufacturers.

An analysis by the Lewin Group in 2012 estimated that a single-payer system would have saved my state of Minnesota $4.1 billion in 2014, while economists estimate that single payer on a national scale would save an estimated $592 billion annually.[1]

Think of the boost our economy would receive if people were no longer going bankrupt because of medical expenses. Medicare for all would also free the private sector from the burden of providing health insurance as an employee benefit, reducing wage stagnation and making our industries more competitive on the global market.

The need for single-payer health insurance is complex, but the concept itself is simple. The vast majority of my classmates are becoming young physicians with the goal of relieving suffering and providing patients the opportunity to live their lives to the fullest.

As economic inequality comes to the forefront as a national issue, medical students are increasingly realizing that the current health insurance system frequently promotes that inequality rather than alleviating it, and just like me they are coming to recognize single-payer health insurance as a necessary, if not sufficient, step to make the provision of health care a tool for social justice.

Our movement has grown larger every year, and the reach of our message has never been broader. If our expanding membership continues to spread awareness about the problems of our health care system and the solutions offered by single-payer health care, our goal will soon be realized and I'll be able to consider my involvement to be a success.

If you care about a health care system that serves the needs of everyone, not just the privileged or the wealthy, there is room for you in this movement.

*Josh Faucher will graduate from Mayo Medical School on May 21 and is pursuing a career in emergency medicine. He co-founded the Mayo Medical School chapter of SNaHP, helped SNaHP grow as a student offshoot of PNHP with national scope, and currently serves as a student member on the PNHP Board of Directors. You can email him at **josh.faucher@gmail.com***

*Reference note : 1. Cost and Economic Impact Analysis of a Single-Payer Plan in Minnesota; **http://growthandjustice.org/images/uploads/LEWIN.Final_Report_FINAL_DRAFT.pdf***

Visit the newly updated SNaHP blog at http://student.pnhp.org

Physicians' Proposal news conference: Doctors unveil single-payer health plan at National Press Club

By PNHP staff

Below are excerpts from the remarks made at the unveiling of "Beyond the Affordable Care Act: A Physicians' Proposal for Single-Payer Health Care Reform" (**pnhp.org/nhi**) and the related publication of "Moving Forward From the Affordable Care Act to a Single-Payer System" in the American Journal of Public Health on May 5, 2016, at the National Press Club. The panel of speakers was moderated by Dr. Robert Zarr.

To view photos from the press conference, please visit our Flickr page (**flickr.com/pnhp_national**). To hear audio highlights alongside these photos, please visit our YouTube page (**https://youtu.be/DsXqAvIDb1o**).

Robert Zarr, M.D., M.P.H.
President, Physicians for a National Health Program

Dr. Zarr

As a pediatrician, I am tired of seeing families postpone medical care because they're afraid of the bill. I see children under-immunized for diseases that are easily preventable. In fact, just this week I saw another 18-month-old toddler who came in, not having had her 12-month shots. We're talking about immunizations for measles, mumps and rubella – delayed in 2016. I see my patients forced to change their doctor because their new insurance card is no longer accepted. Sadly, this is not uncommon. We can do better. Using five successful decades of experience with Medicare, we must improve and extend Medicare to all Americans. We can neither turn back the clock, nor accept the status quo. We must accept the inevitable, single payer, so we can start living without the ever-looming threat of medical and financial disaster.

Steffie Woolhandler, M.D., M.P.H.
Co-chair, Working Group on Single-Payer Program Design

Dr. Woolhandler

Twenty-seven million Americans are still uninsured and that number is not expected to fall. Tens of millions with insurance face sky-high copayments and deductibles that would bankrupt them if they were seriously ill. And many more have narrow network plans that won't cover care at top medical centers. Meanwhile, profit-driven insurers and hospital chains increasingly dominate health care. And insurers' growing demands for documentation wastes doctors and nurses time, and saps their morale. While these trends predated the ACA, the law fueled merger-mania, and added bureaucratic complexity and cost. The alternative we developed calls for radical change: a single-payer national health program. Our plan would cover everyone for all medically necessary care, without copayments or deductibles. And it would guarantee Americans the right to choose any doctor or hospital. Our nation can readily afford this if we replace today's wasteful patchwork of insurance plans with a streamlined single-payer system.

Claudia Fegan, M.D., CHCQM
National coordinator, PNHP

Dr. Fegan

Many people may ask, "Well, why do we have a Physicians' Proposal? Why now? Didn't we get there with the Affordable Care Act?" And the simple answer is "no." The simple answer is, "What is OK about a plan that leaves 27 million people still uninsured?" I'm not even talking about the underinsured; I'm talking about the uninsured. So the Affordable Care Act didn't get there. One, it leaves too many people uncovered. Two, it says it's OK to have higher and higher patient cost sharing. And three, it increases the bureaucracy in health care. The amount of money going to administration, the amount of money deciding who's covered, is increasing, not going down. It's not going to patient care. The Physicians' Proposal is another opportunity to talk about how we can get health reform right.

Karen Higgins, R.N.
Co-president, National Nurses United

Karen Higgins

This updated approach to achieving guaranteed health care for all is essential to providing the health security our patients desperately need. Patients go without medications, or cut pills in half to make them last longer, are kicked out of the hospital when the insurance company says so, or cannot see the provider best suited to their condition because they are "out of network." We should always remember that "coverage" is not "care," particularly in the present system of high deductibles and other out-of-pocket costs that create big barriers to access. Nurses work on the front lines with doctors within our dysfunctional health care system, which is dominated by private insurers, drug companies and corporate hospital chains that put their bottom line ahead of patient needs. For Registered Nurses, it is time to make our health care system reflect the values of caring, compassion and community. It's time for Single-Payer, Improved Medicare for All!

(continued on next page)

BOSTON MAY 25, 2016

Should the U.S. move to a single-payer health care system?

Interview with Marcia Angell, M.D.

According to a new Gallup Survey, 53 percent favor replacing the Affordable Care Act with a single-payer, federally funded health-care plan. That kind of health care system also has the backing of more than 2,000 physicians who have signed a "physicians' proposal" calling for major changes to our health care system.

Dr. Marcia Angell is one of the co-authors of the proposal. She's a member of the faculty of Global Health and Social Medicine at Harvard Medical School, and former editor-in-chief of the New England Journal of Medicine. Highlights of her interview included:

On why the U.S. should adopt a single-payer model:

It is much cheaper. On the first year alone, if we converted to a single-payer system, we would spend no more money than we are spending now. With time, since it's the only way to control cost inflation, it would be much cheaper. I look at it not so much as an economic issue as a moral issue. This is an obligation of any decent society to provide health care to its residents. If every other country can do it with better results than we get in terms of health, while spending less than as much per person on it, we ought to be doing this. If you look at other services that decent societies provide their people—police protection, clean water, education, roads—why is this not considered one of them?

On how the lucrative health care industry in the U.S. influences policy:

[With] politicians, you have to look at who is pulling their strings. There are huge industries in health care in this country that don't exist in other countries. Not only do they have variations of single-payer but they deliver health care in a largely non-profit system…Hospitals (even specialist positions) outpatient dialysis centers, imaging centers—they're profit-oriented.

Even in a non-profit hospital—even at Partners, for example—they can use their operating expenses to expand, and the more they expand the more they become these great conglomerates and buy up physicians and buy up outpatient clinics, the more they can set their own prices. You can't do that in other countries.

On whether switching to a single-payer model would create long waiting lists and less efficient service:

That's simply not true. Very rich people, the sheik of Kuwait, may come here to the Cleveland Clinic when he gets his heart fixed, but it is not the best system in the world by any means. We have 30 million people, even with Obamacare, who are still uninsured. That's just obscene. We distribute health care according to the ability to pay, not according to medical need. There's a huge mismatch between the ability to pay and medical need. The people who most need health care [are] the people least able to pay. If you're well insured you can get all kinds of MRIs you don't need, but if you're not insured—good luck.

Marcia Angell is a lecturer at the Harvard Medical School and the former editor-in-chief of the New England Journal of Medicine.

(***News conference,*** *continued from previous page)*

Adam Gaffney, M.D.
Co-chair, Working Group on Single-Payer Program Design

Dr. Gaffney

The good news is that there is an alternative path, which my colleagues and I are setting forth today. Our proposal sets forth the fundamentals of a far more efficient, fully universal national health program for the U.S. A single-payer national health program would cover everybody in the nation, regardless of age, income, or country of birth. It would provide comprehensive benefits to health care, including important services far too often neglected in today's system, like long-term care. It would, at the same time, eliminate cost sharing – copayments, deductibles, and coinsurance – so that individuals and families would never again need to decide between medicine and rent. The system of single-payer financing is the critical factor that makes such an expansion of coverage economically possible. It's the only realistic way to achieve the long-sought goal of universal health care in America. We hope that this proposal can help to realize it.

Sidney Wolfe, M.D.
Co-founder, Health Research Group, Public Citizen

Dr. Wolfe

All of us here were trained and have provided health care to tens of thousands of patients in this country. And we are part of what we call a health-care-providing system: nurses, doctors, psychologists, physical therapists, pharmacists, dentists and others. But we have another system, and I think it's important to identify it as such because it does eat up about a quarter of our health budget. It's called the health-care-denying and billing system. It starts out with the insurance industry and it foists itself on doctors' offices, pharmacies, hospitals and so forth. There's no other country in the world that has anything remotely like it. If those nations had a system like ours, they would not be able to have health care for everyone. The only thing I can say is that a wealthy country such as ours that refuses to provide health care for everyone cannot be described as morally civilized.

THE HUFFINGTON POST
MAY 9, 2016

The Urban Institute's attack on single payer: ridiculous assumptions yield ridiculous estimates

By David Himmelstein, M.D. and Steffie Woolhandler, M.D., M.P.H.

The Urban Institute and the Tax Policy Center today released analyses of the costs of Sen. Bernie Sanders' domestic policy proposals, including single-payer national health insurance. They claim that Sanders' proposals would raise the federal deficit by $18 trillion over the next decade.

We won't address all of the issues covered in these analyses, just single-payer Medicare for all. To put it bluntly, the estimates (which were prepared by John Holahan and colleagues) are ridiculous. They project outlandish increases in the utilization of medical care, ignore vast savings under single-payer reform, and ignore the extensive and well-documented experience with single-payer systems in other nations – which all spend far less per person on health care than we do.

The authors' anti-single-payer bias is also evident from their incredible claims that physicians' incomes would be squeezed (which contradicts their own estimates positing a sharp rise in spending on physician services), and that patients would suffer huge disruptions, despite the fact that the implementation of single-payer systems elsewhere, as well as the start-up of Medicare, were disruption-free.

We outline below some of the most glaring errors in the Holahan analysis (which served as the basis for Tax Policy Center's estimates) regarding health care spending under the Sanders plan.

1. Administrative savings, Part 1: Holahan assumes that insurance overhead would be reduced to 6 percent of total health spending from the current level of 9.5 percent. They base this 6 percent estimate on figures for Medicare's current overhead, which include the extraordinarily high overhead costs of private Medicare HMOs run by UnitedHealthcare and other insurance firms. However, Sen. Sanders' proposal would exclude these for-profit insurers, and instead build on the traditional Medicare program, whose overhead is less than 3 percent. Moreover, even this 3 percent figure is probably too high, since Sanders' plan would simplify hospital payment by funding them through global budgets (similar to the way fire departments are paid), rather than the current patient-by-patient payments. Hence a more realistic estimate would assume that insurance overhead would drop to Canada's level of about 1.8 percent. Cutting insurance overhead to 2 percent (rather than the 6 percent that Holahan projects) would save an additional $1.7 trillion over the next 10 years.

2. Administrative savings, Part 2: Holahan completely ignores the huge savings on hospital administration and doctors' billing under a streamlined single-payer system. Every serious analyst of single-payer reform has acknowledged these savings, including the Congressional Budget Office, the Government Accountability Office, the Lewin Group (a consulting firm owned by UnitedHealth Group), and even Kenneth Thorpe (a former Clinton administration official who has criticized Sanders' plan, although his recent estimates of savings are far lower than those he made prior to the current presidential campaign).

These provider savings on paperwork would, in fact, be much larger than the savings on insurance overhead. At present, U.S. hospitals spend one-quarter of their total budgets on billing and administration, more than twice as much as hospitals spend in single-payer systems like Canada's or Scotland's. Similarly, U.S. physicians, who must bill hundreds of different insurance plans with varying payment and coverage rules, spend two to three times as much as our Canadian colleagues on billing.

Overall, these administrative savings for doctors and hospitals would amount to about $2.57 trillion over 10 years. Additional savings of more than $1.5 trillion from streamlined billing and administration would accrue to nursing homes, home care agencies, ambulance companies, drug stores and other health care providers.

In total, the Holahan analysis underestimates administrative savings by about $6 trillion over 10 years.

3. Drug costs: Holahan projects that a single-payer plan would have to pay 50 percent higher drug costs than those paid at present by Medicaid. Moreover, their estimate assumes that the U.S. would continue to pay much higher prices for drugs than other nations, despite the fact that a U.S. single-payer system would have much greater negotiating leverage with drug companies than other national health insurance schemes.

Reducing drug prices to the levels currently paid by European nations would save at least $1.1 trillion more than Holahan posits over 10 years.

4. Utilization of care: Holahan projects a massive increase in acute care utilization, but does not provide detailed breakdowns of how big an increase they foresee for specific services like doctor visits or hospital care. However, it is clear that the medical care system does not have the capacity to provide the huge surge in care that he posits.

For instance Holahan's figures for the increase in acute care suggest that Sanders' plan would result in more than 100 million additional doctor visits and several million more hospitalizations each year. But there just aren't enough doctors and hospital beds to deliver that much care. Doctors are already working 53 hours per week, and experience from past reforms tells us that they won't increase their hours, nor will they see many more patients per hour.

Instead of a huge surge in utilization, more realistic projec-

(continued on next page)

Medscape

MAY 20, 2016

Doctor-Workers: Unite! Could disobedience be the path ahead?

By Howard Waitzkin, M.D., Ph.D.

"A person can become free through acts of disobedience by learning to say no to power.... At this point in history the capacity to doubt, to criticize and to disobey may be all that stands between a future for mankind and the end of civilization."
– Erich Fromm, On Disobedience[1]

Disobedience

I confess: I am a disobedient doctor.

After a career in academic medicine and public health, I decided to work part-time in a rural health program. There I began to understand the loss of control over the conditions of medical practice that has affected so many doctors. Administrative demands multiplied and constrained my ability to care for my patients in the ways I thought best.

So I decided to disobey. A seemingly minor training requirement for the International Classification of Diseases, 10th edition (ICD-10), became the administrative demand that pushed me over the line to disobedience. But the struggle might have involved any other segment of clinical medicine, where employer mandates infringe on a doctor's freedom to practice.

Proletarianization

Intrinsically, I have nothing against being a proletarian. I supported much of my education by working as a proletarian—for instance in a tire factory, where I learned first-hand about life as a worker in our capitalist society. Throughout my medical career, I have befriended many "nonprofessional" health workers—wonderful people whose services usually go underappreciated. Such people spend most of their waking lives doing tasks assigned by supervisors, and they enjoy little or no control over the conditions and rhythm of their work.

Medicine, I thought, would provide a way to seize control of my own work process and creativity by organizing at least a

(continued on next page)

(***Urban Institute rebuttal,*** *continued from previous page)*

tions would assume that doctors and hospitals would reduce the amount of unnecessary care they're now delivering in order to deliver needed care to those who are currently not getting what they need. That's what happened in Canada. Doctors and hospitals can adjust care to meet increasing demand, as happens every year during flu season.

Moreover, no surge materialized when Medicare was implemented and millions of previously uninsured seniors got coverage. Between 1964 (before Medicare) and 1966 (the year when Medicare was fully functioning) there was absolutely no increase in the total number of doctor visit in the U.S.; Americans averaged 4.3 visits per person in 1964 and 4.3 visits per person in 1966. Instead, the number of visits by poor seniors went up, while the number of visits by healthy and wealthy patients went down slightly. The same thing happened in hospitals. There were no waiting lists, just a reduction in the utilization of unneeded elective care by wealthier patients, and the delivery of more care to sick people who needed it.

Bizarrely, despite projecting a roughly $1.6 trillion increase in total payments to doctors over 10 years, Holahan says in his discussion that "Physician incomes would be squeezed by the new payment rates."

5. Holahan's argument that the Sanders plan would cause a huge disruption of health care: This argument mirrors scare tactics used by Medicare's opponents in 1963. Back then, there were claims that doctors would boycott Medicare, and Wall Street Journal headlines warned of a "Patient Pileup," as "flocks of Medicare beneficiaries ... suddenly clog the nation's 7,200 hospitals." Nothing like that ever happened, nor did it happen when Taiwan implemented single payer more recently. And there's no reason to think it would happen here.

Moreover, surveys show that most doctors would welcome national health insurance, and thousands of doctors have recently issued a call (and detailed proposal) for single-payer reform in the American Journal of Public Health.

In summary, Holahan grossly underestimates the administrative savings under single payer; projects increases in the number of doctor visits and hospitalizations that far exceed the capacity of doctors and hospitals to provide this added care; and posits that our country would continue to pay much more for drugs and medical equipment than people in every other nation with national health insurance.

Rather than increasing national health spending, as Holahan claims, Sanders' plan (and the plan proposed by Physicians for a National Health Program) would almost certainly decrease total health spending over the next 10 years.

Drs. Himmelstein and Woolhandler are professors of health policy and management at the City University of New York School of Public Health and lecturers in medicine at Harvard Medical School. The opinions expressed do not necessarily reflect those institutions'.

(***Disobedience,*** *continued from previous page*)

large part of the work week as I preferred. A position in academic medicine actually did allow me that liberty, despite the challenges of university bureaucracies—though there, too, autonomy started to erode, a phenomenon usually linked to financial shortfalls and measures of productivity.

