PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter Spring 2008

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM » 29 E. MADISON, SUITE 602, CHICAGO, IL 60602 » WWW.PNHP.ORG » SPRING 2008 NEWSLETTER

Open Letter to the Presidential Candidates

"Political calculus favors mandates or tax incentives, which accommodate insurers, drug firms, and other medical entrepreneurs. But such reforms are economically wasteful and medical dangerous. The incremental changes suggested by most Democrats cannot solve our problems; further pursuit of market-based strategies, as advocated by Republicans, will exacerbate them. What needs to be changed is the system itself." - excerpt from the Open Letter

PNHP is spearheading a campaign to garner 10,000 physician signatories for a letter and advertisement urging the candidates to support single payer national health insurance as the sole hope for affordable, comprehensive coverage.

The campaign is endorsed by Drs. Marcia Angell and Arnold Relman, editors emeriti, New England Journal of Medicine, and many other prominent physicians. PNHP'ers are encouraged to circulate the letter via snail mail or e-mail at www.pnhp.org/letter.

PNHP Media Update

The New York Times, Boston Globe, Newsday, Chicago Sun-Times, Indianapolis Star, Des Moines Register, Atlanta Constitution, New Hampshire Union Leader, LA Times and many other publications have featured op-eds and letters by PNHP'ers in support of single payer in recent months. Thanks to Drs. Bud Goodrich, James Mitchiner, Jeremiah Schuur, John Daley, Richard Dillihunt, Kenneth Brummel-Smith, Michael Kaplan, David Kerns, Miles Weinberger, Donald Mitchell and other PNHP'ers for your media outreach. If your op-ed is published, please send a copy to info@pnhp.org!

Tikkun magazine's January issue featured PNHP Past President Dr. John Geyman's article on the presidential candidates' health plans (online at http://www.pnhp.org/2008plans).

American College of Physicians (ACP) Endorses Single Payer

The 124,000-member ACP endorsed single payer for the first time in December, citing international and other evidence that showed that single payer was efficient and affordable. For details, see page 5.

Drs. Henry Kahn, Andy Coates, and Oliver Fein are among the PNHP'ers invited to speak to ACP chapters on the heels of their endorsement of single payer. Dr. Henry Kahn was "warmly thanked" by the Georgia ACP for defending the ACP's new position.

PNHP'ers Dr. Olveen Carrasquillo, Dr. Linda Prine and others helped garner endorsements of single payer from the National Hispanic Medical Association and the New York Academy of Family Practice (NYAFP). The NYAFP is taking the lead in promoting single payer within the American Academy of Family Practice.

Majority of Physicians Support Single Payer

A majority (59 percent) of physicians in the U.S. support "government legislation to establish national health insurance," up from 49 percent five years ago, according to a study published in the Annals of Internal Medicine in April (reprinted on page 17). The survey, by PNHP Board Member Dr. Aaron Carroll, corroborates the results of recent surveys in New Hampshire, Minnesota, and Massachusetts that found 64-67 percent of physicians in support of single payer in those states.

PNHP 2008 Annual Meeting and Leadership Training
San Diego, October 24-25, 2008

PNHP will repeat its popular Leadership Training course in health policy, politics, and activism October 24 in conjunction with the Annual Meeting October 25 in San Diego. Over 500 physicians and medical students have participated in the program and gained the knowledge base and confidence to speak out in support of health care reform. Space is limited; to register call 312-782-6006. Both events will be held the Westin Horton Plaza. To reserve a room ($225 single/double), call 800-937-8461 before September 26.

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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, Communications Director Mark Almberg, Webmaster/Research Associate Dave Howell, Organizer Todd Main and Office Manager Matthew Petty. Courtney Morrow and Roberto Ramos staff the New York and California chapters of PNHP, respectively.

PNHP Membership Drive Update

Welcome to 981 new members who have joined PNHP in the last year! PNHP now has over 15,000 members. We invite new (and long-time) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community.

PNHP'ers in Alabama, Florida (Tallahasee), Puerto Rico, Michigan (Ann Arbor), Ohio (Columbus), Oregon (Corvalis), Connecticut, Arizona, Minnesota, and New York (Rochester and Ithaca) are starting or reinvigorating PNHP chapters in their areas.

