25TH Anniversary
Physicians for a National Health Program

PNHP
Newsletter
Spring 2012

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM ▪ 29 E. MADISON ST., STE 602, CHICAGO, IL ▪ WWW.PNHP.ORG

Media update

Dr. Claudia Fegan, past president of PNHP, appeared on MSNBC's "Up with Chris Hayes" in March to discuss single payer. On Feb. 8, MSNBC host Lawrence O'Donnell made the case for single payer in a lengthy commentary on women's health care and noted the "virtually indescribable mess" the compromised federal health law has created (online at www.pnhp.org). Must viewing!

Research by PNHPers published in the March issue of Health Affairs showed that computerized health records, whatever their other merits, are unlikely to cut the costs of radiology or laboratory testing. The study received extensive media coverage, including by The New York Times, CNN and The Wall Street Journal. The study's abstract and Boston Globe article on the research are reprinted on page 20.

At least 26 million people to remain uninsured under PPACA

Fewer people will gain coverage under the federal reform law than previously estimated, according to the Congressional Budget Office and the Joint Committee on Taxation. As a result, the law will leave 26 to 27 million people uninsured in 2016, up from the previous estimate of 23 million uninsured (CBO, March 2012). For more facts and figures on the health care crisis, see the Data Update, starting on page 3.

States on the move

PNHP member Dr. Stephen Kemble, president-elect of the Hawaii Medical Association, was appointed to the Hawaii Health Authority by Gov. Neil Abercrombie. Dr. Kemble helped draft the HHA's first report, laying out principles for a new, comprehensive system of universal coverage (see his op-ed, page 30).

Last spring Vermont passed legislation aimed at creating a "pathway to single payer" in five years. Drs. Deb Richter, Marvin Malek, Peggy Carey and other activists are working to keep the multi-stage law on track and counter an advertising campaign spreading misinformation about single payer.

In California, PNHP members are helping to build the Campaign for a Healthy California, a diverse coalition backing state single-payer legislation. Over 500 medical and health professional students rallied in Sacramento in January for single payer.

Recent fiscal studies of single payer in Maryland, Minnesota, and Massachusetts have all demonstrated that it is possible to reduce health spending and provide universal coverage under a single-payer system. For more updates on state single-payer work, see the chapter reports, page 60.

Clearly constitutional: Improved Medicare (or VA) for all

"[Congress] could use the tax power to raise revenue and to just have a national health service, single payer." —Justice Kennedy.

Regardless of how the Supreme Court rules on the individual mandate and the health law in June, the Patient Protection and Affordable Care Act (PPACA) is incapable of resolving our health care crisis. While it might help about half the uninsured gain inadequate public (Medicaid) or private coverage, rising costs will quickly jeopardize those coverage gains. PNHP's senior health policy fellow, Dr. Don McCanne, calls the new standard "unaffordable underinsurance." More fundamental reform is needed. PNHP co-founder Dr. Steffie Woolhandler appeared on Democracy Now! in March, observing that a single-payer system is clearly constitutional.

PNHP's 25th Anniversary – San Francisco, October 27

Save the date! PNHP's 2012 Annual Meeting will be held in San Francisco on Saturday, October 27. It will be preceded by PNHP's popular leadership training course on Friday, October 26. The meeting and hotel rooms are at the Wyndham Parc 55, $219/night if reserved before October 4, 1-800-697-3103. RSVP online to PNHP at www.pnhp.org/meeting.

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PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Board of Directors, 2012

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PNHP membership drive update

Welcome to 400 new members who've joined PNHP in the past year! PNHP's membership is now over 18,000. We invite new (and longtime) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community.

PNHPers in Providence, R.I., St. Louis, Mo., and Eugene, Ore., are starting new PNHP chapters in their areas. To get involved in a PNHP chapter near you, see the chapter reports, page 60, or contact Dr. Ida Hellander in the PNHP national office at (312) 782-6006 or ida@pnhp.org.

PNHP will be hosting exhibits at several medical specialty meetings this year, including the American College of Physicians meeting in New Orleans, April 19-21; the American Psychiatric Association in Philadelphia, May 6-8; and the American Academy of Family Physicians, also in Philly, Oct.16-20.

What PNHP members can do

1. Learn health policy painlessly! Subscribe to the "Quote of the Day" from Dr. Don McCanne, PNHP's senior health policy fellow, to keep up on the latest developments in health policy and politics. Subscribe at www.pnhp.org/qotd.
2. Write a letter to the editor or an opinion piece for your local newspaper, medical specialty journal, or alumni magazine.
3. Give a grand rounds at your hospital on health care reform, or invite another PNHP member to speak at a grand rounds or other hospital forum. For updated slides, visit www.pnhp.org/slideshows, password adams. To invite another member to speak, call the PNHP national office at (312) 782-6006 or e-mail: matt@pnhp.org.
4. Arrange a session on health care reform at the next meeting of your medical society or specialty. Introduce a resolution in support of single payer. Sample resolutions are available at www.pnhp.org/resolutions.
5. Meet with the editorial staff of your local newspaper or TV station. Let reporters know that you're willing to speak out about the flaws in PPACA and the need for single-payer reform.
6. Join or renew your membership in PNHP online today at www.pnhp.org/join. Encourage your colleagues to join PNHP.
7. Form a chapter of PNHP, or get involved in the one nearest you.

It's easy to add PNHP to your will

Revising your will? Please join PNHP National Board member Dr. Hank Abrons in adding PNHP to your will. You just add a sentence that says "I bequeath the following ___ (dollar amount, property, or stocks) to the nonprofit organization Physicians for a National Health Program of Chicago, Illinois. Their FEIN # is 04-2937697 and their mailing address is 29 E Madison, Suite 602, Chicago, IL 60602."

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

UNINSURED AND UNDERINSURED

▸ 49.9 million Americans, 16.3 percent of the population, were uninsured in 2010, an increase of about one million people since 2009, according to the Census Bureau's revised figures.

Employer-based private coverage dropped for the eleventh consecutive year, from 64.2 percent of the population in 2000 to 55.3 percent in 2010. (It's worth noting that a large share of so-called "private" coverage is actually taxpayer-financed coverage for public sector workers. Public employees account for about 21 percent of employees with employer-paid coverage, and 24.7 percent of total spending by employers on private insurance).

Uninsurance among young people between the ages of 19 to 25 dropped slightly, to 29.7 percent, due to the federal health law's provision that allows children up to age 26 to be covered under a parent's health plan. The number of uninsured in Massachusetts, whose 2006 health reform is widely viewed as the model for the federal health law, rose to 370,000 in 2010, representing 5.6 percent of the population, up from 4.3 percent in 2009.

7.3 million (9.8 percent) of all children in the U.S. are uninsured, including 15.4 percent of children in poverty.

The number of Americans living in poverty, 46.2 million, is the largest number recorded in the 52 years that such estimates have been published. Additionally, a record 48.6 percent of the population lived in a household receiving some type of government benefit (U.S. Census Bureau, Income, Poverty and Health Insurance Coverage in the United States: 2010, September 2011).

▸ Access to health care has significantly eroded since 2006. In 2010, more than 81 million working-age adults – 44 percent of those ages 19-64 – were uninsured or underinsured during the year, up from 61 million (35 percent) in 2003. (National Scorecard on U.S. Health System Performance, Commonwealth Fund, October 2011).

▸ People with insurance are going to the doctor significantly less frequently, with the number actually dropping most dramatically after the recession was technically over. People with private coverage under age 65 made 17 percent fewer doctor visits in the second quarter of 2011 than in the second quarter of 2009, according to the Kaiser Family Foundation (Feder, Politico, 11/21/11).

▸ About half (51.9 percent) of unemployed adults aged 18-64 were uninsured in 2010. Compared to uninsured adults who are employed, uninsured individuals who are unemployed are more likely to be in fair or poor health (12 percent vs. 9 percent), more likely to be in serious psychological distress (7 percent vs. 3 percent), more likely to go without needed medical care (40 percent vs. 35 percent), and more likely to fail to get a needed prescription (30 percent vs. 23.2 percent). Similarly, the unemployed with either public or private insurance reported both worse health and less access to needed care and treatment than employed adults with comparable coverage (NCHS Data Brief No. 83, January 2012).

> The U.S. ranks last out of 16 industrialized countries on a measure of mortality amenable to medical care (deaths that might have been prevented with timely and effective care). Premature death rates in the U.S. are 68 percent higher than in the best-performing countries, equivalent to 91,000 excess deaths annually (National Scorecard on U.S. Health System Performance, Commonwealth Fund October, 2011).

▸ California, which already spends the least per Medicaid beneficiary of any state, received approval from the Obama administration to cut the state's Medi-Cal budget. California plans to lower provider reimbursement by 10 percent, to as little as $11 per visit, severely threatening access to care just before the Medicaid program is supposed to serve as the cornerstone of federal health reform. The health law will expand Medicaid to 16 million low-income people nationally (Gorman, LA Times, 10/28/11).

COSTS

▸ U.S. health spending in 2012 is projected to be $2.8 trillion, $8,936 per capita, 17.6 percent of GDP. The Congressional Budget Office estimates that government health spending will rise by 8 percent annually, from $847 billion this year to $1.8 trillion, or 7.3 percent of GDP, in 2022 (Keehan et al, National Health Spending Projections through 2020, Health Affairs, July 2011 and Reuters 2/7/12).

▸ Due to the deep recession, US health spending grew more slowly in 2009 and 2010—at rates of 3.8 percent and 3.9 percent, respectively—than in any other years during the fifty-one-year history of the National Health Expenditure Accounts. Persistently high unemployment, continued loss of private health insurance coverage and increased cost sharing reduced the utilization of care and shifted a larger share of health spending to the federal government. Yet, even in these "slow growth" years, health spending outpaced inflation (Martin et al, Growth in US Health Spending Remained Slow in 2010, Health Affairs, January 2012).

▸ In 2011, health insurance premiums averaged $5,429 for individuals and $15,073 for families, 113 percent higher than in 2001. On average, employees pay 18 percent of premiums for individual coverage and 28 percent for family coverage (Kaiser, Health Employer Benefits Survey, 2011).

▸ U.S. employers are increasingly using high-deductible health plans to cover their employees. These skimpy plans shift a greater share of medical expenses to workers. In 2011, 32 percent of companies with 500 or more employees offered high-deductible plans, up from 23 percent in 2010, according to a survey of 2,844 private and public employers by the benefits consulting firm Mercer. The average deductible nearly doubled between 2003 and 2010, to $1,025 for an individual and $1,975 for a family plan (Helfand, Los Angeles Times, 11/22 and Commonwealth Fund, November 2011).

The Milliman Medical Index measures the cost of health care for a typical family of four with an employer-sponsored PPO. In 2011, the Milliman Medical Index totaled $19,393. In comparison, the median household income in 2010 was $49,445. 62 percent of the population lives in states where large-group health insurance premiums amount to 20 percent or more of median household incomes (Commonwealth Fund, 11/17/11 and, Quote of the Day, Don McCanne, 1/20/12 at www.pnhp.org/blog).

▸ 30 million Americans were contacted by collection agencies for unpaid medical bills in 2010, up from 22 million in 2005, according to the Commonwealth Fund's Biennial Health Insurance Survey. Medical bills make up the majority of collection actions on credit reports, and can stay on a credit report for up to seven years, reducing credit scores and raising the cost of financing a home (Carla Johnson, "Medical bills can wreck credit, even when paid off," AP, 3/4/12).

Emergency rooms have started charging upfront fees as high as $350 to patients with non-urgent problems. Last year about 80,000 patients left hospitals owned by HCA, the nation's largest for-profit hospital chain, without treatment after being told they had to pay $150 in advance. The strategy is designed to boost hospitals' bottom lines by effectively turning away the uninsured and underinsured (after federally mandated screening and stabilization) who often cannot pay their bills (Galewitz, Kaiser Health News, 2/20/12).

▸ The United Auto Workers' (UAW) Retiree Medical Benefits Trust, covering benefits for more than 820,000 retirees and their dependents, is underfunded by nearly $20 billion, according to trust documents filed with the U.S. Labor Department. The UAW agreed to let the big three auto makers, GM, Ford, and Chrysler, offload their obligation to fund health-care benefits for retirees in a 2007 labor agreement. Under the pact, the auto makers committed $54 billion in cash, stock, and future payments to a trio of funds known as voluntary employee beneficiary associations (VEBAs). But the funds have fallen short of the 9 percent rate of return assumed at their creation, and medical costs have risen faster than the anticipated 5 percent annual increase. Faced with an $11.4 billion shortfall, the trust fund that covers health benefits for GM retirees is seeking a 10 percent share of the profit-sharing that GM pays to current workers. UAW retirees also face higher deductibles and out-of-pocket payments this year. Just 26 percent of large U.S. companies provided health care benefits to retirees in 2011, down from 37 percent a decade ago (Pension Trusts Strapped, Wall Street Journal, 11/8/11).

▸ Three big non-profit health insurers in Seattle - Premera Blue Cross, Regence BlueShield and Group Health Cooperative - are facing scrutiny for raising premiums while they amassed a $2.4 billion surplus. A combination of steep rate hikes on individual and small group policies, and declining utilization allowed the insurers to accumulate the cache, which they claim they need in order to invest in new systems and deal with the impact of federal health care reform. A class action lawsuit by consumers is pending, along with legislation to allow the state's insurance commissioner to consider surpluses when reviewing rate-hike requests (The Seattle Times, Feb. 8, 2012).

▸ Indiana state employees' share of the premium for traditional family coverage nearly tripled to over $9,000 in 2012 from $3,500 in 2006 as the state made an all-out effort to push workers into high deductible "consumer directed" health plans (CDHPs). Employees pay no premiums for CDHP coverage and the state deposits $3,000 towards the $5,000 deductible in a health savings account. 90 percent of the state's 28,000 employees are now in the CDHP (Stateline, 11/17/11).

A single payer plan in Maryland would save $6 billion on total health expenditures in 2013 while covering all 736,000 of the state's uninsured, according to an analysis by economist Gerald Friedman of the University of Massachusetts Amherst. Most of the savings would come from slashing administrative costs in physicians' offices and hospitals, and reducing insurance overhead. Savings would also be obtained from reducing the market clout of drug companies, equipment makers, and some hospitals. Even after extending coverage to the uninsured, raising some provider reimbursement rates, and allowing for increased utilization of health services by the underinsured (including dental and home health care) single payer would save about $1,000 per Maryland resident (Gerald Friedman, Financing the Maryland Health Security Act, February 2012).

MEDICARE

▸ Wall Street values Medicare Advantage covered lives (i.e. health plan members) at four times as much as members of employer-sponsored plans and five times as much as members of Medicaid plans, according to Goldman Sachs analysts. In a merger or acquisition, Medicare Advantage enrollees are valued at $6,000 per member, compared to $1,500 for a member in a commercial plan and $1,200 for a Medicaid beneficiary, based on their potential profitability to insurers. Not surprisingly, UnitedHealth Group, WellPoint, Cigna and Aetna are all scrambling to acquire Medicare Advantage customers. UnitedHealth Group projects it will enroll an additional 300,000

Medicare beneficiaries this year, more than offsetting projected losses of 200,000 members in its commercial plans. The firm also plans to expand its Medicare enrollment through the purchase of XLHealth Corp, to a total of 2.5 million members, and boost its Medicaid enrollment by 325,000 members to about 3.8 million (Gentry, Health News Florida, 10/28/11, Krauskopf, Reuters, 11/29/11).

Medicare Advantage plans garner an extra $30 billion annually, about 8 percent of total Medicare spending, by gaming Medicare's new risk adjustment system, according to a study by researchers with the National Bureau of Economic Research. In 2004, Medicare adopted a new formula for risk-adjusting payments to private plans, adding 70 diagnostic categories to the previous risk adjustment variables (age, sex, disability status, and Medicaid eligibility). The private plans quickly adapted and selectively recruited patients with low costs conditional on their medical conditions (e.g. mild diabetes or minimal arthritis), increasing overpayments from the previous $1,800 per patient to $3,000 per patient in 2006 (see editors' note, below). The magnitude of insurers' rip-off of Medicare is probably much larger today as enrollment has increased from 6.8 million beneficiaries (16 percent of Medicare enrollees) in 2006 to 11.9 million beneficiaries (25 percent of enrollees) this year (Brown, Duggan, Kuziemko, and Woolston, "How does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program" NBER Working Paper No. 16977, April 2011).

Editors' note: There is no evidence that risk adjustment works or can work in the dynamic reality of profit-seeking health care insurers/providers. The most interesting part of the 2004 enhancement of Medicare Advantage's risk adjustment formula to us is not that plans beat it, but that the gaming was more lucrative after the enhancement than before. Static analyses of patient diagnoses and costs can virtually always come up with risk adjustment schemes that explain far more of the cost variance than existing schemes – i.e. they're better. But once payments are based on a particular scheme, the gaming is on.

▸ So-called Accountable Care Organizations (ACOs) are springing up all over. According to one consulting firm, there were 164 self-identified "ACO entities" in 41 states by the end of last year. 99 of these are sponsored by hospital systems, 38 by physician groups, and 27 by insurers. States with the highest number of ACOs are California, Massachusetts, New York, Texas, Illinois, Wisconsin and Michigan (Jenny Gold, "ACOs are bursting out all over," Kaiser Health News, 12/1/11).

▸ With revenues from traditional private insurance stagnant, large insurers are increasingly looking for growth in their Medicare and Medicaid business. Commercial business now accounts for less than half of the revenues of the nation's five largest for-profit insurers (WellPoint, UnitedHealth Group, Aetna, Humana, and Cigna). Partly as a result of their growing government contracts, insurers' profit margins rose from 6.9 percent to 8.2 percent in the 18 months since the federal health law passed. Health insurers are looking to pick up $40 billion in Medicaid contracts as the law's Medicaid expansion goes into effect in 2014, and another $10 billion in Medicare revenues (Sarah Frier, Bloomberg, 1/5/12).

▸ An evaluation by the Congressional Budget Office (CBO) found that Medicare's demonstration projects over the past two decades on disease management, care coordination, and value-based payment have failed to reduce costs. "In nearly every program involving disease management and care coordination, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program, when the fees paid to the participating organizations were considered" according to the CBO. Only one of four value-based demonstration projects appeared to produce any savings. In that project, Medicare negotiated a bundled fee for heart bypass surgeries that was about 10 percent less than it had previously paid in itemized fees, but there was no attempt to determine if this strategy reduced total costs or simply shifted costs to other payers. "Other demonstrations of value-based payment appear to have produced little or no savings," the report found (Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-based payment, CBO, January 2012).

CORPORATE MONEY AND CARE

Accretive, a for-profit debt collection firm, is under investigation by the Attorney General in Minnesota for "failing to protect the confidentiality of patient health care records and not disclosing to patients its extensive involvement in their health care…" Fairview hospital paid the firm $75 million in 2011 to manage Fairview's "total cost of care" and reduce costs by, among other things, identifying high cost patients, creating per-patient profit and loss reports and risk scores, conducting medical-necessity reviews, and creating automated care plans. If Fairview made money on its risk-bearing contracts with insurers (similar to the ACO model proposed for Medicare) Accretive would share in the profits. Attorney General Lori Swanson charges that "Accretive showcases its activities to Wall Street investors…patients should have at least the same amount of information about Accretive's extensive role in their health care that Wall Street investors do" (Press Release, MN Attorney General, 1/19/12).

▸ Drug executives topped the charts of CEO pay in 2010, with McKeeson CEO John Hammergren the highest paid executive that year with $145 million in compensation. McKeeson is the largest pharmaceutical distributor in North America, distributing about a third of the nation's drugs with sales of $112 billion. Joel Gemunder, outgoing boss of Omnicare, a firm that dispenses drugs to nursing homes, received total pay of $98 million. Thomas Ryan, CEO of CVS Caremark, with 7,000

pharmacies across the U.S., took home $68 million. Outgoing Aetna CEO Ronald Williams made $58 million (Meet the new 1%: Healthcare CEO's replace bankers as America's best paid, the Guardian, 12/14/11).

The health care industry spent $499.9 million on lobbying in 2011, just 10 percent less than it spent at the very peak of the health reform debate in 2009. The pharmaceutical industry spent the most ($237.5 million) ahead of hospitals/nursing homes ($99.5 million) health professionals ($80.4 million) and insurers/HMOs ($72.4 million). In 2011 the industry deployed 3,116 lobbyists, about half of whom were former government employees ("revolvers"). The industry also made $6.1 million in early contributions to the 2012 elections, about 60 percent to GOP candidates (www.opensecrets.org, accessed on 2/23/12).

▸ GlaxoSmithKline will pay a record $3 billion to settle investigations into its sales and marketing practices, surpassing the previous record of $2.3 billion paid by Pfizer in 2009. The firm was under investigation for illegal marketing of Avandia, a diabetes drug that was severely restricted last year after it was linked to heart risks. Federal prosecutors said the company had paid doctors and manipulated medical research to promote the drug. The settlement also ends a Justice Department investigation into its Medicaid pricing practices and a nationwide investigation led by the United States Attorneys in Colorado and Massachusetts into the sales and marketing of nine other drugs from 1997 to 2004. The firm, with $43 billion in annual revenues, had set aside $5.7 billion to resolve a variety of civil and criminal cases (Wilson, New York Times, 11/3/11).

▸ Medtronic, the world's largest maker of medical devices, will pay $23.5 million to settle charges that it defrauded Medicare and Medicaid by paying kickbacks to doctors to implant its pacemakers and defibrillators. Medtronic paid doctors a fee of $1,000 to $2,000 for each patient with a Medtronic implant they enrolled in two device registries and two post-market studies. Medtronic solicited doctors for the studies to get them to use its devices (AP, 12/12/11).

▸ Merck will pay $24 million to settle charges that it overcharged Massachusetts' Medicaid program. The suit alleged that a generic drugmaker purchased by Merck, Warrick, reported false and inflated prices for a trio of treatments for asthma and other respiratory diseases. 12 other drugmakers charged in the lawsuit for inflating Medicaid prices paid a total of $23.4 million to the state (Boston Globe, 12/21/11).

▸ The Senate Finance Committee is investigating whether the nation's two largest laboratory testing firms and three largest insurers bilked Medicare and Medicaid out of billions of dollars in overpayments. Quest Diagnostics and Laboratory Corporation of America, which control about half the annual $25 billion lab test market, recently paid California settlements of $241 million and $49.5 million, respectively, for allegedly overbilling Medicaid. At least five state attorneys general also have investigations under way. The lawsuits allege that the laboratory firms charged insurers like UnitedHealthcare, Aetna, and Cigna unprofitably low rates while charging much higher rates to Medicare and Medicaid. In exchange for steep discounts, insurers agree to "pull through" or direct Medicare and Medicaid patients from their in-network physicians to the favored laboratory. "The strategy was for UnitedHealthcare to threaten physicians...with financial penalties and ultimately with expulsion from UnitedHealthcare's networks" if they didn't comply (Fiscal Times, 11/8/11).

▸ It's old but worth revisiting: Corporations are now treated as "persons" under U.S. law, claiming rights to equal protection, privacy, and even free speech to protect their actions. But the ruling in the 1886 Supreme Court Case that supposedly established corporate personhood – and has been cited at least thirty-four times to defend corporations' actions, establishing legal precedents – clearly contradicted the notion of corporate personhood, according to Thom Hartmann. Hartmann tracked down the original court documents in Santa Clara County vs. Southern Pacific Railroad, a dispute over fence post taxes, and found that the entire case for corporate personhood rests on a mistake, not the actual Supreme Court ruling but a contradictory head-note added two years later (Hartmann, Unequal Protection: The Rise of Corporate Dominance and the Theft of Human Rights, Rodale Press, 2002).

UPDATE FROM MASSACHUSETTS – THE MODEL FOR THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

A plurality of Massachusetts physicians (who have direct experience with the model for PPACA), would prefer single payer, and that support is increasing, according to a survey by the Massachusetts Medical Society. Of 5 options for health care reform, 41 percent of Massachusetts physicians rated a "single-payer national health care system offering universal health care to all U.S. residents" as the best option for reform, up from 34 percent in 2010. By a large majority, physicians rejected the other options, including a plan based on the current Massachusetss system. Only 17 percent of Massachusetts physicians favored the federal reform law (PPACA), modeled after the plan their state adopted in 2006. Of the other options given, 23 percent of physicians favored a public-option; 15 percent favored high-deductible health plans; and 4 percent favored "other" (Physician Workforce Study, Massachusetts Medical Society, 9/28/11).

▸ After the implementation of health reform in Massachusetts, most of the uninsured are the working poor. A survey of patients without health insurance indicated that two-thirds (65.9 percent) were employed, but only a quarter had access to employer-sponsored insurance. In addition, about one-third (35.2 percent) of uninsured patients reported having lost previous insurance coverage, with the majority of these (51.9 per-

cent) having lost their coverage due to a job loss or transition. This pattern of uninsurance arises, in part, from a loophole that exempts businesses with ten or fewer employees from the requirement to offer insurance. Additionally, an employee who refuses an employer-sponsored plan is ineligible for the subsidized state program (Rachel Nardin et al, Reasons why patients remain uninsured after Massachusetts' health care reform: A survey of patients at a safety-net hospital, Journal of General Internal Medicine, 9/16/11).

Massachusetts' 2006 reform plan created an estimated 18,000 new health care jobs, most of them devoted to administrative tasks (management, business and financial operations, office support, medical records, health information, etc.), according a study of the impact of health care reform on the workforce. Employment in administrative occupations in health care grew by 18.4 percent in Massachusetts compared with 8 percent nationwide. In contrast, non-administrative positions increased by 9.3 percent after reform in Massachusetts, an increase similar to the 8.6 percent seen nationally. According to the authors, "Our analysis supports physicians' concerns about the administrative burden of health care reforms…" (Staiger et al, "Health Care Reform and the Health Care Workorce – The Massachusetts Experience," NEJM, 9/7/11).

▸ Mass-Care, the Massachusetts single-payer coalition, published a detailed report on the impact of that state's health reform. Among the findings: Most of the new coverage comes with high deductibles and co-pays, and health insurance premiums continue to skyrocket statewide. The report can be viewed at www.masscare.org/massachusetts-health-reform-in-practice/

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

The benefits under PPACA's four tiers of plans (bronze, silver, platinum and gold) will be skimpier than most people expect, due to widespread misunderstanding of the term "actuarial value". While most people believe a 70 percent actuarial value, for example, means that the insurance would cover 70 percent of their health expenses, that's not the case. Instead, the plan will only cover 70 percent of the cost of the benefits covered by the plan. Patients are still fully responsible for uncovered services, which can amount to many thousands of dollars and which do not apply towards out-of-pocket limits.

▸ The federal health law will likely increase health disparities between U.S. citizens and non-citizens. As of 2010, there were 21.4 million non-citizens residing in the U.S., including about 11.2 million undocumented immigrants (3.7 percent of the population). Lawfully present immigrants with incomes up to 133 percent of poverty ($14,484 for an individual or $24,645 for a family of three in 2011) will be eligible for the federal health law's Medicaid expansion, but only after a five year wait, although states may waive the waiting period for children and pregnant women. During that period, lawfully present immigrants without access to employer-sponsored coverage and incomes up to 400 percent of poverty ($43,560 for an individual or $74,120 for a family of three in 2011) will be eligible for tax credits for the purchase of private coverage on an exchange. However, undocumented immigrants will remain ineligible for Medicaid and tax credits, and prohibited from purchasing coverage through an exchange, even at full cost (Kaiser Commission on Key Facts, February 2012).