However, entering the world of a nonacademic medical employee revealed the awesome scope of proletarianization—a change in doctors' previous social class position. Until the 1980s, doctors for the most part owned or controlled their means of production and conditions of practice. Although their work often was challenging, they could decide their hours of work, the staff members who worked with them, how much time to spend with patients, what to write about their visits in medical records, and how much to charge for their services.

Dr. Howard Waitzkin

Now the corporations for which doctors work as employees usually control those decisions. Loss of control over the conditions of work has caused much unhappiness in the profession. Early on, an esteemed clinician and mentor described medical proletarianization when it was first emerging as "working on the factory floor."[2] Most doctors have become highly paid employees of hospital and health system corporations,[3] and around one half of doctors report feeling burned out.[4,5] Owing to the mystique of professionalism and their relatively high salaries, doctors often do not realize that their discontent reflects in large part their changing social class position.

Deciding to Disobey

As a doctor-worker, I got into trouble by expressing concerns about the training that our health network (hereafter, referred to as "OHN") was requiring for ICD-10 implementation. Until then, I had received praise and little negative feedback, and had just been reappointed.

OHN had contracted with a corporation (hereafter, "$Corp") to help cope with the transition to ICD-10. This corporation was one of hundreds that have emerged to sell consulting services to healthcare organizations facing the challenges of information technology. Such challenges include electronic health records (EHRs), quality assurance, accountable care, and similar arenas. All involve "metrics" that try to make quality quantifiable, a goal that has generated wide debate.

$Corp's training for ICD-10 took multiple hours of unpaid time, and I decided to disobey the requirement. One reason involved my desire to spend time with a dying friend, which made me even more aware that each moment of life is too precious to waste.

After I previewed the $Corp training, I concluded that its educational quality was poor and that it implicitly encouraged "upcoding," which could generate more payments for OHN. Brief discussions with other practitioners confirmed universal contempt for the training, as well as disgruntled universal compliance. I decided to protest the training.

The Slippery Slope to Fascism

My subsequent interactions with OHN administrators surprised me, despite my knowledge about medical proletarianization. The chief medical information officer (CMIO) at OHN wrote that "Practitioners with incomplete ICD-10 coursework at midnight on 10/7/15 will be suspended until the coursework is completed." In response, I sent an email message asking him to explain the rationale for the training requirement. Copying the chief executive officer (CEO), the CMIO pasted his responses into the text of my original message:

1. Please provide evidence that additional training in ICD-10...improves any measurable patient outcomes, costs, or collections.
Not a debatable point. This is a requirement by OHN, so, sorry to say, whether you agree with it or not, it must be done.

2. Please provide the costs to OHN for the training.
Not relevant, as this is a requirement.

3. Please provide quantitative estimates of the financial benefits of the training for OHN.
Not relevant, as this is a requirement.

4. Please give a concrete description of the process by which you concluded that "completion of this training allows us to achieve both appropriate care and remain fiscally responsible—part of OHN stewardship."
Not relevant, as this is a requirement.

This response pressed one of my alarm buttons, which I might call the "fascism button." In my response, I explained the slippery slope to fascism,[6] when people do what they are ordered in their jobs without understanding why. Such unjustified requirements, I argued, deserve our conscientious questioning and sometimes noncompliance.

Standardization

The CMIO was unimpressed with my argument about incipient fascism in the workplace, so I next appealed to practicality. I proposed coming to the office, unpaid, and practicing ICD-10 within our EHR. His reply? "OHN's transformation is a movement to ensure process consistency and standardization.... Therefore, your request for an 'exception' is outside the organization's expectation."

Again, the CMIO's reply pressed an alarm button. I must behave like an automaton in a medical assembly line, "the factory floor" foreseen by my mentor.

I then requested a face-to-face meeting and details about my forthcoming suspension—including, most importantly, a plan of coverage for my patients. I repeated my concerns about authoritarianism in the medical workplace and the extensive evi-

dence that standardization actually may reduce quality, creativity, and productivity.

Punishment

My moral predicament deteriorated quickly. On the next morning, the CEO sent an email message asking for my resignation effective within 1 week, despite packed schedules that included many unstable patients. Then, 5 days before the deadline for suspension, I received a letter stating that my office hours with patients had been canceled until further notice. Because I needed to respond to lab results and urgent messages, I tried to connect with the EHR but found that I had been cut off.

I now faced the apparent abandonment of hundreds of my patients, many of them unstable, who had not received any alternative plan of care. Medical abandonment is unethical according to the American Medical Association Code of Ethics[7] and is illegal in many states. I contacted the chief of the medical staff, who got me reconnected to the EHR so that I could manage acute problems for my unstable patients.

Because I was not willing to abandon my patients, I also persuaded an administrator to get me reconnected to the ICD-10 training, which I completed under protest late the next night. On the following morning, a Sunday, I received an email message from the CEO thanking me for completing the training and stating that my breach of contract had been "cured."

Redemption

As a doctor-worker, I faced a challenging ethical situation that included loss of professional autonomy, authoritarian practices in the workplace, and apparent abandonment of patients. My first suspension in more than 40 years of practice also raised concerns, such as: Would a report about the suspension from OHN to the National Practitioner Data Bank affect my medical licenses or ability to practice in other settings? Was it my responsibility to blow the whistle on OHN's practices to licensing, accreditation, and insurance agencies?

My small act of conscientious disobedience eventually led to some unexpected responses. My contract and state law required that OHN convene an external review to examine possible interference with my professional judgment, and the coordinator of the state agency that licenses health facilities expressed willingness to investigate this issue and the abandonment of patients.

Facing the probability of external review, the CEO finally met with me in person, and I proposed a formal mediation process. Instead, the CEO composed a document that included an apology, a statement that information about breach of contract would be removed from my personnel file, a commitment to consider individual physicians' preferences in meeting future training requirements, and a promise to meet individually with a physician when a suspension is considered so that patient care would not be disrupted.

Where is the path toward a noncorporatized vision of what we know medicine can be at its best? I don't think that path involves our continuing acquiescence. I confess that I have decided to approach these problems through personal acts of disobedience. For a person like me, closer to the end of my medical career than the beginning, such acts don't risk much. For others, overcoming the risk will require a more organized approach to disobedience.[8] Dare I encourage disobedience in unison? To paraphrase someone else: Doctor-workers of the world, unite!

Dr. Howard Waitzkin is Distinguished Professor Emeritus of Sociology at the University of New Mexico and Adjunct Professor of Internal Medicine at the University of Illinois.

Supplementary Material

"eDocuments of Disobedience," available on request, includes memoranda intended as illustrations for doctor-workers to use when contemplating or executing acts of disobedience.

"Resources for Organizing Among Doctor-Workers" is available upon request and contain links to additional readings and pertinent organizations.

Acknowledgments

I am deeply indebted to my deceased friend, Mark Teismann, PhD, who provided inspiration, encouragement, and critical feedback for me as I wrote this article while he was dying; and to my partner and co-conspirator, Mira Lee, MD, who offered constructive suggestions and reminders that disobedience can transform the world.

References

1. Fromm E. On Disobedience. New York, NY: Harper; 2010.
2. Stoeckle JD. Working on the factory floor. Ann Intern Med. 1987;107:250-251.
3. Peckham C. Medscape physician compensation report 2016. Medscape. April 1, 2016. http://www.medscape.com/features/slideshow/compensation/2016/public/overview?src=ppc_google_rem_salary&gclid=CJ_si83OqMwCFZKCaQodSlAH5w#page=1 Accessed April 24, 2016.
4. Peckham C. Medscape lifestyle report 2016: bias and burnout. Medscape. January 13, 2016. http://www.medscape.com/features/slideshow/lifestyle/2016/public/overview#page=1 Accessed April 24, 2016.
5. Caplan AL. Physician burnout is a public health crisis, ethicist says. Medscape Business of Medicine. March 4, 2016. http://www.medscape.com/viewarticle/859300 Accessed April 24, 2016.
6. Arendt H. Eichmann in Jerusalem: A Report on the Banality of Evil. New York, NY: Viking; 1968.
7. American Medical Association. Opinion 8.115—termination of the physician-patient relationship. In: Code of Medical Ethics. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8115.page Accessed April 24, 2016.
8. Scheiber N. Doctors unionize to resist the medical machine. New York Times. January 9, 2016. http://www.nytimes.com/2016/01/10/business/doctors-unionize-to-resist-the-medical-machine.html?_r=0 Accessed April 24, 2016.

Proposed methods for measuring physician 'value': Rx for failure

CMS's sloppy attribution schemes won't work

By Kip Sullivan, J.D.

I just finished reading the 962-page proposed rule on the "Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015" (MACRA) that the Centers for Medicare and Medicaid Services (CMS) released late in April.

MACRA, you will recall, brought an end to the much-despised Sustainable Growth Rate method of adjusting Medicare payment rates, but as a trade-off the law established the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) for physicians.

I was prepared for the mind-numbing complexity of the CMS document. What I was not prepared for was CMS's glib treatment of two fundamental issues: The woeful inaccuracy of the scores CMS will use to punish and reward doctors, and the cost to doctors of participating in accountable care organizations (ACOs), "medical homes" and other APMs.

Kip Sullivan

These are not peripheral issues. If CMS dishes out financial rewards and punishments based on inaccurate data, MACRA will, at best, have no impact on cost and quality and may well have a negative effect.

The second problem – the high cost of setting up and running APMs – may not be as lethal as the inaccurate-data problem, but at minimum it will reduce physician participation in APMs and, therefore, the already slim probability that APMs will reduce Medicare costs and improve quality.

I begin with a jaw-dropping example of CMS's reckless indifference to its inability to measure physician "merit" accurately.

'Après moi le deluge'

Outside the bubble where Congress and CMS live, there is a widespread recognition that CMS cannot measure physician "performance" accurately. Here are three statements by experts to that effect:

- "*[T]he practical reality is that … CMS, despite heroic efforts, cannot accurately measure any physician's overall value, now or in the foreseeable future.*" (Berenson and Kaye, "Measuring a physician's value…." New Eng J Med, 2013)
- "*We can't estimate what the MIPs performance results will be, but the experience with other individual or group-level assessment of clinician performance generally finds that most clinicians cannot be easily differentiated from average. For example, the value modifier results for 2015, which in Medicare applies to large groups of 100 clinicians or more, found that 80 percent could not be differentiated from average, and they received no adjustment.*" (Kate Bloniarz, MedPAC staff, transcript of January 16, 2016 MedPAC meeting)
- "*The [MIPS] resource use measures are scheduled to become more important, but measures to date have a poor track record in identifying efficient physicians and practices. For example, 96 percent of physician practices were scored as 'average cost' using similar measures in the 2016 Value-Based Payment Modifier program.*" (Clough and McClellan, "Implementing MACRA…." JAMA, 2016)

What these statements tell us is that CMS cannot accurately measure the value or merit of the vast majority of physicians. In a world where evidence guides policy-making rather than group-think, CMS would acknowledge this fact. But CMS refuses to do that.

To the contrary, CMS made it clear they are hell-bent on inflicting rewards and punishments on all doctors who treat Medicare patients regardless of the accuracy of their data.

The proposed rule contains two tables showing how CMS's pay-for-"merit" scheme would affect doctors in the "Merit-based Incentive Payment System" (MIPS) program (which is where most doctors will be in the early years of the MACRA regime).

The tables show that 46 percent of doctors will be deemed to have unacceptable "merit" and therefore worthy of punishment while 54 percent will be "meritorious" and therefore deserving of rewards.

Worse, one of the tables shows that doctors in small clinics will suffer far more than those in large systems. Table 64 shows that 87 percent of solo doctors and 70 percent of 2-to-9-doctor clinics will be punished while only 18 percent of doctors in clinic chains with over 100 doctors will be punished.

CMS's failure to say a word elsewhere in the rule about the disproportionate punishment meted out to smaller clinics, and CMS's refusal to admit it will be dishing out this punishment on the basis of crude measurement, is appalling.

Too much noise, not enough signal

The crudeness of CMS's cost and quality measurement, and the high noise-to-signal ratio of the feedback to physicians such measurement guarantees, is due primarily to two intractable problems: CMS's inability to determine accurately which patients "belong" to which physicians (the attribution problem), and CMS's inability to adjust cost and quality scores for factors

outside physician control (the risk-adjustment problem).

Either problem by itself makes accurate measurement very difficult and, at the individual doctor and clinic level, impossible for all but a few simple process measures. Together the two problems are a lethal one-two punch to the fantasy that CMS or anyone else will ever measure the "value" of the vast majority of physicians accurately.

Of the two sources of noise in CMS's feedback I am discussing here – sloppy attribution and crude risk adjustment – the attribution problem is logically the first one we should address and the one I'll discuss today.

Phantom patients and 'medical hotels'

The "attribution" fad is a relative newcomer as managed care fads go. It arose around 2005, which is approximately when the ACO and "medical home" concepts began their overnight journey from obscurity to conventional wisdom.

CMS inaugurated its first test of the ACO concept, the Physician Group Practice (PGP) Demonstration, in 2005. In November 2006, the amorphous phrase "accountable care organization" was invented at a MedPAC meeting, and in March 2007 the amorphous phrase "medical home" was endorsed by four physician groups.

The ACO and "home" fads triggered the attribution craze because proponents of ACOs and "homes" didn't want to force patients to enroll with ACOs and "homes" and to have to use only the providers in those entities. Apparently ACO and "home" proponents feared that an enrollment requirement would trigger the sort of patient rebellion that HMOs triggered in the 1990s.

In any event, having decided that enrollment was to be avoided and attribution required, CMS and the rest of the health policy cognoscenti then decided that attribution to ACOs and "homes" would be done with a two-step process: (1) Patients would be assigned to primary care doctors from whom they received the plurality of their primary care services (as determined by claims data); (2) patients would, unbeknownst to them, be assigned to the ACO or "home" the doctor they were attributed to was in.

That two-step method was the one CMS used to assign patients to the 10 "group practices" that participated in the PGP demo. CMS continued to use this method in its ACO and "home" demos.

There are two administrative advantages to CMS's two-step method. First, the plurality-of-primary-care method allows CMS to assign a lot more patients than a majority method would. Second, the use of claims data only (as opposed to claims data plus medical records data) makes attribution financially feasible.

But the two-step method has a serious disadvantage: A substantial portion of the patients the method attributes to doctors have no relationship or only a tenuous relationship with the doctor and, therefore, with the ACO or "home" the doctor is part of.

The seriousness of this defect became obvious during the PGP demo. The final evaluation of that demo reported that the PGPs lost 60 percent of their assigned patients over the five-year period the demo ran.

The loss rate appears to be even higher for Pioneer ACOs. The 23 ACOs that were still in the Pioneer demo at the end of 2013 lost 38 percent of "their" patients between 2012 and 2013. Valerie Lewis et al. reported an annual loss rate of 31 percent for simulated Medicare Shared Savings Program ACOs. Friedberg et al. reported a 43 percent loss rate over three years among medical home clinics participating in the Pennsylvania Chronic Care Initiative.

For those of us not steeped in the peculiar traditions of the managed care culture, it is very difficult to understand why doctors should be "held accountable" for phantom patients, or even for patients doctors see only infrequently.

Similarly, it is very difficult for ordinary people to grasp why a clinic should be called a "medical home" when 43 percent of "its" patients disappear from the attribution list over a three-year period.

CMS's silence on sloppy attribution is unacceptable

Since CMS began tinkering with attribution schemes a decade ago, it has acted as if it has no obligation to justify its use of any method of attribution. That see-no-evil attitude is conceivably justifiable for demonstrations affecting small slices of the physician and patient populations. But MACRA is no demonstration project.

Yet CMS's see-no-evil attitude continues in its MACRA rule.

Here is the most informative statement in the MACRA rule that CMS makes about its attribution method: "Commenters [responding to CMS's 2015 request for information on MACRA] also expressed concern that current attribution methods are holding many clinicians accountable for costs they have no control over, while other clinicians have no patients attributed and no way of calculating accurate scores."

Does CMS care what these commenters think? Apparently not. CMS simply tells us they will use the plurality-of-primary-care-visit method under MACRA.

CMS should have made at least these three statements about its attribution method:

1. While cheap, its method has substantially dulled the accuracy of its measurement of physician "performance" in the value-modifier program and the ACO and "home" demos;
2. Its two-step method has created high churn rates among patients assigned to ACOs and "homes"; and
3. CMS has gotten into the habit of using the two-step approach without bothering to justify it, and CMS would now like the public to comment on whether its attribution method can be justified by any moral or logical principle.

It is obvious why CMS made no statements like these in its rule. The attribution problem isn't fixable.

Kip Sullivan, J.D., is a member of the legislative committee of Minnesota Physicians for a National Health Program. His articles have appeared in The New York Times, The Nation, The New England Journal of Medicine, Health Affairs, the Journal of Health Politics, Policy and Law, and the Los Angeles Times.

LOS ANGELES REVIEW OF BOOKS MARCH 7, 2016

Is the path to racial health equity paved with 'reparations'?

By Adam Gaffney, M.D.

"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."
– Dr. Martin Luther King, Jr.