362 Unions and 89 Members of Congress Endorse HR 676

33 state chapters of the AFL-CIO and 362 other union groups in 48 states have endorsed HR 676, The National Health Insurance Act. The number of Congressional co-sponsors for single payer legislation continues to grow, with 89 as we go to press. PNHP's DC chapter chair Dr. Robert Zarr helped garner four co-sponsors on a visit to Capital Hill with lead sponsor Rep. John Conyers last fall. For a list of sponsors, see page 45.

What PNHP Members Can Do

1. Submit an Op-ed or Letter to the Editor to your local newspaper, medical specialty journal, or alumni magazine. **Dr. Don McCanne encourages PNHP'ers to "recycle" his single payer "Quote of the day" messages into letters and op-eds for local publication. Subscribe at Don@mccanne.org.**

2. Set up a Grand Rounds or other conference on health care reform at your hospital, medical school, or professional society (e.g. the local chapter of the American College of Physicians). The PNHP 2008 slide show is available to members on-line at www.pnhp.org/slides under the password "malinow".

3. Offer to advise candidates for Congress or other public office on health policy using research and educational resources from PNHP. Call the PNHP national office if you need assistance.

It's Easy to Add PNHP to Your Will.

You just add a sentence to your will that says, "I bequeath the following _____ (dollar amount, property, or stocks) to the non-profit organization Physicians for a National Health Program of Chicago, Illinois. Their FEIN # is 04-2937697, and their mailing address is 29 E. Madison, Suite 602, Chicago, IL 60602."

The New York Times

DECEMBER 15, 2007

I Am Not a Health Reform

By DAVID U. HIMMELSTEIN
and STEFFIE WOOLHANDLER

In 1971, President Nixon sought to forestall single-payer national health insurance by proposing an alternative. He wanted to combine a mandate, which would require that employers cover their workers, with a Medicaid-like program for poor families, which all Americans would be able to join by paying sliding-scale premiums based on their income.

Nixon's plan, though never passed, refuses to stay dead. Now Hillary Clinton, John Edwards and Barack Obama all propose Nixon-like reforms. Their plans resemble measures that were passed and then failed in several states over the past two decades.

In 1988, Massachusetts became the first state to pass a version of Nixon's employer mandate — and it added an individual mandate for students and the self-employed, much as Mrs. Clinton and Mr. Edwards (but not Mr. Obama) would do today. Michael Dukakis, then the state's governor, announced that "Massachusetts will be the first state in the country to enact universal health insurance." But the mandate was never fully put into effect. In 1988, 494,000 people were uninsured in Massachusetts. The number had increased to 657,000 by 2006.

Oregon, in 1989, combined an employer mandate with an expansion of Medicaid and the rationing of expensive care. When the federal government granted the waivers needed to carry out the program, Gov. Barbara Roberts said, "Today our dreams of providing effective and affordable health care to all Oregonians have come true." The number of uninsured Oregonians did not budge.

In 1992 and '93, similar bills passed in Minnesota, Tennessee and Vermont. Minnesota's plan called for universal coverage by July 1, 1997. Instead, by then the number of uninsured people in the state had increased by 88,000.

Tennessee's Democratic governor, Ned McWherter, declared that "Tennessee will cover at least 95 percent of its citizens." Yet the number of uninsured Tennesseans dipped for only two years before rising higher than ever.

Vermont's plan, passed under Gov. Howard Dean, called for universal health care by 1995. But the number of uninsured people in the state has grown modestly since then.

The State of Washington's 1993 law included the major planks of recent Nixon-like plans: an employer mandate, an individual mandate for the self-employed and expanded public coverage for the poor. Over the next six years, the number of uninsured people in the state rose about 35 percent, from 661,000 to 898,000.

