



## Public Supports National Health Insurance New York Times/CBS News poll

64 percent of Americans think that "the federal government should guarantee health insurance for all Americans," and 76 percent believe that universal access to health care is more important than recent tax cuts, according to a poll by the New York Times/CBS News in February. The survey also found that 60 percent of those polled are "willing to pay higher taxes so that all Americans have health insurance that they can't lose no matter what." Public support for comprehensive health reform is at its highest level in over a decade. More than one-third of Americans (36 percent) say that the US health system needs "complete rebuilding," more than at any time since 1994; 54 percent say the system needs "fundamental" changes. Only 8 percent of those polled believe that the US health system needs only "minor" changes (New York Times/CBS poll February, 2007).

## AFL-CIO Endorses "Medicare for All" and HR 676

The nation's largest labor organization endorsed a "Medicare for All" approach to health reform and pledged to "mobilize America behind a concrete plan to enact universal health care" and "commit its full resources to asserting leadership in this historic effort" at their March 6 meeting in Las Vegas. In a statement issued by the Federation's Executive Council (reprinted on page 36, this issue), the group explicitly rejected the "incredibly ineffective piecemeal approach of the past 10 years" as well as an individual mandate, the centerpiece of the reform passed in Massachusetts: "Universal health care does not mean mandating that everyone must buy a health insurance policy and then handing them the bills." The Federation also pledged to evaluate presidential candidates based on their health plans.

In a statement after the policy was adopted, the Federation's health policy specialist Gerald Shea specifically cited HR 676 as representing the type of reform endorsed by the AFL-CIO. Labor has been at the center of a growing grassroots movement to enact HR 676. The bill has been endorsed by 245 unions in 40 states, including 17 state AFL-CIO federations, in an ongoing campaign led by labor activist Kay Tillow.

## Support for Single Payer (HR 676) Grows in Congress

Single payer legislation (HR 676) was reintroduced in the House in January and has 63 co-sponsors. Seven new members of the House of Representatives are single payer co-sponsors: Henry C. "Hank" Johnson, Jr. (GA-04), John Yarmouth (KY-03), Dave Loebsack (IA-02), Keith Ellison (MN-06), Yvette D. Clarke (NY-11), Betty Sutton (OH-13), and Steve Cohen (TN-09). Two single payer sponsors were elected to the Senate, Sherrod Brown (OH) and Bernard Sanders (VT). A Senate version of HR 676 is in the works.

## 2008 Presidential Candidates' Health Plans

*"Clinton asked at one point for a show of hands from the audience, asking them to declare whether they preferred an employer-based system of insurance, a system that mandates all individuals to purchase insurance, with help from the government if necessary, or one modeled on the Medicare system. Overwhelmingly the audience favored moving toward a Medicare-like system for all Americans." - Washington Post*

In a recent debate in Las Vegas, Sen. Hillary Clinton attacked the private health insurance industry, but failed to say if she would heed the advice given by Iowa voters (above). Rep. Dennis Kucinich endorsed single payer national health insurance. Sen. Barack Obama lacks his own plan, but praised Former Senator John Edward's flawed "pay or play" approach, which attempts to shore up the disintegrating employer-based system of private insurance by mandating that employers and individual purchase coverage (for details, see page 15). Members are encouraged to educate the candidates on the single payer option; materials are updated daily at [www.pnhp.org](http://www.pnhp.org).

## Save the Date - November 2-3, 2007

PNHP's Annual Meeting will be held Saturday, November 3 in Washington, DC. It will be preceded by PNHP's popular leadership training, a one-day crash course in health policy and politics on Friday, November 2, and possibly a lobby day.

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

*National Office Staff:* PNHP's headquarters in Chicago is staffed by Executive Director Dr. Ida Hellander, Webmaster/Research Associate Dave Howell, and Office Manager Matthew Petty. Thanks and best wishes to Nicholas Skala, our departing health policy/media/advocacy staffer, who will be attending Northwestern Law School this fall.

## Registered Nurses Campaign for Single Payer

The California Nurses Association/National Nurses Organizing Committee (CNA/NNOC), which represents 75,000 RNs nationwide, is actively campaigning for single payer bills in Congress (HR 676) and in California (SB 840), and recently joined the AFL-CIO to push for single payer with (and within) that group. The AFL-CIO now represents 325,000 registered nurses. PNHP and CNA/NNOC held a joint press conference in Washington, DC in January to oppose the Bush health proposals and promote comprehensive reform. CNA/NNOC Executive Director Rose Ann DeMoro is an honorary member of PNHP's Board of Directors.

### Membership Drive Update

Welcome to the nearly 900 new members who have joined PNHP in the last year! PNHP now has more than 14,000 members. We invite new (and longtime) PNHP members to participate in our activities and to take the lead on behalf of PNHP in their communities. Thanks to medical student members Ronald Cordario and Eric Pan for staffing a PNHP table at the annual American Medical Student Association meeting in March in Washington, DC. PNHP is hosting membership booths at upcoming meetings of the American College of Physicians (San Diego, April 19-21), the Society of Teachers of Family Medicine (April 25-29, Chicago) and the American Psychiatric Association (May 19-24, San Diego).

### What PNHP Members Can Do

1. Submit an Op-ed or Letter to the Editor to your local news paper, 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 2007 slide show is now available to members. Call Dave Howell 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 printable version is on-line at [www.pnhp.org/physiciansproposal/](http://www.pnhp.org/physiciansproposal/)) and encourage colleagues to join PNHP.
5. Subscribe to Dr. Don McCanne's informative (and persuasive) Quote of the Day column via e-mail by going to [www.pnhp.org/qotd/](http://www.pnhp.org/qotd/).

### 2006 Annual Meeting in Cambridge

Over 300 physicians and medical students attended PNHP's 2006 Annual Meeting in Cambridge, including more than 80 members who came a day early to participate in the PNHP leadership training. PNHP Board Member Dr. Olveen Carrasquillo, co-founder with Dr. Jaime Torres of Latinos for National Health Insurance, presented data on the rising number of uninsured Hispanics and reported that the National Hispanic Medical Association endorsed single payer. Dr. David Himmelstein showed the latest version of the PNHP slide show, with new data on "consumer directed health care." Drs. Danielle Martin and Joel Lexchin updated participants on Canada's health system, including Canadian Doctors for Medicare, a newly-founded organization fighting privatization. ([www.canadiandoctorsformedicare.ca](http://www.canadiandoctorsformedicare.ca)).

# Data Update

## UNINSURED / UNDERINSURED

44.8 million Americans (15.9 percent of the population) were uninsured in 2005 (the most recent year for which data are available), up from 43.5 million (14.9 percent) in 2004. The estimates of the number of uninsured Americans in 2004 and 2005 were revised down - from 45.3 million and 46.6 million, respectively - by the U.S. Census Bureau in March 2007 due to errors in tabulation. As we go to press, the Census Bureau is in the process of revising its remaining data on health insurance coverage.

According to the originally published data, almost all of the increase in the uninsured population in 2005 was among full-time workers or their children. The number of uninsured children rose for the first time since 2001, to 8.3 million.

The largest rise in the uninsured was in families with incomes over \$50,000 per year, up 1.4 million people to 17 million in 2005. Additionally, over a million full-time workers lost coverage between 2004 and 2005.

Among minorities, lack of insurance continues to disproportionately affect Hispanics. 32.7 percent of Hispanics (14.1 million) are uninsured compared to 19.6 percent of Blacks (7.2 million), 17.9 percent of Asians (2.3 million) and 11.3 percent of non-Hispanic whites (22.1 million). ("Income, Poverty, and Health Insurance Coverage in the United States; 2005," Current Population Report, U.S. Census Bureau, August 2006).

▶ 34.7 percent of uninsured children and 35.8 percent of kids with a "gap" in coverage went without care due to cost in 2005, compared with 7.2 percent of insured children. Uninsured kids are twice as likely as those with coverage to go without any medical attention all year, 25.6 percent vs. 12.3 percent. More than one-in-three (35 percent) uninsured children do not have a regular doctor or nurse, compared with 13.5 percent of insured kids.

88.3 percent of uninsured children are in homes where at least one parent works. In 52 percent of two-parent families with uninsured children, both parents work. (Robert Wood Johnson Foundation, "The State of Kids Coverage," 8/9/06; "No Shelter from the Storm," Campaign for Children's Health Care, September 2006).

The percentage of Americans covered by employer-sponsored health insurance fell to 59.5 percent in 2005, down from 63.6 percent in 2000. Among working Americans, the rate of employer-sponsored coverage dropped from 81.2 percent to 77.4 percent over the four-year period. (U.S. Census; Kaiser Foundation, "Changes in Employees' Health Insurance Coverage, 2001-2005," October 2006).

▶ More than one-fifth (21 percent) of adults under 65 report they are paying off medical bill debts; 44 percent of these people owe \$20,000 or more. Of adults making \$40,000 per year or more, 59 percent reported problems with medical bills or accrued debt (Collins, S. et al "Gaps in Health Insurance: An All-American Problem," Commonwealth Fund, April 2006).

▶ A report based on U.S. Census Bureau data found that 56 percent of uninsured Americans lack coverage because they cannot afford it and are ineligible for public health programs. One-quarter of the uninsured are eligible for public programs but not enrolled; 20 percent have incomes greater than 300 percent of poverty, but coverage would consume a high percentage of their income (and is not always available). (Dubay, et al., "The Uninsured and the Affordability of Health Insurance Coverage," Health Affairs Web Exclusive 11/30/06).

Many new health proposals seek to mandate that individuals buy private insurance, yet such coverage is currently nearly impossible to find. 89 percent of Americans who explored obtaining coverage through the individual market between 2003 and 2005 never bought a plan. A large majority (58 percent) found it "very difficult or impossible" to find affordable coverage, and 34 percent said the same of finding adequate benefits. 21 percent were turned down or charged a higher premium because of pre-existing conditions. More than half of adults covered in the individual market pay annual premiums of \$3,000 or more, and 43 percent spent more than 10 percent of their incomes on health costs. (Collins, S., et al, "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," Commonwealth Fund, September 2006).

▶ Uninsured children and those on Medicaid who are admitted to the Children's Hospital in Denver are twice as likely to die during hospitalization, according to a study of hospitalizations of kids aged six months to 18 years. Kids on Medicaid are twice as likely as those with private insurance to be hospitalized for vaccine-preventable illnesses, diabetes and asthma complications, and ruptured appendices. (Todd, J. et al "Increased Rates of Morbidity, Mortality, and Charges for Hospitalized Children With Public or No Health Insurance as Compared With Children With Private Insurance in Colorado and the United States," Pediatrics 118(2) August 2006).

▶ Emergency Department (ED) overcrowding is on the rise. ED visits in the U.S. increased 26 percent between 1994 and 2004, while the number of emergency departments decreased by 9 percent. Over the same period, hospitals have closed 198,000 hospital beds. A survey of 467 24-hour EDs found that 44.9 percent experienced overcrowding in 2004. An ED was deemed "overcrowded" if ambulances had to be redirected

because of a lack of rooms, wait times averaged more than one hour for patients in need of immediate care, or if at least 3 percent of patients left without receiving care. (Kellerman, A. "Crisis in the Emergency Department," NEJM 355(13), 09/28/06; Kaiser Health Policy Report 9/28/06).

One-in-four families affected by cancer say the experience caused the sick person to use up all or most of their savings. In addition, 13 percent borrowed money from relatives, and 11 percent couldn't pay for a basic necessity like food, heat, or housing. Continuous health insurance coverage mitigated, but did not eliminate, these problems. Cancer patients who experienced a gap in coverage were significantly more likely to exhaust their savings (46 percent vs. 22 percent of those continuously insured), borrow money (30 percent vs. 10 percent), be contacted by debt collectors (34 percent vs. 9 percent), be unable to pay for necessities (41 percent vs. 7 percent), or go without care for their cancer due to cost (27 percent vs. 8 percent). (USA Today/Kaiser/Harvard SPH, "National Survey of Households Affected by Cancer," November 2006).

▶ Half of steelworkers retired from bankrupt manufacturers LTV and Bethlehem Steel said they or their spouses had to return to work or postpone retirement to pay for medical expenses because of lost medical benefits. One-quarter said they had to spend a considerable portion of their savings on health care. Of those under age 65, 29 percent reported delaying or going without needed hospital care and 49 percent went without physician care due to cost. (Kaiser Health Policy Report 5/30/06).

▶ The proportion of U.S. physicians providing charity care decreased from 76 percent in 1997 to 68 percent in 2005 despite growth in the number of uninsured. The drop was consistent across most major specialties, practice income levels and geographic regions. (Cunningham, "A Growing Hole in the Safety Net," Center for Studying Health System Change, March 2006).

Three years after a failed four-month strike, only 54 percent of Southern California United Food and Commercial Workers (UCFW) members had health coverage through their employer, compared with 94 percent in September 2003, prior to the strike. Among other restrictions, the new contract increased waiting times for coverage from four months to 12 months for individual coverage and 30 months for family coverage. It also increased deductibles, co-pays and co-insurance while restricting plan options. Only 29 percent of workers hired under the new contract are eligible for coverage, and only 7 percent have enrolled. (Jacobs, K. "Declining Health Coverage in the Southern California Grocery Industry," UC Berkeley Center for Labor Research, January 2007).

## COSTS

▶ Federal tax subsidies for employment-related health coverage totaled \$208.6 billion in 2006, or 35.4 percent of all spending on private insurance premiums, according to health economist Thomas M. Selden of the Agency for Healthcare Research and Quality. Most of these subsidies go to higher income families. By comparison, federal Medicaid spending was \$180.6 billion. (Gross, NYT, 12/3/06).

In 2007, total U.S. health spending is projected to rise to \$2.262 trillion, \$7,498 per capita or 16.2 percent of GDP. By 2016, total health spending is projected to be \$4.137 trillion, 19.6 percent of GDP.

Estimated spending in 2006 was \$7,092 per capita.

Health spending rose 6.9 percent to \$2.0 trillion in 2005 (the latest year for which actual data are available), \$6,697 per capita, or 16.0 percent of GDP. (Poisal, J. et al, "Health Spending Projections Through 2016," Health Affairs 242(1), 2/21/07).

▶ About 48.8 million Americans spent more than 10 percent of household income on medical care in 2003 (19.2 percent of the non-elderly population), up from 37.1 million in 1996. Of this group, 18.7 million (7.3 percent of the non-elderly population) spent more than 20 percent of their income on care. Those more likely to face high costs were low-income people, those with individual coverage, people aged 55 to 64, women, people outside metro areas and those with chronic medical conditions. Full article on page 14. (Banthin, J et al, "Changes in Financial Burdens for Health Care," JAMA 296(22), 12/13/06).

▶ Employer-sponsored health premiums rose an average of 7.7 percent in 2006, more than twice the increase in wages (3.8 percent) or inflation (3.5 percent). The average employer-based premium was \$4,242 for single coverage and \$11,480 for family coverage. Premiums have increased 87 percent over the last six years. Workers pay an average of \$627 toward individual premiums and \$2,973 toward family premiums. The average worker contribution to family premiums has increased \$1,354 since 2000. Companies face premium increases between 10 and 12 percent in 2007. A different survey of 573 large firms by Watson Wyatt Worldwide found employer health costs increased 8 percent in 2006. The consulting firm expects similar increases this year and in 2008. ("Employer Health Benefits 2006 Annual Survey," Kaiser Family Foundation, 09/26/06; Simon, AP 11/13/06; Agovino, AP 2/22/).

▶ In 2005, the retirement health obligations of companies in Standard & Poor's 500 stock index were underfunded by \$321 billion, up from \$287 billion in 2004. In contrast to pension funds, companies rarely set aside money for health plans. On average, S&P 500 firms put away 90 percent of the funds for their pension obligations and just 22 percent of their retiree health benefit funding. (McDonald, WSJ, 6/6/06).

▶ California's independent small-business purchasing pool (PacAdvantage) collapsed after three major health plans pulled out of the pool because of rising costs. Blue Shield of California was the eighth insurer to pull out of the pool since its inception. Although purchasing pools are often touted as a reform model around the nation, the LA Times observed that "The only way a pool of buyers would have enough power to significantly influence costs...is if it included virtually everyone." (Yi, LA Times, 8/12/06).

▶ Physicians and insurers spent \$20 billion in 2004 on "denial management," computer software and consultants to dig through past claims looking for shortchanged payment or for reasons to issue a payment denial. Ingenix, a subsidiary of UnitedHealth, sells the software to both doctors and other insurers. Roughly 30 percent of physician claims are denied the first time around. Sales of such software grew 25 percent last year to \$7.5 billion. (Fuhrmans, WSJ 2/14/07).

▶ Although pay-for-performance (PFP) is being promoted heavily, there is scarce and inconclusive evidence as to whether its incentives improve health care. Of 17 studies analyzed by researchers, only two examined the effect of P4P on access to care (one found a gain, one found a loss). Only one study addressed cost-effectiveness, and no studies examined the optimal duration for incentives or their effects after termination. (Petersen, L. "Does Pay-for-Performance Improve the Quality of Health Care?" *Annals of Internal Medicine* 145(4) 8/15/06).

Employers are shifting workers into high-deductible health plans (HDHPs) to cut benefit costs. Unfortunately most workers with HDHPs have little or nothing in a "health savings account" (HSA). As of January 2006, only 26 percent of the 3.2 million enrollees in HDHPs had any money in an HSA. The average HSA balance is \$1,180, only 25 percent of the average deductible. A study by the GAO found that 57 percent of HSA contributors had incomes above \$75,000. The tax benefits of an HSA are small or nonexistent for low-income workers, but can be 35 percent or more for people in high-income tax brackets. (Cochrane, "HSA Funding: Are Consumers Leaving Money on the Table?" Vimo Research, January 2007; Rauber, San Francisco Business Times 6/1/06; "Early Enrollee Experiences with HSAs and Eligible Health Plans," U.S. GAO, August 2006).

▶ A survey of 10,577 physicians found that those who practice in "high-intensity" regions (areas with high medical spending and utilization) are no more likely to report ease in obtaining needed services for patients or greater ability to provide high-quality care. The proportion of doctors who felt able to easily obtain elective hospital admissions ranged from 50 percent in high-intensity regions to 64 percent in the lowest-intensity region. The proportion who felt able to easily obtain high-

quality referrals ranged from 64 percent in high-intensity regions to 79 percent in low-intensity regions. Fewer physicians in high-intensity regions felt able to maintain good ongoing patient relationships (62 percent vs. 70 percent) or provide high-quality care (72 percent vs. 77 percent). (Sirovich, B. et al, "Regional Variations in Health Care Intensity and Physician Perceptions of Quality of Care," *Annals of Internal Medicine* 144(9), 05/2/06).

▶ Chrysler announced a loss of \$1.5 billion in the third quarter of 2006, in part due to rising health costs. The company spent an estimated \$2.3 billion on health care in 2006. Health costs added an average of \$1,400 to the cost of each vehicle. The company plans to eliminate 13,000 jobs and close two factories, and says that this will reduce their health care liability by between \$2.5 billion and \$3.0 billion. (van Loon, Philadelphia Inquirer, 09/16/06, WSJ 9/17/06, Krisher AP, 2/15/07).

## RACIAL AND ECONOMIC INEQUALITY

▶ 62 percent of non-elderly adult Hispanics and one-third of African Americans were uninsured at some point during 2005, compared with 20 percent of non-elderly adult whites. Working-age Blacks are more likely to report health problems (51 percent) than either whites (38 percent) or Hispanics (28 percent). They are also have a higher rate of outstanding medical bills and debt (44 percent) than whites (33 percent) or Hispanics (29 percent). (Doty, M. "Health Care Disconnect: Gaps in Coverage and Care for Minority Adults," Commonwealth Fund, August 2006).

▶ Disparities pervade all dimensions of health care quality and access but are especially striking in chronic disease management, according to the federal Agency for Healthcare Research and Quality. Blacks have 90 percent more lower extremity amputations for diabetes than whites and Hispanics have 63 percent more pediatric asthma hospitalizations. Poor people are 37 percent less likely to receive recommended diabetes care than higher-income groups. Of all identified racial and ethnic disparities, about one-quarter are improving and one-third are worsening (i.e. decreasing or increasing at a rate of more than one percent per year, respectively). Of the disparities experienced by the poor, 67 percent are worsening.

African-Americans receive significantly poorer quality care than whites on 73 percent (16 of 22) of core quality measures evaluated. Hispanics receive poorer quality on 77 percent of measures. Poor Americans receive poorer quality care on 71 percent of measures compared with the affluent. Quality measures include effectiveness and timeliness of treatment for cancer, diabetes, heart disease, mental health and substance abuse as well as maternal and child health. (Agency for Healthcare Research and Quality, "National Healthcare Disparities Report," U.S. Dept. of HHS, December 2006).

▶ African-American men have a 15 percent higher cancer incidence rate but a 38 percent higher cancer death rate than white men, according to an American Cancer Society analysis of data for 1999-2003. Black women had a 9 percent lower cancer incidence than white women but an 18 percent higher death rate. The report identified poverty as a critical factor influencing underlying risk factors (such as obesity and tobacco use); 24 percent of blacks and 23 percent of Hispanics live below the poverty line, compared with 11 percent of whites. The 5-year relative survival rate for all cancers is lower for African-Americans (57 percent) than it is for whites (68 percent). ("Cancer Facts and Figures: 2007," American Cancer Society, January 2007).

▶ The breast cancer mortality rate in Chicago was 73 percent higher for black women than for white women in 2003, 40.5 breast cancer deaths per 100,000 black women vs. 23.4 percent among white women. Nationally, the breast cancer death rate among white women is 25.2 per 100,000, compared with 34.6 among black women. (Peres, Chicago Tribune, 10/18/06; Ritter, Chicago Sun Times, 10/17/06).

▶ Black Medicare beneficiaries fare worse than white beneficiaries on four outcome measures for diabetes, hypertension and heart disease even when they are in the same health plan, according to a study of more than 430,000 Medicare patients in 151 health plans from 2002 through 2004. The largest disparity was in cardiac care: 72 percent of white patients with heart problems had their cholesterol levels under control, compared with 57 percent of black patients. (Trivedi, A. et al, "Relationship Between Quality of Care and Racial Disparities in Medicare Health Plans," JAMA 296(16) 10/25/06).

## PHARMACEUTICALS, INC.

▶ Prices for the 193 brand-name drugs most-commonly used by people aged 50 and older increased by an average of 6.3 percent between 2005 and 2006, outpacing the 3.8 percent inflation rate. (Kaiser Health Policy Report, 9/20/06).

Pharmaceutical companies contributed \$18.9 million to candidates during the 2006 election cycle, with 68 percent going to Republicans. The top contributors were Pfizer, GlaxoSmithKline and Amgen, each of whom gave more than \$1 million. The top three recipients were former senator Rick Santorum (R-PA - \$395,553), Sen. Orrin Hatch (R-UT - \$336,131), and Senate candidate Mike Ferguson (R-NJ - \$298,673). (Center for Responsive Politics Election 2006 data, www.crp.org, accessed 02/21/07).

▶ Federal and state governments have collected \$3.9 billion in civil damages and criminal penalties from 16 cases involving pharmaceutical companies' overcharges of Medicare, Medicaid and the Federal Employee's Health Benefit Program. An additional 150 federal investigations are pending. (Cohen, Richmond Times-Dispatch, 2/22/07).

▶ Pharmaceutical giant Schering-Plough agreed to pay \$435 million in criminal fines for illegal sales and marketing of its cancer treatment Temodar. The company paid physicians kickbacks, lied to the government and defrauded Medicaid. In exchange for prescribing Temodar, the company would place doctors on medical "advisory boards" whose primary purpose was to pay stipends and provide entertainment for board members. Schering also awarded lucrative and potentially prestigious clinical studies to doctors based on how often they prescribed Temodar. The company also defrauded Medicaid of \$4.3 million by failing to properly report its prices. (Kaiser Daily Policy Report, 1/18/07).

▶ GlaxoSmithKline will pay state attorneys general \$70 million for artificially inflating the average wholesale price of its drugs and \$14 million for blocking applications for a generic version of its antidepressant Paxil. The settlements follow a previous agreement to settle two similar suits for \$165 million. (Kaiser Daily Policy Report 3/29/06 and 8/11/06).

Former Pfizer CEO Henry A. McKinnell left the firm with a \$180 million severance package, including \$82.3 million in pension benefits, \$77.9 million in deferred compensation, and \$20.7 million worth of cash and stock. McKinnell was pushed out in July 2006, partly due to investor anger over his exorbitant compensation. (AP Business, 12/22/06).

▶ Industry-funded clinical trials of breast cancer medications provided positive results 78 percent of the time, compared with 66 percent of non-industry studies, according to a survey of 140 breast cancer studies in 10 medical journals between 1993 and 2003. (Fisher, Raleigh News & Observer, 2/26/07).

▶ Stanford University Medical Center adopted a policy in October prohibiting doctors from accepting gifts from sales representatives for pharmaceutical, medical device and other companies. The ban includes drug samples and small gifts such as pens, free meals, and publishing articles in medical journals that are underwritten by drug companies. The pharmaceutical industry currently spends 90 percent of its \$21 billion annual marketing budget on physicians. (Pollack, New York Times, 9/12/06).

▶ The FDA plans to increase the proportion of its drug-review budget underwritten by pharmaceutical companies from 53 percent to 66 percent in 2007. The FDA currently charges "user fees" to drug makers who use the FDA review process. User fees generated \$232 million in 2004, a 25-fold increase since 1993. Unfortunately, the large proportion of FDA funding from industry translates into increased influence over regulatory operations. The new agreement was reached in closed-door meetings between the FDA and drug executives, many of them former FDA officials. (Integrity in Science Watch, 9/5/06).

▶ Fewer than half of studies on the effects of prescription drugs in children are ever published in medical journals. Between 1998 and 2004, 253 pediatric studies were submitted to the FDA, but only 45 percent were published in peer-reviewed journals. (Benjamin, D. et al, "Peer-Reviewed Publication of Clinical Trials Completed for Pediatric Exclusivity," JAMA 296(10), 9/13/06)

## CORPORATE MONEY AND CARE

▶ Consolidation within the health insurance industry has led to the emergence of insurance giants including Wellpoint (34 million members) and UnitedHealth (28 million members). Wellpoint (formerly Blue Cross of California) merged with Anthem in 2004 and controls Blue Cross plans in 14 states; the firm's revenues are \$52 billion annually. UnitedHealth capped a long series of acquisitions with the purchase of Pacificare in 2005 and has annual revenues of \$64 billion. The top six firms, including Aetna (\$25 billion in revenues, 15 million members), Humana (\$21 billion / 11 million) Cigna (\$16 billion / 9 million) and Health Net (\$13 billion / 7 million), had combined profits of more than \$10 billion. Non-profit Kaiser Permanente has 8.6 million members. (Mattera, Alternet, 2/23/07).

UnitedHealth is under investigation by the SEC for backdating stock options for top executives, including former CEO Dr. William McGuire, who received \$1.6 billion in stock options during his tenure in addition to his \$8 million annual salary. The Wall Street Journal reported that if Dr. McGuire's 12 options grants from 1994 to mid-2002 had been randomly dated, the odds of their occurring at such propitious times were about 1 in 200 million. UnitedHealth restated its financial health for the past 12 years, reducing earnings by \$1.53 billion, and will pay about \$100 million to the IRS for back taxes on the backdated options. (Wall Street Journal, 4/18/06, Minneapolis Star Tribune, 3/6/07).

▶ The rehabilitation and surgery center giant HealthSouth will pay \$445 million for falsely inflating its 2003 earnings report by \$1.4 billion. The settlement follows an earlier \$100 million settlement with the Securities and Exchange Commission. (Bloomberg News and Chicago Tribune, 2/24/06)

▶ Medco Health Solutions, the largest U.S. pharmacy benefit manager, will pay \$155 million to settle fraud allegations. Medco canceled and destroyed prescriptions to avoid penalties, solicited kickbacks from drug makers to promote their products, paid kickbacks to health insurers for their business, switched prescriptions without physician consent, did not fill prescriptions completely and failed to inform physicians about adverse interactions. Medco also agreed to settle allegations of false Medicare claims. (Kaiser Health Policy Report, 10/24/06).

A federal jury ordered Virginia-based insurer Amerigroup to pay \$334 million for conspiring to keep pregnant women and people with health problems in Illinois from enrolling in their Medicaid managed care plan. The company denied the allegations until an internal executive email surfaced which read "we trained the marketing staff constantly to not even approach a pregnant female about joining the plan." Amerigroup still operates Medicaid HMOs in 10 states. (Bush, Chicago Tribune, 10/31/06).

▶ A survey of studies on the performance of nonprofit hospitals in comparison to for-profits found that nonprofits are better on most measures of economic performance, accessibility for unprofitable patients, and quality. A significantly larger number of studies favored nonprofit hospitals on such measures as administrative overhead (3 favored nonprofits vs. 0 favoring for-profits), charges per admission (9 vs. 0), post-discharge mortality (7 vs. 1), process quality measures (5 vs. 0), locating in low-income areas (5 vs. 0) and treating the uninsured (12 vs. 0). On no measure did more studies favor for-profits than nonprofits. (Schlesinger, M. et al, "How Nonprofits Matter in American Medicine, and What to Do about It," Health Affairs Web Exclusive 06/20/06)

▶ Not-for-profit nursing homes provide better quality care than for-profits, but few met quality standards established by Consumer Reports. 7.3 percent of non-profit nursing homes met the magazine's standards, compared with 2.0 percent of for-profit facilities. Independent establishments were more likely to meet quality standards than chains. These findings echo those of an older PNHP study on nursing home quality. (Charlene Harrington et al, American Journal of Public Health 2001, 91:1452; AP 8/6/06).

▶ At this year's "Wall Street Comes to Washington" conference - a gathering of executives from major industries and policymakers - insurance industry analyst Robert Laszewski said the only real movement in the sector is coming from mergers. "It's never been so boring - or so profitable," he said, "the industry has given up managing care and controlling costs. We have a lot of people making themselves really rich and selling their industry down the river. I think my industry is on a long walk off a short pier." (Congressional Quarterly, 6/19/06).

▶ An increasing number of companies are ridding themselves of retiree medical-coverage obligations by establishing union-administered trusts known as voluntary employees' beneficiary associations (VEBAs). Under this arrangement, the company makes a one-time contribution to the trust in exchange for relinquishing its obligations. Goodyear recently established a \$1 billion VEBA. However, the trust is \$200 million short of estimated future medical costs. Executives at GM and other auto makers have expressed interest in a similar arrangement. The consulting firm Mercer estimates 25 per-

cent of large companies have a version of these trusts. Unlike pensions, VEBA benefits are not protected by the government. (Maher, WSJ, 01/29/07).

## HOSPITALS, INC.

▶ Two major hospital firms have agreed to pay nearly \$1 billion to settle allegations of defrauding Medicare. Tenet Healthcare will pay \$725 million and waive \$175 million in past charges. New Jersey-based St. Barnabas Health Care will pay \$265 million and have an independent monitor for six years. Both firms are accused of illegally boosting retail hospital charges to receive higher Medicare payments. In addition, Tenet agreed to pay \$80 million to settle charges that it cheated on its taxes, in part by illegally claiming deductions for payments it made to settle earlier accusations of fraud. (Washington Post, 6/16/06; RTT News 6/29/06, Tenet Press Release, 11/22/06).

▶ HCA was purchased by a private equity consortium for \$21 billion in cash. The deal is one of the largest leveraged buyouts ever completed. Although HCA has faced new Medicare restrictions and a rising number of uninsured patients, investors see huge potential profits in the aging population and growing health spending. (Olson, Forbes.com, 7/24/06).

▶ More than 30 new specialty hospitals will open this year after the Centers for Medicare and Medicaid services decided to end a moratorium on their construction. There are currently 130 specialty hospitals in the U.S. (Washington Times, 8/31/06).

▶ The nonprofit hospital chain Sutter Health will pay \$275 million in rebates to uninsured patients they overcharged for care. A lawsuit showed that despite the hospital's "charity" status, the chain spent only 0.6 percent of its revenue on charity care for the uninsured in 2002-2003 while reaping \$465 million in profits. Uninsured patients will be entitled to a 25 to 45 percent refund on their bills. (Kaiser Health Policy Report, 8/4/06)

## MEDICARE

Private "Medicare Advantage" plans were overpaid 12 percent per beneficiary in 2006 compared to what those patients would have cost in traditional Medicare, costing taxpayers \$4.6 billion (up from \$2.7 billion in 2005). The private plans profit by enrolling healthier than average seniors while collecting the standard Medicare fee. In addition, the Medicare drug bill boosted Medicare HMOs' payments by tens of billions. Enrollment in Medicare Advantage plans increased 19 percent from December 2005 to July 2006, to 7.3 million people. (Medicare Payment Advisory Committee, November 2006).

▶ Prices for the 20 most-prescribed drugs for seniors in Medicare drug plans are up to 900 percent higher than those negotiated by the Department of Veteran's Affairs (VA). The median annual drug price difference between the drug plans and the lowest price negotiated by the VA is \$257. ("Medicare Privatization: Windfall for the Special Interests," Families USA, October 2006; Appleby, USA Today, 8/9/06).

▶ 88 percent of Medicare beneficiaries enrolled in stand-alone drug plans under the Medicare prescription drug benefit are in plans that do not provide coverage during the "doughnut hole," making the beneficiary responsible for 100 percent of drug costs between \$2,250 and \$5,100. Purchasing a plan with "doughnut hole" coverage costs an average of \$458 annually in additional premiums. (Freking, AP/Boston Globe, 9/21/06).

▶ The nation's largest Medicare HMO has canceled its heart-failure "disease management" program a year early due to its failure to deliver expected cost savings. Touted as a way to improve quality and control costs, PacifiCare launched the federally-sponsored demonstration program for seniors with congestive heart failure in January 2004, but the program has actually cost Medicare more than it would have cost to treat those seniors in traditional Medicare. A 2004 Congressional Budget Office examination of 57 "disease management" programs concluded there was no evidence that such programs saved money. (Benko, Modern Healthcare 01/23/06).

