PNHP
PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter

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PHYSICIANS FOR A NATIONAL HEALTH PROGRAM » 29 E. MADISON, SUITE 602, CHICAGO, IL 60602 » WWW.PNHP.ORG » SPRING 2009 NEWSLETTER

Conyers reintroduces H.R. 676

Heartened by the prospects for health reform under a new administration, and following a banner year of endorsements for his single-payer bill, Rep. John Conyers Jr. (D-Mich.) reintroduced H.R. 676 in the 111th Congress on Jan. 26.

Although the legislation is essentially unchanged, H.R. 676 now bears a slightly different name: the "United States National Health Care Act." It retains its subtitle, the "Expanded and Improved Medicare for All Act."

Dr. Quentin Young, national coordinator of PNHP, commented, "We enthusiastically welcome the reintroduction of H.R. 676 by Congressman Conyers. In these difficult economic times, the need for an Expanded and Improved Medicare for All has never been more urgent. This legislation will guarantee quality health care for everyone in the United States and, as a bonus, it will save money, not cost more."

At the end of 2008, H.R. 676 had 93 congressional co-sponsors, the most of any health reform legislation. Because this is a new Congress, representatives who co-sponsored H.R. 676 in the 110th Congress will need to sign on again. As of March 5, over 60 had done so.

As we go to press, PNHP members are participating in delegations to local congressional district offices, urging their lawmakers to co-sponsor the bill again or to endorse it for the first time.

INSIDE

Massachusetts reform plan not a model for U.S.

In February PNHP helped dispel myths about the success of the Massachusetts reform at a standing-room-only briefing on Capitol Hill hosted by the new single-payer alliance, the Leadership Conference for Guaranteed Health Care. PNHP also released a report, with Public Citizen, by Harvard neurologist Dr. Rachel Nardin, along with PNHP co-founders Drs. David Himmelstein and Steffie Woolhandler, on the failure of the Massachusetts health reform to provide universal coverage or contain costs. They also released a letter to Senator Kennedy signed by some 500 Massachusetts physicians warning of the deficiencies of the Massachusetts plan and urging him to support single payer, as he has done in the past. The full report is at www.pnhp.org/mass_report.

Tell Obama, Congress to enact single payer

> *"I happen to be a proponent of a single-payer universal health care program. ... But as all of you know, we may not get there immediately. Because first we have to take back the White House, we have to take back the Senate, and we have to take back the House." (Obama to the Illinois AFL-CIO, 2003)*

Despite the favorable election of 2008 and an outpouring of support for single payer in house parties and on his campaign web site, Obama's health policy (at this writing) is aimed at shoring up the failing employer-based system of private insurance with tax subsidies and mandates. Seven states that have attempted similar piecemeal coverage expansions in the past two decades have failed (www.pnhp.org/states_flatline/). Additional funding for Medicaid, an SCHIP expansion, and COBRA and other subsidies are unlikely to keep up with the rising number of uninsured and greater demands on the safety net during the economic crisis. Single payer is the most "fiscally conservative" reform option because it would cover everyone and free up nearly $400 billion currently wasted on administrative overhead for clinical care.

PNHP president attends White House summit on health reform

The White House invited single-payer advocates Rep. John Conyers, lead sponsor of H.R. 676 (see sidebar), and PNHP President Dr. Oliver Fein to attend the summit after an outpouring of phone calls, e-mails, and the threat of a protest by health professionals in white coats.

After meeting with PNHP co-founder Dr. David Himmelstein, Sen. Bernie Sander (I - Vt.) announced plans to introduce single-payer legislation in the U.S. Senate.

Save the date Oct. 23-24, 2009 PNHP Annual Meeting

Over 275 PNHPers heard Tsung-Mei Cheng, Ph.D., share lessons from Taiwan's new single-payer system at PNHP's 2008 meeting.

PNHP's 2009 Annual Meeting will be held on Saturday, Oct. 24, in Cambridge, Mass. at the Royal Sonesta. It will be preceded by PNHP's popular leadership training, a one-day crash course in health policy and politics on Friday, Oct. 23, at the Harvard Faculty Club. Reserve your hotel room by Sept. 23 for the PNHP rate ($209 single/double) 617-806-4200. CME will be available. Details will be posted at www.pnhp.org/meeting.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Board of Directors, 2009

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Health Policy Q & A with PNHP Co-founders Drs. David Himmelstein and Steffie Woolhandler

Should PNHP support a public Medicare-like option in a market of private plans?

PNHP should tell the truth: The "public plan option" won't work to fix the health care system for two reasons.

1. It foregoes at least 84% of the administrative savings available through single payer. The public plan option would do nothing to streamline the administrative tasks (and costs) of hospitals, physicians offices, and nursing homes. They would still contend with multiple payers, and hence still need the complex cost tracking and billing apparatus that drives administrative costs. These unnecessary provider administrative costs account for the vast majority of bureaucratic waste. Hence, even if 95% of Americans who are currently privately insured were to join a public plan (and it had overhead costs at current Medicare levels), the savings on insurance overhead would amount to only 16% of the roughly $400 billion annually achievable through single payer.

2. A quarter century of experience with public/private competition in the Medicare program demonstrates that the private plans will not allow a level playing field. Despite strict regulation, private insurers have successfully cherry picked healthier seniors, and have exploited regional health spending differences to their advantage. They have progressively undermined the public plan – which started as the single payer for seniors and has now become a funding mechanism for HMOs, and a place for them to dump the unprofitably ill. A public plan option does not lead toward single payer, but toward the segregation of patients; with profitable ones in private plans and unprofitable ones in the public plan.

Would a public plan option stabilize the health care system, or even be a major step forward?

The evidence is strong that such reform would have at best a modest and temporary positive impact – a view that is widely shared within PNHP. Indeed, we remain concerned that a public plan option as an element of reform might well be shaped in a manner to effectively subsidize private insurers by requiring patients to purchase coverage while relieving private insurance of the highest risk individuals, stabilizing private insurers for some time and reinforcing their control of the health care system.

Given the above, is it advisable to spend significant effort advocating for inclusion of such reform?

No, for two reasons:

1. We are doctors, not politicians. We are obligated to tell the truth, and must answer for the veracity of our stance to our patients and colleagues over many years. Ours is a very different time horizon and set of responsibilities than politicians'. Falling in line with a consensus that attempts to mislead the public may gain us a seat at the debate table, but abdicates our ethical obligations.

2. The best way to gain a half a pie is to demand the whole thing.

Is fundamental reform possible?

We remain optimistic that real reform is quite possible, but only if we and our many allies continue to insist on it.

Tikkun
POLITICS • SPIRITUALITY • CULTURE
JANUARY~FEBRUARY 2009

MEMO TO OBAMA:

Seize the Moment for National Health Insurance

By John Geyman, M.D.

First off, congratulations to you and your party on your sweeping election results!

Together with a sizable majority of Americans, I am again hopeful for the future of our country. My special concern, however, is for our failing health care system and how it is pricing health care beyond the reach of ordinary Americans. Our system has come to the point where none of the many incremental reforms will work. The business model of insurance has failed, and we need to rebuild the system on a social insurance model.

Let me be direct. Although we have many dedicated health professionals, an abundance of the latest technologies, and many fine hospitals, health care has become just another commodity to be bought and sold in a deregulated market based on ability to pay, not medical need. As you well know, industry profits handsomely from the status quo, raking in money through insurance, pharmaceuticals, medical devices, and so on. Industry has a war chest to defend itself and demonstrates its political power each time any new reform is brought up.

But the situation has become dire. There is no end in sight in controlling health care costs as they soar upwards at three or four times the cost of living and family incomes. We have had three decades of incremental attempts to rein in costs, including managed care and consumer-directed health care. None have worked. We have a solution in plain sight — single-payer National Health Insurance (NHI). Market stakeholders are fighting it fiercely, but it's the only real reform that has a chance to work.

Most of your advisers will likely caution you that NHI is too radical for Americans to accept, that you need to be more centrist, and that it is not politically feasible. But therein lies your trap. You will be persuaded to add one more incremental attempt to fix things, which will not work, will cost more than ever, will delay real reform, and will add to the pain of so many along the way. Your moment of opportunity will have been lost.

Beyond ideology, these facts support NHI as the treatment of choice in 2009.

- Premiums alone for private health insurance have grown by more than 100 percent since 2000, and are projected to consume all of average household income by 2025, clearly an impossibility way before then.
- According to the Milliman Medical Index, the typical American family of four spent $15,600 on total health care costs in 2008, fully one-quarter of the typical combined family income of $60,000; most consider 10 percent of family income to be the threshold of underinsurance.
- The administrative overhead of private insurers is five to nine times higher than not-for-profit Medicare (average for commercial carriers 19.9 percent, investor-owned Blues 26.5 percent, Medicare 3 percent).
- The inefficiency and bureaucracy of our 1,300 private insurers are not sustainable (e.g., according to the Blue Cross Blue Shield Association, there are 17,000 different health plans in Chicago).
- Private insurers offer much less choice than traditional Medicare; there are near-monopolies in 95 percent of HMO/PPO metropolitan markets, enough to trigger antitrust concerns by the United States Department of Justice.
- Because of costs, about 75 million Americans are either uninsured of underinsured, with large segments of the population forgoing necessary care and having worse health care outcomes; the United States now ranks nineteenth among nineteen industrialized countries in reducing preventable deaths from amenable causes.
- Wall Street is already questioning the future prospects of the private insurance industry; as of November 18, 2008, the average share prices of the top five private insurers were down by between 60 percent and 77 percent, compared to the Standard and Poor's 42 percent.

I expect that none of this is news to you, but what is neglected by almost all economists, "experts" and pundits is that there is already plenty of money in the system, that we waste about one-third of our health care dollar on our inefficient multi-payer financing system and on unnecessary care, and that NHI will save money, not cost more. NHI is the most fiscally responsible thing we can do now about health care. The Conyers bill in the House (H.R. 676) will be financed by payroll and progressive income taxes that will be less than what individuals and employers now pay. The health insurance industry is being propped up by government subsidies to the employer-based system and to privatized public programs. NHI can save some $350 billion through administrative sim-

plification, while offering coverage for all necessary care, full choice of provider and hospital, and mechanisms for cost containment through bulk purchasing, negotiated fees, and global budgets.

NHI by itself will not solve all of our health care problems, but it will provide a structure (as no incremental approach can) to enable other necessary steps. These include acceptance of health care as a right, transition to a not-for-profit system, reimbursement reform, rebuilding of primary care, evidence-based technology assessment, and quality improvement. None of this will be possible by using reforms that leave an obsolete private insurance industry in place, as is more fully discussed in my recent book "Do Not Resuscitate: Why the Health Insurance Industry is Dying, and How We Must Replace It."

FDR almost went for NHI in the mid-1930s, but he backed off, mainly due to the AMA's opposition. Today, the AMA is marginalized with a membership of no more than 30 percent of physicians, and a majority of American physicians now support NHI. Implementing NHI in your presidency can be your FDR-size legacy. It has become an economic, moral, and social imperative. Overnight NHI can bind us together as one society, all of us in the same boat. We can afford it. Yes, we can!

Dr. John Geyman, right, receives the Quentin Young Health Activist Award at PNHP's 2008 Annual Meeting, from PNHP National Coordinator Dr. Young

John P. Geyman, M.D., is professor emeritus of family medicine at the University of Washington, and past president of Physicians for a National Health Program (www.pnhp.org). He is a member of the Institute of Medicine.

'Quote of the Day' an invaluable resource for single-payer advocates

Below you'll find an abbreviated "Quote of the Day" by Dr. Don McCanne, PNHP's senior policy fellow. The quote usually features an excerpt from a late-breaking report or article by a prominent health policy expert, followed by Dr. McCanne's commentary. The quote is posted daily on PNHP's new blog www.pnhp.org/blog or you can subscribe by dropping a note to don@mccanne.org.

Nobel Laureate Joseph Stiglitz on single payer

Democracy Now!
Feb. 25, 2009

We get reaction to President Obama's speech from Nobel economics laureate and former World Bank chief economist, Joseph Stiglitz.

Amy Goodman: And health care? He's called for universal health care, but he does not call for single-payer health care.

Joseph Stiglitz: I think that there are some fundamental problems in the efficiency of our health care system. And what we've seen is that the private health care insurers do not know how to deliver an efficient way.

Goodman: Do you support single-payer health care?

Stiglitz: I think I've reluctantly come to the view that it's the only alternative. You know, we've tried a lot of other things. And we've been — you know, I was in the Clinton administration, and we debated a lot of alternatives, and I've watched things as they've emerged and, you know, evolved over the last twelve, sixteen years, and I think there's a growing consensus that the private market exclusion is not going to work.