1. Health inequality started with the nation's birth

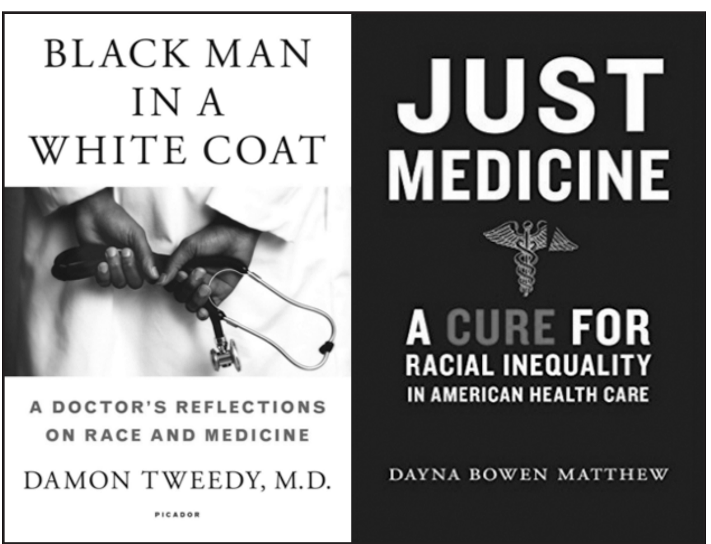
The history of American racial health "disparities" between whites and blacks begins with some of the former forcing some of the latter onto slave ships. This history is well known: the commodification of black bodies through slave labor bled the health and longevity of these men and women. And even after the abolition of slavery, an amalgam of racist terrorism, social segregation, economic marginalization, and political exclusion carried these health inequalities forward well into the 20th century – indeed, into the present day.[1]

Early on, differentials in medical care presumably played little to no role in health inequalities. Health care in the 19th century (and earlier) was distributed unequally, but, with a few exceptions, this hardly mattered: such care was mostly useless and frequently harmful. The picture changed in the 20th century when medicine gained salutary potential; but even with the rise of so-called "scientific" American medicine, racial health inequalities were not abolished. In fact, they were reproduced.

It's worth examining this history before returning to the question posed by this article's title. Consider, for instance, some of the stories compiled by one civil rights group. These stories, of blacks who were denied care in the 1930s through the 1960s, are recounted by the historian Beatrix Hoffman in her indispensible "Health Care for Some: Rights and Rationing in the United States Since the 1930s." They include that of a "17-year-old Negro girl with a bullet wound in her head" who was turned away by a hospital in Washington in 1932 on account of her race, of a seriously injured man in Texas who – despite a fracture of his pelvis – was rejected from an emergency room (his corpse was later found in an alley), and of a woman named Nonnie Clark who – despite having the majority of her body surface area covered in burns – could not be accommodated by Duke University Hospital because it had no open segregated beds on that particular day.[2]

Early in the 20th century, about 40 percent of all hospitals in the Southeast excluded blacks entirely, and segregation was the rule basically everywhere else, including in hospitals in the North.[3] Even when black patients were admitted, it wasn't always for the right reasons. In his "The Care of Strangers: The Rise of America's Hospital System," Charles Rosenberg notes that, in large hospitals, blacks were sometimes embraced for their usefulness as compliant bodies in medical education: "[T]he negro," one observer commented at the time, "is more docile and does not object to being used in clinic for teaching purposes and is one of the most prolific sources in the study of medicine."[4]

At the same time, the government's persistent failure to create a public health care system played a foundational role in structuring American health care inequalities, both by class and race. Despite high hopes that the New Deal might realize such a system, Franklin Roosevelt failed to make health reform a priority (among other issues, he wasn't enthusiastic about the prospects of confronting the rather reactionary doctors' lobby).[5] At the end of World War II, a major campaign for national health insurance did emerge, backed by both Harry S. Truman and – critically – organized labor.[6]



"Our new economic bill of rights," Truman proclaimed to Congress in 1945, "should mean health security for all, regardless of residence, station, or race – everywhere in the United States."[7] Yet this bold vision was soon smothered, the victim of a toxic redbaiting campaign pursued by the American Medical Association (AMA).[8] All that survived of it, at least in the short term, was the Hill-Burton Act, a law that funded a massive campaign of hospital-building throughout the nation. But Hill-Burton was permeated with racism from its birth. While in theory it forbade discrimination by race, the law nonetheless made an allowance for "separate but equal" facilities.[9] The implications were clear: explicit medical segregation had received the imprimatur of the law, together with generous public subsidization.

Only through the combined force of the civil rights movement, the Civil Rights Act of 1964, a number of key legal challenges, and the passage of Medicare in 1965 could the rollback of American apartheid medicine begin, as will be discussed in more detail below. For now, it's worth noting that the impact of the civil rights movement on black health was not insignificant, as demonstrated in a revealing 2013 study by epidemiologist

Nancy Krieger and colleagues. In the early 1960s, these investigators found that black infant death rates were significantly higher in "Jim Crow" states (the 21 states, plus the District of Columbia, with racial discrimination on the law books) than in non-Jim Crow states. This is hardly surprising. Yet, during the late 1960s, the death rate of the former group did improve, and by the 1970s the difference had evaporated. This can be touted as evidence that political change can yield real improvements in health over time. But two additional facts complicate this interpretation. First, after 2000, the gap again opened up, albeit to a lesser extent. And, second, regardless of the impact of the civil rights movement on disparities among blacks, throughout this period black infant death rates were still twice that of whites.[10]

Meanwhile, in terms of life expectancy, recent years have seen the reduction – but not the elimination – of black-white inequalities. As the Centers for Disease Control reported last November, the difference in life expectancy between the two groups fell from 5.9 years (in 1999) to 3.6 years (in 2013). However, even this may not be entirely goods news. A widely covered study published last fall found a unique and disturbing rise in mortality among middle-aged whites (of lower socioeconomic status) between 1999 and 2013, leading the investigators to conclude that falling white-black mortality disparities in this age group "was largely driven by increased white mortality."[11]

Moreover, during this same period and on into the present, a series of events have functioned as starkly visible and undeniable examples of ongoing structural health racism. Following the death last year of Freddie Gray while in policy custody, many made note of the enormous chasm in health and mortality between black neighborhoods like his and adjacent wealthier and whiter ones. Other commentators have highlighted "environmental racism," or inequities in exposure to environmental hazards by race, emblematic of embedded structural inequality. Revealing reporting by the Washington Post, for instance, described Gray's history of childhood lead poisoning, an exposure that is in part racially patterned. More recently, mass poisoning by lead in Flint, Michigan – the disastrous consequence of dim-witted austerity and structural marginalization – has provided yet more evidence of the downstream health consequences of political exclusion.

Inequalities in criminal justice itself – specifically mass incarceration and police violence – are now being explicitly contextualized within a framework of health.[12] In protest of such inequalities (made starkly visible by the killings of men like Eric Garner and the ensuing "Black Lives Matter" protests), medical students throughout the country have begun to advocate for change – for instance, with a solidarity "die-in" action on December 10, 2014, which in turn led to the formation of a new racial health justice organization ("White Coats for Black Lives") on Martin Luther King Day in 2015.[13]

Finally, two new books are tackling head-on the problem of racial health inequality, albeit from very different "expert" perspectives — one from within medicine and the other from a legal perspective. Damon Tweedy's "Black Man in a White Coat," released last year, is a thoughtful memoir that explores the nexus of race and medicine through the eyes of a black physician. Law professor Dayna Bowen Matthew's "Just Medicine: A Cure for Racial Inequality in American Health Care," on the other hand, is an integration of legal analysis and social science that culminates in an overarching policy recommendation.

Does confronting racial health inequality mean that we must embrace the cause of economic redistribution ... or must it proceed along explicitly racial lines?

In what follows, I'll first examine the issue of racism within the medical profession, turning to Tweedy's experiences and reflections as described in his book. Next, I'll focus on Matthew's book, and examine the problem of explicit and implicit medical discrimination historically and in the present — and how civil rights law might be used to combat it. From there, I'll discuss the place of the health system in the perpetuation of inequalities, and the largely neglected role that health care universalism plays in "health equality."

Lastly – but most importantly – I'll explore how health inequities by race and by class intersect. To phrase the question plainly: Does confronting the problem of racial health inequality mean that we must embrace the cause of economic redistribution, as discussed in the first part of this essay? If so, should this economic redistribution proceed within the context of social democracy (or democratic socialism?), or should it – must it – proceed along explicitly racial lines? Is the path to racial health equity paved with "reparations"?

2. Black doctors: Discrimination within the profession

The plotline of Steven Soderbergh's unnerving and beautifully shot series "The Knick" tackles racism within the medical profession by making it viscerally visible in another era. Set in a downtown Manhattan hospital at the turn of the 19th century, the black, eminently qualified physician, Algernon Edwards (Andrew Holland), is treated with derision and disdain by many of the hospital's white staff and administrators. At the same time, the hospital turns away black patients from its outpatient clinic; Edwards surreptitiously begins treating them – under rather suboptimal operative conditions – in the hospital's basement.[14]

But what about after the time period depicted in this series? Into the mid-20th century, blacks were excluded from many medical schools, and those who graduated faced intense discrimination in the course of practice. For instance, even decades after the events depicted in "The Knick," black physicians were unable to provide care for their hospitalized patients in the South. This was because physicians needed to gain entry into county medical societies as a prerequisite to hospital-admitting privileges; and, in the South, these societies entirely or almost entirely denied blacks membership. The AMA virtuously professed that it opposed discrimination, and yet excused itself from doing anything, claiming it was impotent to compel in-

(continued on next page)

(*Reparations,* *continued from previous page)*

tegration. It took decades of political pressure to force change. In 1968, the Medical Committee for Human Rights, a health-oriented civil rights group, took matters into its own hands, invading the AMA's convention at the extravagant Fairmont Hotel in San Francisco. Such actions — in conjunction with the Civil Rights Act and the passage of Medicare — ultimately contributed to the AMA's vote later that year to expel county societies that excluded black members, at long last forcing their disgracefully delayed integration.[15]

This is, of course, not to say that blacks subsequently gained equal footing within the medical profession. Black representation in US medical schools has remained proportionally low over the decades, especially for men. Indeed, a report from the Association of American Medical Colleges last year showed that the number of black male matriculants in medical school is lower now — in absolute terms — than it was in the late 1970s. Tweedy, now an assistant professor of psychiatry at Duke University Medical Center, was one of these matriculants. In his book, he describes some of the challenges he faced.

In addition to being one of only "a handful of black students" in his class at Duke Medical School, Tweedy came from a working-class family, in stark contrast to the majority of his classmates. On the one hand, Tweedy highlights the importance of affirmative action: "So there it was: Not only was I admitted to Duke, when in a color-blind world I might not have been, but I had arrived with a full-tuition scholarship in hand." On the other hand, his first exchange as a first year student with a medical school professor was markedly inauspicious: the professor approached him to ask if he was there to fix the lights. While he was a medical student, patients routinely queried him about his presumed basketball skills. Far worse was his interaction as a resident with a racist patient and his confederate-flag adorned family ("I don't want no nigger doctor," the patient told a nurse). Tweedy's diligence and persistence ultimately, however, won them over. On another occasion, a black patient rejected him, presuming his medical skills to be inferior and seeing the assignment as evidence of racist mistreatment of him as a patient. Given the insecurities that afflict medical students and trainees in general, we can only imagine the additional strain created by such presumptions and prejudices.

There are reams of evidence that point to social and economic inequalities as drivers of racial inequalities. But what about the role of racially discriminatory treatment itself?

Tweedy's book is also very much about the experience of black patients. He bears witness to the second-class care they too frequently experience when, for instance, as a medical student he spends time in a makeshift rural clinic, "nestled within a group of dingy trailers and makeshift houses." The clinic serves poor black patients who cannot afford prescribed treatments. They are likely to see a different doctor at every visit and receive grossly insufficient preventive care. In another chapter, he describes how one black patient, who quite reasonably declines one of his team's medical recommendations, is dispatched with a punitive psychiatric diagnosis.

Toward the conclusion of his book, Tweedy briefly explores the larger and looming question: what is the cause of racial health inequalities? Early in his medical career, he had assumed — like many others — that genetic differences were the primary factor. And indeed, for years, a huge amount of resources have gone into uncovering the genetic sources of health disparities. However, as Jason Silverstein explains in a revealing article in The Atlantic ("Genes Don't Cause Racial-Health Disparities, Society Does"), this money may have been better spent elsewhere. He describes a 2015 paper that systematically reviewed the collective evidence thus far for the proposition that genetic factors explain racial cardiovascular disparities. It's worth quoting from the study's conclusion:

> *The results reveal a striking absence of evidence to support the assertion that any important component of observed disparities in these diseases arises from main-effect genetic mechanisms as we currently understand them … Despite the enormous social investment in genomic studies, this research program has not yet provided valuable population-relevant insights into disparities in the most common cause of morbidity and mortality.*[16]

Why then, Silverstein asks the study's lead author, do genomics still get so much attention? The author responds with a sentiment I've long suspected: if inequalities are built into the very base pairs of our genetic code, what can we really do to alleviate them? More research? In effect, as the investigator tells Silverstein, the fact is that racism and inequities are let off the hook if our genes are the culprits. Tweedy notes that he came to reject this genetic explanation: even if genetic factors play some role with respect to specific diseases, they explain little of the overall differences in health between races.

In contrast, there are reams of evidence that point to social and economic inequalities as drivers of racial inequalities. In the first part of this essay, I focused on the impact of economic injustices on health: a large body of literature has demonstrated that poverty, for instance, is associated with a panoply of poor health outcomes, and some researchers argue that inequality itself causes worse health for everyone in society (perhaps via increased psychosocial strain as well as other factors).[17] No doubt such socioeconomic factors are a major factor in racial health inequalities, given the tight association between economic status and race.[18] Similarly, differences in health care access associated with race (like being uninsured) are no doubt factors as well.

But what might be said about the role of racially discriminatory treatment itself? This issue has received increased attention since the 2002 publication of an Institute of Medicine evidence report, "Unequal Treatment: Confronting Racial Disparities in Health Care." Tweedy quotes from the report's conclusion: "Although myriad sources contribute to [health] disparities, some

evidence suggests that bias, prejudice, and stereotyping on the part of the healthcare providers may contribute to differences in care." Or, as he puts it, the "doctor-patient relationship itself serves as a catalyst for differing outcomes," which is in part the result of the fact that "some doctors are prone to hold negative views about the ability of black patients to manage their health and therefore might recommend different, and possibly substandard, treatments to them."

This issue – namely, the problem of racially disparate treatment – is the central focus of Dayna Bowen Matthew's book. She explores how "implicit bias," as she terms it, deforms physician behavior; in her view, it constitutes the most neglected determinant of inferior health among blacks.

3. Jim Crow medicine: Past and present

Matthew is a law professor with appointments at both the University of Colorado Law School and the Colorado School of Public Health. Matthew is also one of the founders of the Colorado Health Equity Project, a multidisciplinary organization that works to "remove legal barriers to equal health access and health outcomes for Colorado's vulnerable populations," as its website puts it. Her ambitious book lays out a case for a legal remedy for racial health inequality.

Key to her argument is the historical context of civil rights law, which she sees as a swinging pendulum. Hill-Burton, as we've seen, legally enshrined the "separate-but-equal" standard – established in the Supreme Court case Plessy v. Ferguson – within the health care system. Legal challenges to this standard were unsuccessful, until Simkins v. Moses H. Cone Memorial Hospital, the "watershed case," as Matthew puts it, initiated its unraveling. As she recounts it, the case was brought by black practitioners and patients against a discriminatory hospital in North Carolina that received Hill-Burton funds. The Fourth Circuit Court of Appeals decided in favor of the plaintiffs, declaring, as quoted by Matthew, that "Racial discrimination by hospitals visits severe consequences upon Negro physicians and their patients."

She describes two consequences that flowed from this decision. First, the case helped catalyze subsequent successful health-care related civil rights litigation throughout the country. Second, the decision – which the Supreme Court importantly declined to reconsider – helped lead the way to Title VI of the Civil Rights Act of 1964. According to Matthew, Congress took the Supreme Court's decision not to accept the case as a signal that it saw hospital segregation as unconstitutional (and, indeed, several legislators explicitly cited the Simkins decision during debate over the bill). Much good came from this: "From 1963 through the early 1990s," Matthew writes, "Title VI proved an effective weapon against the segregation and discrimination that minority patients and physicians had experienced in American health care since the colonial era." For instance, the Johnson administration required hospitals to comply with Title VI in order to be eligible for Medicare payment. Few could afford not to, and so the age of explicit hospital segregation finally came to a close.

Yet Matthew asserts that, to an extent, this more auspicious era ended abruptly in 2001, when a more conservative Supreme Court ruled in Alexander v. Sandoval, in a decision written by Justice Antonin Scalia, that Title VI was applicable only in cases of deliberate discrimination; disparate impact was not enough.[19] This new standard precluded a great deal of civil rights litigation because it required that plaintiffs produce tangible evidence that racist health care was intentional, which is made difficult when, as she notes, "few Americans are careless enough to create an evidentiary record of outright bigotry." Thus, according to Matthew, with respect to health care discrimination, this decision effectively rendered Title VI "a dead letter." This decision, she argues, must be undone if progress against racial health inequalities is to proceed. In short, unconscious racism in health care must, according to her, be made illegal through an act of Congress and an expansion of Title VI.

This may sound Orwellian to some. Is it meaningful, after all, to talk about outlawing sentiments or attitudes that lie deep within the dark depths of our unconscious? Can we root out biases if we are, by definition, unaware of their very existence? Matthew marshals a body of literature from various disciplines to answer in the affirmative. Conscious racism, she argues, is slowly being replaced by the unconscious variety: "But while overt racism is subject to nearly universal derision, unconscious racism due to implicit bias is hidden, is tolerated, and even excused despite its destructiveness." She persuasively explores various literatures demonstrating that physicians harbor unconscious negative perceptions of blacks. She cites studies that show that patient race affects which treatments doctors recommend, how much time they spend with patients, "the level of verbal exchange and shared decision-making in which they engage" with patients, and even the manner of their nonverbal engagement. She concludes that there is a sufficient base of evidence to conclude that these implicit biases contribute to disparities, that there is reason to believe that such biases, even though they are implicit, are remediable, and that health care providers – both on the individual and institutional level – can therefore be held legally responsible for the results of their implicit biases.

Conscious racism, Matthew argues, is slowly being replaced by the unconscious variety.