▶ A study of 200,000 Medicare beneficiaries found that although those with caps on the amount of medication covered spent 31 percent less on medication than those without caps, they experienced costs from medical events related to improper medication use. The two groups had nearly the same total expense because those with a coverage cap were more likely to skip drug doses, visit emergency departments and incur non-elective hospitalizations. (Hechinger, WSJ, 6/1/06).

▶ Only one-third of eligible seniors have enrolled in the Medicare Savings Program, which subsidizes Medicare premiums and co-payments for low-income seniors. Reasons for low enrollment include lack of awareness, a burdensome application process, and the stigma connected to applying at a Medicaid office. ("Improving Medicare Savings Programs," National Academy of Social Insurance, June 2006).

## POLLS / PUBLIC OPINION

▶ 56 percent of Americans would prefer a universal health care system "like Medicare that is government-run and financed by taxpayers", according to a survey of 1,201 U.S. adults by ABC News and the Kaiser Foundation. The poll also found that 25 percent of Americans had a problem paying



medical bills in 2006 and 28 percent said someone in their family had delayed care. The vast majority (69 percent) of those reporting problems paying medical bills were insured. ("Health Care in America 2006 Survey," Kaiser Family Foundation).

▶ 46 percent of likely voters in 2006 said that they were "very worried" about "having to pay more for health care or health insurance," more than twice the number who reported being worried about being the victim of a violent crime (20 percent), a terrorist attack (20 percent), or losing their job (22 percent). ("Voters on Health Care and the 2006 Elections," Kaiser Family Foundation).

▶ Rising health costs are leading to financial problems for more Americans including: a decrease in retirement savings (36 percent, up from 25 percent in 2004), difficulty paying for basic necessities (28 percent, up from 18 percent), and difficulty paying other bills. (37 percent, up from 30 percent). ("2006 Health Confidence Survey," Employee Benefit Research Institute, November 2006).

▶ A majority of Americans (58 percent) say the FDA does a "fair" or "poor" job of ensuring the safety and efficacy of new drugs. 82 percent say that the FDA's decisions are influenced to "some extent" or "a great extent" by politics rather than medical science. (Integrity in Science Watch 5/30/06).

▶ Between 75 and 90 percent of members of the International Foundation of Employee Benefit Plans support a single-payer system, according to the group's internal surveys. The group - made up of trustees and administrators of employee benefit plans - has 35,000 members nationwide. (Shea, HR Magazine 10/17/06).

A survey of 2,014 California residents found 63 percent would support the U.S. government "guaranteeing health insurance to all citizens, even if it means raising taxes," compared with 31 percent who prefer the current system (8 percent were unsure). A similarly high level of support was expressed for a program in which "everyone is covered under a program like Medicare that is run by the government and financed by taxpayers" (61 percent supported it and 34 percent opposed it). (Baldassare, M. "Californians and their Government," Public Policy Institute of California, January 2007).

▶ The U.S. will require 39 percent more primary care physicians over the next 14 years to meet the demand of an aging population, according to a report by the American Academy of Family Physicians. However, the number of medical students entering primary care fields has decreased by more than half as more graduates enter specialties with higher pay and more control over work hours. (Ritter, AP, 9/27/06).

## MASSACHUSETTS' PLAN STARTS TO UNRAVEL

▶ *Editors' Note: On April 4, 2006, Massachusetts became the first state in the nation to pass an "individual mandate": a legal requirement to purchase private insurance, punishable with a tax penalty. Lawmakers promised comprehensive coverage for low premiums, but quickly discovered they could not keep their promise. The Massachusetts experience is especially important because of its far-reaching implications. As we go to print, nearly every major health reform proposal at the state and national level (including presidential candidate John Edwards') includes an individual mandate. For a thorough critique, see "One Step Forward and Three Steps Back" by Drs. David Himmelstein and Steffie Woolhandler, reprinted on page 37.*

A Massachusetts state panel initially announced that, based on insurers' bids, premiums for the minimum benefit plans mandated under that state's new law would cost an average of \$380 for an individual, \$180 more than former Governor Mitt Romney projected when he began stumping for the law in early 2006. The plans included a \$2,000 deductible (\$4,000 for a family). The Greater Boston Interfaith Organization, originally a supporter of the law, has called for delays in implementation after a survey showed that half of low-income and 40 percent of middle-income uninsured residents would not be able to afford the premiums, even with state subsidies. The state panel subsequently asked insurance companies for cheaper bids and delayed final voting on the plans and premiums until March. As we go to press, the price of the policies have been lowered to \$308 per month. (Boston Globe, multiple dates).

Massachusetts residents who remain uninsured or have coverage less adequate than the minimum benefit package will be fined about \$200 in 2007, and half the average annual premium of a minimum benefit package in 2008. If individual monthly premiums remain at \$308 (\$3696 per year) the penalty for being uninsured (\$1,848) will be higher than that state's normal fines for drunk driving (\$500 min. - first offense), domestic assault (\$1,000 max.), or making a terrorist threat (\$1,000 min.). (Mass-Care "Punitive Index," [www.masscare.org/chapter-58/](http://www.masscare.org/chapter-58/) accessed 02/06/07).

Massachusetts' new law ties its premium subsidies to income relative to the federal poverty level (FPL). From 1996 to 2004 premiums for single coverage nationally increased by 86 percent while the FPL increased only 20 percent. A person at 300% of poverty (about \$23,000 in 1996) who paid \$1,200 (5.2 percent of income) in 1996 would have to pay \$2,230 in 2004 (8.0 percent of income). At \$309 per month, the premiums of the new Massachusetts' plan will consume about 12 percent of the income of such individuals while still imposing a \$2,000 deductible. ("Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level," Kaiser Foundation, February 2007).

## CONGRESS AND THE STATES

► Before they adjourned in 2006, lame-duck Republican lawmakers quietly passed a provision to increase the amount of money individuals can shelter from taxes in health savings accounts. Previously, individuals could only shelter an amount equal to their health plan's deductible, but that amount has now been increased to \$2,700 for an individual and \$5,450 for a family. The lost taxes are expected to cost the government \$1 billion over the next decade, with most of the tax savings going to the wealthy. The same lawmakers failed to reauthorize funding for SCHIP, and President Bush's 2008 budget would also restrict SCHIP funding to children in families with incomes less than 200 percent of the poverty level. At least 17 states have expanded eligibility beyond that (e.g. 250 - 300% of poverty), and 14 states are facing shortfalls. (Kaiser Daily Health Policy Report, 02/06/07; Birnbaum, Washington Post 12/11/06).

A single-payer plan could provide all Connecticut residents with better coverage and cost less than either expanding existing safety net programs or creating a new state purchasing pool, according to a study by the Economic and Social Research Institute. A single-payer system would reduce health spending by \$500 million statewide, save employers now offering coverage 26 percent, and not require any new state funding. By contrast, a state purchasing pool would raise health spending \$30 million, reduce employer costs by 18 percent (mostly through offering less costly coverage), and require an additional \$220 million in state spending. Senate Democrats have instead introduced a \$450 million proposal to boost Medicaid reimbursement and expand various public programs. (Dorn, et al, "Health Coverage In Connecticut: Three Routes to Reform," ESRI, January 2007; Keating, Hartford Courant, 1/26/07).

► A federal judge overturned a Maryland "employer mandate" in June 2006 that would have required any business in the state with more than 10,000 workers to spend at least 8 percent of payroll on health care or contribute to a state fund. Wal-Mart would have been the only employer affected. The judge ruled that the law violated the federal Employee Retirement Income Security Act (ERISA). (Green, Baltimore Sun, 7/21/06).

► Nevada has passed legislation allowing residents to buy approved medications from Canadian pharmacies. The law requires the pharmacists to be licensed by the Nevada State Board of Pharmacy, which has already inspected and approved four Canadian pharmacies. (Wells, Las Vegas Review-Journal, 4/21/06 and 5/5/06).

► Enrollment in Kansas' Medicaid program dropped by 18,000 after new proof-of-citizenship rules took effect on July 1, 2006. The new rules, included in President Bush's Deficit Reduction Act of 2005, require enrollees to present original birth certificates or other documents to prove citizenship. Some health officials are concerned that eligible beneficiaries, particularly older African Americans born at home in the rural South, will have difficulty locating or affording the documents, and undocumented immigrants will be afraid to seek care. (Rothschild, Lawrence Journal World, 11/30/06).

► Advocates say that less than 10 percent of Tennessee's more than 700,000 uninsured residents will be eligible for the state's new AccessTN program and many will be unable to afford it. To be eligible, an individual must have one of 54 specified medical conditions or proof of rejection from at least two insurance companies. The premiums will be between \$273 and \$1,156 per month and have deductibles between \$1,000 and \$5,000. The program will be able to accept only 6,000 enrollees in its first year. (Pinto, Tennessean, 11/20/06).

## INTERNATIONAL HEALTH SYSTEMS

► A new scorecard measuring 37 indicators of overall health system performance against benchmarks achieved in the U.S. or abroad gave the U.S. a score of only 66 out of 100. The U.S. ranked last among 23 industrialized nations on infant mortality (7.0 deaths per 1,000 live births, more than double the rate of the Iceland, Japan and Finland), and did poorly on such measures as ability to see a doctor on the same or next day when needed (47 percent of U.S. adults vs. 81 percent in the highest-performing nations), and percent of national health expenditures going to health insurance administration (7.3 percent of NHE in the U.S. vs. 2.0 percent in the best nations). (Schoen, C. et al. "U.S. Health System Performance: A National Scorecard," Health Affairs Web Exclusive, November/December 2006).

► People in Britain aged 55-64 years are healthier than their U.S. counterparts according to a JAMA study. The British reported lower rates of diabetes (7.2 percent vs. 12.5 percent of Americans), hypertension (35.1 percent vs. 42.4 percent), heart attack (4.2 percent vs. 5.4 percent), stroke (2.3 percent vs. 3.8 percent), lung disease (6.2 percent vs. 8.1 percent), cancer (5.4 percent vs. 9.5 percent) and heart disease (10.1 percent vs. 15.1 percent). The disparity persisted even when controlling for race, ethnicity, education and income. (Banks, J. et al "Disease and Disadvantage in the United States and in England." JAMA 295(17), 5/13/06).

► 51 percent of U.S. physicians report patients often have difficulty paying for medications, compared with between

7 and 27 percent in other English-speaking nations, according to a survey of 6,000 primary care doctors in Australia, Canada, New Zealand, the U.K., and the U.S. Just 40 percent of U.S. physicians have arrangements for patients to see a nurse or doctor after-hours, compared with between 76 and 95 percent in the other nations. Only 28 percent of U.S. doctors and 23 percent of Canadian doctors use electronic medical records, compared with between 79 and 98 percent in the remaining countries. (Schoen, C. et al "On the Front Lines of Care," Health Affairs Web Exclusive 11/2/06).

▶ An international survey of patient views on the care they receive found that U.S. patients feel more negatively about their health system than patients in Australia, Canada, Germany, New Zealand or the United Kingdom. In addition to ranking last overall, the U.S. received the worst patient reviews on four of the six Institute of Medicine quality measures studied: patient safety, patient-centeredness, efficiency, and equity. The U.S. ranked first on effectiveness but only third on timeliness. (Davis, K. et al, "Mirror Mirror on the Wall," Commonwealth Fund, April 2006).

▶ Lower-income patients in the United States receive worse care than their higher-income counterparts on 21 of 30 primary care quality measures, a far higher number of disparities than experienced by lower-income patients in New Zealand (8 measures), Canada (5 measures), Australia (4 measures) and the U.K. (1 measure). U.S. lower-income patients were the most likely of any nation to have difficulty getting care after hours (70 percent), have a cost-related access problem (57 percent), have a care coordination problem (36 percent), and rate their doctor fair or poor (22 percent). (Huynh, P. et al "The U.S. Health Care Divide," Commonwealth Fund, April 2006).

The median waiting time for specialist care or a referral from a specialist to surgery was about 4 weeks in Canada in 2005 according a survey of 33,000 Canadian patients by Statistics Canada, the counterpart to the U.S. Census Bureau. The median waiting time for a diagnostic test was about 3 weeks. PNHP maintains a directory of provincial waiting time data available at [www.pnhp.org/provincewaits.php](http://www.pnhp.org/provincewaits.php) (Statistics Canada Data 2006).

▶ The Canadian Medical Association Journal fired Editor Dr. John Hoey and Deputy Editor Anne-Marie Todkill after Hoey made public accusations that the CMA was censoring the journal. Hoey made the allegation after the CMA pulled an article documenting that some pharmacists demanded and recorded personal information of women purchasing the morning-after birth control pill. (Branswell, Canadian Press, 2/21/06).

▶ The private insurance company BUPA announced it will close operations in Ireland after a judge ordered the company to make payments to the competing nonprofit public insurance company, which enrolls a sicker and costlier population. Like many European nations, Ireland enforces a concept of "risk equalization," whereby if insurers selectively enroll a healthier population, they must make payments to insurers with sicker risk pools. BUPA operations were purchased by a third company, the Quinn Group, which accepted the risk equalization principles. (McCanne, D "Private Insurance Risk Pooling in Ireland and U.S.," Quote of the Day 12/22/06 & RTE Business 02/05/07).

In 2005, 247 physicians returned to Canada to practice there, compared with 186 who left. Canada also registered a net gain of 85 physicians in 2004. Between 2001 and 2005 the number of physician in Canada grew by 5.3 percent, more than keeping up with population growth (4.0 percent). The number of family physicians per 100,000 population increased from 95 in 2001 to 98 in 2005, while the number of specialists dropped slightly from 93 to 92. ("Supply, Distribution and Migration of Canadian Physicians, 2005" Canadian Institute for Health Information, [www.cihi.ca](http://www.cihi.ca))

▶ Legislation proposed in Australia by the government of Liberal (conservative) Party Prime Minister John Howard would allow private insurers to sell coverage for home dialysis, chemotherapy, mental health care, home nursing care and other "substitutes" for hospital care. Australia currently allows private health insurance for hospital care and encourages it with a large tax rebate. The result has been taxpayer subsidization of private coverage for the affluent, who then get faster care. The Doctors Reform Society estimates that at least 30 percent of the cost of the proposed "private insurance" law would be paid by taxpayers. Australia has a national health insurance system funded by taxes and patient fees, but also offers subsidies for private insurance for uncovered services and physician fees beyond what the government program pays. The government accounts for almost 70 percent of health spending. Private health insurance covers 49 percent of the population but accounts for only 7.1 percent of total health spending. (The Guardian, 11/1/06; Frogner et al, "Multinational Comparisons of Health Systems Data, 2005," Commonwealth Fund, April 2006).

▶ New Zealand, the only nation besides the US that allows direct-to-consumer advertising (DTCA), is expected to ban it. Several reviews recommended a ban, which is strongly supported by physicians. A proposal to weaken the ban on DTCA in Europe was rejected by the European Parliament in 2005. (Priest, Medical Reform, Winter 2007).

# Health Care Spending Growth: How Different Is The United States From The Rest Of The OECD?

A new type of analysis sheds light on health spending differences between the United States and other high-income countries.

by **Chapin White**

**ABSTRACT:** This paper compares the long-term (1970–2002) rates of real growth in health spending per capita in the United States and a group of high-income countries in the Organization for Economic Cooperation and Development (OECD). Real health spending growth is decomposed into population aging, overall economic growth, and excess growth. Although rates of aging and overall economic growth were similar, annual excess growth was much higher in the United States (2.0 percent) versus the OECD countries studied (1.1 percent). That difference, which is of an economically important magnitude, suggests that country-specific institutional factors might contribute to long-term health spending trends. [*Health Affairs* 26, no. 1 (2007): 154–161; 10.1377/hlthaff.26.1.154]

# Health Care Spending And Use Of Information Technology In OECD Countries

The United States is an outlier in both its health spending and its use of health information technology.

by **Gerard F. Anderson, Bianca K. Frogner, Roger A. Johns, and Uwe E. Reinhardt**

**ABSTRACT:** In 2003, the United States had fewer practicing physicians, practicing nurses, and acute care bed days per capita than the median country in the Organization for Economic Cooperation and Development (OECD). Nevertheless, U.S. health spending per capita was almost two and a half times the per capita health spending of the median OECD country. One proposal for both lowering health spending and improving quality is the adoption of health information technology (HIT). The United States lags as much as a dozen years behind other industrialized countries in HIT adoption—countries where national governments have played major roles in establishing the rule, and health insurers have paid most of the costs. [*Health Affairs* 25, no. 3 (2006): 819–831; 10.1377/hlthaff.25.3.819]

**SOURCE:** Organization for Economic Cooperation and Development, *OECD Health Data 2005* (Paris: OECD, 2006).

**NOTES:** MRI is magnetic resonance imaging. CT is computed tomography.

\* 2002.

<sup>a</sup> Data not available for 2001, 2002, or 2003.

<sup>c</sup> 2001.

## EXHIBIT 1

### Health Care Spending Per Capita In The United States And Other Organization For Economic Cooperation And Development (OECD) Countries, 1970 And 2002

Country	1970 (\$)	2002 (\$)	Country	1970 (\$)	2002 (\$)
Australia	848	2,756	Ireland	460	2,461
Austria	746	2,308	Japan	566	2,278
Belgium	577	2,614	Luxembourg	638	3,189
Canada	1,135	3,047	Netherlands	1,103	2,748
Denmark	1,423	2,682	Norway	549	3,205
Finland	748	2,020	Portugal	211	1,770
France	810	2,844	Spain	380	1,712
Germany	1,047	2,929	Sweden	1,199	2,617
Greece	672	1,885	Switzerland	1,374	3,581
Iceland	636	2,913	United Kingdom	630	2,246
United States	1,363	5,475			
OECD (non-U.S.)	747	2,504			

**SOURCE:** Author's calculations from OECD Health Data.

**NOTE:** "OECD (non-U.S.," excludes the following countries because of missing data: Czech Republic, Hungary, Italy, Korea, Mexico, New Zealand, Poland, Slovak Republic, and Turkey.

## EXHIBIT 2

### Supply And Use Of Selected Health Care Resources In Organization For Economic Cooperation and Development (OECD) Countries, 2003

Country	Hospitals			Technology			Transplants per 100,000		
	MDs per 1,000	Nurses per 1,000	Acute care beds per 1,000	Acute care bed days per capita	MRI units per million	CT scanners per million	Heart	Kidney	Liver
Australia	2.5 <sup>a</sup>	10.2	3.6 <sup>a</sup>	1.0 <sup>a</sup>	3.7	— <sup>b</sup>	0.4	2.7	0.7
Austria	3.4	9.4	6.0	1.7	13.5	27.2 <sup>a</sup>	0.8	4.7	1.8
Belgium	3.9 <sup>a</sup>	5.8	4.0 <sup>a</sup>	— <sup>b</sup>	6.6 <sup>a</sup>	28.8	1.1 <sup>a</sup>	3.7 <sup>a</sup>	2.1 <sup>a</sup>
Canada	2.1	9.8	3.2 <sup>a</sup>	1.0 <sup>a</sup>	4.5	10.3	0.5	3.5	1.3
Czech Republic	3.5	9.4	6.5	1.8	2.4	12.6	0.5	3.9	0.6
Denmark	2.9 <sup>a</sup>	10.3 <sup>a</sup>	3.4 <sup>c</sup>	— <sup>b</sup>	9.1	14.5	0.5	3.3	0.7
Finland	2.6	9.3	2.3	0.8	12.8	14.0	0.4	3.1	0.8
France	3.4	7.3	3.8	1.0	2.8	8.4 <sup>a</sup>	0.5	3.6	1.4
Germany	3.4	9.7	6.6 <sup>a</sup>	1.9 <sup>a</sup>	6.0 <sup>a</sup>	14.2 <sup>a</sup>	0.5	3.0	1.0 <sup>a</sup>
Greece	4.4 <sup>c</sup>	— <sup>b</sup>	— <sup>b</sup>	— <sup>b</sup>	2.3 <sup>a</sup>	17.1	0.1 <sup>a</sup>	2.1	0.2 <sup>a</sup>
Hungary	3.2	8.6	5.9	1.7	2.6	6.9	0.1	3.3	0.3
Iceland	3.6	13.7	— <sup>b</sup>	— <sup>b</sup>	17.3	20.7	0.0	1.0	0.7
Ireland	2.6	14.8	3.0	0.9	— <sup>b</sup>	— <sup>b</sup>	0.4	3.4	0.7
Italy	4.1	5.4	3.9 <sup>a</sup>	1.0 <sup>a</sup>	11.6	24.0 <sup>a</sup>	0.5	2.7	1.3
Japan	2.0 <sup>a</sup>	7.8 <sup>a</sup>	8.5	2.1	35.3 <sup>a</sup>	92.6	0.0	0.7	0.0
Korea	1.6	1.7	5.9	— <sup>b</sup>	9.0	31.9	0.0	1.8	1.0
Luxembourg	2.7	10.6 <sup>a</sup>	5.7	1.4	11.1	26.7	— <sup>b</sup>	— <sup>b</sup>	— <sup>b</sup>
Mexico	1.5	2.1	1.0	0.2	0.2	1.5	0.0	1.6	0.1
Netherlands	3.1	12.8 <sup>c</sup>	3.2 <sup>a</sup>	0.8 <sup>c</sup>	— <sup>b</sup>	— <sup>b</sup>	0.2	3.7	0.6
New Zealand	2.2	9.1	— <sup>b</sup>	— <sup>b</sup>	3.7	11.5	1.2	2.8	0.9
Norway	3.1	10.4 <sup>c</sup>	3.1	0.9	— <sup>b</sup>	— <sup>b</sup>	— <sup>b</sup>	4.6 <sup>a</sup>	— <sup>b</sup>
Poland	2.5	4.9	5.1	1.4 <sup>a</sup>	1.0	6.3	0.3	2.7	0.4
Portugal	3.3	4.2	3.1	0.9	3.9	12.8	0.2	3.4	1.7
Slovak Republic	3.1	6.5	5.9	1.4	2.0	8.7	0.1	1.9	0.0
Spain	3.2	7.5	3.1	0.8 <sup>c</sup>	7.3	13.0	0.7	5.1	2.5
Sweden	3.3 <sup>a</sup>	9.9 <sup>a</sup>	— <sup>b</sup>	— <sup>b</sup>	— <sup>b</sup>	— <sup>b</sup>	0.3 <sup>c</sup>	3.5 <sup>c</sup>	1.2 <sup>c</sup>
Switzerland	3.6 <sup>a</sup>	— <sup>b</sup>	3.9	1.2	14.2	18.0	0.5	4.0	1.3
Turkey	1.4	1.7	2.3	0.4 <sup>a</sup>	3.0	7.3 <sup>c</sup>	0.0	0.9	0.2
United Kingdom	2.2	9.7	3.7	1.1	5.2 <sup>c</sup>	5.8 <sup>a</sup>	0.3	2.9	1.1
United States	2.3 <sup>a</sup>	7.9 <sup>a</sup>	2.8	0.7	8.6 <sup>a</sup>	13.1	0.7	5.2	1.9
OECD median	3.1	9.2	3.8	1.0	5.6	13.1	0.4	3.3	0.9

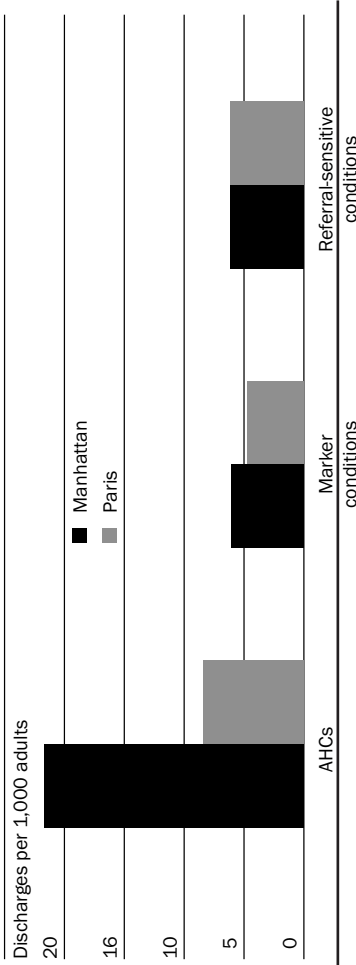
# A New Way To Compare Health Systems: Avoidable Hospital Conditions In Manhattan And Paris

Data on two comparable cities shed light on questions regarding access to primary care.

by **Michael K. Gusmano, Victor G. Rodwin, and Daniel Weisz**

**ABSTRACT:** Based on a comparison of discharges for avoidable hospital conditions (AHCs), we find that Paris provides greater access to primary care than Manhattan. Age-adjusted AHC rates are more than 2.5 times as high in Manhattan as in Paris. In contrast, the difference in rates of hospital discharge for “marker conditions” are only about 20 percent higher in Manhattan. Rates of discharges for AHCs are higher among residents of low-income neighborhoods in both cities, but the disparity among high- and low-income neighborhoods is more than twice as great in Manhattan. Our analysis highlights the consequences of access barriers to care in Manhattan, particularly among vulnerable residents. [Health Affairs 25, no. 2 (2006): 510–520; 10.1377/hlthaff.25.2.510]

**EXHIBIT 3**  
**Hospital Discharges For Avoidable Hospital Conditions (AHCs), Marker Conditions, And Referral-Sensitive Procedures, Manhattan And Paris, 1999–2001**



**SOURCES:** For Manhattan, Statewide Planning and Research Cooperative System (SPARCS), 1999–2001; for Paris, Programme de médicalisation des systèmes d’information (PMSI), 1999–2001.  
**NOTE:** Age-adjusted rates per 1,000 population age 18 and older.

# Immigrants And The Cost Of Medical Care

Immigrants use disproportionately less medical care than their representation in the U.S. population would indicate.

by **Dana P. Goldman, James P. Smith, and Neeraj Sood**

**ABSTRACT:** Foreign-born adults in Los Angeles County, California, constituted 45 percent of the county’s population ages 18–64 but accounted for 33 percent of health spending in 2000. Similarly, the undocumented constituted 12 percent of the nonelderly adult population but accounted for only 6 percent of spending. Extrapolating to the nation, total spending by the undocumented is \$6.4 billion, of which only 17 percent (\$1.1 billion) is paid for by public sources. The foreign-born (especially the undocumented) use disproportionately fewer medical services and contribute less to health care costs in relation to their population share, likely because of their better relative health and lack of health insurance. [Health Affairs 25, no. 6 (2006): 1700–1711; 10.1377/hlthaff.25.6.1700]

# TRENDS

## Twelve-Year Trends In Health Insurance Coverage Among Latinos, By Subgroup And Immigration Status

Subgroup and immigration status make large differences in who is covered and who is not.

by **N. Sarita Shah and Olveen Carrasquillo**

**ABSTRACT:** We examine twelve-year trends in the Latino uninsured population by ethnic subgroup and immigration status. From 1993 to 1999, most Latino subgroups, particularly Puerto Ricans, had large decreases in Medicaid coverage. For some subgroups these were offset by increases in employer coverage, but not for Mexicans, resulting in a four-percent age-point increase in their uninsured population. During 2000–2004, Medicaid/SCHIP expansions benefited most subgroups and mitigated smaller losses in employer coverage. However, during 1993–2004, the percentage of noncitizen Latinos lacking coverage increased by several percentage points. This was attributable to Medicaid losses during 1993–1999 and losses in employer coverage during 2000–2004. [Health Affairs 25, no. 6 (2006): 1612–1619; 10.1377/hlthaff.25.6.1612]

# Changes in Financial Burdens for Health Care

## National Estimates for the Population Younger Than 65 Years, 1996 to 2003

Jessica S. Banthin, PhD

Didem M. Bernard, PhD

**Context** Policymakers as well as physicians need to understand how rapidly rising health care costs are affecting specific groups of patients.

**Objective** To estimate the number and characteristics of individuals in the United States faced with very high financial burdens for health care.

**Design, Setting, and Population** Data from a nationally representative sample of civilian, noninstitutionalized US individuals younger than 65 years from the Medical Expenditure Panel Surveys were used to calculate 2 measures of financial burden as a function of tax-adjusted family income. Total burden included all out-of-pocket expenditures for health care services, including premiums. Health care services burden excluded premiums and, when applied to the insured population, was used to identify the underinsured. We defined the underinsured as insured persons with health care service burdens in excess of 10% of tax-adjusted family income.

**Main Outcome Measures** Total and health care services burdens exceeding 10% and 20% of family income in 1996 and 2003.

**Results** In 2003, there were 48.8 million individuals (19.2%) living in families spending more than 10% of family income on health care, an increase of 11.7 million persons since 1996. Of these individuals, about 18.7 million (7.3%) were spending more than 20% of family income. In 2003, individuals with higher-than-average risk of incurring high total burdens included poor and low-income persons and those with nongroup coverage, aged 55 to 64 years, living in a non-metropolitan statistical area, in fair or poor health, having any type of limitation, or having a chronic medical condition. Applying our definition of underinsured to the insured population, an estimated 17.1 million persons younger than 65 years were underinsured in 2003, including 9.3 million persons with private employment-related insurance, 1.3 million persons with private nongroup policies, and 6.6 million persons with public coverage.

**Conclusions** Our analysis identifies patients at greatest risk of health-related financial burdens that may adversely affect their access and adherence to recommended treatments. Our study also highlights the high costs associated with nongroup health insurance policies.

JAMA. 2006;296:2712-2719

www.jama.com

**Table 4.** Prevalence of High Family Out-of-Pocket Burdens by Health Status Among the Nonelderly Population, 2003\*

Health Status	Population (× 1000)	Persons With Total Family Burden, % (SE)†		Persons With Family Health Care Services Burden, % (SE)‡	
		>10% of Disposable Income	>20% of Disposable Income	>10% of Disposable Income	>20% of Disposable Income
Total	253 905	19.2 (0.5)	7.3 (0.3)	8.5 (0.2)	4.3 (0.1)
Perceived health fair/poor	38 033	32.3 (0.9)	15.7 (0.7)	21.3 (0.8)	11.2 (0.5)
Perceived mental health fair/poor	24 964	33.6 (1.2)	17.6 (1.0)	23.1 (1.2)	12.8 (0.7)
Any limitation§	39 741	31.4 (0.9)	15.1 (0.8)	20.3 (0.7)	10.4 (0.5)
Activity limitations	17 367	40.2 (1.3)	22.2 (1.0)	31.8 (1.2)	17.4 (0.8)
Walking limitations	21 734	35.9 (1.1)	18.3 (0.9)	25.5 (1.1)	13.5 (0.8)
Instrumental activities of daily living limitations	6 414	45.1 (2.1)	25.2 (2.0)	37.0 (2.1)	20.2 (18.4)
Activities of daily living limitations	3 586	44.3 (2.6)	25.5 (2.6)	35.0 (2.7)	21.1 (2.3)

\*Data were calculated using Medical Expenditure Panel Surveys (MEPS) data. Standard errors were adjusted to account for the complex design of the MEPS.

†Total burden includes out-of-pocket premiums for private insurance and expenditures on health care services.

‡Health care services burden includes out-of-pocket expenditures on health care services.

§Any limitations in activities of daily living or instrumental activities of daily living or any activity, functional, or sensory limitations.

## Time to Fix Healthcare

★ EDITORIAL ★

**T**he need to expand access to affordable healthcare is rapidly emerging as the top domestic policy issue in the 2008 presidential race. And no wonder: With the number of uninsured now up to nearly 47 million, and more than one-third of that total consisting of households with family incomes of \$40,000 or more, lack of health insurance has become a concern not just of the poor but also of the middle class. Moreover, soaring medical costs—increasing in large part because at least one of every five healthcare dollars goes to administrative costs and insurance company profits—are a worry even to those who have some form of insurance. More than half of personal bankruptcies today are caused by illness or medical debts.

There's no mystery about the fix Americans want: Nearly two-thirds of those surveyed in a recent New York Times/CBS poll say the government should guarantee health coverage for all Americans. Half said they'd willingly pay as much as \$500 a year more in taxes to pay for universal coverage. To do that, this country needs to establish a single-payer system—one inspired by Canada and other developed countries but distinctly American in approach. There's already legislation, with seventy-eight co-sponsors—the United States National Health Insurance Act (HR 676)—that would accomplish this by expanding and improving the existing Medicare system. The popularity of such an approach, endorsed March 6 by the AFL-CIO executive council, is illustrated by the ease with which California legislators passed a single-payer plan last year—only to have Governor Schwarzenegger veto it. In late February, the plan was introduced again, as part of a reform-from-below push that is seeing states tackle the healthcare crisis.

Ultimately, however, America needs a national fix.

Americans have lost hope that the Bush Administration will do anything to address the national healthcare crisis. Only 24 percent of those in the New York Times/CBS poll said they were satis-

fied with Bush's handling of the issue. And that number will surely shrink with recent revelations about the deplorable conditions at the Army's Walter Reed Hospital—another reminder of this Administration's incompetence. But so far most of the major presidential candidates have failed to take advantage of Bush's low standing to advance bold proposals.

Among the candidates, Congressman Dennis Kucinich has a long record of embracing single-payer proposals. Unfortunately, he is a lonely leader. The front-running Democratic contenders remain vague and cautious. Senator Barack Obama says, "I am absolutely determined that by the end of the first term of the next President, we should have universal healthcare in this country." Senator Hillary Clinton says she would enact "health insurance for every child and universal healthcare for every American"—with specifics "yet to come." Former Senator John Edwards moves beyond rhetoric to a plan: He would require everyone to have insurance and require employers either to provide coverage or pay into a fund to provide it. But although he reaches out to labor on other issues, Edwards is unwilling to embrace HR 676, which has earned support from nine international unions, seventeen state federations and sixty-three central labor councils.