As governor, Mitt Romney tweaked the Nixon formula in 2006 when he helped devise a second round of Massachusetts health care reform: employers in the state that do not offer health coverage face only paltry fines, but fines on uninsured individuals will escalate to about $2,000 in 2008. On signing the bill, Mr. Romney declared, "Every uninsured citizen in Massachusetts will soon have affordable health insurance." Yet even under threat of fines, only 7 percent of the 244,000 uninsured people in the state who are required to buy unsubsidized coverage had signed up by Dec. 1. Few can afford the sky-high premiums.

Each of these reform efforts promised cost savings, but none included real cost controls. As the cost of health care soared, legislators backed off from enforcing the mandates or from financing new coverage for the poor. Just last month, Massachusetts projected that its costs for subsidized coverage may run $147 million over budget.

The "mandate model" for reform rests on impeccable political logic: avoid challenging insurance firms' stranglehold on health care. But it is economic nonsense. The reliance on private insurers makes universal coverage unaffordable.

With the exception of Dennis Kucinich, the Democratic presidential hopefuls sidestep an inconvenient truth: only a single-payer system of national health care can save what we estimate is the $350 billion wasted annually on medical bureaucracy and redirect those funds to expanded coverage. Mrs. Clinton, Mr. Edwards and Mr. Obama tout cost savings through computerization and improved care management, but Congressional Budget Office studies have found no evidence for these claims.

In 1971, New Brunswick became the last Canadian province to institute that nation's single-payer plan. Back then, the relative merits of single-payer versus Nixon's mandate were debatable. Almost four decades later, the debate should be over. How sad that the leading Democrats are still kicking around Nixon's discredited ideas for health reform.

David U. Himmelstein and Steffie Woolhandler are professors of medicine at Harvard and the co-founders of Physicians for a National Health Program.

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THE INDIANAPOLIS STAR

| SATURDAY, FEBRUARY 9, 2008 |

Prescription for change

Hoosier doctor leads drive to fix ailing health system

By Daniel Lee

Dr. Rob Stone was a teenager in Southern Indiana when he felt the call to become a physician.

It began during a stint as a counselor at a camp in Tell City for children with disabilities. An Ivy League education and career as a doctor followed.

Then, decades later, came a second calling: He became an agitator for changing the nation's health-care system.

Stone, an emergency room physician at Bloomington Hospital, has emerged as one of Indiana's most outspoken advocates for making insurance accessible to all. He is co-founder and director of Hoosiers for a Commonsense Health Plan, which contends that the current system is too profit-driven, too inefficient, and leaves too many people without affordable access to health care.

HCHP -- made up of doctors, nurses, social workers, patients and others -- is an affiliate of the national Physicians for a National Health Program.

From its founding in September 2005, HCHP has grown from a small band of advocates to a statewide citizens group with dozens of active volunteers and an e-mail list of more than 1,500.

Stone, 55, said his motivation stems from his many years of seeing the struggles of patients needing care.

"It started dawning on me just how crazy our current system is, and the cost shifting and the crazy patchwork quilt of payer sources, just how insane the system seems to be," Stone said. "That, coupled with watching as the ER became more and more of the safety net for the uninsured."

Stone brings that message to Indianapolis today during a public forum titled "Understanding the Health Care Crisis: Problems and Solutions," which runs from 9 a.m. to noon at Indianapolis First Friends, 3030 Kessler Blvd., East Drive.

One of Stone's favorite targets is Indiana's largest health-care insurance provider, Indianapolis-based WellPoint, a $61 billion health insurance giant that provides coverage to 35 million people in America.

"WellPoint epitomizes our system," he said. "They're it."

Stone's PowerPoint presentation lays out his case. A Medicare-type program for all is better than the current system, he says. Medicare is currently for the elderly.

One slide -- with information attributed to the International Journal of Health Services in 2005 -- shows Medicare overhead spending was 3.1 percent of its budget, compared with 26.5 percent for investor-owned Blue Cross and Blue Shield plans.

Another slide -- with information from the Employer Health Benefits Annual Survey and Bureau of Labor Statistics -- showed that from 2000 to 2006 health insurance premiums rose 87 percent while workers' earnings rose 18 percent.

About 47 million Americans, including 750,000 Hoosiers, are without health insurance.

It's a complex and uphill battle.