The "evidence of malleability" is strong, according to Matthew. In other words, she thinks specific interventions can mitigate implicit biases and, as a result, disparate outcomes. The sorts of interventions she envisions, however, seem of mixed applicability and utility. Nonetheless, overall, she makes a strong case that clinicians make racially biased decisions, whether or not they intend to, and that this issue must be directly addressed. People like me – that is to say, white physicians who believe they are immune from racially biased thought and action – have a great deal to gain from reading this book.

That said, it is also important to examine the larger picture. There is no question that more needs to be done to address physician bias. Yet we also have to keep in mind that, in the

(continued on next page)

(*Reparations,* *continued from previous page)*

pre-Alexander v. Sandoval era (when Title VI was, according to Matthew, more robust), there were still large racial inequalities. Litigation may be a useful tool, but it's a limited, post-facto modality.

More broadly, the recommendations of both Tweedy and Matthew ultimately seem inadequate. Neither gives much credence to the notion that further increasing the universalism of the health system might play an important role in reducing inequalities. Moreover, Tweedy says nothing, and Matthew only a little,[20] about the notion of economic redistribution as a tool against racial health inequalities. In fairness, these concerns are not the focus of their books. However, to my mind, they are crucial considerations in the larger discussion of racial health care justice.

4. Health equity and health system universalism

Martin Luther Kings Jr.'s statement on the evils of health inequality is frequently quoted, but not usually in its full form. In his 1966 speech at the annual meeting of the aforementioned Medical Committee for Human Rights, he said, "Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."[21] Indeed, studies have shown a statistical association between lack of insurance and mortality. Removing the boundaries between individuals and the health care system is a critical step in the movement toward health care equality.

Tweedy, for instance, sees firsthand the harm inflicted on the uninsured when he works at the rural health clinic described earlier. But, even so, like Matthew, he gives insufficient attention in his book to the fact that, even with the reforms of the Affordable Care Act, we will continue to lack universal health care.[22] For instance, under current reforms, 27 million are expected to remain uninsured 10 years from now, according to an approximation of the Congressional Budget Office. We know that Hispanics and blacks are disproportionately represented among the uninsured.[23] Covering these excluded millions seems critical. Moreover, neither author discusses the fact that the US health care system imposes substantial financial burdens at the "point of use," in the form of copayments, deductibles, and co-insurance for medical care, which may deter care for those who need it. Some have legitimately suggested that these forms of cost-sharing disproportionately harm minorities, who have lower median income and net wealth.[24] In other words, the potential harm of, say, a $2,000 medical deductible is dependent on your income and assets: those with fewer resources may lose out on important health care. And finally, though Tweedy refers to the shortcomings of Medicaid, neither he nor Matthew emphasizes that a health care system with a separate tier of access for the poor may be inherently unequal.

But would "true" universal health care do much to combat racial health inequalities, if it were, say, a single-payer system that eliminated out-of-pocket expenses and was equally accessible by all, without tiers or walls?[25] Or would it replicate current biases and inequalities? To some extent, the answer is yes to both questions. But even so, a body of research has suggested that, even if these biases persist, a fully universal system might nonetheless be a powerful tool in reducing racial health care inequalities. That evidence comes from what is arguably a quasi-single-payer system located in the US: the Veterans Administration (VA). Notwithstanding recent scandals that are indeed of great concern, the modern-era VA has justifiably earned praise for delivering a high – indeed, comparatively superior – quality of health care.[26] There is also evidence that it may indeed effectively reduce, even potentially eliminate, some racial health inequalities.

Last fall, a study published in Circulation, the premier journal of the American Heart Association, received wide coverage in the media for some provocative findings. "The US Veterans Health Administration (VHA)," as the study notes in its introductory section, "is a healthcare system that does not impose the typical access barriers of the US healthcare system that may disproportionately impede enrollment of blacks." The investigators therefore hypothesized that racial inequalities in cardiovascular outcomes and mortality found in the general population might be reduced in the VA, a "healthcare system that allows enrollment independent of race or socioeconomic status."[27] Consistent with previous studies, in their analysis of data from the general (non-VA) population, they found racial inequalities much as they expected to find them: blacks had a much higher mortality (after adjusting for various other factors) as compared to whites (indeed, approximately 40 percent to 50 percent higher).[28]

Research suggests a a fully universal health system might be a powerful tool in reducing health care inequalities. The evidence comes from the VA.

In striking contrast, in the VA population, even though the risk of stroke was either higher or similar among blacks as compared to whites depending on which statistical adjustments were used, the risk of coronary heart disease as well as overall death was actually lower among blacks. This is, of course, only a single study, albeit a rather large one with more than three million subjects. An accompanying editorial concedes that a number of factors may be at play. Nonetheless, the fact is that, as described by the investigators, these findings build on an existing literature consisting of multiple studies that together point to a reduction of racial health inequalities within the VA for critically important outcomes like mortality.[29]

No doubt, there are still discriminatory practices in some or all of these facilities, and we can assume that there are conscious or unconscious biases at work in the minds of some of its clinicians, as there are elsewhere. Indeed, other studies clearly show that, even after the significant reorganization and reform of the VA in the late 1990s, there are still racial disparities in the VA.[30] If we moved to a single-payer system on a national level, such biases would still need to be addressed along the lines Matthew argues. But the point is that a more egalitarian structure of

the health care system itself might go even further in reducing them. Indeed, in light of this research, it seems fair to say that health care universalism could be a very powerful tool in combatting ubiquitous racial health inequities. Attaining health care equality, in other words, requires true equality of access. And yet this simple notion is all too often ignored entirely in any discussion of health "disparities."

5. The road to health equality: Is it paved with reparations?

This takes us to the final and most important arena: the issue of economic inequality. The essential point here was made clearly by the scholar Vicente Navarro in a commentary in the Lancet in 1990: "… even if there were no race differentials in mortality, most blacks would still have higher mortality rates than the median or the mean rate in the US population."[31] The logic of this seemingly paradoxical statement is simple. There is currently a (growing) gradient in life expectancy by income: the wealthy live longer than the poor. Thus, if incomes differ by race (as they do), then life expectancy will differ by race, even if racism were eradicated in its entirety from the health care system.

This is an uncomfortable notion, but it's an important one. The ongoing rise in economic inequality was — in part — set into motion by a transatlantic political shift that occurred sometime in the 1970s.[32] The political ground may now be shifting beneath our feet, but we are nonetheless very much still living in that same "neoliberal" era, an era in which economic inequality and health inequality are yoked.

For some, an overarching concern with economic inequality might be thought consistent with a "class first" (as its often termed) mentality toward political change, an approach that is currently under great contestation on the left-leaning side of the political spectrum. For instance, Bernie Sanders's central focus on economic justice has been criticized by the Atlantic's Ta-Nehisi Coates, who argues that his "rising tide lifts all boats" approach is an amplified version of a longstanding inadequate Democratic approach to racial inequality. For Coates, in contrast, the sine qua non of racial justice is reparations. "[T]reating a racist injury solely with class-based remedies," he writes, "is like treating a gun-shot wound solely with bandages." But it bears mention that – in one particular way – Sanders and Coates are both arguing for the same thing: economic redistribution. For Sanders, this redistribution can be colorblind — through greater social welfare programs and progressive taxation — and still benefit minorities; for Coates, it must occur along color lines so as to more directly remunerate the victims of centuries of racist "plunder." Yet there is, in truth, a great deal of overlap between these views. As The Week's Ryan Cooper argued in response to Coates, given entrenched economic inequality between races, "[r]ace-neutral redistribution and welfare are by necessity anti-racist." However, it's important to recognize at the same time that a redistributive approach that is (at least nominally) neutral with respect to race lacks the symbolism of restitution. I can understand how many might feel that this would therefore fall short of justice.

Then again, a stark theoretical dichotomy between class-based and race-based measures is reflective of neither history nor contemporary reality. The very reason that there are economic inequalities between blacks and whites is, of course, slavery, and the legal and extralegal oppression that followed it. In health, we can disentangle the effects of class and race by using sophisticated statistical tools, but what does it really mean when we say that health disparities are – or aren't – attenuated when "adjusting" for socioeconomic status? Theoretically, we are trying to measure the "pure" effect of race.[33] But that's an illusory concept, to some extent: the effects of class and race are intimately interwoven.

In health care, it is at this point clear that we need policies that work to diminish inequalities along the lines of each. A lesson that can be drawn from Tweedy, for instance, is that a health care workforce should reflect the composition of its population. Although he doesn't make the case quite as strongly in his book, he does so in a New York Times op-ed headlined "The Case for Black Doctors." For now, this goal requires affirmative action. Matthew, on the other hand, convincingly demonstrates that racial biases are at work – sometimes invisibly – in the minds of physicians, and whatever happens in the realm of economics or on the health system level, those biases will not suddenly wither. They therefore must be addressed, perhaps through the types of legal measures she describes. More broadly, we must aggressively address the host of environmental and public health inequities – and police violence might be considered in this category – that disproportionately afflict communities of color.

Yet these approaches – if carried out alone – would ultimately be inadequate in the struggle against racial inequalities in health. Health system universalism, on the other hand, is a potentially powerful – albeit insufficient – step toward racial health care justice. Likewise, economic inequality – on the rise, bound with race, tightly corresponding to health and death – must also be addressed. This is where the "liberal" and the "left" frameworks toward health inequalities diverge. The liberal framework seeks to ameliorate the health impact of poverty or inequality with an array of interventions and programs and palliatives; the left approach, in contrast, goes a step further, and aims to level the inequalities themselves.

At the moment, the political winds seem to be favoring the latter. For those concerned with combatting the ills of health inequality – of both race and class – this should be seen as an auspicious development. Health inequities are not the product of our genes: they are the consequences of our history, and of the politics of health.

References

1. One of the two books reviewed in this essay — Dayna Bowen Matthew's "Just Medicine: A Cure for Racial Inequality in American Health Care" – traces the history of health inequalities back to colonialism and the horrors of slavery.

2. Beatrix Rebecca Hoffman, "Health Care for Some: Rights and Rationing in the United States since 1930" (Chicago: University of Chicago Press, 2012), 81-85. The quote is from a docu-

(continued on next page)

(***Reparations,*** *continued from previous page*)

ment from the Southern Conference Educational Fund, quoted by Hoffman on p. 82.

3. Stevens note that in 1910, only 60 percent of hospitals accepted any "colored" patients in this region. Rosemary Stevens, "In Sickness and in Wealth: American Hospitals in the Twentieth Century" (New York: Basic Books, 1989), 50.

4. Quoted by Charles E. Rosenberg, "The Care of Strangers: The Rise of America's Hospital System" (New York: Basic Books, 1987), 302.

5. On health reform during the New Deal era, see Daniel S. Hirshfield, "The Lost Reform: the Campaign for Compulsory Health Insurance in the United States from 1932-1943" (Cambridge, Mass.: Harvard University Press, 1970). See p. 44 on this specific point.

6. Regarding labor's support for national health insurance in this era, see A. Derickson, "'Take Health from the List of Luxuries': Labor and the Right to Health Care, 1915-1949," Labor History 41, no. 2 (2000).

7. Quoted in Alan Derickson, "Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958," The Journal of American History 80, no. 4 (1994): 1341.

8. On the Truman campaign and the physician backlash, see Monte M. Poen, "Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare" (Columbia: University of Missouri Press, 1979).

9. Hoffman, "Health Care for Some," 74.

10. N. Krieger et al., "The Unique Impact of Abolition of Jim Crow Laws on Reducing Inequities in Infant Death Rates and Implications for Choice of Comparison Groups in Analyzing Societal Determinants of Health," American Journal of Public Health 103, no. 12 (2013).

11. Anne Case and Angus Deaton, "Rising Morbidity and Mortality in Midlife among White Non-Hispanic Americans in the 21st Century," Proceedings of the National Academy of Sciences (2015). There has subsequently been some discussion about the failure to fully adjust for age in this paper, but the overall thrust of the paper's findings have held up, as discussed here.

12. For instance, these scholars contextualize deaths at the hands of law enforcement as a public health issue, arguing that such deaths should be made a "reportable health condition." Nancy Krieger et al., "Police Killings and Police Deaths Are Public Health Data and Can Be Counted," PLoS Med 12, no. 12 (2015).

13. The group recently published a paper describing their origins and aims. Dorothy Charles et al., "White Coats for Black Lives: Medical Students Responding to Racism and Police Brutality," Journal of Urban Health 92, no. 6 (2015).

14. I discussed this aspect of the show in greater length in an online article "Just Another Business," Jacobin, November 21, 2015.

15. This paragraph relies throughout on John Dittmer, "The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care," 1st ed. (New York: Bloomsbury Press, 2009), 6-7, 205-07.

16. Jay S. Kaufman et al., "The Contribution of Genomic Research to Explaining Racial Disparities in Cardiovascular Disease: A Systematic Review," American Journal of Epidemiology (2015).

17. The health effects of inequality were presented to a general audience in: Richard G. Wilkinson and Kate Pickett, "The Spirit Level: Why Greater Equality Makes Societies Stronger" (New York: Bloomsbury Press, 2010).

18. Moreover, group-level differences in unhealthy behaviors can be seen (in part) as downstream consequences of social, economic, and environmental disparities, and so might also be considered in this category.

19. However, she notes that "disparate impact" is still sufficient grounds for action by government agencies, though she contends that, practically speaking, these agencies lack sufficient resources for the task.

20. For example, as Matthew notes in passing, "[c]hanging only the law will not solve the socioeconomic disparities that lie at the foundation of our society and produce the poor health experienced by many people." She also makes the important point that universalizing access does not solve other racially patterned "systemic inequities" – for instance, in education or housing.

21. Two articles containing slightly different versions of this quote have recently surfaced. This version is from an AP story headlined "King Berates Medical Care Given Negroes" Oshkosh Daily Northwestern, March 26, 1966, and is available at: http://www.pnhp.org/news/2014/october/dr-martin-luther-king-on-health-care-injustice (accessed January 26, 2016). The other article with a slightly different version of the quote is available at the same page.

22. Tweedy acknowledges that the Affordable Care Act "has some good features," like the expansion of insurance coverage and the prohibition on discrimination based on preexisting conditions. "But whether these and other changes will prove to be fiscally viable over the long term," he states, "in the face of ever-rising health care costs, remains to be seen." It's not quite clear what Tweedy is saying here. Is he calling into question the financial viability of universal health coverage itself? Or is he suggesting that a more robust reform is necessary to cover everybody while also lowering costs? If he means the latter, he does not say it, much less spell it out.

23. According to this November 2015 report from the Kaiser Family Foundation, the uninsurance rate for whites is 9 percent, for blacks is 13 percent, and for Hispanics is 21 percent.

24. "[T]he average family deductibles for bronze and silver plans would bring financial ruin to most African American and Hispanic households." Dominic F. Caruso, David U. Himmelstein, and Steffie Woolhandler, "Single-Payer Health Reform: A Step toward Reducing Structural Racism in Health Care," Harvard Public Health Review 6 (2015). Available here.

25. The argument that single payer could be a tool against racial health inequalities has been made before. See Vijay Das and Adam Gaffney, "Racial Injustice Still Rife in Health Care," CNN.com, July 28, 2015; and Caruso, Himmelstein, and Woolhandler, "Single-Payer Health Reform: A Step toward Reducing Structural Racism in Health Care."

26. This study, for instance, compared the extent to which

VHA patients receive recommended care for a wide variety of conditions as compared to non-VHA patients. It found that the "… VHA had substantially better quality of care than a national sample." S. M. Asch et al., "Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample," Annals of Internal Medicine 141, no. 12 (2004).

27. The study excluded individuals with reduced renal function, given evidence that genetic factors may play a role in black/white disparities in this population. Kovesdy, Csaba P., Keith C. Norris, L. Ebony Boulware, Jun L. Lu, Jennie Z. Ma, Elani Streja, Miklos Z. Molnar, and Kamyar Kalantar-Zadeh, "Association of Race with Mortality and Cardiovascular Events in a Large Cohort of US Veterans," Circulation (September 18, 2015).

28. 42 percent higher if restricted to those with normal kidney function, and 51 percent higher in the overall population.

29. For instance, Jha et al. investigated how race affects mortality in those hospitalized at VA hospitals for one of six conditions, and went so far as to conclude that "equal access to care provided by the VA health care system has closed – and perhaps even crossed – the racial gap in health outcomes for common conditions." Deswal et al. evaluated mortality following admission to a VA hospital among those only with congestive heart failure, concluding that "[i]n the VA healthcare system, a system designed to provide financially 'equal access' to care for all enrolled patients, the racial gap in patterns of healthcare utilization in patients with CHF is small. The observation of better survival in black patients after a hospitalization for CHF is not readily explained by differences in healthcare utilization and needs further evaluation." However, as the investigators' note, white patients were overall sicker, which might account for their worse outcomes in a manner that could not be adjusted for by the investigators. Still, considered together, the fact that, in some instances, blacks do better than whites in the VA system is striking. However, it should probably be taken with something of a grain of salt given the fact that they do worse everywhere else. Overall, it might seem fair to conservatively conclude from such studies that, at the least, racial health inequalities – like mortality – are substantially attenuated within the VA system as compared to the general population. The papers by Jha et al. and Deswal et al. are cited in the paper by Kovesdy et al. See A. K. Jha et al., "Racial Differences in Mortality among Men Hospitalized in the Veterans Affairs Health Care System," Jama 285, no. 3 (2001); A. Deswal et al., "Impact of Race on Health Care Utilization and Outcomes in Veterans with Congestive Heart Failure," J Am Coll Cardiol 43, no. 5 (2004); N. L. Cook and G. A. Mensah, "Eliminating Health Disparities: What Can We Learn from the Veterans Health Administration?" Circulation 132, no. 16 (2015).

30. For just one example, see Amal N. Trivedi et al., "Despite Improved Quality of Care in the Veterans Affairs Health System, Racial Disparity Persists for Important Clinical Outcomes," Health Affairs 30, no. 4 (2011).