Voters have to demand more if they want more. Obama at least recognizes the frustration of Americans for whom meaningful healthcare reform has been a dream deferred at least since the collapse of the Clinton Administration's bureaucratic proposals of the mid-1990s. The Clinton plan rejected single-payer and embraced a complicated hybrid that relied too heavily on the same insurance companies that had failed to make healthcare affordable and accessible. "We can't afford another disappointing charade in 2008, 2009 and 2010," says Obama. He's right. But he and his fellow front-runners should recognize that as long as they avoid talking about single-payer and continue to tinker around the edges of the current system, they are players in the charade.

from the March 26, 2007 issue

# The Boston Globe

MONDAY | JANUARY 29, 2007

## Fix the system with Medicare for all

By Marcia Angell  
*Guest Columnist*

THE GREATEST source of insecurity for many Americans is the soaring cost of health care. Leaving jobs can mean losing health insurance, and even when insurance is offered, many workers turn it down because they can't afford their growing share of the premiums.

Businesses are having trouble, too. Those that provide good health benefits see more of their revenues siphoned off by the health insurance industry, with a resulting loss of competitiveness (General Motors spends far more on health benefits than Toyota).

Insurance is not the same thing as health care -- not by a long shot. Private insurers maximize profits mainly by limiting benefits or by not covering people with health problems. The United States is the only advanced country in the world with a health care system based on avoiding sick people.

It's not surprising, then, that health care reform is at the top of the political agenda. Most current proposals de-couple health benefits from employment and encourage individuals to buy their own insurance. The fact that they were ever coupled is a historical accident; there is no logical reason for it. Yet, employment-based insurance has been the only practical option for people not old enough for Medicare or poor enough for Medicaid, since the individual insurance market is notoriously treacherous.

In his State of the Union address, President Bush proposed tax deductions for individuals who venture into that market and buy insurance on their own. Family premiums above \$15,000 and single premiums above \$7,500 would be taxed. This is a gesture, not a plan. It is just one more example of the conceit, shared by many on the right, that nearly any problem can be solved by jiggering the tax code. In fact, many of the uninsured don't pay taxes at all, and many more would find their small tax relief greatly outweighed by the price of insurance.

More serious proposals are coming from the states, with Massachusetts in the lead. These aim for universal coverage by requiring uninsured individuals to purchase health insurance, under pain of -- you guessed it -- tax penalties, with state subsidies for the poor and near poor.

In Massachusetts, there will be a token contribution by employers who don't provide health benefits, but most of the cost will be borne by individuals. A new state agency, the Commonwealth Health Insurance Connector, is charged with seeing that insurers offer adequate benefit packages at reasonable premiums.

Though well-intentioned, plans like these all have the same fatal flaw: They offer no workable mechanism to control costs, mainly because they leave the private insurance industry in place. Yet, soaring costs are the fundamental problem; lack of coverage follows from that. Already the Massachusetts Connector is having difficulty holding premiums down to the levels forecast when the plan was enacted. Even if they are held down at the start, there is little to stop insurers from raising them afterward, shrinking benefits, or both. It will take a large and costly bureaucracy to ride herd on all the ways to game this system. Perhaps the biggest risk is that failure will give universal care a bad name, just as the failure of the Clinton plan did 13 years ago. (That plan, too, made the mistake of giving the private insurance industry a central role.)

We need to change the system completely and get the insurance industry, as well as employers, out of it. Private insurance companies offer little of value, yet skim off 15 to 25 percent of the health care dollar for profits and overhead. It would make much more sense to extend Medicare to everyone. That could be done gradually by dropping the eligibility age a decade at a time, while phasing out the insurance companies. The loss of insurance jobs would probably be more than offset by job gains in other industries no longer saddled with health costs.

Medicare is not perfect, but its problems are readily fixed. It is far more efficient than private insurance, with overhead of less than 4 percent, and since it is administered by a single public agency, controlling costs would be possible. Unlike private insurers, it cannot select whom to cover or deny care to those who need it most.

It is time to stop tinkering at the margins. Medicare for all is the only reform that has a prayer of providing universal coverage while containing costs.

*Dr. Marcia Angell is a senior lecturer at Harvard Medical School and former editor-in-chief of the New England Journal of Medicine.*



# The Des Moines Register

MARCH 5, 2007

## Mandating private health insurance is misguided Taxpayer-financed health coverage is a better approach.

It sounds simple enough: Get everyone insured by requiring them to purchase health insurance. So-called “individual mandates” are part of Massachusetts’ plan to get all residents covered. They are included in a proposal by California Gov. Arnold Schwarzenegger. In a recent conversation about health reform in Iowa, state Sen. Jack Hatch said he supports individual mandates because they inject “personal responsibility” into health care.

But forcing people to purchase private-sector insurance is far from simple, especially considering the government absolutely must ensure the coverage it makes people buy is adequate.

Proceeding with this idea would be a mistake.

Just a few weeks ago, this editorial page told the story of Jan and Gary Clausen, who didn’t have the option of buying health insurance through an employer. They went out on their own and bought AARP-endorsed plans for about \$700 a month. They were left with more than \$200,000 in medical bills after Gary was diagnosed with cancer.

Some insurance.

If the state is going to force people to purchase insurance, it must guarantee necessary services are covered and the bills are paid when health disasters strike. It must require insurance companies to protect Iowans against catastrophic costs.

### REGISTER EDITORIAL BOARD

Of course, that’s where things really get complicated.

Will the state define coverage in private-sector insurance plans? Will it increase oversight of the insurance industry? Will it prohibit insurance companies from increasing prices? What is the definition of “affordable” insurance? Who will qualify for a public subsidy to purchase insurance, and how will that be paid for?

All these questions and more need to be answered.

But our greatest concern is that an individual mandate moves this country in the wrong direction by relying too heavily on the private sector to achieve universal coverage.

Private is not better than public when it comes to health insurance.

Private health-insurance companies spend a greater percentage of dollars on administrative costs than government programs such as Medicare. Private companies also use health dollars to pay outrageous CEO salaries. UnitedHealth Group Inc. paid a former CEO \$8 million a year. He also had unrealized gains on company stock options totaling nearly \$1.6 billion.

Try finding a government worker with a personal jet.

Private-sector insurance has been a financial failure in

Medicare Advantage plans, where the government subsidizes insurance companies to take over the care of seniors rather than keeping them in less expensive traditional Medicare.

According to a study by The Commonwealth Fund, Medicare spent \$922 more on each senior in private plans than it would have paid to cover those patients in traditional Medicare in 2005. That’s a total of more than 5.2 billion tax dollars that could have been saved or spent elsewhere if seniors would have remained in the basic, government plan.

Why push anyone into the more costly private sector?

A taxpayer-financed system of health care that offers basic coverage for all Americans is a better approach. It would be administered by the government, and it would save money.

According to the National Coalition on Health Care, the nation’s largest alliance working to improve care, a system like this could save 1.1 trillion health-care dollars over 10 years. Of four plans proposed by the coalition, a universal, publicly financed one was the best deal.

Of course, a national system would require those in Washington to get busy solving the problem rather than leaving states to scramble for ways to cover their residents - and pursue misguided ideas like individual mandates.

# Single-Payer, Health Savings Accounts, or Managed Care?

## Minnesota Physicians' Perspectives

By Joel M. Albers, Pharm.D., Ph.D., Breanna Peterson Lathrop, Kirk C. Allison, Ph.D., Charles N. Oberg, M.D., and James F. Hart, M.D.T

### CLINICAL & HEALTH AFFAIRS

#### ABSTRACT

The United States is facing a health care crisis with the number of uninsured Americans exceeding 46 million and health care premiums and overall costs increasing at 3 to 4 times the rate of inflation. Proposed solutions include continuing managed care, moving to a single-payer financing system with universal coverage, and replacing traditional health plans with high-deductible policies that allow patients to draw from health savings accounts (HSAs) to pay out-of-pocket costs. Despite physicians' vital role in health care, few studies have assessed their preferences regarding health care financing systems. We surveyed a random sample of licensed Minnesota physicians to determine their preferences regarding health care financing systems. Of 390 physicians, 64% favored a single-payer system, 25% HSAs, and 12% managed care. The majority of physicians (86%) also agreed that it is the responsibility of society, through the government, to ensure that everyone has access to good medical care. Less than half (41%) said that the private insurance industry should continue to play a major role in financing health care. The accumulating knowledge about physicians' preferences for various health care financing mechanisms merits widespread inclusion in policy debates.

In 2001, the Institute of Medicine reported that the U.S. health care system is failing both clinicians and patients, that their frustration levels have never been higher, and that fundamental changes are needed.<sup>1</sup> By 2005, more than 46 million Americans, including 400,000 Minnesotans, were uninsured, and health insurance premiums and overall costs were rising at a rate 3 to 4 times that of general inflation and wages.<sup>2-4</sup> Employers have been forced to eliminate or cut back on health benefits, often increasing employee out-of-pocket costs beyond many households' ability to pay. In 2004, the average Minnesota household spent \$11,000 on health insurance premiums and out-of-pocket costs; that figure is projected to reach \$22,000 by 2010 if current trends continue.<sup>4</sup>

For those reasons, the consensus among most observers is that urgent reform is needed. Proposed solutions to the health care financing crisis include continuing with the current managed care system, moving to a single-payer system, or moving toward one in which individuals rely on high-deductible health plans with health savings accounts (HSAs). Minnesota has one of the most established managed care systems in the United States, with 4 managed care companies

insuring or handling administrative duties associated with insuring more than 90 percent of Minnesotans who have health coverage. These organizations often group physicians into price-tiered, competitive networks. Recent physician surveys document significant concerns about managed care including concern about ethical issues, physician satisfaction, effects on the physician/patient relationship and on the profession itself, quality of care, and cost-effectiveness.<sup>5-10</sup>

A Medline search produced 4 randomized studies published between 1993 and 2005 that examined physicians' health care financing preferences. They indicate growing support for a single-payer model that is publicly financed and administered by a single, public payer.<sup>11-14</sup> Such systems lower costs through economies and efficiencies of scale and streamlined administration yet still allow physicians to work in private practices and preserve quality care. State and national studies comparing financing models increasingly suggest the potential for a single-payer system to achieve universal, comprehensive coverage without increasing total health care spending.<sup>15-17</sup>

Health savings accounts, enacted by the 2003 Medicare Part D drug law, are tax-free savings

accounts to which individuals and employers contribute. The money can be drawn out to pay for approved medical expenses. Individuals and families with high-deductible health insurance plans are eligible to open HSAs. Proponents of HSAs argue that patients with health insurance policies that require little or no deductible or co-pay perceive health care as being "free" and become insensitive to price. The belief is that these individuals overuse health care and drive up costs. The idea behind what is being called "consumer-directed health care" is that having a high-deductible health plan with an HSA forces consumers to spend their own money, prompting them to cut back on frivolous health care usage. This type of financing system is also designed to encourage physicians and hospitals to compete on price, theoretically lowering costs. Despite health care over-utilization by consumers being greatly overstated and the lack of evidence that consumer-directed health care actually lowers costs or improves quality, high-deductible plans with HSAs have been heavily marketed across the United States and in Minnesota.<sup>18,19</sup>

To date, no one has compared Minnesota physicians' attitudes toward single-payer, consumer-directed, and managed care systems. Thus, we developed and conducted a survey to probe which financing system physicians believe will provide the best care to the most people for a given amount of money.

#### METHODOLOGY

##### Study Sample and Data Collection

Following approval by the University of Minnesota's Institutional Review Board, a list of all 17,766 physicians licensed in Minnesota was obtained from the Minnesota Board of Medical Practice; the number was reduced to 13,770 after eliminating those with out-of-state addresses. A random sample of 1,061 physicians was then generated using Minitab Statistical Software. Surveys accompanied by a cover letter inviting participation and a consent form were mailed on December 6, 2005. Twenty-seven were returned undeliverable and randomly replaced. Physicians could fill out a paper survey or complete an online version. Those who did not respond were sent a second mailing in January of 2006. Altogether, 408 physicians responded by the February 13, 2006, cut-off. Those respondents closely approximate population parameters by sex (within 0.6%), by rural/metropolitan practice (within 1.3%), and across 4 practice categories (within 0.4% to 2.6%). Those categories were primary medicine (internal medicine and family medicine, pediatrics, general practice, and geriatrics), all »

» other medical specialties, general surgery, and surgical specialty (anesthesiology, orthopedics, obstetrics, gynecology, pediatric surgery, and neurosurgery).

### Survey Design

We updated an 11-item survey by McCormick et al. and expanded it to 16 questions in order to reflect current trends and maintain state-to-state comparability.<sup>11</sup> Questions assessed physicians' opinions about various health care financing structures (single payer, HSAs, and managed care) and gathered information about participants' demographics, primary specialty, and geographic and primary practice settings.

To elicit physicians' preferences regarding health care financing structures, we asked, "Which of the following 3 structures would offer the best health care to the greatest number of people for a given amount of money?" Respondents could select "current competitive multi-payer managed care systems," "single payer with universal coverage," or "individualized insurance coverage utilizing health savings accounts" as answers.

We defined those financing mechanisms as follows:

**Multi-payer managed care.** The current market-based system in which individuals are enrolled in 1 of a variety of private insurance plans. Plans offer certain health care benefits and use utilization review to control costs and improve quality.

**Single-payer system.** A single insurance plan administered by a governmental body or publicly accountable commission, guaranteeing coverage and access to necessary medical treatment. Under such a system, hospitals would remain privately owned and physicians would be employed by private groups and practices.

**Individualized coverage utilizing health savings accounts.** Individuals with high-deductible health insurance plans can use pretax money from a health savings account to pay for current and future health expenses.

### Statistical Analysis

We performed chi-square analysis to identify the demographic variables significantly associated with physician financing system preference (2-tailed, alpha .05) including sex, geographic location, primary specialty, and primary practice setting.

To determine the influence of nonresponse bias, we performed a sensitivity analysis recalculating response proportions for managed care, sin-

gle-payer, and HSA preference relative to Minnesota physician population parameters for specialty, sex, and geography (rural versus metropolitan).

Using binary logistic regression models, we assessed the relationship between preferred system and chi-square significant variables (including general attitude, working environment, rural or urban setting, sex, salary system, and other demographic variables). The Likert scale responses "strongly agree" and "somewhat agree" were combined as were "strongly disagree" and "somewhat disagree."

Statistical analysis was performed using Minitab Statistical Software (Release 14) (chi-square, logistic regression) and Microsoft Excel 2000 (sensitivity analysis, binomials).

### Findings

A majority of respondents (72%) were male with a median medical school graduation year of 1979. Nearly half (46%) practiced primary medicine, followed by medical specialty (35%), surgical specialty (12%), and general surgery (6%). More than three-quarters (79%) worked in a metropolitan setting, and nearly two-thirds (65%) practiced in a clinic.

Of the 390 respondents who answered the question about which financing system would offer the best health care to the greatest number of people for a fixed amount of money, 64% said they favor a single-payer financing system, 25% preferred HSAs, and only 12% preferred managed care (Figure 1). Figures 2 through 4 offer a closer look at who prefers those financing structures by sex, geographic location, specialty, and type of practice.

A single-payer system was favored by women physicians over men (female, 76%; male, 59%;  $p=0.03$ ); more male physicians than female preferred HSAs (male, 30%; female, 16%;  $p=0.04$ ). The percentage of male respondents who favored the current managed care system slightly exceeded that of female physicians (12% versus 9%;  $p=0.553$ ).

Geographic setting was also significantly associated across the 3 choices. Urban physicians favored a single-payer system over their rural and suburban colleagues (71%, 60%, and 54%, respectively;  $p=0.009$ ). Rural physicians preferred HSAs over suburban and urban physicians (34%, 32%, 17%;  $p=0.002$ ). Managed care garnered less than 15% support overall, with 14% of suburban physicians, 12% of urban doctors, and 6% of rural respondents favoring it;  $p=0.217$ . Thus, urban physicians had the most support for a single-payer system and the least for managed care. Rural physicians were relatively enthusiastic for HSAs but least supportive of managed care.

When looking at physicians' responses across medical specialty, those practicing primary medicine most favored a single-payer system (74%); general surgeons least favored such a system (36%). Conversely, general surgeons most favored HSAs (55%), and primary medicine physicians least favored them (20%). Managed care found greatest support among physicians who practiced a medical or surgical specialty (17% each) and the least among those who practiced primary medicine (6%). Of those who favored managed care, the significant split was specialists over generalists (17% and 7%;  $p=0.001$ ).

Physicians also were asked who should be responsible for providing access to health care. Nearly all (86%) believed it is the responsibility of society through government to ensure access to good medical care for all, regardless of ability to pay. Only 41% held that the private insurance industry should continue to play a major role in medical care financing and delivery.

Using a regression model, we found that physicians who agreed that it is the government's responsibility to ensure access to medical care were significantly more likely to favor a single-payer financing system (OR 13.51; CI 2.85, 64.15;  $p=0.001$ ). Those who believed the private insurance industry should continue to play a major role in financing medical care were significantly less likely to favor a government-run system (OR 3.45; CI 1.35, 8.33;  $p=0.009$ ).

### Corroborating Results

In order to corroborate our results about physicians' preferences for various financing systems, we asked separate questions about their opinions of each of the 3 structures. We found 56% held a generally favorable view of single-payer systems, 46% of HSAs, and 20% of managed care systems in which physician groups compete for placement in cost-tiered networks. (The total exceeds 100% as some physicians were generally favorable toward more than 1 system.)

Thus, more respondents said they preferred a single-payer system than held a favorable view of such a system. Among those with a favorable opinion of single-payer health care, 96% actually selected single payer as their preference for the way our health care system should be financed in the future; among those with a favorable view of HSAs, only 49% selected HSAs as their preferred model for a health care financing system. However, those who had a generally favorable opinion of competition based on price tiers split between their preference for a system based on managed care and one based on HSAs (36% and 39%); only 25% of those respondents said they preferred a single-payer system. Among those »

» opposed to price-tier competition, 78% preferred a single-payer system and 18% preferred HSAs. Only 4% preferred managed care. Rejecting price-tier competition was largely co-extensive with rejecting managed care.

### Discussion

Despite the prevalence of managed care in Minnesota, our study finds only 12% of sampled physicians favor such systems as a way to finance health care; 25% prefer HSAs, and 64% support a single-payer system.

Eighty-six percent believe it is the responsibility of society through government to ensure access to good medical care for all. Only 41% say the private insurance industry should continue to play a major role in the financing and delivery of medical care, suggesting support for comprehensive public-sector initiatives rather than private-sector approaches.

Stand-alone survey questions about various financing systems showed that nearly 56% of respondents had a generally favorable opinion of single-payer health care systems. Of all specialties, general surgeons had the lowest percentage of respondents who had a favorable view of such a system (36%). Forty-six percent thought favorably of HSAs, and 20% had a positive view of price-tiered competition. This suggests an unwillingness among physician groups to compete directly under managed competition. Yet 118,000 Minnesota state employees and as many as 150,000 employees whose coverage is obtained by a large, multiple-employer group purchaser are enrolled in such managed competition programs.<sup>20</sup>

Our findings are consistent with those of others who have seen a growing trend toward U.S. physicians saying they favor a single-payer health care system. In 1993, Millard et al. found only 25% of surveyed North Carolina physicians supported a single-payer system over managed competition.<sup>13</sup> In 1996, Scanlan et al. compared the opinions of U.S. and Canadian physicians and concluded that U.S. physicians might not easily accept a Canadian-style system because of reticence toward a central government role or centralized planning.<sup>12</sup> By 1999, a national survey of medical school residents and faculty by Simon et al. found 56% favored a single-payer system over managed care.<sup>14</sup> A 2004 survey by McCormick et al. concluded that 64% of surveyed Massachusetts physicians believed single-payer financing would provide the best care for the most people.<sup>11</sup>

In our study, we found that physicians' views on health care financing reflect their experience with Minnesota's concentrated oligopoly of 4

managed care insurers that either enroll or administer benefits for more than 90% of insured Minnesotans.<sup>21</sup> In a 1997 report, Borowsky et al. found fewer than 20% of physicians in the Minneapolis-St. Paul metro area rated 3 managed care plans as either excellent or very good on 7 quality-of-care items.<sup>9</sup> Such findings are consistent with less favorable views of managed care and more favorable views of other systems, including those that haven't been tried.

Study limitations must be considered. First, it is possible that only physicians who feel strongly about health care financing responded to our survey. However, differences between respondent characteristics and physician population are minimal and the results are robust under sensitivity analysis. Lack of response is unlikely to have affected validity.

Second, it may not be possible to generalize the findings of our study to all U.S. physicians. However, as noted, results from a recent survey of physicians in Massachusetts, a state that also has high managed-care penetration, and a national survey of university physicians are similar to ours. Such studies should be replicated in other regions of the United States to get a more complete picture of U.S. physicians' views on this important public policy matter.

### Conclusion

Our survey suggests that the majority of Minnesota physicians have grown weary of the current managed care health system that places a huge administrative layer between them and their patients.

Because physicians play a central role in health care, their experience with and views on system financing have the potential to significantly inform those heading reform initiatives. With more than 46 million Americans lacking health insurance and premiums and health care costs rising at 3 to 4 times the rate of inflation, reform is inevitable and necessary. Our survey shows that nearly two-thirds of Minnesota physicians favor a single-payer health care financing system. Such a majority view could be influential in public debate and in the movement of practitioners and patients toward implementing a universal health care system in Minnesota and the United States. MM

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# The New York Times

DECEMBER 31, 2006

## Health Care Problem? Check the American Psyche

ECONOMIC VIEW

By ANNA BERNASEK

What is the most pressing problem facing the economy? A good case can be made for the developing health care crisis. Soaring costs, growing ranks of uninsured and a steady erosion of corporate health benefits add up to a giant drag on the nation's future prosperity.

While the outlook seems scary, it doesn't have to be. There is a solution, proven effective for hundreds of millions of people: single-payer health insurance.

Yes, single-payer — that much-maligned idea that calls for everyone to pay into one insurer, typically the government or a public agency. The insurer then pays doctors, pharmacists and hospitals at preset rates. Patients who want unapproved procedures and doctors not willing to accept the standard payment remain free to deal with one another directly, outside the system.

Such a system makes it much easier to deal with the growing costs of medical care, like administrative expenses and prescription drugs. It could also reduce the mountains of paperwork plaguing the current system and provide insurance coverage for the 46 million Americans now doing without it.

What's more, as demonstrated in France, Britain, Canada, Australia and other countries with functioning single-payer systems, significant savings can come without hurting the overall health of the population.

There's only one catch. Most Americans just don't believe it can be done. The health care crisis may turn out to be more of a problem of ideology than economics.

The economic case for a single-payer system is surprisingly strong. Start with what we already know. Countries with single-payer systems have long records of spending less on health care than the

United States does. The United States spent an average of \$6,102 a person on it in 2004, according to the Organization for Economic Cooperation and Development, while Canada spent \$3,165 a person, France \$3,159, Australia \$3,120 and Britain just \$2,508.

At the same time, life expectancy in the United States, a broad measure of health, was slightly lower than it was in those other countries in 2004, the latest year for which complete figures are available. And the United States had a higher rate of infant mortality.

To be sure, a single-payer system has plenty of critics. Unattractive features of some such systems, including waiting lists for particular types of care, are often highlighted by skeptics. But supporters note that the overall health of people fares well in those countries.

"The story never changes," said Gerard F. Anderson, a professor at the Johns Hopkins Bloomberg School of Public Health. "The United States is twice as expensive with about the same outcome.

"As a consumer, I don't mind paying more if I'm getting more, but that's just not the case in the U.S.," said Professor Anderson, who publishes an annual review comparing the American health care system with those of its peers.

What may be less well known is the level of administrative waste in the United States health care system, versus that of well-designed systems elsewhere. Although Americans tend to equate efficiency with private enterprise, that's not the case with the current system.

The American system, based on multiple insurers, builds in more unnecessary costs. Duplicate processing of claims, large numbers of insurance products, complicated bill-paying systems and high marketing costs add up to huge administrative expenses.

Then there's an enormous amount of

paperwork required of American doctors and hospitals that simply doesn't exist in countries like Canada or Britain.

"There's little disagreement among economists today that a single-payer system would lead to lower administrative costs," said Len Nichols, a health economist with the New America Foundation, a policy research organization in Washington. But he said that estimates varied widely over how big the savings could be.

One of the first major studies to quantify administrative costs in the United States was published in August 2003 in *The New England Journal of Medicine* by three Harvard researchers, Steffie Woolhandler, Terry Campbell and David U. Himmelstein. It concluded that such costs accounted for 31 percent of all health care expenditures in the United States.

More recently, in 2005, a study by the Lewin Group, a health care consulting firm commissioned to examine a proposal to provide universal health coverage in California, estimated that administrative costs consumed 20 percent of total health care expenditures nationwide.

Then there's the test of time. Health care costs tend to rise over time as new technology and procedures are introduced. Yet here, too, government-funded systems appear to help contain long-term costs.

Consider Canada's system. Professor Anderson points out that in the 1960s, Canada and the United States spent roughly the same per person on health care. Some three decades later, though, Canada spent half as much as America. How did Canada manage this? By controlling the use of medical equipment and hospital resources, which statistics show has helped Canadians keep a lid on costs

See AMERICAN PSYCHE | Next Page

without measurably compromising the overall health of the population.

Economic studies also show that a government-funded system could reduce costs while providing coverage for everyone. The Lewin report on the proposal to provide universal health coverage in California calculated that if such a system had been operating in 2006, it would have saved \$8 billion, or around 4.3 percent of total health spending in the state. From 2006 to 2015, it estimated, savings would total \$343 billion. Currently, California spends about \$180 billion a year on health care.

Despite everything that is known about the economic benefits of a single-payer system, there's one big stumbling block: many Americans don't believe in it. They have heard horror stories from abroad,

often spread by partisan advocates, focusing on worst-case examples. Such tales play upon the aversion of many Americans to government involvement in the economy.

Victor R. Fuchs, an economics professor at Stanford and a specialist in health care economics, explained it this way: "The Canadian system is a nonstarter for the U.S. even though it's a good system for Canadians. You're dealing with two very different countries. We were founded on life, liberty and the pursuit of happiness. They were founded on peace, order and good government. It's a difference of values."

Others in the field echo his skepticism. But that raises questions about how well Americans understand the system they have, and what the alternatives are.

JUDGING from other countries, many features that Americans really like —

being able to choose their own doctor, for example — would remain available in a well-designed single-payer system. And a single-payer system need not mean government-provided care: it often means government-provided insurance that encourages competition among providers.

Much of the resistance to a single-payer system appears to stem from a lack of confidence in the nation's ability to make positive change. With all of its prowess in research and technology, can't the United States match the efficiency of other developed nations, or do even better?

Changing the minds of so many millions of people isn't done overnight. But sooner or later, persuading people to do something that's in their own economic interest ought to succeed.

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## Financial Barriers to Health Care and Outcomes After Acute Myocardial Infarction

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**Context** The prevalence and consequences of financial barriers to health care services and medications are not well documented for patients with an acute myocardial infarction (AMI).

**Objective** To measure the baseline prevalence of self-reported financial barriers to health care services or medication (as defined by avoidance due to cost) among individuals following AMI and their association with subsequent health care outcomes.

**Design, Setting, and Participants** The Prospective Registry Evaluating Myocardial Infarction: Event and Recovery (PREMIER), an observational, multicenter US study of patients with AMI over 12 months in 2498 individuals enrolled from January 2003 through June 2004.

**Main Outcome Measures** Health status symptoms (Seattle Angina Questionnaire [SAQ]), overall health status function (Short Form-12), and rehospitalization.

**Results** The prevalence of self-reported financial barriers to health care services or medication was 18.1% and 12.9%, respectively. Among individuals who reported financial barriers to health care services or medication, 68.9% and 68.5%, respectively, were insured. At 1-year follow-up, individuals with financial barriers to health care services were more likely to have lower SAQ quality-of-life score (77.9 vs 86.2; adjusted mean difference = -4.0; 95% confidence interval [CI], -6.3 to -1.8), and increased rates of all-cause rehospitalization (49.3% vs 38.1%; adjusted hazard ratio [HR], 1.3; 95% CI, 1.1-1.5) and cardiac rehospitalization (25.7% vs 17.7%; adjusted HR, 1.3; 95% CI, 1.0-1.6). At 1-year follow-up, individuals with financial barriers to medication were more likely to have angina (34.9% vs 17.9%; adjusted odds ratio, 1.55; 95% CI, 1.1-2.2), lower SAQ quality-of-life score (74.0 vs 86.1; adjusted mean difference = -7.6; 95% CI, -10.2 to -4.9), and increased rates of all-cause rehospitalization (57.0% vs 37.8%; risk-adjusted HR, 1.5; 95% CI, 1.2-1.8) and cardiac rehospitalization (33.7% vs 17.3%; adjusted HR, 1.7; 95% CI, 1.3-2.2).

**Conclusion** Financial barriers to health care services and medications are associated with worse recovery after AMI, manifested as more angina, poorer quality of life, and higher risk of rehospitalization.

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# The New York Review of Books

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## The Health Care Crisis and What to Do About It

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### Can We Say No? The Challenge of Rationing Health Care

by Henry J. Aaron and William B. Schwartz, with Melissa Cox  
Brookings Institution, 199 pp., \$44.95; \$18.95 (paper)

### The Health Care Mess: How We Got into It and What It Will Take to Get Out

by Julius Richmond and Rashi Fein  
Harvard University Press, 320 pp., \$26.95

### Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System

by John F. Cogan, R. Glenn Hubbard, and Daniel P. Kessler  
American Enterprise Institute/Hoover Institution, 130 pp., \$18.00

BY PAUL KRUGMAN,  
ROBIN WELLS

**T**hirteen years ago Bill Clinton became president partly because he promised to do something about rising health care costs. Although Clinton's chances of reforming the US health care system looked quite good at first, the effort soon ran aground. Since then a combination of factors—the unwillingness of other politicians to confront the insurance and other lobbies that so successfully frustrated the Clinton effort, a temporary remission in the growth of health care spending as HMOs briefly managed to limit cost increases, and the general distraction of a nation focused first on the gloriousness of getting rich, then on terrorism—have kept health care off the top of the agenda.

But medical costs are once again rising rapidly, forcing health care back into political prominence. Indeed, the problem of medical costs is so perva-

sive that it underlies three quite different policy crises. First is the increasingly rapid unraveling of employer-based health insurance. Second is the plight of Medicaid, an increasingly crucial program that is under both fiscal and political attack. Third is the long-term problem of the federal government's solvency, which is, as we'll explain, largely a problem of health care costs.

The good news is that we know more about the economics of health care than we did when Clinton tried and failed to remake the system. There's now a large body of evidence on what works and what doesn't work in health care, and it's not hard to see how to make dramatic improvements in US practice. As we'll see, the evidence clearly shows that the key problem with the US health care system is its fragmentation. A history of failed attempts to introduce universal health insurance has left us with a system in which the government pays directly or indirectly for more than half of the nation's health care, but the actual delivery both of insurance and of care is undertaken by a crazy quilt of private insurers, for-profit hospitals, and other players who add cost without adding value. A Canadian-style single-payer system, in which the government directly provides insurance, would almost surely be both cheaper and more effective than what we now have. And we could do even better if we learned from "integrated" systems, like the Veterans Administration, that directly provide some health care as well as medical insurance.

The bad news is that Washington currently seems incapable of accepting what the evidence on health care says. In particular, the Bush administration is under the influence of both industry lobbyists, especially those representing the drug companies, and a free-market ideology that is wholly inappropriate to health care issues. As a result, it seems

determined to pursue policies that will increase the fragmentation of our system and swell the ranks of the uninsured.

Before we talk about reform, however, let's talk about the current state of the US health care system. Let us begin by asking a seemingly naive question: What's wrong with spending ever more on health care?

### 1. IS HEALTH CARE SPENDING A PROBLEM?

In 1960 the United States spent only 5.2 percent of GDP on health care. By 2004 that number had risen to 16 percent. At this point America spends more on health care than it does on food. But what's wrong with that?

The starting point for any discussion of rising health care costs has to be the realization that these rising costs are, in an important sense, a sign of progress. Here's how the Congressional Budget Office puts it, in the latest edition of its annual publication *The Long-Term Budget Outlook*:

*Growth in health care spending has outstripped economic growth regardless of the source of its funding.... The major factor associated with that growth has been the development and increasing use of new medical technology.... In the health care field, unlike in many sectors of the economy, technological advances have generally raised costs rather than lowered them.*

Notice the three points in that quote. First, health care spending is rising rapidly "regardless of the source of its funding." Translation: although much health care is paid for by the govern-

ment, this isn't a simple case of runaway government spending, because private spending is rising at a comparably fast clip. "Comparing common benefits," says the Kaiser Family Foundation,

*changes in Medicare spending in the last three decades has largely tracked the growth rate in private health insurance premiums. Typically, Medicare increases have been lower than those of private health insurance.*

Second, "new medical technology" is the major factor in rising spending: we spend more on medicine because there's more that medicine can do. Third, in medical care, "technological advances have generally raised costs rather than lowered them": although new technology surely produces cost savings in medicine, as elsewhere, the additional spending that takes place as a result of the expansion of medical possibilities outweighs those savings.

So far, this sounds like a happy story. We've found new ways to help people, and are spending more to take advantage of the opportunity. Why not view rising medical spending, like rising spending on, say, home entertainment systems, simply as a rational response to expanded choice? We would suggest two answers.

The first is that the US health care system is extremely inefficient, and this inefficiency becomes more costly as the health care sector becomes a larger fraction of the economy. Suppose, for example, that we believe that 30 percent of US health care spending is wasted, and always has been. In 1960, when health care was only 5.2 percent of GDP, that meant waste equal to only 1.5 percent of GDP. Now that the share of health care in the economy has more than tripled, so has the waste.

