PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter Spring 2006

New York Times Endorses National Health Insurance

The New York Times endorsed national health insurance for the first time October 17, 2005, in an editorial opposing employer-mandated coverage (reprinted on page 25). The Times also published an outstanding series of eleven op-eds on health care reform by economist Paul Krugman, who endorses single payer and cites research by PNHP on administrative overhead and other issues. We reprint the entire series in this issue (pages 3, 14-23).

PNHP in the News

Dr. Garrett Adams and Kentucky PNHP'ers were featured in the Louisville Courier-Journal (reprinted on page 71) for their work on a state resolution endorsing the Conyers-McDermott single payer bill (HR 676) in Congress. Dr. David McLanahan and Seattle PNHP'ers published an op-ed on single payer in the Seattle Post Intelligencer (see page 35), while Dr. Susanne King has published several columns in the Berkshire Eagle in Massachusetts, most recently on the VA and quality (page 26).

PNHP successfully publicized research by Dr. Sarita Mohanty and colleagues showing that immigrants utilize 55 percent less health care per capita than U.S. born residents (abstract is reprinted on page 24). The story was picked up by papers in areas with large immigrant populations, including San Jose, Houston, and Miami.

A study co-authored by PNHP'er Dr. Jim Kahn showing that 21 percent of private health spending in California goes for billing and insurance-related paperwork appeared in the November issue of Health Affairs and was covered on public radio and in the San Francisco Chronicle.

A study by PNHP co-founders Dr. David Himmelstein and Steffie Woolhander and heavily publicized by PNHP was cited as the "most-read" Health Affairs article last year ("Illness and Injury as Contributors to Bankruptcy" Health Affairs, February 2, 2005). The groundbreaking study found that about half of all personal bankruptcies are due to illness, and that 75 percent of medical debtors had health insurance at the time they got sick.

Several PNHP members have done radio interviews or published letters and op-eds on the Medicare drug bill, including Drs. Oliver Fein, chair of PNHP's New York Metro Chapter (reprinted on page 13). Thanks to everyone helping with outreach to the press - you are making a difference.

The Business Case for Single Payer

Both GM and Ford are cutting jobs, in part due to the high cost of health care. National health insurance is the only reform that will slash administrative waste, reign in costs, and end health benefits hassles, as the business press has begun to realize. "America, like this adamantly pro-market newspaper, may have no other choice than to accept a more overtly European-style system." (The Economist, 1/28/06).

PNHP'ers are encouraged to speak to their colleagues in business about the economic case for single payer. Dr. Rocky White recently spoke to the Denver Metro Chamber of Commerce, and Dr. Deb Richter has garnered the support of businesses in Vermont.

PNHP Annual Meeting November 4, 2006 - Cambridge

PNHP's 2006 Annual Meeting will be held on Saturday, November 4, at the Harvard Faculty Club in Cambridge. The meeting will also feature pre-conference Leadership Training on November 3; CME may be available. PNHP will also host a training this Spring (TBA). If you are interested in Leadership Training, please drop a note to pnhp@aol.com

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EDITORS
Ida Hellander, M.D.
David Himmelstein, M.D.
Steffie Woolhandler, M.D., MPH

STAFF
Ida Hellander, M.D., Executive Director
Nicholas Skala, Research Associate
Matthew Petty, Office Manager

Membership Drive Update

"No social advance rolls in on the wheels of inevitability. It comes through the tireless efforts and persistent work of dedicated individuals" Martin Luther King, Jr.

Welcome to over 700 new members who have joined PNHP in the past year! PNHP's membership is now just over 14,000. We invite new (and longtime) members to participate in our local chapters and to take the lead on behalf of PNHP in their area (see Chapter Reports, pages 68-69). Retired members take note! Several retired PNHP'ers, including Dr. Don McCanne, are devoting themselves full-time to work for single payer national health insurance.

What PNHP Members Can Do:

1. Submit an Op-ed or Letter to the Editor to your local newspaper, medical specialty journal, or alumni magazine.
2. Set up a Grand Rounds or other conference on health care reform at your hospital, medical school, or professional society. The PNHP 2006 slideshow is now available to members. Call Nick Skala at 312-782-6006 for details.
3. Offer to speak at your church, local Rotary Club, Chamber of Commerce, or other business or civic group.
4. Circulate copies of the "Physicians Proposal for Single Payer" (a PDF digital and printible version is on-line at www.physiciansproposal.org) and encourage colleagues to endorse and join PNHP.

2005 Annual Meeting December 9-10, Philadelphia

Over 220 physicians and medical students from 34 states attended PNHP's 2005 Annual Meeting in Philadelphia, including 75 attendees who came a day early (in a snowstorm) to participate in Leadership Training.

PNHP President Dr. John Geyman presented research from his new book on Medicare ("Shredding the Social Contract" Common Courage Press, 2005), showing how privatization is just the latest strategy in a decades-old campaign to undermine Medicare.

Dr. Adewale Troutman addressed health disparities, while Dr. Steffie Woolhandler showed the latest version of the PNHP slide show, with new data on medical bankruptcy and "consumer-directed health care."

In Memorium

PNHP sadly reports that Dr. Carol Kirschenbaum, a tireless organizer for universal health care in North Carolina and longtime PNHP Board member, died June 16, 2005 after a long battle with cancer. Kirschenbaum and her husband Dennis Lazoff founded the North Carolina Ad Hoc Committee to Defend Health Care and campaigned to make health care a right in that state's constitution. Her warmth, humor, and dedication inspired us all.

Pride, Prejudice, Insurance

By Paul Krugman
November 7, 2005

The New York Times

General Motors is reducing retirees' medical benefits. Delphi has declared bankruptcy, and will probably reduce workers' benefits as well as their wages. An internal Wal-Mart memo describes plans to cut health costs by hiring temporary workers, who aren't entitled to health insurance, and screening out employees likely to have high medical bills. These aren't isolated anecdotes. Employment-based health insurance is the only serious source of coverage for Americans too young to receive Medicare and insufficiently destitute to receive Medicaid, but it's an institution in decline. Between 2000 and 2004 the number of Americans under 65 rose by 10 million. Yet the number of nonelderly Americans covered by employment-based insurance fell by 4.9 million.

The funny thing is that the solution - national health insurance, available to everyone - is obvious. But to see the obvious we'll have to overcome pride - the unwarranted belief that America has nothing to learn from other countries - and prejudice - the equally unwarranted belief, driven by ideology, that private insurance is more efficient than public insurance.

Let's start with the fact that America's health care system spends more, for worse results, than that of any other advanced country.

In 2002 the United States spent $5,267 per person on health care. Canada spent $2,931; Germany spent $2,817; Britain spent only $2,160. Yet the United States has lower life expectancy and higher infant mortality than any of these countries.

But don't people in other countries sometimes find it hard to get medical treatment? Yes, sometimes - but so do Americans. No, Virginia, many Americans can't count on ready access to high-quality medical care.

The journal Health Affairs recently published the results of a survey of the medical experience of "sicker adults" in six countries, including Canada, Britain, Germany and the United States. The responses don't support claims about superior service from the U.S. system. It's true that Americans generally have shorter waits for elective surgery than Canadians or Britons, although German waits are even shorter. But Americans do worse by some important measures: we find it harder than citizens of other advanced countries to see a doctor when we need one, and our system is more, not less, rife with medical errors.

Above all, Americans are far more likely than others to forgo treatment because they can't afford it. Forty percent of the Americans surveyed failed to fill a prescription because of cost. A third were deterred by cost from seeing a doctor when sick or from getting recommended tests or follow-up.

Why does American medicine cost so much yet achieve so little? Unlike other advanced countries, we treat access to health care as a privilege rather than a right. And this attitude turns out to be inefficient as well as cruel.

The U.S. system is much more bureaucratic, with much higher administrative costs, than those of other countries, because private insurers and other players work hard at trying not to pay for medical care. And our fragmented system is unable to bargain with drug companies and other suppliers for lower prices.

Taiwan, which moved 10 years ago from a U.S.-style system to a Canadian-style single-payer system, offers an object lesson in the economic advantages of universal coverage. In 1995 less than 60 percent of Taiwan's residents had health insurance; by 2001 the number was 97 percent. Yet according to a careful study published in Health Affairs two years ago, this huge expansion in coverage came virtually free: it led to little if any increase in overall health care spending beyond normal growth due to rising population and incomes.

Before you dismiss Taiwan as a faraway place of which we know nothing, remember Chile-mania: just a few months ago, during the Bush administration's failed attempt to privatize Social Security, commentators across the country - independent thinkers all, I'm sure - joined in a chorus of ill-informed praise for Chile's private retirement accounts. (It turns out that Chile's system has a lot of problems.) Taiwan has more people and a much bigger economy than Chile, and its experience is a lot more relevant to America's real problems.

The economic and moral case for health care reform in America, reform that would make us less different from other advanced countries, is overwhelming. One of these days we'll realize that our semiprivatized system isn't just unfair, it's far less efficient than a straightforward system of guaranteed health insurance.

(Additional Op-Eds by Paul Krugman on pages 14-23)

Data Update

Uninsured and Underinsured

- The number of uninsured Americans rose to 45.8 million (15.7 percent of the population) in 2004 from 45 million in 2003, according to the U.S. Census Bureau. Of those, 8.3 million were children (11.2 percent of all kids). Hispanics had the highest rate of uninsurance (32.7 percent) followed by African-Americans (19.7 percent), Asians (16.8 percent), and non-Hispanic whites (14.9 percent). The proportion of middle-class Americans (incomes $50,000 to $75,000 per year) without coverage increased from 12.5 percent in 2003 to 13.3 percent (7.8 million individuals) in 2004.

  The percentage of people covered by employer-based insurance fell from 60.4 percent in 2003 to 59.8 percent in 2004, while the percentage of people covered by public programs rose from 26.1 percent to 26.6 percent. The proportion of Americans in Medicaid grew from 12.4 percent in 2003 to 12.9 percent in 2004 (37.5 million people). The proportion of Americans in Medicare remained at 13.7 percent (39.7 million people) (U.S. Census Bureau, "Income, Poverty and Health Insurance Coverage in the United States: 2004" available at www.census.gov).

- Between 2000 and 2004 the number of uninsured Americans increased by 6 million. The rise in uninsurance was driven by two factors: rising poverty and a fall in employer-sponsored coverage. The number of Americans living at or below 200 percent of poverty increased by 9.1 million between 2000 and 2004. The overall U.S. poverty rate increased from 11.3 percent to 12.7 percent . These low-income adults were much more likely to lack coverage in 2004 (40.3 percent uninsured) than adults overall (20.6 percent).

  The proportion of small businesses (those with less than 200 employees) which provide coverage for their workers dropped from 68 percent in 2000 to 63 percent in 2004. Among very small firms (3-9 workers), just 52 percent offer health benefits. For workers earning less than 200 percent of poverty, employer-sponsored coverage dropped sharply from 34.7 percent in 2000 to 30 percent in 2004 (Holahan, J. and Cook, A., "Changes in Economic Conditions and Health Insurance Coverage," Health Affairs Web Exclusive, 11/01/05).

- Children in Florida who enter the hospital without health insurance are more than twice as likely to die there as children with private or public insurance, according to a report released by All Children's Hospital and USF Health. Of the nearly 11,000 children hospitalized in Florida with injuries in 2002, 131 died. About 18 percent of those deaths were uninsured patients, even though those patients were only 8.5 percent of hospitalizations (St. Petersburg Times, 10/4/05).

- About 650,000 of the nation's 8.3 million uninsured children are "medically vulnerable" in that they have special health care needs - defined as an ongoing physical, emotional, behavioral, developmental or other health conditions causing them to use more health services or limit their activities more than other children - according to a study by the Center for Studying Health System Change. The study refutes the myth that all uninsured children are healthy (Center for Studying Health System Change Issue Brief No. 98, September 2005).

Uninsured and Underinsured Children

A third of the nation's 8.3 million uninsured children receive no medical care during the course of a year. In addition, children who have gaps in their health coverage over the course of a year (8 percent of U.S. children) have access to care problems "virtually equal" to those of kids who lack coverage the entire year (7 percent of children). Children with gaps in their coverage are just as likely as uninsured kids to miss doctor's appointments (13 percent), have trouble filling prescriptions due to cost (10 percent) and postpone medical care (20 percent). In comparison, only 4 percent of children with continuous coverage postpone care (New England Journal of Medicine, 7/27/05).

- The State Children's Health Insurance Program (SCHIP) provided coverage to 3.95 million children in December 2004, roughly the same number of children as covered in December 2003.

  Among states, enrollment in SCHIP varied as some programs expanded slightly while others - most notably Texas and Florida - made deep cuts. Texas cut enrollment in 2004 by 23 percent (102,000 children) while Florida cut enrollment by 15 percent (48,000 children). Idaho, Montana, and Utah capped enrollment in their programs due to budget difficulties, while 8 of the 30 states that charge premiums increased their fees in 2004. SCHIP was established by Congress in 1997 as a federal-state partnership, and enrollment grew steadily, by about 900,000 children a year, in each of the first three years. By 2001, with over 3.4 million children in the program, states started to curtail outreach efforts, increase premiums, or restrict eligibility or premiums in response to budgetary pressures.

  According to the Urban Institute, "SCHIP outreach has for all intents and purposes ceased to exist." (Urban Institute, May 2005; Kaiser Commission on Medicaid and the Uninsured, "SCHIP Enrollment in December 2004").

- About 19.4 million children (29 percent of all children) were covered by Medicaid in 2004, up from 22 percent in 1999. Over the same period, the percentage of children covered by private insurance fell from 65 percent to 59 percent (Cauchon, USA Today, 8/02).

  While Medicaid is an important source of coverage for children, like SCHIP it is an unstable source due to the vagaries of state rules and funding. For example, 21,500 kids in Missouri were due to lose coverage at the end of 2005 because their families failed to pay the premiums newly-mandated by the state legislature. In Massachusetts, about 1,200 children lost coverage when the state's Medicaid office started using a different computer system to calculate benefit eligibility (Young, St. Louis Post-Dispatch, 10/5; Misra, Boston Globe, 9/30).

- Some California insurers are selling health policies that require members to go to Mexico for care, where costs are 40 percent lower. An estimated 160,000 people have cross-border coverage, mainly Mexicans legally employed in the U.S. in agriculture, hotels (e.g. the landmark Hotel Del Coronado in San Diego), retail, casinos and local government. Monthly premiums average about $100 for individuals and $350 for families in the Blue Shield "Access Baja" plan (Marosi, LA Times, 08/25/05).

- Fifty percent of Katrina evacuees over age 18 in Houston shelters lacked health insurance, according to a survey by the Kaiser Family Foundation. Of those with coverage, 34 percent were covered by Medicaid and 16 percent by Medicare. Forty percent were identified as being physically disabled or having a chronic illness such as high blood pressure, diabetes or heart disease. Before the storm, 36 percent of evacuees used Charity Hospital of New Orleans as their primary source of care, and 60 percent had an annual income of less than $20,000. Thirty-eight percent of evacuees who did not leave prior to the storm said they were either physically unable to do so or were caring for someone who was unable to leave (Kaiser Daily Health Policy Report, 9/16/05).

- An estimated 200,000 Hurricane Katrina victims in Louisiana lost their health benefits at the end of 2005 when their employers failed to make premium payments, according to Blue Cross/Blue Shield of Louisiana. A rule imposed by state officials that insurance companies keep medical policies active even if premiums had not been paid expired in November 2005 (Graham, Chicago Tribune, 12/29/05).

Veterans Denied Health Coverage

A quarter of a million veterans (263,257) were denied enrollment for VA health coverage in 2005, according to the Department of Veterans Affairs. The veterans exceeded the income limit (usually around $25,000 to $30,000) and did not have service-related injuries or illnesses. Additional veterans might not have even attempted to enroll because they were aware that they would not qualify. The VA suspended enrollment for such veterans in January 2003 to reduce costs (AP/Los Angeles Times, 1/24/06).

- An estimated 1.3 million U.S. children aged 8 to 18 provide essential care for relatives who are ill or have disabilities, according to a study by the United Hospital Fund. The results are based on a phone survey of 2,000 US households. Most child caregivers are helping parents or grandparents with illnesses such as Alzheimer's or cancer; 58 percent are helping with at least one routine daily activity, such as bathing or eating; nearly all help with shopping and household tasks; and child caregivers have more anxiety and depression than other children. Caregiving children are more likely to be from low-income, minority and single-parent families (Kaiser Daily Health Policy Report, 9/14/2005).

- Despite President Bush's pledge to "expand community health centers to every poor county in America," a survey by the National Association of Community Health Centers and the George Washington University found 929 poor counties (more than half of all poor counties) lacked even one health center. In FY 2002 and 2003, allotted funding allowed only one-third of qualified applications for new centers to gain funding. In 2004, 90 percent of qualified applications were rejected. For every low-income patient a center treats, there are four others needing their services (Prosner, M., "Growing Uninsured, Budget Cutbacks," Natl' Assn. of

Donald Berwick on Consumer-Directed Health Care and Pay-for-Performance

Editors' Note: We came upon the following striking quotes by Donald Berwick in an interview published in Health Affairs. Dr. Berwick is widely recognized as the leading expert on quality improvement in health care. The first quote is on consumer-directed health care and the second is on pay-for-performance.

"I do not believe that making the individual American patient more "cost-sensitive" has any rationale in science, ethics, or evidence. It will fail, and it will fail miserably. It will result in a shifting of care away from the people who need it the most. It is a displacement of responsibility for changing the system. You know, if CalPERS or Xerox or GE can't change care through using its purchasing power, then I absolutely promise you that Mrs. Jones can't."

"I do not think that the way to get better doctoring and better nursing is to put money on the table in front of doctors and nurses. I think that's a fundamental misunderstanding of human motivation. I think people respond to joy and work and love and achievement and learning and appreciation and gratitude – and a sense of a job well done. I think that it feels good to be a good doctor and better to be a better doctor. When we begin to attach dollar amounts to throughputs and to individual pay, we are playing with fire. The first and most important effect of that may be to begin to dissociate people from their work. That's really where we've come to, and we've done it by pay-for-performance in terms of throughput measurements and manipulating payment schemes." (Health Affairs, 1/25/05).

Community Health Centers, March 2005 & McCanne, D. "Does President Bush Support Community Health Centers?" Quote of the Day, 03/07/05).

Underinsured in America

15.6 million U.S. adults are underinsured and often go without needed care and medications due to costs, according to a survey of 3,293 adults ages 19 to 64. An "underinsured" individual was defined as someone with health expenses that exceed 10 percent of their income (5 percent for low-income individuals) or with a health care deductible higher than 5 percent of their income. Among the underinsured, 38 percent did not fill prescriptions due to cost; 32 percent went without seeing a doctor when needed; 30 percent avoided medical tests, treatment or follow-up care and 18 percent declined care from specialists. Forty-six percent reported being contacted by a collection agency about unpaid medical bills, and 35 percent said they changed their lifestyle to cover medical expenses (Schoen, C., et al, "Insured But Not Protected: How Many Adults Are Underinsured?" Health Affairs Web Exclusive, 06/14/05).

- A survey of people regarding potentially life-threatening symptoms found that the uninsured are less than half as likely as the insured (37 percent vs. 82 percent) to see or talk to a medical provider when faced with a serious symptom. The survey also found that the uninsured are more likely than the insured (23.2 percent vs. 18.9 percent) to report the recent onset of a potentially life-threatening symptom. The study refutes the claim that uninsured individuals "choose" to be uninsured but seek care when needed (Hadley, J. and Cunningham, P.J., "Perception Reality and Health Insurance: Uninsured as Likely as Insured to Perceive Need for Care but Half as Likely to Get Care," Center for Studying Health System Change Issue Brief No. 100, October 2005).

Socioeconomic Inequality and Care

- Blacks are significantly less likely than whites to receive new treatments for heart disease according to studies published in journal Circulation. Blacks are 50 percent less likely than whites to receive clot-dissolving drugs after a heart attack, and 40 percent less likely to undergo angioplasty within 48 hours of a heart attack (Circulation, 3/15/05 and Kaiser Policy Report, 03/16/05).

- One measure of the growth in income inequality (a significant predictor of health outcomes) is the ratio of CEO to worker pay. In 1982, the average American CEO earned 42 times the wages of the average American worker. In 2004, the average CEO made $11.8 million, 431 times the pay of the average worker (Anderson, "Executive Excess 2005", Institute for Policy Studies, August 30, 2005).

Costs

- In 2005, insurance premiums rose 9.2 percent, more than three times faster than wages (up 2.7 percent) and 2.5 times the rate of inflation (3.5 percent) in 2005 (Vrana, LA Times, 9/15).

U.S. Health Spending: $2 Trillion

U.S. health care spending in 2004 was $1.9 trillion ($6,280 per capita). Health spending accounted for 16 percent of U.S. GDP, compared with 15.9 percent in 2003, and 9.1 percent in 1980.

Americans spent $188.5 billion for prescription drugs in 2004, up $14 billion from 2003, an 8.2 percent increase. The rate of increases for other categories of health spending between 2003 and 2004 were: hospital care (up 8.6 percent); physician services (up 9.0 percent); nursing home care (up 4.3 percent) and home health care (up 13.3 percent). Overall health spending rose 7.9 percent, the slowest rate of increase since 2000, but still far faster than the rate of inflation.

The overhead cost of private insurance rose from 14.2 percent of premiums in 2003 to 14.4 percent in 2004. Total private insurance premiums in 2004 were $658.5 billion, while benefits paid were $563.5 billion.

CMS estimates that national health spending will increase from $2.1 trillion in 2006 to $3.8 trillion (19 percent of GDP) in 2015 in the absence of reform (Smith, C. et al, "National Health Spending in 2004," Health Affiars 25(1); January/February 2006).

- Employer-sponsored health insurance premiums are expected to increase 9.9 percent in 2006 according to a survey of 400 employers by Hewitt Associates. On average, family coverage cost $10,880 in 2005 (of which employers paid $8,167 and workers paid $2,713) and individual coverage cost $4,024 ($3,413 paid by employers, $610 by workers) (Higgins, Washington Times, 10/11/05).

- The California Public Employees' Retirement System (CalPERS) is the nation's third-largest buyer of health insurance. In 2006, it will purchase coverage for about 1.2 million people at an estimated cost of $4.3 billion. Despite its purchasing power, CalPERS' premiums for PPO coverage in 2006 increased 9.5 percent from the previous year, while its premiums for HMO coverage increased 8.7 percent (Vrana, LA Times, 6/16/05).

- A majority of Americans with employer-sponsored coverage are in PPOs. In 2005, PPO enrollment increased to 61 percent of workers, up from 55 percent in 2004; HMO enrollment continued to decline, to 21 percent in 2005, from 25 percent in 2004 (Washington Times, 9/15/05).

- An estimated 77 million Americans (37 percent) age 19 or older have difficulty paying medical bills, have accrued medical debt, or both. Two-thirds of people with a medical bill or debt problem went without needed care because of cost - nearly three times the rate of those without these financial problems (Doty, M. et al, "Seeing Red: Americans Driven Into Debt by Medical Bills," Commonwealth Fund, August 2005).

- Nearly one-fourth (23 percent) of Americans had problems paying medical bills in 2004, and 61 percent of those reporting problems were covered by health insurance, according to a national survey of 1,531 adults. Twelve percent of Americans report that they spent all or most of their savings to pay medical bills, and 18 percent say that medical bills are their largest monthly expense, excluding rent or mortgage. Those covered by Medicare reported fewer difficulties paying for care; 18 percent of seniors reported skipping a treatment or prescription because of cost, compared with 32 percent of those under age 65 (USA Today/Kaiser/Harvard School of Public Health "Health Care Costs Survey," August 2005).

In 2005, UnitedHealth spent only 78.2 percent of the health care premiums it collected on benefits; 21.8 percent went to overhead (Kaiser Policy Report, 10/18/05, Foundation for Consumer and Taxpayer Rights Press Release, 01/19/05).

- Among large employers (20,000+ employees), the use of "co-insurance" to shift more of the cost of health care to workers increased dramatically from 2004 to 2005, rising from 26 percent to 37 percent of large employers. Co-insurance requires workers to pay a proportion (anywhere from 10 to 90 percent) of incurred hospital, physician, lab, and other costs. Co-insurance costs are in addition to co-pays and deductibles. Because they are specifically designed to shift a larger share of costs onto patients (and away from the insurer), co-insurance plans have lower premiums. One benefit consultant remarked that the increased use of co-insurance "signals [employers'] preference for keeping the cost down...by shifting it to those who use it most."

  Many small employers have raised deductibles or dropped coverage altogether. The percentage of employers with 10-49 employees who offer any kind of coverage decreased from 63 percent in 2003 to 58 percent in 2005. Although high-deductible health plans are cheaper than traditional plans (18 percent less than the average PPO, and 13 percent less than the average HMO), Mercer analysts say the difference is not enough to keep small businesses from dropping coverage (Mercer HR Consulting Press Release, 11/21/05).

- "We need a simple national health care plan that covers everybody. The failure of Bush's complicated Medicare prescription drug benefit demonstrates that." (John J Sweeney, AFL-CIO president, quoted in the New York Times, 1/18/06).

- Health care is labor's biggest issue, especially at the Big 3 automakers. GM spends almost $6 billion annually on health care for its workers and retirees. The firm reached a deal with United Auto Workers (UAW) members in October to cut health care costs by about $1 billion annually by increasing the share of premiums, co-pays and deductibles workers pay and to reduce GM's retiree health care liabilities by $15 billion (25 percent) over a seven-year period (Durbin, AP 10/17).

  UAW members ratified a similar deal with Ford in December. (McCracken/Stoll, WSJ, 12/23/05).

- Most (56 percent) of employees who are covered by a "consumer-directed" health plan would prefer to be back in their old plan, according to a study by the pro-HSA research firm McKinsey & Company. In two of the four large companies surveyed for the study, only one-in-four (24 percent and 27 percent) workers preferred the CDHP (McKinsey & Company, "CDHP Report - Early Evidence is Promising, June 2005).

Starbucks chairman Howard Schultz said the firm expects to spend over $200 million on health care for its U.S. employees in 2005, more than the company spends on coffee (AP 9/15/05).

- Individual health insurance is so costly that current proposals for tax credits and other subsides are unlikely to lower the number of uninsured, according to a study by the Congressional Budget Office. A survey of 1,718 employed individuals who lack employer-sponsored coverage found that a 10 percent decrease in the cost of premiums would only increase the proportion of individuals with private insurance by 5.7 percent (Congressional Budget Office, "Price Sensitivity of Demand for Nongroup Health Insurance," CBO Background Paper August 2005).

Study: Single-Payer Would Save the Most

Single-payer national health insurance would save the U.S. $1.136 trillion over the next decade - more than any other proposal - according to a fiscal study of four major reform options by economist Kenneth Thorpe of Emory University. The study, commissioned by the National Coalition on Health Care, also estimated the potential savings from a "pay or play" or employer mandate plan ($320 billion over 10 years), the expansion of existing government programs to the uninsured ($320 billion), and the creation of a program similar to the Federal Employees' Health Benefits Program ($370 billion) (Thorpe, K. "Impacts of Health Care Reform," National Coalition on Health Care," May 23, 2005, www.nchc.org).

Corporate Money and Care

- The Medical-Banking Complex: UnitedHealth and the Blue Cross/Blue Shield Association are chartering their own banks to get a share of the estimated $10 to $20 billion projected to be in health savings accounts by 2010. The "Blue Healthcare Bank," will begin operations by summer 2006. The bank will allow members to save and withdraw money for health expenses and will offer "credit lines" to pay for care. The move follows the creation of a jointly branded BC/BS debit card with VISA for accounts linked to health plans. HSAs add the administrative cost of banking and debit cards to the already high administrative costs of the insurance industry (Skidmore, San Diego Union Tribune, 12/06/05 & McCanne, D. "Blue Bank and Blue Visa to Administer HSAs," Quote of the Day, 12/07/05).

- New York state-based Health Insurance Plan (HIP) of New York and Group Health Inc. are merging. The purchase price is undisclosed. The combined firm will have 4 million members, including 1.1 million municipal employees, and $7 billion in annual revenue. While both insurers are currently non-profit, the new firm is expected to convert to for-profit status (Perez-Pena, New York Times, 9/30/05).

Insurance Mergers Reduce Competition, Reward Execs $590 Million

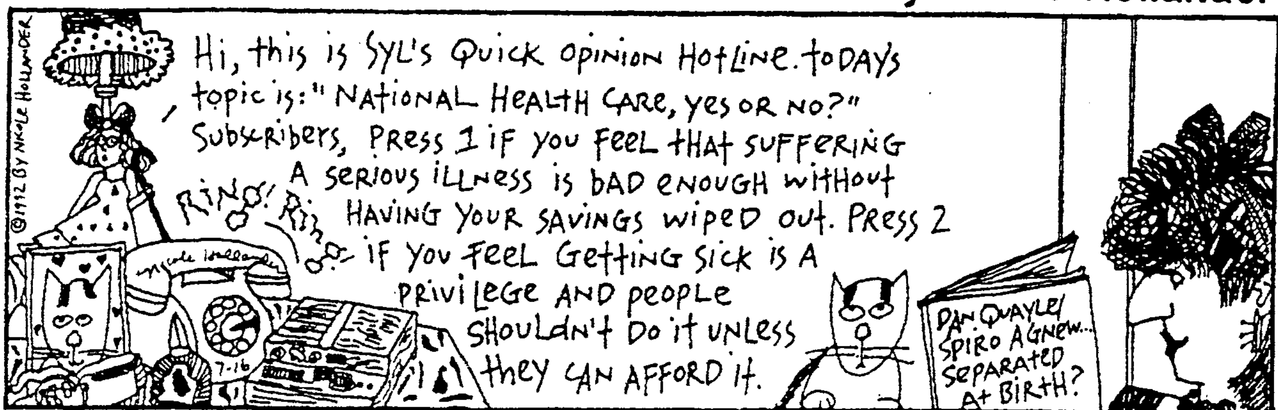
Indiana-based insurance giant WellPoint is buying New York's WellChoice for $6.5 billion in cash and stock. WellChoice, which owns Empire Blue Cross Blue Shield, is the largest insurer in New York state with five million members. The new firm will have more than 33 million enrollees in 14 states (Kaiser Policy Report, 09/28/05 and 10/03/05).

Wellpoint was created last year by the $18.4 billion merger of Anthem, Inc. the owner-operator of several (formerly non-profit) Blue Cross plans, and California's Wellpoint Health Networks. A handful of top executives received $245 million in bonuses from the deal (Axis Benfits Consultants "Renewal Outlook," Vol. 4 No. 2, Fall 2005)

UnitedHealth Group bought PacifiCare Health Systems for $9.2 billion in cash, stock, and assumed debt. PacifiCare's 2.5 million commercial plan enrollees and 716,000 Medicare-Advantage plan members will bring UnitedHealth's membership to 26 million. The deal includes a $345 million windfall to top executives at PacifiCare (Kaiser Policy Report, 11/18/05).

Analysts expect the nation's 13 remaining publicly-traded managed care operators to continue merging and purchasing smaller companies. Already, just 5 health insurers enroll over half (88.6 million) of the 173 million Americans with private health insurance: WellPoint (32.7 million), UnitedHealth (25.7 million), Aetna (13.7 million), Cigna (9.7 million), and Humana (6.8 million). (Foundation for Taxpayer and Consumer Rights, Press Release, 1/21/06).

The editors provide this compendium of facts and figures relevant to the health care crisis in order to help members stay current with the latest data. We welcome submissions for this section (please be sure to include a source) to pnhp@aol.com



- Giant insurers, tiny benefits: Insurance-giant Wellpoint is marketing skimpy high-deductible health policies over the internet. The "Tonik" health plan is aimed at healthy (and profitable) 19 to 30 year olds. It has three tiers of coverage with catchy names: "thrill seeker," "part-time daredevil" and "calculated risk-taker." The plans feature high deductibles ($1,500 to $5,000) and, in the fine print, limited benefits (e.g. no maternity coverage) for premiums of $65 - $125 a month (Lee, Indianapolis Star, 12/25/05).

- Similarly, Aetna is targeting healthy young adults by "life stage," marketing plans with names like "new graduate," "between jobs" and "getting married." Although they advertise a $5,000 to $25,000 "out-of-pocket maximum," several types of medical expenses, which are potentially very costly, are excluded (e.g. charges by out-of-network providers). Aetna also notes, in the fine print, that their new plans "do not convert." In other words, in order to change coverage (say, from "new graduate" to "getting married") enrollees must go through medical underwriting again, risking being denied coverage (McCanne, D. "Aetna Makes it Easier to Buy Under-Insurance," Quote of the Day 09/21/05).

Corporate Conflict of Interest

- Senate Majority Leader Bill Frist (R-TN), a potential presidential candidate in 2008, sold all his stock in HCA, his family's hospital corporation, about two weeks before it issued a disappointing earnings report and its price dropped 15 percent. Frist's shares were sold by July 1 and those of his wife and children by July 8, five days before the July 13 earnings report. Frist's father (Thomas Frist) founded the company, and his brother (Thomas Frist Jr.) is a director and leading stockholder. The family is worth $1.1 billion (Katz, Washington Post, 09/21/05).

Corporate-Government Revolving Door

The former chief lobbyist for HMO-giant Humana, Ray Ramthun, is now the senior health policy advisor for the White House's National Economic Council. (Congressional Quarterly, 5/13/05).

Former Republican aide John E. McManus, who-formed his own lobbying firm after helping draft the Medicare drug bill for the Ways and Means committee Republican members, received $620,000 in consulting fees from PHARMA, Merck and other firms to help them navigate the bill (Pear, New York Times 08/19/05).

- Twenty-seven percent of the children of Wal-Mart workers are on Medicaid or SCHIP, according to a leaked board of directors memo. (the full text of the memo is available at: http://www.nytimes.com/packages/pdf/business/26walmart.pdf - no hyphen). A separate study found Wal-Mart increases state Medicaid expenditures by $898 per employee (Hicks, M. "Does Wal-Mart Cause an Increase in Anti-Poverty Program Expenditures?" Kaiser Report, 11/07/05).