▸ The federal health law included $11 billion in funding for the expansion of community health centers in anticipation of increased demand by up to 32 million newly insured patients. But so far most of the money allotted is being used just to keep existing centers operating, after the budget for community health centers was reduced by $600 million as part of the federal budget compromise. Making matters worse, states have also cut their direct funding for community health centers for the fourth consecutive year. State funding is down from a peak of $626 million in 2008 to $335 million in 2012 (Galewitz, "Administration Scales Back Expansion of Community Health Centers," Kaiser Health News, October 6, 2011; Torres, "States Cut Community Health Center Funding," 12/8/11).

▸ Since the federal health law passed, more than 1,500 employers and health plans covering 3 million people have been exempted from rules designed to eliminate so-called mini-med plans, which have benefit caps as low as a few thousand dollars per year. Six states have received waivers to exempt insurers operating in their state from rules about how much of the premium dollar must be spent on patient care, while another 7 states have applications pending. Insurers and employers won the right to limit patients' appeals to an independent arbiter, and rules about the use of electronic health records have been eased twice (Los Angeles Times, 12/14/11).

▸ A loophole in the federal health law would allow self-insured employers to engage in "target dumping" of sicker workers onto the health exchanges, according to two law professors at the University of Minnesota. Unlike the Massachusetts' reform upon which it is based, PPACA does not exclude employees who reject an employer-sponsored plan from participating in the subsidized exchange program. There are several approaches firms could use to encourage higher-cost workers to voluntarily leave their health plan, including: limiting the number of specialists in the provider network, tying premium discounts to participation in wellness programs, and raising cost-sharing.

Large firms may also steer their retirees in the direction of the exchange, where premiums for the oldest enrollees can't be more than three times higher than those for the young. Already at least one firm, 3M, has announced that it will convert the firm's contribution to a portable health reimbursement account for retirees effective January 1, 2015. Large firms may also limit hiring of full-time workers, and refer part-time workers who

are not eligible for employer-paid benefits to the exchanges in 2014, particularly low-wage workers who may be eligible for premium subsidies. According to one large employer, "Our senior managers – many of whom are familiar with health insurance systems outside the United States – are beginning to ask, 'Why are we in the health benefits business?'" (Kramer, Health Affairs, 2/12 and Stawicki, MPR News, 11/30/11).

▸ It's telling that that the most popular feature of PPACA, supported by 84 percent of Americans, is the requirement that health plans provide easy-to-understand benefit summaries. The least popular element is the individual mandate, opposed by 63 percent (Kaiser Family Foundation, November Health Tracking Poll, 2011).

▸ It's outrageous that the private insurance industry may occupy up to one-half of the seats on the governing Board of an exchange, according to the 644-page final rule promulgated by the Department of Health and Human Services. Although HHS noted that commenters recommended that individuals with ties to the insurance industry participate through a technical panel or advisory group instead of through board membership, HHS left to this to the states' discretion, along with other matters such as what constitutes "essential benefits." (DHHS, PPACA Establishment of Exchanges and Qualified Health Plans, Final rule, Federal Register March 27, 2012, pages 34-37).

INTERNATIONAL

▸ The latest attack on the British National Health Service is turning out to be very profitable to U.S. consulting firms. A conglomerate including McKinsey, KPMG and PricewaterhouseCoopers has signed a contract worth 7.1 million British pounds to help 31 groups of GPs manage budgets covering both outpatient and inpatient care for patients in their regions and to cut some $30 billion from the NHS budget. Successive waves of reform over the past decade have led to a rapid increase in funds diverted from patient care into administrative overhead. Last year the NHS paid 57 management consulting firms, IT and legal professionals 9.7 million pounds (NHS reforms: American consultancy McKinsey in conflict-of-interest row. Guardian, 11/5/11).

▸ Despite massive physician and public opostition to the "Health and Social Care Bill," which allows private delivery of health care funded by the NHS, the bill, associated with numerous scandals, passed in February. Among them is the disclosure that the international consulting firm McKinsey wrote whole sections of the bill and has been touting the bill's money-making opportunities to its private clients. In one memo, a McKinsey executive wrote to an NHS chief that "We had good discussions…on how international hospital provider groups may help to tackle the performance improvement of English hospitals. They would be ready to step in if there were 500 million British pounds revenue on the table, can keep real estate and pensions with the NHS, needs free hand on staff management. This may now be a time when both sides [the NHS and foreign firms] may usefully explore their position as an input into how policy would be shaped." The British Medical Association and the Royal College of General Practitioners were among the many groups opposing the bill (David Rose, "The Firm that Hijacked the NHS," Daily Mail, 2/12/12).

▸ One of the reasons why the U.S. does not have a national health program is because of a low rate of union membership, just 13.3 percent, down 12.4 percentage points since 1980. An analysis of factors affecting union membership in 21 countries found that globalization and technology, often cited as "inevitably" decreasing unionization, have little impact, whereas the national political climate – which can expand legal rules such as whom labor law covers, whom unions can bargain for and represent, and how free unions are to organize – is the determining factor. Countries with strong social democratic traditions – Sweden, Denmark, Norway, and Finland – have the highest rates of unionization, and single payer national health systems. Public sector labor laws have generally been more neutral and less hostile to organizing in the U.S. than the National Labor Relations Act, as rewritten by the GOP-run Congress in the 1947 Taft-Hartley Act. As a result, the proportion of public sector workers organized in the U.S. is relatively high, about 40 percent, and is the likely reason public sector workers have come under attack in states like Wisconsin and Indiana in recent years. (Politics Matter: Changes in Unionization Rates in Rich Countries, 1960-2010, Center for Economic Policy and Research, November 2011).

In 1997, South Korea replaced its multi-payer (>350 insurers) health system with a government-run single-payer system, the National Health Insurance Corporation. The proportion of the population covered has increased to 99 percent from 94 percent in 1997, and the benefits package is more comprehensive, including almost all inpatient and outpatient services, dental care, traditional medicine, prescription drugs, and preventive services. Since the reforms began, the number of physicians per capita has doubled and total health spending as a percent of GDP has increased from 4.2 percent in 1997 to 6.9 percent in 2009, in line with expectations based on GDP growth. Out-of-pocket costs as a proportion of total health spending have decreased from 54.9 percent in 1995 to 38.1 percent over the same period (Catalyzing Change: The System Reform Costs of Universal Coverage, Rockefeller Foundation, 2010 and OECD Health Report, 2011).

▸ A study of 30 industrialized countries by researchers at Yale found that countries with high health care spending relative to spending on social services (such as rent subsidies, employment training, unemployment benefits, old-age pensions, family support and other services that can extend and improve life) had worse outcomes on measures of population health like infant mortality, life expectancy, and years of life lost. While

other industrialized nations in the Organization for Economic Cooperation and Development (OECD) spend about $2 on social services for every dollar spent on health care, the U.S. spends just 90 cents. Although the U.S. spends the most on health care, it ranks tenth in spending on the combination of health care and social services, and is one of only three industrialized nations to spend the majority of its health and social services budget on health care *per se*. In 2005, the U.S. spent 29 percent of GDP on health and social services, behind countries like Sweden, France, Belgium and Denmark, which spend 33 to 38 percent of their GDP (E Bradley and L Taylor, "To Fix Health, Help the Poor," New York Times, 12/8/11).

▸ Japan celebrated 50 years of universal health coverage in 2011. Although costs are low by international standards, a lack of equity and rise in the proportion of people who are not paying into the system are causing growing concern. There is more than a three-fold difference in the proportion of their incomes that citizens pay in premiums to Japan's 3,500 different plans, and 1.6 percent of the population has not paid premiums for more than 18 months and faces severely restricted benefits. Noting the "inherent weakness of a social health insurance system that is fragmented by employment and residential status" a team of researchers led by Naoki Ikegami, chair of health policy at Keio Medical School in Japan, recommends that Japan consolidate its insurance plans to equalize premium contributions, delink insurance coverage from employment, and improve administrative efficiency. One option would be to unify all the plans nationally, as was accomplished in South Korea (see above). Another option is regional unification, along the lines of Canada with its history of provincially-based insurance that must meet federal standards (Naoki Ikegama et al, Japanese universal health coverage: Evolution, achievements, and challenges. Lancet, published online September 1, 2011).

▸ Switzerland's fragmented health system, often cited as a model for the U.S., is also facing health financing inequalities. The Swiss have a universal, highly regulated system of social insurance based on private insurance plans. But like Japan, premiums vary more than three-fold, from 11.8 percent of income for the lowest income quartile to 3.4 percent for the highest income quartile. Out-of-pocket costs in Switzerland are a whopping 60 percent higher than in the U.S. and three times the Organization for Economic Cooperation and Development average. Financing health care is a major burden for low-income families and enrollment is rising in lower-cost plans with high-deductibles and limited choice of provider. Switzerland has high administrative costs for both the mandated coverage (5.9 percent) and private supplemental insurance plans (17.0 percent). Although they are prohibited from making a profit on the mandated social insurance coverage, private insurers appear to compete mainly on risk-selection. Consolidation of Switzerland's small population into a single risk pool would improve equity while lowering administrative costs. Although defeated in a 2007 ballot measure (after a campaign of misinformation by Switzerland's private insurance industry) Swiss voters will get another chance under a new initiative launched this year (OECD Reviews of Health Systems: Switzerland 2011, 10/18/11 and Dr. Don McCanne, Quote of the Day, 10/24/2011 at www.pnhp.org/blog).

▸ There was a 9 percent jump, to 27,600 people, in the number of affluent Germans switching back into the public system last year after previously opting – permanently - for private coverage. Although German law only allows people to go back to public coverage under exceptional situations to prevent adverse selection and gaming, it appears that skyrocketing private insurance premiums are behind the surge by the affluent of reentry into the statutory system, using "tricks" if necessary ("Many seek to switch to public health insurance," The Local – Germany's News in English, January 8, 2012 and Dr. Don McCanne, "Germany's painful lesson on private insurance" 1/9/12, www.pnhp.org/blog).

PNHP and Delivery System Reform: Six Important Principles

By Dr. Steffie Woolhandler, 2011 PNHP Annual Meeting

1. Non-profit
2. All capitation payments must be used for patient care, not for capital improvements, profits, bonuses or exorbitant salaries. Ban on retaining surplus (see note, below)
3. Separate capital funding based on regional health planning
4. Eliminate insurance middlemen
5. Rich and poor in the same plan
6. Quality data used for improvement, not financial reward

It is crucial that all capitation payments be spent on patient care, with an absolute prohibition on retaining unspent funds for capital investment. This ban on retaining surplus (which should apply to both capitated and globally budgeted providers) is the key to making non-profits behave like non-profits, as well as enabling real health planning. Absent this prohibition, these institutional providers have a strong incentive to cherry pick patients, to expand lucrative services like elective procedures and to minimize unprofitable services (e.g. mental health); organizations able to accumulate a surplus will grow and prosper, regardless of community need, while those that don't accumulate surplus funds will be starved of funds for modernization and growth.

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From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy

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The United States has been singularly unsuccessful at controlling health care spending. During the past four decades, American policymakers and analysts have embraced an ever changing array of panaceas to control costs, including managed care, consumer-directed health care, and most recently, delivery system reform and value-based purchasing. Past panaceas have gone through a cycle of excessive hope followed by disappointment at their failure to rein in medical care spending. We argue that accountable care organizations, medical homes, and similar ideas in vogue today could repeat this pattern. We explain why the United States persistently pursues health policy fads—despite their poor record—and how the promotion of panaceas obscures critical debate about controlling health care costs. Americans spend too much time on the quest for the "holy grail"—a reform that will decisively curtail spending while simultaneously improving quality of care—and too little time learning from the experiences of others. Reliable cost control does not, contrary to conventional wisdom, require fundamental delivery system reform or an end to fee-for-service payment. It does require the U. S. to emulate the lessons of other nations that have been more successful at limiting spending through budgeting, systemwide fee schedules, and concentrated purchasing.

KEY WORDS: health reform; accountable care organizations; cost control.
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The United States has the most expensive medical care system in the world by a large margin, with per capita expenditures of $7960 in 2009.[1] Moreover, despite a recent slowdown due largely to the recession's impact, the U.S. is projected to spend over $30 trillion on medical care in the coming decade.[2] Over four decades after President Richard Nixon declared a cost crisis, the United States has yet to get a firm grip on rising medical care costs.

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The failure to control health care spending has been accompanied by a distinctive dynamic. Since the 1970s, American policymakers and policy analysts have relentlessly searched for the "the Big Fix,"[3] a reform that will decisively rein in spending and simultaneously improve the coordination and quality of medical care. The combination of these ambitious goals and our dismal record of cost containment has not diminished the health policy community's endless enthusiasm for the latest fad. We have run through a truly staggering list of proposed panaceas: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), managed care, capitation, integrated delivery systems, health savings accounts (HSAs) and consumer-directed care, pay for performance (P4P), health information technology (HIT), comparative effectiveness research (CER) and much more. Now, bundled payment, value-based purchasing, patient-centered medical homes, and accountable care organizations (ACOs) have emerged as the solutions of the day, propelled forward by the 2010 Patient Protection and Affordable Care Act (ACA) and by private sector initiatives.

Reforms aimed at slowing health care spending have encompassed (and often combined) a range of organizational (HMOs, ACOs), financial (bundling, HSAs, P4P, ACOs), and informational (HIT, CER) approaches. Some reforms have called for more patient cost-sharing, others for tighter control of medical services by health plans, and still others for more evidence to guide medical decision-making. Thus the U.S. has moved rhetorically from the era of managed care to consumer-directed health care and now into the era of value purchasing and delivery system reform. The range of available ideas is evidently narrow enough that we are now repeating fads—yesterday's conviction that capitation held the key to stemming the tide of rising costs is reborn in today's faith in bundling while integrated delivery systems and HMOs have morphed into ACOs.[4]

THE SEARCH FOR THE HOLY GRAIL

Fads in American health policy come and go so quickly that there is too little reflection about their origins, effects, and whether any are actually effective approaches to controlling

health care spending. Why do American analysts keep searching for the Holy Grail in health policy and what impact has that quest had on our medical care? American health policy is dominated by the search for these policies largely because of their political appeal. Reform labels promise to modernize and rationalize the health care system. Who can oppose the march of progress to replace paper medical records or our ostensibly antiquated fee-for-service payment arrangements? How can anyone oppose reforms that promise to curb medical spending and yet improve health outcomes? Indeed, because panaceas promise to moderate spending by reducing ineffective care, improving coordination, and keeping people healthy, such policies offer the prospect of painless cost control.[5]

That is powerfully alluring for politicians who want to avoid the conflict associated with policies such as imposing budgetary caps, limiting payments, restricting the availability of services, or cutting benefits. Further, if new organizations can be created to handle the task of making the difficult choices, or if new payment tools can be adopted that automatically unleash the right incentives, politicians can avoid blame for unpopular decisions. Innovation and its promise to enhance efficiency is an appealing substitute for policy realism and political will.

Many of these reform ideas are framed in ways that makes rational criticism seem implausible. Few will defend "medical homelessness" or argue that the U.S. medical care system needs less coordinated care. Indeed, a key characteristic of many reforms is that their descriptive labels are not actually descriptive, but instead comprise persuasive definitions.[6] We used to label health care organizations by their primary characteristics; Kaiser Permanente was accurately known as a "prepaid group practice." But beginning with the Nixon administration's campaign to promote Health Maintenance Organizations in the 1970s, policymakers and analysts increasingly started to label organizations and policies more by their aspirations, rather than by their substantive characteristics. "Managed care" and "patient-centered medical homes" exemplify such marketing slogans, terms that imply success by their very use. Yet many so-called managed care plans actually don't do much to manage care.[7] And whether a health care institution is "patient centered" is an empirical question (assuming we could agree on a definition of what it means to be patient-centered). In other words, the language used to describe many health reforms is meant to convince rather than to describe and explain, and that obscures realistic assessments of their appeal and impact.

Another reason that Americans look for the "big fix" is the absence of a coherent national health system. In most industrialized democracies, health care spending is controlled "upstream" through budgeting, fee schedules, and systemwide limits on medical capacity. But adopting such measures in the U.S. political system has been and remains extraordinarily difficult. Restraining spending requires reducing the income of health care providers who historically have been effective at resisting robust cost controls.[8] In addition, government measures to reduce spending growth invite charges of rationing that tap into many Americans' distrust of government—recall the hysteria over mythical "death panels" during the 2009-2010 health care reform debate. And America's fragmented political institutions give opponents multiple chances to defeat or weaken proposals to limit spending.

In fact, the U.S. has not had a national health system at all and consequently, cost containment efforts often focus "downstream" to regulate the costs of individual medical encounters.[9] These efforts are typically led by individual employers and health plans, actors that by definition cannot pursue systemwide solutions. Our enthusiasm for innovative and organizational solutions to cost containment is, then, partly a product of our political incapacity to produce universal health insurance. Belief in "American exceptionalism"—that as a nation we are too different culturally, socially, and politically to learn from other countries—has reinforced America's tendency to look inward for solutions to control health care spending.

Problems with Panaceas

There are five major problems with the endless search for cost control panaceas. The first is that the yearning for a transcendent solution inevitably produces a cycle of exaggerated expectations, followed by deep disappointment. The problem, as Bruce Vladeck argues, begins when a "modestly successful innovation is hyped as the unique and unitary solution to some complex, persistent problem."[10] Thus many policy analysts celebrated the rise of managed care during the early to mid-1990s as the solution to America's health care spending problem. But as health care costs started to accelerate again, analysts quickly turned to writing managed care's obituary.

Similarly, it will be difficult for ACOs to meet the lofty expectations that now surround them. ACO euphoria is evident in Ezekiel Emanuel and Jeffrey Liebman's foolhardy prediction that "By 2020, the American health insurance industry will be extinct," replaced entirely by ACOs.[11] Given the hype about their transformational impact, it is worth remembering the Centers for Medicare and Medicaid Services (CMS) median estimate that the ACO Shared Savings Program will reduce federal government spending on Medicare by only a total of $470 million during 2012-15, a tiny fraction of total program expenditures.[12] Moreover, a recent review by the Congressional Budget Office of disease management, care coordination, and value-based payment demonstrations—all ideas currently touted as solutions to Medicare's financing challenges—found that "most programs have not reduced Medicare spending."[13]

Second, because we invest so much hope and faith in new solutions, and because persuasive labels make these ideas appear self-evidently right, the real-world challenges in making policies work are commonly overlooked. Aspirations are undercut by implementation problems, unanticipated outcomes and political constraints. Managed care triggered backlash from providers and patients. Supposedly the least effective form of managed care—PPOs—surprisingly emerged as the victor in the market by the beginning of the 2000s.[14] ACOs may enhance integration of some providers and foster better coordination of some care. But the incentives to create ACOs may also lead to greater consolidation of health care providers and to hospitals purchasing physician practices, both of which could raise overall health spending.[15]

A third problem is generalizability. The enthusiasm for particular reforms often stems from positive results in a particular geographic and institutional settings: Kaiser Permanente, the Palo Alto clinic and the Mayo Clinic were held up as exemplars in the past, today they are joined by the Veterans Administration, Geisenger, and Intermountain. These institutions have in many cases produced impressive results. But the success of any particular institution does not imply that its performance can be extrapolated to the whole of American medicine. The difficulties Kasier has had in making its model work outside of its traditional regions illustrates this point.[16] And the VA has a level of organizational centralization that is not found in most other areas of American medicine. Creating new types of organizations is extraordinarily difficult and replicating them across different institutional, political, economic and geographic settings is even more so.[17]

A fourth problem is that these reform ideas usually focus on reducing the utilization of medical services. There are, to be sure, many instances of low-value medical care in the U. S. worth reducing.[18,19] And in the past decade, increases in Medicare expenditures on physician services have been driven mostly by growth in service volume and intensity.[20] But a predominant focus on utilization diverts us from other important sources of high health care spending.[21–23] The difference between Canadian and American spending on hospital and physician care, according to a recent study, is mostly explained by prices and administrative expenses, reflecting the lower costs of Canada's single-payer system.[24] Only 14% of the difference is attributable to higher utilization of medical services in the U.S. Yet American policy analysts continue to focus on ways to limit excessive utilization, while giving comparatively short shrift to policies—such as all-payer reform—that could lower prices and administrative costs.

The final and most serious problem is that the American quest for cost control fads hasn't worked—which helps explain why the U.S. keeps searching for more panaceas. Medical care spending did slow for a time during the managed care era but, emblematic of the issues described above, much of that slowdown was attributable to price restraints.[25] Still, the overall record of health care cost control in the U.S. is dismal. That doesn't mean that the latest fad of delivery system reform is a bad thing. Perhaps these and other reform ideas currently in vogue will produce some savings. But even if they don't reduce spending, reforms that encourage ACOs and medical homes will be worthwhile if they improve the delivery and quality of care, and patient outcomes. Cost savings should not be the only metric by which we judge the desirability of health care reforms.

Emulation, Not Innovation

We do not know how far ACOs will spread or what impact they, medical homes or other delivery system reforms will have on health care spending. But our history of failed cost control offers sobering lessons about exaggerated expectations, the limits of organizational reforms, and the recurring temptation to oversell reform ideas like ACOs as panaceas and the harbingers of a new, radically transformed, and vastly improved health care system. Such ideas should be seen as supplements, rather than the basis for a national strategy of health care cost control.

We believe that the U.S. needs less innovation and more emulation.[26] That is, in order to control costs effectively Americans should focus less on (re)inventing the latest delivery system or payment method, and instead pay more attention to what other countries do to slow health care spending.[27] Global budgets, fee schedules, systemwide payment rules, and concentrated purchasing power may not be modern, exciting or "transformational". But they have the advantage of working.

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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The New York Times

MONDAY, MARCH 19, 2012

The Health Law Mandate

"White House Set to Shape Debate Over Health Law" (front page, March 9), about the Supreme Court's hearings on the health law, doesn't mention an important new argument against the Affordable Care Act's mandated purchase of private insurance, the key issue before the Supreme Court.

Last month, an amicus brief was filed by 50 doctors and two nonprofit organizations arguing that Congress could avoid a mandate by legislating a national single-payer system that provides nearly universal insurance coverage.

Congress has already created two limited single-payer systems — Medicare and the veterans' health system — and no legal barriers prevent doing more. Since a mandate isn't necessary for Congress to exercise its legitimate role in regulating health insurance, there is no justification under the Constitution's "necessary and proper" clause for such a legislative requirement.

How this argument will influence the court remains to be seen. But the brief is another reminder that the single-payer idea, although currently off the table in Washington, should not be counted out.

ARNOLD S. RELMAN
Cambridge, Mass., March 9, 2012

The writer, professor emeritus of medicine and social medicine at Harvard Medical School, is a former editor in chief of The New England Journal of Medicine.

25TH Anniversary
Physicians for a National Health Program

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Health law, constitutional or no, fails to remedy ailment: doctors group

FOR IMMEDIATE RELEASE
March 26, 2012

Contact:
Garrett Adams, M.D., president PNHP
Mark Almberg, PNHP communications director

Leaders of Physicians for a National Health Program, an organization of 18,000 doctors who advocate for single-payer national health insurance, released the following statement today:

Regardless of whether the Supreme Court upholds or overturns the Affordable Care Act in whole or in part, the unfortunate reality is that federal health law of 2010 will not work: (1) it will not achieve universal coverage, as it leaves at least 26 million uninsured, (2) it will not make health care affordable to Americans with insurance, because gaps in their policies will leave them vulnerable to bankruptcy in the event of major illness, and (3) it will not control costs.

Why? Because the ACA perpetuates a dominant role for the private insurance industry. That industry siphons off hundreds of billions of health care dollars annually for overhead, profit and the paperwork it demands from doctors and hospitals; it denies care in order to increase insurers' bottom line; and it obstructs any serious effort to control costs.

In contrast, a single-payer, improved-Medicare-for-all system would achieve all three goals – truly universal, comprehensive coverage; health security for our patients and their families; and cost control. It would do so by replacing private insurers with a single, nonprofit agency like Medicare that pays all medical bills, streamlines administration, and reins in costs for medications and other supplies through its bargaining clout.

The major provisions of the ACA do not go into effect until 2014. Although we will be counseled to "wait and see" how this reform plays out, we've seen how comparable reforms in Massachusetts and other states have worked over the past few decades. They have invariably failed our patients, foundering on the shoals of skyrocketing costs – even as they have profited the big private insurers and Big Pharma.

The Supreme Court's ruling is not expected until June. Regardless of how it rules, we cannot wait for an effective remedy to our health care woes any longer, nor can our patients. The stakes are too high.

We pledge to continue our work for the only equitable, financially responsible and humane cure for our health care mess: single-payer national health insurance, an expanded and improved Medicare for all.

The statement that PNHP issued upon the passage of the health law in March 2010, "Health bill leaves 23 million uninsured," is available at http://bit.ly/dmzmF0. A fact sheet on the crisis in U.S. health care and the case for single-payer health reform, "The case for an improved Medicare for all," is available at http://bit.ly/IRr9ww. A recent, detailed analysis of the Massachusetts health reform can be found at http://bit.ly/J6KTc4.

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Physicians for a National Health Program (www.pnhp.org) is an organization of more than 18,000 doctors who support single-payer national health insurance. To speak with a physician/spokesperson in your area, visit www.pnhp.org/stateactions or call (312) 782-6006.

USA TODAY

MONDAY, APRIL 26, 2012

Happy birthday, ObamaCare

By Marcia Angell

The Patient Protection and Affordable Care Act, otherwise known as ObamaCare, turned 2 years old Friday, just in time for this week's Supreme Court hearings on its constitutionality. The major provisions of the law, meant to increase the number of insured Americans while controlling costs, will be implemented in 2014, but a few are already in effect. What are its prospects, and will it survive intact to its next birthday? The outlook, I'm afraid, is not good.

For starters, the law was greatly weakened before it was even enacted. To win the support of the powerful health insurance industry, President Obama included the unpopular mandate requiring uninsured Americans to buy private insurance. Not only did this set off a legal battle, it preserved and expanded the central role of the insurance companies, whose abuses caused many of health care's problems in the first place. They will get millions of new customers, many with government subsidies. In addition, the idea of a "public option" — government-sponsored insurance to compete with private insurers — was scuttled, wasting critical opportunities to try to control costs.

Let's look briefly at the major provisions: First, the law encourages employers to provide health benefits by fining large companies that don't and subsidizing small ones that do. Second, Medicaid, the federal/state program for the poor, will be expanded to cover an additional 16 million people. And third, everyone else without Medicare or employer-sponsored insurance, estimated as another 16 million people, will have to buy private insurance or be fined. States will create (or have created for them by the feds) shopping exchanges to pool risks and offer a menu of approved insurance plans for individuals and small businesses, with subsidies for people earning less than 400% of the federal poverty level. (Note that of the roughly 50 million uninsured people when the law was enacted, 18 million would be left uncovered.)

Insurance abuses addressed

The law addresses the worst abuses of insurance companies by prohibiting them from excluding people with pre-existing conditions, dropping policy holders who develop expensive illnesses, or using more than 20% of premiums for overhead, marketing and profits. But companies can still set their own prices, and they'll be allowed to charge older customers up to three times more than young people.

