PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

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PNHP Annual Meeting, Saturday, Oct. 29, Washington, D.C. Whither delivery system reform?

PNHP's 2011 Annual Meeting will feature health economist Robert Evans from Canada, Dr. Jacqueline Davis, co-founder of Keep our NHS Public, from the U.K.; Phillip Longman, author of "Best Care Anywhere" on the VA; as well as PNHP leaders and a special discussion on delivery system reform. The meeting will be held at the Gallaudet University Kellogg Conference Hotel in Washington, D.C. ($169 single/double if reserved by Oct. 21; call 202-651-6000) and will be preceded by PNHP's popular leadership training. Register online at www.pnhp.org/meeting or call 312-782-6006.

Robert Evans, Ph.D.

Vermont, Hawaii take steps toward single payer

While states are blocked from adopting single-payer plans by the Affordable Care Act before 2017, Vermont passed "pathway" legislation to get started on the journey this spring, after Harvard health economist William Hsiao, Ph.D., reported that a "public-private" single-payer system could save $2.1 billion in Vermont by 2024. For details, see the special section on Vermont starting on page 22, this issue, and www.pnhp.org/states/vermont. In Hawaii, PNHP member Dr. Stephen Kemble was appointed to the Hawaii Health Authority to help design a universal health system for that state. Hawaii's exemption from the 1974 ERISA law – and island geography – may give them a good shot at single payer. Stay tuned.

Special section on delivery system reform

The Obama health plan has unleashed another frenzy of corporate consolidation in the health care industry. Deals like UnitedHealth's recent purchase of the management arm of Monarch Healthcare, a California group with 2,300 physicians, are accelerating. A gold-rush mentality has taken hold as firms seek to position themselves to cash in on federal incentives to form "accountable-care organizations" or ACOs. Is there any alternative?

In a special section on delivery system reform starting on page 51, we highlight models for delivery system reform driven by patient needs, not corporate profit. What are the lessons for single payer advocates from the VA, the U.K.'s National Health Service (NHS), and several years of primary care reform in Canada? How should PNHP approach delivery system reform? Comments invited at policy@pnhp.org.

PNHP in the news

PNHPers published over 20 op-eds and letters supporting single payer on Medicare's anniversary, including in the Oregonian and the Chicago Sun-Times. Dr. Ann Settgast's op-ed titled "Medicare, an effective program, turns 46," appeared in the Minneapolis Star Tribune on July 30. For more news about how chapters are responding to the current political climate, see the chapter reports starting on page 80, this issue.

The Boston Globe, CBS News, U.S. News and World Report and the Los Angeles Times are among the media to report on research led by PNHP members on restricted access to mental health care and the ongoing epidemic of medical bankruptcy in Massachusetts, the model for national health reform (for details, see pages 11 and 12). Research on the rise of the for-profit hospice industry by PNHP board member Dr. Robert Stone and co-author Joshua Perry, J.D. received press coverage in CBS Moneywatch, Healthcare Finance News and UPI, among others.

The New York Times reported receiving over 500 positive letters and only two negative ones in response to Dr. Samuel Metz's Aug. 23 letter supporting single payer (reprinted on page 20, this issue).

Finally, the deficit crisis has prompted five newspapers to endorse single payer in recent weeks, including the St. Louis Post-Dispatch (see page 10), the Kansas City Star, the Charleston (W.Va.) Gazette, the Cleveland Plain Dealer and the Cape Cod Times.

In This Issue

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Board of Directors, 2011

Editors: The PNHP Newsletter is edited by PNHP co-founders Drs. David Himmelstein and Steffie Woolhandler, and Director of Policy and Programs Dr. Ida Hellander.

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PNHP membership drive update

Welcome to 402 new members who have joined PNHP in the past year! We invite new (and longtime) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community. To get involved in a PNHP chapter near you, see the chapter reports, page 80, or contact our National Organizer Ali Thebert at organizer@pnhp.org.

PNHP hosted exhibits at several medical specialty meetings this year, including the American College of Physicians, American Academy of Family Physicians and the American Psychiatric Association.

Call for PNHP board nominations

PNHP is seeking nominations for its Board of Directors. Please send the nominee's name and a one-paragraph description with professional biographical details and information about their single-payer activism to nominations@pnhp.org by October 1.

NOW affirms support for Medicare for All

The National Organization for Women reaffirmed its support for single payer at its national conference in Tampa, Fla., in June. Looking ahead to the 2012 elections, NOW's President Terry O'Neill said, "Candidates who want women's support need to stand with us in support of single-payer health care legislation on the state and federal levels."

What PNHP members can do

1. Give a grand rounds presentation on the U.S. health care crisis and the need for single-payer national health insurance. Updated slides covering the new health law are available at www.pnhp.org/slideshows. To invite another member to speak, call the PNHP national office at 312-782-6006 or e-mail info@pnhp.org.

2. Write an op-ed or letter to the editor for your local newspaper, specialty journal or alumni magazine. Dr. Don McCanne encourages PNHPers to "recycle" his single-payer "Quote of the Day" messages into letters and op-eds for local publication. Subscribe at www.pnhp.org/qotd.

3. Introduce a resolution supporting single payer to your medical specialty society. Sample resolutions are available online at www.pnhp.org/resolutions.

4. Join or renew your membership in PNHP online today at www.pnhp.org/join.

5. Encourage your colleagues to join PNHP.

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

UNINSURED

▸ 60.3 million Americans (19.8 percent) were uninsured for at least part of 2010, up from 58.5 million people in 2009, according to the National Center for Health Statistics. 48.6 million Americans (16.0 percent) were uninsured at the time of interview for the 2010 survey, up from 46.3 million people in 2009, with the majority, 35.7 million Americans (11.7 percent of all Americans) uninsured for more than one year, up from 32.8 million people the previous year, according to an analysis of data from the National Health Interview Survey.

There was a slight drop in the number of uninsured children as public programs for children, primarily Medicaid and CHIP, continued to expand. Still, 8.7 million children were uninsured for at least part of 2010, including 5.8 million who were uninsured at the time of interview, and 3.4 million who had been uninsured for more than a year, despite the doubling of public coverage from 20.0 percent of children in 1998 to 39.8 percent of children in 2010 (Cohen et al., National Center for Health Statistics, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2010", June, 2011).

Nine million working-age Americans - 57 percent of people who had health insurance through a job that was lost - became uninsured between 2008 and 2010, according to a survey by the Commonwealth Fund. Among those who lost employer-sponsored coverage, only 25 percent were able to find another source of coverage, and only 1 in 7 were able to retain their job-based coverage through COBRA. Additionally, 32 percent of working-age adults (49 million people) spent 10 percent or more of their income on health care and premiums (meeting the definition for being "underinsured"), up from 21 percent, or 31 million adults, in 2001. In 2010, 75 million adults went without necessary health care due to cost, 73 million reported having trouble paying bills or were in medical debt, and 29 million used up all of their savings to pay medical debts. A quarter of adults with chronic conditions skipped prescriptions due to cost ("New health insurance survey: 9 million adults joined ranks of uninsured due to job loss in 2010," The Kaiser Family Foundation 3/16/11).

▸ Between 23 and 40 million people will remain uninsured after the federal health law is fully implemented, according to estimates by the Congressional Budget Office (CBO) and the McKinsey consulting firm, respectively (McKinsey Quarterly, "How US health care reform will affect employee benefits," June 2011).

▸ One-third of people under 65 who are diagnosed with cancer are uninsured during or after diagnosis, with 75 percent reporting that their lack of coverage is due to high premium costs or a pre-existing condition exclusion (American Cancer Society, "A National Poll: Facing Cancer in the Health Care System," 2010).

UNDERINSURED

Nearly half (48 percent) of families with chronic conditions in high deductible health plans (HDHP) report financial burdens related to medical costs, compared to 21 percent of families in traditional plans. In addition, nearly twice as many lower-income families in HDHP spend more than 3 percent of their incomes on health care as lower-income families in traditional plans (53 percent verus 29 percent). High deductible health plans are defined as a health plan with at least a $1,000 deductible for individual coverage or $2,000 for family coverage. Families with high deductible plans were also older, on average, than those in traditional plans, and were more likely to have had no other choice of health plan due to cost (Galbraith et al., "Nearly half of families in high deductible health plans whose members have chronic conditions face substantial financial burden," Health Affairs, 2/11).

▸ Cancer patients face high out-of-pocket costs. Using data from the National Medical Expenditure Panel Survey, researchers found that 13.4 percent of non-elderly adult cancer patients spent at least 20 percent of their income on health care and insurance, compared to 9.7 percent of people with other chronic conditions and 4.4 percent of people without cancer or chronic diseases. Cancer treatment was most unaffordable for those with non-group private insurance: 43 percent of cancer patients with individual health insurance spent over one-fifth of their income on medical expenses, compared to 9 percent of patients with employer-sponsored insurance and 26 percent of the uninsured (Bernard et al., "National Estimates of Out-of-Pocket Health Care Expenditure Burdens Among Nonelderly Adults With Cancer: 2001 to 2008" Journal of Clinical Oncology, June, 2011).

A cancer diagnosis is also a risk factor for personal bankruptcy. A study linking data from Washington state bankruptcy-court records and a National Cancer Institute registry of 231,799 cancer cases, found that 4,805 of the individuals, 2.1 percent, sought personal bankruptcy protection in the years following the diagnosis. Sufferers of lung, thyroid and leukemia/lymphoma cancers found themselves most likely to turn to Chapter 7 or Chapter 13 at the one-, two-, and five-year marks after their diagnosis. For example, five years after receiving a diagnosis of lung cancer, 7.7 percent of victims sought bankruptcy (Rachel Feintzeig, "Study Illuminates Link Between Cancer, Bankruptcy," Wall Street Journal blog Bankruptcy Beat, 6/7/11).

▸ The number of hospital emergency departments (ED) in non-rural areas declined 27 percent between 1990 and 2007. Safety-net hospitals, hospitals in counties with a high poverty rate, and for-profit hospitals with low profitability or located in highly competitive markets were more likely to close their ED's. For-profit hospitals were twice as likely to close their EDs as facili-

ties that were nonprofit or publicly owned (Hsia, Kellermann, and Shen, "Factors Associated With Closures of Emergency Departments in the United States" JAMA, 5/18/11).

> Although access to care problems are most severe among the uninsured, they also affect a large proportion of the general population. Eighty-five percent of the uninsured report delaying needed medical care due to costs in 2010, while 48 percent report trouble paying medical bills. Overall, fifty-four percent of Americans report delaying needed care in 2010, while 25 percent report having trouble paying medical bills, according to a survey by the Kaiser Family Foundation (December Health Tracking Poll, 2010, Kaiser Family Foundation).

SOCIOECONOMIC INEQUALITY

▸ Federal revenues as a proportion of GDP are at their lowest level in 60 years. In 2010, federal revenues were equivalent to 14.9 percent of the GDP, down from 20.6 percent a decade earlier.

Meanwhile, income inequality in the U.S. is rising dramatically. From 1980 to 2005, more than four-fifths of the total increase in American's incomes went to the richest 1 percent. In 2010, the share of income going to the top 1 percent of taxpayers jumped to 24 percent, up from 9 percent in 1976. The CEOs of America's largest corporations make 531 times more than the average worker, up from 42 times as much in 1980 (Reducing the Deficit, Congressional Budget Office, March 2011 and Nicholas Kristof, "Our Banana Republic," The New York Times, 11/06/10).

> The economic crisis has hit Hispanic and black households the hardest. Between 2005 and 2009, the median wealth of Hispanic households dropped by 66 percent, compared to a 53 percent drop in median wealth of black households and a 16 percent drop among non-Hispanic white households. The declines have led to the largest wealth disparities in the 25 years that the Census Bureau has been collecting the data. Median wealth for non-Hispanic white households is now 20 times higher than for black households, and 18 times higher than for Hispanic households (Sabrina Tavernise, "Recession Study Finds Hispanics Hit the Hardest," The New York Times, 7/26/11).

COSTS

▸ Health care premiums will rise 8.5 percent in 2012, according to a PricewaterhouseCoopers survey of 1,700 firms. Employers are offering workers more meager plans in response to rising costs: 17 percent of employers surveyed most commonly offered high-deductible health plans to their workers this year, up from 13 percent in 2010 (Merrill Goozner, The Fiscal Times, 5/18/11).

▸ U.S. health expenditures in 2011 are projected to be $2.7 trillion, $8,649 per capita, 17.7 percent of GDP. Over the next decade, health spending is predicted to grow 5.8 percent annually. In 2020, after the Patient Protection and Affordable Care Act is fully implemented, health spending is projected to be $4.6 trillion, $13,709 per capita, 19.8 percent of GDP (Office of the Actuary, CMS, National Health Spending Projections Through 2020, Health Affairs, July 28, 2011).

▸ Starbucks spent over $250 million on health insurance for its U.S. employees in 2010, more than it spent on coffee (Jennifer Haberkorn, "Starbucks CEO rethinks health law," Politico 03/22/11).

▸ The total cost of health care for a family of four covered by a preferred provider plan (PPO) in 2011 is estimated to be $19,393, up 7.3 percent from 2010, according to the Milliman Medical Index. Employer contributions account for 59 percent, $11,385, of the total, while employees pay 41 percent of the cost, $8,008. Employees contribute an average of $4,728 to premiums and pay $3,280 in out-of-pocket costs (Don McCanne, www.pnhp.org/blog, "The Milliman Medical Index ($19,393) in perspective, 5/12/11).

> The average cost of employer-sponsored health coverage rose 5 percent to $13,770 ($1,147 per month) for family coverage and $5,049 ($421 per month) for individual coverage in 2010. Twenty percent of plans for families cost $16,524 or more. The cost of employer-sponsored coverage has more than doubled since 2000 (Employer Health Benefits Annual Survey, 2010, Kaiser Family Foundation).

MEDICAID

▸ Medicaid spending is set to decline for only the second time in the program's 46-year history as additional federal funding from the 2009 economic stimulus package dries up as of July 2011. Medicaid spending was up 8.2 percent to $354 billion in 2010 due to a 14.2 percent increase in federal funding. With enrollment expected to grow 6.1 percent in the coming year due to the continued economic downturn, 24 states are planning to cut payments to providers and 20 states are planning to cut benefits. Medicaid currently consumes about 22 percent of state budgets (Robert Pear, "As Number of Medicaid Patients Goes Up, Their Benefits Are About to Drop," The New York Times 06/15/11).

▸ Ignoring the state's disastrous experience with for-profit Medicaid managed care in the mid-1990s (when up to 50 percent of funding was diverted to overhead and profits by unscrupulous firms), Florida legislators are again pushing for privatization of the state's Medicaid program, claiming it will control costs. In fact, per capita Medicaid spending rose much more slowly between 2001 and 2009 than spending on private coverage by large employers (up 30 percent vs. 112 percent, respectively) (Greg Mellowe, Florida Center for Fiscal and Economic Policy 4/1/11; investigative reporters Fred Schulte and Jenni

Bergal published a series of articles on fraud in Florida's 1990s Medicaid managed care programs in the Florida Sun Sentinel).

Children with Medicaid coverage are much more likely to be denied treatment or made to wait long periods for an appointment with medical specialists. Across eight different specialties, 66 percent of children with Medicaid were denied an appointment at a doctor's office compared to 11 percent with private coverage. In clinics that accepted both, the average wait time for an appointment was 22 days longer for a child with Medicaid compared to one covered by private insurers. The study increased concern about the quality of care for patients under the Affordable Care Act, which relies heavily on Medicaid expansion to increase health coverage nationwide (Bisgaier and Rhodes, "Auditing Access to Specialty Care for Children with Public Insurance," NEJM, 6/16/11).

▸ Enrollment in Oregon's "standard" Medicaid program plummeted from 104,000 in 2003 to 24,000 in 2005 after higher premiums, higher cost-sharing, and strict payment deadlines were imposed on enrollees. Compared to the beneficiaries of Oregon's "plus" Medicaid program, which remained unchanged, the 104,000 beneficiaries in the original "standard" plan had worse health outcomes, more unmet health needs, reduced use of medical care, and greater medical debt and financial strain (Wright et al., Health Affairs, December 2010).

MEDICARE

Administrative costs for Medicare were 1.4 percent in 2008, excluding overhead in private Medicare Advantage and Part D pharmaceutical plans, according to the 2010 Medicare Trustees report. Medicare's administrative overhead fell slightly to 1.3 percent in 2009. Including the overhead from private plans in Medicare's overhead raises it to 5.3 percent, the figure reported in the National Health Expenditure Accounts (2008) (CMS, 2009 and 2010 Annual Reports of the Boards of Trustees, www.cms.gov and CMS, National Health Expenditures by Type of Service and Source of Funds, calendar years 2008 to 1960).

▸ Medicare benefits are inadequate. Medicare households on average spent $4,620 on health care in 2009, more than twice what non-Medicare households spent, according to the Kaiser Family Foundation. The program for 47 million seniors and the permanently disabled currently covers less than half of the health care costs of beneficiaries, who, on average, subsist on incomes below $22,000 a year and have less than $33,100 in retirement accounts and other savings.

On top of standard premiums of $115.40 a month, enrollees pay a $1,132 deductible for each hospital stay, and hundreds of dollars a day more for long hospital stays. Medicare beneficiaries are also responsible for 20 percent of the bills for most outpatient care. Medicare doesn't cover dental, vision, hearing or long-term care, and has no cap on out-of-pocket spending (Levey, "Making Medicare beneficiaries pay more," Los Angeles Times, 7/15/11).

▸ It's old, but we hadn't seen it: The Veterans Health Administration provides care at a lower cost than Medicare, according to a study that compared the cost of care at six VA facilities to the cost of the same care delivered in the private sector at Medicare payment rates. The study conservatively estimated that contracting out services provided by the VA would have cost the taxpayer 21 percent more than the VA's actual budget. About half of the savings came from the VA's discounted prices for outpatient pharmaceuticals; the VA also saved substantial sums on inpatient care, rehabilitation and partial hospitalization, outpatient diagnostic care, and durable medical equipment (Nugent et al., "Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices," Med. Care Res. and Rev. 61:4, 12/04).

"Costs for Medicare patients are being better contained than those covered under commercial insurance plans" according to David Blitzer, chairman of the Standard and Poors (S&P) Index Committee. Medicare spending, as measured by the S&P Medicare Index, increased by 2.8 percent between March 2010 and March 2011, a far lower rate of inflation than seen for private medical coverage, which rose 7.6 percent, according to the S&P. Medicare's hospital costs also rose more slowly, at 1.2 percent, compared to an 8.4 percent jump in the hospital commercial index (Maggie Mahar, "Medicare Breaks the Inflation Curve," Health Beat Blog, 05/20/11).

▸ Private Medicare Part D plans pay substantially higher prices for brand-name drugs than Medicaid, according to a study by the Office of the Inspector General. Both Medicaid and Part D plans receive rebates on brand-name drug purchases. While rebates reduced Part D expenditures by 19 percent for the 100 brand-name drugs reviewed (from $24 billion to $19.5 billion) in 2009, Medicaid's rebates reduced their expenditures 45 percent (from $6.4 billion to $3.5 billion). (Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D, Office of the Inspector General, DHHS, August 2011).

CORPORATE MONEY AND CARE

▸ U.S. physicians spend nearly four times more on billing and insurance-related overhead each year ($82,975 vs. $22,205 per physician) than their Canadian counterparts, with U.S. medical practice staff spending over 20.6 hours per week on bureaucratic tasks, compared to just 2.5 hours per physician per week under Canada's single-payer program (Morra et al., "U.S. physician practices versus Canadians," Health Affairs, 8/11).

▸ Seven top executives at drug, insurance, and hospital trade associations received a total of $33.2 million in compensation during the height (2008-2009) of the health care reform fight. PhRMA's Billy Tauzin topped the list at $9.1 million, followed by Scott Serota at Blue Cross/Blue Shield ($7.2 million), Charles Kahn III, Federation of American Hospitals ($4.5 million), Karen Ignani, America's Health Insurance Plans ($3.8 million),

Richard Umbdenstock, American Hospital Association ($3.8 million), Stephen Ubl, Advanced Medical Technology ($2.4 million), and James Greenwood, Biotechnology Organization ($2.4 million). (Kaiser Health News, How Top Health CEOs Were Paid 2008-2009, 1/5/11).

The nation's five largest for-profit health insurers netted $11.7 billion in profits in 2010, up 51 percent from 2008, because medical costs grew slower than forecast as insured patients skimped on medical care to avoid costly co-pays and deductibles during the severe recession. UnitedHealthcare was the leader in profitability, taking in over $4.6 billion in profits, followed by WellPoint ($2.9 billion) and Aetna ($1.8 billion). Profits were up 361 percent over 2008 at Cigna, to $1.3 billion in 2010, and up 70 percent at Humana, to $1.1 billion. Meanwhile, health insurers are proposing double-digit premium increases, claiming that demand for medical services may surge at the end of the year ("Health Insurers Pocketed Huge Profits in 2010 Despite Weak Economy," Health Care For America Now, 3/03/11 and Reed Abelson, "Health Insurers Making Record Profits as Many Postpone Care," The New York Times, 5/13/11).

▸ Share prices of the 51 health care cmpanies listed in the S&P 500 rose an average of 6 percent in the year after the federal health reform passed in March 2010, triple the S&P 500 average (Russ Brit, "Insurers gain big in health reform's first year," MarketWatch 3/22/11).

CEOs at the nation's five largest for-profit insurance companies garnered $54.4 million in compensation in 2010. The top-paid executive was Cigna's David Cordani ($15.2 million), followed by WellPoint's Angela Braly ($13.5 million), UnitedHealthcare's Stephen Hemsley ($10.8 million), Aetna's Mark Bertolini ($8.8 million), and Humana's Michael McCallister ($6.1 million) (Executive PayWatch, AFL-CIO, 2011).

▸ The nation's seven largest for-profit health insurers made a mistake in processing nearly one out of every five (19.3 percent) medical claims in 2010, according to the American Medical Association. Anthem Blue Cross Blue Shield was the worst, with an error rate of 39 percent. Medicare, which uses private intermediaries to process claims, had an error rate of 3.8 percent. Physicians received no payment at all from commercial health insurers on nearly 23 percent of claims they submitted, most commonly because of deductibles that shifted responsibility for payment to patients (American Medical Association, 2011 National Health Insurer Report Card).

▸ UnitedHealth, WellPoint and Aetna profited a record $2.51 billion in the second quarter of 2011. Based on their strong performance during the first half of this year, UnitedHealth, WellPoint and Aetna have all raised their profit forecast for 2011. Aetna's chief financial officer, Joseph Zubretsky, assured investors that the firm would not risk adding people to its rolls who might have substantial medical needs. "We would like to have both profit and growth, but if you have to choose between one or the other, you take margin and profit and you sacrifice the growth line." In 2008, WellPoint's Angela Braly promised analysts that the firm would "not sacrifice profitability for membership." (Wendell Potter, "Fresh evidence that insurance companies value profits over people," Huffington Post, 8/1/11).

▸ Seven of California's largest health insurers were fined close to $5 million by state regulators in 2010 for failing to pay doctors and hospitals in a fair and timely fashion. Investigators determined that insurers paid about 80 percent of claims correctly, well below the legal requirement of 95 percent. Five of the insurers were also found to have improper provider appeals processes, sometimes requiring providers to appeal to the same person who denied their claim. Insurance companies will also be required to pay tens of millions in compensation to unpaid doctors and hospitals (Victoria Colliver, "California Largest Insurers Continue to Cheat," San Francisco Chronicle, 11/30/10).

Despite publicly claiming to support health reform and making substantial contributions to Democratic politicians, the insurance industry lobbying group, America's Health Insurance Plans (AHIP) also funneled $86.2 million to the U.S. Chamber of Commerce in 2009 to oppose the federal health law. Moreover, the nation's five largest health insurance companies have started a new coalition to lobby exclusively for their own interests and profits, independent of the small and non-profit insurers that are also represented by AHIP. The "Big Five" — Wellpoint, UnitedHealthcare, Aetna, Cigna, and Humana — have already enlisted the services of corporate public relations firms APCO Worldwide and Weber Shandwick as well as law firm Alston & Bird LLP to help craft political strategy. For starters, they seek to strip the 2010 health reform bill of provisions such as minimum requirements for the proportion of insurance premiums spent on paying for health care rather than for overhead and profit (Drew Armstrong, "Insurers Gave U.S. Chamber $86 Million Used to Oppose Obama's Health Law," Bloomberg, 11/17/10, and "UnitedHealth Joins WellPoint to Hone Health-Law Lobby," Bloomberg, 1/31/11).

▸ Indianapolis-based WellPoint was among the top donors to Republican organizations active in the Wisconsin recall elections. The giant insurer gave $450,000 to the Republican State Leadership Committee (RSLC), which spent about $370,000 on the special elections, and $250,000 to the Republican Governors Association. Wellpoint gave $842,000 to the RSLC for the 2010 elections (Salant, WellPoint Joins Koch Help Fight Wisconsin State Senate Recalls, Bloomberg.com, 8/4/11).

▸ Health insurance giants are on a buying spree for firms in health IT, physician management, and other industries that are "much less regulated" than health insurance, and will give them an advantage in controlling health care costs, according to UnitedHealth's Rick Jelinek. Since June 2009, the seven largest

insurance companies have made 25 major corporate acquisitions, including only six that were health plans. In December, Humana purchased Concentra, a network of urgent and occupational care centers in 40 states; over one-third of Humana enrollees live within 10 miles of a Concentra clinic (Christopher Weaver, "Health Insurers Respond To Reform By Snapping Up Less-Regulated Businesses," Kaiser Health News, 3/19/11).

▸ Judgments and settlements under the False Claims Act for defrauding the U.S. government have resulted in over $25 billion in repayments to the federal government since 1986, with 19 of the 20 highest payments coming from health care corporations. In 2009, pharmaceutical giant Pfizer paid a total of $2.3 billion, including $1 billion under the False Claims Act and $1.3 billion as a criminal fine for paying kickbacks to physicians and other criminal offenses. Hospital chain HCA has paid $1.7 billion to the federal government, including a $900 million settlement in 2000 for Medicare payment manipulation, kickbacks, bill coding fraud and padding. Major settlements and judgements, each involving hundreds of millions of dollars, have hit the nation's largest health firms including Tenet Healthcare, Merck, GlaxoSmithKline, Serono, Bayer and many others (Donald R. Soeken, International Whistleblower Archive, www.whistleblowing.us).

▸ With two million prisoners, the U.S. incarcerates a higher proportion (1 percent) of its adults than any other nation. For-profit companies have found ways to exploit this unconscionable situation. Private prisons, like private insurers, avoid the medically needy to boost profits. A study in Arizona found that by cherry-picking inmates and skimping on care, private prisons are able to reap profits even as they fictitiously appear to lower states' costs. In 2009, after adjusting for medical costs, medium-security state run prisons in Arizona cost $2,834 less per prisoner than privately-run prisons. (Monica Almeida, "Private Prisons Found to Offer Little in Savings," The New York Times, 5/18/11).

BIG PHARMA

▸ The Pharmaceutical Research and Manufacturers of America (PhRMA) lobbying group spent at least $101.2 million to influence the national health reform debate in 2009 alone. Billy Tauzin, then-CEO of PhRMA, reports that spending went towards advertising, "grassroots" efforts, lobbying, polling and consulting. PhRMA also donated to right-wing organizations such as the Heritage Foundation, National Review, Pacific Research Institute and the Hudson Institute (Bara Vaida and Christopher Weaver, "Drug Lobby's Tax Filings Reveal Health Debate Role," Kaiser Health News, 12/01/10).

▸ Drug companies claim to spend an average of $1.3 billion on R&D to bring a single new drug to market, but the true net median cost was likely closer to $59.4 million in 2000 ($98 million in 2011 dollars), according to a new study. The $59.4 million figure excludes research (including the cost of discovery and early development), because it cannot be accurately measured and is, in any event, likely to be small for large pharmaceutical firms net of taxpayer subsidies; over 84 percent of all funds for discovering new medicines come from public sources. Previous research has shown that, net of taxpayer contributions, drug companies spend just 1.3 percent of revenues on basic research to discover new molecules. Pharmaceutical R&D is increasingly churning out products ("me-too drugs") that have few benefits over existing drugs; these slightly modified copies enable companies to profit from high-cost, patented drugs without the risks of original drug development (Light and Warburton, "Demythologizing the high costs of pharmaceutical research," BioSocieties, 2011, and Light and Lexchin, "Foreign free riders and the high price of U.S. medicines," British Medical Journal 2005; 331).

▸ Novo Nordisk will pay $25 million to settle claims of illegally marketing a hemophilia drug, Factor VII, to the U.S. Army as a treatment for trauma wounds and severe bleeding. Despite only being approved by the FDA for hemophilia treatment, the military began using Factor VII (sold as NovoSeven) as a treatment for combat wounds in Iraq in 2003, and it was soon adopted by trauma centers worldwide. Clinical studies have since shown that Factor VII does not control severe bleeding and can cause blood clots that lead to heart attack or stroke. In 2010, Novo Nordisk reported $1.6 billion in sales of NovoSeven, including approximately $250 million for unapproved usage (Robert Little "Drugmaker pays $25 million to settle military claim," The Baltimore Sun, 6/10/11).

▸ The pharmaceutical industry spent $6.1 billion in 2010 to influence American doctors, and another $4 billion on direct-to-consumer advertising, according to IMS Health (Erica Mitrano, "Just say no to drug reps," SoMdNews.com, 7/15/11).

▸ Two giant pharmacy benefit management firms are merging in a $29.1 billion deal. St. Louis-based Express Scripts is buying rival Medco based in Franklin Lakes, New Jersey. The new firm, Express Scripts Holding Company, will be based in St. Louis (Jaimy Lee, Modern Healthcare Business News, July 21, 2011).

HOSPICE, INC.

▸ For-profit hospices are expanding rapidly and may be cherry-picking the most profitable patients, according to a recent study. The number of for-profit hospices increased from 725 in 2000 to 1,660 in 2007, while the number of nonprofit hospices remained stable at 1,205 in 2007. Overall, 52 percent of facilities are for-profit, 35 percent are nonprofit and 13 percent are government-owned. Hospice care is funded by Medicare on a per-diem basis, with a fixed rate ($143 in 2010) paid to providers for each day that a patient is in a facility. Because the first and last days of care are more expensive to provide, longer length of stay generates higher profit. The study found that patients in for-profit facilities averaged a 20-day stay, compared to 16 days in nonprofit centers. For-profit hospices also had twice as many dementia patients compared to nonprofits and had

fewer cancer patients; end-of-life care is much more expensive for cancer patients than for those with dementia. An earlier (2005) study found that large, investor-owned hospices generate margins nine times higher than those of large nonprofits due to cherry-picking and paying lower salaries and benefits to less-skilled staff (Wachterman MW et al., "Association of Hospice Agency Profit Status With Patient Diagnosis, Location of Care, and Length of Stay," JAMA, Feb. 2, 2011).

> Hospice care costs for nursing home patients jumped nearly 70 percent between 2005 and 2009, from $2.5 billion to $4.3 billion, while the number of hospice patients increased by only 40 percent, according to the Office of the Inspector General (OIG). Hospices with a large share of patients in nursing homes were typically for-profit and appeared to seek out patients with certain characteristics associated with a longer life expectancy and lower demand for care.
>
> The Medicare program paid for-profit hospices more for patients than it paid nonprofit and government-owned hospices in 2009. For-profit hospices received about $12,600 per patient, while nonprofit and government entities received between $8,200 and $9,800 per beneficiary. (Charles Fiegl, "Medicare hospice care to face increased scrutiny," Amednews, 7/28/11; DHHS Office of the Inspector General, "Medicare Hospices that focus on Nursing Facility Residents," July, 2011).

▸ For-profit hospices also provide poorer care: a full range of end-of-life services is provided half as often, and family counseling services are received only 45 percent as often at for profit facilities compared to nonprofits. For-profit hospices are also only half as likely to provide palliative radiotherapy, a symptom-relieving treatment for cancer patients. Hospice facilities are usually not chosen by the family: they are recommended by nursing home or hospital staff. For-profit hospices also recruit patients directly from nursing homes and hospitals; Miami-based VITAS Hospice Services, the largest nationwide hospice chain, pays a commission to recruiters who provide incentives to hospital and nursing home staff to refer profitable hospice patients. For-profit hospices have been indicted for paying kickbacks to medical staff for certifying patients as hospice-eligible without examining them. In 2008, Medicare expenditures on hospice exceeded $11 billion, serving more than 1 million patients (Marlys Harris, "The Big (and Profitable) Business of Dying, CBS MoneyWatch, 5/21/11; J. Perry and R. Stone, "In the Business of Dying: Questioning the Commericalization of Hospice," Journal of Law, Medicine and Ethics, 5/18/11).

INTERNATIONAL

▸ Taiwan's single-payer national health insurance program, adopted in 1995, recently underwent reforms designed to make the financing more equitable and the system as a whole more transparent. Premiums were lowered from 5.17 percent to 4.91 percent of salary, while supplementary taxes were assessed on capital gains. The reforms also included an expansion of physician payment via capitation (Elaine Hou, "Taiwan's NHI system gets healthier," Taiwan Today, 2/11/11).

▸ The National Institute of Health and Clinical Excellence (NICE) in England has received worldwide praise for its objective examinations of the safety and cost-effectiveness of new medications, which impact coverage decisions for the NHS and many other nations. As a result, it has garnered the enmity of the pharmaceutical industry, which, along with the current Health Secretary Andrew Lansley, is pushing to revoke NICE's authority, and make pharmaceutical purchasing decisions the responsibility of each of the country's 150 proposed GP consortia. Currently, NICE only rejects coverage for approximately 5 percent of prescribed drugs, mainly cancer drugs which painfully extend the lives of terminally ill patients for a few weeks at massive cost; the standard limit for these treatments under NICE is £30,000 (US$50,000) per quality-adjusted life year (Polly Toynbee, "Forget patients. Andrew Lansley is the servant of big pharma," Guardian, 11/01/10).

▸ Germany, with 160 nonprofit insurance funds, has one of the most bureaucratic health systems in the world, after the U.S. Six years ago Germany adopted a DRG-like payment system for hospitals, which has added to administrative overhead. Practicing physicians have to spend substantial amounts of time on documentation because hospitals now face a fleet of doctors hired by insurance companies to challenge charges. Meanwhile, for-profit hospitals (about 20 percent of all hospitals) game the system, illegally cherry-picking the healthiest patients. Worse, the system is creating a perverse incentive for doctors and hospitals to over-treat, with a marked rise in well-reimbursed orthopedic and cardiac procedures (Polly Toynbee, "German health warning: don't burden doctors with a costly paperchase," Guardian, 03/16/2011).

▸ Spending on health care in the U.S. in 2008 far exceeded that seen in other countries, according to an analysis of health data from Australia, Canada, Denmark, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. No country spent more than 70 percent of U.S. spending ($7,538 per capita, 16 percent of GDP). Despite higher spending, the U.S. ranked sixth of of seven countries in terms of quality in a 2010 cross-national study by The Commonwealth Fund, with only average performance on effectiveness and patient-centeredness and low performance on safety and coordination (David Squires, "The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations," The Commonwealth Fund, July 2011).

