

Where We've Been and Why We'll Win

By Scott Goldberg, MS3

PNHP note: The following text contains the prepared remarks of Scott Goldberg, a third-year student at University of Chicago Pritzker School of Medicine, for the opening session of the 4th Annual SNaHP Summit at the University of Illinois-Chicago medical campus on Feb. 14, 2015.

Last week, a 55-year-old Spanish-speaking woman, I'll call her Mrs. H, was admitted to the general medicine service I was rotating on. For the last few years, she had become progressively short of breath to the point that she required 3 liters of oxygen at rest. Now, I don't know the details of how she came to our hospital, but supposedly the pulmonologist agreed to evaluate her for a transplant. Through a translator, she told our team the first time she met us that her life was in our hands.

So, we ran a series of tests and determined that she likely had idiopathic pulmonary fibrosis. It's a progressive interstitial lung disease of unknown etiology whose only cure is transplantation. We finished the work-up and were preparing to send her home to be followed as an outpatient, when the transplant team social worker called the intern to say that Mrs. H could no longer receive her care at our hospital. We were out-of-network. When we broke the news to her, she cried. She had trusted us. She had come to believe that we would be able to provide her with a life-saving transplant.

After letting the news sink in, she asked: "How will I afford the care I have already received? I have no money." The resident assured her that it wouldn't be an issue, but outside her room afterward, the resident admitted that she wasn't sure if the expensive workup would be covered. In the end, all we could do was try to get Mrs. H an appointment at another hospital and send her home with a stack of medical records and a prescription for home oxygen. Oh, and I forgot to mention – Mrs. H actually has health insurance. If she didn't, she would never have even made it through the door.

I bring up the story of Mrs. H because it encapsulates everything that's wrong with a system that is run by profit-driven, private insurance companies. We have a system that doesn't prevent you from incurring crippling medical debt. That doesn't actually provide you with all medically necessary care. A system where you're now forced to buy insurance with such high premiums, deductibles, and out-of-pocket expenses that you have to make decisions like – if I buy these prescriptions then I can't pay my electric bill. Insurance that restricts your choice of doctor and hospital and undermines the doctor-patient relationship. A system that causes profound emotional and financial suffering, and frankly leads to the deaths of tens of thousands of people each year. If 20,000 Americans died each year from an infectious outbreak or a terrorist attack, people would be up in arms. But Americans have become resigned to the fact that this is just how our system works: that the one percent benefit – the hospital executives, the CEOs of insurance and pharmaceutical companies, and the politicians who greedily accept their campaign contributions – while the rest of us suffer.

But I'm not up here to convince you that American health care is unequal, unjust, and completely broken. You are here because you know this. You have seen and heard the stories of people like Mrs. H. You are here – not just because you couldn't find a date on Valentine's Day – but because you want to do something to fix it. I know many of you here are already convinced that a single payer, national health insurance system, Medicare for All, call it what you will, is the only way to provide truly universal and equitable health care, and you are totally committed to making this a reality. But for those who are not yet convinced, I commend you for coming to the summit to learn more. You may not think so, but this is a small act of courage. A majority of health care providers support NHI, but most of them have not taken the step that you have today. They have given in to disenchantment and resignation. But you have not. You know that you have the power to do something about it.

So here's where I'm going to take you over the next 25 minutes. First, I'll briefly explain what single payer is. Although if you want to learn more, I encourage you to attend the Single Payer 101 workshop during the first breakout session. Second, I'll provide a history of 100 years of universal health care efforts in the US in 8 minutes. Then, I'll end by offering some insights into why we will achieve Medicare for All in our lifetime and what we can do to get there as soon as possible.