To finance the law, the payroll tax that supports Medicare will be increased for high earners, who will also pay a small additional tax on unearned income. In addition, support for private Medicare Advantage plans will be reduced, and there will be unspecified cuts in Medicare payments to hospitals and other medical facilities, and a variety of fees levied on health companies.

Runaway costs

That's the theory. What's the likely reality? At the time of enactment, the non-partisan Congressional Budget Office estimated that over 10 years, the new funding would more than cover the cost to the federal budget. But costs to the private sector — businesses and individuals — were not addressed in the CBO analysis, nor was cost inflation. Given the influx of new customers and government money, health costs will likely rise rapidly and quickly outstrip funding. There will, of course, be revisions to the CBO analysis as the law is implemented and conditions change, but none can be more than crude estimates.

Monday's Supreme Court hearing was just the beginning of a torrent of legal challenges to various provisions of the law. For example, many states, particularly Republican ones, have indicated that they will not establish state insurance exchanges or cooperate with the federal government in doing so, and that will be litigated, too.

Regulating the law will be a bureaucratic nightmare. Even in friendly states, establishing insurance exchanges will be a complicated job involving multiple state agencies. Monitoring insurance companies will be even harder. The prohibitions against abuses can almost certainly be skirted, and insurers have a strong incentive to do so.

So I fear that this 2-year-old law will unravel before it is fully implemented. As state exchanges falter, individuals and businesses could be faced with prohibitively high premiums or punishing fines. The most vulnerable Americans will be those in their 50s and early 60s, who will have to pay the highest premiums and are most likely to have chronic illnesses.

Of course, if there is a Republican sweep in November, ObamaCare will be systematically dismantled.

When Obama was an Illinois state senator, he favored a single-payer health system— such as Medicare — for all. Even as president, he admitted in the summer of 2009 that a single-payer system was the only way to provide universal care. He was right then.

Medicare outperforms private insurance on every measure. It insures nearly everyone older than 65 for the entire package of benefits, no one can be excluded or dropped from coverage, and its overhead is very low. When ObamaCare inevitably fades away, it will be time to revisit the single-payer option.

How about lowering the Medicare age gradually, one decade at a time, beginning with age 55?

Marcia Angell, M.D., is senior lecturer in social medicine at Harvard Medical School and former editor in chief of the New England Journal of Medicine.

THE AMERICAN PROSPECT

FRIDAY, MARCH 23, 2012

Single Payer and the Supreme Court

Surprisingly, several groups seek to challenge the Affordable Care Act from the left.

By Robert Kuttner

When the Supreme Court begins its extraordinary three days of hearings on the constitutionality of the Affordable Care Act, one of the oddities will be an amicus brief challenging the act's individual mandate from 50 doctors who support national health insurance. They point out the inconvenient truth that, contrary to the administration's representations, the government did not need to require citizens to purchase insurance from private companies in order to meet its goals of serving the health-care needs of the populace. Congress could have enacted a single-payer law.

Since the Constitution unambiguously gives Congress the power to tax, there has never been a serious constitutional challenge to our tax-supported systems of health insurance, Medicare, and the services of the Veterans Health Administration system. In the words of the brief:

"Amici thus submit this brief for the purpose of disputing the primary tenet of the Government's position, that Congress cannot regulate the national healthcare market effectively unless it has power to require that citizens purchase insurance from private insurance companies. On the contrary, as set forth herein, Congress has already demonstrated that it can regulate healthcare markets effectively by implementing a single payer system such as Medicare or the VHA."

Much of the brief is devoted to demonstrating the superior efficiencies of single-payer systems, but it is also offers a formidable summary of the constitutional argument against the government's view of what the Commerce Clause permits.

"Government contends that the provision is not only 'reasonable' but also 'necessary' to its broader regulation of the national healthcare market. Brief for Petitioners. In particular, the Government contends that the individual mandate is 'key to the viability of the Act's guaranteed-issue and community-rating provisions.' But while it might be true that these provisions will adversely impact private insurers' profits, and that the individual mandate offsets this adverse impact by guaranteeing the private insurers a large stream of new customers who are required by law to purchase insurance, that is not sufficient to render the individual mandate constitutional. If it were, Congress could 'reform' any private industry – whether it be automobiles, coal, pharmaceuticals or any other – by enacting legislation requiring every that American purchase the industry's goods or services in exchange for some perceived public good the industry provides. Yet Congress has never before enacted such a mandate."

Ouch.

The brief further contends that none of the cases cited by the government "support the conclusion that the commerce power permits Congress to enact any regulation it finds necessary to the viability of a larger scheme regulating interstate commerce."

It would be more than a little ironic if a majority of the Court struck down the Affordable Care Act by relying on these arguments. These points have been made by others, of course. But what's nervy is that some single-payer advocates are tactically allying themselves with the political right in a momentous Supreme Court battle.

The brief is filed in the name of two groups, Single Payer Action and It's Our Economy, and was written by attorney Oliver Hall. It explicitly asks the Court to uphold the ruling of the Court of Appeals for the Eleventh Circuit finding the individual mandate unconstitutional.

This tactic must have given some single-payer advocates pause, since the most prominent single-payer group, Physicians for a National Health Plan (PNHP) and such noted proponents of national health insurance as Drs. David Himmelstein and Steffie Woolhandler of Physicians for a National Health Program are not on the brief.

If the Affordable Care Act were to be struck down, it would be a political blow to the Obama administration, as well as another case of overreach by the Roberts Court.

But the Court could well uphold the act. Some observers have suggested that the conservatives on the Court are having second thoughts about the unintended consequences of the Citizens United decision on unlimited political giving. Justices Scalia and Kennedy, moreover, have gone both ways on prior cases involving the reach of the commerce clause and may decide that this is not the time to further risk the Court as an institution, which severely impaired its credibility in Bush v. Gore.

On the other hand, if the Court struck down only the individual mandate, the rest of the act would live on. And the administration and Congress would have to find other ways to prevent uninsured people from free-riding on the system. As my colleague Paul Starr has proposed, a Court finding that the mandate was illegal would not necessarily kill the whole law. Other incentives and disincentives could be created so that most people would find it attractive to purchase insurance.

The amici have a point. A single-payer program would be more efficient and unambiguously constitutional, and even the Affordable Care Act need not be such a gravy train for the insurance industry. This brief, though risky, could turn out to be constructive mischief.

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How PNHP works: An overview

We reproduce below reflections by PNHP co-founders Drs. Steffie Woolhandler and David Himmelstein on PNHP's unique structure and how members can become more involved. These comments arose from an email interchange with a group of colleagues who supported an amicus brief opposing the Obama reform's individual mandate and raised criticisms and suggestions regarding PNHP's strategy and work plan.

Dear Colleagues:

We agree with many of the points that have been made, but fear that a misconception about the nature of PNHP underlies several of the comments. PNHP is a network of colleagues interested in working together for change, not an instrument that is wielded at the will of a group of leaders. Urging that "PNHP" take action is rarely apropos. The Chicago office – with a staff of 4.5 FTEs – serves to facilitate communication among members and chapters, and to help publicize their work. It is not in a position to implement "PNHP policy," take political action on behalf of the organization, etc. Our group's very limited financial resources dictate this limited staff role, but we believe that it is also a positive thing in the sense that the membership IS the organization. Moreover, PNHP's virtually complete reliance on the limited funds that we raise from members has insulated the organization from the pressures that inevitably arise when outside funders provide a significant chunk of the budget.

The main implication of the fact that PNHP is a network, not an instrument, is that initiating work depends almost entirely on an individual or group within the organization who take the lead in demonstrating work that captures the imagination of others. We (and we believe others involved in PNHP's leadership) are open to a wide variety of methods of work. But the proposer of such work must be prepared to leads its implementation, not merely ask that others do the job. Concretely, this usually means that an individual or local chapter pioneers a tactic – such as shareholder resolutions at insurance firms (Dr. Rob Stone and colleagues), or building links with local Occupy groups (Dr. Steve Auerbach in New York, as well as many others), or local ballot initiatives or state-level reform efforts (initiated in Massachusetts in 1986, and in many others states since) – which then attracts others locally and serves as a model for similar, and often coordinated work elsewhere. Hence, what we need from an informal caucus such as yours (and from other activists within PNHP) are attractive invitations to join in new work, and – even better – effective models of work.

Thanks to all for your intense commitment to figuring out the best ways forward.

— David Himmelstein and Steffie Woolhandler

The Courier-Journal

FRIDAY, APRIL 20, 2012

Medicare for everyone

Despite certain positive and/or promised benefits in the Affordable Care Act ("Obamacare"), there is one major flaw that mars the whole endeavor: the legislation keeps the private insurers in the mix. We will never be able to contain costs as long as those for-profit corporations dominate the system. The companies are legally required to serve their shareholders. Our premiums will rise and patients' care will be cut in order to benefit stockholders. And should the U.S. Supreme Court approve the mandate, the insurers will profit from the sale of policies in the state "exchanges."

As 2001 Nobel laureate Joseph E. Stiglitz has explained, the free market does not work in health care. Other advanced industrialized nations understand this: they offer publicly funded health care to all their people while supporting capitalism in other areas of the economy.

Let's improve Medicare and eliminate its projected shortfall. Disallow the private Advantage plans that cost taxpayers more than regular Medicare. Fix Plan D by negotiating with drug companies and buying in bulk. Set fair reimbursement rates for doctors and hospitals. Then expand Medicare to everyone. No mandate needed, no constitutional question to be resolved.

HARRIETTE SEILER
Louisville, Ky.

BMJ

MONDAY, DECEMBER 5, 2011

List of essential services under U.S. health reforms is 'skimpy' and dangerous, say doctors

By Jeanne Lenzer

A national doctors' organization says that most of the authors of a federally sponsored report on recommended health insurance coverage have financial ties to insurers and drug companies and that the insurance scheme will leave many U.S. citizens without access to health care.

The Institute of Medicine, which was contracted by the federal government to write the report, brought in security guards at the institute's annual meeting to prevent doctors from distributing leaflets outlining the financial conflicts of interest of the report's authors. The doctors, former institute fellows and members of Physicians for a National Health Program, were registered at the meeting and tried to give the leaflets to colleagues attending it.

Danny McCormick, assistant professor at Harvard Medical School and a former fellow of the institute, distributed leaflets at the meeting. He has signed a protest letter sent to the U.S. secretary of health and human services, Kathleen Sebelius, along with more than 2,400 doctors, nurses, and health advocates, stating that the recommendations for "essential benefits" to be provided under the Affordable Care Act will provide "skimpy" care that would endanger the health of many citizens.

Although the report outlines 10 categories of benefits that insurers must cover, such as costs of hospitalization, preventive care, and ambulance transport, it does not prohibit insurers from shifting costs to patients through premiums, co-payments, deductibles, and cost sharing. In the event of a catastrophic illness or injury, patients could be hundreds of thousands of dollars in debt.

Dr. McCormick said that a serious pitfall of the recommended essential benefits is that they would give patients the illusion that they have "real insurance." He said, "Most patients, no matter how well informed, have no idea what their insurance policy covers. It's only when some catastrophic event occurs that they find out that they are not fully covered."

Nor would the insurance scheme necessarily cut over-testing and over-treatment, which Dr. McCormick says should be cut. Although the report panel recommends establishing an independent "national health benefits council" to review scientific evidence regarding new technologies, the plan does not task the council with assessing current testing and treatment strategies that might be unnecessary or dangerous.

Howard Brody, a member of the Institute of Medicine and Physicians for a National Health Program, told the BMJ that the Affordable Care Act "is truly a game changer" that will extend coverage to more people. Nevertheless, he added, "It's not enough."

Dr. Brody called the act a "sop to the insurance industry" and a "political decision, not a scientific decision," since a single-payer system is considered unacceptable in the United States. He said that the institute was assigned a narrow task of defining only "what absolutely must be covered." Unfortunately, he said, nothing in the recommendations would prevent insurers from providing "shoddy" coverage.

Dr. Brody said that the institute's actions to prevent doctors from leafleting about the panelists' conflicts of interest were "indefensible." He said, "The institute is supposed to be an educational organization, the elite of American medicine, yet they treat their own members as if they were children incapable of assessing the information for themselves."

The institute said that it complied with its policy on conflicts of interest by promptly disclosing committee members with a conflict of interest but whose expertise was needed to fulfill the committee's charge.

BMJ 2011; 343 doi: 10.1136/bmj.d7932

Health Insurance Company CEOs' Total Compensation in 2011

Cigna	David Cordani	$19.1 million
Coventry	Allen Wise	$13.6 million
WellPoint	Angela Braly	$13.5 million
UnitedHealth Group	Stephen J. Hemsley	$10.8 million
Aetna	Mark Bertolini	$8.8 million
Humana	Michael B. McCallister	$7.3 million

The average worker made $34,053 in 2011.

Source: http://www.aflcio.org/Corporate-Watch/CEO-Pay-and-the-99/CEO-Pay-by-Industry

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Mass. health reform's impact augurs poorly for federal health law: new report

FOR IMMEDIATE RELEASE
Oct. 25, 2011

While the Massachusetts health care reform in 2006 reduced the number of people who are uninsured in the state by about half, it did so at a high price and is unsustainable over the long haul because of skyrocketing costs, a group of Boston-area physicians and researchers say in a new report released today. The results do not augur well for the similarly structured Affordable Care Act, they say.

The report, titled "The Massachusetts Model of Health Reform in Practice," presents data showing how the Massachusetts law has resulted in a surge in the sale of skimpy, inadequate insurance policies with high deductibles, along with a sharp rise in health care premiums for individuals and small businesses.

The authors also document how the law has created a financial crisis for the state's safety-net hospitals and community health centers by cutting their public funding and redirecting the money to subsidize the purchase of private insurance policies.

The financial burden of the reform has fallen disproportionately on lower-middle-class families, they say. Meanwhile, the number of uninsured is once again on the rise.

Those are just some of the findings in a new, exhaustively documented report released today by Mass-Care and the Massachusetts chapter of Physicians for a National Health Program. The report, which is extensively illustrated with tables and graphs, draws on hundreds of sources, including academic studies, government statistics and surveys, in the most comprehensive compilation of its kind.

Other findings include the following:

- The use of high-deductible health plans more than tripled for residents with private insurance
- Good health insurance coverage at small businesses all but disappeared after the reform
- Most of the gains in the number of insured represented a shift of patients from the state's former Free Care Pool to costlier private insurance programs, where the patients sometimes face new co-payments and premiums that impede their access to care
- The reform did not reverse the growing use of the state's emergency departments
- The rate of personal bankruptcies linked to medical debt has not significantly decreased

Benjamin Day, executive director of Mass-Care and the study's lead author, said, "Based on what we've seen in Massachusetts, and given the similarities between our state law and the new federal law, it's reasonable to expect a similar course for the Affordable Care Act: a significant initial expansion of insurance coverage and a moderate improvement in access to care.

"However, by not addressing any of the underlying problems of the health care system – its uncontrollable costs, high levels of inequality, and high administrative costs associated with having multiple private insurers – we will see a worsening cost crisis for the rest of the population and a failing safety net for the most vulnerable populations," Day said.

The report finds that small businesses were hit particularly hard by health reform. Quality coverage for small business employees all but disappeared over a few short years after reform – while the share of all insurance plans with high deductibles tripled – and health care premiums for small employers rose more rapidly after the reform than in other states (7 percent faster for individuals and 14 percent faster for families).

Dr. Rachel Nardin, chief of neurology at Cambridge Hospital, assistant professor of neurology at Harvard Medical School and co-author of the study, said, "The Massachusetts reform built on a complex blend of public and private insurers, adding to the administrative complexity and cost of the system. To achieve cost-effective, high-quality and truly universal care, we need a single-payer system."

Nardin's views echo those of other Massachusetts doctors. The Massachusetts Medical Society's newly released 2011 survey of physician attitudes toward health reform showed 41 percent of the respondents would select a single-payer system as their first choice for national reform, versus 17 percent who would prefer the Affordable Care Act model. Support for single-payer reform rose 7 percentage points in the year since the last survey.

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A PDF of "The Massachusetts Model of Health Reform in Practice" is available here: http://masscare.org/massachusetts-health-reform-in-practice/

By Danny McCormick, David H. Bor, Stephanie Woolhandler, and David U. Himmelstein

DOI: 10.1377/hlthaff.2011.0876
HEALTH AFFAIRS 31,
NO. 3 (2012): 488–496

Giving Office-Based Physicians Electronic Access To Patients' Prior Imaging And Lab Results Did Not Deter Ordering Of Tests

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David H. Bor is the chief of medicine at Cambridge Health Alliance.

Stephanie Woolhandler is a professor at the CUNY School of Public Health at Hunter College, in New York City.

David U. Himmelstein is a professor at the CUNY School of Public Health at Hunter College.

ABSTRACT **Policy-based incentives for health care providers to adopt health information technology are predicated on the assumption that, among other things, electronic access to patient test results and medical records will reduce diagnostic testing and save money. To test the generalizability of findings that support this assumption, we analyzed the records of 28,741 patient visits to a nationally representative sample of 1,187 office-based physicians in 2008. Physicians' access to computerized imaging results (sometimes, but not necessarily, through an electronic health record) was associated with a 40–70 percent greater likelihood of an imaging test being ordered. The electronic availability of lab test results was also associated with ordering of additional blood tests. The availability of an electronic health record in itself had no apparent impact on ordering; the electronic access to test results appears to have been the key. These findings raise the possibility that, as currently implemented, electronic access does not decrease test ordering in the office setting and may even increase it, possibly because of system features that are enticements to ordering. We conclude that use of these health information technologies, whatever their other benefits, remains unproven as an effective cost-control strategy with respect to reducing the ordering of unnecessary tests.**

The Boston Globe

MONDAY, MARCH 19, 2012

Scientists stand firm on health IT study

By Liz Kowalczyk

Dr. Danny McCormick of Cambridge Health Alliance and his colleagues faced criticism this month when they published a study saying that electronic health records may not be a panacea for skyrocketing costs that many had hoped for. Dr. Farzad Mostashari, the national coordinator for health information technology, posted a blog criticizing the study as too narrow and outdated, saying it "tells us little" about the systems' ability to save money.

McCormick and his coauthors responded on the Health Affairs website last week, saying that some of Mostashari's assertions are mistaken.

"Some take us to task for claims we never made, or for studying only some of the myriad issues relevant to medical computing," they wrote. "And many reflect wishful thinking regarding health IT; an acceptance of deeply flawed evidence

CONTINUED ON NEXT PAGE ▸

The Boston Globe TUESDAY, MARCH 6, 2012

Doctors may order more — not fewer — imaging tests with electronic access to results, study finds

By Chelsea Conaboy

Electronic health records may not be as effective as expected at reducing the number of costly and unnecessary tests doctors order for their patients, a study published Monday in Health Affairs found. Among a national sampling of more than 1,100 doctors surveyed in 2008, those who had electronic access to results of imaging tests such as CT scans and MRIs ordered more tests, not fewer.

Experts have long thought that electronic health records would save money by preventing duplicate tests through better tracking of patient care, and by providing doctors with tools to decide who would benefit from certain tests.

The most advanced records systems may be able to do that, but the ones that had been rolled out nationally when the study was done didn't appear to be functioning well enough to do that, said lead author Dr. Danny McCormick, director of the Division of Social and Community Medicine at Cambridge Health Alliance.

The study "doesn't say, for sure, that we would never get there with even greater resources expended. We don't know," he said. "But I think it raises a caution."

The authors looked at surveys completed by doctors after 28,741 patient visits in 2008. After using statistical methods to adjust the data for variations between physician practices, researchers found that those doctors who had electronic access to imaging results were 40 percent more likely to order tests than those who had no electronic access to results.

McCormick said that electronic records have undoubtedly improved health care quality for patients and that, in his own practice, he would never choose to go back to the old way of doing things. However, he said, the nation has dedicated a lot of money to improvements in health IT -- the 2009 stimulus bill set aside about $27 billion in incentives for hospitals and doctors to adopt electronic records -- and policymakers must be realistic about the financial outcomes of that investment.

"If this study is right, then it's better to know about that now, so that we can perhaps start to implement other more fundamental reforms," he said.

He and his co-authors are advocates for a national single-payer health plan.

Dr. David Bates, chief quality officer for Brigham and Women's Hospital, said electronic health records have come a long way since 2008, and past studies have shown that it is harder to change doctor's habits in using imaging tests than in other things, such as ordering blood work.

But Bates said the authors are right that simply giving doctors access to information is not enough. These tools must be linked with financial incentives, he said, "so that providers are on the hook for providing more cost-effective care."

The authors note in the study that they did not look at whether doctors' systems included "decision support" tools, which may help physicians decide whether to order a test by providing them information about national radiology guidelines, for example, or send them an alert if they are ordering a duplicate test.

Electronic records "are not a solution," said Dr. David Blumenthal, chief health information and innovation officer at Partners HealthCare, who served two years as President Obama's national health IT coordinator. "They are a facilitator."

Decision support tools are the most powerful components, he said, and the biggest benefits in cost savings and improvements in care will come when they become more widely available to doctors.

◂ CONTINUED FROM PREVIOUS PAGE

of its benefit, and skepticism about solid data that leads to unwelcome conclusions."

The study looked at surveys completed by doctors after 28,741 patient visits in 2008. It found that physicians with electronic access to results from imaging tests, such as MRIs or CT scans, were at least 40 percent more likely to order tests than those who had no electronic access to results.

A chorus of critics said the study was outdated, because systems have come a long way since 2008 and now include tools to help providers decide when a particular test is necessary.

"Seemingly surprising headlines can be tempting, but it's important to get the facts," Mostashari wrote on his blog. "The evidence shows we are on the right track to establishing the health IT foundations for a true 21st century US health system where patients get better care, while we reduce health care costs."

McCormick and colleagues disputed their critics' main points.

"While the proportion of outpatient physicians utilizing health IT has grown since 2008," they wrote, "we are unaware of any `game changing' health IT developments in the past four years that are would produce substantially different results if the study were repeated today."

Healthcare Reform 2.0

BY STEPHANIE WOOLHANDLER AND DAVID HIMMELSTEIN

The health care reform process exposed how corporate influences render the US government incapable of making policy on the basis of evidence and the public interest."This statement, featured on the December 2009 cover of one of the world's most important medical journals, The Lancet, shortly before the passage of the Obama health reform bill, highlights the major current problem in health policy. The problem is not the state's domination of the human body, but the state's abdication to corporate America of its obligations regarding the health of the human body.

What role did the health industry play in the Obama health reform? Insurance firms donated hundreds of millions of dollars to Democrats as well as to Republicans. They then donated another $100 million dollars to an ad campaign opposing the bill. So while the Democrats embraced the centrist mandate-style reform (a reform first proposed by President Richard Nixon in an effort to block Senator Ted Kennedy's single-payer bill in 1971), the advertising campaign (which appeared under the name of the US Chamber of Commerce but was actually paid for by the insurance industry) opposed it from the right. The insurance industry's funding of both the right and center of the reform debate was aimed at shutting out voices to the left of the administration. Meanwhile, the Pharmaceutical Manufacturers of America (PharMA) donated more than $100 million to a campaign supporting reform, which promises to expand the market for their products, while eschewing price controls. The Senate framework on which President Barack Obama's reform was based was written by Liz Fowler, the former vice president for public policy for WellPoint/Anthem, the nation's largest private insurer.

U.S. Health Care in Crisis

Obviously, our health system has grave problems requiring reform. These problems are epitomized by the unrelenting growth in the number of uninsured Americans over the past several decades. Our research group at Harvard published a study in 2009 showing that 45,000 Americans die annually due to lack of health insurance—about 1 death per 1,000 uninsured people (Wilper 2009: 2289–2295). That is not only an indictment of the current state of the health system, but also very worrisome in the context of the Obama reform. If Obama's plan works as hoped (that is, if everything goes right), it will still leave 24 million people uninsured when it is fully implemented in 2019, according to the Congressional Budget Office (CBO 2009). Twenty-four million uninsured Americans is simply unacceptable. Meanwhile, the safety-net hospitals on which these uninsured (and many underinsured) people will continue to rely will suffer a $36 billion cut to help pay for the reform. On a brighter note, community health centers are slated to receive an extra $1 billion annually due to an amendment submitted by the country's only socialist senator, Bernie Sanders of Vermont.

The problems in US health care finance are not restricted to the uninsured; our fragmented, inadequate payment system causes tremendous suffering among insured Americans as well. Research we undertook with colleagues at Harvard Law School and Ohio University found that more than half of all US bankruptcies are due, at least in part, to medical illness or medical bills (Himmelstein and Warren 2005; Himmelstein and Thorne 2009: 741–746). This headline from our study was widely cited in the 2009–2010 health reform debate. But another of our findings received much less attention—in the overwhelming majority of medical bankruptcies, the patient had health insurance, at least when they first got sick. In our most recent data on bankruptcy filers in 2007, 78 percent of those whose illness caused a medical bankruptcy had health insurance. In some cases patients started the illness with insurance, only to lose it along with their job after they became sick. In many more cases, people had insurance—usually private health insurance—which they held on to throughout the bankrupting illness. Yet they were bankrupted anyway by gaps in their coverage, like copayments, deductibles, and uncovered services.

Others have found similar results. Surveys by the Commonwealth Fund found that even among Americans who were insured all year, 16 percent report being unable to pay their medical bills, 15 percent had been called by a collection agency about medical bills, 10 percent changed their way of life to pay medical bills, and 10 percent were paying off medical bills over time (Doty 2008).

To summarize, about one-third of Americans are inadequately insured, either completely uninsured or underinsured, such that a major illness would likely bankrupt them. They are often denied care, and they are sicker and die younger than the well-insured.

Overuse, Overtreatment

At the same time that many are denied access to vital care, we have tremendous overuse of medical services

in this country. The Dartmouth Group has documented huge variations in health spending in different regions of the country; high-cost areas (such as Florida, New York City, or Boston) have health care spending 60 percent higher than low cost areas, like Minnesota or Northern California, after adjusting for the health of the population (Dartmouth Health Atlas). One very high spending area is along the border between Texas and Louisiana, Cameron Parish, Louisiana, and the contiguous Jefferson County, Texas. There, per capita spending is nearly twice what it is in Rochester, Minnesota, home of the Mayo Clinic. One of us (SW) grew up and went to medical school in Louisiana, and can say with 100 percent certainty that the quality of medical care is not higher in Cameron Parish than it is at the Mayo Clinic. And indeed that was exactly the conclusion of the Dartmouth Group authors: the quality of care is actually higher in parts of the United States that spend less per capita.

Why do some regions have higher medical costs than others? The Dartmouth Group, which has been doing geographic-based health policy analyses for decades, has explored the causes of this higher spending. Much of it is explained by Roemer's Law (first enunciated by the late public health scholar, Milton Roemer), which tells us that if there is an empty hospital bed, it will be filled; if there is an idle surgeon, he/she will soon operate (Shain and Roemer 1959: 71–3). And that is precisely what the Dartmouth Group has found; areas with more specialists, more hospitals, more machines, tend toward overtreatment. The lower-spending areas are more primary care-oriented and have a lower density of specialist care. We need good specialist care; patients should have access to expensive scanners and high-technology treatments when they need them, but in the United States we are oversupplied with specialized resources. High-technology care such as CT scans and cardiac stents are overused in situations where they are unnecessary, even harmful. So, overtreatment exists in the United States side by side with medical deprivation; we are rationing medical care in the face of a surplus of medical resources.