Big Pharma

- Wholesale prices for brand-name prescription drugs increased an average of 6.6 percent between 2004 and 2005, more than twice the rate of inflation (Gross, D. et al, "Trends in Manufacturer Prices of Prescription Drugs Used by Older Americans," AARP November 2005).

- Humana and Aetna have deals with Wal-Mart and CVS, respectively, to "co-brand" Medicare drug plans with the retailers and peddle the plans to seniors in the retailers' pharmacies. The drug stores will accept other plans in their pharmacy, but will exclusively sell the plan of the preferred insurer (Howington, Louisville Courier-Journal, 07/14).

Drug Lobby Employs 1,300 Lobbyists to Sway Congress

The pharmaceutical industry spent $800 million on federal lobbying and campaign contributions between 1998 and 2004, the most of any industry. The industry employs 1,291 lobbyists - more than any other - more than half of whom are former U.S. government officials. More than 3,000 individuals have lobbied for the industry since 1998, including 75 former lawmakers.

Drug companies spent $116 million on lobbying in 2003, the year Congress approved the new Medicare drug bill. The bill, which prohibits Medicare from negotiating drug prices, was crafted by former Rep. Billy Tauzin, now president of the drug industry's trade association, PhRMA. In addition, GlaxoSmithKline and Pfizer spent $45.1 million on political advertising in 2003-2004, mostly to promote the Medicare bill directly to Americans. The industry spent $128 million on lobbying for tax breaks (and defending the Medicare drug bill) in 2004. No interest spent more money to sway public opinion over this time period (Ismail, M. "Drug Lobby Second To None," Center for Public Integrity, 07/07/05).

- Minnesota health insurers are suing GlaxoSmithKline for gaming the federal patent system to keep a generic alternative to the antidepressant Paxil from reaching the market. GSK allegedly claimed to hold patents on scientific proce-

dures that are in the public domain. GSK also listed invalid patents with the FDA and harassed generic drug manufacturers with frivolous lawsuits. Paxil costs $93 per month, compared to $63 for the generic (Phelps, Minneapolis Star Tribune, 5/12/05).

VA Better Drug Buyer Than Medicare Plans

The prices of drugs negotiated by ten of the largest private Medicare drug plans are 84 percent higher than those obtained by the federal government (VA); 61 percent higher than the prices negotiated by Canada; 3.5 percent higher than the prices at Drugstore.com; and 2.9 percent higher than the prices available at the large retailer Costco, according to a Congressional investigation. Medicare beneficiaries with high expenses will be particularly harmed by high drug prices, because once their costs exceed $2,250, the plans stop paying and seniors must pay the next $2,850 out of pocket. Since Medicare heavily subsidizes the private plans, their high drug prices gouge taxpayers, as well as vulnerable seniors (Committee on Government Reform - Minority Staff, "New Medicare Drug Plan Fails to Provide Meaningful Drug Price Discounts," U.S. House Special Investigations Division, November 2005).

AARP Profits from Medicare Drug Bill

The American Association of Retired People (AARP), a pivotal backer of the 2003 Medicare drug plan, made a deal with UnitedHealth to sell the insurer's Medicare drug plan under the AARP name. AARP will receive a "royalty-based fee" from UnitedHealth. AARP already makes $300 million (39 percent of its total income) annually from insurance royalties (Alonso-Zaldivar, LA Times, 06/08/05; BusinessWeek 01/24/05).

- Forty-one of the 44 brand-name medications most commonly purchased on-line are less expensive in Canada, according to a survey of 12 Canadian internet pharmacies and the 3 major U.S. chain pharmacies on-line. The largest price difference was for Zyprexa, on which patients could save $1,159 annually by ordering the drug from Canada (Quon, B. et al, "A Comparison of Brand-Name Drug Prices between Canadian-Based Internet Pharmacies and Major U.S. Drug Chain Pharmacies," Annals of Internal Medicine, 143(6); 397-403, 09/20/05).

- Caremark Rx, the Tennessee-based pharmacy benefit management firm, will pay $137.5 million to settle charges of kickbacks at AdvancePCS, a Caremark subsidiary. AdvancePCS took payments from drug companies in return for favorable treatment for their brands in contracts with the Federal Employee Health Benefit Program and other federal health care programs. As part of the settlement, AdvancePCS agreed to refrain from "drug switching" (substituting a favored drug brand for the one prescribed) and will disclose payments it receives from drug companies (Kaiser Policy Report, 9/9/05).

- GlaxoSmithKline has agreed to pay $150.8 million to settle charges that the firm inflated average wholesale prices for two anti-nausea drugs (Zofran and Kytrill) in order to overcharge government health programs. GSK charged hospitals less for the drugs than Medicaid reimbursed for their use, essentially giving providers a kickback for using GSK drugs (Loyd, Philadelphia Inquirer and WSJ, 9/21/05).

- Generic drug-maker Mylan will pay $12 million to four insurers for illegally inflating prices on anti-anxiety medications. The company secured exclusive supply agreements for key ingredients in the drugs to corner the market. The average price for 100 tablets of lorazepam and clorazepate rose from $16.95 to $64.31 as a result of the scam (Phelps, Minneapolis Star Tribune, 6/3/05).

- A Seattle Times series identified 26 cases in which physicians were paid to divulge confidential information about drug trials to investors before official results were available. The practice is being driven by hedge funds, the largely unregulated investment pools that cater to the super-rich. Elite investors pay up to $1 million per year to "matchmaker" firms which pair them with drug researchers, who are paid $300 to $500 per hour to consult with investors. The Supreme Court established in 1983 that the practice is illegal (Kaiser Policy Report, 8/9/05, Seattle Times 09/17/05).

- A survey of 3,247 biomedical scientists published in Nature found that 15.5 percent of respondents had revised the "design, methodology or results of a study in response to pressure from a funding source." Also, 12.5 percent said they did not question the use of "flawed data or questionable interpretation of data" by colleagues (Martison, B., et al, "Scientists Behaving Badly," Nature 435; 737-738 6/9/05).

Medicare HMOs: The Final Frontier

- Medicare Part B premiums increased to $88.50 per month in 2006, up $10 (Kaiser, 9/19/05).

- Medicare currently pays private plans an average of 107 percent of the cost of traditional Medicare. Even the pro-privatization 17-member Medicare Payment Advisory Commission (MedPAC) wants to end the favorable treatment received by private plans over traditional Medicare. With only one dissenting vote, MedPAC recommended that Congress 1) eliminate the $10 billion "stabilization fund" for regional PPOs that starts in 2007; 2) set benchmark payments to HMOs and PPOs at 100 percent of the cost of traditional Medicare, and phase-out the "hold-harmless" rule that prohibits Medicare from risk-adjusting (and lowering) payments to private plans (saving $22 billion over 10 years); and 3) stop making "indirect medical education" payments to managed care plans (saving $5 billion over 5 years) (Commonwealth Fund, "MedPAC Votes to Urge Billions in Cuts to Private Plans in Medicare," Health Policy Week, April 25, 2005).

- Medicare will overpay rural PPOs by an estimated $60 billion over the next decade. VA health economist Steven Pizer said regional PPOs will avoid competing with HMOs and focus on underserved areas that are profitable only because of Medicare's incentive payments. By sidestepping markets with existing HMOs, PPOs will be able to attract healthier Medicare enrollees by offering a skimpier and less costly benefits package, costing Medicare $60 billion more than if seniors stayed in traditional Medicare (Pizer, S., et al, "Defective Design: Regional Competition in Medicare," Health Affairs Web Exclusive, August 23, 2005).

GOP Gives HMOs $22 Billion Gift

HMOs will receive $22 billion in overpayments over the next decade if congressional Republicans have their way. In "one of the rawest displays of lobbyists' power in the Capitol," staff and GOP lawmakers, meeting behind closed doors, "tweaked" a budget bill to hand "HMOs a $22 billion gift by protecting the inflated reimbursements they currently reap through Medicare." Republicans took out a provision that would require HMO premiums to be risk-adjusted for the health of their enrollees, a provision that would, according to the Congressional Budget Office, save Medicare $22 billion over 10 years, and which was recommended by MedPAC (see above) (New York Times, 1/25/05, and "Closed Door Deal Makes $22 Billion Difference" Washington Post, 1/24/05)

- The Center for Medicare and Medicaid Services (CMS) expects to spend $250 - $300 million to promote the Medicare drug benefit and convince seniors to sign-up (Young, The Hill 11/22/05).

Seniors' "Locked-In" to HMOs

As of January 2006, lock-in provisions will restrict Medicare beneficiaries' ability to change health plans. Before, Medicare patients could switch among Medicare HMOs and the traditional program freely during the year. Now, seniors will only be able to change plans once a year during open enrollment, in November-December. In 2001, 18.1 percent of Medicare managed care beneficiaries changed plans, and most (51.4 percent) returned to the traditional system. The lock-in will hurt seniors who want to leave HMOs because of quality issues, in order to keep a doctor, or over problems with benefits (Laschober, M. "Estimating Medicare Advantage Lock-In Provision Impact on Vulnerable Medicare Beneficiaries," Health Care Financing Review, 26(3) Spring 2005).

- As we go to press, about 20 states are picking up the tab for problems with the Medicare drug benefit. States are helping low-income seniors denied coverage pay for prescription drugs until the federal government remedies a widespread pattern of problems. Federal officials in Medicare claim that they are not responsible, and the states will have to seek reimbursement from the drug plans for their expenses. In many states low-income residents have been charged a full $250 deductible and co-payments higher than $5 per prescription, despite rules stating that low-income enrollees would not be responsible for such costs. New Jersey and California are each spending about $1 million a day on medications for seniors having problems with the program, tiny Maine reports spending $2 million on drug benefit problems in the first week and New Hampshire Gov. John Lynch reported the program "has been a nightmare for many of our citizens." (Pear, New York Times, 1/8/06; Pugh, Miami Herald, 1/8/06).

Medicare Part D: Seniors with Chronic Disease Face High Drug Costs

Under the new Medicare drug plan, seniors with chronic medical conditions will still spend over twice as much out-of-pocket on medications as the average senior. Researchers at the University of Maryland projected that the average beneficiary in Part D will spend $722 out-of-pocket in 2006. Beneficiaries with chronic diseases will pay much more: $1,581 for those with diabetes, $1,435 for chronic lung disease, and $1,844 for mental illness (Stuart, B. et al "Assessing the Impact of Coverage Gaps in the Medicare Part D Drug Benefit, Health Affairs Web Exclusive, 04/19/05).

Polls and Public Opinion

- Almost three-quarters of working Americans (72 percent) would like to see the federal government "guarantee health coverage for all Americans," a finding which crosses party affiliations from Democrats (88 percent) to Independents (73 percent) and Republicans (55 percent). Just 30 percent of working Americans say they are satisfied with the health care system, down from 36 percent in 1994 (Peter D. Hart Research Associates, "Labor Day: 2005, The State of Working America," August 2005).

> **65 Percent of Americans Support Government Health Insurance**
>
> A nationwide survey by the authoritative Pew Research Center found that 65 percent of Americans said they support "government health insurance even if taxes increase." Even among those identified as "social conservatives," 59 percent support a tax-financed government system. For other groups, the percent supporting were: "populist conservatives" (63 percent), "conservative Democrats" (73 percent) and "liberals" (90 percent). Only one group, "Enterprisers" (libertarian conservatives), did not provide majority support (24 percent) (Pew Research Center, "Beyond Red vs. Blue," Survey Report, 5/10/05).

- An Arizona Republic poll of registered voters in the state found that 81 percent support a "federally-organized universal health care system." The survey also indicated that 39 percent of registered voters worry about their ability to afford health care or prescription drugs in the coming year. In contrast to the overwhelming support for universal health care, only 8 percent of voters supported efforts to save the state money by lowering the Medicaid income limit or excluding more families from coverage (Crawford, Arizona Republic, 1/4/06).

- A Seattle ballot initiative advising the mayor and council that "health care is a right" and that "Congress should implement that right" passed with 69.8 percent of the vote (Seattle City Council Advisory Ballot Measure No. 1, November 2005).

- A survey of 1,000 Vermont residents found that 86 percent believe that "everyone should have access to the same basic coverage." A separate poll of 400 likely voters in Vermont found that 63 percent support a "state run system to guarantee access to health care to all residents," and 67 percent support higher taxes for such a system if it reduced their premiums (AARP, "Health Care in Vermont: Support for Universal Coverage," October 2005; Channel 3 News Poll, May 4-May 7 2005).

- Health care ranks second among the issues Americans think are most important for the federal government to address. About 22 percents of U.S. residents said that health care is the most important issue for the federal government to address. The Iraq war (28 percent) ranked first. The survey of 1,205 residents also asked about the importance of specific health care issues. Of those, 26 percent said increasing the number of people covered by health insurance is the most important issue to be dealt with, 25 percent said lowering the cost of health care and 15 percent said lowering the cost of prescription drugs (Schuler, Congressional Quarterly, 8/29/05).

- Medicare is viewed favorably by 96 percent of U.S. adults, according to a Harris Interactive poll of 2,242 residents. "Universal health insurance" was favored either "somewhat" or "strongly" by 75 percent of respondents (Wall Street Journal / Harris Poll, 10/20/05).

> **Michigan Business Executives for Single-Payer**
>
> A survey of 350 business executives in Michigan by their Chamber of Commerce found that 42 percent supported a national health system, and 40 percent specifically supported single-payer. The overwhelmingly Republican group gave President Bush a 70 percent approval rating (Haglund, mlive.com, 09/16/05).

Congress Watch

- As we go to press, HR 676, the National Health Insurance Act (based on the Physicians' Proposal for Single Payer National Health Insurance) has 63 co-sponsors: Abercrombie (HI); Badwin (WI); Becerra (CA); Brown (FL); Capuano (MA); Carson (IN); Christensen (VI); Clay (MO); Conyers (MI - sponsor); Cummings (MD); Davis (IL); Delahunt (MA); Engel (NY); Evans (IL); Farr (CA); Fattah (PA); Filner (CA); Frank (MA); Grijalva (AZ); Gutierrez (IL); Hastings (FL); Hinchey (NY); Honda (CA); Jackson (IL); Jackson-Lee (TX); Jones (OH); Kilpatrick (MI); Kucinich (OH); Lantos (CA); Lee (CA); Lewis (GA); Lynch (MA); Maloney (NY); McDermott (WA); McGovern (MA); McKinney (GA); McNulty (NY); Miller (CA); Nadler (NY); Napolitano (CA); Olver (MA); Owens (NY); Pastor (AZ); Payne (NJ); Rangel (NY); Rush (IL); Sanders (VT); Schakowsky (IL); Scott (VA); Serrano (NY); Solis (CA); Stark (CA); Thompson (MS); Tierney (MA); Towns (NY); Udall (NM); Velaquez (NY); Waters (CA); Watson (CA); Waxman (CA); Weiner (NY); Woolsey (CA); Wynn (MD) (An updated list of sponsors can be found at thomas.loc.gov).

- A proposed amendment to the U.S. Constitution (H.J. Res. 30 - introduced by Rep. Jesse Jackson, Jr.) to guarantee "health care as a fundamental right for every American" has 28 co-sponsors.

Malpractice Update

- Jury awards are "not key drivers of malpractice insurance increases," according to a recent Dartmouth study. Insurers' investment income and state regulations that adjust premiums based on expected investment returns are better explanations. Malpractice payments grew 4 percent per year between 1991 and 2003, and only 6 percent in total between 2000 and 2003. In 2002, malpractice premiums for internists, general surgeons and obstetricians rose an average of 20-25 percent, with some individuals experiencing much higher increases. (PNHP's Dr. Gordon Schiff has a special interest in malpractice and quality issues. If you have an interesting story or data, email Dr. Schiff at gdschiff@aol.com) (Chandra, A. "The Growth of Physician Medical Malpractice Payments," Health Affairs Web Exlcusive, 5/31/05).

International Health Systems

- A Quebec study of the impact of co-pays on prescription drugs found they reduced the use of essential medications by seniors and low-income welfare recipients, and increased serious adverse events and emergency room visits. Participants were monitored for 32 months before and 17 months after the introduction of co-pays; essential drug use decreased by 9.1 percent among seniors and 14.4 among the poor. Serious adverse events related to the lack of essential drugs increased from 5.8 per 10,000 person-months to 12.6 in the elderly, and from 14.7 to 27.6 in low-income welfare recipients. Related ED visits increased from 32.9 per 10,000 person-months to 47.1 among the elderly and from 69.6 to 123.8 in the poor (Tamblyn, R. et al, "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons," JAMA 285(4):421-429).

The median waiting time for non-emergency surgery in Canada across all provinces was 4.3 weeks in 2003, according to Statistics Canada, the counterpart of the U.S. Census Bureau. The median waiting time to see a specialist was 4.0 weeks (www.statcan.ca). This refutes the 17.8 weeks figure for surgery or specialty care heavily publicized by the ultraconservative Fraser Institute. A critique of the Fraser data can be found in the Canadian Health Services Research Foundation Newsletter, Vol. 1 No. 4, available at www.chsrf.ca.

- In a six-nation survey of residents with health problems, Americans reported the highest rates of medical errors, disorganized care and financial burdens. Compared with residents of Canada, Britain, New Zealand, Germany and Australia, residents of the U.S. who had experienced a serious condition or hospitalization reported the highest rate of disorganized care at doctors' offices - 33 percent - followed by Germany (26 percent), Canada (24 percent) and New Zealand (21 percent). More than half (51 percent) of U.S. patients reported going without prescriptions or doctor visits due to costs, compared with 38 percent in New Zealand, 34 percent in Australia, 26 percent in Canada and 13 percent in the U.K. The U.S. also fared worst in the percentage reporting errors in treatment, medication or laboratory procedures (34 percent). Thirty percent of patients in Canada reported these problems, and 22 percent in Britain. The survey included more than 2,200 patients worldwide (Schoen, C. et al "Taking The Pulse Of Health Care Systems: Experiences Of Patients With Health Problems In Six Countries," Health Affairs Web Exclusive, 11/03/05).

The New York Times

Sunday, January 15, 2006

To the Editor:

"States Intervene After Drug Plan Hits Early Snags" (front page, Jan. 8) reports that Medicare recipients are being denied promised prescription help. I would add that this has already increased hospitalizations.

I was outraged last week when one of my patients required hospital admission after stopping her medications because she couldn't afford the new $45.57 co-payment demanded by her assigned private pharmaceutical benefit management company. Medicaid had previously covered her prescriptions.

The administration has designed a drug benefit to protect the pharmaceutical industry and discredit Medicare, our one single-payer health insurance program. Today's mess could have been avoided if Congress had included the pharmacy benefit in Medicare and allowed Medicare to negotiate prices.

Congress should make changes in the drug benefit, instead of letting it serve as an opening wedge to privatizing and thus undermining original Medicare. Then it should extend Medicare coverage to everyone.

OLIVER FEIN, M.D.
New York, Jan. 9, 2006

The writer is chairman of the Metro New York chapter of Physicians for a National Health Program.

Ailing Health Care

By Paul Krugman
April 11, 2005

The New York Times

Those of us who accuse the administration of inventing a Social Security crisis are often accused, in return, of do-nothingism, of refusing to face up to the nation's problems. I plead not guilty: America does face a real crisis -- but it's in health care, not Social Security.

Well-informed business executives agree. A recent survey of chief financial officers at major corporations found that 65 percent regard immediate action on health care costs as "very important." Only 31 percent said the same about Social Security reform.

But serious health care reform isn't on the table, and in the current political climate it probably can't be. You see, the health care crisis is ideologically inconvenient.

Let's start with some basic facts about health care.

Notice that I said "health care reform," not "Medicare reform." The rising cost of Medicare may loom large in political discussion, because it's a government program (and because it's often, wrongly, lumped together with Social Security by the crisis-mongers), but this isn't a story of runaway government spending. The costs of Medicare and of private health plans are both rising much faster than G.D.P. per capita, and at about the same rate per enrollee.

So what we're really facing is rapidly rising spending on health care generally, not just the part of health care currently paid for by taxpayers.

Rising health care spending isn't primarily the result of medical price inflation. It's primarily a response to innovation: the range of things that medicine can do keeps increasing. For example, Medicare recently started paying for implanted cardiac devices in many patients with heart trouble, now that research has shown them to be highly effective. This is good news, not bad.

So what's the problem? Why not welcome medical progress, and consider its costs money well spent? There are three answers.

First, America's traditional private health insurance system, in which workers get coverage through their employers, is unraveling. The Kaiser Family Foundation estimates that in 2004 there were at least five million fewer jobs providing health insurance than in 2001. And health care costs have become a major burden on those businesses that continue to provide insurance coverage: General Motors now spends about $1,500 on health care for every car it produces.

Second, rising Medicare spending may be a sign of progress, but it still must be paid for -- and right now few politicians are willing to talk about the tax increases that will be needed if the program is to make medical advances available to all older Americans.

Finally, the U.S. health care system is wildly inefficient. Americans tend to believe that we have the best health care system in the world. (I've encountered members of the journalistic elite who flatly refuse to believe that France ranks much better on most measures of health care quality than the United States.) But it isn't true. We spend far more per person on health care than any other country -- 75 percent more than Canada or France -- yet rank near the bottom among industrial countries in indicators from life expectancy to infant mortality.

This last point is, in a way, good news. In the long run, medical progress may force us to make a harsh choice: if we don't want to become a society in which the rich get life-saving medical treatment and the rest of us don't, we'll have to pay much higher taxes. The vast waste in our current system means, however, that effective reform could both improve quality and cut costs, postponing the day of reckoning.

To get effective reform, however, we'll need to shed some preconceptions -- in particular, the ideologically driven belief that government is always the problem and market competition is always the solution.

The fact is that in health care, the private sector is often bloated and bureaucratic, while some government agencies -- notably the Veterans Administration system -- are lean and efficient. In health care, competition and personal choice can and do lead to higher costs and lower quality. The United States has the most privatized, competitive health system in the advanced world; it also has by far the highest costs, and close to the worst results.

Over the next few weeks I'll back up these assertions, and talk about what a workable health care reform might look like, if we can get ideology out of the way.

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The Medical Money Pit

By Paul Krugman
April 15, 2005

The New York Times

A dozen years ago, everyone was talking about a health care crisis. But then the issue faded from view: a few years of good data led many people to conclude that H.M.O.'s and other innovations had ended the long run of rising medical costs.

But the pause in the growth of health care costs in the 1990's proved temporary. Medical costs are once again rising rapidly, and our health care system is once again in crisis. So now is a good time to ask why other advanced countries manage to spend so much less than we do, while getting better results.

Before I get to the numbers, let me deal with the usual problem one encounters when trying to draw lessons from foreign experience: somebody is sure to bring up the supposed horrors of Britain's government-run system, which historically had long waiting lists for elective surgery.

In fact, Britain's system isn't as bad as its reputation -- especially for lower-paid workers, whose counterparts in the United States often have no health insurance at all. And the waiting lists have gotten shorter.

But in any case, Britain isn't the country we want to look at, because its health care system is run on the cheap, with total spending per person only 40 percent as high as ours.

The countries that have something to teach us are the nations that don't pinch pennies to the same extent -- like France, Germany or Canada -- but still spend far less than we do. (Yes, Canada also has waiting lists, but they're much shorter than Britain's -- and Canadians overwhelmingly prefer their system to ours. France and Germany don't have a waiting list problem.)

Let me rattle off some numbers.

In 2002, the latest year for which comparable data are available, the United States spent $5,267 on health care for each man, woman and child in the population. Of this, $2,364, or 45 percent, was government spending, mainly on Medicare and Medicaid. Canada spent $2,931 per person, of which $2,048 came from the government. France spent $2,736 per person, of which $2,080 was government spending.

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Amazing, isn't it? U.S. health care is so expensive that our government spends more on health care than the governments of other advanced countries, even though the private sector pays a far higher share of the bills than anywhere else.

What do we get for all that money? Not much.

Most Americans probably don't know that we have substantially lower life-expectancy and higher infant-mortality figures than other advanced countries. It would be wrong to jump to the conclusion that this poor performance is entirely the result of a defective health care system; social factors, notably America's high poverty rate, surely play a role. Still, it seems puzzling that we spend so much, with so little return.

A 2003 study published in Health Affairs (one of whose authors is my Princeton colleague Uwe Reinhardt) tried to resolve that puzzle by comparing a number of measures of health services across the advanced world. What the authors found was that the United States scores high on high-tech services -- we have lots of M.R.I.'s -- but on more prosaic measures, like the number of doctors' visits and number of days spent in hospitals, America is only average, or even below average. There's also direct evidence that identical procedures cost far more in the U.S. than in other advanced countries.

The authors concluded that Americans spend far more on health care than their counterparts abroad -- but that they don't actually receive more care. The title of their article? "It's the Prices, Stupid."

Why is the price of U.S. health care so high? One answer is doctors' salaries: although average wages in France and the United States are similar, American doctors are paid much more than their French counterparts. Another answer is that America's health care system drives a poor bargain with the pharmaceutical industry.

Above all, a large part of America's health care spending goes into paperwork. A 2003 study in The New England Journal of Medicine estimated that administrative costs took 31 cents out of every dollar the United States spent on health care, compared with only 17 cents in Canada.

In my next column in this series, I'll explain why the most privatized health care system in the advanced world is also the most bloated and bureaucratic.

Passing the Buck

By Paul Krugman
April 22, 2005

The New York Times

The United States spends far more on health care than other advanced countries. Yet we don't appear to receive more medical services. And we have lower life-expectancy and higher infant-mortality rates than countries that spend less than half as much per person. How do we do it?

An important part of the answer is that much of our health care spending is devoted to passing the buck: trying to get someone else to pay the bills.

According to the World Health Organization, in the United States administrative expenses eat up about 15 percent of the money paid in premiums to private health insurance companies, but only 4 percent of the budgets of public insurance programs, which consist mainly of Medicare and Medicaid. The numbers for both public and private insurance are similar in other countries -- but because we rely much more heavily than anyone else on private insurance, our total administrative costs are much higher.

According to the health organization, the higher costs of private insurers are "mainly due to the extensive bureaucracy required to assess risk, rate premiums, design benefit packages and review, pay or refuse claims." Public insurance plans have far less bureaucracy because they don't try to screen out high-risk clients or charge them higher fees.

And the costs directly incurred by insurers are only half the story. Doctors "must hire office personnel just to deal with the insurance companies," Dr. Atul Gawande, a practicing physician, wrote in The New Yorker. "A well-run office can get the insurer's rejection rate down from 30 percent to, say, 15 percent. That's how a doctor makes money. It's a war with insurance, every step of the way."

Isn't competition supposed to make the private sector more efficient than the public sector? Well, as the World Health Organization put it in a discussion of Western Europe, private insurers generally don't compete by delivering care at lower cost. Instead, they "compete on the basis of risk selection" -- that is, by turning away people who are likely to have high medical bills and by refusing or delaying any payment they can.

Yet the cost of providing medical care to those denied private insurance doesn't go away. If individuals are poor, or if medical expenses impoverish them, they are covered by Medicaid. Otherwise, they pay out of pocket or rely on the charity of public hospitals.

So we've created a vast and hugely expensive insurance bureaucracy that accomplishes nothing. The resources spent by private insurers don't reduce overall costs; they simply shift those costs to other people and institutions.

It's perverse but true that this system, which insures only 85 percent of the population, costs much more than we would pay for a system that covered everyone.

And the costs go beyond wasted money.

First, in the U.S. system, medical costs act as a tax on employment. For example, General Motors is losing money on every car it makes because of the burden of health care costs. As a result, it may be forced to lay off thousands of workers, or may even go out of business. Yet the insurance premiums saved by firing workers are no saving at all to society as a whole: somebody still ends up paying the bills.

Second, Americans without insurance eventually receive medical care -- but the operative word is "eventually." According to Kaiser Family Foundation data, the uninsured are about three times as likely as the insured to postpone seeking care, fail to get needed care, leave prescriptions unfilled or skip recommended treatment. And many end up disabled -- or die -- because of these delays.

Think about how crazy all of this is. At a rough guess, between two million and three million Americans are employed by insurers and health care providers not to deliver health care, but to pass the buck for that care to someone else. And the result of all their exertions is to make the nation poorer and sicker.

Why do we put up with such an expensive, counterproductive health care system? Vested interests play an important role. But we also suffer from ideological blinders: decades of indoctrination in the virtues of market competition and the evils of big government have left many Americans unable to comprehend the idea that sometimes competition is the problem, not the solution.

In the next column in this series, I'll talk about how ideology leads to "reforms" that make things worse.

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A Private Obsession

By Paul Krugman
April 29, 2005

The New York Times

American health care is unique among advanced countries in its heavy reliance on the private sector. It's also uniquely inefficient. We spend far more per person on health care than any other country, yet many Americans lack health insurance and don't receive essential care.

This week yet another report emphasized just how bad a job the American system does at providing basic health care. A study by the Robert Wood Johnson Foundation estimates that 20 million working Americans are uninsured; in Texas, which has the worst record, more than 30 percent of the adults under 65 have no insurance.

And lack of insurance leads to inadequate medical attention. Over a 12-month period, 41 percent of the uninsured were unable to see a doctor when needed because of cost; 56 percent had no personal doctor or health care provider.

Our system is desperately in need of reform. Yet it will be very hard to get useful reform, for two reasons: vested interests and ideology.

I'll have a lot more to say about vested interests and health care in future columns, but let me emphasize one key point: a lot of big companies are essentially in the business of wasting health care resources.

The most striking inefficiency of our health system is our huge medical bureaucracy, which is mainly occupied in trying to get someone else to pay the bills. A good guess is that two million to three million Americans are employed by insurers and health care providers not to deliver health care, but to pass the buck to other people.

Yet any effort to reduce this waste would hurt powerful, well-organized interests, which have already demonstrated their power to block reform. Remember the "Harry and Louise" ads that doomed the Clinton health plan? The actors may have seemed like regular folks, but the ads were paid for by the Health Insurance Association of America, an industry lobbying group that liked the health care system just the way it was.

But vested interests aren't the only obstacle to fixing our health care system. We also have a big problem with ideology.

You see, America is ruled by conservatives, and they have a private obsession: they believe that more privatization, not less, is always the answer. And their faith persists even when the evidence clearly points to a private sector gone bad.

I could cite many examples of this obsession at work. But a particularly good illustration of ideology-induced obliviousness is the 2004 Economic Report of the President, which devotes a whole chapter to health care that can be read as a sort of conservative manifesto on the subject.

The main message of that report is that U.S. health care is doing just fine. Never mind the huge expense, the low life expectancy, the high infant mortality; it's a market-based system, so it must be good.

The report even takes a Panglossian view of uninsured Americans - one that is completely at odds with the grim statistics I cited above - suggesting that "many of them may remain uninsured as a matter of choice," perhaps because "they are young and healthy and do not see the need for insurance."

The president's economists had only one criticism of the system: insurance is too comprehensive, which encourages people to consume too much health care. As they see it, insurance covers too large a percentage of medical costs. The answer to this problem is the creation of, you guessed it, private accounts, which have now superseded tax cuts as the answer to all problems.

Indeed, a new paper by Martin Feldstein of Harvard, which clearly reflects the administration's views, suggests that Social Security privatization and health savings accounts - tax shelters designed to encourage people to pay medical costs out of their own pockets - are only the beginning. "Investment-based personal accounts," he says, are the way to go for unemployment insurance and Medicare, too.

O.K., let's not turn this into a Bush-bashing session. President Bush didn't cause the crisis in American health care. His health care policies have made things only a little bit worse.

The point, instead, is that even though all the evidence suggests that we would be much better off under a system of universal coverage, any such move will be fiercely opposed, on principle, by conservatives who want us to move in the opposite direction.

And reform will also be opposed by powerful vested interests - my next subject in this series.

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A Serious Drug Problem

By Paul Krugman
May 6, 2005

The New York Times

There was a brief flurry of outrage when Congress passed the 2003 Medicare bill. The news media reported on the scandalous vote in the House of Representatives: Republican leaders violated parliamentary procedure, twisted arms and perhaps engaged in bribery to persuade skeptical lawmakers to change their votes in a session literally held in the dead of night.

Later, the media reported on another scandal: it turned out that the administration had deceived Congress about the bill's likely cost.

But the real scandal is what's in the legislation. It's an object lesson in how special interests hold America's health care system hostage.

The new Medicare law subsidizes private health plans, which have repeatedly failed to deliver promised cost savings. It creates an unnecessary layer of middlemen by requiring that the drug benefit be administered by private insurers. The biggest giveaway is to Big Pharma: the law specifically prohibits Medicare from using its purchasing power to negotiate lower drug prices.

Outside the United States, almost every government bargains over drug prices. And it works: the Congressional Budget Office says that foreign drug prices are 35 to 55 percent below U.S. levels. Even within the United States, Veterans Affairs is able to negotiate discounts of 50 percent or more, far larger than those the Medicare actuary expects the elderly to receive under the new plan.

After the drug bill's passage, Jacob Hacker and Theodore Marmor of Yale University estimated that a sensible bill could have delivered twice as much coverage for the same price.

Needless to say, apologists for the law insist that the prohibition on price negotiations had nothing to do with catering to special interests - that it was a matter of principle, of preserving incentives to innovate. How can we refute this defense?

One way is to challenge claims that the pharmaceutical industry needs high prices to innovate. In her book "The Truth About the Drug Companies," Marcia Angell, the former editor in chief of The New England Journal of Medicine, shows convincingly that drug companies spend far more on marketing than they do on research - and that much of the marketing is designed to sell "me, too" drugs, which are no better than the cheaper drugs they replace. It should be possible to pay less for medicine, yet encourage more real innovation.

Another answer is to point to the haste with which key players in the drug bill's passage cashed in - making the claims that they wrote a pharma-friendly Medicare bill out of genuine concern for the public's welfare look ludicrous.

Let's look at just two examples.

Billy Tauzin, who shepherded the drug bill through when he was a member of Congress, now heads the Pharmaceutical Research and Manufacturers of America, the all-powerful industry lobby group, for an estimated $2 million a year. In his new job, he's making novel arguments against allowing Americans to buy cheaper drugs from Canada: Al Qaeda, he suggests, might use fake Viagra tablets to get anthrax into this country.

