PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter

Winter 2011

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM » 29 E. MADISON, SUITE 602, CHICAGO, IL 60602 » WWW.PNHP.ORG » WINTER 2011 NEWSLETTER

Single-payer governor elected in Vermont; In Congress, H.R. 676 sponsors retained

Vermont's single-payer movement took a giant step forward on Nov. 2 with the election of the pro-single-payer candidate for governor, Peter Shumlin. The state Legislature has already hired William Hsiao, architect of Taiwan's single-payer system, to design three options for health reform, including a single-payer plan. PNHP's Dr. Deb Richter is mobilizing physician, grassroots and business support to make Vermont the first state to pass single payer. Funds are needed to hire organizers and to "immunize" Vermonters against an inevitable tide of propaganda from the insurance industry.

California and Hawaii also elected gubernatorial candidates who have supported single payer in the past – Jerry Brown and Neil Abercrombie.

In congressional races, the co-sponsors of H.R. 676, the single-payer legislation in the House, were generally re-elected by large margins. Seventy-nine of the 81 co-sponsors of H.R. 676 who ran for re-election were returned to office. Rep. John Conyers Jr. has announced he will reintroduce H.R. 676 in the next session. For more election news, see page 9.

Dr. Deb Richter

Massachusetts: Physicians favor single payer; Single-payer ballot initiatives pass in 14 districts

A survey of 1,000 physicians by the Massachusetts Medical Society prior to the passage of national health reform found that single payer was their top-ranked option, favored by 34 percent. Only 14 percent favored modeling national health reform on the Massachusetts health law of 2006, the template for President Obama's plan. (See page 38 for details.) Massachusetts voters expressed their overwhelming preference for single payer on Nov. 2 by passing pro-single-payer ballot initiatives in 14 of 14 districts, including some of the most conservative districts in the state.

PNHP sounds alarm on Deficit Commission, hosts congressional briefing Sept. 23

Improved Medicare for All is the best remedy for the budget deficit, according to PNHP leaders. PNHP hosted a congressional briefing on Sept. 23 to oppose cuts to Medicare and Social Security proposed by the president's Deficit Commission. PNHP Board Member Dr. Olveen Carrasquillo and PNHP Congressional Fellow Dr. Margaret Flowers participated in the briefing, along with Princeton economist Tsung-Mei Cheng, Ph.D., and Michele Evermore of National Nurses United. For details, see page 18.

$56.5 million for 6 insurance CEOs while uninsured figure skyrockets to 50.7 million

CEOs at six of the nation's largest health insurers averaged $9.4 million in pay in 2009. Top earners included Aetna's Ronald Williams, who took home $15.3 million, including salary, incentives, and stock options; WellPoint's Angela Braly ($12.8 million); UnitedHealth Group's Stephen Hemsley ($9.5 million, on top of $99 million in stock option gains the previous year); Humana's Michael B. McCallister ($6.2 million), Cigna's David Cordani ($5.6 million) and Centene's Michael Neidorff ($7.1 million) (Wall Street Journal CEO Compensation Study, 11/16/10).

The number of Americans without health insurance climbed to 50.7 million in 2009. The U.S. will spend $8,289 per capita on health care this year. For more data see "Health Crisis by the Numbers" starting on page 3.

Annual Meeting 2010 'spectacular'

PNHP's 2010 Annual Meeting in Denver was a "spectacular" success with over 250 participants, including 100 physicians and medical students who came a day early to participate in Leadership Training. Democracy Now host Amy Goodman's inspiring address is now available online at http://www.pnhp.org/goodman. PNHP's 2011 Annual Meeting will be held on October 28 in Washington, D.C.

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PNHP membership drive update

Welcome to 437 new members who have joined PNHP in the past year! PNHP now has over 18,000 members. We invite new (and longtime) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community.

PNHPers in Maine, Tennessee, Oregon, Alabama, New Hampshire, North Carolina, Wisconsin and New Jersey are starting or reinvigorating PNHP chapters in their areas. To get involved in a PNHP chapter near you, see the chapter reports, page 52, or contact our national organizer Ali Thebert at ali@pnhp.org.

PNHP hosted exhibits at several medical specialty meetings this year, including the American College of Physicians, American College of Emergency Physicians, American Academy of Family Practice, and American Academy of Pediatrics. Special thanks to PNHPer and child psychiatrist Dr. Audrey Newell of Ann Arbor, Mich., who has hosted PNHP's exhibit at the American Psychiatric Association for over a decade.

What PNHP members can do

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

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

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

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

5. Encourage your colleagues to join PNHP.

It's easy to add PNHP to your will

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

Health Crisis by the Numbers

UNINSURED AND UNDERINSURED

▶ A record 50.7 million Americans (16.7 percent), including 7.5 million children, were uninsured in 2009, up from 46.3 million (15.4 percent) in 2008. The huge increase in Americans lacking health coverage was almost entirely due to a sharp decline in the number of people with employer-based coverage, down 6.6 million since 2008. Since 2000, employer-based coverage has plummeted from 64.2 percent of the population to 55.8 percent. The increase in uninsured would have been much higher had there not been a huge expansion of public coverage, primarily Medicaid, to an additional 5.8 million people last year. Medicaid now covers more than 48 million people, a record 15.7 percent of the population (U.S. Census Bureau, 9/16/10; Kaiser Daily Health Policy News, 9/10).

Over 14.1 million children – 22.7 percent of children with continuous insurance coverage – were underinsured in 2007. Estimates were based on data in the 2007 National Survey of Children's Health. Underinsurance was defined by parents' or guardians' judgments of whether their children's insurance covered needed services and providers, and reasonably covered costs. Inadequate coverage of charges was the most common source of underinsurance among children. Children enrolled in private plans were more than three times as likely to have inadequate coverage of charges as children in public plans. Compared with fully insured children, underinsured children had significantly greater odds of having difficulty obtaining referrals and care coordination (2.61:1), obtaining needed specialty care (2.07:1), and of having delayed or forgone care in the past year (3.51:1) (Kogan, NEJM, 8/26/10).

▶ Uninsured non-elderly patients hospitalized for heart attack, stroke, or pneumonia are more likely to die than those with private insurance, according to an analysis of discharge data on over 150,000 adults. Uninsured patients with heart attacks were 52 percent more likely to die in the hospital than the privately insured, while those who had a stroke were 49 percent more likely to die in the hospital. Among inpatients with pneumonia, having Medicaid coverage increased the chance of death 21 percent compared to private coverage. Excluding patients who died in the hospital, Medicaid patients also had longer lengths of stay and higher costs (Hasan O, Orav EJ, Hicks LS, Insurance status and hospital care for myocardial infarction, stroke, and pneumonia, Journal of Hospital Medicine, 6/10).

▶ Migraine sufferers who lack private health insurance are about twice as likely to get inadequate treatment for their headaches as their privately insured counterparts. People with Medicaid also get substandard care. Because migraine is common in the United States, affecting about 18 percent of women and 6 percent of men, and because so many Americans lack health insurance, a startling 5.5 million people are at risk of getting substandard care for their often painful and disabling headaches, according to a study by Massachusetts PNHP Chair Dr. Rachel Nardin and colleagues at Harvard (A. Wilper et al., Neurology, 4/13/10).

▶ Two provisions in the federal health bill designed to reduce the number of uninsured children and young adults will have limited impact. One measure, intended to prevent health insurers from denying new policies to children with pre-existing conditions, has already been skirted by the nation's largest insurers. WellPoint, UnitedHealth Group, Aetna, Cigna and Humana all stopped offering child-only policies in response to the measure. Another measure allows children under 26 to remain on their parents' policies. While beneficial, this provision will expand coverage to only about 20 percent of the young adults who need it (LA Times, Duke Helfand, 9/21/10).

▶ The federal health law established a $5 billion fund for state-based high risk pools for up to 6 million people with pre-existing conditions until 2014, when the exchanges start. But the new plans have found just 8,011 takers since starting up this summer. The Missouri experience is instructive. Only 140 people have enrolled in the new plan, which has premiums as high as $972 a month. The plans are "only" allowed to charge older enrollees four times more than younger people, and cap out-of-pocket costs beyond premiums at $5,950, but premiums and deductibles vary widely from state to state. Additionally, people must have been uninsured for six months and, in most states, been denied coverage by an insurer to be eligible (Politico Pulse, Haberkorn, 10/25/10, Wall Street Journal, 11/12/10).

SOCIOECONOMIC INEQUALITY

▶ Income inequality is closely associated with health inequalities such as lower life expectancy, higher infant mortality, more preventable deaths, and other health disparities.

Income inequality in the U.S. in 2009 (the most recent year for which there is data) was at its highest level since the Census Bureau began tracking household income in 1967. According to the international Gini index, the U.S. also has the greatest income inequality among Western industrialized nations.

In 2009, 43.6 million Americans (14.3 percent of the population) lived at or below the poverty level, the highest number in the 51 year recorded history of the index, according to the

Bureau of the Census. For a family of four that means living with an income of $21,954 or less in 2009. Child poverty rose from 19 percent to 20.7 percent (U.S. Census Bureau, 9/10).

▶ Nearly one in every four dollars is going to the richest 1 percent of Americans, according to a study of tax records from 1913 to 2008 by economists Emmanuel Saez and Thomas Piketty. The share of total income going to the richest 1 percent of Americans peaked in both 1928 and in 2007, at over 23 percent. After 1928, the share of national income going to the top 1 percent steadily declined, to 9 to 11 percent in the 1950s and 1960s, and to 8 to 9 percent in the 1970s. After this, the share going to the richest 1 percent began to climb again, reaching a peak of more than 23 percent in 2007 (Aftershock, Robert B. Reich, 2010, Alfred A. Knopf).

▶ African Americans with muscular dystrophy die 10 to 12 years younger than their white counterparts. The black-white mortality gap, which was calculated on the basis of 20 years of data, is among the largest ever observed in the annals of research into racial disparities in health care. "Inequities in the health delivery system – and the multiple ways in which race constrains access to care – seem the most likely explanation for the observed MD [muscular dystrophy] black-white mortality gap," an accompanying editorial notes. But lack of insurance, or having only poor quality insurance like Medicaid, may also contribute to the disparity (N. Mejia and R. Nardin, editorial, Neurology, 9/14/10).

COSTS

▶ The U.S. will spend an estimated $2.6 trillion on health care in 2010, 17.3 percent of GDP, $8,289 per capita, according to the CMS Office of the Actuary. National health spending is projected to rise to $4.6 trillion, 19.6 percent of GDP, by 2019 (Sisko et al., Health Affairs, 9/9/10).

> The annual Milliman Medical Index (MMI) reports total annual medical spending for a typical American family of four covered by an employer-sponsored preferred provider organization (PPO) program. The MMI represents the total cost of payments to healthcare providers, and excludes the non-medical administrative component of health plan premiums. The total 2010 medical cost for a typical American family of four is $18,074, or over one-third of the median household income of $50,221 in 2009 (U.S. Bureau of the Census, 9/10 and Milliman Medical Index, Modern Healthcare, 5/11/10).

▶ Average annual premiums for employer-sponsored health insurance in 2010 are $5,049 for single coverage and $13,770 for family coverage. Since 2000, average premiums for family coverage have increased 114 percent, while the amount of the premium paid by employees with family coverage has increased 147 percent, as firms shift the cost burden. Employees with family coverage now pay an average of 30 percent of the premium, or $3,997, while those with individual coverage contribute $899 annually, 9 percent of the total premium.

The average cost of group health insurance coverage is expected to rise 8.8 percent from 2010 to 2011, the biggest increase since 2005, when premiums rose by about 9.2 percent.

Among large firms, health premiums have doubled over the past decade, from $4,083 in 2001 to an estimated $9,821 in 2011. Employees' share of medical costs-including employee contributions and out-of-pocket costs-will have more than tripled, from $1,229 in 2001 to $4,386 in 2011 (Kaiser Employer Health Benefits 2010, Hewitt, 2010).

▶ A record 20 states cut Medicaid benefits in fiscal year 2010 to deal with an average increase in Medicaid spending of 8.8 percent in 2010, the highest rate of growth in eight years. (Kaiser Family Foundation, 9/30/10).

▶ Retail prices for the 217 most popular brand-name drugs have increased 41.5 percent over the past five years, compared to a 13.3 percent rise in the consumer price index. Prices on brand-name drugs rose 8.3 percent during 2009 alone, the largest increase in years, even as overall consumer prices fell 0.3 percent. The prostate drug Flomax had the highest price increase in 2009, 24.8 percent, to $4.09 a pill (AARP report, New York Times, 8/24/10).

▶ Premiums in the individual market are rising rapidly. In California, Anthem, the state's largest for-profit insurer with 800,000 individual subscribers, originally sought an increase of up to 39 percent, which they scaled back to an average of 14 percent after a public outcry. Anthem's profits in the last quarter of 2009 alone were $2.7 billion. Health Net is raising premiums for 38,000 subscribers by an average of 16 percent and Aetna is raising premiums an average of 19 percent for 65,000 enrollees (Los Angeles Times, 9/8/10).

CORPORATE MONEY AND CARE

▶ Swiss drug giant Novartis will pay $422.5 million to settle a federal investigation of their off-label marketing of six drugs, including Trileptal, an anti-seizure medication the firm promoted for neuropathic pain and bipolar disorder. The firm was accused of paying illegal kickbacks to physicians through speaker programs, advisory boards, travel and other means. The settlement includes a $170 million criminal fine. Other pharmaceutical companies paying large fines for fraud in recent years include Pfizer, which paid $2.3 billion; Eli Lilly, $1.4 billion; Allergan, $600 million; AstraZenica, $520 million; Bristol-Meyers Squibb, $515 million; and Forest Laboratories, $313 million. (New York Times, 10/1/10).

Pharmaceutical companies made up 8 of the government's top 10 fraud settlements in the last year (AP, Perrone, 10/25/10).

▶ Merck will pay $4.6 million in damages for inflating wholesale prices for generic asthma drugs in Massachusetts. The company reportedly inflated wholesale acquisition-cost prices for the generics. MassHealth, the state component of the Medicaid program, relied on those prices for reimbursements (Bloomberg, 9/30).

▶ Drug giants keep on growing: Over the past decade, a total of 1,345 mergers and acquisitions of drug company assets have occurred, at a total price of more than $690 billion. Some of the biggest deals of the decade were made by Pfizer, which purchased Warner-Lambert for $93.4 billion in 2000, Pharmacia for $56 billion in 2002 and Wyeth for $68 billion in 2009. GlaxoWellcome's merger with SmithKline Beecham in 2000 cost $74 billion. Merck merged with Schering-Plough in 2009 in a $41 billion deal. Sanofi-Synthelabo acquired Aventis in 2004 for $65.5 billion while Bayer AG merged with Schering AG in 2006 in a $21.5 billion deal. Roche paid $46.8 billion for the 44 percent of Genentech it did not already own in 2009 (Wall Street Journal, 7/9/10, Business Wire, 3/25/10).

▶ Joel Gemunder, former president and CEO of Omnicare, the nation's largest dispenser of pharmaceuticals to nursing home patients, received a retirement package of at least $130 million, despite the firm paying two hefty fines for fraud on his watch: a $98 million settlement in 2009 for allegations of kickbacks from generic drug manufacturers and $102 million fine in 2006 to settle allegations of Medicaid fraud (Health Care Renewal blog, 8/9/10).

UnitedHealth Group's PacifiCare facing $9.9 billion in fines in story of "intense corporate greed"

PacifiCare is facing $9.9 billion in fines over allegations that it violated California state law nearly 1 million times from 2006 to 2008 after it was purchased by UnitedHealth Group Inc., the nation's largest health insurer. In court filings and other documents, the California Department of Insurance says PacifiCare repeatedly mismanaged medical claims, lost thousands of patient documents, failed to pay doctors what they were owed and ignored calls to fix the problems. "This is about intentional disregard for the interests of doctors, hospitals and patients in California, and the pursuit of cutting costs by any means possible," said Adam Cole, the insurance department's general counsel. "It's a story of intense corporate greed." While denying liability, PacifiCare has already paid $2 million in fines to the state's Department of Managed Health Care over allegations that they improperly denied medical claims (Los Angeles Times, 7/7/10).

▶ Blue Cross and Blue Shield of Vermont overpaid its former CEO, William Milnes, who received a $7.2 million retirement package in 2008, by $3 million over an eight-year period. State regulators have ordered the insurer to pay the money back to subscribers by 2012 in the form of reduced premiums. The firm violated a law limiting reimbursement to the amount necessary "to perform his functions as head of a non-profit health benefits provider" given the size of the company (Burlington Free Press, 6/3/10).

Insurers Invest in Republican Congress

Since January, the nation's five largest insurers and the industry's Washington-based lobbying arm have given three times more money to Republican lawmakers and political action committees than to Democrats. In contrast, in 2009 the industry split its political donations between the two parties, according to federal election filings.

Indianapolis-based WellPoint has given nearly nine times as much to Republicans this year, and Aetna and Humana have given nearly three times more to the GOP.

The largest insurers are also paying hundreds of thousands of dollars to lobbyists with close ties to key Republican lawmakers. WellPoint's lobbying team includes a former senior aide to Wyoming Sen. Mike Enzi. Enzi is a leading proponent of minimizing regulation of health plans, and a high ranking member of the Senate Health Committee. Aetna and Humana have hired former Republican aides to the Senate Finance Committee, which could play an important role in modifying the health care law. Cigna hired the former Republican chairman of the House Energy and Commerce Committee, another key health care panel. Insurers have stepped up lobbying to influence the insurance industry's rules on what should count as medical spending and other regulations. Cigna spent $960,000 on lobbying in the first six months of 2010.

The insurance industry, attracted by the prospect of millions of new customers as a result of the coverage mandate, initially backed President Barack Obama's law. But they are now working to whittle away the law's meager consumer protections. Insurers don't want their products to have to meet federal standards, want to continue to sell limited benefit products to McDonald's (and other firms) that have maximum benefits as low as $2,000 a year, and seek the ability to dodge state regulations by selling their products across state lines. They would also like to see even stiffer penalties for failure to buy mandated coverage than the $95 penalty in 2014 rising to $695 in 2016 (Levey, Chicago Tribune, 10/4/10 and Don McCanne, qotd: "Why are the insurers supporting the Republicans?" 10/4/10 and McClatchy, 8/17/10).

▶ Investor-owned hospital systems ranked lowest in quality in a study of 255 hospital systems for Modern Healthcare conducted by the firm of Thomson Reuters, which produces an annual ranking of the nation's 100 top hospitals. The study

used federally reported core quality measures, inpatient mortality and complications, an inpatient safety index, 30-day mortality and readmissions, and patient perceptions of care to create a composite score to rank hospitals. The 36 Catholic-owned systems ranked best with an average composite score of 84 (lower is better); 11 "other church" systems ranked second (average score 121); and 176 secular not-for-profit systems ranked third (average score 129). The 26 identified investor-owned systems were the outlier, ranking far behind with an average score of 182. Six systems had missing ownership information in the AHA reference guide (Morrissey, Modern Healthcare, 8/9/10).

▶ Sen. Evan Bayh, D-Ind., a staunch opponent of single-payer national health insurance, has about $1 million in stock, about a third of his net worth, invested in just one firm: Indianapolis-based WellPoint. Bayh's wife sits on WellPoint's board, where she's earned over $2 million in compensation over the past six years (Opensecrets.org).

▶ One in five medical claims (20 percent) is processed inaccurately by the nation's seven largest commercial health insurers, according to the AMA's third annual study. The group said that Medicare performed well in how quickly and accurately it paid doctors, but did not release the Medicare data (AP, 6/15/10).

MEDICARE

▶ It's old but worth repeating: A 1997 study found that Medicare beneficiaries who enrolled in Medicare HMOs used 34 percent less inpatient care during the year before enrolling than patients who stayed in traditional, fee-for-service Medicare. In contrast, beneficiaries who disenrolled from Medicare HMOs used 180 percent as much inpatient care in the period after leaving the HMO as that of the fee-for-service group (Morgan et al., The Medicare-HMO Revolving Door: The Healthy Go In and the Sick Go Out, NEJM, 7/17/97).

▶ Although the Medicare Advantage program is sometimes justified as an example of free-market competition, enrollment in Medicare HMOs is highly concentrated among a small number of firms. In most states, two or three firms capture the majority of enrollees. For 14 states and the District of Columbia, a single firm enrolls more than half of all Medicare Advantage enrollees in that state. Only in New York do the top three firms capture less than half of the state's Medicare Advantage enrollment. As of March, 11.1 million people – nearly one-fourth of all Medicare beneficiaries – were enrolled in private Medicare Advantage plans, which cost 14 percent more per beneficiary than traditional Medicare. Most enrollees are in plans run by United Healthcare, Humana, Blue Cross and Blue Shield, and Kaiser Permanente (Kaiser Family Foundation, 6/22/10).

POLLS

▶ There was strong support for single payer at the America Speaks town-hall-style meetings held across the country in June. The program was designed to exclude single payer as an option and background materials included this statement: "the nation does not seem prepared to consider fundamental reform....premium support or single payer." But their Interim Report noted that "many table groups commented that they were not satisfied with the health care options provided in the Options Workbook. Many expressed support for reforms of the health care delivery system in order to reduce health spending, especially a single-payer system." America Speaks is the anti-deficit organization funded primarily by billionaire Peter Peterson. At the main meeting, people demanded to have the option of voting for single-payer reform instead of cutting Medicare and Medicaid, forcing America Speaks founder and president, Carolyn Lukensmeyer, to announce a complicated process of writing in single payer as an alternative (Interim Report to Congress, America Speaks, 7/27/10 and Roger Hickey, Talking Points Memo, "In Deficit 'Town Meetings' people Reject America Speaks' Stacked Deck," 6/27/10).

Twice as many Americans (40 percent) think the health reform law does not go far enough to change the health system as believe the federal government should not be involved in health care (20 percent), according to a new AP poll. The poll, carried out by Stanford University researchers, also found that 90 percent of Americans agree that the health care system should be changed from what it was like before the legislation passed, that four-fifths favor "making sure that more Americans get the health care they need" and "reducing the amount of money that patients pay for health care," while half oppose and only one-fourth favor an individual mandate – an essential element of a system based on private health plans (AP Poll, Washington Post, 9/26/10)

INTERNATIONAL

▶ In 1950, the U.S. ranked fifth in female life expectancy, behind only Sweden, Norway, Australia, and the Netherlands. Today the U.S. ranks 49th in male and female life expectancy combined.

Lower U.S. life expectancy relative to twelve other nations is not due to smoking, obesity, traffic fatalities, or homicides, according to a study of cross-national data on risk factors and the fifteen-year survival of men and women over three decades. In addition, Americans' relative fifteen-year survival rate has been declining. By 2005, fifteen-year survival rates for forty-five-year-old U.S. white women were lower than in twelve comparison countries. (Peter A. Muennig and Sherry A. Glied, What Changes In Survival Rates Tell Us About U.S. Health Care, Health Affairs, 10/7/10).