HMOs and Administrative Costs

One resource available in a surplus is administrators, whose numbers have grown many-fold faster than the ranks of other health personnel (Himmelstein and Lewontin 1996: 172–8). This is a direct consequence of the growth of profit-driven health maintenance organizations (HMOs) and insurers, whose roles have been expanded by the 2010 national health reform.

Profit-driven HMOs are the problem, not the solution. This was demonstrated in the only randomized control trial of health insurance coverage, which compared HMO care to free fee-for-service care. After three to five years, lower-income people with chronic medical conditions who were randomized to HMOs had a risk of dying 21 percent higher than those randomized to free fee-for-service care (Ware 1986: 1017). Historically, there have been some fairly good nonprofit HMOs, including the one in Seattle, which was studied in that experiment. However, virtually all of the growth of HMOs in the past few decades has been in the investor-owned sector. The old style, nonprofit HMOs, which had pluses and minuses relative to fee-for-service health insurance, have been eclipsed by investor-owned plans, the instrument by which Wall Street has come to dominate American medical care. This shift to for-profit organizations has occurred despite strong evidence that the quality of care in for-profit HMOs is lower than in their nonprofit counterparts. In a study we published in the Journal of the American Medical Association (Himmelstein, Woolhandler, and Hellander 1999), we found that for every one of the fourteen quality indicators then being collected, the quality of care was higher in nonprofit plans than in investor-owned HMOs.

Of course, some people do extremely well in HMOs—their CEOs. Multimillion-dollar compensation packages have become the norm for HMO CEOs (for example, the $123 million received by Cigna's chief in 2009) (HCAN Report 2010). This is one contributor to HMOs' very high overhead. The market-leading HMOs often have overhead of 21 percent or more. That means that for every dollar of premium, 21 cents stays with the insurance firm; only 79 cents ever goes to pay for a doctor, nurse, medication, or hospital. These huge costs are generated by running health care as a business rather than as a public service.

For years, Medicare, the federal insurance program that covers Americans over the age of 65, had overhead of only 3 percent. But seniors now have the option of signing up with an HMO and having their premium paid by Medicare. The overhead cost in these Medicare HMOs averages about 14 percent, fourfold higher than in traditional Medicare (GAO 2008; National Health Expenditure Accounts 2005). How can the private HMOs compete with the more efficient traditional Medicare plan? Private Medicare HMOs prosper by cherry-picking—that is, they selectively enroll the lowest-risk, lowest-cost patients and avoid the expensively ill. One important health policy concept is the "20–80 Rule"; 20 percent of patients (that is, the 20 percent of patients who are seriously ill in a given year) account for 80 percent of total health spending. An HMO that is paid based on the average level of spending but successfully recruits only the healthiest people (who cost little) can make tremendous profits.

Research has consistently shown that HMOs behave in precisely this manner. A study of Medicare HMOs in south Florida (Morgan 1997: 169) found that Medicare enrollees who were subsequently recruited to join a Medicare HMO had spending that was only 66 percent of the Medicare average, indicating that the HMO recruited much healthier than average seniors. Some patients left

the HMO and returned to traditional Medicare. In the months after leaving the HMO, the cost of covering these former HMO enrollees was nearly twice the Medicare average. So the HMOs were cherry-picking healthy people, then spitting out the pits (those who got sick) back into traditional Medicare. And the taxpayers bear the burden of subsidizing HMOs exorbitant overhead and profit.

International Experience

Every other developed nation has gotten to universal health care through some form of national health insurance, and all spend far less than we do on health care. In a study we published in the journal Health Affairs, we divided health spending into the publicly paid share and the privately paid share (Woolhandler 2002: 88–98). In the public portion, we included not only government expenditures for Medicare, Medicaid, Veterans Administration, and military, but also the benefit costs for public workers, such as teachers and FBI agents. We also included the so-called tax subsidy to private health insurance, which is money lost to federal, state, and local treasuries because health benefits are not taxable. When we calculated the public share of health spending in this inclusive way, we found that Americans are already paying, through our taxes, the full cost of national health insurance: over $4,400 per capita in tax-supported spending in 2007. Yet we took, on average, an additional $2,880 out of our pockets to pay privately, and still end up with a system that leaves 51 million Americans uninsured.

What do we get for this extra spending? We do not get longer life expectancy—our life expectancy is about two and a half years shorter than that of Canadians or major European nations (OECD 2010). We do not even get more scientific output on a per capita basis: 2 medical journal articles per 1,000 population in the United States versus 4 articles per 1,000 population in Sweden or Switzerland.

It is important to review evidence on Canada's national health program. Because of cultural and medical similarities, our group, Physicians for a National Health Program, often compares the United States to Canada, which has a single-payer Medicare-for-all program (Woolhandler, Himmelstein, and Angell 2003: 798–805). Under the Canada Health Act, a large federal block grant goes to each province that has a health insurance program that is universal, portable, covers all necessary care, and is run as a publicly administered nonprofit system. Public administration is necessary both to make the system fair and to generate administrative savings. Canada's government has not abdicated public responsibility for health as ours has.

If we compare health spending in the two countries, we find that health spending was virtually identical prior to the implementation of Canada's national health program, about 7 percent of GDP, but subsequently diverged, with US costs rising much more rapidly. Now the United States devotes 17 percent of GDP to health care vs. 11 percent in Canada. About half of the total difference is accounted for by the administrative simplicity and lower bureaucratic spending in Canada's single-payer system (Woolhandler and Campbell 2003: 768–775).

Health IT Won't Save Us

Computerization has been offered as a panacea to what ails US health care, including our high administrative costs. Can technology achieve similar savings on administration without the need to go to a full single payer reform? Not likely. In our study of the implementation of computerization in thousands of US hospitals, we found that those with electronic medical records actually had slightly more rapid increases in administrative costs (Himmelstein and Wright 2010: 40–46). Electronic medical records are a useful technology, if done right. But there is not a prayer they will significantly reduce costs.

Massachusetts: A Flawed Model of Reform

In projecting the impacts of the reform enacted nationally in 2010, it is important to review what happened in Massachusetts, a state that since 2006 has been doing a test run of the model for national reform (Himmelstein and Woolhandler 2007: 251–257). In Massachusetts, citizens (and some legal residents) with incomes below the federal poverty line are covered by Medicaid. Those with incomes between 100 and 300 percent of poverty are eligible for a partial subsidy to help them purchase private insurance. Those with incomes above 300 percent of poverty are required to purchase insurance, but when it comes to paying for it, they are on their own. For a woman in her 50s, the premium for the least expensive mandated coverage available through the state's insurance exchange (called the Connector) costs $5,600 annually (MA Connector 2011). The policy carries a $2,000 deductible; if the policyholder became sick, she would have to take another $2,000 out of her pocket before the insurance paid a penny, and would be required to pay a 20 percent coinsurance for the next $15,000 in health spending.

The punishments for refusing to purchase this expensive and skimpy insurance are substantial. If you violate child labor laws in Massachusetts, you can be fined $50; domestic violence carries a fine of $1,000, but being uninsured in Massachusetts carries a fine of $1,212.

The Massachusetts health reform has encouraged and endorsed underinsurance; it has taken many people who were uninsured and transferred them to the ranks of being underinsured, as will happen nationally under the Obama reform (Himmelstein and Woolhandler 2010: 1778). During the health reform debate, President Obama said many times "if you like your current private insurance you can keep it"; he neglected to say that if you do not like your

current job-based health care coverage you will have to keep it, because private insurance is mandated under the new bill and those who turn down job-based coverage will not be allowed to purchase insurance through the new insurance exchanges. The new mandated policies will be required to cover only 60 percent of health costs; the policies now available in Massachusetts illustrate what that means.

Not surprisingly, many people in Massachusetts still find themselves unable to afford care. According to a Boston Globe poll, during a one-year period, about 14 percent of Massachusetts families accumulate new medical debt, another 14 percent fail to fill a prescription because of costs, and 9 percent reporting postponing needed care (Lazar 2008). A recent poll of Massachusetts physicians from the Massachusetts Medical Society found that a plurality of the state's doctors now support a single-payer reform; few favor a Massachusetts-style plan (Massachusetts Medical Society 2010).

What does the American electorate think about single-payer health care? While many people are confused by the fog of political rhetoric, in polls that include an appropriate question, Americans strongly endorse the idea of "expanded and improved Medicare for All." For instance, in a 2006 ABC poll that asked Americans "Would you support a system of government-funded health insurance paid for through taxes, like Medicare?" (ABC News 2006), a two-to-one majority endorsed the idea. So while the American people want an expanded and improved Medicare for All—that is, a single-payer system—corporations deadset against single-payer reform have come to dictate the agendas of both political parties. Hence, the only way to win national health insurance is to build a popular movement to counter corporate power.

Additional information, including the evidence on which this paper is based, is available on the website of Physicians for National Health Program (www.pnhp.org), a 18,000-member single-issue organization advocating single-payer nonprofit health insurance for the United States.

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Connecticut drops insurers from Medicaid

By Phil Galewitz
Kaiser Health News, USA Today

HARTFORD, Conn. – In the past decade, most states have turned Medicaid over to private insurance plans, hoping they could control costs and improve care. Nearly half of the 60 million people in the government program for the poor are in managed-care plans run by insurance giants such as UnitedHealthcare and Aetna.

Connecticut, the "insurance capital of the world," is bucking the trend.

Beginning Sunday, Connecticut will jettison its private health plans from Medicaid, the state-federal health insurance program. Instead of paying the companies a set monthly fee to cover the health costs of more than 400,000 children and parents, the state will assume financial responsibility.

State officials say the companies, including Hartford-based Aetna, did not fulfill their promise of lower costs and better care.

"Connecticut has a 15-year history with managed-care organizations, and there has been a diminishing confidence in the value of what they are providing," says Mark Schaefer, the state's Medicaid director.

Nationally, managed-care plans oversee care for 27 million people enrolled in Medicaid and control $150 billion of the $400 billion in Medicaid spending — numbers likely to increase partly because of the influx of an additional 16 million people expected to be covered by the program beginning in 2014 under the national health care law.

Connecticut's decision stands out at a time when a growing number of states are requiring more people in Medicaid to join managed-care plans. Florida, Texas and California are among nearly two dozen states planning expansions in 2012.

Whether Connecticut's move turns out to be a blip in the industry's growing control of Medicaid or the beginning of a backlash, officials in other states are watching closely. In any case, the reversal of the trend in the insurance industry's home base has given managed care critics a rare, if mostly symbolic, victory.

"There is a cadre of people who hate for-profit health care, and this is another point of ammunition for them to point to and say that if they came to this determination in the insurance capital of the world, how can it be such great shakes?" says Joel Menges, a health care consultant who has worked with the state.

Connecticut has more of its residents employed in the insurance industry than any other — 2.1%, or more than 71,000 people, according to the U.S. Census.

Now, the state is betting that its employees, working with a private, non-profit company, can ensure that Medicaid patients get better care at lower cost.

Connecticut is only the second state in a decade to drop its for-profit managed-care plan. Oklahoma moved away from private plans in 2005, and officials there say they have no regrets. "While achieving very encouraging marks in both member satisfaction and quality, the cost per member has grown at a very low average annual rate of 1.2% over the last five years," says Mike Fogarty, Oklahoma's Medicaid director.

The Connecticut Medicaid managed-care business was worth more than $800 million this year to Aetna, UnitedHealthcare of Minnetonka, Minn., and Community Health Network of Connecticut Inc., a non-profit.

Aetna officials defended their record, saying they held down costs while ensuring patients' access to care. "We continue to see strong interest in managed Medicaid from states that are looking to meet the health needs of this vulnerable population without crippling their state budgets," spokesman Matthew Wiggin says.

"We do not see this as a trend," says Tyler Mason, a spokesman for UnitedHealthcare, which covers more than 3 million Medicaid recipients in 19 states.

Critics of managed care hope Connecticut's reversal will spur other states to look at alternatives. New Haven Legal Assistance Association, an advocacy group for the poor, had complained for years that managed care erected barriers to care and diverted too many resources to administration and profits. It pointed to a 2009 state-commissioned report showing Connecticut was overpaying insurers by nearly $50 million a year — about 6% of total expenses.

Other state reports found the plans were spending too little on health services and published networks of doctors that were misleading because many doctors refused to accept Medicaid patients when "secret shoppers" called for appointments.

Many doctors are happy to see the state's experiment with managed-care plans end. Many had been frustrated with having to follow different rules for different plans. They also complained about payment delays and problems referring patients to some specialists.

Elsa Stone, a North Haven pediatrician who had refused to contract with the state's two for-profit Medicaid plans owned by UnitedHealthcare and Aetna, cheered the decision.

"I don't think there should be a profit motive in health care," she says. "I think all the health care dollars should go to care."

Heather Greene, 36, of Waterbury, Conn., has been on Medicaid for seven years, along with her husband and two children. She says her Aetna plan did not make it easy for her to find a urologist or for her daughter to find an ear, nose and throat specialist. She is cautiously optimistic: "I trust the state a little more than the plans, which are looking to make a profit and cut corners wherever they can."

25TH Anniversary Physicians for a National Health Program

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Doctors Support Occupy Wall Street Because Wall Street Is Occupying Health Care

We support Occupy Wall Street because the private health insurance industry exemplifies the OWS movement's central tenet: its unchecked corporate greed tramples human need.

We support OWS because economic and social inequalities make our patients sick. Low wages, high unemployment, inadequate education, unhealthy food, unaffordable housing, unsafe jobs, a polluted environment, and a lack of access to affordable health care breed death and disability.

We support OWS because health care is a human right. We reject a system that forces us to treat patients differently based on their insurance and the treatments they can "afford."

We support OWS because we believe in evidence, and evidence shows us that profit-driven health care decreases access, raises costs and lowers quality. It's unhealthy for the 99%; only a few corporate executives, bankers, and lobbyists benefit.

We support OWS because our political leaders, held hostage by corporate money, reject evidence-based health policies such as a single-payer reform that would save both lives and money.

We support OWS because the health care economy—like the overall economy—has ample resources to take care of 100%, but those resources are siphoned off by profit-driven corporations in the interest of the 1%.

We support OWS because we took an oath to do no harm, and our corrupt political and economic systems are harming us all.

We support OWS because we are hopeful that we can change our society.

Join us!

Photo: Thomas Altfather Good

Students Occupy for Health Justice

By Danielle Alexander

Albany Medical College students rallied in Lafayette Park in Albany, N.Y., for the "Health Professional Students Day of Action for the 99%" in December. Danielle Alexander, the author, is on the far right.

I met a patient last week who stopped taking her antidepressant medications because she had been denied long-term health insurance and thought it would improve her chances of eligibility. Unfortunately this obviously wasn't in the best interest of her health.

I had another patient who presented to the emergency department with metastatic lung cancer. He had not been to the doctor in over 30 years because he couldn't afford it. If he had sought treatment earlier he may have been cured.

Everywhere I look private health insurance companies are making our patients sicker.

I was proud to be at in Lafayette Park in Albany, N.Y., last Sunday for the Health Professional Students Day of Action for the 99%. We carried a banner that said "Health Professional Students Occupy for Health Justice and Single Payer."

I support the occupy movement because I feel that powerful and profiting insurance companies get in the way of my practice of medicine. Treatment should be the same high quality for everyone; instead, we have to consider what someone can afford.

It too often becomes treatment for the "haves" and neglect for the "have nots." But the thing is, these days you may not know which group you fall into. Insurance plans are so spotty, with major gaps in coverage, that you don't even realize it until you need medical attention, and you find your plan does not cover it.

I see it every day in the clinic – treatment is designed around what the insurance will pay (or not) instead of what is best for the patient first and foremost. It's no fault of the medical team; we want to give the patients the best care, but the insurance industry has our hands tied.

Today's future doctors realize that health care is more than physical health, social determinants of health are equally as important. The schools our kids attend, the neighborhoods we grow up in, the cleanliness of the environment, joblessness, and poverty all deeply impact our health.

A classmate said today, "There is so much inequity and injustice, it cuts into everything, including caring for patients. If you really want to care for patients you've got to care about everything, not just their liver."

I asked some of the other attendees why they support the Occupy movement. "Health care is a fundamental human right and by increasing access to health care we can reduce some of the inequality," said one medical student. Another classmate agreed: "We're here for health care because you can't do anything if you're not healthy." Yet another: "As a future physician, it's disconcerting that patients can't get into my exam room, and I want to change that."

Even early in their medical careers, these students see that there are major problems with the health of our nation.

As I talked with my classmates, I found that we were all there for slightly different reasons. "I feel like too much of our country's infrastructure has been diverted away from the important stuff like health and well-being," said another student. His peer believes "the system is broken and change needs to start somewhere."

The United States is the only industrialized country that does not provide health care to all its citizens regardless of employment status or economic class. Our profit-driven health care industry raises costs and inequality.

But our political system has been corrupted by corporate money and power, and the 1% have rejected evidence-based health policy that save lives and money, namely expanded and improved Medicare for all. We support Occupy Wall Street because economic and social inequality makes our patients sick.

Danielle Alexander is a medical student in Albany, N.Y.

Bangor Daily News
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Where is Marcus Welby when you need him?

By Philip Caper, M.D.

Marcus Welby, M.D., the iconic general practitioner of 1970s TV, will probably never make a comeback. As I described last month, the overwhelming preference of young doctors is to go into medical specialties rather than primary care, mostly due to the much greater earning power of specialists.

But there is another reason for this trend. During the past few decades, medical knowledge has dramatically expanded and many doctors decided that to keep up in their fields, they had to specialize.

This has led to a proliferation of specialists and subspecialists, resulting in growing fragmentation of medical care from a patient's perspective and creating a medical maze that many have trouble negotiating. It has also created gaps in the continuity of care.

The federal health care reform law creates many programs designed to deal with this problem. They may not be enough. But even without them, changes in the way medical care is delivered are taking place at an accelerating pace.

Hospitals are consolidating and buying up doctors' practices and other health care providers such as home health agencies, nursing homes and laboratories. Four systems are emerging in Maine centered around Bangor, Augusta, Lewiston-Auburn and Portland, and around 80 percent of Maine's doctors are employed by one of them.

As a result, solo practitioners such as Dr. Welby will mostly be replaced by teams of health care workers who will function under the umbrella of these emerging health care systems, no longer earning money solely by directly providing services. They will earn their increased incomes by saving money through better management of more expensive technology.

Spurred on by the federal government, doctors and hospitals are adopting electronic systems for financial, administrative and clinical records to help control costs and improve quality or efficiency. But they will succeed if, and only if, the financial incentives that drive so much of our behavior in health care are reformed.

Already under way is a movement away from fee-for-service and toward so-called bundled payments. Rather than paying for each individual service, payers such as health insurers and government will pay a flat rate to a health care system for all services for a group of beneficiaries.

Health care systems, no longer constrained by a specific list of reimbursable services, will be able to expand the range of benefits they provide, as long as they don't exceed their budget. They can do this by substituting low-cost services that are not now reimbursable but may be more appropriate, such as nursing home or home care, for more expensive high-tech services such as hospital care.

But just as fee-for-service can be abused by encouraging too many services, bundled payments can be abused by creating incentives to provide too little care. Most health care professionals would fight energetically against this temptation. The majority of us are committed to doing what's right for our patients and are not businessmen at heart.

The culture of health care must change, and return to one driven by a nonprofit mission of healing, not the bottom line.

Rising health care costs are crippling our ability as communities, states and as a nation to address other needs. They are eating into our wages and our ability to fund education, infrastructure, public safety, economic security and other priorities.

In almost all other wealthy countries, the level of public satisfaction with health care is much higher than it is in the U.S. despite much lower spending. In those countries, everybody is in the same nonprofit system, and people feel they are being treated fairly.

Compare that with the endless bickering, disinformation, class and age conflict and fear-mongering that permeates the debate about health care in the U.S. Much of that conflict is driven by arguments about money — who pays, who benefits and how much.

A single, nonprofit health care system in Maine and the U.S. would go a long way toward fixing that problem.

Physician Philip Caper of Brooklin is a founding board member of Maine AllCare, a nonpartisan, nonprofit group committed to making health care in Maine universal, accessible and affordable for all. He can be reached at pcpcaper21@gmail.com.

Principles for Cost-Effective, Sustainable Health Care Reform

By Stephen Kemble, M.D.

1. Universality -- single risk pool
2. Standardized benefits, adequate for effective medically necessary care
3. Minimize administration
4. Promote professionalism in health care
5. Quality improvement
6. Ensure adequate professional workforce, especially for primary care
7. Accountability must be to the health needs of the population
8. Separate, sustainable funding for health care

Stephen Kemble, M.D.

1. Universality -- single risk pool

Large health care savings become possible if competing plans are consolidated into a universal program with a single risk pool. This will eliminate insurance costs of underwriting, adverse selection, multiple private bureaucracies, brokers, lobbying, and marketing and advertising. Health plan incentives to avoid covering the sick and to "cherry pick" healthier subscribers and risk pools will be eliminated. There will be no pre-existing condition exclusions, cost-shifting, and disputes over who is responsible for paying for care. A broader risk pool will reduce per capita insurance reserve requirements. For businesses, a universal program will uncouple health insurance from employment status, and eliminate employer costs for health benefits administration. Patients will gain free choice of providers, with no restricted panels by plan. Everyone will have access to the same care, and the poor will no longer be relegated to an under-funded Medicaid program. The state will save the cost of eligibility determination for Medicaid. For care providers, there will be no uncompensated care. Universal coverage could remove health care costs from medical malpractice, worker's compensation, and auto insurance, greatly reducing insurance costs, even without tort reform.

2. Standardized benefits, adequate for effective care

A universal program will require comprehensive benefits, adequate for all medically necessary care. Since those now covered under Medicaid will be included, co-pays and deductibles will have to be eliminated or so minimal that they could be waived for those who could not afford them. For the poor, there must be no financial barriers to seeking appropriate care. For those with moderate incomes, there will be no "under-insurance" or unaffordable costs for those with serious or disabling illness. Medical bankruptcy will be eliminated.

3. Minimize administration

With a universal program, billing and clams processing will be vastly simplified and standardized. Electronic health records and gathering of data for quality improvement will be standardized across all patients and providers. So will formulary and prior authorization policies for drugs. Incentives for cost-effectiveness should be at the point of service, between doctor and patient, minimizing central management of health care decisions by the program (managed care) with its high administrative costs. Global budgets for hospitals and integrated care systems will eliminate billing costs that can consume up to 20 percent of hospital budgets.

4. Promote professionalism in health care

In order to protect the public interest and safety, a universal health program must require maintenance of high standards for professional training. Professional scope of practice must be based on training, not lobbying. Physicians and other providers should be required to maintain membership in a professional organization, tied to licensure, to

ensure that peer review and professional ethical standards are enforceable, and to promote continuing education. A universal program will also require organization of physicians and other professionals for negotiation of fees with the program, and for participation in quality improvement. The program should harness professionalism to keep health care equitable and cost-effective. The net income potential for professionals must be commensurate with the training and skills necessary for their scope of practice, and any reduction in professional pay must be tied to reduction in administrative burdens (cost, time, and hassles), reduced risk of lawsuits, and subsidies for training costs.

5. Quality Improvement

A system-wide quality improvement program with professional leadership should replace managed care administered by insurance companies. This program should follow William Deming's Continuous Quality Improvement (CQI) model and focus on improving processes of care, rather than just HEDIS style quality measures. Unlike CQI, other strategies to reduce unnecessary and inappropriate care such as capitation, rating providers, pay-for-performance, and incentives based on outcomes are problematic because they create disincentives to treat difficult and complex patients.

6. Ensure adequate professional work force, especially for primary care

A universal program should improve payment for care coordination. Patients with significant chronic illnesses should be assigned to a "patient-centered medical home." Primary care can also be encouraged with a state-level program similar to the National Health Service, with subsidies for medical education and training tied to commitment to practice in underserved areas and specialties.

7. Accountability must be to the health needs of the population

Health system policies, including fee structure, scope of practice issues, formularies, and covered benefits, must be set by a health authority that is accountable to the health needs of the community and insulated from special interests and lobbying. Funding for capital improvement in hospitals, nursing homes, diagnostic imaging centers, etc. should be determined by public health needs. Health care financing and institutions for delivery of care must both be not-for-profit. A universal health system will benefit from a continuous quality improvement program for administrative systems as well as for health care delivery, with robust feedback from providers and patients that can actually influence policies.

8. Separate, sustainable funding for health care

A universal health system must have its own separate funding stream, whether this is called a health tax or a premium. There must be no mixing of health care funding with general tax revenues. Funding must be responsive to actual costs of care and public health priorities.

Dr. Stephen Kemble is assistant professor of medicine at the University of Hawaii John A. Burns School of Medicine, and also in private practice as a general adult psychiatrist. He is a member of Physicians for a National Health Program. In September he was appointed by Hawaii's Gov. Neil Abercrombie to the Hawaii Health Authority, charged with designing and then running a universal health care system for Hawaii.

INDEPENDENT RECORD

MONDAY, SEPTEMBER 5, 2011

Single payer works

Letter to the Editor

The IR's editorial of Aug. 28 suggests that the "state needs insurance competition, … giving Montanans … choice and competition for their health insurance dollars."

I disagree. The notion that competition and choice between health plans will improve care or lower costs is a fantasy; it hasn't worked for decades. Competing plans do little else than drive up administrative costs currently costing the public nearly one-third of every dollar spent on health care. Of the $6.2 billion Montana spent on health care in 2008, $1.922 billion went to administration, $1,980 per Montanan.

Health care reform could provide better care at less cost by replacing competing insurance companies with a single-payer health plan. An improved Medicare for All would reduce administrative costs leaving the state with enough funds to provide universal care. Vermont recently passed legislation to move in that direction and Montana would be wise to study this option.

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Member, Physicians for a National Health Program

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Demystifying Canada's health care system

The following article is an edited version of an interview given to Your Health Radio in North Carolina on Nov. 16, 2011.

By Khati Hendry, M.D.

I'm occasionally asked what it's like to practice medicine in Canada. I'm a U.S. citizen who trained in the United States and worked there – mainly at community health centers in or near Oakland, Calif. – for almost 25 years. For the past seven years I've been working as a family doctor in a private practice in British Columbia.

Canadians have ready access to health care and generally like their system. As a practitioner, my experience has also been quite good.

Actually, I have to say that when I moved to Canada and started working, it felt a little bit like I had finally stopped banging my head against the wall.

It's quite a relief to be working in a system where you're not spending most of your energy fighting to make things better for your patients – fighting the insurance companies, fighting the bureaucratic rules and regulations, dealing with policies that are constantly changing underneath you, spinning your wheels, and worrying about patients who can't get the care they need.

Canada's single-payer medicare program is incredibly popular. People give it very high marks and say they don't want it taken away.

My typical workday

As far as the day-to-day delivering of medical care in Canada and the U.S. goes, there's not much difference at all. Patients have the same colds, the same problems, and I bring my same expertise into play, order the same tests for investigation, and make referrals.

What's really different is the context in which all this is happening.

For example, today I saw patients all morning. They came in the door, they said hi, they showed their Canadian medicare card. No one had to check whether the card was still valid, or whether they'd changed from one plan to another, or whether they had co-pays. They just came in for a visit.

The patients walked down the hall and I saw them. I did whatever was necessary. I didn't have to fill out any extra forms. I went to my EMR, my electronic medical record, I put down what I did, and my billing report was sent off to medicare by the one, part-time bookkeeper who serves our six-physician practice. I then get paid.

It's amazing. You cut right through all the red tape that exists in the U.S.

