Highlights of the 2014 PNHP Annual Meeting

Over 250 participants from 32 states and the District of Columbia, including 83 medical students and 114 attendees who came a day early to participate in Leadership Training, gathered at the Hampton Inn and Suites in New Orleans on Nov. 14-15. The meeting was chaired by PNHP President Dr. Andrew Coates.

PLENARY SESSIONS

Health policy update: From the ACA and ACOs to single payer

Drs. Steffie Woolhandler and David Himmelstein presented an updated version of the PNHP slideshow with **data on the number of uninsured, rising income inequality, financial barriers to care, international comparisons of quality and administrative costs, for-profit health care, health care consolidation under the Affordable Care Act, and more**. The ACA was not designed to provide universal coverage; it will leave 31 million people uninsured in 2020. Even if the Supreme Court had not made the Medicaid expansion optional, it still would have left 25 million people uninsured. Employer-based insurance benefits are shrinking; 41 percent of employees with private coverage now have deductibles of $1,000 or more. Skimpy exchange plans have made underinsurance "the new normal." **Bronze plans carry deductibles of about $5,000 for single and $10,000 for family coverage**. Due to the high costs, insured patients are delaying or going without needed medical care even for serious conditions like MI and breast cancer.

The U.S. has the highest income inequality of any wealthy nation in the world. The top 1 percent receives 19 percent of total U.S. income. Life expectancy at age 60 for men with incomes above the median is now about 6 years longer than for men with incomes below the median income.

ACOs threaten to be a rerun of the HMO experience, offering "fee-for-non-service." The number of ACOs has grown to more than 650 since 2010. Practices owned by hospitals have higher costs than independent and smaller practices. U.S. hospital administrative costs consume 1.4 percent of GDP. As the UK moves towards a more market-oriented system, the share of their workforce devoted to administration is multiplying.

Drug firms reaped $65.1 billion in profits in 2013, even after paying multiple settlements (from $50 million to $3 billion) for fraud. Drug companies haven't developed an Ebola vaccine because a profit-driven industry does not invest in products for markets that cannot pay. Insurers are increasingly using tiered drug plans, with co-insurance up to 50 percent, and formularies to exclude coverage for costly medications and drive away the expensively ill. **Some insurers don't include a single drug for MS, HIV, Hepatitis C and other expensive illnesses in the lowest drug tier.**

Few families have the assets to pay high out-of-pocket costs. Proposals by the GOP to shift more costs to patients would only make matters worse. Physicians have "extraordinary privilege and responsibility" to advocate for the only solution that works: single-payer national health insurance.

PNHP's updated proposal for reform

Dr. Adam Gaffney reported that the writing committee he chairs along with Drs. Marcia Angell, David Himmelstein, and Steffie Woolhandler has completed work on **an updated PNHP proposal for single-payer national health insurance for publication**. PNHP's original proposals for single payer were published in the New England Journal of Medicine (1989) and the Journal of the American Medical Association (2003). The updated proposal tackles new policy developments, like the impact of the ACA's passage, health system consolidation, and the expansion of for-profit health care. It also offers fresh organizing opportunities, giving PNHP members a tool they can share with colleagues to build support for single payer.

Dr. Adam Gaffney

Panel: The impact of the ACA on the health crisis and the movement for reform

In a panel moderated by Dr. Claudia Fegan, Dr. Diljeet Singh, a gynecologic oncologist, reported that the Supreme Court ruled in **Burwell v. Hobby Lobby** that the ACA cannot require closely held for-profit businesses to cover birth control for their workers if it violates their religious beliefs. Hobby Lobby's owners specifically objected to covering four of the 20 FDA-approved contraceptives, believing them to be abortifacients (despite scientific evidence to the contrary). Insurers of firms that opt-out on religious grounds are required to provide those benefits directly to employees, but Hobby Lobby is in court trying to block

Dr. Diljeet Singh

the workaround. The ruling undermines an essential health benefit for women, adding to the broader assault on reproductive rights in the U.S.