PPACA – THE NEW HEALTH LAW

▸ High-risk insurance pools for people with pre-existing conditions covered only 18,313 people by mid-2011, far below the 375,000 projected for the program created under the federal reform law. In an attempt to beef up enrollment, people will no longer have to produce a letter of denial from an insurance company, brokers will receive commissions for signing people

up, and premiums will be lowered (but not eliminated) in 17 of the 23 states where the plan is federally administered ("Changes to the Pre-Existing Condition Insurance Plan in Your State," HealthCare.gov, 5/31/11).

> Under PPACA, an estimated 28 million people, over half of all adults with family incomes below 200 percent of poverty, will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse, each year. PPACA expands coverage by expanding both Medicaid eligibility and premium subsidies for the purchase of private coverage through state insurance exchanges. Unfortunately, the new coverage will be very unstable, due to fluctuations in family income and composition, which are common in low-income families (Sommers and Rosenbaum, "How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Health Affairs, February 2011).

▸ Three states (Maine, New Hampshire, and Nevada) have received a waiver from the PPACA rule that requires health insurers to spend at least 80 percent of insurance premium revenues on medical care, rather than administrative overhead or profits. Ten more states have waiver requests pending (AP, 6/04/11 and "Companies, unions wrestle with new health care requirement," John Fritze, The Baltimore Sun, 6/4/11).

> In a case that will likely end up in the Supreme Court, the 11th Circuit Court of Appeals ruled 2-1 that the individual-coverage mandate in the Patient Protection and Affordable Care Act is unconstitutional. The U.S. District Court for the Northern District of Florida went further, with Judge C. Roger Vinson arguing that the entire law be struck down because the rest of the law could not serve its purpose without the individual mandate. As former Labor Secretary Robert Reich said, "[no] federal judge has struck down Social Security or Medicare as being an unconstitutional requirement that Americans buy something ... if the individual mandate to buy private health insurance gets struck down by the Supreme Court or killed off by Congress, I'd recommend President Obama immediately propose what he should have proposed in the beginning — universal health care based on Medicare for all, financed by payroll taxes." ("26 States Challenge Health Care Law in Court," Sarah Clune, PBS Newshour, 6/08/11 and John Nichols, "Can we have health reform without an individual mandate?" 8/13/11).

▸ Most health insurance plans sold after Sept. 23, 2010, must provide at least $750,000 in coverage, increasing to $1.25 million in 2011 and be unlimited thereafter. However, four state governments (Florida, New Jersey, Ohio and Tennessee) and 1,372 companies and unions, covering a combined total of 3 million workers, have received federal permission to ignore PPACA and continue to offer skimpy coverage, such as so-called "mini-med" plans covering less than $10,000 in medical costs.

McDonald's offers two levels of coverage to their employees: up to $2,000 in annual benefits for $56/mo. or up to $5,000 in annual benefits for $97/mo. Ruby Tuesday's mini-med plans restrict annual benefits to $1,250 in outpatient care and $3,000 in inpatient care; employees pay $18.43/wk. for the first 6 months, and $7/wk. thereafter. Dennys' hourly employees are provided up to $300 for doctor's visits annually, with no inpatient coverage ("What is a Mini-Med Plan?" The Henry J. Kaiser Family Foundation, 7/05/11).

ARTICLES OF INTEREST

> **"Perspectives on Medicare: What Medicare's Architects Had in Mind,"** Robert M Ball, Health Affairs, 14, no.4 (1995). http://content.healthaffairs.org/cgi/reprint/14/4/62.pdf.
>
> Robert M. Ball was the commissioner of Social Security through the administration of three presidents - John F. Kennedy, Lyndon B. Johnson, and Richard M. Nixon. Medicare was established as an add-on to Social Security, not as a stand alone program, so Ball was intimately involved in its creation. He was involved in writing the legislation, implementing it after LBJ signed it into law on July 30, 1965, and even ceremonially presented the first Medicare cards to Harry and Bess Truman.
>
> Ball described the intentions of Medicare's drafters this way: "For persons who are trying to understand what we were up to, the first broad point to keep in mind is that all of us who developed Medicare and fought for it—including Nelson Cruikshank and Lisbeth Schorr of the AFL-CIO and Wilbur Cohen, Alvin David, Bill Fullerton, Art Hess, Ida Merriam, Irv Wolkstein, myself, and others at the Social Security Administration—had been advocates for universal national health insurance. We saw insurance for the elderly as a fallback position, which we advocated solely because it seemed to have the best chance politically. Although the public record contains some explicit denials, we expected Medicare to be a first step toward universal national health insurance, perhaps with 'Kiddicare' as another step."

▸ **"New Cardiac Surgery Programs Established from 1993 to 2004 Led to Little Increased Access, Substantial Duplication of Services"** Lucas, Siewers, Goodman, Wang, and Wennberg, Health Affairs, 30, No. 8, 2011.

Using Medicare data, the authors identified 301 new cardiac surgery programs that opened between 1993 and 2004, despite decreasing demand for bypass surgery. Of these, 42 percent opened in communities that already had access to cardiac surgery. Overall, travel time to the nearest cardiac surgery program changed little.

This study adds to the literature demonstrating that the increasing proliferation of expensive technology often raises costs without benefiting patients. The lesson for single-payer advocates: effective health planning could save money without compromising access to care.

ST. LOUIS POST-DISPATCH AUGUST 10, 2011

If U.S. is serious about debt, there's a single-payer solution

BY THE EDITORIAL BOARD

If America truly is serious about dealing with its deficit problems, there's a fairly simple solution. But you're probably not going to like it: Enact a single-payer health care plan.

See, we told you weren't going to like it.

But the fact is that everyone who has studied the deficit problem has agreed that it's actually a health care problem — more specifically, the cost of providing Medicare benefits to an aging and longer-living population. The bipartisan National Commission on Fiscal Responsibility and Reform reported last December: "The Congressional Budget Office (CBO) projects if we continue on our current course, deficits will remain high throughout the rest of this decade and beyond, and debt will spiral ever higher, reaching 90 percent of GDP in 2020.

"Over the long run, as the baby boomers retire and health care costs continue to grow, the situation will become far worse. By 2025 revenue will be able to finance only interest payments, Medicare, Medicaid, and Social Security. Every other federal government activity — from national defense and homeland security to transportation and energy — will have to be paid for with borrowed money."

That being the case — and nobody argues that it isn't — there are two broad ways for the government to address its spiraling health care costs. One, shift more of those costs to recipients, by trimming benefits and/or extending eligibility ages and indexing eligibility to personal income. This is politically unpalatable, particularly to most Democrats, President Barack Obama being a conspicuous exception.

The second way for government to address its health costs is not to shift them, but to reduce them. This is what a single-payer health care system would do, largely by taking the for-profit players (insurance companies for the most part) out of the loop.

The advocacy group Physicians for a National Health Program estimates that "private insurance bureaucracy and paperwork consume one-third (31 percent) of every health care dollar. Streamlining payment through a single nonprofit payer would save more than $400 billion per year, enough to provide comprehensive, high-quality coverage for all Americans."

Once everyone is covered, the government would have the clout to bring discipline into the wild west of health care spending. It could insist that providers be paid for quality of service, not quantity. Health facilities and equipment could be managed by regional boards. Medical services could be "bundled" — rather than paying hospitals and doctors and laboratories separately, there would be fixed prices for treatments. And so on.

The Patient Protection and Affordable Care Act passed in 2009 contains many pilot programs designed to test cost-reduction strategies. Most of them won't kick in for another six to eight years, by which time health care costs will be approaching 20 percent of U.S. gross domestic product. The combined state and federal share of that will be 49 percent, up from 45 percent today.

Indeed, a study published this month in the journal Health Affairs estimates that while the Affordable Care Act will pay for itself by 2020, it won't actually "bend the cost curve," as the Obama administration had hoped. But the study, done by the Actuary Centers for Medicare and Medicaid Services, says the ACA will significantly slow the rise of health care costs to state and local governments.

But consider those two findings: In effect, they say that if reducing overall health care costs is the goal, then the ACA didn't go far enough. Thirty million more people will be insured and government costs will grow more slowly. But overall health care costs will continue to explode.

Sooner or later, a nation serious about controlling spending must take broad control of the health care system.

It surely won't be sooner. Compared to the political fight that would erupt over a single-payer plan, the congressional battle over the Affordable Care Act would seem as tame as resolution praising mom, the flag and apple pie.

The ACA was a compromise. Mr. Obama brought everyone to the table — doctors, insurance companies, drug companies, hospitals — and came away with a "best we can get" kind of bill. Many of those at the table turned around and lobbied against it or sought special favors once the bill came before Congress.

It passed by narrow margins, and Congress is decidedly more conservative now. Indeed, the new House majority has voted to repeal the ACA and challenges to its constitutionality continue to work their way toward the Supreme Court.

But now, like a baby discovering its toes, Congress has discovered the deficit. And the plain fact is that unless you want to commit political suicide and cut Medicare to the bone — as Rep. Paul Ryan's, R-Wis., budget plan would do — the best way to seriously address long-term deficits is to get control of health care costs through a single-payer plan.

In 2008, when health care costs amounted to "only" 16 percent of U.S. gross domestic product, Great Britain was spending 8.7 percent of its GDP on health care, and Canada was spending 10.4 percent. Both nations have single-payer plans. Quality of care scores in both nations are at least comparable, and in most cases, better.

Eventually, the United States will have a single-payer plan. But we'll waste a lot of money and time getting there.

LEXINGTON HERALD-LEADER

MARCH 27, 2011

We need single-payer, nonprofit health insurance

By Garrett Adams, M.D.

Since the passage of its landmark health reform law of 2006, the people of Massachusetts have been living like a canary in a coal mine. National health policy experts have been watching them, closely studying how they're faring under the reform.

That watch intensified after enactment of the new federal health law, which is patterned after the Massachusetts plan. Both laws contain an individual mandate requiring people to buy private insurance, for example. The theory is that, as the Bay State goes, so goes the nation.

The first reports were glowing. The number of uninsured went down. Massachusetts now boasts the lowest percentage of uninsured residents in the nation, 4.4 percent.

But with the passage of time, and despite generous dollops of supplementary federal aid to help keep the Massachusetts plan afloat, the canary isn't looking too chipper these days.

Insurance premiums and out-of-pocket health costs keep rising. These skyrocketing costs prompted Gov. Deval Patrick to call for the program's "overhaul" just last week.

Now comes a Harvard research study showing that despite the increase in the number of people covered, the Massachusetts reform hasn't made a significant dent in the medical bankruptcy rate. Families still are being ruined by unpayable medical bills.

The researchers discovered that between early 2007 and mid-2009 — before and after the reform took effect — the share of medical bankruptcies in Massachusetts changed very little, from 59.3 percent to 52.9 percent. The absolute number of medical bankruptcies actually climbed from 7,504 to 10,093.

Lest you think only low-income families are being financially clobbered by medical debt, think again. Two-thirds of the bankruptcy filers were college-educated and 89 percent had health insurance when they filed their court papers.

In explanation, the authors of the study, which appears in the American Journal of Medicine, write: "Health costs in the state have risen sharply since reform was enacted. Even before the changes in health care laws, most medical bankruptcies in Massachusetts — as in other states — afflicted middle-class families with health insurance. High premium costs and gaps in coverage — co-payments, deductibles and uncovered services — often left insured families liable for substantial out-of-pocket costs. None of that changed."

Lead author Dr. David Himmelstein elaborates: "Massachusetts' health reform, like the national law modeled after it, takes many of the uninsured and makes them underinsured, typically giving them a skimpy, defective private policy that's like an umbrella that melts in the rain: The protection's not there when you need it."

Needless to say, these findings don't bode well for the look-alike federal law's ability to end the scandalous blight of medical bankruptcies in the U.S. And behind these statistics are tragic, heart-rending stories.

The crux of the problem is this: Both the Massachusetts law and the new federal law are based on the crumbling foundation of for-profit, employer-based health insurance, a financing model that has outlived its usefulness.

Our present setup is a crazy-quilt patchwork of plans that results in huge inefficiencies and mountains of wasteful paperwork — just ask your doctor! And our current arrangements contain a deeply embedded incentive for private insurers to enlarge their profits by enrolling the healthy, screening out the sick and denying claims.

In Canada, which has a truly universal, non-profit single-payer system of financing care called medicare (bearing resemblance to our own much more limited Medicare program), medical bankruptcies are virtually unknown.

Sure, you'll hear the occasional exaggerated story about wait times in Canada. But if you want to hear real horror stories, you need look no further than our own community. And if you ask Canadians if they'd prefer a U.S.-style health system, 9 out of 10 will say no.

It's never too late to do the right thing. Congress should move beyond patchwork solutions and implement a streamlined single-payer system, an improved Medicare for all.

The savings in bureaucracy alone would be enough to cover everyone, and the threat of medical bankruptcy would vanish overnight. Significantly, a single-payer system's bargaining power would control costs.

We can't wait for the canary to keel over.

About the author: Dr. Garrett Adams is a pediatric infectious diseases specialist in Louisville. He is a co-founder of Physicians for a National Health Program-Kentucky and president of Physicians for a National Health Program.

THE AMERICAN JOURNAL of MEDICINE®

Medical Bankruptcy in Massachusetts: Has Health Reform Made a Difference?

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ABSTRACT

BACKGROUND: Massachusetts' recent health reform has decreased the number of uninsured, but no study has examined medical bankruptcy rates before and after the reform was implemented.

METHODS: In 2009, we surveyed 199 Massachusetts bankruptcy filers regarding medical antecedents of their financial collapse using the same questions as in a 2007 survey of 2314 debtors nationwide, including 44 in Massachusetts. We designated bankruptcies as "medical" based on debtors' stated reasons for filing, income loss due to illness, and the magnitude of their medical debts.

RESULTS: In 2009, illness and medical bills contributed to 52.9% of Massachusetts bankruptcies, versus 59.3% of the bankruptcies in the state in 2007 ($P = .44$) and 62.1% nationally in 2007 ($P < .02$). Between 2007 and 2009, total bankruptcy filings in Massachusetts increased 51%, an increase that was somewhat less than the national norm. (The Massachusetts increase was lower than in 54 of the 93 other bankruptcy districts.) Overall, the total number of medical bankruptcies in Massachusetts increased by more than one third during that period. In 2009, 89% of debtors and all their dependents had health insurance at the time of filing, whereas one quarter of bankrupt families had experienced a recent lapse in coverage.

CONCLUSION: Massachusetts' health reform has not decreased the number of medical bankruptcies, although the medical bankruptcy rate in the state was lower than the national rate both before and after the reform.

 • *The American Journal of Medicine (2011) 124, 224-228*

KEYWORDS: Health care financing; Health care reform; Health economics; Medical bankruptcy

Table 2 Medical Causes of Bankruptcy in Massachusetts, 2007 and 2009

	Percent of All Bankruptcies, 2007 (N = 44)	No. of Debtors and Dependents in Affected Families, 2007*	Percent of All Bankruptcies, 2009 (N = 199)	No. of Debtors and Dependents in Affected Families, 2009*
Debtor cited medical illness/bills as a specific cause of bankruptcy or had large unpaid medical bills†	38.6%	12,700	45.6%§	26,709
Debtor or spouse lost ≤ $ 2 wk of income because of illness or complete disability	34.1%	11,219	32.1%§	18,802
Debtor or spouse lost ≤ $ 2 wk of income to care for ill family member	6.8%	2237	8.2%§	4803
Mortgaged home to pay medical bills‡	8.1%	2665	5.3%§	3104
Any of above	59.3%	19,510	52.9%§	30,985
Any personal bankruptcy	100%	32,268	100%	58,573

*Extrapolation based on number of personal bankruptcy filings during that fiscal year (from reference 6) and household size of medical/non-medical debtors.

†Unpaid medical bills > $5000 or > 10% of family income.

‡Percentage based on homeowners rather than all debtors.

§Difference between percentages in 2007 and 2009 nonsignificant, $P > .40$ for all comparisons.

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Even privately insured have hard time getting psychiatric care in Massachusetts: Harvard study

EMBARGOED until
July 21, 2011, at 12:01 a.m.

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A new study by Harvard Medical School researchers published today [July 21] in the Annals of Emergency Medicine finds that access to outpatient psychiatric care in the greater Boston area is severely limited, even for people with reputedly excellent private health insurance. Given that the federal health law is modeled after the Massachusetts health reform, the findings have national implications, the researchers say.

Study personnel posed as patients insured by Blue Cross Blue Shield of Massachusetts PPO, the largest insurer in Massachusetts. They called every Blue Cross-contracted mental health facility within a 10-mile radius of downtown Boston, stating they had been evaluated in an emergency department for depression and discharged with instructions to obtain a psychiatric appointment within two weeks – i.e. they signaled they needed urgent care.

Only 8 of the 64 facilities (12.5 percent) listed by Blue Cross as preferred providers offered appointments; only 4 (6.2 percent) offered an appointment within two weeks. These findings indicate that even patients with top-drawer private insurance face grave difficulties in securing mental health services in the Boston area.

According to the study, 23 percent of phone calls seeking appointments were never returned, even after a second attempt. Another common reason appointments were unavailable was that 23 percent of psychiatric providers required that the patient already be enrolled with a primary care doctor affiliated with their psychiatric facility.

"People with mental health problems often can't advocate for themselves – especially in a crisis," said lead author Dr. J. Wesley Boyd, an attending psychiatrist at the Harvard-affiliated Cambridge Health Alliance. "Health insurers know this and yet, thanks to their restrictive provider networks and their low reimbursement rates for psychiatric services, they've created a situation where a patient with a potentially life-threatening disorder, such as the severe depression portrayed in our callers' scenario, is essentially abandoned at a time of great need."

"Despite having private coverage, our simulated patient faced daunting barriers when trying to access psychiatric care," Boyd continued. "How likely is it that a real patient in the grip of severe depression would persevere through so many unsuccessful attempts?"

Senior author Dr. Rachel Nardin, chief of neurology at Cambridge Health Alliance, said: "The incentives of the current health insurance system are aligned against patients with mental illness. Insurers try to protect their bottom line by reimbursing poorly for psychiatric services and by constraining their in-network provider lists, both of which limit patients' options so severely as to make services essentially unavailable."

"Lack of adequate access to mental health care strains our entire health care system," said Nardin. "Emergency departments are overwhelmed with boarding psychiatric patients for whom no other resources exist."

"A good first step would be for insurance companies to immediately provide improved reimbursements for psychiatric care," Nardin said. "A more fundamental solution, however, would be to remove private insurers from the picture altogether and to establish a single-payer national health insurance program – a program that would cover mental health services as part of its comprehensive benefits package."

"The crisis in mental health care: A preliminary study of access to psychiatric care in Boston," J. Wesley Boyd, M.D., Ph.D.; Andrew Linsenmeyer, M.D.; Steffie Woolhandler, M.D., M.P.H.; David Himmelstein, M.D.; Rachel Nardin, M.D. Annals of Emergency Medicine, July 21, 2011.

Beyond the flawed Obama health care reform

'The time is always right to do what's right': Dr. King

The following remarks were delivered at the Louisville (Ky.) Urban League on Jan. 15, 2011.

By Claudia Fegan, M.D.

It is indeed an honor and a privilege for me to stand here today celebrating the life and work of Dr. Martin Luther King Jr.

We learned much from Dr. King, even though he was taken from us too soon. He taught us that "the time is always right to do what's right."

As we stand here today, there are 50 million Americans who are uninsured. African Americans are represented disproportionately among the uninsured. We represent only 12 percent of the population, yet we are 20 percent of the uninsured. *This is our issue.*

As a result of not having insurance, we have decreased access to the preventive services that would allow us to live longer, healthier, richer lives. We pay a tremendous price for this.

Our infant mortality rate is about 2.5 times that of whites, our rates of death from heart disease and cancer are 1.5 times that of whites, our rate of death from diabetes is almost 2.5 times that of whites and our rate of death from HIV is 5 times that of whites. African American patients on dialysis are less likely to be referred for evaluation for kidney transplant and therefore, not surprisingly, we are far less likely to get a kidney transplant. *This is our issue.*

The Institute of Medicine in its 2004 study on "The Consequences of Uninsurance" estimated over 18,000 people a year die as a result of not having access to health insurance. Uninsured adults receive fewer and less timely preventive and screening services; uninsured cancer patients die sooner due to delayed diagnosis; the uninsured receive less chronic illness care, poorer hospital care and are more likely to die in the hospital; and the risk of premature death among uninsured Americans is 25 percent higher than among Americans with health insurance.

This is our reality, the reality of health care for African Americans in this country. We will never get more until we demand more. *This is our issue.*

THE FIERCE URGENCY OF NOW

Since 1986, Physicians for a National Health Program has been trying to convince physicians, patients and politicians that if we tossed out the private insurance industry and made the government the single payer for health care in this country, we could provide coverage for everyone with same money we are using now to cover only two-thirds of the country poorly.

I have a patient who is 63 years old. Ms. Lenoir has worked all her life, she is active in her church, she cares for her elderly mother and together she and her husband have raised their children to be self-sufficient members of society. Ms. Lenoir does not have health insurance because her employer has never provided that benefit.

Dr. Claudia Fegan

The problem is Ms. Lenoir needs a new hip. After more than 20 years of arthritis in her hip, the joint is destroyed. She has bone grinding on bone. No amount of anti-inflammatory medication will relieve her pain.

I sent Ms. Lenoir to a pain specialist who injected the joint to provide her with temporary relief and who then called me and said, "This woman needs a new hip." I told her, I know that, but have you got one you can give her? No one will pay for a hip for her until she turns 65 and Medicare will provide her with coverage.

I wish you could look into this woman's eyes each time she comes to see me and feel her pain. Will the legislation passed last year provide her with a new hip before she turns 65 in 2013? No, probably not. *This is our issue.*

In the book "The Heart of Power," David Blumenthal chronicles the efforts of presidents from Franklin Roosevelt through George W. Bush to achieve access to health care for the American public. "Major health reform is virtually impossible: difficult to understand, swarming with interests, powered by money, and resonating with popular anxiety," he writes.

The congressional veteran and co-chair of the 9/11 Commission, Lee Hamilton, said, "Health care is so difficult because Congress is an incremental body and health care is a non-incremental issue."

What Barack Obama did with the passage of the Patient Protection and Affordable Care Act (ACA) was nothing short of miraculous, but it was not enough and it will not solve our problems.

Going forward there will not be a fair, open or honest discourse about this legislation. It is a fact that ACA will do noth-

ing to control costs. That is the major flaw of the legislation.

Why are we still talking about single payer? Because single payer will address the issues of cost, access and quality.

BEING RIGHT IS NOT ENOUGH

Dr. King taught us being right is not enough. We have to win the hearts of the American public. We didn't lose the war to gain access to health care for all Americans. We got battered in an ugly skirmish, but we're not done.

It is time to change our tactics. The opportunity for change is still ahead of us. More recent studies have taught us that actually 45,000 people die each year as a result of not having health insurance, which means 180,000 more people will die before the full implementation the ACA. If everything goes exactly as planned, there will still be at least 23 million uninsured once all the changes have taken effect. *This is our issue.*

Camille Rucks was a security guard for a small company on the South Side of Chicago. In the spring of 2008 she developed breast cancer. She received outstanding care at the University of Chicago and did well. However, in November 2008, which we now know was the beginning of the recession, when her company began to struggle, she was laid off. She thought she was targeted because she had been out sick so much when she was receiving chemo, but it doesn't matter.

In January 2009, when she had some blood-streaked sputum, her primary care physician (PCP) ordered a chest X-ray that showed a spot that raised the question of maybe her cancer had returned. Her oncologist told her she couldn't see her because she was no longer insured. Her surgeon never returned her phone calls.

Her PCP called me because she was not able to get the necessary tests done for Camille because she was no longer insured. I told her PCP to have Camille come see me the next day.

I said, sure, of course, this is what we do; we're the County Hospital. In less than a week she had a CT of her chest, and within two weeks she had been seen by pulmonary and oncology. She did have metastatic cancer and we took care of her. I wish I could tell you this story had a happy ending, but it doesn't. Camille died last year, but she told me she had no regrets. We treated her with dignity and respect.

My question is this: Who doesn't deserve dignity and respect? Why should you have to pass a wallet biopsy before a health care provider determines she can talk to you, order a test, figure out what is wrong or decide how to treat you? *This is our issue.*

AFFORDABLE CARE ACT WILL NOT WORK

The Affordable Care Act has not made health care a right. Access to care is a profit center controlled by the insurance industry. We pay them to limit access to care. We spend more per capita on health care than any country in the world -- more than $8,000 per person -- and yet we are ranked only 36th in the world by the World Health Organization for the care we provide.

Under the ACA, everyone will be required to carry or purchase private insurance. For those who can't afford it, we're requiring states to either cover them under Medicaid or to provide supplements so they can purchase private insurance. This is an industry that has a history of profiteering by retroactively denying coverage to people with illnesses. So now we're requiring everyone to buy coverage, and yes, we have told the insurance companies they can't deny coverage to those with illnesses.

My question is why can't we just pay for the care without having to go through the insurance industry? They are not to be trusted. Ask the state of Massachusetts how it has worked out for them with mandating insurance coverage and paying for those who can't afford it. The cost of premiums has gone up so high so fast in the first year the governor met with the major companies to request they hold off on their premium increases because the costs had exceeded three times the original projections. The state now teeters on insolvency. *This is our issue.*

We spend enough money on health care in this country. We just let too many people who aren't involved in providing care take profit from it.

This is about justice. Health care should be a right to which everyone is entitled. Remember we live in the wealthiest country in the world. We spend more on health care than any other country. It is time we got our money's worth. It is time we got the health care we deserve, not the care the insurance industry is willing to let us have. It is time we made health care a right and not a privilege.

We have to speak up. We have to speak loudly. We have to make our voices heard.

The Affordable Care Act is an opportunity: It is not going to work!

A SIMPLER AND JUST SOLUTION

We have to remind the people -- there is still a simpler, easier solution. People want to know, they have questions. They will ask, is this the answer? Will this work? Will this solve the problem?

Multinational Big Pharma charges the American public the highest pharmaceutical prices in the world, while it sells the very same drugs all over the world at prices one-half, one-third or even one-tenth of the price they charge in the United States. They do this because in the rest of the industrialized world, there is legislation that limits profits for medications, while the U.S. allows these companies to charge whatever the market will bear. The Affordable Care Act does not address this issue. *This is our issue.*

Dr. King said, "When people get caught up with that which is right and they are willing to sacrifice for it, there is no stopping point short of victory." The Affordable Care Act was not victory. We now have a House of Representatives that thinks the American public will be appeased by political theater instead of substance.

What the American public wants is not so different from what African Americans want and deserve. We want guaranteed access to care, freedom of choice of provider, quality health care and two words you don't hear in association with health care very much anymore: trust and respect.

We know it can be done because every other industrialized

country in the world has figured how to do this. Most of them spend less than half what we do and they have better outcomes with more satisfaction.

It is not so complicated what we want: we want a health care system that takes everybody in and leaves nobody out. It is only the phony solutions they are attempting to confuse us with, that are complicated, just so we don't notice they fail to expand coverage to those who need it and deserve it. That's why this will be the civil rights struggle of the 21st century, and *this is our issue*.

I understand people are reluctant to criticize the ACA because our president is under assault from the right and he needs our support. I think Dr. King would tell us it is important to tell the truth: "The time is always right to do what's right."

When I think about this struggle I think about a poem my father taught me as a child. It was written by Langston Hughes and is called "Mother to Son."

Well, son, I'll tell you: Life for me ain't been no crystal stair.
It's had tacks in it, And splinters, And boards torn up,
And places with no carpet on the floor -- Bare.
But all the time I'se been a-climbin' on, And reachin' landin's,
And turnin' corners, And sometimes goin' in the dark
Where there ain't been no light.
So, boy, don't you turn back. Don't you set down on the steps.
'Cause you finds it's kinder hard. Don't you fall now --
For I'se still goin', honey, I'se still climbin',
And life for me ain't been no crystal stair.

The issue of guaranteeing access to care for everyone is an issue of social justice. Battles for social justice are never over, because there will always be reactionary forces waiting in the wings to turn back the clock. There are no easy solutions. We have to be willing to fight for what we believe in and keep fighting.

The night before he was assassinated Martin Luther King said: "Let us stand with greater determination. And let us move in these powerful days, these days of challenge to make America what it ought to be. We have an opportunity to make America a better nation."

I hope you will join me in saying what we expect from any health care program any politician will offer us: Everybody in, Nobody out! Everybody in, Nobody out!

Thank you.

Claudia Fegan, M.D., is acting chief medical officer at the Cook County Health and Hospitals System and past president of Physicians for a National Health Program.

Q: Short of replacing Medicare with a single payer system, how can Medicare be improved?

A: 10 ways to improve today's Medicare

By Drs. David Himmelstein and Steffie Woolhandler

1. Eliminate Medicare Advantage plans.

2. Give Medicare the power to negotiate drug prices.

3. Eliminate private Part D plans, which have high overhead, and replace them with a public drug benefit along traditional Medicare principles.

4. Proscribe participation by for-profit providers, and mandate that participating providers (like hospitals) not pay any individual more than the president of the U.S.

5. Extend the self-referral ban to include doctors who refer patients to their own MRI, CT, PET, and other complex imaging equipment (about half of total cardiologists income currently comes from imaging studies that they order and perform).

6. Ban participating physicians from prescribing medications or medical devices (including orthopedic and cardiac implants) produced by drug or device makers from whom they receive payments.

7. Reduce fees paid to the highest paid specialists, generally those who prescribe or use expensive drugs and devices. Doctors should be paid for the time they actually put in.

8. Revamp Medicare's payment policies for subacute hospital care and so called "long-term acute care" (LTAC). Hospitals currently collect a set fee based on diagnosis for the acute hospital stay, and quickly transfer Medicare patients to a second inpatient facility that collects an additional fee. The result of this financial incentive has been a huge upswing in subacute and LTAC utilization, without any evidence that patients benefit. A colleague who is knowledgeable on this issue informs us that the proportion of Medicare patients with a subacute or LTAC admission after discharge from an acute care hospital has gone from 10 percent to 28 percent since these financial incentives came into effect, with about 600 LTACs appearing de novo.

9. Abolish the Medicare pay-for-performance and ACO schemes, which are causing increases in administrative costs without any evidence of benefit.

10. Of course, the real savings that would allow Medicare to be placed on a sustainable footing could only come under a single-payer plan that could radically cut administrative costs and allow health planning with teeth that would reduce the costly and dangerous proliferation of expensive high-tech facilities.

Tikkun POLITICS · SPIRITUALITY · CULTURE

APRIL 15, 2011

What Happened to Social Justice in Health Care Reform?

By Arthur Sutherland, M.D.

In the wake of Republican House Speaker Paul Ryan's proposals last week to systematically dismantle Medicare and gut the Medicaid program, steps that would inexorably lead to greater suffering and penury and many thousands of preventable deaths, one is prompted to ask, "Have you no sense of decency, sir?"

Posing as champions of fiscal responsibility, Ryan and his GOP cohorts are unleashing a cruel assault on the health and well-being of our most vulnerable populations: the elderly, the disabled, and the poor. They do this even as they hand out ever more favorable tax breaks to the largest corporations and the wealthiest 1 percent of U.S. taxpayers.

While Ryan's latest assault is particularly flagrant, it betokens a wider retreat from the goal of a more just and egalitarian society that has been under way for the past three decades. Its effects can be seen in the policies of both major parties.

The mythology of "free market economics" and the pursuit of individual gain have undermined the conception that society has a moral obligation to care for its members. We have been told, in many and various ways, to let the devil take the hindmost.

The casualties of this ideology go far beyond the poor. The victims represent the vast majority of the population, even those considered relatively well-off. Nowhere is this more evident than in health care.

THE FIRST ANNIVERSARY OF OBAMA'S HEALTH CARE LAW

Take the Obama administration's health care law, for example, whose first anniversary was observed just last month. In view of sharply rising health insurance premiums, co-pays, and deductibles, not to mention special government waivers giving big corporations such as McDonald's the go-ahead to evade standard health policy provisions, the promise of universal, quality coverage looks as remote as ever.

It begs the question: What happened to social justice in health reform?

The short answer is that social justice was not served by the passage of this law. Despite the early rhetoric from President Obama that health reform must cover everyone, control long-term costs, and improve the quality of health care delivery, none of these goals will be met by the Patient Protection and Affordable Care Act (PPACA).

Dr. Arthur Sutherland

I say this with considerable sadness as a physician and as a man of faith. But there is no avoiding coming to terms with the mountain of accumulated evidence and experience, both domestic and worldwide, that achieving social justice in health care is impossible as long as investor-owned health insurance companies dominate the system. And the new law is based on precisely that parasitic and immoral industry.

At the beginning of the reform debate, the president said that all ideas would be put on the table for consideration. But this did not happen. The most rational, proven method of financing comprehensive and affordable health care — single-payer national health insurance, or an improved Medicare for all — was deliberately excluded from the debate.

It took the dramatic civil disobedience and arrest of Dr. Margaret Flowers and other courageous single-payer advocates in Senator Max Baucus' Senate Finance Committee chambers for single payer to register a tiny blip on the congressional radar. Even then, the Medicare-for-all proposal — which enjoys the support of two-thirds of the American people, according to a panoply of polls — was relegated to the sidelines by Baucus and his colleagues, most of them beneficiaries of private health industry largess.

A MODEST REFORM THAT LEFT THE INVESTOR-OWNED SYSTEM IN PLACE

As a result, the bill that Congress fashioned and the president signed is not fundamental reform. It leaves our immoral arrangements essentially in place.

What we have in PPACA is a set of modest restraints on the for-profit health industry that were largely shaped by its medical-industrial lobby. Notwithstanding some beneficial features in the law, such as more funding for community health centers, the ability of young adults to stay on their parents' plan till age twenty-six, the expansion of Medicaid, or regulations curtailing some of the most outrageous practices of the private insurers, PPACA basically maintains our present system.

The new law does nothing to effectively control rising health care costs, including skyrocketing premiums for individuals and businesses alike.

In short, the new law puts corporate interests over patients' rights.

Accommodating the wishes of the private health industry may have been the "politically smart" way to get the bill passed, but it left in place our fragmented, chaotic, and costly health care "non-system" — a non-system that is inherently unjust.

I am disappointed that our nation's religious institutions failed in their prophetic mission to reframe the health reform debate from one of partisan politics to the real moral issue involved here, namely, that "Health care is a human right."

Nowhere is the immorality of our situation more dramatically illustrated than in the number of the uninsured.

The 2009 census figures show that we had 50.7 million people uninsured — an increase of 4.3 million, or nearly 10 percent, over the previous year. The Congressional Budget Office estimates we'll have about 50 million uninsured for the next three years. In 2014, when the new insurance mandates and Medicaid expansion go into effect, the number will drop to about 30 million. But even if PPACA works as planned, we will still have 23 million people without insurance in 2019.

45,000 UNNECESSARY DEATHS EACH YEAR

Lack of health insurance is deadly, as numerous research studies have pointed out. An estimated 45,000 annual deaths can be linked to not having insurance and therefore not having access to care, according to a 2009 article in the American Journal of Public Health.

Under the new law we can also see a trend in the type of insurance coverage that will be offered to the public. That trend will be toward offering high-deductible and co-pay policies like the "medical savings account" products. These types of "under-insurance" policies will put more financial burden on the public, and will leave people with less financial security if they contract any major illnesses.

As a consequence, medical bills will continue to be a major contributing factor to personal bankruptcy. Writing in the American Journal of Medicine, researchers in 2009 found that illness and medical bills can be linked to 62 percent of personal bankruptcies in our nation. Significantly, three-quarters of all medically bankrupt persons were insured at the onset of their illnesses. This statistic could become worse.