In Canada, you're taking care of patients and being concerned about their medical issues. You're practicing medicine, not paperwork.

Khati Hendry, M.D.

Doctors' role in the system

Some people in the U.S. claim that in Canada the government tells physicians what to do. It's a little more complicated than that.

The Canada Health Act stipulates that certain baseline services must be offered in the health care systems in all the provinces. However, each province has the authority to modify what the plan looks like. They just can't drop below the basic package. An individual province can add other services or tweak existing ones.

In addition, each province negotiates with the medical association over how the physicians are going to be paid. Physicians have quite a bit of say in this. There's a back-and-forth in these negotiations, and while it's not the same from province to province, there's ultimately an agreement on a basic fee structure.

In the U.S., of course, physicians have to grapple with multiple fee structures from all the different insurance companies and other payers.

Ironically, I have much more say in Canada over how I take care of my patients than I ever did while working in the States, where I was an employee and I had people micromanaging me, almost on a daily basis, from insurance companies and government agencies.

A lot of people in the U.S. believe we are all employees of the government. That is absolutely not true. Most of the doctors are in private practice. Yes, the financing is publicly administered, but it's not government officials that are running

the medical system. It's the doctors who are running the system in terms of defining what we want our patients to have, and so on.

At the end of the day, you know you're going to get a certain amount of money, and that's what you get. I want to stress this: you get paid, or you almost always get paid unless you did something egregious in billing incorrectly.

In the U.S., by contrast, I remember you would submit your bill and maybe you'd get paid and maybe you wouldn't. Maybe the insurer moved the goalposts. Maybe you'd spend six months trying to get paid. But in Canada, you have an agreement about what you're going to get paid and they pay you.

Patients benefit, too

It's much simpler for the patients, too, because if I want to send someone to the hospital or a specialist, I don't have to worry about what plan they're in, whether we have an agreement with the provider, or whether the plan has been switched from one day to the next. I just write the prescription and that's it.

Medications are somewhat different. The Canada Health Act provides for all medically necessary services, which includes doctor visits, hospital visits and the supporting tests and examinations. Pharmaceuticals were not part of the original plan.

Some of the provinces have made efforts to include a drug benefit, but this remains an open issue. There's cost-sharing in most places, so the situation is not quite as straightforward as with medical services.

What about wait times?

Another question people frequently ask me about is wait times. It really just has to do with supply and demand.

If you're in a rural area – Canada is a big country, so we have a lot of rural areas, including places like the Northwest Territories – you're not going to have immediate access to some specialists. The same is true of rural America, of course.

For some elective procedures you may have to wait a bit – but you won't wait forever. If you need a knee replacement, you will get it done in a reasonable amount of time, e.g. within six or seven months, sometimes sooner. And you won't risk going bankrupt from having it done.

Each province has developed a wait-list system, and each has worked on different ways to expedite some of these elective procedures that people want to go faster. In British Columbia, for example, there is a website you can go to and see which physicians have shorter wait times and then ask to be referred to one of those physicians.

So people are working on the problem. But I want to stress that wait times apply only to elective procedures, non-urgent care. Urgent needs get treated immediately.

Take orthopedics. I often had a hard time getting services for my patients when I was in the States. It wasn't always easy to get what you wanted, especially if your patient was in a safety-net program like Medicaid. So needs would often go unmet.

In Canada, if I have someone who really needs something, they get it. There is an orthopedist at my hospital, 24/7. If someone has a fracture or an acute injury they go there and they're seen that same day – and again, no one goes broke from that because they don't have to pay extra for emergency care.

Family doctors as gatekeepers

Family practice doctors in Canada act as gatekeepers. You get your care through your family doctor. It's not overly specialized in that way. But if someone wants to see a specialist, then I refer them. You could try to see a specialist on your own, but most specialists won't accept you. They prefer the family doctor send you.

The other thing which is kind of interesting is that not only is Canada family-doctor friendly, but the pediatricians and internists in Canada are specialists, meaning that people don't go there for their primary care, they're referred there by the family doctors for a specific issue.

There is a lot of interest in Canada in the concept of the medical home – improving the medical home and making sure everyone has one, because we still do struggle with that, making sure that everyone has their own family doctor. It's a big issue.

It's being done differently in different areas. In Ontario, for example, they are experimenting with multidisciplinary clinics and other innovative settings, sometimes paying physicians by a combination of salary and fee for service. But there's no template for all the provinces.

A sense of security and solidarity

Finally, one of the things I'm most impressed with is that in Canada you never lose your insurance. You never worry about pre-existing conditions. If you lose your job, you don't lose your insurance. If you have dependents, if you're married or single, or whatever your situation may be, you're always covered.

I have never been in a situation in Canada where a patient had to choose between getting treatment for a life-threatening condition and financial disaster. In the U.S., I once had a patient I thought was having a bleed into his brain, a subarachnoid hemorrhage, and I was trying to convince him to go to the emergency room. He was terrified because he had no insurance and thought it would be too expensive.

I've never have that problem in Canada. It's unthinkable.

This article is based on a radio interview Dr. Hendry gave to "Your Health Radio with Dr. Adam Goldstein and Dr. Cristy Page" on WCHL in North Carolina on Nov. 16, 2011. The program is produced weekly by the Department of Family Medicine at the University of North Carolina. For more information about Canada's program and the movement by physicians to preserve and improve it, visit www.canadiandoctorsformedicare.ca.

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The Fight to Save Britain's NHS

The following remarks were delivered to the Annual Meeting of Physicians for a National Health Program in Washington, D.C., on Oct. 29, 2011.

By Jacqueline Davis, M.D.

I've been asked to speak today about our fight to save the National Health Service. Who are "we" and why are we having to fight?

We are the campaigning organizations I work with, in particular Keep our NHS Public, which we started about seven years ago in response to the Labour government's marketization policies for the NHS – the NHS which Tony Blair had promised would be safe in his hands.

Why is the NHS worth defending?

The National Health Service was a great act of social solidarity when it was founded in 1948 in the aftermath of the Second World War. It's ironic that we are told today that we can no longer afford it, given that it was created in a period when the U.K. had huge debts. But it was also a time when people believed in acting together for a common purpose and when they believed the state could intervene for the benefit of society.

The intention was that people should be freed from the fear of the financial consequences of illness and that good health care should be available to all, regardless of wealth.

The three core principles of the program at its founding were these: (1) it meets the needs of everyone, (2) it's free at the point of delivery, and (3) it's based on clinical need, not ability to pay.

By and large the NHS has managed to maintain those principles.

Of course the NHS faces the challenges that all health systems do, e.g. changing demographics, increased range and cost of treatments, rising patient expectations and the global financial crisis. But in the face of all these challenges the NHS still manages to be one of the most cost-efficient and equitable health services in the world.

And the public loves it. At the end of the Labour government's 13 years in power, the NHS had the highest satisfaction ratings ever. It still is the most popular institution in the UK, bar none – and that includes the royal family!

Dr. Jacqueline Davis speaks at PNHP's Annual Meeting at Gallaudet University, Washington.

The neoliberal agenda: dangerous to your health

So if it's so good, why are we having to fight for it? Because there's another big challenge which all public services face – the neoliberal agenda. That agenda still has the upper hand, despite its manifest failures on a global scale.

A successful public service is an affront to the free marketeers. They simply won't let the facts get in their way. Despite all evidence to the contrary, they continue to insist anything the public sector can do, the private sector can do better and more cheaply. Nothing will persuade them otherwise.

So the politicians, for ideological reasons, and the private sector, for financial reasons, have had the NHS – traditionally publicly funded, publicly delivered and publicly accountable – in their sights for some time. They have acted together, beneath the radar, to turn the NHS from a cost-effective, integrated public service into a legitimate-looking cover for a ragbag of competing private providers.

For those who are interested in how this happened, I recommend an excellent book, "The Plot against the NHS," by Colin Leys and Stewart Player.

It's enough now to say that since 2000, successive governments have pursued a policy towards the NHS that the electorate hasn't voted for and doesn't want – a profoundly

anti-democratic state of affairs.

The process actually began under Margaret Thatcher with the "internal market" within the NHS and was continued under New Labour with the Private Finance Initiative and other policies that increased marketization.

Enter Andrew Lansley's health bill

It has now come to crisis point with Andrew Lansley's Health and Social Care Bill. After Prime Minister David Cameron's specific pre-election promise of no more top-down reorganizations, Lansley, Secretary of State for Health, produced a bill the size of a telephone directory. Everyone knew it was going to be very bad news.

And so it has proved. In brief, the proposed changes are as follows:

- The current system of commissioning care will change completely, with 80 percent of the budget going to family doctors (GPs). The GPs will be responsible for commissioning services – hitherto publicly provided NHS services – to any willing provider, i.e. anyone with a mop and a bucket. The latter will be coyly called "part of the NHS family."
- Competition will be paramount and (according to politicians) drive improvements. Anti-competitive behavior will not be tolerated. This will be enforced by an organization called Monitor, chaired by a former senior partner of McKinsey & Company, the U.S.-based management consultants.
- Hospitals will all have to become Foundation Trusts, which are in effect autonomous competing businesses. Their only remit is to make a profit and they don't have to offer services on which they can't make a profit.
- There will no longer be a cap on income that hospitals can make from private patients. This is likely to lead to private patients filling NHS hospital beds, with NHS patients going to the back of the queue and a two-tier service.
- Personal health budgets are being rolled out.

This has all been driven with the usual spin of "patient choice" and "power in the hands of doctors," but even so, the vast majority of health professionals and the public don't want anything to do with this bill.

What are our fears?

Most GPs don't have the time, expertise or interest to get involved in commissioning health care. It will be done – and is already being done in some places – by private companies such as UnitedHealth, which has just signed a big contract in London. If the private sector is commissioning care and at the same time delivering it, the situation is tantamount to putting thieves in charge of the jeweler's shop.

We fear the likely impact on the doctor/patient relationship, especially in primary care. GPs in the U.K. are very effective gatekeepers to secondary care – that's one of the reasons why the NHS is so cost-effective. It's very important that patients trust their judgment and decisions.

Up till now you trusted your GP to give advice on clinical grounds. But now, if your GP says no to treatment, or refuses to give you a referral, will you wonder if it's because they want to pocket the money that is saved? The bill allows them to do that. Or if they refer you to Hips R Us down the road, will you wonder if it's because their wife has a financial interest in that practice? Twenty-five percent of GPs already have a direct interest in the private sector. This suspicion will be very corrosive, and most GPs are worried about it.

We fear GPs will be unwilling or financially unable to refer patients to hospitals, which involves greater expense, and will instead prescribe "care in the community." That term is already becoming weasel-speak for hospital closures.

Hospitals will see their incomes reduced and will turn to private patients to make them up. Until now there has been a cap on private-patient income, but that has been removed. If NHS beds fill with private patients, then NHS patients will have to wait and we will see a two-tier service develop.

With services being provided by competing organizations, we know there will be fragmentation of the care provided to patients and disruption of the patient pathway.

We fear that unprofitable services and patients will be quietly dropped.

We fear the loss of public accountability, with the private sector hiding behind commercial confidentiality, as they did with Independent Sector Treatment Centres, free-standing surgical clinics.

We fear NHS services will be reduced to a core of poor services for poor people, with those who can afford it "topping up" their personal health budgets with supplementary insurance or out-of-pocket payments, and those who can't afford it going without.

And we really fear the arrival of the private companies, many of them from the United States, whose behavior leaves much to be desired. They want to "cherry pick," i.e. to provide care for healthiest patients and to capture the health services they find most attractive, while leaving the NHS to pick up the most complex, expensive patients and to provide the services they find least desirable, such expensive emergency care and training. We fear they will behave in a fraudulent way as they do already in the U.S.

Clever maneuvers by the government

The government was very clever with the bill, which is really about the deeply unacceptable break-up and sell-off of the NHS. They knew they would never get away with that, so they sugarcoated the bitter pill with GP commis-

sioning.

And GPs fell for it initially – many were excited by the prospect of controlling the budget. Then they woke up to the fact that they would be doing this against the backdrop of a required $30 billion in savings over four years, and they would be made the scapegoats for cuts, closures and rationing. They would also have the private sector doing the commissioning, telling them what to do and probably ultimately employing them.

Less than 20 percent of GPs now approve of the bill and very few think it will benefit patients. But because the government has started to implement some of the changes before the bill has been enacted, they have had to get involved or engage others do so on their behalf.

So, you see why we have to fight this.

Because of the complexity of the bill, people, and in particular doctors, were either too busy to look at it or couldn't understand it when they did.

One of the problems we have had is engaging the profession, because (1) they didn't notice what was going on, or (2) they entrusted too much to our union to take on the problem, or (3) they felt powerless, given the lack of any visible sign of opposition. At the same time, there is also a minority of "doctorpreneurs" who see financial opportunities, never mind the long-term consequences.

Because the language used was about patient and doctor empowerment, patients felt reassured by the thought of money and power being in the hands of their local, friendly family doctors. It has been hard work to expose the spin.

Another problem was identifying and co-coordinating all the bodies who were opposed to the proposed legislation, in particular working with the health unions who tend to be suspicious of other organizations.

Keep our NHS Public: how we've fought back

Our organization was vociferous from day one, saying that the bill spelled the end of the NHS. Of course we were accused of shroud waving and gross exaggeration. But we stuck in there and joined together with other campaigning organizations and the pressure has built up over the last year. How did we do it?

We produced analyses and simple 10-point critiques of the bill in our regular campaign newspaper as well as special pamphlets and postcards. We wrote doggedly – all of us would take turns – to national and local papers and had a lot of articles and letters published.

We offered to do public talks, to our own groups and also to anyone from medical students to pensioners, and in fact those two groups turned into some of our most outspoken supporters. We helped organize online petitions. We put a lot of energy into lobbying politicians.

We have helped expose the scandals of the revolving door between government and the private sector and the infiltration of government by corporate interests. We have questioned the neutrality of so called think tanks and helped expose the strength of the health lobbying industry in Westminster.

We marched, we used social media to spread our message, and some of us even got elected to the Council of the British Medical Association so that we could begin to change our union from within.

As the bill passed from the House of Commons to the House of Lords, the profession finally woke up and there has been a flurry of open letters, both to our union, the BMA, asking it to oppose the bill (published in the BMJ), to politicians in both houses and to newspapers.

My professional group, the NHS Consultants' Association, wrote to the Academy of Royal Colleges, the umbrella body for specialist professional bodies, asking them to get involved. They are traditionally very conservative and excuse inaction by saying they are apolitical, but we pointed out that their remit is quality, training and standards, all of which are threatened by the legislation. They have since published a letter to the government stating their concerns.

What next?

Despite what amounts to a public outcry in the last couple of months, the bill is now going through the House of Lords with the prospect that it may emerge with little changed.

The problem we have come to realize is that we aren't just fighting the Tory government; we are fighting the global medical-industrial complex with all its power, influence and money – and its cozy relationship with today's politicians.

It's easy to lose hope but we mustn't. We have to take on this cozy configuration of politicians and giant corporations which have come to a "comfortable accommodation" at our expense. We must change the tone of the debate with these people who know the price of everything and the value of nothing.

We must say that the market should serve society rather than society serving the market, that there are public goods and goals for which the market is not suited, and that what matters is not how affluent a country is but how unequal it is. We must collect evidence and use it to criticize and expose. We must create the strong voice of civil society, and we doctors have a particular duty to be that voice and we must organize and use it.

Firstly because – and we must never lose sight of the fact – we are right. Secondly, we are the patients' true advocates and our patients are depending on us. And finally, Aneurin Bevan, the great founder of the NHS, said, "The NHS will last as long as there are folk left with the faith to fight for it."

We must be those folk because, personally, I am not prepared to let him down.

Dr. Jacqueline Davis is a consultant radiologist working in a hospital in London. She is co-chair of the NHS Consultants' Association, a nationwide group of distinguished physicians representing all specialties, and a member of the Keep Our NHS Public campaign. Since she presented these remarks, the British Medical Association, Royal College of General Practitioners, Royal College of Nurses, and Royal College of Midwives declared their opposition to the bill.

‘Battle over, but war just beginning’:
Dr. Jacky Davis after passage of NHS reform law

On March 23, only days before Lansley's "Health and Social Care Bill" officially became law, Dr. Jacqueline Davis, writing in her personal capacity, made the following comment at redpepper.org.uk:

It is inconceivable that we will all sit back and watch our NHS wantonly destroyed. We must make it clear to coalition politicians that we will not forgive their anti-democratic behavior. There are more than a million people working in the NHS; our votes and those of our friends and families will be used to punish the politicians responsible for this, both locally and nationally. We must also hold Labour to its promise to reverse the legislation when it is back in power.

The fight must go on in other ways too. Many groups have woken up to the dangers of the health bill and joined with campaigning organizations against it. Public health doctors, medical students and patients have all organized to protest and these groups can work together in future. There must be some sort of public statement, possibly a high-profile conference, to decide the way ahead and it must be made clear to politicians that the fight is not over.

We must monitor the changes to the NHS once the legislation comes into effect. By its very nature it will be increasingly difficult to know what is going on, as the service fragments and financial dealings and patient outcomes are lost behind a convenient curtain of "commercial confidentiality." It is essential that we keep track of the bill's effects if we are to show we were correct in our predictions of its dangers. The coalition will certainly not be telling us about the problems that arise, their predilection to massage the truth being only too apparent in their introduction of the bill in the first place.

Finally, we need an urgent inquest into the abysmal failure of medical "leadership." Early and united opposition would have seen off the bill long ago. Instead our leaders, in trade unions and professional bodies, saw "opportunities" and decided they could work with it on our behalf. When they were finally persuaded to see the dangers, their policy changed to seeking "significant amendments," despite the fact that the government showed no sign of conceding any.

Few organizations conducted a proper campaign, even after being mandated to do so. The leaders of the professions were only moved to opposition after internal struggles and grassroots organization. They have not represented their members. They must be held to account for their failure and the whole structure of representation needs critical examination.

In sum, we will need a combination of actions such as continuing media coverage, evidence about the detrimental effects of the bill, protests, occupations and perhaps a refusal to co-operate with the legislation – for example, a boycott of the private sector. This battle may be over but the war is just beginning.

All Unions Committee For Single Payer Health Care—HR 676

WEDNESDAY, NOVEMBER 2, 2011

IBEW Convention Endorses Single Payer

By Kay Tillow

The 38th convention of the International Brotherhood of Electrical Workers (IBEW) has endorsed single-payer health as a solution to the nation's health care crisis.

The 3,000 delegates who attended the IBEW convention called upon "…our international officers (to) do everything in their power and authority to work with other groups and elected officials to build support and action for universal single-payer health insurance…."

The IBEW represents over 725,000 members in the United States and Canada and is one of the largest building trades unions affiliated with the AFL-CIO. The September 2011 convention was held in Vancouver, Canada.

Ed Hill, IBEW International Union president who presided at the convention, said afterwards:

"The IBEW believes that single-payer health insurance in the United States is a worthy long-term goal. While a national single-payer system currently has little chance of becoming a reality in the near future, the 38th IBEW International Convention wanted to go on record in support of the concept in order to help nudge the debate forward and keep the issue in front of elected officials."

Resolution 60 on single payer, which was submitted by IBEW Local 23 in St. Paul, Minnesota, and passed by the convention, cites the fact that the United States is spending 16 percent of our Gross Domestic Product on health care but:

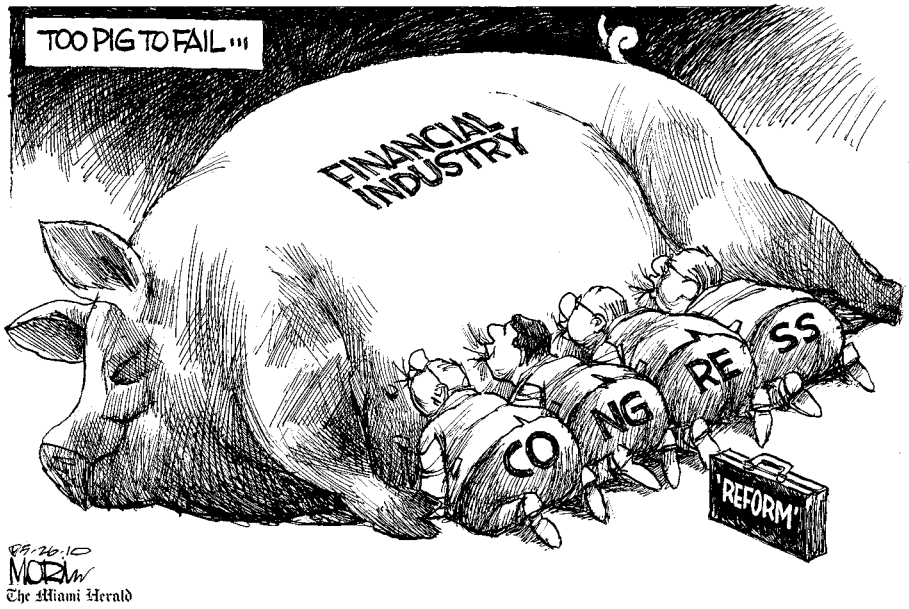
"(T)he battle with employers is on-going concerning the increases in health care costs; battles which for the most part we are losing in the form of costs being passed on to our members."

Resolution 60 states that, "…(R)etirees who have previously sacrificed to obtain health care benefits are now being stripped of those benefits;" and says that "a universal single-payer health care plan would reduce wasteful costs to all Americans while continuing to provide excellent health care coverage."

Resolution 60 also calls for sending a copy of the resolution "to all elected officials in the United States House and Senate and to all elected state legislators."

Health Care Versus Wealth Care: Investors with a Conscience Should Divest from Health Insurance Companies

By Rob Stone



I was the doctor on duty one night in August when the ambulance rushed a man into our Midwestern hospital ER. As I walked into the room, the scene was right out of TV. A nurse was trying to start an IV. Someone was running an EKG. A student had just put oxygen in the patient's nose. The room seemed crowded. The paramedics were sweating and slightly out of breath.

But my attention was on a pale, thin, fifty-five-year-old man sitting bolt upright on a gurney, clutching his chest and straining to breathe. Cold sweat dripped off his nose. I asked a couple of quick questions as I leaned him forward to listen to his lungs. Someone handed me his EKG showing an acute heart attack.

I slipped out of the room for a second to get the cardiologist on the phone. He would be right in, along with the rest of his team. But it was a Thursday night, late, and they were coming in from home. It would be at least twenty minutes until high-tech medicine could work its wonders, until the cardiologist could thread a thin plastic catheter into the patient's heart and put in a stent to open his blockage.

I was back to the room in a flash, and he looked no better. We gave him intravenous nitroglycerin, morphine, and powerful blood thinners. He began to look less frightened and some color crept back into his face. We still had a few minutes before they would be ready for him in the cardiac catheterization lab.

Just then I became aware of a woman quietly sobbing in a chair in the corner of the room, probably his wife. I walked over toward her and, as I neared, I reached out to touch her shoulder. She suddenly turned a fierce face up at me, saying: "When he told you he'd been having pain for two hours, he was lying! He's been having chest pains for the last two weeks!"

She didn't let up: "We were in the ER six months ago with his chest hurting, and they told him to see his cardiologist, but we don't have any insurance. They won't see him again without cash up front! What are we supposed to do?"

Her voice rising, she added: "And you know what else? They're suing us in small claims court right now over the bill from our last ER visit!"

Here was this poor woman, in my ER, not only deathly afraid that she might lose her husband tonight, but also afraid that whether he lived or died they might face an impossibly huge medical bill and lose their house, their car, everything.

The patient was a self-employed house painter, and he'd had a previous heart problem. Self-employed and a pre-existing condition — in America today with those two strikes, you are out. There is no way to afford health insurance. Is the Affordable Care Act going to fix this?

The Affordable Care Act and the Health Care Lobby

The Affordable Care Act (ACA) faces an uncertain future. The 11th Circuit Court of Appeals in August ruled the individual mandate unconstitutional. Judge Hull, who cast the deciding vote, was a Clinton appointee. The verdict states:

This economic mandate represents a wholly novel and potentially unbounded assertion of congressional authority: the ability to compel Americans to purchase an expensive health insurance product they have elected not to buy, and to make them re-purchase that insurance product every month for their entire lives.

The ACA was essentially written in the Senate Finance Committee chaired by Max Baucus. The actual author was his chief health care aide, Liz Fowler. Her job before working for Baucus? Vice president of WellPoint/Anthem/Blue Cross, the country's largest health insurer.

The health insurance industry played both sides against the middle during the congressional debate. While publicly claiming to be in favor of reform, they secretly funneled millions to front groups and organizations like the Chamber of Commerce, which fought the bill tooth and nail. What the insurers wanted most out of the deal was the individual mandate — a federally enforced requirement that all Americans buy their defective products, with taxpayer-financed subsidies for those who couldn't afford the premiums. What they wanted least were regulatory burdens that might limit their profitability.

Not being able to buy insurance if you are sick is one of the catch-22 aspects of our crazy system. In the eyes of insurance bureaucrats, it seems that life itself is a pre-existing condition. The ACA's ban on the use of pre-existing conditions to deny insurance coverage is scheduled to go into effect in 2014. Preventing that will be the next target of their lobbying fury.

It's Good to Be an Insurance Company

In this down economy, there are few bright spots for investors. Thank God for health insurance.

The Big Five health insurers — WellPoint, UnitedHealth, Aetna, Humana, and Cigna — together cover almost 100 million of us. Their profits from April to June 2011 totaled over $3.3 billion, 13 percent over their second quarter profits in 2010. Last year was their best year ever. For the twelve months ending in July 2011, these giants saw their average stock price rise almost 50 percent. These are huge corporations: WellPoint and UnitedHealth are in the top fifty of the Fortune 500.

What to do with all that profit? WellPoint, the behemoth created a decade ago from formerly nonprofit Blue Cross plans in fourteen states, spent $67 million on lobbying over the past three years. They paid their CEO, Angela Braly, $13 million in 2010, but that was paltry compared to the reimbursement package of UnitedHealth CEO Stephen Hemsley, who cleared $37 million, including the stock options he exercised.

Those stock options take on extra significance when company stock repurchases are considered. WellPoint, to take only one example, spent $21.6 billion of patients' premium dollars to buy back its own stock from 2003 through 2010.

Spending billions on stock buybacks benefits a tiny elite of CEOs, board members, and top officers, who are compensated largely with stock options. They buy the stock back to push the price upward. Their options increase in value as the share price rises. This is an enormous transfer of wealth from individuals and employers to top management. It benefits the largest Wall Street stockholders as well, but not you, not me, not patients.

This industry exists to collect premiums and process claims, and while they have no problems collecting our premiums, it's a different story when they have to pay. The June 2011 AMA Health Insurer Report Card revealed commercial health insurers have an average claims-processing error rate of 19.3 percent, an increase of 2 percent compared to last year. The increase in overall inaccuracy represents an extra 3.6 million in erroneous claims payments compared to last year and added an estimated $1.5 billion in unnecessary administrative costs to the health system. Medicare, by comparison, had an error rate of less than 4 percent.

They are obviously not using their piles of cash to improve service. What about lowering premiums? In our dreams.

Health insurance premiums have more than doubled over the last ten years, rising at four times the overall rate of inflation. (Over the same period Medicare premiums have barely risen at all, with no increase in out-of-pocket expenses.) While premiums have risen, coverage has shrunk. Copays and deductibles increase every year. People with individual coverage can have annual deductibles of $10,000 and more. No wonder illness leads to bankruptcy, even if you have insurance.