Goodman: Joe Stiglitz, I want to thank you for being with us. http://www.democracynow.org/2009/2/25/stieglitz

COMMENT:

By Don McCanne, MD

What does Joseph Stiglitz have to say?

That's a question we ask when we are faced with difficult issues such as the current financial crisis, and what we should do about the troubled banks. To our benefit, Amy Goodman did ask him, and we learn what he has to say.

At the end of the interview, Amy Goodman tacked on this crucial question regarding our health care crisis. Single payer?

Joseph Stiglitz's response must be shared with the nation, and especially with those in Washington who say that single payer is not feasible. We should inundate Washington with his statement that single payer is "the only alternative."

The Atlanta Journal-Constitution

There is a cure available for our health care woes

By DR. OLIVER FEIN

The report last week that the U.S. economy lost nearly 2 million jobs this year, and 533,000 jobs in November alone, sent shudders through our nation's households. That's the biggest one-month plunge in jobs in 34 years. "Horrendous" was how one economist put it, while others said the number of unemployed, and underemployed, could easily double over the next year.

These job losses spell disaster for our health. Millions of people are losing their employer-sponsored health insurance, joining the 46 million who already lack coverage. Millions more are finding it harder to pay their co-pays and deductibles and are scrimping on their medications and doctor visits. Many go without care, risking their health and often their very lives.

In short, affordable health care has never been more urgently needed. Yet most of the health reform proposals coming out of Washington these days won't get us there.

Sen. Max Baucus (D-Mont.) recently unveiled his proposals for incremental health reform, which largely mirror the ideas of President-elect Barack Obama and Sen. Edward Kennedy (D-Mass.).

However well-intentioned, the Obama/Baucus/Kennedy approaches share a fatal flaw: they preserve a central role for the private health insurance industry.

To varying degrees, they would mandate that everyone buy private health insurance — the private insurance that is failing us today. Some of these plans offer a Medicare-like, public option that people could buy into, but experience with Medicare shows that the private plans refuse to compete on a level playing field. They cherry-pick healthier patients and insist on more than their share of payment.

Experience with mandate-based plans in Washington state (1993), Oregon (1992) and Massachusetts (1988 and today) shows that they simply don't work, achieving neither universal health care nor cost containment.

As long as we rely on private health insurers, universal coverage will be unaffordable. These companies generate immense overhead costs and force doctors and hospitals to spend heavily on billing and paperwork.

Administration consumes about one-third of every health care dollar in the U.S. By contrast, in countries with nonprofit national health insurance, administrative costs consume only half that amount.

There is a cure, however. Eliminating the private insurance industry would save $400 billion annually in administrative costs, enough to ensure that everyone is covered and to eliminate all co-pays and deductibles.

At this critical juncture, a single-payer plan is the only medically, morally and fiscally responsible path to take.

We already have an example of an American single-payer system that works — traditional Medicare. It's not perfect, but people with Medicare are far happier than those with private insurance. Doctors face fewer hassles in getting paid, and Medicare has been a leader in keeping costs down, at least until Washington politicians decided to pay private insurance plans to enroll seniors at a cost 12- to 19-percent higher than traditional Medicare.

Single-payer systems give patients complete freedom to choose their doctor and hospital. They also enhance cost containment through global budgeting, the bargaining power of being the sole buyer, and an emphasis on primary care and prevention.

With a universal plan of this type, doctors and other health professionals could return to their main task: caring for their patients.

Single payer, or an improved Medicare for All, is embodied in the U.S. National Health Insurance Act, H.R. 676, sponsored by Rep. John Conyers (D-Mich.) and 92 other members of Congress.

Opponents of single payer often admit it's the best, most efficient and equitable way to provide quality care, but say it's not politically feasible and is therefore off the table in this round of the debate. How so? A solid majority of physicians, 59 percent, and an even higher percentage of the public, 62 percent or more, support national health insurance, recent surveys show. Single payer should be front and center.

Medicare for All is within reach, but only if we are prepared to take on the private health insurance industry. The time is now. It requires only the political will.

Dr. Oliver Fein is associate dean and professor of clinical medicine and public health, Weill Cornell Medical College in New York and president of Physicians for a National Health Program.

SUNDAY, DECEMBER 14, 2008

Note: This article was originally published under the title of "There is a cure available for current plan."

Talking Points: Why the mandate plans won't work, and why single-payer "Medicare for All" is what we need

By Len Rodberg, Ph.D.

1. The health care crisis has worsened. Over 46 million Americans lack health insurance. A comparable number are underinsured. Those with insurance are paying more and more of the premiums and more out-of-pocket as well. And even the insured face bankruptcy if they get sick. Many have to choose between paying for medicine and paying for food and housing. And with the recent economic downturn, the ranks of those without insurance are growing.

2. A majority of physicians (59 percent) and an even higher proportion of Americans (62 percent or more) support single-payer national health insurance or "Medicare for All." In spite of this, all we are hearing about today are mandate plans that would require everyone to buy the same private insurance that is already failing us. These proposals don't regulate insurance premiums, they don't keep the insurance companies from refusing to pay many of our bills, and they don't improve the insurance we now have. Some offer a "public option," but this will quickly become too expensive as the sick flee to the public sector because private insurers avoid them, abandon them, or make it too difficult for them to get their bills paid.

3. These mandate proposals won't work, either to expand coverage or to contain costs. Plans like these have been tried in many states over the past two decades (Massachusetts, Tennessee, Washington State, Oregon, Minnesota, Vermont, Maine). They have all failed to durably reduce the number of uninsured or to contain costs.

4. These mandate plans will add hundreds of billions of dollars to the nation's health care costs. In this economic downturn, we need to assure health care for all without adding to the nation's cost and the government's deficit. The bottom line is: these proposals don't reform our fragmented, inefficient system, they just add to its complexity and costs.

5. As long as we continue to rely on private for-profit insurers, universal coverage will be unaffordable. Their administrative costs consume nearly one-third of our health care dollar. We will never have enough money to provide everyone with decent care until we eliminate private insurance with its enormous waste and inadequate coverage. And we will never be able to keep costs down and get the care we need as long as the wasteful and unnecessary insurance companies stand between us and our doctors.

6. Every other industrialized country has some form of universal health care. None uses profit-making, investor-owned insurance companies like ours to provide health care for all their people.

7. We have an American system that works. It's Medicare. It's not perfect, but Americans with Medicare are far happier than those with private insurance. Doctors face fewer hassles in getting paid, and Medicare has been a leader in keeping costs down. And keep in mind that Medicare insures people with the greatest health care needs: people over 65 and the disabled. We should improve and expand Medicare to cover everyone.

8. A single-payer "Medicare for All" system is embodied in H.R. 676, sponsored by Rep. John Conyers. It would have:
- Automatic enrollment for everyone
- Comprehensive services covering all medically necessary care and drugs
- Free choice of doctor and hospital, who remain independent and negotiate their fees and budgets with a public or nonprofit agency
- Public or nonprofit agency processes and pays the bills
- Entire system financed through progressive taxes
- Help job growth and the entire U.S. economy by removing the burden of health costs from business
- Cover everyone without spending any more than we are now.

9. The growth in health care costs must be addressed if any proposal is to succeed.
- Single payer offers real tools to contain costs: budgeting, especially for hospitals, planning of capital investments, and an emphasis on primary care and coordination of care.
- Mandate plans offer only hopes: competition among insurance companies, computerization, chronic disease management. Competition among the shrinking number of insurance companies has already failed to contain costs and, in the absence of single payer and reformed primary care, computerization and chronic disease management will raise costs, not lower them.

10. Single-payer Medicare for All is the right answer:
- **It is right on choice.** It provides free choice of doctor and hospital, the choice Americans want and value. In mandate plans, we lose those choices.
- **It is right on efficiency.** Single payer would slash administrative costs and promote efficient primary care. It would also enhance evidence-based quality assurance.
- **It is right on accountability.** It will be a public, nonprofit system that will respond to what doctors and their patients need, not what corporate executives and their stockholders want.

References for these talking points are available at http://www.pnhp.org/change/TalkingPoints.pdf

The Boston Globe

MONDAY, MARCH 2, 2009

Massachusetts healthcare reform is failing us

By Susanne L. King

MASSACHUSETTS HAS been lauded for its healthcare reform, but the program is a failure. Created solely to achieve universal insurance coverage, the plan does not even begin to address the other essential components of a successful healthcare system.

What would such a system provide? The prestigious Institute of Medicine, part of the National Academy of Sciences, has defined five criteria for healthcare reform. Coverage should be: universal, not tied to a job, affordable for individuals and families, affordable for society, and it should provide access to high-quality care for everyone.

The state's plan flunks on all counts.

First, it has not achieved universal healthcare, although the reform has been a boon to the private insurance industry. The state has more than 200,000 without coverage, and the count can only go up with rising unemployment.

Second, the reform does not address the problem of insurance being connected to jobs. For individuals, this means their insurance is not continuous if they change or lose jobs. For employers, especially small businesses, health insurance is an expense they can ill afford.

Third, the program is not affordable for many individuals and families. For middle-income people not qualifying for state-subsidized health insurance, costs are too high for even skimpy coverage. For an individual earning $31,213, the cheapest plan can cost $9,872 in premiums and out-of-pocket payments. Low-income residents, previously eligible for free care, have insurance policies requiring unaffordable copayments for office visits and medications.

Fourth, the costs of the reform for the state have been formidable. Spending for the Commonwealth Care subsidized program has doubled, from $630 million in 2007 to an estimated $1.3 billion for 2009, which is not sustainable.

Fifth, reform does not assure access to care. High-deductible plans that have additional out-of-pocket expenses can result in many people not using their insurance when they are sick. In my practice of child and adolescent psychiatry, a parent told me last week that she had a decrease in her job hours, could not afford the $30 copayment for treatment sessions for her adolescent, and decided to meet much less frequently.

In another case, a divorced mother stopped treatment for her son because the father had changed insurance, leaving them with an unaffordable deductible. And at Cambridge Health Alliance, doctors and nurses have cared for patients who, unable to afford the new copayments, were forced to interrupt care for HIV and even cancers that could be treated with chemotherapy.

Access to care is also affected by the uneven distribution of healthcare dollars between primary and specialty care, and between community hospitals and tertiary care hospitals. Partners HealthCare, which includes two major tertiary care hospitals in Boston, was able to negotiate a secret agreement with Blue Cross Blue Shield of Massachusetts to be paid 30 percent more for their services than other providers in the state, contributing to an increase in healthcare costs for Massachusetts, which are already the highest per person in the world. Agreements that tilt spending toward tertiary care threaten the viability of community hospitals and health centers that provide a safety net for the uninsured and underinsured.

There is, though, one US model of healthcare that meets the Institute of Medicine criteria: Medicare. Insuring everyone over 65, Medicare achieves universal coverage and access to care, is not tied to a job, and is affordable for individuals and the country. Medicare simplifies the administration of healthcare dollars, thereby saving money. We need to improve Medicare, and expand this program to include everyone.

A bill before Congress, the United States National Health Insurance Act, would provide more comprehensive coverage for all. The bill includes doctor, hospital, long-term, mental health, dental, and vision care, prescription drugs, and medical supplies, with no premiums, copayments, or deductibles.

People would be free to choose doctors and hospitals, and insurance would not be tied to a job. Costs would be controlled because health planning in a national health program can reestablish needed balance between primary/preventive care and high-tech tertiary care. A modest, progressive tax would replace what people currently pay out of pocket. This program would pay for itself by eliminating the wasteful administrative costs and profits of private insurance companies, and save $8 billion to $10 billion in Massachusetts alone.

We must let Congress know we want improved access to affordable healthcare for all, not more expensive private health insurance we can't afford to use when we are sick. Massachusetts healthcare reform fails on all five Institute of Medicine criteria. Congress should not make it a model for the nation.

Susanne L. King, M.D., practices in Berkshire County.

See also "Grim Prognosis For Massachusetts Reform" (Letter, Health Affairs, March 10, 2009) by Drs. David Himmelstein and Steffie Woolhandler.

Med students set up action network

PNHP medical students, working with fellow activists in the American Medical Student Association, have established a new "quick response" network to influence the national health care policy debate. The new group is called STAT, for Student Action Team.

In its first month of operations, STAT signed up over 230 students who have committed themselves to taking one or two actions each month in support of single-payer health reform. Such actions could include, for example, sending e-mail messages and calling key lawmakers on single-payer legislation or responding to a late-breaking news item with a letter to the editor.

PNHP medical student board members Gabe Silverman (MS3, Univ. of Pittsburgh), Kirsten Austad (MS1, Harvard), Dan Henderson (MS3, UConn) and David Marcus (MS4, SUNY Downstate) are spearheading this effort. To join, e-mail info@pnhp.org.