What we need in America is a national health program that covers everyone — especially the most vulnerable such as immigrants and all those made poor and marginalized in our society.

Even with PPACA, we will still be rationing health care by wealth and position in society. This is not social justice and our faith communities need to speak and demand that the system be changed.

As a member of a church and as a member of Physicians for a National Health Program, I work to share the solid research that shows a single-payer national health insurance program, like an expanded and improved Medicare for all, is a just way to improve our nation's health and wellness.

With its efficiency, transparency, and enormous clout in the marketplace, an improved and expanded Medicare program could control long-term costs, implement national standards, and provide for regional planning to improve the quality of care we receive. Improved Medicare for all would cover everyone in America — all of our neighbors. This would result in health care justice grounded in the equality of all human persons before God, which is exactly what God demands of us in our scriptures and in our professed religious traditions.

Why can't we do this?

Arthur J. Sutherland III, M.D., F.A.C.C., of Memphis is coordinator of the Tennessee chapter of Physicians for a National Health Program (www.pnhp.org). He is a retired physician and founder of the Sutherland Cardiology Clinic. He works with The Healthy Memphis Common Table, which is addressing the obesity and diabetes epidemics, health literacy, and efforts to eliminate social and health disparities. Dr. Sutherland is also a member of the Memphis School of Servant Leadership and works with the Memphis Theological Seminary in its urban ministry program.

the Charleston Gazette

JULY 30, 2011

Care can be universal, cheaper

By James T. Binder, M.D.

In the fall of 1982, when I working as a pediatrician in upstate New York, a mother made an appointment to have her child seen on an urgent basis. The child did not really need to be seen quickly, but the mother didn't know better. She was just worried about her child. She arrived and checked into the clinic. The receptionist greeted her with, "I should have known -- Medicaid."

The humiliation that mother experienced was the price she paid to obtain health care for her child. She was poor.

It is almost 30 years later, and this condescension for those using Medicaid insurance persists. And, in many instances, the actual medical care provided is inferior. A number of health care experts consider Medicaid close to having no medical insurance at all. The system is chronically and grossly underfunded.

The U.S. Government Accountability Office recently reported that less than half of physicians are willing to accept children with Medicaid and CHIP as new patients, and over four-fifths experienced difficulty referring Medicaid and CHIP children to specialty care. I can say, from my experience at Marshall University Department of Pediatrics over the last 11 years, that obtaining competent mental-health treatment in the Huntington area for children with Medicaid is sometimes close to impossible.

Many mental-health care clinicians, as well as other specialists, in Huntington and across the country, don't accept Medicaid because payments are low and unreliable. It is understandable. However, it is likely this contributes to the overuse of psychotropic medications in children, since it makes it harder for them and their families to be referred for psychotherapy.

In addition to the inability to access specialty care, parents of the children with Medicaid insurance typically do not have medical coverage. Clinicians cannot possibly provide good health care for children without treating the family. A new mother with untreated depression can affect her child's school performance years later; a father with an untreated chronic lung condition cannot play actively with his children.

I think one of the reasons the system remains in place, despite all its deficiencies, is covert prejudice against the poor. The poor have no political clout. Poverty is a very complex, multiproblem condition. It seems to me that promoting healthy bodies and healthy minds for all children living in poverty is essential to any efforts to help them overcome poverty. Universal, caring and comprehensive health care is needed.

There is a way to accomplish it. But we cannot listen to conservatives (e.g. Rep. Paul Ryan) who would eliminate government health insurance for the poor, and we cannot heed the liberals who want to place more and more people into a broken and inadequate system. Sixteen million more people will be added to Medicaid as a result of the health care reform passed by congress and President Obama last year. And, sadly, private insurance will reap even more profit than they do now, once the new law takes effect.

The U.S. Government Accountability Office recently reported that less than half of physicians are willing to accept children with Medicaid and CHIP as new patients, and over four-fifths experienced difficulty referring Medicaid and CHIP children to specialty care.

We must advocate for a non-tiered system and creation of a comprehensive national health insurance program. A universal plan would be equitably funded, based on the current tax structure. We already put enough money into health care to cover every American for all necessary medical care. Huge savings would result from eliminating the bureaucratic costs of private insurance (20 to 30 percent of health care spending goes for unnecessary bureaucracy, advertising and private profits).

It would be an expanded and improved version of Medicare. Almost every other industrialized country provides some version of this for their citizens, and at a much lower cost. Everyone in; no one out!

Dr. Binder is associate professor of pediatrics at Marshall University School of Medicine in Huntington, W.Va., and a member of Physicians for a National Health Program.

StarTribune

JULY 30, 2011

Medicare, an effective program, turns 46

By Ann Settgast, M.D.

Whether the debt ceiling is raised or not in the days ahead, Minnesotans and the nation have reason to celebrate this weekend. Saturday marked Medicare's 46th birthday.

While we have a long way to go before our health care system works well for all patients, this anniversary gives us an opportunity to reflect on what we've done right.

Surprisingly, Medicare was born out of bitter controversy in 1965. It was condemned by some as "socialized medicine," a threat to basic freedoms. As a physician, I'm embarrassed to say organized medicine was among its key opponents. It all seems silly today.

Since its inception, Medicare has afforded hundreds of millions of Americans access to high-quality health care. It has reduced poverty among seniors and improved the financial security of their families. It has become one of the most popular government programs in history.

Current political discourse is centered on spending cuts, including Medicare. But covering Americans via Medicare saves money. No, that is not a typo.

Medicare boasts far lower administrative costs than the leanest private insurance company. While it is true that Medicare spending has risen dramatically over time, its growth is far less than that of the private sector.

And remember that Medicare pays for the care of our sickest and oldest, while private insurers foot the bill for the young and healthier.

In fact, uninsured Americans in their late 50s and early 60s routinely delay needed care, only to become expensive Medicare recipients once they reach 65.

Medicare is not the cause of health care inflation; rather, it is a victim of our country's skyrocketing health care costs. Cuts to Medicare will not control these costs.

Rather, they will reduce access to care by the nation's elderly, worsen their health status, and increase financial hardship among already-struggling Americans.

Not only is Medicare less expensive than private insurance, it provides superior service. An example is the free choice of doctor granted to patients under Medicare -- a basic freedom many privately insured Americans are currently denied.

As a practicing internist, I can attest to the lower "hassle factor" doctors incur when dealing with Medicare rather than interacting with multiple private payers, each requiring different rules and regulations. Expecting us to treat patients differently because they have different or no insurance contradicts our professional responsibility.

Medicare is far from perfect, and it has some serious limitations. But for this weekend, let's celebrate a government program that actually works incredibly well. Americans are proud of Medicare. It should be strengthened, expanded and improved to include all of us. A sustainable Medicare-for-all system is the reform our nation needs.

Ann Settgast, M.D., is a primary care doctor practicing in the Twin Cities. She co-chairs the Minnesota chapter of Physicians for a National Health Program.

The New York Times

AUGUST 23, 2011

Invitation to a Dialogue: A National Health Plan

To the Editor:

In “Will Health Care Reform Survive the Courts?” (State of Play, Sunday Review, Aug. 21), Philip M. Boffey states that “reforms would work far less well without an individual mandate” that requires citizens to buy health insurance or pay a penalty.

I disagree. Health care reform could provide better care at less cost by replacing individual mandates with a single-payer national health care plan financed by taxes. Congress’s power to mandate purchase of private products sold at a profit is disputable, but Congress’s power to tax is not.

Other industrialized countries have national health plans providing care to more citizens at less cost with better outcomes than our system. And they don’t use mandates that allow insurers to charge different prices for different people.

These health care systems have three common properties: public subsidies ensure that everyone has access to care regardless of health, wealth or employment; primary care is encouraged; and publicly accountable, transparent, not-for-profit agencies transfer funds from patient to provider.

There is no need to experiment with mandates. Convert our current health care system into a national health plan.

SAMUEL METZ
Portland, Ore., Aug. 21, 2011

The writer, an anesthesiologist, is a founding member of Mad as Hell Doctors, a traveling group of speakers from Oregon's PNHP Chapter.

The New York Times

JUNE 12, 2011

Medicare Saves Money

By PAUL KRUGMAN

Every once in a while a politician comes up with an idea that's so bad, so wrongheaded, that you're almost grateful. For really bad ideas can help illustrate the extent to which policy discourse has gone off the rails.

And so it was with Senator Joseph Lieberman's proposal, released last week, to raise the age for Medicare eligibility from 65 to 67.

Like Republicans who want to end Medicare as we know it and replace it with (grossly inadequate) insurance vouchers, Mr. Lieberman describes his proposal as a way to save Medicare. It wouldn't actually do that. But more to the point, our goal shouldn't be to "save Medicare," whatever that means. It should be to ensure that Americans get the health care they need, at a cost the nation can afford.

And here's what you need to know: Medicare actually saves money — a lot of money — compared with relying on private insurance companies. And this in turn means that pushing people out of Medicare, in addition to depriving many Americans of needed care, would almost surely end up increasing total health care costs.

The idea of Medicare as a money-saving program may seem hard to grasp. After all, hasn't Medicare spending risen dramatically over time? Yes, it has: adjusting for overall inflation, Medicare spending per beneficiary rose more than 400 percent from 1969 to 2009.

But inflation-adjusted premiums on private health insurance rose more than 700 percent over the same period. So while it's true that Medicare has done an inadequate job of controlling costs, the private sector has done much worse. And if we deny Medicare to 65- and 66-year-olds, we'll be forcing them to get private insurance — if they can — that will cost much more than it would have cost to provide the same coverage through Medicare.

By the way, we have direct evidence about the higher costs of private insurance via the Medicare Advantage program, which allows Medicare beneficiaries to get their coverage through the private sector. This was supposed to save money; in fact, the program costs taxpayers substantially more per beneficiary than traditional Medicare.

And then there's the international evidence. The United States has the most privatized health care system in the advanced world; it also has, by far, the most expensive care, without gaining any clear advantage in quality for all that spending. Health is one area in which the public sector consistently does a better job than the private sector at controlling costs.

Indeed, as the economist (and former Reagan adviser) Bruce Bartlett points out, high U.S. private spending on health care, compared with spending in other advanced countries, just about wipes out any benefit we might receive from our relatively low tax burden. So where's the gain from pushing seniors out of an admittedly expensive system, Medicare, into even more expensive private health insurance?

Wait, it gets worse. Not every 65- or 66-year-old denied Medicare would be able to get private coverage — in fact, many would find themselves uninsured. So what would these seniors do?

Well, as the health economists Austin Frakt and Aaron Carroll document, right now Americans in their early 60s without health insurance routinely delay needed care, only to become very expensive Medicare recipients once they reach 65. This pattern would be even stronger and more destructive if Medicare eligibility were delayed. As a result, Mr. Frakt and Mr. Carroll suggest, Medicare spending might actually go up, not down, under Mr. Lieberman's proposal.

O.K., the obvious question: If Medicare is so much better than private insurance, why didn't the Affordable Care Act simply extend Medicare to cover everyone? The answer, of course, was interest-group politics: realistically, given the insurance industry's power, Medicare for all wasn't going to pass, so advocates of universal coverage, myself included, were willing to settle for half a loaf. But the fact that it seemed politically necessary to accept a second-best solution for younger Americans is no reason to start dismantling the superior system we already have for those 65 and over.

Now, none of what I have said should be taken as a reason to be complacent about rising health care costs. Both Medicare and private insurance will be unsustainable unless there are major cost-control efforts — the kinds of efforts that are actually in the Affordable Care Act, and which Republicans demagogued with cries of "death panels."

The point, however, is that privatizing health insurance for seniors, which is what Mr. Lieberman is in effect proposing — and which is the essence of the G.O.P. plan — hurts rather than helps the cause of cost control. If we really want to hold down costs, we should be seeking to offer Medicare-type programs to as many Americans as possible.

The New York Times

MAY 21, 2011

A Doctor's Push for Single-Payer Health Care for All Finds Traction in Vermont

By ABBY GOODNOUGH

MONTPELIER, Vt. — Many people move to Vermont in search of a slower pace; Dr. Deb Richter came in 1999 to work obsessively toward a far-fetched goal.

She wanted Vermont to become the first state to adopt a single-payer health care system, run and paid for by the government, with every resident eligible for a uniform benefit package. So Dr. Richter, a buoyant primary care doctor from Buffalo who had given up on New York's embracing such a system, started lining up speaking engagements and meeting with lawmakers, whom she found more accessible than their New York counterparts.

"I wrote a letter to the editor, and the speaker of the House called me up to talk about it," Dr. Richter, recalled recently. "It was astounding. In New York, I couldn't even get an appointment with my legislator."

Twelve years later, Dr. Richter will watch Gov. Peter Shumlin, a Democrat, sign a bill on Thursday that sets Vermont on a path toward a single-payer system — the nation's first such experiment — thanks in no small part to her persistence. Though scores of people pushed for the bill, she was the most actively involved doctor — "the backbone," Mr. Shumlin has said, of a grass-roots effort that helped sway the Democratic Legislature to pass it this spring even as other states were suing to block the less ambitious federal health care law.

"We wouldn't be where we are without Deb," Mr. Shumlin said in an interview. "She's made this her passion. And like anyone that's making significant social change, she has qualities of persuasiveness and leadership and good judgment that are hard to find."

As in all states, the cost of health care has increased sharply in Vermont in recent years. It has doubled here over the last decade to roughly $5 billion a year, taking a particular toll on small businesses and the middle class. All 620,000 of the state's residents would be eligible for coverage under the new system, which proponents say would be cheaper over all than the current patchwork of insurers. A five-member board appointed by the governor is to determine payment rates for doctors, what benefits to cover and other details.

But much remains to be worked out — so much that even under the most optimistic projections the plan might not take effect until 2017. Most significantly, Mr. Shumlin still has to figure out how much it will cost and how to pay for it, possibly through a new payroll tax. Whether he will still be in charge by 2017 is among the complicating factors.

Dr. Deb Richter said at the signing ceremony, "This bill the governor is signing today is a major step in the right direction. It will set in place something that has never been done before in this country — set us on a path to establishing health care as a public good." (Photo courtesy of Vermont for Single Payer)

"If we had the exact same Legislature and the same governor we could get it done," Dr. Richter said. "It's a big if, because the opposition has a ton more money to convince people that the governor is evil and this is socialized medicine and all kinds of other scary stuff."

The opposition will probably include insurance companies, drug makers and some employers who say there are too many unknowns. Many doctors, too, are wary of the change and what it might mean for their income. Dr. Richter said she believed a "slim majority" of the state's 1,700 licensed physicians were supportive.

"One of the bigger worries I have is we've had all this hoopla and nothing's going to happen," she said at a coffee shop here recently on a rare quiet afternoon. "But it might also be helpful to us, because it's going to be hard for any opposition to be steadily pushing for seven years."

The federal health care law has complicated Vermont's plans, requiring the state to first create a health insurance

exchange to help residents shop for coverage by 2014. The state would then need a federal waiver to trade its exchange for a government-run system.

Dr. Richter said she embraced the idea of a single-payer system as a young doctor in Buffalo, where many of her patients put off crucial treatments because they were uninsured. As a medical student, she saw a patient with a life-threatening heart infection caused by an infected tooth that had gone untreated because he lacked dental insurance.

"He was in the hospital for six weeks, and I was like, 'This makes no sense,' " she said.

She went to a meeting of Physicians for a National Health Program, a group that advocates for a national single-payer system, and started researching the concept. Before long she became a vocal advocate, even becoming president of the physicians' group, and moved to Vermont.

John McClaughry, a former Republican state senator who is against the new law, said Dr. Richter meant well but did not understand the "long-term damage" it would wreak. In particular, he said the law would drive away businesses that did not want to help pay for it.

"She'll tell you that putting in single-payer will attract businesses from all over the place," said Mr. McClaughry, vice president of the Ethan Allen Institute, a conservative research group. "I don't think she has any appreciation of business decisions at all."

Since moving with her husband and two sons to a rambling old house within view of the State House, Dr. Richter has given about 400 talks on the single-payer concept, tutored lawmakers in the State House cafeteria and testified before the Legislature more times than she can remember. Once, she presented a printout of all the insurance companies her small practice in Cambridge had billed over five years.

"It was like 190 pages long," she said. "Here we were, this tiny rural clinic having to bill all these different addresses. And all of them have different rules and reimbursements; I mean, it's ridiculous."

Some supporters of single-payer health care say Vermont's law does not go far enough, mostly because it would allow at least a handful of private insurers to stay in the market indefinitely. Self-insured businesses like IBM, the state's largest employer, could continue providing health coverage to workers under the law, though they would have to help finance the new system, possibly through a payroll tax.

Physicians for a National Health Program is among the critics, saying the law "falls well short of the single-payer reform needed." Allowing private insurers to remain in the state will prevent meaningful savings, the group says.

Dr. Richter acknowledges that the law will not allow for "strict single-payer," but said it still promised "health care for everybody, for less cost."

"This is not the top of the mountain, but it's the first time anyone has headed up the mountain," she said. "No other place in the country has gotten this far."

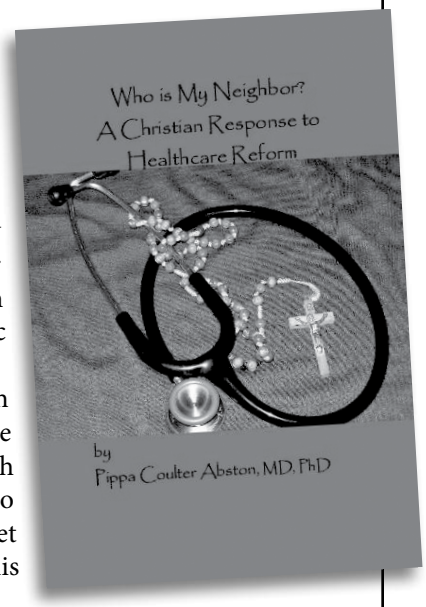
'Who is My Neighbor? A Christian Response to Healthcare Reform'

A new book by Pippa Abston, M.D., Ph.D.

Dr. Pippa Coulter Abston, a pediatrician and leader of North Alabama Healthcare for All, a chapter of Physicians for a National Health Program, has written a new book titled "Who is my neighbor? A Christian response to healthcare reform."

A columnist at The Huntsville Times writes, "The book is structured around lines from the parable of the Good Samaritan, the story told by Jesus in which a heathen foreigner shows by example how to care for someone in need. Using simply told, heart-wrenching illustrations from her own work, Abston walks through the experience of navigating today's insurance maze from the doctor's point of view. In non-exaggerated explanations, she clicks through all the arguments against 'socialized' medicine, as detractors disparage it, showing why good medicine for all means better physical health for all, better health options for all, and better economic health for the country."

This 132-page softcover, which sells for $11 plus shipping, can be obtained from blurb.com, which prints books on demand. You can go directly to Dr. Abston's title and get more ordering information via this link: bit.ly/od3EET.



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Vermont health law spurs fresh interest in single-payer reform: doctors group

As governor signs a 'universal health care' bill, a national physicians group says the Vermont developments show that many Americans want to go beyond the new federal health law to more fundamental reform

FOR IMMEDIATE RELEASE
May 25, 2011

Contact:
Garrett Adams, M.D.
David Himmelstein, M.D.

Gov. Peter Shumlin's signing of Vermont's health reform bill this Thursday is spurring renewed interest in single-payer health reform across the United States, even though the Vermont legislation is much more modest in its actual reach than a single-payer plan would be, a spokesperson for a national doctors group said today.

"The people of Vermont, including the state's doctors, nurses and other health professionals, have inspired the entire nation by their unflagging dedication to winning a publicly financed, comprehensive and equitable health care system based on the principle that health care is a human right," said Dr. Garrett Adams, president of the 18,000-member Physicians for a National Health Program. "We salute their efforts and the efforts of their many organizations, even as we share their conviction that their work has just begun."

"This praise also extends to Gov. Peter Shumlin, who was elected to office on a single-payer platform and who has made many speeches in support of publicly financed care," Adams said. "The governor has argued, for example, that single payer is the best way for Vermont to get its economy back on track and to create jobs."

"Credit is also due to Sen. Bernie Sanders and other members of the state's congressional delegation who are seeking waivers from the federal government so Vermont can innovate with its own model of reform," he said. As of now, the federal Affordable Care Act prohibits states like Vermont from adopting their own models of reform until 2017. Shumlin, Sanders and others are trying to move that date up to 2014.

Adams continued: "Vermonters, like their counterparts across the United States, recognize that our current way of financing care – using wasteful, inefficient middlemen known as private health insurance companies – is broken and economically unsustainable. Many also understand that the new federal health law, while containing modest benefits, is an insufficient remedy, among other reasons because it retains a central role for these same greedy insurers."

He noted that several other states, including California, are looking at variations of a single-payer model for reform.

Adams said while the Vermont law declares health care to be a "public good" and says the state has a responsibility to "ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters," a praiseworthy objective, the actual provisions of the law fall considerably short of the single-payer reform needed to realize those goals.

A major problem, he said, is that the Vermont law will permit multiple private insurers to operate in the state indefinitely, setting the stage for multi-tiered care, rising costs and needless waste.

"Allowing multiple insurers in the system will deny Vermonters the enormous administrative savings they would otherwise get under a true single-payer plan," Adams said. "Having multiple insurers also nullifies the potential bargaining power of a 'single payer' to negotiate reduced prices for pharmaceutical drugs and other goods and services."

Dr. David Himmelstein, co-founder of Physicians for a National Health Program, said that the law's emphasis on complying with the Affordable Care Act means that it will leave the door open for burdensome co-pays, deductibles and other out-of-pocket expenses that deter people from seeking timely care. Finally, to the extent the law permits large, for-profit institutional providers to allocate their profits as they see fit, it will deny the system the ability to do effective health planning.

"In this context, the continuing mobilization of Vermont's broad-based movement for true single-payer reform will be essential," Himmelstein said. "Such a mobilization can bolster the governor's clear enthusiasm for the single-payer project and the courage of the Legislature as they face the inevitable onslaught of corporate opposition to deep-going health reform."

"We remain hopeful that the rhetorical commitment to further reform will become a reality," Himmelstein said. "Much more work, including continuing advocacy for a national solution – a single-payer system as embodied in legislation such as H.R. 676, the Expanded and Improved Medicare for All Act – will be needed in the years ahead to achieve Vermonters' goal of universal access to high-quality, affordable care."

The Washington Post

MAY 9, 2011

Vermont closing in on single payer

By Ezra Klein

Kevin Outterson is an associate professor of health law, bioethics and human rights at Boston University, as well as a blogger at the Incidental Economist. He's also been following the Vermont health-care reform process in some detail, and is one of fairly few people who has actually read the 141-page single-payer bill that the governor is poised to sign. Earlier this afternoon, he walked me through what he's learned.

Ezra Klein: What is Vermont passing, exactly? My understanding is that they're not going to sign this legislation and wake up with single-payer health care the next day. So what's in this bill, and what does it do?

Kevin Outterson: This bill is more of a framework. For example, they left out all the financing. But it sets a planning process for a single-payer — or what they're calling a "single-payment" — system. If you read the various reports and presentations they've released so far, you can get a sense of where that's going. Their plan is to roll every payer they can into one system. It's easy to do with state and municipal employees. They might be able to do it with the individual and small-group markets that they regulate under the terms of the Affordable Care Act. They are going to ask the Obama administration for waivers for Medicaid, so they'd get the Medicaid money and use it in this system, and they also want a waiver for Medicare, which I'm not sure anyone has ever done before. And the last group they're trying to woo in are the large, national employers who are regulated by ERISA. Their plan is to tax these employers whether they pay in or not, and then these employers have to ask themselves, "We're already paying this tax, why wouldn't we just put our employees into Green Mountain Care?"

EK: So all these different players remain part of the health-care system. But now their payments run through the Vermont state government.

KO: Right. So employers would still be paying in, the Vermont state government would still pay in, the federal government would still be paying in, but all the money would then flow through Green Mountain Care, the single-payment system. And for all providers, there'd just be one contract. It'd equalize payment rates between private insurance and Medicare and Medicaid. It'll dramatically reduce their paperwork. That's why they're supporting it. And Blue Cross/Blue Shield of Vermont, which is the biggest insurer in the state, supports it.

EK: Wait, Blue Cross/Blue Shield supports it? Why? Won't this put them out of business?

KO: You would think. But this is one of those Blue Cross plans that never sold out to Anthem. They're still nonprofit. And they've got 70 percent of the market in Vermont. So the theory is they would administer the payment system. But they're not alone. The Vermont Medical Association and the Vermont hospitals are supporting this legislation. [PNHP correction: the Vermont Medical Society has taken a neutral stance on the bill.] The most vocal opponents are the state association of insurance agents, and the drug companies are about to descend in force, because there's a lot in there the drug industry won't like.

EK: How quickly could something like this be up and running in Vermont?

KO: They can do a single-payment system fairly quickly for the state and municipal employees and the individual and small-group exchange markets that they regulate under the ACA. So that's the core. And it's pretty substantial. And if they get Blue Cross in, then they get Blue Cross's customers. Then there's Medicaid and Medicare, which will be a long process going back-and-forth with the Center on Medicaid and Medicare Services. And then the discussion with the big employers is happening now, as Vermont can toss this tax into place pretty quickly, which will force those guys in.

EK: But there's no financing mechanisms in the bill yet, right? That seems like a pretty big omission.

KO: Vermont has a study group that's been working on financing for a while and that's been negotiating with these big employers to join the party. And they need them there: If they don't tax the big guys, they don't have the money, and if they don't get buy-in from the big guys and they move their offices to New Hampshire, Vermont has a problem. But let's say you're Wal-Mart. You might be willing to take a risk on paying a bit more in Vermont because if it works and spreads, this might fix your long-term problems nationally. If I was a national employer with 3 or 4 million lives in my care, I might be willing to invest a little money to see if Vermont can do this.

EK: That national question seems like the interesting one. In Canada, single payer began in a single province and then spread across the whole country. If Vermont pulls this off successfully, it seems like the sort of thing that, in 10 or 20 years, could lead to very large changes in America's health-care system.

KO: The first thing I posted on was the incredible power of Vermont's version of the Independent Payment Advisory Board to control costs. If they do this and they're successful, there are a number of other states that will want to try it. It's a 20-year time horizon, but if you think national single-payer is a political nonstarter, this is where the action is. But that's the question: whether they can control costs. That'll be everything.

State-Based Single-Payer Health Care — A Solution for the United States?

William C. Hsiao, Ph.D.

The United States faces two major problems in the health care arena: the swelling ranks of the uninsured and soaring costs. The Patient Protection and Affordable Care Act (ACA) makes great strides in addressing the former problem but offers only modest pilot efforts to address the latter. Experience in countries such as Taiwan and Canada shows that single-payer health care systems can achieve universal coverage and control inflation of health care costs. Because of strong political opposition, however, the U.S. Congress never seriously considered a single-payer approach during the recent reform debate. Now Vermont, wishing to solve the intertwined problems of costs and access through systemic reform, is turning in that direction. Vermont Governor Peter Shumlin campaigned on a platform of single-payer health care, and Democratic legislative leaders are committed to this approach.

In Vermont, the status quo in health care has become untenable. Despite numerous reforms over the past 15 years, Vermont's health care costs are escalating rapidly, straining the state budget, household incomes, and employers' bottom lines. More than 7% of Vermonters are uninsured, and another 15% have inadequate insurance.

The Vermont Legislature passed Act 128 in May 2010 authorizing a study to find the most viable and practical systemic solutions to these problems.[1] The goals are clear and ambitious: Vermont wants to achieve universal coverage, reduce the rate of cost increases, and create a primary care–focused, integrated delivery system. The question is how to achieve those goals. My team of health system analysts at the Harvard School of Public Health was commissioned by the Vermont Legislature to develop and evaluate three options for health system reform and determine which option would best achieve the stated goals.

We conducted extensive fiscal, legal, institutional, and stakeholder analyses in Vermont to gain an in-depth understanding of the hurdles confronting any such plan and to design ways of overcoming or navigating around them. Our findings presented a striking picture. Vermont faces a $150 million budget shortfall. Employers argue that health care costs jeopardize their businesses' financial viability, while families struggle to pay out-of-pocket health care costs. Vermont businesses and workers are unwilling to spend more for health care.

On the other hand, Vermonters are also largely unwilling to reduce their level of benefits. Our analysis found that, on average, Vermonters have rich insurance benefits approaching the ACA's "platinum" standard. Similarly, physicians and hospitals are unwilling to accept reductions in their net incomes.

Our analyses led us to adopt several design principles that shaped our recommended design. First, we wanted to design a system capable of achieving universal coverage and reducing the cost inflation rate. Any increases in spending to cover the uninsured and underinsured would have to come from savings generated by systemic reforms. Any financing mechanism should not increase the costs to the state, businesses, and households. Second, we aimed to maintain Vermonters' current average benefits. Third, we sought to maximize federal revenues from all sources. Fourth, we would not reduce overall net income of physicians, hospitals, or other providers. Finally, we sought to eliminate the perverse incentives inherent in the fee-for-service system, through risk-adjusted capitation payment plus performance bonuses, to provide incentives for the formation of accountable care organizations and care integration.

We found that the system capable of producing the greatest potential savings and achieving universal coverage was a single-payer system — one insurance fund that covers everyone with a standard benefit package, paying uniform rates to all providers through a single payment mechanism and claims-processing system. Our analysis showed that Vermont could quickly save almost 8% in health care expenditures through administrative simplification and consolidation, plus another 5% by reducing fraud and abuse.

We recommended that the single payer be a public–private

Estimated Impact of the Recommended Single-Payer Plan for Vermont.*					
Variable	**2015**	**2016**	**2017**	**2018**	**2019**
Savings (millions of dollars)	580	770	880	990	1,100
Additional expenditures (millions of dollars)	380	395	408	420	435
Payroll tax (% of total payroll)					
Employer share	10.60	9.40	9.10	8.90	8.70
Employee share	3.60	3.10	3.00	2.95	2.90
Number of new jobs created	3800	3600	3400	3200	2900
Impact on gross state product (millions of dollars)	110	90	75	57	33

* All dollar figures represent 2010 dollars. "Additional expenditures" represent the total additional cost of covering the uninsured, bringing benefits for underinsured people up to the standard benefit, covering some dental and vision care, investing in primary care and hospital capacity, and achieving uniform payment rates.

partnership. An independent board with representation from both the major health care payers (employers, the state, and workers) and the major beneficiaries and recipients of payment (providers and consumers) would negotiate updates to the benefit package and payment rates. We also proposed contracting out claims administration through a competitive bid to create incentives to develop more efficient systems.

This system reduces the rate of cost increases over time by insulating major decisions about health care spending from politics, as well as by paying providers through capitation rather than fee for service, promoting delivery-system integration, and reducing the practice of defensive medicine by implementing a no-fault medical malpractice system. All told, we estimated that Vermont could save 25% in health care expenditures over 10 years (estimated savings for the first 5 years are shown in the table).

Eligibility for coverage in the system would be based solely on proof of Vermont residency, the same requirement currently used by Vermont Medicaid; this approach effectively divorces health benefits from employment. However, we proposed to finance the system through a payroll contribution on all Vermont wages, split between employer and employee, to preserve the federal tax treatment of health benefits — a tax expenditure worth $400 million to $500 million in Vermont. We recommended delaying the implementation of the single-payer system until after Vermont's insurance exchange has been operating for a year, at which point the state will have a basis for arguing for a waiver from the ACA requirements and estimating the amount of a federal block grant it would receive before 2017, when current ACA law allows for waivers.[1]

We used two economic models to estimate the impact of the proposed system. We fed estimated savings and costs under the single-payer system into a MicroSimulation Model, developed by the Massachusetts Institute of Technology's Jonathan Gruber, which simulated the likely responses to the ACA by employers and low-income workers and estimated the amount of state and federal spending under the law, as well as computing the payroll contribution rates necessary to finance our plan. We then fed those results into a macroeconomic model developed by Regional Economic Models to estimate the effects on jobs and the gross state product that would result from additional spending for health care when more people were covered and the increase in household income and consumption when insurance premiums decreased with a single-payer plan. The models predicted that, as compared with implementing the ACA, the single-payer system would result in lower spending by employers, the state, and households and in the creation of more jobs in Vermont. For example, without single-payer reforms, we predict that employers would pay 12% of their payrolls in health insurance premiums in the first year, with further increases to follow.

The governor has already introduced legislation establishing the first building blocks of a single-payer system: payment reform, the creation of the independent board, and the mandate to build Vermont's health insurance exchange as a platform for a single-payer infrastructure. Legislation establishing universal coverage and its financing will follow, when the state can obtain waivers from Medicare's and Medicaid's provider-payment rules and the ACA's individual mandate and subsidy rules. Innovative state reforms are being encouraged, as illustrated by President Obama's support for the Wyden–Brown

bill,[2] which would grant waivers from ACA requirements in 2014 if states can meet the ACA's goals. The Vermont single-payer plan certainly can.

Perhaps we are at the dawn of systemic reform in U.S. health care. The Vermont single-payer plan will never be as efficient as Taiwan's or Canada's because it must work within the bounds of federal laws and programs and the realities of porous state borders. Nevertheless, it can produce substantial savings to fully fund universal coverage, reduce health care costs for most businesses and households over time, and reform a fragmented delivery system. Of course, someone will bear the burden — mostly the private insurance industry and high-wage businesses that don't currently offer insurance. But if Vermont can navigate its political waters and successfully implement this plan, it will provide a model for other states and the country as a whole.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Department of Health Policy and Management, Harvard School of Public Health, Boston.

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THE BARRE MONTPELIER TIMES ARGUS

JANUARY 23, 2011

Vermont doctors say patient needs are buried in paperwork

By Kevin O'Connor

RUTLAND — Middlebury's Dr. Jack Mayer knows that most patients want health care reform to cut rising prices. But he, along with a growing group of Vermont medical providers, hopes to point a scalpel at piles of related paperwork.

Back in 1976 when Mayer opened his first pediatric office in the tiny northernmost town of Enosburg Falls, the Bronx native often bartered his services for eggs, firewood or knitted afghans.

In a larger community and practice 35 years later, Mayer now works with two fellow physicians, a nurse practitioner and two full-time billing clerks who process claims for more than 200 insurance plans.

"Every company has its own paperwork, payment schedules and policies about what it will cover," says Mayer, who notes that such overhead eats upward of 30 percent of U.S. medical expenses. "The administrative costs of my practice are enormous and don't go toward improving health or patient care."

Mayer isn't alone in his assessment. So many Vermont medical professionals have similar concerns, the Legislature — now contemplating several plans to change the state's health care system — will hold a public hearing in Montpelier this week to receive their testimony.

"What I hear from all my colleagues is, 'For every hour I put into clinical care, I put another into paperwork,'" says Dr. Deborah Richter, a Cambridge physician. "They can't give the care that patients need because of these obstacles."

Richter is president of the Vermont Health Care for All campaign, which for almost a decade has pushed for what a state consultant proposed last week: a single-payer system to provide medical coverage to all residents.

Richter wasn't sure if her peers would respond when the Legislature — welcoming public comment through Feb. 3 — invited them to speak Thursday from noon to 2 p.m. at the Statehouse. So far 50 colleagues have confirmed they'll be there.

"These are busy doctors," she says, "but they're willing to talk."