OK, so what is single payer? It is as simple as the name suggests. One payer – in most cases, the government – reimburses providers of care for the services they deliver. The beauty of the system is in its simplicity. Our neighbors to the north, Canada, have a model system that is publicly funded and privately delivered. It insures all Canadians while spending half of what we do through mechanisms like global budgeting, bulk purchasing of pharmaceuticals, and minimal administrative costs. Unlike the system we have, as a government-run program it is transparent and accountable to its citizens. We actually have a system similar to, though not exactly the same as single payer in this country, Medicare, which protects its card-carrying members from financial ruin while spending about 15% less than private insurance. Surely, Medicare can be improved. And the way to do so is by expanding it to everyone, thereby giving it the power to negotiate drug prices, spread the risk, and eliminate substantial waste. There is a bill in Congress with extensive support called HR 676 that, if passed, would transform not only the way we provide health care but the very fabric of our society. It would eliminate the financial burden associated with paying for care and lift up the economic fortunes of 80% of the population. It would convey to the world that Americans look out for each other not just for themselves. Now, health care "experts" will tell you that health insurance can't be that simple. That it is more "complicated" than single payer supporters understand. But this is simply a tactic used to marginalize critics and entrench their authority as experts. Don't let anyone tell you that you need a masters in health policy or even an encyclopedic understanding of the data to advocate for health reform – all you need is commonsense, a bit of evidence, and the experience of most of the industrialized world to draw upon. Astrophysics is complicated; the provision of social goods is not.

Now, on to the history of universal health care efforts in the US. I think this background is important not only so you can learn from the movement's successes and failures, but so that you see yourselves as activists in a historic struggle. The fight for NHI is not a fleeting issue. It is a monumental cause that affects all Americans. It is a movement on par with the movements for the abolition of slavery, for women's suffrage, for the end of the war in Vietnam, and for civil rights for African Americans. When you see it in that context, you can fully dedicate yourself to the movement. You can realize that total commitment demands not just working as a doctor and educating others, but a lifetime commitment to action. We really are at a crossroads. The heart of medicine is broken and it is our duty to fix it.

So on to the history, for which I am indebted to a talk given by Karen Palmer at the 1999 PNHP annual meeting. The campaign for health insurance began in earnest in 1917, with the proposal of a bill by the American Association of Labor Legislation (the AALL). But it was defeated by state medical societies, the commercial life insurance industry, and the American Federation of Labor who feared it would weaken unions by usurping their role in providing social benefits.

Next came Franklin D. Roosevelt (FDR). We might have thought the Great Depression would create the perfect conditions for passing compulsory health insurance, but with millions out of work, unemployment insurance took priority followed by old age benefits. FDR's Committee on Economic Security feared that inclusion of health insurance in its 1935 bill, would threaten the passage of the entire Social Security legislation. It was therefore excluded.

There was one more push for national health insurance during FDR's administration: the Wagner National Health Act of 1939. Though it never received FDR's full support, Wagner's bill gave general support for a national health program to be funded by federal grants to states and administered by states and localities. However, the 1938 election brought a conservative resurgence, and with the beginning of the WWII, any chance at NHI was lost.

But in 1945, for the first time, NHI received the unreserved support of an American president. Harry S Truman proposed a single, universal egalitarian system that included all classes of society. Congress had mixed reactions to Truman's proposal, but the AMA, the American Hospital Association, the American Bar Association, and most of the nation's press had no mixed feelings; they hated the plan.

In 1946, the Republicans took control of Congress and had no interest in enacting national health insurance. They charged that it was part of a large socialist scheme. Truman responded by focusing even more attention on a national health bill in the 1948 election. After his surprise victory in 1948, the AMA thought Armageddon had come. They assessed their members an extra \$25 each to resist national health insurance, and in 1945 they spent \$1.5 million on lobbying efforts, which at the time was the most expensive lobbying effort in American history. The AMA and its supporters were very successful in linking socialism with national health insurance, and as anti-Communist

sentiment rose in the late 1940's and the Korean War began, national health insurance became improbable. Truman's plan died in a congressional committee. Instead of a single health insurance system for the entire population, America would have a system of private insurance for those who could afford it and public welfare services for the poor.

But single payer supporters regrouped and switched their focus to passing universal health care for the elderly. In 1958, spurned by single payer activists, Rhode Island congressman Aime Forand introduced a proposal to cover hospital costs for the aged on social security. Predictably, the AMA undertook a massive campaign to portray a government insurance plan as a threat to the doctor-patient relationship. But by concentrating on the elderly, the terms of the debate began to change for the first time. There was major grassroots support from seniors and the pressures assumed the proportions of a crusade. In the entire history of the national health insurance campaign, this was the first time that a ground swell of grassroots support forced an issue onto the national agenda. In the end, the government ignored the AMA's protests and proposed legislation that ultimately became Medicare and Medicaid. In 1965, Lyndon Johnson signed it into law as part of his Great Society Legislation.