UConn medical students Emily Allen, Andrew Scatola, Teresa Doucet, Daniel Henderson and Erica Hinz at PNHP's 2008 Annual Meeting

CALIFORNIA STUDENT LOBBY DAY 2009:

'We're the future of health care, and we're for single-payer'

SACRAMENTO – Over 450 medical students and other health professional students from 17 academic institutions across California flooded the Capitol on Monday, Jan. 12, to tell legislators, "We're the future of health care — and we're for single payer."

It was the largest and most representative Student Lobby Day for single payer yet, nearly doubling last year's turnout.

Following a march to the Capitol Building and a rally on its steps, the students visited the offices of almost every one of the 120 legislators, urging him or her to support the California Universal Healthcare Act, the state single-payer bill, and to endorse Rep. John Conyers' national bill, H.R. 676. By end of day, the students had secured 20 additional co-sponsors for the state legislation.

Since 2006, the state single-payer bill has twice passed the California legislature, only to be vetoed both times by Gov. Arnold Schwarzenegger.

The Monday march, rally and office visits were preceded by a well-attended training session the day before. "One of the most exciting parts of our Sunday training was watching each legislative visit group transform itself from a collection of individuals who had never met into an organized team, energized and educated about sharing our message," said Jennifer Alloo (MS2, UC Irvine), a co-coordinator of the event.

California Physicians' Alliance (CaPA) Medical Student Fellow Parker Duncan at Lobby Day

The training session closed with inspirational remarks by former Sen. Sheila Kuehl, the chief sponsor of last year's bill, S.B. 840. Kuehl has since left the Senate, and state Sen. Mark Leno has taken up the legislation's banner, now named S.B. 810.

At Monday's rally, Leno gave a rousing speech for single payer. Other speakers included Richard Quint of the California Physicians' Alliance (CaPA, PNHP's California chapter), Deborah Berger of the California Nurses Association, Brian Hurley of the American Medical Student Association and students Tanya Brown, Dan Stein, Nancy Anaya-Navarro and Marc Montecillo.

A sea of placards, made possible by the support of the California School Employees Association, helped convey the rally's message. Organizers said a local CBS television station broadcast a story about the events later that day.

Organizers attributed the larger turnout at this year's event in part to a more ambitious outreach program. CaPA Student Fellow Parker Duncan, MPH (MS4, UC Irvine), was part of this effort, having given over 20 talks to medical student and other health professional student groups on campuses throughout the state in recent months.

Educate the 111th Congress about H.R. 676

The new Congress needs to hear from physician-constituents about their support for single-payer national health insurance (H.R. 676).

There are many ways to contact your legislators, but not all are created equal.

A personal visit is best. A phone conversation with a legislative health aide is better than a written letter, and a written letter is better than an e-mail. But even a quick e-mail can help!

The sample letter (below) can serve as the basis for a letter or a phone conversation. Act today!

For help arranging or preparing for a meeting, contact Danielle Alexander at danielle@pnhp.org.

Useful talking points for single payer may be found on page 6, this issue.

Sample letter to your U.S. representative

Use "as is" or, better yet, add some details from your own experience and/or locale. You can also adapt this letter to urge your senator to introduce comparable legislation in the U.S. Senate.

Dear Rep. _____,

I write as a constituent – and as a physician – to express my support for single-payer national health insurance and to urge you to co-sponsor H.R. 676, the U.S. National Health Care Act, introduced by Rep. John Conyers Jr.

As a physician, I see the results of our health care crisis every day. More than 46 million Americans are uninsured. Even for those lucky enough to have insurance, rising costs and deteriorating coverage cause nearly a third to go without needed care because they can't afford it. Indeed, of the 1 million Americans bankrupted in part by medical bills annually, more than three-quarters had insurance when they got sick.

Unlike other piecemeal reforms presently under consideration, single-payer national health insurance would save enough on paperwork and other administrative costs — more than $400 billion per year — to provide comprehensive coverage to all Americans. It would provide full choice of doctor and hospital for patients, and would free physicians from arbitrary and meddlesome insurance-company dictates regarding patient care. It would help us control the skyrocketing health care costs that are crippling our economy.

Please join with the two-thirds of Americans who support such a system and co-sponsor H.R. 676.

Sincerely,

New resources for promoting single payer

A special section of the PNHP website is devoted to new and updated materials to use with Obama and the new Congress (www.pnhp.org/change).

- The full text of the new H.R. 676, along with the list of this year's and last year's co-sponsors.

FACT SHEETS:

- The single-payer path to genuine health care reform: H.R. 676
- Backgrounder on single-payer national health insurance
- Financing single-payer national health insurance: Myths and facts
- The Massachusetts plan: a failed model for reform
- The Federal Employee Health Benefits Plan: Why it won't work as a national model
- Congressional visit "How to" kit

NEW SLIDESHOWS

- Dr. David Himmelstein's "Why Mandate Model Reform Plans Fail."
- PNHP's 2009 Slideshow, password: fein

PETITION KIT

- Poster for your office waiting room
- Petition for patients to support H.R. 676

111th Congress co-sponsors of H.R. 676 as of March 5

Rep. Conyers, John, Jr. (MI-14), Sponsor
Rep. Abercrombie, Neil (HI-1)
Rep. Baldwin, Tammy (WI-2)
Rep. Berman, Howard L. (CA-28)
Rep. Bishop, Sanford D., Jr. (GA-2)
Rep. Brady, Robert A. (PA-1)
Rep. Brown, Corrine (FL-3)
Rep. Capuano, Michael E. (MA-8)
Rep. Clarke, Yvette D. (NY-11)
Rep. Clay, Wm. Lacy (MO-1)
Rep. Cleaver, Emanuel (MO-5)
Rep. Cohen, Steve (TN-9)
Rep. Costello, Jerry F. (IL-12)
Rep. Cummings, Elijah E. (MD-7)
Rep. Davis, Danny K. (IL-7)
Rep. Delahunt, William D. (MA-10)
Rep. Doyle, Michael F. (PA-14)
Rep. Edwards, Donna F. (MD-4)
Rep. Ellison, Keith (MN-5)
Rep. Engel, Eliot L. (NY-17)
Rep. Farr, Sam (CA-17)
Rep. Fattah, Chaka (PA-2)
Rep. Filner, Bob (CA-51)
Rep. Frank, Barney (MA-4)
Rep. Green, Al (TX-9)
Rep. Grijalva, Raul M. (AZ-7)
Rep. Gutierrez, Luis V. (IL-4)
Rep. Hastings, Alcee L. (FL-23)
Rep. Hinchey, Maurice D. (NY-22)
Rep. Hirono, Mazie K. (HI-2)
Rep. Honda, Michael M. (CA-15)
Rep. Jackson, Jesse L., Jr. (IL-2)
Rep. Jackson-Lee, Sheila (TX-18)
Rep. Johnson, Henry C. "Hank," Jr. (GA-4)
Rep. Kaptur, Marcy (OH-9)
Rep. Kennedy, Patrick J. (RI-1)
Rep. Kildee, Dale E. (MI-5)
Rep. Kilpatrick, Carolyn C. (MI-13)
Rep. Kucinich, Dennis J. (OH-10)
Rep. Lee, Barbara (CA-9)
Rep. Maloney, Carolyn B. (NY-14)
Rep. Massa, Eric J. J. (NY-29)
Rep. McDermott, Jim (WA-7)
Rep. McGovern, James P. (MA-3)
Rep. Meeks, Gregory W. (NY-6)
Rep. Moore, Gwen (WI-4)
Rep. Nadler, Jerrold (NY-8)
Rep. Napolitano, Grace F. (CA-38)
Rep. Olver, John W. (MA-1)
Rep. Payne, Donald M. (NJ-10)
Rep. Pingree, Chellie (ME-1)
Rep. Polis, Jared (CO-2)
Rep. Rush, Bobby L. (IL-1)
Rep. Ryan, Tim (OH-17)
Rep. Schakowsky, Janice D. (IL-9)
Rep. Scott, Robert C. "Bobby" (VA-3)
Rep. Thompson, Bennie G. (MS-2)
Rep. Tierney, John F. (MA-6)
Rep. Tonko, Paul D. (NY-21)
Rep. Velazquez, Nydia M. (NY-12)
Rep. Watson, Diane E. (CA-33)
Rep. Welch, Peter (VT)
Rep. Wexler, Robert (FL-19)
Rep. Woolsey, Lynn C. (CA-6)
Rep. Yarmuth, John A. (KY-3)

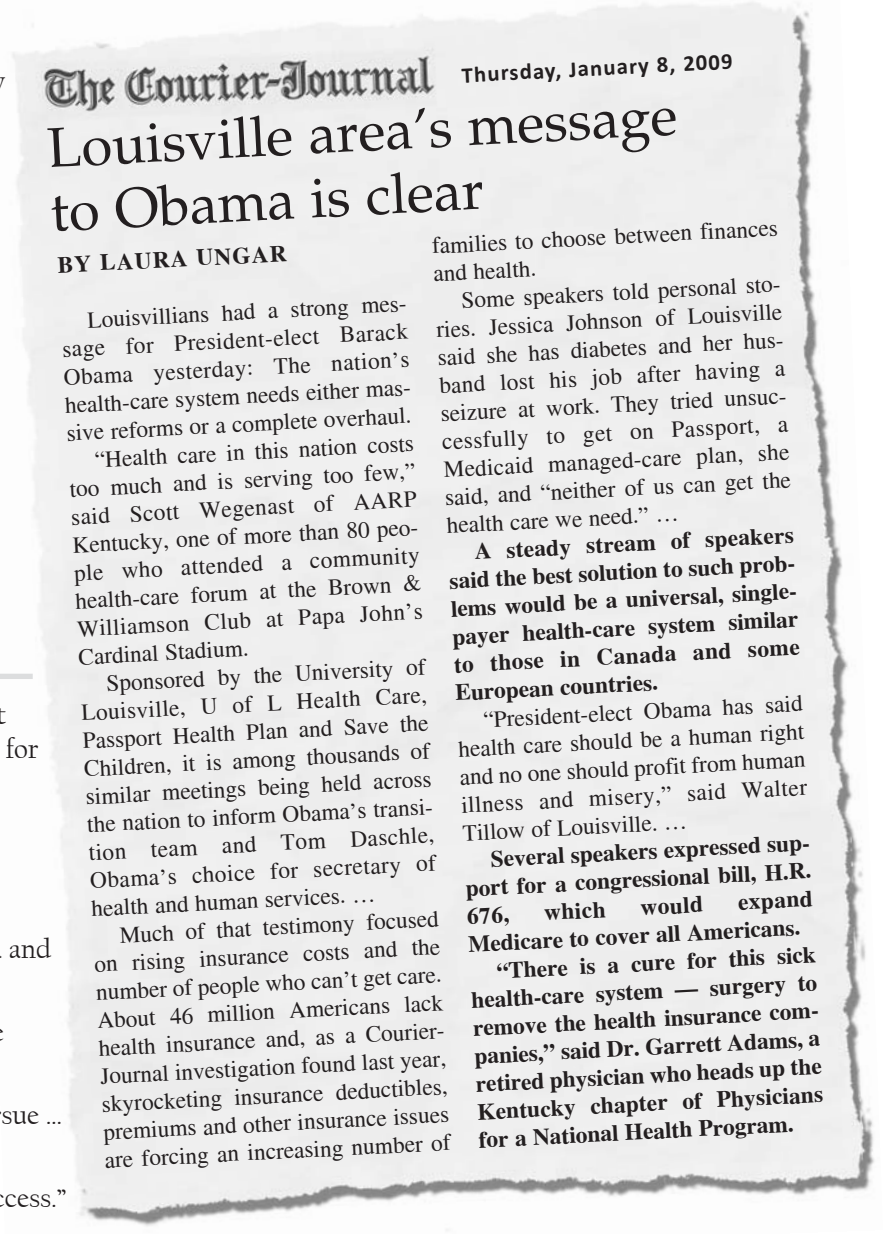
House Parties send single-payer message to Obama's transition team

PNHP members participated in scores, and possibly hundreds, of the late-December "health care community discussions" called for by the Obama-Biden Transition Team.

The official discussion guidelines did not mention single payer and were framed so as to preclude its consideration. Yet in the 40-plus reports of these meetings that PNHP members sent into our office, a majority of those present – in meetings as small as 10 and as big as 150 – supported single payer.

These results confirm recent public opinion polls. They also confirm the findings of the Citizens' Health Care Working Group town hall meetings in 2006, where 25 of the 29 meetings supported single payer.

Many of our physician members and friends sent us short reports about their local meetings. Here are some excerpts.



The Courier-Journal Thursday, January 8, 2009

Louisville area's message to Obama is clear

BY LAURA UNGAR

Louisvillians had a strong message for President-elect Barack Obama yesterday: The nation's health-care system needs either massive reforms or a complete overhaul.