▶ The U.S. ranks 42nd globally in deaths among children younger than 5, behind all of Western Europe and many other nations. The U.S. child mortality rate is 6.7 deaths per 1,000 children, down over 40 percent since 1990, but not enough to keep up with gains by other nations. Singapore has the lowest child mortality rate in the world at 2.5 deaths per 1,000 children. The high U.S. child mortality rate is not explained by the diversity of the U.S. population, high numbers of immigrants, or poverty, and was not limited to black and Latino populations. The data suggest broader problems with the nation's fragmented, poorly organized health care system, says Dr. Christopher Murray, an author of the study. By comparison, the child mortality rate in Sweden was 2.7; Japan 3.3; Norway 3.4; Canada 4.9 and the U.K. 5.3. (Murray et al., The Lancet, 5/24/10 and Levey, Tribune Washington Bureau, 5/24/10).

▶ Despite spending twice as much per capita on health care as other developed countries, the United States ranked last in a study of quality, efficiency, and equity compared to six other countries – Britain, Canada, Germany, Netherlands, Australia, and New Zealand. Britain ranked first in quality while the Netherlands ranked first overall on all scores. The U.S. ranked last or next to last in all categories, particularly on measures of access, efficiency, equity, premature deaths, infant mortality, and healthy life expectancy among older adults. U.S. patients with chronic conditions were the most likely to say they had gotten the wrong drug or test results, or suffered delays waiting for test results. The U.S. system was also the least equitable and least accessible, with 54 percent of people with chronic conditions going without needed care in 2008, compared with 13 percent in Britain and 7 percent in the Netherlands (Reuters, June 23, 2010).

▶ It's old but we hadn't seen it: According to the consulting firm McKinsey, the U.S. health system is "intrinsically more expensive" than those in other developed nations due to "costs not borne in other countries, which are unique to the U.S. system with its significant for-profit element and its multiple state and multiple-payor administrative structure." McKinsey estimates that "the U.S. spent $412 per capita on health care administration and insurance in 2003 – nearly six times as much as the OECD average. This is because of its unique multi-payor system [and other differences]....This total does not include the additional administrative burden of the multi-payor structure and insurance on hospitals and outpatient centers which is accounted for under providers' operational costs. Nor does it include the extra costs incurred by employers because of the need for robust human resources departments to administer health care benefits" ("Accounting for the Cost of Health Care in the United States," 1/07, McKinsey Global Institute, pages 8, 9, and 16).

▶ The British Medical Association has launched a public campaign against privatization of the National Health Service (NHS) in England. They note that market-based reforms are having a negative impact on the NHS, including increasing bureaucracy and raising costs. The number of senior managers in the NHS rose by 91 percent between 1995 and 2008, twice the rate of increase of doctors and nurses. "Independent Sector Treatment Centres" received full payment but delivered only 85 percent of contracted care, while the Private Finance Initiative for hospitals, valued at 11 billion British pounds, will end up costing taxpayers 63 billion pounds (British Medical Association press release, 2/12/10).

> "Health and Human Services Secretary Kathleen Sebelius says that 'every cost-cutting idea that every health economist has brought to the table is in this bill.' That is probably true – but it also shows that American health policy researchers pay scant attention to international experience.
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> "No other country relies primarily on the use of electronic medical records or paying medical providers on the basis of relative "quality" in order to control spending. The new law seems based on the hope that if a large variety of reforms are tested, at least some will succeed; but nobody knows how many will work in practice or whether they will save money at all.
>
> "We do know that other rich democracies that spend much less than the U.S. on medical care do so largely by adopting budgetary targets for health expenditures and by tightly regulating what the governments and insurers pay hospitals, doctors, and other medical care providers. Outside of Medicare, the current reform contains no such measures" (Jonathan Oberlander and Theodore Marmor, The Health Bill Explained At Last, New York Review, 8/19/10).

PPACA – The New Health Law

▶ Liz Fowler, the former WellPoint executive who authored the framework for the health reform legislation under Senate Finance Committee Chairman Max Baucus (D-Mont.), was appointed deputy director of the Health and Human Services Office of Consumer Information and Insurance Oversight (The Hill blogs, 8/2/10).

▶ Initial startup costs for the state-based insurance exchanges contained in PPACA are projected to be $4.4 billion. Based on the Massachusetts experience, exchange-related administrative costs will add an estimated $37.7 billion to national health spending through 2019 (Sisko et al., Health Affairs, 9/9/10).

▶ A new model of care encouraged by the health law – accountable care organizations – has set off a feeding frenzy among industry groups intent on getting a slice of the action, or protecting their own financial interests. "ACOs are the latest fad," said Dan Hawkins, senior vice president for policy and research at the National Association of Community Health Centers. "I call them the hula hoop of health care because

everyone wants one even if they haven't actually been defined anywhere. The whole doggone health care community is in a frenzy to own and dominate these ACOs" (Kaiser Health News, 10/10/10).

New Health Law 'A Good Deal for Pharma'

Pharmaceutical companies will provide discounts to seniors totaling less than 1 percent of their annual revenues – about $2 billion annually – in the deal they struck with the White House over health reform. Drugmakers agreed to a 50 percent discount on brand-name drugs for seniors in the "doughnut hole" in exchange for continuing the bans on having government negotiate drug prices for Medicare beneficiaries and on allowing drug re-importation, policies that had the potential to significantly reduce drug costs. Worldwide sales by brand-name drugmakers in 2008 totaled $288 billion. Pfizer, the world's largest drug company, will cede less than half of 1 percent of its $50 billion annual revenue. Les Funteyder, a health care analyst in New York, called it "a good deal for pharma." (Bloomberg, 9/30/10).

▶ The federal subsidy to help laid-off American workers pay for continued health coverage through the COBRA program helped less than 2 million individuals (and possibly far less, estimates vary widely) – far fewer than the 7 million persons eligible to receive the aid – according to the Employee Benefit Research Institute (EBRI). Even with a subsidy of 65 percent of premiums, COBRA premiums are not affordable, especially when families have seen a decline in income. Health insurance premiums averaged $4,824 a year for employee-only coverage and $13,375 for family coverage in 2009. After the subsidy, premiums would be $1,688 for employee-only coverage and $4,681 for family coverage. These findings suggest that the impact of the subsidies that will become available in 2014 under the health reform law may not lower the number of uninsured as much as expected (EBRI, 10/14/10).

▶ Under PPACA the Department of Health and Human Services (HHS) was given an expanded role in regulatory oversight of insurers. Unfortunately, they have been waiving PPACA regulations intended to end abusive insurance practices such as low annual dollar caps on coverage and excessive administrative costs.

As of October, the Department of Health and Human Services has already issued waivers to "dozens" of companies' health plans so that they do not have to abide by health law's requirement for a minimum annual-limit of $750,000 next year. (The law raises the annual-limit floor to $1.25 million in 2012, to $2 million in 2013, and phases it out entirely in 2014). At least one million workers are affected by the move. Most of the waivers have gone to limited-benefit plans (mini-med plans) offered by employers like McDonalds. Such plans offer as little as $2,000 a year in benefits. HHS reports they are expediting processing of such waivers, generally processing them within 24 hours.

Employers with limited-benefit plans are also on track to receive waivers from the requirement that large-group plans pay out a minimum of 85 percent of premiums in benefits. HHS says they will take into consideration mini-med plans' "special circumstances" and "high expense structure relative to [their] lower premiums." With so few benefits paid out, such plans can't meet the required medical loss ratios (Bloomberg, 10/6/10, DHHS, 9/30/10, "Statement on the application of medical loss ratio standards to certain health plans under the Affordable Care Act," http://www.hhs.gov/news/press/2010pres/09/20100930c.html accessed on 10/13/10).

THE HUFFINGTON POST NOVEMBER 17, 2010

Single payer after the midterm elections

By Quentin Young, M.D.

While it's clear from post-election surveys that having voted for "health care reform" was not a major cause of the Democrats' defeats, the new health law didn't help. What should have been a feather in the administration's cap – i.e. a genuine reform that guaranteed truly universal, comprehensive care – instead became an albatross.

Many Democrats, sensing the electorate's unease with the new health law's mandates to buy private insurance, its lack of cost controls, and its limited reach – e.g. 23 million will remain uninsured in 2019 – found it difficult to defend. Some even boasted they voted against it.

In a fundamental sense, health care reform was botched by Congress. People wanted serious reform and didn't get it. The big insurance and drug companies got their way, making a few concessions that they are already trying to wriggle out of.

As a result, what was adopted last March was so defective that ultra-conservatives were actually able use it against the president's party.

Yet those who might interpret the election results as a repudiation of any health care reform should pause for a moment and consider these developments:

In Vermont, Peter Shumlin, an outspoken supporter of single-payer health reform who defeated four opponents (some of whom also supported single payer) in the primary, went on to win the governor's race.

Shumlin reports that he has already spoken with President Obama and Health and Human Services Secretary Kathleen Sebelius about getting the necessary federal waivers to implement a single-payer system in the state of Vermont.

Besides Shumlin, four other political heavyweights in the state also support single payer: Former governor Howard Dean, Senators Bernie Sanders and Patrick Leahy, and Rep. Peter Welch.

Dr. Deb Richter, a family physician in the Green Mountain State, says, "Peter Shumlin's election shows Vermonters want a single-payer health care system. We're going to get this done."

In California, Jerry Brown won the governorship, defeating Meg Whitman, who spent $141 million of her own money in her failed campaign. In his 1992 presidential primary bid, Brown declared his support for single-payer health reform, and California activists hope he will sign a single-payer bill in 2011 when it comes to his desk. (The Legislature there has twice passed a single-payer bill, only to have it vetoed both times by Gov. Arnold Schwarzenegger.)

In Hawaii, former congressman Neil Abercrombie, a co-sponsor of Rep. John Conyers' single-payer bill, H.R. 676, was elected governor. He, too, takes office in a state where many lawmakers have signaled their openness to the single-payer alternative.

Significantly, in the House races, only one of 88 co-sponsors of H.R. 676, Rep. Phil Hare, D-Ill., was defeated in the general election by a Republican. Seven other co-sponsors were lost due to death, resignation, defeat in the primary or retirement. Just one of those went to a Republican, Tom Reed, who won Rep. Eric Massa's old seat in New York.

The battle for fundamental health reform remains front and center, on both the state and national levels. The Medicare-for-all proposal is clear, legitimate and compelling in its logic. The destructive role of private corporations in our health system is also plainly evident.

The Congressional Progressive Caucus also did well, losing only three of its 69 members. In contrast, over half of the 54-member conservative Blue Dog Democrats went down to defeat.

In Massachusetts, voters in 14 of 14 legislative districts affirmed their support for single-payer health reform by turning in a majority of "Yes" votes (overall, around 2 to 1) for the following ballot question: "Shall the representative from this district be instructed to support legislation that would establish health care as a human right regardless of age, state of health or employment status, by creating a single payer health insurance system like Medicare that is comprehensive, cost effective, and publicly provided to all residents of Massachusetts?"

Benjamin Day, executive director of Mass-Care, writes:

"The ballots spanned 80 different cities and towns in a state of 351 municipalities, winning in every city and town reporting results so far [as of Nov. 3] except two. Five of the districts backing single-payer reform voted for Scott Brown in last year's special Senate election, which was largely seen as a referendum on national health reform, showing that the goal of improved and expanded Medicare for All is supported by a diverse range of communities across the state."

A similar referendum in 2008 swept 10 of 10 different legislative districts in Massachusetts, refuting the Republican boast that single-payer health care reform is unpopular.

Apparently, whenever people are given serious choices, single payer's popularity is sustained, even in the face of scurrilous attacks from the right claiming it is "socialistic" or "un-American."

There were also setbacks to the single-payer cause, too.

The defeat of Sen. Russ Feingold of Wisconsin was a very heavy loss. Just last February, Feingold had reaffirmed his longtime support for single payer. He should be sought out to help lead the movement for single payer in this new phase.

One of the most egregious results was the election of former hospital company executive Rick Scott to the governor's mansion in Florida. In 1997, Scott was forced to resign his post as CEO of Columbia/HCA, a giant hospital chain, amid a scandal pointing to massive Medicare fraud and other improper billing practices. The company ultimately admitted to 14 felonies and agreed to pay the federal government over $1.7 billion in fines. Scott spent at least $73 million of his own money to get elected to Florida's top office.

In Arizona and Oklahoma, ballot initiatives purporting to uphold "freedom of choice" in health care passed. Couched in anti-mandate language, these initiatives are in fact intended to keep patients prisoner of their insurance company networks and are really directed against enactment of single-payer systems.

So what to do going forward?

Aside from the very promising prospects for fundamental reform in Vermont, one of the immediate tasks of single-payer supporters is to block the proposals from the co-chairs of the Deficit Commission to reduce Social Security and Medicare benefits. The commission is set to make its recommendations to Congress by Dec. 1.

As my colleague Dr. Margaret Flowers has testified, the best way to safeguard Medicare is to improve its benefits and to expand it to cover everyone.

Otherwise the battle for fundamental health reform remains front and center, on both the state and national levels. The Medicare-for-all proposal is simple, clear, legitimate and compelling in its logic. The destructive role of private corporations in our health system is also plainly evident.

Just as women's suffrage and civil rights laws were widely seen as unattainable – sometimes just a few years before they were enacted – single payer is an idea whose time has come. It is unstoppable.

Quentin Young, M.D. is national coordinator or Physicians for a National Health Program.

Republicans provided model for new health law

In a recent "60 Minutes" interview, President Obama confirmed that a political decision was made to introduce the Republican model of health care reform. "We thought that if we shaped a bill that wasn't that different from bills that had previously been introduced by Republicans - including a Republican governor in Massachusetts who's now running for president - that, you know, we would be able to find some common ground there." According to PNHP Senior Health Policy Fellow Dr. Don McCanne, "The tragedy is not that this decision would be so costly politically, but rather that we are locked into a very expensive and quite ineffective model - the version that has now been abandoned by the Republicans."

The Charlotte Observer

THURSDAY, NOV. 18, 2010

New health law falls short

By Margaret Flowers, M.D.

It's been said that a society can be judged by how it treats its most vulnerable. If that's the case, what can we say about today's United States?

I recently toured several cities in North Carolina to speak about national health insurance. I had the pleasure of meeting with physicians, health advocates and citizens from all walks of life.

Many of the physicians I met are working in health centers that treat the uninsured. While such efforts are important and commendable, the doctors are saying that they are unable to meet the growing need.

The Census Bureau reports that the number of uninsured in the U.S. jumped 10 percent to 51 million people in 2009. In North Carolina, about 1.7 million - nearly 1 in 5 residents - lacked coverage last year. That's 300,000 more than the year before. Much of the increase, of course, can be chalked up to job losses.

We know that people who lack insurance suffer much more than their insured counterparts. They also more frequently die of preventable causes. A recent study in the American Journal of Public Health, for example, shows about 45,000 deaths annually can be linked to lack of health insurance. That's about 120 preventable deaths a day.

And then there's the problem of underinsurance - people having poor-quality insurance policies that require high co-pays, deductibles and other out-of-pocket expenses. These onerous "cost sharing" measures are obstacles to getting care. The gaps in such policies can easily lead to personal bankruptcy in the event of serious illness.

Sadly, the new federal health law falls short of the remedy we need.

Most of the provisions in the legislation do not take effect until 2014. Thus, for the foreseeable future, literally tens of millions of Americans will remain uninsured. In fact, the Congressional Budget Office estimates that about 23 million people will still lack coverage in 2019. That's a deadly scenario.

I'm a pediatrician, so I was particularly interested in two provisions in the federal bill relating to children that kicked in last month. One measure allows children under 26 to remain on their parents' policies. While beneficial, this provision will expand coverage to only about 20 percent of the young adults who need it.

Another measure would prevent health insurers from denying new policies to children with pre-existing conditions. However, just before it went into effect, insurers like WellPoint, UnitedHealth Group, Aetna, Cigna and Humana announced that they would no longer offer new policies to individual children.

What can we conclude from these and similar episodes? As long as private insurers occupy a commanding role in our health system, we will never be able to achieve truly universal or affordable care. The insurers make money by enrolling the healthy, screening out the sick, denying claims and raising premiums. They do not put patients' interests first; they do not provide care.

And yet the new health law keeps the big insurers - the main obstacle to care - at the heart of our system.

There is a better alternative: a national health insurance program that is publicly financed and privately delivered. This solution is commonly referred to as improved Medicare for all. It's supported by about two-thirds of the population and a solid majority of physicians, according to national surveys.

Improved Medicare for all would be truly universal - every person living in the United States would be guaranteed high-quality care from birth to death. People would no longer worry about losing coverage if they changed jobs or became unemployed. Coverage would be comprehensive, including dental care, vision care, mental health services and prescriptions.

Patients would be able to go to any physician and any health facility of their choice, and decisions about treatment would be made by patients and their health professionals without interference by insurance company administrators.

By replacing our inefficient, dysfunctional patchwork of private insurers with a streamlined, single payer of all medical bills, much like Medicare operates today, our nation would save about $400 billion annually in reduced administrative costs.

That's enough to cover everyone, with no co-pays or deductibles. We'd also acquire very strong cost-control tools like the ability to negotiate fees and purchase medications in bulk.

I urge you to learn more about the improved-Medicare-for-all approach to health care. Let's be the great society that we have the potential to be.

Margaret Flowers, M.D., lives in Baltimore and is congressional fellow for Physicians for a National Health Program (www.pnhp.org). She is also a board member of Healthcare-Now (www.healthcare-now.org).

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Overall assessment of the Patient Protection and Affordable Care Act of 2010 (PPACA)

By John Geyman, M.D., past president, PNHP
July 22, 2010

In previous articles I have examined PPACA from the perspectives of the four main goals of health care reform — cost containment, affordability, improved access and quality of care. (See my posts at the PNHP blog or at The Huffington Post.) Here I draw these goals together in asking whether this legislation delivers enough to be worth the $1 trillion investment over the next 10 years, and whether it will really work.

On the positive side of the ledger, the PPACA brings some welcome changes; It:

- Will extend health insurance to 32 million more people by 2019.
- Provides subsidies to help many lower-income Americans afford health insurance.
- Starting in 2014, expands Medicaid to cover 16 million more lower-income people.
- Provides new funding for community health centers that could enable them to double their current capacity.
- Eliminates cost-sharing for many preventive services.
- Phases out the "doughnut hole" coverage gap for the Medicare prescription drug benefit.
- Will create a new national insurance plan for long-term services: Community Living Assistance Services and Supports (CLASS) program.
- Will establish a nonprofit Patient-Centered Outcomes Research Institute to assess the relative outcomes, effectiveness and appropriateness of different treatments.
- Initiates some limited reforms of the insurance industry, such as prohibiting exclusions based on pre-existing conditions and banning of annual and lifetime limits.
- Contains some provisions to improve reimbursement for primary care physicians and expand the primary care workforce.

On the negative side of the ledger, however, these are some of the reasons that the PPACA will fall so far short of needed health care reform that it is not much better than nothing:

- Surging health care costs will not be contained as cost-sharing increases for patients and their families.
- Uncontrolled costs of health care and insurance will make them unaffordable for a large and growing part of the population.
- At least 23 million Americans will still be uninsured in 2019, with tens of millions more underinsured.
- Quality of care for the U. S. population is not likely to improve.
- Insurance "reforms" are so incomplete that the industry can easily continue to game the system.
- New layers of waste and bureaucracy, without added value, will further fragment the system.
- With its lack of price controls, the PPACA will prove to be a bonanza for corporate stakeholders in the medical-industrial complex.
- Perverse incentives within a minimally-regulated market-based system will still lead to overtreatment with inappropriate and unnecessary care even as millions of Americans forgo necessary care because of cost.
- The "reformed" system is not sustainable and will require more fundamental reform sooner rather than later to rein in the excesses of the market.

How did this latest reform effort get so far off track? Here are three of the major reasons:

- The issues and policy options were framed as the political process was being hijacked by the very interests that are largely responsible for today's cost, access and quality problems in health care. As examples, the drug industry lobbied successfully to avoid any price controls of drugs, as the VA does so well; the insurance industry avoided real rate controls over their premiums and ended up with other loopholes to game the new system; and all

of the corporate stakeholders will gain subsidized new markets without significant regulation of the market.

- The quest for bipartisanship was futile as reform got run over in the middle of the road. The big questions cannot be answered in the political center, such as whether health care should be a right or a privilege, or whether health care resources should be allocated based on ability to pay or medical need.

- Market failure was not recognized as the wellspring of our system problems. When it was agreed to "build on the strengths of the present system" instead of more fundamental reform, corporate stakeholders and their lobbyists found willing legislators to craft centrist "remedies" which could be sold to the public as reform. But the various incremental tweaks of our existing system, such as employer and individual mandates, have failed over the last 20 or 30 years to remedy cost, access and quality problems. In the absence of real health care reform, we can now expect these kinds of unfavorable outcomes in coming years:

- soaring costs without effective price controls throughout the system.
- managed care fails to control costs or improve quality.
- persistent financial and other access barriers for many millions of Americans.
- growing backlash by physicians and consumers.
- gaming of private plans and adverse selection in public plans.
- consolidation among hospitals sustaining high prices.
- increased cost-sharing for employees as employers cut back benefits.
- continued high levels of inappropriate and unnecessary care.
- added bureaucracy and waste in an even more fragmented and dysfunctional system.

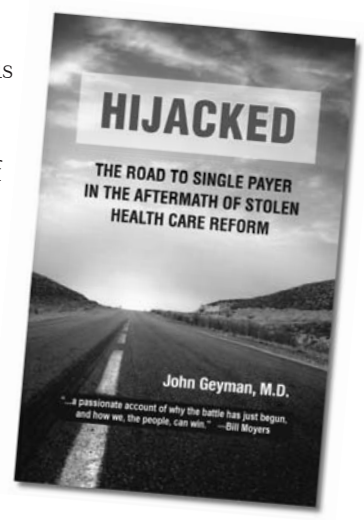
We have yet to learn that an unfettered health care marketplace can only perpetuate our problems, not fix them. Most industrialized nations have learned this many years ago, and are able to achieve better quality of care with improved outcomes for their populations even as they spend much less on health care than we do. We have to conclude that a larger role of government will be required to assure real and sustainable health care reform.

There is a fix in plain sight for our problems — single-payer financing coupled with a private delivery system. The private insurance industry has outlived its usefulness, and is only being kept alive by government subsidies, whether by overpayments of private Medicare plans or this latest provision in the PPACA to pay out nearly half of a trillion dollars in subsidized premiums for their inadequate coverage.