NOTHING BUT BILLING

Take Dr. Adam Sorscher, an 18-year primary care physician who juggles work at Central Vermont Medical Center in Berlin, Dartmouth-Hitchcock Medical Center in Lebanon, N.H., (the New Hampshire hospital is Vermont's second-largest health care provider) and the Good Neighbor Health Clinic in White River Junction. He finds problems wherever he goes.

"I see people at the clinic who have neglected preven-

tive care because of the high cost," Sorscher says, "and then we have to provide therapies that are more expensive and wouldn't have been necessary if the health care system was better organized."

Or consider Dr. William Eichner, an eye specialist who opened his Middlebury practice in 1976 and has added branches in Rutland and Ticonderoga, N.Y. To do so, he has increased his staff to 20 — three of whom focus solely on financial paperwork.

"They don't greet patients, they don't handle charts," the ophthalmologist says. "They do nothing but handle billing and insurance claims."

That frustrates more and more doctors. Richter points to a 2006 survey she sent to Vermont's 840 primary care physicians. Of the 300 who responded, four out of five agreed with such statements as "Unnecessary paperwork increasingly is taking away more of my time from my patients" and "I don't find the intrusion from outside managers and companies helpful."

Providers say the resulting costs are pricing out more and more patients.

"I feel ashamed we're the last developed country in the world not to have universal health care," Eichner says. "I feel a moral imperative that everyone has access and that it be affordable."

'HAVE TO KOWTOW'

Burlington's Dr. Peggy Carey recalls when, lacking health insurance in her 20s, she was diagnosed with diabetes. Inspired by a nutrition course she took to deal with her diagnosis, she went to medical school and now works as a family doctor in a group practice.

"I wanted to change the system," says the former English teacher turned 19-year physician.

Carey belongs to the doctor-led Vermont for Single Payer campaign and Physicians for a National Health Program. But she fights her biggest battles inside her practice.

"The majority of the paperwork that comes to me is not in reference to patient care," she says, "but to what insurance plans allow or don't allow."

The problem isn't limited to physical health. Psychiatrist Dr. Alice Silverman moved to St. Johnsbury two decades ago because the state's rural Northeast Kingdom lacked enough mental health workers. Today she's president of the Vermont Psychiatric Association — yet remains one of her region's few resources.

"I've had a waiting list for years," she says, "and there's no one else I can refer to."

Even so, insurance hurdles keep more people out of Silverman's office.

"I may have someone who's suicidal, but insurers say they have to see a provider in network, even when there is no one in network," she says. "In psychiatry, people feel embarrassed enough — to have to call and get approval is a real obstacle. I spend 30 percent of my time trying to get care authorized."

Burlington's Dr. Joe Lasek, another psychiatrist, can relate. He works at the Howard Center, a private, nonprofit human service agency that takes care of his billing paperwork. But he still must tackle other insurance issues.

"If I try to get diagnostic tests or follow-up treatment for my patients, insurance companies can say no," he says. "I have sick and sometimes suicidal patients who aren't getting care."

Such problems are keeping other professionals out of the business. Lasek's wife has a medical degree.

"One of the main reasons she's not practicing is these hassles," her husband says. "I have other friends who are pulling back their hours or retraining in another field."

Berlin's Dr. Stuart Williams says a growing number of his colleagues support change. The 30-year practitioner is on the board of the Vermont Academy of Family Physicians, which found that a majority of members surveyed favor a single-payer system.

"It seems that physicians have capitulated responsibility to insurers," Williams says. "We've become second tier when we recommend a procedure to a patient and have to kowtow to prior approval and paperwork to put that care in place."

DIFFERENT ANSWERS

Doctors may agree on the problem, but they aren't united on the solution. While the Vermont Psychiatric Association has endorsed a single-payer plan, Williams — a member of the council of the Vermont Medical Society — says other medical specialists haven't voiced a formal position.

Single-payer supporters believe state involvement will eliminate private insurers' profit motives for questioning care. But they know that skeptics fear government interference.

"People worry that outsiders would be making decisions," Sorscher says, "but important decisions already are being made by corporate entities."

Proponents also point to the federal Medicare health insurance program, which, even with its own funding problems, estimates its overhead to be about 3 percent — a tenth of that of private insurers.

"It works for everyone over 65," Eichner says. "Why not make it universal?"

Back in Middlebury, Mayer says physicians of all political opinions may complain about paperwork, but ultimately they're most concerned about patients.

"If we as a nation take as a basic premise that health care should be a universal right of all citizens, equally, like Medicare, we will figure out an equitable way to pay for that," he says. "My decision-making is impacted when I have to think about a person's personal economics and how much some treatment will cost them. It's just not fair for those financial considerations to get between me and the care my pediatric patients deserve."

THE BARRE MONTPELIER TIMES ARGUS

MARCH 27, 2011

Medical students rally for single-payer system in Vermont

More than 200 medical students, other health-professional students, physicians, nurses and health reform advocates rallied at the Vermont Statehouse in Montpelier on March 26 in support of a single-payer health care system.

By Daniel Staples, Staff Writer

MONTPELIER, Vt. — U.S. Sen. Bernie Sanders and Gov. Peter Shumlin spoke before health profession students who gathered Saturday at the Statehouse in support of single-payer health care.

The Vermont House passed a version of the universal health care bill, which is being championed by Shumlin, with a party-line vote of 92-49 Thursday.

The bill, which will be debated in the Senate, is a critical step toward the creation of a publicly financed medical system that would deliver benefits to every resident of the state.

The students, who came from New England, New York and Pennsylvania, and as far away as Oregon, expressed concerns over the mire of paperwork and bureaucracy that they say would hamper them from practicing medicine in the way they are being trained to.

"I want my future patients to have a comprehensive health care insurance," said Larry Bodden, a medical student at the University of Vermont.

"Whether or not the single-payer health care reforms are passed could have an effect on where I decide to practice," Bodden said.

Bodden said he believes having a single-payer system could draw top medical professionals to the state to practice.

Bodden and 38 other medical students at the school have written and signed a letter that lays out what they would like to see in a single-payer health care system that included attracting high-quality health care professionals to the state. The letter, Bodden said, is the students' way to influence the passing of single-payer health care reforms.

"Our goal is to have a single-payer system that is balanced and sustainable," Bodden said.

UVM Medical School student Calvin Kegan said he came out for the event because he thinks that, "as Vermont is courageously undertaking the path to universal health care that is more sustainable as a whole, it is important for future health care professionals to express their support for legislation that could affect them throughout their entire practices."

Kegan said that he believes the current system is frustrating for physicians as the paperwork and bureaucracy can be cumbersome.

A copy of the letter was presented to Sanders, who said that he would submit it to be included in the congressional record.

"It's inspiring," said Sanders. "It's one thing for Vermonters to get behind this cause, but when you see physicians and young people from all over leading the way for health care reform, you begin to see that they are saying that they can't provide the care they want to with the system we have in place now."

Sanders said that politicians and lobbyists, including those for drug and insurance companies in Washington, are watching the progress of the Vermont health-care bill very closely.

"If we win here, they know it will spread," Sanders said.

In his address to the crowd, Sanders said that under the current system patients often wait too long to seek care, and when they finally do, they are much sicker, which leads to more hospitalizations and emergency room visits.

Sanders said that with a new system, patients will be able to seek care before their conditions reach such desperate stages.

Shumlin touted his belief that Vermont can lead the way for health care reform for the nation.

The Impact of **Single-Payer** Health Care on Physician Income in Canada, 1850–2005

| Jacalyn Duffin, MD, PhD

This study traces the average net income of Canadian physicians over 150 years to determine the impact of medicare. It also compares medical income in Canada to that in the United States. Sources include academic studies, government reports, Census data, taxation statistics, and surveys. The results show that Canadian doctors enjoyed a windfall in earnings during the early years of medicare and that, after a period of adjustment, medicare enhanced physician income. Except during the windfall boom, Canadian physicians have earned less than their American counterparts. Until at least 2005, however, the medical profession was the top-earning trade in Canada relative to all other professions. (*Am J Public Health.* 2011;101:1198–1208. doi:10.2105/AJPH.2010.300093)

AS THE UNITED STATES STRUGGLES WITH HEALTH REFORM, Canadians observe with a mix of fascination and horror as the lies about their health care system swirl in the US media. The discussion was particularly intense in the months leading up to passage of the Patient Protection and Affordable Care Act on March 23, 2010.[1,2] Many of these myths have been exposed. Canadians do have free choice and good access; public administration does not add to cost, rigidity, or complexity of services, nor does it exclude private-sector involvement.[3] The majority of Canadians who receive health care in the United States did not seek it deliberately; rather, they fell ill while traveling. Furthermore, their out-of-country costs are covered by the Canadian system.[4] Nevertheless, the supposed faults and flaws of the Canadian system are used in US political arguments about the merits and demerits of a single-payer system.

Among the persistent myths is one about physician income and freedoms. Increasingly, US doctors are committed to the concept of coverage for all citizens.[5] But some are concerned about what might be at stake for them personally. Others who oppose the changes worry about their incomes and their freedom as professionals should the president succeed with "Canadian-style," "government-run," single-payer health care. In speaking to the media immediately after President Obama's speech to the Joint Session of Congress in September 2009, physician–Congressman Charles Boustany of Louisiana characterized the proposals as having the potential to destroy jobs, explode the deficit, ration care, and take away "the freedom American families cherish."[6] Even proponents of health care reform think that medical income will decline.[7] Indeed, evidence for better Canadian health care delivery to marginalized groups has been related to the lower fees commanded by physician services in that country. This argument relies on the idea that lower fees mean that relatively fewer tax dollars go to medical practitioners and more to services for health promotion and disease prevention.[8] But fees are only tangentially indicative

of earnings. For instance, Canadian physicians have lower practice expenses for a variety of reasons, including the lesser costs of billing, administration, and malpractice coverage. For both policymakers and historians, reliable information on physician net income (after expenses, before taxes) in both Canada and the United States is difficult to find. Impressionistic evidence documents disparities in earnings that typify both nations—disparities between family doctors and specialists, women and men, rural and urban practices. But it is generally acknowledged that "detailed and accurate comparative physician income studies are lacking."[9]

This article addresses that information gap by tracing the long view of the average Canadian physician's net income—after expenses and before taxes—in three distinct periods: before, during, and after the advent of Canadian medicare. Sources include the Canada Census, government statistics, academic surveys, and special reports that were prepared during the advent of the current Canadian system. It will show that Canadian physicians are well paid and that medicare did not diminish their earnings. Rather medicare resulted in an initial, brief windfall of high earnings, even when compared with US data. The windfall was followed by a period of readjustment. Subsequently, Canadian medicare has maintained physicians as the top-earning professional group in that country.

A CAPSULE HISTORY OF MEDICARE IN CANADA

Taxpayer-funded medicare in Canada did not appear at a single point in time: it emerged over a quarter century from 1962, when physician services were covered across Saskatchewan, to 1987, when the demise of optional "full billing" in Ontario began. It continues to evolve in addressing new technologies and changing needs. More information about this history, with images, timelines, and links to reports and legislation can be found at the government Web site for Health Canada, the CBC Digital Archives, and the new Online Exhibition of the Canadian Museum of Civilization.[10]

Saskatchewan Came First, 1944–1962

Canadian medicare did not begin on a fixed date; nor was it a project of a single political party.[11] The first experiment began in a single province with the Saskatchewan election of June 1944. As the Second World War dragged on, many jurisdictions in Canada had begun planning for social programs to avoid another postwar economic depression. The leader of Saskatchewan's left-leaning Cooperative Commonwealth Federation party was Tommy C. Douglas, a Baptist preacher and a gifted orator. In his youth, Douglas suffered from severe osteomyelitis; the gratis services of a kind surgeon led to his recovery. Douglas said that "no boy should have to depend either for his leg or his life upon the ability of his parents to raise enough money to bring a first-class surgeon to his bedside."[12]

In 1944, Douglas and his team campaigned on a platform that promised free access to health care for all citizens. Their sweeping electoral victory made Douglas premier of what was frequently called "the first socialist government in North America." He immediately ordered a survey on health care needs, and he invited Henry E. Sigerist, the eminent, Swiss-born physician and historian of medicine from Johns Hopkins University, to chair the health care reform. Sigerist's survey found that Saskatchewan needed exactly what Douglas had promised: government-funded hospital, medical, nursing, and physiotherapy care; physicians on salary; more clinical facilities; and a medical school.[13]

Hospital coverage was implemented throughout the province in 1947. A pilot project for medical care was launched in the town of Swift Current, and lengthy negotiations began with the provincial medical profession. Immensely popular, Douglas went on to win four straight elections. Eventually his team made concessions to the wary physicians, the most significant of which was fee-for-service payment for medical services rather than the proposed salary. Legislation for province-wide medical coverage was finally passed in 1962. A bitter, three-week doctors' strike followed this new law, but the doctors lost.[14] Within a year and despite their initial opposition, Saskatchewan doctors were earning more than they had in the past. One reason was that all their bills were paid and paid in full.

The Rest of Canada Came Next

While Douglas worked toward medical coverage in the 1940s and 1950s, public hospital insurance was becoming the norm in many other provinces. In 1950, 50% of Canadians had some form of private or nonprofit insurance for hospital care. A mere six years later, 99% of the population in all 10 provinces enjoyed government plans for hospital care. The following year, federal legislation, called the Hospital Insurance and Diagnostic Services Act (1957),[15] promised

that half the costs of hospital care would be covered by the federal government. Since that time, transfers of funding from the federal government to the provinces, where the programs are administered, has provided more (or less) national leverage in health care policy.

In 1961, a national Royal Commission on Health Care Services was ordered by the Canadian Prime Minister, John Diefenbaker, the Conservative leader from Saskatchewan. The mandate was to survey all health-service needs, not only hospital care ones. It was chaired by Diefenbaker's law school classmate, the Saskatchewan judge, Emmett Hall. The Commission toured the country and met with more than 400 different groups to gather information. Hall's 1964 report recommended universal medicare for the entire country and adequate remuneration for doctors.[16] An old-school Tory, Hall expected citizens to accept certain responsibilities for maintaining their health and to tolerate taxation for such a worthy cause; in exchange, the state should provide education for health professionals, as well as free doctoring and hospital coverage for its citizens. Hall was confident that the physicians and the elected officials could negotiate fees without costly third parties.[16]

In 1966, the Canadian Medical Care Act[17] was introduced by the Liberal government of Lester Pearson and was passed almost unanimously by parliament. But health care is a provincial matter, and this legislation was federal. Once again, large transfer payments were the carrot incentive to induce provincial buy-in. Physicians were suspicious of the cumbersome system, and implementation took place slowly in the various provinces. By 1972, all 10 provinces had enacted plans for both hospital and medical services. Revisions to the plans were made in 1977, and Hall conducted another national review in 1980.

The 1984 Canada Health Act[18] clarified general principles and specified terms of federal transfers. Physicians were paid—sometimes wholly, sometimes in part—from the public purse depending on their location. In Ontario for example, the province would cover 80% of the negotiated fee, and physicians were entitled to bill patients privately for the remaining 20%. Three years later, to remain eligible for the federal transfer payments, Ontario required elimination of "full billing," which the media had successfully labeled "extra billing." Only a minority of physicians used this symbolic remnant of discretionary fees, but most of the province's doctors went on strike over the issue. Again, the doctors lost, and some scholars suggest that public reaction to this strike cost the profession credibility and respect.[19]

In times of economic stress during the 1990s, federal transfer payments dwindled. Wealthier provinces, such as Alberta, took this change as a cue to allow more private services.[20] Nevertheless, most jurisdictions had already implemented the medicare plans.

Medicare in the Recent Past

Canadians may complain about wait times, but health care is the country's most popular social program. Every major political party was involved in its implementation, and a publicly funded health care provision continues to be endorsed by every political party in every province. Proposing to abolish, or even alter it, is a form of political suicide. Recent reviews recommend changes within the system, rather than dismantling it.[21]

Notwithstanding the enthusiasm of their patients, Canadian doctors have not been universally vocal in their support of medicare; some continue to believe that their incomes would be higher with private practice. Many physicians claim that larger slices of the health care pie go to hospitals or to purchasing drugs rather than to medical services. In 2005, a successful Supreme Court challenge, launched by orthopedic surgeon Jacques Chaoulli and his patient, threatened the status quo by asserting that patient rights were infringed by wait times.[22] The Canadian Medical Association (CMA) endorses medicare in principle; however, recent CMA presidents, Brian Day (2007–2008) and Robert Ouellet (2008–2009), both advocated more private practice. In 2006, Canadian Doctors for Medicare emerged in response to these trends and now boasts nearly 2000 members.

One issue that gets lost in these cross-currents is that the actual amounts of physician net earnings are unknown to the general public. Since the 1990s, information on gross earnings (or billings) and on numbers of physicians is accessible from several sources, including the Canadian Institute for Health Information and annual provincial reports, such as British Columbia's "Blue Book."[23] But these reports do not provide the expenses of practice, often between 40% and 60% of gross income; nor do they detail allowable deductions. As a result, they inflate indications of individual doctors' earnings and may also minimize benefits.

CANADIAN MEDICAL INCOME

For this article on the history of physician income, the three periods under study were (1) before medicare, up to 1962; (2) during the advent of medicare, roughly 1962 to 1987; and (3) following the nationwide implementation of medicare, from 1987 forward.

Before Medicare

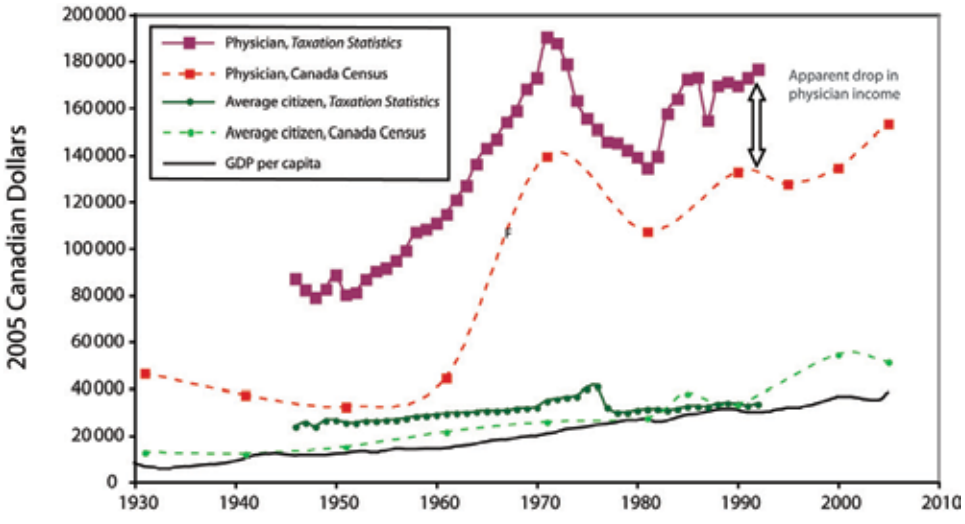
No official reports track Canadian medical income before 1900, but examples from surviving account books offer information about individual practitioners.[24] By contrast, reliable statistics on wages of ordinary citizens are available. For example, from 1850 until 1880, the average wage of a laborer was roughly $300 a year with a range of $167 to about $400 (Canadian dollars of the time).[25] Compared with ordinary workers, 19th-century doctors appear to have been well off (Figure A, available as a supplement to the online version of this article at http://www.ajph.org). Nevertheless, their assets were smaller than those of lawyers, and true wealth came from sources other than clinical practice. Studies of medical income in 19th-century United States suggest a similarly wide range and diversity in earnings.[26]

Between 1900 and 1930, most Canadian doctors enjoyed a "comfortable but not affluent income" that rose from Can$2000 to Can$6600.[27] According to the Canada Census between 1931 and 1961, physicians admitted to generous incomes rising from Can$3095 to Can$6575 and ranging between two and three times national averages.[28] During this period, top earners were lawyers in 1931 and 1941; doctors in 1951; and chemical engineers in 1961. The Census relies on self-reporting. Compared with government taxation sources, it seems that doctors (and others) underestimated their earnings by 15% to 60%. Consequently, the ratio of medical income to that of average earners is probably a more reliable indicator than the actual amounts. Before medicare, according to the Census, medical income was above average, but it was declining from three and a half to two times that of all Canadians by 1961 (Figure 1).

The Advent of Medical Care, 1962–1987

The best source on net medical income through this period is the annual *Taxation Statistics* of the federal Department of Revenue, the so-called "green books."[29] The amounts were taken from income tax returns. They were always greater than those reported in the Census for the professions and for average earners. From 1946, physician income was specified in *Taxation Statistics* under "professions," with law, dentistry, engineering, and architecture. Figure 1 shows that, according to taxation data, medical earnings rose steadily through the advent of medicare.

More information on doctors' earnings was made available during the Hall Commission survey. The federal Department of Health and Welfare reported physician income in a special "Health Care Series" with yellow covers.[30] These reports collected data back to 1957 and then tracked rising public expenditure on physician services that marked the shift from private to public payment forward to 1972. Attention was



Note. Conversion to 2005 dollars through historical Consumer Price Index, 1914–2006, Statistics Canada, CANSIM Table 326-0002, http://www5.statcan.gc.ca/cansim/pick-choisir?lang=eng&searchTypeByValue=1&id=3260002 (accessed August 28, 2009). Gross domestic product per capita, reference 56.
Source. Canada Census, 1931–2006, *Taxation Statistics* (Ottawa, Ontario: Revenue Canada, 1948–1995).

FIGURE 1—Net income of Canadian physicians and average citizens from two sources (Canada Census and *Taxation Statistics*), with gross domestic product (GDP) per capita, 1930–2005.

given to gender, location, and specialty, and comparisons were made with other professionals and ordinary workers. These "green" and "yellow" books show that medicare enhanced physician earnings at the outset—for example, Saskatchewan doctors saw an abrupt rise in income in the year following their 1962 strike, when the new medicare system ensured that all their bills were paid in full.

Three contradictory reasons were said to have prompted publication of the "yellow books." First, the reports would allay medical fears and ensure that the profession was not being shortchanged. Second, the books demonstrated the greater income from group practice, a method promoted by Hall. Third, physicians suspected that the government chose to publish the books in order to manipulate public opinion by featuring their wealth.

The media loved the "yellow books" and "green books," but doctors resented them. D.A. Geekie, communications director of the CMA, opined that they were "malicious," seeking to "compare sheeps to goats if not alligators"; the "only reason for publishing such data," he wrote, "is to exaggerate the gap between the average Canadian and the high earning physicians."[31] They were "inaccurate," "inappropriate," and morally "wrong."[32]

To express these concerns in 1972, the *Canadian Medical Association Journal* constructed a medical metaphor. "Every fall," it complained, "there is a short epidemic of newspaper articles . . . about physicians' earnings. . . . The causative organism . . . [is] the publication of two separate but related government reports": the "green books" and "yellow books." "We receive a number of missiles asking why we don't put a stop to such reporting or provide an explanation to put the profession in a more favourable light."[33]

The following year, medical frustration and suspicion prompted Geekie to construct an imaginary interview with the hypothetical "Dr Joe Average Canuck" and his wife, Ethel, who earns "no income but spends well . . . almost lavishly." "([N]o male chauvinism intended for the 12% of the profession that is female)," wrote Geekie, but Joe "is a pretty nice guy. He works hard, is conscientious, and serves good Scotch." Yet, Joe laments, "'I am not nearly as well off as most people believe.'" The fictitious interviewer "suggested there had to be a limit to what Canada could pay physicians." Then the phone rang, and Doc Canuck rushed off to an emergency, although he was not on call.[34]

Sympathy for the doctors' plight can be found in the graph of percentage change in net earnings through this same period (Figure B, available as a supplement to the online version of this article at http://www.ajph.org). With periodic controls set on their fees and no protection from inflation of expenses, a yo-yo effect of chaotic swings for the percentage of change of physician earnings contrasts starkly with the slow steady rise for average Canadians exemplified by employees and laborers. The supposedly reassuring numbers were alarming. Physician resentment over the "yellow books" ended with the books' demise in 1973. This quiet execution coincided with the first year since 1957 that the percentage of change of medical income actually fell below that of average Canadians. For once, the government may also have found the report embarrassing.

Notwithstanding the marked drop in the percentage of change of earnings for 1972, medical income had peaked at an all-time high in the preceding year (Figure 1). Henceforth, analysts would refer to this rise as the "windfall" of early medicare, which ended after the 1971–1972 peak year.[35] In his annual rant of 1975, Geekie described a dramatic reversal in "pecking order of the various professional groups," referring to yet another decline in the percentage of change of medical earnings, although actual income amounts continued to rise.[36] This "period of adjustment" set the stage for a future climate of mistrust.[37]

The 1970s was a decade of tension. Physicians continued to be the top earners, but their net incomes rose at a rate that was less than in the recent past, less than inflation, and less than those of other professions.[38] The result was a steady decline in medical income relative to average earners over a decade until about 1981, although earnings never dipped as low as they had been before medicare (Figure 1). To control costs, some policy analysts recommended closing immigration to foreign graduates and ending the fee-for-service system in favor of salaries.[39] Many anxious reports and editorials appeared; doctors threatened to move to the United States. Medicare was said to have taken a toll on physician morale, professional satisfaction, and financial status.[40] Some surveys aired in American media to emphasize the "dissatisfaction," "bitterness," and thoughts of leaving among Canadian doctors victimized by government interference.[41]

By 1980, an economist recommended what Hall had opposed: that fee schedules be reviewed regularly by a third party.[42] This plan was never implemented. Fees are still negotiated by professional associations and governments without third-party mediators.

Notwithstanding the temporarily reduced rate of change in their earnings, physicians constituted the top-earning profession in Canada every year from 1958 forward and into the present. Their average net income increased at a rate that consistently outstripped that of all citizens: 1200% versus 676% over 4 decades. The ratio of physician income to that of all Canadians was higher than before medicare, ranging between three and five-and-a-half times with an overall upward trend. Sometimes the percentage of increase was less than that of other professions, but actual earnings remained greater. The gap between physicians and the next-highest income group peaked in the early 1970s "windfall" moment, readjusted in the mid-1970s, and then steadily widened again in favor of physicians. The relative drop during the decade of 1971 to 1981 exemplifies the profession–government tension in that time of anti-inflation measures and fixed fees—tensions that pervaded the media and the popular, uncontrolled surveys cited previously.

The "green book" figures were slightly higher than were those in the "yellow books" because *Taxation Statistics* included income sources other than practice, such as securities and real estate; in some years, salaried doctors were excluded. Doctors argued that the "green books" gave a falsely high impression of their earnings and blurred distinctions between general practitioners versus specialists, rural versus urban, male versus female, and

salaried versus private. After 1992, *Taxation Statistics* information on medical earnings dried up, owing to revisions in income tax law that relieved taxpayers of the obligation to specify their occupations.

Late 1980s to 2005

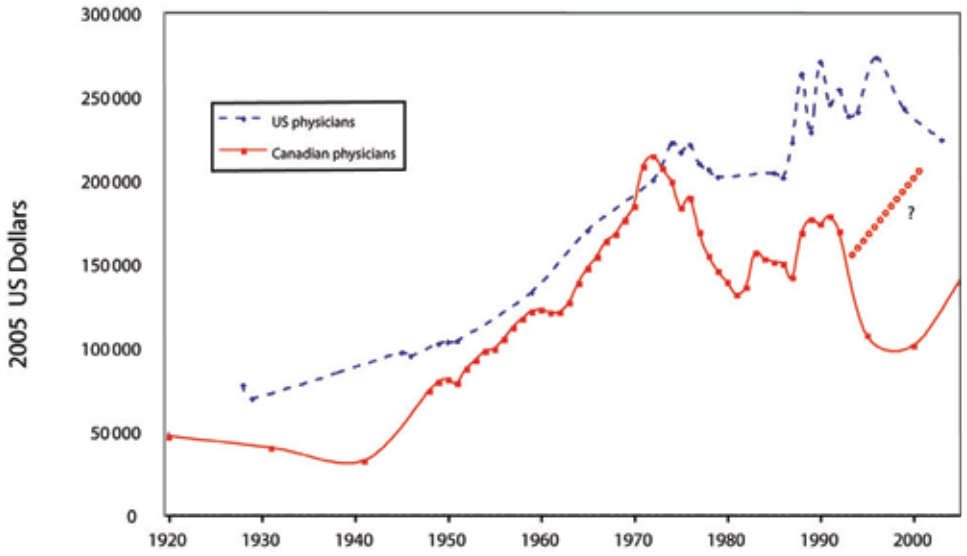
For the most recent decades, the best source on net medical income remains the Canada Census.[43] Once again, the data are self-reported and probably underestimated. Turning from the more reliable *Taxation Statistics* to sole reliance on the Census source generates an apparent, abrupt drop in medical income between 1992 and 1995 (Figure 1). According to the Census, however, the trend in income continued upward with no drop, seemingly at the same rate as before 1992. Therefore, the "drop" between 1992 and 1995 may be an artifact of the Census source and the underreporting that characterizes it for all citizens.

From 1992 to 1995, the *Medical Post* reinstigated its satisfaction surveys, and the CMA conducted a similar study in 1997.[44] But these polls provided no details on income because such questions were not asked.

COMPARISON WITH US PHYSICIANS

Finding reliable historical information about medical earnings in the United States is even more difficult than it is for Canada. Like their northern colleagues, US physicians have not been forthcoming about their earnings, except when it comes to protesting inflated estimates. As early as 1897, an American doctor suggested that rich doctors were charlatans.[45] In 1911, a remark that medics earned "princely sums" drew a sharp rebuke.[46] In 1989, a physician wondered about the uncaring message of ostentation sent by the luxury cars belonging to his colleagues.[47] Most articles on physician earnings in the American peer-reviewed literature address concerns about income of particular medical groups identified by specialty, location, or other characteristics, such as radiologists, neurologists, surgeons, women, and academics.

Without a single-payer system, Americans must rely on volunteer surveys conducted by the profession, scholars, government, or the media. But surveys are vulnerable to the criticisms of definition, response rate, honesty, and variable motivation: those with perceived complaints respond more reliably. And, just as in Canada, disparities emerge involving gender, race, location, and specialty, and between reported versus actual income.



Source. For Canadian physician income, see Canada Census, 1931–2006 and *Taxation Statistics* (Ottawa, Ontario: Revenue Canada, 1948–1995).[24,28] For US physician income, see references 48-54.

[a]Extrapolation of Canadian physician income based on *Taxation Statistics*.

FIGURE 2—Physician income in Canada and the United States, 1920–2005.

American sources for this research included a survey on physician income undertaken by the Committee of Costs on Medical Care just before the stock market crash of 1929,[48] a government study from 1945 to 1966,[49] and sporadic surveys conducted by academics,[50] by the journal *Medical Economics* from 1948 to 2003,[51] and by the American Medical Association in 1928,[52] 1949 to 1950,[53] and from 1988 to 2003[54] (Figure C, available as a supplement to the online version of the article at http://www.ajph.org). Median incomes, if given, were lower than average incomes, but not all surveys provided both figures.

The data points shown in the supplemental figure were consolidated. If two different incomes were reported when these surveys occasionally coincided, an average was taken. Converting Canadian medical incomes (as shown in Figure 1) to historical equivalent US dollars and converting both American and Canadian figures to 2005 US dollars allows comparison of medical earnings in the two countries across 8 decades (Figure 2).[55]

Figure 2 shows that US physicians have almost always earned more than Canadian physicians. The gap closed at the advent of medicare during the 1960s and early 1970s, when Canadian doctor income soared to equal and even exceed that of American doctors. Then the gap widened again; however, the mid-1990s disparity may be apparent, owing to the Canada Census source for the years after 1992. The latest figures suggest a renewed trend to narrow the gap with a relative decline in US physician earnings while the Canadian equivalent continues to rise.

But these differences in income may be common to all Canadian and US earners, not only physicians. The historical

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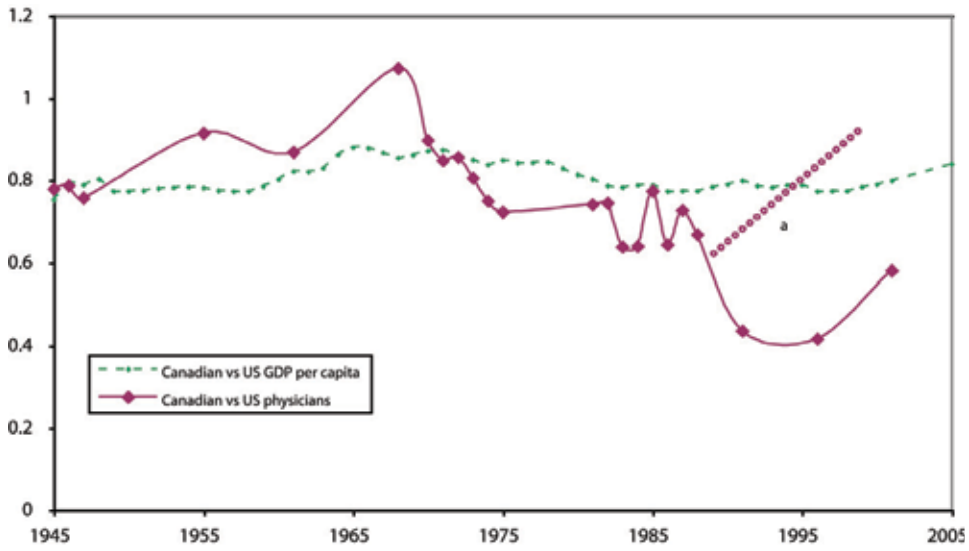
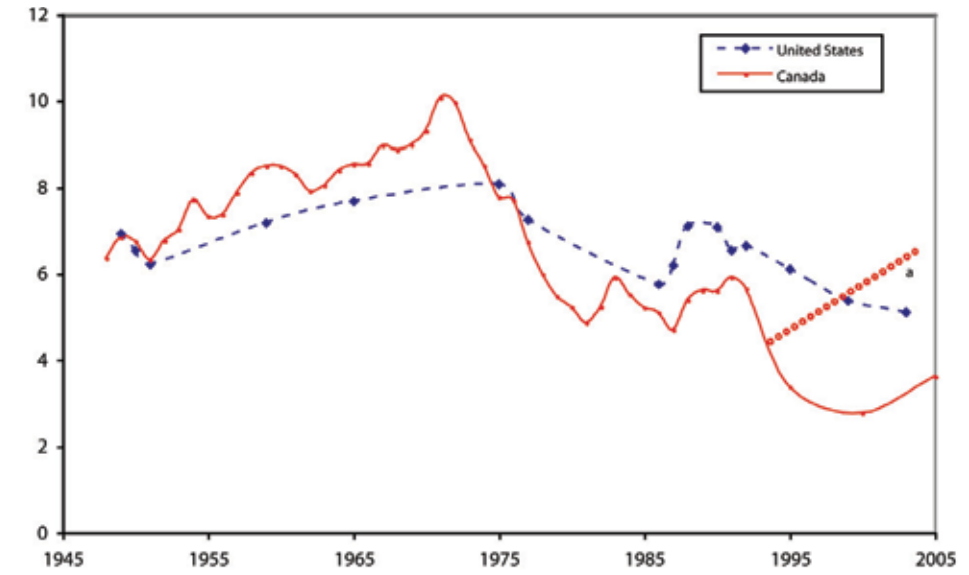


Source. For Canadian physician income, see Canada Census, 1931–2006 and *Taxation Statistics* (Ottawa, Ontario: Revenue Canada, 1948–1995).[24,28] For US physician income, see references 48-54. For gross domestic product per capita in both countries, see reference 56.
[a]Extrapolation of Canadian physician income based on *Taxation Statistics*.