DANESE KENON / THE STAR

Passion for public service: Bloomington doctor Rob Stone consults with Lori Wilbur, Bloomington, at the Volunteers in Medicine of Monroe County clinic. Stone, co-founder of Hoosiers for a Commonsense Health Plan, donates time to the clinic that serves the uninsured.

" 'Single payer' is not a phrase that is rolling off anyone's lips in the presidential race, with the exception of Dennis Kucinich," said Alwyn Cassil, director of public affairs for the Center for Studying Health System Change, a Washington, D.C.-based research group.

Many Americans, she said, tend not to be interested in what they consider a government solution to the health-care crisis. Cassil said hospitals, insurers, device makers and many doctors benefit from the current system.

But Stone does have some allies. Physicians for a National Health Program was founded by two Harvard professors of medicine, David Himmelstein and Steffie Woolhandler, and has grown to more than 14,000 members.

"They're a very dedicated, committed group," Cassil said.

Groups like Stone's, while small in the number of physicians who take part, are credible advocates because they're out on the front lines of medicine and often stand to lose income if the reforms they seek ever become reality, Cassil said.

For its part, WellPoint sees having a competitive, free-market system as key to improving the quality of care and controlling costs.

"We believe a single-payer health-care system would hinder progress in these areas by eliminating competition and restricting patient choice and could require patients to endure long wait times for care while possibly reducing the quality of health care," WellPoint spokesman Jim Kappel said in an e-mail.

In its recent earnings report, WellPoint touted that it lowered its administrative expenses to 14.5 percent of premium revenue in 2007 from 15.7 percent in 2006 even as it added 708,000 members.

The company also pointed to flaws in other nations' health-care systems.

"In Canada, which has a single-payer system, the average wait between a general practitioner referral and a specialty consultation at times has been longer than 17 weeks."

Stone stands by his position. He recalls a patient who refused to seek treatment for chest pains that turned out to be a heart attack. He finally sought treatment for a second attack, only because the first attack left him disabled -- but now eligible for government coverage.

The physician has scaled back his work at Bloomington Hospital to two shifts a week to devote more time to HCHP. He volunteers at a clinic for the uninsured and serves on the hospital's board and as chief of its medical staff. He also is a partner of his physician practice, Unity Physician Group.

Stone and his wife, Karen Green Stone, who heads HCHP's education committee, live in a home that Stone built outside Bloomington. Their home is unofficial headquarters for the state organization.

He is finding many people who are willing to listen.

"Dr. Stone put together an incredible amount of information. It was very eye-opening," said Beth Henricks, a tax consultant and Geist-area resident who saw Stone's presentation to a group of executives several months ago in Indianapolis. "When I see somebody who's that passionate, that's really appealing to me."

Stone's point that the United States already has a "single-payer" program in Medicare that covers millions seemed to make sense, said Henricks, whose company First Advantage has faced annual health insurance premium increases of 20 percent to 25 percent in recent years.

"Medicare works pretty well, and it's been around for a long time, so why not pattern something after Medicare?"

http://www.hchp.info/

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Nation's Largest Medical Specialty Group Endorses Single Payer Health Reform

Says U.S. should learn from other nations' health systems

For Immediate Release:
December 11, 2007

After careful evaluation of the health systems of 12 other nations, the American College of Physicians (ACP), the nation's largest medical specialty society and second largest medical association (124,000 members), endorsed single payer national health insurance as "one pathway" to universal coverage. The ACP represents specialists in internal medicine.

"This new proposal by the ACP brings single payer into the mainstream," said Dr. C. Anderson Hedberg, President Emeritus of the ACP. "It's the logical next step."

Although ACP has advocated universal coverage since 1990, and had their own proposal for reform since 2002 based on a "pluralistic" model, this is the first time they have endorsed single payer national health insurance.

"There's really only one choice for universal health care at a cost we can afford, and that's single payer, Medicare for All," said Dr. Marcia Angell, former editor-in-chief of the New England Journal of Medicine. "There is simply no way to cover everyone in a pluralistic system and control costs."

"This changes the political landscape for the presidential candidates, who now will need to take a fresh look at single payer. It recognizes the political feasibility of single payer as well as its importance as a leading option for health care reform" said Dr. Quentin Young, a "Master" in the ACP and National Coordinator of Physicians for a National Health Program (PNHP).