"Health care in this nation costs too much and is serving too few," said Scott Wegenast of AARP Kentucky, one of more than 80 people who attended a community health-care forum at the Brown & Williamson Club at Papa John's Cardinal Stadium.

Sponsored by the University of Louisville, U of L Health Care, Passport Health Plan and Save the Children, it is among thousands of similar meetings being held across the nation to inform Obama's transition team and Tom Daschle, Obama's choice for secretary of health and human services. …

Much of that testimony focused on rising insurance costs and the number of people who can't get care. About 46 million Americans lack health insurance and, as a Courier-Journal investigation found last year, skyrocketing insurance deductibles, premiums and other insurance issues are forcing an increasing number of families to choose between finances and health.

Some speakers told personal stories. Jessica Johnson of Louisville said she has diabetes and her husband lost his job after having a seizure at work. They tried unsuccessfully to get on Passport, a Medicaid managed-care plan, she said, and "neither of us can get the health care we need." …

A steady stream of speakers said the best solution to such problems would be a universal, single-payer health-care system similar to those in Canada and some European countries.

"President-elect Obama has said health care should be a human right and no one should profit from human illness and misery," said Walter Tillow of Louisville. …

Several speakers expressed support for a congressional bill, H.R. 676, which would expand Medicare to cover all Americans.

"There is a cure for this sick health-care system — surgery to remove the health insurance companies," said Dr. Garrett Adams, a retired physician who heads up the Kentucky chapter of Physicians for a National Health Program.

"Private health insurance companies are the single biggest problem. … Of 14 who spoke to the issue, 78 percent were for single payer." — **Southampton, N.Y.**

"People clearly leaned to a Medicare for All solution." — **Richmond, Va.** (at the Medical Society)

"Participants voted unanimously to support single-payer national health insurance over the plan backed by Obama and Daschle." — **Ann Arbor, Mich.**

"Paying into a public pool, such as Medicare for All, is the much preferred route." — **Helena, Mont.**

"We urge in the strongest possible terms that Obama pursue … the single-payer approach." — **Cambridge, Mass.**

"The group of 70 supported single payer with universal access." — **Bloomington, Ind.**

"The consensus was for single payer. Get the government IN and the insurance companies OUT." — **Portsmouth, N.H.**

"Most believed that a single-payer national health program would be the most effective model of reform." — **San Juan Capistrano, Calif.**

"Get rid of the insurance companies." — **Boca Raton, Fla.**

"79 percent were in favor of a government plan like single payer." — **Clearwater, Fla.**

"Only single-payer health reform, as in H.R. 676, will address most if not all of the problems that beset the current system." — **Rumney, N.H.**

"There was enthusiastic support for single payer. 14 of 20 filled out cards supporting H.R. 676." — **Houston**

"13 of 14 strongly supported a Medicare-type, single-payer health program such as H.R. 676, sponsored by Rep. Conyers." — **Chagrin Falls, Ohio**

"60 percent supported single-payer national health insurance as the best solution." — **Tallahassee, Fla.**

"There was a clear consensus for single payer." — **Elgin, Ill.**

"Single payer had total, unanimous support by the end of the meeting." — **Santa Monica, Calif.**

"The group agreed that the U.S. is in need of a single-payer health care system." — **Portage, Mich.**

"This group unanimously favors a national single-payer system, Medicare for All." — **Saratoga, N.Y.**

The Des Moines Register

The time is now:
Reform health care

EDITORIAL

"There is no way to solve America's economic problems without solving health care," said U.S. Sen. Max Baucus, chairman of the Senate Finance Committee. The $2.3 trillion spent annually on health care "sucks up 16 percent of our economy and is still growing."

Baucus is right, and the 98-page white paper on health care he recently unveiled is a welcome development to push reform. Our view: What's needed is a government-administered health-insurance program - similar to Medicare, which covers seniors and disabled people - available to all Americans.

A single system could reduce administrative expenses associated with facilitating thousands of different private health-insurance plans in this country. It could increase leverage for negotiating lower prices. It could facilitate the expansion of electronic medical records, which would streamline paperwork and help prevent costly medical errors. It would boost the country's economy in the long run.

Grappling with an economic crisis, Washington has focused on bailing out industries, extending unemployment benefits and tweaking interest rates. How can Congress - and taxpayers - also afford to tackle health care?

The country can't afford not to. Anyone who doesn't believe that should:

Ask struggling businesses

Start with the automakers. The Big Three are asking Congress for billions of dollars to help pay future health-care costs for retirees. It's difficult for automakers - which have made generous health-care promises to retirees - to compete with foreign competitors operating in countries with taxpayer-supported health insurance for their citizens.

The cost of health care burdens all American businesses - big and small.

Employer-sponsored health insurance began as a job perk after a labor shortage following World War II. Now it's an expensive obligation for employers who are expected - and encouraged through tax benefits - to offer health insurance to workers.

But such an obligation creates an unfair playing field. Companies that shoulder the cost of providing health insurance have less money to hire workers, develop products and expand - which is exactly what this country needs in a troubled economy. Other companies skate by without this contribution to the overall well-being of their employees and society.

Ask the unemployed

In response to rising unemployment, Congress recently increased the length of time people can collect unemployment benefits - which generally amount to a maximum of a few hundred dollars a week. But for many people, the loss of a job is worse than losing income. It's losing health care.

Granted, federal law allows for people to buy the health-care benefits offered by their employer. However, since the unemployed must pay the entire cost of insurance, this option is frequently unaffordable. The average employer picks up 84 percent of the premium for individual coverage and 73 percent of the premium for family coverage. Lose your job, and covering your family could jump from $300 a month to $1,200 a month - at a time when your income has plummeted.

Ask average workers

For many Americans, every paycheck is a reminder of how expensive it is to buy health insurance. November offered a special reminder, because it's health-benefit re-enrollment time for millions of workers. What they usually get: higher costs and decreased coverage.

Tying jobs to employment also means workers are afraid to quit their jobs to start businesses for fear of losing health insurance - which discourages innovation and entrepreneurship. A national health-care system would allow Americans to secure insurance without help from an employer.

Covering everyone in a national system will require higher taxes. Private-sector workers already pay not only for their own health insurance, but also for covering millions of others. Getting help from taxpayers to pay for health care is hardly a foreign concept in America. Anyone using Medicare or Medicaid or working in the public sector, from teachers to lawmakers, already gets help.

Counting the private and public sectors, this country already spends more than any country in the world on health care. We should spend it more wisely and fairly.

Baucus' plan is a good sign that Congress - as well as President-elect Barack Obama - is serious about reform. The goal should be to create a system all Americans can buy into while controlling costs, making use of electronic medical records and improving health outcomes.

One need only look to history to see that this is the time for such reform. In 1964, the Democrats won control, and the election of Lyndon Johnson was seen as an endorsement of a national health-insurance system.

Congress and Johnson created Medicare. In signing the bill into law, Johnson quoted his predecessor, President Harry Truman: "Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection."

Seniors and the disabled got help. Forty-four years later, after election of another presidential candidate who vowed to address health care, it's time for the rest of America to get help, too.

SUNDAY, NOVEMBER 30, 2008

PAYING MORE, GETTING LESS

BY JOEL A. HARRISON

How much is the sick U.S. health care system costing *you*?

By any measure, the United States spends an enormous amount of money on health care. Here are a few of those measures. Last year, U.S. health care spending exceeded 16% of the nation's GDP. To put U.S. spending into perspective: the United States spent 15.3% of GDP on health care in 2004, while Canada spent 9.9%, France 10.7%, Germany 10.9%, Sweden 9.1%, and the United Kingdom 8.7%. Or consider per capita spending: the United States spent $6,037 per person in 2004, compared to Canada at $3,161, France at $3,191, Germany at $3,169, and the U.K. at $2,560.

By now the high overall cost of health care in the United States is broadly recognized. And many Americans are acutely aware of how much they pay for their own care. Those without health insurance face sky-high doctor and hospital bills and ever more aggressive collection tactics—when they receive care at all. Those who are fortunate enough to have insurance experience steep annual premium hikes along with rising deductibles and co-pays, and, all too often, a well-founded fear of losing their coverage should they lose a job or have a serious illness in the family.

Still, Americans may well *underestimate* the degree to which they subsidize the current U.S. health care system out of their own pockets. And almost no one recognizes that even people without health insurance pay substantial sums into the system today. If more people understood the full size of the health care bill that they as individuals are already paying—and for a system that provides seriously inadequate care to millions of Americans—then the corporate opponents of a universal single-payer system might find it far more difficult to frighten the public about the costs of that system. In other words, to recognize the advantages of a single-payer system, we have to understand how the United States funds health care and health research and how much it actually costs us today.

PAYING THROUGH THE TAXMAN

The U.S. health care system is typically characterized as a largely private-sector system, so it may come as a surprise that more than 60% of the $2 trillion annual U.S. health care bill is paid through taxes, according to a 2002 analysis published in *Health Affairs* by Harvard Medical School associate professors Steffie Woolhandler and David Himmelstein. Tax dollars pay for Medicare and Medicaid, for the Veterans Administration and the Indian Health Service. Tax dollars pay for health coverage for federal, state, and municipal government employees and their families, as well as for many employees of private companies working on government contracts. Less visible but no less important, the tax deduction for employer-paid health insurance, along with other

DOLLARS & SENSE

PHOTO: © ISTOCKPHOTO

health care-related tax deductions, also represents a form of government spending on health care. It makes little difference whether the government gives taxpayers (or their employers) a deduction for their health care spending, on the one hand, or collects their taxes then pays for their health care, either directly or via a voucher, on the other. Moreover,

Tax dollars already pay for at least $1.2 trillion in annual U.S. health care expenses.

tax dollars also pay for critical elements of the health care system apart from direct care—Medicare funds much of the expensive equipment hospitals use, for instance, along with all medical residencies.

All told, then, tax dollars already pay for at least $1.2 trillion in annual U.S. health care expenses. Since federal, state, and local governments collect about $3.48 trillion annually in taxes of all kinds—income, sales, property, corporate—that means that *more than one third (34.4%)* of the aggregate tax revenues collected in the United States go to pay for health care.

Beyond their direct payments to health care providers and health insurance companies, then, Americans already make a sizeable annual payment into the health care system via taxes. How much does a typical household contribute to the country's health care system altogether? Of course, households pay varying amounts in taxes depending on income and many other factors. Moreover, some households have no health insurance coverage; others do have coverage for which they may pay some or all of the premium cost. What I aim to do here is to estimate the average size of the health care cost burden for households at different income levels, both those with job-based health coverage and those with no coverage.

Note that the estimates in the table (right) *do not include* out-of-pocket expenses. For those with health insurance, these include copays, deductibles, and uncovered expenses (consider, for example, that even my high-end policy does not cover commonly used home medical equipment such as oxygen). For those without insurance, of course, out-of-pocket expenses include their full hospital, doctor, and pharmacy bills.

The first row ("Share and Amount of Income Going to Health Care via Taxes Alone") shows how much of the total tax burden on households at three income levels goes into the nation's health care system. In other words, a family with an annual income of $50,000 that has no health insurance nonetheless contributes nearly 10% of its income to health care merely by paying typical income, payroll, sales, excise, and other taxes. A person who earns about $25,000 a year and has no health coverage already contributes over $2,400 a year to the system—enough for a healthy young adult to purchase a year's worth of health insurance.

The next two rows add in, for individuals and for families, the cost of employer-based health insurance. So, a household at the $50,000 income level with family health insurance coverage is paying *over a quarter* of its income into the health care system.