Bankruptcy, Moral and Financial

Every business day in America, 3,700 families file for bankruptcy caused by illness and medical bills, and that number is rising. This shameful situation happens in no other wealthy democracy. It would be a scandal anywhere else. Most medically bankrupt families were middle-class before they suffered financial setbacks. Roughly 60 percent of them had attended college; twenty percent of families included a military veteran or active-duty soldier.

Most astoundingly, 60 percent of the individuals whose illness led to bankruptcy had private health insurance when they got sick. Don't we buy health insurance to avoid financial ruin? High deductibles lead directly to bankruptcy and foreclosure. To make matters worse, they cause people to postpone needed care. All of which lead to higher insurance company profits.

The insurers don't like to tell their customers this, but when they talk to their Wall Street masters, they sing a different tune. Angela Braly of WellPoint, speaking during a conference call for financial analysts in 2008, was asked

if she would consider lowering premiums if that would increase enrollment in Anthem policies. Her reply, "We will not sacrifice profitability for membership," was just what they wanted to hear.

That sentiment hasn't changed. Recently Aetna's chief financial officer, Joseph Zubretsky, made similar comments on a conference call. Concerned that investors might think Aetna was willing to grow by adding people to its rolls who could have substantial medical needs, Zubretsky soothed their fears, "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."

Recall that these are the same companies that developed algorithms to target women diagnosed with breast cancer so they could scour their health records for an excuse to cancel their policies. This inhuman practice, known as rescission, has supposedly been banned by the ACA.

Buying Doctors

If insurance companies are not lowering premiums to attract more customers or investing in infrastructure to reduce errors, what else besides their own stock (and some politicians) are they buying? Doctors! UnitedHealth is quietly buying medical groups who treat patients covered by its plans in several areas of the country. WellPoint announced in June that it would acquire CareMore, which operates twenty-six clinics in the Los Angeles area. Cigna claims that it saves 9 percent on patients treated by doctors in a Phoenix medical group it controls. Is this a good thing?

In July, Kaiser Health News, in an article titled "Managed Care Enters The Exam Room As Insurers Buy Doctor Groups" said:

> 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."

And the losers? Patients, and those of us paying premiums.

Health, Health Care, and Health Insurance

No other wealthy democracy spends as much on health care as we do. It's not even close. Most of our peer countries spend about half as much per capita as we do.

If you hear politicians proclaim "America has the best health care in the world," you can stop listening to them at that point. They are not reality-based. We may be paying the most on the planet for health care, but there is no objective evidence to support the claim that our health care is the best. Again, it's not even close. The World Health Organization ranks U.S. health care thirty-seventh, just below Costa Rica.

No other wealthy democracy relies on for-profit insurance companies. Here we stand alone.

On August 10, 2011, the St. Louis Post-Dispatch editorialized, "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." The editorial goes on to explain that the "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 editorial asserts, "the ACA didn't go far enough," and concludes: "Eventually, the United States will have a single-payer plan. But we'll waste a lot of money and time getting there." Its authors could have added "and waste a lot of lives" too.

What is a "single-payer plan" like the Post-Dispatch endorses? Robert Reich, author, professor, and secretary of labor under Bill Clinton, explained it this way in February 2011:

> 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.

Medicare is a single-payer plan. Everyone over age sixty-five is covered by this simple, single plan, which is publicly financed and privately delivered. How would a single-payer plan save money? The Post-Dispatch explains, "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."

The respected journal Health Affairs published more evidence of the economic advantage of a single payer system on August 19, 2011. The article "US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers" found that U.S. physicians' office staff "spent 20.6 hours per physician per week interacting with health plans — nearly ten times that of their Ontario counterparts. If U.S. physicians had

administrative costs similar to those of Ontario physicians, the total savings would be approximately $27.6 billion per year."

The evidence is overwhelming: the for-profit insurance industry adds a huge amount of inefficiency, bureaucracy and cost to our system while adding no value, only hassle. These companies are parasitic middlemen we would be better off without. Their interest is in wealth care, not health care.

On top of that, the insurance industry is the single greatest barrier to achieving an efficient and affordable system to cover all Americans. If you have any doubt, read Wendell Potter's "Deadly Spin: An Insurance Company Insider Speaks Out on How Corporate PR Is Killing Health Care and Deceiving Americans." During the debate over the ACA, health insurance lobbyists sank the president's public option, even though 70 percent of the public favored it. Their war chests overflow with money and their influence grows every day.

Hoping Congress will fix this leads only to despair. We need new ways to weaken the death grip this powerful industry has on us.

Divestment

There is a battle going on for the soul of America. Before he died, Ted Kennedy wrote to President Obama about health care reform, calling it "the great unfinished business of our society." Kennedy avowed, "What we face is above all a moral issue; that at stake are not just the details of policy, but fundamental principles of social justice and the character of our country."

Back in the ER on that hot August night, I sent my man to the cath lab and they successfully stented his blockage. He went home the next day with a bill for $25,000. I tried to call him a few months later, but the phone number was "no longer in service."

Congress and the politicians are "no longer in service." We've got to look elsewhere.

Could we simply boycott health insurance? No, over 50 million are without insurance now, and they are living sicker and dying younger because they have barriers to care.

Stockholders with a conscience have tried for years to engage corporate leadership and have attempted shareholder resolutions to reform the industry from the inside. Despite their best efforts, they have had no significant positive effect so far.

It is time to move beyond resolutions and on to divestment.

The Divestment Campaign for Health Care is one group that is organizing a push in that direction.

From 1985 to 1990, over two hundred U.S. companies cut all ties with South Africa, resulting in a loss of $1 billion in direct American investment. This economic pressure hastened the fall of apartheid. It happened as a result of people power, democracy in action. Pension funds divested from companies doing business with South Africa. Faith communities declared they would not support injustice. Students called on their universities to cleanse their endowments. An idea was born — "socially responsible investing."

There is nothing socially responsible about investing in the health insurance industry.

Up to now, they have received little scrutiny from investors. One exception is Domini Social Investments, whose Global Investment Standards give "support [for] government's responsibility to provide basic public goods that are as varied as health care, prisons, primary school education, and national security." Domini is "concerned about the extent to which health insurance privatizes a public good." As a result, Domini has disqualified most health insurers from their portfolios.

In contrast, the $4 billion TIAA-CREF Social Choice Equity Fund holds $24 million in WellPoint stock, as well as Aetna and Humana from the health insurance Big Five. WellPoint stock may only represent 0.6 percent of the total fund, but in this large, diversified mutual fund, which includes over 800 individual stocks, WellPoint is in the top 5 percent of the fund's largest holdings. TIAA-CREF has refused to exclude health insurance companies.

The Presbyterian Church USA, often in the vanguard of the faith community, is there again. Their General Assembly meets in the summer of 2012 and they will vote on an "Overture" to "implement divestment procedures as well as encourage individual Presbyterians and congregations to divest of holdings in the [publicly traded health insurance] companies." Other faith groups cannot be far behind.

We have nothing to lose. Health insurance companies have everything to lose as their stock prices drop and their influence wanes. Go to your church, your union, your pension plan, your 401(k) advisor, your university endowment, your city council, your friends and neighbors, and tell them it's time to get the health insurers out!

Who can defend these corporations? There is no business case, no health care case, no moral case to support their ongoing existence. They make their profits by avoiding taking care of sick people — by refusing to issue policies, canceling policies, or denying payment. I went to medical school in order to care for the sick.

The health insurance industry must go.

Rob Stone, M.D., is a gardener, grandfather, and teacher. He has practiced emergency medicine in Bloomington, Indiana, since the early 1980s, and for the past year has been transitioning his medical career to hospice and palliative medicine. He is founder and director of Hoosiers for a Commonsense Health Plan and serves on the board of directors of Physicians for a National Health Program.

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By Jim P. Stimpson, Fernando A. Wilson, and Karl Eschbach

Trends In Health Care Spending For Immigrants In The United States

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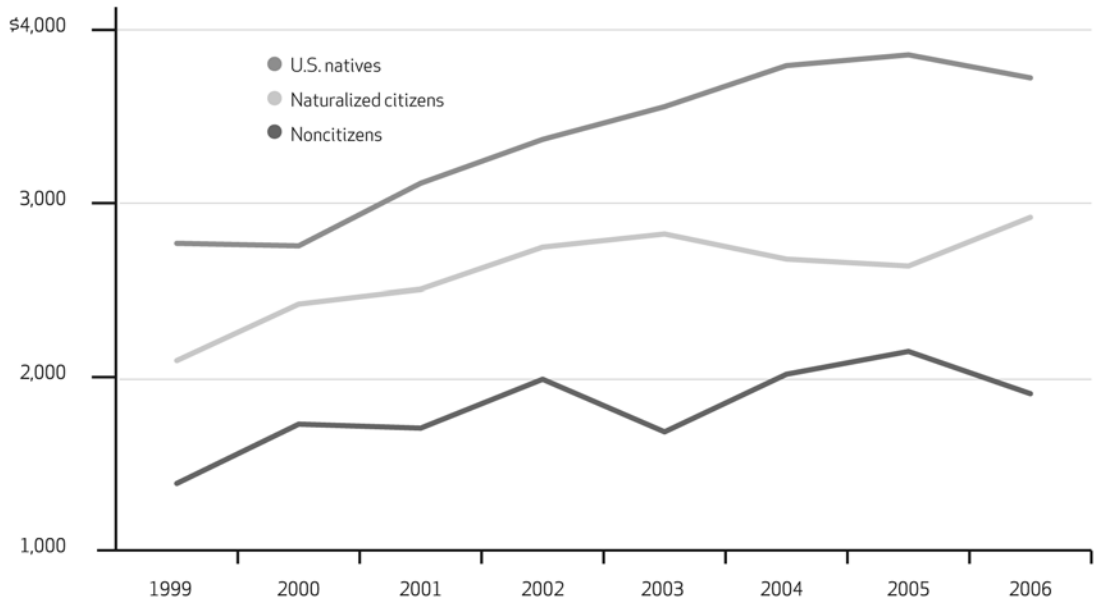
ABSTRACT **The suspected burden that undocumented immigrants may place on the U.S. health care system has been a flashpoint in health care and immigration reform debates. An examination of health care spending during 1999–2006 for adult naturalized citizens and immigrant noncitizens (which includes some undocumented immigrants) finds that the cost of providing health care to immigrants is lower than that of providing care to U.S. natives and that immigrants are not contributing disproportionately to high health care costs in public programs such as Medicaid. However, noncitizen immigrants were found to be more likely than U.S. natives to have a health care visit classified as uncompensated care.**

EXHIBIT 1

Age-Adjusted Total Per Capita Health Spending (2008 Dollars) For U.S. Natives, Naturalized Citizens, And Noncitizens, 1999–2006



SOURCE Authors' analyses of data from Medical Expenditure Panel Surveys, 1999–2006.

By John Creighton Campbell, Naoki Ikegami, and Mary Jo Gibson

Lessons From Public Long-Term Care Insurance In Germany And Japan

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ABSTRACT **The U.S. Congress is considering the Community Living Assistance Services and Supports (CLASS) Act, a voluntary insurance program that would help pay for long-term services and supports to disabled Americans. In Germany and Japan, social insurance programs are universal, support family caregivers, and allow individuals considerable flexibility in securing the services they require. We explored differences between Germany and Japan in program goals, eligibility process, scope, size, and sustainability for possible applications in the United States. Moreover, when we compared public spending on long-term care, we found that spending in the United States is actually higher than in Germany even now, prior to enactment of the CLASS Act, and is only slightly lower than in Japan.**

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Twenty years ago, policy for care of frail older people in Germany and Japan was much like it is in the United States today. Programs financed mostly from tax revenues provided means-tested access to nursing homes and, in some areas, to a few community-based services such as home help. Today, Germany and Japan have universal, comprehensive long-term care systems based on social insurance. A variation on this model is now under consideration in the U.S. Congress, in the form of the Community Living Assistance Services and Supports (CLASS) Act, a national voluntary insurance program that would help pay for long-term services and supports to some disabled Americans. In this article we argue that an even broader program of universal long-term care insurance is a practical and affordable solution to problems of coverage and fairness, and we describe differences between the German and Japanese programs that illustrate some important policy choices.

Public Long-Term Care Spending Compared

We start with a look at what Germany, Japan, and the United States spend on long-term care. Cross-national data compilations that allow separation of spending on the elderly are not available, so we compiled basic data on long-term care spending using best available data from 2005, the latest year with complete data for Germany and Japan.[1–6] We adjusted these data to exclude spending for people under age sixty-five in the United States and Germany, by referring to unpublished data or estimating on the basis of the best information available. (In Japan the official data are broken down by age.)[7,8]

We did our best to define consistent categories across the three countries, again estimating in a few cases. For example, there are no official data on long-term care provided in hospitals and paid by health insurance in Japan. In some instances, we consulted the officials or experts who had compiled the data we used to ensure that our estimates were reasonable.

To maintain comparability among the countries, we excluded most Medicare postacute spending, because it would be regarded as med-

ical rather than long-term care in Germany and Japan. However, we included Medicare home health Part B and Medicare spending for assistive devices because these would be included as long-term care in the other countries.

After converting the spending totals from national currencies to dollars at the purchasing power parity rate for 2005, we controlled for differences in age structure by dividing by the population age sixty-five and older in 2005.[9] The resulting figure, total public spending on long-term care for the elderly per elderly person, is the most useful measure for cross-national comparisons of long-term care policy.

We found that public spending on long-term care, even without counting most postacute care, is higher in the United States than in Germany and only slightly lower than in Japan (Exhibit 1). This is true even though only about 4.5 percent of Americans age sixty-five and older receive publicly funded long-term care,[10] in contrast to 10.5 percent in Germany and 13.5 percent in Japan. Examining the composition of spending (Exhibit 2), we note, for example, that Japan spends a great deal on community services outside the home, particularly adult day care, and that Germany spends a lot on its cash allowance. In the United States, the highest spending is on nursing home care.

The Social Insurance Approach

Germany and Japan have developed public universal long-term care insurance systems that are operated by the government. (Private long-term care insurance was considered in Germany but rejected.[11] It was not considered in Japan.) In both countries everyone contributes to a dedicated fund proportional to income, and everyone is covered, regardless of means or whether potential caregiving relatives are available. Eligibility and levels of need are assessed uniformly across the nation based on an objective procedure.

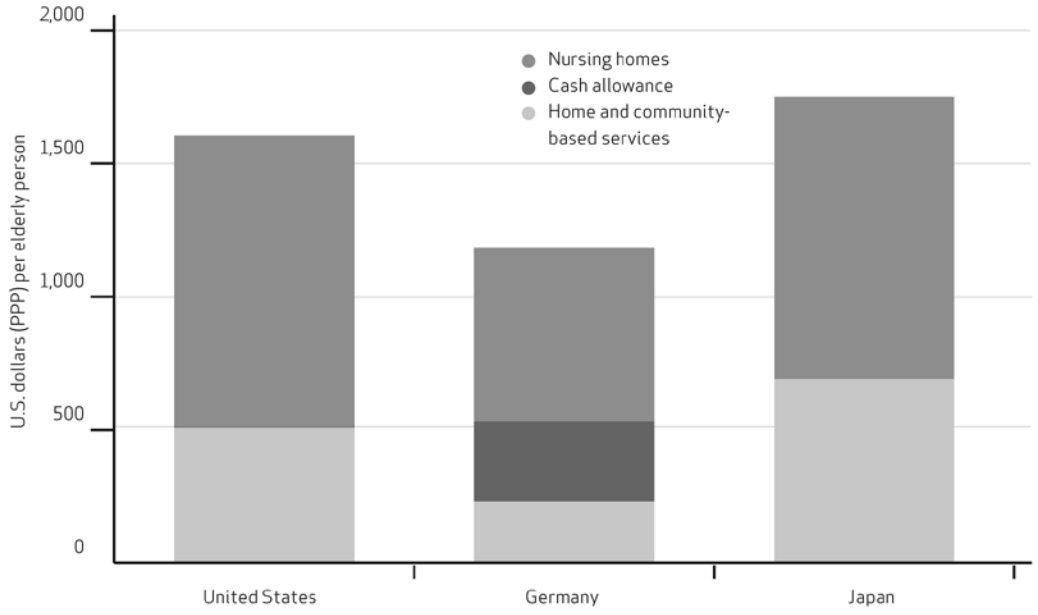
A range of benefits covering a sizable portion of need is offered to people in institutions or living in the community. Recipients themselves do cover some costs. Service providers are overwhelmingly private, whether for-profit or nonprofit, and there are substantial elements of market competition.

In home and community-based services, consumers select the number and type of services they want from an array of licensed providers. A ceiling on those services is determined by their level of need. Because the price for each service is set by the government and is the same in each region, providers compete for customers on the basis of convenience and perceived quality.

In both countries, this long-term care insur-

EXHIBIT 1

Public Long-Term Care Spending For The Elderly In The United States, Germany, And Japan, 2005



SOURCES See the Technical Appendix, online at http://content.healthaffairs.org/cgi/content/full/29/1/hlthaff.2009.0548/DC1 **NOTE** Dollars are U.S. dollars in purchasing power parity (PPP) per person age sixty-five and older.

EXHIBIT 2

Public Long-Term Care Spending For The Elderly In The United States, Germany, And Japan, 2005

	United States	Germany	Japan
Home and community-based services	$512	$480	$617
Care at home	477	441	236
Home help services	474	140	236
Services, no medical	277	140	197
Services with medical	197	0	39
Cash allowance	0	290	0
For caregiving	0	237	0
Caregiver benefits	0	52	0
Respite care	3	11	0
Care outside home	0	17	368
Day care	0	5	293
No medical	0	5	203
With medical	0	0	90
Respite care	0	12	75
In nonmedical facility	0	12	59
In medical facility	0	0	16
Material aid	35	22	14
Assistive devices	35	0	3
Home renovation	0	0	11
No breakdown	0	22	0
Institutional care	1,094	654	1,061
Nursing homes	1,094	654	730
LTC in general hospitals	0	0	222
Care in residential facilities	0	0	109
Dementia group homes	0	0	78
Private-pay homes	0	0	31
Administration	0	51	74
Care management	0	16	74
Accounting	0	35	0
Total LTC	**1,605**	**1,185**	**1,751**

SOURCES See Technical Appendix, online at http://content.healthaffairs.org/cgi/content/full/29/1/hlthaff.2009.0548/DC1 **NOTES** A zero in a specific category, such as day care, can mean that spending is captured in a broader category, such as home and community-based services, rather than no public spending at all. See Technical Appendix. Dollars are U.S. dollars in purchasing power parity per person age sixty-five and older.

ance operates separately and differently from health insurance. Financing pools and management are strictly separate, although the same agencies may handle administrative tasks. Government makes policy, carries out licensing and oversight of providers, and tracks usage and costs, but it does not provide or directly manage services.[12]

This approach has several advantages. Benefit levels are capped by level of need, with remaining costs left up to the individual or family, with special provision for low-income people. Competition in home and community-based services helps assure quality, because recipients can switch. Financing from a social insurance fund is more stable than financing from general revenues. Long-term care insurance also helps relieve pressure on other budgets—state and local in Germany (where social assistance payments for institutionalized older people fell by two-thirds after program implementation),[13] and health insurance in Japan.

In addition, having a comprehensive, unified program means that the government has substantial control of nearly all aspects of the system's operations, including spending. These features may be inherent to public long-term care insurance.[12] Other features are not built in. In fact, Germany and Japan have diverged from each other in several ways.

Key Policy Issues In Long-Term Care Insurance

Exhibit 3 summarizes some differences in the German and Japanese long-term care insurance programs.[13–15]

BASIC APPROACH TO HELPING FAMILIES In both Germany and Japan, families provide most of the care to frail older people living in the com-

EXHIBIT 3

Differences Between Long-Term Care (LTC) Systems, Germany And Japan, 2008

	Germany	Japan
Policy objective	Support family caregivers	Decrease burden of family caregivers
Policy design	Contain spending to within the premium level set by law	Increase expenditures as services become more available
Organized and managed	Sickness funds (but LTC is managed separately)	LTC insurance section of the municipal government or their coalitions
Financing	Premiums 1.95% of income up to a ceiling	Half by premiums, half by taxes 1/3 of premium revenue from those age 65+, with 6 premium levels based on income 2/3 from those ages 40–64 at 1% of income, up to a ceiling
Regional differences	No difference in premium levels	For those age 65+, premiums linked to local spending level For those ages 40–64, pooled at national level and redistributed; municipalities having low income levels and more residents age 75+ receive more
Population covered	All ages	Unconditional for those age 65+ Limited to age-related diseases for those ages 40–64
Percentage of those age 65+ who are eligible	10.5%	17%
Percentage of those age 65+ who are receiving benefits	10.5% (all of those eligible receive benefits)	13.5% (20% of those eligible have not chosen to receive benefits)
Eligibility levels	Three (plus a limited additional hardship level in HCBS)	Two for the "preventive care" program, five for regular LTC insurance
Benefit ceilings per month ($ PPP)	No copayment or deductible Cash: $250–$794 plus caregiver pension premiums HCBS: $490–$1,730 (hardship: $2,260) Institutional care: $1,200–$1,730 Room-and-board costs not covered; low income covered under public assistance	10% copayment (included below) Services only HCBS preventive care: $430–$950 HCBS regular program: $1,440–$3,400 Institutional care: $1,680–$3,670 One-third of room-and-board costs covered, up to all costs paid by LTC insurance if income level is low
Fee schedule for services	Negotiated regionally between sickness funds and providers	Negotiated nationally, conversion factor for regional cost differences

SOURCES Government publications on long-term care insurance (see Notes in text). **NOTES** Benefit amounts are for 2008 for Germany and 2009 for Japan. Converted to dollars using the purchasing parity (PPP) rate of 0.85 euro to the dollar and 116.32 yen to the dollar in 2008 (OECD health data, 2009). Maximum benefit amount for Japan is for municipalities having the highest level. HCBS is home and community-based services.

munity. Government policy aims to supplement informal care, relieve some of the burdens on family members, and improve the lives of older citizens. Germany and Japan do this in different ways.

▶ **GERMANY:** Germany's long-term care insurance system seeks to recognize and encourage family caregiving. Beneficiaries may choose to receive direct services or a cash allowance. Although the cash allowance is half or less the value of home and community-based services for a given level of need, about 72 percent of beneficiaries living at home choose this option. (Another 15 percent choose a combination of cash and services).

Moreover, if a family member provides at least fourteen hours of care a week, long-term care insurance covers that person's social security premiums and respite care for a vacation. One aim is to make the "job" of primary caregiver more attractive relative to regular employment. There are no regulations on how cash is used, and some hire a paid helper.

▶ **JAPAN:** Japan's long-term care insurance program helps family caregivers not by paying them, but by taking on a portion of their tasks. A cash allowance was proposed before the program was enacted, but women's groups argued

In Germany and Japan, benefit eligibility is determined by an objective process that applies the same criteria to everyone.

that boosting household income would not relieve the burdens on caregivers, who are largely female. Only direct provision of formal services, they contended, would make a real difference in the burden on families.[16] Accordingly, only services, not monetary benefits, are provided: home help, adult day care, respite care, home modification, assistive devices, and visiting nurses.

▶ **LESSONS:** What are the lessons? The cash approach, which is also the thrust of the CLASS Act, can maximize consumer choice. On the other hand, insufficient demand for formal services could mean that many localities would never develop enough home and community-based services to meet potential needs. A cash model may appear less expensive depending on the level of payment, but then without the cash option, people tend to use only what they need. A copayment helps limit demand: Home and community-based services recipients in Japan, on average, use only half of their entitlement. Also, as Allison Evans Cuellar and Joshua Wiener[17] note, actual caregiving patterns might not have changed much in Germany with long-term care insurance, while they certainly have in Japan.

DETERMINING ELIGIBILITY AND LEVEL OF NEED In Germany and Japan, benefit eligibility is determined by an objective process that applies the same criteria to everyone.[12]

▶ **LEVELS OF NEED:** In Germany, the semi-public health insurance organizations ("sickness funds") employ a "service corps" of doctors and nurses who certify applicants and assign a level of need.[18] Japan lacks this resource. The Japanese learned from experience that leaving the eligibility decision up to practicing physicians could overwhelm the system. Beginning in 1973 and lasting until 2003, for example, the elderly in Japan received nearly free medical care. They flooded into hospitals, often with little medical justification, and they stayed for some of the longest lengths-of-stay in the industrialized world.[19] As a result, to assess need in the long-term care program, the government administers a questionnaire. The results are analyzed by a computer and reviewed by a local independent committee of physicians, care managers, and academics.

The criteria are similar in the two countries. The need for help in activities of daily living (ADLs) is translated into time required for caregiving. The German system has operated to constrain costs: nearly 30 percent of applications for assistance were rejected in 2007,[20] and eligibility was held to about 10 percent of the population age sixty-five and older. Eligibility screening in Japan was not as effective. Only about 3 percent of applications have been rejected, while the number made eligible for services reached as high as 17 percent of the population age sixty-five and older, more than expected.[21]

Making the assessment process more generous is easy. Following criticism that people with dementia were getting unfair assessments, assessment of cognitive impairment was improved in both countries.[22] Making the process stricter is more difficult, but in Germany it was at least rumored that when enrollment looked too high, a surreptitious word from above got the service corps to tighten up.[23] The Japanese government has tried to push the review committees to toughen up, with moderate success.[21]

▶ **LESSONS:** An objective and speedy need-assessment process that is seen as legitimate has been critical to the success of long-term care policy in Germany and Japan. But a clear lesson is that it is important to get this process right from the start, or perhaps err a bit on the strict side. The Japanese process is quite independent and transparent. In principle, this is good, but it is also harder to manage than a program in which eligibility criteria can be modified quietly inside a bureaucratic organization.

ALL AGES, OR OLDER PEOPLE ONLY? Because it was seen as natural in a social insurance framework, German long-term care insurance covers people of all ages (21 percent of beneficiaries are under age sixty-five). In Japan, coverage is restricted to those age sixty-five and older, although people ages 40–64 with aging-related disabilities such as Alzheimer's or Parkinson's diseases are included (3 percent). When the long-term care issue reached the Japanese policy agenda in the 1990s, the problem of care for frail elderly had dominated. The group age forty and older was added largely to justify collecting premiums from them.[24]

▶ **YOUNG AND OLD:** The needs and preferences of young and old often differ. In Germany, some younger disabled people received fewer benefits after long-term care insurance was introduced.[18] In Japan, the government proposed

lowering the age to twenty for both premiums and coverage in its 2006 reform. This move failed partly as a result of opposition from some organizations of younger disabled people, who feared that existing benefits would be undercut in a system designed primarily for elder care.[25]

▶ **LESSONS:** The lesson is that the policy and politics of this choice are quite difficult. In Germany, younger people rarely choose home and community-based services. This suggests that a cash allowance is necessary if long-term care insurance is to cover both young and old.[18]

BIG OR SMALL? A long-term care program must be large enough to deal with the individual and social problems presented by the growing number of frail older people. Still, there can be wide variation with regard to how many people will be covered and the size of the average benefit package. Japan is higher than Germany on both counts and therefore spends more.