When will we have the political will to face up to our real problems in health care and show that the democratic process can still work?

Adapted from "Hijacked: The Road to Single Payer in the Aftermath of Stolen Health Care Reform," 2010, with permission of the publisher Common Courage Press.

'Hijacked' by Dr. John Geyman



Is the new health law better than nothing? In this well-documented but highly accessible analysis, Dr. John Geyman warns of the consequences of leaving the private insurance industry in a commanding position in our health system. Among those consequences: soaring medical costs and tens of millions of Americans who will remain uninsured and underinsured.

"Hijacked: The Road to Single Payer in the Aftermath of Stolen Health Care Reform" is essential reading for anyone who wants to better understand how the new law came about, what it contains, and what can be done now to advance the more fundamental solution of single-payer national health insurance, an improved Medicare for all.

"A trenchant and highly readable account of how the special interests sabotaged health reform, leading to a law that won't provide universal care nor control escalating costs. Geyman shows us the way to real reform when the current law implodes. An eye-opening book."

– Marcia Angell, M.D., senior lecturer in social medicine, Harvard Medical School, former editor-in-chief, New England Journal of Medicine

"You think the battle for real health care reform is over? John Geyman says 'Not on your life!' And, by the way, your life is what's at stake. This former Republican country doctor and long-time respected scholar, editor, and advocate for reform that puts the patient, not the industry, first, has issued an informed, convincing, and passionate account of why the battle has just begun, and how we, the people, can win."

– Bill Moyers, author of "Moyers on Democracy"

"Hijacked," by John Geyman. Common Courage Press, 2010. Softcover, 300 pages, many tables and charts.

Available now at www.pnhp.org/store at the discounted price of $10.

An Interview About National Health Insurance

By Ellen R. Hale
Louisville Medicine

Garrett Adams, MD, MPH, spent 40 years practicing medicine as a pediatrician, as chief of Pediatric Infectious Diseases at the University of Louisville School of Medicine, and as medical director of communicable diseases at the Louisville Metro Department of Public Health and Wellness. In January, he will begin serving as the president of Physicians for a National Health Program, which since 1987 has been the only national physician organization in the United States dedicated exclusively to implementing a single-payer national health program. As proposed by PNHP, the system would have public funding but private delivery of care. "Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs," according to www.pnhp.org. The Louisville Medicine Editorial Board drafted a list of questions for Dr. Adams. GLMS Communications Associate Ellen Hale interviewed him on the board's behalf.

Dr. Garrett Adams of Kentucky, president-elect of PNHP.

Louisville Medicine: How did you become involved in promoting a single-payer national health program?

Garrett Adams, MD, MPH: In 2003, I read this JAMA article on the "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance." I thought, that just makes sense. I went to the website and endorsed it. At that time, there were 8,000 physicians who had endorsed it; today there are 17,000. I began to think about the way medical care had changed during my years of experience. Doctors were taken away from their patients, and I began to realize that the way medical care was being paid for had really intruded into the physician-patient relationship.

A lot of Americans and even some physicians are not aware of the great disparity in the ability to deliver quality health care among the United States and other developed countries. We're way behind in terms of the efficiency and in terms of quality. And there's this unjustified idea that we have "the best health care in the world." It may be true in isolated instances, but overall it's just wrong. We're being dragged back by this market-driven, profit-driven system that has really put a damper on our ability to provide quality care for everyone in this country.

LM: What do you hope to accomplish as president of PNHP?

GA: We'd like to grow the organization, particularly in the South. One of our goals will be to spread the message of the advantages of a national health system to people who will benefit from it. Some of the worst health statistics are in the South. So these are the people who would benefit from a good national health system. I'd like to recruit physicians to the idea. There's a lot of education that needs to be done. Our challenge is uphill because the private health insurance industry and the for-profit health industry are opposed to many of the ideas of a national health plan. A lot of their effort is misinformation and propaganda, so we want to try to counteract that with facts. For example, the term "socialized medicine" came about when Harry Truman proposed it. The insurance industry hired an advertising firm, and they came up with "socialized medicine." That was during the McCarthy era, and people were just afraid. There's a lot of fear and distrust of government. I'd like to replace the fear with knowledge and understanding and get our government leaders, physicians and the public to understand that we can do better. We're hurting ourselves by not adopting a simplified system that is in the hands of the people rather than the corporate, profit-making organizations.

LM: How would the proposed national health program be in "the hands of the people" instead of "the hands of the government?"

GA: Government is the people. There are American governmental institutions that function very well. Our plan envisages a board, such as the Federal Reserve Board, that would not be run directly by elected officials but more by professionals. Then regional boards would have citizens, physicians and professionals who would make judgments. Medicare in this country has been very successful. There are problems that should be fixed, but it's made a huge difference in the health of our seniors and also in the financial health of our seniors. Without Medicare, so many people would be totally broke.

There are some institutions that do well as policies change and as the political power changes in Washington. For example, the Centers for Disease Control and Prevention is an outstanding example of an American government project that's been very successful and effective. There are lots of things we can be thankful for and proud of that come out of the CDC.

"A national health insurance model or single-payer model is the only model that will control costs. Second to improved quality and improved health care delivery, control of costs is one of the most important advantages of this system. Right away, you gain 30 cents of every dollar that goes into administrative costs."

–Dr. Garrett Adams

LM: Everyone agrees that costs are rising at an unsustainable rate, but getting agreement on solutions to the problem of rising costs is more difficult. What sort of cost-cutting ideas do you think could get widespread public and political support?

GA: A national health insurance model or single-payer model is the only model that will control costs. Second to improved quality and improved health care delivery, control of costs is one of the most important advantages of this system. Right away, you gain 30 cents of every dollar that goes into administrative costs. Twenty percent is the usual administrative expense of an insurance company and then the additional 10 percent is the cost of the providers working with the payers. A dermatologist colleague of mine here asked her billing clerk how many plans were represented in their current bills outstanding. It was 287 plans. That's where a huge amount of expense and time on the part of the physician could be recouped immediately. Medicare, with its faults, has an administrative expense of 3 percent or less. National health insurance would increase it to be more in line with some other developed countries, around 12 percent. The number of billing clerks at Massachusetts General Hospital is about 300. Toronto General, a hospital of equal size, has three billing clerks.

The ability to purchase pharmaceuticals and supplies in volume bulk purchasing would save huge amounts of money. We're paying roughly 40 percent more here per prescription. The Medicare Modernization Act of 2003 strictly forbade Medicare from negotiating with pharmaceutical manufacturers for volume discounts.

LM: As part of the new health reform law, there are incentives for providers to begin using more and more HIT tools. But to ensure that patients are receiving the most benefits from adoption of the tools, the law requires that providers meet certain "meaningful use" standards. In what ways can providers and your proposed singlepayer program work together to ensure patients are receiving the most benefits from the adoption of HIT tools?

GA: The best example is in France where in 1998 they adopted a "carte vitale." Every citizen has a card. This would be the ideal. It has all the information – the patient's medical records, X-rays, consultation results and physicals. The mothers of children under 16 years of age carry the card for their children. So they come to the doctor's office, the doctor swipes the card, and then he has his monitor and he can see all the information. It's always updated after the visit. Patients can go to any doctor, any hospital, anywhere.

LM: Physicians currently have complaints about Medicare regarding payment and services covered, and getting Congress to permanently fix the SGR formula has been a problem for years. Why was Medicare chosen as the model for the national health program? In what ways would it be improved under the national health program?

GA: The defects that are pointed out in that question would have to be corrected. We need higher reimbursements, and we foresee higher reimbursements in a standard formula that doesn't change. The national health program would provide all comprehensive medically necessary care from birth to death. There are no bills to the patient. All the bills go directly to the NHI (national

health insurance), and NHI pays. The bill in Congress that will be reintroduced in January – John Conyers' House Resolution 676 – provides for payment within 30 days.

I just read that AARP reported that the number of doctors refusing Medicare patients is higher now than it's ever been. If I'm asking for Medicare for all, then that means the doctors wouldn't want that because they're refusing Medicare patients. That's why we say improved and expanded Medicare for all.

To quote our national coordinator, Dr. Quentin Young: "Medicare is not without its problems, of course. Its benefits package could be richer. It lacks authority to negotiate lower prices with drug companies. The reimbursement rate to physicians could be enhanced and stabilized, instead of depending on an annual cat-and-mouse game with Congress over a flawed accounting formula that only erodes physician confidence in the program … By replacing our crazy-quilt, inefficient system of private health insurers with a streamlined, publicly financed single-payer program, we would reap enormous savings."

LM: How would a national health program affect physician income?

GA: Higher and more dependable reimbursement for primary care physicians; dependable reimbursement for everyone. High-end specialists would probably make less, but they would still do fine. But the primary care physicians would get more, and they would always be paid. They'd have more time to spend with their patients, which is what most of them went into medicine for in the first place.

LM: In a national health program, would physicians still have the right and realistic ability to open a private practice of medicine in a meaningful manner?

GA: Absolutely. They just submit their bills. The payment schedules will be adjusted regionally. Within a state, there would be negotiations between representatives of physician groups with the regional board for their payment schedule. Say a school physical exam is set at $60. The patient comes in, gets their exam, the office sends the bill to the NHI, and they get their $60.

LM: Do you foresee any problems with setting protocols for treatment based on the input of a small number of physicians, and then making those protocols the only services that will be covered?

GA: No. The concept is very clear that all medically necessary services would be provided. The treating physician makes the choice of what should be done for a patient. Physicians would have muchimproved authority from what we currently have.

LM: Do you foresee any restrictions on a patient's freedom to make decisions on the manner and scope of their medical treatment?

GA: Much less so than now. I see much more freedom of choice for physicians under this program. There's some evidence to support that claim, and that evidence is in Canada and in France. Those doctors are happy with what they can provide for their patients, and they're not constricted by pre-approvals from the insurance company. We wouldn't have to go through the insurance company's denial management. There's more freedom for physicians and better ability to prescribe patient's treatment as they need it.

LM: In a national health program, would individuals have the right to opt out of the system and still purchase private health insurance?

GA: No, because that could undermine the system.

LM: How do you foresee the role of restriction of choice in the overall ability to finance health care for all? Won't it eventually lead either to a two-tier system in which the wealthy are still able to purchase care not available to the average consumer, or conversely to unconstitutional limits on the ability of citizens to spend their money the way they choose?

GA: You can't buy something that is provided by the system. The question presumes that it's an American right to spend money and buy whatever you want to buy. I guess the answer is that national health insurance does interfere with that so-called right. If it's not what's considered medically necessary, then they can buy that. It's an egalitarian system that provides the best for everyone.

LM: What else would you like Louisville's physicians to know?

GA: I would like to invite fellow members of the Greater Louisville Medical Society to go to the website of PNHP to read in depth the answers to all of these questions. I also invite them to join our chapter of PNHP in Kentucky. We have members across the state.

I want this idea to be apolitical. There is a moral premise of providing health care for everyone. This is a simple program. The House bill is 18 pages. Everybody deserves health care. Everybody. Good health care. That's the bottom line. That's where we're starting from.

I like to look around when I'm out in public, say when I walk from here out to my car. I'll see a dozen people, and I'd like to think each one of them has health care. I get choked up because it's not that way now. But it could be, and it should be.

San Francisco Chronicle

FRIDAY, SEPTEMBER 24, 2010

Instead of PPACA, what if everyone had Medicare?

By Henry Abrons, M.D.

The Census Bureau released its annual report on income, poverty and health insurance coverage in the United States earlier this month, and it's no surprise to learn that we're in bad shape. The number of people living in poverty was 43.6 million (14.3 percent), up sharply from 2008, and real per capita income declined 1 percent.

Looking at health insurance, the situation is truly dire. There was a dramatic spike in the uninsured - 4.3 million more, to a record 50.7 million - in spite of the expansion of government health insurance rolls by nearly 6 million.

Those opposing government health insurance should ponder the fact that private health insurance coverage dropped to the lowest level since comparable data were first collected in 1987. On the other hand, those who look to the new health reform law - the Patient Protection and Affordable Care Act (PPACA) - for a solution should be deeply disturbed.

PPACA was not designed to provide universal coverage. In fact, if the new law works as planned, in 2019 there will still be 23 million uninsured. Yet the consequence of being uninsured can be lethal: Research published last year shows about 45,000 deaths annually can be linked to lack of coverage. That number is probably more than 50,000 today.

As Don McCanne, senior health policy fellow at Physicians for a National Health Program, has observed, PPACA is an underinsurance program. Employers, seeing little relief, will expand the present trend of shifting more insurance and health care costs onto employees.

Individuals buying plans in the new insurance exchanges (which won't start until 2014) will discover that subsidies are inadequate to avoid financial hardship. Inevitably, they will end up with underinsurance, spotty coverage and high deductibles.

And workers who are unemployed or without employment-based insurance will move into Medicaid (Medi-Cal in California), where providers are reimbursed at such low rates that many will not accept patients.

When Congress passed the new law last spring, it based its decision on a faulty assumption - namely, that the rest of the population will have sustainable private health insurance. But between 2008 and 2009, the number of people covered by private health insurance decreased from 201.0 million to 194.5 million, and the number covered by employment-based health insurance declined from 176.3 million to 169.7 million.

If this trend continues, as it's bound to do under current economic conditions, the ranks of the uninsured will expand and the new law will fall far short of the mark - either the cost will exceed projections, or coverage will need to be reduced.

The Census Bureau report underscores the urgency of going beyond the Obama administration and swiftly implementing a more fundamental reform - a single-payer national health insurance program - improved Medicare for all.

Improved Medicare-for-all, by replacing our dysfunctional patchwork of private health insurers with a single, streamlined system of financing, would save about $400 billion annually in unnecessary paperwork and bureaucracy. That's enough to cover all of those now uninsured and to provide every person in the United States with quality, comprehensive coverage.

A single-payer plan would also furnish us with effective cost-control tools, like the ability to negotiate fees and purchase medications in bulk. It would permit patients to go to the doctor and hospital of their choice.

Short of a full national plan, some states, like ours, are eyeing a state-based single-payer model. The new health law allows states to experiment with different models of reform, but not until 2017. Congress should move that date forward. There is no time to waste.

Henry Abrons, M.D., is a member of Physicians for a National Health Program-California (www.pnhpcalifornia.org).

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Don't weaken Medicare – strengthen it and expand it to all

By Margaret Flowers, M.D.

The following article summarizes a Congressional Briefing held on Sept. 23, 2010, titled "An analysis of proposed changes to Medicare before the Deficit Commission and a better alternative: Improved Medicare for all."

Presenters and honorary hosts:

Tsung-Mei Cheng, distinguished health economist and expert on comparative health systems at Princeton University. Professor Cheng writes and lectures internationally on such topics as single-payer systems, health care quality, financing, pay-for-performance and technology assessment. She also hosts Princeton's television program, "International Forum."

Olveen Carrasquillo, M.D., nationally recognized authority on health disparities, minority health, health services research, health policy, access to care and national health insurance. He is presently chief of the Division of General Internal Medicine in the Department of Medicine at the Miller School of the University of Miami and a member of Physicians for a National Health Program.

Michele Evermore, a legislative advocate for National Nurses United. Formerly served as senior legislative officer in the Office of Congressional and Intergovernmental Affairs at the Department of Labor and for 10 years as a congressional staffer for Sen. Tom Harkin in his personal office and on the Health, Education, Labor and Pensions Committee and for then-Ranking-Member George Miller on the House Education and Labor Committee.

The Honorable Raúl M. Grijalva (Honorary Host), Co-chair, Congressional Progressive Caucus

The Honorable Lynn Woolsey (Honorary Host), Co-chair, Congressional Progressive Caucus

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The Deficit Commission has marked Medicare and Medicaid as potential targets for lowering the federal deficit. They are reportedly considering at least three possibilities:

- Shifting more seniors into Medicare Advantage
- Shifting more of the cost onto the individual through higher co-pays and deductibles
- Switching to a voucher program for the purchase of private insurance.

These approaches would be misguided, ineffective and harmful.

Attributing the deficit to Medicare and Medicaid is misguided because these necessary social insurance programs are not the causes of our soaring health care costs, but are rather the result of the lack of a rational health care system.

- Medicare, which currently covers 43.4 million people, accounts for 13 percent of total federal outlays (FY 2010) and Medicaid accounts for 8 percent.
- Medicare and Medicaid together account for a much smaller proportion of our GDP (‹ 5 percent) than do our other health care costs and they are rising at a slower rate.

The most effective way to control rising health care costs would be to address the underlying causes: the corporatization of health care and the lack of health planning.

The changes proposed by the deficit commission will not have a positive effect.

▪ Shifting more seniors into Medicare Advantage will increase federal spending because these are for-profit plans with higher administrative costs, currently 14 percent more expensive than traditional Medicare.

▪ Shifting more of the cost of health care onto individual Medicare beneficiaries through increased co-pays and deductibles or by changing to a voucher system will reduce federal spending. However, the deleterious effect on seniors is likely to be significant while the impact on total health spending is marginal.

▪ Increasing co-pays and deductibles will place increased financial strain on seniors already burdened with high out-of-pocket costs. According to the Kaiser Family Foundation's analysis of the CMS Medicare Beneficiary Survey Cost and Use File for 2005, seniors earning less than 200 percent of Federal Poverty Level (FPL) spend 22 percent of their income on health care. Those with incomes between 200 and 400 percent of FPL spend an average of 15 percent of their income on health care.

▪ A recent article published in the New England Journal of Medicine documents that raising Medicare HMO co-pays and deductibles results in fewer outpatient visits and more hospital admissions and days in the hospital. It is reasonable to expect that the savings may be offset by greater hospital costs and will certainly lead to poorer health outcomes for seniors.

▪ Converting Medicare from a defined benefit program to a defined contribution program in which seniors are given vouchers to purchase insurance also seeks to shift more of federal health care spending onto the individual. This will likely increase total health care spending as it further dilutes market power on the demand side by further fragmenting the Medicare population.

Of course, single-payer supporters already know that the best way to preserve and protect our American legacy, Medicare, is to improve it and expand it to everyone: Everybody in, nobody out.

And now let us examine why expanding and improving Medicare to everyone will control total health care costs while protecting individual patients from financial ruin, improving the health of our population and stimulating the economy.

First it is important to understand that health care costs per capita in the United States are the highest in the world. These high costs are due in large part to the use of a fragmented multi-payer (multiple insurance plans) model with associated high administrative costs.

▪ One-third of our health care dollars are used for administration rather than direct patient care.

▪ Administrative costs include developing and marketing plans, determining eligibility for the various plans and then processing the claims for the various plans which each have different rules.

▪ Contrast this with the relatively streamlined administrative cost of Medicare which is less than 3 percent.

▪ There are significant costs to providers (both clinicians and health facilities) in terms of both time and money to interact with the various plans. According to Jim Kahn of the University of California San Francisco Philip R. Lee Institute for Health Policy Studies, every full-time physician spends over $85,000 on billing and insurance functions.

Dr. Kahn states that "Overall, for health care funded through the private insurance system, fully 38 cents of each dollar goes to administration and profits, leaving only 62 cents for clinical care. 20 cents is avoidable administration – which would mainly disappear with single payer."

▪ Simplifying administration by switching to a national single public fund to collect and pay out our health care dollars will save about 15 percent of total health care spending (over $400 billion per year).

Health care costs in the United States are also very high because the prices we pay for medical goods and services are among the highest in the world. This is a result of a profit-driven model and the lack of a single system with which to negotiate for fair prices.

There has been a temptation to blame over-utilization of health care services and goods for soaring health care costs.

▪ Americans have fewer physician visits and fewer days in the hospital than people in other industrialized nations.

▪ Except for some very expensive, highly technical procedures, people in the U.S. use less health care services per capita than people in other nations.

The growth of health care costs has occurred more slowly for Medicare than it has for the private insurance sector. According to the Kaiser Family Foundation, per capita health care costs rose 6.8 percent for Medicare and 7.1 percent for private insurance during the period from 1998 to 2008. This is impressive considering that Medicare is responsible for a population with greater health care needs: those 65 years of age and older and members of the disability community.

We can preserve and protect our American legacy, Medicare, with its lower administrative costs and slower growth in total costs, by

▪ expanding it to the entire population

▪ placing everyone in a single risk pool

▪ using a streamlined payment mechanism

▪ financing the program with progressive taxation that will typically amount to less than what people are paying now for premiums and out-of-pocket medical expenses.

(Continued on next page)

There will be adequate funds to pay for health care for each person when he or she needs it without fear of losing coverage or going bankrupt.

In addition, improving and expanding Medicare to the entire population will create a health system with proven cost controls:

- global budgeting for medical institutions
- negotiation of fair prices for goods and services.

It is true that Medicare has weaknesses. We can improve Medicare by making it more comprehensive, removing financial barriers to care such as co-pays and deductibles and improving reimbursement rates.

There are important advantages of creating a national single-payer health system in the U.S. A big plus is that it will virtually eliminate bankruptcies due to medical debt.

- A study published in June, 2009 found that 62 percent of personal bankruptcies in the U.S. were due to medical costs.
- Nearly 80 percent of those who became bankrupt due to medical costs had health insurance.
- In a single-payer system, all medically necessary care is covered throughout the life of the patient.
- People pay into the system based on their ability to pay.
- There is an end to the loss of coverage with the loss of employment.
- There is an end to higher charges based on age, gender or medical condition.

A national single-payer health system will create conditions that will stimulate our economy. In some ways, single payer is a jobs bill.

- For small businesses, single payer means relief from the increasing burden of providing health benefits to employees.
- Single payer ends job-lock, providing greater security for those who may choose to open their own business.
- Single payer enables those who are staying in jobs until they are eligible for Medicare to retire early, which opens jobs for those who are younger.
- By controlling rising health care costs, single payer will allow large businesses to be more competitive in the global market.

The changes to Medicare that are being considered by the Deficit Commission are misguided and harmful. Rather than cutting our important social insurance programs, Congress could address both our health care crisis and our federal deficit woes by improving and expanding Medicare to all people in our nation.

The Taiwan experience

The most recent nation to adopt a single-payer health system is Taiwan in 1995. We look to their experience to see the impact of changing from multiple private payers and a high number of uninsured to a universal single-payer system.

Prior to having a national health insurance system, only 59 percent of people in Taiwan had health care coverage and health care costs were rising by nearly 14 percent each year.

When the new system in Taiwan began, after a planning period, the remaining 41 percent of people had access to coverage overnight. By the end of the first year, 90 percent of people were enrolled. Within nine years, more than 99 percent of people were enrolled and this percentage has remained steady. The current satisfaction rate with the system is 83 percent (similar to the satisfaction rate for Medicare in the U.S.).

The single-payer system in Taiwan has effectively controlled the rise of health care costs.