Professor Donald Light said the ACA allows drug companies to continue to engage in "**market spiral pricing**," setting high prices for products because the patent system gives them a quasi-monopoly, and then raising prices in subsequent years. He noted that drug prices don't reflect added clinical value or R & D costs. **Of 994 new drugs released between 2002 and 2011, 918 provided no clinical benefit and only two were clinical breakthroughs**. High co-pays and deductibles on costly patented oncology and Hepatitis C drugs mean that medical impoverishment is now "official U.S. policy." In contrast, researchers at Italy's Mario Negri Institute do not patent their work. A single-payer system could negotiate prices, limit waste on marketing, and fund research for public health rather than private profit using the Mario Negri model.

Dr. Jason Kelley talked about the challenges facing Vermont's Act 48, their 2011 "pathway to single payer" legislation. The delivery system in Vermont is rapidly changing. Sixty-five percent of physicians in the state work for the University of Vermont's Fletcher Allen health system and there are only about 60 private practices left statewide. **"Private, for-profit-insurance free" may be a more attainable goal than single payer, he noted, due to the difficulty of integrating Medicare and self-insured businesses into single payer at the state level**. The opposition

Drs. Dave Dvorak and Elizabeth Rosenthal

is ramping up misinformation, e.g. claiming that the disastrous experience with their state's health exchange for the ACA means "the government can't do anything right" and "Canadians are flocking to Vermont for medical care." Kelley recently counted the cars with Canadian license plates in the University of Vermont hospital parking lot, finding a total of one car from Ontario. Single-payer activists are rebutting the arguments against single payer whenever they appear in the state's 24 newspapers.

The ACA hasn't slowed down single-payer activists in Minnesota, according to Dr. Inge De Becker. **Chapter members have given 64 presentations this year, up from 40 in 2013**. They have published eight letters and op-eds, have an article forthcoming in the Minnesota Medical Association (MMA) journal, and co-sponsored a forum on single payer with the MMA and the Minnesota Academy of Family Physicians. They are promoting medical student chapters in Duluth, Minneapolis, and Rochester (Mayo), and working with state Sen. John Marty on a bill to study the economic implications of health care reform options. They hope to develop a strategy to reach all 17,000 physicians in Minnesota in 2015.

Single payer: a powerful tool for better care, better health, and reduced costs

Dr. Donald Berwick addressed the meeting via video link. He ran on a single-payer, Medicare-for-All platform in the Massachusetts gubernatorial primary and received 21 percent of the vote. A full transcript of his remarks is posted on the PNHP website. **Single payer is a "smart way to achieve quality of care" and the Triple Aim, he noted**. Single payer is a "strong lever" for addressing the first aim, better care for individuals. Single payer makes it possible to make care safer based on science, using payment as leverage, and the single database to meaningfully measure quality. It also makes it possible to shift resources to areas of need in order to achieve justice and equality in health care. The second aim is better population health. Single payer makes it possible to "invest upstream" and address population-based causes of poor health, such as in housing, and to track patients to invest in prevention, something that is impossible under our fragmented system. Single payer is especially critical for the third aim, lowering costs. Reducing the complexity of the system will reduce overhead, saving 15 percent of health spending. The single payer will also have bargaining power in payments for hospital supplies, drugs, and more. **Our current, multi-payer, fragmented system makes it harder to get to the Triple Aim**.

While campaigning, Berwick noticed that people don't understand the term single payer. Medicare-for-all is somewhat better known, but the public tends to think of it as government-run health care, like the British National Health Service. He noted that people in working-class communities are weary, they've been "worn down by forces they do not understand." He noted that the business community doesn't understand the benefits of single payer, the improvements and cost reductions that would result. **He recommended action at the state level for single payer; forging an alliance of groups, including business, for single payer; making the case that government can solve problems**

and manage its business well; and continuing to make the economic case for single payer. "Overall, I'll tell you this. My takeaway is that given my experience in living rooms, libraries, and town meetings, this [single payer] is possible. This can be done."