This inefficiency is a bad thing in itself. What makes it literally fatal to thousands of Americans each year is that the inefficiency of our health care system exacerbates a second problem: our health care system often makes irrational choices, and rising costs exacerbate those irrationalities. Specifically, American health care tends to divide the

population into insiders and outsiders. Insiders, who have good insurance, receive everything modern medicine can provide, no matter how expensive. Outsiders, who have poor insurance or none at all, receive very little. To take just one example, one study found that among Americans diagnosed with colorectal cancer, those without insurance were 70 percent more likely than those with insurance to die over the next three years.

In response to new medical technology, the system spends even more on insiders. But it compensates for higher spending on insiders, in part, by consigning more people to outsider status—robbing Peter of basic care in order to pay for Paul's state-of-the-art treatment. Thus we have the cruel paradox that medical progress is bad for many Americans' health.

This description of our health care problems may sound abstract. But we can make it concrete by looking at the crisis now afflicting employer-based health insurance.

## **2. THE UNRAVELING OF EMPLOYER-BASED INSURANCE**

In 2003 only 16 percent of health care spending consisted of out-of-pocket expenditures by consumers. The rest was paid for by insurance, public or private. As we'll see, this heavy reliance on insurance disturbs some economists, who believe that doctors and patients fail to make rational decisions about spending because third parties bear the costs of medical treatment. But it's no use wishing that health care were sold like ordinary consumer goods, with individuals paying out of pocket for what they need. By its very nature, most health spending must be covered by insurance.

The reason is simple: in any given year, most people have small medical bills, while a few people have very large bills. In 2003, health spending roughly followed the "80–20 rule": 20 percent of the population accounted for 80 percent of expenses. Half the population had virtually no medical expenses; a mere 1 percent of the population

accounted for 22 percent of expenses.

Here's how Henry Aaron and his coauthors summarize the implication of these numbers in their book *Can We Say No?*: "Most health costs are incurred by a small proportion of the population whose expenses greatly exceed plausible limits on out-of-pocket spending." In other words, if people had to pay for medical care the way they pay for groceries, they would have to forego most of what modern medicine has to offer, because they would quickly run out of funds in the face of medical emergencies.

So the only way modern medical care can be made available to anyone other than the very rich is through health insurance. Yet it's very difficult for the private sector to provide such insurance, because health insurance suffers from a particularly acute case of a well-known economic problem known as adverse selection. Here's how it works: imagine an insurer who offered policies to anyone, with the annual premium set to cover the average person's health care expenses, plus the administrative costs of running the insurance company. Who would sign up? The answer, unfortunately, is that the insurer's customers wouldn't be a representative sample of the population. Healthy people, with little reason to expect high medical bills, would probably shun policies priced to reflect the average person's health costs. On the other hand, unhealthy people would find the policies very attractive.

**Y**ou can see where this is going. The insurance company would quickly find that because its clientele was tilted toward those with high medical costs, its actual costs per customer were much higher than those of the average member of the population. So it would have to raise premiums to cover those higher costs. However, this would disproportionately drive off its healthier customers, leaving it with an even less healthy customer base, requiring a further rise in premiums, and so on.

Insurance companies deal with these problems, to some extent, by carefully screening applicants to identify those with a high risk of needing expensive



treatment, and either rejecting such applicants or charging them higher premiums. But such screening is itself expensive. Furthermore, it tends to screen out exactly those who most need insurance.

Most advanced countries have dealt with the defects of private health insurance in a straightforward way, by making health insurance a government service. Through Medicare, the United States has in effect done the same thing for its seniors. We also have Medicaid, a means-tested program that provides health insurance to many of the poor and near poor. But nonelderly, nonpoor Americans are on their own. In practice, only a tiny fraction of nonelderly Americans (5.3 percent in 2003) buy private insurance for themselves. The rest of those not covered by Medicare or Medicaid get insurance, if at all, through their employers.

Employer-based insurance is a peculiarly American institution. As Julius Richmond and Rashi Fein tell us in *The Health Care Mess*, the dominant role of such insurance is the result of historical accident rather than deliberate policy. World War II caused a labor shortage, but employers were subject to controls that prevented them from attracting workers by offering higher wages. Health benefits, however, weren't controlled, and so became a way for employers to compete for workers. Once employers began offering medical benefits, they also realized that it was a form of compensation workers valued highly because it protected them from risk. Moreover, the tax law favored employer-based insurance, because employers' contributions weren't considered part of workers' taxable income. Today, the value of the tax subsidy for employer-based insurance is estimated at around \$150 billion a year.

Employer-based insurance has historically offered a partial solution to the problem of adverse selection. In principle, adverse selection can still occur even if health insurance comes with a job rather than as a stand-alone policy. This would occur if workers with health problems flocked to companies that offered health insurance, while

healthy workers took jobs at companies that didn't offer insurance and offered higher wages instead. But until recently health insurance was a sufficiently small consideration in job choice that large corporations offering good health benefits, like General Motors, could safely assume that the health status of their employees was representative of the population at large and that adverse selection wasn't inflating the cost of health insurance.

In 2004, according to census estimates, 63.1 percent of Americans under sixty-five received health insurance through their employers or family members' employers. Given the inherent difficulties of providing health insurance through the private sector, that's an impressive number. But it left more than a third of nonelderly Americans out of the system. Moreover, the number of outsiders is growing: the share of nonelderly Americans with employment-based health insurance was 67.7 percent as recently as 2000. And this trend seems certain to continue, even accelerate, because the whole system of employer-based health care is under severe strain.

We can identify several reasons for that strain, but mainly it comes down to the issue of costs. Providing health insurance looked like a good way for employers to reward their employees when it was a small part of the pay package. Today, however, the annual cost of coverage for a family of four is estimated by the Kaiser Family Foundation at more than \$10,000. One way to look at it is to say that that's roughly what a worker earning minimum wage and working full time earns in a year. It's more than half the annual earnings of the average Wal-Mart employee.

Health care costs at current levels override the incentives that have historically supported employer-based health insurance. Now that health costs loom so large, companies that provide generous benefits are in effect paying some of their workers much more than the going wage—or, more to the point, more than competitors pay similar workers. Inevitably, this creates pressure to reduce or eliminate health benefits. And

companies that can't cut benefits enough to stay competitive—such as GM—find their very existence at risk.

Rising health costs have also ended the ability of employer-based insurance plans to avoid the problem of adverse selection. Anecdotal evidence suggests that workers who know they have health problems actively seek out jobs with companies that still offer generous benefits. On the other side, employers are starting to make hiring decisions based on likely health costs. For example, an internal Wal-Mart memo, reported by *The New York Times* in October, suggested adding tasks requiring physical exertion to jobs that don't really require it as a way to screen out individuals with potential health risks.

So rising health care costs are undermining the institution of employer-based coverage. We'd suggest that the drop in the number of insured so far only hints at the scale of the problem: we may well be seeing the whole institution unraveling.

Notice that this unraveling is the byproduct of what should be a good thing: advances in medical technology, which lead doctors to spend more on their patients. This leads to higher insurance costs, which causes employers to stop providing health coverage. The result is that many people are thrown into the world of the uninsured, where even basic care is often hard to get. As we said, we rob Peter of basic care in order to provide Paul with state-of-the-art treatment.

Fortunately, some of the adverse consequences of the decline in employer-based coverage have been muted by a crucial government program, Medicaid. But Medicaid is facing its own pressures.

### **3. MEDICAID AND MEDICARE**

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The US health care system is more privatized than that of any other advanced country, but nearly half of total health care spending nonetheless comes from the government. Most of this government spending is accounted for by two great social insurance programs, Medicare and Medicaid. Although

Medicare gets most of the public attention, let's focus first on Medicaid, which is a far more important program than most middle-class Americans realize.

In *The Health Care Mess* Richmond and Fein tell us that Medicaid, like employer-based health insurance, came into existence through a sort of historical accident. As Lyndon Johnson made his big push to create Medicare, the American Medical Association, in a last-ditch effort to block so-called "socialized medicine" (actually only the insurance is socialized; the medical care is provided by the private sector), began disparaging Johnson's plan by claiming that it would do nothing to help the truly needy. In a masterful piece of political jujitsu, Johnson responded by adding a second program, Medicaid, targeted specifically at helping the poor and near poor.

Today, Medicaid is a crucial part of the American safety net. In 2004 Medicaid covered almost as many people as its senior partner, Medicare—37.5 million versus 39.7 million.

Medicaid has grown rapidly in recent years because it has been picking up the slack from the unraveling system of employer-based insurance. Between 2000 and 2004 the number of Americans covered by Medicaid rose by a remarkable eight million. Over the same period the ranks of the uninsured rose by six million. So without the growth of Medicaid, the uninsured population would have exploded, and we'd be facing a severe crisis in medical care.

But Medicaid, even as it becomes increasingly essential to tens of millions of Americans, is also becoming increasingly vulnerable to political attack. To some extent this reflects the political weakness of any means-tested program serving the poor and near poor. As the British welfare scholar Richard Titmuss said, "Programs for the poor are poor programs." Unlike Medicare's clients—the feared senior group—Medicaid recipients aren't a potent political constituency: they are, on average, poor and poorly educated, with low voter participation. As a

result, funding for Medicaid depends on politicians' sense of decency, always a fragile foundation for policy.

The complex structure of Medicaid also makes it vulnerable. Unlike Medicare, which is a purely federal program, Medicaid is a federal-state matching program, in which states provide on average about 40 percent of the funds. Since state governments, unlike the federal government, can't engage in open-ended deficit financing, this dependence on state funds exposes Medicaid to pressure whenever state budgets are hard-pressed. And state budgets are hard-pressed these days for a variety of reasons, not least the rapidly rising cost of Medicaid itself.

The result is that, like employer-based health insurance, Medicaid faces a possible unraveling in the face of rising health costs. An example of how that unraveling might take place is South Carolina's request for a waiver of federal rules to allow it to restructure the state's Medicaid program into a system of private accounts. We'll discuss later in this essay the strange persistence, in the teeth of all available evidence, of the belief that the private sector can provide health insurance more efficiently than the government. The main point for now is that South Carolina's proposed reform would seriously weaken the medical safety net: recipients would be given a voucher to purchase health insurance, but many would find the voucher inadequate, and would end up being denied care. And if South Carolina gets its waiver, other states will probably follow its lead.

Medicare's situation is very different. Unlike employer-based insurance or Medicaid, Medicare faces no imminent threat of large cuts. Although the federal government is deep in deficit, it's not currently having any difficulty borrowing, largely from abroad, to cover the gap. Also, the political constituency behind Medicare remains extremely powerful. Yet federal deficits can't go on forever; even the US government must eventually find a way to pay its bills. And the long-term outlook for federal finances is dire, mainly because of Medicare and

Medicaid.

The chart in figure 1 illustrates the centrality of health care costs to America's long-term budget problems. The chart shows the Congressional Budget Office's baseline projection of spending over the next twenty-five years on the three big entitlement programs, Social Security, Medicare, and Medicaid, measured as a percentage of GDP. Not long ago advocates of Social Security privatization tried to use projections like this one to foster a sense of crisis about the retirement system. As was pointed out last year in these pages,<sup>11</sup> however, there is no program called Social Security, Medicare, and Medicaid. In fact, as the chart shows, Social Security, whose costs will rise solely because of the aging of the population, represents only a small part of the problem. Most of the problem comes from the two health care programs, whose spending is rising mainly because of the general rise in medical costs.

To be fair, there is a demographic component to Medicare and Medicaid spending too—Medicare because it only serves Americans over sixty-five, Medicaid because the elderly, although a minority of the program's beneficiaries, account for most of its spending. Still, the principal factor in both programs' rising costs is what the CBO calls "excess cost growth"—the persistent tendency of health care spending per beneficiary to grow faster than per capita income, owing to advancing medical technology. Without this excess cost growth, the CBO estimates that entitlement spending would rise by only 3.7 percent of GDP over the next twenty-five years. That's a significant rise, but not overwhelming, and could be addressed with moderate tax increases and possibly benefit cuts. But because of excess cost growth the projected rise in spending is a crushing burden—about 10 percent of GDP over the next twenty-five years, and even more thereafter.

Rising health care spending, then, is driving a triple crisis. The fastest-moving piece of that crisis is the unraveling of employer-based coverage. There's a gradually building crisis in Medicaid. And there's a long-term federal budget

crisis driven mainly by rising health care spending.

So what are we going to do about health care?

#### **4. THE "CONSUMER-DIRECTED" DIVERSION**

As we pointed out at the beginning of this essay, one of the two big reasons to be concerned about rising spending on health care is that as the health care sector grows, its inefficiency becomes increasingly important. And almost everyone agrees that the US health care system is extremely inefficient. But there are wide disagreements about the nature of that inefficiency. And the analysts who have the ear of the Bush administration are committed, for ideological reasons, to a view that is clearly wrong.

We've already alluded to the underlying view behind the Bush administration's health care proposals: it's the view that insurance leads people to consume too much health care. The 2004 Economic Report of the President, which devoted a chapter to health care, illustrated the alleged problem with a parable about the clothing industry:

*Suppose, for example, that an individual could purchase a clothing insurance policy with a "coinsurance" rate of 20 percent, meaning that after paying the insurance premium, the holder of the insurance policy would have to pay only 20 cents on the dollar for all clothing purchases. An individual with such a policy would be expected to spend substantially more on clothes—due to larger quantity and higher quality purchases—with the 80 percent discount than he would at the full price.... The clothing insurance example suggests an inherent inefficiency in the use of insurance to pay for things that have little intrinsic risk or uncertainty.*

The report then asserts that "inefficiencies of this sort are pervasive in the US health care system"—although,

tellingly, it fails to match the parable about clothing with any real examples from health care.

The view that Americans consume too much health care because insurers pay the bills leads to what is currently being called the "consumer-directed" approach to health care reform. The virtues of such an approach are the theme of John Cogan, Glenn Hubbard, and Daniel Kessler's *Healthy, Wealthy, and Wise*. The main idea is that people should pay more of their medical expenses out of pocket. And the way to reduce public reliance on insurance, reformers from the right wing believe, is to remove the tax advantages that currently favor health insurance over out-of-pocket spending. Indeed, last year Bush's tax reform commission proposed taxing some employment-based health benefits. The administration, recognizing how politically explosive such a move would be, rejected the proposal. Instead of raising taxes on health insurance, the administration has decided to cut taxes on out-of-pocket spending.

Cogan, Hubbard, and Kessler call for making all out-of-pocket medical spending tax-deductible, although tax experts from both parties say that this would present an enforcement nightmare. (Douglas Holtz-Eakin, the former head of the Congressional Budget Office, put it this way: "If you want to have a personal relationship with the IRS do that [i.e., make all medical spending tax deductible] because we are going to have to investigate everybody's home to see if their running shoes are a medical expense.") The administration's proposals so far are more limited, focusing on an expanded system of tax-advantaged health savings accounts. Individuals can shelter part of their income from taxes by depositing it in such accounts, then withdraw money from these accounts to pay medical bills.

What's wrong with consumer-directed health care? One immediate disadvantage is that health savings accounts, whatever their ostensible goals, are yet another tax break for the wealthy, who have already been showered with tax breaks under Bush. The right to pay medical expenses with pre-tax income

is worth a lot to high-income individuals who face a marginal income tax rate of 35 percent, but little or nothing to lower-income Americans who face a marginal tax rate of 10 percent or less, and lack the ability to place the maximum allowed amount in their savings accounts.

A deeper disadvantage is that such accounts tend to undermine employment-based health care, because they encourage adverse selection: health savings accounts are attractive to healthier individuals, who will be tempted to opt out of company plans, leaving less healthy individuals behind.

Yet another problem with consumer-directed care is that the evidence says that people don't, in fact, make wise decisions when paying for medical care out of pocket. A classic study by the Rand Corporation found that when people pay medical expenses themselves rather than relying on insurance, they do cut back on their consumption of health care—but that they cut back on valuable as well as questionable medical procedures, showing no ability to set sensible priorities.

**B**ut perhaps the biggest objection to consumer-directed health reform is that its advocates have misdiagnosed the problem. They believe that Americans have too much health insurance; the 2004 Economic Report of the President condemned the fact that insurance currently pays for "many events that have little uncertainty, such as routine dental care, annual medical exams, and vaccinations," and for "relatively low-expense items, such as an office visit to the doctor for a sore throat." The implication is that health costs are too high because people who don't pay their own medical bills consume too much routine dental care and are too ready to visit the doctor about a sore throat. And that argument is all wrong. Excessive consumption of routine care, or small-expense items, can't be a major source of health care inefficiency, because such items don't account for a major share of medical costs.

Remember the 80–20 rule: the great bulk of medical expenses are accounted

for by a small number of people requiring very expensive treatment. When you think of the problem of health care costs, you shouldn't envision visits to the family physician to talk about a sore throat; you should think about coronary bypass operations, dialysis, and chemotherapy. Nobody is proposing a consumer-directed health care plan that would force individuals to pay a large share of extreme medical expenses, such as the costs of chemotherapy, out of pocket. And that means that consumer-directed health care can't promote savings on the treatments that account for most of what we spend on health care.

The administration's plans for consumer-directed health care, then, are a diversion from meaningful health care reform, and will actually worsen our health care problems. In fact, some reformers privately hope that George W. Bush manages to get his health care plans passed, because they believe that they will hasten the collapse of employment-based coverage and pave the way for real reform. (The suffering along the way would be huge.)

But what would real reform look like?

## 5. SINGLE-PAYER AND BEYOND

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How do we know that the US health care system is highly inefficient? An important part of the evidence takes the form of international comparisons. Table 1 compares US health care with the systems of three other advanced countries. It's clear from the table that the United States has achieved something remarkable. We spend far more on health care than other advanced countries—almost twice as much per capita as France, almost two and a half times as much as Britain. Yet we do considerably worse even than the British on basic measures of health performance, such as life expectancy and infant mortality.

One might argue that the US health care system actually provides better care than foreign systems, but that the effects of this superior care are more than offset by unhealthy US lifestyles.

Ezra Klein of The American Prospect calls this the "well-we-eat-more-cheeseburgers" argument. But a variety of evidence refutes this argument. The data in Table 1 show that the United States does not stand out in the quantity of care, as measured by such indicators as the number of physicians, nurses, and hospital beds per capita. Nor does the US stand out in terms of the quality of care: a recent study published in Health Affairs that compared quality of care across advanced countries found no US advantage. On the contrary, "the United States often stands out for inefficient care and errors and is an outlier on access/cost barriers."<sup>[2]</sup> That is, our health care system makes more mistakes than those of other countries, and is unique in denying necessary care to people who lack insurance and can't pay cash. The frequent claim that the United States pays high medical prices to avoid long waiting lists for care also fails to hold up in the face of the evidence: there are long waiting lists for elective surgery in some non-US systems, but not all, and the procedures for which these waiting lists exist account for only 3 percent of US health care spending.<sup>[3]</sup>

So why does US health care cost so much? Part of the answer is that doctors, like other highly skilled workers, are paid much more in the United States than in other advanced countries. But the main source of high US costs is probably the unique degree to which the US system relies on private rather than public health insurance, reflected in the uniquely high US share of private spending in total health care expenditure.

Over the years since the failure of the Clinton health plan, a great deal of evidence has accumulated on the relative merits of private and public health insurance. As far as we have been able to ascertain, all of that evidence indicates that public insurance of the kind available in several European countries and others such as Taiwan achieves equal or better results at much lower cost. This conclusion applies to comparisons within the United States as well as across countries. For example, a

study conducted by researchers at the Urban Institute found that

*per capita spending for an adult Medicaid beneficiary in poor health would rise from \$9,615 to \$14,785 if the person were insured privately and received services consistent with private utilization levels and private provider payment rates.*<sup>[4]</sup>

The cost advantage of public health insurance appears to arise from two main sources. The first is lower administrative costs. Private insurers spend large sums fighting adverse selection, trying to identify and screen out high-cost customers. Systems such as Medicare, which covers every American sixty-five or older, or the Canadian single-payer system, which covers everyone, avoid these costs. In 2003 Medicare spent less than 2 percent of its resources on administration, while private insurance companies spent more than 13 percent.

At the same time, the fragmentation of a system that relies largely on private insurance leads both to administrative complexity because of differences in coverage among individuals and to what is, in effect, a zero-sum struggle between different players in the system, each trying to stick others with the bill. Many estimates suggest that the paperwork imposed on health care providers by the fragmentation of the US system costs several times as much as the direct costs borne by the insurers.

The second source of savings in a system of public health insurance is the ability to bargain with suppliers, especially drug companies, for lower prices. Residents of the United States notoriously pay much higher prices for prescription drugs than residents of other advanced countries, including Canada. What is less known is that both Medicaid and, to an even greater extent, the Veterans' Administration, get discounts similar to or greater than those received by the Canadian health system.

We're talking about large cost savings. Indeed, the available evidence suggests that if the United States were

to replace its current complex mix of health insurance systems with standardized, universal coverage, the savings would be so large that we could cover all those currently uninsured, yet end up spending less overall. That's what happened in Taiwan, which adopted a single-payer system in 1995: the percentage of the population with health insurance soared from 57 percent to 97 percent, yet health care costs actually grew more slowly than one would have predicted from trends before the change in system.

If US politicians could be persuaded of the advantages of a public health insurance system, the next step would be to convince them of the virtues, in at least some cases, of honest-to-God socialized medicine, in which government employees provide the care as well as the money. Exhibit A for the advantages of government provision is the Veterans' Administration, which runs its own hospitals and clinics, and provides some of the best-quality health care in America at far lower cost than the private sector. How does the VA do it? It turns out that there are many advantages to having a single health care organization provide individuals with what amounts to lifetime care. For example, the VA has taken the lead in introducing electronic medical records, which it can do far more easily than a private hospital chain because its patients stay with it for decades. The VA also invests heavily and systematically in preventive care, because unlike private health care providers it can expect to realize financial benefits from measures that keep its clients out of the hospital.

In summary, then, the obvious way to make the US health care system more efficient is to make it more like the systems of other advanced countries, and more like the most efficient parts of our own system. That means a shift from private insurance to public insurance, and greater government involvement in the provision of health care—if not publicly run hospitals and clinics, at least a much larger government role in creating integrated record-keeping and quality control. Such a system would probably allow individuals to purchase additional

medical care, as they can in Britain (although not in Canada). But the core of the system would be government insurance—"Medicare for all," as Ted Kennedy puts it.

Unfortunately, the US political system seems unready to do what is both obvious and humane. The 2003 legislation that added drug coverage to Medicare illustrates some of the political difficulties. Although it's rarely described this way, Medicare is a single-payer system covering many of the health costs of older Americans. (Canada's universal single-payer system is, in fact, also called Medicare.) And it has some though not all the advantages of broader single-payer systems, notably low administrative costs.

But in adding a drug benefit to Medicare, the Bush administration and its allies in Congress were driven both by a desire to appease the insurance and pharmaceutical lobbies and by an ideology that insists on the superiority of the private sector even when the public sector has demonstrably lower costs. So they devised a plan that works very differently from traditional Medicare. In fact, Medicare Part D, the drug benefit, isn't a program in which the government provides drug insurance. It's a program in which private insurance companies receive subsidies to offer insurance—and seniors aren't allowed to deal directly with Medicare.

The insertion of private intermediaries into the program has several unfortunate consequences. First, as millions of seniors have discovered, it makes the system extremely complex and obscure. It's virtually impossible for most people to figure out which of the many drug plans now on offer is best. This complexity, coupled with the Katrina-like obliviousness of administration officials to a widely predicted disaster, also led to the program's catastrophic initial failure to manage the problem of "dual eligibles," i.e., older Medicaid recipients whose drug coverage was supposed to be transferred to Medicare. When the program started up in January, hundreds of thousands of these dual eligibles found that they had fallen through the cracks, that their old

coverage had been canceled but their new coverage had not been put into effect.

Second, the private intermediaries add substantial administrative costs to the program. It's reasonably certain that if seniors had been offered the choice of receiving a straightforward drug benefit directly from Medicare, the vast majority would have chosen to pass up the private drug plans, which wouldn't have been able to offer comparable benefits because of their administrative expenses. But the drug bill avoided that embarrassing outcome by denying seniors that choice.

Finally, by fragmenting the purchase of drugs among many private plans, the administration denied Medicare the ability to bargain for lower prices from the drug companies. And the legislation, reflecting pressures from those companies, included a provision specifically prohibiting Medicare from intervening to help the private plans get lower prices.

In short, ideology and interest groups led the Bush administration to set up a new, costly Medicare benefit in such a way as to systematically forfeit all the advantages of public health insurance.

## **6. BEYOND REFORM: HOW MUCH HEALTH CARE SHOULD WE HAVE?**

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Imagine, for a moment, that some future US administration were to push through a fundamental reform of health care that covered all the uninsured, replaced private insurance with a single-payer system, and took heed of the VA's lessons about the advantages of integrated health care. Would our health care problems be solved?

No. Although real reform would bring great improvement in our situation, continuing technological progress in health care still poses a deep dilemma: How much of what we can do should we do?

The medical profession, understandably, has a bias toward doing whatever will bring medical benefit. If that means performing an expensive surgical procedure on an elderly patient who

probably has only a few years to live, so be it. But as medical technology advances, it becomes possible to spend ever larger sums on medically useful care. Indeed, at some point it will become possible to spend the entire GDP on health care. Obviously, we won't do this. But how will we make choices about what not to do?

In a classic 1984 book, *Painful Prescription: Rationing Hospital Care*, Henry Aaron and William Schwartz studied the medical choices made by the British system, which has long operated under tight budget limits that force it to make hard choices in a way that US medical care does not. *Can We Say No?* is an update of that work. It's a valuable survey of the real medical issues involved in British rationing, and gives a taste of the dilemmas the US system will eventually face.

The operative word, however, is "eventually." Reading *Can We Say No?*, one might come away with the impression that the problem of how to ration care is the central issue in current health care policy. This impression is reinforced by Aaron and his co-authors' decision to compare the US system only with that of Britain, which spends far less on health care than other advanced countries, and correspondingly is forced to do a lot of rationing. A comparison with, say, France, which spends far less than the United States but considerably more than Britain, would give a very different impression: in many respects France consumes more, not less, health care than the United States, but it can do so at lower cost because our system is so inefficient.

The result of Aaron et al.'s single-minded focus on the problem of rationing is a somewhat skewed perspective on current policy issues. Most notably, they argue that the reason we need universal health coverage is that a universal system can ration care in a way that private insurance can't. This seems to miss the two main immediate arguments for universal care—that it would cover those now uninsured, and that it would be cheaper than our current system. A national health care system will also be better at rationing

when the time comes, but that hardly seems like the prime argument for adopting such a system today.

Our Princeton colleague Uwe Reinhardt, a leading economic expert on health care, put it this way: our focus right now should be on eliminating the gross inefficiencies we know exist in the US health care system. If we do that, we will be able to cover the uninsured while spending less than we do now. Only then should we address the issue of what not to do; that's tomorrow's issue, not today's.

## 7. CAN WE FIX HEALTH CARE?

Health policy experts know a lot more about the economics of health care now than they did when Bill Clinton tried to remake the US health care system. And there's overwhelming evidence that the United States could get better health care at lower cost if we were willing to put that knowledge into practice. But the political obstacles remain daunting.

A mere shift of power from Republicans to Democrats would not, in itself, be enough to give us sensible health care reform. While Democrats would have written a less perverse drug bill, it's not clear that they are ready to embrace a single-payer system. Even liberal economists and scholars at progressive think tanks tend to shy away from proposing a straightforward system of national health insurance. Instead, they propose fairly complex compromise plans. Typically, such plans try to achieve universal coverage by requiring everyone to buy health insurance, the way everyone is forced to buy car insurance, and deal with those who can't afford to purchase insurance through a system of subsidies. Proponents of such plans make a few arguments for their superiority to a single-payer system, mainly the (dubious) claim that single-payer would reduce medical innovation. But the main reason for not proposing single-payer is political fear: reformers believe that private insurers are too powerful to cut out of the loop, and that a single-payer plan would be too easily demonized by business and political propagandists as "big

government."

These are the same political calculations that led Bill Clinton to reject a single-payer system in 1993, even though his advisers believed that a single-payer system would be the least expensive way to provide universal coverage. Instead, he proposed a complex plan designed to preserve a role for private health insurers. But the plan backfired. The insurers opposed it anyway, most famously with their "Harry and Louise" ads. And the plan's complexity left the public baffled.

We believe that the compromise plans being proposed by the cautious reformers would run into the same political problems, and that it would be politically smarter as well as economically superior to go for broke: to propose a straightforward single-payer system, and try to sell voters on the huge advantages such a system would bring. But this would mean taking on the drug and insurance companies rather than trying to co-opt them, and even progressive policy wonks, let alone Democratic politicians, still seem too timid to do that.

So what will really happen to American health care? Many people in this field believe that in the end America will end up with national health insurance, and perhaps with a lot of direct government provision of health care, simply because nothing else works. But things may have to get much worse before reality can break through the combination of powerful interest groups and free-market ideology.

### Notes

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# Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise

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Many politicians and business leaders are advocating high deductible health insurance plans linked with health savings accounts—so-called consumer-directed healthcare. These policies penalize the sick, discourage needed care (especially primary and preventive care), and direct tax subsidies towards the wealthiest Americans. They offer little hope of slowing the growth of health care costs and add further bureaucratic costs and complexity to our health care financing system.

**KEY WORDS:** health care financing; health insurance; access to care.

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## INTRODUCTION

Consumer-directed healthcare (CDHC) is center stage in health policy debates. Many politicians and corporate leaders hope that high deductible health insurance policies will cut costs by coaxing people to think twice before visiting the emergency department (ED), drug store, or MRI suite. The basic idea is that Americans are too well insured; if they spend their own money – so the logic goes – they will spend it more wisely.

Sometimes, after a morning in the clinic during cold season when we are inundated with sniffers seeking antibiotics, we see the attraction of such incentives. But then comes a patient with sniffles and pneumonia, or a diabetic heading toward a foot amputation for want of timely podiatric care and reluctance to endure constant needling, or a woman looking for any excuse to put off the discomfort and embarrassment of a mammogram or pelvic exam, or a middle-aged man who finds the prospect of colonoscopy disquieting. Little of what we do to our patients is pleasant for them, and past studies indicate that patients facing steep out-of-pocket costs skip vital care, not just useless visits.<sup>1</sup>

Medical care differs from most consumer goods. So far as we know, there is no biological need for a flat-panel television. True, clothing, food, and shelter are necessities, but neither bad genes nor bad luck compels you to buy the high-priced versions—those purchases are generally driven by comfort, aesthetics, or social norms, not fear for life and limb.

For patients, the luck of the draw usually dictates the care they must buy. Men do not require Pap smears, birth control

pills, obstetrical care, or routine breast exams. Americans of European descent rarely suffer sickle cell disease, or non-Jews Tay Sachs. Diabetes and cancer – which reflect a mix of bad luck and bad choices – do not just bring medical complications; they bring financial ones as well. In addition, CDHC ups the ante, amplifying the financial consequences of both bad luck and unfortunate choices.

## PLAYING THE NUMBERS

Consumer-directed healthcare policies offer lower premiums in exchange for higher deductibles—at least \$1,050 per person and \$2,100 per family annually, often as high as \$10,000 annually. In the ideal case, such plans are coupled with health savings accounts (HSAs)—tax-free accounts that can be used to pay for the deductible and for medical services like cosmetic surgery that are entirely excluded from coverage. However, half of CDHC enrollees have nothing in their HSAs.<sup>2</sup>

Under CDHC, healthy people with very low medical expenses win; they get lower premiums and pay only trivial additional amounts out-of-pocket. However, others lose. The Medical Expenditure Panel Survey (MEPS) – which collects detailed medical spending data on a nationally representative sample of Americans – allows prediction of some likely losers.

Using data from the 2003 MEPS,<sup>3</sup> we tabulated the numbers and proportions of insured individuals with various conditions whose health care costs exceeded \$1,050 or \$2,100, as well as the mean and median expenditures for these groups. Precise modeling of CDHC's financial impact is difficult for several reasons: (1) the complexity of the thousands of different CDHC plans now on the market; (2) variability in families' marginal tax rates, which determine the size of the tax subsidy to HSAs (those with higher incomes generally enjoy larger tax subsidies); (3) variations in families' insurance coverage (in some families, husbands, wives, children, and step children have different coverage); and (4) the fact that individuals' coverage may change in the course of a year. However, the Federal Government's thresholds for defining high deductible health plans that qualify for HSA tax exemptions – \$1,050 for an individual and \$2,100 for a family – provide a reasonable estimate of the spending levels likely to delineate winners from losers.

We inflated 2003 spending figures to 2006 dollars using Centers for Medicare and Medicaid Services' projected change in per capita personal health expenditures between 2003 and 2006.<sup>4</sup> We omitted individuals over 65 from most analyses because most CDHC proposals exclude this group, many of whom have costly illnesses and virtually all of whom are covered by Medicare.

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**WINNERS AND LOSER**

Ladies, we lose. Not only do we (including one of the authors) suffer the pain of childbirth, but it is also expensive. Additionally, we are more diligent in seeking care for chronic illnesses like diabetes and hypertension. While only one third of insured men under 45 hit \$1,050 each year in medical costs, 55.6% of insured young women reached this figure (Table 1). Similar cost disparities disadvantage insured women between 45 and 65, 74.2% of whom “consume” \$1,050 or more in medical care annually. Overall, insured women’s median health expenditure is \$997 higher than men’s. Even subtracting a few hundred dollars for the cost of mammograms and Pap smears (exempted from the deductible in a few CDHC plans), women are still big losers.

The odds are even worse for sick people. More than 90% of insured diabetics cross the \$1,050 annual spending mark; more than half spend at least \$5,000. Similar figures apply to the millions of people with heart disease, emphysema, arthritis, or a history of stroke. Even hypertension or asthma makes you a very bad bet to stay under \$1,050, or even \$2,100.

Most kids are lucky—they use less than \$500 worth of care each year. However, needing even a single prescription medication changes the odds. Of the 12.1 million insured kids in that category, 58.6% zoomed past \$1,050.