Meanwhile, Thomas Scully, the former Medicare administrator - who threatened to fire Medicare's chief actuary if he gave Congress the real numbers on the drug bill's cost - was granted a special waiver from the ethics rules. This allowed him to negotiate for a future health industry lobbying job at the very same time he was pushing the drug bill.

If all this sounds like a story of a corrupt deal created by a corrupt system, it is. And it was a very expensive deal indeed. According to the Medicare trustees, the fiscal gap over the next 75 years created by the 2003 law - not the financing gap for Medicare as a whole, just the additional gap created by legislation passed 18 months ago - will be $8.7 trillion.

That's about three times the amount President Bush proposes to save by cutting middle-class Social Security benefits.

In fact, I have a suggestion for Mr. Bush. One way to prove that he's really sincere about addressing long-run fiscal problems, that his calls for benefit cuts aren't just part of an ideological agenda, would be to put Social Security aside for a while and fix his own Medicare program. Oh, never mind.

Nonetheless, someone will eventually have to take on the health care special interests. Who might do that? I'll write about that in the next installment of this series.

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Always Low Wages. Always.

By Paul Krugman
May 13, 2005

The New York Times

Last week Standard and Poor's, a bond rating agency, downgraded both Ford and General Motors bonds to junk status. That is, it sees a significant risk that the companies won't be able to pay their debts.

Don't cry for the bondholders, but do cry for the workers.

Standard and Poor's downgraded GM and Ford sooner rather than later because it believes that the public is losing interest in S.U.V.'s. But the companies were vulnerable because they still pay decent wages and offer good benefits, in an age when taking care of employees has gone out of style. In particular, they are weighed down by health care costs for current and retired workers, which run to about $1,500 per vehicle at G.M.

So the downgrade was a reminder of how far we have come from the days when hard-working Americans could count on a reasonable degree of economic security.

In 1968, when General Motors was a widely emulated icon of American business, many of its workers were lifetime employees. On average, they earned about $29,000 a year in today's dollars, a solidly middle-class income at the time. They also had generous health and retirement benefits.

Since then, America has grown much richer, but American workers have become far less secure.

Today, Wal-Mart is America's largest corporation. Like G.M. in its prime, it has become a widely emulated business icon. But there the resemblance ends.

The average full-time Wal-Mart employee is paid only about $17,000 a year. The company's health care plan covers fewer than half of its workers.

True, not everyone is badly paid. In 1968, the head of General Motors received about $4 million in today's dollars - and that was considered extravagant. But last year Scott Lee Jr., Wal-Mart's chief executive, was paid $17.5 million. That is, every two weeks Mr. Lee was paid about as much as his average employee will earn in a lifetime.

Not that many of them will actually spend a lifetime at Wal-Mart: more than 40 percent of the company's workers leave every year.

I'm not trying either to romanticize the General Motors of yore or to portray Wal-Mart as the root of all evil. GM was, and Wal-Mart is, a product of its time. And there's no easy way to reverse the changes.

What should be clear, however, is that the public safety net F.D.R. and L.B.J. created is more important than ever, now that workers in the world's richest nation can no longer count on the private sector to provide them with economic security.

When they reach 65, most Wal-Mart employees will rely heavily on Social Security - if the privatizers don't kill it. And many Wal-Mart employees already rely on Medicaid to pay for health care, especially for their children.

Indeed, a growing number of working Americans have turned to Medicaid. As the Kaiser Family Foundation points out, that's why children have for the most part have retained health coverage, despite a sharp decline in employer-based health insurance since 2000.

Yet our current political leaders are trying to privatize Social Security and reduce benefits. And they are slashing funds for Medicaid even as they give big tax cuts to people like Mr. Lee.

The attack on the safety net is motivated by ideology, not popular demand. The public isn't taken with the vision of an "ownership society"; it seems to want more, not less, social insurance. According to a poll cited in a recent Business Week article titled "Safety Net Nation," 67 percent of Americans think we should guarantee health care to all citizens; just 27 percent disagree.

The question is whether the public's desire for a stronger safety net will finally be seconded by corporations that haven't yet adopted the Wal-Mart model of minimal benefits and always low wages.

Last year Richard Wagoner Jr., G.M.'s chief executive, gave a speech about the costs of America's "Kafkaesque" health care system that sounded a lot like my recent columns. And his company has made it clear that it likes Canada's system: in 2002 the president of General Motors of Canada and the head of the Canadian Auto Workers signed a joint letter declaring that "it is vitally important that the publicly funded health care system be preserved and renewed."

But according to The Journal Register News Service, which covered Mr. Wagoner's speech, he "stressed later to reporters that he was not proposing a national health care plan." Why not?

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One Nation, Uninsured

By Paul Krugman
June 13, 2005

The New York Times

Harry Truman tried to create a national health insurance system. Public opinion was initially on his side: Jill Quadagno's book "One Nation, Uninsured" tells us that in 1945, 75 percent of Americans favored national health insurance. If Truman had succeeded, universal coverage for everyone, not just the elderly, would today be an accepted part of the social contract.

But Truman failed. Special interests, especially the American Medical Association and Southern politicians who feared that national insurance would lead to racially integrated hospitals, triumphed.

Sixty years later, the patchwork system that evolved in the absence of national health insurance is unraveling. The cost of health care is exploding, the number of uninsured is growing, and corporations that still provide employee coverage are groaning under the strain.

So the time will soon be ripe for another try at universal coverage. Public opinion is already favorable: a 2003 Pew poll found that 72 percent of Americans favored government-guaranteed health insurance for all.

But special interests will, once again, stand in the way. And the big debate among would-be reformers is how to deal with those interests, especially the insurance companies. These companies played a secondary role in Truman's failure but have since become a seemingly invincible lobby.

Let's ignore those who believe that private medical accounts - basically tax shelters for the healthy and wealthy - can solve our health care problems through the magic of the marketplace. The intellectually serious debate is between those who believe that the government should simply provide basic health insurance for everyone and those proposing a more complex, indirect approach that preserves a central role for private health insurance companies.

A system in which the government provides universal health insurance is often referred to as "single payer," but I like Ted Kennedy's slogan "Medicare for all." It reminds voters that America already has a highly successful, popular single-payer program, albeit only for the elderly. It shows that we're talking about government insurance, not government-provided health care. And it makes it clear that like Medicare (but unlike Canada's system), a U.S. national health insurance system would allow individuals with the means and inclination to buy their own medical care.

The great advantage of universal, government-provided health insurance is lower costs. Canada's government-run insurance system has much less bureaucracy and much lower administrative costs than our largely private system. Medicare has much lower administrative costs than private insurance. The reason is that single-payer systems don't devote large resources to screening out high-risk clients or charging them higher fees. The savings from a single-payer system would probably exceed $200 billion a year, far more than the cost of covering all of those now uninsured.

Nonetheless, most reform proposals out there - even proposals from liberal groups like the Century Foundation and the Center for American Progress - reject a simple single-payer approach. Instead, they call for some combination of mandates and subsidies to help everyone buy insurance from private insurers.

Some people, not all of them right-wingers, fear that a single-payer system would hurt innovation. But the main reason these proposals give private insurers a big role is the belief that the insurers must be appeased.

That belief is rooted in recent history. Bill Clinton's health care plan failed in large part because of a dishonest but devastating lobbying and advertising campaign financed by the health insurance industry - remember Harry and Louise? And the lesson many people took from that defeat is that any future health care proposal must buy off the insurance lobby.

But I think that's the wrong lesson. The Clinton plan actually preserved a big role for private insurers; the industry attacked it all the same. And the plan's complexity, which was largely a result of attempts to placate interest groups, made it hard to sell to the public. So I would argue that good economics is also good politics: reformers will do best with a straightforward single-payer plan, which offers maximum savings and, unlike the Clinton plan, can easily be explained.

We need to do this one right. If reform fails again, we'll be on the way to a radically unequal society, in which all but the most affluent Americans face the constant risk of financial ruin and even premature death because they can't pay their medical bills.

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Medicine: Who Decides?

By Paul Krugman
December 26, 2005

The New York Times

Health care seems to be heading back to the top of the political agenda, and not a moment too soon. Employer-based health insurance is unraveling, Medicaid is under severe pressure, and vast Medicare costs loom on the horizon. Something must be done.

But to get health reform right, we'll have to overcome wrongheaded ideas as well as powerful special interests. For decades we've been lectured on the evils of big government and the glories of the private sector. Yet health reform is a job for the public sector, which already pays most of the bills directly or indirectly and sooner or later will have to make key decisions about medical treatment.

That's the conclusion of an important new study from the Brookings Institution, "Can We Say No?" I'll write more about that study another time, but for now let me give my own take on the issue.

Consider what happens when a new drug or other therapy becomes available. Let's assume that the new therapy is more effective in some cases than existing therapies - that is, it isn't just a me-too drug that duplicates what we already have - but that the advantage isn't overwhelming. On the other hand, it's a lot more expensive than current treatments. Who decides whether patients receive the new therapy?

We've traditionally relied on doctors to make such decisions. But the rise of medical technology means that there are far more ways to spend money on health care than there were in the past. This makes so-called "flat of the curve" medicine, in which doctors call for every procedure that might be of medical benefit, increasingly expensive.

Moreover, the high-technology nature of modern medical spending has given rise to a powerful medical-industrial complex that seeks to influence doctors' decisions. Let's hope that extreme cases like the one reported in The Times a few months ago, in which surgeons systematically used the devices of companies that paid them consulting fees, are exceptions. Still, the drug companies in particular spend more marketing their products to doctors than they do developing those products in the first place. They wouldn't do that if doctors were immune to persuasion.

So if costs are to be controlled, someone has to act as a referee on doctors' medical decisions. During the 1990's it seemed, briefly, as if private H.M.O.'s could play that role. But then there was a public backlash. It turns out that even in America, with its faith in the free market, people don't trust for-profit corporations to make decisions about their health.

Despite the failure of the attempt to control costs with H.M.O.'s, conservatives continue to believe that the magic of the private sector will provide the answer. (There must be a pony in there somewhere.) Their latest big idea is health savings accounts, which are supposed to induce "cost sharing" - meaning individuals will rely less on insurance, pay a larger share of their medical costs out of pocket and make their own decisions about care.

In practice, the health savings accounts created by the 2003 Medicare law will serve primarily as tax shelters for the wealthy. But let's put justified cynicism about Bush administration policies aside: is giving individuals responsibility for their own health spending really the answer to rising costs? No.

For one thing, insurance will always cover the really big expenses. We're not going to have a system in which people pay for heart surgery out of their health savings accounts and save money by choosing cheaper procedures. And that's not an unfair example. The Brookings study puts it this way: "Most health costs are incurred by a small proportion of the population whose expenses greatly exceed plausible limits on out-of-pocket spending."

Moreover, it's neither fair nor realistic to expect ordinary citizens to have enough medical expertise to make life-or-death decisions about their own treatment. A well-known experiment with alternative health insurance schemes, carried out by the RAND Corporation, found that when individuals pay a higher share of medical costs out of pocket, they cut back on necessary as well as unnecessary health spending.

So cost-sharing, like H.M.O.'s, is a detour from real health care reform. Eventually, we'll have to accept the fact that there's no magic in the private sector and that health care - including the decision about what treatment is provided - is a public responsibility.

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First, Do More Harm

By Paul Krugman
January 16, 2006

The New York Times

It's widely expected that President Bush will talk a lot about health care in his State of the Union address. He probably won't boast about his prescription drug plan, whose debut has been a Katrina-like saga of confusion and incompetence. But he probably will tout proposals for so-called "consumer driven" health care.

So it's important to realize that the administration's idea of health care reform is to take what's wrong with our system and make it worse. Consider the harrowing series of articles The New York Times printed last week about the rising tide of diabetes.

Diabetes is a horrifying disease. It's also an important factor in soaring medical costs. The likely future impact of the disease on those costs terrifies health economists. And the problem of dealing with diabetes is a clear illustration of the real issues in health care.

Here's what we should be doing: since the rise in diabetes is closely linked to the rise in obesity, we should be getting Americans to lose weight and exercise more. We should also support disease management: people with diabetes have a much better quality of life and place much less burden on society if they can be induced to monitor their blood sugar carefully and control their diet.

But it turns out that the U.S. system of paying for health care doesn't let medical professionals do the right thing. There's hardly any money for prevention, partly because of the influence of food-industry lobbyists. And even disease management gets severely shortchanged. As the Times series pointed out, insurance companies "will often refuse to pay $150 for a diabetic to see a podiatrist, who can help prevent foot ailments associated with the disease. Nearly all of them, though, cover amputations, which typically cost more than $30,000."

As a result, diabetes management isn't a paying proposition. Centers that train diabetics to manage the disease have been medical successes but financial failures.

The point is that we can't deal with the diabetes epidemic in part because insurance companies don't pay for preventive medicine or disease management, focusing only on acute illness and extreme remedies. Which brings us to the Bush administration's notion of health care reform.

The administration's principles for reform were laid out in the 2004 Economic Report of the President. The first and most important of these principles is "to encourage contracts" -- that is, insurance policies -- "that focus on large expenditures that are truly the result of unforeseen circumstances," as opposed to small or predictable costs.

The report didn't give any specifics about what this principle might mean in practice. So let me help out by supplying a real example: the administration is saying that we need to make sure that insurance companies pay only for things like $30,000 amputations, that they don't pay for $150 visits to podiatrists that might have averted the need for amputation.

To encourage insurance companies not to pay for podiatrists, the administration has turned to its favorite tool: tax breaks. The 2003 Medicare bill, although mainly concerned with prescription drugs, also allowed people who buy high-deductible health insurance policies -- policies that cover only extreme expenses -- to deposit money, tax-free, into health savings accounts that can be used to pay medical bills. Since then the administration has floated proposals to make the tax breaks bigger and wider, and these proposals may resurface in the State of the Union.

Critics of health savings accounts have mostly focused on two features of the accounts Mr. Bush won't mention. First, such accounts mainly benefit people with high incomes. Second, they encourage wealthy corporate employees to opt out of company health plans, further undermining the already fraying system of employment-based health insurance.

But the case of diabetes and other evidence suggest that a third problem with health savings accounts may be even more important: in practice, people who are forced to pay for medical care out of pocket don't have the ability to make good decisions about what care to purchase. "Consumer driven" is a nice slogan, but it turns out that buying health care isn't at all like buying clothing.

The bottom line is that what the Bush administration calls reform is actually the opposite. Driven by an ideology at odds with reality, the administration wants to accentuate, not fix, what's wrong with America's health care system.

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Health Care Confidential

By Paul Krugman The New York Times
January 27, 2006

American health care is desperately in need of reform. But what form should change take? Are there any useful examples we can turn to for guidance?

Well, I know about a health care system that has been highly successful in containing costs, yet provides excellent care. And the story of this system's success provides a helpful corrective to anti-government ideology. For the government doesn't just pay the bills in this system – it runs the hospitals and clinics.

No, I'm not talking about some faraway country. The system in question is our very own Veterans Health Administration, whose success story is one of the best-kept secrets in the American policy debate.

In the 1980's and early 1990's, says an article in The American Journal of Managed Care, the V.H.A. "had a tarnished reputation of bureaucracy, inefficiency and mediocre care." But reforms beginning in the mid-1990's transformed the system, and "the V.A.'s success in improving quality, safety and value," the article says, "have allowed it to emerge as an increasingly recognized leader in health care."

Last year customer satisfaction with the veterans' health system, as measured by an annual survey conducted by the National Quality Research Center, exceeded that for private health care for the sixth year in a row. This high level of quality (which is also verified by objective measures of performance) was achieved without big budget increases. In fact, the veterans' system has managed to avoid much of the huge cost surge that has plagued the rest of U.S. medicine.

How does the V.H.A. do it?

The secret of its success is the fact that it's a universal, integrated system. Because it covers all veterans, the system doesn't need to employ legions of administrative staff to check patients' coverage and demand payment from their insurance companies. Because it's integrated, providing all forms of medical care, it has been able to take the lead in electronic record-keeping and other innovations that reduce costs, ensure effective treatment and help prevent medical errors.

Moreover, the V.H.A., as Phillip Longman put it in The Washington Monthly, "has nearly a lifetime relationship with its patients." As a result, it "actually has an incentive to invest in prevention and more effective disease management. When it does so, it isn't just saving money for somebody else. It's maximizing its own resources. ... In short, it can do what the rest of the health care sector can't seem to, which is to pursue quality systematically without threatening its own financial viability."

Oh, and one more thing: the veterans health system bargains hard with medical suppliers, and pays far less for drugs than most private insurers.

I don't want to idealize the veterans' system. In fact, there's reason to be concerned about its future: will it be given the resources it needs to cope with the flood of wounded and traumatized veterans from Iraq? But the transformation of the V.H.A. is clearly the most encouraging health policy story of the past decade. So why haven't you heard about it?

The answer, I believe, is that pundits and policy makers don't talk about the veterans' system because they can't handle the cognitive dissonance. (One prominent commentator started yelling at me when I tried to describe the system's successes in a private conversation.) For the lesson of the V.H.A.'s success story – that a government agency can deliver better care at lower cost than the private sector – runs completely counter to the pro-privatization, anti-government conventional wisdom that dominates today's Washington.

The dissonance between the dominant ideology and the realities of health care is one reason the Medicare drug legislation looks as if someone went down a checklist of things the veterans' system does right, and in each case did the opposite. For example, the V.H.A. avoids dealing with insurance companies; the drug bill shoehorns insurance companies into the program, even though they serve no real function. The V.H.A. bargains effectively on drug prices; the drug bill forbids Medicare from doing the same.

Still, ideology can't hold out against reality forever. Cries of "socialized medicine" didn't, in the end, succeed in blocking the creation of Medicare. And farsighted thinkers are already suggesting that the Veterans Health Administration, not President Bush's unrealistic vision of a system in which people go "comparative shopping" for medical care the way they do when buying tile, represents the true future of American health care.

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Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis

Sarita A. Mohanty, MD, MPH, Steffie Woolhandler, MD, MPH, David U. Himmelstein, MD, Susmita Pati, MD, MPH, Olveen Carrasquillo, MD, MPH, and David H. Bor, MD

Objectives. We compared the health care expenditures of immigrants residing in the United States with health care expenditures of US-born persons.

Methods. We used the 1998 Medical Expenditure Panel Survey linked to the 1996-1997 National Health Interview Survey to analyze data on 18398 US-born persons and 2843 immigrants. Using a 2-part regression model, we estimated total health care expenditures, as well as expenditures for emergency department (ED) visits, office-based visits, hospital-based outpatient visits, inpatient visits,and prescription drugs.

Results. Immigrants accounted for $39.5 billion (SE=$4 billion) in health care expenditures. After multivariate adjustment, per capita total health care expenditures of immigrants were 55% lower than those of US-born persons ($1139 vs. $2546). Similarly, expenditures for uninsured and publicly insured immigrants were approximately half those of their US-born counterparts. Immigrant children had 74% lower per capita health care expenditures than US-born children. However, ED expenditures were more than 3 times higher for immigrant children than for US-born children.

Conclusions. Health care expenditures are substantially lower for immigrants than for US-born persons. Our study refutes the assumption that immigrants represent a disproportionate financial burden on the US health care system.

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PNHP Immigrant Fact Sheet

Immigrant Population

- The U.S. immigrant population was 28.4 million in 2000, or 10.4% of the population, but immigrants account for 7.9% of U.S. health care expenditures ($39.5 billion in 1998), significantly less than their proportion of the population.

Insurance Status and Costs

- Immigrants consume 55% less health care than U.S.-born residents ($1,139 vs. $2,546 per capita).
- Immigrants consume less health care per capita regardless of insurance status including those with private insurance ($1,711 vs. $1,906 for U.S.-born) and those with public insurance ($2,749 vs. $3,447).
- Immigrants are more likely to be uninsured than U.S.-born residents (24.6% vs. 10.0%) but utilize less health care than other uninsured residents ($459 vs. $629 per capita).

- According to the National Resource Council, immigrants will pay, on average, $80,000 more in taxes than they use in government services over their lifetimes.

Utilization

- Per capita, immigrants utilize 64% less emergency department care, 49% less doctors' care, 31% less inpatient hospital care, and 69% less on prescription drugs than U.S.-born residents.
- Latino immigrants utilize half as much health care as U.S.-born Latinos (49% less) and less than one third of U.S.-born whites (70% less).
- 30% of immigrants utilize no health care in the course of a year compared to 20% of U.S.-born residents.

Children

- Immigrant children utilize 74% less healthcare than U.S.-born children ($270 vs. $1,059 per capita).
- Immigrant children visit emergency rooms significantly less than nonimmigrant children, but their individual ER costs are nearly three times higher ($45 vs. $18 per capita), suggesting that immigrant children forego needed care until experiencing an emergency.
- Immigrant children utilize 71% less doctors' care, 90% less inpatient hospital care, and 72% less prescription medications than U.S.-born residents.

Source: Mohanty et al, AJPH, August 2005

Note: For the purposes of the study, an immigrant was defined as being born in a foreign country. The data contains no information about citizenship or legal status.

Wrong Solution for the Uninsured

As well-meaning legislation goes, it would be hard to beat the law recently approved by the New York City Council over the veto of Mayor Michael Bloomberg. It requires certain large grocers to provide health care benefits for their employees. The law — like a handful of similar efforts from Long Island to San Francisco — is a response to the growing strain on Medicaid and other government assistance programs from uninsured workers.

A major inspiration for the legislation is clearly Wal-Mart. One report showed that nearly 9,000 Wal-Mart workers needed public insurance in Wisconsin, and that more than 10,000 children of the store's workers in Georgia were treated at taxpayer expense. The list goes on. Fed up, Maryland, New Jersey and Pennsylvania are in various stages of trying to force the big employer to take care of its own.

While it's easy to sympathize with the frustration of local governments left holding the bag, this kind of piecemeal legislation is no answer. For one thing, it's very possibly illegal — federal law generally protects employers from this kind of local mandate. And while it's emotionally satisfying to take a whack at the big-box stores, it hardly addresses the real problem. In New York, caring for the city's working uninsured costs more than $600 million annually, according to a Columbia University report. Wal-Mart can't be blamed for any of that, as it has been unsuccessful in pursuing a site in the city.

The nation's health care problems are too complicated to be addressed by a chock-a-block system of overzealous, homespun laws that fail to address the overarching problem of the uninsured and may not hold up in court, anyway. The problem cries out for a federal solution. Without some kind of aid, many small businesses would crumble under the cost of health care benefits — which the New York City law estimates at $5,000 per employee per year.

For right now, there is a commendable effort in Congress to post on the Internet the names of employers with large numbers of workers on public aid, the idea being that shame can be an effective weapon. The same kind of shame, however, should also be aimed at Washington lawmakers who have done nothing to solve the larger problem, the crying need for national health insurance.

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The Des Moines Register **Editorials | Jan. 17, 2006**

Wal-Mart Law The Wrong Approach on Health Care

While millions of people flock to shop at Wal-Mart every day, the company has also gained a flock of critics for running small stores out of business, paying low wages and forcing many of its employees to turn to taxpayer-financed programs like Medicaid for health care.

It's easy to throw stones at such a big target. But the Maryland General Assembly went too far last week when it overrode the governor's veto and required employers with more than 10,000 workers — i.e., Wal-Mart — to spend at least 8 percent of their payroll on employee health care or pay into a fund for the uninsured.

Maryland is the first state in the country to pass a "Wal-Mart bill," but labor unions are pushing legislatures in at least 30 other states — including Iowa — to enact similar requirements. It should end there: The law is unfair because it targets only companies of a certain size. Of the state's large employers, only Wal-Mart spends less than 8 percent on health care. Other government mandates, such as those requiring companies to pay minimum wage or honor medical leave, apply to all companies.

So why did Maryland do it?

"The taxpayers are giving a health-care subsidy to the largest retailer on Earth," said Maryland lawmaker Kumar Barve.

But that rationale is misguided because it assumes providing health care is the responsibility of employers. It shouldn't be. Employers don't pay workers' car insurance, homeowners' insurance or grocery bills. They shouldn't be responsible for picking up their health care tab, either.

Unfortunately, the twists and turns of this country's history have led to employer-based health insurance. Following World War II, a labor shortage and wage-freeze led to some companies offering insurance as a "perk." Now it's become an expectation that burdens companies financially. Worse, it keeps workers in dead-end jobs they hate. It thwarts entrepreneurial spirit when people are forced to stay with a company solely because it provides health insurance.

The United States is alone in the world in tying jobs to health care.

The country should be moving away from employer-based health care and toward a tax-financed system that provides health care to all Americans, regardless of where or if they're employed.

What has happened in Maryland should be a wake-up call to businesses all over America to get on board with reforming health care. The best action for employers to take: support the expansion of the existing, tax-financed Medicare program for seniors to cover all Americans.

Companies and workers could contribute to the Medicare fund through payroll taxes the same way they pay into Social Security. Because Medicare has lower administrative costs and covers a larger pool of people, that may be cheaper for companies than the premiums they're currently paying to private insurance companies to cover workers.

Maryland lawmakers had good intentions. They want more residents to have access to health care. They're tired of Wal-Mart employees ending up on the public dime. But the move is unfair to large business and, in the long run, detrimental to moving this country toward a single system of health care that covers all Americans.

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Where does all the money go?

Berkshire Eagle

By Dr. Susanne King
Tuesday, February 7, 2006

The United States spent $1.9 trillion on health care in 2004, 16 percent of the nation's economy. Yet 46 million Americans remain uninsured, a 6 million increase since President Bush took office. In his State of the Union address last week, the president failed to mention these statistics, nor did he offer any effective solutions to the health care crisis.

His suggestion for wider use of electronic records could help provide more efficient care, but provides no help toward addressing the glaring inequities and financial costs of our health care system. The health savings accounts he proposes, which would make patients "take ownership" of their health care, are unaffordable for the vast majority of people who don't have extra money for a savings account, or for the enormous deductible they would have to pay before using the account. Health savings accounts please Wall Street banks, as the New York Times noted last week; that should make us all suspicious.

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When I was in medical school, I spent a few of my clinical clerkships in the Veterans' Administration (VA) hospital allied with my medical school. The difference between the VA hospital and the private hospitals where I also trained was remarkable. In the VA hospital, laboratory and radiology services were so slow and inept that medical students would wheel patients to the X-ray department and perform blood counts in the laboratory. The elevators never worked. Nor did many of the ancillary staff. I directed my first "code blue" (a cardiac arrest) as a junior medical student on a young veteran with pneumonia. I ran the code until the resident physician arrived from the far reaches of the hospital.

But all that has changed. Last week I spoke with my nephew, a junior medical student who has just finished a rotation at a VA hospital. He spoke of the high quality of care he observed there, as well as the efficiency of the system. Recent studies have shown that both the quality of care and patient satisfaction are higher in the VA system than in the private sector.

And the VA system has improved health care to veterans, even as it is spending less per patient. Between 1999 and 2003, the number of patients enrolled in the VA system increased by 70 percent, yet funding only increased by 41 percent. Amazingly, the VA system has been able to provide better care, for satisfied patients, with less money. Why hasn't President Bush looked at a government program that works, to offer a solution to the health care crisis?

My nephew, a future doctor of America, said that the VA system has made him a believer in a national health care system, a "single-payer" insurance system. "Single-payer" means that there would be one administrator of health care funds, the government, which would collect and disperse the $1.9 trillion that are now administered by a huge patchwork of private insurance companies. That is a major reason why health care in the U.S. is so expensive, yet provides too little care to too few people. Too much of the $1.9 trillion goes toward the profiteering of drug and insurance companies. There is no private insurance in the VA system; and an additional source of savings is that drug companies have to negotiate prices with the VA, with resultant discounts for VA drugs, making their prices more commensurate with drug prices in other countries.

While many Americans cannot afford insurance coverage or medications, drug companies made more profits in 2002 than the other 490 companies in the Fortune 500 combined. The new Medicare drug bill, however, does not allow Medicare to negotiate with drug companies; it is yet another gift to the pharmaceutical industry from the Bush administration. While he is handing huge profits to the drug companies, as well as the insurance companies who are anticipating their windfall profits from Medicare, he plans to reduce payments to hospitals, the actual providers of care.

A new study from the University of California supports a 2003 study by Harvard researchers, Drs. David Himmelstein and Steffie Woolhandler, on the administrative costs that beleaguer our current health care system. Using conservative estimates, they found that only 66 percent of the health care dollar actually goes toward medical care. The rest goes toward billing (every doctor's nightmare), marketing, insurance company profits, and administration. The Harvard study showed that a single-payer national health insurance, which would eliminate the insurance companies and streamline the healthcare system, would save almost $300 billion, enough to provide comprehensive health care for everyone.

Our veterans have the reformed health care system they deserve, one that provides comprehensive, high quality, efficient health care for their entire lives, including nursing home care. And we all deserve this kind of care.

Unlike the VA, which is restricted to specific public hospitals with salaried doctors, a single-payer national health care system would include private hospitals and doctors' offices. But like the VA, everyone would be covered for all their health care needs, and, like the VA, this health care system would decrease administrative costs and prescription drug costs.

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And here at home in Massachusetts, where we spend more per person on health care than anywhere in the world, the state Legislature's health care conference committee still hasn't been able to negotiate legislation to expand access to affordable health insurance. Ironically, financing is the sticking point, as the legislators look for more money to finance a plan that includes the insurance companies, with their administrative waste, profits and complexity.

It would be so simple if our Legislature would just consider single-payer legislation for our state, the Massachusetts Health Care Trust (Senate Bill 755). No extra funds would be needed; the studies have been done which show a single-payer system is feasible with the money we currently spend on health care. We need to elect the legislators who will make affordable health care reform happen.

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Executive Summary (Excerpt)

HOW HIGH IS TOO HIGH? IMPLICATIONS OF HIGH-DEDUCTIBLE HEALTH PLANS

Karen Davis, et al, The Commonwealth Fund, www.cmwf.org
April 2005

The major purported advantages of HDHPs are that they will a) lower health care costs by causing patients to be more cost-conscious in their health care decisions, and b) make health insurance premiums more affordable for the uninsured. The authors find, however, that such plans are unlikely to have a substantial effect on either costs or coverage.

- Only 4 percent of health care expenses are accounted for by households with spending below the minimum deductibles required for participation in a health savings account (HSA). Altering the financial incentives for patients with health care spending under the deductible is unlikely to affect health care outlays significantly.

- The major effect of high deductibles is not lower total health care costs, but rather a one-time shift in spending from insurance premiums to patient out-of-pocket outlays. In future years, premiums are likely to continue to rise.

- High-deductible plans in the individual health insurance market are unlikely to be affordable for those Americans who are currently uninsured. Two-thirds of the uninsured have incomes that are less than twice the federal poverty level. Premiums for HDHPs equal about 6 percent of income for a 25-year-old man living at twice the poverty level and about 20 percent of income for a 60-year-old woman at that same income level. Researchers have found that few low-income individuals can afford to purchase coverage if premiums exceed 5 percent of income.

- Low-income individuals and families would be at risk for spending substantial sums of income out-of-pocket. The ceiling on out-of-pocket expenses constitutes 26 percent of income for single individuals and families at twice the federal poverty level.

Little advantage can be gained from providing people with incentives to choose an HDHP. Such incentives are essentially a tax break for higher-income individuals and, moreover, drain the federal treasury of $6 billion to $16 billion over 10 years. Further tax incentives proposed by the President in the fiscal year 2006 budget would provide an additional $48 billion over 10 years in subsidies to small businesses and individuals for HDHP/HSAs—funds that might be better spent on covering the uninsured through public programs or helping states maintain or expand coverage through Medicaid or other state insurance programs. If HSAs continue to be conditional on purchase of an HDHP, several policy changes might be considered to better target incentives and ensure access to care:

- Permit employers to lower deductibles for lower-wage workers.
- Exempt primary care and preventive services from the deductible.
- Guarantee choice of a comprehensive health plan to workers covered under employer plans.
- Permit greater flexibility in benefit design.
- Set an income ceiling on eligibility for HSAs.

High-deductible plans can deter patients from seeking needed care and add to financial burdens, particularly on low-income families and those with chronic illnesses. The modifications suggested here—particularly those intended to protect lower-wage adults and ensure access to early preventive and primary care—would help mitigate the most potentially harmful effects of these plans.

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Issue Brief

No. 288

December 2005

Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/ Commonwealth Fund Consumerism in Health Care Survey

by Paul Fronstin, EBRI, and Sara R. Collins, The Commonwealth Fund

- ***The latest "big idea"***—Promoting consumerism in health care is the latest big idea in health insurance in the United States. One of the leading manifestations of this is the use of high-deductible health plans with savings accounts, such as health savings accounts (HSAs) and health reimbursement arrangements (HRAs), collectively known as consumer-driven health plans (CDHPs). The first EBRI/Commonwealth Fund Consumerism in Health Care Survey was conducted to provide reliable national data on the growth of high deductible plans and their impact on the behavior and attitudes of health care consumers. The study defines high-deductible plans as those that would qualify for federal HSA tax preferences: with deductibles of $1,000 or more for individual plans and $2,000 or more for family plans.
- ***Lower satisfaction with consumer-driven plans***—The EBRI/Commonwealth Fund Consumerism in Health Care Survey—the first national survey of its kind—found that individuals with more comprehensive health insurance were more satisfied with their health plan than individuals in high deductible plans, with or without accounts. Specifically, 63 percent of individuals with comprehensive health insurance were extremely or very satisfied with their health plan, compared with 42 percent of CDHP enrollees and 33 percent of HDHP participants. About 60 percent of individuals with comprehensive insurance reported they were extremely or very likely to stay with their current health plan if they had the opportunity to switch, compared with 46 percent of CDHP enrollees and 30 percent of HDHP enrollees.
- ***Higher out-of-pocket costs***—Despite similar rates of health care use, individuals with CDHPs and HDHPs are significantly more likely to spend a large share of their income on out-of-pocket health care expenses than those in comprehensive health plans. Two-fifths (42 percent) of those in HDHPs and 31 percent of those in CDHPs spent 5 percent or more of their income on out-of pocket costs and premiums in the last year, compared with 12 percent of those in more comprehensive health plans.
- ***More missed health care***—Individuals with CDHPs and HDHPs were significantly more likely to avoid, skip, or delay health care because of costs than were those with more comprehensive health insurance, with problems particularly pronounced among those with health problems or incomes under $50,000. About one-third of individuals in CHDPs (35 percent) and HDHPs (31 percent) reported delaying or avoiding care, compared with 17 percent of those in comprehensive health plans.
- ***More cost-conscious consumers***—Among people in the plans who did receive care, there is evidence that they are more cost-conscious than those in comprehensive health plans. People in the CDHPs and HDHPs were significantly more likely to say that the terms of their health plans made them consider costs when deciding to see a doctor when sick or fill a prescription, to report that they had checked whether their health plan would cover their costs as well as the price of a service prior to receiving care, and to discuss treatment options and the cost of care with their doctors. Nevertheless, they were also more likely to go without care.
- ***Lack of information***—Few health plans of any type provide cost and quality information about providers to help people make informed decisions about their health care. The study also found very low levels of trust in information provided by health plans.