FIGURE 3—Ratio of Canadian gross domestic product (GDP) per capita to US GDP per capita and ratio of Canadian physician income to US physician income, 1945–2005.



Source. For Canadian physician income, see Canada Census, 1931–2006 and *Taxation Statistics* (Ottawa, Ontario: Revenue Canada, 1948–1995).[24,28] For US physician income, see references 48-54. For gross domestic product per capita in both countries, see reference 56.
[a]Extrapolation of Canadian physician income based on *Taxation Statistics*.

FIGURE 4—Ratio of Canadian physician income to Canadian gross domestic product (GDP) per capita and ratio of US physician income to US GDP per capita, 1945–2005.

gross domestic product (GDP) per capita in each country reflects average earnings of all citizens. Canadian GDP per capita is close to the income of the average worker (Figure 1). It has never equaled that of the United States, ranging from a high of 91.4% in 1904 to a low of 60.3% in 1934 with other peaks in the late 1960s and early 1970s.[56]

Through time, the ratio of Canadian to US physician earnings, as shown in Figure 2, has ranged from 0.4 to 1.1. Figure 3 compares this ratio of physician income in the two countries to the ratio of the GDP per capita between the two countries for the same period. It appears that, in the early years of medicare—roughly 1962 to 1970—Canadian doctors fared at least as well or better than their country as a whole relative to the United States. Then, as medicare became established, Canadian physicians fared less well. Once again, however, the wider gap after the mid-1990s could be attributable to the Census source that suggests a falsely lower medical income.

However, it is perhaps more meaningful to compare physician incomes to the GDP per capita within each country—i.e., Canadian physicians to Canadian citizens, and US physicians to US citizens—something the Canadian government had been trying to do with "yellow books" of the 1960s and early 1970s (Figure 4).

Figure 4 shows that the ratio of physician earnings to the GDP per capita in their own countries has been high, ranging from roughly 3 to 10 times. Surprisingly, the greatest ratio was Canadian, not American, from roughly 1962 to 1972, when physician earnings reached 10 times the GDP per capita of that

nation during the "windfall" years of early medicare. Indeed, Canadian physicians also seem to have experienced the lowest ratios in the 1980s and mid-1990s. Since then, the Canadian ratio has been increasing, although it remains smaller than its American equivalent. But, again, Canadian values from the mid-1990s may be falsely low owing to the use of the Census source in the absence of disaggregated tax data.

Overall, Figure 4 shows that the US ratio has usually been higher than the Canadian ratio, and its range narrower, from just above five to just over eight times the GDP per capita in that country; the trend may be declining since the mid-1990s. In 2005, US doctors earned about five-and-a-half times the US GDP per capita; Canadian doctors earned about four times their country's GDP per capita. These estimates are backed by a recent international study of physician supply.[57]

SUMMARY

To summarize these results, Canadian doctors were always well paid. Before 1900, they were comfortable, but they drew on many income sources and carried large debts. The advent of medicare resulted in a temporary boom that raised expectations and provoked a funding crisis. Following the 1971–1972 peak in medical earnings, controls—on fees, wages, and prices—set the thermostat for reactions between the profession and government. Annual percentage changes in medical income were sometimes negative or less than inflation for several years. This situation fostered insecurity and a lingering physician mistrust of government. However, the years after 1981 saw a steady rise in medical income. Data for physician income after 1992 may be falsely low owing to the Census source. Changes promised to the Canada Census in 2010 imply that its accuracy could decline further in the future, and information on health and income data will be even more difficult to obtain.[58] Nevertheless, the trends revealed in this research are reliable. Over nearly 60 years, into the 21st century, physician income grew at a rate of increase that outpaced that of other Canadians. Since 1958 through the advent of medicare, until at least 1992 and probably into the present, physicians, as a professional category, were the top earners in the country.

Compared with the best figures available for US physicians, Canadian doctors have almost always earned less. However a comparison of medical earnings to the GDP per capita in each country shows that Canadian physicians earned proportionately most in the early years of medicare, peaking around 1972 when amounts equaled and briefly exceeded US medical income. Their earnings then returned to three or four times that of the GDP per capita, a level that is nonetheless greater than it had been before medicare, and that is still rising. An analogy can be found here with the apparent boom in US medical income associated with the advent of US Medicare in 1966.[59]

The observation that Canadian physicians are paid less than their American counterparts invites us to ask, what do Canadians "get" in exchange for paying their physicians less than their American counterparts? A 1990 study showed that, although per capita expenditures on health in the United States were higher than those in Canada, the actual number of services was fewer.[60] In other words, Canadian citizens were getting more and spending less. Perhaps the corollary of this observation is that Canadian doctors suffer because they work more for less. Other comparisons suggest that the high costs of American care are not owing to the admittedly higher physician fees and income, but rather to the much greater costs of administration generated by the private insurance industry.[61]

In Canada, proportionately more resources are devoted to public health and to providing free access to all citizens through a system that costs less than its American counterpart and is associated with longer lifespan and lower infant mortality. In other words, better health indicators and greater accessibility are correlated with the lower physician income.

Is it possible that high physician income could be correlated with lower health outcomes? The health indicators of Cuba, for one extreme example, are among the best in the world for a developing nation; yet, physicians in that country—the vast majority of whom are in general practice—are known to exist on derisory salaries amounting to less than US $600 a year.[62] Anthropological researchers characterize the health of the country as a "gift," provided by the collective, including its doctors.[63]

Using the gift analogy then, Canada's doctors, who often pay lip service to "advocacy," "accountability," and "teamwork," can be seen to make an investment in public health stemming from their lower earnings relative to American doctors. But we have no idea what the contribution has been costing them in recent years—if anything—because we cannot obtain the figures.

No one is proposing to cut physician incomes to the insignificant amounts of Cuba. Yet how much money do doctors really need? A few scholars have used a variety of economic theories to analyze physician income. By whatever model they chose to define the task, the amounts paid in Canada and the United States were said to be too great.[64] In other words, whether or not it correlates with lower health indicators, high medical income could be a moral problem.

OBSERVATIONS AND RECOMMENDATIONS

From this research, we observe that even when the readjustments resulting from various policy and payment alterations are taken into account, Canadian medicare did not lead to a loss in physician income. Rather, physician incomes grew more quickly than those of other Canadians and are considerably greater. In short, the medical-income argument against moving toward a Canadian-style system is feeble. The only way to revive it would be to find different and more reliable data.

Therefore, a recommendation arising from this work is to make more data on physician income available. The information for this research was not easily gathered; better figures may reside in sources currently inaccessible to the average practitioner or historian. Distinctions between specialties, race, gender, and geographic location would emerge.

This information problem raises several questions relevant to both countries. Why should medical income be secret? Are physicians embarrassed by their

wealth? Someone has to be the top earner. What is wrong with that person being a doctor instead of a hockey player? Even more puzzling—if not ironic—is the effect of Canadian legislation, such as the Ontario Public Sector Salary Disclosure Act (1996), which ensures that the actual names and actual incomes of citizens paid more than Can $100 000 from the public purse are published every year in the so-called "sunshine lists" at government Web sites and in leading newspapers.[65] This move to greater accountability makes an annual spectacle of the wages of teachers, professors, police officers, hospital administrators, and government employees—anyone paid by tax dollars. Journalists and voyeuristic citizens use the lists to scrutinize individual and collective use of resources.[66] But doctors' names do not appear in these famous lists unless they enjoy public-sector salaries, such as stipends for academic or hospital administration. Yet, they are paid by the taxpayer whether their earnings derive from salaries or from fee billings; transparency and accountability dictate that taxpayers have a right to know how all their money is spent.

Therefore, physicians should join citizens in encouraging the revival of those annual "green" and "yellow" reports, or their equivalents. Doctors might be pleasantly surprised to discover that patients believe that they are entitled to high incomes because of their many years of expensive study, heavy responsibilities, and long hours of work. In turn, citizens might have reason to take pride in remunerating hardworking physicians at a level that is decent without being obscene.

The universal, single-payer system has been good not only for Canadians but also for their doctors. At least, it has done no harm. ■

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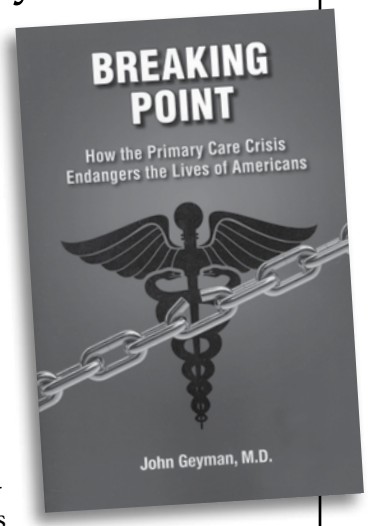

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The NEW ENGLAND JOURNAL of MEDICINE

Perspective

DECEMBER 2, 2010

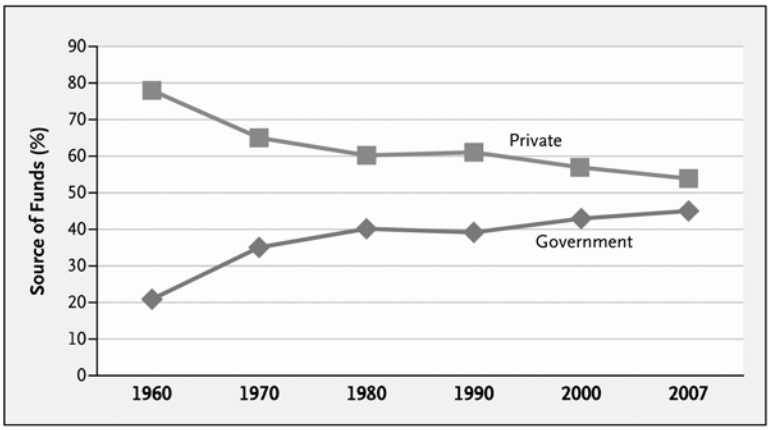
Government Payment for Health Care — Causes and Consequences

Victor R. Fuchs, Ph.D.

From modest beginnings in the late 19th century, government's role in paying for health care has expanded greatly in every high-income country. Today, most of these countries have some form of national health insurance — that is, all or virtually all of the population is eligible for health care that is paid for in full or in large part by a government-organized insurance system. The United States has long been criticized (and praised by some) for being an exception to the rule in its approach to financing health care. Even in this country, however, government's role in paying for care has increased greatly over the past 50 years (see graph). Government's share of total personal health care expenditures in the United States grew from 20% in 1960 to almost 50% in 2007 and will undoubtedly exceed the private sector's share when the programs that were enacted in the 2010 health care reform legislation become activated.

What explains the widespread role of government in paying for health care? Some U.S. critics argue that it is all a big mistake. But in 1775, Samuel Johnson contended that "uniformity of practice seldom continues long without good reason."[1] Two centuries later, George Stigler, a Nobel Prize winner in economics, wrote, "If an economic policy has been adopted by many communities, or if it is persistently pursued by a society over a long span of time, it is fruitful to assume that the real effects were known and desired."[2] If we follow Stigler's line of thought, we should observe the consequences of a policy and from them infer the cause or causes.

The most obvious, easily quantifiable difference between the United States and countries that have national health insurance is that those countries spend much less on health care, whether measured per capita or as a share of the gross domestic product. Not only is the United States the highest spender, but the gap between it and the other countries is unnaturally large — we spend 50% more than the next-highest spender and twice as much as the average country in the Organization for Economic Cooperation and Development. One explanation that is frequently offered is the role of "special interests" in the United States. There is little doubt that the suppliers of health care goods and services — manufac-



Source of Funds for Personal Health Care Expenditures in the United States, 1960–2007.

turers of drugs, devices, and equipment, as well as physicians and hospitals — prefer higher expenditures to lower ones. But isn't that true in every country? The difficult question is why the special interests have more influence over health policy in the United States than they do elsewhere. The answer probably lies in part in the structure of the U.S. political system, including the role of primary elections, long and expensive election campaigns, the separation of powers, the numerous congressional committees and subcommittees with overlapping authority, and the need for supermajorities in the Senate in order to pass meaningful legislation. But the quirks of the political system can't be the whole answer. If the U.S. public wanted a different outcome, over time they could move policy in that direction.

It should be noted that the higher expenditures in the United States do confer some benefits. There is less likelihood of having to wait for a diagnostic or therapeutic procedure or to travel far to obtain it. Also, the amenities in hospitals, clinics, and physicians' offices are usually superior to those in other countries that have a per capita income close to that of the United States. It would be of interest to determine how these benefits are distributed and how they are valued by people at different income levels.

A second large difference between health care in the United States and in countries with national health insurance is the more important role of redistribution in the latter countries. Such redistribution is evident in the greater equality of access to care and in the sharing of costs through taxes on income or payroll, value-added tax or sales tax, or other forms of taxation that are either proportional or progressive with respect to income. Of course, all insurance is redistributive after the fact. The large amount of care utilized by a small proportion of policy holders is paid from the premiums of others who use little care. The important distinction is that under a national health insurance system, the redistribution occurs before the event, since it is clear that some individuals will pay much less tax than the value of their insurance and some will pay much more.

Since redistribution plays a greater role in the health care systems of other countries than it does in the United States, there is an implication that a more egalitarian ethos holds sway in Europe, Canada, Australia, and New Zealand. From de Tocqueville to the present, many observers have commented on the stronger role of individualism in the United States than elsewhere, but there is no consensus regarding its explanation. Possible contributors to the phenomenon include the heterogeneity of the population, the revolutionary origins of the country with its dedication to "life, liberty, and the pursuit of happiness," and the absence of many centuries of a common language, history, and culture. In speculating about the possible rise of despotism in a democracy, de Tocqueville painted a grim picture of individualism taken to the extreme. He wrote, "Each . . . living apart, was a stranger to all the rest — his children and private friends constitute to him the whole of mankind; as for the rest of his fellow citizens, he is close to them, but he sees them not; he exists but in himself and for himself alone."[3]

The lower spending and the greater redistribution in countries that have national health insurance are not independent phenomena. If spending in these countries were at U.S. levels, the taxation required to accomplish their redistribution goals would probably wreck the economy. Given the social or political desire to redistribute health care resources, constraints on spending become a necessity. These constraints take various forms, such as controls over the number and specialty mix of physicians, limits on facilities

and acquisition of expensive technologies, hard bargaining over prices charged by drug companies and other suppliers, and restraints on physicians' fees and incomes, among others.

Because the governments in these countries pay for most medical care — usually 70 to 90% of total expenditures — they are in a good position to apply these cost-restraining measures. They have what economists call "monopsony power." The U.S. government, although it pays for almost 50% of health care, makes very little use of its power to restrain costs. Thus, in one sense, Americans wind up in the worst of all worlds, with government bearing a big part of the burden of paying for health care, with the concomitant large burden of taxes, but exercising very little control over the cost of care. As an indication of how absurd the situation is in the United States, government currently spends more per capita for health care than eight European countries spend from all sources on health care. Though life expectancy is far from a perfect measure of the quality of care, it is not without interest to note that life expectancy at birth in every one of these eight countries is higher than that in the United States.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From Stanford University, Stanford, CA.

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Resolution to Establish a Single Payer Task Force in AAFP

Submitted by Richard Bruno (OHSU) and Elizabeth Wiley (Georgetown), medical student members of PNHP

Passed by the AAFP Student Congress on July 30, 2011

WHEREAS, current AAFP policy calls for healthcare coverage of all Americans, and

WHEREAS, quality healthcare should be a right, regardless of income, for every child, pregnant women, their families, and ultimately all individuals, and

WHEREAS, everyone should receive care in a medical home with a primary care physician, and access to medical subspecialists, surgical specialists, mental and dental professionals, and

WHEREAS, everyone should receive all recommended and needed services, and

WHEREAS, the current number of Americans without health insurance now exceeds 52 million, including 9 million children, with the Patient Protection and Affordable Care Act estimated to leave 27 million still uninsured in 2019, and

WHEREAS, the current economic climate has resulted in more and more businesses withdrawing coverage from employees, and

WHEREAS, millions of families currently with insurance have coverage so skimpy that a major illness would lead to financial ruin, and medical illness and bills contribute to more than one-half of all bankruptcies in the US, and

WHEREAS, the healthcare infrastructure is inadequate and deteriorating (e.g., reductions in the number of emergency rooms, decreases in hospital beds, and a decline in the ability to fulfill projected physician workforce requirements), and

WHEREAS, the US spends twice as much per capita in healthcare costs compared to other western democracies, yet fails to include all its citizens and fails to achieve equivalent healthcare statistics (e.g., life expectancy, infant mortality and vaccination rate), and

WHEREAS, a single source government health insurance has been shown in other countries to reduce the vast sums of money spent on administrative costs that could more appropriately go to direct patient care, and

WHEREAS, medical malpractice premiums would decrease in a single-payer system because settlements would not have to cover future medical expenses of the plaintiff, and

WHEREAS, a single payer system would increase one's choice of doctors and portability and eliminate job lock, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians establish through its Commission on Governmental Relations a voluntary task force of physicians, residents, and students to evaluate the benefits to patients, families, and the US population in implementing a national single payer healthcare system, and that this task force make public its findings by July 2012.

This resolution will be taken up by the AAFP Scientific Assembly in Orlando in September. In addition, PNHP member Dr. Jeffrey Cain is running for president of AAFP.

The Des Moines Register

JUNE 3, 2011

It's now time for significant change in U.S. health care

By David E. Drake

As a physician I am regularly faced with patients who have inadequate or no health insurance. A person may call my office to discover that their health "insurance" does not cover mental health or they have such a high deductible they can't afford to see me. In both cases my office may refer the person to a clinic with a sliding scale, to the same place where I might refer someone who had no insurance at all.

The provision of health care in the U.S. is neither a system nor is it "insurance" of health. What we have is an increasingly broken and costly disconnected patchwork of private insurance plans that are tied to employment or retirement benefits, the latter of which have also been in jeopardy.

Once one loses their job, within a short time health coverage goes with it. Then if the person fails to meet the poverty guidelines for Medicaid, they might qualify for some coverage by Iowa Cares. Iowa Cares can work well for folks living in Polk County or Iowa City, but the many counties distant from those facilities can find persons traveling a day for a routine medical appointment.

The need for a single-payer of health care is more pressing than ever.

Recently, I was overwhelmed to learn what my own health insurance was going to cost. Having switched from providing coverage to my own family and my one employee in a group to an individual plan -- as my one employee went on Medicare -- I was astounded to learn that the "insurance" carrier had denied me coverage and had listed me as having multiple pre-existing conditions -- 90 percent of which were not accurate.

When corrected in a letter by my primary care physician, the "insurance" company accepted me but at a rate of $700 per month for my own plan and another nearly $800 for my wife and two adult kids. The total premium has come to $1,473.15.

What we need in this state and in the U.S. in a true system of health care coverage - not one plagued by hundreds of separate health plans with different deductibles, co-pays, and co-insurances.

While traveling in the United Kingdom and France recently I stopped and talked to people about their health care. And while it's true that folks will complain about the waiting time to see a specialist not one person wanted to give up their system of health care in exchange for the craziness we find in the United States. In fact several U.K. residents were astounded and disbelieving when I described to them what I face everyday in my office as patients present to me in need of care. Residents of Scotland told me they don't even carry an insurance card.

Vermont is the first state to have the support of its legislature and governor to begin proceeding to develop our nation's first universal health care system of payment. As in Canada, physicians and other health care providers, will be able to remain in private practice and will be able to bill one source for their fees. Vermont is expected to have its single-payer system in effect, using Medicare-for-all as its model, by 2017. In the meantime Blue Cross and Blue Shield, Vermont's main provider of insurance, has not fought the change but sees itself as the possible intermediary between the government and health care providers.

I currently hire a billing service to deal with the complicated challenges of billing and a half-time person in my office who mostly calls insurance companies to verify and clarify benefits. This is a great cost to any medical practice, and I would gladly have staff to only bill one source of payment for my services and to know that everyone who called my office was covered.

We all deserve competent and comprehensive health care - including mental health. Health care should not be tied to employment. I believe it is a right and not a privilege. I know the change will come. I just hope it comes sooner than later.

David E. Drake, D.O., is a physician specializing in family psychiatry. He is in private practice in Des Moines.

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Managed Competition for Medicare? Sobering Lessons from the Netherlands

Kieke G.H. Okma, Ph.D., Theodore R. Marmor, Ph.D., and Jonathan Oberlander, Ph.D.

Discussions about U.S. health care reform are often parochial, with scant attention paid to other countries' experiences. It is thus surprising that in the ongoing debate over Medicare, some U.S. commentators have turned to the Netherlands as a model of regulated competition among private insurance companies.[1] The Dutch experience is particularly relevant given the proposal by Congressman Paul Ryan (R-WI) to eliminate traditional Medicare and instead provide beneficiaries with vouchers to purchase private insurance. (The Republican majority in the House passed the Ryan plan as part of the 2012 budget resolution, but it was defeated in the Senate.)

It is easy to understand why Dutch health care — which does rely on regulated private insurance — would appeal to advocates of Medicare vouchers. Indeed, U.S. ideas about managed competition helped to shape health care reform in the Netherlands.[2] But careful examination of the Dutch experience shows that insurance competition has not produced the expected benefits and in fact has created new problems, calling into question the merits of this reform model and its suitability for Medicare.

Before 2006, the Netherlands had a mixed health insurance system, with more than 60% of the population covered by mandatory social insurance, administered by nonprofit sick funds. The remaining population had private insurance, voluntarily purchased, and the uninsured rate was about 1.5%.

In 2006, the Netherlands replaced this arrangement with a mandated private insurance system similar to Switzerland's.[3] Under this reform, all legal residents of the Netherlands are required to purchase basic insurance from private insurers. Private plans are heavily regulated. They cannot turn down applicants, regardless of health status, and must charge community-rated premiums. A risk-equalization scheme varies payment to health plans according to their enrolled populations' risk profiles. The aim is to reduce plans' incentives to select profitable patients and ensure that plans with sicker, higher-cost populations are not financially penalized. Insurance plans are expected to compete on the basis of price and quality by selectively

contracting with networks of hospitals, physicians, and other medical care providers.

In 2011, insurance premiums averaged about €1,200 ($1,749) per person, with a mandatory deductible of €170 ($248). Workers must additionally contribute earmarked payroll taxes for health insurance — 7.75% of their wages, up to a maximum of €2,590 ($3,774). General taxes also help to fund government health care expenditures, including paying all premium costs for children under the age of 18 years. A separate insurance program, requiring another 12% payroll tax, finances long-term care. Supplemental coverage for services such as dental care and physical therapy is purchased by about 90% of persons with basic insurance.

Advocates of this system argued that competition among private insurers would reduce health care spending, enhance consumer choice, and improve the quality of care and the health system's responsiveness to patients — arguments that are being repeated in the U.S. debate over Medicare. The reality of managed competition in the Netherlands, however, has not matched the rhetoric.[3]

Four key points emerge from the Dutch experience. First, competition has not sharply slowed the rate of growth in health care spending. Health care expenditures continue to outpace general inflation, having increased at an average annual rate of 5% since 2006. At the same time, the total costs of health insurance for Dutch families, including premiums and deductibles, increased by 41%. According to Statistics Netherlands, in 2010 the country spent 14.8% of its gross domestic product on health care and welfare (including long-term care and other social services).

Reforms aimed at increasing and managing competition also produced high administrative costs and complexity. Administering premium subsidies for low-income people has proven expensive. More than 40% of Dutch families now receive such subsidies — and the national tax department hired more than 600 extra staff members to check incomes each month and calculate the value of the vouchers.

Second, some Dutch people remain uninsured, and there has been a substantial increase in the number of insured persons failing to pay their insurance premiums. The number of uninsured people has decreased since 2006, from about 240,000 to 150,000. But a growing number of "defaulters" — 319,000 in 2010 — haven't paid their insurance premiums for more than 6 months. Insurers can legally terminate their coverage. The increase in defaulters (who, together with the uninsured, account for about 3% of the population) has embarrassed the Dutch government. Policymakers have responded by pressuring insurers not to drop them and by covering missing payments with public funds. A 2011 law gives the government the authority to garnish delinquent workers' wages to pay for insurance premiums (they are also subject to a premium fine).

Third, the expansion of consumer choice has not worked as envisioned. In 2006, about 18% of Dutch people switched insurance plans. But the following year less than 5% switched, and 80% of them did so as a result of changes made by their employers rather than individual decisions. Since 2007, only about 4% of the Dutch population, on average, has changed plans each year. Moreover, accelerating consolidation of the health insurance market has restricted meaningful choice of insurance plan. Currently, four insurance conglomerates control about 90% of the Dutch health insurance market. Recent polls suggest public dissatisfaction with private insurers, with 65% of insured people reporting that they have low or very low levels of trust in private plans.

Fourth, notwithstanding the rhetoric of competition, the Netherlands still relies heavily on regulation. Indeed, the Dutch case shows that competitive systems that seek to escape supposedly centralized, bureaucratic control of medical care paradoxically require sophisticated regulation and government intervention in order to work. The government has not abandoned its traditional tools, including global budgets and constraints on prices and patient cost sharing. It sets fees for independent specialists and general practitioners and controls prices for most hospital services.[4] In 2010, for example, payments to specialists were reduced in response to budget overruns.

The Dutch Ministry of Health regularly engages in talks with the health insurance industry when there are complaints about rising premiums or copayments. Insurers must offer comprehensive coverage, and direct payments by patients amount to less than 10% of total medical care costs, among the lowest percentages in industrialized countries. The comprehensiveness of health insurance in the Netherlands provides a critical contrast to the Ryan Medicare

plan, which would erode the U.S. government's contribution to the point that 65-year-old beneficiaries would pay about two thirds of medical costs themselves.

The myth that competition has been key to cost containment in the Netherlands has obscured a crucial reality. Health care systems in Europe, Canada, Japan, and beyond, all of which spend much less than the United States on medical services, rely on regulation of prices, coordinated payment, budgets, and in some cases limits on selected expensive medical technologies, to contain health care spending.[5] Systemwide regulation of spending, rather than competition among insurers, is the key to controlling health care costs. The Netherlands, after all, spent much less on medical care than the United States with virtually universal insurance coverage long before it began experimenting with managed competition in 2006.

The Dutch experience provides a cautionary tale about the place of private insurance competition in health care reform. The Dutch reforms have fallen far short of expectations — a reminder that policy intentions should not be confused with outcomes and that managed competition is hardly a panacea. The idea that the Dutch reforms provide a successful model for U.S. Medicare to emulate is bizarre. The Dutch case in fact underscores the pitfalls of the casual use (and misuse) of international experience in U.S. health care reform debates.[5] Before we learn *from* other countries' experiences with medical care, we first need to learn *about* them.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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KHN KAISER HEALTH NEWS
The Washington Post
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Managed Care Enters The Exam Room As Insurers Buy Doctor Groups

By CHRISTOPHER WEAVER
KHN Staff Writer

Even if UnitedHealth Group isn't your insurance company, there's a good chance it touches you in some way. The $100 billion behemoth sells technology to hospitals and other insurers, distributes drugs, manages clinical trials and offers continuing medical education, among other things, through the growing web of firms it owns.

Now, that touch could get a lot more personal. United's health services wing is quietly taking control of doctors who treat patients covered by United plans in several areas of the country -- buying medical groups and launching physician management companies, for example.

It's the latest sign that the barrier between companies that provide health coverage and those that actually provide care to patients is crumbling.

Other large insurers, including Humana and WellPoint, have announced deals involving doctors in recent months, part of a strategy to curb rising health costs that could cut into profits and to weather new challenges to their business arising from the federal health law. But United is the biggest insurer by revenue, making the trend much more significant.

Many patients insured by these companies are going to see much tighter management of their care.

"Health care costs are still going to rise," said Wayne DeVeydt, chief financial officer of WellPoint, which entered the business of running clinics in June with the announcement that it would acquire CareMore, a health plan operator based near Los Angeles that owns 26 clinics. "But the only way to stem those costs in the long term is to manage care on the front end."

That means enlisting doctors. Their orders drive most health care spending, including the wasteful share: treating heart patients with expensive stents when cheaper drugs might work, or overusing high-tech imaging devices, for example. By managing doctors directly, insurers believe they can reshape the practice of medicine - and protect their profits.

For instance, CIGNA, another large insurer, saves 9 percent on patients treated by doctors in a Phoenix medical group it controls, said Stephanie Gorman, president of CIGNA Arizona. CIGNA has expanded the group over the last 18 months in response to the health law, and it now serves patients at 32 locations.

"The doctors, at the end of the day, control the patients and currently they're financially incentivized to do more tests, more procedures," said Chris Rigg, a Wall Street analyst for Susquehanna Financial Group. "But, if they're employed by a managed care company, they're financially incentivized" to do less.

That thought unnerves consumer advocate Anthony Wright of Health Access in Sacramento, Calif., who worries profit pressure could affect care decisions. But Wright also said there may be upsides to more tightly managed care: "No patient wants to get more procedures than they actually need."

INSURERS RESPOND TO COST PRESSURES

Insurance companies are pursuing doctors in response to increasing financial pressure. The health law cuts government spending on private Medicare plans that many insurers offer, imposes rules that could limit profits, and increases scrutiny of their rates. Adding to the pressure, the insurers' customers are tired of rising prices.

Employers and other customers "are saying, I want more value for the dollars I spend in health care," said Dawn Owens, chief executive officer of OptumHealth, United's health services subsidiary. But, "there's also a realization that the delivery system isn't ready for that kind of change. That's where we come in."

The tools needed to control costs and improve care are things insurers have "invested in over the years," she said. "The provider community doesn't have those tools."

United's strategy has stirred little controversy, in part because few are aware of it. But word is getting out among potential competitors.

Dr. Amir Bacchus, chief medical officer of HealthCare Partners of Nevada, a large physician group, said he learned about United's plans in a phone call from a United recruiter. He was asked if he'd be interested in joining the company to manage 500 doctors at a network of clinics United planned to build around the country, one part of its physician strategy.

By adding physicians in some places, United "can

definitely control the health system" in those areas, said Bacchus, who declined United's overture. "It's a threat for us," he added. "They are going to compete directly with our business model."

Gail Wilensky, a United board member and health official in President George H.W. Bush's administration, said the insurer doesn't seek to control every doctor who sees patients enrolled in its health plans. Typically, insurers contract with doctors to care for their policyholders. She also cautioned the strategy has not yet proven its success and is in its early stages.

"It's just trying many different ways to see what appeals to the American public and what adds value," she said. "Whether it will actually mark the trend of the future, I don't know."

Rigg, the Wall Street analyst, said that the announced deals were "not needle movers yet" for investors. But four of the five largest health insurers have increased physician holdings in the last year. In addition to the moves by WellPoint and CIGNA, Humana acquired the urgent care chain Concentra in December. Aetna, the third largest insurer, will not be joining the trend, its chief executive, Mark Bertolini, said in an April interview.

Nonprofit Highmark, which runs BlueCross BlueShield plans in Pennsylvania and West Virginia, also struck a deal last week laying the groundwork for it to acquire West Penn Allegheny Health System, a Pittsburgh-based chain of six hospitals. Other regional insurers, especially those specializing in private Medicare plans, such as Peoples Health in Louisiana, have bought or developed clinics over the last year.

GROWING APPETITE FOR DOCTOR GROUPS

United's OptumHealth subsidiary, meanwhile, is buying doctors' groups, building management companies to organize physicians, fostering new partnerships with medical groups and hiring doctors at a group it already controls.

Optum brings technology, data and population health skills to physician groups it acquires, said Owens, the CEO: "We help them modernize the way medicine is actually practiced." Some of the deals were initiated by doctors' groups looking for help, she added.

Owens said Optum's deals will serve all the players in the health system, including rival health plans whose policyholders may use the same physicians.

Optum declined to discuss details, but documents show the company cut deals in California, Arizona, Nevada and other markets. In Orange County, Calif., for example, Optum's Collaborative Care unit acquired the management arm of AppleCare Medical Group and Memorial Healthcare IPA.

In Phoenix, Collaborative Care launched Lifeprint, a physician network that serves United's private Medicare plans. And in Texas, Collaborative Care acquired an 80 percent stake in WellMed Medical Management, which runs a medical group with clinics in Texas and Florida, according to filings with state insurance commissioners.

United has also ramped up hiring at a Las Vegas medical group it already owned as the result of its 2008 acquisition of health plan operator Sierra Health Services.

In some cases, the company obscured its role. For instance, another Collaborative Care business, NextDoor Health, which is partnering with a local doctors' group to open retail clinics at Wal-Mart stores in Texas and other states, describes itself on its website only as "a privately held LLC based in Minneapolis." United is based just outside of Minneapolis.

Paul DeMuro, a Calif.-based Latham & Watkins attorney who represents physician practices, said one reason companies keep physician deals quiet is that, as is the case with real estate developers, news of a big project can inflate prices. The prices for doctors' practices are already "absurd," he said.

Insurers managed physician practices before, especially in the 1990s. But customers rejected those tightly managed plans. Some local plans, and larger insurers such as Kaiser Permanente, continue to employ practicing doctors. But the biggest national insurers shed such arrangements.

One reason the strategy makes sense now is that the health law could reward such arrangements. The law envisions so-called accountable care organizations, groups of doctors and hospitals that take responsibility for patients and the financial risk that comes with them. If they cut spending, they would keep some of the savings.

While hospitals are widely seen as the natural leaders of ACOs, United's strategy positions it to lead the new systems, too, a company executive acknowledged.

Collaborative Care, the United subsidiary, employs "care givers that take risk," said Todd Cozzens, the CEO of Optum's Accountable Care Solutions, another subsidiary. "In markets where they're strong, they're definitely going to set up ACOs."

Some observers watching the developments say the health law, which in part was sold as a way to rein in insurers, has had the opposite result, opening the door for the companies to take control of even more parts of the health system.

"There's a gigantic Murphy's law emerging here," said Ian Morrison, a California-based health care consultant who does some work for United, as well as most of its competitors. "The very people who were the demons in all of this, that the public can't stand" - managed-care firms - "are the big winners."

THE WALL STREET JOURNAL.

MAY 12, 2011

Reforms Prod Insurers to Diversify

Editor's note: ACOs and healthcare information technology have not been shown to control costs but are proving to be a diversification targets and profit centers for big insurers as detailed below.

By AVERY JOHNSON

Major U.S. health insurers, including Aetna Inc., Humana Inc. and WellPoint Inc., are retooling to become more than just health plans, in the wake of the federal health-care overhaul that is changing the rules for the industry's core business.

Diversification plans, touted in meetings with investors this year, include stepped up acquisitions and partnerships that will allow the companies to employ doctors directly, deliver health-information technologies, and participate in new hospital-doctor groups known as accountable-care organizations.

Managed-care companies have been on buying sprees before, mostly to gobble up competing insurers and expand their networks and membership. But with the health law stripping thick profit margins from the business of providing health-care benefits, that isn't such a popular strategy anymore.

Insurance profit margins have historically averaged 7% to 8%, said Carl McDonald of Citigroup Investment Research, but the health overhaul—which requires insurers to spend more on medical care instead of profits—is expected to reduce that to between 3% and 5%.

Meanwhile, health IT, especially, is growing briskly, and can command fat margins because of relatively low overhead. UnitedHealth Group Inc., which until recently has been largely alone in its quest to supplement core insurance operations, is expected to earn margins of about 14% this year on its health IT business, and has earned margins higher than 20% in years past, according to Goldman Sachs.