**CDHC: A BAD BET**

Women, with rare exceptions, do not choose their sex. Yet, CDHC will penalize them, as well as men whose major sin is

chronic illness, and many of us who are turning gray. Moreover, as healthy, low-cost patients flee to CDHC plans, premiums for the sick who remain in non-CDHC coverage will skyrocket. Already in the Federal Employee Health Benefits Program, CDHC plans are segregating young, higher-income men from the costlier female and older workers.<sup>5</sup> For Wal-Mart’s management, shifting to CDHC plans is an explicit strategy to push sicker, high-cost workers to quit.<sup>6</sup>

Consumer-directed healthcare also seems unfair and unwise on other accounts. It seems unfair because the HSA’s tax breaks selectively reward the wealthiest Americans. A single mother with one child who makes \$16,000 annually would save \$19.60 in income taxes by putting \$2,000 into an HSA.<sup>7</sup> A similar mom earning \$450,000 would save \$720 in taxes.

It seems unwise because CDHC incentives selectively discourage low-cost primary and preventive care. Even 1 day in the hospital would push a patient past the deductible threshold, eliminating any cost-saving incentives for the small group of sick patients who account for the vast majority of health costs. So who would skimp? Patients without known heart disease trying to decide whether their chest pain warrants an ED visit would skimp; or perhaps a young woman whose abdominal pain may be caused by indigestion, or an ectopic pregnancy; or a young man with mild hypertension.

Consumer-directed healthcare incentives to skimp on these relatively low-cost services are unlikely to constrain overall health spending. The United States already has the world’s highest out-of-pocket spending and the highest health costs. Copayments in Switzerland – a nation near the top of the health spending charts – have not reduced total health expenditures.<sup>8</sup> In Canada, charging copayments had little

**Table 1. Mean and Median per Capita Health Spending and Percentage Spending Less than \$1,050 and \$2,100 Among Insured Americans According to Age, Sex, and Diagnosis, 2006**

	N (millions)	Mean per capita annual expenditure	Median per capita annual expenditure	Percent of individuals with annual expenditure <\$1,050	Percent of individuals with annual expenditure <\$2,100
<b>Nonelderly Americans</b>					
Diabetic on insulin or oral agent	5.196	10,760	5,774	8.6	17.0
Receiving therapy for arthritis	9.657	10,277	5,425	7.2	20.1
Diagnosed hypertension	26.867	7,035	3,161	21.7	37.3
Asthma attack in the past year	6.887	5,823	2,478	26.9	45.2
Diagnosis of angina or CHD	2.986	13,520	5,925	6.1	12.7
Child needing prescription medication	12.121	2,673	1,305	41.4	65.4
History of stroke	1.833	14,793	8,487	6.5	13.4
Diagnosis of emphysema	1.050	10,213	4,785	15.1	24.7
<b>Males</b>					
0–18 years	32.184	1,535	452	70.6	83.8
18–44 years	35.165	2,766	463	66.9	80.5
45–64 years	26.728	5,947	1,849	37.6	53.8
>64	14.514	9,943	4,231	18.0	29.2
<b>Females</b>					
0–18 years	30.292	1,356	450	71.8	84.8
18–44 years	39.628	3,363	1,266	44.4	62.8
45–64 years	28.279	5,974	2,871	25.8	41.3
>64 years	19.864	9,320	4,334	14.6	27.7
Males 18–64	61.892	4,140	847	54.2	69.0
Females 18–64	67.907	4,451	1,844	36.7	53.8



impact on costs; doctors less frequently saw the poor (and often sick) patients who could not pay, but their appointment slots were filled by more affluent patients who could.<sup>9,10</sup> This offset has not been examined in U.S. studies that are the basis for the claim that copayments reduce costs. Higher copayments for medications in Quebec resulted in increased ED visits, hospitalizations, and deaths for the poor and elderly,<sup>11</sup> confirming the Rand experiment finding in the United States that copayments increase the risk of dying for the sick poor.<sup>1</sup>

Moreover, CDHC and HSAs add new layers of expensive health care bureaucracy. Already, insurers and investment firms are vying for the estimated \$1 billion annually in fees for managing HSAs, and Blue Cross and UnitedHealth have chartered their own banks and announced special health care credit cards<sup>12</sup>—presumably charging hefty interest to patients with empty HSAs. Patients must assiduously document their out-of-pocket payments to assure that coverage kicks in once the deductible is met. For doctors, CDHC means collecting fees directly from patients, many of them unable to pay, a task even costlier than billing insurers.<sup>13</sup> Moreover, doctors and patients will still have to play by insurers' utilization review and other rules—failure to do so disqualifies bills from counting toward the patient's deductible.

Some propose mitigating CDHC's adverse effects by waiving out-of-pocket costs for some high-value services such as recommended preventive care. This approach would add complexity to our already Byzantine reimbursement system. Accurately linking out-of-pocket cost to clinical value – as they suggest – would require much more than a list of procedures. For instance, the cost effectiveness of a pap smear depends on the details of sexual history. Are we really to report to insurers the number of lifetime male sexual partners for each of our female patients? Additionally, how will insurers tailor financial incentives to get patients to the ED promptly if their undiagnosed chest pain signifies cardiac ischemia, but not if it is heartburn?

Behind the rhetoric of consumer responsiveness and personal responsibility, CDHC sets in motion huge resource transfers. The sick and middle-aged pay more, whereas the young and healthy pay less. Women spend more, whereas men spend less. Workers bear more of the burden, whereas employers bear less. The poor skip vital care while the rich enjoy tax-free tummy tucks. And, as in every health reform in memory, bureaucrats and insurance firms walk off with an ever larger share of health dollars.

**Conflicts of Interest:** None disclosed.

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### PNHP 2007 Annual Meeting November 3, Washington, DC

PNHP's Annual 2007 Meeting will be held in Washington, DC on Saturday, November 3. It will be preceded by a PNHP Leadership Training Institute, a one-day crash course in health policy and politics, on Friday, November 2. Spaces fill quickly! If you are interested in leadership training, please drop a note to Dr. Ida Hellander at [pnhp@aol.com](mailto:pnhp@aol.com).

The PNHP national office also has a DVD of Dr. Steffie Woolhandler giving the PNHP slide show available for teaching purposes. Copies are just \$20, or free if you renew your PNHP membership at the regular (\$120) level or above.

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The "News" section of the PNHP web site is now updated daily ([www.pnhp.org/news](http://www.pnhp.org/news)) with relevant articles on single payer, press releases, and Dr. Don McCanne's column, the "Health Policy Quote of the Day".

PNHP Senior Health Policy Fellow Dr. Don McCanne's column is comparable to a masters course in health policy in easy-to-digest nuggets. He covers the latest developments in research on the health care crisis, evidence-based health policy, and the politics of health care reform.

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 Thanks also to anyone whose name  
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# AFL-CIO Endorses Medicare for All

AFL-CIO Executive Council statement  
Health Care  
March 06, 2007  
Las Vegas

The nation is once again focused on the crisis in health care and the American people are looking for a comprehensive solution, instead of the inaction and incredibly ineffective piecemeal approach of the past 10 years.

Nearly forty-seven million U.S. citizens are uninsured. Tens of millions more worry about losing the coverage they have. Workers fear changing or losing jobs because they are at risk of losing their health care coverage. American businesses that provide adequate health benefits are at a significant disadvantage, competing in the global marketplace with foreign companies that do not carry health care costs on their balance sheets. The same is true for businesses in domestic competition against employers that provide little or no coverage.

As a society, we all benefit from improvements in public health. We are a more creative, vibrant, productive and democratic nation because of it. We are all at risk of illness, injury or poor health, and we all suffer when individuals are denied needed care. The shortcomings of the American health care system—which ignores these fundamental realities—strain our nation's social and economic fabric.

The time for talking about this crisis is past. All families deserve the security of a universal health care system that guarantees access based on need rather than income. Health care is a fundamental human right and an important measure of social justice.

As a nation, we need to exert the political will to enact comprehensive health care reform nationwide. There is strong evidence the crisis can be solved with tools at hand and at a cost that pales in comparison to the toll in human lives the current system exacts.

It is time to mobilize America behind a concrete plan to enact universal health care and the AFL-CIO commits its full resources to asserting leadership in this historic effort.

Universal health care does not mean mandating that everyone must buy a health insurance policy and then handing them the bills. Meaningful health care reform must be measured by the following tests:

## Universal Coverage

- Everyone should have health care coverage, without exclusions or penalties.
- While the market has an important role to play, our government—as the voice of all of us—must play the central role in regulating, financing and providing health care.
- Coverage should be accessible through the largest possible groups that pool risk to ensure coverage regardless of gender, age, health status or other factors.

## Comprehensive, Affordable Coverage

- Coverage should be affordable and comprehensive.
- Unions and employers should continue to play a role and retain the ability to supplement coverage.

## Choice of Providers

- Individuals should retain the ability to select their own doctors and other health care providers.

## Financing Through Shared Responsibility

- Because everyone faces the possibility of poor health, risks should be shared broadly to ensure fair treatment and equitable rates, and everyone should share responsibility for contributing to the system through progressive financing.
- A level playing field should be provided for all businesses. Every employer must participate in ensuring health coverage and no employer should be disadvantaged because of the age or health of its workforce or number of retirees.

## Effective Cost Control

- Reform efforts must include effective mechanisms for controlling costs, requiring information on provider performance and enhancing efficiency.
- Investments should be made in systems and technology to reduce medical errors and costs, streamline administration and promote best practices.
- Employees who are frontline caregivers should have a protected voice in improving health care.

## Do No Harm

- Until we have a comprehensive alternative for all Americans, reform efforts should not undermine existing coverage or put people at risk of unmet health care needs.

Our approach should be to build on what's best in American health care. At the same time, we should draw from the best experiences of other countries that have achieved universal coverage at a fraction of U.S. health care costs.

One concrete plan that meets the test of comprehensive, universal health coverage would build on our nation's successful universal health coverage plan for seniors: Medicare.

In its 40-year history, Medicare has delivered substantial advances for the health care of older Americans and people with disabilities. Medicare has guaranteed coverage, made health care more affordable, included a form of shared financial responsibility, significantly reduced administrative costs compared with those of private plans and has been the largely unheralded financier of America's medical science advances. Medicare also has been a leader in advancing quality care and improvements in health care service delivery in the United States.

Such an approach would require updating and expanding Medicare benefits to fit the working population and children, as well as negotiating prices with physicians and providers that

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families—and the country—can afford. It would encourage innovation in health care services and medical technology. Employers' responsibility for health care financing would be broadly and equitably shared, substantially reducing burdens on all businesses and reducing disadvantages currently faced in the global marketplace. In building on Medicare to move toward a universal program, we can find a practical, achievable and affordable solution to our country's health care crisis.

We call on congressional leaders to unite behind such a plan.

Unlike our fragmented and flawed health care system, a successful universal health care system would provide benefits and cost savings for all stakeholders. The leadership to make comprehensive reform possible, then, must come from all quarters:

- Governments will have to forge the tough consensus that commits necessary public funding while paying only for care that is effective and efficient, based on the best science available.
- Employers must provide strong political support for a transition away from the current employment-based system and be willing to provide continuing financial contributions sufficient to responsibly contribute to the new funding requirements.
- Unions and other organizations that represent users of health services must make enactment of comprehensive health reform legislation a top priority and make a long-term commitment to improving health care service delivery.
- Health care providers and practitioners need to commit their leadership and lend their knowledge and experience to achieving necessary improvements in the quality and effectiveness of care, and use their considerable political clout to support the effort.

We will mobilize our members to build support for bold, meaningful and comprehensive reform and work to pass legislation that assures everyone affordable, comprehensive coverage. We will recruit employers to join us in achieving universal coverage. And we will evaluate the health proposals of candidates for president in 2008 based on the test we have outlined and their capacity to make meaningful change to meet this urgent goal.

Until comprehensive national reform is enacted, we will continue to defend the health benefits workers have fought and sacrificed to establish over the past 50 years, and we will strongly oppose President George W. Bush's changes in the tax treatment of existing employer-provided coverage.

We also will continue to fight to preserve and expand the State Children's Health Insurance Program (SCHIP) and Medicaid coverage, improve the Medicare drug benefit and alleviate the legacy health care costs that threaten coverage for millions of workers and retirees, as well as the health of the economy. And we will continue to push for comprehensive reforms at the state level, with the knowledge that other nations have built the political consensus for national reform by first enacting comprehensive care region by region.

# The New Massachusetts Health Reform: *Half a Step Forward and Three Steps Back*

BY STEFFIE WOOLHANDLER AND  
DAVID U. HIMMELSTEIN

Massachusetts runs in regular cycles. Every eighty-six years our Red Sox win the World Series. Once a decade Harvard hires a senior woman scientist. And every twenty years our legislature passes a universal health care bill that the governor hopes to use as a springboard to the White House.

Unfortunately, Governor Mitt Romney's stab at universal coverage looks set to repeat the flop of Michael Dukakis's bill two decades ago. Then as now, our governor crowed about "Health Care for All" in the statehouse rotunda. But Dukakis's plan imploded within two years, and today 250,000 more people are uninsured in Massachusetts than on the day it was signed.

## The Structure of the New Bill

The new bill includes two provisions meant to expand coverage. First, it will modestly expand Medicaid eligibility. Second, it requires people with incomes above 100 percent of the poverty line to purchase a private insurance policy. The state will offer partial subsidies for the purchase of this private coverage to families with incomes below 300 percent of the poverty line (about \$30,000 for a single person or \$60,000 for a family of four). Those above three times the poverty line will have to pay the full cost of their own coverage.

To help make coverage more affordable, a new state agency called "the Connector" will connect people with the private insurance plans that sell the coverage. The Connector is also supposed to help design affordable plans. Massachusetts citi-

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Steffie Woolhandler and David U. Himmelstein, "The New Massachusetts Health Reform: Half a Step Forward and Three Steps Back," *Hastings Center Report* 36, no. 5 (2006): 19-21.

HASTINGS CENTER REPORT

zens will be allowed to use pre-tax dollars to purchase coverage (although this tax break mostly helps affluent taxpayers in high tax brackets).

Businesses that employ more than ten people and fail to provide health insurance will be assessed a token fee (not more than \$295 annually—about fifteen cents per hour of labor) to help subsidize care. Additionally, hospitals won a rate hike assuring them better payments from state programs, and several provisions were included that are meant to attract additional federal funding to help pay for the Medicaid expansion.

The new plan is half a step forward for Massachusetts. One positive element in it is that all legal Massachusetts residents with incomes below 100 percent of the poverty line will now get publicly paid coverage. However, less than 17 percent of uninsured people in the state have incomes that low. Moreover, new federal Medicaid regulations that require proof of legal status will disenroll undocumented immigrants, as well as some African-Americans who lack birth certificates because they were born at home in the rural south. The bill also includes funds to help a few safety net hospitals keep their doors open. (Disclosure: We work at one such hospital.) However, it phases out the state's free-care pool, which has sustained safety net hospitals and covered many undocumented immigrants.

Unfortunately, the bill also takes three steps back. First, the contention that the bill will generate universal coverage is based on extremely fuzzy math. The politicians assumed that only about 500,000 people in Massachusetts are uninsured. The Census Bureau says that 748,000 are uninsured. Why the difference? The 500,000 figure came from a telephone survey conducted in English and Spanish. Anyone who did not have a telephone or who spoke another language (roughly one-third of immigrant families in Massachusetts) was, in effect, counted as insured—a dubious assumption since nationally 43.9 percent of phoneless adults are uninsured<sup>1</sup> and many non-English speaking immigrants lack coverage. The Census Bureau's 748,000 figure comes from a much more thorough survey, the Current Population Survey, which is carried out in person, door-to-door, with surveyors who speak multiple languages (including Portuguese and Haitian Creole, common in Massachusetts). In sum, the calculations behind the reform plan overlook everyone who lacks a phone or does not speak English or Spanish, nearly half of whom are likely to be uninsured. Hence, the level of funding in the bill for insurance subsidies and Medicaid expansion is grossly inadequate to cover the actual costs.

Second, 83 percent of the new coverage is of the “buy it yourself” variety. The linchpin of the bill is an individual mandate that forces near-poor and middle-income uninsured people to purchase coverage (or suffer tax penalties). Unfortunately, few of the uninsured can actually afford adequate coverage. Currently, a reasonably comprehensive health insurance policy in Massachusetts costs about \$6,000 annually for an individual or \$14,000 for a family. A wealthy uninsured person could afford that—but few of the uninsured are wealthy.

Only 23 percent of those without coverage make more than five times the poverty level.

Third, the legislation promises that the Connector will help the uninsured find comprehensive and affordable private health plans, but that's like promising delicious chocolate chip cookies with no fat, sugar, or calories. While officials have projected that the mandatory policy will cost only \$300 per month for an individual plan and \$600 for a family, the only way to get private plans that cheap is to strip down the coverage: boost copayments and deductibles and exclude important services from coverage altogether. Such stripped-down coverage may let politicians claim they've done something useful, but it provides neither adequate access to care nor real financial protection. In the RAND Health Insurance Experiment (the only randomized controlled trial comparing high-deductible plans to comprehensive coverage), high deductibles caused a 17 percent fall in toddler immunizations and swelled the number of children failing to see a doctor in the course of a year from 15 percent to 32 percent among school-aged children and from 5 percent to 18 percent among infants and toddlers.<sup>2</sup> While high deductibles reduced children's use of “rarely effective care” by 33 percent, they also reduced “highly effective care” by 28 percent. Adults in the RAND Experiment also used less preventive and primary care, and had higher blood pressure and higher risks of dying, when high deductibles were placed on their insurance coverage.

Stripped-down plans like those that the Massachusetts uninsured will be forced to buy also do little to protect people against financial catastrophe due to illness. In our own work on medical bankruptcy, 76 percent of those bankrupted by medical problems had insurance at the onset of the illness that bankrupted them; many were ruined by copayments, deductibles, and uncovered expenses such as physical therapy.

### **Covert, Regressive Taxes Rather than Cost Containment**

The individual mandate will force working families to make bitter choices: pay premiums they cannot afford or buy stripped-down policies—or both. The vast majority of the new money in the bill comes from the mandated premium payments of low-to-middle-income families who are now uninsured. While families will pay these premiums to private insurance companies rather than to the government, they are in fact a highly regressive new tax: the wealthy contribute virtually no new money to the system, while the near-poor who were previously uninsured foot the bill.

Moreover, the legislation will do nothing at all to contain the skyrocketing costs of care in Massachusetts. With costs 30 percent above the national average, Massachusetts already has the highest per capita health care costs in the world. Predictably, rising costs will force more and more employers to drop coverage, while state coffers will be drained by the continuing cost increases in Medicaid and the private insurance subsidies for the near-poor. When the next recession hits, tax

revenues will fall just as newly unemployed people flood the Medicaid program or apply for the insurance subsidies promised in the reform legislation. The program is simply not sustainable over the long—or even medium—term.

### What Are the Alternatives?

In announcing the new bill, Governor Romney proclaimed that the bill marked the demise of the movement for single-payer national health insurance. Yet single-payer contains two elements lacking in the Massachusetts bill: universal coverage and cost control.

A simple single-payer plan would make coverage affordable by eliminating the multiple, competing insurers that generate our massive health administrative costs, currently at least 31 percent of total health spending.<sup>3</sup> For instance, Massachusetts Blue Cross spends only 86 percent of premiums paying for care. It spends the rest—more than \$700 million annually—on billing, marketing, and other administrative costs. Harvard Pilgrim and Tufts Health Plan—Massachusetts’s other largest insurers—are little better; each collected about \$300 million more in premiums than it paid out in benefits. That’s ten times as much overhead per enrollee as Canada’s national health insurance program. And our hospitals and doctors spent billions more fighting with insurers over payments for each bandaid and aspirin tablet. Overall, Massachusetts residents will spend \$13.3 billion on health care bureaucracy in 2006. If we cut bureaucracy to Canada’s levels we could save \$9.4 billion annually, enough to cover all of the 748,000 uninsured in Massachusetts and improve coverage for the millions more who are now under-insured.

A broad spectrum of researchers have concluded that single-payer is the only reform option that can expand coverage without increasing costs. Back in the 1980s, the Congressional Budget Office and the General Accounting Office estimated that universal coverage under single-payer was a break-even proposition because administrative savings would offset new clinical costs. More recently, a raft of studies by the Lewin Group—a fairly conservative consulting firm—evaluated proposed state single-payer plans and reached the same conclusion. Another consulting firm engaged by the Massachusetts Medical Society estimated that a single-payer plan could actually decrease spending while covering everyone in Massachusetts.

And despite millions spent by drug and insurance firms on “think tanks” and public relations denigrating the single-payer

option, and tens of millions of dollars lobbying politicians to keep single-payer off the table, it remains popular. Nearly two-thirds of Massachusetts physicians support it,<sup>4</sup> along with the Massachusetts Nurses Association and dozens of other labor and consumer groups and seniors organizations. Nationally, 62 percent of Americans favor “a universal health insurance program, in which everyone is covered under a program like Medicare that’s run by the government and financed by taxpayers.”<sup>5</sup>

The Massachusetts legislation raises ethical and policy issues that go far beyond health care. Has our democracy become incapable of enacting reforms, like single-payer, that benefit the vast majority of Americans but threaten the multi-million dollar paychecks of executives and the outrageous profits of private firms? Must every initiative to help the poor also further enrich the wealthy? Must we slash the estate tax if we hope to raise the minimum wage?

The Massachusetts legislature has answered: Yes. Their bill will generate huge new revenues for private insurers, vastly increase payments to already flush hospitals, excuse the wealthy from sharing the burden of covering the uninsured, and saddle working families with huge bills for

nearly useless coverage.

Our patients and our democracy deserve better.

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# The Commodification of Health Care

By BERNARD LOWN, MD

Dr. Bernard Lown, MD, a cardiologist who invented defibrillation and many other innovations in cardiac care, is professor emeritus at the Harvard School of Public Health and Senior Physician at the Brigham and Women's Hospital, Boston. He was co-recipient of the Nobel Peace Prize 1985, on behalf of the International Physician for the Prevention of Nuclear War (IPPNW) which he co-founded.

Health care in America is in deep crisis. A public service has been transformed into a for-profit enterprise in which physicians are "health care providers," patients are consumers, and both subserve corporate interests. The effect has been to convert medicine into a business, deprofessionalize doctors and far worse, depersonalize patients.

In my lifetime in medicine, now spanning 50 years, I have witnessed a remarkable transformation. From a healing occupation dominated by professionals, medicine has increasingly become an industrial process run by technicians.

Underlying the breakdown of the health care system is a far deeper phenomenon - the onrushing marketization of all human transactions. The overall impact is to denature fundamental human values and tear apart the ties that nurture communal life. Yet no such profound developments are without opportunities to mobilize people on the basis of their most intimate undermined self-interest. What is happening within the medical system affords a profound education for the public on a much wider issue; the fundamental flaws of a market-driven consumer society.

## THE TRANSFORMATION

In less than two decades, health care for a majority of American's was brought under control of what is called managed care, run by large insurance companies. The growth of fully privatized Health Maintenance Organizations (HMOs) was spectacular, increasing from 12% of those covered by private insurance in 1981, to 80% of the 200 million covered in 1999. The proffered rationale for the sweeping corporatization was the need to contain health care costs, founded on the belief is that only competitive, investor-owned organizations have the financial discipline to stem the inflation of health care expenditures.

Until the advent of HMO's, health costs were rising, on average about 11% annually - three or more times the rate of inflation. In 1995 American health expenditures for the first time surpassed \$1 trillion dollars per year. In Massachusetts where I live, with a population of 6.1 million, total spending for health care last year was over \$50 billion dollars. This exceeds the health budget of India and is nearly equal to that of China, the most populous nations on earth. Many

establishment economists have maintained that the USA cannot afford to invest 16% of its gross national product (GNP) on health. The stated reason for governmental encouragement of the private sector is to contain such mounting costs.

However, no major social transformation results from a single cause. The change in health care could not have happened without a multiplicity of forces working together. In my view, these include: the medical scientific and technological revolution; an altered conception of the meaning of health; the attending changes in the doctor patient relationship; growing patient dissatisfaction with a depersonalized system; the demographic transformation brought about by an aging population; the huge profits to be made; and the insatiable appetite of corporate America.

## THE SCIENTIFIC-TECHNOLOGIC REVOLUTION

Colossal medical achievements characterize our era. People residing in industrialized nations no longer need fear succumbing, unexpectedly, to dreaded pestilence. The introduction of sulfanilamide, in the mid 1930's and penicillin during the last stages of WWII wrought a health care revolution and contributed to a demographic transition. Infectious disease, the leading cause of global fatality, could be contained. The most telling single statistic - embodying scientific advances - is the expansion of the human life span by an average of 25 years since the beginning of the 20th century. People not only live one third longer, but are far healthier, and their state of good health is maintained into ripe old age. According to the ancient Greeks, upon reaching the age of 50, one entered the senescent phase of life. At present, it is not unusual for a septuagenarian to continue gainful employment, partake of travel, sports and other vigorous activities.

Science has improved human life during all of its stages. The fetus can be monitored from near conception, prematurely delivered when in distress, and kept miraculously alive when weighing less than a kilo. Numerous congenital abnormalities no longer need shorten or disfigure life. Defective organs, be they hips, hearts or livers, when beyond repair, can be replaced. Many cancers can be restrained in their wanton proliferation, and a cure for many of the malignancies is in the offing. Coronary artery disease, the major cause of premature death in industrialized societies, is now being defanged as its pathogenesis is increasingly comprehended. I am optimistic that within the next decade this massive affliction will be controllable as well as largely preventable.

But science is not all pluses. Three essential adverse consequences will be touched upon. First is the presumption of medicine as merely a science, reducing human beings into biomedical models with physicians serving as superspecialized technologists; second is the short shrifting of social and psychological factors as playing a role in disease; and third is the distancing of doctor from patient and

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## SCIENCE CONTRIBUTES TO ABANDONING HEALING

The practice of medicine has increasingly shifted to a scientific paradigm which approaches the patient as a biomedical being. Medical students are selected based on their achievements in pre-medical science course, not their affinity for the humanities nor their readiness to serve people. The medical school curriculum responds to the promises of science by progressively diminishing training in interpersonal relations. Little time is devoted to mastering history-taking or acquiring skill in the physical examination. Training is focused on proficiency in science and gaining competence in a host of technologies and procedures. Students are inculcated with a reductionist medical model in which human beings are presented as complex biochemical factories. A sick person is merely a repository of malfunctioning organs or deranged regulatory systems that respond to some technical fix. Within this construct, the doctor, as exacting scientist, uses sophisticated instruments and advanced methods to engage in an exciting act of discovery.

The fact that doctors are trained largely in tertiary care hospitals, veritable emporia of cutting edge technologies, further conditions the young with a mindset favoring the technical. This is reinforced by their teachers, future role models, who are almost exclusively highly trained specialists. Bedside teaching rounds are largely replaced with chart rounds and examining computer print-outs of the latest laboratory data. On rounds, attending physicians evince scant interest in the sick patient and instead fixate on the biochemical, molecular or genetic derangements. The focus of teaching necessarily shifts from an holistic approach dealing with an ailing person to the dysfunctional organ. Human interactive skills are deemed outmoded and are minimally cultivated. The patient is increasingly referred to not by name but by the deranged organ as the liver, kidney, heart patient or whatever ails.

What in olden times could only be exposed by pathologists during a post mortem examination, can now be imaged speedily, accurately and safely. No structure is hidden from view. Young doctors glory in being scientists with a commitment to master these sophisticated instruments and complex methodologies. The trainee physician quickly learns that compared with the sharp images provided by ultrasonography, MRI, CT, endoscopy, and angiography, a patient's history is flabby, confused, and subjective. Being deskilled in bedside medicine, young doctors have but little choice in dealing with patients except to rely on sophisticated medical gadgetry. There is no consideration of the prohibitive economic costs of immediately resorting to expensive technologies and bypassing the patient who is the ultimate repository of relevant information.

Contributing to the popularity of specialization is that early in their careers doctors learn that ascent on the academic ladder is for

those who master these elegant technologies, not for those who evince interest in afflicted human beings.

This trend is reinforced and accelerated by the billions of dollars poured by the government into medical research. The physician most gifted in obtaining grant funding is promoted in academe. Advance is unthinkable without a thick bibliography and success in obtaining grant support. Prestige no longer belongs to a beloved family physician nor to an astute bedside clinician, but is the prize for those who breach the scientific frontier.

Not only contemporary philosophic notions of illness, but powerful economic incentives reinforce these views. The shift from a patient-focused health care system to one based on disease, relates to lucrative fiscal rewards for the practitioners of scientific based medicine. Reimbursement is greatest for the specialists who are captains of complex and invasive technologies; cardiologists foremost among these. Society places a far higher premium on using technology than on listening or counseling. A doctor earns more from performing a procedure requiring a single hour than from an entire day spent communicating with patients. The following fact is illustrative. In 1982 U.S cardiologists earned \$127,000 annually. By 1987, their income had nearly doubled to \$225,000 coincident with the introduction of coronary angioplasty, which is pursued with ideological fervor though supported by scant evidence that it prolongs life or protects against a heart attack.

The enormous appeal for specialization skews the distribution of doctors. Unlike any other country, 70 per cent of practicing physicians in the U.S are specialists. Another lesson of the American experience is that a medical care system skewed towards science-based, curative medicine entrusted to highly trained specialists, costs grows astronomically and health care is increasingly rationed along class lines.

Scientific medicine that ignores the ailing human being has additional negatives. It leads to the medicalization of people and thereby warps the social fabric in numerous ways. Government funding of medical research requires an enthusiastic public. Every medical center dependent on such government largesse has a public relation staff generating a continuous Niagara of information about this or that scientific break-through or medical miracle. The bottom line message to the public has been that scientific medicine has a potential cure for all that ails. The massive medical industrial complex in the USA, now far larger than the military, further contributes to the hype since it needs to cultivate an ever growing number of customers for its expensive wares. It enfleades the media with stories about health and the value of its commercial products. Pharmaceutical conglomerates, major players in this game, currently advertise directly to the public - to the tune of \$2.7 billion in 2001. In a complete reversal of norms of medical practice, these advertisements urge people to recommend a particular drug to their doctors. In fact, patients may be among the first to learn the merits, but rarely the limitations, of a newly released drug.

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As Ivan Illich predicted in *Medical Nemesis*, medicine has expanded into almost all facets of human existence. Brought into the domain of medicine are an array of "proto illnesses" - conditions that do not cause symptoms or impair life in any way but are prognosticators of potential illness far in the future - are brought into medicine. Among this ever-mounting list are such conditions as high blood pressure, elevated blood sugar, cholesterol levels, osteoporosis, colonic polyps, heart murmurs, carotid artery narrowing, memory loss, sun exposure, and the list is constantly expanding. As scientific insight advances one may reasonably anticipate the emergence of a whole gamut of tests predictive of potential disease. Furthermore, it is certain that risk factors for future illness will be recognized ever earlier in life - soon, at birth, in utero, and with genetic mapping even before conception.

A recent study highlights the problem with this approach. At the National Institute of Health, 1000 healthy asymptomatic individuals had brain screening with magnetic resonance imaging. Of these, 18% demonstrated incidental abnormal findings and three were found to have unsuspected brain tumors. Should then the entire population be screened, and why only the brain? The negatives of such sweeping dominance of medical science are evident. Everyone is tied umbilically from birth to the medical establishment, resulting in an unceasing preoccupation with the struggle of surviving rather than with the challenge of creative living.

I harbor even deeper misgivings about the biomedical model and the current dominant scientific paradigm in medicine. This model, rooted in Cartesian dualism, is now under serious philosophical challenge. Science is fundamentally reductionist; it orients to probabilities not certainties, it searches the very depth to focus on genes and molecules, on electrons and subatomic particles. Defining a complex amalgam - such as an individual - is beyond its purview. But the practice of medicine ultimately is focused on the individual.

The biomedical model is additionally challenged by the theories of chaos and complexity. These theories question the basis of determinism as the explanation for cause and effect. They suggest that small, barely perceptible initial conditions of a system can result in disproportionately large changes in the same system over time, and emphasize the limitations of a reductionist approach in describing natural phenomena. The implications are that some systems are unpredictable and will remain so. Traditional science cannot accurately predict the trajectory of complex systems such as people. Physicians face a sea of uncertainty in dealing with a particular human being, confronting a system with an infinitude of interacting variables shaped by familial, cultural, social, and economic factors, conditioned with conditioned responses and inundated with subconscious mental content-- virtual memories of the night. The extant medical scientific vocabulary is dismissive of these "unknowables," communicating a largely irrelevant and nonexistent degree of determinism.

For physicians and patients, the building blocks of communication are metaphors and narratives, the ancient tools for comprehending the world. They enable coping with the subjective and the unmeasurable; the prevalent depression among the elderly; the grief of the bereaved; the suffering of those with terminal illness; or the despair of a mother with a dying child - all of which the physician is committed to assuage. Listening with care to a human narrative provides insight to emotional complexity and permits a glimpse into the mind of another, indispensable to the act of healing. When these are ignored, as they are in scientific-based medicine, patients feel abandoned with dire consequences for patients as well as the profession.

## CONSEQUENCES OF ABANDONMENT

At a time when doctors are performing the near miraculous, the profession's reputation is increasingly discredited. More and more, patients complain about not being listened to and being abandoned. As medicine has conquered acute illness, it increasingly fails in coping with the growing toll of chronic disease - arthritis, cardiovascular

ailments, cancer, diabetes, pulmonary impairments and neurological derangements. Lacking a cure, these illnesses require the art of healing for which the contemporary physician is poorly trained. And public, led to expect miracles which are not forthcoming, grows disillusioned and angry.