31. V. Navarro, "Race or Class Versus Race and Class: Mortality Differentials in the United States," The Lancet 336, no. 8725 (1990).

32. On the transatlantic intellectual roots of neoliberalism, see Daniel Stedman Jones's excellent "Masters of the Universe: Hayek, Friedman, and the Birth of Neoliberal Politics" (Princeton: Princeton University Press, 2012). Jones emphasizes the "underappreciated real significance of the transatlantic nature of neoliberalism – it didn't just happen in different places at the same time, it happened across and between them."

33. For a very good discussion of this issue, and of how race and class inequities must both be studied and addressed, see Ichiro Kawachi, Norman Daniels, and Dean E. Robinson, "Health Disparities by Race and Class: Why Both Matter," Health Affairs 24, no. 2 (2005).

Adam Gaffney is a physician and writer whose work has also appeared (either in print or online) in the New Republic, Salon, US News & World Report, Jacobin, In These Times, USA Today, CNN.com, and on his blog at www.theprogressivephysician.net. He is a fellow in pulmonary and critical care medicine at Massachusetts General Hospital. He is also an adviser to the board of the Physicians for a National Health Program. All views expressed are his alone.

Focus on Racial Justice

Members of a panel on "single payer and racial justice" at PNHP's 2015 Annual Meeting in Chicago take a question from the floor. From left, Dr. Donald Moore, PNHP New York Metro; Vanessa Van Doren, PNHP student board member; Dr. Nahiris Bahamón, Residents for a National Health Program; and Nicolás E. Barceló, White Coats for Black Lives. Photo: Rob Zalas.

THE AMERICAN JOURNAL OF
MANAGED CARE

JUNE 4, 2016

Dr. Susan Rogers: Improve cancer care with single payer

By Surabhi Dangi-Garimella, Ph.D.

On the first day of the annual meeting of the American Society of Clinical Oncology, being held June 3-7, 2016, in Chicago, Illinois, healthcare experts from the United States, Canada, and the United Kingdom, compared and contrasted the care models that are widely adopted in each nation. Placing a significant emphasis on reviewing the value of cancer care, panelists discussed how the National Institute for Health and Care Excellence (NICE) in the United Kingdom, and the Canadian healthcare model, seek to optimize the cost and value of cancer care. Panelists identified opportunities for constructive interventions that could help fill up gaps in the US healthcare system.

United States

Susan Rogers, MD, FACP, Stroger Hospital of Cook County, Physicians for a National Health Program, introduced the US healthcare system. Her talk was entitled, "Perverse Incentives and Broken Markets: How Did We Get Here and How Do We Correct It?"

Rogers posed the question, "Why do we need a single payer?" But before trying to answer that question, she took a step back to explain some of the basic reasons for seeking health insurance. Rogers said that insuring against health:

- Protects financial assets
- Improves access to care
- Protects health

"The United States has five health delivery systems," Rogers said, listing them as Medicare; Medicaid; private insurance offered to workers where they have to contribute to the premium; healthcare for Native Americans, vets, and the military, provided and delivered by the government (socialist medicine); and the uninsured.

"We are spending a lot of money on healthcare. US public spending per capita for health is greater than the total spending in other nations," Rogers said, with data showing that US spends significantly greater than the highest amount spent by other developing countries. She added that the increased spending does not guarantee an improvement in infant mortality rates or improve longevity.

So how can access to better healthcare be improved? Rogers pointed out that employment alone does not insure health benefits, because a lot of employers prefer part-time employees, who then do not qualify to receive the benefits. With Medicaid expansion following the Affordable Care Act (ACA), there was hope that disparities in access to healthcare would be addressed. But it was not to be. "If half the physicians are not participating in Medicaid managed care plans, how can patients access care with those doctors?" Rogers asked. Despite the provisions within the Act, the Congressional Budget Office has estimated that 30 million will remain uninsured in 2016 and the number will hover around 29 million till 2019.

Dr. Susan Rogers

The ACA has not really helped the US population, Rogers said, because a standard benefits package was not developed under the ACA. While copays and coinsurance were eliminated for enrollees, but it was only for preventive services. "ACA makes underinsurance the norm," she said. With the average deductibles steadily rising, from $300 in 2006 to $1,077 in 2015, medical bankruptcies are significantly higher, especially among cancer patients, Rogers pointed out.

Voting for a Single Payer System

Rogers is a big proponent of a single payer system – she believes it presents several advantages that private plans do not. When a person seeks care at a site, some of the providers may not be in-network, and so when the patients uses those services, they may end up being very expensive, she explained. "A single-payer system, on the other hand, will remove provider restrictions and improve access and choice for all."

While it might cost more to cover everyone (she showed an estimate of $243 billion), a single-payer system can be kept funded by eliminating discrepancies in service costs, reducing administrative costs, reducing drug prices could via negotiations, and by introducing a payroll tax instead of a deduction.

Belgium was the first developed country to introduce a government-backed universal health insurance, back in 1945. Subsequently, several countries in Europe and in Asia followed suit.

"ACA is based on private insurance and will not be able to solve patient access issues," Rogers said. "A single payer will be the only insurance plan that can allow cost control, provide access, and provide better choice."

PNHP note: The text above was excerpted from a much longer article originally titled "Lessons in cancer care from NICE and Health Canada at ASCO." The full article is available at ***bit.ly/29hT2UD***.

April 26, 2016

The association between income and life expectancy in the United States, 2001-2014

By Raj Chetty, PhD; Michael Stepner, BA; Sarah Abraham, BA; Shelby Lin, MPhil; Benjamin Scuderi, BA; Nicholas Turner, PhD; Augustin Bergeron, MA; David Cutler, PhD

Abstract

Importance The relationship between income and life expectancy is well established but remains poorly understood.

Objectives

To measure the level, time trend, and geographic variability in the association between income and life expectancy and to identify factors related to small area variation.

Design and Setting

Income data for the US population were obtained from 1.4 billion deidentified tax records between 1999 and 2014. Mortality data were obtained from Social Security Administration death records. These data were used to estimate race- and ethnicity-adjusted life expectancy at 40 years of age by household income percentile, sex, and geographic area, and to evaluate factors associated with differences in life expectancy.

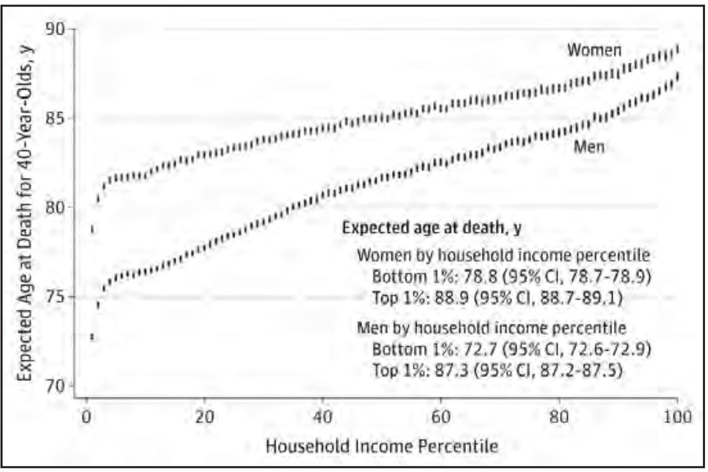
Exposure

Pretax household earnings as a measure of income.

Main Outcomes and Measures

Relationship between income and life expectancy; trends in life expectancy by income group; geographic variation in life expectancy levels and trends by income group; and factors associated with differences in life expectancy across areas.

Race- and Ethnicity-Adjusted Life Expectancy for 40-Year-Olds by Household Income Percentile, 2001-2014



Results

The sample consisted of 1,408,287,218 person-year observations for individuals aged 40 to 76 years (mean age, 53.0 years; median household earnings among working individuals, $61,175 per year). There were 4,114,380 deaths among men (mortality rate, 596.3 per 100,000) and 2,694,808 deaths among women (mortality rate, 375.1 per 100,000). The analysis yielded 4 results. First, higher income was associated with greater longevity throughout the income distribution. The gap in life expectancy between the richest 1 percent and poorest 1 percent of individuals was 14.6 years (95 percent CI, 14.4 to 14.8 years) for men and 10.1 years (95 percent CI, 9.9 to 10.3 years) for women. Second, inequality in life expectancy increased over time. Between 2001 and 2014, life expectancy increased by 2.34 years for men and 2.91 years for women in the top 5 percent of the income distribution, but by only 0.32 years for men and 0.04 years for women in the bottom 5 percent (P<.001 for the differences for both sexes). Third, life expectancy for low-income individuals varied substantially across local areas. In the bottom income quartile, life expectancy differed by approximately 4.5 years between areas with the highest and lowest longevity. Changes in life expectancy between 2001 and 2014 ranged from gains of more than 4 years to losses of more than 2 years across areas. Fourth, geographic differences in life expectancy for individuals in the lowest income quartile were significantly correlated with health behaviors such as smoking (r=-0.69, P<.001), but were not significantly correlated with access to medical care, physical environmental factors, income inequality, or labor market conditions. Life expectancy for low-income individuals was positively correlated with the local area fraction of immigrants (r=0.72, P<.001), fraction of college graduates (r=0.42, P<.001), and government expenditures (r=0.57, P<.001).

Conclusions and Relevance

In the United States between 2001 and 2014, higher income was associated with greater longevity, and differences in life expectancy across income groups increased over time. However, the association between life expectancy and income varied substantially across areas; differences in longevity across income groups decreased in some areas and increased in others. The differences in life expectancy were correlated with health behaviors and local area characteristics.

Health Affairs

MAY 2016

INSURANCE COVERAGE & COSTS

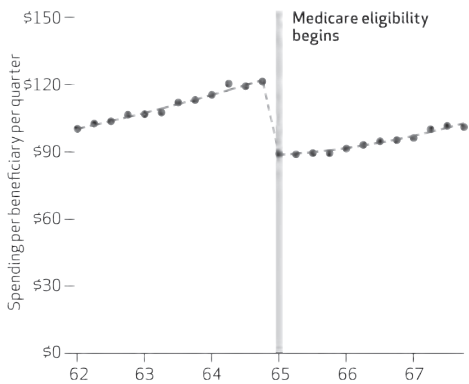
By Jacob Wallace and Zirui Song

Traditional Medicare Versus Private Insurance: How Spending, Volume, And Price Change At Age Sixty-Five

ABSTRACT To slow the growth of Medicare spending, some policy makers have advocated raising the Medicare eligibility age from the current sixty-five years to sixty-seven years. For the majority of affected adults, this would delay entry into Medicare and increase the time they are covered by private insurance. Despite its policy importance, little is known about how such a change would affect national health care spending, which is the sum of health care spending for all consumers and payers—including governments. We examined how spending differed between Medicare and private insurance using longitudinal data on imaging and procedures for a national cohort of individuals who switched from private insurance to Medicare at age sixty-five. Using a regression discontinuity design, we found that spending fell by $38.56 per beneficiary per quarter—or 32.4 percent—upon entry into Medicare at age sixty-five. In contrast, we found no changes in the volume of services at age sixty-five. For the previously insured, entry into Medicare led to a large drop in spending driven by lower provider prices, which may reflect Medicare's purchasing power as a large insurer. These findings imply that increasing the Medicare eligibility age may raise national health care spending by replacing Medicare coverage with private insurance, which pays higher provider prices than Medicare does.

EXHIBIT 1

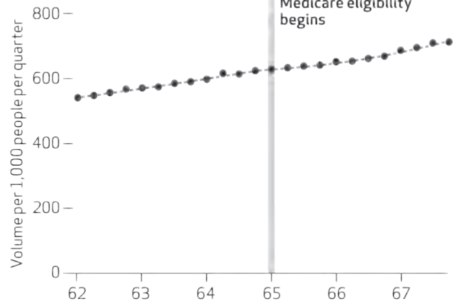
Unadjusted spending before and after the transition from private insurance to Medicare at age 65



SOURCE Authors' analysis of data for 2007–13 from Truven Health Analytics' Medicare and Commercial Claims and Encounters database. NOTES Average spending on analyzed services (in 2013 US dollars) per beneficiary per quarter. The line was generated from regressions of spending on age and age squared, with a binary variable for ages sixty-five and older. The model allowed for different age coefficients in the private insurance and Medicare samples. Analyzed services are listed in Appendix 1 (see Note 20 in text).

EXHIBIT 3

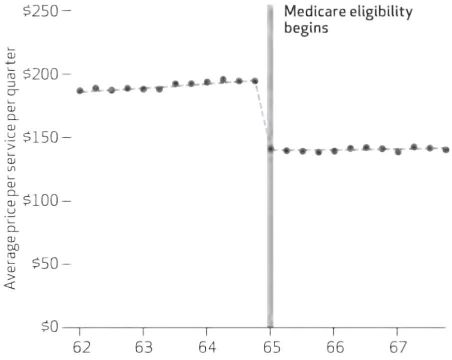
Unadjusted utilization before and after transition from private insurance to Medicare at age 65



SOURCE Authors' analysis of data for 2007–13 from Truven Health Analytics' Medicare and Commercial Claims and Encounters database. NOTES Volume is average use of analyzed services per 1,000 beneficiaries per quarter. The line was generated from regressions of utilization on age and age squared, with a binary variable for ages sixty-five and older. The model allowed for different age coefficients in the private insurance and Medicare samples. Services with both professional and facility claims on the same day were counted once. Analyzed services are listed in Appendix 1 (see Note 20 in text).

EXHIBIT 4

Unadjusted average price of services before and after transition from private insurance to Medicare at age 65



SOURCE Authors' analysis of data for 2007–13 from Truven Health Analytics' Medicare and Commercial Claims and Encounters database. NOTES Average price (in 2013 US dollars) per analyzed service per quarter. The line was generated from regressions of price on age and age squared, with a binary variable for ages sixty-five and older. The model allowed for different age coefficients in the private insurance and Medicare samples. Analyzed services are listed in Appendix 1 (see Note 20 in text).

Contents lists available at ScienceDirect
American Journal of Emergency Medicine
journal homepage: www.elsevier.com/locate/ajem

Correspondence

Prior authorization for child and adolescent psychiatric patients deemed to be in need of inpatient admission☆

To the Editor:

Four million children and adolescents in the US suffer from a serious mental disorder that causes significant functional impairments at home, at school and with peers [1]. In any given year, only 20% of children with mental disorders are identified and receive mental health services [2]. In youth, many of these disorders can have life-long deleterious effects.

Although obtaining timely care for young people with psychiatric disorders is vitally important, by requiring prior authorizations before patients are admitted, insurers make obtaining needed care difficult.

Previous research has examined the prior authorization process among adult psychiatric patients deemed in need of hospital admission [3]. In the current study we sought to formally examine this process as it pertains to children and adolescents who are deemed in need of inpatient admission.

To do so, between the periods of May 2014 and October 2014, licensed social workers employed in the psychiatric consultation service embedded in the emergency room at Hasbro Children's Hospital in Rhode Island, completed paperwork each time they contacted an insurance company on behalf of a child deemed in need of psychiatric admission. For each patient, the social workers recorded the patient's age, gender, race, chief complaint, insurance company, time on the phone required to obtain authorization, decision and length of stay authorized. The Lifespan Institutional Review Board approved this study.

We obtained 203 data sheets, and of these individuals, 55.7% (113/207) were female and 44.3% (90/203) were male. They ranged in age from 4 to 19 years old—although only one patient was 19 years of age—and the average age was 13.6. The most common reasons for admission included suicidal ideation or a suicide attempt (114 patients, or 56.2%), aggression (44 patients, or 21.7%), and homicidal ideation (21 patients, or 10.4%). Other chief complaints included eating disorder, anger, self-injurious behavior, and auditory hallucinations.

The average time required to obtain authorization from the insurance company from the time of first contact to authorization was 59.8 min ranging from 3 min to 270 min. There were variations in time required based on insurance type. Blue Cross Blue Shield, which was used by 18.2% (37/203), required 76.5 min on average to complete the authorization process. United Health Care, which was utilized by 27.6% (56/203) of patients, required 56 min on average and Neighborhood Health Plan, which was the most popular insurance and was utilized by 43.8% (89/203) of patients, required 51.4 min. Forty-eight percent (98/203) of our 203 data sheets had the number of days approved listed on their form, and the average was 2.42 days, which included some patients boarding overnight in the medical hospital before a psychiatric bed was available. All 203 requests for authorization were granted and none were denied.

One study found that the median length of stay (LOS) for emergency room visits for primarily psychiatric reasons was, on average, 61 min longer than the median LOS for other visits [4]. Being between ages 6 and 13 years old, in particular, predicted an extended stay. Extended lengths of stay (EL-LOS) can create safety risks. One study found that patients with EL-LOS's can "threaten provider safety" [5].

Given that 100% of our attempts to obtain authorization were granted, the need to obtain prior authorizations appears to function more as an administrative hurdle rather than an effective triage mechanism, because if professionals know they or their colleagues are going to have to spend lengthy amounts of time on the phone with the insurance company, they may think twice prior to trying to admit a given patient.

The requirement to obtain prior authorization is common across the country. One national survey of the time that physicians and other practice administrators spend interacting with insurance companies calculated that the annual cost to our health care system for all physicians nationwide to engage in these non-reimbursable interactions was at least between $23 billion and $31 billion [6]. If physicians and social workers doing psychiatric consultations in the emergency room are spending significant amounts of time obtaining authorization rather than seeing patients, the costs could also be astoundingly high.

Insurance reviews and pre-authorization requests are just a part of what makes accessing needed psychiatric care difficult for children and adolescents, given that finding comprehensive services for children is only possible in certain parts of the country. Adding prior authorization to an already difficult process, especially for psychiatric patients who are deemed to be of "imminent risk" to themselves or others, seems both dangerous and predatory.