Since 2010, about 20% of deals by managed-care companies involved health IT firms, up from 7% in 2007, while insurers buying other insurers dropped to 27% of the deals from 39% over the same period, according to FactSet Research Systems, a company that ran an analysis on the market.

At Aetna, new Chief Executive Mark Bertolini is implementing a strategy that will see the Hartford, Conn., insurer get more deeply into health-information technology and run the back-end operations of the new accountable-care organizations, or ACOs.

"Our core business is necessary but not sufficient," said Mr. Bertolini. He pledged to transform Aetna into "more than an insurance company."

Earlier this year, Aetna spent $500 million on technology company Medicity, which sells software to securely transmit health data so health-care providers with many different systems can share patient information. Besides commanding higher margins, health IT businesses are expanding due to some $27 billion in federal funding available for hospitals and doctors to computerize their records.

In March, Aetna announced plans to partner with Carilion Clinic in Virginia to build an ACO—a concept outlined in the health law to make the health-care system more interconnected and hold costs down. In late April, Aetna said it was buying Prodigy Health Holdings for $600 million to get more deeply into the business of providing midsized companies with a self-funded insurance option—which Mr. Bertolini pointed to as evidence of further diversification.

In the accountable-care organizations, the hospitals or doctor groups would take on some of the financial risk of caring for patients—the role traditionally played by insurers. Aetna hopes to provide ACOs with the know-how. And even if the law is ultimately repealed, health insurers see opportunities to sell services to help improve how the health system works, which was a major focus of the debate on the overhaul.

"Health-care reform was an action-forcing event: Everyone's antenna is up and saying, 'We've got to change,'" said Mr. Bertolini.Further into the future are plans for a health-care app store. By the end of the year, the insurer hopes consumers will be able to download mobile applications, such as a program that could help patients find doctors much like opentable.com helps diners find restaurants. Already, doctors can install CareSuite, a workflow tool for physician offices. The tools will be available to users regardless of whether Aetna is their insurer.

Reinventing the health-insurance industry has its challenges. Diversification "may take away management focus from the core business and also [runs] the risk that they may not do well in some of these newer areas," said Matthew Borsch, a Goldman Sachs analyst who follows health insurers.

But industry executives point out that newer areas are growing a lot faster than the traditional core business. For instance, specialty businesses, such as stand-alone dental or vision coverage, command margins over 10%, said Mr. McDonald of Citigroup.

He also pointed to the new frontiers that health plans are exploring to export their model overseas, which can bring margins in the teens.

Michael McCallister, chief executive of Humana, is getting into the business of employing doctors and is eyeing home health care because, he said, "these areas are growing faster than the core and will continue to do so." Home health, for instance, commands margins in the midteens, said Sheryl Skolnick, an analyst at CRT Capital Group LLC, and also has the benefit for an insurer of keeping patients at home instead of at costly nursing facilities.

Humana in December spent nearly $800 million to buy Concentra, which runs urgent- and occupational-care clinics in about 40 states. Last month, the company reorganized its business units to better reflect its new diversified structure.

Concentra employs about 1,000 primary-care doctors who are near to where three million Humana members live, the insurer said. Humana hopes the centers can provide an alternative to costly emergency-room care for its members: A typical visit to a Concentra urgent-care clinic costs $190 to $200, including an X-ray, according to the company, while a comparable ER visit would range from $350 to $650 or more, with additional services for X-rays.

The Concentra deal is also a way to capitalize on the looming shortage of primary-care doctors when an estimated 32 million additional people gain coverage in 2014 due to the health law.

Meanwhile, WellPoint earlier this year said it is diversifying more heavily into consumer-oriented and health IT businesses. At an investor conference, the company outlined plans to create a "portfolio of new noncore growth businesses." Chief Financial Officer Wayne DeVeydt said, "WellPoint is actively engaged in a range of partnership discussions with leading technology and consumer companies to redefine health IT."

ACOs: A Brief Comment on an Untested Theory

By Drs. Steffie Woolhandler and David Himmelstein

While the term ACO remains at best vaguely defined, the concept is hauntingly similar to the capitated managed care experiment that proved disastrous in the 1990s. In both instances, providers receive a set annual payment to cover the costs of all care, and get to keep whatever they don't spend on patients. The obvious winning strategy - from a business point of view - is to recruit relatively healthy patients, offering luxurious care for the healthy and minimally ill, and subtle queues that those with expensive illness would be better off elsewhere. Neither risk adjustment nor quality monitoring schemes are up to the task of blunting these incentives.

An ACO can game risk adjustments by ferreting out additional diagnoses that may be clinically unimportant but would up its capitation payment, and make its outcomes look better as well. The Dartmouth group has already shown that more expensive providers label their patients with more diagnoses in this way. Quality monitoring efforts measure only a tiny slice of what's important in medicine. Overarching measures of quality like death rates and family/community well being are either too rare to measure in a statistically reliable manner, too subtle to capture with current or foreseeable measurement strategies, or too biased by differences in the baseline health of enrollees. Evidence from the UK shows that providers will improve on the aspects of care that are measured, but neglect those that are not, and it's far from clear that monitoring of quality measures has actually improved quality or can prevent abuses.

In sum, the ACO strategy remains an untested theory for health reform. Considerable experience with similar reforms in the past suggests that this ACO strategy will lead to yet another health policy dead end.

Des Moines Register: VA health system for everyone?

The Des Moines Register

Why don't we expand VA health system?

Editorial
May 29, 2011

The Register recently editorialized that it doesn't make sense to operate a multi-billion VA health care system that runs parallel to the nation's vast private health care system of hospitals and clinics. It serves only one segment of the population. A better option would be providing veterans health insurance, similar to Medicare for seniors. Then they would be allowed to go to any hospital or clinic, rather than having to travel long distances for care. The thousands of health care workers currently employed by the government could work in the private sector and treat more Americans.

On the opposite page (excerpt and link below), Donald Cooper, director of VA Central Iowa Health Care System, takes issue with that idea. He suggests instead that Americans should learn from the VA. It certainly does have a record of providing good care. For example, it does a better job preventing hospital-acquired infections than private hospitals. A "connected" system of facilities allows for easy access to comprehensive medical records, which can prevent unnecessary tests and medical errors.

He makes good points. And he got us thinking: Maybe the VA shouldn't be dismantled. Maybe it should be available to everyone. What if the VA's hospitals and clinics became THE health care system in this country?

After all, a single system would make more sense than the hodgepodge of thousands of private and public hospitals, clinics and insurer plans. The VA is wildly popular with politicians of both political parties. The program pays a fraction of what private insurance companies pay for prescription drugs, and the VA provides not only hospital care but also nursing home care. It's comprehensive.

Perhaps it should be expanded.

Of course once some politicians figure out that is "socialized" medicine, the idea would go over like a lead balloon. The VA is truly socialized health care. The workers are employed by the government. The buildings are owned by Uncle Sam. The entire operation and all the care is funded with tax money.

This newspaper has supported a taxpayer-financed system of health insurance. Pool tax money to provide everyone with government insurance that helps pay for services offered by private hospitals, clinics and doctors. That's what some other countries do.

We never have argued the government should also own facilities and employ workers who provide care.

But Cooper -- as well as the experts and studies he refers to -- certainly should give all of us something to think about. They agree "consistent, safe, high quality care requires a reliable delivery system that sets high standards of clinical practice, monitors clinical performance indicators, and employs systematic use of process improvement tools and practices." That "best care comes from systems just like VA health care."

What about the rest of us?

We'll take it.

And...

The Des Moines Register

VA offers lessons for U.S. health care

By Donald C. Cooper, Director of VA Central Iowa Health Care System
May 29, 2011

As your (prior May 9) article infers, it is widely recognized that our nation is facing a growing health care crisis with a fragmented delivery system, escalating costs, and highly variable quality and financing systems that create an excessive administrative burden and incentives for overutilization of diagnostic procedures and specialized care.

Health care leaders have consistently observed that the best care requires an integrated health care system, one that treats the whole patient and coordinates care across the full continuum of services from primary care to acute specialized care, from post-surgery rehabilitation to nursing home and end-of-life care. We know that the best care comes from comprehen-

sive integrated delivery systems - systems just like VA health care.

Health care experts also agree that consistent, safe, high quality care requires a reliable delivery system that sets high standards of clinical practice, monitors clinical performance indicators, and employs systematic use of process improvement tools and practices. The evidence shows that consistent, high quality care comes from the rigorous application of evidence-based medicine supported by a comprehensive, easily accessible, electronic patient health record. We know that the best care comes from systems just like VA health care, an integrated health system with an award winning lifetime electronic patient record that improves patient safety, enhances coordination of care, and supports consistent application of clinical guidelines and monitoring of quality indicators across 153 medical centers and over 800 community based clinics across the country.

Comment: **By Don McCanne, MD**

Wow! The Des Moines Register previously has supported single payer reform, but now they seem to be broadening their position by supporting a publicly owned and operated national health service - socialized medicine! Not only should everyone be covered by a universal, taxpayer-financed risk pool, but that pool should be used to pay for integrated health care - a system "just like VA health care."

Currently there is considerable interest in integrated health care systems. The concept of accountable care organization (ACO) has been advanced as a model for integrating health care delivery. Unfortunately, ACO was narrowly defined in the Affordable Care Act (ACA) which led to a proposed set of rules that have been largely rejected by the health care community. This stumbling block should not prevent us from moving forward with efforts to establish integrated health care that is designed specifically to benefit patients, much like the VA health care system.

H.R. 676, single payer legislation sponsored by John Conyers, calls for conversion of for-profit institutions of the health care delivery system into non-profit, eliminating passive investors, while being run by boards representing the public interest. The VA system would remain independent for the first ten years, at which time merging it with the single payer system would be considered. Could H.R. 676 be an incremental step towards a national health service?

Unfortunately, ACA has left our health care system highly fragmented. The first attempt to form integrated health systems through the ACO model has demonstrated that organizing within such a fragmented system is about like herding cats. Obviously a properly designed single payer system would provide the guidance and incentives to encourage patient-oriented integrated systems. What the VA system has shown us is that government ownership can much more readily facilitate health system integration. It's already been done - by the government!

The nation most often cited for an example of a national health service is the United Kingdom. For less than half of what we are spending ($3129 vs. $7538 per capita, PPP adjusted), they have achieved most of the goals of a high-performance system that have remained elusive in the United States. Just imagine what an integrated national health service in the United States would be like at our current level of spending.

As the editorial board of the Des Moines Register says, "We'll take it." Anyway, it's definitely something worth thinking about.

I TAKE IT YOU'LL BE PAYING WITH CASH

A Transatlantic Review of the NHS at 60

Editors note: President Obama's appointment — during a congressional recess — of Dr. Donald Berwick to head the Centers for Medicare and Medicaid Services focused attention on Berwick's positive view of Britain's National Health Service. We reprint below the July 1, 2008 speech that got Berwick in hot water.

By Donald M. Berwick, MD, MPP, FRCP
President and CEO, Institute for Healthcare Improvement, Cambridge, MA
NHS Live: Wembley: 1 July 2008

Let me begin with thanks – twice. First, thanks for letting me work with you for almost 15 years; this has been one of the most satisfying journeys of my entire career. My colleagues in the Institute for Healthcare Improvement feel the same. Second, thanks for what the NHS does as an example for health care worldwide.

If you're a cynic, you'll want to go get a cup of tea about now. I am going to annoy you, because I am not a cynic. I am romantic about the NHS; I love it. All I need to do to rediscover the romance is to look at health care in my own country.

A TOWERING BRIDGE

The National Health Service is one of the truly astounding human endeavors of modern times. Just look at what you are trying to be: comprehensive, equitable, available to all, free at the point of care, and – more and more – aiming for excellence by world-class standards. And, because you have chosen to use a nation as the scale and taxation as the funding, the NHS isn't just technical – it's political. It is an arena where the tectonic plates of a society meet: technology, professionalism, macroeconomics, social diversity, and political ambition. It is a stage on which the polarizing debates of modern social theory play out: between market theorists and social planning, between enlightenment science and post-modern skeptics of science, between utilitarianism and individualism, between the premise that we are all responsible for each other and the premise that we are each responsible for ourselves, between those for whom government is a source of hope and those for whom government is hopeless. But, even in these debates, you have agreed hold in trust a commons. You are unified, movingly and most nobly, by your nation's promise to make good on an idea: the idea that health care is a human right. The NHS is a bridge – a towering bridge – between the rhetoric of justice and the fact of justice.

No one in their right mind would expect that to be easy. No one should wonder that, as the NHS celebrates its 60th birthday this week – an age at which humans recognize maturity, it seems still immature, adolescent, still searching.

You could have chosen an easier route. My nation did. It's easier in the United States because we do not promise health care as human right. Most of my countrymen think that's unrealistic. In America, they ask, "Who would assure such a right?" Here, you answer, "We do, through our government." In America, people ask, "How can health care be a human right? We can't afford it." We spend 17% of our Gross Domestic Product on health care – compared with your 9%. And, yet we have almost 50 million Americans, one in seven, who do not have health insurance. Here, you make it harder for yourselves, because you don't make that excuse. You cap your health care budget, and you make the political and economic choices you need to make to keep affordability within reach. And, you leave no one out.

FRAGMENTS

In the United States, our care is in fragments. Providers of care, whether for-profit or not-for-profit, are entrepreneurs. Each seeks to increase his share of the pie, at the expense of others. And so we don't have a rational structure of inter-related components; we have a collection of pieces – a caravan site. These disconnected, self-referential pieces cost us dearly. The entrepreneurial fragments create what the great health services researchers, Elliott Fisher and Jack Wennberg, call "supply-driven care." In America, the best predictor of cost is supply – the more we make, the more we use – hospital beds, consultancy services, procedures, diagnostic tests. Fisher and Wennberg find absolutely no relationship – none – between the supply and use, on the one hand, and the quality and outcomes of care, on the other hand. The least expensive fifth of hospital service areas in the US have better care and better outcomes than the most expensive fifth. Here, you choose a harder path. You plan the supply; you aim a bit low; historically, you prefer slightly too little of a technology or service to much too much; and then you search for care bottlenecks, and try to relieve them.

In the US, we favor specialty services and hospitals over primary care and community-based services. Americans are not guaranteed a medical home, as you are, and we face a serious shortage of primary care physicians. Hospitals, on the other hand, are abundant, with many communities vastly over-bedded – an invitation to supply-driven care. Coordinated care – care that keeps people from having to use hospitals – is rare; so are adequate home health care, hospice services, school-based clinics. Community social services and our mental health services are undefended, isolated, and insufficient. Public health and prevention are but stepchildren. Here, in the NHS, you have historically put primary care – general practice – where it belongs: at the forefront.

In the US, we can hold no one accountable for our problems.

Accountability is as fragmented as care, itself; each, separate piece tries to craft excellence, but only within its own walls. Meanwhile, patients and carers wander among the fragments. No one manages their journey, and they are too often lost, forgotten, bewildered. Here, in England, accountability for the NHS is ultimately clear. Ultimately, the buck stops in the voting booth. You place the politicians between the public served and the people serving them. That is why Tony Blair commissioned new investment and modernization in the NHS when he took office, it is why government has repeatedly modified policies in a search for traction, and it is why your new government chartered the report by Lord Darzi. Government action on the NHS is not mere restlessness or recreation; it is accountability at work through the maddening, majestic machinery of politics.

In the United States, we fund health care through hundreds of insurance companies. Any American doctor or hospital interacts with a zoo of payment streams. Administrative costs for this zoo approach 20% of our total health care bill, at least three times as much as in England.

In the United States, those hundreds of insurance companies have a strong interest in not selling health insurance to people who are likely to need health care. Our insurance companies try to predict who will need care, and to find ways to exclude them from coverage through underwriting and selective marketing. That increases their profits. Here, you know that that isn't just crazy; it is immoral.

EQUITABLE, CIVILIZED AND HUMANE

So, you could have had a simpler, less ambitious plan than the NHS. You could have had the American plan. You could have been spending 17% of your GDP and made health care unaffordable as a human right instead of spending 9% and guaranteeing it as a human right. You could have kept your system in fragments and encouraged supply-driven demand, instead of making tough choices and planning your supply. You could have made hospitals and specialists, not general practice, your mainstay. You could have obscured – obliterated – accountability, or left it to the invisible hand of the market, instead of holding your politicians ultimately accountable for getting the NHS sorted. You could have let an unaccountable system play out in the darkness of private enterprise instead of accepting that a politically accountable system must act in the harsh and, admittedly, sometimes unfair, daylight of the press, public debate, and political campaigning. You could have a monstrous insurance industry of claims, rules, and paper-pushing, instead of using your tax base to provide a single route of finance. You could have protected the wealthy and the well, instead of recognizing that sick people tend to be poorer and that poor people tend to be sicker, and that any health care funding plan that is just, equitable, civilized, and humane must – must – redistribute wealth from the richer among us to the poorer and less fortunate.

Britain, you chose well. As troubled as you may believe the NHS to be, as uncertain its future, as controversial its plans, as negative its press, as contentious its politics, as beleaguered as it sometimes feels, please lift your eyes and behold the mess – the far bigger, costlier, unfair mess – that a less ambitious nation could have chosen.

Is the NHS perfect? Far, far from it. I know that as well as anyone in this room. From front line to Whitehall, I have had the privilege to observe its performance and even to help to measure it. The large scale facts are most recently summarized in the magisterial report by Sheila Leatherman and Kim Sutherland sponsored by The Nuffield Trust called The Quest for Quality: Refining the NHS Reforms. They find some good news. For example, after ten years of reinvestment and redesign, the NHS has more evidence-based care, lower mortality rates for major disease groups (especially cardiovascular diseases), lower waiting times for hospital, outpatient, and cancer care, more staff and technologies available, in some places better community-based mental health care, and falling rates of hospital infection. An important, large scale patient safety campaign has begun in England, as well as among your cousins in Wales, Scotland, and Northern Ireland. There is less progress in some areas, especially by comparison with other European systems, such as in specialty access, cancer outcomes, patient-centeredness, life expectancy and infant mortality for socially deprived populations. In other words, in improving its quality, two facts are true: the NHS is en route, and the NHS has a lot more work ahead.

How can you do even better? I have ten suggestions:

1. First, put the patient at the center – at the absolute center of your system of care. Put the patient at the center for everything that you do. In its most helpful and authentic form, this rule is bold; it is subversive. It feels very risky to both professionals and managers, especially at first. It is not focus groups or surveys or token representation. It is the active presence of patients, families, and communities in the design, management, assessment, and improvement of care, itself. It means customizing care literally to the level of the individual. It means asking, "How would you like this done?" It means equipping every patient for self-care as much as each wants. It means total transparency – broad daylight. It means that patients have their own medical records, and that restricted visiting hours are eliminated. It means, "Nothing about me without me." It means that we who offer health care stop acting like hosts to patients and families, and start acting like guests in their lives. For professionals made anxious by this extreme image, let me simply remind you how you probably begin every encounter when you are following your best instincts; you ask, "How can I help you?" and then you fall silent and you listen.

2. Second, stop restructuring. In good faith and with sound logic, the leaders of the NHS and government have sorted and resorted local, regional, and national structures into a continual parade of new aggregates and agencies. Each change made sense, but the parade doesn't make sense. It drains energy and confidence from the workforce and middle managers, who learn not

to take risks, but rather to hold their breaths and wait for the next change. It is, I think, time to stop. No structure in a complex management system is ever perfect. There comes a time, and the time has come, for stability, on the basis of which, paradoxically, productive change becomes easier and faster, as the good, smart, committed people of the NHS – the one million wonderful people who can carry you into the future – find the confidence to try improvements without fearing the next earthquake.

3. Third, strengthen the local health care systems – community care systems – as a whole. What you call "health economies" should become the core of design: the core of leadership, management, inter-professional coordination, and goals for the NHS. This should be the natural unit of action for the Service, but it is as yet unrealized. The alternative, like in the US, is to have elements – hospitals, clinics, surgeries, and so on – but not a system of care. Our patients need integrated journeys; and they need us to tend and defend those journeys. I believe that the NHS has gone too far in the past decade toward optimizing hospital care – a fragment – and has not yet optimized the processes of care for communities. You can do that. It is, I think, your destiny.

4. Fourth, to help do that, reinvest in general practice and primary care. These, not hospital care, are the soul of a proper, community-oriented, health-preserving care system. General practice, not the hospital, is the jewel in the crown of the NHS. It always has been. Save it. Build it.

5. Fifth, please don't put your faith in market forces. It's a popular idea: that Adam Smith's invisible hand would do a better job of designing care than leaders with plans can. I do not agree. I find little evidence anywhere that market forces, bluntly used, that is, consumer choice among an array of products with competitors' fighting it out, leads to the health care system you want and need. In the US, competition has become toxic; it is a major reason for our duplicative, supply-driven, fragmented care system. Trust transparency; trust the wisdom of the informed public; but, do not trust market forces to give you the system you need. I favor total transparency, strong managerial skills, and accountability for improvement. I favor expanding choices. But, I cannot believe that the individual health care consumer can enforce through choice the proper configurations of a system as massive and complex as health care. That is for leaders to do.

6. Sixth, avoid supply-driven care like the plague. Unfettered growth and pursuit of institutional self-interest has been the engine of low value for the US health care system. It has made it unaffordable, and hasn't helped patients at all.

7. Seventh, develop an integrated approach to the assessment, assurance, and improvement of quality. This is a major recommendation of Leatherman and Sutherland's report, and I totally concur. England now has many governmental and quasi-governmental organizations concerned with assessing, assuring, and improving the performance of the NHS. But they do not work well with each other. The nation lacks a consistent, agreed map of roles and responsibilities that amount, in aggregate, to a coherent system of aim-setting, oversight, and assistance. Leatherman and Sutherland call this an "NHS National Quality Programme," and it is one violation of my proposed rule against restructuring that I have no trouble endorsing.

8. Eighth, heal the divide among the professions, the managers, and the government. Since at least the mid-1980's, a rift developed that has not yet healed between the professions of medicine formally organized and the reform projects of government and the executive. I assume there is plenty of blame to go around, and that the rift grew despite the best efforts of many leaders on both sides. But, the toll has been heavy: resistance, divided leadership, demoralization, confusion, frustration, excess economic costs, and occasional technical mistakes in the design of care. The NHS and the people it serves can ill afford another decade of misunderstanding and suspicion between the professions, on the one hand, and the managers and public servants, on the other hand. It is the duty of both to set it aside.

9. Ninth, train your health care workforce for the future, not the past. That workforce needs to master a whole new set of skills relevant to the leadership of and citizenship in the improvement of health care as a system – patient safety, continual improvement, teamwork, measurement, and patient-centered care, to name a few. Scotland announced last week that all its health professionals in training will master safety and quality improvement as part of their qualification. Far be it for me to suggest copying Scotland, but there you have it. I am pleased that Lord Darzi's Next Stage report suggests such standards for the preparation of health care professionals in England.

10. Tenth, and finally, aim for health. I suppose your forebears could have called it the NHCS, the "National Health Care Service," but they didn't. They called it the "National Health Service." Maybe they meant it. Maybe they meant to create an enterprise whose product – whose purpose – was not care, but health. Maybe they knew then, as we surely know now, even before Sir Douglas Black and Sir Derek Wanless and Sir Michael Marmot, that great health care, technically delimited, cannot alone produce great health. Developed nations that forget that suffer the embarrassment of growing investments in health care with declining indices of health. The charismatic epidemics of SARS, mad cow, and influenza cannot hold a candle to the damage of the durable ones of obesity, violence, depression, substance abuse, and physical inactivity. Would it not be thrilling in the next decade for the NHS – the National Health Service – to live fully up to its middle name?

Those are my observations from far away – from an American fan, distant and starry-eyed about the glimpses I have had of your remarkable social project. The only sentiment that exceeds my admiration for the NHS is my hope for the NHS. I hope that you will never, never give up on what you have begun. I hope that you realize and reaffirm how badly you need, how badly the world needs, an example at scale of a health system that is universal, accessible, excellent, and free at the point of care – a health system that is, at its core, like the world we wish we had: generous, hopeful, confident, joyous, and just. Happy birthday!

theguardian

MAY 21, 2011

Editors' note: The current conservative government in England is seeking to radically restructure their VA-like health system.

The Plot Against the NHS by Colin Leys and Stewart Player – review

Authors anatomise 'the diseased political corpus that has begun to infect the NHS with a commercial ethos'

By Richard Horton

A year ago Peter Martin, the chief executive of Tribal Group plc, which describes itself as a "leading provider of commissioning services to the NHS", presented his view of the future for the health sector in England. He was bullish. Although he described market conditions as "challenging", he saw an "improved flow of service delivery opportunities" that would significantly support Tribal's revenue growth. Andrew Lansley's 2010 white paper would bring "major changes in structure of UK health markets". Martin's goal was to focus Tribal's health business on the profit-making opportunities these reforms would create. He set out five growth priorities: commissioning for GP consortia, clinical support services, patient management services, informatics outsourcing and hospital management services.

This is the future for the NHS that David Cameron and Nick Clegg have planned for us since the launch of the coalition. Despite their claims to the contrary, they have been laying the ground for wholesale privatisation of the NHS, the destruction (without any democratic mandate) of one of Britain's most cherished and effective postwar institutions, and the transfer of its stewardship and operations to organisations concerned only with maximising revenues and reducing costs. The word "quality" appears nowhere in Tribal's vision as communicated to investors.

How has the NHS arrived at this moment of crisis? Colin Leys and Stewart Player provide an indispensable guide to understanding the origins of what they call a plot against the NHS. Surely this is an exaggeration? Not so. Cameron, Clegg and Lansley are merely continuing two decades of policies – begun by Tony Blair, endorsed by Gordon Brown, and supported by successive Labour governments – aimed at introducing markets into the health service. Where Labour tried to hide its intentions, the only difference with the Conservative-Liberal alliance is their shameless transparency.

Looking back at Labour health policy now, I have to ask myself how so many of us were unable to see through the mists of what Leys and Player call the "misrepresentation, obfuscation, and deception" perpetrated by Blair, Brown, and a host of health ministers all too willing to genuflect to the market zeitgeist. Too many of us – whether doctors, nurses, or just members of the public – were willing to be bewitched by Labour's mellow language of reform. The words are all too familiar now: modernisation, choice, empowerment, diversity, plurality, improvement, contestability, and, most beguiling of all, patient-led.

The Department of Health created a commercial directorate to oversee the plan to privatise the NHS. A group of passionate market advocates were hired to transform a public sector institution into a target for private sector takeover. People such as Mark Britnell, who was the Department of Health's director general for commissioning when Labour was in office and who later joined KPMG – able to sell his experience in government to the world of management consulting – have now been outed as agents for the merciless dismemberment of the NHS. There was a revolving door between civil servants in the department and McKinsey, KPMG and Deloitte. Ex-ministers, such as Patricia Hewitt and Lord Warner, traded their knowledge of NHS privatisation with those who could benefit in the commercial sector.

Doctors' leaders were little better. The British Medical Association's John Chisholm and Simon Fradd, who led negotiations with government to revise the GP contract in 2002, won a huge victory by making out-of-hours care for patients optional. Nine out of 10 GPs stopped offering services to patients from 6.30pm to 8am. This withdrawal of NHS care allowed private providers to step in and take over. After Chisholm and Fradd had succeeded in putting out-of-hours care out for private tender, they set up Concordia Health, a private company, that offered to run those very same services, only now at a profit to themselves.

The networks of health institutions that propped up the case for marketisation and privatisation of the NHS were intricate. They include private providers, such as UnitedHealth (whose president of global health, Simon Stevens, was once a key Labour adviser); thinktanks, such as the King's Fund (whose trustees have included Stevens and Julian Le Grand, his successor in Number 10); and lobbyists, including several NHS outsourcing and private equity businesses.

Having anatomised the diseased political corpus that has begun to infect the NHS with a commercial ethos that will increase costs, cut services and reduce quality, Leys and Stewart try to look to the future. They mount a strong defence, claiming there is no evidence the NHS is in urgent need of fundamental reform. Given the statement by Steve Field, who is leading Cameron and Clegg's pause to review the Lansley reforms, that the current Bill could "destroy key services" and destabilise the NHS, it seems that the gathering momentum for markets as the solution to whatever ills the NHS might have could be about to stall.

But we should be sceptical that any real change in direction is likely. Although there might well be a pause in plans for privatisation, there is no serious counterproposal to strengthen the NHS without the entry of private providers. The only source of political opposition to private markets in healthcare can come from Labour. But as one shadow spokesman said to me recently, Labour opposition leaders are like "invertebrate slugs". Labour in opposition is too inexperienced, too busy defending its legacy, too frightened to offer policies that might sound like spending commitments, too bankrupt to think beyond shoring up its own survival, and too lacking in imagination to bring in independent policy experts to strengthen its thinking.

And new thinking is urgently needed. I don't fully agree with Leys and Stewart that NHS reform is unnecessary. Consider one example: child health. The unfortunate truth is that the care offered to children with cancer, asthma, meningitis and pneumonia, among other chronic conditions, is inferior in Britain compared with many of our European neighbours. We should not be complacent about these failings. Markets and privatisation are certainly not the answer. But neither is defending an NHS as if it were perfect with no problems to solve.

Richard Horton is editor in chief of the Lancet.

Nine Essential Characteristics of the British NHS at its Founding and The Inverse Care Law

The following is a list of nine essential and distinctive characteristics of the British NHS upon its founding, according to the famous Welsh general practitioner and author, Julian Tudor Hart.

1. A united national service devoted directly and indirectly to care, fully available to all citizens.

2. A gift economy including everyone, funded by general taxation, of which the largest component was income tax.

3. Its most important inputs and processes are personal interactions between lay and professional people.

4. Its products were potentially measurable as health gains for the whole population.

5. Its staff and component units were not expected to compete for market share but to cooperate to maximize useful service.

6. Continuity was central to its efficiency and effectiveness.

7. Its local staff and local populations believed they had moral ownership of and loyalty to neighborhood NHS units.

8. None of its decisions and few of its procedures could be fully standardized. All of its decisions entailed some uncertainty and doubt. They were therefore unsuited to commodity form, either for personal sale or for long-term contracts.

9. The NHS was a labour-intensive economy. Every new diagnostic or therapeutic machine generates new needs for more skilled staff able to control and interpret the work of the machines and translate them into human terms.

Hart also authored The Inverse Care Law, published in the Lancet in 1971:

> "The availability of good medical care tends to vary inversely with the need for the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced."

EDITORIAL | Annals of Internal Medicine

Reconsidering the Veterans Health Administration: A Model and a Moment for Publicly Funded Health Care Delivery

Since the Veterans Health Administration (VHA) was systemically (and systematically) "reengineered" to follow a more decentralized, managed care template more than 15 years ago (1–3), it has demonstrated accumulating achievements in health and health care delivery, over time outshining not only its own performance but that of others (4–6). In chronic disease management and preventive care, the VHA has surpassed Medicare (7), commercial managed care (8), and various community health systems in adherence to broadly accepted process measures (9).

Furthermore, beneficiaries of the VHA seem to have health outcomes—including mortality—that are the same as or better than those of Medicare (10–12) and private-sector patients (13). These findings are noteworthy given the population served by the VHA, which is recognized to be highly and relatively burdened by socioeconomic disadvantage, comorbid illness, and poor self-reported health (1). It is remarkable that the VHA has been able to attain this superior-quality care at a lower cost than that purchased through Medicare, with expenditures that have increased at a much slower rate (adjusted annual per capita growth rate, 0.3% vs. 4.4%) (14, 15).

In this issue, Keating and colleagues (16) offer the latest report on VHA performance and extend to cancer care what has already been shown for care provided for various other medical conditions. By using process measures that reflect receipt of high-quality care based on national guidelines, this study compares treatment of older male veterans in the VHA system with that of fee-for-service Medicare patients with a diagnosis of colorectal, lung, prostate, or hematologic cancer. Keating and colleagues found that patients treated in the VHA system received care that was equal to or better than that among patients with Medicare coverage treated in the community. Patients in the VHA system had higher rates of curative resection for colon cancer, recommended chemotherapeutic regimens for hematologic neoplasms, and bisphosphonate use for multiple myeloma.

When comparing care delivered in different settings, a major concern is that observed differences may actually reflect differences in patient populations. The authors use state-of-the-art statistical methods to address this issue. By using an analysis weighted by the propensity for each patient to be treated in the VHA, they adjusted for characteristics, such as age, race, and region, that could have a confounding effect if, in addition to being associated with the likelihood of being treated in one setting or the other, they also influence the appropriateness of treatment or whether patients follow through on treatment recommendations.

The propensity score method deals with the selection bias introduced by significant group differences by giving additional weight to Medicare patients who most closely match VHA patients in these characteristics. This weighting balances the distribution of such characteristics and levels the ground for comparisons and estimates on quality of care between the 2 groups. The propensity score approach cannot address bias introduced by variables that are not included in the analysis and may actually increase the confounding effect associated with these factors.

Because the data that the authors examined is administrative in nature, such unmeasured factors are a key limitation. However, the authors attempted to account for this unobserved variable bias by using sensitivity analyses to estimate the potential effect on their results of differences in the prevalence of poor performance status or severe comorbid illness. On the basis of these analyses, the authors conclude that their study may have actually underestimated the quality of care provided in VHA settings compared with non-VHA settings.

The only process measure for which VHA patients had lower scores than Medicare patients was the use of 3-dimensional conformal radiation therapy (3DCRT) versus intensity-modulated external-beam radiation therapy for prostate cancer (61.6% vs. 86.0%; $P < 0.001$). This substantial divergence may reflect varying adoption rates of new technology by 2 distinct health care financing schemes, highlighting the difference between the market-driven practices of the fee-for-service sector and the careful consideration to large capital investments required of systems that must adhere to an annual budget.

The evidence on the benefit of 3DCRT versus conventional radiation therapy before 2001 was limited to data suggesting that it was associated with lower rates of acute toxicity (17, 18). The pivotal study demonstrating improved progression-free survival with higher doses of radiation, which is only feasible with 3DCRT, was published in 2005 and thus was not available when the patients in Keating and colleagues' study were undergoing treatment (19). As such, the observed rates of 3DCRT use in the VHA and Medicare cohorts may reveal overzealous application of new treatment modalities before clear value was proved. If we ever hope to control health care costs as providers and as a nation, policies to encourage high-quality evidence of benefit before rapid dissemination of novel technologies, especially expensive ones, are needed both in the VHA and Medicare settings.

In the wake of legislation to comprehensively reform health care in the United States while preserving its underlying multiple-payer structure, one might be tempted to wistfulness when considering the quality of care in the

VHA. Despite the clamor of special interests, corporate lobbying, and the particular American distaste for government-run institutions, the public option may yet find its voice in the latest round of accomplishments demonstrated by the VHA. "Thanks" to proposals to repeal of the historic Patient Protection and Affordable Care Act, it is ironic that the moment for reconsideration has returned—and with it, the opportunity to celebrate more vociferously the triumphs of the country's largest integrated and publicly funded health care network.

Of course, given the pressing and very real need of uninsured and underinsured persons, the obvious hope is that the proposed repeal remains a symbolic gesture, and a symbolic gesture only. Still, the results of Keating and colleagues' analysis provide a poignant reminder that a vision for a national, integrated, government-run health care system not only exists but is, in fact, successful.

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IMPROVING PATIENT CARE | ORIGINAL RESEARCH

Quality of Care for Older Patients With Cancer in the Veterans Health Administration Versus the Private Sector

A Cohort Study

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Background: The Veterans Health Administration (VHA) is the largest integrated health care system in the United States. Studies suggest that the VHA provides better preventive care and care for some chronic illnesses than does the private sector.