I shall touch on three of the many consequences now in evidence. One relates to the current litigation craze, a nightmare for physicians. Nearly one in three practicing doctors will be sued over a lifetime of medical practice for real or imagined wrongs. This is not surprising. As patients lose their individual identities, the ancient covenant of trust between doctor and patient unravels. When history taking is short shrifted, the doctor is likely to become lost in a sea of dire possibilities, warranting a profusion of technological interventions. In contrast, a careful history,

a thorough physical examination, and a few simple routine tests provide about 85 percent of the basic information required for a correct diagnosis. Since it is uneconomic to spend much time with patients, diagnosis is performed by exclusion. This opens floodgates for endless tests and procedures in an effort to cover all diagnostic options and thereby parry accusations of negligence in a court of law. With this kind of defensive medicine, minor problems receive comprehensive and costly work-ups. However no procedure is completely safe. Even an innocuous intravenous line can become a source for infection or the nidus for a blood clot. It is ironic that the quest to avoid litigation sets the stage for the legal entrapments it aims to avert.

A second even more persuasive line of evidence of the public's diminished trust of the medical profession is the increasing popularity of alternative medicine with its exotic and unproven treatments. Included among these are hypnosis, acupuncture, chiropractic,

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herbalism, homeopathy, biofeedback, guided imagery, relaxation, yoga, meditation, faith healing, prayer, Christian science, megadoses of vitamins, massage, naturopathy, chelation, urine therapy, Bach flower remedies, iridology, orgone accumulators, ozone generators and a host of others. Doctors deem these practices the negation of science, evoking images of 19th century charlatans hyping snake oil, leeches and astrology.

Yet national surveys indicate that in 1997 more than two-fifths of the adult population - 83 million people - used at least one of 16 listed alternative therapies, an increase of 20 million since 1991. Astonishingly, in 1997 visits to practitioners of alternative therapy exceeded the number of visits to all primary care physicians by an estimated 243 million. And the use of alternative therapies are not confined to a narrow segment of society. The largest users are women, the middle-aged (35-49), individuals with some college education, and people with annual incomes exceeding \$50,000. This trend may be interpreted as a vote of no confidence in scientific medicine among the educated, affluent middle classes, or as a dissatisfaction with a chaotic and impersonal health care system, or as a search for values not provided by the modern physician.

A third line of evidence, which I believe is the most telling indication of the loss of trust in the profession, is the seeming widespread public indifference to the corporate take over of community-owned hospitals, and the stripping away of physicians' clinical autonomy. The commodification of health care has been met by public silence. By contrast, whenever corporate interests have eyed popular programs such as Social Security or Medicare, angry public outcry has prevented a direct assault on these safety nets. No such outcry could be heard from Main Street as Wall Street privatized billions of dollars worth of public health institutions. Perhaps patients saw little reason to defend a dysfunctional system.

### AN IDIOSYNCRATIC HEALTH CARE SYSTEM

In the late 1930's, the Roosevelt Administration was moving toward a national single payer health care system. However mobilization for WWII put all social programs on a back burner. The war-time wage freeze forced unionized labor to seek higher pay through fringe benefits; mainly employer-financed private health insurance. Like any other business, the goal of health insurance firms is to make money. An opposite model had been adopted by nearly all developed countries, a social insurance model which shares the risk of sickness by spreading the cost to all of society. In the business model, the exclusion of the poor, the aged, the disabled and the sick is sound fiscal policy since it maximizes profit. In the social insurance model, denying coverage to some members of society contravenes the fundamental purpose of health insurance.

Indeed, failure of the business model is an ugly blot on the American escutcheon and deflates its pretense of moral global leadership. Today over 46 millions Americans are without health insur-

ance, their numbers rising by about 1 million annually. If one considers that an additional 20-30 million are underinsured; close to 1 in 3 of the population face major problems in financing illness for their families.

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Moreover, notwithstanding prodigious expenditures, the U.S. health care system often provides poor quality care. One robust proxy for quality is life expectancy, and in this index the U.S. ranks number 25, behind most other industrialized countries. Though others spend far less than the US, they deliver far more health care. One example should suffice. From 1960 to 1989, America's two major industrial competitors, Germany and Japan, more than doubled psychiatric beds. During this same period, USA reduced psychiatric beds by three quarters, from 560,000 to 70,000. Mentally ill patients were dumped into inadequately prepared communities and became the street people and the drug culture now plaguing America's large cities. Currently, a psychiatric patient needs to

be violent, suicidal or homicidal to be hospitalized. Mental illness is now criminalized - many more of the mentally ill are in jail than are in psychiatric hospitals; 10% of prison inmates are schizophrenic.

### CORPORATE MEDICINE

Neoliberalism proclaims the supremacy of the market to bring efficiencies to all human transactions. According to its more avid ideologues, the market's power derives from biology and is imbedded in our selfish genes. They aver, in the jargon of economists, that most people are maximizers of utility, meaning they navigate life by rationally calculating their self interest. Supplied with proper information their decisions are consistently on target. Forgotten in this economic babble is that the market episodically implodes, spewing woe and misery for all who are caught in its web. The liberal economist, Robert Kuttner has reflected, that historically, government has had to intervene, not only to redress the gross inequality of market determined income and wealth, but to rescue the market from itself when it periodically goes haywire. It is no secret that markets cannot properly value a host of essential societal needs such as education, health, public infrastructure, clean air and water, food safety, etc. As evidence one might reflect on ozone depletion, deforestation, species extinction, desertification, ocean pollution, global warming, and the systematic despoiling of the natural world, the mindless exposure of human beings to numerous carcinogens. John Kenneth Galbraith captured the essence in his oft quoted phrase that we live in a society characterized by "Private affluence and public squalor." Marx phrased it even more pungently, "With an adequate profit, capital is very bold. A certain 10% will seek its employment anywhere; 20% will produce eagerness; 50% positive audacity; 100% will make it ready to trample on all human laws; 300%, and there is no crime which it will not scruple, no risk it will not run, even to the chance of its owner being hanged."

While one can debate these matters endlessly, the serious flaws

in the theory and the practice of market-driven managed health care are neon lighted. Key assumptions in market theory are that the consumer knows what he needs, appreciates differences in quality, is offered these at different price levels, has bargaining power and can exercise free choice to buy or not to buy. None of these is true in health care. Patients usually do not know what is wrong; they do not comprehend the diagnostic possibilities; they are not familiar with the therapeutic options, they cannot assess the quality of care needed, and they do not appreciate the numerous potential outcomes. No amount of surfing the internet, browsing the media, reading popular health books, or sharing nostrums with neighbors can provide the necessary insights. These are the very reasons that they seek out the expertise of intensely trained and experienced health professionals. They need to nurture a relationship of trust with their doctors on whom they must rely on for their well being and even survival.

Furthermore, being sick is incompatible with acting as a savvy consumer. People do not shop for new homes or automobiles while in pain, bleeding or short of breath. Market forces can regulate the costs of houses and cars, things we choose to buy. But nobody chooses to be sick. The patient has little choice but to buy and therefore lacks bargaining power.

There is a deeper problem. Healthcare does not lend itself to the efficiencies of industrialization. Common sense indicates that patients cannot be standardized, and most of their parts are not interchangeable. Health care is a customized service resisting commodification and is incompatible with the efficiencies of industrialized assembly line or other mass production technologies. Such basics are ignored by the high priests of market medicine.

Market medicine is additionally flawed because it diverts economic resources from the community, from medical education and from research. The profits generated are not reinvested locally, but are distributed to remote investors and senior management as large dividends, hefty bonuses and egregious salaries. The market has been presented as the solution, but now we know it to be the problem.

As Neoliberalism sweeps the globe, it is important for people in other nations to grasp the dimensions of the health care crisis in the USA. Sooner or later they will be facing the proponents of marketization of their own medical arrangements. The impact of corporate privatization and the commodification of health care is now eminently clear. Health care costs continued to soar, exceeding two trillion dollars annually - 16 percent of GNP - by 2006, nearly twice what is spent other industrialized countries. High administrative overhead, a mark of business inefficiency, is double that in other industrialized nations. Masterminding the system is a prodigious bureaucracy that inundates health workers with a glut of paperwork, while health policy is being defined in corporate boardrooms from which the public is totally excluded.

Patient dissatisfaction is at an all time high, as assembly line

medicine puts a premium on hastening patient throughput. Downsizing, common in industry, is now depleting hospital staffing. Experienced as well as novice nurses, overburdened with high patient loads and administrative responsibilities, are often unable to provide competent and compassionate bedside care. The current mantra of reducing costs, whatever the human consequences, translates into burdening the sick with their own care. The anxiety, anguish, pain and sense of abandonment experienced by the sick and their families is not computed as debits in the outcome ledgers of marketized medicine.

## THE CHALLENGE

The most fundamental of questions can no longer be ignored; in a democratic society is health a fundamental right of the many or a privilege for the few? The underlying concept of market philosophy

is that those without means go without some products or services. The dissolution of the Soviet Union, has hastened the tempo of global capitalism in expanding the reach of market dominion to all precincts of human life.

But the public is not about to succumb to this Darwinian philosophy. People are not about to sacrifice education, health, safety nets for the aged and the afflicted, a healthy environment and a host of other areas defining the commons, the gains of which entailed more than a century of intense struggle. Numerous public opinion polls document the fact that Americans overwhelmingly oppose transforming health care from a social service to a

mere economic commodity. They are unwilling to replace the ancient bond of understanding between patients and doctors with a business contract.

Conditions are ripe to mobilize the public around the issue of health care, for few issues are more intimate or more potent. Indeed a powerful backlash is in evidence across the USA. Newspapers daily proclaim the mounting crisis in care and cost. Surveys show most Americans favoring national health insurance - despite a virtual blackout on mention of this option in the mass media now dominated by corporate interests. Hundreds of local citizen groups and labor unions across the nation join with thousands of doctors and nurses in rejecting the precepts of market medicine.

Only a wide mobilization of health professionals and patients can reclaim the soul of medicine. And the political movement for this transformation must educate the public

on issues transcending health, nourishing resistance to corporate domination in other spheres of life. The health of a civil society is ultimately secured by interacting dependencies of people expressed in communal life. We are bound together by a moral set of values that sees the welfare of other human beings as a benefit to the self. Citizenship must afford not only equal rights but equitable opportunities to share in the wealth produced by the many for the benefit of society writ large. The medical plains offer a unique challenge for progressives to mobilize people ready and eager to be engaged.

**Healthcare does not lend itself to the efficiencies of industrialization. Common sense indicates that patients cannot be standardized, and most of their parts are not interchangeable. Health care is a customized service resisting commodification and is incompatible with the efficiencies of industrialized assembly line or other mass production technologies.**

**Conditions are ripe to mobilize the public around the issue of health care, for few issues are more intimate or more potent.**

## We can afford to go for the gold: universal health care The money is already in the system -- let's just do it!

By ANA MALINOW

Advocates for children and elected officials are meeting this week in more than 35 cities nationwide with the admirable goal of increasing children's health insurance coverage.

Unfortunately, the centerpiece of their discussions -- the state programs for low-income children (S-CHIP and Medicaid) -- offers little hope of universal care for children.

As a physician, I know that the best way to provide comprehensive, universal care to children is to provide it to all Texans: through a single-payer "Medicare for All" system for the state.

Because I am a pediatrician who faces the reality of our state's health crisis day in and day out, I know intimately the futility of such band-aid programs. The advocates who fight to maintain and defend them do great work to promote child well being: I benefit from their efforts every day. But despite good intentions, the efforts of incremental health system reformers have failed to herald meaningful steps toward universal coverage -- either for children or for our nation as a whole -- because they do not address the reason so many Texans are uninsured in the first place: skyrocketing health care costs. Even S-CHIP, the largest coverage expansion in a generation, made only a small dent in the number of uninsured children because the government program could not keep up with eroding private coverage. Although 5 million children have been added since 1997, the number of unin-

sured children still stands at 9 million.

Even if every uninsured child in Texas eligible for CHIP or Medicaid were to be covered, half of the 1.4 million uninsured children would remain uninsured. More than 5 million Texans would still lack health insurance. Expansion of public programs would do nothing to curb costs of premiums for small-business owners in Texas, who have seen increases up to 75 percent in the past three years. Focusing on expanding current programs deludes us into thinking we are fixing the problem of the uninsured. In reality, it does little more than entrench us further in a failed, expensive, unjust health care system.

There is an alternative. Our current system allowing private insurers to cover the healthy and profitable while screening out everyone else allows one-third of our health spending to be diverted to needless bureaucracy and paperwork. Eliminating the private insurance companies and replacing them with a single public payer would save more than \$350 billion per year, enough to provide coverage for all of the uninsured. Combined with what we're already paying for health care, this is sufficient to provide comprehensive coverage to everyone without any additional spending.

I know what you're thinking: Why reach for the "pie in the sky" when we actually have a chance with children? (Forget the fact that we've had this chance for years.) The answer is that S-CHIP and Medicaid don't give us a chance to provide good coverage to children. They buy us an expensive and inadequate band-aid. And as long

as we allow for-profit insurance companies, it will keep falling off like tape in water.

I propose that child advocates at this week's town hall meetings stop supporting changes that are guaranteed to fail. I propose that we stop thinking of universal health care as "pie in the sky," as institutional forces once called the abolition of slavery, women's right to vote and the Civil Rights Act. We can have whatever kind of health care system we want. We don't need to spend more money, we already spend enough. We don't need to sacrifice quality or ration care any more than we do now.

Texans -- and all Americans -- want a health care system that is affordable, accountable, accessible, comprehensive, universal and just. We have many examples: Medicare, the Veterans Administration, the rest of the industrialized world. The only lasting, affordable, feasible solution to our health care crisis is national health insurance -- an expanded and improved Medicare for All, which continues to be publicly financed and privately delivered.

Child advocates this week and our new state and federal legislators should stop looking for piecemeal solutions and instead support a system where everyone pays into it equitably and every one takes out according to medical need; a health care system that excludes no one and is accountable to the people it serves; a health care system that is comprehensive and just, because that is what we as Americans, young and old alike, deserve.

*Malinow, a pediatrician at Ben Taub General Hospital, is president of Physicians for a National Health Program. The Houston town meeting will be held from 9:30 a.m. to noon Thursday at Texas Children's Hospital's Feigin Center.*

# Study shows U.S. residents are less healthy, less able to access health care than Canadians

**U.S. residents are less healthy, less able to access health care than Canadians**  
Universal coverage appears to reduce healthcare inequalities

PNHP PRESS RELEASE | MAY 30, 2006

## **“Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross National Population-Based Survey”**

By Karen E. Lasser, MD, MPH, David U. Himmelstein, MD, and Steffie Woolhandler, MD, MPH

*American Journal of Public Health | July 2006, Vol. 96, No. 7*

A study by Harvard Medical School researchers in the July, 2006 issue of the *American Journal of Public Health* finds that U.S. residents are less healthy than Canadians. Moreover, despite spending nearly twice as much per capita for health care, U.S. residents experience more problems getting care and more unmet health needs.

The study analyzes the Joint Canada-U.S. Survey of Health, the first-ever cross national health survey carried out by the two nations' official statistics agencies. The authors found that U.S. residents were less healthy than Canadians, with higher rates of nearly every serious chronic disease examined in the survey, including diabetes, arthritis, and chronic lung disease. U.S. residents also had more high blood pressure (18% of U.S. residents versus only 14% for Canadians). U.S. rates of obesity and sedentary lifestyle were higher; with 21% of U.S. respondents reporting obesity versus 15% of Canadians. However, U.S. residents were slightly less likely to smoke.

Canadians had better access to most types of medical care (with the single exception of pap smears). Canadians were 7% more likely to have a regular doctor and 19% less likely to have an unmet health need. U.S. respondents were almost twice as likely to go without a needed medicine due to cost (9.9% of U.S. respondents couldn't afford medicine vs. 5.1% in Canada). After taking into account income, age, sex, race and immigrant status, Canadians were 33% more likely to have a regular doctor and 27% less likely to have an unmet health need. For each of these measures, the average Canadian did about as well as insured U.S. residents.

Race and income disparities, although present in both countries, were larger in the U.S. Nonwhites were more likely than whites to have an unmet health need in the U.S. (18.6% vs. 11.1%); while in Canada they were not (10.8% vs. 10.2%). Notably, both white and non-white Canadians had fewer unmet health needs than white U.S. residents. After taking into account income, age, sex, race and immigrant status, poor U.S. residents (making less than \$20,000 per year) were 2.6 times less likely to have a regular doctor than the affluent (those making \$70,000 or more). In Canada, the poor were

only 1.7 times less likely.

In the U.S., cost was the largest barrier to care. More than seven times as many U.S. residents reported going without needed care due to cost as Canadians (7.0% of U.S. respondents vs. 0.8% of Canadians). Uninsured U.S. residents were particularly vulnerable; 30.4% reported having an unmet health need due to cost.

Lead author Dr. Karen Lasser, primary care doctor at Cambridge Health Alliance and Instructor of Medicine at Harvard commented, “Most of what we hear about the Canadian health care system is negative; in particular, the long waiting times for medical procedures. But we found that waiting times affect few patients, only 3.5% of Canadians vs. 0.7% of people in the U.S. No one ever talks about the fact that low-income and minority patients fare better in Canada. Based on our findings, if I had to choose between the two systems for my patients, I would choose the Canadian system hands down.”

“These findings raise serious questions about what we're getting for the \$2.1 trillion we're spending on health care this year,” said Dr. David Himmelstein, Associate Professor of Medicine at Harvard and study co-author. “We pay almost twice what Canada does for care, more than \$6,000 for every American, yet Canadians are healthier, and live 2 to 3 years longer.”

Dr. Steffie Woolhandler, also an Associate Professor of Medicine at Harvard and study coauthor, commented: “Our study, together with a recent study showing that people in England are far healthier than Americans, is a terrible indictment of the U.S. healthcare system. Universal coverage under a national health insurance system is key to improving health. It's striking that both whites and non-whites do better in Canada. A single-payer national health insurance system would avoid thousands of needless deaths and hundreds of thousands of medical bankruptcies each year. In 1971, Congress almost passed national health insurance. Since then, at least 630,000 Americans have died because they failed to act. How much longer must we wait?”

The study used data from the Joint Canada/U.S. survey of Health (JCUSH), conducted jointly by Statistics Canada (the Canadian counterpart to the U.S. Census Bureau) and the U.S. National Center for Health Statistics. The JCUSH surveyed 3,505 Canadians and 5,183 U.S. residents between November 2002 and March 2003 in order to gauge health status, rates of illness, behavioral risk factors, use of health care, and access to health care services in the two countries.

# Foreign free riders and the high price of US medicines

Donald W Light, Joel Lexchin

The US government, backed by the pharmaceutical industry, wants to convince Americans that they're paying more for drugs because they're contributing more than their fair share of the costs of research and development. Not so, argue two researchers who have looked at the evidence.

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The United States government is engaged in a campaign to characterise other industrialised countries as free riding on high US pharmaceutical prices and innovation in new drugs.<sup>1</sup> This campaign is based on the argument that lower prices imposed by price controls in other affluent countries do not pay for research and development costs, so that Americans have to pay the research costs through higher prices in order to keep supplying the world with new drugs.<sup>1,2</sup> Supporters of the campaign have characterised the situation as a foreign rip-off.<sup>3</sup> We can find no evidence to support these and related claims, and we present evidence to the contrary. Furthermore, we explain why the claims themselves contradict the economic nature of the pharmaceutical industry.

## Origins of the campaign

The campaign, strongly backed by the pharmaceutical industry, seems to have started in the late 1990s as a response to a grass roots movement started by senior citizens against the high prices of essential prescription drugs.<sup>4</sup> This issue was the most prominent one for both parties in the 2000 elections and has since been fuelled by a series of independent reports documenting that US drug prices are much higher than those in other affluent countries.<sup>5-7</sup> The idea that other countries are

exploiting the US has led to a hearing of the US Senate Committee on Health, Education, Labor and Pensions and was behind a Department of Commerce report that strongly advocated that other developed countries raise prices on patented medicines.<sup>8</sup> But are higher prices really necessary?

## The free rider myth

We can find no convincing evidence to support the view that the lower prices in affluent countries outside the United States do not pay for research and development costs. The latest report from the UK Pharmaceutical Price Regulation Scheme documents that drug companies in the United Kingdom invest proportionately more of their revenues from domestic sales in research and development than do companies in the US. Prices in the UK are much lower than those in the US yet profits remain robust.<sup>9,10</sup>

Companies in other countries also fully recover their research and development costs, maintain high profits, and sell drugs at substantially lower prices than in the US. For example, in Canada the 35 companies that are members of the brand name industry association report that income from domestic sales is, on average, about 10 times greater than research and development costs.<sup>11</sup> They have profits higher than makers of computer equipment and telecommunications carriers<sup>12</sup> despite prices being about 40% lower than in the US.<sup>11</sup>

## Lower prices do not lead to less research

Mark McClellan, the former commissioner of the Food and Drug Administration, maintained that low prices are "slowing the process of drug development worldwide."<sup>1</sup> A corollary to this claim is that drug companies are shutting down their European operations because prices are too low and moving to the US. This assertion is contradicted by the industry's data. The European Federation of Pharmaceutical Industries and Associations reported that, between 1990 and 2003, its members increased their research and development investments in Europe by 2.6-fold and in the US by fourfold.<sup>13</sup> The federation concluded that this differential was due to multiple factors, such as the economic and regulatory framework, the science base,



RICHARD DU TOIT/NATUREPL

Are European patients really getting a free ride?

the investment conditions, and societal attitudes towards new technologies.

On several measures, other developed countries spend proportionately as much as the US on research and development. The table presents the spending on research and development as a percentage of gross domestic product for eight developed countries.<sup>14</sup> The US is about at the median. Prices in the countries with better ratios than the US were 31-36% less than those in the US.<sup>15</sup> Pharmaceutical companies commit as large a percentage of sales to research and development in Europe as in the US, about 19% on average over the past seven years.<sup>9 13</sup> This little reported fact contradicts the widely circulated claims that European countries deliberately ignore research and development costs in calculating prices.<sup>1</sup>

### Europe no less innovative than the US

Contrary to claims of American dominance, pharmaceutical research and development in the US has not produced more than its proportionate share of new molecular entities. The US accounts for just under 48% of world sales and spent 49% of the global total on research and development to discover 45% of the new molecular entities that were launched on the world market in 2003, less than its proportionate share. European countries account for 28% of world sales, 36% of total research and development spending, and 32% of new molecular entities, more than its proportionate share.<sup>13</sup>

#### Limited investment in breakthrough research

Pharmaceutical research and development is traditionally divided into three categories:

- Basic—work to discover new mechanisms and molecules for treating a disorder
- Applied—work that develops a discovery into a specific practical application, including research on manufacturing processes and preclinical or clinical studies
- Other—work that includes drug regulation submissions, bioavailability studies, and post-marketing trials.

Although all types of research are valuable, it is basic research that leads to important therapeutic breakthroughs. Only a fraction of overall industry expenditure is on basic research, and it does not require the high prices currently seen in the US to support it.

The Pharmaceutical Research and Manufacturers of America reports that companies invest on average about 18-19% of domestic sales into research.<sup>9</sup> This figure is considerably higher than that produced by the US National Science Foundation.<sup>16</sup> Its 1999 data show that drug companies invest 12.4% of gross domestic sales on research and development (10.5% in-house and 1.9% contracted out), but only 18% of the amount spent in-house went on basic research. Assuming that 18% of contracted out research is also spent on basic research (the actual figure is not reported) then only 2.2% ( $18\% \times 12.4\%$ ) of revenue goes to basic research. The after tax cost of \$1 of research and development expenditures in the US seems to be \$0.53 to \$0.61, owing to tax incentives to do research.<sup>17</sup> Thus US pharmaceutical companies devote a net of only about 1.3 cents

Ratio of pharmaceutical spending on research and development to gross domestic product and ratio of drug prices to US prices, 2000<sup>12 15</sup>

	Country							United Kingdom	United States
	Canada	France	Germany	Italy	Sweden	Switzerland			
% of GDP	0.08	0.14	0.11	0.06	0.35	0.55	0.32	0.24	
% of US price	63.6	55.2	65.3	52.9	63.6	69.2	68.6	100	

GDP=gross domestic product.

( $2.4\% \times (0.53 + 0.61) / 2$ ) of every dollar from sales to innovation.

Only 10-15% of newly approved drugs provide important benefits over existing drugs.<sup>18 19</sup> From a drug company's point of view, investing principally in research to produce new variations of existing drugs makes sense. Government protections from normal price competition do not distinguish between the lower risk, less costly derivative kind of research and high risk basic research needed to discover new molecules.

### Misusing economic theory

The industry's principal claims, as well as being contradicted, are based on false premises. Firstly, counting which country discovers the most new molecular entities is irrelevant in a global market. Companies know that where a good drug is discovered does not matter, and often a discovery comes from research in several countries. Whether domestic revenues recover a given country's research and development costs is also irrelevant. If this were not the case the industry would have shut down operations in Switzerland long ago because of its small market size.

If revenues are inadequate, it would make more sense to conclude they do not cover all marketing costs rather than research costs. Research is central to the industry, and costs associated with it should be deducted first. Pharmaceutical companies report that they invest around three times more in the combination of marketing, advertising, and administration than in research, leaving ample room to cut costs.<sup>20</sup>

Secondly, every student in introductory economics learns that fixed costs like research do not determine prices.<sup>21</sup> The market sets prices, implying they are open to free trading like stock prices. Patents, and especially patent clusters, turn the market into a monopoly, and only a monopoly can claim that fixed costs determine prices because it can make that a self fulfilling prophecy. The claim by companies that they have to set prices at 50-100 times production costs to recover research and development costs has never been substantiated, because they have never opened their books to independent public inspection to prove it. What we do know is that all research and development costs are fully recovered each year from domestic sales in the UK and Canada at prices that are far lower than those in the US.

Thirdly, free rider is both a vivid public image of someone jumping on for a free ride and a highly misleading economic term. Technically it refers to a method for allocating fixed costs in proportion to the prices that different groups pay. For example, if Group A (call it Europe) pays \$1 per pill and Group B (call it



### Summary points

Prices of patented drugs are substantially higher in the US than in other affluent countries

Published reports indicate that pharmaceutical companies in affluent countries recover research and development costs from domestic sales with substantial profits

Discovery of innovative new drugs in Europe is proportionately equal to that in the US

US pharmaceutical companies invest just 1.3% of net sales in basic research

The idea that the US is subsidising other rich countries contradicts basic economics and the global nature of pharmaceutical markets

the US) pays \$2 a pill and each buys a million pills, then this accounting method would assign half as much of the fixed cost to Group A as to Group B. If, however, the fixed costs are only \$300 000 (a tenth of the total revenue) for the two million pills, the fixed costs could be allocated by volume rather than by price (\$150 000 for each group) and conclude that Group A more than pays the fixed costs and Group B pays much more than it has to. In short, the free riding argument economically is the artefact of an accounting convention and can be eliminated by Group B cutting its prices in half, rather than forcing Group A to double its prices.

### Conclusions

The pharmaceutical industry has provided invaluable medicines to cure and relieve millions of patients throughout the world. As an industry, it drives economic growth and employs thousands of skilled people. But it also uses false economics and makes up stories to justify higher prices. Higher prices strain budgets, causing millions of US patients not to take the drugs their doctors think necessary. The pharmaceutical industry and the US government want to blame other developed countries for these higher prices rather than make drugs more affordable.

**Contributors and sources:** This article is based on all the major documents we could locate, a careful search of the websites of the European Federation of Pharmaceutical Industry Associations and Pharmaceutical Research and Manufacturers of America, and a Medline search. DWL is a professor of comparative health care policy, a contributor to the WHO Observatory volume on European pharmaceutical policy, and a member of the taskforce for the Gates Foundation on how best to make vaccines for global diseases economically viable. JL has been conducting research into pharmaceutical policy for over 20 years and has acted as a consultant to various national governments and the WHO on pharmaceutical matters. DWL had the idea for the article, wrote the first draft, and is the guarantor. JL did the analyses, edited the draft, and made empirical contributions.

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PNHP National Coordinator Dr. Quentin Young with Rose Ann DeMoro, Executive Director of California Nurses Association and an honorary member of PNHP's Board of Directors. According to DeMoro, "the AFL-CIO's new policy statement on healthcare is a strong endorsement of single payer and our new affiliation will both strengthen and nurture that commitment. On behalf of our wonderful membership of hardworking, caring, and deeply committed nurses, I would like to say how wonderful it is that nurses and physicians have allied to bring quality healthcare and dignity to everyone in America." (See page 36 for the AFL-CIO statement.)

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behind Canadian healthcare debates

Myth Busted June 2005



## Myth: Canada has a communist-style healthcare system



Amazingly, Canada joins Cuba and North Korea as countries where it is a crime to provide and accept private payment for health-care services ostensibly provided by the government.<sup>i</sup>

Is private provision of healthcare a crime in Canada? Is it illegal to pay for healthcare out of your own pocket? Many critics of Canadian healthcare argue the answer to both these questions is “yes” and claim that every time a patient waits for a service or access to technology, it is a result of Canada’s communist-style healthcare system.

The truth is Canada does not have a government-funded and -operated monopoly, but rather a series of taxpayer-funded insurance schemes for hospital care and certain doctors’ services, supplemented by private insurance and out-of-pocket payments for other health services. While there are some restrictions on what private insurance can cover, many types of private payment are allowed for many healthcare services.

### Comrades in care?

The first thing to note is that governments do not provide the majority of healthcare in Canada. Most hospitals are owned by not-for-profit organizations, such as community and religious groups. Physicians are not civil servants; most of them are not even employees, but rather independent entrepreneurs able, in many provinces, to incorporate themselves as businesses for tax purposes.<sup>ii, iii</sup>

Canadian governments do fund most healthcare services through provincial insurance plans, including all medically necessary hospital and physician care, as required by the Canada Health Act. However, a sizeable amount of healthcare spending is private — approximately 30 percent in 2002, according to the Organisation for

Economic Co-operation and Development.<sup>iv</sup> In Canada, private insurance and out-of-pocket payments usually cover things like prescription drugs and dental and eye care, which do not fall under the act.<sup>v, vi</sup> This means that Canadians spend as much or more privately on healthcare as do citizens of 15 other OECD countries, including Germany, France, Sweden, and the U.K.<sup>iv</sup>

### Is private payment for healthcare illegal in Canada?

The argument that Canada and the communist countries of Cuba and North Korea are the only ones in the world to disallow private payment for healthcare originated with a rhetorical piece written in the late 1990s, but it has grown to the status of urban myth.<sup>vii</sup>

It is true that regulations in six of the 10 provinces make private insurance illegal for the physician and hospital services covered by provincial insurance plans. (And even in the four provinces that do allow this private insurance, little use is made of the provision in practice.) However, every province allows patients to use their own money to privately purchase medically necessary care, as long as it is delivered by “opted out” private doctors — those who have given up their right to get paid from the provincial public plan. The intent of this is to make sure doctors are not getting double-paid — once from the provincial plan and then again from private insurance or the patient — for medically necessary, taxpayer-funded services.<sup>viii</sup> It also prevents the diversion of resources, both financial and human, to the private system, which would place further stress on the public one.<sup>ix, x</sup>

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Canada is not the only country to place restrictions on private insurance, either. In Australia, for example, private insurance does not cover physician services provided outside of a hospital, nor does it cover the gap between what hospital care costs and what medicare will pay.<sup>xi</sup>

### Are international “solutions” less monopolistic?

Systems in other countries are often held up as examples of how Canada should reduce its alleged healthcare monopoly. In particular, France’s healthcare system is lauded as a model for how Canada might “introduce” private payment and improve the health-care system without giving up universal access.

In France and some other European countries, every citizen is covered by a sickness fund administered by the government. The funds partially reimburse patients for medical care, including hospital and GP visits, prescription drugs, nursing home use, and some dental and vision care. Most people also purchase supplementary insurance to cover co-payments and care categories with lower reimbursement levels.<sup>xii</sup>

The irony is that, overall, public financing covers 76 percent of all health expenditures in France — six percent more than the amount of public financing in Canada.<sup>iv, xiii</sup> Unfortunately, the decision to concentrate private payment in co-payments and other direct charges appears to cause some people, particularly the poor, to avoid seeking expensive but necessary forms of care.<sup>xiv</sup>

### The true cost of healthcare

One of the main reasons the Canada Health Act requires public payment for medically necessary healthcare is to obtain the economic efficiencies of a single-payer system. Tax-funded systems have greater potential (not always realized) to control costs than multi-payer systems,<sup>xv, xvi</sup> and research shows the more insurers there are, the higher the costs of running the system. For example, the annual overhead costs of the provincial insurance plans are 1.3 percent of expenditures for physicians and hospitals, while Canada’s private insurers average 13.2 percent in administrative costs.<sup>xvii</sup>

Tax-funded insurance plans have important social benefits as well. First, they are less regressive, in that they play a “Robin Hood” role of levelling out income gaps to ensure poorer and sicker people are not denied care.<sup>xv</sup> Second, they ensure that insurance is offered for all medically necessary services, not just the profitable ones.<sup>xviii</sup>

Clearly, the argument that Canada has a communist-style healthcare system that outlaws private payment is false. With 30 percent of healthcare spending coming from private sources, Canada is on par with most other developed countries, each of which has a complex mix of public and private financing in different sectors.<sup>iv</sup> While private insurance for publicly covered services is largely illegal, there is nothing to stop patients from paying out of their own pockets if they can find a doctor who is not part of the public plan.<sup>viii</sup>

*Mythbusters are prepared by knowledge transfer and exchange staff at the Canadian Health Services Research Foundation and published only after review by researcher experts on the topic. © CHSRF 2005*

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## Myth: The cost of dying is an increasing strain on the healthcare system

In the ongoing quest to identify the cause of growing healthcare budgets, fingers are pointed in a number of directions — the aging population and expensive new technology in particular.