▶ **EFFECTS OF PRIOR POLICIES:** Another lesson is that policy "heritage" matters. Before introducing long-term care insurance in 1995, Germany offered only institutional care financed largely from social assistance plus some subsidized charity services. Long-term care insurance represented a great improvement. Services became available, more people could afford nursing homes without public assistance, and families welcomed recognition as well as the cash for services that many were already providing. A relatively small program thus sufficed. Moreover, fiscal conservatives had dominated the policy debate, leading to strict spending rules. New legislation is required to make any changes in the amount of revenues raised, benefits paid out, or premiums charged. Until recently, there was also no cost-of-living adjustment in benefits.

If Japan had initiated long-term care insurance earlier, it might have taken the same route, but the ruling Liberal Democratic Party (LDP) had made care for frail old people a big campaign promise for the 1990 general election. Under the resulting "Gold Plan," many people were already receiving many services before long-term care insurance was enacted, which made a severe approach to eligibility or benefits politically impossible.[16]

Accordingly, at least half of the recipients in Japan would be ineligible for any benefits in Germany,[26] and the ceiling on benefits differs between the two countries (Exhibit 3) Germany covers about half of assessed need (a quarter with the cash allowance); Japan covers full need (less a 10 percent copay). However, for home and community-based services, on average Japanese use only about half of the entitlement.[5]

▶ **SCALE OF SERVICES PROVIDED:** The scale of service provision is quite different. In Germany, the minority who choose any services mostly use home help, with 380,000 clients in 2005. In Japan in 2007, 1.2 million clients received home help, and another 1.6 million were attending adult day care centers.[27] Adult day care and "night care," or short stays in nursing homes for respite (about 300,000 users), are particularly popular in Japan because many frail older people live in the same household with their primary caregiver.

Although there is no optimal size for comprehensive long-term care insurance, it should be big enough to respond to need without bankrupting the economy.

▶ **LESSONS:** As a result of media talk of "twenty-four-hour care" early on, many in Japan expected that burdens on family caregivers would disappear. The traditional image of oppressed daughters-in-law has remained so pervasive that a common criticism of long-term care insurance from the media and public is that despite high benefit levels, it fails to do enough. One lesson is to control expectations. Although there is no optimal size for comprehensive long-term care insurance, it should be big enough to respond to need without bankrupting the economy.

HOW TO CONTROL THE PROGRAM The primary goal of comprehensive long-term care insurance in these two countries was to meet needs, not save money. But controlling costs is still crucial for sustainability, and although having prices fixed by the government is most important, it is not enough.

▶ **GERMANY:** In Germany, tight control over the eligibility process and the strict fiscal rules imposed to get the program passed combined to constrain expenditures effectively. There were financing difficulties, in that premium revenues grew slowly in a poor economy. But once the program was well established, the rate of growth in spending actually stayed below the growth of the population age seventy-five and older.[28]

In a sense, the rules were too stringent. With no cost-of-living adjustment, real benefits were actually declining. Attempts at improvements were stymied by deadlock in the governing coalition. But in 2008 a major incremental reform was passed that raised the contribution rate from 1.7 percent to 1.95 percent, hiked benefits slightly, adjusted for cost of living, and improved services moderately.

▶ **JAPAN:** In Japan a provision linking spending at the municipal level with the premium charged to older residents serves as a weak brake. The government has pursued various other strategies to constrain spending, such as limiting the number of institutional beds, qualifying services (for example, beneficiaries are not allowed to receive too much assistance with housework when living with family members), and exhorting efficiency. Except for the cap on beds, these had limited impact.

More important, the original legislation specified a financial review every three years. This facilitates financial planning for municipalities and allows fee-schedule modifications—for example, to cut prices on profitable services or give incentives to care for heavier cases.

Unlike Germany, rapid expansion was expected in Japan as more people sought services. Total expenditures reached ¥6.8 trillion in 2005, considerably higher than the projected ¥5.5 trillion (roughly $52 billion versus $42 billion in purchasing power parity).[29] The main problem was the soft eligibility process, which brought high enrollment in the two lowest categories of need—from about 840,000 (39 percent of all eligibles) in 2000 to just over 2 million (49 percent) in 2005. Some perceived an impending financial crisis.[30]

The government's response was a clever reform in 2006 that lowered the numbers and usage of low-need recipients without pushing them out of the program.[31] The roughly 25 percent of those eligible with the lowest need were transferred from the main long-term care program into a new system for "preventive caregiving." They had lower benefit ceilings and were given rather authoritative advice about the services they should receive, including strength training and other activities aimed at postponing disability.

Enrollment and usage at the lighter need levels dropped, and the growth rate of total beneficiaries leveled off to approximate the growth in the population age seventy-five and older.[5] The spending curve was bent downward significantly by these and other reforms.[32]

▶ **LESSONS:** The lesson here is that spending rules can work—perhaps too effectively in Germany. The Japanese approach of a periodic financial review also has merit.

OTHER DIFFERENCES In at least two areas, German policymakers are exploring approaches introduced in Japan. In Germany, long-term care insurance is a uniform national program, while in Japan, municipalities have limited autonomy to consider new facilities and stimulate services. The idea of involving local government in the planning process has attracted attention in Germany.[33] In addition, Japanese long-term care insurance includes an elaborate system of care managers to advise recipients and monitor the services they get. In the 2008 reform, Germany started a program of local support centers for information and coordination modeled on care management practices observed in Japan.[34]

Unsolved Problems

Establishing a comprehensive long-term care system does not solve all of the thorny problems of providing good long-term care efficiently. For example, Germany and Japan both worry about recruiting and maintaining a skilled workforce when labor costs need to be kept low and the number of younger workers available is decreasing. Both countries have trouble coordinating services between medical care and long-term care. Quality control is always a concern: Germany has stressed building quality into contracts between insurers and providers, while Japan emphasizes training.[35]

The biggest unsolved problem is overinstitutionalization. The German and Japanese governments both hoped, along with gerontologists around the world, that improving care in the community would lower nursing home usage and spending. However, this has not occurred. In Germany, the proportion of beneficiaries who receive institutional care has been increasing, from 27 percent in 1997 to 31.5 percent by 2005, including many who require only low levels of care.[3] In Japan, demand for nursing homes exploded with the new program. The result is long waiting lists. Low-income individuals and those with no families or relatives are prioritized for admission, just as they were before long-term care insurance.[5,36]

Although long-term care insurance has not led quickly to deinstitutionalization, it has brought innovation in institutional care in Japan. For example, 20,000 Alzheimer Group Homes—small facilities that house nine people with dementia in an independent unit with a small stable staff—have sprung up around the country.[27] These are modeled on a concept originally developed in Scandinavia, and most are run by for-profit companies. Long-term care insurance pays the caregiving costs—a monthly fee depend-

13.5%

Japan

Japan provides public benefits to 13.5% of its population age 65+, but it spends 9% more per capita than the United States spends.

10.5%

Germany

Germany provides public benefits to 10.5% of its population age 65+, but it spends 26% less per capita than the United States spends.

4.5%

United States

The United States provides public benefits to 4.5% of its population age 65+.

ing on the level of need—and families pay for all room and board. Also, Japan has seen rapid growth in residential facilities designed for older people, many with a home care agency or a clinic, or both, in the building. Long-term care insurance covers the risk of high-price care, so developers are constructing specialized residential facilities at reasonable cost.

Both countries continue to try to shift the balance away from institutionalization and toward home and community-based services. Japan has decreased the proportion of room-and-board costs paid by long-term care insurance, and Germany has decreased the gap in benefits between home care and institutional care for lighter-care cases. In general, having a comprehensive system rather than a collection of fragmented programs facilitates effective policy making.

Concluding Comments

Germany and Japan introduced comprehensive long-term care insurance because their frail older populations were growing; their traditional resources for care were declining; and their existing fragmented long-term care programs were increasingly seen as costly, inefficient, and unfair. The situation in the United States today is similar, if not worse.

Germany passed its long-term care insurance legislation in 1994, when 15.8 percent of its population was age sixty-five and older. In Japan, the legislation passed in 1997, when the elderly share of the population was 15.7 percent. Population aging is about to pick up in the United States, and it should cross the same line toward the end of this decade.

Although the lives of frail old people and their family caregivers in Germany and Japan remain difficult—arguably the human condition—comprehensive long-term care insurance has undoubtedly brought major improvements for them. It has also been popular with the general public and has been accepted as a normal component of social policy in both countries.

These two models of comprehensive long-term care insurance differ sharply. Japan offers a high level of services in the community and provides benefits to 13.5 percent of its population age sixty-five and older, yet its per capita public expenditure is only 9 percent more than what the U.S. government spends. Germany mostly offers cash to support family caregiving, providing benefits to 10.5 percent of its population age sixty-five and older, and spends 26 percent less than the United States spends. Only 4.5 percent of Americans age sixty-five and older receive publicly supported long-term care, but spending is quite high. If the United States adopts the CLASS Act, that could be a significant step along the road toward a comprehensive long-term care insurance system that would cover everyone and still allow control over spending. ■

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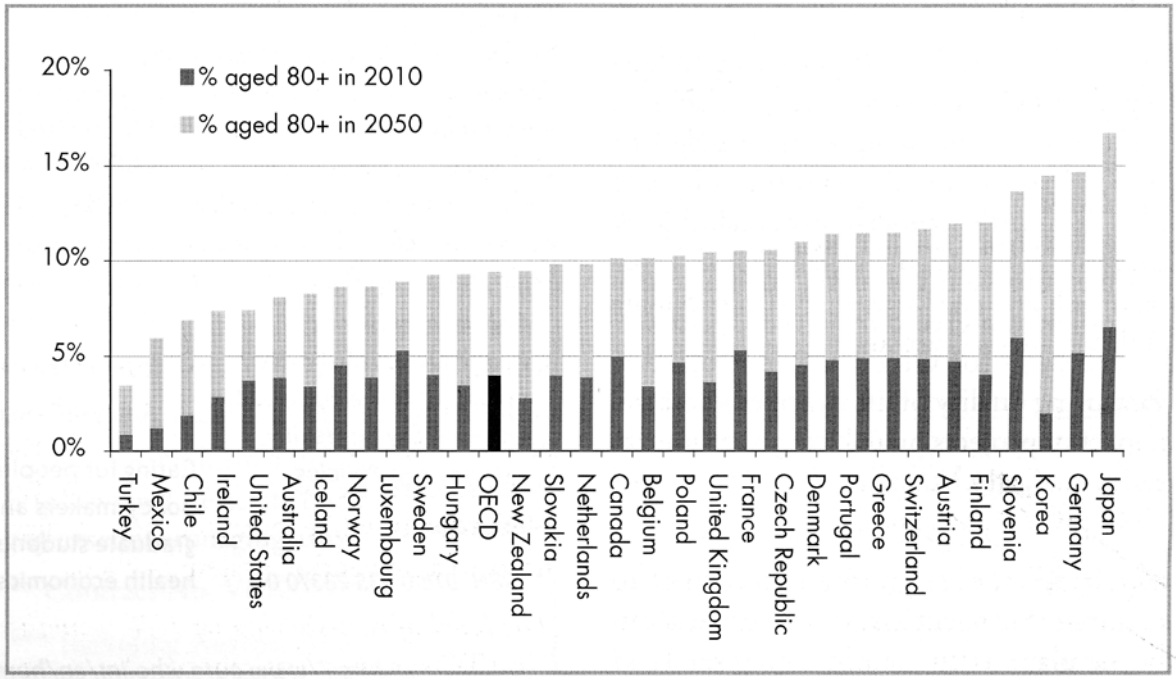
Figure 1: The share of the population aged over 80 years in the OECD, 2010 and 2050



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SPECIAL ARTICLE

The Long-Term Effect of Premier Pay for Performance on Patient Outcomes

Ashish K. Jha, M.D., M.P.H., Karen E. Joynt, M.D., M.P.H., E. John Orav, Ph.D., and Arnold M. Epstein, M.D.

ABSTRACT

BACKGROUND

Pay for performance has become a central strategy in the drive to improve health care. We assessed the long-term effect of the Medicare Premier Hospital Quality Incentive Demonstration (HQID) on patient outcomes.

METHODS

We used Medicare data to compare outcomes between the 252 hospitals participating in the Premier HQID and 3363 control hospitals participating in public reporting alone. We examined 30-day mortality among more than 6 million patients who had acute myocardial infarction, congestive heart failure, or pneumonia or who underwent coronary-artery bypass grafting (CABG) between 2003 and 2009.

RESULTS

At baseline, the composite 30-day mortality was similar for Premier and non-Premier hospitals (12.33% and 12.40%, respectively; difference, −0.07 percentage points; 95% confidence interval [CI], −0.40 to 0.26). The rates of decline in mortality per quarter at the two types of hospitals were also similar (0.04% and 0.04%, respectively; difference, −0.01 percentage points; 95% CI, −0.02 to 0.01), and mortality remained similar after 6 years under the pay-for-performance system (11.82% for Premier hospitals and 11.74% for non-Premier hospitals; difference, 0.08 percentage points; 95% CI, −0.30 to 0.46). We found that the effects of pay for performance on mortality did not differ significantly among conditions for which outcomes were explicitly linked to incentives (acute myocardial infarction and CABG) and among conditions not linked to incentives (congestive heart failure and pneumonia) (P=0.36 for interaction). Among hospitals that were poor performers at baseline, mortality was similar in the two groups of hospitals at the start of the study (15.12% and 14.73%; difference, 0.39 percentage points; 95% CI, −0.36 to 1.15), with similar rates of improvement per quarter (0.10% and 0.07%; difference, −0.03 percentage points; 95% CI, −0.08 to 0.02) and similar mortality rates at the end of the study (13.37% and 13.21%; difference, 0.15 percentage points; 95% CI, −0.70 to 1.01).

CONCLUSIONS

We found no evidence that the largest hospital-based pay-for-performance program led to a decrease in 30-day mortality. Expectations of improved outcomes for programs modeled after Premier HQID should therefore remain modest.

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The Toxicity of Pay for Performance

By Donald M. Berwick

Despite their superficial logic, systems of merit pay or pay for performance have features that are toxic to systemic improvement. Contingent rewards doled out by supervisors cause decreased focus on customer needs, loss of accurate information about defects and improvement opportunities, avoidance of stretch goals, and decreased innovation. They may also erode teamwork. Pay for performance may mark a naive understanding of the complexity of human motivation.

She sat across the table from me, all ears--one of my very best employees. It was time for her annual merit review, and, according to the organization's policies, she was to be rated as "unsatisfactory," "satisfactory," "superior," or "outstanding" and receive a salary boost of zero, 4 percent, 5 percent, or 6 percent, respectively.

I had prepared carefully. Her work was promising indeed. Although she lacked formal training, she had clear leadership potential and enormous native talent for planning and organizing projects. To excel further, she would need to work on her writing and presentation skills, and some further study of simple statistical methods would strengthen her technical analyses. Tactfully, respectfully, pausing regularly for her questions, I explained my review and offered her guidance. She asked no questions but only nodded agreement with a friendly smile on her face.

I ended with a review of my advice and a handshake of congratulations for her fine efforts. I paused for her reflections. " So," she asked, beaming--her first words since I had begun, "which is it ... 4 percent, 5 percent, or 6 percent?"

It took me a few moments to absorb the full import of her question. But, finally, I saw the truth: she had not heard a word that I had said. "Four percent, 5 percent, or 6 percent?" That was her question, and that--and that alone--was what she was waiting to hear from me.

So embedded in our culture is the idea that "you get what you pay for," so familiar are the assumptions behind "pay for performance," so fair and obvious does it seem that people should be paid for their worth in American culture, that it may take a sledgehammer to ring a note of question. Indeed, in many corporate cultures, and most that I have worked in, to raise fundamental questions about these assumptions is inevitably to invite accusations of naivete and inexperience.

Linking pay to merit is an absolutely obvious instrument of proper management. Because it is absolutely obvious, it is difficult in the extreme to see that it is very nearly absolutely wrong. "Pay for performance" is as toxic to true organizational performance as any of the perfidious tactics of outmoded control-based management that enlightened organizations have long since, and much more readily, abandoned.

It is not necessary to recount here the classical arguments in favor of merit pay. They fall generally into two categories: arguments of *fairness* (good performance *deserves* its reward) and arguments of *incentive* (pay contingent on good performance generates more good performance).

In passing, we might note how thin is the empirical evidence for either of these arguments. There is little but logic or anecdote behind either assertion; in the entire volume of "classic" Harvard Business School papers assembled in a collection called "Appraising Performance Appraisal," only a single experimental study appears.[1] But, as it happens, little real evidence can be found on either side of the "pay for performance" debate. (Alfie Kohn, a popular author on management systems of reward and incentive, claims that the evidence that does exist weighs heavily against contingent pay as a support for organizational or group effectiveness.[2]) Indeed, it is remarkable that an issue of such consequence for the guidance of organizations and so hotly contested from time to time has not benefited more from proper social-scientific experimentation. We who debate pay for performance on either side must fall back on belief and logic for now for the bulk of our arguments.

Some clear definitions, first, may help. Our topic here is "pay for performance," a contingent relationship, enforced and implemented in an organizational hierarchy, in which supervisors judge the merit of the work of those below them in the hierarchy and, based on those judgments, give out variable and contingent financial rewards. "Merit" can refer to meeting any goals or standards, whether negotiated in advance with the employee or announced arbitrarily, whether financial or nonfinancial, whether specific or ambiguous, whether quantitative or qualitative, whether measured in terms of throughput (e.g. "patients per day") or internal process (e.g. "reliable"). "Rewards" (and their opposite, "punishments") can be purely financial (such as salary increases or bonuses), or they may consist of other forms of organizational currency (such as promotion or perquisites). A key and essential component of "pay for performance" is the notion of *contingency,* the "merit" and the "reward"

are linked explicitly, and the ultimate judge of both is the supervisor. Paying assembly-line workers on the basis of their productivity is "pay for performance"; so is paying individual doctors on the basis of their "clinical performance," however defined.

No dispute exists here about the value and appropriateness of dialogue between workers and supervisors about goals and performance. It is useful--indeed essential--in an effective organization for information to flow freely about the extent to which needs are met, customers are satisfied, plans are implemented successfully, and goals are achieved. For many purposes, quantitative information is clearer and more instructive than mere narrative, and, accordingly, no dispute exists here about the great value of measuring performance in many dimensions and at many locations in the sequence of production.

Nor is there dispute here about the probability of and need for variation in compensation among individuals. There is a market for talents and experience, and an organization that tries to ignore the conclusions of that market will have trouble recruiting and retaining the people who can help it most. Changes in the cost of living, issues about the sharing of organizational profits, and employee demands that their compensation increase in accord with their skills will always be facts of organizational life, and compensation will therefore vary among people and over time.

No dispute exists here either about decisive remedial managerial action for either egregious misconduct or ineptitude, or, for that matter, about the festival celebration of real heroes. Those who cannot or should not do a job should leave that job--and be removed by the organization if they do not leave of their own accord; the occasional gold medalist deserves her medals and our applause.

But "pay for performance" goes beyond any of these. It is necessarily contingent and usually one-directional (top down), while dialogue about performance is not. It involves, not variation in pay that is a fact of life enforced by the environment, but variation that senior leaders enforce by choice--and could change if they wished. It is not just a process applied to the occasional miscreant or the rare hero but one maintained in the very fabric of the organization, affecting all by design.

Under this definition, "pay for performance" is guaranteed to be toxic in any organization in at least the following ways.

1. "Pay for performance" makes the supervisor the customer. Organizations accountable to society or to markets must meet the needs of their customers in order to thrive--this is the central strategic message in modern quality management. Forget your customer, and, sooner or later, your customer will forget you. Modern management systems seek ways to help their employees at all levels to inquire about external needs and demands and to take initiative to meet those needs. A "customer-focused" organization has inverted the pyramid of accountability; employees who meet and know the external customer are the *internal* customers of the management system. In such an organization, every supervisor needs to know how to improve his or her own ability to help others meet customers' needs.

"Pay for performance" distorts this focus; it changes the direction of concern. Not in theory but almost always in fact the employee facing a supervisor about to dispense "4 percent, 5 percent, or 6 percent" has one question foremost in mind, namely, "How can I please the supervisor?" This is, simply stated, *not* the key question upon which organizational survival depends. It diverts energy away from the true interests of the organization. The interests of the organization lie outside its walls; "pay for performance" turns people inward.

2. "Pay for performance" *deprives the organization of essential information.* Because of this inversion of customer-supplier relationships within the organization, valuable information decays. Two losses are the most costly ones. First, supervisors learn less than they otherwise could about their own opportunities for improvement. Few employees facing merit reviews muster the courage to correct their supervisors or to ask for better help in meeting customer needs. The person best able to help the supervisor gain knowledge about needed improvements in management is the employee, who is placed by "pay for performance" in the worst possible circumstance for giving that help.

Second, in the setting of performance review, the organization loses valuable information about defects. Suppose, for example, the supervisor credits the employee with a successful result on the basis of which the merit pay will increase, while the employee knows that the apparent "success" is not at all what it is being cracked up to be. What the organization needs is the information that the result was not good and that the information system is flawed; what the organization will probably get is a silent smile, warm thanks, and an employee now trapped between honesty and ingratitude.

3. "Pay for performance" increases internal competitiveness and barriers. In the pursuit of quality, good fences make bad neighbors. A great organization today seeks constantly to cut windows between its functional areas and to help all employees feel more and more part of one team, with common pursuits and shared self-interest. "Pay for performance" never seems to hit this theme

properly. *Either* the contingency is individualized and people come to worry that they must cling to the credit so they will not lose the pay *or* the contingency is set at such an extreme level of aggregation that the "congratulations for great performance" rings hollow to individuals, no one of whom ever can believe that he or she, alone, had much at all to do with the performance for which they are rewarded. The contingency upon which such variable pay is based tends therefore to be either fragmenting, at one extreme, or irrelevant, at the other. Either is damaging to the relationships within the organization. If merit pay is individual, and especially if it is distributed down functional lines of hierarchy, then employees will decrease the extent to which they share information and efforts across boundaries. One hospital CEO described to me his system of profit-center management, in which middle management bonuses depended on local budget performance. I asked him if one of his managers would transfer resources from his department to another's if it would help the organization as a whole. "Yes," the CEO answered honestly, "if he were crazy."

If merit pay appears in organization-wide bonuses, then employees tend to feel helpless in responding to the contingency. I recall one hard day seeing patients at one stage in my professional life, a day that had been a constant uphill battle against missed appointments, unannounced patients with extremely complex problems, battles for approval with an outside utilization review office, and a frustrating search for speech therapy services for a mute three-year-old. The world seemed arrayed in opposition to my effectiveness, and I was exhausted as I began to open my mail late in the afternoon. Therein was a check for a "productivity bonus" of $297 and a note of organizational congratulations for my fine efforts--as it were, "Keep it up, fella." The first thought I had is not publishable. My second was, "Somebody doesn't understand at all."

4. "Pay for performance" costs a great deal to administer. I know of no specific studies of the proportion of organizational energy that a "pay for performance" system consumes, but experience suggests that it is substantial. Elements of cost include the following: (1) supervisory training; (2) creating and managing forms and records; (3) supervisory meetings and upward reporting; (4) making decisions; (5) justification, revision, grievance, and reply; (6) administration of raises, bonuses, and rewards; (7) goal setting and goal negotiation; and (8) collecting and analyzing performance information. Greater still are the opportunity costs. Even at its best, "pay for performance" is still a system of "inspection" in a technical sense. Quality management theory counsels that the bulk of management energy should be devoted not to inspection of quality but to planning and improvement. Whatever time the management system is devoting to the inspection inherent in "pay for performance" is time denied to the much more significant management enterprise of quality planning and improvement.

Even if "pay for performance" produced benefit for the organization (and I dispute that it typically does produce benefit), the benefit would have to be great enough to outweigh the high costs of maintaining the system.

5. "Pay for performance" is inescapably unfair. Statistical specialists working in quality management study the proportions of variation in quality and occurrence of defect that turn out empirically to be due to *people* in a system of production compared with other causes in the system (such as the rules of procedure, the equipment, the raw materials, measurement error, and so on).[3] Even in service industries, and, to the extent it has been studied, even in health care, the preponderance of variation is not due to the people but is due instead to other sources. (The relevant mental experiment would be to substitute a new work force, randomly chosen from qualified candidates, in the current system and then to ask if basic performance levels would change.)

At a deeper level, even that proportion of variation in performance that *is* attributable to "human" attributes of the system of production is itself complex in structure. A worker brings many attributes to the work: skills, knowledge, attitude, mood, experience, ethnicity, nonwork constraints, and ambitions, to name a few. A "pay for performance" system, especially if maintained for purposes of incentive, can reasonably attach a contingent reward for an individual only to that portion of variable performance that is not only attributable to the individual but that is also, at least in principle, *under the control* of that individual. An "incentive" to make me a competitive downhill skier would have no chance of success; I have bad knees.

An all-knowing supervisor could adjust for this problem and make the contingencies apply only to the worker-controllable variation in performance. In practice, that is impossible. A back-of-the-envelope calculation shows the magnitude of the issue. Imagine, for argument's sake, that 30 percent of the variation in the productivity of physicians in an HMO is associated with individual characteristics (a proportion far greater than in most industries and unlikely to actually occur). Imagine, further, that half of that proportion is attributable to "controllable" characteristics (like effort level and learnable skills), with the other half being associated with relatively immutable traits (like the use of language, speed of calculation, and cautiousness in the face of risk). Thus, of variation in performance, 15 percent could be said to be susceptible to

the motivation associated with merit pay and 85 percent not.

Now, imagine that a supervisor who observes variation in performance that is (in actual fact) not alterable by motivation reaches the correct conclusion (i.e., "Incentives cannot help"), say, four out of five times. Imagine, also, that the same supervisor, when observing variation that is (in actual fact) alterable through motivation reaches the correct conclusion (i.e., "Incentives can help") fully *half* the time. A simple calculation shows that, of all the instances in which the supervisor *thinks* that motivating the workers will produce better performance, fewer than one-third actually *are* of that type. [Here is the calculation: The supervisor attributes 0.2 x 85% = 17% of the observed variation to the worker when, in fact, the worker could not control the cause and the supervisor attributes 0.5 x 15% = 7.5% of the observed variation correctly to the worker's motivation. Thus, when the supervisor says, "This was controllable by worker motivation, and I expect that incentives can help," the statement is correct only 7.5/(7.5 +17) = 31% of the time.]

From the worker's point of view, this produces extraordinary irrationality in the reward structure. More than half the time that the supervisor "rewards" or "punishes" performance, for example, the worker is not in fact in control of that performance. The sense develops that the reward structure is blunt, arbitrary, and often unfair, because, statistically, it *is,* despite the best efforts of the supervisor to be fair. The unfairness comes from the statistical hazards of attributing cause in a complex causal system. Further, in the calculations used here in the example, I presume that the discrimination abilities of the supervisor (80 percent "specificity" and 50 percent "sensitivity" for detecting variation that is reachable by incentives) are considerably better than I believe these abilities to be in most performance appraisal systems.

6. "Pay for performance" reduces intrinsic motivation. Many tasks, especially in health care, are potentially intrinsically satisfying. Relieving pain, answering questions, exercising manual dexterity, being confided in, working on a professional team, solving puzzles, and experiencing the role of a trusted authority--these are not at all bad ways to spend part of one's day at work. Pride and joy in the work of caring is among the many motivations that do result in "performance" among health care professionals.