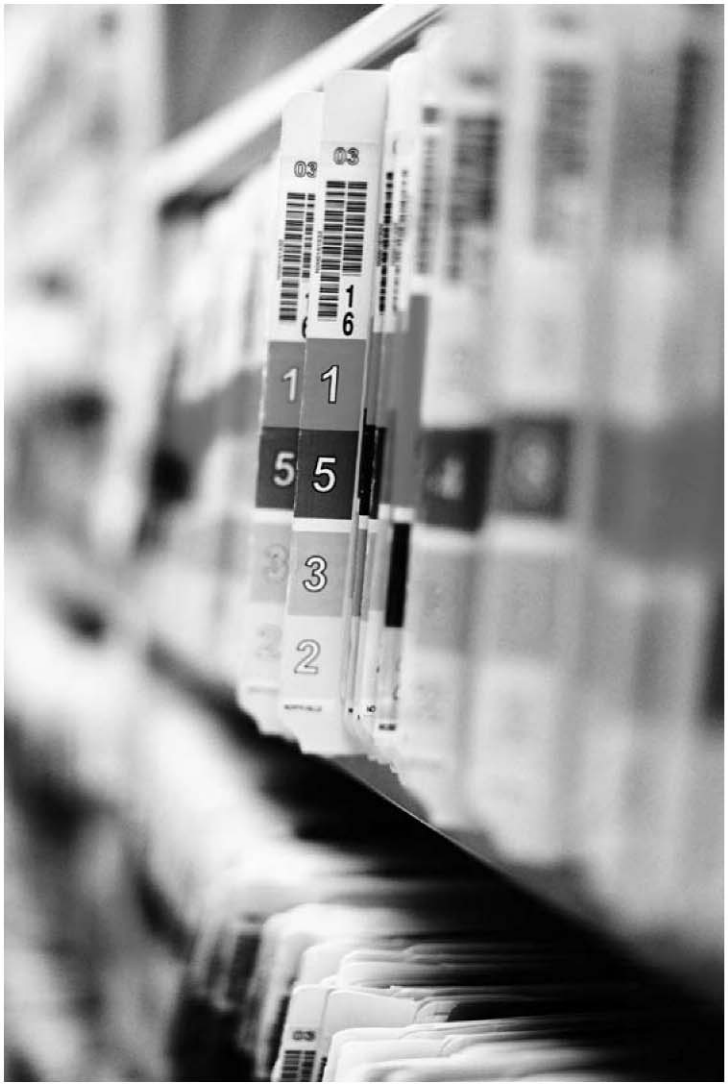
How were these figures derived? The tax component of the figures represents 34.4% of the total tax burden (federal, state, and local) on households at the three income levels. Of course, estimating average combined federal, state, and local taxes paid by households at different income levels is not a simple matter. The most comprehensive such estimates come from the Tax Foundation, a conservative think tank. Other analysts, however, including the liberal Center on Budget and Policy Priorities, view the Tax Foundation's figures as overestimating the total tax burden. The center has published its own estimates, based on figures from the Congressional Budget Office and Congress's Joint Committee on Taxation. The figures in the table are based on the CBO's numbers, which fall in between the Tax Foundation's esti-

What Americans Pay into the U.S. Health Care System Today		Household Income Level		
		$25,000	$50,000	$75,000
Share and Amount of Income Going to Health Care via Taxes Alone		9.0% ($2,425)	9.8% ($5,300)	10.7% ($8,633)
Share and Amount of Total Wage Packet Going to Health Care for Households with Insurance	Individual	22.0% ($6,904)	16.8% ($9,779)	15.4% ($13,112)
	Family	37.2% ($14,531)	26.4% ($17,406)	22.3% ($20,749)

Note: The share of total wage packet going to health care was calculated as follows:

$$\frac{\text{(amount of total tax burden going to health + annual health insurance premium)}}{\text{(annual salary + payroll tax [FICA and Medicare] + annual health insurance premium)}}$$

Further details of the calculations are available at www.dollarsandsense.org.



mates and the JCT-based estimates. (Estimates based on the Tax Foundation and JCT figures, along with details of the analysis, can be found at www.dollarsandsense.org.) It is worth noting that using the Tax Foundation's numbers, which show a larger share of income going to taxes at every income level, would have made the story even worse. For a family with health insurance earning $50,000 a year, for instance, the share of income going into health care would have been 28.7% rather than 26.4%.

For insurance premiums: in 2007, the average annual premiums for health insurance policies offered through employers were $4,479 for individuals and $12,106 for families, according to the Kaiser Family Foundation's annual survey of health benefits. Of course, some employers pay all or a large share of that premium while others pay half or less, leaving much of the premium cost to the worker. Either way, however, the full premium cost represents a bite taken out of the worker's total "wage packet"—the cost of wages plus benefits. This becomes evident when premiums go up: workers either see their own premium payments rise directly, or else face cuts or stagnation in their wages and non-health benefits. For that reason, economists typically view the entire premium as a cost imposed on the worker regardless of variations in employer contribution.

These figures are not meant to be exact, but do offer reasonable estimates of how much U.S. families are actually paying into the country's health care system today. Again, they do not include out-of-pocket expenses, which averaged 13.2% of all health care expenditures in 2005. Moreover, they do not include the risk of bankruptcy that health care costs impose: 50% of consumer bankruptcies in the United States stem from medical bills, including a surprising number among households that do have some kind of health coverage. Nor do they include the approximately 20% of auto

MORE TAXPAYER DOLLARS, LESS MEDICAL RESEARCH

The United States accounts for 51% of all global spending on medical research, according to a 2006 Global Forum for Health Research report. The report estimated that 60% of this is public funding, 8% comes from nonprofit institutions, and only 32% comes from the private sector. Even more important, most basic research—the research that undergirds most applied research and that requires long-term investment before any payoff can be expected—is heavily funded by the public.

That the United States spends the most money, however, does not necessarily mean that this country does the most research. U.S. heart surgeons charge twice as much as Canadian heart surgeons—or more—for the same coronary bypass operation, with no difference in morbidity or mortality. Likewise, U.S. taxpayers pay more for the same research. It isn't how much you pay, but how much quality research is carried out. When I lived in Canada and in Sweden, if I applied for a research grant for, say, $200,000, an additional circa 15% would be tacked on to cover administration of the grant and other so-called indirect costs. In the United States, the indirect-cost "surcharge" on a research grant to a university can range from about 50% at public universities up to 100% at private universities. Whereas in Canada and Sweden, libraries, computer centers, offices for grad students, and so on are included in university budgets, in the United States much of the funding for these basic facilities is drawn from the "overhead" line added on to grants. So, the same $200,000 research project would cost about $230,000 in Sweden or Canada, versus $300,000 to $400,000 in the United States.

DOLLARS & SENSE

PHOTO: © JUPITER IMAGES

insurance premiums or the 40% of workers' compensation premiums that pay for medical expenses.

WHERE DOES ALL THE MONEY GO?

After you've finished gasping in surprise at the share of your income that is already going into health care, you may wonder where all that money goes. One answer is that the United States has the most bureaucratic health care system in the world, including over 1,500 different companies, each offering multiple plans, each with its own marketing program and enrollment procedures, its own paperwork and policies, its CEO salaries, sales commissions, and other non-clinical costs—and, of course, if it is a for-profit company, its profits. Compared to the overhead costs of the single-payer approach, this fragmented system takes almost 25 cents more out of every health care dollar for expenses other than actually providing care.

Compared to the overhead costs of the single-payer approach, our fragmented system takes almost 25 cents more out of every health care dollar for expenses other than actually providing care.

Of the additional overhead in the current U.S. system, approximately half is borne by doctors' offices and hospitals, which are forced to maintain large billing and negotiating staffs to deal with all the plans. By contrast, under Canada's single-payer system (which is run by the provinces, not by the federal government), each medical specialty organization negotiates once a year with the nonprofit payer for each province to set fees, and doctors and hospitals need only bill that one payer.

Of course, the United States already has a universal, single-payer health care program: Medicare. Medicare, which serves the elderly and people with disabilities, operates with overhead costs equal to just 3% of total expenditures, compared to 15% to 25% overhead in private health programs. Since Medicare collects its revenue through the IRS, there is no need to collect from individuals, groups, or businesses. Some complexity remains—after all, Medicare must exist in the fragmented world that is American health care—but no matter how creative the opponents of single-payer get, there is no way they can show convincingly how the administrative costs of a single-payer system could come close to the current level.

Some opponents use current U.S. government expenditures for Medicare and Medicaid to arrive at frightening cost estimates for a universal single-payer health care system. They may use Medicare's $8,568 per person, or $34,272 for a family of four (2006). But they fail to mention that Medicare covers a very atypical, high-cost slice of the U.S. population: senior citizens, regardless of pre-existing conditions, and people with disabilities, including diagnoses such as AIDS and end-stage renal disease. Or they use Medicaid costs—forgetting to mention that half of Medicaid dollars pay for nursing homes, while the other half of Medicaid provides basic health care coverage, primarily to children in low-income households, at a cost of only about $1,500 a year per child.

GETTING WHAT WE'VE ALREADY PAID FOR

Americans spend more than anyone else in the world on health care. Each health insurer adds its bureaucracy, profits, high corporate salaries, advertising, and sales commissions to the actual cost of providing care. Not only is this money lost to health care, but it pays for a system that often makes it more difficult and complicated to receive the care we've already paid for. Shareholders are the primary clients of for-profit insurance companies, not patients.

Moreover, households' actual costs as a percentage of their incomes are far higher today than most imagine. Even families with no health insurance contribute substantially to our health care system through taxes. Recognizing the hidden costs that U.S. households pay for health care today makes it far easier to see how a universal single-payer system—with all of its obvious advantages—can cost most Americans less than the one we have today. ■

Joel A. Harrison, PhD, MPH, lives in San Diego, where he does consulting in epidemiology and research design. He has worked in the areas of preventive medicine, infectious diseases, medical outcomes research, and evidence-based clinical practice guidelines. He has lived and studied in both Canada and Sweden.

SOURCES Center on Budget and Policy Priorities, "The Debate Over Tax Levels: How Much Does a Typical Family Pay?" March 11, 1998; Center on Budget and Policy Priorities, "Tax Foundation Figures Do Not Represent Middle-Income Tax Burdens: Figures May Mislead Policymakers, Journalists, and the Public," April 13, 2006; Center on Budget and Policy Priorities, "Clearing Up Confusion on the Cost of Covering Uninsured Children Eligible for Medicaid or SCHIP," March 13, 2007; Gary Claxton et al., "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs* 26(5), 2007 [based on "Employer Health Benefits 2007 Annual Survey" by the Kaiser Family Foundation]; Congressional Research Service, "U.S. Health Care Spending: Comparison with Other OECD Countries," September 17, 2007; Andrés de Francisco and Stephen Matlin, eds., *Monitoring Financial Flows for Health Research 2006* (Global Forum for Health Research, 2006); Tax Foundation, "Who Pays America's Tax Burden, and Who Gets the Most Government Spending?" March 2007; Public Citizen Congress Watch, "Rx R&D Myths: The Case Against the Drug Industry's R&D 'Scare Card'," July 2001; Steffie Woolhandler et al., "Health Care Administration in the United States and Canada: Micromanagement, Macro Costs," *Int'l Journal of Health Services* 34(1), 2004; Steffie Woolhandler and David Himmelstein, "Paying for National Health Insurance—And Not Getting It," *Health Affairs* 21(4), July/August 2002.

ADDENDUM: A Tax Foundation report states, "In 2004 Americans paid a total of $3 trillion in total taxes." The U.S. Bureau of Economic Analysis under its National Economic Accounts section gives the following numbers for U.S. Gross Domestic Product in billions of dollars: 2004 - $11,685.9 and 2006 - $13,194.7. Using the Tax Foundation tax estimates, the estimated tax percentage of GDP for 2004 was 25.67% ($3 trillion/$11.6859 trillion). The "$3.5 trillion" is a ballpark rounding estimate for total taxes for 2006 from multiplying 0.26 by the 2006 GDP.

Tortoises 1, Hares 0:
How Comparative Health Trends between Canada and the United States Support a Long-term View of Policy and Health

By Clyde Hertzman and Arjumand Siddiqi

HEALTHCARE POLICY, 4(2) 2008: 16-24

Canadians are, on average, healthier than Americans. This is widely known, at least among students of such matters. Less widely known is that this situation was not always so. Fifty years ago, life expectancies were more or less equal on both sides of the border, as were infant mortalities. The gap shown in Figure 1 has emerged over the last half century. Why did this happen?

To answer this question, we need to start with the work of Thomas McKeown (1979). McKeown studied mortality and its putative determinants, as they gradually unfolded over decades, in 19th- and 20th-century England and Wales. This long view demonstrated conclusively that the factors that led to large declines in mortality from the major infectious diseases of antiquity were to be found outside the medical care system per se, since the force of mortality from these diseases declined in the decades prior to the advent of effective healthcare interventions.

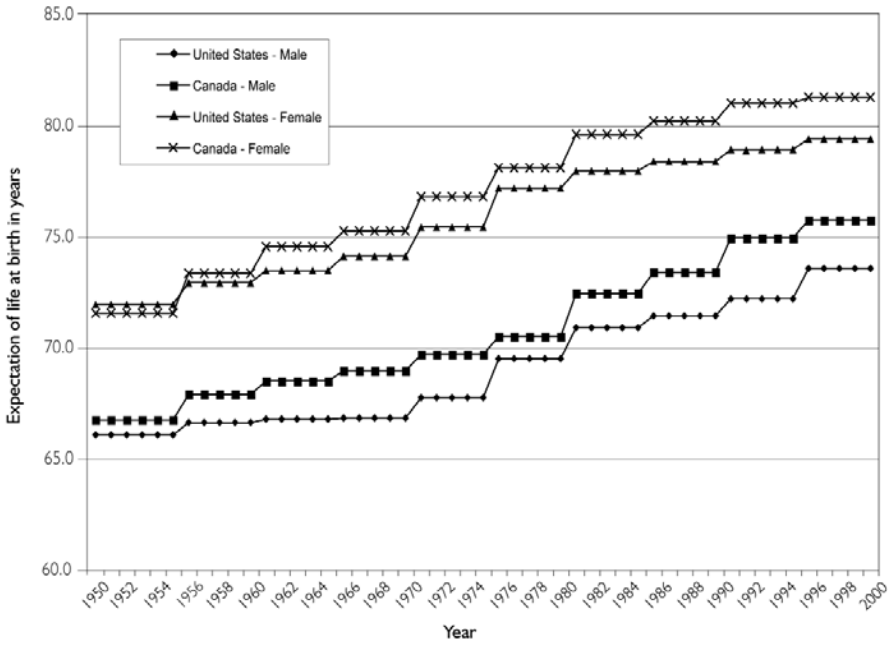
McKeown's work redirected our attention towards such factors as economic growth, rising living standards and improved nutrition. This shift has been foundational for the field of population health and a prime motivator of the search for determinants of health embedded in those aspects of society that are not specifically designed to support health or fight disease. Often neglected, however, is McKeown's view of time.