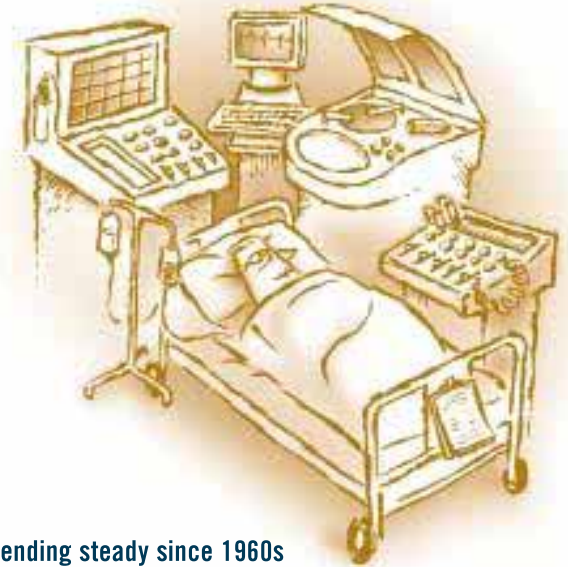
There is a widespread belief that healthcare systems are spending more and more to provide intensive and aggressive care to older patients living out their final months. These “heroic efforts” to treat the dying are becoming a bigger spending factor than in the past, so the myth goes, due to the availability of more expensive technology.

The image of teams of doctors, nurses and other healthcare professionals gathered around elderly patients, with an arsenal of the best drugs and equipment at their side, is a convenient one — but how close is it to reality?

### Thirty years of evidence

The perception that the cost of treating the dying drives up healthcare budgets is not new, but it has also been debunked by more than 30 years’ worth of evidence. Research on healthcare spending shows that end-of-life costs tend to account for a minority of total costs to healthcare systems; research from both North America and Europe shows that acute healthcare costs during the last year of life account for only about 10 to 12 percent of total healthcare budgets.<sup>i, ii</sup>

The American Medicare plan, which covers only healthcare for seniors, has been particularly well-researched. Studies dating back to the 1970s have shown that the five to six percent of seniors who die each year account for about 27 to 30 percent of that program’s costs for treating the elderly.<sup>iii-vi</sup>



### Spending steady since 1960s

This myth stays alive for a couple of significant reasons. First, the increasing number of seniors in the population has led to the belief that the costs of treating them will overwhelm the system — a myth refuted by another *Mythbuster* on the aging population.<sup>vii</sup> Second, improvements in care in recent years, largely due to new and more expensive technology, have led to the belief that these resources are too often being used in last-ditch efforts to keep patients alive — and causing increases in healthcare budgets.

Despite these developments, the data appear to show that the proportion of healthcare spending going to care for those at the end of life has largely remained stable over time.<sup>iii</sup> In the United States, for example, the money being spent in the last year of life has remained steady since the late 1960s, when their Medicare program was first introduced to provide hospital and physician coverage to seniors older than 65.<sup>iv, viii, ix</sup>

And despite changes to the technology available, the fact is most people still die without an expensive, high-tech struggle.<sup>1</sup> Indeed, a major study of Manitoba patients found that 38 percent of seniors in that province died after only two weeks or less in a hospital,<sup>x</sup> and 46 percent of Medicare recipients in the United States received no hospital treatment at all in the year before they died.<sup>xi</sup>



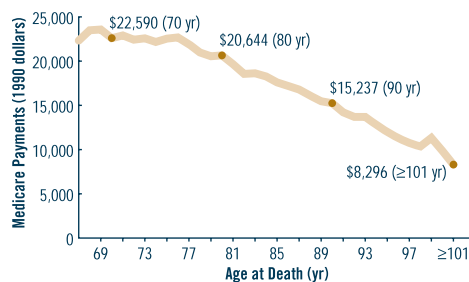
## Nursing homes affect costs

Research shows that the older people are when they die, the lower the medical costs incurred during the final year.<sup>v, xii-xiv</sup> Instead, these individuals appear to be using nursing home services to a much greater degree.<sup>x</sup> American research has shown nursing home costs make up 62 percent of spending in the last 18 months of life for people who were older than 85 when they died, and 24 percent of spending for those who were between the ages of 65 and 74 when they died.<sup>xi</sup>

In addition, recent studies of Manitoba's nursing homes show that because individuals being admitted to nursing homes are spending more time living in the community before they go into a care home, they are older and frailer when they enter a facility, and they die after a shorter stay.<sup>xv, xvi</sup> The Manitoba research shows that while admission rates have remained stable in that province, the average number of days spent in a care home declined by about 20 percent between 1985 and 1999.<sup>xvi</sup>

**American Medicare payments on hospitals and physicians in the last two years of life decline with increasing age at death**

*Data from Lubitz et al, 1995*



## Research can't do everything

Clearly, research has debunked the myth that the cost of dying is growing and overwhelming the healthcare system. The question that research will never answer, however, is whether that spending is *too high* — that's a question of values, which number-crunching will never answer.

Even if society does decide that spending at the end of life is too high, it is unclear what could be done about it. Research has shown some likelihood of reducing costs with increased use of hospice and advance directives,<sup>ii</sup> but there are other critical and possibly disturbing policy implications that will emerge as people try to decide how aggressive medical care at the end of life should be and how costs can be reduced.

In the end, it is difficult to predict which patients receiving treatment will live and which will die (with the exception of some forms of terminal cancer). In other words, care in the last year of life is not so much "spending on the dying" as it is just providing regular medical care for people who have serious health problems.<sup>iv, v, xvii</sup>

Mythbusters are prepared by Knowledge Transfer staff at the Canadian Health Services Research Foundation and published only after review by researcher experts on the topic.  
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A series of essays giving the research evidence  
behind Canadian healthcare debates



## Myth: User fees would stop waste and ensure better use of the healthcare system.

There's an old idea that frequently sparks debate: that patients rampantly abuse the healthcare system. They indulge in unnecessary, expensive medical procedures all because they can get them for free. So why not teach Canadians to be more responsible by making them pay a charge for every health service used?

Because the idea just doesn't hold water. Research has long proven that user fees won't eliminate inappropriate care nor do much to reduce costs, and even the claim that patients waste healthcare resources is faulty.

### Patients abusing health services? The true story

Robert Evans, a health economist at the University of British Columbia, explains: medical procedures are not hotcakes. People aren't going to line up eagerly demanding heart transplants just because someone else is paying.

What's more, patients can't really waste healthcare resources. Institutional and hospital care, physician visits, prescription drugs, and other medical services, make up most of total Canadian health spending.<sup>i</sup> But most of that spending is beyond a patient's control: many visits to doctors, all hospital care and prescription drugs, can only be given on a doctor's order.<sup>ii</sup>

That means patient-initiated abuse happens mostly during physician visits — which made up about 13.5 per cent of total health spending in 2000. But roughly half of physician services are referrals, or call-back visits to the same doctor, says Evans. So "first visits" initiated by patients probably made up about six to seven per cent of all spending. Since most of these visits are reasonable, Evans estimates patient-initiated abuse is



probably about one to two per cent of total spending — hardly rampant.

### Tried, tested and quite untrue

In any case, user fees are unlikely to reduce costs. Researchers found that user charges — implemented in Saskatchewan in 1968 and abolished seven years later — reduced the annual use of physician services by about six per cent. But this happened mainly because the elderly and the poor saw about 18 per cent less of their doctors.<sup>iii</sup> What's more, Saskatchewan's overall healthcare costs didn't shrink — thanks to physician fee increases and people with higher incomes, who saw their doctors more often.<sup>ii</sup> The fees also didn't affect the cost of hospital services, the most expensive form of care.

Another famous study on user fees is the U.S. Rand Health Insurance Experiment, which assigned individuals to insurance plans with different rates of user fees.<sup>iv</sup> Researchers found people got less medical care in those plans with heavier charges. But the proportion of inappropriate antibiotic use, hospital stays and admissions was the same<sup>v vi</sup> — with or without user fees — proving that the fees don't solve such problems.

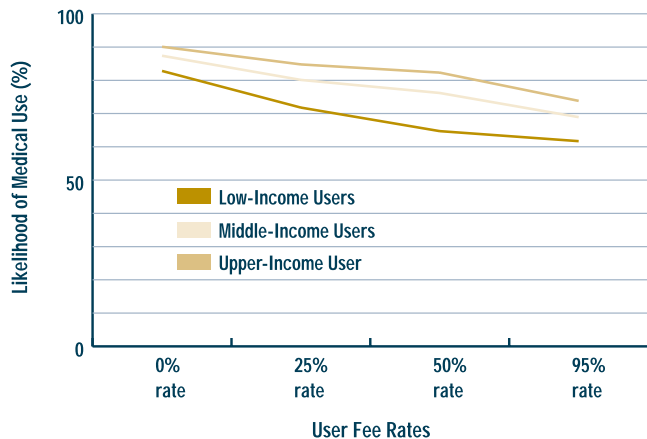


What changed was the way high-risk and low-income patients used medical services. Everyone used fewer medical services, but the decline was greater among poorer people. Sick people were also more likely to die when user charges were installed.<sup>vii</sup>

However, Rand investigators found healthcare costs for people who paid user fees were lower than people with total health coverage. This seems to prove user charges at least lowered costs. But that disputes the findings in Saskatchewan, where costs didn't decrease. Why?

While the Saskatchewan experience affected all patients, Rand involved a dispersed group of 5,800 people, so each doctor only had a few patients enrolled in the study. That's not enough to provide evidence on the effect of user fees on the system. Therefore the Rand experiment, unlike the Saskatchewan experience, does not address the question of *overall* costs. We just can't conclude from Rand that healthcare costs would drop across the system; the evidence simply isn't there.<sup>viii</sup>

### Effect of User Fees on Medical Use, Rand Health Insurance Experiment



People do reduce their use of health services when user fees increase — but the poor, often the ones who need medical care most — are the hardest hit. In the Rand experiment, low-income users cut their likelihood of medical use from 82.8 per cent when they didn't have to pay, to 61.7 per cent when user charges were highest.

Data from Manning WG et al. 1987. "Health insurance and the demand for medical care: Evidence from a randomized experiment." *American Economic Review*, 77(3):251-277.

### Penny wise, pound foolish?

But both studies do confirm it's mostly the poor who use less medical care when forced to pay extra charges. In the long run that would probably cost more, because the old and poor are less healthy than other groups.

In Quebec, for instance, when the elderly and people on welfare had to pay user fees for prescription drugs, they took less medicine. But that resulted in sicker patients and more visits to hospital emergency departments.<sup>ix</sup> These findings echo earlier research, which showed that user fees helped reduce costs in the short term, but eventually led to more spending because more people would neglect to get early treatment.

Despite the rhetoric, user fees don't lead to a more affordable health system. Research has shown time after time that user fees inevitably create advantages for the rich and healthy while making matters worse for the sick and poor.

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## UNIVERSAL HEALTH CARE: A REGIONAL PERSPECTIVE—WHY NOT A “GEORGIA SECURECARE”?

Henry S. Kahn, MD

Despite conventional wisdom that southern states have neither the money nor popular support for such a program, a Georgia group has outlined a universal, comprehensive, single-payer proposal called “Georgia SecureCare.” The group’s telephone survey in 2003 found that a majority of households was concerned about losing health insurance or access. Economic analyses demonstrated that SecureCare would reduce statewide health care spending by \$0.72 billion (~2%) in the first year while providing all Georgia residents with a generous benefit package. Despite initial increased healthcare utilization costing about \$3.84 billion, notable savings were attributable to lower annual administrative costs (\$3.82 billion) and bulk purchasing (\$0.74 billion saved for prescription drugs and durable medical equipment). For most families and for large employers, annual expenditures for health would decline. Georgia respondents to the telephone survey initially expressed ~72% support for SecureCare. After furnishing them with common objections to the plan, their support dropped to ~62%. A universal, state-sponsored plan would likely save money for Georgia, and it could easily win broad-based popular support. (*Ethn Dis.* 2006;16[suppl 3]:S3-4-S3-7)

**Key Words:** Financing, Government, Georgia, Healthcare Systems, Health Care, Models, Economic, National Health Insurance

“Of all the forms of inequality, injustice in health care is the most shocking and most inhuman.”

*Martin Luther King, Jr.*—March 1966

### INTRODUCTION

The recent Hurricane Katrina disaster demonstrated how poorly the American healthcare system attends to the needs of its poor and minority subpopulations. This wake-up call should remind us that our peculiar system for financing healthcare delivery is ripe for change. Indeed, several proposals exist for the creation of universal, consolidated (single-payer), comprehensive healthcare financing. But some ask—most often in the conservative South—if changing the system will be too costly. They suggest that a universal health care financing system is merely a liberal fantasy with no popular support.

Is it possible that southerners fail to grasp the painful paradox about the current American system? Our healthcare system suffers from a structural problem: Americans are paying for universal health insurance, but they are not getting it.<sup>1</sup> Despite spending far more per capita than other societies for health care, America is farther away than most industrialized countries from providing care to all in need. Data from 1998–2000<sup>1,2</sup> show that our *public* spending alone, including direct government payments, public employees’ benefit costs, and tax subsidies, equaled or exceeded the *total* amount spent on health care per capita in most other

industrialized nations (Figure 1). More recent data indicate that American public expenditures for health care continue to rise,<sup>3</sup> yet we continue to experience ever increasing rates of uninsurance.

### MODEL PROGRAM FOR CHANGE

For more than a decade, the “Georgians for a Common Sense Health Plan” (GCSHP) has been meeting in Atlanta to consider how Georgia could respond to the major deficiencies in healthcare financing. Drawing from the thinking of “Physicians for a National Health Program” and the “Physicians’ Working Group for Single-Payer National Health Insurance”—as well as our community-based experience—the GCSHP has committed itself to key principles that should be incorporated into any future health plan:

- Universal coverage—covering everyone with full choice of provider.
- Comprehensive coverage—all needed care with no deductibles, minimal co-payments.
- Single, public payer for simplified reimbursement.
- Improved health planning.
- Public accountability for quality and cost, but minimal bureaucracy.
- A mechanism that would discourage investor-owned HMOs and hospitals.

### Is Georgia Ready for Major Health Financing Reform?

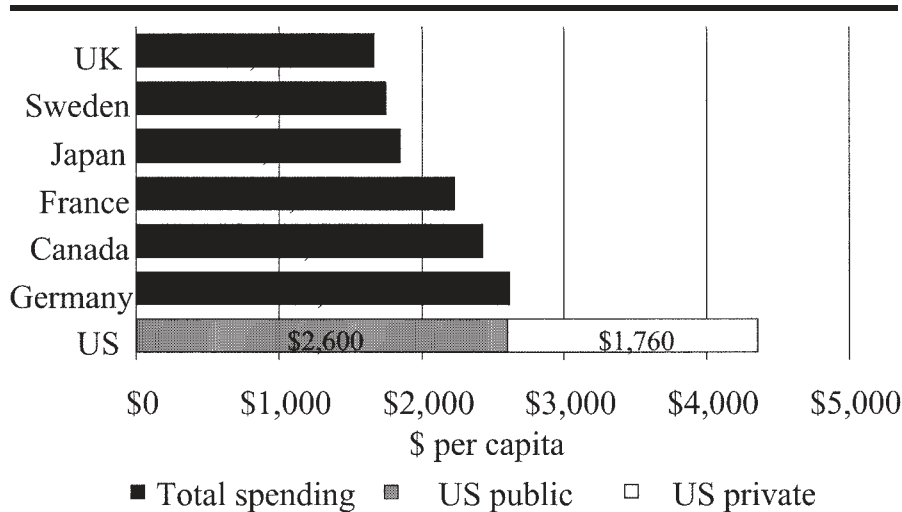
Based on these key principles, the GCSHP attempted to find out if our

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**Fig 1. US public spending per capita for health (1999 estimates) was greater than total spending in other nations<sup>1</sup>**

ideals were realistic for our conservative state. We received funding from the Healthcare Georgia Foundation to answer three questions:

- (1) Are Georgians concerned?
- (2) Would our financing reform be affordable and sustainable? and
- (3) How wide and deep is Georgia political support for such health care change?

For addressing question one, a stratified sample of 800 Georgia households was identified for participation in a telephone survey (unpublished data).

**Table 1. Level of concern about health care or insurance among Georgians**

Are you concerned about health care or insurance?	TOTAL Response (%)	Strongest Subgroups	Subgroup Response (%)	
Very concerned	36	Income <\$30,000	52	
		No health insurance	48	
		Democrat (ID)	45	
		African American	45	
		Democrat (history)	44	
		South Georgia resident	44	
		Not registered to vote	43	
		Not married	42	
		Living in rural area	41	
		Somewhat concerned	23	Republican (history)
Republican (ID)	21			
Income ≥ 50,000–\$80,000	20			
Not very concerned	15	Income > \$80,000	32	
		Ages 60 years and older	30	
		Men	29	
		Men, ages 18 years to 49 years	29	
		Men > age 50 years	29	
		North Georgia resident	29	
		Not at all concerned	25	

In response to the question, “How concerned are you that you might lose your health insurance or that your access to health care might be restricted?,” 59% of Georgians said they were “very concerned” or “somewhat concerned.” Expressions of greatest concern came from households making <\$30,000 per year or having no health insurance. Many of this group lived in rural areas or were employed part-time. (Table 1)

To determine whether financing reform would be affordable and sustainable, GCSHP outlined a hypothetical plan, named “Georgia SecureCare,” which would be operated by the state or a non-profit agency. In this hypothetical scenario, the plan would enroll all Georgia residents, including undocumented aliens. It would replace all existing public and private health insurance; coverage would no longer be connected to a job. Georgians would have full choice of any primary care physician or healthcare provider. There would be no deductibles and no co-payments with the exception of a \$25 co-payment for visiting a specialist without a referral from a primary care doctor. The coverage would include doctors, hospitals, emergency care, prescriptions, mental health services, dental care and long-term care. Simply by showing a SecureCare health card, a resident of Georgia would have generous access to doctors, hospitals, and other providers.

Doctors could remain independent; their fees would be negotiated collectively with the SecureCare Trust Fund. Hospitals, with incentives to become not-for-profit, would each negotiate a global budget with SecureCare, instead of billing for each admission, each hospital service, and each bandage. Local planning boards would allocate major capital expenditures and expensive technology. Progressive taxes or “premiums” would go into the SecureCare Trust Fund, and the consolidated public agency handling SecureCare would process and pay bills. The plan

would be subject to accountability and quality control.

### Proposed Funding Sources

SecureCare would be financed with funds that would have been used for public programs under current law, a new payroll tax to replace employers' healthcare contributions, and other dedicated taxes. It is important to recognize that this financing structure would replace the previous structure based heavily on employer premiums to insurance companies, personal premiums to insurance companies, private co-payments, deductibles, and conventional payments made out-of-pocket. Our detailed estimates of SecureCare financial requirements and expenditures were created from extensive spreadsheets based empirically on the Georgia healthcare payers and expenditures in the year 2003.<sup>4</sup> The reorganized sources of funding would include the following, with more than two thirds of the entire budget stemming from the first two sources:

- An employer payroll tax equal to 9.1% of wages and salaries for all employees (\$14.2 billion).
- Government spending for discontinued health programs (\$12.8 billion).
- An income-tax surcharge for all Georgians computed to be equal to about 22.2% of each taxpayer's federal income tax (\$6.0 billion).
- A one percentage-point increase (one penny per dollar) in the state sales tax on non-grocery items (\$1.25 billion).
- A tobacco tax increase of 50 cents per pack with proportionate increases for other tobacco taxes (\$215 million).
- An increase in taxes on alcoholic beverages (\$52 million).

The GCSHP analyses indicated that Georgia spent \$37.15 billion for health care in 2003.<sup>4</sup> The implementation of SecureCare was projected to cost an additional \$3.84 billion for increased

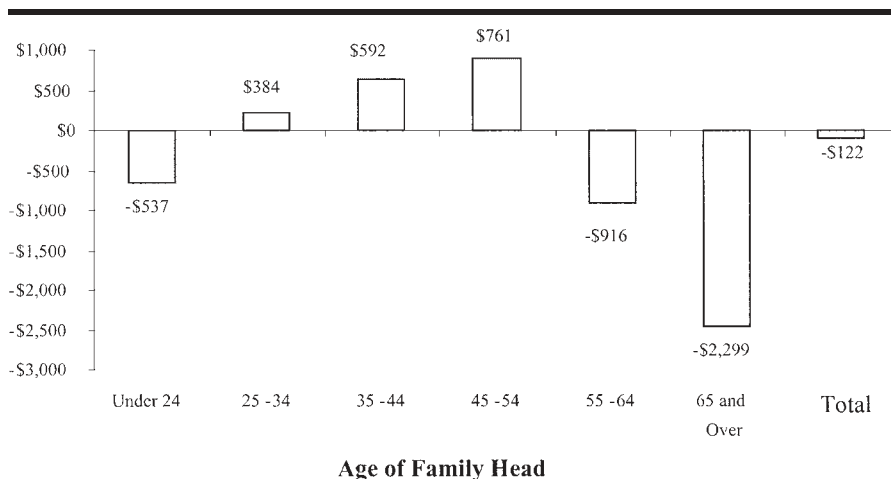


Fig 2. Change in average family health spending by age of family head under the Georgia SecureCare program in 2003: after wage effects<sup>4</sup>

utilization in the first year associated with initial unmet health care needs. At the same time, we identified annual savings of \$3.82 billion for administrative expenses, and another \$0.74 billion savings realized with the bulk purchases of prescription drugs and other items. Upon implementation of our hypothetical SecureCare plan, the net change for health spending in Georgia would be a decrease of \$0.72 billion, a savings of ~2% of the entire state health budget. Under this hypothetical, money-saving plan Georgia would for the first time provide generous, comprehensive benefits for all its residents.

### Impact of the Plan on Families

In 2003 Georgia families would have received more comprehensive coverage while saving an average of \$122 on health care as a result of the SecureCare plan. In households headed by persons 55 years and older, the average savings per year would be greater than for younger heads of household (Figure 2).<sup>4</sup> Households headed by persons in their peak earning years (ages 25 to 54) would spend more for their health care.

From the perspective of annual family incomes, rather than age of family head, those families receiving average or

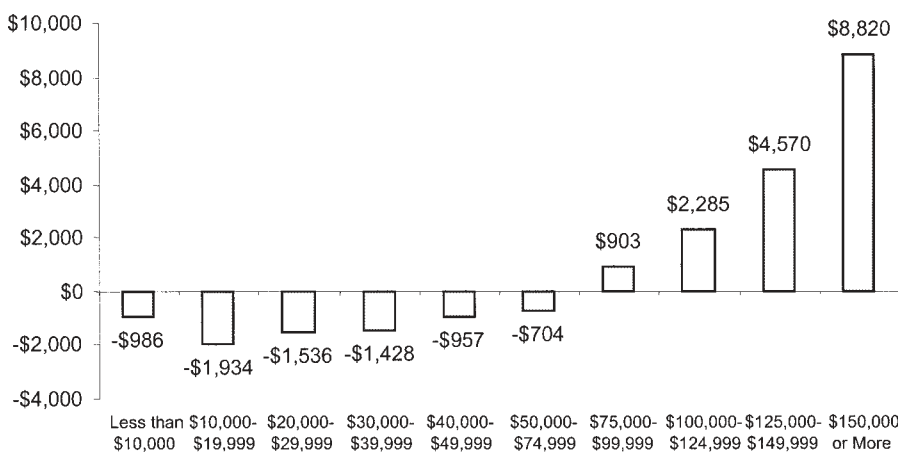


Fig 3. Change in average family health spending by family income under the Georgia SecureCare program in 2003: after wage effects<sup>4</sup>

lower-than-average incomes would save the most through the SecureCare plan (Figure 3). Those families in higher income brackets (\$75,000 to \$150,000 or more) would have, on average, a larger annual outlay for health care.

### Impact of the Plan on Private Employers

Our GCSHP spreadsheets demonstrated that SecureCare implemented in 2003 would have required Georgia employers, on average, to spend more for health care than they actually did.<sup>4</sup> For the average employer offering no health coverage, expenditures would have increased by about \$2,453 per worker. However, the workers and their dependents would have acquired generous coverage that was not available to them before. For the average employer who previously offered a health plan, expenditures would have increased only by about \$122 per worker. These estimates were made without consideration of the wage effects that might have moderated the impact of an additional payroll tax.

Private employers currently providing health insurance for 1,000 or more workers would likely have saved money under the SecureCare plan. The average savings for those firms would be about \$115 per worker per year. Companies of that size that currently do not provide coverage would expend an additional \$2,643 per worker per year.

### WOULD GEORGIANS SUPPORT SECURECARE?

In order to answer the GCSHP third question, “How wide and deep is

Georgia political support for such health care change?,” our household telephone survey asked its respondents twice whether they would support SecureCare. The initial question was posed immediately following the explanation of SecureCare principles and its proposed structure. Then, following extensive presentation of the funding sources and a list of 16 common objections to a universal, single-payer system we posed the same question for a second time.

Responding to the initial question, 72% said they would “strongly support” or “somewhat support” SecureCare. The strongest positive sub-group responses came from: African Americans; families making less than \$30,000 annually; persons without health insurance; persons identifying themselves as Democrats; and persons not registered to vote. When asked again, following recitation of SecureCare’s potential drawbacks, the percentage saying they “strongly supported” or “somewhat supported” the plan was reduced to 62%. The sub-group giving the strongest positive responses comprised people with no health insurance.

Although Georgia may typify a conservative region of the country in some respects, our household survey and economic analyses confirm that Georgians are concerned about the current health care system, that they would benefit from a universal, single-payer financing system, and that a solid majority is in support of such a major reform.

With the current unsustainable rate of inflation in health care costs and the rising numbers of persons who are

uninsured or underinsured, the GCSHP has found that most of our fellow Georgians want a change. Like other Americans, Georgians have come to see the current health care system as an embarrassment, a failed experiment, and a threat to their well-being. Most would agree with the recent comment of Professor Arnold Relman that “a real solution to the healthcare crisis will not be found until the public, the medical profession, and the government reject the prevailing delusion that health care is best left to market forces.”<sup>5</sup>

### RESOURCES ON THE INTERNET

- . Georgians for a Common Sense Health Plan. [www.commonsensehealthplan.org](http://www.commonsensehealthplan.org)
- . Proposal of the Physicians’ Working Group for Single-Payer National Health Insurance. [www.physiciansproposal.org](http://www.physiciansproposal.org)
- . Physicians for a National Health Program. [www.pnhp.org](http://www.pnhp.org)

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# The Best Medical Care In the U.S.

How Veterans Affairs transformed itself—and what it means for the rest of us

BY CATHERINE ARNST

**R**AYMOND B. ROEMER, 83, has earned his membership in “the greatest generation.” A flight engineer during World War II, his B-24 was shot down over Potsdam during a bombing run. He managed to parachute out, but the jump landed him in enemy territory. Roemer spent 11 months in a German POW camp until he was liberated by General George S. Patton’s troops in April, 1945.

A month later he came home to Buffalo with a Purple Heart and a few crushed vertebrae from that parachute jump. He married his high school sweetheart, started a successful metal-fabricating business, and signed up for health benefits with Blue Cross/Blue Shield. He can afford to be treated at any of some 20 well-regarded hospitals in the area, but Roemer has made what may seem a bizarre choice. He goes to the Veterans Affairs Medical Center in Buffalo, a hulking, gray edifice first opened in 1950. He doesn’t go just for his service-related injuries, either. His primary care doctor is at the VA, he fills his prescriptions there, and he uses the hospital for his vision and hearing needs. He even persuaded his 59-year-old son and business partner, Nicholas, a Vietnam War vet, to enroll with the VA.

Every day some 1,400 patients pass through the Buffalo VA’s unprepossessing entrance, into what many might assume

is a hellish health-care world, understaffed, underfunded, and uncaring. They couldn’t be more wrong. According to the nation’s hospital-accreditation panel, the VA outpaces every other hospital in the Buffalo region. “The care here is excellent,” says Roemer. “I couldn’t be happier, and my friends in the POW group I belong to all feel the same.”

## LOWER COSTS, HIGHER QUALITY

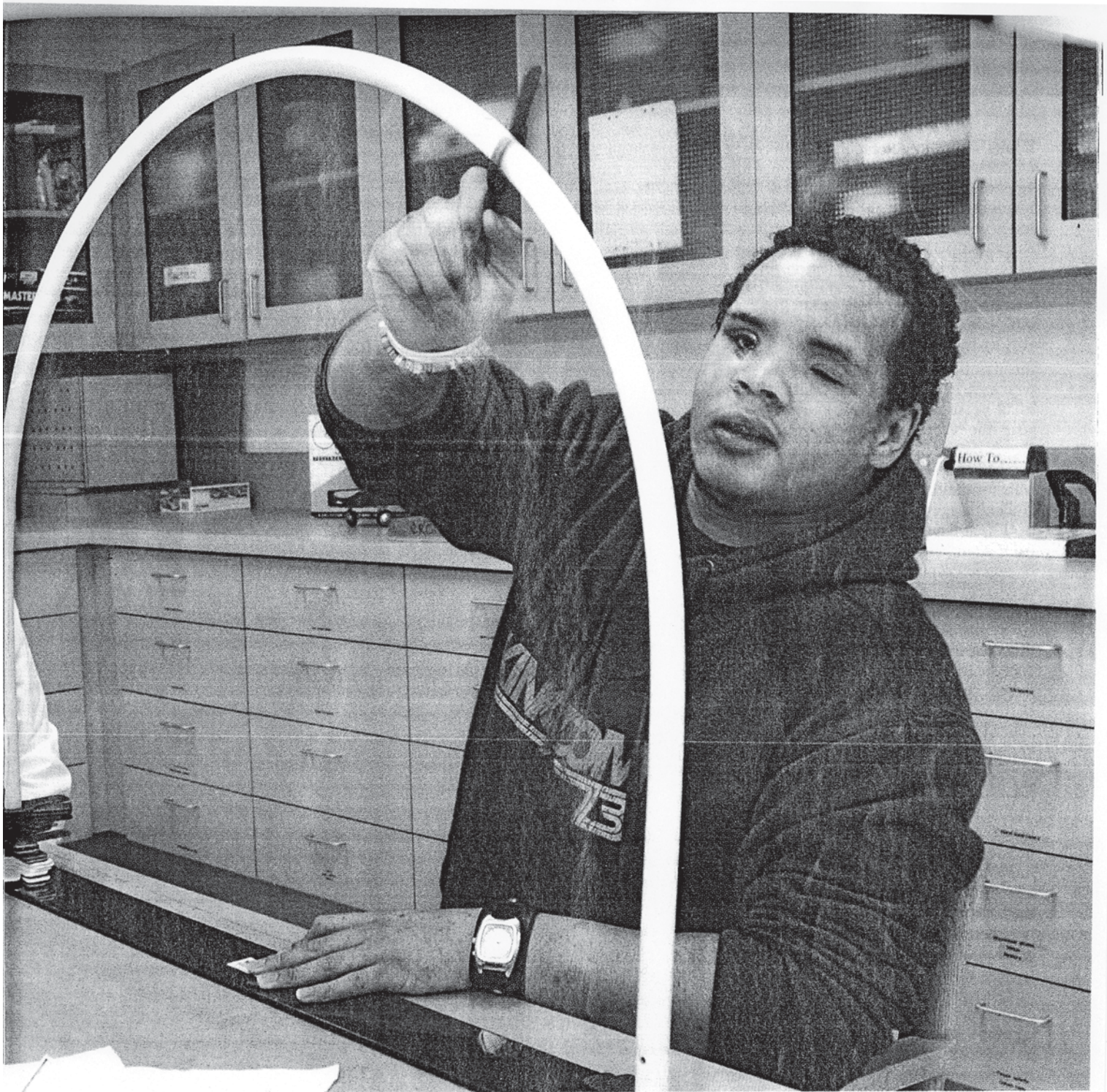
ROEMER SEEMS TO HAVE stepped through the looking glass into an alternative universe, one where a nationwide health system that is run and financed by the federal government provides the best medical care in America. But it’s true—if you want to be sure of top-notch care, join the military. The 154 hospitals and 875 clinics run by the Veterans Affairs Dept. have been ranked best-in-class by a number of independent groups on a broad range of measures, from chronic care to heart disease treatment to percentage of members who receive flu shots. It offers all the same services, and sometimes more, than private sector providers.

According to a Rand Corp. study, the VA system provides two-thirds of the care recommended by such standards bodies as the Agency for Healthcare Research & Quality. Far from perfect, granted—but the nation’s private-sector hospitals provide only 50%. And while studies show that 3% to 8% of the nation’s prescriptions are filled erroneously, the VA’s prescription accuracy rate is greater than 99.997%, a level most hospitals only dream about. That’s



Because the VA treats patients for life, it has an incentive to invest in **preventive care**, reaping the benefit of lower long-term costs. And its **advanced patient-records database** has nearly eliminated drug errors

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largely because the VA has by far the most advanced computerized medical-records system in the U.S. And for the past six years the VA has outranked private-sector hospitals on patient satisfaction in an annual consumer survey conducted by the National Quality Research Center at the University of Michigan. This keeps happening despite the fact that the VA spends an average of \$5,000 per patient, vs. the national average of \$6,300.

To much of the public, though, the VA's image is hobbled by its inglorious past. For decades the VA was the health-care system of last resort. The movies *Coming Home* (1978), *Born on the Fourth of July*

(1989), and *Article 99* (1992) immortalized VA hospitals as festering sinkholes of substandard care. The filmmakers didn't exaggerate. In an infamous incident in 1992, the bodies of two patients were found on the grounds of a VA hospital in Virginia months after they had gone missing. The huge system had deteriorated so badly by the early '90s that Congress considered disbanding it.

Instead, the VA was reinvented in every way possible. In the mid-1990s, Dr. Kenneth W. Kizer, then the VA's Health Under Secretary, installed the most extensive electronic medical-records system in the U.S. Kizer also decentralized decision-making,

closed underused hospitals, reallocated resources, and most critically, instituted a culture of accountability and quality measurements. "Our whole motivation was to make the system work for the patient," says Kizer, now director of the National Quality Forum, a nonprofit dedicated to improving health care. "We did a top-to-bottom makeover with that goal always in mind."