- There was an expected bump the first year of implementation as total health care costs rose 18 percent (compared to almost 14 percent per year prior to the new system).
- Within 10 years, the rise of health care costs had fallen to a more manageable 3.5 percent to 4.5 percent per year, despite the fact that there is high use of the system (average of 15 visits/patient/year).
- Administrative costs for the system are a low 1.4 percent.

The proven strengths of the Taiwanese system are:

- the ability to control national health expenditures
- the simplicity of uniform rates and fees
- a uniform information technology system
- a single standard of care for all people
- increased choice: patients are able to choose their health provider freely and the system covers some alternative therapies such as Chinese medicine
- as it is in the U.S. under traditional Medicare, physicians are able to use their best clinical judgment without interference from either insurance or government administrators
- the important physician-patient relationship is not compromised as it is under the current multiple-insurance based model used in the U.S.

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Single payer: lower costs, higher quality

By James G. Kahn, M.D., M.P.H.

The following text is the testimony of California PNHP's President Dr. James Kahn to the California Assembly Health Committee on June 29, 2010, in Sacramento.

Thank you for inviting me to speak before your committee. Health care reform is a timely and pressing issue, and I'm pleased to contribute to the discussion.

My name is James G. Kahn. I am a professor of health policy at the University of California, San Francisco, and president of the California chapter of Physicians for a National Health Program.

I want to thank Sen. Mark Leno for his inspirational leadership for universal health care, as well as his co-authors such as on this committee.

My perspective in assessing health care interventions is that of a hard-nosed, data-driven economist. My research at UCSF focuses on how to critically read evidence on intervention effectiveness and how to shift resources to the most efficient uses. My assessments are intended to be pragmatic and realistic.

My pragmatic and realistic assessment of single-payer health care - as encompassed in S.B. 810, the California Universal Health Care Act - is that it would sharply reduce inefficiency and waste, while returning to medicine a focus on providing the best quality health care.

I will highlight two major points in my testimony - the huge savings realized by single payer due to increased efficiency, and the interest of physicians in single payer.

First I would like to establish an important fundamental concept: single payer is a financing intervention - how we pay for care - not a change in how health care is delivered. All monies are collected and disbursed by a trust fund. The provider system remains as it is today - mainly private hospitals, medical offices, and so on - with the same incentives to attract and retain patients, and even greater autonomy in medical decision making. Thus, single payer is a public-private partnership, adopting the best traits of both systems.

My particular expertise in health system research is in billing and insurance-related administrative costs. My colleagues and I have demonstrated that as much as 1 dollar in every 7 that goes into a medical office is used to collect payment - for contracting, billing, co-payment collection, and repeated appeals of claim denials. Overall, for health care funded through the private insurance system, fully 38 cents of each dollar goes to administration and profits, leaving only 62 cents for clinical care. Twenty cents is avoidable administration - which would mainly disappear with single payer. This translates to billions of dollars that become available to pay for health care - more than $200 billion per year in the United States, and $30 billion in California.

That's why economists like single payer - it improves the technical efficiency of providing health care.

Why do physicians like single payer? In one national survey, published in the Annals of Internal Medicine, 59 percent said they support national health insurance.

There are several reasons:

* Doctors have long felt mistreated by insurers: unpaid or under-paid for delivered health care services. Private insurers have a far worse payment track record than Medicare.

* Doctors resent the time they have to spend on billing and insurance-related administration - an average of nearly 60 minutes per day. They'd rather provide health care.

* Doctors would like to see that all patients have quality insurance that assures access to needed services. In this way, care decisions can reflect clinical decisions which take into account what care is needed, rather than financial constraints.

When you put together administrative efficiency and doctors focused on providing care, you get lower costs and higher quality.

The other rich democracies (the countries in the OECD) spend approximately half as much per person as we do on health care. Much of that savings is in lower administrative costs.

And they have much better health care quality and outcomes. This was recently demonstrated again in a Commonwealth Fund multi-country study.

In economics, it is often said that people are willing to pay for quality. In health care, we have the remarkable situation of how paying less - reducing the system's fat - is the route to improved quality.

The new federal health reform legislation, which expands private insurance, does not provide the benefits of single payer. It does, however, allow states to implement single payer. PNHP-California encourages you to do so.

Thank you.

Single-payer system takes center stage in Vermont

Vermont's new governor-elect Peter Shumlin makes the case for a single payer system first and foremost as an economic issue based on the trajectory of cost increases for the state, employers and individuals. Shumlin campaigned on a platform that calls for implementation of a single payer system, with benefits that follow the individual and are not a requirement of the employer. The system would reimburse based on outcomes rather than fee for service using technology for medical records and payment. It would also eliminate private insurers and their administrative costs.

Earlier this year, Harvard Economics Professor William Hsiao, an expert on health care systems, was commissioned by the Vermont legislature to develop implementation plans for healthcare system options including a single payer system. In a New York Times interview, Hsiao contends that "you can have universal coverage and good quality health care while still managing to control costs. But you have to have a single-payer system to do it."

Vermont would require a waiver from the federal government to implement a single payer program. Shumlin is already lobbying President Obama about this waiver. According to Shumlin, "the waivers is the easy part. The hard part is designing a single payer health care system that works and that delivers quality health care, gets insurers off our providers' backs, has a reimbursement system that makes sense. ... I believe if we design that system, we can sell it."

There is solid evidence to back up Shumlin's belief. Exit polls tallied 59% of Vermont voters either backing national health care reform as-is (16%) or backing expansion of reform (43%). And with the Vermont executive and legislative branches firmly controlled by one political party, there is the very real opportunity for a viable single payer system to be enacted.

According to Shumlin, "in Vermont, the cost of health care is estimated to increase by $1 billion from 2010 to 2012. For the average Vermont family of four that's a $7,000 increase on top of the $32,000 that we now spend for health care coverage each year. Our rate of increase exceeds the national average. It is not sustainable. Health care costs are crippling our economy, hampering business growth, driving up property taxes, and bankrupting too many individuals.

Martha Retallick, Western Sky Communications

Single-payer supporters rally in Vermont.

These costs must be brought under control. The only way to do this is for the state of Vermont to lead the nation in comprehensive health care reform. 47,000 Vermonters have no insurance. When these Vermonters become sick, they are faced with a choice—seek the care they need and risk bankruptcy, or avoid care and face debilitating health or even death. When they do choose to seek care, it is the insured that pay for it.

This is an unacceptable choice in a civilized society. It also imposes ethical dilemmas on health care professionals trying to treat the uninsured. Unfortunately, this problem isn't confined to the uninsured. Tens of thousands of Vermonters are underinsured. All too often Vermonters don't get the care they need because of unaffordable deductibles, co-pays, and coinsurance."

Gov.-elect Shumlin: 'Vermont has an opportunity to pass a single-payer system'

Green Mountain Daily, Nov. 10, 2010 *(excerpt)*

GMD: [W]hat should reformers expectations really be over the first term?

Gov.-elect Peter Shumlin: Well, we're going to get Dr. [William] Hsiao's work back shortly. I'm going to start assembling in the next few weeks a team of people – I abhor ribbon commissions because they just sit on shelves collecting dust. What I do like is a group of really informed people that can sit around and chart an ambitious course. I'll be putting that group together. I am convinced that Vermont has an opportunity to pass a single-payer health care system that does three things. First, that contains costs so that we're not spending a million dollars a day than we were before. Second, where health care follows the individual and is not a requirement of the employer. And third, where health care is a right, not a privilege. They're the sort of principles that I go into this with.

Now, I got a lot of criticism during the campaign ... saying, "He's overpromising more than can be delivered." And what I've said about this health care vision is this is not a promise, it's a plan. My promise is that I will work as hard as I can over the next two years to make this happen as quickly as I can.

INDEPENDENT RECORD

NOVEMBER 5, 2010

Privatizing Medicaid is wrong way to go

By ROBERT PUTSCH, M.D.

The IR's Oct. 14 headline caught me off guard: "Gov mulls privately run Medicaid." Is this the same governor who in August 2009, welcomed President Obama saying: "Did you know that, just 300 miles north of here ... they offered universal health care 62 years ago?"

Gov. Schweitzer certainly understands that the Canadians didn't accomplish universal care by privatizing health care programs that are publicly funded. Thanks to excellent coverage by reporter Mike Dennison it appears that the state is considering a five-county Medicaid demonstration project and it includes a proposal from Centene Corp.

So what's going on? To begin with, Medicaid, at $315.2 billion per year in 2005, covering 60.4 million people, has become the nation's largest public health insurance program. This caught the attention of health insurance companies. United Health Group and WellPoint and smaller companies such as Centene all want a cut of the pie.

Centene, in fact, is listed by Goldman Sachs as one of the country's fastest growing Medicaid HMOs. John Geyman, in his book "Do Not Resuscitate," says "two of these companies (WellCare and Centene) have grown 300 to 400 percent since their IPOs all within the last six years." As if to emphasize Geyman's point, Centene joined the Fortune 500 list this summer.

And these details leave me wondering. How can a company that specializes in managed Medicaid plans and CHIP become a darling of Wall Street?

After all, Medicaid has often been targeted in budget cuts around the country and is widely regarded as being underfunded. Beyond that, all of the money going into Medicaid is tax financed. We're not arguing here about what percentage of the money is tax based — Medicaid is 100 percent funded by state and federal taxes.

By that measure, Centene is a publicly funded "private" corporation. Geyman once again hits the nail on the head: "Privatization of public programs has clearly been a bonanza for private insurers."

Listed on the New York Stock exchange as CNC, Centene's CEO is Michael Neidorff, who earns (according to Reuters) $6.1 million a year and has $9.5 million in stock options. Wall Street likes the company's ability to generate profits. On July 27, Centene's CEO laid out the following company policy: "Protecting our earnings stream is crucial and we will continue to be bottom-line focused."

Hopefully, thinking about how these outfits make tons of money and attract the attention of Wall Street makes you as uncomfortable as it does me. It begs another question: How do companies squeeze profits out of an underfunded public program?

Massachusetts' experience is instructive. In 2009 Massachusetts transferred 30,100 green-card-holding immigrants from its state-subsidized insurance program to a Centene subsidiary, CeltiCare. CeltiCare was paid $1,500 per enrollee for a plan that covered less than the one it replaced; $1,500 is well below Kaiser's projections for adequate care. Eight months after the plan became active, a brief study in the Aug. 5 New England Journal of Medicine accused Centene of "rationing by inconvenience."

Medicaid managed care plans profit by cutting costs, by exclusionary contract language, and by denying care. In New Jersey, private Medicaid plans enrolled large numbers of low-income families and then denied up to 30 percent of their claims for hospital care. Both Montana and Massachusetts undertook earlier attempts to provide private Medicaid funding in mental health with disastrous results.

But there's another key item I haven't mentioned. It's called the medical loss ratio. Centene's is variously reported as 81-82 percent. That means that they spend either 81 or 82 cents on every dollar on actual care. The company gets to keep the rest. So if Montana continues down this path, the state will see 18 to 19 cents of every tax dollar spent on Medicaid feed Centene's bottom line.

Finally, Centene began its involvement in Montana quite a while back. They undertook renovations at the old American Legion baseball park in Great Falls and it's now called Centene Stadium. They then announced the development of a data processing center in Great Falls. That deal was worked out and had the attention of both state and local development authorities. Makes one wonder whether the current privatization proposal is about health care for families living on the margin or about employment and business. Think about it. What's the deal here?

The Schweitzer administration and Legislature should focus on building a robust and functional state-managed Medicaid program. At the very least, a state-run program doesn't have to add a profit motive to the costs of serving children and families in Montana. Beyond that, I liked the rest of Gov. Schweitzer's comments to the crowd greeting President Obama at the Gallatin Field Airport hangar. He reminded them that the Canadians had recently selected the "father" of Canada's single-payer health care system, former Saskatchewan Premier Tommy Douglas, as the greatest Canadian.

Remember, Medicaid covers four of 10 births in the U.S. and provides care for one in every three children. Montana can ill afford to expose at-risk families to denials and the profit-making focus of yet another health insurance company.

Robert Putsch, a retired physician and a clinical professor emeritus of medicine at the University of Washington School of Medicine and member of Physicians for a National Health Program, a national organization dedicated to the establishment of a single-payer sytem, lives year round in Canyon Creek.

THE DAILY GAZETTE

SUNDAY, NOVEMBER 7, 2010

Free clinic is vital till single-payer health care system arrives

By Andrew D. Coates, M.D.

The Schenectady Free Health Clinic provides high-quality care to some 2,600 patients, about 18 percent of Schenectady County's uninsured, free of charge. The need for the clinic is increasing.

The Census Bureau recently reported a one-year 10 percent increase in the uninsured – to 50.7 million people, or 16.7 percent of our population. A jump of 4 million people is alarming. Harvard researchers recently showed that for every 1 million with diminished access due to no health insurance, roughly 1,000 people die.

Daunting out-of-pocket expenses, co-insurance payments, co-pays and high deductibles, together with unaffordable premiums, weigh upon everyone. Our nation spends, per person, more than twice what any other nation spends for health care.

Yet for all the money, our health outcomes remain mediocre. Among many health indicators the United States continues to rank dead last among developed nations. In life expectancy our rank in the world is now number 49.

Awareness of the ongoing health care crisis led the Capital District chapter of Physicians for a National Health Program to sponsor a fundraiser for the Schenectady Free Health Clinic on Oct. 29. As physicians we know intimately that preventable tragedy can result when money causes a person to postpone or forgo necessary care.

Because perverse financial incentives so often undermine the practice of medicine, we also recognize the Schenectady Free Health Clinic as an oasis of compassionate care. The event brought over one hundred people together to celebrate the best of our community, including its physicians, people who refuse to forget those most in need. We are pleased to report over $8,500 in new donations for the clinic.

But is something wrong with this picture? Health care crisis? Free clinic? Aren't we supposed to be "status post health reform"?

The omnibus bill signed by President Obama earlier this year promises to decrease the number of uninsured starting in 2014. Even so, the Congressional Budget Office estimates that if the new health law works just as planned, 10 years from now there will still be about 23 million people with no health insurance.

The cornerstone of the reform is compulsory private health insurance. Curiously, although passed by Democrats, the individual mandate was first proposed by GOP leaders (including George H.W. Bush) and first enacted in 2006 in Massachusetts under Republican Gov. Mitt Romney. The legislation President Obama signed will make it federal policy in 2014.

From the Massachusetts experience we know that the individual mandate can neither control costs nor cover everybody. Because health insurance is simply not affordable for millions who will be required to purchase it, under the new law federal taxpayers will give an estimated $447 billion by 2019 to private insurance companies to subsidize premium payments for those with low incomes.

The reform also aims to add some 16 million people to Medicaid by increasing income eligibility to 133 percent of the federal poverty level (excluding all undocumented immigrants and also legal immigrants who have lived here for six years or less).

Overall, regrettably, reducing by half the number of uninsured while expanding the influence of private insurance companies, means we still need free health clinics. Health reform worthy of the name should eliminate that need.

At the fundraiser for the Schenectady Free Health Clinic, Dr. Paul Sorum, founder of the local chapter of Physicians for a National Health Program, made a spirited appeal. He pointed out that the Schenectady free clinic reminds us all of the way medicine ought to be practiced. Everyone should have access to comprehensive, quality care, with no payments for individual services, he explained, for user fees undermine the doctor-patient relationship.

A system of single-payer national health insurance remains the best way to provide access to care for everybody, with each person paying a fair share. Out of pocket expenses including co-pays, for necessary care, would be eliminated.

Fiscally responsible, single-payer would save about $400 billion annually, eliminating the wasteful paperwork and bureaucracy associated with multiple private insurers while creating strong cost-control tools, like bulk purchasing, needs-based planning and the elimination of profiteering from the sick.

Sooner or later a Medicare-for-all finance system will begin to heal our broken health system. Until then, Schenectady Free Health Clinic will remain vital to our community.

Dr. Coates practices internal medicine in Albany. He is assistant professor of medicine and psychiatry at Albany Medical College and newly elected chair of the Capital District Chapter of Physicians for a National Health Program.

THE HUFFINGTON POST

MAY 12, 2010

Napalm, Big Health Insurance, and Divestment

By Rob Stone M.D.

The modern era of fire as a weapon of war came with jellied gasoline, or napalm, dropped from bombers in the late days of WWII. The bombing of Tokyo created a firestorm that incinerated more people than the nuclear bombing of Hiroshima.

The modern era of corporate shareholder activism was born during the Vietnam War when the Medical Committee for Human Rights and its leader Dr. Quentin Young were given shares in Dow Chemical Company, infamous for manufacturing the napalm used in Vietnam. In 1968 Dr. Young submitted a resolution to Dow "that napalm shall not be sold to any buyer unless that buyer gives reasonable assurances that the substance will not be used on or against human beings."

Dow fought inclusion of the proposal in its proxy statement and the Securities and Exchange Commission (SEC) initially sided with the company. Dr. Young appealed and the DC District Court ruled that part of the original intent of Congress in creating the SEC was "to give true vitality to the concept of corporate democracy [emphasis added]," and the resolution made it onto the proxy.

Isn't "Corporate Democracy" an oxymoron? What are the effects of corporations on our democracy?

The corrosive effect of corporate influence on democracy was recognized by Abraham Lincoln in a letter to Col. William Elkins, November 21, 1864:

> "I see in the near future a crisis approaching that unnerves me and causes me to tremble for the safety of my country. . . . corporations have been enthroned and an era of corruption in high places will follow, and the money power of the country will endeavor to prolong its reign by working upon the prejudices of the people until all wealth is aggregated in a few hands and the Republic is destroyed."

Nobel economics prizewinner and conservative icon Milton Friedman (Capitalism and Freedom, 1962) framed the crisis very differently from Lincoln:

> "Few trends could undermine the very foundations of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their shareholders as possible."

While Lincoln felt corporations could destroy the Republic, Friedman felt that free society itself was threatened by the idea of any corporate responsibility other than making a profit.

The health insurance industry has been profitable for its investors. The five largest health insurance companies sailed through the worst economic downturn since the great Depression to set new industry profit records in 2009. WellPoint, UnitedHealth, Aetna, Humana, and CIGNA enjoyed combined profits of $12.2 billion, up 56 percent from 2008. It was the best year ever for Big Insurance.

Dr. Rob Stone

You can argue for a robust profit motive for flat screen TVs, but health insurance companies don't even make a product. The only thing they make is money.

In 2007 WellPoint convinced the Federal Deposit Insurance Corporation to allow the company to incorporate as a bank in Utah. WellPoint chose Utah, a state where they sell no health insurance, because Utah has such loose banking regulations. Even Utah's regulators balked at first, arguing that WellPoint was an insurance company, not a bank. But WellPoint succeeded in being reclassified as a financial institution.

When John McCain was running for president he drew this parallel between banking and health insurance (Washington Post 9/21/08):

> "Opening up the health insurance market ... as we have done over the last decade in banking, would provide more choices of innovative products less burdened by regulation."

We know where financial deregulation got us.

Support for healthcare reform ran strong through most of 2009 with polls showing backing for the public option consistently over 60 percent through September. Now the consensus post-passage seems to be that the reform bill is unpopular. An April public opinion poll sheds light on how confused and frustrated people are. Although 58 percent supported repealing the bill, 67 percent still felt it was important that Congress work on "establishment of a public option that would give individuals a

choice between government-provided health insurance or private health insurance," and they wanted it done in the current legislative session!

How do you reconcile 58 percent in favor of repealing the bill but 67 percent still favoring a public option? People aren't as stupid as politicians make them out to be. They understand that this bill doesn't go nearly far enough. They resent having no choice but to buy private insurance.

That's why we say, Healthcare Reform, We're STILL FOR It... and we're not done yet.

Have no doubt - the lobbyists for Big Insurance aren't done yet.

Why do we need health insurance companies? We know that they raise premiums with no justification and cancel policies with the flimsiest of excuses. They notified their investors that they will spend billions of their record profits this year, not on anything to improve our lives, but to buy back their stock to bolster the share price, which increases executive compensation.

We know Big Insurance spent millions to influence Congress, and it resulted in a bill with some tissue paper handcuffs of new regulation, but a program that has the potential to bring them huge profits. Insurance corporations will be handed at least $447 billion in taxpayer money to subsidize the purchase of their shoddy products. This money will enhance their financial and political power and their ability to block future reform.

Before he died, Ted Kennedy wrote President Obama about healthcare reform, which he called "the great unfinished business of our society." He made it clear that "what we face is above all a moral issue; that at stake are not just the details of policy, but fundamental principles of social justice and the character of our country."

This is about justice and the character of our country. To care about such things would not fulfill the fiduciary responsibility of Big Insurance's executives and boards of directors. They are wedded to a business model that we can no longer afford, financially or morally. They profit by collecting premiums from healthy people and avoiding by any means possible paying for the care of the sick. I went to medical school so that I could take care of sick people.

Dr. Quentin Young is still going strong at 87. He is the national coordinator of Physicians for a National Health Program and recently had this to say, "The grave crisis engulfing the American health system is fundamentally the work product of the for-profit health insurance industry, which is driving up medical costs relentlessly."

When his resolution calling on Dow to stop selling napalm was finally voted on, it went down in flames. Dow won that battle, but has never escaped the tarnish of napalm.

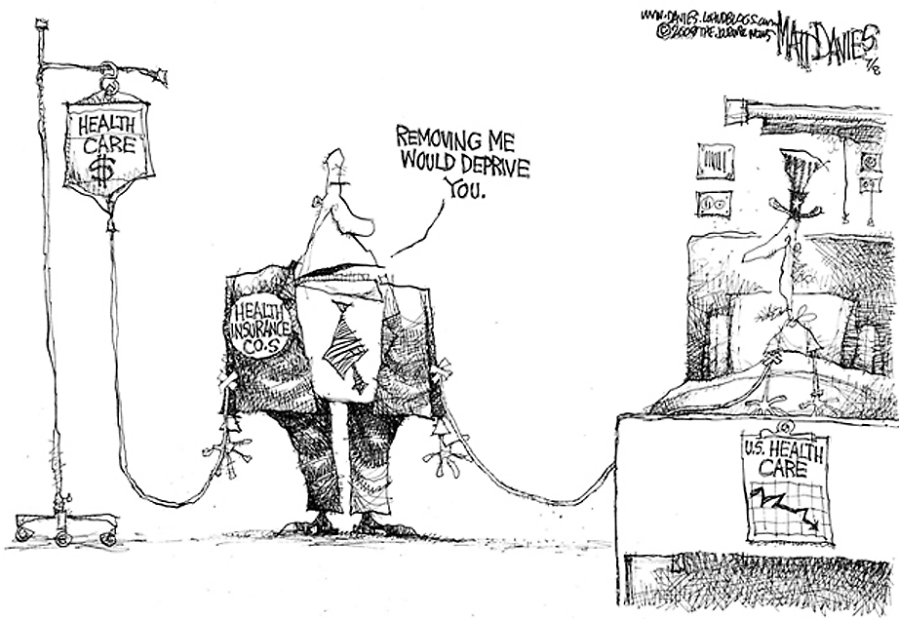
I am sponsoring a resolution on the WellPoint/Anthem proxy calling on the company to study the feasibility of returning to its Blue Cross, charitable, non-profit roots (HuffingtonPost 4/12/10). My prediction is that even if it passes, WellPoint is incapable of reforming itself.