Population health has rarely returned to the type of evidence McKeown used: tracing health trends that emerge slowly over decades and trying to account for them according to gradually evolving factors deeply embedded in society. Instead, we have tended to focus on cross-sectional and short-term follow-up studies. These have been very useful in many respects. They have demonstrated that, in all wealthy countries, there is a gradual, non-threshold decline in health status from the richest to the poorest groups and from the most to the least educated groups in society. This phenomenon is known as the socio-economic gradient in health.

Short-term follow-up studies have also shown which countries in Central and Eastern Europe did, or did not, experience a profound health crisis immediately following the collapse of the Soviet system in the late 1980s and early 1990s. But short-term studies have not given us satisfactory answers to the question of why some wealthy societies are healthier than others. This is a critical question for population health and health policy alike.

The long-term Canada-United States comparison clearly demonstrates that slow-moving processes can cumulate over time to have big effects. Figure 1 compares American and Canadian life expectancy, in five-year averages, from 1950 to 2000, showing the gap gradually widening in favour of Canada until, by the end of the 20th century, it reached approximately two years. One crucial detail is that during the late 1970s, the gap narrowed considerably. But starting around 1980, it re-opened

FIGURE 1. Male and female life expectancy in Canada vs. the United States



and has not closed again. Although differences in infant mortality contributed to the gap, it is driven, primarily, by differences in adult mortality. A two-year life expectancy gap may not sound large, but during ages 25 to 64, it translates into annual mortality rates that are 30% to 50% higher in the United States.

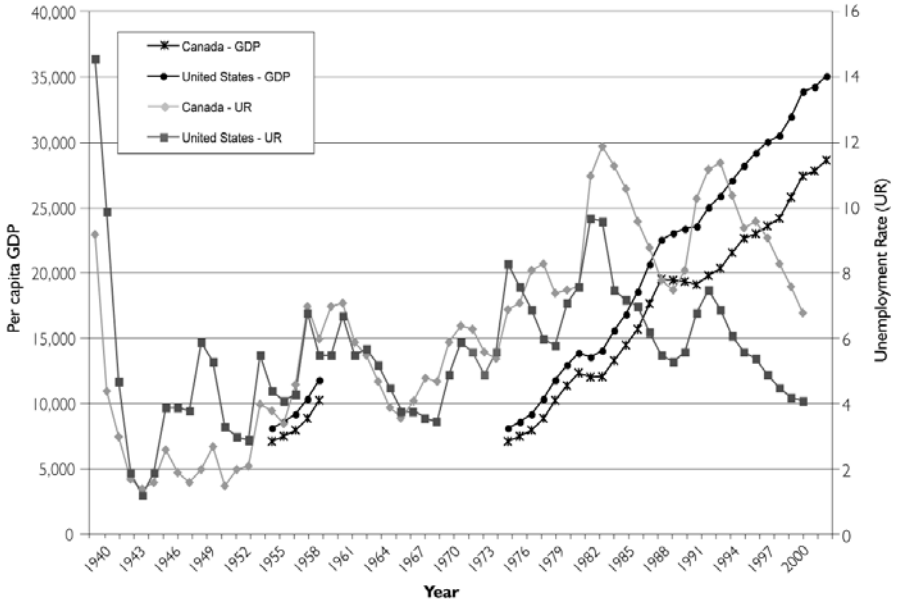
Between the early 1970s and the late 1990s, the socio-economic gradient in health status remained stable in Canada. Over the 25-year period from 1971 to 1996, each income quintile experienced roughly equal gains in life expectancy (Wilkins et al. 2002). In the United States, by contrast, the highest income quintiles gained life expectancy at a significantly faster pace than the lowest quintile (Singh and Siahpush 2002). By the end of the 20th century, the poorest 20% of Canadians enjoyed the same life expectancy as Americans of average income (Singh and Siahpush 2002; Wilkins et al. 2002). Something big happened here, albeit gradually, and it deserves recognition and explanation.

In order to understand these emerging differences, we compared Canada and the United States on a range of determinants of health for which routine data have been collected for all or most of the period between 1950 and the present (Siddiqi and Hertzman 2007). This analysis, briefly summarized here, led us to three key conclusions:

1. Greater economic well-being and spending on healthcare did not yield better health outcomes.

As in McKeown's work, our most definitive conclusions are the negative ones: identifying what did not matter. From 1975 to 1988, purchasing power parity (PPP)-adjusted gross domestic product (GDP) per capita grew in both Canada and the United States, tracking closely through business cycles (Figure 2). Throughout this period, the United States remained approximately 10% higher than Canada. From 1988 to 1993, however, there was a brief break in this

FIGURE 2. Per capita gross domestic product and unemployment rates, 1940–2002



pattern. Income essentially stagnated in Canada while continuing to grow in the United States. After 1994, parallel growth resumed, but the ground lost during the five-year period of stagnation in Canada was not made up. PPP-adjusted GDP per capita remained approximately 20% lower than in the United States.

Unemployment rates in the two countries show a similar parallelism. From the end of the Second World War until 1982, unemployment rates in Canada and the United States overlapped from business cycle to business cycle, such that no systematic trend can be detected. But from 1982 until 2000, unemployment rates were consistently 2% to 4% higher in Canada than in the United States.

During the 1960s, Canada spent approximately 0.5% of GDP more on healthcare than the United States did. Healthcare spending in the two countries then converged, however, in the 1970-1973 period, at approximately 7% of GDP. After that, spending rates diverged dramatically. From 1973 to 1993, spending on healthcare in Canada rose to 10% of GDP and stayed between 9% and 10% until 2002. In the United States, spending on healthcare rose to 13.5% by 1993, and further to 14% by 2002.

Canada's universal, single-payer medicare plans (for hospitals' and physicians' services) were fully in place by 1971, and the spending gap began to emerge at exactly that point. (The US medicare plan, established in 1965, is universal only for seniors.) Thus, the 30-year period subsequent to 1971 has been characterized by universal access to care "on equal terms and conditions" in Canada, but by much more rapidly growing spending (though unequal access) in the United States. As of the end of this follow-up period, Canada was spending 4% of GDP less than the United States on healthcare. (By 2006, the difference was over 6%.)

The conclusion is clear: the country with lower rates of economic growth, higher unemployment and less spending on healthcare far outstripped its neighbour in mortality reduction.

2. Public provision and income distribution trump economic success where population health is concerned.

In 1980, public social expenditures consumed approximately 13% of GDP in both Canada and the United States. By 1990, a large gap had opened, such that Canada was spending more than 4% of GDP more than the United States

(› 18% and ‹ 14%, respectively). These rates were largely unchanged by 1998. In the 1970s, the Gini coefficient of income inequality, post-tax and post-transfer, was approximately two points lower (i.e., the income distribution was more egalitarian) in Canada than in the United States. Canadian Gini coefficients were in the high 20s in Canada and in the low 30s in the United States. From then until the late 1990s, the Gini stayed in the same range in Canada but increased in the United States. By the late 1980s, there was a five-point gap, and by the late 1990s this had grown to approximately seven points. In other words, over this time and by this measure, the distribution of income became increasingly unequal in the United States but not in Canada. The United States has long been a more unequal society than Canada, but the difference has become much more marked since 1980.

Taxes generally take more from those with higher incomes, and transfer payments provide more support for those with lower incomes, thus mitigating the inequality of incomes received from employment alone. In the early 1980s, the net impact of the Canadian tax and transfer programs (that is, their effectiveness in income redistribution) was to reduce the Gini by approximately 24%. During the 1980s and early 1990s, the redistributive work of these programs rose to a 31% reduction in Gini, then fell to slightly under 30% by the late 1990s. In the United States the redistributive work of taxes and transfers remained between 22.5% and 24.5% from the late 1980s to the late 1990s. Thus, the relative redistributive work of the Canadian programs rose compared to the US programs from the late 1980s to the late 1990s. "Market" incomes, before payment of taxes and receipt of transfers, were becoming increasingly unequal in both countries over this period, but Canadian fiscal and other public policies significantly mitigated the impact of this trend. American policies did not.

The relative differences between the countries were particularly marked in their success at poverty reduction (Zuberi 2001). In 1974-1975, taxes and transfers reduced the poverty rate by approximately 11% in both countries. By 1994, poverty reduction had risen to 24% in Canada, but only to 13% in the United States.

In contrast to economic growth and health expenditure, these time trends of changing public expenditure and income redistribution correspond to the changes in relative health status and the relative steepness of the socio-economic gradient in Canada and the United States. The period during which Canadian life expectancy increasingly surpassed the United States was a time when Canada's levels of public spending on social programs and the redistributive impact of its fiscal system and social protection policies worked much more powerfully than those in the United States to maintain a more equitable distribution of income in the face of contrary market forces. The effects go well beyond money income: equity of access to education, as well as, of course, healthcare (not shown here) surpassed those in the United States.

3. The gradual development of public provision represents the build-up of social infrastructure that has long-lasting effects on health status.

Public provision and income redistribution do not fall from the sky, but are products of a society's evolving institutional landscape. A powerful example of potential health benefits comes from the fact that, despite periods of relatively high unemployment, Canadian health status continued to improve. Where the labour market intersects with social protection, Canada differed from the United States during this period. In particular, Canada scored higher on indexes of unemployment protection, labour relations and corporate governance (Estevez-Abe et al. 2001).

Unemployment protection represents the extent to which wages and benefits accrue to individuals, even in times of unemployment. The higher the unemployment protection score, the greater the wages and benefits afforded to unemployed workers. This index depends upon a set of social policies that are designed to stabilize the labour market and reduce risk (as does the scale on labour relations). Unemployment protection, in particular, is mandated through policies that transfer financial risk to corporations, governments and insurance companies. Such policies are meant to help maintain and sustain the middle class by reducing the burden of risk on individuals in the labour market who are less able to bear it. As Zuberi (2006) has shown, Canadian unemployment protection policies have also benefited highly vulnerable members of the labour force, such as immigrant workers, in ways that US policies have not.

Corporate governance refers to the extent to which the state has a role in determining and enforcing the rights and responsibilities of corporations. Higher scores on this index suggest greater government input. Compared with the United States, Canada features lower incomes for chief executive officers and other upper management and higher tax rates (and fewer loopholes) for large corporations. These features of the institutional landscape are reasonable places to look for an explanation of the observation that Canadians have experienced health gains even during periods of high unemployment.

Although this is only one example, there is reason to believe that comparisons of public policies in a number of other areas with implications for health - such as immigrant-welcoming policies, access to education, regional equalization and the organization of urban space, to name a few - show a similar advantage for Canada.

Understanding the origin and development of institutions with health-supporting or health-threatening capacity poses a timescale challenge of its own. How far back in time should we go? Would telling a full, complete

story of institutional evolution and public provision in the United States have to start at least as far back as the Depression-era New Deal? Would it have to take account of the post-war GI bills and the Great Society programs prior to the Reagan-era rollbacks, when American health status started its current relative decline? In Canada, the history might stem from a more muted response to the Great Depression; but a gradual phasing in of national hospital and unemployment insurance, old age pensions, physician coverage, federal-provincial social assistance transfers, increasing secondary and tertiary education subsidies, increasingly progressive labour legislation after the Second World War, and the gradual embrace of a series of policies and programs that have turned Canada into the world's most multicultural society. From the standpoint of health, these represent a relatively successful evolutionary trajectory in Canada and a relatively unsuccessful one in the United States. Relative mortality measures provide a hard-edged way of keeping score.