Keeping that goal in sight will be challenging as more and more Iraq vets come

#### **AFTER IRAQ**

Therapist Daniela Lita with vet Poole, who is recovering from injuries suffered in a roadside bomb attack

home. Some Sunbelt facilities are already overcrowded as the veterans' population ages and moves south. Much also depends on the amount of money Washington is willing to allocate to veterans' care. Kizer complains that budget allocations did not keep pace with inflation for the entire five years he was at the VA.

## MIGHTY FORCE FOR CHANGE

THE VA'S RADICAL overhaul has caught the attention of health-care policy wonks, who have in turn sung the system's praises in prestigious medical journals. Last year the Canadian journal *Healthcare-Papers* devoted an entire issue to the lessons other systems can take from the VA's transformation.

The biggest lesson? A nationwide health-care network that gets its funding from a single payer can institute mighty changes. Proponents of national health-care reform extrapolate even further. "The VA proves that you can get better results with an integrated, organized, national health-care system," says Dr. Lucian Leape, a professor at the Harvard School of Public Health and a leading expert on hospital safety. "We will not achieve even close to the level of quality and safety we need [in the U.S.] as long as we have individual practitioners and hospitals doing individual things."

The VA is, in many ways, the exact opposite of America's fragmented private-sector system, where doctors work for hospitals as independent contractors, and third-party insurers pay the bills as they see fit. By far the largest health-care network in the U.S., the VA serves 5.4 million patients—double the number it treated 10 years ago. All veterans are eligible for free or low-cost care, paid for out of the federal budget. The 2006 allocation comes to \$35 billion.

Not having to rely on piecemeal insurance payments means the VA can finance large-scale improvements such as the electronic medical-records system, up and running in all of its facilities since 2000. In contrast, only some 20% of civilian hospitals have computerized their patient records. Because the VA is a nationwide health-care system, its electronic network is national, which means all of its facilities can share data. When hospitals were evacuated from New Orleans during Hurricane Katrina, the VA's patients were the only ones whose medical records could be accessed immediately anywhere in the country.

The VA's charter also confers some unique advantages. Because it treats patients throughout their lives, it can invest

in prevention and primary care, knowing it will reap the benefits of lower long-term costs. Because the government pays the bills, the VA doesn't have to waste time or money on claims-related paperwork. Unlike Medicare, the VA is allowed to negotiate prices with drug companies and other suppliers, and it uses that power aggressively. The consumer group Families USA estimates that Medicare Part D enrollees, on average, pay 46% more than the VA for the same drugs.

The VA also gets to keep any money it saves through cost efficiencies. In the private sector the savings flow back to whoever is paying the bills. And because its doctors are salaried employees, the VA can implement systemwide changes without having to persuade outside doctors to go along. That doesn't mean it's

settling for second-rate physicians. Among the VA staff is a Nobel prize winner, and clinical research is conducted throughout the system. The Buffalo VA recently hired one of the city's top surgeons, Dr. Miguel A. Rainstein, as chief of surgery. He had spent 26 years in private practice, where, he concedes, he made a lot more money, but he was ready for a lifestyle change. "I feel the VA has always gotten a bad rap. They have an excellent medical staff here, in surgery and in specialties."

The staff is happier, too, since much of the bureaucracy that once hobbled the organization has been streamlined. Kizer ended Washington's centralized decision-making and set up a military-like organization of 22 regional divisions. And doctors don't have to worry as much

## Winning Scorecard

Hospitals in the Veterans Affairs system outpace those in the private sector by many measures

### QUALITY of Care

The latest Rand Corp. study found that VA patients, on average, received about two-thirds of the care recommended by national standards, compared with just half for patients at a sample of the nation's other hospitals. Here's the breakdown:

HEALTH INDICATOR	VA SCORE*	NATIONAL SAMPLE**
Overall	67%	51%
Chronic care	72	59
Lung disease	69	59
Heart disease	73	70
Depression	80	62
Diabetes	70	47
Hypertension	78	65
High cholesterol	64	53
Osteoarthritis	65	57
Preventive care	64	44
Acute care	53	55
Screening	68	46
Diagnosis	73	61
Treatment	56	41
Follow-up	73	58

\*596 VA patients \*\*992 patients at non-VA hospitals  
Data: Rand Corp.; Agency for Healthcare Research & Quality

### Patient SATISFACTION

For the sixth year in a row, veterans in 2005 were happier than other patients with their health care.

	VA	PRIVATE SECTOR
Inpatient	83*	73
Outpatient	80	75

\*Out of 100 Data: American Customer Satisfaction Index

### TECHNOLOGY Use

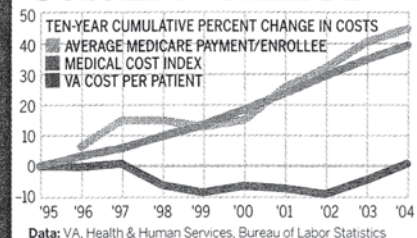
The VA has the most advanced electronic-records system in the U.S.

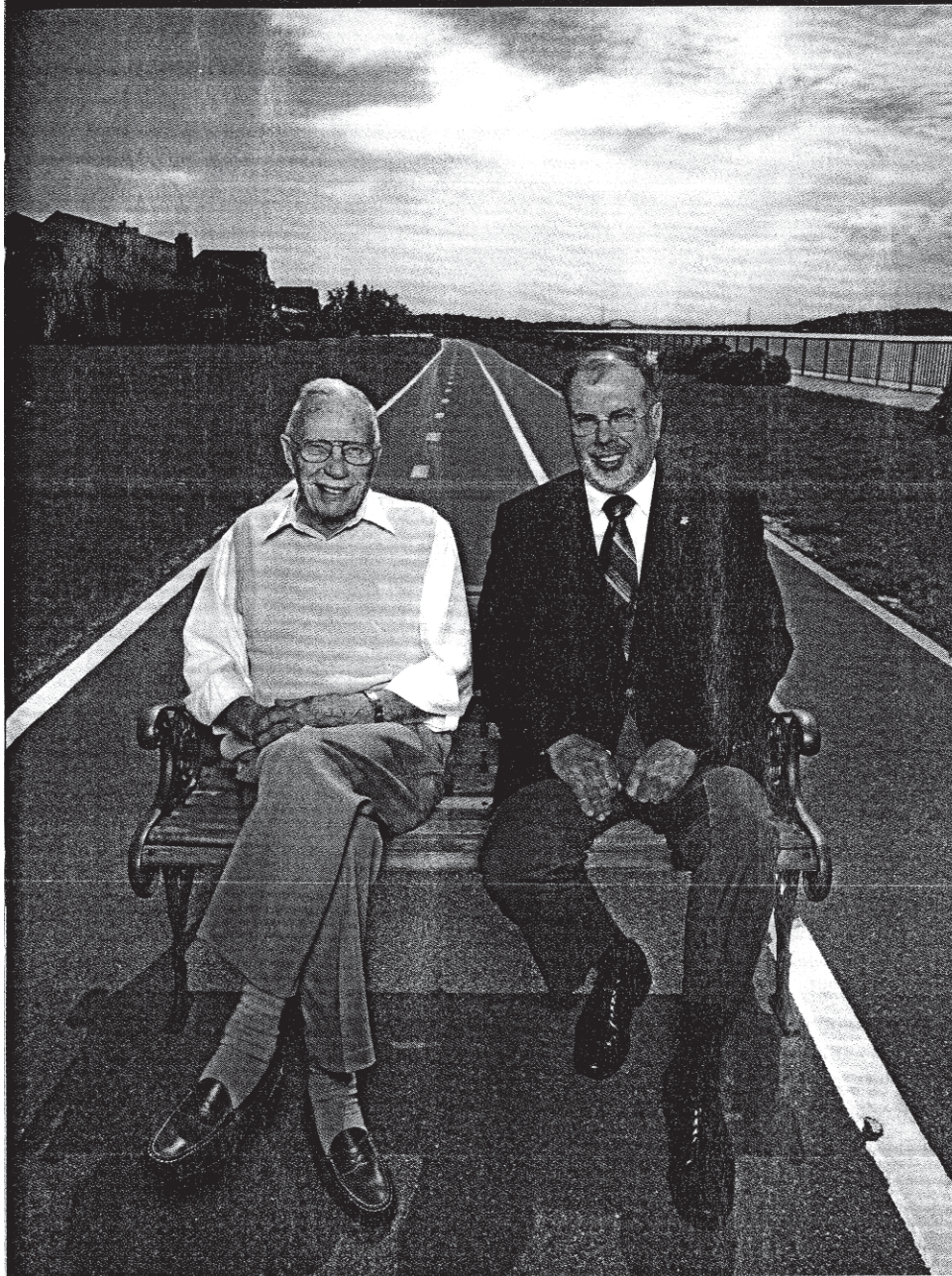
PERCENTAGE OF NEW-DRUG AND PROCEDURE ORDERS ENTERED ELECTRONICALLY

VA	94%
Academic medical centers	30
Nationwide	8

Data: Commonwealth Foundation

### Cost EFFICIENCY





CHRIS CRISMAN

about malpractice lawsuits, since government agencies are somewhat protected. That made it easier for the VA to go out on a limb in 2005 and institute a systemwide policy of apologizing to patients for medical errors—an act of contrition rarely done in the private sector. “Most families just want to hear an apology when a mistake is made,” says Dr. Jonathan B. Perlin, Kizer’s successor as Under Secretary for Health.

The “Sorry Now” program, as it’s called, is an extension of Kizer’s plan to transform the VA from an unaccountable bureaucracy into a transparent system that constantly seeks to improve care. “They’ve adopted a culture of patient safety and quality that is pervasive,” says Karen Davis, president of Commonwealth

Fund, which studies health-care issues.

The centerpiece of that culture is VistA, the VA’s much praised electronic medical-records system. Every office visit, prescription, and medical procedure is recorded in its database, allowing doctors and nurses to update themselves on a patient’s status with just a few keystrokes. In 1995, patient records at VA hospitals were available at the time of a clinical encounter only 60% of the time. Today they are 100% available. Some 96% of all prescriptions and medical orders, such as lab tests, are now entered electronically. The national comparison is more like 8%. “One out of five tests in a civilian hospital have to be repeated because the paper results are lost,” says Veterans Affairs Secretary R. James Nicholson. “That’s not

**FATHER AND SON**  
Ray and Nick Roemer can afford private doctors but choose the VA

happening in our hospitals.” VistA is a big reason why the VA has held its costs per patient steady over the past 10 years despite double-digit inflation in health-care prices.

VistA has also turned out to be a powerful force for quality control. The VA uses the data gathered in its computers to pinpoint problem areas, such as medication errors. The network also allows it to track how closely the medical staff is following evidence-based treatment and monitor deficiencies. Such tracking pays off. When Rand did an extensive study comparing quality of care at the VA with private-sector hospitals, it found that performance measurement played an important role in helping the VA score higher in every category except acute care, where it came in about even.

All of these changes are evident at the Buffalo VA. The patients in its waiting rooms hint at the hospital’s special mission—a mixture of frail old men, Vietnam

**“The care here is excellent. I couldn’t be happier, and my friends in the POW group I belong to all feel the same”**

—Raymond Roemer, World War II vet

era vets with ponytails and tattoos, and a scattering of young, clean-cut guys recently back from Iraq. The few women are usually wives since only 7% of veterans are female. A nurse meets with each patient on arrival, updating electronic records so that the doctor can get up to speed immediately. (Patients can also access their own records if they want, a rare option in most medical-records systems.)

At the hospital pharmacy, prescriptions are doled out by robotic devices—one reason the organization is able to hold copays at \$8. Each bottle of medicine carries a bar code that is scanned by the computer. If a patient is allergic or takes a conflicting drug, the system will sound an alarm. Similar bar codes are affixed to patient ID bracelets to protect against the

wrong patient getting a procedure, a common mixup in hospitals. The bar code idea was thought up by a VA nurse in Topeka, Kan., who noticed that rental cars were checked in with portable bar code scanners and figured the same technology could be used in hospitals.

## ELECTRONIC HOUSE CALLS

DR. JOHN SANDERSON, the Buffalo VA's director of medicine, clicks on to VistA as soon as he enters the clinic each morning to check the progress of his patients. Sanderson is a primary care doctor, so he plays point man in the team of specialists assigned to each vet according to the patient's needs. He meets with an elderly man with severe asthma, takes a quick look at his electronic records, and learns that the patient has not yet had a pneumonia shot. That's a big issue at the VA. The organization has cut hospitalizations by 4,000 patients a year since its pneumonia vaccination rate went from 29% in 1995 to 94% last year.

Sanderson also decides the patient needs to see a pulmonary specialist and arranges an appointment with one on the spot so the vet doesn't have to make a second trip. Such consideration for the patient is evident throughout the hospital. In every department of the giant building hangs a poster with the name, photo, and phone number of the supervisor, inviting patients to call with questions or complaints. The hospital is determined that no patient remain in the waiting room more than 15 minutes. Sanderson would like to get that down to five. After every outpatient visit and inpatient release, a staffer follows up with a call a few days later for feedback on the vet's experience and to make sure there are no problems.

Sanderson is able to spend more time with his patients because he spends less time record-keeping than his counterparts in private practice. That lets him fo-

## PLAYBOOK: BEST-PRACTICE IDEAS

### Medical MAKEOVER

The Veterans Affairs health network went from one of the worst in the nation to the best in just 10 years. It has some unique attributes that can't be duplicated at civilian hospitals. Still, other providers—and industries—can learn a lot from the military's rulebook.

**HIRE LEADERS WHO LOVE A CHALLENGE** When Dr. Ken Kizer became Health Under Secretary in 1994, Congress handed him a mandate to fix the VA, and he ran with it. "There was a universal consensus back then that if there was a single organization that couldn't be changed, it was the VA," he says. "I decided I would make this a model system, a case study for radical change." Kizer is often described as hard-nosed, abrasive, and brilliant. He got the job done in just five years. But Congress forced him out in '99.

**ESTABLISH A CULTURE OF QUALITY** Kizer decided from the outset that the VA would focus on quality of patient care above all. Every change, from the practice of medicine to the way prescriptions are filled, was redesigned with that goal in mind. "Culture of quality" is not just a meaningless slogan at the VA. Practices and outcomes are evaluated constantly, and staffers throughout the system meet regularly to discuss ways to improve patient care.

**IT'S THE TECHNOLOGY, STUPID** The VA has by far the most advanced electronic medical-records (EMR) system in the U.S., called VistA. Every one of the VA's facilities is linked to the national database, and every patient protocol and interaction is recorded. The resulting efficiencies and error reductions have more than covered the cost of implementing VistA. Also, the VA now has the data in hand to determine how well it is meeting its quality benchmarks.

cus on preventive care, and particularly diabetes prevention. Some 23% of the VA's patients have diabetes, and without close monitoring they can go on to develop a range of complications. The VA scored very high in the Rand study on diabetes care—70 out of 100, vs. 57 for the private sector. But to keep patients from developing diabetes in the first place, the VA offers overweight patients the opportunity to join a weight-management program that pairs them with a nutritionist. Few insurers will pay for such prevention in a civilian setting. To Sanderson, preventive care is just one reason he is sure

the changes at the VA "have saved thousands of lives over the years."

Staffers in Buffalo embrace the hospital's high level of commitment to patient care in part because many of them are veterans themselves. Diane DiFrancesco, a nurse in the intensive-care unit, is also a flight nurse in the U.S. Air Force Reserve. Her husband, a pilot in the reserves, is on his third tour of duty in Iraq. She has been at the Buffalo VA since 1987, a longevity typical at the facility, where the annual turnover rate is half that of other area hospitals. "People here really want to help the vets," she says. "Once you get used to

**With Walter Reed Army Medical Center in the news lately for poor care and treatment of returning soldiers from Iraq, some have suggested that this debacle is an indictment of national health insurance. Some clarifications are in order:**

1) The operation of Walter Reed was outsourced to a Halliburton-connected company in 2002, over the objections of some Army medical personnel and leadership. This outsourcing resulted in drastic reductions in maintenance and other staff, and the loss of institutional experience. The contracting process was also questionable. A bid from a group of gov-

ernment employees initially came in lower than the Halliburton company's bid, but the bids were subsequently recalculated to make the private firm the low bidder. For more detail see: <http://www.pnhp.org/BushVA>

2) Walter Reed is an Army hospital owned by the Department of Defense. The VA hospitals are run by the Veterans Administration (Veterans Health Administration), which is a separate structure. The reporting in the news media has clouded this fact and has led some to presume that all government-run health efforts are substandard. Nevertheless, the

VA health system, while not perfect, continues to rank higher than private sector care in both patient satisfaction and objective quality measures. It is a leader in the use of electronic medical records, access of patients to their medical records, transparency and accountability in dealing with medical errors, and the use of AHRQ quality guidelines.

(contributed by Dr. Anne Carroll)

For more information on the source of the crisis at Walter Reed, see California Nurses Association's Deborah Burgers article "We're All at Walter Reed." (<http://www.pnhp.org/BurgerVA>)



it here, it's hard to work anywhere else."

This Band of Brothers mentality goes a long way toward attracting and keeping the VA's unique group of patients. "I've never been very comfortable in hospitals, but I like the idea that the patients here and I have something in common," says Nick Roemer, Ray's son, who first used the Buffalo VA three years ago when he hurt his wrists. He has private insurance but figured it would be cheaper and faster to come to his father's caregiver. "You can talk to people here. They're like you."

The VA's mission brings with it some special burdens, however. Its patients are generally older, poorer, and sicker than those in civilian hospitals; there is also a higher prevalence of mental illness and addiction. And it has large numbers of patients with a malady that is much less common in civilian hospitals: post-traumatic stress disorder (PTSD).

It was the PTSD program that persuaded Steve to enter the fold. A 40-year-old police officer in the Buffalo area who asked that his last name not be used, Steve has been a sergeant in the reserves for 21 years, serving in Afghanistan, Bosnia, and Panama, and Iraq in 2004. When he returned

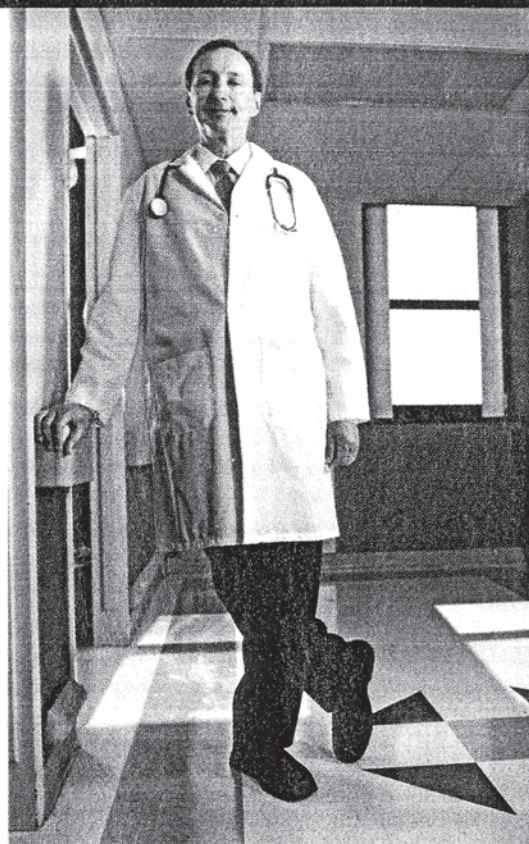
from Iraq, he couldn't sleep and constantly felt anxious. He resisted visiting a VA facility because of negative impressions carried over from the early '90s, but he figured "a civilian doctor would have no clue. They don't understand where we're coming from." At the VA he felt he could be treated properly and comfortably. "To be honest, I don't want to bring it up with anyone outside the vet community." Now he's sending literature about the PTSD services to everyone in his unit who's still in Iraq.

Those returning vets are one of the biggest challenges looming for the VA. It recently reported that the number of PTSD cases has doubled since 2000, to an all-time high of 260,000. The Iraq war has also left vets with injuries that are horrendous even by wartime measures because battle field medicine can treat traumas that in past wars would have meant certain death. In World War II, there were two to three soldiers wounded for every one killed. In Iraq, 9 to 10 are wounded for each killed.

Marine Corporal Jason Poole, 23, is living proof of the improved chances of survival and the advanced medicine offered by the VA. The native of Bristol, England, now a U.S. citizen, was on his third tour in Iraq in 2004, 10 days shy of coming home, when his patrol was hit by a roadside bomb that left him in a coma for two months. Shrapnel went through his left ear and out his left eye. He was unable to walk, talk, or breathe without a tube. Treated at the brain trauma unit of the VA hospital in Palo Alto, Calif., one of four VA polytrauma clinics for the severely wounded, Poole has had nine reconstructive surgeries in two years. He still gets physical therapy, but he is now walking, talking, and taking classes at a community college. "I've been treated amazingly here," he says. "Everyone has been working so hard for me."

The VA is opening 22 more polytrauma clinics to care for the growing numbers of soldiers with severe injuries. Most will eventually be treated at standard hospitals like the one in Buffalo, and that could send the VA's costs skyrocketing.

It doesn't help that the VA must worry about getting shortchanged by Washington. President George W. Bush wants to hold down costs by raising eligibility requirements for vets. So far, Congress has rebuffed him. That doesn't mean Capitol Hill is always on the VA's side, though. Kiz-



**“Thousands of lives” have been saved by the VA’s focus on preventive care**

—Dr. John Sanderson, director of medicine at the Buffalo VA



**“Once you get used to it here, it's hard to work anywhere else”**

—Diane DiFrancesco, intensive-care nurse at the Buffalo VA Medical Center, where the staff turnover rate is half that of other local hospitals

er, the turnaround's architect, was forced out in 1999 when Congress refused to reconfirm him after he closed hospitals in key districts. Dr. Dennis S. O'Leary, president of the Joint Commission on Accreditation of Healthcare Organizations, praises Nicholson and Perlin for sticking with Kizer's reforms. But he warns that "the most common reason hospitals go into the tank is a change in leadership." Since the VA is as affected by politics as any other federal entity, that will always be a concern, he says.

It's not a concern yet, and civilians are taking notice of the military way of medicine, with some hospitals using versions of VistA. The VA's other advantages may not be as easy to adapt, but as Harvard's Leape says, "the VA is a dramatic example of what can happen if you have the will and the leadership to make change happen." ■

CHRIS CRISMAN

# Chapter Reports

New Hampshire PNHP'ers have been reaching out to the medical community, citizen groups and presidential candidates in anticipation of the 2008 primaries. Following a successful presentation to the state medical society, Dr. Marcosa Santiago coordinated a "Health Care Security NOW" forum with representatives from the Medical Society and NH Citizens' Alliance for Action as well as Rep. Dennis Kucinich (D-OH). More than 100 people attended, including many state legislators. Dr. Santiago and Dr. Thomas Clairmont testified on single payer at a NH General Assembly hearing. Contact Dr. Santiago at [cosy@diacad.com](mailto:cosy@diacad.com).

Florida PNHP leader Dr. Greg Silver has been bringing the single payer message to community organizations and the airwaves. Most recently, he spoke to a group of 75 senior activists in Fort Meyers. He was also the featured guest on the local radio program "Radioactivity Live" on WMNF. Contact Dr. Silver at [drsilver@drsilver.net](mailto:drsilver@drsilver.net).

PNHP's California chapter, the California Physicians' Alliance, has been reaching the medical community and public with events centered around their state single-payer bill, SB 840. The bill passed both houses of the Assembly last year but was vetoed by Governor Schwarzenegger. Partnering with the citizen single-payer group OneCareNow and the American Medical Student Association, the chapter helped organize a lobby day with 250 medical and health students and participated in a rally which drew 500 supporters to the state capitol. The chapter's extensive speakers bureau, (including Drs. Richard Quint, Nancy Greep, Jeffery Gordon, Barry Massie and Ron Adler) have spoken across the state, including at the University of California, the Naval Regional Medical Center and the League of Women Voters. Dr. Sal Sandoval is participating in the organization of the 2007 "Journey for Justice," a 10-day march through 11 central California cities to demand a single-payer health program. PNHP Senior Health Policy Fellow Dr. Don McCanne is a frequent speaker both at conferences and to the media. His influential and widely-read "Health Policy Quote of the Day" is available to PNHP'ers by email for free. Subscribe by dropping a note to [don@mccanne.org](mailto:don@mccanne.org).

PNHP members in Georgia have been reaching out to the progressive and medical communities through public forums, grand rounds and legislative efforts. The chapter presented a seminar on their state "SecureCare" plan to the Georgia Progressive Summit, which includes trade union, civil rights, environment and peace groups. Leader Dr. Henry Kahn has maintained an active speaking schedule both in Georgia and neighboring South Carolina. His recent engagements have

included: a graduate nursing seminar at the University of Georgia, the Department of Medicine at the Tenet-owned Atlanta Medical Center, and the Departments of Medicine and Pediatrics at the University of South Carolina. Contact Dr. Kahn at [hkahn@emory.edu](mailto:hkahn@emory.edu).

Washington State PNHP'ers are successfully organizing around their state single-payer legislation. The chapter has helped facilitate more than 100 meetings between state legislators and constituents in favor of single-payer, and eight chapter members have testified before hearings of the state House and Senate. The chapter has also been focusing on speaking engagements to gain endorsements of the bill. Recent endorsers include the state chapters of the League of Women Voters, the National Alliance on Mental Illness and the Alliance for Retired Americans. Contact chapter leader Dr. David McLanahan at [mcltan@comcast.net](mailto:mcltan@comcast.net).

PNHP's Pennsylvania chapter has enjoyed record success in outreach to the medical community this year, including grand rounds at all five medical and osteopathic schools in the Philadelphia area as well as at seven additional hospitals. Their talented speakers' bureau, including Drs. Gene Bishop, Adam Gilden Tsai, Walter Tsou, Scott Tyson and William Wood, also reached numerous community and health professional groups such as the American Association of Physician Assistants and the League of Women Voters. In Pittsburgh, Dr. Scott Tyson gave Grand Rounds at Mercy Hospital and spoke to more than 150 medical students. Contact Dr. Tsou at [macman2@aol.com](mailto:macman2@aol.com).

PNHP's Colorado chapter, Health Care for All Colorado, has expanded to five active chapters across the state. Chapter leaders Drs. Rocky White and Elinor Christensen are members of the Colorado Medical Society Physician Congress for Health Reform and have been advocating the single-payer solution. The chapter trained 12 new speakers in 2006, and members have spoken to dozens of groups, including the Older Women's League, American Business Women of America, the United Methodist Church, the South Denver Chamber of Commerce and the Colorado Business Group on Health. Dr. Anne Courtright has made eight presentations in the Pueblo area, including the Pueblo West Rotary, and the Westminster Presbyterian Church. Contact Dr. White at [whtfarms@fone.net](mailto:whtfarms@fone.net).

Alabama PNHP'er Dr. Wally Retan has been speaking on the need for single-payer to medical and businesses audiences. Dr. Retan spoke to medical staffs at Baptist Medical and Trinity Hospitals as well as the Etowah County Medical Society. He also presented to a group of retired physicians and businesspeople in Tuscaloosa. Contact Dr. Retan at [wretan2900@charter.net](mailto:wretan2900@charter.net).

PNHP's Illinois chapter has been working on media and coalition-building within the health and medical communities. PNHP Chapter Chair Dr. Rob McKersie presented grand rounds at the Children's Hospital in Peoria and spoke the Cook County Board; Dr. Chris Masi spoke at the Children's Hospital in Chicago; Dr. Gordon Schiff spoke to students at an AMA-sponsored meeting; and Drs. John Rolland and Arnold Widen each spoke at the University of Illinois Chicago. Dr. Quentin Young spoke on the need for single-payer to the National Conference for Labor Representatives in Health Care. The chapter has built a coalition around its new state single-payer bill (HB 311), including nursing, public health, disability, women's, seniors' and labor groups. PNHP'ers were quoted in all three of the state's major newspapers in response to the governor's flawed "individual mandate" plan. Contact Dr. McKersie at [dejadog@hotmail.com](mailto:dejadog@hotmail.com).

In Arizona, PNHP member Phil Lopes has become Minority Leader of the state House of Representatives, and has reintroduced a bill (HB 2677) to create a single-payer program for that state. Dr. George Pauk has been active in organizing around the bill, most recently speaking to the Universalist Unitarian Congregation in Phoenix. Contact Dr. Pauk at [gpauk@earthlink.net](mailto:gpauk@earthlink.net).

Minnesota PNHP members have been successful in spreading the single-payer message through their 13-member Minnesota Universal Health Care Coalition ([www.muuhcc.org](http://www.muuhcc.org)), which added the State Council of SEIU and the Minneapolis Metropolitan Business Alliance this year. Chapter members gave talks to medical, labor, business and community groups this year, including 45 by PNHP'er Kip Sullivan. Dr. Lisa Nilles had an op-ed on single-payer published in the state's largest newspaper. Led by chair Dr. Susan Hasti, MUHCC is working on building a "single-payer caucus" in the state legislature and Drs. Katja Rowell and Jack Garland have given testimony to lawmakers. Contact Dr. Nilles at [eanilles@comcast.net](mailto:eanilles@comcast.net).

In Ohio, PNHP Past President Dr. Johnathan Ross has been reaching out to the medical community and citizen groups, most recently addressing activist audiences in Akron and Cleveland. Dr. Ross has also presented grand rounds at the University of Cincinnati and to both the Pediatrics and Internal Medicine departments at Case Western. Ohio PNHP'ers continue to be active in the Single-Payer Action Network (SPAN) state coalition, which has grown to 2,300 supporters in 12 local chapters. Contact Dr. Ross at [drjohnross@ameritech.net](mailto:drjohnross@ameritech.net).

The NYC Metro PNHP chapter continues a vigorous campaign to reach physician, community, student and church audiences. Speaking engagements have included the national conventions of the American Medical Student Association, the Student National Medical Association, and the American Medical Association as well as the New York Chapter of the American College of Physicians. Chapter Chair Dr. Oliver Fein taped a video editorial which will be broadcast on the popular WebMD website and Dr. Olveen Carrasquillo's research on uninsured Latinos was published in the journal *Health Affairs* (see abstract on page 13). The chapter has also been active in addressing non-medical audiences, most recently in talks to the League of Women Voters and the Greater NY Chamber of Commerce. Members also organized a successful campaign to use the celebration of Dr. Martin Luther King's birthday to highlight the need for single-payer. Dr. Elaine Fox is spearheading an effort to build a single-payer coalition on Long Island. Contact Joanne Landy at [jlandy@igc.org](mailto:jlandy@igc.org).

In Tennessee, chapter leader Dr. Arthur Sutherland had success reaching fellow physicians through a pro-single payer guest editorial he published in the *Memphis Medical Society Quarterly*. The article was so well-received that it was republished in the monthly magazine of the Tennessee Medical Association, and the Memphis society has decided to start a blog on the topic. Nashville members Drs. Dick Braun, James Powers and Jim Hudson hosted a successful town meeting on single-payer in April with a video and panel discussion. Contact Dr. Sutherland at [asutherland@sutherlandclinic.com](mailto:asutherland@sutherlandclinic.com).

In Virginia, chapter coordinator Dr. Joe Mason has been working hard to build support for single-payer among civic and health audiences, including physician assistant groups and Rotary clubs. He also addressed the Charlottesville City Council in support of HR 676 and will speak to the University of Virginia Democrats club on the need for single-payer. Contact Dr. Mason at [jmason54@earthlink.net](mailto:jmason54@earthlink.net).

In Upstate New York, the PNHP Capital District's Dr. Chris Clader and Besty Swan organized an open house for local physicians and others who are interested in single-payer and PNHP, and the chapter is helping other physicians to host similar events at their offices. The chapter is also on the airwaves: Dr. Paul Sorum will be on an hour-long local radio panel speaking about the need for single-payer. Chapter members also presented to the Medical Society of Schenectady County and are encouraging them to formally endorse single-payer. Along with Drs. Andy Coates and Richard Propp, Dr. Sorum continues to speak to medical, student and community groups around the area. Contact Dr. Sorum at [pnhpcapitaldistrict@nycap.rr.com](mailto:pnhpcapitaldistrict@nycap.rr.com).

OPPOSING VIEWS:

# State plans miss the point

## Neither state goes far enough. People will still lack care.

By Don McCanne

Americans need more than affordable insurance; they need affordable health care. California Gov. Arnold Schwarzenegger plans to copy the Massachusetts reform in shrinking the numbers of uninsured people by forcing them to buy stripped down, bare-bones policies.

With premiums for family coverage now averaging \$10,000 a year, the only way that states can make premiums affordable is to strip down the plans, which then forces policyholders to pay out of pocket when they get sick. High deductibles, co-payments and benefit reductions are destroying the financial protection that insurance should provide.

Half of U.S. bankruptcies are a result, in part, of medical illness or medical bills. Three-quarters of Americans who are forced into medical bankruptcy had health insurance at the onset of the ill-

ness that bankrupted them. Worse, suffering and death can occur when patients cannot afford the care that their private insurance does not cover.

The big winners in the Schwarzenegger and Massachusetts health plans are private health insurance firms. The new insurance mandates will hand them billions in wasteful administrative fees that do not occur in government insurance programs such as Medicare. Private insurers will continue their cream-skimming, enrolling primarily the low cost, healthy workforce and their families, while leaving the costs of the unprofitable sick and elderly to the taxpayers.

State health programs are interdependent on federal programs such as Medicare, Medicaid and the Veterans Affairs' system, and are regulated by federal laws. The states alone cannot enact the structural changes that would be required to cover everyone and control costs. They are limited to building on



the existing system by tweaking it to nominally expand coverage to the uninsured.

Money is not the problem. We already are spending enough on health care to provide high-quality, comprehensive services for everyone. But our inefficient, private-sector insurance bureaucracies have failed and need to be replaced with single-payer national health insurance. Every other developed nation has covered its citizens through some form of non-profit national health insurance.

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