

Highlights of the PNHP 2011 Annual Meeting

Nearly 300 participants from 38 states and the District of Columbia, including 41 medical students and 112 attendees who came a day early to participate in Leadership Training, gathered at the Kellogg Hotel at Gallaudet University on Oct. 28-29. The meeting was chaired by PNHP President Dr. Garrett Adams.

PLENARY SESSIONS

The case for single payer in the Obama era

Dr. David Himmelstein presented data on the U.S. health care crisis with updated slides (available from PNHP) on the uninsured and underinsured, poverty, income inequality, health disparities, financial barriers to care, poor health statistics by international standards, rising administrative costs and more. Canada, other industrialized countries, and our Medicare program have done a better job of controlling health care costs and reducing bureaucracy. ACOs and other gimmicks that don't fundamentally change our market-driven health care system will only exacerbate the problem of rising costs. Risk-adjustment has increased, not decreased, overpayments to Medicare Advantage plans; such overpayments now consume \$30 billion of Medicare's budget annually. Coverage expansions under the ACA, if it survives Supreme Court challenge, will be short lived. The real solution is single-payer national health insurance.

The Canadian health system at 45: Lessons for the U.S.

Dr. Robert Evans, renowned Canadian health economist, said that although the Canadian health care system, which grew out of the vanguard province of Saskatchewan, is financially sustainable and enjoys overwhelming popularity, it is under serious assault by the right wing in Canada. Dr. Evans noted that although Canada is in a recession, it is in far better shape economically than the U.S. because it did not deregulate the financial industry. Despite its superior record on costs and outcomes, the right has been relentless

in pushing privatization of the health care system. Claims that an aging population are driving up medical costs are false; rising lab and imaging tests are a real driver. Ominously, in recent years the right has started using the courts to push their agenda. Medicare has public support, and while problems exist (e.g. in coverage for medications), Canadians overwhelmingly favor public solutions.

The fight to save the NHS

Dr. Jacqueline Davis, a consultant radiologist and co-founder of Keep our NHS Public, talked about the reasons the National Health Service is worth defending: It meets the needs of everyone, is free at the point of delivery, and treatment is based on clinical need and not ability to pay; care is publicly funded, publicly delivered and publicly accountable. It is the most popular institution in the UK. Since 2000, governments have sought, beneath the radar, to turn the NHS from a cost-effective integrated public health service into a collection of competing private providers under the NHS trademark. Dr. Davis noted that having private firms like UnitedHealth purchase (or "commission") the care and also deliver the care is like "putting the thieves in charge of the jeweler's shop." New legislation would put general practitioners, GPs, in charge of the NHS budget at the same the government is pushing \$30 billion in NHS cuts over the next four years. If hospital services are unprofitable, they may be



Past President Dr. Oliver Fein and PNHP President Dr. Garrett Adams enjoy a break during the 2011 Annual Meeting in Washington, D.C.

cut. Meanwhile, the limit on income from private patients has been lifted, creating the potential for a two-tier system. Private providers will cherry-pick patients, leaving the complex expensive patients to the NHS. An active campaign is underway to protect the NHS, and it is gaining support. Currently less than 20 percent of GPs support the reform. Dr. Davis noted that in England they aren't just fighting the Tory government, they are fighting the global medical industrial complex.

Single payer and delivery system reform

Dr. Gordon Schiff talked about the need for any reform to meet three conditions: improve continuity, simplify coverage, and “make sense” in terms of our goals for reform. In contrast with our current expensive, wasteful, inequitable market-based system, we seek a system that is “frugal and efficient” with “structural support for quality,” with a “focus on prevention and a longer horizon,” “publicly accountable,” that “minimizes conflicts of interest,” is “stable and enduring” and “governed by professional values.”