Every Democratic presidential nominee since LBJ has declared themselves a supporter of health care for all. But none of them have supported Medicare for All during their campaigns. As you may know, Barack Obama expressed support for single payer while a relatively unknown state senator from Illinois, but we all know how that turned out. Soon after Obama rode the populist wave into the White House, he excluded single payer activists from even one seat at the table of the health care reform process and eagerly sought out deals with private insurers and big Pharma to secure their support for the Patient Protection and Affordable Care Act. They were happy to concede on matters like denial of coverage for preexisting conditions as long as the government would offer no competing public plans and force Americans to purchase private insurance. This was achieved in outward defiance of public opinion. Contrary to what people think, a majority of Americans (and doctors) have and continue to support single payer. Just this January, a poll found that over 50% of 1,500 likely voters support a single payer system – almost 80% of Democrats and even 25% of Republicans.

Now, I'm not disillusioned by this history. In fact, there are important lessons that can inform our efforts and that give me hope that we will be successful where those before us were not.

First, the AMA has opposed single payer since 1917. But while the AMA could honestly say it represented the voice of doctors, it no longer can. Maybe about 60% of physicians, or less, are members. And many doctors, particularly non-specialists, feel out of touch with its stances. This provides an opening, for another physician organization to step into the void that speaks on behalf of what is just and right for patients. You may see where I'm going with this – but this is where PNHP comes in. PNHP is the only physician organization dedicated to the sole purpose of transforming American health care by passing NHI. And the organization can only grow. If there are 800,000 active doctors in this country, then about 2.5% of them are members of PNHP. This means we, as students

and future doctors, have a lot of work to do to get our colleagues to sign up. We should be doing this on a daily basis. Think about all the time you spend with fellow students, residents and even attendings. Think about how many times the issue of insurance comes up and you want to scream out: “If we had single payer, this would not be an issue!” Now, every time that thought comes to mind, do something about it. Mention single payer and encourage those around you to sign up for PNHP. These conversations are not, at the core, political. They are essential to the foundations of our profession, and we must normalize them. So here’s what I ask of you – I want you to recruit at least one new colleague to PNHP each month. Keep track and then send Emily your tallies at the end of the month. It’s a modest ask, but if everyone here does it we’ll have nearly 2,000 new members in a year. Then, we can start to envision a future where PNHP will take over from the AMA as the organization that speaks on behalf of what is best for doctors and patients.

Now, while the AMA might have been a major barrier to NHI in the 20th century, our biggest barrier now is private health insurance companies and Big Pharma. You all know that we are facing one of the most well-financed and formidable opponents in American history. Both have fought tooth and nail against single payer with their army of lobbyists and have contributed heavily to candidates for public office to protect their position and maximize their profits. It is no secret that they spent \$173 million to defeat the public option, which amounted to about a million dollars a day during the debate over health reform. So when we talk about single payer, we must talk about the massive profits reaped at the expense of patient care. The neoliberal corporate agenda has infiltrated health care and we must vigilantly fight back against the idea that health care is a commodity and, instead, declare that health care is a public good that all Americans, regardless of race or class, should have access to.

But I am not discouraged by our well-resourced foes for three reasons. One, their arsenal of smear tactics is dwindling. The fear of “socialized medicine” is waning. Communism coming to America is an outdated notion. Two, these companies are universally despised. A recent poll demonstrated that almost all Americans believe that private insurance companies are the biggest problem in our system. So there’s our message right there – *we must get rid of private insurance companies to have real health reform*. Three, ultimately, the system cannot function without us. If we remain silent, we will only allow these companies to continue to reap massive benefits at the expense of our patients and our professional code of ethics. If we, as health care providers, are united in opposition, we will not be defeated.

This brings me to my finale. So you may believe that after 100 years of struggle, that we will never achieve NHI. But let me tell you why we will win and what we have to do to get there.

Allow me to begin with a lesson from Canadian history. The movement toward universal health care in Canada started in 1916 (depending on when you start counting), and took until 1962 for passage of both hospital and doctor care in a single province. It took another decade for the rest of the country to catch on. That is about 50 years all together.