The case for campaign finance reform

Lawrence Lessig

Law professor and activist Lawrence Lessig from Harvard spoke about the concentration of power and influence over Congress by large donors, and how it works to block action on single payer and climate change, and assured that over 90 percent of the economic gains of the recovery went to the 1 percent. **In the U.S. the largest donors comprise less than 0.01 percent of the population**, a lower share than people on the nominating committee in Hong Kong (0.024), where huge street protests have erupted over the stipulation they nominate candidates acceptable to China. Political scientists Martin Gilens of Princeton and Benjamin Page of Northwestern pored through nearly 2,000 public policy polls and found that as the proportion of wealthy people favoring a policy rises, Congress is more likely to enact the desired change. In contrast, the data show that Congress is indifferent to the priorities of people of lesser means. While some groups favor a constitutional amendment for campaign finance reform, **Lessig favors legislation for public financing of elections**, such as by giving every person a $50 voucher to donate to candidates, or giving public funds to candidates who limit donations to $100 per person, as in Connecticut's 2005 law.

SELECTED WORKSHOPS

Single payer and the crisis in mental health care

Dr. Steve Kemble reported that **Medicaid managed mental health care has reduced access to care for the seriously mentally ill in Hawaii**. Over half of psychiatrists have stopped accepting Medicaid, and hospital and emergency room mental health costs have risen 30 percent. Medicaid managed care has demoralized the workforce with the need for preauthorization, a rigid formulary, and by limiting the scope of practice to medication management. Dr. Wes Boyd reported on his research showing that psychiatrists waste nearly 1 million hours on the phone annually with insurance plans seeking authorization to admit patients; no preauthorization is required for patients with Medicare. In his most recent study, simulated patients were only able to obtain appointments with 26 percent of the doctors in a Blue Cross network; the remainder had full practices, didn't take adult outpatients, had wrong numbers or didn't return calls, limiting access to care. **A single-payer mental health system would assure access, slash bureaucracy, eliminate corporate managed care, and provide specialized services for the seriously mentally ill.**

How the fight for Medicaid expansion helps the movement for single payer in red states

Twenty-three states have not expanded Medicaid. Dr. Ed Weisbart noted that although Medicaid is far from perfect, until we get to single payer, **Medicaid is the only safety net for many low-income Americans**. He urged single-payer activists to be knowledgeable and vocal in support of Medicaid expansion in red states; he has made many new contacts in Missouri this way. With CHIP in crisis, Medicaid is especially critical to children. **Sam Dickman presented data showing that from 7,000 to 17,000 Americans die each year from the lack of Medicaid expansion**. Hundreds of thousands more suffer catastrophic medical costs, experience depression, miss mammograms and pap smears, and go without treatment for their diabetes. Dickman's data is available by state for sharing with the media. Dr. Rob Stone stressed the importance of joining forces with organizations fighting for social justice.

Three single-payer systems: reports from the front lines

Professor Karen Palmer reported that Canada's provincially based system features public financing of care, but private delivery. Patients can choose their doctors and doctors can choose their practice settings. **For-profit surgery centers and other investor-owned health enterprises are suing for the right to operate in Canada, despite evidence that profit-driven care is higher-cost and lower quality**. Canadian Doctors for Medicare (www.canadiandoctorsformedicare.ca) is leading the fight against privatization. Dr. Mira Lee described **South Korea's transformation from having 367 health plans to a universal, single-payer system in 1989**. Insurance overhead costs fell from 8 percent to 3.4 percent, and out-of-pocket costs decreased by 4.2 percent under single payer. About 90 percent of their delivery system is private. Dr. Carol Paris recently practiced psychiatry in New Zealand's national health service. **Their 75-year-old NHS provides universal, comprehensive coverage to all "kiwis," including coverage for mental health care**. Treatment decisions don't require preauthorization and billing is simple. They encourage collaboration between specialists and primary care providers.