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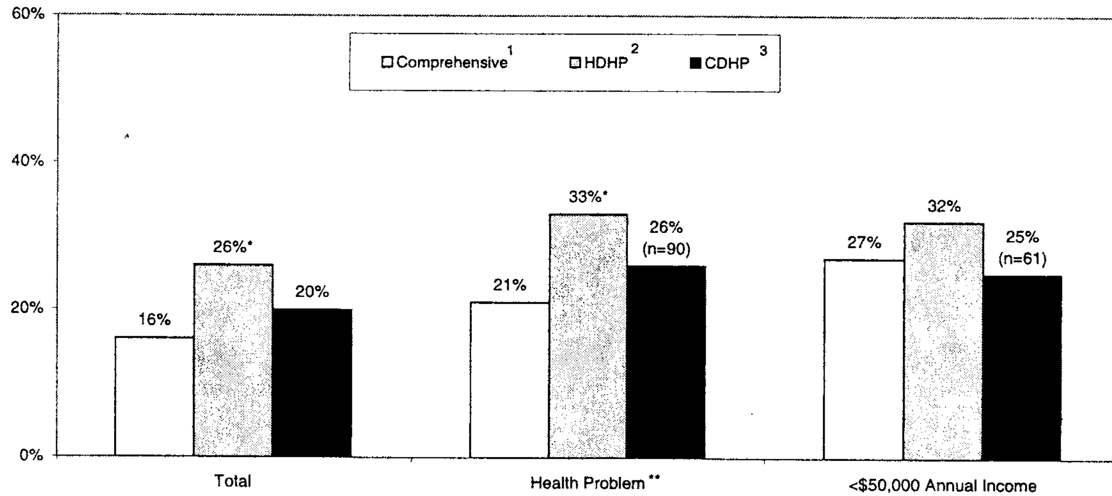
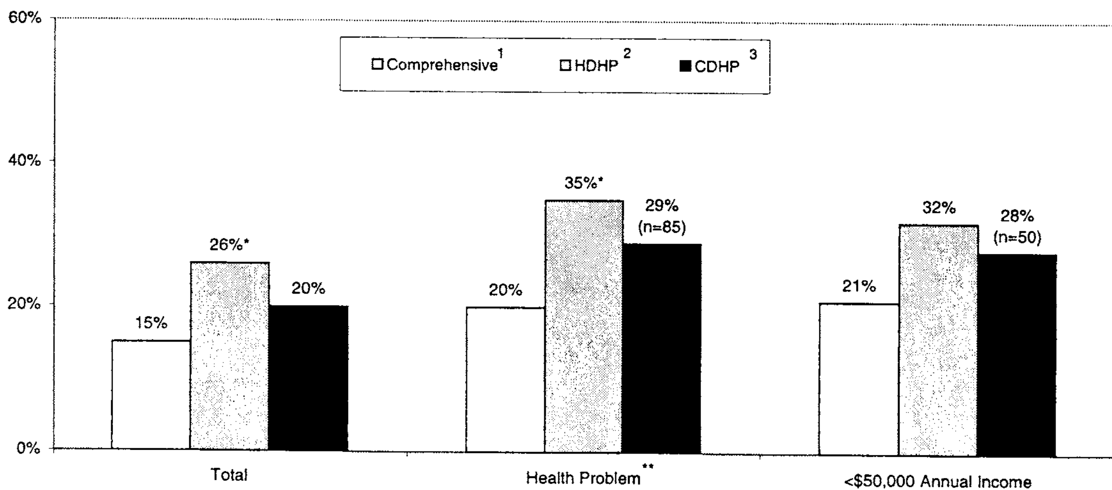
Figure 17
Percentage of Adults Who Have Not Filled a Prescription Due to Cost
Percentage of adults 21–64



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.
[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.
** Health problem defined as fair or poor health or one of eight chronic health conditions.
Note: Percentages may not sum to totals due to rounding.

Figure 18
Percentage of Adults Who Have Skipped Doses to Make a Medication Last Longer
Percentage of adults 21–64 with prescriptions in the last 12 months



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).
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** Health problem defined as fair or poor health or one of eight chronic health conditions.

DEPT. OF PUBLIC POLICY

THE MORAL-HAZARD MYTH

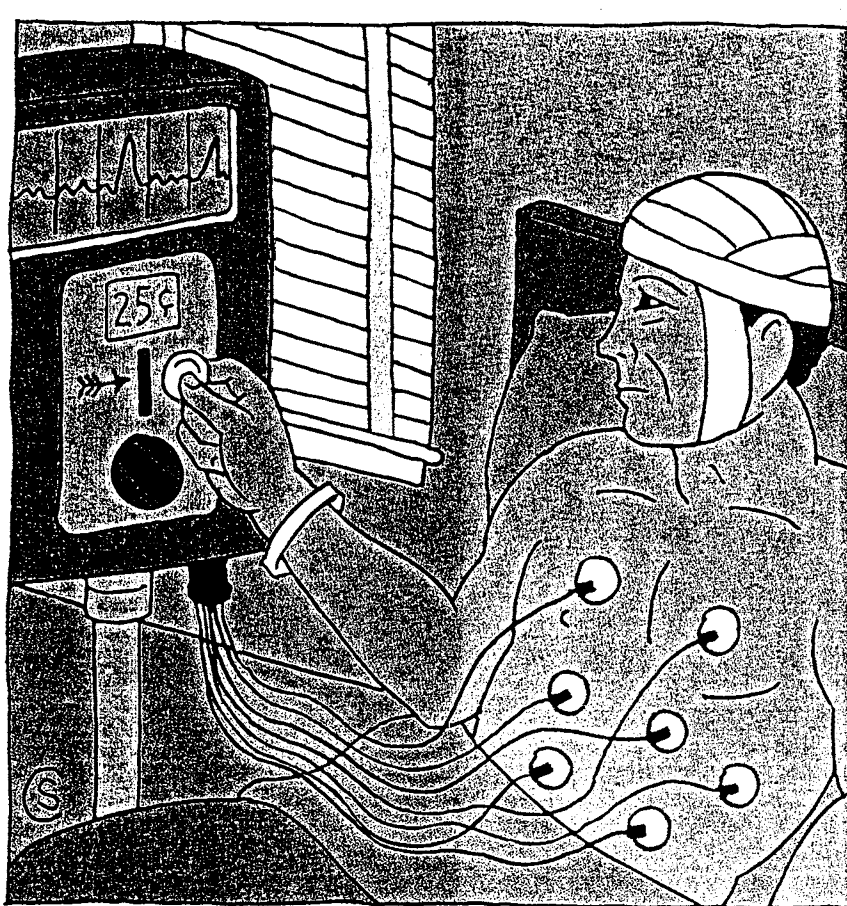
The bad idea behind our failed health-care system.

BY MALCOLM GLADWELL

Tooth decay begins, typically, when debris becomes trapped between the teeth and along the ridges and in the grooves of the molars. The food rots. It becomes colonized with bacteria. The bacteria feeds off sugars in the mouth and forms an acid that begins to eat away at the enamel of the teeth. Slowly, the bacteria works its way through to the dentin, the inner structure, and from there the cavity begins to blossom three-dimensionally, spreading inward and sideways. When the decay reaches the pulp tissue, the blood vessels, and the nerves that serve the tooth, the pain starts—an insistent throbbing. The tooth turns brown. It begins to lose its hard structure, to the point where a dentist can reach into a cavity with a hand instrument and scoop out the decay. At the base of the tooth, the bacteria mineralizes into tartar, which begins to irritate the gums. They become puffy and bright red and start to recede, leaving more and more of the tooth's root exposed. When the infection works its way down to the bone, the structure holding the tooth in begins to collapse altogether.

Several years ago, two Harvard researchers, Susan Starr Sered and Rushika Fernandopulle, set out to interview people without health-care coverage for a book they were writing, "Uninsured in America." They talked to as many kinds of people as they could find, collecting stories of untreated depression and struggling single mothers and chronically injured laborers—and the most common complaint they heard was about teeth. Gina, a hairdresser in Idaho, whose husband worked as a freight manager at a chain store, had "a peculiar mannerism of keeping her mouth closed even when speaking." It turned out that she hadn't been able to afford dental care for three years, and one of her front teeth was rotting. Daniel, a construction worker, pulled out his bad teeth with pliers. Then, there was Loretta, who worked nights at a university research center in Mississippi, and was missing most of her teeth. "They'll break off after a while, and then you just grab a hold of them, and they work their way out," she explained to Sered and Fernandopulle. "It hurts so bad, because the tooth aches. Then it's a relief just to get it out of there. The hole closes up itself anyway. So it's so much better."

People without health insurance have bad teeth because, if you're paying for everything out of your own pocket, going to the dentist for a checkup seems like a luxury. It isn't, of course. The loss of teeth makes eating fresh fruits and vegetables difficult, and a diet heavy in soft, processed foods exacerbates more serious health problems, like diabetes. The pain of tooth decay leads many people to use alcohol as a salve. And those struggling to get ahead in the job market quickly find that the unsightliness of bad teeth, and the self-consciousness that results, can become a major barrier. If your teeth are bad, you're not going to get a job as a



Policymakers want to get people to limit their use of health care, but is less really better?

receptionist, say, or a cashier. You're going to be put in the back somewhere, far from the public eye. What Loretta, Gina, and Daniel understand, the two authors tell us, is that bad teeth have come to be seen as a marker of "poor parenting, low educational achievement and slow or faulty intellectual development." They are an outward marker of caste. "Almost every time we asked interviewees what their first priority would be if the president established universal health coverage tomorrow," Sered and Fernandopulle write, "the immediate answer was 'my teeth.' "

The U. S. health-care system, according to "Uninsured in America," has created a group of people who increasingly look different from others and suffer in ways that others do not. The leading cause of personal bankruptcy in the United States is unpaid medical bills. Half of the uninsured owe money to hospitals, and a third are being pursued by collection agencies. Children without health insurance are less likely to receive medical attention for serious injuries, for recurrent ear infections, or for asthma. Lung-cancer patients without insurance are less likely to receive surgery, chemotherapy, or radiation treatment. Heart-attack victims without health insurance are less likely to receive angioplasty. People with pneumonia who don't have health insurance are less likely to receive X rays or consultations. The death rate in any given year for someone without health insurance is twenty-five per cent higher than for someone with insur-ance. Because the uninsured are sicker than the rest of us, they can't get better jobs, and because they can't get better jobs they can't afford health insurance, and because they can't afford health insurance they get even sicker. John, the manager of a bar in Idaho, tells Sered and Fernandopulle that as a result of various workplace injuries over the years he takes eight ibuprofen, waits two hours, then takes eight more—and tries to cadge as much prescription pain medication as he can from friends. "There are times when I should've gone to the doctor, but I couldn't afford to go because I don't have insurance," he says. "Like when my back messed up, I should've gone. If I had insurance, I would've went, because I know I could get treatment, but when you can't afford it you don't go. Because the harder the hole you get into in terms of bills, then you'll never get out. So you just say, 'I can deal with the pain.' "

One of the great mysteries of political life in the United States is why Americans are so devoted to their health-care system. Six times in the past century—during the First World War, during the Depression, during the Truman and Johnson Administrations, in the Senate in the nineteen-seventies, and during the Clinton years—efforts have been made to introduce some kind of universal health insurance, and each time the efforts have been rejected. Instead, the United States has opted for a makeshift system of increasing complexity and dysfunction. Americans spend $5,267 per capita on health care every year, almost two and half times the industrialized world's median of $2,193; the extra spending comes to hundreds of billions of dollars a year. What does that extra spending buy us? Americans have fewer doctors per capita than most Western countries. We go to the doctor less than people in other Western countries. We get admitted to the hospital less frequently than people in other Western countries. We are less satisfied with our health care than our counterparts in other countries. American life expectancy is lower than the Western average. Childhood-immunization rates in the United States are lower than average. Infant-mortality rates are in the nineteenth percentile of industrialized nations. Doctors here perform more high-end medical procedures, such as coronary angioplasties, than in other countries, but most of the wealthier Western countries have more CT scanners than the United States does, and Switzerland, Japan, Austria, and Finland all have more MRI machines per capita. Nor is our system more efficient. The United States spends more than a thousand dollars per capita per year—or close to four hundred billion dollars—on health-care-related paperwork and administration, whereas Canada, for example, spends only about three hundred dollars per capita. And, of course, every other country in the industrialized world insures all its citizens; despite those extra hundreds of billions of dollars we spend each year, we leave forty-five million people without any insurance. A country that displays an almost ruthless commitment to efficiency and performance in every aspect of its economy—a country that switched to Japanese cars the moment they were more reliable, and to Chinese T-shirts the moment they were five cents cheaper—has loyally stuck with a health-care system that leaves its citizenry pulling out their teeth with pliers.

America's health-care mess is, in part, simply an accident of history. The fact that there have been six attempts at universal health coverage in the last century suggests that there has long been support for the idea. But politics has always got in the way. In both Europe and the United States, for example, the push for health insurance was led, in large part, by organized labor. But in Europe the unions worked through the political system, fighting for coverage for all citizens.

From the start, health insurance in Europe was public and universal, and that created powerful political support for any attempt to expand benefits. In the United States, by contrast, the unions worked through the collective-bargaining system and, as a result, could win health benefits only for their own members. Health insurance here has always been private and selective, and every attempt to expand benefits has resulted in a paralyzing political battle over who would be added to insurance rolls and who ought to pay for those additions.

Policy is driven by more than politics, however. It is equally driven by ideas, and in the past few decades a particular idea has taken hold among prominent American economists which has also been a powerful impediment to the expansion of health insurance. The idea is known as "moral hazard." Health economists in other Western nations do not share this obsession. Nor do most Americans. But moral hazard has profoundly shaped the way think tanks formulate policy and the way experts argue and the way health insurers structure their plans and the way legislation and regulations have been written. The health-care mess isn't merely the unintentional result of political dysfunction, in other words. It is also the deliberate consequence of the way in which American policymakers have come to think about insurance.

"Moral hazard" is the term economists use to describe the fact that insurance can change the behavior of the person being insured. If your office gives you and your co-workers all the free Pepsi you want—if your employer, in effect, offers universal Pepsi insurance—you'll drink more Pepsi than you would have otherwise. If you have a no-deductible fire-insurance policy, you may be a little less diligent in clearing the brush away from your house. The savings-and-loan crisis of the nineteen-eighties was created, in large part, by the fact that the federal government insured savings deposits of up to a hundred thousand dollars, and so the newly deregulated S. & L.s made far riskier investments than they would have otherwise. Insurance can have the paradoxical effect of producing risky and wasteful behavior. Economists spend a great deal of time thinking about such moral hazard for good reason. Insurance is an attempt to make human life safer and more secure. But, if those efforts can backfire and produce riskier behavior, providing insurance becomes a much more complicated and problematic endeavor.

In 1968, the economist Mark Pauly argued that moral hazard played an enormous role in medicine, and, as John Nyman writes in his book "The Theory of the Demand for Health Insurance," Pauly's paper has become the "single most influential article in the health economics literature." Nyman, an economist at the University of Minnesota, says that the fear of moral hazard lies behind the thicket of co-payments and deductibles and utilization reviews which characterizes the American health-insurance system. Fear of moral hazard, Nyman writes, also explains "the general lack of enthusiasm by U.S. health economists for the expansion of health insurance coverage (for example, national health insurance or expanded Medicare benefits) in the U.S."

What Nyman is saying is that when your insurance company requires that you make a twenty-dollar co-payment for a visit to the doctor, or when your plan includes an annual five-hundred-dollar or thousand-dollar deductible, it's not simply an attempt to get you to pick up a larger share of your health costs. It is an attempt to make your use of the health-care system more efficient. Making you responsible for a share of the costs, the argument runs, will reduce moral hazard: you'll no longer grab one of those free Pepsis when you aren't really thirsty. That's also why Nyman says that the notion of moral hazard is behind the "lack of enthusiasm" for expansion of health insurance. If you think of insurance as producing wasteful consumption of medical services, then the fact that there are forty-five million Americans without health insurance is no longer an immediate cause for alarm. After all, it's not as if the uninsured *never* go to the doctor. They spend, on average, $934 a year on medical care. A moral-hazard theorist would say that they go to the doctor when they really have to. Those of us with private insurance, by contrast, consume $2,347 worth of health care a year. If a lot of that extra $1,413 is waste, then maybe the uninsured person is the truly efficient consumer of health care.

The moral-hazard argument makes sense, however, only if we consume health care in the same way that we consume other consumer goods, and to economists like Nyman this assumption is plainly absurd. We go to the doctor grudgingly, only because we're sick. "Moral hazard is overblown," the Princeton economist Uwe Reinhardt says. "You always hear that the demand for health care is unlimited. This is just not true. People who are very well insured, who are very rich, do you see them check into the hospital because it's free? Do people really like to go to the doctor? Do they check into the hospital instead of playing golf?"

For that matter, when you have to pay for your own health care, does your consumption really become more efficient? In the late nineteen-seventies, the RAND Corporation did

an extensive study on the question, randomly assigning families to health plans with co-payment levels at zero per cent, twenty-five per cent, fifty per cent, or ninety-five per cent, up to six thousand dollars. As you might expect, the more that people were asked to chip in for their health care the less care they used. The problem was that they cut back equally on both frivolous care and useful care. Poor people in the high-deductible group with hypertension, for instance, didn't do nearly as good a job of controlling their blood pressure as those in other groups, resulting in a ten-per-cent increase in the likelihood of death. As a recent Commonwealth Fund study concluded, cost sharing is "a blunt instrument." Of course it is: how should the average consumer be expected to know beforehand what care is frivolous and what care is useful? I just went to the dermatologist to get moles checked for skin cancer. If I had had to pay a hundred per cent, or even fifty per cent, of the cost of the visit, I might not have gone. Would that have been a wise decision? I have no idea. But if one of those moles really is cancerous, that simple, inexpensive visit could save the health-care system tens of thousands of dollars (not to mention saving me a great deal of heartbreak). The focus on moral hazard suggests that the changes we make in our behavior when we have insurance are nearly always wasteful. Yet, when it comes to health care, many of the things we do only because we have insurance—like getting our moles checked, or getting our teeth cleaned regularly, or getting a mammogram or engaging in other routine preventive care—are anything but wasteful and inefficient. In fact, they are behaviors that could end up saving the health-care system a good deal of money.

Sered and Fernandopulle tell the story of Steve, a factory worker from northern Idaho, with a "grotesquelooking left hand—what looks like a bone sticks out the side." When he was younger, he broke his hand. "The doctor wanted to operate on it," he recalls. "And because I didn't have insurance, well, I was like 'I ain't gonna have it operated on.' The doctor said, 'Well, I can wrap it for you with an Ace bandage.' I said, 'Ahh, let's do that, then.' " Steve uses less health care than he would if he had insurance, but that's not because he has defeated the scourge of moral hazard. It's because instead of getting a broken bone fixed he put a bandage on it.

At the center of the Bush Administration's plan to address the health-insurance mess are Health Savings Accounts, and Health Savings Accounts are exactly what you would come up with if you were concerned, above all else, with minimizing moral hazard. The logic behind them was laid out in the 2004 Economic Report of the President. Americans, the report argues, have too much health insurance: typical plans cover things that they shouldn't, creating the problem of overconsumption. Several paragraphs are then devoted to explaining the theory of moral hazard. The report turns to the subject of the uninsured, concluding that they fall into several groups. Some are foreigners who may be covered by their countries of origin. Some are people who could be covered by Medicaid but aren't or aren't admitting that they are. Finally, a large number "remain uninsured as a matter of choice." The report continues, "Researchers believe that as many as one-quarter of those without health insurance had coverage available through an employer but declined the coverage. . . . Still others may remain uninsured because they are young and healthy and do not see the need for insurance." In other words, those with health insurance are overinsured and their behavior is distorted by moral hazard. Those without health insurance use their own money to make decisions about insurance based on an assessment of their needs. The insured are wasteful. The uninsured are prudent. So what's the solution? Make the insured a little bit more like the uninsured.

Under the Health Savings Accounts system, consumers are asked to pay for routine health care with their own money—several thousand dollars of which can be put into a tax-free account. To handle their catastrophic expenses, they then purchase a basic health-insurance package with, say, a thousand-dollar annual deductible. As President Bush explained recently, "Health Savings Accounts all aim at empowering people to make decisions for themselves, owning their own health-care plan, and at the same time bringing some demand control into the cost of health care."

The country described in the President's report is a very different place from the country described in "Uninsured in America." Sered and Fernandopulle look at the billions we spend on medical care and wonder why Americans have so little insurance. The President's report considers the same situation and worries that we have too much. Sered and Fernandopulle see the lack of insurance as a problem of poverty; a third of the uninsured, after all, have incomes below the federal poverty line. In the section on the uninsured in the President's report, the word "poverty" is never used. In the Administration's view, people are offered insurance but "decline the coverage" as "a matter of choice." The uninsured in Sered and

Fernandopulle's book decline coverage, but only because they can't afford it. Gina, for instance, works for a beauty salon that offers her a bare-bones health-insurance plan with a thousand-dollar deductible for two hundred dollars a month. What's her total income? Nine hundred dollars a month. She could "choose" to accept health insurance, but only if she chose to stop buying food or paying the rent.

The biggest difference between the two accounts, though, has to do with how each views the function of insurance. Gina, Steve, and Loretta are ill, and need insurance to cover the costs of getting better. In their eyes, insurance is meant to help equalize financial risk between the healthy and the sick. In the insurance business, this model of coverage is known as "social insurance," and historically it was the way health coverage was conceived. If you were sixty and had heart disease and diabetes, you didn't pay substantially more for coverage than a perfectly healthy twenty-five-year-old. Under social insurance, the twenty-five-year-old agrees to pay thousands of dollars in premiums even though he didn't go to the doctor at all in the previous year, because he wants to make sure that someone else will subsidize his health care if he ever comes down with heart disease or diabetes. Canada and Germany and Japan and all the other industrialized nations with universal health care follow the social-insurance model. Medicare, too, is based on the social-insurance model, and, when Americans with Medicare report themselves to be happier with virtually every aspect of their insurance coverage than people with private insurance (as they do, repeatedly and overwhelmingly), they are referring to the social aspect of their insurance. They aren't getting better care. But they are getting something just as valuable: the security of being insulated against the financial shock of serious illness.

There is another way to organize insurance, however, and that is to make it actuarial. Car insurance, for instance, is actuarial. How much you pay is in large part a function of your individual situation and history: someone who drives a sports car and has received twenty speeding tickets in the past two years pays a much higher annual premium than a soccer mom with a minivan. In recent years, the private insurance industry in the United States has been moving toward the actuarial model, with profound consequences. The triumph of the actuarial model over the social-insurance model is the reason that companies unlucky enough to employ older, high-cost employees—like United Airlines—have run into such financial difficulty. It's the reason that automakers are increasingly moving their operations to Canada. It's the reason that small businesses that have one or two employees with serious illnesses suddenly face unmanageably high health-insurance premiums, and it's the reason that, in many states, people suffering from a potentially high-cost medical condition can't get anyone to insure them at all.

Health Savings Accounts represent the final, irrevocable step in the actuarial direction. If you are preoccupied with moral hazard, then you want people to pay for care with their own money, and, when you do that, the sick inevitably end up paying more than the healthy. And when you make people choose an insurance plan that fits their individual needs, those with significant medical problems will choose expensive health plans that cover lots of things, while those with few health problems will choose cheaper, bare-bones plans. The more expensive the comprehensive plans become, and the less expensive the bare-bones plans become, the more the very sick will cluster together at one end of the insurance spectrum, and the more the well will cluster together at the low-cost end. The days when the healthy twenty-five-year-old subsidizes the sixty-year-old with heart disease or diabetes are coming to an end. "The main effect of putting more of it on the consumer is to reduce the social redistributive element of insurance," the Stanford economist Victor Fuchs says. Health Savings Accounts are not a variant of universal health care. In their governing assumptions, they are the antithesis of universal health care.

The issue about what to do with the health-care system is sometimes presented as a technical argument about the merits of one kind of coverage over another or as an ideological argument about socialized versus private medicine. It is, instead, about a few very simple questions. Do you think that this kind of redistribution of risk is a good idea? Do you think that people whose genes predispose them to depression or cancer, or whose poverty complicates asthma or diabetes, or who get hit by a drunk driver, or who have to keep their mouths closed because their teeth are rotting ought to bear a greater share of the costs of their health care than those of us who are lucky enough to escape such misfortunes? In the rest of the industrialized world, it is assumed that the more equally and widely the burdens of illness are shared, the better off the population as a whole is likely to be. The reason the United States has forty-five million people without coverage is that its health-care policy is in the hands of people who disagree, and who regard health insurance not as the solution but as the problem.

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Single-Payer Plan the Only Solution

by David McLanahan, M.D.

Hurricanes Katrina and Rita have focused the nation's attention on our country's disadvantaged. Our residents and politicians have indicated a national will to repair New Orleans and with it, some of the inequities in our social fabric. Now is an opportune time to begin reconstruction of a health care system that has become a threat to all of us regardless of social status.

The Seattle Post-Intelligencer / CodeBlueNow series of essays initiated by former Govs. Booth Gardner and Arne Carlson on the current state of the U.S. health care system is timely and appropriate. Everyone agrees that the system is broken and needs to be changed.

However, a fundamentally different solution, rather than adjusting our dangerously ineffective, market-based approach, is necessary. The current system has resulted in an increasing number of uninsured (currently 45.8 million, almost one-sixth of our citizens), deteriorating benefits for those with insurance and overall rising costs.

Unpayable bills for medical care is the No. 1 cause of personal bankruptcy in our country. We lag far behind other industrialized (and many emerging) countries in typical health care indicators such as infant mortality and life expectancy rates, despite spending 15 percent of our gross national product on health care and 40 percent more per capita than the next most expensive system. According to a study comparing primary care in the United States, Canada, Great Britain, New Zealand and Australia, the United States ranked last or next to last in almost every measure of care, including access, coordination and patient/physician relationship.

Every other industrialized country has some form of government-administered national health insurance. A single, non-profit insurance plan is the only way to counter our system's duplication of administrative costs, overhead and the necessity for assuring investor profits that squander health care dollars. Innumerable studies, undertaken by both government and independent investigators, have concluded that savings from conversion to a single-payer insurance plan would readily fund current care as well as extending health coverage to the uninsured and the underinsured.

A single-payer plan that could work in the United States has been proposed by an organization of 13,000 physicians, Physicians for a National Health Program. This plan's essential feature is the elimination of all financial barriers to health care. Every American, independent of employment status, income or medical circumstances, would be covered for all necessary health care, including provider and hospital services, diagnostics, drugs, mental health, dental services and long-term care. All insurance premiums, co-pays and deductibles would be removed. Choice of physician and hospital would be broader than under present insurance plan restrictions.

Our health care delivery system would remain in its current format -- private physicians, group practices, community health centers, hospitals and drug companies. Only the paperwork and bills would be routed through and paid by a federal agency. Physicians would be paid by a simple fee schedule covering all patients or through an employer-based calculation.

Repeated surveys have indicated that a majority of Americans support government-guaranteed universal health insurance. Forty percent of physicians support some form of a single-payer program.

So why haven't we moved in that direction? It's because the entities controlling our for-profit health care system have been adept at guarding their turf. Insurance conglomerates, pharmaceutical companies and many provider organizations, all interested in protecting their profits and privileges, have convinced politicians that our system should not be changed fundamentally.

Scare tactics have been all too effective in deflecting the public's attention from the abundant evidence that we would be vastly better served by national health insurance. Consider, for example, that the highest quality health care delivery in our country is provided by the government-administered Veterans Affairs system, now outperforming the very best private hospitals, including Johns Hopkins, the Mayo Clinic and Massachusetts General Hospital, in 17 categories of quality health care indicators.

We must capitalize on the current focus on the holes in our safety net so sadly exposed by suffering from the hurricanes. We must honestly define the problem and consider how to implement much-needed reform. As former governors Gardner and Carlson conclude, we have suffered from a lack of leadership. They note, "the citizens must take charge" and our political representatives must get the message. We look forward to participating in that discussion.

David McLanahan, M.D., was a surgeon at Pacific Medical Centers for 25 years. Also contributing to the column were doctors Hugh Foy and Erika Goldstein, Harborview Medical Center; Kaj Johansen, Vascular Institute of the Northwest; Richard Kovar, medical director, Country Doctor Community Health Centers; and Peter McGough, chief medical officer, UW Medicine Neighborhood Clinics.

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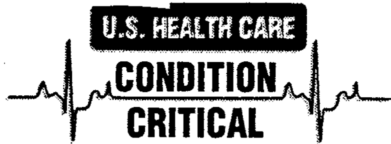
The Des Moines Register

December 7, 2005



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THE REGISTER'S EDITORIALS

A system that works for America

The U.S. health-care system doesn't work for ordinary people. It doesn't work for Bill Cotton of Des Moines, who is spending his life savings for his wife's nursing-home care. Or Hollee Crees of West Des Moines, who has had to fight the state of Iowa to keep her son on Medicaid. Or John Greener of Washington, Iowa, who can't retire from teaching because his health care would be unaffordable.

And they're *insured*. Then there are the 45 million Americans without health insurance.

The Register's editorial board has pushed repeatedly for a tax-financed system of health care that provides basic care for all Americans. We have suggested using Medicare as a financing model that could be gradually expanded to cover everyone. Why Medicare? It's a proven model that provides uniform coverage with low administrative costs — around 3 percent, compared with an average of 15 percent in the private sector. Medicare is familiar, which makes it politically palatable.

Medicare was created 40 years ago because seniors needed help with health care. Now everyone needs it. It makes sense to build on the idea of pooling people together, lowering costs through economies of scale and greater negotiating leverage, and offering uniform benefits people can understand.

We realize our suggestion is hardly simple. Medicare would need to be reformed before it could be expanded — and not in the way Congress "reformed" it in 2003. It should provide a uniform drug benefit that allows the government to negotiate the cost of drugs. It should offer a more comprehensive package of benefits, which would eliminate the need to purchase supplemental insurance. It should do a better job of coordinating patients' care.

But wouldn't a system like that break the budget? No. A taxpayer-financed system, covering all Americans, could *save* 1.1 trillion health-care dollars over 10 years, concluded a recent study by the the nonprofit, nonpartisan National Coalition on Health Care, the nation's largest alliance working to improve health care.

The coalition offered four scenarios for reforming health care in this country. All are comprehensive reform plans, not tinkering around the edges. All would provide everyone with health insurance, increase efficiency and improve quality of care. All four would save money. The one that would save the most money: a universal, publicly financed program.

Kenneth Thorpe, a former government economist, estimated the cost and savings using Congressional Budget Office methodology. He assumed employers would pay 75 percent of the tax for covering employees and workers would pay the remaining 25 percent through payroll taxes. The benefits wouldn't be bare bones either. They would be similar to what federal employees enjoy. The system would provide drug coverage and wouldn't require purchasing supplemental insurance.

The coalition isn't a bunch of left-wing nuts. It's co-chaired by former Iowa Gov. Robert Ray, a Republican. Members include Principal Financial Group, AARP and Blue Shield of California.

None of the coalition's coverage and cost scenarios exactly matches the expansion of Medicare that the Register advocates. But they clearly indicate that Medicare expansion would be feasible and save money.

The alternative to comprehensive reform is to keep putting Band-Aids on a system that doesn't work even for the insured. Quality and availability of care varies for those covered by Medicare versus Medicaid versus benefits through public jobs versus thousands of different plans through private employers versus insurance bought in the open market. And millions are uninsured. The fractured system's very structure — or lack of it — makes it wasteful.

Instead, the United States could use the money it's already spending on health care to cover all Americans.

One system. Everyone pays for it. Everyone is insured by it. It would be more efficient and more humane.

It would work for ordinary people. It would work for America.

The obstacle: Special interests

So what stands between America and a tax-financed system of health care?

Powerful special interests that funnel cash to politicians for their political campaigns and lobby heavily to protect their bottom lines.

Reforming the current system theoretically could eliminate the health-insurance industry, although parts of that business would likely remain. Consumers in many countries with national health-care systems buy insurance policies to cover care beyond what the government provides. The pharmaceutical industry would see smaller profits if a government system negotiated down the cost of drugs for everyone.

Two other key players, physicians and businesses, have historically opposed a taxpayer-financed system. Their main national associations continue to do so. As members' costs and frustration mount, however, views are starting to change.

Business associations have long advocated market-based solutions rather than a government system. Yet, in part because of existing government involvement, the free market hasn't worked in health care. Businesses large and small see that each year when they receive their annual health-insurance rate increases.

The American Medical Association, too, has fought the idea of a national system, but some physician groups are coming around. Many doctors are growing tired of the paperwork burden of dealing with thousands of different private insurance plans in addition to government programs. And physicians embrace a credo of providing health care to everyone.

The business and medical lobbies wield considerable clout in the halls of Congress. If some of that clout shifted toward pushing reform, rather than resisting it, Congress would be forced to respond.

MYTHS AND TRUTHS

Opponents to a taxpayer-financed system that covers everyone use scare tactics to resist change. Some of their common themes:

- Government-financed care would be socialism. America should rely on a free-market economy.

The truth: There is no true free market in many aspects of health care.

There is no free market when the government is a huge purchaser of services and when insurance companies do the buying for individuals. There is no free market when many workers can afford to purchase only the health insurance their employers offer. There is no free market when complex billing systems make it virtually impossible for an individual to shop for the best quality and price.