This is a quote from Karen Palmer's speech: "We fought, threatened, the doctors went on strike, refused patients, people held rallies and signed petitions for and against it, burned effigies of government leaders, hissed, jeered, and booed at the doctors or the Premier depending on whose side they were on. In a nutshell, we weren't the stereotypical nice polite Canadians. Although there was plenty of resistance, now you could more easily take away Christmas than health care."

What Karen Palmer depicts is the power of direct action and social movements. I have been reading a lot of Noam Chomsky recently – if you haven't read it yet, go out and buy "Understanding Power: The Indispensable Chomsky." As someone who has been speaking, reading, and participating in social movements for 70 years, he has unparalleled insight into how social change happens.

I want you to look around you. Our movement is growing exponentially. There are now 35 student PNHP chapters, with 10 new ones in the last year alone. There are now 19,602 PNHP members. Much of that growth has come from students. There are now 731 student members. The second SNaHP summit had 40 students, the third had 80, and the fourth has 160. At this rate, in nine years we will have the support every single medical student in the country.

So why do I bring up the power of students? Historically, students have been the stimulus and source for broader activism. Just recently in Chile, following three years of nationwide student protests, the country will make college tuition-free and are paying for it with a 27% tax on corporations. Look at the civil rights movement in the US. It was the Student Nonviolent Coordinating Committee (SNCC) that spearheaded the civil rights movement. The Freedom Riders, not all, but the majority were young people and students. Over time, it grew and became a mass popular movement and achieved historic things. We don't know the names of the leaders of SNCC, but that is the point with movements that Chomsky makes. We know the name of Martin Luther King Jr, but who do you think organized the marches, the talks, the sit-ins? Members of SNCC did. They did the heavy lifting of organizing, going door to door, and putting their lives on the line. Our movement does not need a figurehead. It needs unified direct action.

As Chomsky has said: "Direct action carries the message forward in a very dramatic fashion. Direct action means putting yourself on the line. It indicates a depth of commitment and clarification of the issues, which often stirs other people to do something." Achieving single payer will require resistance and civil disobedience. All the great movements in history have. In the US, the sit-down strikes of the 1930s were a major impetus for passing significant New Deal legislation. The reason is that manufacturers could perceive that a sit-down strike was just one step before taking over the enterprise, kicking out the owners and managers, and saying 'we'll run it ourselves.' This is no different from our health care system, where physicians have become employees of profit-driven hospitals. We must take back the system and run it ourselves.

The same was true of the civil rights movement. Institutional segregation had been going on for hundreds of years, but what sparked the movement? A couple incidents of direct

action. Rosa Parks insisting on sitting in the front of the bus. Black students sitting at a lunch counter in Greensboro. Without the direct action, the movement would probably never have happened. You can make as many speeches as you like but they will never have the effect of those actions. And while the movement started with students, it became broad-based and diverse. Just like the movement for single payer, we must reach out to and build ties with labor unions (over 600 have already endorsed HR 676), civic and faith-based movements, and even businesses. While businesses may seem like natural allies of the private insurance companies, many of them feel the strain of paying to insure their employees and would clearly benefit from government-run health insurance. Winning single payer will take a powerful coalition but as students and future physicians we can kick start this movement with direct action.

In closing, Americans are literally dying for equitable, universal health care access. And so I know that deep down you feel, as I do, that the time has come for direct action. The question is – when do we get started? Here’s one idea – Medicare’s 50th birthday is this July. A national student walk-out once school starts would be a powerful action. We can’t predict exactly when we’ll get single payer, but what we can control is our ability to be united, mobilized, and ready to act.

When I talk to people about single payer, I often hear: “Oh yeah, I support single payer but it will never happen in this country.” I tell them that people once thought the abolition of slavery and women’s suffrage could never be won – that these were “unrealistic” dreams. And yet both of these “unrealistic” dreams were ultimately won. While moderates were advocating for incremental change, the activists pushed for revolutionary change and were successful. What seemed impossible yesterday is something we accept as a given today. So next time someone says single payer will never happen, tell them this: “If you believe it won’t happen, it never will. But if you believe that the only way it will happen is to actually do something about it, then I am sure you will make the only choice that a moral and principled person would, and that is to join me in this struggle.”

Thank you.