CONCLUSIONS

The comparative perspective and long-term view employed here have allowed us to detect the gradual divergence in health status between two societies whose fate is closely interconnected and to specify which features of institutions and policies may have the greatest returns to population health. The lesson is of public provision and redistribution trumping traditional economic growth and direct health spending in producing population health. Even when a long view is taken on wealth, spending on healthcare and actual health, associations are non-existent. Canadian health status increasingly surpassed that of the United States in a period in which US economic growth moved increasingly ahead of Canadian growth and US unemployment rates - for the first time since the Second World War - were consistently lower. Moreover, spending on healthcare in the United States increasingly surpassed that in Canada (and everywhere else in the world) during a time in which Canada had a national medicare scheme and the United States did not.

The approach we have taken focuses naturally on the introduction and evolution of institutional differences. In the context of thinking about population health, the historical, dynamic approach casts a clearer light on what has been going on than does the cross-sectional approach. The latter has been dominant in the literature so far, and has led to a number of ambiguities and unresolved controversies, such as, for example, the ongoing debate over absolute versus relative incomes.

Early cross-national research showed a consistent association between income inequality and health status (Wilkinson 1990, 1992). Soon, however, the results of these studies were contested, with charges of poor-quality data and lack of control for potential confounders such as transfer payments and social spending (Judge 1995). The characterization of transfers and social spending as "confounders" illustrates a core problem with an approach that reduces broad, long-term questions of society and health to isolated, current-time variables like income inequality. Instead, the perspective taken here would construe transfer payments and social spending as part of a gradually unfolding institutional landscape. Through a variety of mechanisms, this changing landscape, in turn, has the capacity to transform inequality, health and the relationship between the two.

The Canada-United States case study demonstrates what Roy Amara, former head of the Institute for the Future in California, once formulated as Amara's Law: people typically overestimate the short-run impact of innovations and underestimate their long-run impacts. Institutional and policy changes might take place with the stroke of a pen, but their impacts may unfold gradually over decades to influence population health. Moreover, a series of decisions taken over time may gradually unfold as an institutional/policy regime that would be unrecognizable from those of the past. At the same time, population health trends can change slowly over years and decades, resulting in large differences between societies that no one would have watched for or anticipated. Trends in human health, especially when based upon unambiguous endpoints like mortality, are brutally objective as measures of long-term societal success or failure. Those interested in health policy should be closely watching these big, slow-moving trends.

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PNHP Chapter Reports – Spring 2009

In **Arizona,** PNHP members have been building the single-payer Arizona Coalition for State and National Health Plans. Dr. George Pauk, state Sen. Phil Lopes and other PNHPers helped to defeat a ballot initiative that would have prohibited a single-payer system. Dr. James Dalen's op-ed on the need to de-link insurance from employment appeared in the Arizona Republic. PNHP President Dr. Oliver Fein spoke to the Arizona chapter of the ACP in Tucson. Contact Dr. Pauk in Phoenix at gpauk@earthlink.net and Dr. Eve Shapiro in Tucson at shapiroe@u.arizona.edu.

PNHP's **California** chapter, the California Physicians' Alliance (CaPA), is active in speaking, medical student outreach, lobbying, and grassroots coalition-building at both the state and national levels. S.B. 810, "The California Universal Healthcare Act" (formerly S.B. 840) has a new lead sponsor in the 2009 legislative session, Sen. Mark Leno. CaPA Medical Student Fellow Parker Duncan and Dr. Richard Quint helped organize a successful lobby day in Sacramento with over 450 health professional students. Dr. Hank Abrons and new CaPA Chair Dr. Jim Kahn are active in lobbying and building alliances with other groups in support of H.R. 676. Contact Roberto Ramos at capa13@sbcglobal.net.

In **Colorado,** PNHPer Dr. Rocky White was recently profiled in YES magazine as a former Republican from a conservative, evangelical background who got involved in health reform a decade ago as a result of his medical practice's financial difficulties. Last summer, Dr. White ran a successful campaign to get the Colorado Democratic Party to endorse single-payer and H.R. 676. While their state bill was bogged down in the Legislature, the chapter, Health Care for All Colorado, took the issue directly to the county assemblies of the Democratic Party, gathering resolutions of support. At their convention in May, party delegates voted unanimously in favor of including single-payer and H.R. 676 in their platform. Contact Dr. White at whtfarms@fone.net.

PNHPers in the **District of Columbia** are active in coalition-building, speaking, lobbying and media outreach. Staffer Danielle Alexander and Dr. Robert Zarr collaborated with others in helping establish a new national single-payer coalition on Nov. 10-11, co-convened by PNHP, the California Nurses Assn./NNOC, Healthcare-Now and Progressive Democrats of America. They have also been facilitating visits to congresspersons by PNHP delegations. Drs. Zarr and David Rabin spoke about Taiwan's single-payer system and single-payer at a hearing convened by Rep. Sheila Jackson Lee (D-Texas), and student member Eric Pan spoke about single payer at a University of Maryland pre-med student society meeting. Contact Dr. Zarr at rlzarr@yahoo.com.

PNHPers in **Florida** have established a new chapter in Tallahassee. The chapter hosted PNHP co-founder Dr. Steffie Woolhandler in April for a series of debates with Dr. Jeremy Lazarus of the AMA at the medical school and medical society. In the spring, Byron Tucker presented to medical students on single-payer and in Palm Beach, the late Dr. David Prensky played a leading role in the successful effort to have the U.S. Conference of Mayors endorse H.R. 676. The chapter is working closely with the local League of Women Voters. Contact Dr. Ray Bellamy at ray.bellamy@med.fsu.edu.

In **Georgia**, PNHP members are working on outreach and speaking engagements. Longtime PNHP leader Dr. Henry Kahn has maintained an active speaking schedule, most recently addressed the Georgia chapter of Amnesty International on H.R. 676 after members of that group heard him speaking at a forum. The chapter hosted Dr. Oliver Fein in November for grand rounds and meetings with medical students, activists and the Atlanta Journal-Constitution editorial board. To get involved with the chapter, contact Dr. Kahn at hkahn@emory.edu.

Hawaii PNHP leader Dr. Leslie Gise organized a very successful symposium at the annual meeting of the American Psychiatric Association entitled "Health Care Financing Reform: The Good, the Bad and the Necessary." Dr. Gise also continues to be a frequent speaker at grand rounds and other medical events, as well as an advocate to policy makers. Contact Dr. Gise at leslieg@maui.net.

The **Illinois** PNHP chapter, Health Care for All Illinois, has been engaged in state and federal legislative activity around H.R. 676 and state single-payer bill H.B. 311. The chapter organized a series of six citizen legislative hearings convened by H.B. 311 sponsor Rep. Mary Flowers, chair of the House Health Committee, which drew large crowds and much press attention. An official hearing and lobby day is set for March 24. Dr. Anne Scheetz has been an active speaker to church and community groups. Dr. Pam Gronemeyer has been bringing the single-payer message to the Metro-East St. Louis Area, speaking to community groups and at local Democratic Party events. Dr. Quentin Young continues to speak at grand rounds and events across the state. The chapter next plans congressional visits to keep Illinois congresspeople solidly in favor of single payer. Contact the chapter at info@pnhp.org.

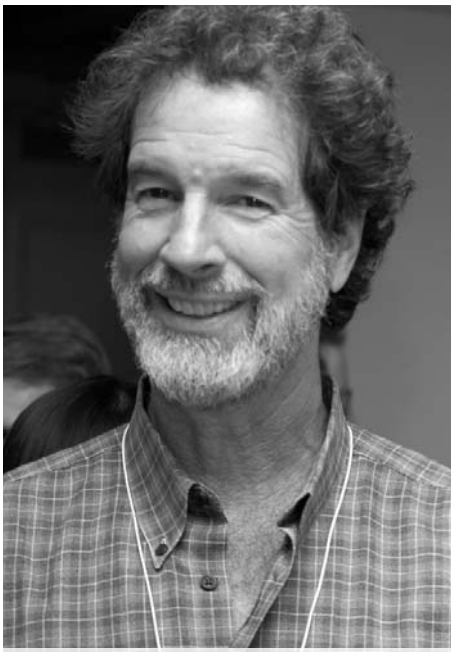
In **Indiana**, Hoosiers for a Commonsense Health Plan leader Dr. Rob Stone has been

Drs. Quentin Young and Claudia Fegan of Illinois

working with the League of Women Voters to arrange speaking engagements and other publicity for single-payer. Relatively new chapters of HCHP in Fort Wayne and New Albany have gotten stronger, supplementing more established chapters in Bloomington and Indianapolis. Dr. Stone spoke to the New Albany City Council before they passed a resolution in support of H.R. 676. Both Dr. Stone and Dr. Jonathan Walker have had op-eds published in the Fort Wayne Journal Gazette. Many HCHP members participated in Obama-Daschle community discussions on health care across the state. Dr. Aaron Carroll's study – which found 59 percent of physician support national health insurance – received extensive news coverage, including from CNN, when it was released in the spring. Contact Dr. Stone at grostone@gmail.com or www.hchp.info.

Iowa PNHP leader Dr. Miles Weinberger led a talk and discussion on single payer for the University of Iowa AMSA group. Dr. Jess Fiedorowicz gave a talk at a medical-psychiatry nursing conference, dedicating a portion of the talk to single-payer. Dr. David Drake spoke to the Des Moines University AMSA chapter. Contact Dr. Weinberger at miles-weinberger@uiowa.edu.

Members of PNHP's **Kansas** chapter, Heartland Health Care for All, have been active in physician, medical student and community speaking and outreach. The chapter hosted Rep. John Conyers for a town hall meeting in October. Drs. Jon Jacobs and Josh Freeman presented grand rounds to the Dept. of Medicine at St. Luke's Hospital in September. Dr. Freeman also presented on primary care and single payer at Lawrence Memorial Hospital. Dr. Jacobs presented grand rounds at KU-Witchita, UMKC Medical School, and St. Louis University. Tim Lyon of the student chapter at KU Medical School spoke at a "First Friday" talk to 40 attendees. Dr. Freeman also made a presentation on single payer at the annual meeting of the Missouri Association for Social Welfare. Contact Dr. Freeman at jfreeman@kumc.edu or Dr. Jacobs at jonjacobs@pol.net.



Dr. Rob Stone of Indiana

Drs. Kevin Grumbach and Floyd Huen of California

The **Kentucky** PNHP chapter recently hosted a meeting featuring Rev. David Bos of the Presbyterian Church, whose efforts led to the denomination's endorsement of single payer and the appropriation of $25,000 to conduct nationwide single-payer education. Chapter leader Dr. Garrett Adams has kept an active speaking schedule, recently being invited by the neighboring Tennessee chapter to address a rally in Nashville on the eve of the Oct. 6 presidential debate. Contact Dr. Adams at kyhealthcare@aol.com.

In Maryland, PNHPers have been coalition-building with groups like the NAACP, AFSCME, Progressive Democrats of America, the Greens and others. Dr. Margaret Flowers and Brigitte Marti have been speaking regularly at local venues, including churches and chapters of the League of Women Voters. They have also been actively engaged in assisting lobbying efforts in Washington for H.R. 676. Contact Dr. Margaret Flowers at conversationcoalition@gmail.com.

Massachusetts PNHPers have been active on the legislative advocacy, student organizing, and physician speaking fronts. The chapter is leading the way in publicizing the inadequacies of the Massachusetts health reform. Their letter to Senator Ted Kennedy identifying the deficiencies of that plan and encouraging him to craft a national single-payer solution has been signed by more than 500 doctors. The chapter sponsored a leadership training event on Feb. 7 that drew 100 participants. Chapter members also gave seven grand rounds at area hospitals and have helped organize student events with AMSA chapters at the Boston medical schools. Contact Dr. Rachel Nardin at rnardin@bidmc.harvard.edu.

Michigan PNHPers have maintained an active speaking schedule focused on outreach to the physician community. Dr. Jim Mitchiner lectured on single-payer at Botsford Hospital, Kalamazoo Center for Medical Studies, University of Michigan–St. Joseph Mercy Hospital and Western Michigan University. Dr. Mitchiner also spoke on single payer to the American College of Emergency Physicians Council Meeting and at the Bronson Hospital Medical Ethics Conference. He joined with Dr. Andy Zweifler to write a joint letter to John Dingell in support of H.R. 676 and plan a community health meeting in Ann Arbor. Contact Dr. Mitchiner at jmitch@med.umich.edu or Dr. Zweifler at zweifler@umich.edu.

The **Minnesota** PNHP chapter has been very active in lobbying state and national legislators (on a state single-payer bill and H.R. 676), writing op-eds, and enlisting physician support for single payer. The chapter ran a full-page, sin-

Dr. Andy Coates from upstate New York

gle-payer ad on the back cover of Minnesota Physician, and Dr. Ann Settgast, a leader of the chapter, was invited to contribute articles to that magazine and the local ACP publication. The ad included the signatures of 200 doctors from the state on a petition in support of H.R. 676. The chapter also held a speakers' training workshop last year modeled on the PNHP national meeting. PNHP members have also spoken to at least three local meetings of the Minnesota Democratic-Farmer-Labor Party and written numerous op-eds and letters to the editor. Contact Dr. Settgast at settg001@umn.edu or Dr. Elizabeth Frost at libbess@gmail.com.