Objective: To assess the quality of cancer care for older patients provided by the VHA versus fee-for-service Medicare.

Design: Observational study of patients with cancer that was diagnosed between 2001 and 2004 who were followed through 2005.

Setting: VHA and non-VHA hospitals and office-based practices.

Patients: Men older than 65 years with incident colorectal, lung, or prostate cancer; lymphoma; or multiple myeloma.

Measurements: Rates of processes of care for colorectal, lung, or prostate cancer; lymphoma; or multiple myeloma. Rates were adjusted by using propensity score weighting.

Results: Compared with the fee-for-service Medicare population, the VHA population received diagnoses of colon ($P < 0.001$) and rectal ($P = 0.007$) cancer at earlier stages and had higher adjusted rates of curative surgery for colon cancer (92.7% vs. 90.5%; $P < 0.010$), standard chemotherapy for diffuse large B-cell non-Hodgkin lymphoma (71.1% vs. 59.3%; $P < 0.001$), and bisphosphonate therapy for multiple myeloma (62.1% vs. 50.4%; $P < 0.001$). The VHA population had lower adjusted rates of 3-dimensional conformal or intensity-modulated radiation therapy for prostate cancer treated with external-beam radiation therapy (61.6% vs. 86.0%; $P < 0.001$). Adjusted rates were similar for 9 other measures. Sensitivity analyses suggest that if patients with cancer in the VHA system have more severe comorbid illness than other patients, rates for most indicators would be higher in the VHA population than in the fee-for-service Medicare population.

Limitation: This study included only older men and did not include information about performance status, severity of comorbid illness, or patient preferences.

Conclusion: Care for older men with cancer in the VHA system was generally similar to or better than care for fee-for-service Medicare beneficiaries, although adoption of some expensive new technologies may be delayed in the VHA system.

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COMMENTARY

Building the Patient-Centered Medical Home in Ontario

Richard H. Glazier, MD
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THE CONCEPT OF THE PATIENT-CENTERED MEDICAL home is gaining traction in debates about expanding access, improving quality, and restraining the cost of health care. These homes include physician-led multidisciplinary teams that provide comprehensive primary care, expanded hours (with possible open-access scheduling), integrated evidence-based quality measurement, better communication for the patient experience, and modern health information technology. The timing seems right in the United States and a proof-of-concept project has shown promising change.[1] Yet concerns are being raised about slow uptake[2] and whether this concept will withstand the test of health care reform.[3] Some authorities suggest that the Ontario experience with medical homes could be a blueprint for reform in US primary care.[4] Ontario offers tangible real-world lessons for both countries about the consequences of decisions made in the course of home construction.

The Ontario medical homes are one of the world's largest experiments in primary care reform. From 2002 to 2010, about 75% of the region's 13 million residents and 10 000 primary care physicians joined medical home models with patient rostering, after-hours coverage, incentives for preventive health care, and payments for chronic disease management.[5] The single most notable change (involving almost 4 million patients) was to switch from predominantly fee-for-service to predominantly capitation practices. Close to half of the capitation practices also had multidisciplinary clinician teams. These large-scale changes came about incrementally with the introduction of several new models through government negotiations with organized medicine.

One outcome has been increased primary care physician incomes. As medical homes were introduced voluntarily, inducements were needed for physicians to leave the traditional fee-for-service model. Stabilizing and enhancing the primary care workforce was a government goal, for which increased funding was knowingly committed. Ontario patient-centered medical homes have yielded improved work satisfaction and financial benefits to primary care physicians with typical annual net earnings increasing from about Can$162 000 to about Can$207 000.[6] Government negotiators likely underestimated the distinct popularity of capitation, which is now expected to overtake all other models during 2010. The estimated annual incremental total direct physician expenditures for capitated medical homes has been at least Can$160 million.

Publicly funded health care aims to support patients in most need, but negotiations in Ontario resulted in models that somewhat compromised this outcome. Parties involved in the negotiations could not agree on case-mix or socioeconomic adjustments (in turn, capitation payments were adjusted for age and sex alone). Without finer case-mix adjustment, practices in the healthier and wealthier areas obtained attractive revenue projections with capitation, and the majority chose this model[7] in accordance with economic theory. Conversely, physicians treating sicker patients had no incentive to join a capitation model and enjoyed relatively few financial incentives for providing better fee-for-service care.

Such adverse risk selection and "cherry picking" was accentuated because capitated medical homes were allowed to de-roster patients who sought outside primary care. This provided a strong incentive for some medical homes to drop precisely those patients with higher health needs and complex care. Such off-the-roster patients could continue to receive fee-for-service care within their original home but were not tracked, did not receive reminders for needed care, were not included in most incentives for chronic disease management, and may have missed out on other benefits of a medical home including access to nonphysician health professionals.

Demographic diversity also led to other economic inequities. That is, policy makers funding capitation did not want to pay twice for the same service from fee-for-service physicians who were contacted by a patient living in a capitated medical home. In Ontario, that translated into financial penalties for out-of-group primary care visits. Such duplication was most likely to occur in urgent care clinics,

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walk-in centers, or other facilities typical of urban settings. In contrast, rural settings had few such alternatives. Hence, rural practices gained the most with capitation. Conversely, major cities with urban poor and recent immigrants were much less likely to be served by primary care physicians working in a capitated medical home.[7]

Medical homes have the potential to reduce emergency department use by providing timely access to primary care. In particular, expanded clinic hours were required of Ontario's medical homes; however, entire groups were exempted if the majority of physicians provided hospital-based services. As a consequence, one survey found that less than a third of medical homes mentioned extended-hour clinics on their telephone messages despite the general requirement to hold such clinics.[8] Medical homes, furthermore, had no requirement for open-access scheduling or other timely access strategies despite the benefits of such patient-centered processes.[9]

Limiting emergency department care is typically a public relations nonstarter, so Ontario's medical homes were designed with no direct disincentives against emergency department care. Administrative data showed that blended capitation was associated with 30% fewer after-hours visits and 20% more emergency department visits than blended fee-for-service practices.[6] Of note, this pattern of emergency department care existed prior to capitation, indicating a strong attraction of such practices to the medical home model. Regardless of explanation, Ontario's medical homes did not appear to reduce emergency department use.

A timely and transparent evaluation of medical homes in Ontario would have allowed for mid-course corrections and adjustments. Instead, the government-funded evaluation of team-based capitation practices began 2 years after the model was established. Moreover, the results of the evaluation will be made public only under "terms and conditions which the Minister, in his sole discretion considers appropriate" (Service Agreement, Section 11.8, Intellectual Property Rights). Such confidentiality agreements would generally not be tolerated in medical science. A rigorous evaluation of Ontario medical homes, therefore, may never be made public, receive external scrutiny, or become available to policy makers elsewhere.

Ontario's medical homes are laudable in their innovation, scope, and workforce stabilization. They are a step forward in bringing change to a situation "exemplified by individuals making personal heroic efforts to compensate for the absence of systems and support."[10] Political negotiations, however, resulted in policies that favored self-selection of healthier patients, disincentives in major cities, gaps for vulnerable groups, and suboptimal access to care. Improved primary care income is always welcome, but the lack of an open evaluation mechanism is troubling. Others may want to examine the Ontario blueprints for large-scale primary care reform. However, they will want to consider their political landscape, choose locally appropriate construction methods, and carefully select building materials for patient-centered medical homes in the United States.

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PNHP hosts teleconference with Bruce Vladeck on Medicare

Over 130 PNHP members participated in a conference call with former Medicare Director Bruce Vladeck, Ph.D., on July 14. Although Medicare has low overhead, good patient satisfaction ratings and a better record of cost control than private insurers, the program has inadequate benefits, covering less than half the health care costs of the elderly. In PNHP's view, the best way to fix Medicare is to replace it with a system of single-payer national health insurance, emphasizing primary care. Former PNHP presidents Dr. Claudia Fegan and Dr. John Geyman, board member Dr. Andy Coates, co-founder Dr. David Himmelstein and Dr. Diljeet Singh helped lead the discussion. Suggestions for future conferences are welcomed at organizer@pnhp.org.

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Primary Health Care in Canada: Systems in Motion

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Context: During the 1980s and 1990s, innovations in the organization, funding, and delivery of primary health care in Canada were at the periphery of the system rather than at its core. In the early 2000s, a new policy environment emerged.

Methods: This policy analysis examines primary health care reform efforts in Canada during the last decade, drawing on descriptive information from published and gray literature and from a series of semistructured interviews with informed observers of primary health care in Canada.

Findings: Primary health care in Canada has entered a period of potentially transformative change. Key initiatives include support for interprofessional primary health care teams, group practices and networks, patient enrollment with a primary care provider, financial incentives and blended-payment schemes, development of primary health care governance mechanisms, expansion of the primary health care provider pool, implementation of electronic medical records, and quality improvement training and support.

Conclusions: Canada's experience suggests that primary health care transformation can be achieved voluntarily in a pluralistic system of private health care delivery, given strong government and professional leadership working in concert.

The Canadian Health System

Canada has thirteen provincial and territorial health care systems that operate within a national legislative framework, the Canada Health Act (1984). The act defines the following standards to which provincial health insurance programs must conform in exchange for federal funding: universality (coverage of the whole population on uniform terms and conditions), portability of coverage among provinces, public administration, accessibility (first-dollar coverage for physician and hospital services), and comprehensiveness (defined as medically necessary health services provided by hospitals and physicians) (Marchildon 2005). In practice, medical necessity is broadly defined, covering the vast majority of physicians' services. But the extent of public coverage for pharmaceuticals, home care, long-term care, and the services of nonphysician providers such as chiropractors, optometrists, and physiotherapists varies across the provinces and territories. Other health care policies, ranging from waiting-time targets to the structure of primary care provision, also differ in each jurisdiction.

Most of health care in Canada is publicly financed but privately delivered. The Medical Care Act (1966), which, together with the Hospital and Diagnostic Services Act (1957), established the basis for Canada's universal, publicly financed health insurance system, known as Medicare, effectively enshrined private fee-for-service practice as the dominant mode of practice organization and physician payment in Canada (Naylor 1986). Physicians were brought into Medicare on terms that included the continuation of fee-for-service remuneration, clinical autonomy, and control over the location and organization of their medical practice. As Carolyn Tuohy observed, this founding bargain or accommodation between the medical profession and the state "made no changes in the existing structure of health care delivery [and] placed physicians at the heart of the decision-making system at all levels" (Tuohy 1999, 56). Indeed, federal and provincial policymakers have been hesitant to challenge this accommodation for fear of jeopardizing the medical profession's allegiance to Medicare. The leverage afforded to provinces and territories as the single payer for physicians' services has thus been mitigated by the need to negotiate, rather than impose, changes in physicians' payment systems and accountability arrangements.

Primary Health Care in Canada

By international standards, Canada has a low physician-to-population ratio.1 But the general practitioner-to-population ratio is above the average for member countries of the Organization for Economic Cooperation and Development and is similar to that of the United States, though below that of several other high-income countries.2 Family physicians comprise 51 percent of the physician workforce (Canadian Institute for Health Information 2010c). In 2007, 23 percent of family physicians reported being in a solo practice, while 74 percent said they were in a group or interprofessional practice (College of Family Physicians of Canada et al. 2007a). About half (48.3%) derive 90 percent or more of their professional income from fee-for-service payments; most of the remainder obtain their professional income through a mix of payment types (College of Family Physicians of Canada et al. 2007b).

Ninety-one percent of Canadians say they have a regular

source of care, usually a family physician (Canadian Institute for Health Information 2009), although many report difficulty obtaining access to both primary and referred care (Blendon et al. 2002; Canadian Institute for Health Information 2009; Schoen et al. 2007, 2008, 2010). For example, 13 percent say they have difficulty obtaining access to routine or ongoing care (Canadian Institute for Health Information 2009), and 33 percent report that the last time they were sick or needed care, they had to wait six or more days for a doctor's appointment (Schoen et al. 2010). Although obtaining access may be arduous, 76 percent of Canadian adults rate the quality of care they receive from family physicians as excellent or very good (Canadian Institute for Health Information 2009).

Canadians are entitled to choose their own family physician, and because the Canada Health Act prohibits user charges for insured services, medically necessary physicians' services are free at the point of care. Although direct access to specialists is not prohibited, a family physician's referral to specialist care is the norm in Canada, and many provinces discourage direct access to specialists by paying lower fees for nonreferred consultations. The extent and type of arrangements for after-hours care vary regionally and, in traditional fee-for-service practices, are at the physician's discretion.

The Climate for Primary Health Care Reform

During the 1980s and 1990s, primary health care reform in Canada was characterized by false starts, myriad small-scale pilot and demonstration projects, futile advocacy of fundamental systemwide change, and failure to embrace the alternative strategy of progressive incremental change (Hutchison, Abelson, and Lavis 2001). In the 1990s, while contending with the fiscal fallout from the recession in the early part of the decade, the federal and provincial/territorial governments cut or limited health care spending, made only paltry investments in primary health care innovation, and failed to address the conspicuous lack of primary health care infrastructure in the areas of information technology, administration, staffing, and quality improvement. During this period, innovations in the organization, funding, and delivery of primary health care were at the periphery of the system rather than at its core, although some of those initiatives laid the groundwork for later advances.

While Canada's primary health care system was stagnating, many other countries were moving forward with systemic primary care reform. As a consequence, Canada began to lag behind other high-income countries on many primary care access and quality indicators. For example, in 2001, 41 percent of adult Canadians said they had difficulty getting care on nights and weekends (tied with the United States for the highest among the five countries surveyed), and 26 percent reported that access to care was worse than two years earlier (highest among the five countries) (Blendon et al. 2002). In a 2000 survey, Canadian family physicians were more concerned than those in the other countries surveyed about primary care quality (Australia, New Zealand, the United Kingdom, and the United States): 59 percent thought their ability to provide quality care had fallen in the past five years, and 61 percent were "very concerned" that their quality of care would decline in the future (Blendon et al. 2001). Despite the country's universal coverage, the years of constrained funding and inattention from policymakers had clearly taken a toll on Canadians' ability to obtain primary health care services.

In the early 2000s, a new policy environment emerged as policymakers in several provinces appeared to absorb the lessons of the past:

- Policy legacies and entrenched professional and public values limit the possibilities for radical, "big bang" reform.
- There is no single "right" model for the funding, organization, and delivery of primary health care. Different models have different strengths and weaknesses and may perform better or worse in different contexts and with different target populations. Most are capable of evolutionary development. Some models may be complementary.
- No single funding or payment method holds the key to transforming primary health care. Changing physicians' payment methods may facilitate, but does not ensure, change in the organization and delivery of care. Conversely, organizational change and improved quality of care are possible through varied arrangements for remunerating physicians.
- Primary health care renewal demands major investments in system transformation and infrastructure (appropriate premises and staffing, information management systems, and tools and facilitation to support the coordination of care and the improvement of quality) (Hutchison 2008; Hutchison, Abelson, and Lavis 2001).

This article describes the context, extent, and main characteristics of primary health care reform in Canada during the past decade. We outline the dominant primary heath care reform strategy, the goals for reform, the available policy levers, and the provincial/territorial primary health care policy initiatives that have been implemented since 2000 at either a system level or on a more limited scale to gain experience before extending them to the entire system. We then summarize the major achievements, describe interprovincial variations in policy innovation, and identify key reform challenges. Finally, we consider the transformative potential of the reform strategies that have been adopted in relation to the goals for primary health care identified by Canadian and international policymakers.

Methods

Our policy analysis draws on descriptive information from published and gray literature, government and government agency websites, and a series of semistructured interviews with informed observers of primary health care in Canada. We con-

ducted interviews with informants from only those provinces and territories for which we lacked sufficient information from other sources to accurately portray their reform initiatives and policy environment: Nova Scotia, New Brunswick, Newfoundland and Labrador, Northwest Territories, Manitoba, and Alberta. We selected as informants individuals who had a detailed knowledge of past and current reforms in their respective jurisdictions and were not affiliated with either the provincial/territorial government or the provider associations.

We initially contacted these prospective informants via email, explaining the research project and goals of the interview and requesting an appointment. The interviewers made at least four attempts to reach each prospective participant. They used a script that we developed for one-on-one, semistructured telephone interviews that asked four questions about the historical background and current climate, four questions about the general approach to reform and key policy levers, and two concluding questions about the changes in the policy environment over time and lessons learned. The interviewers obtained verbal consent from the participants to audiotape all interviews. The interviews were completed with five informants between September 2009 and October 2009. One informant provided information about two provinces.

In this article, we use primary health care as an inclusive term covering a spectrum of activities from first-contact episodic care to person-centered and comprehensive care sustained over time. The term may include population-based approaches (as in community health centers) to health promotion, community development, and the social determinants of health, although most primary health care in Canada is provided by physicians working in a family practice model of care.

Results

A New Policy Environment

Beginning in the late 1990s, Canada's improved fiscal climate and higher federal health care funding (some earmarked for primary health care) made investments in primary health care easier for provincial governments to contemplate. In 2000, in keeping with the recommendations of various federal and provincial reports, the First Ministers (the prime minister of Canada and the provincial and territorial premiers) established the $800 million Primary Health Care Transition Fund to accelerate primary health care reform. The fund was used to support pilot and demonstration projects, as well as research at the provincial/territorial and national levels.

The 2003 First Ministers Health Accord included a $16 billion federal investment in the Health Reform Fund, which was targeted to primary health care, home care, and catastrophic drug coverage. At their September 16, 2004 meeting on the future of health care, the First Ministers established a goal of 50 percent of Canadians having 24/7 access to multidisciplinary primary health care teams by 2011, and they agreed to "accelerate the development and implementation of the electronic health record." The primary care reform agenda was given further impetus by the findings and recommendations of two national reviews of health care (Commission on the Future of Health Care in Canada 2002; Senate Standing Committee on Social Affairs, Science and Technology 2002), the growing political and public concern about health care access and quality, the mounting dissatisfaction among family physicians with their working conditions and their ability to provide high-quality care (e.g., Blendon et al. 2001; Cohen et al. 2001; Commonwealth Fund 2000; Woodward et al. 2001), and medical school graduates' declining interest in family medicine (Canadian Institute for Health Information 2001). These concerns were both fueled and reflected by the media, with particular attention to emergency room "overcrowding," which was increasingly attributed to patients' having difficulty accessing family physicians. In this climate, organized medicine in several provinces—having previously adopted a cautious, if not hostile, attitude toward primary health care reform—began to negotiate the nature and terms of that reform in the early 2000s.

Reform Strategy

Because of Canada's formidable policy legacy of physicians' autonomy and self-management, its provincial and territorial governments, without exception, adopted a voluntary approach to physicians' engagement in incremental reform. In those jurisdictions where primary health care transformation has been the most far-reaching (Ontario, Alberta, British Columbia, and Quebec), major initiatives have been negotiated with the provincial medical association that serves as the physicians' bargaining agent. Key policy innovations have often been embedded in a formal agreement between the medical association and the government or health ministry. Most of the evolving provincial/territorial primary health care systems encompass a diversity of funding, physicians' payments, and organizational models.

Goals and Objectives for Primary Health Care

Although the goals and objectives of the provinces and territories for primary health care and its reform differ, they do contain recurring themes: improved access to primary care services; better coordination and integration of care; expansion of team-based approaches to clinical care; improved quality/appropriateness of care, with a focus on prevention and the management of chronic and complex illness; greater emphasis on patient engagement/self-management and self-care; and the implementation and use of electronic medical records and information management systems. Less consistently identified objectives include better experiences for patients and providers, delivery of a defined set of services to a specific population, adoption of a population-based approach to planning and delivering care, community/public participation in governance and decision making, building capacity for quality improvement, responsiveness to patients' and communities' needs, greater health equity, and health system accountability, efficiency, and sustainability.

These objectives of Canadian primary health care reform mirror the Institute of Medicine's six goals for improvement: safety, effectiveness, efficiency, person centeredness, timeliness, and equity (Institute of Medicine 2001), with a heavy emphasis on timeliness and effectiveness and on cost control rather than efficiency.

Policy Levers

Provincial and territorial governments are the principal funders of primary health care services, which also is their most potent policy lever. Desired innovations in the organization and delivery of care are often linked with the provision of funding or resources that enhance primary care providers' (especially physicians') income, quality of working life, or professional satisfaction. Other policy levers are contractual agreements with providers; funding of health professional training programs that determine the number and types of health human resources available to provide primary health care; development or modification of governance structures; and regulation and legislation. The last tend to be only rarely used to advance primary health care reform, except in relation to the scope of practice of regulated primary health care professionals.

Key Initiatives

We identified several primary health care reform initiatives that have been implemented broadly in one or more jurisdictions to advance the policy objectives just summarized. These include interprofessional primary health care teams, group practices and networks, patient enrollment with a primary care provider, financial incentives and blended-payment schemes, primary health care governance, expansion of the primary health care provider pool, implementation of electronic medical records, and quality improvement training and support.

Interprofessional Primary Health Care Teams. Although interprofessional primary health care teams are being introduced across the country, only a few provinces—Alberta, Quebec, and Ontario—have made substantial progress toward the First Ministers' goal of giving 50 percent of Canadians access to multidisciplinary primary health care teams by 2011.

In Alberta, three-quarters of the province's family physicians participate in Primary Care Networks, which were introduced in 2005 through an agreement by the Alberta Medical Association, the provincial health ministry, and Alberta's regional health authorities. Primary Care Networks are run by physicians and may have a single or, more often, multiple sites. The Primary Care Network model allows for wide local variation in the organization and delivery of services. As of January 2011, there were thirty-nine Primary Care Networks, with 3 to 273 physicians, averaging 58 physicians per network as well as other health professionals, which may include nurses, dietitians, social workers, mental health workers, and pharmacists. Given the networks' large size and organizational diversity, the extent to which care is delivered by teams at the practice level is highly variable. In an evaluation of the effectiveness of ten Primary Care Network teams using the Team Effectiveness Tool (TET), eight teams had mean scores in the range indicating "no significant concerns," one of which had a mean score in the "effective team" range (Drew, Jones, and Norton 2010; Saskatchewan Health 2002). Low scores on the "team partnership" subscale pointed to that dimension of team effectiveness as an area of weakness (Drew, Jones, and Norton 2010).

In Quebec, 219 Family Medicine Groups (Groupes de médicine de famille), involving 3,177 family physicians (37% of the province's family medicine workforce), have been established since 2002. The Ministry of Health and Social Services hopes to accredit 300 groups, which are expected to cover 75 percent of Quebec's population. Family Medicine Groups consist of six to ten physicians working with nurses and sometimes other providers to offer primary care services to registered patients on the basis of contractual agreements with the provincial government. A second private clinic model, the Network Clinic, was established in many regions through contractual agreements with regional health authorities. Network Clinics have an enhanced interdisciplinary team and complement Family Medicine Groups by providing extended hours of service and on-site access to diagnostic services (Pineault et al. 2009). Family Medicine Groups are linked with Centres de santé et de services sociaux (CSSS), which represent a merger of local institutions (acute care, long-term care, and community health centers), mostly through their Centres locaux de services communautaires (CLSCs), which are community-governed, interdisciplinary primary health care organizations that, as part of the CSSS, provide primary health and social services to geographically defined populations. Introduced in 1972, CLSCs were intended to be the dominant or exclusive model of primary health care in Quebec. But the continuing opposition to the model by organized medicine consigned CLSCs to minority status, and as a result, the proportion of Quebec's family physicians working in CLSCs has never exceeded 20 percent (Lévesque, Roberge, and Pineault 2007).

Early evidence suggests that the performance of Quebec's Family Medicine Groups is superior to that of other primary health care models (Beaulieu et al. 2006; Haggerty et al. 2008; Pineault et al. 2008; Provost et al. 2010; Tourigny et al. 2010). For example, Beaulieu and colleagues (2006) found that the integration of nurses and a linked clinical care protocol in Family Medicine Groups had a positive impact on the accessibility, coordination, and comprehensiveness of care and patient knowledge. And in a study of the provision of clinical preventive services, Provost and colleagues (2010) found that rates of preventive care delivery were higher in Family Medicine Groups and CLSCs than in traditional fee-for-service practices.

In Ontario, Community Health Centres and Family Health Teams are the chief interprofessional primary health care models. Together they now account for 21 percent of family physicians practicing in the province. The number of family physicians working in interprofessional teams increased from 176 in 2002 to more than 2,500 in early 2011.

The first Community Health Centres were established in 1979.

In 2004/2005, the provincial government announced its intention to create twenty-one new Community Health Centres and twenty-eight satellite clinics. Forty-eight new centers and satellites are now in operation, bringing the number of Community Health Centres (not including satellites) to seventy-three. Community Health Centres employ more than 300 physicians; 290 nurse practitioners; more than 1,700 other clinical, health promotion, and community development professionals; and more than 800 administrative and management personnel.

In a multifaceted study of four organizational/physician payment models in Ontario in 2005/2006, Community Health Centres performed better than fee-for-service practices and two capitation-based models in chronic disease management, health promotion, and community orientation (Hogg et al. 2009; Muldoon et al. 2010; Russell et al. 2009) but were the least efficient model (Milliken et al. 2011).

Established in 2005, Family Health Teams are the provincial government's flagship initiative in primary health care renewal and are the first explicitly interprofessional primary health care model introduced to Ontario in three decades. Currently, 170 teams are operational, and 30 are under development. They include more than 2,100 family physicians and approximately 1,400 other primary health care professionals, most commonly nurses, nurse practitioners, dietitians, mental health workers, social workers, pharmacists, and health educators. Nurse Practitioner–Led Clinics are similar in concept to Family Health Teams except that the ratio of family physicians to nurse practitioners is much lower and physicians function mainly as consultants. Four Nurse Practitioner–Led Clinics have been established, and twenty-two are in various stages of development. No studies of Family Health Teams' performance have been published to date, but a multiyear evaluation of the Family Health Team initiative, commissioned by the Ontario Ministry of Health and Long-Term Care, is in its third year.

Smaller-scale initiatives to create interprofessional primary health care teams, some led by physicians and others by the community, are under way in the remaining provinces and territories. Saskatchewan, for example, has created thirty "central" primary health care teams, usually with three to ten physicians (not necessarily in the same location) and one to two nurse practitioners per team. Some of these "central teams" are linked to smaller satellite teams, which, at a minimum, are staffed by a nurse practitioner and a visiting physician from the central team. Most teams are based in rural or northern regions.

Group Practices and Networks. The encouragement of group practice and the support of primary health care networks have been a key part of the reform strategies in Quebec, Alberta, and Ontario. Groups and networks provide a critical mass to enable quality improvement, 24/7 access to care, and economies of scale. Ontario has created an alphabet soup of primary health care organizational models (referred to as Patient Enrolment Models), most of which require participating physicians to be part of a group practice or practice network. Such models now encompass two-thirds of Ontario's family physicians. Practice networks in Ontario, as elsewhere, include both solo and group practices.

Patient Enrollment with a Primary Care Provider. Patients' formal enrollment with a primary care physician or group is an integral feature of primary care reform only in Quebec and Ontario. In both cases, enrollment is voluntary. More than half of the Quebec population is currently registered with a family physician; enrollments with a primary care physician in Ontario grew from 600,000 in 2002 to 9.5 million in February 2011, 72 percent of the provincial population.

Financial Incentives and Blended-Payment Schemes. During the past decade, primary health care reform initiatives throughout Canada have included a shift from unitary physician payment methods (mainly fee-for-service but also capitation or salary) to payment arrangements that include blends of fee-for-service, capitation, salary, or payments per session (e.g., per half day), and targeted payments designed to encourage or reward the provision of priority services. Nationally, the proportion of family physicians who receive 90 percent or more of their professional income from fee-for-service payments declined from 58.7 percent in 2002 to 48.3 percent in 2007 (Canadian Medical Association 2002; College of Family Physicians of Canada et al. 2007b). The shift has been most far-reaching in Alberta, Quebec, and Ontario in association with the development of Primary Care Networks, Family Medicine Groups, and patient enrollment models, respectively, and in British Columbia through a program of targeted incentive payments known as the Full Service Family Practice Incentive Program.

Alberta's Primary Care Network physicians receive a base remuneration (usually fee-for-service) plus targeted payments for after-hours coverage and other priority activities. In addition, Primary Care Networks receive supplementary funding on a per-patient basis to support enhanced staffing (including administration), premises and equipment, chronic disease management, expanded office hours, and 24/7 access to appropriate primary care.

Quebec's Family Medicine Groups receive a small annual fee for each registered patient, supplemental fees for registered patients from vulnerable populations, and payment for time spent attending meetings and completing paperwork. Funding also is available to support staffing, premises, and information technology. The bulk of the remuneration for physicians in Family Medicine Groups and Network Clinics continues to come from fee-for-service payments (Pineault et al. 2008).

The two-thirds of Ontario's family physicians who practice in a Patient Enrolment Model are paid through various blends of capitation, fee-for-service, and targeted payments. Capitation is the principal component for 50 percent of Patient Enrolment Model physicians, and fee-for-service is the main element for another 45 percent. The rest receive salary-based blended payments. All payment models include special fees or premiums (which vary across models) for providing priority services such as care of seniors, enrollment of new patients, and after-hours care. Most payment models include fees for preventive care outreach, pay-for-performance payments for preventive screening and immunizations, and bonus payments for the provision of

certain services (obstetrical deliveries, hospital services, palliative care, prenatal care, and care of patients with serious mental illness) above threshold levels.

A growing, but still limited, body of evidence suggests that the payment models and incentives introduced in Ontario are improving preventive care delivery, chronic disease management, physician productivity, and access to care. A study during the mid-1990s of the provision of preventive care to unannounced standardized patients by primary care physicians in south central Ontario found that being paid by salary or capitation (versus fee-for-service) payment was positively associated with the provision of evidence-based preventive care (Hutchison et al. 1998). An econometric study by investigators from the McMaster University Centre for Health Economics and Policy Analysis assessed physicians' responses to financial incentives, including preventive care pay-for-performance bonuses and special payments for priority services (e.g., obstetrical deliveries, prenatal care, hospital care, palliative care, in-office technical procedures, home visits, and care of patients with serious mental illness) above specified thresholds. Using a controlled before-after design, the study found that the pay-for-performance incentives led to an increase over baseline levels in the provision of four of five preventive services: 5.1 percent for seniors' influenza vaccination; 7 percent for Pap smears, 2.8 percent for mammography, and 56.7 percent for colorectal cancer screening (Hurley et al. 2011). There was no detectable response to the special payments for priority services above threshold levels.

Tu, Cauch-Dudek, and Chen (2009) assessed hypertension management during 2004/2005 by Ontario physicians working in salaried (Community Health Centre), capitation-based-blended-payment (Primary Care Network), and traditional fee-for-service practices. After controlling for patients' sociodemographic factors and co-morbid conditions, treatment and control rates were found to be higher in the Primary Care Network (capitation model) practices, which were more likely than the fee-for-service practices to employ nurses and nurse practitioners.

Kantarevic, Kralj, and Weinkauf (2010) found that Family Health Group (fee-for-service-based, blended-payment model) physicians provided more services and visits, saw more patients, made fewer referrals, and treated more complex patients than did traditional fee-for-service physicians, suggesting that the incentives included in this model increase physicians' productivity. Effects on quality of care were not assessed.

In a study of after-hours care in a single northern Ontario community, Howard and colleagues (2008) observed a lower six-month prevalence of emergency department use by patients of Family Health Network physicians (capitation-based, blended-payment model), compared with patients of physicians in Family Health Groups (fee-for-service-based, blended-payment model) and traditional fee-for-service practices. In a study of after-hours telephone information provided by Ontario family physicians, Howard and Randall (2009) found that physicians participating in Patient Enrolment Models, all of which require and financially reward physicians to provide after-hours care to enrolled patients, were more likely than physicians in conventional fee-for-service practice to suggest that patients use an after-hours clinic operated by the group or network with which the physician was affiliated (32% versus 10%) and were less likely to provide no instructions (11% versus 26%) or only to suggest using an emergency department or urgent care center or calling 911 (13% versus 24%).

British Columbia's targeted incentive program, introduced in 2002/2003, gives incentive payments to family physicians for chronic disease management, obstetrical care, complex care, mental health care, end-of-life care, and case conferencing (Cavers et al 2010). Manitoba initiated a demonstration project that supports fee-for-service family physician groups to establish interprofessional collaborative teams and integrate electronic medical records into day-to-day patient management. The initiative includes a pay-for-performance scheme based on twenty-seven clinical process indicators.

Beginning in 2001, the Northwest Territories government negotiated and implemented a wholesale transition from fee-for-service to salary remuneration of family physicians. By 2009, 95 percent of family physicians were on a salary-based contract that includes sick leave, maternity leave, and recruitment and retention bonuses.

Primary Health Care Governance. The predominance of independent, physician-owned and -managed solo and small-group family practices has inhibited the development of regional or local governance mechanisms for primary health care. Primary health care providers and stakeholders in most communities and health regions have no collective voice and no means for assuming collective responsibility and being held accountable for addressing their patients' and the local population's needs. The current wave of reform does, however, offer examples of primary health care governance initiatives, sometimes aligned with other reform elements such as funding mechanisms and organizational arrangements.

In Quebec, Family Medicine Groups have been associated from the outset with a set of contractual agreements between accredited clinics and other health institutions at the local, regional, and provincial levels. These contractual agreements formalize the collaboration and sharing of resources among and within primary care clinics. In addition, regional and local departments of family medicine have been established in Quebec (Département régional de medicine générale). These departments, composed of elected representatives from each local area's pool of general practitioners, have a mandate to coordinate the supply and planning of primary care services and to work in close collaboration with regional health authorities and local health centers. For example, these departments control the entry of new general practitioners into the area and determine where these newcomers will perform their mandatory emergency room or long-term care service requirements. As such, they represent one of the first attempts at integrating general practitioners into the governance of Quebec's health system.

British Columbia has supported the development of Divisions of Family Practice in eighteen communities and plans, by 2012,

to extend this support to any community or region in the province where family physicians wish to establish a division. These divisions are local organizations of family physicians who are prepared to work together at the community level to improve clinical practice, offer comprehensive services to patients, and participate in health-service decision making in partnership with their regional health authority and the Ministry of Health Services. (Five regional health authorities govern, plan, and coordinate health care services in conformity with the goals, standards, and performance agreements established by the Ministry of Health.) The initiative is sponsored and funded by the General Practice Service Committee, a joint committee of the British Columbia Ministry of Health Services and the British Columbia Medical Association. The divisions are expected to work with their health authority and local community agencies to identify and address gaps in the delivery of health services at the community level. Although membership in the divisions is voluntary, a division must include the majority of family physicians in the community.

Expansion of the Primary Health Care Provider Pool. In response to public concerns about access to primary health care and pressure from professional associations and advocacy groups, provincial and territorial governments moved during the last decade to increase the numbers and types of primary health care providers. The greater number of medical school spaces and family medicine residency positions has resulted in a 9 percent rise in the number of family physicians per 100,000 Canadians, from 94 in 2000 to 103 in 2009 (Canadian Institute for Health Information 2010c). Most provinces and territories have introduced or expanded training and/or employment opportunities for midwives and nurse practitioners, and Ontario has established a university-based training program for physicians' assistants.