In the rancorous debates about compensation, fees, and reimbursement that so occupy the time of health care leaders and clinicians today, it is all too easy to neglect, or even to doubt, the fact that nonfinancial and intrinsic rewards are important in the work of medical care. Unfortunately, neglecting intrinsic satisfiers in work can inadvertently diminish them. Indeed, it has been possible in experimental settings to demonstrate a reduction in satisfaction from work by introducing extrinsic motivational factors. Students who will gladly work on a puzzle spontaneously when an experimental psychologist leaves them alone in a room will cease such spontaneous effort when the psychologist first offers to pay them to solve the puzzle.[4]

It is too much to say that pay for work does not support work, but it is psychologically tenable to assert that contingent pay for better work may decrease the joy one feels in that work. W. Edwards Deming called this phenomenon "overjustification" and believed that paying people to achieve what they would want to achieve anyway tends to reduce their satisfaction in the achievement.[5] My seven-year-old daughter read book after book until her teacher began giving reading assignments and "stars" for completion, at which time completing reading "homework" became a nightly crisis.

7. "Pay for performance" slows change. Especially in health care, breakthroughs in performance will require substantial changes in the way we do our work. We require an unprecedented level of innovation if we are to produce better outcomes at substantially lower cost. Innovation does not come without risk.

Logically, I see no reason why contingent pay should decrease risk taking; in theory, one ought to be able to rig it to support change. In actual practice, however, "pay for performance" seems almost always to exert a highly conservative, "antichange" influence. When goals that will be the bases for variable compensation are set in advance, employees argue not for higher aspirations but for lower ones. The conversation about performance is a debate about what is possible, not about how to make something unprecedented possible. Long arguments take shape about how, exactly, performance will be measured—arguments that do not focus on the processes of work but rather on the processes of *counting* work. Usually, failed experiments (the inevitable result of the willingness to take risks) result in deductions from "peformance" scores, even if the risks were undertaken with the interests of the organization firmly in mind. Efforts in innovation, learning, and the satisfaction of curiosity--enormous assets in any organization that wants to accelerate improvement--are rarely counted as "performance," and even training and education, being nowhere reflected on the balance sheet, tend to be treated as "benefits" instead of as forms of "performance." Thus, "pay for performance," often introduced to assist an organization whose overall performance is unsatisfactory, tends to impede exactly those forms of systemic innovation and learning that are, in the long run, most likely to dig it out of trouble.

8. "Pay for performance" is disrespectful of human relationships. In most of adult social human interaction, contingency rewarding is rude. Who would accept a dinner invitation offered "in return for your good behavior"? We solve problems together in sports teams, families, clubs, and neighborhoods, not by explicit, contingent economic exchange, but rather by building on our shared purposes, our common curiosity, our love, our sense of duty, or even by identifying the same enemy. Pay for performance is, with a few minor exceptions, generally reserved for only two settings: commercial contracts and work.

This segregation of work as *different* from other forms of human interaction is so common as to seem inescapable. But any student of the interior life of organizations knows that the social relationships--the noneconomic forces--endure nonetheless. Our employees help each other; affection develops and matures; teamwork counts on its own merits; people share their curiosity; and tribes emerge bound by common rituals and common enemies. When one looks closely, the contingent reward system--"pay for performance "--is as dissonant and distorting of the real life of the work setting as it would be at a dinner party. People hate it; it feels wrong; it has little to do with their valued relationships; it is an unwelcome game. Most of all, it erodes the potential for the true, interpersonal, adult-to-adult relationship of equals among all of the parties to organizational life. Fundamentally, as a human being, the CEO is not different in worth, character, or dignity from the lowest-level employee. In the final analysis, we either believe that or we do not and our actions reveal our beliefs far better than our words. Contingent pay down the line of hierarchy enforces the erosive fiction that we are *not* all of the same stuff.

This point echoes of course in religion, ethics, and values. But it echoes also in organizational performance. I cannot name a great team I have known in which an *internal* structure of contingent pay, doled out by one team member to another, seemed at the root of its greatness. Relationships mattered, purpose mattered, but "pay for performance" was not in the picture.

If "pay for performance" was not superficially logical, it would not have survived in the face of its obvious defects and in the face of the dearth of good evidence to support it. It takes courage in organizations openly to doubt its worth, and even more courage to abandon it in favor of less well-described approaches to both pay and performance.

Defenders of merit pay will ask what the alternative is. There are no superb answers. Any viable system of compensation must respect market forces, employee demands for growth, and numerous other real-world factors. In addition, there are now strong pressures for various forms of gain-sharing, in which employees as a group benefit as stakeholders in overall organizational performance. Clever recognition and celebration systems, sometimes including financial reward, can apparently help support morale and energy for improvement. Some companies report success with "pay for learning" systems, in which growth in skills is recognized in the pay structure. These are all ideas worth developing further, but, for the present, the answers remain incomplete to the question, "If I do not pay people according to their performance, upon what other basis will I vary their pay?"

I find myself an extremist and therefore suspicious of my answer. But it is, nonetheless, the best answer I have yet found regarding merit pay for doctors or any group of workers; namely, "Stop it." Merit pay, "pay for performance," and their close relatives are destructive of what we need most in our health care industry--teamwork, continuous improvement, innovation, learning, pride, joy, mutual respect, and a focus of all of our energies on meeting the needs of those who come to us for help. We can find better ways to decide on how we pay each other and better uses for our energies than in the study and management of carrots and sticks.

Donald M. Berwick, *M.D., is a practicing pediatrician and is President of the Institute for Healthcare Improvement, Boston, Massachusetts.* This article appears as a chapter in *Measuring Clinical Care – A Guide for Physician Executives.* Tampa, Fla.: American College of Physician Executives, 1995. *Quality Management in Health Care,* 1995, 4(1), 27-33

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Chapter Reports, Spring 2012

In **Alabama**, Dr. Pippa Abston, physician coordinator of North Alabama Healthcare for All, and other PNHP members are speaking out against proposals to privatize the state's Medicaid program. Dr. Abston, a Huntsville pediatrician, regularly blogs at pippaabston.wordpress.com. Her most recent posts have focused on explaining (and musing upon) the provisions of H.R. 676, the "Expanded and Improved Medicare for All Act." Contact Dr. Abston at pabston@aol.com.

PNHP members in **Arizona** hosted visits by Dr. Margaret Flowers and Kevin Zeese to Phoenix and Tucson in February. The events were co-sponsored by the Occupy movement and other groups, and single-payer health care was a prominent theme. Contact Dr. George Pauk at gpauk@earthlink.net.

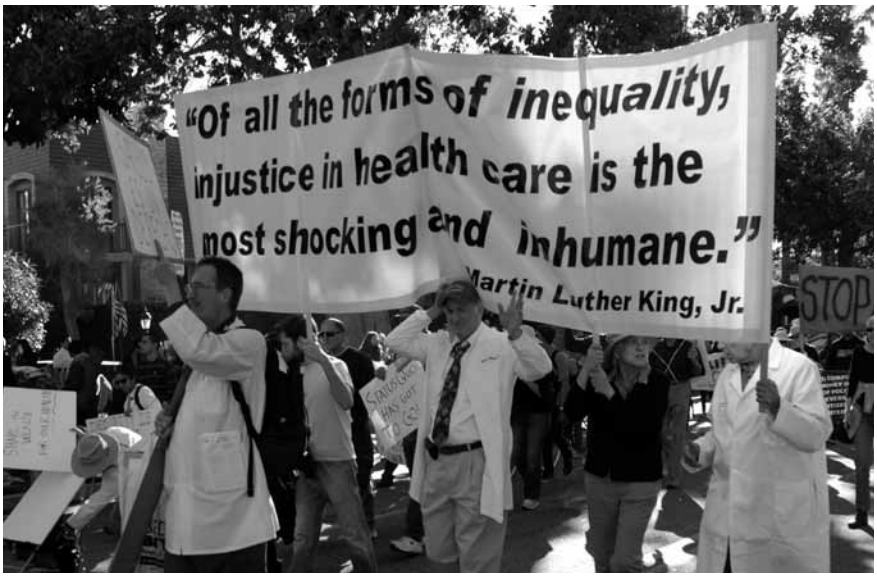
Over 500 medical students, other health professional students, **California** PNHP members, nurses and other single payer advocates rallied in Sacramento on January 9 in support of state single-payer legislation, S.B. 810. The rally and subsequent lobbying were the culmination of a year of organizing by Shearer Student Fellow Joey Foy and leaders of California Health Professional Student Alliance (CaHPSA). Rally speakers included PNHP leaders Dr. Quentin Young, Dr. Claudia Fegan and Dr. Art Chen, along with the bill's author, state Sen. Mark Leno. A parallel solidarity action in Los Angeles co-sponsored by Occupy drew 300 participants. Although S.B. 810 was narrowly defeated, support for single payer continues to grow and the bill will be reintroduced next year. Dr. Chen was featured on the cover of Time magazine's "Person of the Year: the Protester" and gave a keynote address at the American Medical Student Association's Annual Meeting in Houston. Dr. Paul Song and Lisa Ling hosted the chapter's first-ever fundraiser at a jazz club in southern California. Staffer Molly Tavella is doing outreach to community health clinics. Dr. Young spoke at about a dozen venues during his months-long stay in the state. Numerous members have joined the revitalized speakers bureau, while the statewide single-payer coalition, Campaign for a Healthy California, is gaining momentum to meet the challenges ahead. The PNHP chapter has a new office located at 620 3rd St., Oakland, CA 94607, with a new phone number, (510) 590-9691. The e-mail and website addresses are unchanged: info@pnhpcalifornia.org and www.pnhpcalifornia.org.

Some of the marchers in support of California's state single-payer bill, S.B. 810, pause at an intersection in Sacramento on their way to a rally on the Capitol steps, Jan. 9. PNHP and its autonomous student program, CaHPSA, were key organizers.

Georgia PNHP, along with the local Healthcare-Now group, has placed op-ed commentaries in several regional newspapers in support of single payer. Members are set to participate in a three-day "Global Health and Humanitarian Summit" in Atlanta in mid-April. Contact Dr. Henry Kahn at hkahn@emory.edu.

Last year **Hawaii** PNHP member Dr. Stephen Kemble was appointed by Gov. Neil Abercrombie to serve on the Hawaii Health Authority (HHA) and more recently was appointed to the governor's "Health Transformation" team. The HHA is charged with "overall health planning" and "developing a comprehensive plan to provide universal health care in Hawaii." It was created by legislation (H.B. 1504) passed in 2009 in honor of Ah Quan McElrath (1915-2008), a tireless advocate for social justice, but the law was ignored by the previous administration. The nine-member HHA, which includes Jory Watland, the longtime head of Health Care for All Hawaii, submitted principles for cost-effective, sustainable health care reform, including single-payer financing, in December, along with a critique of the state's Medicaid managed care program (www.hawaii.gov/budget/hha-1). Dr. Kemble is also active in promoting single payer from his position as president-elect of the Hawaii Medical Association, which endorsed single payer in 2009. Dr. Leslie Gise is active in recruiting her colleagues to support single payer and join PNHP. Contact Dr. Gise at leslieg@maui.net.

In **Illinois**, Dr. Pamella Gronemeyer of Glen Carbon, near Edwardsville, and other activists helped form the Illinois Single Payer Coalition, to which PNHP Illinois (formerly Health Care for All Illinois) belongs. The chapter co-sponsored a "Soul of Medicine" dinner with Chicago Physicians for Social Responsibility to honor two progressive physicians, Dr. Helen Binns and Dr. Claudia Fegan, on March 2. Dr. David Gill of Bloomington, running for Congress on a single-payer platform in the 13th CD, has won a closely contested Democratic Party primary. PNHPers have also been active in Occupy Chicago, doing teach-ins on health disparities and other topics. Dr. David Ansell, author of "County," spoke at the Annual Meeting of the American Medical Student Association in March. Dr. Diljeet Singh, co-president of PNHP Illinois, has recently accepted a new position in Arizona, where she will continue to advocate for single payer. Contact Dr. Scheetz at anneschеetz@gmail.com.



PNHP California members marched in the "Occupy contingent" of the annual Rose Parade in Pasadena, Calif., on Jan. 2, and got a great reception from the crowd, Dr. Robert Vinetz and other members say.

The **Kentucky** chapter of PNHP held a very successful annual meeting in Louisville in January, which included a lecture by Dr. David Ansell, the chief medical officer at Rush University Medical Center in Chicago. Dr. Ansell's talk revolved around his experience at Cook County Hospital (described in his book "County") and how that experience convinced him of the need for a single-payer health system. Dr. Edgar Lopez, co-coordinator of the Kentucky chapter, and Dr. Garrett Adams, also of Louisville, accompanied Dr. Ansell on several of his other speaking engagements, including a grand rounds at the University of Louisville School of Medicine and a public lecture at the Hotel Louisville. Last September, Dr. Adams testified in Washington, D.C., at the U.S. Senate Subcommittee on Public Health and Aging, chaired by Sen. Bernie Sanders, about the difficulties and health problems some of his patients in Appalachia face. The topic was "Is poverty a death sentence?" Contact Dr. Lopez at e.lopez@insightbb.com.

Members of **Maine** AllCare, PNHP's affiliate in Maine, denounced the state government's move to throw 65,000 people off the Medicaid rolls. Members have also stepped up their advocacy of single payer. Dr. Julie Pease had a letter published in the Portland Press Herald and has developed a new slideshow for her talks. Dr. Philip Caper writes a regular column in the Bangor Daily News about the need for more fundamental health care reform, and recently gave his fourth hour-long radio interview on single payer. The chapter is hosting a broadly sponsored visit by PNHP advisory board member Dr. Margaret Flowers in May. Dr. Caper has been elected to the State Democratic Platform Committee, which has recommended endorsing single payer for Maine and the nation. Contact Dr. Caper at pcpcaper21@gmail.com.

Maryland PNHPers have been energized by the release of a new economic impact study of their state's single-payer legislation. The 31-page report, "Financing the Maryland Health Security Act," (on-line at www.md.pnhp.org) was prepared by Gerald Friedman, Ph.D., an economist at the University of Massachusetts, Amherst. It shows how a publicly financed, single-payer health plan such as the one envisioned in Maryland's S.B. 206 would assure quality, comprehensive care to everyone in the state without increasing overall health spending. With copies of the report in hand, the PNHP chapter, along with members of Healthcare-Now and the Green Party, held a Lobby Day at the State House in Annapolis on March 12, urging lawmakers to support S.B. 206. Contact Dr. Eric Naumburg at enaumburg@hotmail.com.

In **Massachusetts**, PNHP members have been working with the Occupy Boston Health Justice Working Group in conducting speak-outs and free health screenings. Last October, PNHP-Massachusetts and Mass-Care, a single-payer coalition that represents more than 100 groups, released a comprehensive report titled "The Massachusetts Model of Health Reform in Practice and the Future of National Health Reform." (See more on this report, page 19.) On the same day of its release, Mass-Care and PNHP participated in a public legislative hearing on the state's single-payer bill. Single payer would cover everyone and reduce health spending in Massachusetts by 16 percent, according to a recent fiscal study by economist Gerald Friedman (on-line at www.masscare.org). A day-long Health Justice Conference is set for this fall. Contact Ben Day at director@masscare.org.

PNHP members in **Minnesota** have given grand rounds at the Mayo Clinic in Rochester and at hospitals in the Twin Cities, St. Cloud, Duluth and New Ulm. They introduced a single-payer resolution to the Minnesota Medical Association and co-hosted a fundraiser with Health Care for All Minnesota featuring T.R. Reid. In September, members helped to host a nationwide meeting of state lawmakers on single payer sponsored by PNHP and Milbank Memorial Fund. In March, PNHP-MN held its annual Day on the Hill, meeting with 50 state legislators and the governor. A new fiscal study by The Lewin Group found that a single-payer plan for Minnesota could cover all the uninsured and save 9 percent ($4.1 billion) on health spending in 2014 (on-line at www.pnhpminnesota.org). In the past year, 200 new members have signed the chapter resolution, which now has nearly 700 physician and medical student signatures in support of single payer at the state and national level. Contact pnhpminnesota@gmail.com.

Missouri now has a PNHP chapter—in St. Louis! Thanks to the organizing efforts of Dr. Ed Weisbart and Linda Lieb, among others, the new chapter was officially established on March 5. Its founding caps several initiatives undertaken by PNHPers in recent months, including Dr. Weisbart's work in getting an endorsement of H.R. 676 from the Consumers Council of Missouri, an influential consumer advocacy group. Contact pnhpstl@gmail.com.

Dr. Wink Dillaway is the new president of PNHP **New Jersey** and is helping to revitalize the chapter's activities and outreach efforts, including through increased cooperation with Healthcare-Now. Dr. Peggy Carey of Vermont will speak at a forum there on May 6, and Dr. Andy Coates of New York, president-elect of PNHP, is set to speak there in October. Contact Dr. Dillaway at w.dillaway@gmail.com.

PNHP members in **New Mexico** pushed the Legislature to support a constitutional amendment that reads: "Health care is a fundamental right that is an essential safeguard of human life and dignity. The state shall ensure that every resident has the opportunity to realize this right by establishing a comprehensive system of quality health care that is accessible to each resident on an equitable basis regardless of ability to pay." State Sen. Jerry Ortiz y Pino and Rep. Gail Chasey are the key sponsors. Supporters of the amendment were prominent at a January rally of 200 in Santa Fe organized by the Occupy movement. The House adjourned before taking action. Dr. Bruce Trigg of PNHP says, "We are trying to set an ethical standard." Contact Dr. Trigg at trigabov@aol.com.

Health Care for All NC (HCFANC), the **North Carolina** affiliate of PNHP, hosted a successful visit to the state by PNHP N.Y. Metro board member Dr. Steve Auerbach in December. Dr. Auerbach, a prominent activist in Occupy Wall Street's "Healthcare for the 99% Working Group," spoke at general assemblies of the Occupy movement in Chapel Hill and Durham and at the HCFANC Annual Meeting in Greensboro. Dr. Jessica Schorr-Saxe had an op-ed on the theme of Dr. Martin Luther King's birthday and single payer in the Charlotte Observer in January. Contact Dr. Jonathan Kotch at jonathan_kotch@unc.edu.

The **New York Metro** chapter has focused its energies on Occupy Wall Street (OWS) activities, a newly updated state single-payer bill introduced by Assemblyman Richard Gottfried, the defense of Medicare and Medicaid (the chapter issued a press release denouncing proposed cuts, leading to several radio engagements), and a renewed effort to get grand rounds and other speaking engagements. The chapter has played a central role in two OWS working groups: Medical Support to provide direct service at Zuccotti Park and at demonstrations, and the advocacy group "Healthcare for the 99%." The latter has organized more than 30 demonstrations, teach-ins and speak-outs, including an action at Pfizer on Feb. 29 that denounced the giant drug company's profiteering and its links to the conservative American Legislative Exchange Council.

Photo: Thomas Altfather Good

Members of PNHP's New York Metro chapter were part of Occupy Wall Street's "Healthcare for the 99%" action against the Pfizer drug company's profiteering and links to ALEC, an ultra-conservative think tank, Feb. 29.

The chapter holds monthly public forums; a recent one featured medical students and another was titled "Separate and Unequal: Medical Apartheid in New York City." New chapter board member Dr. Adam Gaffney reports that PNHPers attended seven student fairs last fall and added more than 200 students to the chapter database. Dr. Steffie Woolhandler, who recently relocated to New York, traveled to Capitol Hill in September and gave a briefing to Congressional Progressive Caucus members and staff on "Single payer and cost control." Contact Laurie Wen at laurie@pnhpnymetro.org.

In **Upstate New York**, PNHPers in Albany, Ithaca and other cities have participated in Occupy actions, held forums on "Health care for the 99%," and, in cooperation with the statewide coalition Single Payer New York, lobbied for state single-payer legislation at the Capitol. Dr. Andy Coates, PNHP's national president-elect, blogs on single-payer themes at the Albany Times Union, and has recently had several op-eds published in the area denouncing Gov. Andrew Cuomo's peremptory closings of many mental health centers. Contact pnhpcapitaldistrict@gmail.com.

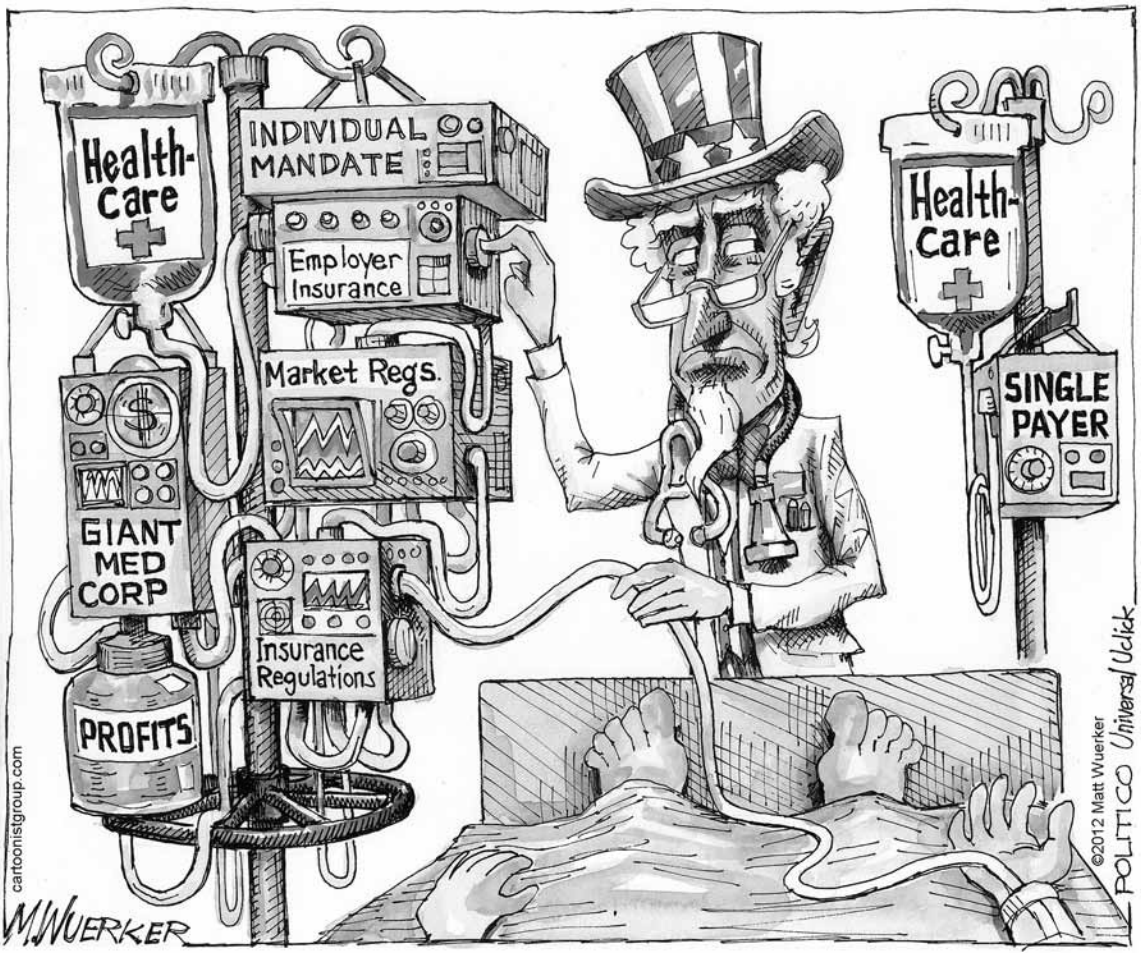
PNHP **Oregon**, notably its chapters in Portland, Corvallis and Eugene, has continued to work closely with Mad as Hell Doctors (MAHD) in speaking out at town halls, civic and church groups, and the Occupy movement. It recently joined a new Healthcare for All Oregon Coalition with 35 other groups, which is launching a "Health care is a human right" campaign. Last fall, MAHD organized a national radio ad campaign for an improved Medicare for all, featuring one-minute spots by bluegrass/country-western musician Bob Wickline. Dr. Samuel Metz of Portland has had several opinion pieces published in the regional and national press, and is a key organizer of a broadly sponsored series of talks by Drs. Arnold Relman and Marcia Angell set for late April. The chapter is also working on a fiscal feasibility study for state-based single-payer legislation, which is expected to be reintroduced in 2013. Contact Dr. Mike Huntington at mchuntington@comcast.net.

A new chapter of PNHP was formally established in **Rhode Island** on January 31! In the run-up to its founding, Dr. J. Mark Ryan (now president of the chapter), Dr. Christine Herbert (vice president), Linda Ujifusa (secretary) and other activists laid the groundwork by seeking out grand rounds and other speaking engagements, writing opinion pieces and letters to the editor (Dr. Ryan had an opinion piece in the Newport Daily News), and drafting the chapter's mission statement and bylaws. The chapter's website is at www.pnhp.org/ri, where people can join, send letters to lawmakers, and sign the chapter resolution online. Contact pnhp.ri@gmail.com.

In the wake of last spring's enactment in **Vermont** of Act 48, "An act relating to a universal and unified health system," members of Vermont PNHP and Vermont Health Care for All have been busy explaining the law to the public, making efforts to influence its implementation, and rebuffing a well-funded disinformation campaign about single-payer approaches to reform. The Green Mountain Care Board, which the law created, is up and running and is focusing on possible benefits packages. The state government's main focus has been on establishing the ACA-related state insurance exchange, which the governor has said can facilitate the creation of a single-payer system in 2017, and taking an in-depth look at delivery and payment reform (away from fee for service). PNHP members have been writing letters to the editor and op-eds on some of the hot-button issues (e.g. Dr. Susan Deppe's piece titled "Single-payer health care will increase choice"), urging their colleagues to contact state lawmakers on key committees, and taking advantage of new channels of influence like public access television. The chapter and VHCFA brought in Wendell Potter, the former Cigna executive turned whistleblower, to help them strategize about how best to combat the influence of the private insurance industry and Big Pharma. Contact Dr. Peggy Carey at peggycareyster@gmail.com.

More than 800 people attended the annual meeting of the **Western Washington** chapter of PNHP on March 3 in Seattle, where speakers included journalist Amy Goodman of Democracy Now, Rep. Jim McDermott, D-Wash., Dr. Quentin Young, PNHP's national coordinator, and Teresa Mosqueda of the Washington State Labor Council and Healthy Washington Coalition. A 20-minute video capturing the highlights of the meeting is available at http://bit.ly/wnUUCO. The chapter has collaborated with the Occupy movement, helped form the Occupy Seattle Health Care Working Group, built a chapter meeting around a Skype presentation by PNHP's Dr. Steve Auerbach of Occupy Wall Street, and sent a delegation to a national Occupy forum in Olympia, Wash., in February. Contact Dr. David McLanahan at mcltan@comcast.net.

Members of the **Wisconsin** chapter of PNHP have worked with a statewide coalition of groups to "Save Badger Care," i.e. to preserve funding and eligibility for the state's Medicaid program. The program has been under assault by Gov. Scott Walker and conservative Republican lawmakers. If the governor's proposed cuts go through, the state Department of Health Services estimates that 65,000 people, including 35,000 children and pregnant women, will lose coverage. Chapter member Laura Berger, RN, had a letter published in the Wisconsin State Journal that concluded: "Commercial insurers must do everything possible to make their Wall Street investors happy, no matter how the government tries to regulate them. Let's get the insurance industry out of the picture and cover everyone. It can be done: Medicare for all." Contact Dr. Melissa Stiles at melstiles1@gmail.com.



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