- There would be rationing of care.

The truth: That one isn't a myth. The myth is that there's no rationing now. Private insurance companies are the epitome of organizations that ration. They don't cover some drugs, some doctors, some services. And there's no greater rationing than leaving millions of people uninsured.

- Canada has universal care and its system is failing.

The truth: Every country has problems with its health-care system, and Canada is no exception. But nearly the same percentages of Canadians as Americans rate their health-care system as excellent.

- The government would be making my health decisions for me.

The truth: Medicare, a tax-financed system of care for seniors, allows enrollees to choose to visit doctors and hospitals that accept Medicare. People still have the right to make their own health-care decisions. Certain procedures aren't covered, but that's no different from private-sector health insurance.

What is Medicare?

Former President Lyndon Johnson signed the federal Medicare program into law in 1965. It's the nation's largest health-insurance program, providing coverage for 40 million Americans, including those over age 65, some disabled people and those suffering kidney failure.

Part A of Medicare covers hospitalization and is funded through payroll taxes paid by working Americans. Part B of Medicare covers other services, such as doctors' visits. Enrollees pay premiums that cover 25 percent of the program's cost. General revenues pay for the remaining 75 percent. Medicare Part D refers to the recently added drug benefit, which is funded through premiums paid by enrollees and general revenues. Many seniors purchase "Medigap" policies from private insurance companies to help pay some of the costs original Medicare doesn't cover.

More options are now available through Medicare Advantage plans. Private insurance companies, subsidized by the government, provide all coverage — what would have been handled through original Medicare and through supplemental insurance.

A history of stalled reforms

1910s: President Woodrow Wilson proposes a single-payer health-care system modeled after plans in Germany and Great Britain. Opposition by labor unions and animosity toward Germany after World War I prevent its adoption.

1920s: The first of what we now call HMOs arises.

1930-1940s: Blue Cross and Blue Shield form.

1935: The Social Security Act passes. Pressure from the American Medical Association results in cutting national health insurance from the bill.

1949: President Harry S. Truman proposes a single-payer plan financed through a payroll tax, paid half by employers and half by employees. The AMA opposes the plan.

1965: President Lyndon B. Johnson creates Medicare, to cover seniors, and Medicaid, to cover the poor.

1970s: President Richard Nixon backs national health reform. When Nixon resigns, the idea fizzles

1993: President Bill Clinton introduces a health-care plan and names Hillary Rodham Clinton chair of the commission. The plan dies in Congress the next year.

2003: President George W. Bush signs Medicare reform into law, which includes prescription-drug coverage.

— Source: Stanford School of Medicine

WHAT YOU CAN DO

GET INVOLVED:

Join local and national groups working toward health-care reform:

- Iowa Citizen Action Network, www.iowacan.org, Des Moines office — (515) 277-5077, Iowa City office — (319) 354-8116
- Iowa for Health Care, www.iowaforhealthcare.org
- National Coalition on Health Care, www.nchc.org, (202) 638-7151
- Physicians for a National Health Care Program, www.pnhp.org, (312) 782-6006

SHARE YOUR THOUGHTS:

Go to DesMoinesRegister.com/forums to post your views about health-care reform.

Or send us a letter to the editor:

By e-mail: letters@news.dmreg.com

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- Americans and Canadians rate their own health fairly similarly, according to a first-of-its-kind survey of users of each system, "The Joint Canada-United States Survey of Health." Download a report on the survey and read an online-exclusive essay about the results, written by Register editorial writer Andie Dominick.

- Savings from four approaches to comprehensive health-care reform would range from $320.5 billion to $1.1 trillion, according to "Impacts of Health Care Reform: Projections of Costs and Savings," a report by professor Kenneth Thorpe of Emory University, prepared for the National Coalition on Health Care. Read a summary of the approaches and download the report.

Family Medicine and Health Care Reform

JOHN P. GEYMAN, M.D.
University of Washington
Seattle, Washington

A growing part of the U.S. population, together with many health professionals, have become concerned about problems in our health care system. Health care costs continue to rise, unabated, several times faster than the cost of living, rendering medical insurance and health care unaffordable for millions of low- and middle-income families. Despite a booming economy in the 1990s, 45 million Americans are uninsured, and tens of millions are underinsured. Many people delay or avoid seeking needed care, which creates higher rates of preventable morbidity, hospitalizations, and death among this group compared with well-insured, more affluent Americans. All market-based incremental efforts over the past 30 years have failed to contain health care costs, while the private insurance industry has gained from its high administrative charges and profits—about 30 percent of the health care dollar.[1]

Rising costs have forced employers to move toward defined-contribution health care coverage for their employees, and away from the defined-benefits approach started in the 1940s. The employer-based health insurance system is starting to fall apart, providing less coverage at more cost to less than two thirds of the U.S. workforce, and then only if these employees work full time.

Because a managed-care strategy has failed to control health care costs over the past 20 years, the current administration and stakeholders in the market-based system now favor consumer-directed health care (CDHC) to contain costs. Under the guise of "personal responsibility and choice," the concept of CDHC places more financial responsibility on individuals and their families for their own health care decisions through increased cost-sharing. It is well established, however, that increased cost-sharing leads to adverse outcomes for many people who cannot afford necessary care. Supporters are energetically pursuing CDHC without regard for its hazards: many Americans avoid preventive care, delay needed care, and do not take their medications when even small copayments are imposed.[2-4] One half of insured adults with high-deductible health plans experience debt problems.[5] Three out of four insured adults who declare bankruptcy do so because of medical debts.[6] Moral hazard, as the premise underlying CDHC, holds that the insured overuse health care services. But, it fails to recognize other factors that have greater impact on health care inflation, such as new medical technologies and the aging population.

The current health care system is not sustainable and needs structural reform. Four basic alternatives exist on the state and federal levels: the status quo with small incremental changes; employer mandate, whereby employers are given incentives to offer health insurance to their employees; individual mandate, whereby individuals are expected to acquire their own insurance coverage and take more responsibility as prudent buyers of their own health care; and a system of social insurance (single-payer).[1] Reputable studies in California, Vermont, Massachusetts, and Georgia have demonstrated that a single-payer system could save money while offering coverage to everyone.[7-11]

A national study[12] has shown that a single-payer system could provide all necessary care for Americans while saving more than $200 billion a year, largely through administrative simplification and not-for-profit ▸

The Author

JOHN P. GEYMAN, M.D., is professor emeritus of family medicine at the University of Washington, Seattle. He also is president of Physicians for a National Health Program.

Address correspondence to John P. Geyman, M.D. 53 Avian Ridge Ln., Friday Harbor, WA 98250 (e-mail: jgeyman@u.washington.edu). Reprints are not available from the author.

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financing. Single-payer health insurance is a more accountable system and would enhance access, cost containment, and quality of care. The money exists in the system ($1.8 trillion) and could be rechanneled to direct patient care. Patients and their families would gain improved affordability and access to care. Employers would have healthier workforces, allowing them to compete better in global markets. Physicians and other providers would have markedly reduced administrative overhead in dealing with single-buyer coverage instead of over 1,000 private insurers.

Family medicine has a mixed track record concerning health care reform. On one hand, it has a rich legacy of public service, and is the best-distributed specialty in American medicine, serving urban, suburban, and rural areas. Family physicians also are the mainstay of public safety-net programs in community health centers, the Indian Health Service, and other underserved settings. In its earlier years, family medicine was a counterculture force for health care reform.[13] On the negative side, however, the field has recently charted its own future with the Future of Family Medicine report, which calls for "universal access" but leaves in place an enormous and wasteful for-profit private health insurance industry.[14] We cannot have it both ways, as the California Health Care Options study has shown.[7] Under CDHC, millions of Americans do not have adequate financial security to cover the costs of their necessary health care. In Massachusetts, for example, Blue Cross is marketing a preferred provider organization (PPO) plan with deductibles up to $5,000 for individuals and up to $12,500 for families.[15]

Incremental "reforms" of our market-based system have failed and will continue to fail until we have the political will to establish a new system based on universal access, affordability, comprehensiveness, quality, sustainability, and accountability. If we do not educate ourselves on system problems and alternatives, we fail our patients, their families, and the public interest. Now is the time to advocate for effective system reform or become part of the problem. The choice is ours, and our field could yet play a major role in leading the country toward social justice and a better health care system for all.

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EDITOR'S NOTE: The Future of Family Medicine report[1] was published in the March 2004 issue of the *Annals of Family Medicine.* An editorial[2] in the January 1, 2005, issue of *American Family Physician* updated readers on the progress of the Future of Family Medicine project. In this editorial, Dr. Geyman offers a different viewpoint about what is ailing the American health care system, and his recommendations for reform.

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Discussion

Extraordinary claims require extraordinary evidence

Donald W. Light[a,b,*], Rebecca N. Warburton[c]

[a] University of Medicine and Dentistry of New Jersey, Stratford, NJ 08084, USA
[b] Center for Bioethics, University of Pennsylvania, USA
[c] Michael Smith Foundation for Health Research Scholar, School of Public Administration, University of Victoria, Vic., BC, Canada

JEL classification: L65; O31

Keywords: Pharmaceutical industry; R&D cost; Internal validity; External validity; Bias [1, 253]

1. Extraordinary claims require extraordinary evidence

At the beginning of 2003, the *Journal of Health Economics* published a paper of great importance in public policy by DiMasi, Hansen, and Grabowski (referred to hereafter as "DHG 2003"). The paper is based primarily on confidential, proprietary data supplied by pharmaceutical companies to the Tufts Center for the Study of Drug Development, a research center that receives significant unrestricted grants from pharmaceutical companies (TCSDD, 2004a,b). This commentary is intended to invite discussion among health economists and other researchers about the quality of data and sampling used in estimating the costs of pharmaceutical R&D.

DHG 2003 estimates that it costs $802 million on average (in 2000 dollars) to research and develop a self-originated new chemical entity, including failures and cost of capital. It is worth noting that after adjusting for inflation, the DHG 2003 cost estimates are roughly two to four times as high as other estimates of pre-approval drug R&D costs (Love, 2003; Public Citizen, 2001; OTA, 1993). The 2003 article represents a sophisticated analysis that builds on the authors' equally important article in 1991, and adds several refinements and extensions of that prior analysis. There are, however, problems with the data and sampling on which these results depend, and this commentary focuses on those problems.

* Corresponding author. Tel.: +1 609 915 1588; fax: +1 609 924 1830.
E-mail address: dlight@princeton.edu (D.W. Light).

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A careful review of the article identified six serious sources of doubt about the validity and usefulness of the source data and methods used in DHG 2003:

(1) First, the inherent comparability and reliability of the survey data must be questioned because of variations in internal company cost allocation methods over time and across companies. Because cost data used was proprietary and confidential, readers cannot know how each company collected its data, or what was counted as research costs, and no independent verification of the accuracy of the information is possible. Firms reported R&D expenditures stretching back more than 10 years (to 1980), during which several firms underwent mergers and/or changed accounting systems or practices. The degree of potential variation is large, and these many variations in practice may compound on each other, making any point estimate misleading. (Internal validity)
(2) Second, considering the clear interest of pharmaceutical companies in higher (rather than lower) estimates of drug development costs, and sampled firms' likely awareness of the intended use of the survey data, it is not unlikely that companies would deliberately and systematically overstate costs in their survey responses (OTA, 1993). The survey design did not permit independent review of the reported costs, so upward bias cannot be ruled out. (Internal validity.)
(3) Third, the small, non-random firm sample ($n=10$) and drug sample ($n=68$) introduce another potentially large source of variation and error into cost estimates. Although the sampling of drugs was reported to be random, this is misleading, because the selection of firms participating in the survey (which preceded the selection of drugs) was not random (DHG 2003, pp. 157–158); randomization cannot be recovered once lost at the first stage of sample selection. A total of 24 firms were invited to respond; 12 firms accepted and were asked to provide data on an unstated number of drugs, randomly selected from those companies' drugs in the proprietary database; 10 firms provided usable data, covering development of 76 drugs; but drug data were usable for only 68, and complete for even fewer (it is noted as an example that only 66 drugs had Phase I trial cost data). No information is provided about how invited firms were selected, nor whether they were selected from the universe of all US research-oriented pharmaceutical firms or some other less representative universe. The 42% of invited firms that responded (10 of 24) self-selected, and given the industry interest in higher cost estimates it cannot be ruled out that firms with higher than average costs were most likely to choose to participate. (Internal validity)
(4) Fourth, the findings concern U.S. "self-originated new chemical entities" (NCEs; drugs that were researched, discovered, and developed in-house), whose costs are higher than those for more typical "new" drugs. Only 35% of new drugs approved by the FDA (from 1990 to 2000, FDA, 2004; from 1989 to 2000, NIHCREF, 2002) contained a new molecular entity, and only 62.4% of the survey firms' approved NCEs were said to be self-originated (DiMasi et al., 2003b, p. 3, note 1). Thus "self-originated new chemical entities" represented about 22% (62.4 of 35%) of new drug approvals. The number of truly self-originated NCEs may be even smaller, because the authors note that all phases of work may not have been done in-house and because there are well-documented examples of companies making such claims that do not comport with the facts (Mitsuya et al., 1989 Weinhold General Accounting Office, 2003). This might

not matter much, in terms of estimating typical drug development costs, if all drug development costs were similar, but they are not. According to DiMasi et al., 1991 (footnote 48), self-originated NCEs are 3.7 times more costly to develop than acquired or licensed-in NCEs, and many times more costly than new formulations, combinations or administrations of existing drugs. The DHG 2003 estimates therefore pertain to the most costly 22% of new drugs. (External validity.)

(5) Fifth, estimates of company spending on drug development are presented without deducting (or at least identifying) government subsidies to this work. The industry receives taxpayer funds from the NIH and other agencies, though amounts are not disclosed at the request of drug companies (General Accounting Office, 2003; National Science Foundation, 2003). Given the use of cost data to justify drug prices and patent protection, private (company-paid) cost and not social (total) cost is the policy-relevant figure. (External validity)

(6) Finally, the cost estimates are not adjusted for tax deductions and credits. Drug R&D expenses are fully tax-deductible each year, and there are special drug R&D tax provisions. The OTA (1993) estimated that tax savings and tax credits reduced R&D spending by nearly 50%. Lower tax rates in the 1990s might reduce that figure somewhat, but pre-tax costs clearly overstate true private (company) costs by a substantial percentage. (External validity)

These significant concerns about internal and external validity call the study results into question. Good science depends on different investigators analyzing the same data. Yet this science-based industry refuses to allow independent parties to check the validity of their cost data and analyze it so that policy can be based on solid, objective, reproducible evidence.

The estimate of R&D cost in this article is widely cited and accepted as an authoritative "fact" in the press and in the highest national and global policy circles. Given the prominent use of these cost estimates by the pharmaceutical industry and its advocates to influence national and international policies, it is critical that they be scientifically valid and relevant to the policy uses made of them. Shortly after DHG 2003 appeared, the Tufts Center for the Study of Drug Development announced that the average cost of developing a self-originated new chemical entity, including post-approval studies, was $897 million (TCSDD, 2003; Kaitin, 2003; DHG 2003). This figure, like the ones that preceded it, is based on confidential, unsystematic data, and has dubious scientific validity. In addition, adding post-approval studies to the costs of R&D is inherently questionable, because these "seeding trials" are designed primarily to familiarize physicians with the new drug and encourage its use; they are rarely randomized or blinded, but instead feature open-label case series, and are often sponsored by company marketing departments (Kessler et al., 2004).

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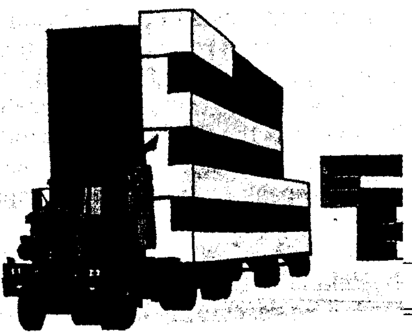
Inside



Canadian tide turns as residents return home

Experts say an improving climate for physicians in Canada and an increasingly hostile one in the United States are driving the change.

Myrle Croasdale
AMNEWS STAFF

JOHN WARNER, MD, RETURNED TO his native Canada in 1991 after completing medical training in the United States. That was unusual then, but now, with prospects in Canada getting more attractive to its native physicians and prospects in the United States comparatively less so, such a move is becoming more common.

For the first time in 30 years, Canada is seeing more physicians return than leave, according to the Canadian Institute for Health Information. In 2004, 202 physicians left the United States for Canada, while 162 Canadian doctors moved south.

A net gain of 40 physicians might seem small, but for much of the 1980s and 1990s, Canada lost hundreds of doctors per year to the United States, peaking with a net loss of 443 doctors in 1994, as 583 left and 140 returned.

Deepening administrative burdens from managed care insurers and rising medical liability rates are some of the reasons more of Dr. Warner's Canadian colleagues are returning home after training or practicing in the United States.

The shift also is attributed to the Canadian government's efforts to rein-

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Canadian tide turns as residents return home

Continued from page 1

vest in upgrades, such as new operating rooms, under the single-payer system. In some provinces, physicians are being offered higher reimbursements. All of this is to stem a growing shortage of doctors and increase access to quality care. Such stability follows deep cutbacks in Canada's reimbursement and health care infrastructure during the 1980s and 1990s.

Dr. Warner, a urologist in Toronto, did a fellowship at the Memorial Sloan-Kettering Cancer Center in New York City before returning to Canada in 1991. A visit this summer by a urology colleague from New York gave the two time to compare their practice environments.

"It's definitely becoming less attractive to practice in the United States," Dr. Warner said.

According to Steve Slade, a consultant with the National Physicians Data Base for the CIHI, not only are more physicians returning to Canada, but the physicians as a group are older. In 1994, 53% of the Canadian doctors returning from the United States were younger than 35. In 2004, only 31% were younger than 35.

Ruth Collins-Nakai, MD, president of the Canadian Medical Assn., said several forces are likely at work in this repatriation trend. And, Canada is actively recruiting doctors.

In 1999, the Canadian Medical Forum estimated that medical school enrollment needed to increase from 1,600 a year to 2,500 to meet population needs. According to the Ontario Ministry of Health, that province is short 1,000 physicians.

This has resulted in more recruiting incentives, such as debt assistance for those heading to rural areas and the lifting of billing caps that, for example, limited how many procedures surgeons could be paid for each year.

Robert Cooper, MD, a medical professor at Leonard Davis Institute of Health Economics at the University of Pennsylvania and a physician workforce expert, said the grapevine was full of talk on good job opportunities in Canada.

"They like their culture, their families and they're going back because they have the job opportunities now," Dr. Cooper said. "Canada is recruiting from all over, even U.S. doctors."

Pediatric orthopedist Kellie Leitch, MD, finished her U.S. fellowship in 2002 and went back to Canada because of its increasingly physician-friendly environment.

"I'm a fierce Canadian. The Canadian taxpayers paid for my education, and I felt an obligation to come home," Dr. Leitch said. Canada covers the cost of medical education for Canadians, not just at its own schools, but at U.S. and other foreign schools as well. The money does not need to be repaid, even if a physician does not return to Canada.

"My Canadian colleagues have always had the desire to come home, but the resources weren't available," Dr. Leitch said.

Improved opportunities and better facilities helped Dr. Leitch make her decision. A new robotics laboratory at the University of Western Ontario, London, was especially appealing. Now division chief of pediatric surgery at Children's Hospital in London, Dr. Leitch has a position that allows her to do research in the new lab, while a cross appointment at the business school lets her use her MBA.

U.S. blues

Robert McKendry, MD, professor of rheumatology at the University of Ottawa, has studied physician emigration from Canada to the United States and suggested that the older ages of the physicians moving back to Canada also could indicate an erosion of the U.S. health care environment. "Maybe those who moved to the United States found the pastures not as green as they expected," he said.

Dr. Warner said that considering the quality of life, pay and practice costs, he thinks he's about even with his U.S. friends.

Many of the more livable U.S. cities are too competitive for a urologist who wants to subspecialize, he said, and the larger incomes U.S. doctors earned are eroding. Recent surveys from the Medical Group Management Assn. showed that physician pay is flat or declining in many specialties.

Canadian salary figures were not available at press time, although CIHI data indicate that Canadian physicians have average billings about 25% less than their U.S. colleagues.

But doctors in Canada do not have the paperwork of multiple insurers or the steep increases in liability insurance premiums. In Ontario, considered a high-risk province, an ob-gyn would pay the equivalent of $65,000 for coverage, while in Florida, also considered high-risk, insurance would cost $277,000. Liability costs are increasing in Canada, though they're blunted by a tort-based compensation system, with compensation limited to cases in which fault is proven or settlement is made. ◆

Private health insurance: In one door and out the other?

The Supreme Court decision to invalidate Quebec's laws banning private health insurance for services covered under the Canada Health Act continues to stir the passions of physicians and health care providers. At their annual meeting, delegates of the Canadian Medical Association condemned the failures of the public health care system. By a two-thirds majority, they voted to entertain, after a 6-month period of study, the introduction of "private supplementary health insurance." An opposing motion by the Canadian Association of Internes and Residents was defeated by the same margin.

The opinions of national medical associations carry considerable weight among politicians, especially when funding for national health care is their largest budget item. By shifting its weight from the left foot to the right, the CMA will embolden conservatives to push for parallel private care and will strengthen the resolve of social democrats to fix the public system.

Can the public system be fixed so that it delivers necessary medical services as defined, vaguely, under the Canada Health Act? The Court's decision should not be interpreted as favouring private over public health care. The Court recognized the legitimacy of the government monopoly of health care services. Such a monopoly (and private monopolies) are constitutionally acceptable and sometimes desirable, provided that principles of distributive justice are satisfied. However, a monopoly health care system that does not deliver promised care in a timely, nonarbitrary and fair manner fails this legal test. Governments must either fix the dysfunctions of their health care monopoly or permit individuals to seek care (and the private health insurance to purchase it) elsewhere.

The case that provoked the Supreme Court judgment arose in Quebec and centred on an individual who, in the Court's opinion, had to wait too long for elective orthopedic surgery. The Court's judgment, in a 4 to 3 decision, strictly applies only to Quebec. In fact, one of the judges making up the majority, Justice Marie Deschamps, limited her judgment to Quebec's charter of rights and freedoms, and did not pronounce on Canada's.

The government of Quebec has asked for and received a stay of 1 year, which could potentially be extended to 2 or 3 years if Quebec so requests. In the interim, the Charest government will go to the polls. Quebec has perhaps the most social-democratic electorate of any province. It is unlikely that Mr. Charest will champion the cause of private health insurers in his re-election campaign. He will attempt to fix the public system.

Three approaches will likely be tried. First, all expert health care commissions in Quebec and the rest of Canada have recommended increasing the efficiency of the public system by getting physicians, nurses and other health care providers to work in teams, not silos. Governments can use sticks and carrots to accelerate this change. Second, more of the public's tax dollars can be diverted into health care, as proposed by the Wait Time Alliance. Third, because the other 2 solutions are so difficult to bring about, governments can reduce the number of services covered by their monopoly, turning them over to the private sector. As the fastest growing component of public health care is prescription drug coverage, it is likely that governments will delist some prescription drugs by increasing the number of products that can be obtained without a prescription, thus shifting the costs to patients. Drugs to treat hyperlipidemia and hypertension are good candidates. Larry Lynd and colleagues comment on this in an article released early online.[1] Is this likely to be any more palatable to voters?

In the debates and discussions that will ensue, we need to remember that there is virtually no disagreement that private health care is more expensive and less efficient than publicly funded care. Recent research has shown this to be true,[2,3] and in an article released early online,[4] Stephen Duckett describes the situation in Australia, where 40% of hospital admissions are in the private sector.

The Supreme Court decision and the subsequent rightward lean of the CMA will have an effect on government actions. Given widespread electoral support in Canada for the public system, however, we can expect governments in most, if not all, provinces to fix or at least palliate the public system and so nudge the public's dissatisfaction past the Supreme Court. — *CMAJ*

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The ONION | September 07, 2005

Cheney Dropped from White House HMO

WASHINGTON, DC—Citing Dick Cheney's pre-existing health conditions and his refusal to meet regularly with his primary care physician, the White House's health-insurance provider terminated the vice president's coverage Monday.

AmeriHealth, the parent company of the HMO serving the executive branch, issued a "termination of benefits" notice to Cheney Aug. 3. The form letter, addressed to "Member #782B-11107-3905C (Cheney, Richard Bruce)," informed the vice president that his health coverage would cease, "effective immediately."

Speaking to reporters Monday, Cheney expressed dismay over being dropped from the HMO.

"I am a victim of a bureaucracy," Cheney said. "This action on the part of AmeriHealth is exceedingly unfair."

In the form letter, Ameri-Health customer-service manager Bob Kielas apologized for any inconvenience caused by the adjustment, and encouraged the vice president to contact an AmeriHealth customer-service representative to make arrangements for his final payments.

Cheney said he was on hold for "almost half an hour" during a phone call he made to AmeriHealth shortly after receiving the notice. "This is a contemptible way to treat a customer," he said. "It's complete bullshit, to speak frankly."

Cheney said he was "reasonably certain" that his premiums were still being automatically deducted biweekly from his pay.

"I'm supposed to be covered," the vice president said. "This is a nightmare."

Those close to Cheney report that the vice president has long complained about having to see doctors within the HMO network, rather than choosing his own specialist. In 2003, Cheney wrote a letter of complaint when, instead of being admitted to the Bethesda Naval Hospital for treatment of his angina, he was directed to an HMO-approved urgent-care clinic in Clarendon, VA. According to the vice president, he sat in a crowded lobby between a mother with a colicky baby and a drunken Georgetown student with a broken nose for several hours, and both were examined before him.

Last February, Cheney received a bill for $2,000 for a coronary procedure that was only partially covered by his HMO. In a call that was recorded for quality-assurance purposes, Cheney argued for nearly 20 minutes with an associate customer-service representative identified only as "Heather." Cheney grew progressively more belligerent on the phone, until Heather said, "Sir, if you continue to use that type of language, I will have to end this call."

White House sources say that, while Cheney received his letter early this month, he was unaware of the cancellation on Aug. 23, when he visited the hospital following a possible heart attack and was told that he was "not in the computer."

Although the vice president was admitted to the hospital and learned that he had only been suffering acid reflux, he received a bill Monday for $1,500.

"This is a complete and total outrage," Cheney said. "Ameri-Health cannot possibly expect me to pay that kind of money out of pocket."

The Vice President waits to see his primary-care physician at a Washington-area clinic.

Cheney said he is unsure what action he will take if his HMO membership is not reinstated.

"I'm still too young for Medicare, and I'll simply run into the same pre-existing-condition clause if I purchase a health-insurance policy on my own," Cheney said. "Sometimes I just feel hopeless. There are very few health-care options available to someone like me."

JRSM JOURNAL OF THE ROYAL SOCIETY OF MEDICINE December 2005

A surrealistic mega-analysis of redisorganization theories

Andrew D. Oxman David L Sackett Iain Chalmers Trine E Prescott

Background We are sick and tired of being redisorganized.

Objective To systematically review the empirical evidence for organizational theories and repeated reorganizations.

Methods We did not find anything worth reading, other than Dilbert, so we fantasized. Unfortunately, our fantasies may well resemble many people's realities. We are sorry about this, but it is not our fault.

Results We discovered many reasons for repeated reorganizations, the most common being 'no good reason'. We estimated that trillions of dollars are being spent on strategic and organizational planning activities each year, thus providing lots of good reasons for hundreds of thousands of people, including us, to get into the business. New leaders who are intoxicated with the prospect of change further fuel perpetual cycles of redisorganization. We identified eight indicators of successful redisorganizations, including large consultancy fees paid to friends and relatives.

Conclusions We propose the establishment of ethics committees to review all future redisorganization proposals in order to put a stop to uncontrolled, unplanned experimentation inflicted on providers and users of the health services.

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Outcomes and Cost of Coronary Artery Bypass Graft Surgery in the United States and Canada

Mark J. Eisenberg, MD, MPH; Kristian B. Filion, BSc; Arik Azoulay, BComm, MSc; Anya C. Brox, BSc; Seema Haider, MSc; Louise Pilote, MD, MPH, PhD

Background: We sought to determine whether there is a difference in in-hospital outcomes and costs for coronary artery bypass graft surgery (CABG) between the United States and Canada.

Methods: We compared the outcomes and costs of treating 12 017 consecutive patients (4698 US and 7319 Canadian patients) undergoing CABG at 5 US and 4 Canadian hospitals. Participating hospitals used the same cost accounting system to provide patient-level clinical, resource utilization, and cost-of-treatment data (excluding physicians' fees). Canadian costs were converted to US dollars using purchasing power parities.

Results: Compared with Canadian patients, US patients were older (mean±SD age, 68.0±10.4 vs 63.7±9.8 years [$P<.001$]), more likely to be female (27.4% vs 21.8% [$P<.001$]), and discharged from the hospital sooner (mean±SD length of stay, 8.7±0.1 vs 9.5±0.1 days [$P<.001$]). In-hospital costs of treatment were substantially higher in the United States than in Canada (mean±SD cost, $20 673±$241 vs $10 373±$123 [$P<.001$]; median, $16 036 vs $7880). After controlling for demographic and clinical differences, length of stay in Canada was 16.8% longer than in the United States; there was no difference in in-hospital mortality; and the cost in the United States was 82.5% higher than in Canada ($P<.001$).

Conclusions: The in-hospital cost of CABG in the United States is substantially higher than in Canada. This difference is due to higher direct and overhead costs in US hospitals, is not explained by demographic or clinical differences, and does not lead to superior clinical outcomes.

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Out of Pocket Spending, Private Health Insurance and Co-Pays in Canada

Excerpted from: "Exploring the 70/30 Split: How Canada's Health System is Financed"
Canadian Institute for Health Information - 2005 (full text at: www.pnhp.org/canfinance.pdf)

Out of Pocket Spending in Canada

In 2002, individual Canadians paid an estimated $17 billion (out-of-pocket) to cover various health care services, up from $13 billion in 1998. For example, they spent $3.6 billion out-of-pocket health care dollars on over-the-counter drugs and personal health supplies. Personal health supplies include oral hygiene products, diagnostic supplies (for example, diabetic test strips) and medical supplies (such as incontinence products). Other major areas of out-of-pocket spending include dental care ($3.4 billion), prescribed drugs ($2.9 billion), nursing homes and other institutions ($3.0 billion) and vision care ($2.0 billion).

Private Health Insurance

Research suggests that in most OECD countries private health insurance plays a supporting role in publicly financed systems. In 2002, private health insurance accounted for an average of 7.2% of total expenditures on health and about 22% of private health spending in comparator OECD countries. Over the last decade, there has been relatively little change in the percentage of total health expenditure covered by private health insurance across the OECD. The role of private health insurace varies from country to country. For example, in France, the Netherlands and Canada, it accounts for any wherefrom 10 to 17 percent of total spending on health. This represents about half of all private spending. In OECD countries with significant levels of private health insurance, a large proportion of it is usually provided by employers.

Effect of Co-payments

What effect do copayments have on access to care and outcomes? Probably the best-known study to address this question is the Rand Health Insurance Experiment in the U.S. It randomly allocated participants to insurance plans with different copayment structures. The study found that those in plans with higher user fees, particularly individuals with low incomes, used fewer services. But sick people were more likely to die when user charges were in place, and rates of inappropriate antibiotic use and hospital admissions were about the same regardless of the level of user fees.

A large Canadian study based on the experience in Saskatchewan in the 1970s found similar results. When copayments were in effect, the poor used fewer physician services. Moreover, because high-income residents used more physician services and physician fees increased, overall health care costs were not lower when copayments were in place. Studies have shown that in both New Zealand and France it is primarily those with lower incomes who use health services less when they have to pay user fees. And, as in Saskatchewan, the introduction of copayments in Switzerland did not reduce total health expenditures.

American, Canadian and Western European studies have also found that cost sharing for out-of-hospital pharmaceuticals decreases utilization for the elderly and those in lower-income groups. This has been linked to adverse health outcomes and higher utilization of emergency departments among these groups. Likewise, New Zealand research suggests that some people avoid seeking help for early symptoms and may end up in emergency rooms because they are unable or unwilling to pay a user fee (about CA$30) to consult with a family physician.

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Living in the parallel universe in Australia: public Medicare and private hospitals

Published at www.cmaj.ca on Sept. 13, 2005.

The decision in the recent Chaoulli court case may presage the development of a nontrivial private sector in the Canadian health care system. Australia models many aspects of its Medicare system on Canada's plan: Australia has a national, universal scheme that is administered, in terms of hospital access and fees, at the State level within a national framework. But in Australia, a prominent private system exists alongside the public system. In 2003/04 about 40% of all hospital admissions were to private hospitals.

About 43% of the people residing in Australia have private health insurance. This dual system has deleterious implications for the equity and efficiency of the health care system, and similar ill effects could occur if Canada were to follow the Australian path of health care organization.

The current Liberal federal government in Australia has supported expanding the role of private health insurance. In 1996 it introduced a subsidy to the industry in the form of a rebate against the cost of insurance. Effectively, the government pays 30% (a larger proportion, for older people) of the cost of any private health-insurance package. The government also introduced other incentives to take out insurance: a higher federal tax (a 1% surcharge on taxable income) on high-income earners that can be avoided if they take out private insurance; policies to reduce unexpected gaps between bills from hospitals and doctors and the benefit payments from health insurance funds; and — the most effective policy, in terms of increasing membership — the 1999 Lifetime Health Cover policy, which encourages Australians to take out health insurance by age 30 and maintain it life-long.[1] Higher-income groups seem to have benefited more from these changes than those with lower incomes.[2]

The current net cost of private health insurance coverage for private hospital care for a couple is US$1000–$2500 per year, after taking into account the government rebate. Packages at the lower end of the price range have higher "front-end" deductibles and, hence, higher out-of-pocket costs when a person is admitted to hospital. Costlier insurance packages cover better amenities.