We need to move beyond shareholder resolutions and begin building a divestment campaign like the one aimed at American corporations doing business with South Africa's apartheid government. From 1985 to 1990, over 200 U.S. companies cut all ties with South Africa, resulting in a loss of $1 billion in direct American investment. (May 4 was the 16th anniversary of Nelson Mandela's election as president of South Africa, after spending 27 years in prison.)

The health insurance industry is the poster child for the corrosive effect huge corporations have on our Democracy. Their growing, unchecked power threatens our economy and our very health. Divestment opens a new avenue to expose them for the parasitic middlemen they are.

Will this reform bill be a step in the right direction, or a bail out for the insurance industry? Can we break the death grip Big Insurance has on Congress? Will we ever achieve affordable, universal coverage, like a single-payer Medicare for All program?

Burning questions remain. We're not done yet.



BusinessWeek HealthDay News for Healthier Living JUNE 23, 2010

U.S. Health Care Ranks Low Among Developed Nations: Report

Despite high cost, it delivers too little to patients, Commonwealth Fund says

By Steven Reinberg, HealthDay Reporter

Compared with six other industrialized nations, the United States ranks last when it comes to many measures of quality health care, a new report concludes.

Despite having the costliest health care system in the world, the United States is last or next-to-last in quality, efficiency, access to care, equity and the ability of its citizens to lead long, healthy, productive lives, according to a new report from the Commonwealth Fund, a Washington, D.C.-based private foundation focused on improving health care.

"On many measures of health system performance, the U.S. has a long way to go to perform as well as other countries that spend far less than we do on health care, yet cover everyone," the Commonwealth Fund's president, Karen Davis, said during a Tuesday morning teleconference.

"It is disappointing, but not surprising, that despite our significant investment in health care, the U.S. continues to lag behind other countries," she added.

However, Davis believes new health care reform legislation - when fully enacted in 2014 - will go a long way to improving the current system. "Our hope and expectation is that when the law is fully enacted, we will match and even exceed the performance of other countries," she said.

The report compares the performance of the American health care system with those of Australia, Canada, Germany, the Netherlands, New Zealand and the United Kingdom.

According to 2007 data included in the report, the U.S. spends the most on health care, at $7,290 per capita per year. That's almost twice the amount spent in Canada and nearly three times the rate of New Zealand, which spends the least.

The Netherlands, which has the highest-ranked health care system on the Commonwealth Fund list, spends only $3,837 per capita.

Despite higher spending, the U.S. ranks last or next to last in all categories, Davis said, and scored "particularly poorly on measures of access, efficiency, equity and long, healthy and productive lives."

The U.S. ranks in the middle of the pack in measures of effective and patient-centered care, she added.

Overall, the Netherlands came in first on the list, followed by the United Kingdom and Australia. Canada and the United States ranked sixth and seventh, Davis noted.

Speaking at the teleconference, Cathy Schoen, senior vice president at the Commonwealth Fund, pointed out that in 2008, 14 percent of U.S. patients with chronic conditions had been given the wrong medication or the wrong dose. That's twice the error rate observed in Germany and the Netherlands, she noted.

"Adults in the United States [also] reported delays in being notified about abnormal test results or given the wrong results at relatively high rates," Schoen said. "Indeed, the rates were three times higher than in Germany and the Netherlands."

"As a result we rank last in safety and do poorly on several dimensions of quality," Schoen said.

In addition, many Americans are still going without medical care because of cost, she said. "We also do surprisingly poorly on access to primary care and access to after hours care given our overall resources and spending," Schoen said.

In fact, 54 percent of people with chronic conditions reported going without needed care in 2008, compared with 13 percent in Great Britain and 7 percent in the Netherlands, she said.

The United States also ranked last in efficiency, Schoen said. There are too many duplicate tests, too much paperwork, high administrative costs and too many patients using emergency rooms as doctor's offices. In addition, poverty appears to be a big factor in whether Americans have access to care, the report found.

The United States also performed worst in terms of the number of people who die early, in levels of infant mortality, and for healthy life expectancy among older adults, Schoen said.

Dr. David Katz, director of the Prevention Research Center at Yale University School of Medicine, commented that "as a physician and public health practitioner, I have routinely spoken out in favor of health care reform in the U.S. The responses evoked have not always been kind. Prominent among the counterarguments has been: 'You should see what health care is like in other countries.'"

"This report utterly belies the notion that the former status quo for health care delivery in the U.S. was as good as it gets. Others have been doing better and we can, and should, too," he said.

However, at least one expert doesn't believe that health care reform, as it now stands, will solve these problems.

Dr. Steffie Woolhandler, a professor of medicine at Harvard Medical School and co-founder of Physicians for a National Health Program, said that "the U.S. has the worst health care system among the seven countries studied, and arguably the worst in the developed world."

"Unfortunately, the U.S. will almost certainly continue in last place, since the recently passed health reform will leave 23 million Americans without coverage while enlarging the role of the private insurance industry, which obstructs care and drives up costs," she said.

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International comparisons: It's the insurance, stupid!

Below you'll find a sample "Quote of the Day" by Dr. Don McCanne, PNHP's senior health policy fellow. The quote usually features an excerpt from a late-breaking news story or health policy article, followed by a concise commentary. It can be viewed daily at PNHP's blog, www.pnhp.org/blog/, or you can subscribe to it at www.pnhp.org/qotd.

Consumers and Insurance: Experiences In Eleven Countries

By Chris Fleming
Health Affairs Blog
November 18, 2010

As the United States begins implementing health reform, how does the U.S. experience compare with that of other high-income countries? To answer that question, The Commonwealth Fund conducted its thirteenth annual health policy survey, this year focusing on access, cost, and care experiences. The survey findings were published today in a Health Affairs Web First article by Commonwealth Fund Senior Vice President Cathy Schoen and coauthors.

Overall, the survey identified significant differences between countries and found that US adults — even when insured — were the most likely to incur high medical expenses, spend more time on paperwork, and have more claims denied.

The countries surveyed were Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.

Key findings include the following:

- Twenty percent of US adults surveyed said they had had serious problems paying medical bills in the previous year. Responses to the same question from the other ten countries were in the single digits. US respondents were also significantly more likely than adults in other countries to have gone without care because of cost.
- Thirty-five percent of US adults had out-of-pocket medical spending of $1,000 during the previous year, a far higher percentage than in any other country.
- A lower proportion of adults in the United States (70 percent) than in all other countries except Sweden (67 percent) and Norway (70 percent) were confident that they would receive the most effective treatment when needed.
- When asked about access to prompt medical care, 57 percent of US adults said they had seen a doctor or nurse the same or next day the last time they were sick and needed care. Switzerland had the most rapid access (93 percent). Adults in three other countries (Canada, Norway, and Sweden) reported longer waits than US adults.
- Nearly one third of US adults (31 percent) reported either denial of payments by insurers or time-consuming interactions with insurers, a higher rate than in all other countries. Twenty-five percent of US respondents reported that their insurance company denied payment or did not pay as much as expected; 17 percent said they spent a lot of time on paperwork or disputes for medical bills or insurance — the highest rates in the survey.
- The United States had the widest and most pervasive differences in access and affordability by income of the eleven countries. The United Kingdom had the least.

http://healthaffairs.org/blog/2010/11/18/consumers-and-insurance-experiences-in-eleven-countries/

And...

How Health Insurance Design Affects Access To Care And Costs, By Income, In Eleven Countries

By Cathy Schoen, Robin Osborn, David Squires, Michelle M. Doty, Roz Pierson and Sandra Applebaum
Health Affairs, November 18, 2010

US Insurance Reforms: Challenges Ahead

Concerns expressed by US respondents were concentrated in the working-age population that is the target of insurance reforms. In this age group, wide disparities by income for those insured throughout the year underscore the importance of the Affordable Care Act's emphasis on benefits with income-related provisions. ... However, by international standards, the United States will remain an outlier for cost sharing. The annual limits for the least expensive benefit option will range from $2,000 per person ($4,000 per family) for those with incomes just above 133 percent of poverty, to $6,000 per person above subsidy thresholds. Families can opt for lower cost exposure, but only if they can pay higher premiums. [Despite the ACA's subsidies of some premiums and cost sharing], it is still possible that some of the insured will remain at substantial financial risk for care they cannot afford when sick and bills they cannot pay.

http://content.healthaffairs.org/cgi/content/full/hlthaff.2010.0862v1

Comment by Don McCanne, M.D.:

Compared to other high-income nations, the health care financing system in the United States does not perform well. We pay more; we have greater problems paying medical bills; we have excessive out-of-pocket spending; we have greater hassles with insurers; and we have the greatest disparities in access and affordability based on income levels.

We clearly needed reform, but will the Patient Protection and Affordable Care Act (PPACA) correct these deficiencies? It looks grim. The law has perpetuated the flawed system that we already have, one based on the U.S. version of dysfunctional private insurance plans plus a welfare program - Medicaid.

PPACA does include some important insurance regulations such as guaranteed issue and removal of annual and life-time spending caps, but it doesn't do much to end the administrative hassles that are designed to protect the insurers from loss (i.e., protect them from having to pay medical bills). In fact, by making plans with low actuarial values the new standard, patients will face even greater out-of-pocket expenses and administrative hassles when they access health care. The government subsidies are not adequate to reduce the problems that patients already have with paying their medical bills.

Although other countries have special provisions for low-income individuals, Medicaid is unique in that beneficiaries are enrolled in an entirely different program that generally pays much lower rates than do private insurers. Thus the Medicaid networks of willing providers can be quite different from the networks for the private insurers, which in themselves also can vary greatly from plan to plan. Care can be very disruptive as individuals move in and out of the Medicaid program because of fluctuations in their eligibility, or move between various private plans based on such factors as employment, place of residence, or premium affordability. Such disruptions can aggravate the access problems noted in this study.

Another important observation in this study is the protection that is afforded by Medicare. Quoting from Schoen et al., "U.S. adults under age sixty-five were significantly more likely to report insurance paperwork, disputes, or insurance surprises than were those sixty-five and older and covered by Medicare (35 percent compared to 16 percent). The high rates of insurance concerns among younger adults may stem from unstable coverage as well as complex benefit designs."

What we needed was a program that includes everyone, funds care equitably, eliminates financial barriers to care, provides automatic life-long enrollment, provides choice of any health care professionals and facilities, and has public funding that would ensure adequate capacity in the system. A single-payer, improved Medicare for all would have those goals.

Instead, we'll be pouring even more money into the system we have, and still compare unfavorably to these other high-income nations, that is unless we are willing to do something about it. We need to tell our policy makers, "It's the insurance, stupid!"

Fixing Medicare's Physician Payment System

Bruce C. Vladeck, Ph.D.

Now that Congress has completed the epochal, exhausting, and contentious task of enacting comprehensive health care reform, it must confront another health care issue that is perhaps even more politically difficult: reform of Medicare's physician payment system. On April 15, Congress voted to postpone a 21% reduction in Medicare fees that was to have gone into effect April 1, but a longer-term solution is not yet in sight.

The problems with the Medicare physician payment system are twofold, and each dimension poses complex political difficulties. First, Medicare is captive to an arbitrary, if elegantly conceived, formula for total payments to physicians - the sustainable growth rate (SGR). In the alternate reality of the Congressional budget process, the SGR will reduce Medicare's physician payments, which already trail those from private insurers, as far into the future as the eye can see. Second, there is widespread consensus that the relative fees in the current system are a significant cause of the growing imbalance in supply and utilization between primary care and specialty services in the U.S. health care system. That imbalance, in turn, is widely perceived as a major cause of both excessive costs and inadequate quality of care. This is not just a Medicare problem: the Medicare Resource-Based Relative Value Scale is used by most private insurers to set relative prices for physicians.

In 1997, when Congress refined the formula by which the annual change in Medicare physician fees was determined, it decided that total physician payments per beneficiary should grow no faster than the economy as a whole, as measured by the gross domestic product (GDP). Policymakers were concerned about increases in the volume of services that beneficiaries received; since total spending equals price times volume, under an aggregate cap, if volume grew more quickly, fees would grow more slowly or be reduced.[1] The expectation that total physician spending could be kept to such a level was probably unrealistic, since few countries have ever attained that target, and an increasing proportion of health care services were migrating from inpatient hospitals to the lower-cost settings of outpatient facilities and physicians' offices, which many thought would improve outcomes and save money. But the economy was growing robustly, and the SGR's framers were pursuing a broader agenda of trying to drive the entire Medicare system away from fee for service toward private, capitated plans.

Moreover, the excessively ambitious growth target is only the beginning of the problem. The SGR is a cumulative, prospective formula; if actual spending in a given year exceeds that year's target, the following year's spending is supposed to be reduced proportionately, but if that reduction is insufficient, then additional reductions must come in the future. Every time Congress postpones a formula-determined fee reduction, it compounds the difference between actual and expected fees, making the (theoretical) eventual adjustment that much more severe. Thus, since the SGR was implemented in 1998, total Medicare physician expenditures have exceeded the allowed amounts by only $20 billion (on a total of almost $1 trillion), but to recoup that all in 1 year would require a 21% reduction in 1 year's fees. And those reduced fees would then become the base for payment levels in all subsequent years.[2]

Thus, since the SGR was implemented in 1998, total Medicare physician expenditures have exceeded the allowed amounts by only $20 billion (on a total of almost $1 trillion) ... In a rational world, Congress would write off the $20 billion as a relatively small policy error and establish a more realistic prospective formula.

In a rational world, Congress would write off the $20 billion as a relatively small policy error and establish a more realistic prospective formula. But under Congressional budget rules, the cost of doing so is not $20 billion, but $20 billion per

year, compounded by inflation, times 10 years. The Congressional Budget Office and the Office of Management and Budget are required to assume that someday Medicare's physician fees will be permanently lowered to SGR levels and that anything above that amount is "extra spending."

Of course, even $250 billion over 10 years is a rounding error relative to an annual deficit of $7 trillion, but elected officials, while steering every nickel they can to their constituents or contributors, like to pose as sworn opponents of deficit spending. Out of context, $250 billion certainly seems like a lot of money, and in today's U.S. Senate, it takes only a handful of politicians to bring the legislative gears to a halt. In fact, early last year, the House of Representatives passed legislation that would have changed the budget rules to permit a more sensible fix for the SGR, but the proposal died in committee in the Senate.

The country's long-term budgetary status is a serious problem, and budget discipline has to begin somewhere. But everyone seems to agree that reducing Medicare's physician fees by 21%, in perpetuity, while private fees continue to increase might create access problems for at least some beneficiaries and might harm providers whose high volume of service to Medicare beneficiaries leaves them especially dependent on Medicare revenues.

As if that weren't problematic enough, the basic mechanics of the Medicare Physician Fee Schedule, which was supposed to change physician payment to increase rewards for primary care services at the expense of procedural and interventional services, appears to have gone totally off track. For various reasons, the fee schedule, which originally did increase the prices of evaluation and management services relative to those of surgery or invasive procedures, turned in the other direction through the process of annual updating of relative value units.[3] Surgeons, radiologists, and some medical specialists are now paid two to three times as much per hour as providers of cognitive services, which is about where we began 20 years ago; this was the situation that the fee schedule was supposed to fix.

The question of the relative virtues of primary versus specialty care can be debated ad nauseam, but in other wealthy countries that serve their populations at least as well as we do, the ratio of primary care physicians to specialists is much higher than in the United States, and the gap in compensation is much smaller or the poles even reversed.[4] Young physicians, burdened by increasing educational debts, may well choose a career path on the basis of a major difference in compensation, especially when the better-compensated positions require less ongoing responsibility for patients and offer better working hours.

Under a budget constraint, however, changes to the relative fees paid to various categories of physicians give rise to zero-sum "distributional politics"; there may be a theoretically correct way to determine relative fees, but that is largely irrelevant to a legislative process in which various groups are free to pursue their self-interests. The only general solution to such a political free-for-all is to increase the total pot available for distribution - as is customarily done, for instance, in the realm of agricultural policy. Last year's House-passed health care reform bill took this approach, and the final reform law does add a modest amount of money to primary care fees.

But here the two dimensions of the problem intersect. The way to redress the imbalance between primary care and specialty compensation while shrinking the disparity between Medicare and private insurance is to add more money to primary care while leaving specialists' fees unchanged, on average. But doing so worsens the federal deficit, providing fodder for those who pose, at least, as opponents of deficit spending. And then the pundits argue that fixing the current system isn't really worth the bother - that fee-for-service payments are so intrinsically counterproductive that we should just scrap them in favor of something better.[5] Except that no one knows what that something is.

The enactment of health care reform after many considered it irreversibly derailed by the Senate election in Massachusetts has suggested to some that perhaps the U.S. political system is not so hopelessly gridlocked after all. Health care reform, some believe, might be a harbinger of a more sensible and productive approach to solving serious policy problems. Untying the political knots enmeshing Medicare physician payment will test that optimism.

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

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TORONTO STAR

Public health care as sustainable as we want it to be

Claim that medicare is too costly to maintain is based on economic and political myths

By Robert G. Evans

"There are stark and unpalatable choices that we face with respect to health care, but there is no magic solution. We absolutely must have an adult debate about how we deal with this." That's what David Dodge, former governor of the Bank of Canada and former deputy finance minister, told the Liberal policy conference last March.

Dodge joined a list of economists and other pundits who predict that public health care will be financially unsustainable in coming years as Canada faces an aging population and escalating costs for scientific advances in care and treatment. But an "adult debate" on the sustainability of public health care must start from who and what drives health-care spending.

It's true that total health-care spending in Canada has risen in recent years, taking larger shares of both government revenues and budget allocations. This has led to accusations of "crowding out" other public programs by those favouring further privatization of health care.

The data tell a much more nuanced story. The central fact is that, recession years apart, medicare spending — hospitals and physicians' services — has fluctuated between 4 per cent and 5 per cent of gross domestic product since 1975. After the introduction of medicare in the late 1960s these costs stabilized because universal, comprehensive coverage consolidated expenditures in the hands of a single payer. The cost of health services not covered by medicare has risen from 3 per cent of GDP in 1975 to 7 per cent in 2009.

Today, Canada's expenditures on health care match those by other OECD countries. The public share of overall health costs in Canada is relatively low for high-income OECD countries, around 70 per cent. Private insurance, primarily for prescription drugs and dentistry, now accounts for 12.7 per cent of Canadian health spending, 14th highest in the world. The OECD outlier is the United States, where extensive private finance supports uncontrollable cost escalation (now over 16 per cent of GDP). Getting these costs under control will be the major task facing Obama's health-care reform.

Provincial governments' spending on health care over the past 15 years has taken increasingly larger bites out of their expenditure budgets. But this is a simple consequence of large cuts in non-health programs, not of out-of-control medicare spending. These cuts in non-health spending are traceable to substantial cuts in personal and corporate income taxes by the federal and most provincial governments, particularly since 1997. Between 1997 and 2004, these tax cuts removed an estimated $170.8 billion from public sector revenues. Total provincial revenues are by now roughly $35 billion per year less, or about half provincial spending on medicare. Cumulative federal cuts are at least as large.

The provinces' revenue shortfalls were not all self-inflicted. The federal government's large cuts in financial transfers since the mid-1990s also left big holes in provincial budgets. Subsequent increases have not fully made up the loss.

What are the real motives behind the claims of financial unsustainability? Two, I think. First, under Canada's universal tax-financed medicare, higher-income people contribute proportionately more to supporting the health-care system, without receiving preferred access or a higher standard of care. Any shift to more private financing would reduce the relative burden on those with higher incomes and offer (real or perceived) better or more timely care for those willing and able to pay.

Second, every dollar of health-care expenditures is also a dollar of someone's income. The Ontario government's recent change in reimbursement for generic drugs made this clear: the shares of Shoppers' Drug Mart fell 10 per cent overnight. Privatization is a way to avoid cost containment, reopening greater income opportunities for providers of care (and private insurers) outside public control. Expenditures would accordingly rise, as in the United States, but public budgets might (in the short term) be contained. "Unsustainable" public spending magically becomes sustainable when shifted from taxpayers to patients.

It is time, long past time, for an "adult conversation" about these motivations, and for a clear identification of the winners and losers from eroding or dismantling medicare. (Economists who evade this issue should be shamed.)

But it is also time for an adult conversation about the real drivers of cost escalation. Researchers have known for decades that population aging is a real but a minor factor. Its impact will certainly increase, but it will remain secondary to increases in intensity and costliness of care. This is the real issue. Where is the money going, both public and private, and are we getting value? Again the Ontario generic drug initiative makes the point. Rising expenditures are not a law of nature; several hundred millions will be cut at a stroke. The real issue is political; those millions are also cut from pharmacy's incomes.

Are there other opportunities? Yes. Medical imaging and laboratory testing are currently the major sources of cost escalation. What are the benefits? No one knows. Ultrasound

THE GLOBE AND MAIL

NOVEMBER 12, 2010

Privatizing health care is risky for all of us

By Danielle Martin and Irfan Dhalla

In poll after poll, Canadians reaffirm their commitment to a health-care system in which access is based on need rather than wealth. So it stands to reason that opening up medicare to a private second tier would be bad for people who have no choice but to rely on the public system. With a relatively fixed number of health-care providers, wait times in the public system would increase as staff were recruited to the private sector. From Australia to Zimbabwe, this scenario has unfolded repeatedly around the world.

But, deep down, some of us wonder: If I had the money to buy my way to the front of the line, wouldn't I be better off in a two-tier system?

The answer, perhaps surprisingly, is probably not. Private health care would be almost as bad for the wealthy as for the poor, as long as the public system provides high-quality care (and most Canadians who use the system rate it highly).

The reason is, there's such a thing as too much health care – too many tests, too many interventions and too many pills. The emergence of for-profit health care in Canada would produce just this situation – not enough health care for some, and too much health care for others.

This is exactly what happens in the United States, where people with private health insurance find themselves subjected to the risks of unwarranted procedures. The U.S., for example, has the highest rate of invasive cardiac procedures in the world – 45 per cent more than the next highest country. Yet, all these additional procedures have not bought Americans better heart health. Worse still, each invasive cardiac procedure carries a small but real risk of a serious complication – stroke, a torn coronary artery or even death.

Similarly, in a two-tier system, the wealthy would be bombarded with advice to get "checked out," and many would end up receiving unwarranted screening tests such as CT scans, which produce enough radiation to increase the risk of cancer.