Dr. Steffie Woolhandler presented data showing that ACOs, pay-for-performance, and risk-adjustment schemes raise costs and reward gaming. Overpayments to Medicare HMOs, almost 8 percent of total Medicare spending, increased after risk-adjustment by 70 diagnostic groups. Up-coding, cherry-picking, and other forms of gaming reward bad actors, who then have a surplus to invest in new facilities that raise costs even further. Financial incentives to improve quality don't work and are counterproductive. **Six important principles for delivery system reform are:** non-profit; all capitation payments must be used for patient care, not for capital investments, profits, bonuses or exorbitant salaries; separate capital funding based on regional health planning; eliminate insurance middlemen; rich and poor in same plan; quality data used for improvement, not financial reward.

Best Care Anywhere: Lessons from the VA

Philip Longman, author of “Best Care Anywhere: Why VA Health Care is Better than Yours,” spoke about his journey of discovery that the VA is a leader in quality in the U.S. health system. The VA's long-term relationship with patients is one reason for its success, giving it an incentive to invest in strategies to keep patients healthy and out of hospitals and VA-owned nursing homes over the long term. It has a highly regarded electronic medical records system and is a leader in evidence-based medicine. As one of the highest performing health systems in the U.S., the VA provides a useful model for U.S. delivery system reform. Longman recently spoke to 15,000 veterans and their families at the annual convention of the American Legion about the success of the VA's system of “socialized medicine” and received a standing ovation. He suggested looking to the VA for lessons about Medicare payment reform (i.e. moving away from FFS and towards sala-



Dr. Jacky Davis answers questions from Dr. Jennifer Voorhees about the National Health Service in England.

ried practice) and is in agreement with PNHP that delivery systems should, like the VA, be not-for-profit. [Note: PNHP disagreed with his admonition to push Medicare payment reform in lieu of single payer.]

'Why are we here': Address to Leadership Training participants

Dr. Claudia Fegan related a story about a patient at Cook County Hospital who she helped get the best care possible until his death. “Why are we here?” she asked. “We are here because every patient deserves to be treated with dignity and respect.” She went on to describe how U.S. health care is being steadily undermined by private insurers, big employers like Wal-Mart, and federal lawmakers who refuse to recognize that access to health care should be a right and not a privilege based on your ability to pay. “We are here because we know there is a better way to guarantee the public access to quality health care: a single-payer health system” that would embrace everyone, including immigrants.

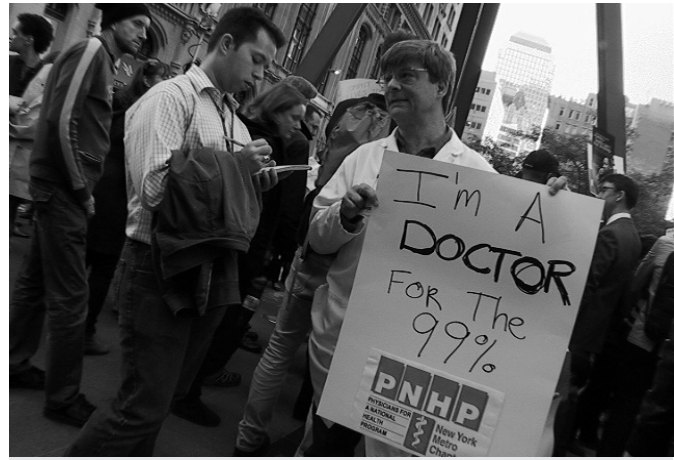
SELECTED STRATEGY WORKSHOPS

State single-payer efforts

Could a single-payer system in one state “laboratory” break the federal logjam to reform? Vermont recently passed legislation creating a multi-year “roadmap” to a publicly funded health care system for all Vermonters, while physicians and medical students in California are preparing for their annual lobby day for S.B. 810, California's state single-payer bill. While the ACA throws up several immediate roadblocks to single payer (requiring states to create “exchanges” by 2014, for starters), discussion of state plans is one way to engage physicians, policy makers, and the public in dialogue about reform, and physician activism in particular can have an enormous impact at the state level.