In **New Hampshire,** PNHP members organized a book party for "10 Excellent Reasons for National Health Care." They helped lead at least two Obama-Daschle health care community discussions, one in Rumney and the other in Portsmouth, both of which were well-attended. Both meetings endorsed single payer. Members are seeking resolutions of support for H.R. 676 in both the state House and Senate. Contact Dr. Marcosa Santiago at cosy@diacad.com.

PNHP's **New Mexico** chapter, now renamed the Network of Professionals for a National Health Program, has been revitalized in the wake of hosting Dr. Oliver Fein in September for a chapter meeting, grand rounds, and a meeting with Senator (then candidate) Tom Udall. Contact Dr. Bruce Trigg at bruce.trigg@state.nm.us.

New York Metro PNHPers have continued to expand their speaking, student outreach, and public event activities. Dr. Oliver Fein debated single-payer skeptics at NYU and New York Medical College. Dr. Mary O'Brien spoke at Cornell University. The chapter hosted a successful student leadership training session attended by 43 medical student activists from throughout the state. Len Rodberg, Ph.D. has continued to provide policy support. About 200 people attended a party and celebration with Rep. John Conyers around the release of "10 Excellent Reasons for National Health Care" edited by Mary O'Brien and Martha Livingston. Contact the chapter through their website at www.pnhpnymetro.org.

Members of the **Albany / Upstate New York** PNHP chapter have been marching, lobbying, taking to the airwaves, writing opinion pieces, and coalition building. As a result of cumulative lobbying efforts, the New York State Assembly voted to endorse H.R. 676 this summer. Dr. Andy Coates is lending support to two newly-forming upstate PNHP groups: one in Ithaca and one in Cooperstown. The various groups are now coordinating their actions on a statewide level: the Single Payer New York coalition was founded in Albany on Sept. 13, drawing about 150 people. It has already mapped out plans to visit every congressperson in the state, and has met with other state officials, as well. Dr. Paul Sorum now has a regular radio hour in which he advocates for single payer. Contact Dr. Coates at esquincle@verizon.net.

In **Ohio**, Dr. Richard Wyderski (Dayton) spoke to the national convention of the Southern Christian Leadership Conference and to the NAACP's national health council about H.R. 676 and single-payer, after which he was made a member of the group's health committee. Dr. Johnathon Ross had an op-ed on single payer published in the Toledo Blade in December; he also spoke before the Mansfield Ohio United Labor Council, gave a psychiatry grand rounds at Henry Ford Hospital in Detroit, and presented the PNHP slide show at Wright State University Medical School at the invitation of the AMSA chapter. PNHP members have been active with others, including the Single Payer Action Network, in pressing a state single-payer bill. PNHPers were also active in numerous Obama-Daschle house meetings around the state. Contact Dr. Johnathon Ross at drjohnross@ameritech.net.

Oregon PNHPers have revived their state chapter and are organizing with renewed enthusiasm. The chapter hosted PNHP Senior Health Policy Fellow Dr. Don McCanne, who gave grand rounds at hospitals in Portland and Corvallis and appeared on two Oregon radio programs. Those interested in participating in chapter activities can contact Dr. Mike Huntington (Corvallis) at mchuntington@comcast.net or Dr. Paul Gorman (Portland) at gormanp@comcast.net.

Pennsylvania PNHPers joined with student members of the American Medical Student Association (AMSA) last year for a rally in support of single payer. About 60 attendees participated in the event, which was followed by a lobby day in the state capitol. Dr. Scott Tyson and other leaders continue their legislative advocacy on behalf of their state single-payer bill. In Eastern PA, contact Dr. Tsou at macman2@aol.com; in Western PA, contact Dr. Tyson at styson@pediatricssouth.com.

Kay and Walter Tillow of All Unions Committee for Single Payer Health Care–HR 676

The **Tennessee** PNHP chapter, which has experienced important membership growth, has been working with the Tennessee Health Care Campaign to promote H.R. 676. Together they have hosted 26 house parties with 435 participants viewing the Frontline documentary, "Sick Around the World." They also helped organize an Oct. 6 rally for health care that included a talk by Dr. Garrett Adams of Kentucky. Contact Dr. Arthur J. Sutherland at asutherland@sutherlandclinic.com.

PNHP members in **Virginia** are starting a new state chapter under the leadership of Drs. Jan Gable, Susan Miller and others. PNHPers participated in an Obama-Daschle community discussion at the Richmond Medical Society, where, Dr. Miller reports, the crowd of 70 clearly leaned toward a Medicare-for-All approach. Contact Dr. Gable at jangable@email.com.

PNHP's **Western Washington** chapter succeded in urging the Seattle City Council to pass a resolution endorsing single payer. It has also has been using a series of town-hall meetings on health organized by the state legislature as a platform for spreading the single-payer message, and is challenging a Mathematica report that misrepresents the costs of a single-payer program in the state. Drs. David McLanahan, Donald Mitchell, and others hosted a speaker's training session in September to help newer members become activists. Contact Dr. McLanahan at pnhp.westernwashington@comcast.net.

Members in **Spokane, Washington**, have formed the Inland Northwest chapter, co-chaired by Drs. Jeremy Graham and Chris Anderson. In addition to a plenary formation meeting, the chapter held a community discussion on health reform in December. The chapter plans to promote single payer to medical students, residents and clinicians as well as local business groups. Contact Dr. Graham at jeremydgraham@gmail.com.

Health Crisis by the Numbers

COSTS

- Health spending in 2009 is estimated at $2.5 trillion dollars, $8,160 per capita or 17.6 percent of GDP (Centers for Medicare and Medicaid Services, Health Affairs, 2/24/09).
- Health insurance premiums have tripled in the past decade, to $4,704 for employer-sponsored single coverage and $12,680 for family coverage in 2008. Employees paid an average of $3,354 of the premiums out-of-pocket for family coverage (Claxton et al, Health Affairs, 9/24/08)

UNINSURED AND UNDERINSURED

- 45.7 million Americans were uninsured in 2007 (the most recent year for which data is available), including 8.1 million children (Census Bureau).
- The proportion of the population covered by employer-sponsored coverage dropped to 59.3 percent in 2007, down from 69.0 percent in 2000 (Census Bureau)
- An estimated 25 million non-elderly adults (14 percent) were underinsured in 2007, a 60 percent increase since 2003. More than one in four adults (49.5 million) were uninsured during all or part of 2007. Adding uninsured and underinsured adults together, an estimated 75 million adults – 42 percent of the under-sixty-five adult population – had either no or inadequate health insurance in 2007, up from 35 percent in 2003 (Schoen et al, Health Affairs, June 2008).
- The Institute of Medicine estimated that 18,000 Americans died in 2000 due to lack of health insurance.

CORPORATE HEALTH CARE

- The CEO's of five large health insurance firms received a combined $73.3 million in compensation in 2007. Cigna CEO Edward Hanway received the highest pay, $25.8 million, followed by Coventry Health Care CEO Dale Wolf ($14.8 million), UnitedHealth Group CEO Stephen Hemsley ($13.2 million), Humana CEO Michael McCallister ($10.3 million) and Wellpoint CEO Angela Brady ($9.1 million) (AFL-CIO Executive Pay Watch Database of SEC filings).

Nancy Ann DeParle, newly appointed director of the White House Office of Health Reform, has strong ties to corporate health care. She has served as an investment advisor for JP Morgan and received over $978,000 in total compensation in 2006-2007 for sitting on the boards of Boston Scientific, a medical device maker, Cerner, a medical computing firm, and DaVita, one of the nation's largest for-profit dialysis firms, which have higher mortality rates than non-profit dialysis centers. She also sat on the Board of Triad, a for-profit hospital firm, and reaped more than $1 million when Triad was sold. Cerner stands to gain huge profits from the stimulus bill's investment in electronic medical records. DaVita is the fifth largest contributor to Sen. Max Baucus, chair of the Senate Finance Committee; the firm donated $48,350 between 2003 and 2008 (Open Secrets.org/politicians database). She has also served on the boards of Medco, the large drug management firm that is integral managed care, Medquest, a firm that owns a string of outpatient imaging centers, Legacy, a for-profit hospital firm, and Accredo, a biotech firm.

- Private Medicare Advantage plans cost the government 13 percent more per beneficiary on average in 2008 than the traditional Medicare program (Medicare Payment Advisory Commission). Overhead in the private plans is also much higher, at 13 percent, compared to 2-3 percent in traditional Medicare.

PUBLIC OPINION

- Support for government-sponsored national health insurance has grown over the past thirty years. 59 percent of Americans say the "government in Washington [should] provide national health insurance," including 49 percent who say it should cover all medical problems, according to a new CBS/New York Times poll. Less than one-third of Americans (32 percent) say health care should be left to "private enterprise." In 1979, 40 percent of Americans favored national health insurance and 48 percent favored "private enterprise" (CBS/NYT poll, January 2009).

Dr. Oliver Fein: 'Build the grassroots movement for single payer'

PNHP's new president, Dr. Oliver Fein, can be hard to keep up with.

In recent months he's participated in PNHP activities in Philadelphia, Atlanta, Albuquerque, and Washington, D.C., not to mention New York City, where he chairs the N.Y. Metro chapter. And now he's getting ready for a spring tour that includes the AMSA convention in Virginia and PNHP events in Washington state, Ohio, Indiana and Minnesota.

Dr. Fein, known as "Oli" to his fellow PNHP board members and friends, appears to relish getting out into the field where our members are.

"I especially enjoy giving talks at the local level," he said. "It's very rewarding – both fun and energizing. As PNHP members, we need to reach out to get our message across not only to the physician community, but to the larger community as a whole."

"One way to get our message out is through the media," he said. "But another is through that very basic process of talking to community groups, churches, seniors' organizations and unions about single payer."

Dr. Fein said one of his key goals as president is to multiply such outreach opportunities by building more PNHP chapters.

"I would like to see PNHP grow at the grass roots, to have more locally based advocacy groups," Dr. Fein said. "For example, we should have a presence among faculty and students at every medical school campus across the country. Single payer should be part of the curriculum. And it's really important to build chapters among community physicians, too."

"A stronger organization will help PNHP meet today's political challenges," he said. These include "keeping the single-payer message alive and challenging President Obama's flawed health care reform proposals, without being perceived as undermining the president's positive proposals such as maintaining and strengthening SCHIP or ending the unfair subsidy to private insurers under the Medicare Advantage program."

"Another challenge is replying to those who say, 'Don't let the perfect be the enemy of the good,'" suggesting that single-payer advocates are ideological purists who should be prepared to settle for something less."

On this latter point, he said, "Our advocacy of single payer is based on the evidence. It's not ideologically driven. If piecemeal, so-called incremental reforms worked, we'd support them. But they've repeatedly failed. The single-payer financing model, on the other hand, has proven its effectiveness."

Dr. Fein brings years of experience to his new role. He's a general internist and a professor of clinical medicine and clinical public health at Weill Medical College of Cornell University, where he also serves as associate dean responsible for the Office of Affiliations and the Office of Global Health Education.

He obtained his M.D. from Western Reserve University and spent 17 years at the Columbia Presbyterian Medical Center developing community-based ambulatory care practices and its Division of General Internal Medicine. He was a Robert Wood Johnson Health Policy Fellow, serving in the office of Senate Majority Leader George Mitchell. He is also the immediate past vice president of the American Public Health Association.

He also finds time to write, contributing, for example, to a chapter on the feasibility of fundamental health reform in the new book "10 Excellent Reasons for National Health Care."

How does he manage to do it all?

"I've had a very supportive family and a great group of colleagues. They have helped me make advocacy of single payer a priority," Dr. Fein said. "That's meant working many evenings and weekends on this goal, since I still have my patient care, administrative and teaching responsibilities."

From the tone of his voice, however, it's clear he wouldn't have it any other way.

Kudos to Past President Dr. Ana Malinow

"The more I listen, the more I hear that all Americans want a health care system that is affordable, accountable, accessible, comprehensive, universal and just — not another Band-Aid that will condemn thousands of us to unnecessary pain, suffering, bankruptcy and death," writes Dr. Ana Malinow in a Feb. 28 op-ed in the Houston Chronicle. "Listen for yourself, and you will hear Americans clamoring for true health care reform."

Dr. Malinow, a pediatrician and an assistant professor of pediatrics at Baylor College of Medicine, has contributed more than her share to that growing clamor for genuine reform. In the course of her tenure as president of PNHP, she provided strong leadership to our organization even as she stepped up her own public speaking, media interviews and writing in support of single payer. She also found time to lead Health Care for All Texas, which she co-founded.

Thank you, Dr. Malinow, for your terrific work!