Onerous prior authorization requirements that single out the most severely ill psychiatric patients should be halted. It burdens our psychiatric clinicians and functions to limit care by placing time consuming bureaucratic burdens on clinicians rather than meaningfully evaluating patient's needs. Insurance companies need to stop requiring prior authorizations so that our patients receive the safest and most timely care possible.

Amy Funkenstein MD
Department of Psychiatry, Tufts Medical Center, Boston, MA

Stephanie Hartselle MD
Department of Psychiatry and Human Behavior, Warren Alpert School of Medicine, Brown University, Providence, RI

*J. Wesley Boyd MD, PhD**
Center for Bioethics, Harvard Medical School
26 Central Street, Somerville, MA, 02143
Department of Psychiatry, Cambridge Health Alliance/Harvard Medical School
26 Central Street, Somerville, MA, 02143
*Corresponding author. Tel./fax: + 1 781 449 1995
E-mail addresses: jwboyd@cha.harvard.edu

http://dx.doi.org/10.1016/j.ajem.2016.02.027

☆ Disclosures: None.

0735-6757/© 2016 Elsevier Inc. All rights reserved.

References

[1] National Research Council and Institute of Medicine. Preventing Mental, Emotional, and Behavioral Disorders Among Young People. Available at http://iom.nationalacademies.org/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx. [Accessed July 21, 2015].

[2] U.S. Public Health Service. Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services; 2000.

[3] Funkenstein A, Malowney M, Boyd JW. Insurance prior authorization approval does not substantially lengthen the emergency department length of stay for patients with psychiatric conditions. Ann Emerg Med 2013;61(5):596–7.

[4] Case SD, Case BG, Olfson M, Linakis JG, Laska EM. Length of stay of pediatric Mental Health Emergency Department visits in the United States. J Am Acad Child Adolesc Psychiatry 2011;50(11):1110–9.

[5] Stephens RJ, White SE, Cudnik M, Patterson ES. Factors associated with longer length of stay for Mental Health Emergency Department patients. J Emerg Med 2014;47(4):412–9.

[6] Casalino LP, Nicholson S, Gans DN, Hammons T, Morra D, Karrison T, et al. What does it cost physician practices To interact with Health Insurance plans? Health Aff 2009; 28(4):w533–43.

By Samuel L. Dickman, Steffie Woolhandler, Jacob Bor, Danny McCormick, David H. Bor, and David U. Himmelstein

DOI: 10.1377/hlthaff.2015.1024
HEALTH AFFAIRS 35,
NO. 7 (2016): 1189–1196
©2016 Project HOPE—
The People-to-People Health
Foundation, Inc.

Health Spending For Low-, Middle-, And High-Income Americans, 1963–2012

ABSTRACT **US medical spending growth slowed between 2004 and 2013. At the same time, many Americans faced rising copayments and deductibles, which may have particularly affected lower-income people. To explore whether the health spending slowdown affected all income groups equally, we divided the population into income quintiles. We then assessed trends in health expenditures by and on behalf of people in each quintile using twenty-two national surveys carried out between 1963 and 2012. Before the 1965 passage of legislation creating Medicare and Medicaid, the lowest income quintile had the lowest expenditures, despite their worse health compared to other income groups. By 1977 the unadjusted expenditures for the lowest quintile exceeded those for all other income groups. This pattern persisted until 2004. Thereafter, expenditures fell for the lowest quintile, while rising more than 10 percent for the middle three quintiles and close to 20 percent for the highest income quintile, which had the highest expenditures in 2012. The post-2004 divergence of expenditure trends for the wealthy, middle class, and poor occurred only among the nonelderly. We conclude that the new pattern of spending post-2004, with the wealthiest quintile having the highest expenditures for health care, suggests that a redistribution of care toward wealthier Americans accompanied the health spending slowdown.**

Samuel L. Dickman (samuel.dickman@ucsf.edu) was a student at Harvard Medical School, in Boston, Massachusetts, at the time this work was carried out. He is currently a medical intern at the University of California, San Francisco.

Steffie Woolhandler is a professor of health policy at Hunter College, City University of New York, in New York City, and a lecturer in medicine at Harvard Medical School.

Jacob Bor is an assistant professor in the Departments of Global Health and Epidemiology at the Boston University School of Public Health, in Massachusetts.

Danny McCormick is an associate professor of medicine at Harvard Medical School and chief of the Division of Social and Community Medicine in the Department of Medicine at the Cambridge Health Alliance, in Cambridge, Massachusetts.

David H. Bor is an associate professor of medicine at Harvard Medical School and chief of the Department of Medicine at the Cambridge Health Alliance.

David U. Himmelstein is a professor of health policy at Hunter College, City University of New York, and a lecturer in medicine at Harvard Medical School.

For decades, US medical spending growth outpaced gross domestic product growth. Medical costs started slowing in 2004,[1] and slower growth continued for a decade, ending in 2014.[2] Previous studies have attributed a substantial portion of the slowdown (37–77 percent) to the lingering effects of the Great Recession (2007–09), with the remainder presumably accounted for by factors that predated the recession, such as rising copayments and deductibles, improved delivery system efficiency, the expiration of patents for several expensive drugs, and a decrease in costly medical innovations.[3–5] These studies have not explored how Americans at different income levels experienced the slowdown and whether health expenditure trends differed according to need or income.

Need plays a greater role in determining the consumption of medical care than for most goods and services. Moreover, health insurance has insulated most patients from the cost of their care, and Medicaid and Medicare have heavily subsidized care for the poor and elderly, who tend to have the greatest health needs.[6] However, recent increases in copayments and deductibles for the privately insured,[7] along with flat income growth,[8] may have constrained health spending overall and skewed it toward wealthier Americans.

We used national survey data to analyze trends in health spending for different income groups over the past half-century, with particular attention to the recent spending slowdown.

Study Data And Methods

DATA SOURCES We analyzed individual-level data from twenty-two nationally representative surveys of health expenditures by and on behalf of the civilian noninstitutionalized US population conducted over the past fifty years: the Survey of Health Services Utilization and Expenditures (SHSUE), conducted in 1963 and 1970 ($N = 7,759$ and 11,619, respectively); the 1977 and 1980 National Medical Care Utilization and Expenditure Surveys ($N = 38,815$ and 17,123, respectively); the 1987 National Medical Expenditure Survey (NMES) ($N = 23,652$); and the 1996–2012 Medical Expenditure Panel Surveys (MEPS) (N = 21,571–37,418 per year), carried out annually by the Agency for Healthcare Research and Quality. All of these surveys tabulated health expenditures (including all out-of-pocket and third-party payments) based on respondents' reports, which surveyors then verified with providers. The surveys also collected demographic information, including income and family size.

ANALYSIS Our main analysis examined trends in mean per capita health spending for each income quintile. We also explored income-related trends according to payer, type of service, and self-reported health status. Expenditure figures for all years were adjusted to 2012 dollars using the Consumer Price Index.[9]

We divided the population in each survey year into income quintiles (fifths) based on family income as a percentage of poverty. We used the Census Bureau's poverty measure (federal poverty level), which standardizes for age and family size (and, in 1963 and 1970 only, for farm versus nonfarm status). Because of limitations in the 1977 data, for that year we calculated poverty levels standardized for family size but not age. In 2012, income quintile cut points were at 125 percent, 230 percent, 361 percent, and 558 percent of the federal poverty level, corresponding to annual incomes for a family of three (two adults and one child) of $22,689, $41,820, $65,462, and $101,094.

In addition to total health expenditures, we calculated estimates for five subcategories of health services: inpatient care; outpatient care (including emergency care and outpatient lab tests and imaging); dental care; prescription medicines; and other (including home health care, vision aids, and medical supplies). Because expenditures for over-the-counter drugs were not included in MEPS and the 1987 NMES, we also excluded such expenditures in analyses of the earlier surveys.

We analyzed payments from six sources: private insurers; Medicare; Medicaid; other public payers (including workers compensation, the Department of Veterans Affairs, TRICARE [civilian coverage for military personnel and dependents], and other government sources); out of pocket; and unclassified.

We also analyzed income-related trends in self-reported health status (which correlates closely with more objective measures of health).[10,11] MEPS respondents rated their health on a five-point scale: excellent, very good, good, fair, or poor. The earlier surveys used a four-point scale: excellent, good, fair, or poor. To harmonize the scales, we recorded "very good" responses in MEPS as halfway between "good" and "excellent." We then calculated a mean health status score for each income quintile relative to the mean for the total population each year. We explored different definitions of this variable, which yielded substantially similar results.

We evaluated time trends in health spending according to income quintile using linear regression. We chose 2004 as the start of the recent health spending slowdown based on prior national health spending tabulations.[12] We conducted sensitivity analyses using cut points between 2002 and 2006 (data not shown); the choice of years did not substantially change our estimates.

To assess differences in health expenditures after adjustment for differences in age and health status among income groups, we used multiple linear regression with health status coded categorically on a five-point scale, age coded as a continuous variable, and the bottom income quintile's health spending for each survey year as the reference group. Analyses with and without adjustment for age and health status yielded similar time trends; in most cases, we report the unadjusted figures. (Detailed age- and health status–adjusted estimates are available in online Appendix Exhibit 1.)[13]

Analyses were conducted for each data year and income quintile. However, to smooth and simplify our visual presentation of the data, our graphs display two-year moving averages for 1996–2012 (the period for which annual data were available) and pool data for the middle-three quintiles (which followed similar trends).

Finally, to assess whether a small number of very-high-cost patients drove our findings, we repeated our analyses using quantile regression at the fiftieth, seventy-fifth, ninetieth, ninety-fifth, and ninety-seven and a half percentiles of expenditures.

Our estimates incorporated person-level weights that allowed extrapolation to the entire US noninstitutionalized population. The 1963 SHSUE survey was a simple random sample, with each respondent having equal weight. For all other surveys, we used SAS software survey procedures that adjust confidence intervals for the complex survey design.

Analyses were conducted using SAS, version 9.3.

LIMITATIONS Several caveats apply to our findings. Although MEPS and its predecessors accurately reflect national trends in medical spending (and are widely used for analyses of expenditures for population and disease subgroups), they understate total expenditures as tabulated in the National Health Expenditure Accounts (NHEA) because of a number of factors including the exclusion of people in institutions (for example, nursing homes) and the military, alternative medicine (for example, acupuncture), and "non–patient care revenues"; and the underrepresentation of high-expenditure patients.[14,15] Prior studies examining trends in health spending by age and sex adjusted for this discrepancy by scaling their estimates to data from the NHEA.[16] However, such adjustment was not possible in our analysis because income data are not available in the NHEA.

Second, the 1963, 1970, 1977, and 1980 surveys recorded charges instead of actual payments for medical services. Because charges often exceed actual payments, the pre-1987 surveys probably overestimate spending. However, this discrepancy would likely be similar across income groups and should not greatly distort income-related trends.

Study Results

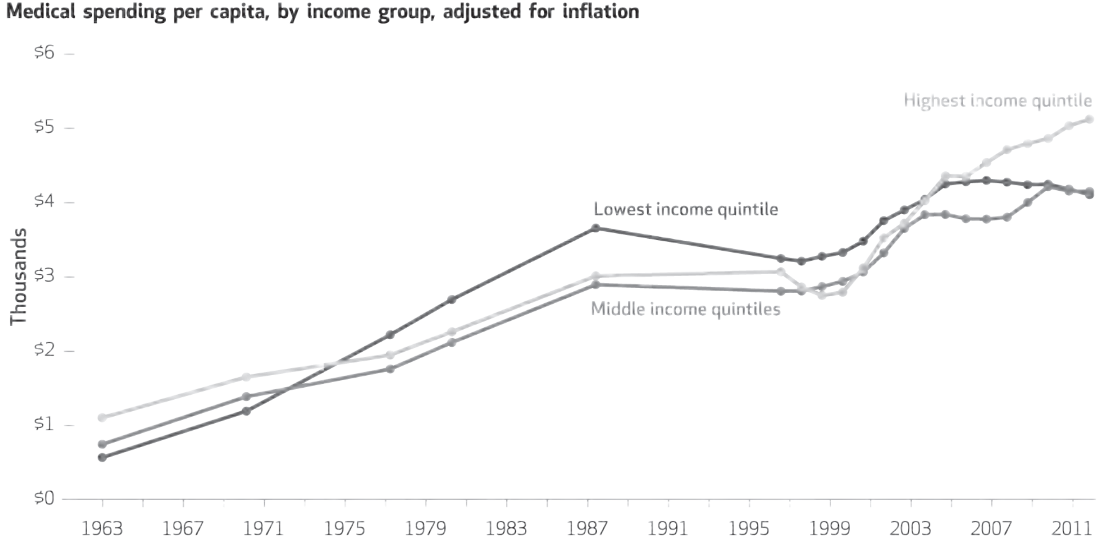
Per capita health expenditures grew 549 percent (adjusted for inflation) between 1963 and 2012 (Exhibit 1). As has been widely observed, spending rose rapidly between 1963 and 1987, surged again from 2000 through 2004, started slowing prior to the Great Recession, and slowed further during and after the recession.

Expenditures for the poorest group grew more rapidly than for other Americans from 1963 (before the implementation of Medicare and Medicaid) through 1987, when Medicare accounted for 24.6 percent and Medicaid accounted for 23.8 percent of the bottom quintile's expenditures; expenditure growth differed little among the top four quintiles. By 1977, expenditures for the poorest quintile exceeded those for all other Americans by 23 percent.

Between 2004 and 2012, per capita expenditures for the poorest quintile fell at a rate of $19.27 annually—3.7 percent over the eight-year period (Appendix Exhibit 2).[13] Meanwhile, health expenditures for the wealthiest group out-

EXHIBIT 1

Medical spending per capita, by income group, adjusted for inflation



SOURCES Authors' analysis of data from the 1963 and 1970 Surveys of Health Services Utilization and Expenditures; the 1977 and 1980 National Medical Care Utilization and Expenditure Surveys; the 1987 National Medical Expenditure Survey; and the 1996–2012 Medical Expenditure Panel Surveys. **NOTES** Data represent two-year moving averages for years 1996–2012. Data before 1996 are shown for the survey years only; trends between data points are interpolated. The population was divided in each survey year into income quintiles; for simplification, the middle three quintiles were combined since they followed similar trends. Online Appendix Exhibit 8 displays confidence intervals for all estimates (see Note 13 in text).

paced those of the three middle quintiles. While per capita expenditures rose at a rate of $106.04 annually (19.7 percent over eight years) for the wealthiest group, they increased only 12.5 percent during this period for the middle three quintiles. As a result, by 2012 the top income quintile, which until the early 2000s had among the lowest per capita health spending, had the highest expenditures of any income group.

As expected, individuals reporting worse health status had higher health expenditures (data not shown). The lowest income quintile had the worst health status, and the wealthiest the best throughout the study period (Appendix Exhibit 3),[13] and shifts in health status did not explain the recent divergence in health expenditures among income groups. The proportion of elderly people in the poorest quintile fell gradually over time, from 15.9 percent in 1963 to 10.9 percent in 2012. After adjustment for health status and age, health expenditures were higher for the top income quintile than for less affluent Americans throughout the fifty-year period (Exhibit 2). In 2000 age- and health status–adjusted per capita health expenditures for individuals in the top quintile were $616 (18 percent) higher than for people in the lowest quintile; the difference increased to $1,743 (43 percent) in 2012 (Appendix Exhibit 1).[13]

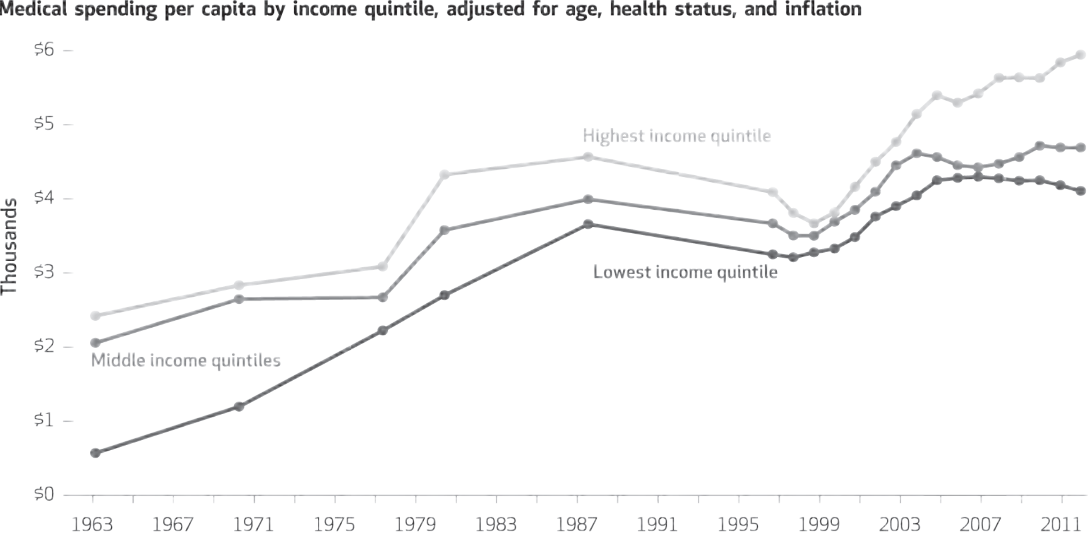
Expenditure trends differed markedly in people older and younger than age sixty-five. From 2004 to 2012, the elderly of all incomes experienced similar, flat expenditure growth, with the poorest fifth continuing to have the highest expenditures (Exhibit 3). In contrast, the nonelderly population experienced a sharp income-based divergence in expenditure growth after 2004; spending grew rapidly in the top income quintile, modestly in the middle-three quintiles, and minimally among the poorest group (Exhibit 4) (see also Appendix Exhibit 4).[13]

Prescription drug spending grew similarly for all income groups after 2004 (Appendix Exhibit 2).[13] However, both inpatient and outpatient expenditures grew rapidly for the wealthiest quintile while remaining flat or actually declining for the poorest group. The income-related divergence in outpatient expenditures reflects both volume and price effects; wealthy individuals had both rising volumes of medical visits (Appendix Exhibit 5)[13] and increasing payments per visit. By 2012 the top income quintile made 40 percent more outpatient visits per capita than other Americans, and spending per visit was also higher ($303 versus $241).