Private hospitals have 2 roles in Australia. In the first, they fulfill a supplementary or "top-up" function: patients can purchase additional amenities such as single-occupancy room accommodation and better meals. The second and more contentious role is that of an alternative provider of services available in the public sector: patients are able to pay to bypass public waiting lists or to guarantee that their elective surgery shall be performed by their specialist rather than by a surgeon in training. These complementary roles create inequity and (because the private sector contributes very little to surgical training) also militate against comprehensive training for health professionals.

Many surgeons practise in both the public and the private sectors for ideological, financial or convenience-related reasons. Public-sector constraints are such that, inevitably, surgeons are unable to get the operating sessions that they would desire in the public sector; thus, the private sector provides additional scope.

The greater the proportion of time a surgeon spends in the private sector, the less time he or she is available for work in the public sector. Arguably, greater reimbursement in the private sector provides some incentive to delay operations in the public sector so that patients are "forced" to move into the more lucrative private sector.

A reduction in surgical time in the private sector (and public-sector funding constraints) contributes to increased wait times in the public sector. Australian data have shown that in any specialty, the greater the proportion of surgeries performed in the private sector, the longer the public-sector waiting times, and the shorter the waiting times for procedures in private hospitals.[3] Waiting times currently vary by specialty; for example, the median wait in an Australian public hospital is 46 days for orthopedic surgery, but 60 days for ophthalmology. Relations between the public and private sectors are therefore complex, and the development of private services in Canada could lead to a reduction in access to services similar to that experienced by Australians.

Public and private sectors in Australia are not perfect substitutes for one another. Private hospitals there tend to specialize in elective procedures; for example, 50% of orthopedic and urologic surgeries are undertaken in private hospitals, whereas almost no neurologic or cardiothoracic surgeries are done in these venues (Table 1). This "division of labour" also sidesteps the scheduling problems inherent to providing emergency services.

Because private hospitals have tended to specialize in elective surgery, Australians still rely on the public sector for their emergency services. Public hospitals have therefore not undergone "ghettoization" into services oriented mainly toward poor people and those who are other-

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wise disadvantaged. This factor has been important to maintaining high-quality services in public hospitals in Australia.

Trends

Between 1994 and 2004, patient separations (a count of discharges and transfers from hospital and in-hospital deaths that acts as a measure of hospital activity) grew by about 218 000 per annum. Of these, about 194 000 (89%) were same-day separations. Private-hospital activity has been growing faster than that of public hospitals; about 60% of the additional separations occurred in the private sector.

Before 1999, patient separations from private and public hospitals grew at roughly the same rate: about 100 000 per annum. This balance changed in the period 1999/2000 through 2001/02, however, when the health insurance policy changes showed their most concentrated effect. The combined growth across the 2 sectors was about 10% higher than in previous years, but in public hospitals the rate declined to an annual increase of about 40 000, compared with an increase to about 180 000 additional separations at private hospitals. Most of the increase was in same-day or short-stay procedures; numbers in longer-diagnosis–related groups grew relatively little over this period. (Australian National Diagnosis Related Groups classify medical admissions into groups with similar clinical conditions or related diagnoses and therefore similar resource usage. This facilitates comparisons of the activity and performance of hospitals.)

Two key effects explained this differentiation: a shift from the public to the private sector and an increase in overall provision of private hospital services, responding to either unmet need or to created demand. Table 2 shows the 12 diagnosis-related groups with the greatest increase in activity over this period.

The effect of the changes in health-insurance policy is that about 180 000 patients per annum have been shifted from the public to the private sector. The Australian government subsidy to private health insurance now costs about A$3 billion per year. If three-quarters of the subsidy is attributed to inpatient care (the approximate proportion of hospital v. "ancillary" insurance), the cost for the 180 000 patients shifted to private hospitals is around $A12 500 per patient, well above the costs of the types of additional patients treated in private hospitals (Table 2).

The overall effect on health expenditure has also been substantial. Before the introduction of the rebate, the health share of gross domestic product (GDP) in Australia was about 8.5%. The current share is about 9.5%, a considerable change in the historic level of health spending (Table 3).

About half of the 1% increase

Table 1: Most frequent patient separations* at private hospitals in Australia, 2001/02

Diagnosis-related group	Separations
Other colonoscopy, same day	169 366
Chemotherapy	121 804
Other gastroscopy for non-major digestive disease, same day	101 092
Major lens procedure	89 251
Renal dialysis	88 807
Dental extraction or restoration	73 776
Knee procedure	63 557
Follow-up after a completed treatment with endoscopy	61 359
Mental health treatment, same day, without ECT	50 352
Other skin, subcutaneous tissue or breast procedure	49 189
Vaginal delivery without a complicating diagnosis	36 462
Abortion with D&C, aspiration curettage or hysterotomy	35 532
All other diagnosis-related groups	1 416 233
Total	2 356 780

Note: ECT = electroconvulsive therapy, D&C = dilation and curettage.
*Discharges, transfers and in-hospital deaths.

Table 2: Estimated additional patient separations in private hospitals, 1999–2002

Diagnosis-related group	Additional separations*	Average LOS, d	Cost per separation, A$
Other colonoscopy, same day	43 390	1.00	630
Major lens procedure	17 330	1.02	1 457
Abortion with D&C, aspiration curettage or hysterotomy	16 110	1.01	613
Follow-up after a completed treatment with endoscopy	15 550	1.01	603
Other factors influencing health status, age < 80 yr	13 240	1.54	982
Dental extraction and restoration	12 990	1.01	772
Other skin graft or débridement procedure without severe complications or comorbidity	11 910	1.35	1 482
Other skin, subcutaneous tissue or breast procedure	11 820	1.10	919
Sleep apnea	11 180	1.02	489
Endoscopic procedure for female reproductive system	9 820	1.06	1 079
Local excision and removal of an internal fixation device, excluding those in the hip or femur	8 230	1.30	1 242
Knee procedure	7 930	1.23	1 388
All other diagnosis-related groups†	52 000	3.23	2 285
Total	231 500	2.65	1 919

Note: LOS = length of stay, A$ = Australian dollars, D&C = dilation and curettage.
*Calculated by comparing expected growth based on the pre-1999 trend with the actual growth in the 1999–2002 period (adjusted for underreporting of diagnosis-related group).
†Including diagnosis-related groups that increased or reduced patient separations.

Table 3: Health spending as a percentage of Australia's gross domestic product

Fiscal year	Public sector, %		Private sector, %	Total,* %
	Non-rebate	Rebate		
1995/996	5.6	0.0	2.7	8.4
1996/97	5.7	0.0	2.8	8.5
1997/98	5.8	0.1	2.7	8.6
1998/99	5.8	0.2	2.8	8.7
1999/2000	5.9	0.3	2.7	8.9
2000/01	6.0	0.3	2.8	9.2
2001/02	6.1	0.3	3.0	9.3
2002/03	6.2	0.3	3.1	9.5

*Totals may be affected by rounding.

in health spending as a share of GDP has been driven by the continuation of a secular trend in the growth in the public share of GDP, and about half by the changes in the role of the private sector. Some 0.3 percentage points of the 1% growth in GDP share is due to government expenditures on the rebate account, and about 0.2 points is due to growth in private-sector expenditure. This is a shift from the pre-rebate picture of relative stability in private-sector share. The increase in private expenditure over the period results in part from increased out-of-pocket expenditures (to meet gaps between rebates and the fees charged by surgeons and hospitals) and to the cost of purchasing the insurance itself (or, more accurately, the increased proportion of the populace who have health insurance).

Conclusion

The Australian experience with a dual system of health care has been mixed. Certainly, consumers (and the medical profession) welcome and support the wider choices arising from the existence of private hospitals. But this choice has come at the expense of equity, with access to elective surgery particularly affected: those with health insurance have faster access to elective surgery than those without.

A further worrying aspect of policy direction in Australia has been that those with private health insurance have become a group with political influence. Private-health-insurance lobbyists have mounted a successful campaign over decades to obtain government financial support for their industry: now, that support is greater than subsidies to agriculture, manufacturing and mining combined. This support is inefficient, in that the government expenditure for each additional patient treated in the private sector is well over the contemporary price paid for treating additional patients in the public sector. The additional government support is also probably impeding the ability of government to expand the public sector.

The Australian experience suggests that Canadians should be wary about allowing a significant private sector to develop in Canada, particularly if it seeks the level of subsidy that the Australian private sector has been able to garner.

Stephen J. Duckett
Professor of Health Policy
La Trobe University
Melbourne, Australia

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The NATION'S HEALTH
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Universal health care is the answer to our nation's rising health costs

By Walter Tsou, MD, MPH – APHA President
November 2005 Issue

By 2010, the U.S. national health objective is to ensure that all Americans are covered by health insurance — an issue that is of high importance to APHA. Short of a political miracle, however, it is unlikely we will reach this goal. The price that we pay for our national failure is a missed opportunity that is much larger than most of us realize.

Guarantees of universal health coverage offer an opportunity to account for not only current health expenses, but more significantly, future health care costs. Such guarantees are not trivial, and have far-reaching benefits for both individuals and the business community. Many corporations grapple with the dilemma of paying for both employee health premiums and medical costs for their retirees. For a well-established Fortune 500 company such as General Motors, future retiree health costs are around $60 billion.

Providing coverage of future health care costs also offers a solution to the nation's malpractice crisis. For example, if the parents of a brain-injured infant sue for malpractice, they may seek damages not only for pain and suffering, but also the cost of future medical expenses for the child. In the case of a severely injured baby who would be expected to live to adulthood, such medical expenses could easily amount to millions of dollars. Under a universal health care plan, however, such future costs could be covered by the health care system and would not be included in a lawsuit, thus reducing the cost of litigation.

The dysfunction of our fragmented health care system was apparent in the aftermath of Hurricane Katrina. The Gulf Coast evacuees, now scattered across the nation, have ongoing medical and prescription needs. Who pays their bills — their home states or their newfound states? Those fortunate enough to be covered by Medicare or the Veterans Health Administration have full public financing and can concentrate on their care instead of how their bills will be paid.

Our health care system is a dismal product of our belief that health care is a market commodity, not a public good. For those of us in public health, we see the anguish of the uninsured on a daily basis: the delayed care, the inability to order diagnostic tests, the inability to refer patients for specialty services and the frustration of caring health professionals. We are the only nation in the developed world that continues to do a "wallet biopsy" before an actual biopsy.

The prevailing national vision for the future of health care, with components such as health savings accounts, will not achieve universality and could in fact destroy any hope for future cost savings. As was confirmed by the bipartisan National Coalition on Health Care — co-chaired by former Presidents George H. Bush, Gerald Ford and Jimmy Carter — universal health care saves health costs. Unfortunately, ideology often trumps rationality, at great expense in both dollars and lives.

Dr Tsou, a PNHP Board Advisor, can be reached at walter.tsou@apha.org

Health Spending In The United States And The Rest Of The Industrialized World

Examining the impact of waiting lists and litigation reveals no significant effects on the U.S. health spending differential.

by Gerard F. Anderson, Peter S. Hussey, Bianca K. Frogner, and Hugh R. Waters

PROLOGUE: A cycle of unsustainable spending growth followed by fervent cost containment initiatives has been a regular feature of the health care landscape for the past half-century. In such a closely studied field, it is inevitable that a cascade of theory and analysis follows every turn of the cycle; currently, though, there seems to be much less agreement about what is driving growth and how to control it than there was during the 1990s, when managed care and managed competition were all but smothered in a gushing, bipartisan embrace. Observers and analysts are divided about whether prices, technology, aging, waste, inefficiency, the legal system, new disease patterns, corporate consolidation, or profligate providers and consumers are chiefly to blame for the rate of climb. Nor is there much sign of consensus about how to slow the trend. The system has turned decisively toward increased cost sharing, but without any assurance that this strategy will abate growth or merely relocate the burden. Magic-bullet solutions like consumer choice, disease management, evidence-based practice, and information technology pique policymakers' interest but inevitably fall short of slaying the dragon.

Under these confusing circumstances, *Health Affairs* is once again publishing its annual analysis of spending trends in thirty member countries of the Organization for Economic Cooperation and Development (OECD). These comparative analyses can't explain everything. But as this year's exercise demonstrates, they can be very helpful in putting the conventional wisdom in perspective. Jerry Anderson and his colleagues offer compelling evidence in the following paper that the hoped-for savings from tort reform may be overblown, as are some common preconceptions about the lavish endowments of the U.S. system.

The authors are all affiliated with the Bloomberg School of Public Health at the Johns Hopkins University. Anderson (ganderso@jhsph.edu) is a professor in the Department of Health Policy and Management; Peter Hussey holds a doctorate in health services research from the department; Bianca Frogner is a doctoral candidate there; and Hugh Waters is an assistant professor in the Department of International Health.

ABSTRACT: U.S. citizens spent $5,267 per capita for health care in 2002—53 percent more than any other country. Two possible reasons for the differential are supply constraints that create waiting lists in other countries and the level of malpractice litigation and defensive medicine in the United States. Services that typically have queues in other countries account for only 3 percent of U.S. health spending. The cost of defending U.S. malpractice claims is estimated at $6.5 billion in 2001, only 0.46 percent of total health spending. The two most important reasons for higher U.S. spending appear to be higher incomes and higher medical care prices.

Once again, the latest data from the Organization for Economic Cooperation and Development (OECD) show that the United States spends much more on health care than any other country. In 2002 the United States spent $5,267 per capita—$1,821 more than Switzerland, which had the second-highest per capita spending, and $3,074 more than the median OECD country.[1] The magnitude of this spending differential leads to the logical question: Why is U.S. health spending so much greater than that of other countries?

In previous papers we have argued that the primary reason is that "it's the prices, stupid." We have shown that the United States pays much higher prices than other countries for pharmaceuticals, hospital stays, and physician visits.[2] This price differential continued in 2002. For example, the average cost of a hospital day in the United States in 2002 was $2,434, compared with $870 in Canada and even less in other OECD countries.[3] The United States also pays much higher prices for physician services and pharmaceuticals.[4]

Part of the difference can be explained by higher U.S. incomes and cost of living. However, even after adjusting for each country's per capita gross domestic product (GDP), U.S. health spending is still $2,037 higher than the predicted value.[5] In past papers we have also examined other possible causes, including population aging and administrative complexity. Neither of these factors explains a sizable portion of the higher levels of U.S. health spending.

In this paper we examine two commonly proposed explanations. One is that other countries have constrained the supply of health care resources, particularly for elective services, which has led to waiting lists and lower spending. A second is the threat of malpractice litigation and the resulting defensive medicine in the United States. A common assumption is that malpractice litigation is much more common in the United States, adding to malpractice premiums and, more importantly, the practice of defensive medicine.

We begin by presenting the latest OECD health spending data. We then examine the roles of supply constraints and of malpractice litigation and defensive medicine in explaining the variation in health spending. We conclude that supply constraints and waiting lists do not appear to translate into significant savings in other countries and that malpractice and defensive medicine are responsible for only a small portion of the U.S. spending differential.

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Total Health Spending

Per capita health spending in the United States in 2002 was 53 percent above that of Switzerland, the next-highest-spending country, and 140 percent above the OECD median (Exhibit 1).[6] Health spending equaled 14.6 percent of U.S. GDP in 2002. Only two other countries, Switzerland and Germany, spent more than 10 percent of their GDP on health care.

EXHIBIT 1
Per Capita Health Spending In Organization For Economic Cooperation And Development (OECD) Countries, 2002

	Total health spending			
Country	Per capita ($PPP)	Percent of GDP	Absolute difference as percent of GDP, 1992–2002	Average real annual growth per capita, 1992–2002 (%)
Australia[a]	2,504	9.1	1.0[b]	4.1
Austria	2,220	7.7	0.2	2.0
Belgium	2,515	9.1	1.1	3.0
Canada	2,931	9.6	–0.4	2.2
Czech Republic	1,118	7.4	2.0	5.3
Denmark	2,583	8.8	0.3	2.5
Finland	1,943	7.3	–1.8	0.7
France	2,736	9.7	0.7	2.3
Germany	2,817	10.9	1.0	2.0
Greece	1,814	9.5	1.6	4.4
Hungary	1,079	7.8	0.1	3.5
Iceland	2,807	9.9	1.6	4.0
Ireland	2,367	7.3	0.2	7.3
Italy	2,166	8.5	0.1	1.5
Japan[a]	2,077	7.8	1.6[b]	3.6
Korea	996	5.1	0.7	6.7
Luxembourg	3,065	6.2	0.0	3.5
Mexico	553	6.1	0.5	2.2
Netherlands	2,643	9.1	0.7	2.9
New Zealand	1,857	8.5	1.0	3.8
Norway	3,083	9.6	1.4	4.4
Poland	654	6.1	–0.1	4.1
Portugal	1,702	9.3	2.3	5.0
Slovak Republic	698	5.7	–[c]	–[c]
Spain	1,646	7.6	0.4	2.6
Sweden	2,517	9.2	0.9	3.3
Switzerland	3,446	11.2	1.9	2.5
Turkey[d]	446	6.6	2.8[e]	9.2
United Kingdom	2,160	7.7	0.8	3.8
United States	5,267	14.6	1.6	3.3
OECD median	2,193	8.5	0.8	3.4

SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2004* (Paris: OECD, 2005).
NOTES: PPP is purchasing power parity. GDP is gross domestic product.
[a] 2001.
[b] 1992–2001.
[c] Not available.
[d] 2000.
[e] 1992–2000.

In most countries, health spending increased more rapidly than GDP. U.S. health spending as a percentage of GDP increased by 1.6 percentage points from 1992 to 2002 (from 13.0 percent to 14.6 percent)—twice the OECD median increase of 0.8 percentage points. This was during a period when managed care and greater cost sharing were credited for holding down U.S. health spending.[7]

In every OECD country, growth in health spending outpaced overall inflation during the period 1992–2002. In the United States, real annual growth averaged 3.3 percent, similar to the OECD median of 3.4 percent.[8]

Role Of Supply Constraints

During 1970–2002 many OECD countries relied on supply constraints to control health spending. In contrast, the United States relied more on demand-side policies. Supply constraints included limiting the number of hospital beds that could be built; controls on the diffusion of medical technology; limits on the number of physicians; limits on what specialties physicians could enter; and drug formularies.[9] The difference in U.S. health spending may be attributable to the lack of U.S. supply constraints, the better access to new expensive technologies, and the lack of waiting lists. Here we examine three questions: How does the supply of health care resources in OECD countries compare with that in the United States? To what extent do OECD countries have waiting lists for services, and how are they attempting to reduce them? And how much in potential savings do these waiting lists represent?

■ **Do Americans have access to a greater supply of health care resources?** Surprisingly, Americans have access to fewer health care resources than people in most other OECD countries, measured in three major categories: hospital beds per capita, physicians and nurses per capita, and magnetic resonance imaging (MRI) and computed tomography (CT) scanners per capita.

The number of hospital beds per capita in the United States was in the bottom quartile of OECD countries in 2002 (Exhibit 2). Also, the number of U.S. physicians per capita (2.4) was below the OECD median of 3.1 in 2002. However, the growth rate in the number of U.S. physicians per capita between 1992 and 2002 exceeded the growth rate of the OECD median. Despite this growth, the United States still had fewer physicians per capita than the OECD median in 2002.

The supply of nurses was lower in the United States than the OECD median, and it grew at half the rate of the OECD median of 1.3 percent per year between 1992 and 2002. One area where the United States exceeded the OECD median was the nurse staffing level in acute care hospitals. In 2002 there were 1.4 nurses per U.S. hospital bed, compared with the OECD median of 1.0 nurses per bed.

High-technology medical equipment is frequently cited as the main driver of escalating health spending.[10] Although the United States tends to be an early adopter of medical technologies, it does not acquire medical technology at high levels once the technology has diffused widely.[11]

EXHIBIT 2
Supply Of Selected Health Care Resources In Organization For Economic Cooperation And Development (OECD) Countries, 2002

	Hospital beds	Physicians		Nurses			Technology	
Country	Number per 1,000	Number per 1,000	Average annual growth, 1992–2002 (%)	Number per 1,000	Average annual growth, 1992–2002 (%)	Number per acute care bed	MRI units per million	CT scanners per million
Australia[a]	3.7[a]	2.5	0.5	10.4	-1.1	1.5	4.7[b]	–[c]
Austria	6.1	3.3	3.2	9.3	1.6	0.8	13.4	27.3
Belgium	–[c]	3.9	1.4	5.6	–[c]	–[c]	–[c]	–[c]
Canada	3.2[a]	2.1	0.0	9.4	-1.7	–[c]	4.2[a]	9.7[a]
Czech Republic	6.5	3.5	2.6	9.4	1.1	0.5	2.2	12.1
Denmark	3.4[a]	3.3	1.0	9.7	0.9	1.3[a]	8.6	13.8
Finland	2.3	3.1	1.8	9.0	3.6	–[c]	12.5	13.3
France	4.0[a]	3.3	0.6	7.2	2.4	0.5[a]	2.7	9.7
Germany	–[c]	3.3	1.7	9.9	–[c]	0.5[a]	5.5[a]	13.3[a]
Greece	4.0[b]	4.5[a]	1.9[d]	4.0[b]	1.3[e]	0.9[f]	2.4	17.7
Hungary	5.9	3.2	1.0	8.5	1.0	0.8	2.5	6.8
Iceland	–[c]	3.6	1.8	14.0	0.6	–[c]	17.4	20.9
Ireland	3.0	2.4	1.8	15.3	2.1	1.5	–[c]	–[c]
Italy	4.6[a]	4.4	1.6	5.4	–[c]	1.0[a]	10.4	23.0
Japan	–[c]	2.0	1.6	8.2	2.7	–[c]	35.3	92.6
Korea	5.7	1.5	4.1	1.7	–[c]	–[c]	7.9	30.9
Luxembourg	5.8	2.6	2.2	10.8	–[c]	0.7	4.5	24.7
Mexico	1.0	1.5	1.4	2.2	1.0	2.1	1.1	2.6
Netherlands	3.3[a]	3.1	1.6	12.8[a]	–[c]	–[c]	–[c]	–[c]
New Zealand	–[c]	2.1	1.0	9.4	0.7	–[c]	–[c]	11.2
Norway	3.1	3.0[a]	1.6[d]	10.4[a]	–[c]	1.6	–[c]	–[c]
Poland	4.6	2.3	0.5	4.8	-1.0	–[c]	–[c]	–[c]
Portugal	3.2[a]	3.2[a]	1.1[d]	3.8[a]	2.4[d]	1.2[a]	–[c]	–[c]
Slovak Republic	5.5	3.6	–[c]	7.1	–[c]	0.6	2.0	10.6
Spain	2.8[b]	2.9	2.1	7.1	–[c]	0.9[b]	6.2	12.8
Sweden	2.4[b]	3.0	1.3	8.8[b]	0.1[e]	–[c]	7.9[f]	14.2[f]
Switzerland	3.9	3.6	1.8	10.7[b]	–[c]	1.2	14.1	18.0
Turkey	2.1	1.3	2.7	1.7	1.3	0.4	3.0	7.5
United Kingdom	3.9	2.1	2.1	9.2	1.5	1.7	4.0	5.8
United States	2.9	2.4[a]	2.6[d]	7.9[a]	0.7[d]	1.4	8.2[a]	12.8[a]
OECD median	3.7	3.1	1.6	8.9	1.33	1.0	5.5	13.3

SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2004* (Paris: OECD, 2005).
NOTES: U.S. data on magnetic resonance imaging (MRI) and computed tomography (CT) scanners may be an underestimate since the numbers in locations with multiple scanners are undercounted.
[a] 2001.
[b] 2000.
[c] Not available.
[d] 1992–2001.
[e] 1992–2000.
[f] 1999.

Although the United States has a relatively low supply of these health care resources, they may be used more efficiently than in other countries. For example, lengths of hospital stay are generally shorter and more intensive, and CT and MRI scanners may be used more frequently than in other countries. The greater intensity of care could explain why the United States has fewer health care resources and pays higher prices for their use.

■ **What is the role of waiting lists?** In many countries, persistent waiting lists occur, especially for elective surgical procedures. U.S. patients seldom have to wait very long to receive elective surgery, although waits are common for physician appointments, in emergency rooms, and in other settings.[12] One possible explanation for the lower costs in other countries is that the waiting lists for elective procedures hold down use and spending. Several international studies by Robert Blendon and colleagues have surveyed the public about waiting lists for elective surgery in the United States, Australia, Canada, and the United Kingdom. In a recent survey about access to care, about a third of the population sampled in Australia, Canada, and the United Kingdom believed waiting times to be one of their two biggest health care problems.[13] In these countries, the average wait for nonemergency surgery was more than one month, with between a quarter and a third of respondents reporting waiting more than four months. In contrast, only 3 percent of the U.S. population believed that long waiting times were an important issue; average waiting times for nonemergency surgery were less than one month, with only 5 percent of respondents waiting more than four months.

Australia, Canada, and the United Kingdom have been investing considerable public resources to reduce waiting times in recent years. Their policies include extra funding of health services, increasing the supply of surgical suites and physicians, improving waiting list management, and shifting services to the private sector.[14]

■ **How much savings are possible through waiting lists?** Waiting lists could explain part of the difference in health spending between the United States and other OECD countries. However, there are several reasons to believe that they explain little of the difference. First, not every OECD country experiences waiting lists, although every country spends much less than the United States on health care. The OECD Waiting Times project identified twelve OECD countries that considered waiting times for elective surgery to be a high priority but also identified seven countries besides the United States that did not perceive that they had a problem with waiting times.[15] Health spending in the twelve countries with waiting lists averaged $2,366 per capita, while in the seven countries without waiting lists, it averaged $2,696—both much less than U.S. spending of $5,267 per capita.

A second reason is that the procedures for which waiting lists exist in some countries represent a small part of total health spending. Using U.S. survey data, we calculated the amount of U.S. health spending accounted for by the fifteen procedures that account for most of the waiting lists in Australia, Canada, and the United Kingdom.[16] Total spending for these procedures in 2001 was $21.9 billion, or only 3 percent of U.S. health spending in that year.[17]

As noted above, the United States does not have a lower supply of health care resources than other countries with waiting lists and supply constraints, at least

at the level of hospital beds, physicians, nurses, and high-tech scanning equipment. It is possible that some countries constrain supply at a lower level, such as surgical suites, thereby limiting use and creating waiting lists. However, countries with perceived problems with waiting lists, including Canada, Australia, and the United Kingdom, are beginning to address these issues.

Role Of Malpractice Litigation

Medical malpractice litigation is another commonly cited reason for higher U.S. health spending. The U.S. Department of Health and Human Services (HHS) reports that "Americans spend far more per person on the costs of litigation than any other country in the world."[18] Is this true, and does the litigious U.S. society contribute to the large spending differential?

We examined data on the number of malpractice claims against physicians and the awards resulting from those claims in the United States, Canada, Australia, and the United Kingdom. All four countries, with legal systems rooted in British law, manage malpractice claims through a British-style tort system. Data on the amount of malpractice awards are not published by the OECD; for this study, we abstracted the data from national reports and databases.[19] To determine the impact of malpractice on health spending, we examine three questions: Do U.S. citizens sue more often? Are U.S. settlements and jury awards to plaintiffs higher? And have total malpractice awards been increasing more rapidly in the United States?

■ **Are more malpractice claims filed in the United States?** The United States had 50 percent more malpractice claims filed per 1,000 population filed than the United Kingdom and Australia, and 350 percent more than Canada (Exhibit 3). Two-thirds of the U.S. claims were dropped, dismissed, or found in favor of the defendant; in one-third, plaintiffs received compensation after a settlement or judgment. The same distribution of claim results occurred in Canada.[20] In the United Kingdom, fewer claims are dropped and dismissed and more are settled; during 1995–2002, 36 percent of claims were dropped, 60 percent were settled, 1 percent were found for the defendant, and 2 percent were found for the plaintiff.[21] No data on the distribution of claim results were available for Australia.

EXHIBIT 3
Malpractice Claims And Payments In Four Countries, 2001

Country	Claims per 1,000 population	Average payment per settlement or judgment ($PPP)	Average payments per capita ($PPP)	Average annual real growth in total payments, 1997–2001 (%)
United States	0.18	265,103	16	5
Canada	0.04	309,417	4	20[a]
United Kingdom	0.12	411,171	12	10
Australia	0.12	97,014	10	28

SOURCES: Australia: Australian Competition and Consumer Commission. Canada: Canadian Medical Protective Association. United Kingdom: National Health Service Litigation Authority. United States: National Practitioner Data Bank Public Use File (payments) and Physician Insurance Association of America (claims).
NOTES: PPP is purchasing power parity. Claims and payments are for cases against physicians only. For further details, see Note 19 in text.
[a] 1998–2001.

■ **Are claim payments higher in the United States?** Surprisingly, U.S. malpractice payments (including both cases that resulted in a judgment for the plaintiff and cases resulting in a settlement) were lower, on average, than those in Canada and the United Kingdom. In 2001 the average payment in the United States was $265,103, which was higher than in Australia but 14 percent below Canada and 36 percent below the United Kingdom.[22] While U.S. media and public attention have focused on multimillion-dollar awards at the upper end of the range, the average was actually smaller than in Canada and the United Kingdom in 2001.

Possibly the most important and best summary measure of the magnitude of malpractice awards is total payments divided by total population. On this measure, the United States is only slightly higher than the other three countries: $16 per capita in 2001, compared with $12 in the United Kingdom, $10 in Australia, and $4 in Canada. In all four countries, however, malpractice payments represent less than 0.5 percent of health spending.

These figures do not include the legal costs of defending malpractice claims. Legal costs are estimated to average $27,000 per claim in the United States, which adds approximately $1.4 billion in costs to the $4.4 billion paid in settlements and judgments.[23] The costs of underwriting insurance against malpractice claims are estimated at an additional 12 percent, or $700 million.[24] The cost of defending U.S. malpractice claims, including awards, legal costs, and underwriting costs, was an estimated $6.5 billion in 2001—0.46 percent of total health spending.

In Canada, the total amount spent on malpractice payments was $127 million (adjusted for purchasing power parities, or PPPs) in 2001. An additional $76.9 million (PPP) was spent on legal costs, and $32.5 million was spent on underwriting costs.[25] The total cost including awards, legal costs, and underwriting costs was $237 million (PPP) in 2001—0.27 percent of total Canadian health spending. Data on legal and other costs are not available for the other two countries.

Defensive medicine—tests or procedures ordered by physicians to protect against the risk of being sued—could contribute more to health spending than malpractice payments do. Several attempts have been made to quantify the amount spent on defensive medicine, but estimates vary widely. The difficulty lies in determining what services are purely "defensive"—that is, both inappropriate overuse and motivated by fear of litigation. For example, a physician might ask for a second opinion on a difficult diagnosis, mindful of the potential of litigation, but that second opinion could be considered appropriate care. Other services could be considered inappropriate overuse but were motivated by incentives other than the litigation threat, such as payment policy. These gray areas make precise estimates

"It is difficult to establish how much care is attributable to defensive medicine, in either the United States or other countries."

of the cost of defensive medicine extremely difficult.

One estimate of this cost has come from HHS, which estimates that $70–126 billion (5–9 percent) in health spending per year would be saved if malpractice tort reform, similar to policies in California, were passed at the national level.[26] This estimate was constructed by extrapolating the findings from a study by Daniel Kessler and Mark McClellan.[27] They found lower hospital spending for Medicare patients hospitalized for two diagnoses (acute myocardial infarction and ischemic heart disease) in states with certain types of tort reform. However, the Congressional Budget Office (CBO) was unable to replicate these results using a broader set of diagnoses.[28] The CBO also found mixed evidence for defensive medicine in the published literature; it thus concluded that "savings from defensive medicine would be small" following tort reform. These two widely divergent conclusions by two government agencies underscore the uncertainty around the contribution of defensive medicine to health spending. If the upper estimate of 9 percent were accurate and for some reason little defensive medicine were practiced in other countries, it could explain some of the differential in per capita health spending between the United States and other OECD countries. Given the number of malpractice claims observed, however, defensive medicine is likely to exist in other countries as well.

■ Have claim payments been growing more rapidly in the United States? Between 1996 and 2001, U.S. total malpractice payments grew at an average annual rate of 5 percent over inflation. These increases are commonly blamed for the rapid rise in U.S. malpractice premiums. The growth in malpractice awards was even more rapid in Australia, Canada, and the United Kingdom: 10–28 percent above inflation (Exhibit 3). These rates indicate that malpractice payments are a growing problem in these countries.

Insurance market dynamics and investment return rates also affect malpractice insurance premiums.[29] Insurance markets are organized differently in the four countries. British and Canadian physicians are protected from malpractice litigation risks by a single national organization, with premiums subsidized by the government. Australia has a private insurance system more similar to the U.S. system, but the Australian government subsidizes physicians' malpractice premiums and reinsures high-cost claims. These arrangements may provide more insulation from malpractice insurance market dynamics for physicians in Australia, Canada, and the United Kingdom than for U.S. physicians.[30] Nonetheless, the rapid increases in malpractice costs have stimulated debates over new policies in these countries.

Discussion

Although malpractice litigation is a growing problem in the United States as well as in Australia, Canada, and the United Kingdom, there is limited evidence that it is responsible for much of the difference in health spending levels between the United States and these countries. In all four countries, malpractice litigation costs for claims against physicians are small compared with total health spending. Some additional costs may be associated with claims against institutional providers or other clinicians. Increased use of services because of defensive medicine probably contributes more to health spending than the actual costs of litigation, however. Unfortunately, it is difficult to establish how much care is attributable to defensive medicine, in either the United States or other countries. Physicians may practice more defensively in the United States because of the greater frequency of claims. Although those claims on average do not result in larger awards or settlements than in other countries, the process of defending a claim is nonetheless adversarial and can result in a tarnished professional reputation. The upper estimate of 9 percent of additional costs attributable to defensive medicine would explain only part of the higher U.S. health spending. This assumes that there is much less defensive medicine practiced in other countries.