Even if there were a well-developed private health-care system in Canada, the wealthy would still need to use the public system for many forms of health care – trauma care, for example – because the private system would focus on elective and outpatient care. The erosion of political support for medicare probably would result in worse public care for everyone.

A two-tier system also would be bad for business. In a world where wealth buys faster access to more health care, corporations would be expected to pay for their employees to jump to the front of the line. Some Canadian businesses do this already, purchasing too much health care – executive physicals, for example – for their most-favoured employees. The cost of providing too much health care for a large proportion of the work force would be enormous.

Bank CEOs understand this already. Charles Baillie, the former CEO of TD Bank, said a few years ago: "I choose to talk about health care as a banker – as a corporate leader – because I believe it's high time that we in the private sector went on record to make the case that Canada's health-care system is an economic asset, not a burden, one that today, more than ever, our country dare not lose."

Danielle Martin is a family physician at Women's College Hospital in Toronto; Irfan Dhalla is a general internist at St. Michael's Hospital. Both serve on the board of Canadian Doctors for Medicare.

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for low-risk pregnancies is up 50 per cent in 10 years. Why? Patterns of medical practice and hospital use vary widely across the country, for no apparent reason. Toronto's Institute for Clinical Evaluative Science, among others, has tracked some of these large unexplained variations, but they are largely ignored. These are what we need to discuss, not "stark choices" about relieving the burdens on and improving the benefits for high-income taxpayers — and, incidentally, opening new markets for private insurers. Panic-mongering about a "grey tsunami" is simply a distraction.

Canadians consistently show that they support public health care. In May, a national poll by Nanos Research confirmed that 90 per cent of Canadians feel that health care is the most important national issue, and almost 90 per cent support public solutions to problems in the health-care system. They are right. Canada's health-care system is as sustainable as we want it to be.

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Newsweek

NOVEMBER 5, 2010

Repeal and Replace?

Not so fast. An insurance-company defector explains why the most controversial provision of the health-care law will survive.

By Wendell Potter

Conservatives who voted for congressional candidates because they pledged to repeal and replace the health-care-reform law are in for a rude awakening. Once those newly elected members of Congress have a little talk with the insurance industry's lobbyists and executives, they will back off from that pledge. They will go through the motions, of course. They'll hold hearings and take to the floor of both Houses to rail against the new law, and they'll probably even introduce a bill to repeal it with much fanfare - but it will all be for show. That's because health insurers, one of Republican candidates' biggest and most reliable benefactors - the industry contributed three times as much money to Republicans as to Democrats since January - can't survive without it.

Despite all the attacks on "Obamacare," the new law props up the employer-based system that insurers and large corporations benefit from so greatly. It also guarantees that private insurers will get billions of dollars in new revenue. And the insurers won't have to share a penny of that windfall with a government-run public option the president once said was necessary "to keep insurers honest."

I know what the insurers are thinking because, not long ago, I was on their side. I am sorry to admit it, but over nearly two decades I had a hand in planning the industry's PR and public-policy strategies to either kill or shape any health-care reform proposal that might hinder profits. I was part of the strategic-communications team that planned and carried out the successful attack on the Clinton plan in the 1990s as well as the one that killed the patients' bill of rights a few years later. I left my job handling communications for Cigna in 2008 because I didn't have the stomach to be part of yet another spin campaign to cheat Americans out of the reform they needed.

For months before I left my job, I worked closely with my counterparts at the other big insurers to develop the list of must-haves our well-connected army of lobbyists would take to Capitol Hill when lawmakers began drafting reform legislation. Despite their public statements to the contrary, insurance companies really liked much of what was in both House and Senate versions of the bill - big chunks of which they actually wrote behind the scenes - especially the requirement that all Americans buy insurance if they're not eligible for an existing public program like Medic-aid or Medicare.

During the reform debate, the industry's deception-based PR strategy had two active fronts. One was a highly visible charm offensive designed to create an image of the industry as an advocate for reform and a good-faith partner with the president and lawmakers in achieving it. The second was a secret fearmongering campaign using shadowy "AstroTurf" groups and business and political allies as shills to disseminate misinformation and lies - like the one about the creation of "death panels" - with the sole intent of killing any reform that might hurt the bottom line.

Although I was ashamed of many of the things I did during my career, I didn't plan to speak out about the industry's devious practices until I saw Karen Ignagni, president of America's Health Insurance Plans, tell President Obama at the end of his March 2009 White House Forum on Health Reform, "You have our commitment to play, to contribute, and to help pass health-care reform this year." Then I knew the industry's disingenuous charm offensive had begun. Soon after that I read that, Aetna chairman and CEO Ron Williams, the driving force behind the industry's effort to get the individ-

ual mandate enacted, had met with the president half a dozen times. I knew Williams was trying to persuade the president to drop his insistence on the public option and to embrace the individual mandate. Sure enough, Williams got his wish.

It is ironic, of course, that the requirement to purchase insurance has become the centerpiece of Republicans' condemnation of the new law and their court challenge of its constitutionality. Insurers have no reason to worry, however, because they fare very well when the Republicans are in charge. Their profits soared - as did the number of Americans who are uninsured and underinsured - during the Bush years and Republican control of Congress.

The real reason insurers want the GOP leading Congress again is not to repeal "Obamacare," but to try to gut some of the provisions of the law that protect consumers from the abuses of the industry, such as refusing to cover kids with preexisting conditions, canceling policyholders' coverage when they get sick, and setting annual and lifetime limits on how much they'll pay for medical care. Insurers also hate the provision that requires them to spend at least 80 percent of premium revenues on medical care, as well as the one that calls for eliminating the billions of dollars that the government has been overpaying them for years to participate in private Medicare plans. (Be on the lookout for a death panel-like fearmongering campaign to scare people into thinking, erroneously, that Granny and Pawpaw will lose their government health care if Congress doesn't restore those "cuts" to Medicare.)

Insurers are not waiting for all their new members of Congress to be sworn in to get what they want. They and their big-business allies are already pressuring the Obama administration to waive or delay the implementation of provisions they don't like, all the while working behind the scenes not only to protect the individual mandate but to have the government enforce it with much greater gusto. The one thing the industry didn't like about the mandate provision was that the penalties for not buying their overpriced products won't inflict nearly enough financial pain.

Retiring Sen. Judd Gregg (R-N.H.), who once had been a part of the repeal-and-replace brigade, provoked the wrath of conservative pundits shortly before the midterm elections when he said, in a moment of unguarded candor, that repealing the law was not realistic. Instead, he said, the GOP should focus on "retooling" it. You can be certain that insurance-industry lobbyists will be helping their newly expanded congressional caucus determine what needs retooling. As my former Cigna colleague Bill Hoagland, the company's top lobbyist, told the Associated Press a few days ago: "If you ended up repealing [the individual mandate], the whole thing blows up. It doesn't work. The cost would explode." In other words, feel free to repeal those pesky consumer protections, but keep your hands off our mandate.

Potter is a senior analyst at The Center for Public Integrity. This piece is based on his new book "Deadly Spin," published by Bloomsbury Press.

Insurers mulled pushing Michael Moore 'off a cliff'

An excerpt from Amy Goodman's "Democracy Now" interview with Wendell Potter on Nov. 16, 2010.

WENDELL POTTER [former executive, Cigna]: ... We were concerned that the movie ["Sicko," the documentary by Michael Moore] would be as successful as "Fahrenheit 9/11" had been. And we knew that if it were, it really would change public opinion about our health care system in ways that would be harmful to the profits of health insurers. So, it was very important for this [attack] campaign to succeed. At one point during a strategy meeting, one of the people from [the insurance companies' public relations firm] APCO said that if our efforts, our initial efforts, were not successful, then we'd have to move to an element of the campaign to push Michael Moore off a cliff. And not meaning to do that literally, but to -

AMY GOODMAN: Are you sure?

WENDELL POTTER: Well, I'm not sure. To tell you the truth, when I started doing what I'm doing [as a whistleblower], I was concerned about my own health and well-being, maybe just from paranoia. But these companies play to win. And we're talking about some big bucks at stake here – billions and billions and billions of dollars.

AMY GOODMAN: So what were they talking about when they said, "If this doesn't work, we're going to push him off the cliff"?

WENDELL POTTER: Well, it would be just an incredibly intense PR effort, if necessary, to spend more premium dollars to defame Michael Moore, to discredit him even more as a filmmaker.

Full: http://bit.ly/8ZfRHE

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Massachusetts doctors snub state's health reform as model for country, pick single-payer system instead

FOR IMMEDIATE RELEASE
Oct. 22, 2010

Contact:
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Mass-Care: The Massachusetts Campaign for Single Payer Health Care

BOSTON – For the first time the Massachusetts Medical Society has asked doctors what they think about health reform in its annual "Physician Workforce Survey" of 1,000 practicing physicians in the state, and the results may strike some as surprising.

A plurality of the physician respondents, 34 percent, picked single-payer health reform as their preferred model of reform, followed by 32 percent who favored a private-public insurance mix with a public option buy-in. Seventeen percent voted for the pre-reform status quo, including the permissibility of insurers offering low-premium, high-deductible health plans.

Remarkably, only 14 percent of Massachusetts doctors would recommend their own state's model as a model for the nation. A small number of respondents, 3 percent, chose an unspecified "other."

In other words, the doctors with the most on-the-ground experience with the Massachusetts plan, after which the Obama administration's new health law is patterned, regard it as one of the least desirable alternatives for financing care.

The findings contrast with an earlier survey of Massachusetts physicians' opinions on health reform funded by the Blue Cross Blue Shield of Massachusetts Foundation and the Robert Wood Johnson Foundation. That survey, published in the New England Journal of Medicine in October 2009, found that three-fourths of doctors in the state support the Massachusetts reform law. However, the survey did not allow respondents to express their preference for alternative models of health reform.

Dr. Rachel Nardin, chair of neurology at Cambridge Hospital and president of the Massachusetts chapter of Physicians for a National Health Program, said: "Massachusetts physicians realize that the state's health reform has failed to make health care affordable and accessible, and won't work for the nation. These findings show the high support for single-payer Medicare for all by physicians on the front lines of reform."

While many in the country look to Massachusetts as a role model for the country, Dr. Patricia Downs Berger, co-chair of Mass-Care, the single-payer advocacy coalition in Massachusetts, and a member of the Massachusetts Medical Society, notes, "Physicians in Massachusetts, particularly after health reform, know from experience that the current health care system is not sustainable and is not addressing the deep inequalities and high costs faced by patients, and they are calling for a more fundamental change."

A survey published in the Annals of Internal Medicine in April 2008 showed that 59 percent of U.S. physicians support government action to establish national health insurance, an increase of 10 percentage points over similar findings five years before.

By Barbara Starfield

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Reinventing Primary Care: Lessons From Canada For The United States

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ABSTRACT **Canada is, in many respects, culturally and economically similar to the United States, and until relatively recently, the two countries had similar health systems. However, since passage of the Canada Health Act in the 1970s, that nation's health statistics have become increasingly superior. Although the costs of Canada's health system are high by international standards, they are much lower than U.S. costs. This paper describes several factors likely to be responsible for Canada's better health at lower cost: universal financial coverage through a so-called single payer; features conducive to a strong primary care infrastructure; and provincial autonomy under general principles set by national law.**

This paper compares the health system characteristics of Canada and the United States, as well as costs of care, population health status, and the degree of disparities in health and health services in the respective countries. The results of these comparisons and those with other industrialized countries are discussed in the context of recently enacted U.S. reforms.

Similarities And Differences

In many ways, Canada is more similar to the United States than any other country is. The two countries share a history as British colonies, and both are Anglo-Saxon countries with the same primary language. Although smaller in population (about 33 million versus about 300 million), Canada is geographically vast—even larger than the United States. Their populations are similarly heterogeneous, including the percentage that is foreign-born: 20 percent in Canada versus 13 percent in the United States.

TAXES AND FINANCES From a financial and economic standpoint, there are also a number of similarities. The two countries' tax structures are similar: 36 percent of revenues raised come from personal income taxes in both countries, and the highest tax rate for personal income is 46 percent in Canada and 44 percent in the United States. The percentage from social security taxes is similar as well—17 percent in Canada and 21 percent in the United States. Approximately 10–11 percent is raised from corporate taxes in both nations, and maximum corporate tax rates are also similar—36 percent in Canada and 39 percent in the United States. The percentage of gross pay going to disposable income, or income after taxes and social transfers, is somewhat higher in the United States (89 percent) than in Canada (76 percent).[1,2]

HEALTH SYSTEMS When it comes to health systems, there are both similarities and differences between the nations. In 2007 the United States had 2.4 physicians per 1,000 population—growth from 1990 to 2007 of 1 percent—compared with Canada's ratio of 2.2 per 1,000 population and growth of 0.2 percent. In the United States, there are 50 percent more specialists than primary care physicians, compared with 10 percent more specialists in Canada.[3] In 2007 Canada had 99 general physicians and 94 specialist physicians per 100,000 population.[4] Comparable figures for the United States are 100 gen-

eral physicians (including family physicians, general pediatricians, general internists, and obstetrician/gynecologists) and 207 specialists per 100,000.[5] (These data may differ slightly from other data because of a very stringent definition of *specialists*.)

MEDICAL EDUCATION Medical education systems are similar in both countries. Some Canadian medical schools require only two years of university education, whereas others require three or four. All are accredited by the Joint Liaison Committee on Medical Education, which also accredits U.S. medical schools. Canadian and U.S. medical school curricula are virtually identical, as are the characteristics of residency programs. In the early 1990s, half of Canadian medical graduates went into family medicine,[6] but this percentage declined to 32 percent by 1998 and 24.5 percent by 2004.[7]

FEDERAL SYSTEM STRUCTURE One notable feature makes comparisons with Canada particularly apt for the United States. Canada's health care system has a strong federal structure but also allows considerable flexibility in health policy making at the provincial and territorial levels.

The Provincially Based Canadian Health Care System

In contrast to the historical roots of health systems in many Western industrialized countries, Canada's health reform efforts are relatively recent—although old enough to have become stable. Before the 1950s, Canada's health care system resembled that of the United States today. Canada's current health care system can be traced to reforms enacted in Saskatchewan in 1947, when publicly administered hospital insurance was introduced. That was followed in the 1950s and 1960s by increasing public coverage of ambulatory services for Saskatchewan residents.

One by one, other provinces followed Saskatchewan's example. By 1972 the advantages of such coverage were sufficiently well accepted to lead to the passage of the Canada Health Act, which made universal coverage available to all citizens across the entire country.[8] Canada's national health care system included features that offered strong support for primary care—for example, no copayments for primary care visits, coupled with incentives to seek comprehensive care from generalists.[9]

LIMITED PRIVATE INSURANCE In Canada, private health insurance for medical care services is not permitted for services covered by the governmental health insurance, which covers hospital, ambulatory, and nursing home care. The Canada Health Act mandates that all "necessary care" be provided without charge to patients. (Pharmaceuticals, private rooms in hospitals, dental care, home care, physiotherapy, and chiropractic care are not covered by the act.)

PUBLIC INSURANCE PLANS Public insurance plans are administered by ten provincial and three territorial governments, which may add services to those covered by the national government. Consolidated government financing of health comes partly from the federal government, which has been decreasing its share of the funding from 25.2 percent in 2005 to 21.4 percent in 2009. The remainder is generated by provincial and local governments through a variety of taxes.[10]

Details of administering public health plans are set by the provincial governments and vary across provinces. For example, there are major differences from one province to another in who qualifies for admission to a nursing home. Prescription drug benefits also vary, as provinces can set their own payment rates and policies regarding such issues as use of generic drugs and deductibles or copays.[11]

PRACTICES AND HEALTH CENTERS As in most countries, private practitioners and specialized health centers continue to exist in Canada. The Canada Health Act prohibits these doctors and clinics from participating in the governmental insurance plan if they accept private insurance for covered services.

Most hospitals and nursing homes are government financed but operated by community and regional boards. Ambulatory services are provided by physicians who bill primarily by fee-for-service—in Canada, this is called the assessment fee system—with rates set by negotiation with provincial medical associations. Specialists are paid more for a visit made on referral—paid through consultation fees—than for a nonreferred visit. This acts as a deterrent to direct access to specialists for services that should be provided in primary care.

In 2005 the Supreme Court in Quebec ruled for a physician who argued that prohibiting private insurance jeopardizes the well-being of people urgently needing treatment. Since then, the provincial government of Quebec decided to pay for key procedures such as cancer surgery, heart surgery, joint replacement surgery, cataract treatment, and certain tests such as mammography in private centers. The situation is in considerable flux, as other provinces contemplate similar changes.

COSTS At least until now, the administrative simplicity of the Canadian national health insurance has been partly responsible for much lower costs of health care in Canada. In recent years, those costs have been approximately $2,500 less per person per year than in the United States,

with a growth rate of about 3.5 percent per year in Canada versus a U.S. rate of about 5 percent. The system enjoys the support of the vast majority of Canadian citizens.[12]

CARE SEEKING Joseph Ross and Allan Detsky[13] contend that Canadians arguably have more choice in access to providers and services. There are no restrictions on Canadians' choice of physicians or hospitals, whereas Americans are often restricted in such choices by the terms of their insurance plans.

Although the Canadian system provides incentives for seeking care from primary care physicians rather than from specialists, patients can see any specialist on referral as well as directly. If patients consult specialists directly, these specialists can be paid for a nonreferral visit at the lower "assessment" fee. In contrast, 40 percent of Americans report difficulties in seeing a specialist. Of those who report difficulty, 40 percent cite long waiting times, 31 percent cite a denied referral, and 17 percent say they cannot afford private insurance.[13]

AVAILABILITY OF TECHNOLOGY Although there is a much greater supply of the most sophisticated technology, such as magnetic resonance imaging (MRI), in the United States than in Canada, Canadians' waiting times for such diagnostic services are relatively short. Virtually all high-tech diagnostic services are available in Canada, and for those services required but not available, patients are referred to the United States with reimbursement by Canadian health insurance. There is little elective use of U.S. services by Canadians[14] and no copayments to deter use.

USE OF SERVICES An international comparison of physician use—both the likelihood of seeing one or more physicians and the frequency of visits to physicians—found that low-income people in the United States have many fewer visits than wealthier people. However, in Canada the differences among income groups are smaller, even after differences in self-reported health are controlled for. Also, in Canada the frequency of visits to primary care physicians is "pro-poor," meaning that there are more visits by needier populations[15]—at least in part as a result of the absence of copays and better distribution of primary care physicians.[9] Within Canada, a study in Ontario found that family income was not independently associated with less use of either primary or specialist care, even after higher illness rates among lower-income people were controlled for. There are differences by education level in frequency of use of specialist visits and number of nonreferred specialist visits,[16] which may suggest that highly educated Canadians are able to persuade specialists to grant them an appointment without a referral.

Health Status Comparisons

Canada differs greatly from the United States in terms of health status and health system characteristics.

INTERNATIONAL RANKINGS Exhibit 1 shows how the United States and Canada rank among industrialized countries for major indicators of health. Of the twelve indicators, Canada has better rankings than the United States for ten, thus confirming findings from the 1990s. The earlier study examined health outcomes, costs of care, and the primary care orientation of thirteen Organization for Economic Cooperation and Development (OECD) countries. Canada ranked third on costs of care, behind the United States

EXHIBIT 1

Health Outcomes: How Canada And The United States Rank Among Organization For Economic Cooperation And Development (OECD) Countries, 2009

	Canada (rank)	U.S. (rank)
Life expectancy at birth	9	25
Life expectancy at age 65 (males)	4	8
Life expectancy at age 65 (females)	4	14
Potential years of life lost (age 70)	13	21
Ischemic heart disease mortality, males	7	5
Ischemic heart disease mortality, females	7	9
Stroke mortality, males	2	4
Stroke mortality, females	3	6
All cancer mortality, males	12	7
All cancer mortality, females	22	23
Infant mortality	24	26
Asthma mortality, ages 5–39	18	21

SOURCE OECD health data, 2009. **NOTE** Age-standardized where appropriate.

and Germany. In all thirteen health indicators in the earlier study, Canada ranked well above—in other words, better—than the United States, consistent with its much higher primary care services rating and ranking.[17]

HEALTH STATUS RANKINGS Exhibit 2 provides death rates for major causes of death in the two countries. The OECD data are also consistent with a variety of studies showing that Canadians, on average, are healthier than Americans, with lower rates of mortality, mobility limitations, obesity, hypertension, diabetes, and respiratory disorders. These differences have been attributed to better access to health services and fewer social disparities overall.

The United States does marginally better on five-year survival from cancer.[18] In women, the survival figure is 61 percent in the United States versus 58 percent for Canada. Comparable figures for men are 57 percent U.S., 54 percent Canada.[19] Part of the slight U.S. superiority here may be a result of more rapid availability of new drugs,[20] some of which may be major advances. However, these figures do not control for possible differences in detection at earlier stages, which would artificially elevate short-term survival in the United States.

Studies of deaths from treatable conditions also show better performance of the Canadian health system compared with that of the United States, and the differences are not a result of existing racial disparities. That is, the worse health of the U.S. population compared with that of Canadians is found even when comparisons are restricted to the white population.[8] Long-term comparisons show that the life expectancy of Americans has been worse than that of Canadians since the beginning of the twentieth century, but that most of this difference was a result of lower life expectancy among African Americans. However, this situation changed in the 1970s, when Canadian life expectancy rose even above that of white Americans.

Differences in death rates have increased over time, with Canada improving in rank and the United States declining in rank.[21] Differences by cause of death for conditions amenable to medical care are on the order of 25–60 percent lower in Canada than among U.S. whites and have increased over time since the 1980s. In particular, death rates from cervical cancer, hypertension and stroke, ischemic heart disease, tuberculosis, appendectomy, cholecystectomy (gall bladder removal), and hernia declined in both countries but to a greater extent in Canada.[8]

Survival rates from various cancers (summarized by Stephen Kunitz and Irena Pesis-Katz)[8] showed few if any differences in the survival of various income groups in Canada but substantial differences in the United States. Their analysis also found that survival of poor people in Canada is better than in the United States for both African American and white populations. What's more, it showed that there are few, if any, differences in survival among middle- and upper-income people in the two countries but better survival among lower-income Canadians than among lower-income Americans.

EXHIBIT 2

Health Data For Canada And The United States, 2004–2006

	Canada	U.S.
Life expectancy at birth (years)	80.7	78.1
Life expectancy at age 65, males (years)	18.2	17.4
Life expectancy at age 65, females (years)	21.4	20.3
Potential years of life lost, age 70, males	4,168	6,291
Potential years of life lost, age 70, females	2,554	3,633
Acute myocardial infarction deaths, males	58.3	53.8
Acute myocardial infarction deaths, females	28.1	29.5
Stroke mortality, males	33.9	37.2
Stroke mortality, females	30.9	36.2
All cancer mortality, males	204.6	193.5
All cancer mortality, females	162.9	148.6
Infant mortality	5.0	6.7
Diabetes mortality, males	23.2	23.4
Diabetes mortality, females	14.7	17.6
Deaths from respiratory disease, males	57.1	70.4
Deaths from respiratory disease, females	34.3	49.7

SOURCE OECD health data 2009. **NOTES** Mortality is rate per 100,000. Data for specific years for individual listings may differ from those in Exhibit 1.