After 2004, private insurance expenditures for different income groups diverged strikingly, rising rapidly for the wealthiest quintile while falling for the poorest 20 percent (Appendix Exhibit 2).[13] This was true whether average private insurance expenditure was calculated per capita (Appendix Exhibit 2)[13] or per continuously enrolled privately insured nonelderly person (Appendix Exhibit 6).[13]

EXHIBIT 2

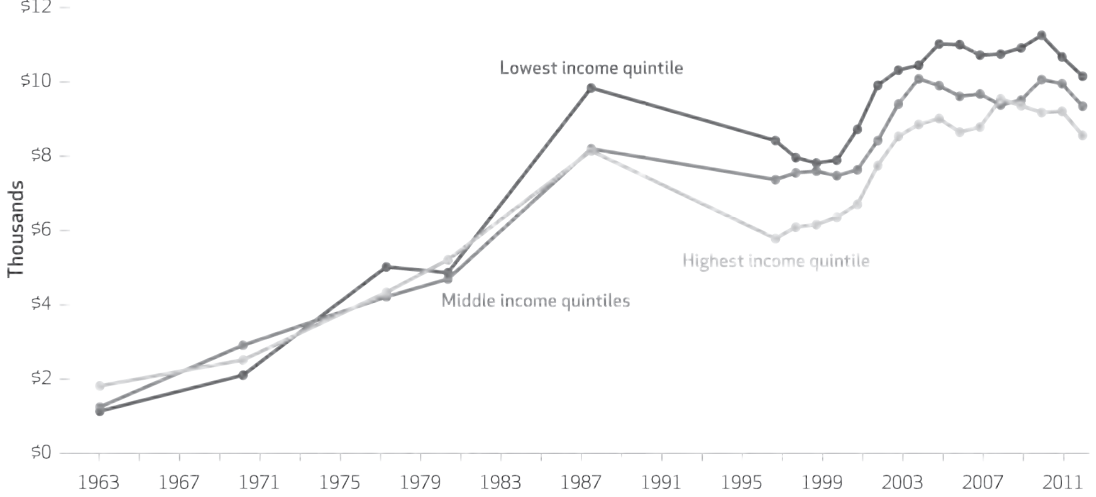
Medical spending per capita by income quintile, adjusted for age, health status, and inflation



SOURCES Authors' analysis of data from the 1963 and 1970 Surveys of Health Services Utilization and Expenditures; the 1977 and 1980 National Medical Care Utilization and Expenditure Surveys; the 1987 National Medical Expenditure Survey; and the 1996–2012 Medical Expenditure Panel Surveys. **NOTES** Data represent two-year moving averages for years 1996–2012. Data before 1996 are shown for the survey years only; trends between data points are interpolated. The population was divided in each survey year into income quintiles, and for simplification, the middle three quintiles were combined since they followed similar trends.

EXHIBIT 3

Medical spending per capita for people older than age sixty-five, by income quintile, adjusted for inflation

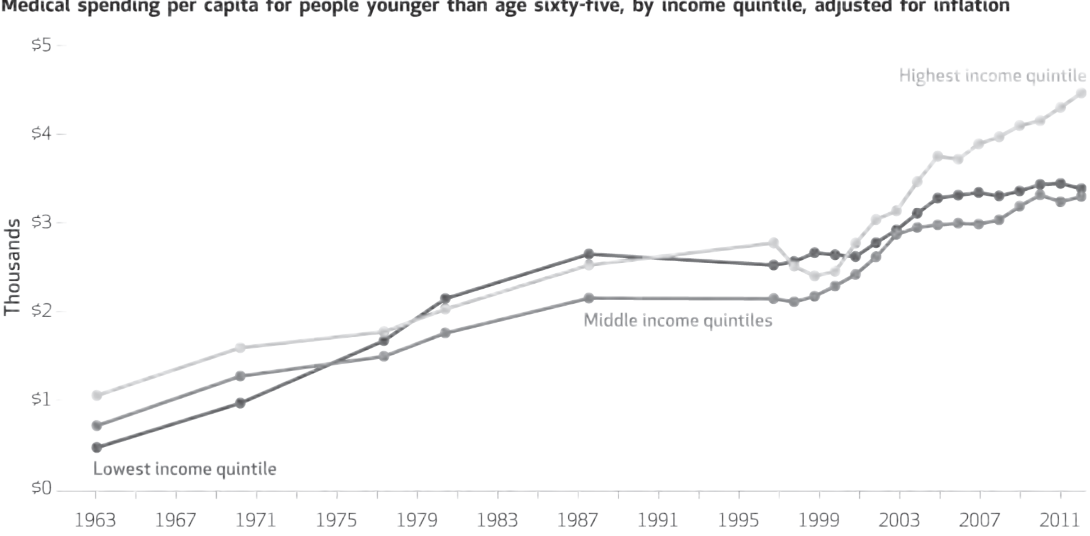


SOURCES Authors' analysis of data from the 1963 and 1970 Surveys of Health Services Utilization and Expenditures; the 1977 and 1980 National Medical Care Utilization and Expenditure Surveys; the 1987 National Medical Expenditure Survey; and the 1996–2012 Medical Expenditure Panel Surveys. **NOTES** Data represent two-year moving averages for years 1996–2012. Data before 1996 are shown for the survey years only; trends between data points are interpolated. The population was divided in each survey year into income quintiles, and for simplification, the middle three quintiles were combined since they followed similar trends.

We explored income-related trends for particular payer and age subgroups, although sample-size limitations preclude firm conclusions about differences. Per capita Medicare expenditure growth on behalf of the poor was slower than for other income groups after 2004, although interpretation of this finding is complex because many poor Medicare beneficiaries have supplemental Medicaid coverage. For those younger than age sixty-five, private insurance expendi-

EXHIBIT 4

Medical spending per capita for people younger than age sixty-five, by income quintile, adjusted for inflation



SOURCES Authors' analysis of data from the 1963 and 1970 Surveys of Health Services Utilization and Expenditures; the 1977 and 1980 National Medical Care Utilization and Expenditure Surveys; the 1987 National Medical Expenditure Survey; and the 1996–2012 Medical Expenditure Panel Surveys. **NOTES** Data represent two-year moving averages for years 1996–2012. Data before 1996 are shown for the survey years only; trends between data points are interpolated. The population was divided in each survey year into income quintiles, and for simplification, the middle three quintiles were combined since they followed similar trends.

tures per enrollee fluctuated for the poorest group (these estimates are based on small numbers since relatively few in this group had private coverage), grew modestly for the middle three income quintiles, and sharply for the wealthiest. Medicaid spending per nonelderly recipient declined during this period (Appendix Exhibit 6),[13] although no trend was evident in the proportion of total spending for the poorest quintile that was attributable to Medicaid. In contrast, Medicare's share of spending rose sharply during this period among the nonelderly poor (presumably because of expenditures for people with long-term disability or end-stage renal disease; data not shown).

To explore whether a small number of high-cost patients accounted for the income-based trends we observed, we repeated our analyses using quantile regression. Prior to 2004, the faster growth of expenditures for the poorest group (and slower growth for the wealthiest) was driven by the costliest (and presumably sickest) 10 percent of patients (Appendix Exhibit 7a).[13] After 2004, expenditures surged for both low-cost and high-cost affluent patients but fell for both low-cost and high-cost low-income patients (Appendix Exhibit 7b).[13]

Discussion

The slowdown in health spending growth between 2004 and 2013 was widely reported and much celebrated.[5,17–20] Our data suggest a sobering interpretation: Slower spending growth (at least through 2012) was concentrated among poor and middle-income Americans, leading to a growing disparity in health expenditures across income groups. It is unclear whether the recent acceleration of spending growth [2] will reverse this trend.

The pattern of sharply rising spending for the wealthy and flat or slow growth for others mirrors the widening gap in the consumption of other goods[21] and could represent a shift from need-based to income-based receipt of medical care. We fear that it might presage deepening disparities in health outcomes.

Prior to the implementation of Medicaid and Medicare in 1966, the poor had the lowest health expenditures despite their greater medical need, while expenditures for the wealthy were nearly twice as high as those for the poor. Subsequent to these public investments, health spending tracked closer to medical need, with the poorest income quintile having the highest expenditures and the top quintile the lowest. (However, after adjustment for age and health status, the health expenditure gap between income groups was never fully reversed.)

The pattern we observed could represent a shift from need-based to income-based receipt of medical care.

Several factors probably account for the gradual, instead of sharp, upswing in spending for the poorest Americans after the passage of Medicaid and Medicare. First, Medicaid enrollment ramped up over time. Only about half of states implemented the program immediately; although almost all did so by 1971, enrollment did not level off until 1976. Second, many impoverished neighborhoods lacked doctors' offices and clinics, and it took time to build up the capacity of neighborhood health centers and other clinics in underserved areas. Third, in 1972 Medicare was expanded to two small but expensive nonelderly groups, many of whom were poor: the chronically disabled and patients with end-stage renal disease. As a result, Medicare's share of expenditures for the nonelderly bottom quintile rose from near zero in 1970 to 5.6 percent in 1977 and 8.0 percent in 1987.

The pattern of higher (unadjusted) expenditures for poorer people persists to this day for the elderly, virtually all of whom have public coverage through Medicare. Among the nonelderly, however, the income-related pattern reversed after 2004; wealthy individuals—who are the healthiest segment of the population—came to have the highest expenditures.

The shift of some lower-income families from private coverage to Medicaid,[4] which pays lower fees, could explain part of the widening gap in per visit payments, as well as the drop in out-of-pocket and private insurer expenditures for this group between 2004 and 2012. However, this would not explain the disparate trends in outpatient visit rates, the divergence between the wealthy and the middle class, or the fall in expenditures among poorer people with private insurance.

The slowdown in medical spending growth between 2004 and 2013 was the sum of disparate trends: flat spending for the elderly and poor, slow growth for the nonelderly middle class, and exuberant growth for the nonelderly wealthy.

An increasing share of medical resources is being devoted to people with the least medical need.

Personal health care expenditures totaled $2.3793 trillion in 2012;[18] if all income groups had experienced the same growth as the wealthiest quintile between 2004 and 2012, personal health spending would have been approximately $2.5370 trillion in 2012—an increase of $157 billion in that year alone.

Much discussion of the current slowdown in health spending has focused on whether it is primarily caused by structural or cyclical factors.[3–5,12,17–20,22] Although cyclical (that is, recession-related) factors could result in the observed income-related trends in health spending, the divergence in spending among the quintiles appears to predate the Great Recession by several years.[1,5]

Some structural changes, such as improved efficiency of providers or slower diffusion of expensive medical technology and drugs, would be expected to affect all income groups uniformly. Other structural changes—particularly increased cost sharing for the privately insured—would be expected to have a greater impact on low- and middle-income people, consistent with our findings. Cost sharing and depressed income among the poor and middle class might explain why spending by the privately insured dropped after 2008[19] and why regions of the United States most affected by the Great Recession experienced the slowest growth in health spending for the privately insured between 2007 and 2011.[3]

A mix of cyclical and structural factors—the lingering effects of the Great Recession on nonwealthy households and increased cost sharing—seems the best explanation for the rising income-based spending disparities we observed. Wages for most workers have been slow to rebound from the recession. Meanwhile, the percentage of privately insured workers with individual-plan deductibles of at least $2,000 has increased sixfold since 2006.[7] Such high-deductible plans cause particularly large drops in health care use among the highest-cost (that is, sickest) enrollees[23] and disproportionately affect low-wage workers.

The trend toward higher copayments and deductibles seems likely to continue under the Affordable Care Act (ACA). A typical individual silver-tier plan sold through the insurance exchanges carries a $2,907 deductible.[24] While the ACA's Medicaid expansion will boost expenditures for the eight million newly enrolled, they constitute only 13 percent of the poorest quintile, and several states are imposing cost sharing on Medicaid enrollees,[25] which might dampen usage increases.

The rising income-based disparity in spending suggests a shift from allocation of health care according to need to allocation by willingness (and ability) to pay. It is unclear whether this shift arises from the underuse of needed care among the poor or overuse of unnecessary care by the wealthy. The sharp spending increase among the nonelderly top income group merits further study and could be caused by the widening gap in cost-sharing requirements in private insurance plans for employees of small versus large firms[6] (the latter of which tend to pay higher wages), the rise of concierge medical practices, or supply-induced demand.[26–28] Irrespective of the cause, the pattern suggests that the efficiency of medical spending is declining, with an increasing share of medical resources devoted to people with the least medical need.

Conclusion

Increasing income inequality has drawn much attention in recent years. Our findings suggest that inequality in health care spending is also on the rise: Expenditures for the poorest (and sickest) segment of the population are actually falling, while those for the wealthy are growing rapidly and now exceed those for other Americans. This pattern, which has not been seen since before Medicare and Medicaid were introduced, could portend a widening of disparities in health outcomes.[29,30] ■

This study was presented at the national meeting of the Society of General Internal Medicine, April 24, 2015, in Toronto, Ontario. Samuel Dickman received funding support from the Center for Primary Care at Harvard Medical School. Benjamin Smith provided valuable feedback on early drafts of the article.

NOTES

1 Roehrig C, Turner A, Hughes-Cromwick P, Miller G. When the cost curve bent—pre-recession moderation in health care spending. N Engl J Med. 2012;367(7):590–3.

2 Martin AB, Hartman M, Benson J, Catlin A. National health spending in 2014: faster growth driven by coverage expansion and prescription drug spending. Health Aff (Millwood). 2016;35(1):150–60.

3 Dranove D, Garthwaite C, Ody C. Health spending slowdown is mostly due to economic factors, not structural change in the health care sector. Health Aff (Millwood). 2014; 33(8):1399–406.

4 Henry J. Kaiser Family Foundation. Assessing the effects of the economy on the recent slowdown in health spending [Internet]. Menlo Park (CA): KFF; 2013 Apr 22 [cited 2016 Jun 6]. Available from: http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/

5 Cutler DM, Sahni NR. If slow rate of health care spending growth persists, projections may be off by $770 billion. Health Aff (Millwood). 2013;32(5):841–50.

6 Banks J, Marmot M, Oldfield Z, Smith JP. Disease and disadvantage in the United States and in England. JAMA. 2006;295(17):2037–45.

7 Claxton G, Rae M, Panchal N, Damico A, Bostick N, Kenward K, et al. Employer health benefits: 2014 annual survey [Internet]. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2014 [cited 2016 Jun 9]. Available from: https://kaiserfamilyfoundation.files.wordpress.com/2014/09/8625-employer-health-benefits-2014-annual-survey6.pdf

8 DeNavas-Walt C, Proctor BD, Smith JC. Income, poverty, and health insurance coverage in the United States: 2011. Washington (DC): Census Bureau; 2012 Sep. (Report No. P60-243).

9 Crawford M, Church J, Akin B, editors. CPI detailed report: data for December 2015 [Internet]. Washington (DC): Department of Labor; 2015 [cited 2016 Jun 9]. Available from: http://www.bls.gov/cpi/cpid1512.pdf

10 Schnittker J, Bacak V. The increasing predictive validity of self-rated health. PLoS One. 2014;9(1):e84933.

11 Mavaddat N, Parker RA, Sanderson S, Mant J, Kinmonth AL. Relationship of self-rated health with fatal and non-fatal outcomes in cardiovascular disease: a systematic review and meta-analysis. PLoS One. 2014; 9(7):e103509.

12 Blumenthal D, Stremikis K, Cutler D. Health care spending—a giant slain or sleeping? N Engl J Med. 2013; 369(26):2551–7.

13 To access the Appendix, click on the Appendix link in the box to the right of the article online.

14 Aizcorbe A, Liebman E, Pack S, Cutler DM, Chernew ME, Rosen AB. Measuring health care costs of individuals with employer-sponsored health insurance in the U.S.: a comparison of survey and claims data. Stat J IAOS. 2012;28(1–2): 43–51.

15 Selden TM, Levit KR, Cohen JW, Zuvekas SH, Moeller JF, McKusick D, et al. Reconciling medical expenditure estimates from the MEPS and the NHA, 1996. Health Care Financ Rev. 2001;23(1):161–78.

16 Meara E, White C, Cutler DM. Trends in medical spending by age, 1963–2000. Health Aff (Millwood). 2004; 23(4):176–83.

17 Orszag P. Economy can't be all that's slowing health costs. Bloomberg View [serial on the Internet]. 2013 Sep 24 [cited 2016 Jun 6]. Available from: http://www.bloomberg.com/news/2013-09-24/economy-can-t-be-all-that-s-slowing-health-costs.html

18 Hartman M, Martin AB, Lassman D, Catlin A, National Health Expenditure Accounts Team. National health spending in 2013: growth slows, remains in step with the overall economy. Health Aff (Millwood). 2015; 34(1):15–60.

19 Ryu AJ, Gibson TB, McKellar MR, Chernew ME. The slowdown in health care spending in 2009–11 reflected factors other than the weak economy and thus may persist. Health Aff (Millwood). 2013;32(5): 835–40.