Another piece of conventional wisdom about why U.S. health care costs are so much higher than other countries' is also probably overstated. It is common for people to wait for nonemergency medical procedures in some OECD countries, but these procedures do not contribute much to health spending. In the United States, the procedures that necessitate waiting lists in other countries would account for only 3 percent of health spending. Other types of services, which are not included in this estimate, also might involve waiting lists in some countries, such as diagnostic tests and physician visits. However, there is some evidence that Americans wait for some of these services, too. In a recent survey, U.S. respondents reported more difficulty making an appointment with a physician quickly; more difficulty getting care on nights, weekends, and holidays; and more frequent delays of treatments because of their cost than was the case with people in other countries.[31]

THE FINDING THAT LITIGATION AND WAITING LISTS do not explain most of the higher U.S. health spending is perhaps not surprising considering previous research showing that the prices of care, not the amount of care delivered, are the primary difference between the United States and other countries.[32] These higher prices are increasingly making health care unaffordable for many Americans.[33] Equally troubling, the more-costly U.S. health care has not resulted in demonstrably better technical quality of care or better patient satisfaction with care.[34] Future U.S. policies should focus on the prices paid for health services and on improving the quality of those services.

This research was supported by a grant from the Commonwealth Fund. The authors thank Jonathan Cylus for preparing the data tables and Randall Bovbjerg and two anonymous reviewers for comments on a draft.

NOTES

1. Purchasing power parities (PPPs) were used to adjust for cost-of-living differences between countries.
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3. G.F. Anderson, P.S. Hussey, and J. Cylus, *Multinational Comparisons of Health Systems Data, 2005*, Commonwealth Fund Chartpack (New York: Commonwealth Fund, forthcoming).
4. G.F. Anderson et al., "Doughnut Holes and Price Controls," *Health Affairs* 21 July 2004, content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.396 (8 April 2005).
5. We calculated predicted U.S. health spending based on a simple regression of health spending per capita on GDP per capita for OECD countries (excluding the United States) in 2002.
6. The OECD definition of *total health spending* is slightly different than that used in the Centers for Medicare and Medicaid Services (CMS) National Health Accounts data.
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8. The real growth rate was calculated using each country's national currency units adjusted for inflation by the country-specific GDP price index.
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13. R.J. Blendon et al., "Inequities in Health Care: A Five-Country Survey," *Health Affairs* 21, no. 3 (2002): 182–191.
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15. Ibid.
16. The procedures are coronary artery bypass graft, cataract extraction, myringoplasty, myringotomy, septoplasty, tonsillectomy and/or adenoidectomy, varicose vein stripping/ligation, hemorrhoidectomy, cholecystectomy, inguinal herniorrhaphy, cystoscopy, prostatectomy, hysterectomy, total hip replacement, and total knee replacement. The procedures were taken from a list compiled by the Australian Institute of Health and Welfare of high-volume procedures with significant waiting times. Australian Institute of Health and Welfare, *Australian Hospital Statistics 2002–2003* (Canberra: AIHW, 2004), 120–122.
17. Authors' calculation using Medical Expenditure Panel Survey (MEPS) 2001 Inpatient, Outpatient, and Office Visit files for the fifteen common elective surgical procedures. Only two-digit *International Classification of Diseases*, Ninth Revision (ICD-9) codes are collected in MEPS. This results in an overestimation of the procedure costs because of the generalized categories of procedures.
18. U.S. Department of Health and Human Services, "Addressing the New Health Care Crisis" (Washington: Office of the Assistant Secretary for Planning and Evaluation, 3 March 2003).
19. The sources for malpractice claims and payments are as follows. Australia: Australian Competition and Consumer Commission; Canada: Canadian Medical Protective Association; United Kingdom: National Health Service Litigation Authority; United States: National Practitioner Data Bank (NPDB) Public Use File (payments) and Physician Insurance Association of America (claims). The number of U.S. claims was estimated by dividing the number of claims for which a payment was reported to the National Provider Data Bank (16,688) by the average proportion of claims resulting in a payment (0.33). The proportion of claims resulting in a payment is based on claims tracked by the Physician Insurance Association of America, which tracks many claims filed in the United States. Australian figures are based on claims opened in 2001 and the payments expected for those claims. U.K. claims figures are for claims opened in 2001. All other figures are based on payments made in 2001.
20. In Canada in 1998–2002, 62 percent of claims were dropped or dismissed, 29 percent were settled, 7 percent were found for the defendant, and 2 percent were found for the plaintiff.
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22. The comparison of one single year of data across countries obscures changes that are occurring over time. For example, Canadian payments in 2001 included one for a large class-action suit. Excluding that suit, Canadian payments averaged $249,750 (PPP) in 2001. In the United States, malpractice insurance companies are legally required to report all award payments to the NPDB, which is maintained by the Health Resources and Services Administration (HRSA). Some settlements may not be reported if the settlement does not name a specific physician. HRSA also has very little infrastructure for enforcement of the regulation. See J.T. Hallinan, "Attempt to Track Malpractice Cases Is Often Thwarted," *Wall Street Journal*, 27 August 2004. The average reported here does not include installments of multipart payments that are disbursed in years other than 2001. HRSA reports that "most cases" do not include multipart payments. Total payments for 2001 using the NPDB were $4.4 billion. The U.S. Government Accountability Office (GAO) has estimated payments at $5.2 billion. U.S. Government Accountability Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, Pub. no. GAO-02-702 (Washington: GAO, June 2003). The private consulting firm Tillinghast–Towers Perrin has estimated $11.4 billion in payments and the costs associated with settling claims against physicians. Its estimate was based on analysis of a proprietary database. Tillinghast–Towers Perrin, *U.S. Tort Costs: 2003 Update*, February 2003, www.towersperrin.com/tillinghast/publications/reports/2003_Tort_Costs_Update/Tort_Costs_Trends_2003_Update.pdf (8 April 2005). The Physician Insurance Association of America (PIAA), an association of physician-owned insurance companies, estimates that the average payment for claims against its beneficiaries was $310,215.
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34. P.S. Hussey et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs* 23, no. 3 (2004): 89–99; and K. Davis et al., "Mirror, Mirror on the Wall: Looking at the Quality of American Health Care through the Patient's Lens," January 2004, www.cmwf.org/usr_doc/davis_mirrormirror_683.pdf (8 April 2005).

What If We Were Equal? A Comparison Of The Black-White Mortality Gap In 1960 And 2000

Closing this gap could eliminate more than 83,000 excess deaths per year among African Americans.

by David Satcher, George E. Fryer Jr., Jessica McCann, Adewale Troutman, Steven H. Woolf, and George Rust

ABSTRACT: The United States has made progress in decreasing the black-white gap in civil rights, housing, education, and income since 1960, but health inequalities persist. We examined trends in black-white standardized mortality ratios (SMRs) for each age-sex group from 1960 to 2000. The black-white gap measured by SMR changed very little between 1960 and 2000 and actually worsened for infants and for African American men age thirty-five and older. In contrast, SMR improved in African American women. Using 2002 data, an estimated 83,570 excess deaths each year could be prevented in the United States if this black-white mortality gap could be eliminated.

THE 1985 TASK FORCE report on black and minority health raised national concern that 60,000 excess deaths were occurring annually because of health disparities, primarily among African Americans.[1] Healthy People 2010 named the elimination of health disparities as one of two overriding goals of the nation's public health agenda for this decade.[2] Health disparities are observed across a broad range of racial, ethnic, socioeconomic, and geographic subgroups in America, but the history of African Americans, rooted in slavery and postslavery segregation, motivates our focused analysis of black-white health disparities.[3]

In the past forty years, African Americans have witnessed some progress in civil rights, housing, education, employment, and health care. In 1960 segregation was evident in hospitals and doctors' offices throughout the South.[4] In 1960 there was no Medicare or Medicaid, and the infant mortality rate was 44.3 per 1,000 for African American babies and 29.2 for whites.[5] Health care and health status are now better for African Americans, but how far have we come in reducing inequality?

Study Data And Methods

Using vital statistics data from the National Center for Health Statistics (NCHS) for each decade from 1960 through 2000, we examined U.S. mortality for African Americans, standardized using death rates for age and sex categories among whites in those same years. We then examined trends in standardized mortality ratios (SMRs) during the forty-year period. Since 1960 there have been minor changes in the way race was reported, but none that greatly affected this analysis.

We calculated the SMR employing the direct method of rate standardization, in which the age-specific death rate among African Americans was divided by the corresponding age-specific rate for whites.[6] We determined the number of excess deaths among African Americans by applying the age-specific mortality rate of whites to the African American population of the same age and calculated the difference between that value and the actual number of deaths.

Study Results

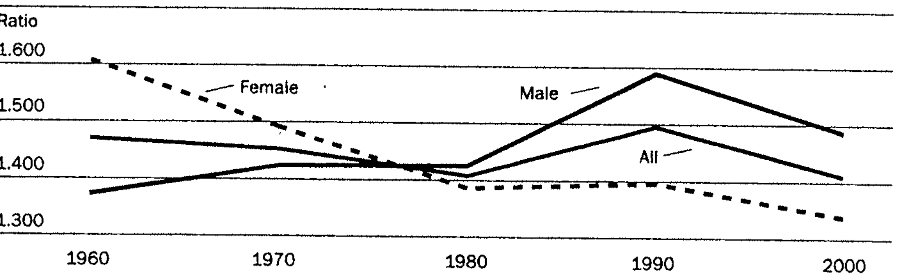
Large reductions in death rates occurred between 1960 and 2000 for all twenty-two age/sex groups, but the disparity between the higher mortality rates of blacks and lower rates among whites did not change appreciably. The SMR for blacks was 1.472 in 1960 and 1.412 in 2000. In the most recent available data, the SMR was 1.405 in 2002. Thus, in 2002, blacks suffered 40.5 percent more deaths (83,570 deaths) than would be expected if they had experienced the mortality rate of whites. This increased by a third from 62,718 in 1960 (because of population increases).

While overall SMRs remain remarkably flat over four decades, these data mask the effect of sex. The female SMR is trending downward (improving), while the male SMR is trending upward (Exhibit 1). The SMR for African American females improved overall from 1.607 to 1.342 between 1960 and 2000, and especially for women ages 25–34, for whom SMR dropped from 3.214 to 2.196. The SMR for African American men actually worsened from 1.376 to 1.487 during these four decades, with a peak of 1.588 in 1990.

Half of the African American population's age-sex subgroups, especially men age forty-five and older, experienced an increase in the SMR between 1960 and 2000 (Exhibits 2 and 3). Most excess deaths in 2000 occurred among middle-aged adults, which was also true in 1960. Only among the very oldest (age eighty-five and older) were African American death rates lower than those of whites.

The African American infant mortality rate has dropped by two-thirds over four decades, from 44.3 per 1000 in 1960 to 14.1 per 1,000 in 2000, in parallel with a drop in the overall U.S. infant mortality rate from 26.0 to 6.9. However, the black-white infant mortality gap as measured by SMR actually worsened from 1960 (1.970 for male and 2.073 for female infants) to 2000 (2.519 for male and 2.515 for female infants).

EXHIBIT 1
Standardized Mortality Ratios For Blacks And Whites, By Sex, For Each Decade 1960–2000



SOURCE: National Center for Health Statistics, Vital Statistics Data, 1960–2000
NOTES: Standardized mortality ratio (SMR) is calculated by the direct method of rate standardization, in which the age-specific death rate among African Americans is divided by the corresponding age-specific rate for whites.

David Satcher, U.S. surgeon general under President Bill Clinton, is director of the National Center for Primary Care and a professor of community health and preventive medicine at the Morehouse School of Medicine in Atlanta, Georgia. George Fryer is a professor of pediatrics at the University of Rochester (New York) School of Medicine and Dentistry and associate director of its Center for Child Health Research. Jessica McCann is an analyst at the Robert Graham Center in Washington, D.C. Adewale Troutman is director of the Louisville (Kentucky) Metro Health Department. Steven Woolf is professor and director of research in the Department of Family Medicine at Virginia Commonwealth University in Richmond. George Rust (GRust@msm.edu) is deputy director of the National Center for Primary Care and a professor of family medicine at Morehouse School of Medicine.

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EXHIBIT 2
Mortality Among African American Males In 1960 And 2000, Standardized On Rates For Age And Sex Categories Among The White Population That Year

	African American deaths per 100,000		White deaths per 100,000		African American excess deaths		Standardized mortality rates	
Age (years)	1960	2000	1960	2000	1960[a]	2000[b]	1960	2000
<1	5,307	1,653	2,694	656	7,342	2,951	1.970	2.519
1–4	208	61	105	32	1,121	325	1.988	1.883
5–14	75	31	53	20	489	324	1.425	1.500
15–24	212	181	144	108	891	2,163	1.475	1.686
25–34	402	272	163	134	2,680	3,411	2.466	2.022
35–44	762	457	333	234	4,663	5,967	2.291	1.949
45–54	1,625	1,060	932	503	6,171	10,472	1.743	2.109
55–64	3,316	2,173	2,225	1,178	6,733	10,390	1.490	1.845
65–74	5,799	4,066	4,848	2,950	3,630	7,977	1.196	1.378
75–84	8,605	8,240	10,300	6,818	–2,322	4,836	0.835	1.209
>84	14,845	15,495	21,750	16,898	–2,022	–1,319	0.683	0.917

SOURCE: National Center for Health Statistics, Vital Statistics Data, 1960–2000.
NOTES: See text for explanation of standardized mortality rates. 95 percent confidence intervals are available from the authors on request; contact George Rust via e-mail, GRust@msm.edu.
[a]Total African American population in 1960 = 18,872,000.
[b]Total African American population in 2000 = 35,303,000.

EXHIBIT 3
Mortality Among African American Females In 1960 And 2000, Standardized On Rates For Age And Sex Categories Among The White Population That Year

	African American deaths per 100,000		White deaths per 100,000		African American excess deaths		Standardized mortality rates	
Age (years)	1960	2000	1960	2000	1960[a]	2000[b]	1960	2000
<1	4,162	1,353	2,088	538	6,097	2,330	2.073	2.515
1–4	173	51	85	25	956	278	2.034	2.000
5–14	54	22	35	14	418	225	1.550	1.507
15–24	108	60	55	42	738	523	1.958	1.433
25–34	273	127	85	58	2,447	1,900	3.214	2.196
35–44	568	275	191	126	4,638	4,501	2.975	2.184
45–54	1,177	594	459	283	6,995	7,001	2.565	2.098
55–64	2,510	1,213	1,079	736	9,494	6,538	2.327	1.650
65–74	4,064	2,659	2,779	1,894	5,525	7,513	1.462	1.404
75–84	6,730	5,968	7,697	4,860	–1,547	6,202	0.874	1.228
>84	13,053	14,442	19,478	14,949	–2,442	–1,140	0.670	0.966
All age-gender groups[c]					62,718	83,369	1.472**	1.412**

SOURCE: National Center for Health Statistics, Vital Statistics Data, 1960–2000.
NOTES: See text for explanation of standardized mortality rates. 95 percent confidence intervals are available from the authors on request; contact George Rust via e-mail, GRust@msm.edu.
[a]Total African American population in 1960 = 18,872,000.
[b]Total African American population in 2000 = 35,303,000.
[c]Total for both males and females, significant at the .05 level.

Discussion

These data demonstrate that survival has improved dramatically for both African American and white populations in all age-sex strata over the past forty years but that there has been little improvement in the relative black-white mortality gap. In the words of musician Wynton Marsalis, race is the elephant in America's living room.

Surprisingly, health disparities may be even more resistant to change than other social determinants. For example, between 1960 and 2000, median income among blacks rose from 65 percent to 84 percent of the median income of whites. The ratio of African American to white high school dropout rates declined from almost 2.2 times higher in 1967 to 1.4 times higher in 1997.[7] Meanwhile, the Census Bureau reported a reduction in all five measures of residential segregation for African Americans between 1980 and 2000.[8] These data show that inequities can be reduced even as absolute rates are improving for both black and white populations.

> **"Data show that inequities can be reduced even as absolute rates are improving for both black and white populations."**

In contrast, mortality disparities (SMRs) have displayed a remarkably flat line over four decades. The only economic indicator of inequality that has remained this flat over decades is wealth or net worth, which for African Americans in 2002 was only about 7 percent ($5,988) of the $88,651 median wealth for non-Hispanic whites.[9] In the process quality control models of Joseph Juran, this lack of variability in SMR over time would be considered a statistical process that is "under control"—that is, this complex system is consistently producing a predictable result.[10]

■ **What will it take to reduce disparities?** What "systems change" could we undertake as a nation to assure that these mortality ratios do not remain flat over the next four decades? Examples of systems change in health care would include universal health insurance coverage, a primary care medical home for each American, proportionate representation of African Americans in the health professions, and the elimination of bias in the delivery of diagnostic and therapeutic interventions. Systems change related to the health of communities would have to be much broader: from nonviolent and exercise-friendly neighborhoods to more nutritious food outlets, educational equality, career opportunities, parity in income and wealth, home ownership, and ultimately hope.[11]

Some age-sex subgroups are doing better than others. For example, SMR improved among nonelderly, African American adult women, especially in the childbearing ages (15–44). Improvements were greatest from 1960 to 1980, but rates have been relatively flat during the past two decades. This pattern is similar to women's gains in earnings, which rose steadily for African American women from around 66 percent of white women's earnings in 1960 to 92 percent in 1980, then flattened and gradually slipped back to 89 percent by 2000.[12] Medicaid, with its coverage for prenatal care and family planning, may also have contributed. Medicaid covers 62 percent of African American births but only 23 percent of births to white, non-Hispanic mothers.[13]

■ **Focus on African American men.** African American men, especially those ages 45–64, experienced a significant increase in SMR, or less improvement in mortality rates for African American men than among white men in the same age group.[14] One factor is that health access expansions have consistently excluded nonelderly, nondisabled adult men. When Medicare was passed into law, the average African American man did not live long enough to become eligible for Medicare. Low-income adult men generally can only become eligible for Medicaid coverage by becoming blind, disabled, or elderly.

Three other trends may contribute to increasing health inequities of African American men. First, black men have not experienced

the same improvements in income inequality (earning only 78 percent of white men's earnings in 2000 compared with black women's 89 percent of what white women earn). Second, there was a spike in gun-related homicide deaths starting in 1983 and peaking in 1994–95.[15] Third, the death rate related to HIV infection has disproportionately affected communities of color, with the black-white ratio of deaths from infectious diseases rising threefold from 1.86 in 1979 to 5.80 in 1998.[16] Mitchell Wong and colleagues recently demonstrated that racial disparities in years of potential life lost were largely attributable to cardiovascular disease (34 percent of racial differences), HIV/AIDS (11.2 percent), trauma (10.7 percent), and diabetes (8.5 percent).[17] Robert Levine found that from 1979 to 1998, the black-white ratio of age-adjusted, sex-specific mortality increased for all but one of nine causes of death that accounted for 83.4 percent of all U.S. mortality.[18]

Study limitations. Limitations of our analysis must be acknowledged. First, we examined only mortality data and not measures of morbidity, functional status, and quality of life. Second, we did not control for covariates such as income, education, socioeconomic status, and region. Third, we examined only five data points over forty years. Finally, these data document the problem, but not its causes or potential solutions.

THE INTERRELATEDNESS of personal health behavior, social determinants, neighborhood ecology, provider bias, structural inequities, and institutionalized racism suggests that eliminating disparities will require large-scale, multidimensional, community-participatory interventions focused explicitly on health disparities for specific population groups, as well as on broader dimensions of social equality and economic justice.[19] Even so, disparities-specific interventions could eliminate thousands of premature deaths in the United States each year.

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Uninsured Texas Patient Disconnected From Life Support Against Wishes

Excerpted from an op-ed by Robert Frank, New York Times, 1/19/06, "Weighing the True Costs and Benefits in a Matter of Life and Death"

"Do the poor deserve life support" asks the economist Steven E. Landsburg... Mr. Landsburg invokes "economic considerations" to suggest that the answer is "no."...

...The patient was Tirhas Habtegiris, a 27-year-old legal immigrant being kept alive by a ventilator as she lay dying of cancer last month in the Baylor Regional Medical Center in Plano, Tex. Physicians offered no prospect for her recovery. She was hoping, however, to hang on until her East African mother could reach her bedside.

Ms. Habtegiris had little money and no health insurance. On Dec. 1, hospital authorities notified her brother that unless another hospital could be found to treat his sister, Baylor would be forced to discontinue care after 10 days. But even with Baylor's assistance, the family was unable to find a willing hospital. True to its word, Baylor disconnected her ventilator on Dec. 12, invoking a law signed in 1999 by George W. Bush, then governor of Texas. The law relieved doctors of an obligation to provide life-sustaining treatment 10 days after having provided formal notice that such treatment was found to be medically "inappropriate."

Unlike the comatose Terri Schiavo, Ms. Habtegiris was fully conscious and responsive when she was disconnected, according to her brother. She wanted to continue breathing. Her brother and several other family members have described the agonizing spectacle of her death by suffocation over the next 16 minutes. Her mother never got there. (Baylor officials have said their decision had nothing to do with financial considerations.)...

...In the wealthiest nation on earth, a genuine cost-benefit test would never dictate unplugging a fully conscious, responsive patient from life support against her objections. Mr. Landsburg's argument to the contrary is wrongheaded, not just morally, but also economically.

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A Widening Rift In Access And Quality: Growing Evidence Of Economic Disparities

Americans appear willing to pursue excellence for some while tolerating the deterioration of care for others.

by Robert E. Hurley, Hoangmai H. Pham, and Gary Claxton

ABSTRACT: Data from the Community Tracking Study provide a valuable perspective from which to observe how economic disparities—largely a function of different sources of coverage—influence access to medical care in the United States. Many recent investments and initiatives are focused on affluent communities and are accessible mainly to people with employer-based or Medicare coverage. For people with Medicaid or no coverage at all, access to basic care is worsening, as a result of stalled coverage expansions and service cutbacks. An improving economy could forestall further cuts and permit reversal of earlier ones, but progress in closing this rift does not appear imminent.

THE WIDENING RIFT BETWEEN THE economically well-off and the rest of American society chronicled in many sectors is increasingly apparent in the health care arena. Notable advances in technological capability, clinical performance, and administrative ingenuity found in parts of the health care system are not being evenly distributed, because of a growing inability or unwillingness to ensure equal access to high-quality care.

Medical progress comes at a high price and represents a major shift of resources into the health care sector of the economy.[1] Many of these investments yield valued benefits to consumers and sustain a host of related occupations, enterprises, and industries; as a result, the country spends a growing portion of its resources in pursuit of medical excellence. Although this remains a laudable goal, it has become more challenging to guarantee that the excellence that is possible in the medical care system is available to all.

Findings from the most recent round of site visits of the Community Tracking Study (CTS) reveal sizable economic disparities associated with both the source of coverage of benefits and the geographic distribution of resources for service delivery. In this paper we examine the issue of economic disparities in access to and quality of medical care, based on the findings of CTS Round Five. The study and its methodology have been described in detail elsewhere.[2]

The Center for Studying Health System Change (HSC) has been conducting in-depth tracking of local market developments in twelve metropolitan markets since 1996 through on-site and telephone interviews with leaders in the principal health care sectors. The fifth round of site visits from January through June 2005 involved interviews with more than 1,000 respondents. The markets were randomly drawn from among large (Boston, Miami, Orange County, and northern New Jersey), midsize (Cleveland, Indianapolis, Phoenix, and Seattle), and small (Lansing, Syracuse, Greenville, and Little Rock) metropolitan areas.

What The Interviews Revealed

The Round Five interviews revealed trends in several areas.[3] Hospitals and physicians are displaying a strong commitment to increased specialization of medical care, including acquisition and application of new diagnostic and treatment techniques and technologies, in both full-service and freestanding facilities. Competition between physicians and hospitals remains intense in many markets, and new forms of joint ventures and revenue sharing are emerging between both parties to try to repair what has become a more contentious relationship in recent years and to offer consumers better and more convenient services.

Hospitals are engaged in major construction initiatives after a decade-long lull in capital spending.[4] Some projects have been undertaken to upgrade facilities to make them more suitable for providing state-of-the-art care that meets the expectations of contemporary customers—patients and physicians. Other projects involve extending services to new locations closer to more-affluent and well-insured customers. Sizable amounts are being spent for information technology (IT) to enable hospitals to address quality and safety performance gaps and to respond to incentive-based compensation initiatives being launched by private payers and Medicare. Nascent growth in new insurance product designs that engage consumers through increased cost sharing is also making hospitals and physicians more attentive to anticipating customers' demands for quality, accommodation, and amenities. Positioning for more "consumer-driven" care is widely evident.

Juxtaposed against these examples of clinical and administrative expansions are several trends suggesting that the yields from these investments have not been evenly distributed and that in a number of instances, access to existing resources has declined. Most states are still emerging from the most severe downturn in tax revenues since World War II, and state policymakers have scrambled since 2001 to deal with huge budget shortfalls.[5] Medicaid, the largest single state-level expenditure category, has borne a major portion of the cuts, but other human service programs that depend heavily on state spending, including public health and mental health, have been affected as well.

Bob Hurley (rhurley@hsc.vcu.edu) is an associate professor in the Department of Health Administration, Virginia Commonwealth University, in Richmond. Hoangmai Pham is a senior health researcher at the Center for Studying Health System Change (HSC) in Washington, D.C. Gary Claxton is a vice president at the Henry J. Kaiser Family Foundation in Washington, D.C. Hurley and Claxton are senior consulting researchers at HSC.

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For services for the severely and persistently mentally ill, who depend almost exclusively on public financing, the past four years have had brutal consequences. Homelessness and substance abuse have worsened in many communities at the same time that state and local spending to address them has been flat or declined. Local government and charitable support for programs serving uninsured people, including undocumented immigrants, has also waned and failed to offset cuts in state funds.

Coverage And The Hierarchy Of Access To High-Quality Care

A clear hierarchy of access to care is apparent in many communities, which closely corresponds to insurance coverage and its sponsorship. Long-standing anxiety about prospects for a "two-tier" health care system has, in fact, given way to a three-tier reality in the CTS markets (Exhibit 1).

■ **Employer-sponsored and Medicare coverage.** People with employer coverage have benefited most from the developments described earlier. Medicare has moved in close coordination with private insurers, leading the way in a number of payment practices. Renewed efforts in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 to expand Medicare beneficiaries' enrollment in private plans will promote an even higher degree of conformity between these two sources of sponsorship.

Both private insurers and Medicare have supported intensified emphasis on specialized care in both overt and subtle ways. Although largely unintended, Medicare's payment systems have benefited specialized, procedure-oriented care, such as cardiac and orthopedic surgery.[6] Contracting with physician-owned ambulatory surgery and imaging centers is widespread among private plans and growing in most markets, which often enables physicians to capture an increased proportion of service revenues. Direct access to specialty care has become health plans' benefit design of choice, as the primary care gatekeeping function has been jettisoned. Sizable payment differentials between primary care and specialist physicians are standard practice among health plans, especially as more specialists have clustered in large group practices that are more potent negotiating entities.

Private payment levels for providers, especially hospitals, have risen in the last two CTS rounds, providing the resources needed to undertake major construction projects. These expansions further advance the development of technologically sophisticated care that can be aggressively marketed to able-to-pay patients and their sponsors. Many of these facilities are most accessible to affluent, well-insured consumers. Likewise, hospital-specialist joint ventures flourish mainly for profitable services and populations.

Although still embryonic, performance-based incentives are also making their presence felt.[7] Payers such as WellPoint (Anthem) in Indianapolis and Cleveland have led the way with incentive payment systems for hospitals. Several plans in Orange County and Boston participate in pay-for-performance (P4P) initiatives with physician groups. Tufts Health Plan in Boston, Blue Shield of California, and Aetna in Seattle and northern New Jersey have all pioneered tiered networks. Medicare has begun its own hospital incentive initiatives through the Hospital Quality Initiative and the Premier Hospital Demonstration, and it has signaled its intention to extend this to physicians and other providers.[8] Believing that Medicare and private payers will increasingly link quality reporting to payment, many hospitals and some physician groups in CTS markets have felt pressured to make larger investments in IT.

Commercial health plans are heavily promoting new product designs and decision-support tools that attempt to give consumers more engagement and greater empowerment by sharing with them performance information on health care systems. The designs, with their emphasis on serving up information about provider performance variation that can be acted upon, will promote further positioning by providers to attract consumers who will have added control over discretionary care spending.

■ **Medicaid and other state and local programs.** The first half of the decade has been a difficult one for people whose care is sponsored by Medicaid and other programs funded by state and local governments. Dramatic drops in state revenues clashed sharply with rising Medicaid expenditures. Efforts to continue Medicaid (and related State Children's Health Insurance Programs, or SCHIP) expansions that were set in motion in 1997 were "casualties of the withering fire of sustained deficits," as one respondent phrased it. Adhering to commitments to not give up hard-won gains in eligibility, most state Medicaid agencies have used other tech-

EXHIBIT 1
Coverage Patterns In Community Tracking Study (CTS) Sites, 2003

Site	Private or Medicare coverage[a] (%)	Non-Medicare public coverage (%)	Uninsured (%)
Boston, MA	83.9	10.8	5.3
Cleveland, OH	81.5	10.7	7.8
Greenville, SC	76.9	9.2	13.9
Indianapolis, IN	78.4	12.2	9.4
Lansing, MI	82.9	10.0	7.1
Little Rock, AR	76.6	9.8	13.6
Miami, FL	59.0	18.2	22.8
Northern New Jersey	78.7	8.3	12.9
Orange County, CA	69.9	10.0	20.2
Phoenix, AZ	74.1	12.7	13.2
Seattle, WA	84.3	8.0	7.7
Syracuse, NY	78.5	14.4	7.1
Large metro markets	74.7	11.5	13.8

SOURCE: Community Tracking Study Household Survey, Round Four, 2003. More information on the survey design and methods is available at http://hschange.org/index.cgi?data=02.
[a] Includes employer, individual, and military coverage.

"Public mental health systems' ability to care for people with chronic mental illnesses is in serious decline."

niques, including reducing or freezing provider payments, eliminating certain benefits, instituting copayments, setting service limits such as total inpatient days or prescriptions covered, shrinking periods of guaranteed eligibility, and narrowing the time window for reapplying for coverage renewal.

Medicaid payment reductions and freezes have exacerbated problems with access to key services such as mental health and dental care, as well as many types of specialty care. Applying copayments, eliminating benefits, and setting arbitrary limits on services is seen by some observers as "cost shirking," which leaves providers caring for these patients in the position of either dropping them or absorbing the cost of their uncompensated care. More commonly, providers avoid undertaking care for these patients to evade such discomforting situations.

Some health plans are bearing the brunt of cutbacks in Medicaid. In Orange County, the highly regarded quasi-public authority, CalOptima, which has served Medi-Cal beneficiaries for the past decade, has been forced to spend down its reserves, as state payment rates have not kept up with service costs—it has received only one 3 percent increase in the past five years. Rates for disabled beneficiaries that were once pegged to 95 percent of Medi-Cal fee-for-service (FFS) payments have fallen below 75 percent of the cost of care. In Michigan, the prolonged economic downturn and repeated Medicaid cuts have led officials to warn the state's fifteen health plans that it will soon request permission from the Centers for Medicare and Medicaid Services (CMS) to deviate from paying them required "actuarially sound" rates. Failure to obtain such permission could mean converting 900,000 covered lives in managed care plans back to FFS Medicaid.

Public mental health services have been severely affected by state budget distress, since so much of this care is funded by state funds and federal block grants that have not increased to meet growing costs. In virtually every site, observers portray public mental health systems' ability to care for people with chronic mental illnesses as being in serious decline and disarray. Homeless shelters and local jails are characterized as the twenty-first-century versions of the state mental hospital of fifty years ago. Many general hospitals have phased out inpatient psychiatric units because, they contend, they lose too much money serving publicly or unsponsored patients.

Local support for mental health services has also lagged, especially for crisis care, which increasingly is rendered in the emergency departments (EDs) of general hospitals. In Orange County, with a population of three million, the county mental health agency maintains a crisis inpatient unit of only ten beds. Community mental health administrators in several markets related that budget cuts and growing patient populations have prompted them to modify the definition of who can qualify as "severely mentally ill" as they align staffing supply with patient demand. In Boston, the site of some of the preeminent U.S. health care providers and insurers, informed observers use words like "appalling" and "horrible" to describe the current state of mental health services for the chronically mentally ill.

■ **Unsponsored and unfortunate.** Despite its limitations, the value of state and local coverage is most evident when one looks at those who cannot qualify for any coverage. The past success of SCHIP and Medicaid expansions means that most of the uninsured are adults. Demand for uncompensated care is increasing, particularly in communities such as Orange County, Phoenix, and Miami, where undocumented immigrant populations continue to grow rapidly (see Exhibit 1). Little Rock and Greenville are seeing smaller but notable upticks in their immigrant populations, as the composition of local labor markets changes.

Subsidies ranging from Section 330 grants to federally qualified health centers (FQHCs) to hospital taxation schemes are offsetting a portion of the cost of care to the uninsured, which is typically clustered in a few provider sites. These funds are usually adequate to buy a modicum of urgent care, but obtaining other forms of care, particularly specialty services and pharmaceuticals, is more difficult. Several communities and state medical societies have tried to address the specialty shortage by coaxing physicians to donate a limited amount of appointment time for patients who are unable to pay. Demand for these programs greatly outstrips supply in most markets. A program in Little Rock reported a 60 percent increase in the past two years in requests for assistance finding physicians who will donate care. People administering these programs suggest that physician participation is proving difficult to sustain, as "donor fatigue" sets in.

The availability of pharmaceuticals is a severe problem for the uninsured because of costs. Administrators of free clinics and community health centers (CHCs) in several markets related how carefully they guard limited drug supplies or funds for buying drugs, because just a few patients with serious or chronic conditions can deplete supplies. These facilities try to qualify patients for drug companies' charity and discount programs, but the administrative effort involved is a major impediment. According to some clinics, it is very difficult to obtain drugs for undocumented people from some of the programs. Given the prevalence of chronic disease among many people without regular coverage, inability to obtain appropriate medications is a severe medical management handicap.

Beyond Coverage: Not Getting What Isn't Paid For

The coverage axis provides a partial perspective on the widening disparity in high-quality care available at the community level. Subtler aspects of the rift can be seen when examining which providers deliver what care to whom, and how they get paid.