Dr. Carol Paris, Dr. Mira Lee, and Karen Palmer (left to right)

Talking about single payer in the wards

University of Illinois medical students Anna Zelivianskaia and Desiree Conrad encouraged physicians and students to look for opportunities to make short, factual comments on single payer, using cases on the wards that illustrate facets of the health care crisis as teachable moments, without taking too much attention away from patient care. They noted that administrative overhead in our fragmented health system consumes over 31 percent of health spending, one of the main reasons why U.S. health costs about twice the OECD average, with worse outcomes and major health disparities by insurance status. **They encouraged participants to have a long-term plan in mind for health professionals who are interested (e.g. to come to a meeting or participate in a lobby visit) and to keep some resources on hand for people who want more information**. Being ready to answer the "hard questions" is helpful although you can always say you'll find out about something you don't know (the FAQ on the PNHP website is a helpful resource). Some typical concerns are about physician incomes under a single payer (they won't change much because single payer is not financed by cutting physician incomes, but the gap between specialists and primary care doctors may narrow) and the role of government (as payer only, no role in medical decision making). They noted that it is easier to approach students and residents than attendings at first.

Effective outreach in your specialty

Dr. Robert Zarr

Dr. Ray Drasga described several strategies that he has used in his outreach to oncologists, including publishing **an evidence-based article for single payer in a prominent oncology journal, hosting a booth at the oncology society's annual meeting, and outreach to well-known colleagues** in his specialty. President-elect Dr. Robert Zarr promoted a single-payer resolution to the American Academy of Pediatrics, and a group of PNHPers in family medicine is forming to promote a resolution to the American Academy of Family Physicians. PNHP has a template medical society resolution and recommends Drasga's article as a model for activists in other specialties, although more informal articles for newsletters and other publications can also reach a large audience. Physicians today are becoming corporate employees subject to much bureaucracy and many constraints. It's important to stress that, under single payer, physicians' workflow will be simplified.

PNHP DINNER PRESENTATIONS

Mistreating health inequities: The new biopolitics of race, health, and justice

Penn law professor Dorothy Roberts presented data showing that breast cancer mortality in Chicago among blacks and whites

Dorothy Roberts

was similar in 1980, but by 2005 the death rate in white women had been halved while it remained high in black women. This disparity stemmed from black women's relative lack of access to health care, not genetic differences. The human genome project proved that humans are 99.9 percent the same and proved there is no genetic basis for race. **Race is a social and political construct, and injustice and inequities in income, employment, housing, health care, education, and other social factors - not genes - create health disparities**. Yet some scientists, science writers, and drug companies are resurrecting the idea that there are racial genes to explain disparities like high rates of infant mortality and premature births among blacks (e.g. "Study Points to Genetics in Disparities in Pre-Term Births"), and to gain patent approval for race-specific treatments, like the antihypertensive BiDil, a combination of two generic drugs that had only been tested in blacks, but which was said to target "ethnic differences in the underlying pathophysiology of heart failure." Roberts said that the current attempt to attribute disparities in health to race – rather than racism – is due to our society's desire to blame the victim and evade responsibility. Instead of fixing social injustices, we are going in the wrong direction, looking to "punitive controls" and "private technological fixes."

AWARDS

The 2014 Dr. Quentin Young Health Activist Awards were presented to **Dr. Susan Rogers**, for her speaking and support of medical students in Chicago and nationally, and **Dr. Ed Weisbart**, for his exemplary work speaking, building the Missouri chapter of PNHP, and making single-payer work fun.

The Nick Skala Health Activist Awards were presented to **Scott Goldberg**, for outreach to the media and founding a student chapter of PNHP at the Pritzker School of Medicine at the University of Chicago, and to **Josh Faucher**, for founding a PNHP medical student chapter at the Mayo Medical School.

Slides and other materials from the 2014 meeting are available at www.pnhp.org/2014-annual-meeting-materials.

Photos by Annette Gaudino.

Physicians for a National Health Program, 29 E. Madison St., Ste. 602, Chicago, IL 60602, (312) 782-6006.