20 Chandra A, Holmes J, Skinner J. Is this time different? The slowdown in healthcare spending [Internet]. Cambridge (MA): National Bureau of Economic Research; 2013 Dec [cited 2016 Jun 6]. (Working Paper No. 19700). Available from: http://www.nber.org/papers/w19700

21 Cynamon BZ, Fazzari SM. Inequality, the Great Recession, and slow recovery [Internet]. Rochester (NY): Social Science Research Network; 2014 Oct 24 [cited 2016 Jun 6]. Available from: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2205524

22 Levine M, Buntin M. Why has growth in spending for fee-for-service Medicare slowed? [Internet]. Washington (DC): Congressional Budget Office; 2013 Aug [cited 2016 Jun 6]. (Working Paper No. 2013-06). Available from: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44513_MedicareSpendingGrowth-8-22.pdf

23 Brot-Goldberg ZC, Chandra A, Handel BR, Kolstad JT. What does a deductible do? The impact of cost-sharing on health care prices, quantities, and spending dynamics [Internet]. Cambridge (MA): National Bureau of Economic Research; 2015 Oct [cited 2016 Jun 6]. (Working Paper No. 21632). Available from: http://www.nber.org/papers/w21632

24 Coleman K, Geneson J. Deductibles, out-of-pocket costs, and the Affordable Care Act [Internet]. Mountain View (CA): Health Pocket; 2013 Dec 12 [cited 2016 Jun 6]. Available from: http://www.healthpocket.com/healthcare-research/infostat/2014-obamacare-deductible-out-of-pocket-costs#.VJXx9ABo

25 Dickson V. Medicaid cost-sharing could reduce enrollment, experts warn. Mod Healthc. 2014;44(38):12.

26 Fisher ES, Wennberg JE. Health care quality, geographic variations, and the challenge of supply-sensitive care. Perspect Biol Med. 2003; 46(1):69–79.

27 Enterline PE, Salter V, McDonald AD, McDonald JC. The distribution of medical services before and after "free" medical care—the Quebec experience. N Engl J Med. 1973; 289(22):1174–8.

28 Beck RG, Horne JM. Utilization of publicly insured health services in Saskatchewan before, during, and after copayment. Med Care. 1980; 18(8):787–806.

29 National Academies of Sciences, Engineering, and Medicine. The growing gap in life expectancy by income: implications for federal programs and policy responses. Washington (DC): National Academies Press; 2015.

30 Case A, Deaton A. Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. Proc Natl Acad Sci USA. 2015;112(49):15078–83.

JUNE 2, 2016

For second year in a row, NY Assembly passes universal health care bill

By Simon Rosenbluth

ALBANY, N.Y. - The Assembly voted 86-53 Wednesday to pass universal health care legislation in New York, marking the second time in two years the bill passed the Democrat-controlled house.

The issue of health care has received increased attention since the passage of the Affordable Care Act in 2010. But some state lawmakers, physicians, nurses and patients say the federal program doesn't go far enough and legal challenges are still threatening its full implementation.

The New York Health bill (A.5062-a) passed by the Assembly Wednesday would provide universal, complete health care coverage to every New Yorker without deductibles, co-pays, or limited provider networks.

"Health insurance plans have now asked the state for a 17 percent rate increase, with some plans as high as 45 percent," said Assembly Health Committee Chair Richard Gottfried, lead Assembly sponsor of the bill. "Year after year, the cost of coverage for families and employers goes up faster than wages and inflation. Premiums, deductibles, co-pays, out-of-network charges, and uncontrolled drug costs undermine health care and family finances, and are a heavier burden on employers and taxpayers."

Based on a recent national poll by Gallup, 58 percent of Americans, including 41 percent of Republicans, are in favor of a single-payer system, showing there is support for this movement.

This sentiment was revealed on Tuesday, May 24, as hundreds crowded inside the Capitol in Albany to fight for universal health coverage in New York state.

The determined and energized crowd held signs and chanted slogans on the Million Dollar Staircase, calling for universal health care in New York, an effort that began in 1992, the first time this bill was introduced. Gottfried was in attendance to stress the importance of passing this piece of legislation.

Many others spoke up to endorse the bill, including those with first-hand experience of how the current system operates. Marva Wade, vice president of the New York State Nurses Association, said passing the bill would mean "full access and better care for all, with huge savings for the vast majority of New Yorkers."

Umair Jangda, a doctor at Jamaica Hospital in Queens, recounted a story of a patient who was diagnosed with leukemia and was unable to afford treatment due to the pharmaceutical company spiking the cost of the drug. He was a recent, legal immigrant who was uninsured, meaning the cost of being treated was simply unaffordable. Dr. Jangda pointed out that this is a common occurrence and that it upsets him seeing so many patients who could potentially be treated, but are not, because of the cost.

Beyond a moral standpoint, the current system is also bad for businesses and job growth, according to Cor Drost, president and CEO of the Ithaca-based medical device manufacturer Transonic Systems, Inc. He said that due to high insurance costs, many companies are forced to move jobs to other countries, such as Canada, where employee medical insurance costs substantially less. In order to stay competitive, he argued, companies must resort to these money-saving tactics, even if it means hurting local economies.

"The Affordable Care Act has made important improvements to the system, but as long as our health coverage comes from insurance companies, it will be an increasingly unbearable burden," Gottfried said. "One-in-three Americans still put off medical treatment due to cost in 2015, and 40 percent of New Yorkers reported having cut down on other expenses to afford health care."

The Senate bill (S.3525) is sponsored by Bill Perkins, D-Harlem, and was amended in the Senate Health Committee on April 29. It has 22 sponsors in that house.

The New York Times

MAY 23, 2016

Is single payer our health salvation?

By Anne Scheetz, M.D.

Re: "Why a Single-Payer Plan Would Still Be Really Costly" (The Upshot, May 17):

Our health care costs more because our administrative costs, a result of a financing system that relies on for-profit insurance companies, are so high. Some of those costs are borne by physicians, who must pay for complex billing systems, denial management, preauthorization requirements, collections management and bad debt, as well as devoting patient time to discussing insurance coverage rather than medical issues.

If we substantially decrease those costs to physicians, as a single-payer system would do, we could decrease insurance payments to physicians and still give all of them a raise. No economic miracle involved; just a matter of the people who do the work, rather than a wasteful middleman, taking home the money.

The writer, a retired internist, resides in Chicago.

PNHP chapter reports

PNHP and its former **California** chapter – which was also known as the California Physicians Alliance (CaPA) – have agreed to an amicable separation. CaPA wished to continue its paid efforts to enroll individuals in private insurance plans through the ACA's exchange, an activity the PNHP Board and some California members considered incompatible with PNHP's focus on single-payer advocacy. PNHP wishes CaPA well in its continuing work. All California-based PNHP members remain members of national PNHP. The San Francisco Bay Area chapter has elected to affiliate with national PNHP rather than CaPA, and activists in other parts of the state are collaborating in the formation of additional California chapters. **Members interested in helping to organize new California-based chapters are invited to contact Emily Henkels, PNHP's national organizer, at e.henkels@pnhp.org.**

In July, PNHP members in Los Angeles and San Francisco hosted welcome dinners for incoming interns and current residents, events that were co-sponsored by Residents for a National Health Program, the residents and fellows section of PNHP.

Resident welcome dinner in San Francisco with PNHP member Dr. Jeff Gee (first row, right).

In **Illinois**, the PNHP chapter is active in promoting single payer to the medical community. This spring the chapter co-sponsored its annual Soul of Medicine Dinner in Chicago with Physicians for Social Responsibility; PNHP leader Dr. Duane Dowell was this year's honoree. In June, Dr. Bill Reed hosted a welcome dinner for incoming and current residents in conjunction with Residents for a National Health Program (the residents and fellows section of PNHP). Several local leaders have recently given presentations, including Dr. Pam Gronemeyer, who received an Outstanding Working Women of Illinois award from the Illinois Federation of Business Women recognizing her single-payer activism; Dr. Claudia Fegan, who delivered grand rounds in honor of Dr. Quentin Young to the Department of Medicine at Stroger (Cook County) Hospital, and was also named one of Modern Healthcare's "10 Minority Executives to Watch"; Dr. Susan Rogers, who gave a presentation on single payer and cancer care to over 500 attendees of the American Society of Clinical Oncology's annual meeting in June; and Dr. Stephen Stabile, who spoke to family medicine residents at Presence St. Mary and Elizabeth Medical Center and to medical, dental and nursing students at an Illinois Primary Care Association meeting. To get involved in PNHP Illinois, contact Dr. Anne Scheetz at **annescheetz@gmail.com**.

In **Indiana**, Hoosiers for a Commonsense Health Plan hosted an event in May featuring former health insurance industry executive Wendell Potter and a showing of the documentary "Fix It." Potter also gave a presentation in Bloomington during his national book tour for "Nation on the Take." Single-payer activists also marched in the Bloomington Fourth of July Parade, carrying the Medicare for All banner. To get involved in Indiana, contact Dr. Rob Stone at **grostone@gmail.com**.

PNHP National Coordinator Dr. Claudia Fegan was named one of Modern Healthcare's "10 Minority Executives to Watch."

Kentuckians for Single-Payer Health Care is active in garnering media attention and raising public awareness of single payer. Drs. Peter Esch, Barbara Casper, Edgar Lopez, Morris Weiss, Steve Lippmann, and medical students Brandi Jones and Mallika Sabharwal spoke at a press conference in Louisville celebrating the publication of the Physicians' Proposal for Single Payer Health Reform in the American Journal of Public Health. The event was covered by the Courier-Journal, Business First, and the Greater Louisville Medical Society News. Chapter members also spoke to labor groups, like the Kentucky State Council of Machinists, and Dr. Ewell Scott spoke to candidates about the proposal. Kentuckians for Single Payer set up several showings of the documentary "Fix It" in Louisville and Morehead, including at the Thomas Jefferson Unitarian Church, Chapel House Seniors' Residence, Fourth Avenue United Methodist Church, and Central Presbyterian Church. Single-payer activists also secured a regular monthly spot on the new progressive radio station, Forward Radio, and distributed information at the Walk for Multiple Sclerosis, the Mighty Kindness Festival and the St. Patrick's Day Parade. To get involved in Kentucky, contact Dr. Garrett Adams at **KYHealthCare@aol.com**.

Kentuckians for Single-Payer Healthcare leaders at a press conference in Louisville.

In **Missouri**, a new student chapter of PNHP formed at A.T. Still University - Missouri School of Osteopathic Medicine this spring under the leadership of medical student Daniel Boron-Brenner. PNHP Missouri chapter leader Dr. Ed Weisbart gave more than a dozen single-payer presentations around the state this spring, reaching hundreds of community members, physicians, health professionals and students. To get involved in Missouri, contact Dr. Ed Weisbart at **edweisbart@gmail.com**.

In **Maine**, Maine AllCare hosted several screenings of the documentary "Fix It." At the Maine caucuses and conventions, volunteers gathered almost 1,000 names of citizens in support of universal health care. Maine AllCare now has local chapters in Portland, Rumford, Brunswick and Blue Hill. The Maine AllCare board also hired a consultant to begin planning for a citizen initiative in 2020 to bring health care to everyone in Maine. To get involved in Maine, contact Dr. Julie Pease at **jkpease-md@gmail.com**.

In **Massachusetts**, Mass-Care members partnered with Progressive Democrats of America to present a resolution to the Massachusetts Democratic Convention floor on June 4 to include single payer in the party platform both at the state and national level. The groups gathered nearly 700 delegate signatures to bring the resolution to a vote. PNHP Massachusetts chapter leader Dr. Adam Gaffney delivered a national PNHP webinar on "New data on the impact of class, race, and single payer on health." The webinar can be viewed on PNHP's YouTube page at bit.ly/298X8vn. To get involved in Massachusetts, contact Dr. Gaffney at **gaffney.adam@gmail.com**.

In **Nevada**, the new PNHP chapter has been meeting regularly via video conference call. The chapter now includes members from several medical and allied health specialties and has the active involvement of two deans at the newly forming University of Nevada - Las Vegas School of Medicine. Members have published letters to the editor and opinion pieces in several local newspapers, and chapter co-chair Dr. Sean Lehmann recently appeared on "Nevada Newsmakers," a local television program, where he was interviewed on the topic of single payer.

Dr. Sean Lehmann appeared on the May 17 edition of "Nevada Newsmakers."

Las Vegas-area members have connected with local founders of the new Healthcare-NOW chapter, and recently met together for a screening of the documentary "Fit It." The group is working on outreach activities for a visit in August from PNHP Missouri chapter leader Dr. Ed Weisbart, who will be speaking to the Nevada Academy of Family Physicians. To get involved in PNHP Nevada, contact Dr. Joanne Leovy at **nevadapnhp@gmail.com**.

In **New York**, the New York Metro Chapter of PNHP was active in getting the New York State Assembly to pass a state single-payer bill, the New York Health Act, for the second year in a row. The Senate version of the bill currently has 22 co-sponsors (32 votes are needed for passage). Leading up to the vote, the N.Y. Metro and Capital District chapters of PNHP hosted a lobby day in Albany that drew over 100 health professionals from across the state, including physicians, nurses, social workers, medical students, as well as residents from the Montefiore Social Medicine Residency Program. The chapter's annual fundraising gala honored registered nurse Mary Dewar, Drs. Jack Geiger and Lewis Goldfrank, Rebecca Mahn, a fourth-year medical student at Albert Einstein College of Medicine, and Alexander Edwards, a recent graduate of the Mailman School of Public Health. The chapter's monthly educational forum recently featured Kamini Doobay, a medical student and organizer of the New York City Coalition to Dismantle Racism in the Health System. Three local medical student chapters plan to collect and publicly display (online) the names of faculty and students who support single payer. To get involved in PNHP N.Y. Metro, contact Katie Robbins, MPH, at **katie@pnhpnymetro.org**.

PNHP N.Y. Metro members march in the New York Pride Parade in June.

In **North Carolina**, the Healthcare Justice chapter of PNHP in Charlotte hosted a daylong workshop with PNHP National Organizer Emily Henkels on the topic of developing an organizing strategy for single payer. The chapter hosted a screening of the documentary "Fix It" accompanied by a panel discussion featuring Dr. Andrea DeSantis and three local business people. Drs. DeSantis, Shami Hariharan, and Jessica Schorr Saxe spoke to medical students and residents about single payer and forming a local

SNaHP chapter. Board member Karen Bean and other chapter activists lobbied with the League of Women Voters in support of Medicaid expansion. Chapter Chair Dr. Saxe's recently talked to Democratic Women of Union County and to the Health Services Research Program at the University of North Carolina, Charlotte (UNCC). The talk at UNCC yielded the group an intern who will work with the chapter's Communications Committee. To get involved in the Healthcare Justice chapter in North Carolina, contact Dr. Saxe at **jessica.schorr.saxe@gmail.com**.

Healthcare Justice board members at a training with PNHP National Organizer Emily Henkels (front row, center).

In **Ohio**, the Ohio State SNaHP chapter hosted a debate with the Benjamin Rush Institute over the resolution, "Be it resolved: The government can provide more compassionate and efficient healthcare for all Americans than the free market." PNHP members Dr. Donald Mack and Brad Cotton won the day for single payer. The chapter also hosted a viewing of "Take Care, Mr. Elson," a New York Times documentary about the failure of the ACA to help a low-income, working, 60-year-old community health center patient with several chronic conditions. An invigorating discussion followed the screening. To get involved in Ohio, contact Dr. Johnathon Ross at **drjohnross@ameritech.net**.

In **Pennsylvania**, Health Care for All Philadelphia marched on the first day of the Democratic National Convention in Philadelphia to protest the absence of single payer in the Democratic Party platform and the opposition to single payer by candidate Hillary Clinton. The group joined with the Poor People's Economic Human Rights Campaign and thousands of others in the March for Our Lives (**www.march4ourlives2016.org**). Medical students also participated in the actions through SNaHP chapters at Temple University, Cooper Medical School, and University of Pennsylvania. To get involved in Pennsylvania, contact Dr. Walter Tsou at **macman2@aol.com**.

Dr. Walter Tsou interviewed by MedPage Today on single payer

In **Rhode Island**, PNHPers helped legislators develop a state single-payer bill that has been introduced in both the House and Senate. The chapter is doing outreach to academics, labor, faith and student groups and has garnered support from Ric McIntyre, chair of the Economics Department at the University of Rhode Island, the Service Employees International Union 1199, Bishop Knisely of the Rhode Island Episcopal Church, and the Brown University Medical School SNaHP chapter. To get involved in Rhode Island, contact Dr. J. Mark Ryan at **ujiryan@gmail.com**.

Dr. J. Mark Ryan, state Rep. Aaron Regunberg, and SNaHP leaders from Brown Medical School in Rhode Island.

In **Western Washington**, the PNHP chapter participated in two demonstrations against Zoom-Care, a for-profit operator of urgent care clinics. PNHPers also met with Seattle City Council members urging them to support a resolution calling on the state's congressional delegation to expand and improve Social Security and Medicare. The resolution passed unanimously. Several chapter members met with medical students participating in the annual Seacouver (Seattle-Vancouver) Study Tour co-sponsored by the American Medical Student Association. The tour exposes students to the health care systems in the U.S. and Canada through visits to medical settings, lectures by experts, and opportunities to interview community members. The chapter continues to hold well-attended monthly meetings with speakers. Recent topics have included health care in Cuba, the PNHP Physicians' Proposal for Single Payer Health Reform, and ColoradoCare. To get involved in PNHP Western Washington, contact Dr. David McLanahan at **pnhp.westernwashington@comcast.net**.

In **West Virginia**, PNHP member Lynn Yellott submitted a resolution in support of single payer to the West Virginia Democratic Convention. The resolution was adopted unanimously by the Resolutions Committee, and was subsequently adopted by the full convention. To get involved in West Virginia, contact Lynn Yellott at **lynnyellott@gmail.com**.

"According to your carrier, this little piggy has insurance, but this little piggy has none."

NON-PROFIT ORG
U.S. POSTAGE PAID
PHYSICIANS FOR A
NATIONAL HEALTH
PROGRAM

29 E. Madison St., Suite 1412
Chicago, IL 60602-4410

Phone: (312) 782-6006
Fax: (312) 782-6007
info@pnhp.org
www.pnhp.org

Address Service Requested