Occupy Wall Street

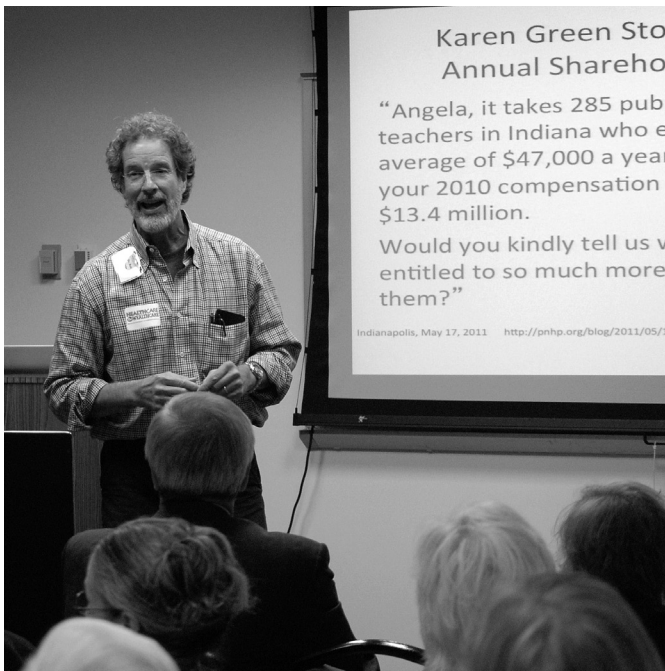
This workshop generated enormous optimism and interest, especially among the medical students. Drs. Steve Auerbach (who appeared on the Keith Olbermann show), Margaret Flowers, and others from across the country described their involvement and encouraged PNHPers to volunteer at first-aid stations, lead teach-ins, write op-eds, and constructively engage with the Occupy movement. In New York, PNHP members and others have formed “Healthcare for the 99%” and participated in a march on the health insurance industry. In D.C., Dr. Flowers is active in the OccupyWashingtonDC.org occupation and led a march on the national headquarters of America’s Health Insurance Plans, where several PNHP leaders spoke. N.Y. PNHPers have drafted the statement “Why doctors support Occupy Wall Street.”



Dr. Steve Auerbach, shown above being interviewed in Zuccotti Park, led a workshop on Occupy Wall Street that was a highlight of the Annual Meeting.

Faith, social justice, and organizing in the South

Dr. Pippa Abston from Alabama noted that it helps to find a point of agreement with questions coming from a faith perspective and to reframe our proposal in meaningful terms. For instance, some Christians think Jesus was opposed to government. A possible response is that he was certainly opposed to the oppressive power structures in his day. In our time the oppression comes from corporate power and can best be combated with participatory government. Dr. Garrett Adams and Dr. Art Sutherland talked about the challenges and opportunities for organizing in the South, a region of huge disparities and inequality in health care, and (in Louisville, Ky.) home of insurance giant Humana.



Dr. Rob Stone sharing what he’s learned from taking on giant insurers like Wellpoint in the Divestment workshop.

Divestment – Health Care not Wealth Care!

Margaret Mead’s observation to “never doubt that a small group of thoughtful, committed citizens can change the world” is a perfect fit for this group. Dr. Rob Stone described how they have been meeting via conference calls, fielding shareholder resolutions, publishing articles, including Stone’s thoughtful piece in Tikkun titled “Health Care Versus Wealth Care: Investors with a Conscience Should Divest from Health Insurance Companies,” doing research, and making connections with socially responsible investing groups such as Domini, a fund that doesn’t invest in health insurance firms. The Presbyterian church will be considering a resolution to divest next summer.

Organizing by medical specialty

PNHP members are opening dialogue on single payer within medical societies through letters, resolutions, debates, and other means. Dr. Robert Zarr, president of the D.C. chapter of the American Academy of Pediatrics, used his position to promote a resolution for single payer before the national AAP, stimulating discussion and building support. Medical student Richard Bruno brought a resolution on single payer to the American Academy of Family Practice, while Dr. Deborah Leiderman co-authored a letter with other neurologists in PNHP to the American Academy of Neurology. Psychiatrists Drs. Audrey Newell and Leslie Gise have exhibited and promoted debates at the American Psychiatric Association. [PNHP can help you identify and organize other pro-single-payer physicians in your specialty.]

Canada’s lessons for the U.S.