■ **Location matters.** The distribution of lower-income patients among providers has long been skewed, as delivery of the majority of care for indigent populations

is clustered among a small proportion of providers, mostly at safety-net institutions.[9] Concentration has been mitigated by the legal obligation all general hospitals have had, through the Emergency Medical Treatment and Active Labor Act (EMTALA), to provide at least emergency care to all patients, regardless of ability to pay—a modifying effect that had previously included physician services because of physicians' traditionally close affiliations with these hospitals.[10] Moreover, some hospitals receive disproportionate-share hospital (DSH) payments from Medicare and Medicaid for providing uncompensated care.

Evidence suggests that these lines of segregation are hardening, driven largely by the dictates of geography and channeled in part through growing disparities in access to physician care. Underlying this phenomenon is the interaction of two major trends: (1) growth of investments by both hospital systems and physicians in specialty services and relocated services, such as diagnostic testing from inpatient to outpatient settings; and (2) the recent burst of hospital facility expansions. In Indianapolis, Seattle, Phoenix, northern New Jersey, Greenville, and Miami, one or both are occurring most prominently in high-growth, affluent communities.

Hospital expansions in affluent areas have the potential to worsen disparities when they reflect a differential investment of resources between poorer and wealthier communities.[11] Institutions serving poorer populations begin with major disadvantages; they are less likely to have sufficient capital or the financial health to obtain debt financing to invest in new building. In New Jersey, for example, the suburban St. Barnabas and Atlantic hospital systems have ample ability to finance hundreds of millions of dollars' worth of expansion projects, while three inner-city hospitals serving lower-income populations had to close during the past two years, and more closures are anticipated in similar communities.

■ **Priorities matter, too.** The effect of new facilities in affluent areas and investment in specialty services on the supply of physician services is also evident. Newer facilities might more easily attract qualified physician staffs. But many physicians, particularly specialists, are becoming less dependent on their traditional affiliations with existing general hospitals. With new, alternative sources of revenue such as facility fees from surgery and diagnostic centers and the ability to concentrate patient care responsibilities at these freestanding facilities, specialists no longer have the same need to take ED call or to maintain admitting privileges at multiple hospitals, especially those serving lower-income patients.

From physicians' perspectives, these new arrangements allow them to maintain or improve incomes and lifestyles after a period of substantial financial pressures in private practice, while avoiding the opportunity cost in both time and reimbursement, and the perceived higher malpractice risk of caring for poorly insured patients.[12] These motivated one large orthopedic surgery group in Phoenix to drop their admitting privileges at one of the market's largest hospitals.

A different perspective on priorities is the concerted effort by some facilities such as public academic health centers (AHCs) to alter their perceived role as primarily safety-net providers because of the opportunity costs they incur in both reputation and economic terms. The University of Arkansas for Medical Sciences and University of California, Irvine, medical centers are two examples of institutions that have struggled to control the amount of routine inpatient care provided to people without coverage, to enable the institutions to provide more-intensive care commensurate with their specialized capabilities and to achieve center-of-excellence status with selected payers and consumers. They hope that this, in turn, will result in improved payer mix and competitive position.

Unfavorable payer mix for both hospitals and physicians can perpetuate second-class status. Budget cuts have made Medicaid payment rates even less competitive, especially to specialty service providers, who are seeing increased demand by privately insured and Medicare patients. Moreover, incentive-based compensation is largely unknown in FFS Medicaid and exists on only a limited basis among health plans in Medicaid. Safety-net providers are also well aware that performance-based compensation schemes among private payers typically do not provide for socioeconomic adjusters necessary to equalize differences in patients' access to care and allow for fair comparisons. Without such adjustment, providers already stressed with lower or no reimbursement for care of the poorly insured or uninsured face the threat of widening disparities in resources compared with their counterparts caring for Medicare or privately insured patients.

The Fault Line Runs Through The ED Floor

Interviews conducted with ED directors provided a glimpse of what some characterized as "ground zero" for the economic disparities influencing access to high-quality care and also a microcosm of many of the ills afflicting the health care system. EMTALA obligates EDs to evaluate and stabilize all patients who seek care. This open door is subject to exploitation, and the ED directors interviewed decried the extent to which patients and competing providers, including private physicians, rely on this policy to use EDs for care that should be available elsewhere. In some cases, this is an act of "dumping," as patients are sent from private facilities to public EDs, where they can obtain a consultation or a needed prescription, or be referred to an outpatient clinic. In other cases, it reveals the frustration of community-based primary care providers who, knowing that they will be unable to find office-based specialty care for a Medicaid or uninsured patient, send such patients to the ED because the hospital has a call list of available specialists who will see patients in the ED.

But the call lists themselves are becoming problematic, as specialists' economic ties and loyalties to full-service facilities have been weakened, resulting in serious difficulties in getting specialty coverage for poorly insured or uninsured patients. In northern New Jersey, Seattle, Phoenix, Miami, and Little Rock, hospitals reported increased difficulty staffing physician ED call schedules for specialists, in-

cluding neurosurgeons, cardiologists, and general surgeons, and some are resorting to employing specialists or paying them extra to take ED call. One Phoenix-area hospital reported paying each of its neurosurgical groups $10,000 per week to be available for trauma care, in addition to their regular per patient reimbursement.

Even when specialty consultation is available during an ED visit, follow-up care is a persistent problem for uninsured patients who are subsequently discharged. In one public AHC, an ED medical director, board-certified in both emergency medicine and internal medicine, set up his own follow-up clinic because he was unable to get colleagues in specialty departments to provide timely follow-up appointments. Senior executives in this and other AHCs acknowledged, regretfully, that clinical departments commonly allocated appointment slots based on referred patients' type of coverage.

The ED is particularly vulnerable to being a dumping ground for the chronically mentally ill. One ED medical director contended that as far as he could see, EMTALA is not being applied to this population at many hospitals, because they routinely turn such people away. Another noted that law enforcement officials often insist on admitting disruptive or intoxicated people to the ED so that officials can get on to other more pressing business, because no crisis or detoxification facilities are readily available. Such patients present serious security and management burdens for busy EDs and contribute further to the sense of overload and "controlled chaos" found in many of them.

Can The Trajectory Be Altered?

There are indications that the trajectory of unequal access and care can be altered. Most states indicate that their revenue pictures are finally improving, which has enabled them to consider restoring some of their recent budget cuts. In Massachusetts, the economic upturn, coupled with an urgent need to reconfigure Medicaid and safety-net care funding, has stimulated a vibrant debate about universal coverage for state residents.[13] In California, the dismal state of services for the chronically mentally ill, who constitute much of the state's homeless population, triggered sufficient community concern that a targeted tax proposition was passed to generate an estimated $600 million in new revenues each year to support service innovation.[14] And in northern New Jersey, a market that exhibits many trends that threaten to worsen disparities in access and quality, the state is increasing its uncompensated care fund, most recently with a series of controversial tax assessments including a 3.5 percent tax on the revenues of privately owned ambulatory surgical centers and a 6 percent gross receipts tax (the first of its kind in the United States) on physicians for cosmetic medical procedures, with respondents predicting a chilling effect on the development of new ambulatory surgery centers.

In other states, Medicaid enrollment has grown, despite budget distress, to offset gaps in private coverage worsened by the recession. In politically conservative Arizona, the Arizona Health Care Cost Containment System (AHCCCS), through repeated expansions, has grown from covering 200,000 in 1984 to covering more than one million, or nearly 20 percent of the state's population; unlike in most Medicaid programs, payment rates to providers in Arizona are maintained on a par with Medicare rates. At the local level, well-crafted, community-anchored limited-benefit programs such as the Wishard Health Advantage program in Indianapolis and the Ingham Health Plan in Lansing have grown by picking up people who have lost coverage as a result of unemployment or unaffordability.

"Most private providers of medical care will continue to engage in payer-mix management as well as medical management."

But the cost of Medicaid for states remains a source of great anxiety.[15] Without major reform, the program's long-term financing seems an unsustainable burden on most states. However, current discussions of federal-driven reform, including those led by the Medicaid Reform Commission, raise the possibility that the redesigned Medicaid program will either pay for less by reducing benefit packages or services or pay for fewer by shrinking eligible populations, or both. Any combination of those scenarios will, at best, lead to greater shifting of costs to private plans and providers or, at worst, shift more people into the lowest level of the coverage hierarchy described earlier.

Continued erosion in private insurance and further hollowing out of benefit packages for those with private insurance, which result in varying degrees of underinsurance, also place added pressure on public sponsors of care.[16] The growing number of undocumented people to be cared for, mainly by already-stretched safety-net providers, intensifies pressure on providers who are least able to cross-subsidize care. Finally, despite quixotic litigation regarding billing and collection practices for the uninsured, and policymakers' "saber rattling" about greater accountability by not-for-profit institutions to earn their tax-exempt status, it seems reasonable to expect that most private providers of medical care will continue to engage in payer-mix management as well as medical management.[17] The ED, and the crucial doorstop role of EMTALA, remains the exception that proves the general rule that equal access to care is not guaranteed throughout the health care system.

There is every reason to expect that Americans will demand and receive more and better health care, shifting more resources into the health care sector. However, not all will be able to afford this care, and there is growing evidence that U.S. society is prepared to tolerate trading off pursuing excellence for some, at the expense of deteriorating care for others.

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U.S. Cancer Expert: Canadians Aren't Aware of Value of Medicare System

Canadian Associated Press | September 27, 2005

by John Kotter

EDMONTON - World-renowned cancer specialist Eduardo Bruera is homesick for Canada's health-care system.

Dr. Bruera left Edmonton's Cross Cancer Institute after 15 years in 1999 to become chairman of the department of palliative care at the University of Texas M.D. Anderson Cancer Center in Houston. After working in both countries, Bruera, an oncologist, has a message for people who complain about medicare or who want to expand the use of private health insurance in Canada.

"The portability and the universality of health care in Canada are unbelievably good. I think Canadians are not aware of that," said Bruera, who was to compare care in the two countries in a speech Wednesday at the annual conference of the Canadian Hospice Palliative Care Association.

"Don't look at the United States. The public health-care system makes it possible for patients to access palliative care in Canada earlier and more effectively."

Since moving to Texas, Bruera said he can't get over the spectre of crushing debt that even upper-middle-class Americans face when a family member is dying from an advanced illness.

Even premium private health insurance in the United States rarely covers all the costs, which can lead to bereaved survivors facing an almost never ending list of medical bills, he said.

Of every $100 spent by families on medical care at the M.D Anderson Centre, only $32 is paid for by private insurance, he said.

More than 41 million Americans don't have health insurance, he said. Of those who are insured, one in three will lose all their financial assets during illness.

"To me it is an enormous impact on quality of life. The burden of dying in the U.S. of cancer is much heavier than the burden . . . in Canada."

Bruera's remarks come as the federal and provincial governments work to come to grips with a Supreme Court of Canada decision in a Quebec case earlier this year which approved some uses of private health insurance.

Since the ruling, provinces such as Alberta have been actively considering expanding the use of private health insurance.

The province is expected to announce by the end of October which private insurance firm will be chosen to conduct an actuarial study of the pros and cons of such a scheme.

Premier Ralph Klein has said allowing private insurance firms to sell policies would benefit Albertans who want to shorten their waiting times for non-emergency medical procedures.

However, the province has yet to define exactly what it means by "non-emergency."

Bruera said he is "100 per cent sure" that private insurance would not improve palliative care.

"In general, services such as palliative care, that is not highly profitable or high tech, are generally not insured very well in the U.S.," he said.

"If you privatize parts of the system, the juicy parts, the ones that are more profitable, will be taken by the private insurers. The most costly and less rewarding will be left for the government services."

Unions Supporting Single-Payer and HR 676
(Partial Listing)

California Nurses Association (CA)
Plumbers, Steamfitters, and Refrigeration Fitters, Local 393, AFL-CIO, San Jose, CA.
California State Pipe Trades Council, United Association, AFL-CIO (CA)
South Bay AFL-CIO Labor Council, San Jose, CA
Local 409, Plumbers and Pipefitters, United Association, San Luis Obispo, CA
Local 675, United Steelworkers (USW), Carson, CA
Western Connecticut Central Labor Council, Waterbury, CT
United Association of Plumbers and Pipefitters, Local 630, West Palm Beach, FL
Plumbers and Steamfitters HVAC, Local 188, United Association, Savannah, GA.
Local 2320, United Automobile Workers, Chicago, IL
Steelworkers Active Organization of Retirees (SOAR) Chicago, IL, Chapter 31-9
American Guild of Musical Artists (AGMA), Chicago/Midwest Region (IL)
Northwest Indiana Federation of Labor, AFL-CIO, Hammond, IN
St. Joe Valley Project Jobs with Justice, South Bend, IN
United Steelworkers of America, Local 6787 (IN)
Community Action Program (CAP), Southern Indiana, United Automobile Workers (UAW) (IN)
District Council 62, American Federation of State, County and Municipal Employees (AFSCME) (IN)
Kentucky State AFL-CIO, Convention, October 2005
Nurses Professional Organization, Louisville, KY
United Steelworkers of America, Local 1693, Louisville, KY
Local 576, Laborers' International Union of North America (LIUNA), Louisville, KY
Jefferson County Teachers' Association (National Education Association) (KY)
American Federation of State, County and Municipal Employees (AFSCME) Local 2629, AFL-CIO (KY)
Paper, Allied-Industrial, Chemical, Energy International Union (PACE) Local 5-2002, Louisville, KY
Local 576 Laborers' International Union Retirees' Council, LIUNA, AFL-CIO, Louisville, KY
Local 3310, Communications Workers of America (CWA) (KY)
Community Action Program (CAP), 3rd & 4th Areas, Kentucky, United Automobile Workers (UAW) (KY)
Local 619, Graphic Communications Conference/IBT, Louisville, KY
Local 2322, United Automobile Workers (MA)
Local 2222, International Brotherhood of Electrical Workers (IBEW), Boston, MA
Metropolitan Detroit AFL-CIO Central Labor Council (MI)
Local 6000, United Auto Workers (UAW), State of Michigan Employees, Region 1A, Retiree Chapter (MI)
Duluth (Minnesota) AFL-CIO Central Labor Body (MN)
District Council 5, American Federation of State, County and Municipal Employees, AFSCME, St. Paul, MN
Greater St. Louis Labor Council, AFL-CIO, St. Louis, MO
Local #36, Sheet Metal Workers, St. Louis, MO
Building and Construction Trades Council of St. Louis, AFL-CIO, St. Louis, MO
Southeast Missouri Building and Construction Trades Council, Cape Girardeau, MO
Local 6355, Communications Workers of America (CWA), Missouri State Workers Union (MO)
Central New Mexico Labor Council, Albuquerque, NM
Local Lodge 794, International Association of Machinists and Aerospace Workers (IAM), Albuquerque (NM)
New York Professional Nurses Union (NYPNU), New York, NY
Local 1375, United Steelworkers of America (USWA), Warren, OH
American Federation of Government Employees Local 2028, Pittsburgh, PA
Independent State Store Union (ISSU) Harrisburg, PA
National Association of Letter Carriers (NALC), Branch 84, Pittsburgh, PA
United Electrical Workers (UE), Pittsburgh, PA
Local 506, United Electrical Workers, Erie, PA
Washington Alliance of Technology Workers (WashTech), Seattle, WA
Communications Workers of America (CWA), Local 37083, Seattle, WA
Washington Chapter 10, The Retired Public Employees' Council of Washington, AFSCME (WA)
Washington State Alliance for Retired Americans (WA)
South Central Federation of Labor, Madison, WI

Thanks to Kay Tillow, RN, for her tireless efforts to garner labor's support for reform. For an updated list or sample resolution, see www.unionsforsinglepayerHR676.org or write mail@unionsforsinglepayerHR676.org.

Chapter Updates

Arizona PNHP'er Phil Lopes, a member of the Arizona state legislature, has introduced a bill to implement a state single-payer system. PNHP members kicked off their campaign with a press conference on February 2nd. Dr. Eve Shapiro continues to be active in speaking to medical and citizen groups around the state. Contact Eve Shapiro at shapiroe@u.arizona.edu

Members of PNHP's **California** chapter, the California Physicians Alliance (CaPA), were very active in 2005 in speaking, media, and legislative outreach around SB 840, Sen. Sheila Keuhl's single payer bill. Special thanks to the dozens of CaPA members who became active this year and spoke to physician, student, community and church groups and/or participated in press conferences and rallies across the state. CaPA Chair Dr. Bree Johnston and Dr. Richard Quint are particularly active in outreach to medical students and residents. Dr. Jeannie Brewer appeared in a PBS television special "Working Uninsured." Drs. Paul Heineken and David Siegel testified before the state legislature. PNHP Senior Health Policy Fellow Dr. Don McCanne continues to be a frequent speaker to both state and national groups. Members are encouraged to subscribe to Dr. McCanne's popular health policy "Quote of the Day" (via e-mail to don@mccanne.org). Contact Carla Woodworth at capa@jps.net for more information or a speaker.

In **Colorado**, Dr. Rocky White is doing outreach to Republican and business groups. Dr. White recently spoke to the Denver Chamber of Commerce and is educating Republican state legislators about single-payer. Health Care for All - Colorado (HCAC) raised $12,000 at their fundraiser in April and the group is actively recuriting physicians in support of single-payer. Dr. Glenn Pearson and Dr. Elinor Christensen (President of HCAC) are frequent speakers at Grand Rounds and public forums across the state. Contact Dr. White at whtfarms@fone.net.

District of Columbia PNHP'ers are active in speaking and organizing for single-payer. The chapter hosted a leadership workshop in October attended by 15 members. Dr. Robert Zarr spoke on a panel with John Podesta (former Clinton Chief-of-Staff) and Michael Cannon (Cato Institute proponent of HSAs) at a national bioethics conference. Dr. Harvey Fernbach and Dr. Jerry Earll are frequent speakers, at medical and citizen meetings, most recently to the Public Policy Institute of Virginia. For more information or a speaker contact Dr. Zarr at rlzarr@yahoo.com.

PNHP'ers in **Hawaii** are working with legislators to ensure that single-payer is included in a recently-passed bill to study options for health reform. Dr. Leslie Gise chaired a symposium on single-payer at the annual meeting of the American Psychiatric Association. More than 110 psychiatrists stayed for the entire three-hour program. To get more information contact Dr Gise at leslieg@maui.net.

Illinois PNHP members are active in speaking and organizing. Dr. Basil Bradlow was featured on a local talk radio station and gave a presentation to medical students at the University of Chicago who are forming a student chapter of PNHP. Dr. Quentin Young is serving as a member of the state's commission on health reform (as mandated by the Illinois Health Care Justice Act). Dr. Rob McKersey and other PNHP'ers are giving testimony at the commission's hearings across the state. A new grassroots group has formed to put a statewide referendum on single-payer on the 2006 ballot. PNHP'ers are encouraged to download and circulate their petition, which is available at www.illnoishealthcarenow.org. For more information or a speaker contact info@pnhp.org.

In **Indiana**, PNHP'ers are active in speaking and building support statewide for single-payer. Dr. Robert Stone, Dr. Chris Stack, Dr. Aaron Carroll and Milton Fisk, Ph.D. have lectured at several recent Grand Rounds and public forums. Dr. Stone appeared on a public television forum with local politicians. Dr. Carroll created a slide presentation on single payer that is being shared with PNHP'ers nationally, and he is helping to recruit pediatricians to PNHP. Contact Dr. Stone at grostone@insightbb.com.

Kentucky PNHP'ers were successful in passing a highly-publicized resolution supporting single-payer in the Health Committee of the Kentucky House of Representitives, and they expect the bill to pass the full House. The group is networking with medical, religious and union groups across the state. Dr. Garrett Adams gave a well-received presentation to a national committee of the Presbyterian Church. He and Dr. Adewele Troutman were featured in a lengthy article in the Louisville Courier-Journal (excerpted on page 71). Nurses' union leader Kay Tillow led successful campaigns to get the state auto workers' union (UAW), the state AFL-CIO, and many other unions to endorse single-payer. Dr. Ewell Scott's resolution supporting single-payer passed the Morehead, KY city council in early 2005. Contact Dr. Garrett Adams at kyhealthcare@aol.com.

In **Massachusetts**, PNHP'ers garnered 300 physicians' signatures for a letter criticizing Governor Mitt Romney's reform plan and calling for a statewide single-payer plan instead. Drs. Julie Silverhart and Steffie Woolhandler spearheaded media outreach; the letter was published in the Berkshire Eagle and received coverage in the Cambridge Chronicle and on NPR. Drs. David Himmelstein and Steffie Woolhandler's research on bankruptcy due to medical bills continues to receive a lot of attention and was the most frequently viewed article on the Health Affairs web site through in 2005. They hope to host a second "Leadership Training" for PNHP'ers at the Harvard Faculty Club in May of 2006. Members interested in participating should write to pnhp@aol.com. Fore more information, contact Dr. Silverhart at jsilverhart@glfhc.org.

In **New Jersey**, PNHP'ers are active in speaking to medical and student groups on single payer. Dr. Wink Dillaway spoke to two medical student groups and Dr. Charles Granatir presented to the delegates of the American Academy of Orthopedic Surgeons in D.C.. Six physicians, including Dr. Dick Pierson, are forming a NJ chapter of PNHP. Contact Dr. Pierson at rnp1@columbia.edu or Dr. Dillaway at w.dillaway@umdnj.edu.

PNHP members in **New Mexico** have reinvigorated outreach to the media and state legislators. Recent polling indicates that more than 70 percent of New Mexicans favor single-payer. PNHP'ers will be meeting with Democratic U.S. Senator Jeff Bingaman, who is interested in health care reform. Contact Dr. Sandra Penn at sanpenn4@hotmail.com.

New York-Metro PNHP'ers are active in speaking, public forums and outreach to medical students. The chapter has hosted several speaker's trainings (including one for medical residents) and hosted a media training on November 19. Special thanks to Martha Livingston, PhD, for her help with speaker training. Drs. Mary O'Brien and Rick O'Keefe spoke to medical staff at Columbia Health Services. Dr. Olveen Carrasquillo made presentations on single-payer to the Congressional Black Caucus and the Congressional Hispanic Caucus and is active with Dr. Jaime Torres in starting Latinos for National Health Insurance. The chapter also continues to hold their popular monthly forums. Chapter Chair Dr. Oliver Fein is a frequent speaker to medical, student, and grassroots groups and has debated the AMA at numerous venues, including SUNY Downstate, Mt. Sinai School of Medicine and the University of Medicine and Dentistry of New Jersey. Contact Joanne Landy at jlandy@igc.org.

In **Upstate New York**, Drs. Andy Coates and Paul Sorum are active in speaking and outreach to media and community groups in the Albany area. The new "Capital PNHP" chapter hopes to work on state-based legislation, outreach to grassroots activists and other health professionals, and media outreach. Contact Dr. Coates by at esquinicle@capital.net.

In **North Carolina**, PNHP members and friends are greatly saddened by the death of tireless health care activist and PNHP National Board of Directors member Dr. Carol Kirschenbaum. Dr. Jonathan Kotch is active in organizing with the North Carolina Ad Hoc Committee to Defend Health Care and plans a fundraising letter for December. The group continues to campaign around HB 1358 to make access to health care "a fundamental right" in the state. Contact Dr. Johnathan Kotch at jonathan_kotch@unc.edu.

In **Oregon**, Dr. Frank Turner is giving talks and would like to hear from other Oregon PNHP'ers who want to become active. He is helping with a grassroots initiative to require the legislature to develop a single-payer plan by 2009. Contact Dr. Turner at turners@rio.com.

In **Pennsylvania**, PNHP members are introducing a state single-payer bill and are organizing a campaign to support it. Drs. Scott Tyson and Walter Tsou are frequent speakers around the state. Contact Dr. Scott Tyson at tysmar@aol.com.

In **Utah**, Dr. Joe Jarvis is active in speaking and coalition-building on the need for single payer. He is engaged in dialogue with the state's Chamber of Commerce and with large provider groups. He is working with other single-payer supporters to launch a progressive health policy group in the state. Stay tuned. Contact Dr. Jarvis at jqjarvis@ix.netcom.com.

Washington PNHP'er Dr. David McLanahan and others hosted a successful Seattle-area forum on single-payer with PNHP President Dr. John Geyman and HR 676 lead sponsor Rep. Jim McDermott. The event was attended by more than 200 people. The PNHP chapter had its first meeting in October, and their op-ed "Single-Payer Plan the Only Solution" appeared in the Seattle Post Intelligencer in November and is reprinted on page 35. They hope to organize physicians statewide. During the 2005 municipal elections, a ballot measure in Seattle affirming the right to health care and urging the city to act received 70 percent of the vote. Contact Dr. McLanahan at pnhp.seattle@comcast.net.

New PNHP Board Members

(South) Garrett Adams, MD, MPH is a specialist in pediatric infectious disease and epidemiology. He received his medical degree from Wake Forest School of Medicine and completed his internship and residency at Vanderbilt and the Children's Hospital of Los Angeles. He is recently retired from the full-time faculty of the University of Louisville School of Medicine where he was Chief of Pediatric Infectious Diseases and Medical Director of Communicable Diseases at the Louisville Metro Health Department. For forty years Dr. Adams attended the health care needs of sick children and their families. During his career he witnessed deterioration in access to health care and health care delivery in the U.S. He is devoting his retirement to health care reform and is the state coordinator and founding member of the Kentucky chapter of PNHP (kyhealthcare@aol.com - www.kyhealthcare.org).

(North Central) Aaron E. Carroll, MD, MS is an Assistant Professor of Pediatrics at Indiana University School of Medicine. After graduating from Amherst College in 1994, Dr. Carroll received his MD from the University of Pennsylvania School of Medicine in 1998. He completed an internship and residency in Pediatrics at the University of Washington in Seattle. He stayed at the University of Washington to complete a health services research fellowship in the Robert Wood Johnson Clinical Scholars Program. During that time he received his masters degree in Health Services and a certificate in Public Health Informatics. Dr. Carroll is an Assistant Professor of Pediatrics in the Children's Health Services Research Program at the Indiana University School of Medicine, and an Affiliated Scientist at the Regenstrief Institute for Health Care. His research interests include the use of mobile technology in pediatric health care, decision analysis and cost-effectiveness analysis, and physician knowledge, attitudes, and beliefs about national health insurance. He is active in PNHP's new Indiana chapter. He became interested in PNHP while he was a fellow, and has both conducted research in and spoken frequently about physicians and national health insurance. (aaecarro@iupui.edu)

(West) Joseph Q. Jarvis MD MSPH received medical (1982) and public health (1986) degrees from the University of Utah School of Medicine, where he also completed post-graduate training in family medicine, public health, and occupational medicine. Dr. Jarvis began his career as a primary care physician at a community health center in Salt Lake City. He served as a medical officer for the Occupational Safety and Health Administration, US Department of Labor, in Washington DC. He held the position of Nevada State Health Officer from 1987 to 1989, and has worked for the Colorado Department of Public Health and Environment. Dr. Jarvis has been a member of the faculty of the University of Colorado Health Science Center and the National Jewish Center in Denver. He currently provides consultation in public and environmental health to clients nationwide. Dr. Jarvis joined PNHP in 1990. He resides in Salt Lake City where he is president of the Utah Alliance for Health Policy Solutions, a 501 c3 corporation he founded with two other PNHP members 4 years ago. (jqjarvis@ix.netcom.com)

(North East) Robert Zarr, MD, MPH, FAAP, is a board-certified pediatrician at the Upper Cardozo Community Health Center in Washington, DC, where he cares for a low-income and immigrant population in a setting with few resources. Dr. Zarr graduated from the Baylor College of Medicine and completed his pediatric residency at Texas Children's Hospital in Houston. Dr. Zarr is fluent and literate in Spanish and has worked in the US and abroad. He is active in Washington, DC in multiple public health projects including asthma management, injury prevention, literacy promotion, breastfeeding awareness, youth advocacy, and tuberculosis screening. Dr. Zarr is an Executive Board Member of the DC chapter of the American Academy of Pediatrics. He holds appointments as Assistant Clinical Professor of Pediatrics at George Washington University and Associate Medical Director of Pediatrics for Unity Health Care. (rlzarr@yahoo.com)

Physician-in-Training: Jay Bhatt, MS III, Philadelphia College of Osteopathic Medicine. Bhat received his BA from the University of Chicago. He is the National Vice-President of the American Medical Student Association. He has been involved in several issues including smoke-free public space, eliminating health care disparities, and access to health care. He is also active in the American Public Health Association, where he is seeking to mobilize more public health (and medical students) in support of single payer. (jaybh@pcom.edu)

The Courier-Journal

LOUISVILLE, KENTUCKY | courier-journal.com | A GANNETT NEWSPAPER

MONDAY
JANUARY 30, 2006

Support swells for universal health care

State panel endorses plan for U.S. system

By Laura Ungar
lungar@courier-journal.com
The Courier-Journal

It is the paradox of America's medical system: While hands can be transplanted and the tiniest babies kept alive, many people cannot afford to see a doctor and live with the threat of financial ruin if they get sick.

Francene Shepard of Louisville had a heart attack in 1999, needed stents to open blocked arteries and ran up about $50,000 in medical bills that went unpaid.

Ian Copeland, a 27-year-old self-employed carpet cleaner who lives in Louisville, goes to the emergency room when he's sick because he cannot afford a private doctor.

"It's a gamble," said his mother, Michelle Copeland. "If something happens, it could be devastating."

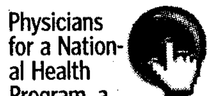
Such stories are increasingly common and are leading to growing support among some politicians and medical groups for implementing a national health system offering care for all, including the 45 million Americans and more than half a million Kentuckians without health insurance.

Earlier this month, the Kentucky House Health and Welfare Committee voted to urge Congress to pass a bill, introduced by Democratic Rep. John Conyers Jr. of Michigan, that would expand Medicare to cover all Americans.

The bill would create a "single-payer" health-care system, publicly financed and privately delivered. All Americans would have access regardless of employment, income or health. Each year, the program would set reimbursement rates for health-care providers and negotiate the cost of prescription drugs.

See HEALTH, Back Page, col. 1

ON THE WEB



Physicians for a National Health Program, a nonprofit organization of physicians, medical students and other health-care professionals who support a national health-insurance program, outlines the options at www.pnhp.org.

A possible groundswell

A 2002 report by the Institute of Medicine, which advises the federal government on health issues, said 18,000 adults die each year because they lack health insurance. Overall, the United States has a lower life expectancy than several countries, including Canada and the United Kingdom, that have national systems.

"The health-care system is in a deepening crisis," said Dr. Steffie Woolhandler, an associate professor of medicine at Harvard University and co-founder of Physicians for a National Health Program. "The public is quite fed up."

There are signs that the idea of a national system has increasing support here:

► A poll last year by the Pew Research Center found that 65 percent of Americans favor national health insurance, even if it means higher taxes.

► An Indiana University poll, published in the Annals of Internal Medicine in 2003, said 49 percent of doctors support government legislation to establish national health insurance, while 40 percent oppose it.

Membership in Physicians for a National Health Program, meanwhile, has risen from about 10,000 to 14,000 in recent years.

Dr. Garrett Adams, a retired physician who heads up the Kentucky chapter of Physicians for a National Health Program, said universal health care is a matter of fairness and humanity. His group prefers a national system to state efforts.

Adams said the problems faced by the uninsured are particularly acute in Kentucky, which was shown in a recent Courier-Journal investigation to be among the least healthy states in the nation.

"This is so wrong," Adams said. "They're real lives. They're people."

Shepard, a 51-year-old home health aide who spoke before the state House Health and Welfare Committee, said that since her heart attack, she has been diligent about getting care at the Family Health Centers' Portland clinic.

But with a low income, specialized care can be a struggle.

A national program would help her "and others like me who fall through the cracks," she said in an interview.

One patch of common ground for supporters and opponents is the belief that the current U.S. system has serious problems.

A 2003 ABC News/Washington Post poll showed that more than half of Americans are dissatisfied with the quality of health care, the first majority in three polls since 1993.

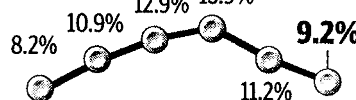
Sandie Limpert of Louisville, a 53-year-old graduate student who has gone half her adult life without health insurance, said she believes the system is in such disarray that a major overhaul would be better than small reforms.

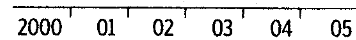
"It's like we're trying to plug our fingers into the dam," she said. "But it's only a matter of time before the whole thing cracks and explodes."

Reporter Laura Ungar can be reached at (502) 582-7190.

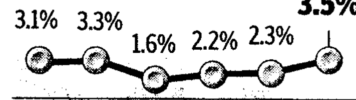
Health insurance premiums ahead of inflation

Increases in health insurance premiums from year before





Overall inflation



Source: Kaiser Family Foundation

The Courier-Journal

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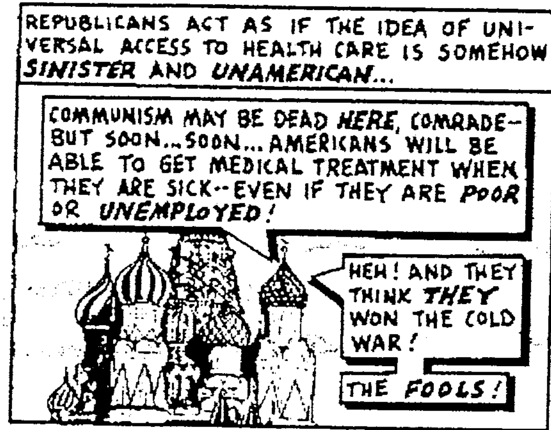
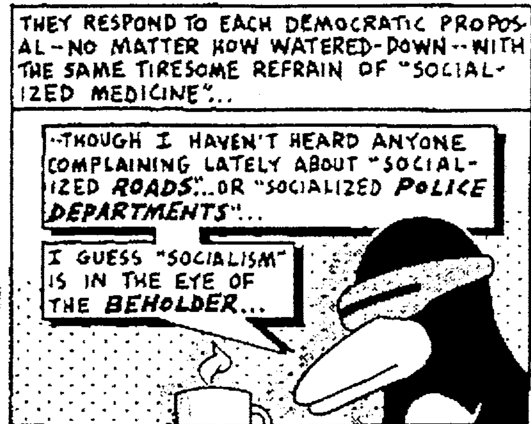
THIS MODERN WORLD by Tom Tomorrow





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