Midwifery is now a legal and regulated profession in eight provinces and one territory: Ontario (1994), British Columbia (1998), Alberta (1998), Quebec (1999), Manitoba (2000), Northwest Territories (2005), Saskatchewan (2008), Nova Scotia (2009), and New Brunswick (2010). In Ontario, the first province to recognize midwifery and fund midwifery services, the number of midwives has grown by 150 percent since 2002 to more than five hundred, and midwives now attend 10 percent of births in Ontario.

Nurse practitioners are licensed in every Canadian province and territory. The number of licensed nurse practitioners in Canada, most of whom are primary health care nurse practitioners (Donald et al. 2010), more than doubled from 800 to 1,990 between 2004 and 2008 (Canadian Institute for Health Information 2010a, 2010b). In 2008, more than 50 percent of Canadian nurse practitioners were based in Ontario (Canadian Institute for Health Information 2010a), and between 1999 and 2010, the number of primary health care nurse practitioners licensed in Ontario increased tenfold from 130 to 1,362 (College of Nurses of Ontario 2008, 2011). In comparison, the province of Quebec still has fewer than 100 nurse practitioners. In a study of chronic disease management by Ontario's primary health care practices (Russell et al. 2009), a high overall score for processes of care was associated with the presence of a nurse practitioner, independent of the organizational and payment model.

Perhaps not surprisingly given the population growth, the interprovincial variability in the introduction of nonphysician primary health care providers, and the recency of many of these initiatives, this expansion of the provider pool has yet to be reflected in greater national-level access to care. For example, the percentage of adult Canadians with no regular place of care rose from 9 to 14 percent between the 2007 and 2010 Commonwealth Fund International Health Policy Surveys (Commonwealth Fund 2010; Schoen et al. 2007). While the percentage that were seen on the same day the last time they were sick increased from 22 to 28 percent, the percentage waiting six or more days to be seen also increased, from 30 to 32 percent. The percentage that found it somewhat or very difficult to get care on nights and weekends without going to the emergency room declined only marginally, from 65 to 63 percent.

Implementation of Electronic Medical Records. Family physicians' use of electronic medical records varies widely among the provinces (from 12.8% in Prince Edward Island to 56% in Alberta, as of 2007) (College of Family Physicians of Canada et al. 2007c). Across the provinces, the use of paper-only charts ranged from 37 percent (Alberta) to 83 percent (Prince Edward Island), and the exclusive use of electronic records ranged from 0 percent (Prince Edward Island) to 21.7 percent (Alberta). In large measure, this variation reflects the extent to which provinces have subsidized the acquisition, implementation, and ongoing use of electronic records. Since 2007, government support for the implementation of electronic medical records has accelerated in some provinces. For example, the Ontario government is extending to all primary care physicians its subsidies for the adoption and continued use of electronic medical records, which previously were available only to physicians working in specific primary care reform models. In 2010, the federal government made $380 million available to support the implementation of electronic medical records by community-based physicians and nurse practitioners. In the Commonwealth Fund's International Health Policy Surveys of primary care physicians, the use of electronic medical records reported by Canadian respondents increased from 23 to 37 percent between 2006 and 2009 (Schoen et al. 2006, 2009).

Quality Improvement Training and Support. Over the last several years, sometimes in partnership with the provincial medical association, governments and health ministries in British Columbia, Alberta, Saskatchewan, and Ontario have attempted to address the quality gap between current and achievable primary health care performance by mounting quality improvement learning collaboratives based on the Institute for Healthcare Improvement's Breakthrough Series model (Institute for Healthcare Improvement 2003).

Primary health care quality improvement in British Columbia is funded and organized through the Practice Support Program, a joint initiative of the British Columbia Medical Association Section of General Practice, the Ministry of Health Services, and

the regional health authorities. The program supports physicians and their office staff to plan and implement enhancements in clinical care and practice management through a series of learning sessions and action periods with the assistance of practice support teams consisting of facilitators and peer champions. Practice teams comprising a physician and a medical office assistant can work on one or more modules that address clinical workflow redesign (Chronic Disease Management, Patient Self-Management, Mental Health, End-of-Life Care), practice management redesign (Advanced Access, Group Medical Visits), or use of information technology (Chronic Disease Management Toolkit) (MacCarthy et al. 2009, Weinerman et al. 2011). As of March 2009, approximately one-third of British Columbia's family physicians had participated in the Practice Support Program (Cavers et al. 2010).

Alberta's Access, Improvement and Measures (AIM) collaboratives guide practice teams (physicians, health professionals, and office staff) through a facilitated learning process composed of six structured learning sessions and intervening action periods that over fourteen months sequentially address patient access, office efficiency, and clinical care improvement. Since 2005, improvement teams from 137 primary health care clinics, representing about one-third of the province's family physicians, have participated in these collaboratives (Alberta AIM 2010).

Between 2005 and 2009, more than a quarter of Saskatchewan's family physicians participated in chronic disease management collaboratives focusing on diabetes and coronary artery disease. Fifty-four primary care practices (47 family physicians and 170 other providers) are participating in another large-scale collaborative launched in November 2009, concentrating on depression, chronic obstructive pulmonary disease, and office redesign.

In 2007, the Ontario Ministry of Health and Long-Term Care created the Quality Management Collaborative (since renamed the Quality Improvement and Innovation Partnership, QIIP) to help Family Health Teams navigate the transition to a new team-based model of primary health care delivery. In 2009 QIIP became an independent, not-for-profit organization, still funded by the Ministry of Health, with a broadened mandate to support sustained quality improvement across the primary health care sector. QIIP has completed three learning collaboratives with 122 interdisciplinary teams from Family Health Teams and Community Health Centres. Each team directed its quality improvement efforts to diabetes care, colorectal cancer screening, and office practice redesign (access and efficiency) and were supported in their quality improvement work by one of fourteen full-time-equivalent quality improvement coaches. In 2010, QIIP launched the Learning Community, which combines virtual and face-to-face learning to support the acquisition and application of quality improvement methods in primary health care. With the support of the quality improvement coaches, 127 interdisciplinary primary health care teams are participating in one or more of six Action Groups (diabetes, hypertension, asthma, chronic obstructive pulmonary disease, integrated cancer screening, and office practice redesign) in wave 1 of the Learning Community. Ninety-two teams are participating in wave 2, which began in early 2011 with a focus on office practice redesign.

Summary of Major Achievements since 2000

- Interprofessional primary health care teams have been established in all provinces and territories and are proliferating in Ontario, Alberta, and Quebec. These teams are designed to improve access to care and continuity and coordination of health care services and, like Patient-Centered Medical Homes, are viewed as key to delivering high-quality primary health care.

- Formal patient enrollment with a primary care physician has been broadly implemented in two provinces, Quebec (58% of the population) and Ontario (72% of the population), providing the foundation for a proactive, population-based approach to preventive care and chronic disease management and laying the groundwork for systematic practice-level performance measurement and quality improvement.

- The number of primary care physicians participating in blended-payment arrangements—which include combinations of fee-for-service, capitation, sessional payments, salary, infrastructure funding, and targeted payments for priority activities or performance levels—has increased dramatically, if unevenly, across the country, with a corresponding decrease in strictly fee-for-service arrangements. Blended-payment arrangements allow health care funders to align payments with health system goals, balance the perverse incentives inherent in individual payment methods (e.g., overservicing in fee-for-service, skimping and cream-skimming in capitation, and shirking in salary), support the development of appropriate infrastructure (e.g., information management systems, accessible premises, quality improvement mechanisms), and encourage the provision of priority services, processes, and outcomes of care.

- Training programs for family physicians, midwives, and nurse practitioners have been substantially expanded. This, together with the development of interprofessional health care teams and quality improvement work focused on system redesign at the practice level, should improve timely access to primary health care and may reduce downstream health care utilization and costs.

- Organizations with a mandate to support primary health care improvement and innovation have been established and funded by several provinces' ministries of health. Embedding quality improvement in the fabric of primary health care practice is essential to creating a high-performing health system.

Variation among Provinces and Territories

Table 1 shows the variation among Canada's provincial and territorial health care systems in the system-level implementation of primary health care initiatives. System-level initiatives are those that have been implemented broadly within the jurisdiction or on a more limited basis in a jurisdiction with a policy commitment to later broad-scale implementation and a policy environment conducive to systemwide spread. Major reform initiatives have been pursued most aggressively in Ontario, Alberta, and Quebec, followed closely by British Columbia, with fewer system-level initiatives in the remaining provinces and territories. The initiatives are quite different in each jurisdiction. For example, interprofessional primary health care teams in Ontario contain a broad array of providers, whereas those in Quebec are largely confined to physicians and nurses. Similarly, the character of innovative payment and incentive schemes differs substantially from one jurisdiction to another.

Challenges

System Complexity

An incremental and pluralistic approach to primary health care renewal runs the risk of creating a lack of system coherence, high administrative and transaction costs associated with multiple funding, and organizational models and a change process that can become bogged down in the details of implementing and coordinating a multitude of reforms (Hutchison, Abelson, and Lavis 2001). But in a policy environment constrained by policy legacies unfavorable to sweeping health system change, it is likely to be the only feasible strategy for transforming the system (Hutchison, Abelson, and Lavis 2001). Moreover, renewing primary health care by working incrementally toward a desired set of system characteristics can lead to change that is both fundamental and coherent (Commissaire à la santé et au bien-être du Québec 2009).

Physicians' Engagement

Given the "founding bargain" with the medical profession on which Canadian Medicare is based, Canadian primary care physicians have been hesitant to embrace any organizational or payment model that they see as threatening their professional autonomy, particularly when the reforms appear to be motivated by a desire to contain costs. To address this reticence, several provincial governments are negotiating primary health care reform initiatives with the provincial medical association representing family physicians on the basis of voluntary participation and pluralism of organizational and remuneration models. This approach recognizes that for Canada, system-level innovation in primary health care is possible only with the support or, at a minimum, the acquiescence of organized medicine. Furthermore, that support is most likely to be obtained if the medical association is present at the policy table. This strategy has allowed large numbers of primary care physicians to view new organizational

Table 1.
System-level Primary Health Care Initiatives

		BC[a]	AB[b]	SK[c]	MB[d]	ON[e]	QC[f]	NB[g]	PE[h]	NS[i]	NL[j]	NT[k]	YT[l]	NU[m]
Inter-professional teams			+			+	+							
Group practices/networks			+			+	+							
Patient enrollment			+			+	+							
Payment/incentive schemes		+	+		+	+	+					+		
Governance		+					+							
Additional providers	FPs[n]	+	+		+	+	+	+	+	+	+		+	+
	Other		+			+	+							
EMR Implementation[o]		39%	56%	28%	35%	40%	20%	30%	13%	40%	47%	65%[p]	ND	ND
Quality improvement support		+	+	+		+								

Note: A + indicates a system-level initiative; an empty cell indicates the absence of a system-level initiative. ND = no data available.
[a]British Columbia
[b]Alberta
[c]Saskatchewan
[d]Manitoba
[e]Ontario
[f]Quebec
[g]New Brunswick
[h]Prince Edward Island
[i]Nova Scotia
[j]Newfoundland and Labrador
[k]Northwest Territories
[l]Yukon
[m]Nunavut
[n]Canadian Institute for Health Information. 2010a
[o]College of Family Physicians of Canada et al. 2007c
[p]Personal communication, Ewan Affleck, Medical Director, Yellowknife Health and Social Services Authority, January 3, 2011

and remuneration models as opportunities to enhance their effectiveness, the quality of their working lives, and their income. This strategy also, however, has limited the content of reforms to generally agreed-upon changes, whereas more profound and innovative transformations have often faced the opposition of professional associations and made much slower progress.

Teamwork

The transition to team-based care is indeed challenging, especially for physicians who are socialized and accustomed to being the undisputed team leader. In an interprofessional environment, the participation of other professional and administrative staff in policy and management decisions is no longer discretionary. Tension is often greatest between nurse practitioners and physicians. Nurse practitioners are trained and licensed as autonomous professionals (in contrast to registered nurses and physician assistants) and see themselves as "equal members of the health care team." Nonetheless, policy legacies (physicians' control of their work environment) and institutional arrangements (physicians' ownership and governance of group practices and networks) often work against these expectations. The substantial overlap in scope of practice between physicians and nurse practitioners thus demands a thoughtful and respectful approach to determining each person's roles and responsibilities.

The effective implementation of interprofessional primary health care models will require that change management support is available to providers as they make the transition.

Requirements for Investment

The costs of primary health care renewal are substantial. Where it has been most successful, "buying system change" has entailed increases in physicians' incomes and significant investments in primary health care infrastructure. And because the transformation is still incomplete, the federal and provincial governments must maintain these investments despite the recent economic recession and the deficits incurred to combat it.

Although many provincial and territorial governments have made sizable investments in primary health care information technology, the implementation of electronic medical records remains limited, and most currently approved systems have frustratingly inadequate performance measurement, disease management support, and registry capability. Only 37 percent of Canadian respondents to the 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians reported using a computer to generate lists of patients according to diagnosis (the second lowest of the eleven countries in the survey), and 22 percent said they used a computer to generate lists of patients overdue for tes ts or preventive care (the lowest among the countries studied) (Schoen et al. 2009). Only 14 percent of Canadian family physicians used nine or more of fourteen electronic information functions. This was the lowest of the eleven countries and in striking contrast to the United Kingdom, Australia, and New Zealand, where 89 to 92 percent of primary care physicians use nine or more functions. Arguably, investment and activity at both the provincial/territorial and federal levels have focused excessively on designing the overall architecture for health information technology and too little on putting clinically useful electronic medical records into the hands of health care providers.

Equity

Despite universal insurance coverage and the absence of user charges for physicians' and most diagnostic services in Canada, the research evidence points to persisting inequities in access to care. After needs for care are taken into account, patients who are poor, poorly educated, or both still have less overall access to specialists' and (possibly) family physicians' services, preventive care, and services for specific health problems (e.g., cardiovascular and mental health care) (Hutchison 2007). A population-based study in Ontario (Glazier et al. 2009) found that better-educated individuals were more likely to receive specialist services, to see specialists more often, and to bypass family physicians to obtain specialist care. Among respondents to a 2003 national population survey, low income was independently associated with self-reported unmet health care needs (Sibley and Glazier 2009). With minor exceptions (e.g., the expansion of Community Health Centres in Ontario), Canada's reform of primary health care has failed to address this issue. "Healthcare providers, planners, managers and policymakers need information (not to mention resources and commitment) at the practice, local, regional, provincial/territorial and pan-Canadian levels so that targeted programs to address disparities can be developed and implemented" (Hutchison 2008, 20).

Evidence-Informed Decision Making

Effective improvements in the quality of a health system require both ongoing performance measurement and the rigorous and timely evaluation of health care policy, management, and delivery innovations. Most provinces and territories are moving in this direction, but the process is not yet complete. Although commissioned evaluations of major initiatives are becoming increasingly common, they often begin too late to allow for the collection of baseline data or to provide useful feedback on the implementation process. Evaluation results are also not consistently made public.

To guide primary health care system planning and management, a suite of relevant health system performance indicators need to be identified and utilized at the local, regional, provincial, and national levels. Various provincial health quality councils (Ontario Health Quality Council, Health Quality Council of Alberta, and Quebec's Commissaire à la santé et au bien-être) have begun to assess the performance of primary care and its contribution to the overall performance of their health care systems. These analyses have highlighted Canadian primary care clinicians' lack of capacity to assess the clinical impact of the care

they provide and to compare their own performance with that of their counterparts in other countries further advanced in the primary care reform process.

The lively pace and variability of primary health care reform initiatives in several Canadian provinces have created promising opportunities to evaluate their impacts within and across jurisdictions. But the absence of good baseline data, the lack of an agreed-upon and applied set of primary health care performance measures, the voluntary participation of patients and providers, and the confounding of primary care physicians' payment methods and organizational forms have made the evaluation of primary health care transformation challenging.

Transformative Potential

During the last decade, Canada's provinces and territories have, to varying degrees, reformed primary health care through initiatives that focus on strengthening the infrastructure of primary health care and establishing funding and payment mechanisms that support the improvement of performance. These policy initiatives reflect the recommendations of two national reviews of health care in Canada completed in 2002, the shared commitments to primary health care renewal by the prime minister and the provincial and territorial premiers in 2000, 2003, and 2004, as well as the declared primary health care goals of individual provincial and territorial governments. The initiatives are also consistent with a report from the Canadian Academy of Health Sciences that envisions an integrated health care system that will

- Offer primary care practices that are responsible for a defined population.
- Be focused on the person (and family or friend/caregiver).
- Provide comprehensive services using interprofessional teams.
- Link with other sectors in health and social care.
- Be accountable for outcomes (Nasmith et al. 2010).

This approach to improving primary health care is congruent with the Institute of Medicine's insistence in Crossing the Quality Chasm that health care that is safe, effective, patient centered, timely, efficient, and equitable must focus on system redesign (Institute of Medicine 2001). The extent to which the structural reforms that have been successfully implemented since 2000 at a system level in several provinces have actually improved processes and outcomes of care will become evident over the current decade.

Conclusion

A culture change in primary health care is gathering force in several Canadian provinces. The general shape of transformed primary health care is becoming clear. The renewed system will offer interprofessional team-based care, multicomponent funding and payment arrangements, enrollment of patients, ongoing performance measurement, and quality improvement processes. As is usual in Canadian health care, the other provinces will likely follow the leaders, each in its own way and in its own time. The pace of transformation will undoubtedly be influenced by the documented accomplishments of the pacesetting provinces and the flow of earmarked federal funding to advance the primary health care reform agenda.

Perhaps the main message emerging from the recent Canadian experience is that primary health care can be transformed in a pluralistic system of private health care delivery through a process that is voluntary and incremental and has strong government and professional leaders working together. This incremental approach enables a relatively quick, systemwide implementation of those reform elements with broad public and stakeholder support. The variety of models offers opportunities to those ready to embrace innovation without imposing changes on the remainder. Given the collective bargaining rights of Canada's medical associations, broad-based primary health care transformation is possible only with the support of organized medicine. A second message is that a single-payer, publicly funded health care system need not be the enemy of health care reform, innovation, and quality improvement.

Endnotes

1 In 2008, Canada had 2.2 physicians per 1,000 population, compared with the OECD median of 3.2 per 1,000 (OECD 2009).

2 The OECD's mean of 0.88 and median of 0.73, versus Canada's 1.04 per 1,000 population in 2008, the United States 0.96, Australia 1.43, Austria 1.53, Belgium 2.01, France 1.64, and Germany 1.48 (OECD 2009).

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PNHP Chapter Reports – Fall 2011

PNHPers in **Alabama** are growing their chapter through extensive outreach efforts to legislators and the public. Single-payer activists joined forces for a large party celebrating Medicare's 46th anniversary in July. Dr. Pippa Abston's new book, "Who is my neighbor? A Christian response to healthcare reform" received a positive review in The Huntsville Times; Dr. Abston also regularly blogs on single payer at pippaabston.wordpress.com. Drs. Wally Retan and Mark Wilson both had pro-single-payer op-eds published in The Birmingham News. To get involved in northern Alabama, contact Dr. Abston at pabston@aol.com; in the greater Birmingham area, write Dr. Wally Retan at HealthCareForEveryone@charter.net.

Arizona's PNHP chapter is actively opposing cuts to the state's safety-net programs. It held a press conference denouncing cuts to Medicaid, and Dr. George Pauk appeared on MSNBC and other media sharply criticizing the cut-off in Medicaid funding for organ transplants. During a Society of General Internal Medicine meeting in Phoenix, over 300 doctors from across the country rallied outside the Capitol to protest Arizona's anti-immigrant legislation. The effort was led by Dr. Oliver Fein, past president of PNHP, Dr. Olveen Carrasquillo, PNHP board member, and Dr. Cristina Gonzalez of New York in collaboration with Arizona PNHPers and others. Activists sued the state government to block cuts to the Medicaid program and are now appealing the verdict. Contact Dr. Eve Shapiro in Tucson at shapiroe@u.arizona.edu or Dr. Pauk of Phoenix at gpauk@earthlink.net.

Members of PNHP **California** are meeting with legislators; holding conferences, lobby days and rallies; and helping to build a statewide single-payer coalition. Their single-payer lobby day in Sacramento drew over 300 medical and health-professional students. New PNHP chapters have been launched in Chico and the East Bay area. Activism has increased statewide, and included a rapid mobilization to get their state single-payer bill, SB 810, passed out of committee at the eleventh hour. Their second annual Summer Conference brought over 200 activists to Los Angeles in July and featured APHA past president Dr. Carmen Nevarez, Dr. Paul Song, Dr. Jeoffry Gordon, Michael Lighty of CNA/NNU and former state Sen. Sheila Kuehl. PNHPers helped organize a protest outside America's Health Insurance Plans' annual meeting in San Francisco. Two California med students traveled to Vermont for the student rally for single payer. Dr. Richard Quint had a letter on concierge medicine published in the San Francisco Chronicle. Contact Dr. Bill Skeen at bill@pnhpcalifornia.org.

Single-payer activists in **Colorado** hosted Dr. Margaret Flowers for a very successful chapter visit in April. The four-city tour included multiple media appearances, public events, grand rounds and medical student outreach. State Senator Dr. Irene Aguilar, past president of Health Care for All Colorado, was recently named "Senator of the Year" by the Colorado Cross-Disability Coalition. PNHP members Ann Molison and Chris Gibbar each had letters published in The Coloradoan calling for the defense of Medicare and the need for an improved Medicare for all. Contact info@healthcareforallcolorado.org.

Arizona PNHPers rallied alongside members of National Nurses United and other allies on March 5 in Phoenix calling for the restoration of funds for organ transplants for Medicaid patients.

At the annual meeting of the American Psychiatric Association in Honolulu, **Hawaii**, last May, psychiatrists who support single payer met as a group to discuss how to advance their goals. Dr. Audrey Newell of Ann Arbor, Mich., received an award for her years of dedicated service promoting single payer at the APA conferences. PNHPer Dr. Steven Kemble is president-elect of the Hawaii Medical Association and was recently appointed to the Hawaii Health Authority to design a universal health plan for the state. Dr. Leslie Gise has recruited many new members to the organization. Contact Dr. Kemble in Honolulu at sbkemble@hawaii.rr.com or Dr. Gise in Kula at leslieg@maui.net.

Health Care for All **Illinois** co-sponsored an April 11 lobby day for single payer that brought busloads of health professionals, medical students and others to Springfield, the state capital. In Chicago, the PNHP chapter joined with Physicians for Social Responsibility to host a "Soul of Medicine" event, presenting an award to longtime PNHP member Dr. Lee Francis; sponsored a chapter visit by Dr. Oliver Fein, past president of PNHP; and co-sponsored a packed public meeting in July with authors Dr. David Ansell ("County") and John Dittmer, Ph.D. ("The Good Doctors"). Drs. Duane Dowell, Claudia Fegan, Peter Gann, Pam Gronemeyer, Susan Rogers, Anne Scheetz, Diljeet Singh, Phil Verhoef and Quentin Young have spoken at many events, including grand rounds at Rush and Northwestern University. Activists are staffing single-payer information booths at local farmers' markets. In downstate Illinois,

co-president Dr. Gronemeyer has hosted public forums. Dr. Claudia Fegan was published twice in the Hyde Park Herald and Dr. Scheetz's commentary on the need for single payer appeared in the Chicago Tribune. Contact Dr. Scheetz at annescheetz@gmail.com.

The **Indiana** PNHP affiliate, Hoosiers for a Commonsense Health Plan, boasts 11 chapters across the state and is building grassroots support for single payer through a petition signature-gathering effort at county fairs and farmers' markets. The chapter hosted Wendell Potter (the former Cigna executive turned industry whistle-blower) who spoke before more than 400 people in January. In May, Dr. Rob Stone and others mobilized for WellPoint's annual meeting to present a resolution calling for WellPoint to revert to nonprofit status. After the meeting, the Hoosiers rallied in downtown Indianapolis with Donna Smith of "Sicko" and others, and then gathered for their annual strategy meeting. Dr. Stone is a regular contributor to The Huffington Post and was interviewed with Karen Green Stone on radio about how single payer can reduce racial disparities. Contact Dr. Rob Stone at grostone@gmail.com.

Kentuckians for Single Payer Health Care hosted Dr. Claudia Fegan, past PNHP president, for a chapter visit commemorating the work of the Rev. Dr. Martin Luther King Jr. Events included a public forum at the Louisville Urban League. Her visit received coverage from the Louisville Courier-Journal and several other media outlets. Dr. Ewell Scott had multiple letters to the editor published in the Lexington Herald-Leader, and Dr. Garrett Adams' op-ed, "Why we need single-payer, nonprofit health insurance" also appeared there. Dr. Adams presented grand rounds in Arkansas in August. Dr. Edgar Lopez was interviewed by Spanish-speaking newspaper Al Día en América. Contact Dr. Syed Quadri at hinmed@gmail.com.

Katie Robbins of Healthcare-Now, left, joins Drs. Quentin Young and Diljeet Singh during a break at PNHP's last Annual Meeting in Denver.

PNHP's local chapter, **Maine** AllCare, is reaching out to physicians, the public and legislators to promote single-payer health insurance in the wake of the recent legislative repeal of numerous consumer protections regarding health insurance. Activists are moving forward with a state single-payer bill, focusing on a feasibility study. Dr. Richard Dillihunt's call for national health insurance appeared in The Portland Herald. Dr. Phil Caper, Joe Lendavi and Julie Pease were published in the Portland Press Herald regarding the need to eliminate the profit motive from our health care system. Activists are planning a chapter visit with Dr. Margaret Flowers this winter. Contact Dr. Phil Caper at pcpcaper21@gmail.com.

From left, Leonard Rodberg and Laurie Wen of PNHP's N.Y. Metro chapter; Wendell Potter, former Cigna executive and author of "Deadly Spin"; and Dr. Oliver Fein, chapter chair, gathered for a few moments before Potter spoke at a N.Y. Metro forum earlier this year.

In **Maryland**, PNHPers are moving forward with their state single-payer bill while continuing to build support for national health insurance. Activists held their first rally and lobby day with allied organizations earlier this year. The chapter raised funds for an economic impact study for single payer in Maryland by holding house parties, a movie night with an auction, music events and a direct-mail appeal. The chapter held a successful annual meeting with over 60 activists from across the state. Members have presented at grand rounds, spoken at public events and hosted public forums. Dr. Eric Naumburg was interviewed by The Baltimore Sun. Dr. Carol Paris' article on "Private Insurance Induced Stress Disorder (PIISD)" was published in Psychiatric Times, evoking many positive responses. Dr. Adriane Fugh-Berman and Dr. Paris were interviewed for an article on the harmful role of the for-profit pharmaceutical industry; the article appeared in three newspapers in southern Maryland. Contact Dr. Naumburg at enaumburg@hotmail.com.

The **Massachusetts** PNHP chapter hosted two forums at Harvard Medical School, one on health care reform after PPACA and another on the effects of the Massachusetts reform on the safety net. Each was attended by at least 80 people. The chapter helped send several busloads of health-professional students to Vermont for the student rally for single payer, and has worked to restore health coverage for 30,000 legal immigrants who were dropped from state-supported coverage in 2009. Summer interns Ibrahima Sankare and Jennifer Lin worked with chapter member Dr. Danny McCormick and staffer Ben Day to produce

an update on the Massachusetts health reform, set for release in September. Interns also helped create a chapter website with a single-payer resolution that physicians can sign on to. Intern Desiree Otenti is working on a research project looking at the barriers to post-acute care faced by Medicaid patients. The published work of other researchers, including Drs. Rachel Nardin, J. Wesley Boyd, Andrew Linsenmeyer, David Himmelstein and Steffie Woolhandler, along with Ben Day, the chapter's executive director, received substantial media coverage. Co-chair Dr. James Recht had an opinion piece published at CommonDreams.org. Contact Ben Day at ben@pnhp.org.

Physicians for single payer in **Michigan** are speaking throughout the state and within specialty organizations. Dr. Jim Mitchiner gave a presentation on single payer to the Society for Academic Emergency Medicine's annual meeting in Boston and is moderating a panel on health reform at the Michigan State Medical Society this fall. For the sixth year in a row, he will introduce a single-payer resolution at the American College of Emergency Physicians, aiming to further educate ER doctors on the issue. Dr. John Cavacece's op-ed calling for an improved Medicare for all appeared in the Grand Rapids Press. Several op-eds by Dr. Mitchner were published by AnnArbor.com. Contact Dr. Mitchiner at jmitch@umich.edu.

Members of PNHP **Minnesota** held their annual summer celebration and fund-raiser in June, featuring author T.R. Reid, and raised about $10,000. Earlier in the year, they helped build a Twin Cities student medical student lobby and now have a student chapter of more than 60 members. In April, they hosted Dr. David Himmelstein, whose visit included a presentation at the Mayo Clinic, a fund-raising party and a breakfast with legislators. Drs. Elizabeth Frost and Ann Settgast both had op-eds published around Medicare's 46th anniversary, and an op-ed by Dr. Ralph Bovard calling for an end to rationing based on ability to pay (by implementing single payer) appeared in the Star Tribune. The chapter is hosting a national meeting of state legislators on state-based single-payer efforts sponsored by the Milbank Memorial Fund in late September. Contact pnhpminnesota@gmail.com.

Dr. Dimitri Drekonja, left, medical students Kirsten Kesseboehmer and Elliot Johnson, and Dr. Ann Settgast stand outside the State Capitol in St. Paul, Minn., on March 31 during a break in their lobbying efforts for single-payer legislation there.

PNHP members in **Montana** participated in a June 29 meeting in Bozeman's Labor Temple, sponsored by the Montana Human Rights Network, to discuss prospects for a state-based universal health care plan. Kim Abbott from the National Economic and Social Rights Initiative said the Legislature's failure to pass enabling legislation for implementing the Affordable Care Act has created an opening for a state-based solution, including the possibility of a single-payer system. Participants discussed the experience of other states pursuing similar efforts. Contact Dr. Richard Damon at richanna@bresnan.net.

Activists in **New Mexico** hosted Dr. Margaret Flowers in April for a whirlwind chapter visit of grand rounds, medical school forums, public lectures, radio interviews and more. The trip was covered by several media outlets, including the McClatchy-Tribune News Service. PNHPers put forth a state constitutional amendment to make health care a human right and worked in a coalition with a broad range of community and faith groups, including New Mexico's Public Health Association, to raise awareness. Medical student James Besante has been educating potential Congressional candidates about single payer. Dr. Bruce Trigg's op-ed calling for health care as a human right appeared in the Albuquerque Journal. Contact Dr. Trigg at trigabov@aol.com.

The **New York Metro** chapter has held forums on topics such as Vermont's health law, PPACA and single payer, and a report-back by a chapter-organized group of health professionals who visited hospital systems in Toronto to see how Canada's single-payer system works. The chapter sent single-payer supporters to Vermont for the student rally, and sponsored events related to Medicare's anniversary in four of the five boroughs. Through congressional visits and a public statement (which led to several radio interviews), they have spoken out against cuts to Medicare, Medicaid and Social Security. Contact Laurie Wen, the chapter's executive director, at laurie@pnhpnymetro.org.

In **Upstate New York**, activists hosted a chapter visit with PNHP President Dr. Garrett Adams this spring. Activities included pediatric grand rounds, a fund-raising dinner and an hour-long public radio interview broadcast to seven states. The following week, Dr. Adams appeared at a press conference with Assemblyman Richard Gottfried, who announced the introduction of his single-payer bill in the state's lower chamber. New York PNHPers worked with allied organiza-

tions to hold a lobby day on Gottfried's bill, receiving much media attention. Dr. Andy Coates, the chapter's chair, blogs on single payer at the Times-Union and has done numerous radio interviews. Albany Medical School students were instrumental in the organizing for the Vermont student rally for single payer. Contact Dr. Coates at esquincle@verizon.net.

The **Oregon** chapter recently held a strategy meeting that drew over 60 people. Participants mapped out plans for a speakers bureau and fund-raising. They decided not to reintroduce their state single-payer bill this year, choosing instead to focus on building the grassroots movement. Op-eds and letters by Dr. Sam Metz have appeared in The Oregonian, Portland Alliance and The New York Times. Dr. Paul Gorman spoke on the benefits of single payer before the Clatsop County Medical Society. Working with the Mad as Hell Doctors, the chapter has been promoting a national radio campaign with Bob Wickline's folksy song about Medicare for All. PNHPers are invited to visit madashelldoctors.com to hear the 60-second spot that has now run in at least 11 states. Inquiries about adapting the ad to suit your state are welcomed. Contact Dr. Mike Huntington at mchuntington@comcast.net.

Tennessee now boasts two chapters and PNHPers are working to start two more. They are having a leadership training session in September and reaching across several Southern states to build the southern constituency for an improved Medicare for all. A letter to the editor on the limitations of the federal health reform and the continued need for health care justice by Dr. Art Sutherland was printed in the Memphis Commercial Appeal. Contact Dr. Sutherland at asutherland@sutherlandclinic.com.

PNHP members in **Vermont** celebrated the enactment of Act 48, "An act relating to a universal and unified health system," upon its signing by Gov. Peter Shumlin on May 26. Drs. Deb Richter, Marvin Malek, Francis Pasley and Susan Deppe published op-ed pieces; Dr. Alice Silverman, president of the Vermont Psychiatric Association, was among those who testified in support (the VPA endorsed the reform); Dr. Peggy Carey, the new PNHP chapter's chairperson, did several radio interviews. In the run-up to its passage (and with PNHP support), more than 50 doctors made a "house call" for single payer at the Capitol, over 200 health-professional students from the Northeast rallied for single payer on the Capitol steps, and more than 200 physicians from 39 states said they'd seriously consider relocating to Vermont if it were to implement a single-payer system. (See extensive coverage starting on page 32 in this issue.) Dr. Richter, PNHP past president, is speaking about the new law at town forums and Rotary clubs across the state and served on the nominating committee for the Health Reform Board; she also helped draft Vermont Health Care for All's brochure on the law (vermontforsinglepayer.org). Contact Dr. Peggy Carey at peggycareyster@gmail.com.

Members of Wisconsin PNHP rallied on July 30 in downtown Madison, Wis., as part of the nationwide observances of Medicare's 46th anniversary. They called for an improved Medicare for all.

The **Western Washington** chapter of PNHP helped build a Medicare anniversary event in July that included a parade of over 100 people marching behind a brass band in downtown Seattle; co-sponsored a public meeting at the Seattle Labor Temple under the slogan of "Save our lifeline: Medicare, Medicaid and Social Security" that drew another 100 people; and Dr. Don Mitchell, chapter president, headed a panel on health reform at the Washington State Labor Council. Earlier in the year the chapter held its 6th annual meeting, featuring Katie Robbins of Healthcare-Now, Dr. Margaret Flowers, Mark Dudzic of the Labor Campaign for Single Payer, and others. Contact Dr. David McLanahan at mcltan@comcast.net.

PNHP members in **Wisconsin** were among the tens of thousands who rallied for weeks inside and outside the Capitol in Madison to oppose the proposals of Gov. Scott Walker to cut publicly funded health care and to curtail the collective bargaining rights of public workers. The Madison chapter held a Medicare anniversary rally downtown, and is working with other groups to defend BadgerCare and other public programs. Letters to the editor and opinion articles by PNHPers have appeared in local newspapers, including articles by Drs. Timothy Shaw, Melissa Stiles, David Knutzen and Charles Benedict. An op-ed by Dr. Margaret Flowers was printed in The Capital Times during her chapter visit last winter, which included medical student events, a public forum at a local labor hall, a fund-raiser and multiple radio interviews. Contact Dr. Stiles at melstiles1@gmail.com.

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