The Canada Health Act requires that the provinces provide coverage that is 1) universal, 2) provides comprehensive benefits with 3) no financial barriers to care, and that is 4)



Medical and public health students Whitney Rudin, Tajh Goswami, and Sadiqa Mahood get acquainted at the PNHP Annual Meeting.

publicly administered and 5) portable between provinces. Currently there is no coverage for undocumented immigrants, although community clinics and hospitals tend not to ask for proof of coverage or payment. Most Canadians have supplemental, employer-sponsored coverage for medications and dental; there is a national push to add pharmaceuticals to the benefit package, or “pharmacare.” The federal government’s transfer payment, accounting for about 25 percent of health spending, is leverage for assuring that provinces meet the principles of the Canada Health Act.

Building an effective chapter of PNHP

Dr. Ann Settgaest, co-chair of PNHP’s Minnesota chapter, gave pointers for chapter building, including using a resolution to build membership; holding noon conferences and grand rounds for residents and physicians, and lunchtime talks for medical students; holding events with PNHP leaders and single-payer experts; building a speakers bureau by going to talks in pairs; using national PNHP’s help for websites and e-mail blasts; and fundraising via one letter to the members annually and a “summer celebration” to supplement dues. Her final advice: Do not try to do too much and keep it simple! Dr. Mike Huntington of Oregon talked about creative ways to educate audiences about single payer, drawing on his experiences touring with the Mad as Hell Doctors.

Labor and the movement for single payer

Labor is critical to the movement for genuine health care reform. Currently, workers’ health benefits are being reduced or eliminated and raises (when achieved) are offset by increases in cost-sharing for health services. Verizon workers are taking action to prevent the loss of their hard-won health benefits over the years. Rising health care costs are hurting labor and draining the trust funds for retiree health benefits, including Voluntary Employee Benefit Associations which are supposed to fund health benefits for

retired autoworkers. Single payer, H.R. 676, is supported by over 585 union organizations in 49 states, including 135 central labor councils and area labor federations, 39 state AFL-CIO’s and 22 international/national unions. See www.unionsforsinglepayerHR676.org for details.

PNHP DINNER PRESENTATIONS

‘Physician Activism from Public Hospitals to Single Payer’

Drs. David Ansell and Mardge Cohen reflected on the lessons from their experiences as residents at Cook County Hospital (now Stroger Hospital) in Chicago. Dr. Ansell was recruited to the giant public hospital by the legendary chief of medicine, Dr. Quentin Young, and Dr. Mardge Cohen, then in her first year of residency. For Dr. Ansell, the experience of taking care of the poorest, most vulnerable and disenfranchised patients with few resources instilled a lifelong commitment to equity in health care. Leadership positions at two private hospitals within blocks of Cook County (but a world apart in terms of resources for patient care) convinced him of the need for single-payer national health insurance. Dr. Cohen’s main lesson from County was that “the patient is always right” whether that is at Cook County, where she opened the first clinic for women and children with HIV, or in Rwanda, where she works with women infected with HIV during the genocide. In a show of hands, a high proportion of participants in the PNHP Annual Meeting said they had previously worked in a public institution, further testament to the role of public hospitals in spawning physician activism. Dr. Ansell, an internist and medical director of Rush Hospital in Chicago, is the author of “County: Life, Death, and Politics at Chicago’s Public Hospitals.” Dr. Ansell is available to travel to deliver grand rounds presentations on single payer: david_ansell@rush.edu

Rep. John Conyers Jr., lead sponsor of H.R. 676, made a surprise appearance at the dinner. He praised PNHP for its research and education efforts, thanked Dr. Quentin Young, PNHP’s national coordinator, for his dedication and commitment to the cause, and encouraged PNHPers to speak to their legislators if they have not already signed on to H.R. 676.

Awards

2011 Dr. Quentin Young Health Activist Award recipients: Ellen Oxfeld, Ph.D., Marvin Malek, M.D., and Alice Silverman, M.D., for their superb work in Vermont. Mike Huntington, M.D., and the “Mad as Hell Doctors” for their creative engagement of new audiences.

Nick Skala Health Activist Award recipient: Richard Bruno, for his tireless support for single payer while in medical school in Oregon.