Women of low socioeconomic status have poorer age-adjusted survival from breast cancer in the United States (compared to women of higher socioeconomic status) but not in Canada. This relative advantage in breast cancer survival in Canada is primarily in the nonelderly population. Among U.S. low-income women older than age sixty-five, breast cancer survival rates are similar to those in Canada, most likely due to U.S. Medicare coverage.[22]

Confirmation that the U.S. health disadvantages are not due to racial and ethnic differences is provided by a comparison of health status in the United States and England, in which only the non-Hispanic white U.S. population was included.[23] This study stratified the two populations according to social status and found consistently worse health—as measured by self-reports as well as lab tests—at all U.S. social levels. Although social policies may contribute to these differences, the much stronger primary care infrastructure in England, as in Canada, is a factor.

The 2002–03 Joint Canada/United States Survey found higher rates of obesity, more poor health among low-income groups, similar rates of dental services among those with dental insurance, and more medication use among those ages 45–64 in the United States than in Canada. Having any type of insurance in the United States was associated with higher likelihood of identifying a usual source of care.[24] The relative superiority of health in Canada, especially below age sixty-five, increased after the provincial plans and Canada Health Act were passed.

Useful Lessons From Canada And Elsewhere

Differences in health—both overall and regarding social disparities—in two countries that are otherwise quite similar are attributed to the important effect of two related phenomena: achievement of important health-system characteristics and a strong clinical primary care infrastructure in Canada.[17] Several international studies have confirmed the importance of three health-system characteristics of countries that achieve better health at lower cost: government attempts to distribute resources, such as personnel and facilities, equitably; universal financial coverage either through a single payer or regulated by the government; and low or no cost sharing for primary care services.[17,25,26]

The benefits of health insurance are widely known. Less well known is that a major function of health insurance is to facilitate access to primary care services.[27,28] Within the United States, states and areas with better primary care resources have better health status, as measured by many health indicators, including life expectancy. Additionally, there is no clear relationship between insurance characteristics—such as the extent of population coverage and cost of premiums—and supply of primary care physicians at the state level.[29,30]

PRIMARY CARE U.S. policy achieves none of the three structural characteristics of good health systems.[31,32] Canada achieves all three. At the same time, although Canada's efforts to distribute resources equitably have been more extensive and successful than in the United States, Canada's are less adequate than in other countries, such as Sweden, Finland, Denmark, the Netherlands, Spain, and the United Kingdom.[9]

The important clinical features of primary care include person-focused, rather than disease-focused, care over time; easy access to facilitate first-contact use of services; comprehensiveness of services within primary care settings; and coordination of care when people seek care elsewhere. These features are all reflected in the joint principles[33] of the U.S. primary care organizations.

The U.S. neglect of primary care is reflected in differences in people's reported experiences with their care. In 2007, fewer than one in eight Canadians believed that their health system needed rebuilding, compared with more than one in three Americans. Similarly, fewer than one in eight reported forgoing care in Canada compared with more than one in three in the United States. Fewer than one in eight Canadians thought that they received unnecessary care, compared with one in five Americans.

There are few differences in accessibility to primary care among those with insurance in the United States and Canada, whereas there is greater accessibility to specialist care in the United States. Similar levels of coordination-of-care problems are found in both countries. Yet Canadians are more likely than Americans overall to report positive experiences with patient-centered care.[34] Canadians also are less likely than Americans to report a variety of medical, medication, and lab errors.

Canadians with chronic illnesses spend less out of pocket for drugs, use fewer drugs, are less likely to see many specialists, and report less conflicting advice, compared to their U.S. counterparts.[35] Because Canada does not do as well as other countries on various aspects of primary care, the even poorer U.S. experiences in these areas are more striking.

Declines in the primary care workforce in the past decade in Canada are being addressed. The effort includes reallocation of funds to increase the number of instructional hours for family physicians in the first two years of postgraduate

training and to provide for family medicine support groups.[36] In contrast, the United States continues to follow a long pattern of rising production of specialists with falling supplies of primary care physicians. Unless there is concerted action to rebuild the U.S. primary care workforce, only about 16 percent of entering residents are likely to embrace primary care.[7,37]

UNIVERSAL SYSTEM The United States is the only OECD country to lack a universal, publicly accountable health insurance system and the only one to rely on employer-based health insurance for the nonelderly population. Of seven OECD countries that are commonly thought to provide lessons for U.S. health reform, three—Canada, the Netherlands, and the United Kingdom—have no cost sharing for primary care (although the Netherlands is instituting copayments for certain insurance options).

France protects patients with chronic illnesses from coinsurance fees. Germany does not impose cost sharing for preventive services for children and for those who identify a regular source of care. Germany also limits yearly copays to 1–2 percent of annual income for people with chronic illnesses or low incomes.[38] Both Australia and New Zealand require copayments, with exceptions for some low-income patients.

The Netherlands, New Zealand, and the United Kingdom require patients to register with a general practitioner, who acts a gatekeeper to specialists.[34,35] The pharmaceutical review process is stronger in Canada than in the United States by virtue of reviewing both the clinical and cost-effectiveness of drugs compared with alternative therapies (instead of just placebos). Several countries make concerted efforts to distribute resources across their populations according to different degrees of need.[17]

The United States also is the only industrialized country to lack a national strategy to address important building blocks of a strong primary care system, including services delivery, workforce, information systems, medical products, vaccines, technology policy, financing, leadership, and governance.[39] International experiences demonstrate that national stewardship, financing, and generation of resources are important for an adequate primary care infrastructure.[40]

Universal health insurance alone is not sufficient to raise a country's health levels to match those of countries with the best levels.[17] Within the United States, there is a greater relationship between the presence of a good supply of primary care physicians and life expectancy than there is between either broad insurance coverage or affordability of coverage and life expectancy.[29,30] Universal coverage alone, particularly if not organized through a single payer with uniformity of benefits, could expand access to inappropriate services.

Conclusion

Canada's experiences show how these critical features of health systems can be achieved in the context of a federal structure with decentralized administrative control. Although Canada has achieved better health levels than the United States has for many decades, the gap has widened over time, following the development of the different provincial plans that culminated in national legislation in the early 1970s.

Comparisons of OECD data since the 1970s indicate U.S.-Canadian gaps. These have widened from one or two international rankings in the 1970s to as many as fifteen—depending on the health indicator. This has occurred even as Canadian ranks dropped for some indicators after some moves to reduce federal support for the provinces.[41]

Despite persistently higher rates of unemployment, lower gross domestic product (GDP), and a lower percentage of GDP spent on health, Canadian policies provide better social support, including health services, than is the case in the United States. Thus, Canadian policies can inform U.S. policy with regard to access to and use of appropriate primary care–oriented medical services, social welfare, public support of education, and increasingly progressive labor legislation.[42] Although Canada has not yet achieved levels of health commensurate with those of several other industrialized nations, its cultural, political, and economic similarities and historical background make its experiences relevant to U.S. efforts to improve health services without increasing their cost. ■

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The TSX Gives a Short Course in Health Economics: It's the Prices, Stupid!

By Robert G. Evans

Abstract

The fall in Shoppers Drug Mart shares last April 8 gave a crystal-clear demonstration of the link between health expenditures and health incomes. Reacting (finally) to the excessive retail prices of generic drugs, the Ontario government effectively halved the rate of reimbursement of ingredient costs and banned the "professional allowances" (kick-backs) paid to pharmacies by generic manufacturers. Taxpayers and private payers will save hundreds of millions of dollars, and pharmacy revenues will fall by an equivalent amount. Patients will still get their drugs, with no loss of quantity, quality or even convenience; no one's health is threatened. But investor profits will fall. There are similar savings opportunities throughout the health system. Health costs are primarily a political, not an economic, problem.

Wednesday, April 7, 2010. The shares of Shoppers Drug Mart (SC-T) closed on the Toronto Stock Exchange at just under $44. The next morning they were trading below $37. Nearly a fifth of the company's market value, about $1.6 billion, had vanished literally overnight. It got worse. On June 29, Shoppers bottomed at $32.57 a share. The company had lost a quarter of its market value since the evening of April 7. (Shoppers has since recovered somewhat; on October 1, it closed at $38.82.)

LESSON ONE: Every dollar of expenditure on health services (or anything else) is a dollar of someone's income.

There is no mystery about where the money went. The Minister of Health of Ontario announced, on that Wednesday evening, that as of July 1 the Ontario Drug Benefit (ODB) Plan would change the rate at which pharmacies were reimbursed for the ingredient costs of generic drugs dispensed to beneficiaries. By June 29, it was clear that they were going ahead as planned. Pharmacies had previously been receiving 50% of the price of the corresponding branded and originally patented drug; henceforth they would receive only 25%. At the same time, the "professional allowances" (less politely, kickbacks) paid by generic manufacturers to pharmacies would be banned. Shoppers, the largest chain pharmacy in Canada, would see this change come straight off its bottom line – as indeed would every other pharmacy in Ontario – and the stock market reacted accordingly.

The Ontario government estimated that this change would reduce ODB outlays by about $500 million per year, or 12% of the estimated $4.1 billion that the Ontario government spent on drugs in 2009 (CIHI 2009). But private payers in Ontario, both insurers and individual patients, spent another $7.6 billion, and as of April 1, 2012, they too will be paying no more than 25% of the price of the originally patented drug.

Nationally, about a quarter of private spending is for non-prescription drugs and related items. So if one assumes an equivalent 12% saving on generics for private payers, that would amount to 7.6 × 0.75 × 0.12 = $684 million. The numbers are rough, but the total savings look "not unadjacent to" $1.2 billion per year.[1]

That's an average of nearly $100 for every resident of Ontario. It is also an estimate of the annual revenue lost by Ontario pharmacies. The savings and the loss

are opposite sides of the same coin. And the savings/lost revenue will increase over the next few years as several high-volume "blockbuster" drugs come off patent and more generic alternatives become available (Picard 2010; Cutler 2007). The fall in Shoppers' capitalization represents Bay Street's (rather unstable) guesstimate of the present value of its share of that lost stream of future revenue. No wonder Jürgen Schreiber (CEO of Shoppers) was upset.

LESSON TWO: Winners and losers are always unevenly distributed.

The gainers from this policy change are Ontario taxpayers, patients and (eventually) privately insured workers and their employers. Patients benefit immediately, taxpayers will gain as the debt burden is lessened and workers/employers will gain as, if and when, private insurance premiums fall (or rise less rapidly), leaving more cash on the table to be divided between them.

Investors, in and out of Canada, will lose; the market has already made a preliminary calculation of their loss. Shoppers Drug Mart is a blue-chip stock, popular with mutual funds and exchange-traded funds offering steady growth with good dividends. (It has a beta of 0.40.) These folks have had a nasty surprise. Overall, the net effect has probably been to shift wealth down the income distribution because stock ownership is highly correlated with income and pharmaceutical use is not.

Pharmacists, qua pharmacists, will probably be little affected. The steady up-trend in prescriptions to be filled will not change, and failing significant technical changes in the dispensing process, pharmacists will be needed to fill them. Assuming that the market for pharmacists' services is reasonably competitive, and chains like Shoppers pay no higher wages and hire no more pharmacists than they have to (they are, after all, for-profit corporations, not charities), then pharmacists' wages and employment are unlikely to change.[2]

Those pharmacists who own their own stores, however, definitely will lose – their profits will fall along with those of corporate pharmacies. They are, in a sense, their own shareholders. But it is the return to store ownership, not the wages of pharmacists, that will fall.[3] Expressions of distress by pharmacists' organizations will reflect this impact on pharmacy owners.

LESSON THREE: It's the prices, stupid!

Health expenditures are driven by prices as well as quantities: $E = P \times Q$. Q is unchanged; Ontarians are still getting their prescriptions filled. The reforms have cut the prices paid for generic prescriptions, not the quantity provided. Pharmacies have had their profits cut but have not gone out of business, and it appears that Bay Street has significantly reduced its June 29 estimates of the impact of the reforms. As the price cuts are extended to private payers, there could be some reduction in the numbers of pharmacy outlets, but Ontario is heavily over-endowed with pharmacies, especially in urban areas.[4] Indeed, this density is likely a consequence of the overpricing of generic drugs.

The ODB reforms do contain provisions to protect access to pharmacy services in regions with low dispensing volumes, where lower reimbursement might really threaten patients' access to drugs, but this is a small fraction of the Ontario population. Because the vast majority of prescriptions are filled in markets densely populated with pharmacies, there seems no good reason to let the rural tail wag the urban dog.

Shoppers initially threatened to terminate free delivery services and other benefits to patients, but this move seems questionable. Providing such services is a marketing decision, not an act of charity. If they add to profits, they continue. If not, well, the pharmacy can always offer these services for a price to those willing to pay.[5]

Lesson Four: Rising health costs are not a law of nature, like the tides. They are responsive to well-crafted policy.

This episode gives the lie to those who allege that containing health costs must necessarily impose unacceptable cuts to the quantity and/or quality of health services, threatening Canadians' health. Such claims are the basis for the argument that universal public health insurance is "fiscally unsustainable." They are also false.

The interests driving these claims are not difficult to discern; see Lesson One, above. But the implicit assumptions are twofold, and both are wrong. First, they assume that the prices currently paid for health services are determined through some market or other process such that they reflect the real costs of production. Imposed reductions must therefore result in reduced quantity or quality of services. The Ontario reform demonstrates that this is incorrect. The second assumption is that the services currently being pro-

vided are all necessary and effective in promoting patients' health. This assumption flies in the face of a vast literature on prescribing appropriateness and clinical variations; for the merest scratch on the surface of the latter, see Evans (2009).

LESSON FIVE: Cost containment is primarily a political, not an economic, problem.

The shares of Jean Coutu, the large Quebec pharmacy chain, also fell on April 8, from $10 to $9, and bottomed on June 29 at $7.88. Investors expected Quebec to follow Ontario's lead. More generally, Ontario is only about 40% of Canada. If its reforms rolled across the country, could we be seeing national savings – pharmacy revenue losses – in the $2–$3 billion range? The answer appears to be no, not so much, and the reasons are quite instructive.

The government of British Columbia did react, very quickly. Health Minister Kevin Falcon announced that PharmaCare would negotiate a mutually acceptable agreement with pharmacies to reduce the reimbursement rate for generic drugs. Reductions will apply to private payers as well. But the reimbursement rate was reduced only to 35% of the corresponding previously patented drug, phased in over three years. There would also be additional payments to pharmacists for various other services, of possible value to patients but of clear benefit to pharmacies.

Alberta had, in fact, acted earlier to reduce payments for generic drugs, first for new generics and then, effective April 1, 2010, all generic drugs. But the cuts were from 75% to 56% of the corresponding branded product (45% for new generics), so that Albertans after their reform are still paying higher prices than the ODB was paying before July 1, 2010.

As the Alberta government's press release notes, disingenuously: "The pharmacy industry indicated it had some concerns with reductions to generic drug prices. … Government recognizes that reducing the price of generic drugs will impact revenues of pharmacy businesses" (Alberta 2010). Well, duh! (Yet again, see Lesson One, above.)

Unlike Ontario, neither Alberta nor British Columbia eliminated kickbacks from generic manufacturers to pharmacies. And both left in place maximum dispensing fees well above Ontario's rate of $8.50 (Alberta, $11.93; BC, $10.50). In short, while recognizing that generic drug prices were too high, both Alberta and British Columbia struck a political compromise between the financial interests of taxpayers and private payers on the one hand, and pharmacies on the other.

There is no economic reason why governments in both Alberta and British Columbia could not have followed Ontario and gone for 25% or even less. The government of British Columbia, in particular, seems proud that they achieved a "negotiated" rather than an imposed settlement. But pharmacies negotiated with a gun at their heads. By leaving so much money on the table, these governments in effect bought ideological comfort and, presumably, political advantage with other people's money. (In BC, some of mine.)

Well, it isn't the first time that has happened. The point that comes through loud and clear, however, is that had they wanted to cut drug costs still further, they could easily have done so. Both the previous and the new lower costs of generic drugs are the result of political choices, not economic forces.

Quebec is more involved. Current legislation requires the provincial government to pay no more for a drug than the lowest price available in any other province. That would force them to match Ontario's 25%, and the government says they will. But:

> This same law prohibits private plans from adopting the same control approach as the RAMQ [Quebec's health insurance plan]. Indeed, private plans are obligated to reimburse an original drug at a minimum of 68% of the amount claimed, even if the generic drug is sold to the pharmacist at a maximum of 25% of the price of the original. (Tagsa 2010)

In effect, the government of Quebec is trimming its own costs while leaving private payers exposed to higher charges. And in Quebec, employer-based insurance is de facto compulsory. Employers and employees are thus being milked to subsidize pharmacies – a distinctly perverse approach to cost control!

Nonetheless, pharmacy owners are said to be outraged that they were not consulted. (What, exactly, might they have said? It's a zero-sum game.) They have demanded various forms of compensation, and have taken a page from the Big Pharma playbook. Current or planned generic production in the province will be suspended if their prices fall.

That argument makes no economic sense. Generics are an internationally traded commodity. What possible benefit would there be to Quebeckers at large from paying a premium, directly or indirectly, for local production

– and supporting the price of Jean Coutu shares?

But that is an economist talking. The political calculation is likely to be different – as it was in Alberta and British Columbia. At time of writing, the Quebec poker game was still in session. The important point is that it is a political poker game. Whatever emerges, any suggestion that Quebeckers will pay prices for generic drugs that approximate their real economic costs, or are determined by competitive market forces, would be incredibly naïve or simply dishonest.

LESSON SIX: In the health services sector, regulation works. Markets don't.

In October 2007, the Canadian Competition Bureau released a report on generic drug prices (Canada 2008). Bay Street analysts are paid to assess the profit potential of publicly traded corporations. They ignored the Competition Bureau report, if they noticed it at all. A small prize will be given to the reader who can find a response in Shoppers Drug Mart share prices during October 2007.

Yet, the Bureau clearly stated that retail prices for generic drugs were too high. Competition among generic suppliers was effective in holding down prices paid by pharmacies, but not prices charged by pharmacies; the benefits of competition were being appropriated before reaching the retail payer (and hence were capitalized in, e.g., Shoppers share prices). The Competition Bureau's report contains thoughtful discussion of the ways in which the competitive market forces of the economic textbooks have been subverted in this market, and hopeful suggestions as to how they might be strengthened and made more effective. The TSX apparently did not fancy their chances.[6]

The report ends on a rather wistful note:

> Individual plan members and persons paying out of pocket can also play a key role in helping to obtain the benefits from competition by being effective shoppers. The more that consumers compare prices and services when shopping for drugs, the more incentive the pharmacies will have to make lower prices and better services available to patients. (Canada 2008)

Indeed. And if wishes were horses, beggars might ride. In the real world:

> it is the cash-paying customer without a drug plan who typically pays the highest price for prescription drugs. Sullivan says many pharmacy computers are set up so that if a regular pharmacy client loses their employer-paid benefits, and that information is entered on the screen, "a completely different" higher price for the prescription automatically pops up. (Silversides 2009)

The central point is that over half of prescription drug costs (55% in 2009), generic and patented, are paid privately and always have been. Yet, this private market has not restrained prices. Conceivably, an activist provincial government might try to restructure the drug dispensing process to create genuine market competition, but such restructuring would have to be extensive, complex, politically costly and highly uncertain of outcome.

Why would any rational government take on such a dubious task when regulatory alternatives are ready to hand? Such a quixotic enterprise might please ideological marketophiles and congenital economists, but the more realistic folk who decry regulation and champion "the market" in health services typically do so precisely because they understand how little threat markets pose to existing price and income patterns.[7] The Ontario government has instead chosen to cut the Gordian Knot. Its example has forced other provinces, perhaps half-heartedly and despite ideological reservations, to follow along.

LESSON SEVEN (EXTRA CREDIT): All six of these lessons apply across the whole health system.

Prescription drugs account for only 13.9% of Canadian health spending, and generics for less than half of that. Even if provinces could pick up, for their residents, all of the $2–$3 billion in annual savings that might be on the table, that is small change compared to last year's estimated total of $183.1 billion, increasing about $10 billion a year.

But wait! There's more!

When Canada's Medicare was extended to cover physicians' services in the late 1960s, the rate of escalation of physician and hospital costs was dramatically reduced. The universal public system both avoids the very large administrative overheads generated by private insurance (Woolhandler et al. 2003) and possesses a significant degree of bargaining power in negotiating with providers. The sectoral price inflation endemic to private or mixed financing systems – over and above general inflation rates – is substantial-

ly reduced. A universal pharmacare program could do the same.

But in Canada, we still finance prescription drugs on the American Plan – multiple public and private payers, very expensive and highly inequitable. Commentators have noted for years that we incur substantially higher costs as a result. Most recently, Gagnon (2010) calculates that a true pharmacare system similar to medicare – universal, first-dollar, tax financed, with a single public payer – could reduce total drug costs by as much as $10.7 billion per year, even assuming a 10% increase in utilization. That begins to sound like serious money.

About $1.5 billion could be saved by eliminating most of the administrative overhead, the extra paper pushing (and the tax-expenditure subsidies) associated with private insurance. But the big money comes from aggressive price negotiating with the pharmaceutical industry. When governments are themselves on the hook for drug costs – directly accountable – it concentrates the political mind wonderfully. Promoting industrial policy by giving away their citizens' money to Big Pharma is likely to look less attractive.

These savings are not imaginary; examining New Zealand's Pharmac program for drug purchasing, Morgan (in Evans et al. 2007) has calculated potential savings for Canada of a similar magnitude. So fierce opposition to a medicare-type Pharmacare program from Big Pharma and the private insurance industry is a given. The potential savings are their revenues – once more, see Lesson One, above.[8]

But there is another source of resistance. In cutting about $10 billion from Canadians' total drug bill, genuine pharmacare would also double the public share. Opposition thus comes not only from anti-tax ideologues and assorted libertarian loonies, but also from quite clear-eyed occupants of the upper income brackets. Tax-financed pharmacare, like medicare, would transfer some of the overall payment burden from the unhealthy and unwealthy to the healthy and wealthy. The latter are thus natural allies of Big Pharma and the private insurers in protecting our high-cost drug financing system. And they make their dollars count, politically.

Pharmaceuticals are not the only sector where prices are out of line. Payments to physicians account for the same share of health spending ($25.6 billion in 2009) as pharmaceuticals ($25.4 billion), and they have been on a bit of a tear lately. According to the Canadian Institute for Health Information (2009), per capita expenditures have risen 45% in the last 10 years, after adjusting for general inflation. This increase is second only to pharmaceuticals (a whopping 74%). But in the last five years, the escalation of payments to physicians has accelerated – 24% above inflation and population growth since 2004, compared with 16% in the previous five years – while in all other major expenditure categories the growth, while still very significant, has slowed. (Pharmaceuticals fell from 46%, 1999–2004 to 19%, 2004–2009; hospitals are down to a mere 11%.)

These are very big numbers. If payments to physicians had merely kept pace with inflation and population growth over the last decade, our annual doctor bill would now be $7.9 billion lower. Similar restraint in prescription drugs would have saved us $11.0 billion.[9]

Research currently nearing completion at the Centre for Health Services and Policy Research at UBC suggests that the growth in physician expenditures is, like that of pharmaceuticals, largely a consequence of increasing relative prices – sector-specific inflation. There is thus considerable scope for cost containment in physicians' services, as in prescription drugs, by focusing on the prices being paid. The real problem is, as always, the political difficulty of containing the income aspirations of powerful actors on the supply side.

The economics is, by comparison, easy.

Acknowledgment

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Footnotes

1 The cut to 25% is not the whole story; there are to be a variety of other compensatory payments to pharmacies to cushion the shock. On the other hand, the proportionate savings to private payers may be even greater than those to the ODB.

2 This prediction assumes that because the overall volume of dispensing work will not be reduced, requirements for pharmacists will not change, i.e., the average number of prescriptions filled per pharmacist will remain constant. Conceivably, however, efforts to restore the profitability of pharmacies could lead to fewer pharmacies and higher dispensing rates per pharmacist – reducing the demand for pharmacists. Introduction of "robo-pharmacy" could have even more dramatic effects.

3 If the option of opening one's own pharmacy enables pharmacists to bargain for higher wages than the market would otherwise provide for work of similar effort and knowledge, then any such premium would be reduced as store ownership becomes less attractive.

4 A recent analysis of the supply and geographic distribution of pharmacies in Ontario (Law et al. 2010) shows that the majority of the population (63.6%) live within an 800-metre walk of one or more pharmacies, and nearly all (90.7%) live within a five-kilometre driving distance. A randomly distributed cut of 20% in the number of outlets (conservative, since closures would be more likely in pharmacy-dense areas) would have virtually no impact on these access measures.

5 The announcement by Loblaws that they were considering opening dispensaries in their stores took some of the wind out of Shoppers PR sails, though that may have been just a shot across the bow in response to Shoppers' intrusion into the grocery market.

6 Still, the clear message, from a disinterested public agency, that Canadians were paying too much for generic drugs can only have strengthened the political position of the Ontario government.

7 There are examples of successful cost containment through competition – New Zealand's Pharmac and Medicaid in the United States, or, for that matter, hospital or pharmacy purchasing in Canada. But these are competitive tendering processes at wholesale, by a single buyer or a coordinated group, not a fragmented retail market. Even very large private insurers have been remarkably ineffective, worldwide, in mobilizing their potential market power to restrain price inflation in the health sector.

8 When the United States introduced the Medicare Part D coverage of prescription drugs for the elderly, the pharmaceutical industry lobbied successfully to have the legislation specifically prohibit the Social Security Administration from negotiating drug prices with suppliers. They were well aware of the potential impact on prices of a large public buyer.

9 Of course, the population is also aging. Demography would account for an increase of about 5%.

Victory at Harvard for primary care

As we go to press, we just got news that a group of primary care clinicians, led by progressive medical students and residents, has forced Harvard Medical School to back down from its plans to abolish its division of primary care. Indeed, Harvard responded to the group's petitions, town hall meetings, and other advocacy activities by establishing a well-funded new "Center for Primary Care." The group of advocates plans to continue working through a new organization, Primary Care Progress, which plans a blog, speakers bureau, and programs to encourage clinical innovations in primary care. For more information, see PrimaryCareProgress.org or e-mail Dr. Andrew Morris-Singer at info@primarycareprogress.org.

PNHP Chapter Reports – Winter 2011

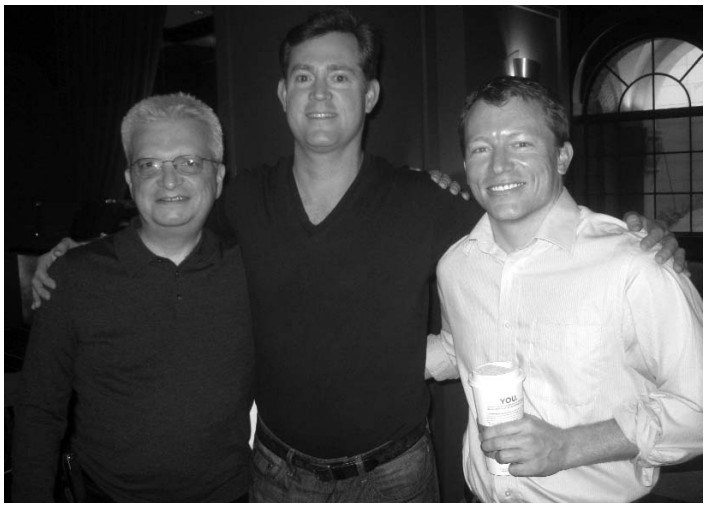
North **Alabama** Healthcare for All joined many other PNHP affiliates in holding a "birthday party" on Medicare's 45th anniversary. The event's slogan was "Let's protect Medicare, improve it and expand it to everyone." Held in Huntsville's public library, it featured Dr. Wally Retan of Birmingham, who spoke out against cuts to Medicare being considered by the federal Deficit Commission. Dr. Retan's pro-single-payer op-ed appeared in the Birmingham News in October. Huntsville pediatrician Dr. Pippa Abston, physician coordinator of the chapter, and other PNHP members have been educating elected officials and candidates about single-payer Medicare for all, noting that incumbents who speak out for single payer are typically re-elected. Follow Dr. Abston's blog at http://pippaabston.wordpress.com; contact her at pabston@aol.com.

PNHPers in **Arizona** worked with the Arizona Coalition for a State and National Health Plan to oppose Proposition 106, a ballot initiative that would potentially block the state from adopting a single-payer system. Dr. George Pauk says the ballot initiative, which passed, was crafted in part by the national right-wing, pro-industry American Legislative Exchange Council, and was bankrolled to the tune of $2 million by conservative interests. Prop. 106 is one of several similar measures across the country misleadingly named the "Freedom of Choice in Health Care" acts. Contact Dr. Pauk in Phoenix at gpauk@earthlink.net or Dr. Eve Shapiro in Tucson at Shapiroe@u.arizona.edu.

PNHP **California** held an all-day conference on single-payer health reform at the UCLA campus. The meeting drew 150 people and featured speakers Drs. Walter Tsou, Margaret Flowers, Paul Song, Don McCanne, Paul Hochfeld, Matt Hendrickson and the chapter's new executive director, Dr. Bill Skeen, along with allies like former state Sen. Sheila Kuehl and Michael Lighty of the nurses' union. Many of the presentations are available online at the chapter's new website: www.pnhpcalifornia.org. California's state single-payer bill, S.B. 810, after having advanced through the Senate and the key Assembly committees, foundered at the 11th hour after the Democratic leadership decided not to put it to a vote, apparently fearing unpredictable consequences in the November elections. State Sen. Mark Leno has promised to reintroduce the bill in the 2011 legislative session. The chapter is busy organizing medical students for a lobby day in Sacramento with the help of Molly Tavela, this year's John Shearer Fellow. More recently the chapter has been helping out with a 24-city tour of the state by the Mad as Hell Doctors (see Oregon), while Dr. Hank Abrons' op-ed "What if everyone had Medicare?" appeared in the San Francisco Chronicle. Contact Dr. Bill Skeen at bill@pnhpcalifornia.org.

Colorado PNHPers have been active in speaking, writing and lobbying for single payer in their state as part of the Health Care for All Colorado coalition. Dr. Kathlene Waller's pro-single-payer letter to the editor "Maybe answers are over the rainbow" appeared in the Fort Collins Coloradoan. Contact Dr. Elinor Christiansen at echris7doc@gmail.com.

In the **District of Columbia,** PNHP board member Dr. Robert Zarr and Dr. Harvey Fernbach successfully debated members of the ultra-conservative Benjamin Rush Society at George Washington University on the question, "Is health care a human right?" Dr. Zarr is coordinating work around a single-payer resolution for the American Academy of Pediatrics. Dr. Margaret Flowers testified before the National Commission on Fiscal Responsibility and Reform against cuts to social insurance programs. Dr. Quentin Young, PNHP's national coordinator, and Dr. Flowers spoke at the Congressional Black Caucus Foundation. Two successful PNHP fund-raisers were held with Dr. Young's visit to the city – one at Public Citizen and the other at the home of Dr. Deborah Schumann in Maryland. PNHP recently sponsored a congressional briefing on "the proposed changes to Medicare before the Deficit Commission and a better alternative: improved Medicare for all," (see pages 18-20). PNHPers also participated in the "One Nation Working Together" march in Washington on Oct. 2 with a large, well-received PNHP banner reading "Single Payer: Improved Medicare for All." Drs. Zarr and Flowers were among the featured speakers at a Leadership Institute sponsored by the American Medical Student Association. Medical student Richard Bruno reports that one outcome of the highly stimulating session was a pledge by AMSA to invite a PNHP speaker to its annual meeting. Contact Dr. Zarr at rlzarr@yahoo.com.



Californians attending PNHP's Spring Meeting in Chicago included Dr. Steve Tarzynski, Dr. Matt Hendrickson and J.B. Fenix, the chapter's past medical student fellow.

Dr. Mardge Cohen, left, pauses for a moment with Drs. Susan Baldwin and Diljeet Singh at PNHP's Annual Meeting in Denver. Baldwin and Singh led the workshop on single payer and women's reproductive rights.

In **Georgia**, PNHP members and other single-payer supporters rallied on Medicare's anniversary in front of Medicare's offices in Atlanta to underscore public support for the program and to call for its improvement and expansion to cover everyone. Contact Dr. Henry Kahn at hkahn@emory.edu.

PNHP's **chapter** in Illinois, Health Care for All Illinois, sponsored a very successful membership workshop on lobbying skills this summer. Chapter co-chairs Dr. Diljeet Singh and Dr. Quentin Young have delivered many grand rounds at area hospitals. Dr. Anne Scheetz is retiring from active practice and devoting the bulk of her time to organizing for the chapter and the Illinois Single Payer Coalition. State Rep. Mary Flowers is planning to reintroduce her single-payer bill, H.B. 311, this January and is seeking new sponsors on both sides of the aisle. PNHP member Dr. David Gill was a candidate for Congress in the 15th District, running on a strong single-payer plank and won 35 percent of the vote. PNHP members also educated Rep. Jan Schakowsky and Sen. Dick Durbin about the need to stop the Deficit Commission from making cuts to Medicare, Medicaid or Social Security. Contact the chapter at info@healthcareil.org.

In **Indiana**, PNHPers introduced a shareholder resolution at the annual meeting of the insurance giant WellPoint in Indianapolis, calling on the company to return to nonprofit status. The measure received over 30 million votes, or 9.4 percent of the shares voted. Hoosiers for a Commonsense Health Plan hosted a rally outside WellPoint's headquarters featuring chapter chair Dr. Rob Stone, Dr. Quentin Young and insurance company whistle-blower Wendell Potter. Stone spoke on the need to divest from health insurance companies. This divestment campaign is patterned after the anti-apartheid campaigns in the 1980s. Indiana PNHPers also played an important role in providing members of the League of Women Voters with the information they needed to convince the national League to endorse Medicare for All at their annual meeting in Atlanta. Contact Dr. Stone at grostone@gmail.com.

PNHPers in **Kentucky** joined with Kentuckians for Single Payer Healthcare in celebrating Medicare's 45th anniversary in Lexington and Louisville. In Lexington they gathered scores of signatures for an improved Medicare for all. After the Louisville "birthday party," participants walked to the offices of Sen. Jim Bunning, Sen. Mitch McConnell and Rep. John Yarmuth, urging them to oppose any cuts in Medicare, Social Security or Medicaid, and to support single-payer legislation such as H.R. 676. Contact Dr. Garrett Adams at kyhealthcare@aol.com.

In **Maine**, PNHP members have established Maine AllCare, a nonprofit educational group dedicated to educating legislators and the public about out-of-control health costs and the single-payer alternative. As one of their first projects they hosted two public events in mid-October featuring Harvard economist Dr. William Hsiao, including testimony before the state Legislature on "Taiwan's single-payer health reform and its lessons for the U.S. and Maine." Contact Dr. Philip Caper at maineallcare@gmail.com.

Michigan PNHPers were joined by other PNHP members from around the country and activists from Healthcare-Now at the U.S. Social Forum on June 22-26 in Detroit, where they participated in panels on single payer and health reform. As part of the activities, Dr. Margaret Flowers and others met with the Detroit-based staff of Rep. John Conyers Jr., sponsor of H.R. 676. Dr. James Mitchiner's op-ed, "Model exists to provide health insurance for all – it's called Medicare," appeared in the Ann Arbor News. Contact Dr. Mitchiner at jmitch@umich.edu.

Jane Hamsher of FireDogLake, left, participated in PNHP's Spring Meeting in Chicago, as did PNHP's Dr. Quentin Young and Terry O'Neill, president of the National Organization for Women.

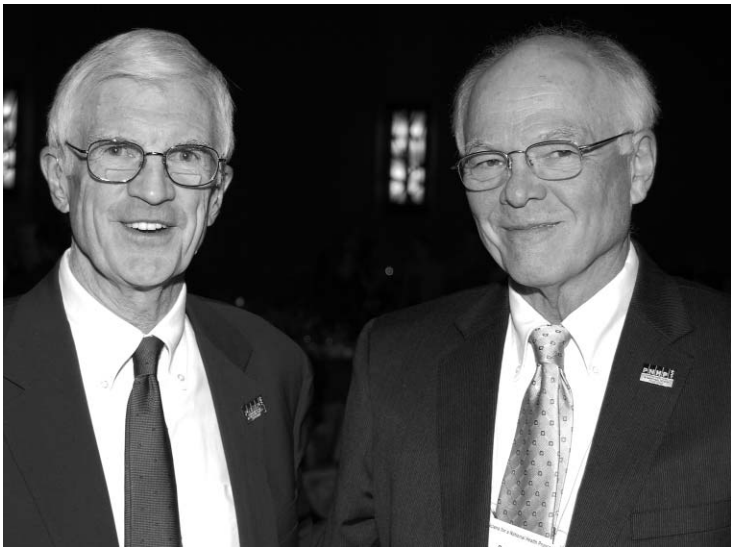
Minnesota's PNHP chapter co-hosted a successful annual fundraiser featuring Donna Smith of the nurses union (and of "Sicko" fame) and several state lawmakers who have championed single-payer legislation. Dr. Ann Settgast reports that a pro-single payer candidate for governor, Mark Dayton, is close to winning (pending recount results). The Minnesota Universal Health Care Coalition, of which PNHP is a part, staffed a table at the Minnesota State Fair for eight days, enlisting the help of 150 volunteers and collecting thousands of signatures. The chapter had two interns this summer, one a first-year medical student, the other pre-law. Intern Kathy Mahan prepared a side-by-side comparison of state-based single-payer bills, which can be accessed via the PNHP website or via this link: http://bit.ly/dBPIfn. A single-payer resolution to the state's medical society recently won about one-third of the vote. Contact Dr. Settgast at settg001@umn.edu or Dr. Elizabeth Frost at libbess@gmail.com.

In **Missouri**, Dr. Ed Weisbart, Dr. Pamella Gronemeyer and other PNHPers are working with Missourians for Single Payer, which sponsored a public showing of Dr. Paul Hochfeld's film "Health, Money and Fear." Weisbart also volunteered at the National Association of Free Clinics event in New Orleans, where more than 1,200 uninsured patients were seen each day. Contact Dr. Weisbart at edweisbart@gmail.com.

Dr. Thomas Clairmont and other PNHPer in **New Hampshire** hosted Dr. Oliver Fein, PNHP's president, for a whirlwind chapter visit in June that included 11 events in two days, including grand rounds, meetings with medical students, media interviews and public meetings. Contact Dr. Clairmont at tppc48@aol.com.

Dr. Elizabeth Frost, left, and Dr. Ann Settgast, leaders of PNHP in Minnesota, received the Dr. Quentin Young Health Activist Award at the Annual Meeting in Denver, along with Dr. Pippa Abston of Alabama.

Dr. William Thar, the new chair of **New Jersey's** PNHP chapter, says members have been working with the grassroots group Healthcare-Now and are hosting Dr. Margaret Flowers for a chapter visit. As part of the chapter's outreach, one of its members recently spoke to the Morristown Tea Party group. Contact Dr. Thar at tharb@comcast.net.



Dr. Robert B. Johnston of Colorado, left, and Dr. Garrett Adams, PNHP's president-elect, take a break from the proceedings of the Annual Meeting in Denver.

In **New York State's Capital District**, PNHP received excellent media coverage for its celebrations of Medicare's birthday in Syracuse, Rochester and Albany. The theme was "Improve and expand Medicare to all." The district's medical student chapter held a successful luncheon this summer, and second-year students are working hard to hand over leadership to first-year students. The chapter helped send several buses to the "One Nation Working Together" march in Washington with single-payer signs, and plans to hold its annual meeting at a free clinic in Schenectady. Contact the chapter at pnhpcapitaldistrict@gmail.com.

New York Metro PNHPers are involved in speaking, lobbying and outreach in support of single payer. The chapter sponsored a "summer strategy meeting" which focused on reaching out to local social justice organizations and building coalitions. The chapter's annual medical student forum, which drew 40 medical students, featured presentations by Drs. David Himmelstein and Steffie Woolhandler, who have been appointed professors of health policy at City University of New York. PNHP President Dr. Oliver Fein made visits to several PNHP chapters across the country where he delivered grand rounds, met with grassroots groups and gave media interviews. Contact the chapter at info@pnhpnymetro.org.

As this newsletter was going to press, **North Carolina** PNHP members were hosting Dr. Margaret Flowers for a

chapter visit in Charlotte, Greensboro and Durham/Chapel Hill, where she was scheduled to give grand rounds and public talks about single-payer Medicare for all, including at a number of churches. Contact pres@healthcare-forallnc.org.

In **Ohio,** PNHP members and others protested a decision by St. John Medical Center and the Cuyahoga Physicians Network to terminate their relationship with Dr. George Randt, a longtime and highly esteemed internist. Dr. Randt said he had been told by a hospital official that he wasn't seeing enough patients per hour. In the ensuing brouhaha he emerged as an eloquent spokesman for putting "patients first" and for an expanded and improved Medicare for All. Despite protests, the hospital did not reverse its decision. Meanwhile Dr. Johnathon Ross had two opinion pieces supporting single payer published, one in the Cleveland Plain Dealer and another in the Toledo Blade. Contact Dr. Ross at drjohnross@ameritech.net.

PNHPers in **Oregon** have been on the move – literally. In October, the Mad as Hell Doctors, led by Drs. Paul Hochfeld and Michael Huntington, hopped in their van and launched a 24-city tour of California, where they spoke to audiences both large and small and received extensive regional media coverage for single payer. Back home, Dr. Samuel Metz reports that the chapter is working on state single-payer legislation and has lobbied federal lawmakers like Sen. Ron Wyden to support waivers allowing experimentation with a single-payer system sooner rather than later. The chapter is planning a single-payer strategy conference financed in part by a grant from a local church. Contact Dr. Metz at samuelmetz@samuelmetz.com.

In **Pennsylvania**, PNHP Past President Dr. Ana Malinow, who is bilingual, recently spoke about the need for single payer on a nationally syndicated Spanish-language radio show. Dr. Walter Tsou is a frequent public speaker to both grassroots and professional groups. He recently spoke at a forum "Health Care Reform: We're Not Done Yet!" in Philadelphia. Contact Dr. Tsou in Philadelpia at macman2@aol.com or Dr. Scott Tyson in Pittsburgh at styson@pediacssouth.com.

Dr. Arthur Sutherland recently announced two new PNHP chapters in **Tennessee** – the Middle Tennessee chapter, chaired by Dr. James Powers, and the State of Franklin Upper East Tennessee chapter, chaired by Dr. Robert Funke. PNHP continues to grow in the Volunteer State, Dr. Sutherland says. Contact him at asutherland@sutherlandclinic.com.

Dr. Claudia Fegan, PNHP past president, and Rose Roach of the California School Employees Association were featured speakers at the Annual Meeting in Denver.

In **Texas**, on the eve of Medicare's 45th anniversary, the Houston Chronicle published an opinion piece by PNHP member Christine Adams, who wrote the following about proposals by some members of the Deficit Commission to cut Medicare benefits: "Rather than cut Medicare, if we want to dramatically reduce health care costs and thus lower our national debt, we need to build on what works and expand to a 'Medicare for All' national health insurance program." PNHP members continue to work closely with Health Care for All Texas. Contact info@hcfat.org.

PNHPers in **Vermont** are active in speaking, lobbying and pushing single payer forward at the state level. There is strong support for single payer among many of the state's elected officials and candidates, including Gov.-elect Peter Shumlin. In January, the results of a state-financed $300,000 study of three models of reform (including single payer) conducted by Harvard economist Dr. William Hsiao will be released. Sen. Bernie Sanders has pledged to seek whatever federal waivers are needed to allow the state to adopt a single-payer system. Dr. Deb Richter, a past president of PNHP, is a frequent speaker and often appears in the local media. Contact Vermont for Single Payer at hcforall@sover.net.

PNHP members from the Western **Washington** chapter demonstrated with other single-payer groups outside the quarterly meeting of the National Association of Insurance Commissioners in Seattle. The NAIC, which was discussing how the new health law will be implemented, was deluged by 1,400 lobbyists from "the medical-industrial complex," reports Dr. Don Mitchell. "Our message asked the commissioners, 'Which side are you on – the corporations or we the people?'" Meanwhile, chapter member Dr. Ken Fabert spoke to PNHPers on the topic of "Test driving single payer in New Zealand," having just returned from a six-month locum tenens there. Contact Dr. David McLanahan at mcltan@comcast.net.

In **Wisconsin**, PNHP members held a very successful speakers training session with help from Dr. Claudia Fegan and PNHP organizer Ali Thebert. Dr. Susan Carson recently spoke about the new health law and how it contrasts with single payer on Madison's leading community radio station. Dr. Margaret Flowers is scheduled to make a chapter visit in mid-November. Contact Dr. Rian Podein at rpodein@gmail.com.

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