PNHP is a 15,000 member organization headquartered in Chicago that has advocated for single payer national health insurance since 1986. The group's peer-reviewed research and reform proposals in support of single payer are on-line at www.pnhp.org.

The ACP said their recommendation is based on a large and growing body of evidence that the U.S. health system is performing poorly compared to nations with single payer national health insurance:

"Single-payer systems generally have the advantage of being more equitable, with lower administrative costs than systems using private health insurance, lower per capita health care expenditures, high levels of consumer and patient satisfaction, and high performance on measures of quality and access." (ACP Position Paper, Annals of Internal Medicine, 1 Jan 2008, p. 55-75)

"The ACP endorsement of single payer is an important step forward for the medical profession," said Dr. John Geyman, author of "The Corrosion of Medicine: Can the Profession Reclaim its Moral Legacy" and Past President of PNHP. "Instead of ideology and unbridled self-interest, they are putting patients' needs first."

Early Outcomes from Massachusetts' Health Care Reform

An Open Letter to the Nation from Massachusetts Physicians

We write to alert colleagues and the nation to the disturbing early outcomes of Massachusetts' widely-heralded approach to health care reform. Although we wish that the current reform could secure health insurance for all, its failings reinforce our conviction that only a single payer program can assure patients the care they need.

In 2006, our state enacted a law designed to extend health coverage to virtually all state residents. Political leaders in other states as well as several Democratic presidential candidates have embraced this model.

Massachusetts' law mandates that uninsured individuals must purchase private insurance or pay a fine. The law established a new state agency to ensure that affordable plans were available; offered low income residents subsidies to help them buy coverage; and expanded Medicaid coverage for the very poor. (Immigrants are mostly excluded from these subsidized programs.) Moneys that previously funded free care for the uninsured were shifted to the new insurance program, along with revenues from new fines on employers who fail to offer health benefits to their workers. In addition, the federal government provided extra funds for the program's first two years.

While patients, the state and safety net providers struggle, private insurers have prospered under the new law, and the costs of bureaucracy have risen. Blue Cross, the state's largest insurer, is reaping a surplus of more than $1 million each day

Starting January 1, 2008 Massachusetts residents face fines if they cannot offer proof of insurance. Yet as of December 1, 2007 only 37% of the 657,000 uninsured had gained coverage under the new program. These individuals often feel well served by the reform in that they now have health insurance. However, 79% of these newly insured individuals are very poor people enrolled in Medicaid or similar free plans. Virtually all of them were previously eligible for completely free care funded by the state, but face co-payments under the new plan. In effect, public funds for care of the poor that previously flowed directly to hospitals and clinics now flow through insurers with their higher administrative costs.

Among the near poor uninsured (who are eligible for partial premium subsidies) only 16% had enrolled in the new coverage. And barely 7% of the uninsured individuals with incomes too high to qualify for subsidies had enrolled according to the official state figures. Few can afford premiums for even the skimpiest coverage; the lowest cost plan offered for a couple in their fifties costs $8,200 annually, and carries a $2,000 per person deductible.

Moreover, the state's cost for subsidies is running $147 million over the $472 million budgeted for fiscal year 2007. Meanwhile, collections from fines on employers who fail to provide coverage are 80% below the original projections. The funding gap will widen in future years as health care costs escalate and insurers raise premiums. Already, state officials speak of making up the shortfall by forcing patients to pay sharply higher co-pays and deductibles, and by slashing funds promised to safety net hospitals.

While patients, the state and safety net providers struggle, private insurers have prospered under the new law, and the costs of bureaucracy have risen. Blue Cross, the state's largest insurer, is reaping a surplus of more than $1 million each day, and awarded its chairman a $16.4 million retirement bonus even as he continues to draw a $3 million salary. All of the major insurers in our state continue to charge overhead costs five times higher than Medicare and eleven-fold higher than Canada's single payer system. Moreover, the new state agency that brokers private coverage adds its own surcharge of 4.5% to each policy it sells.

A single payer program could save Massachusetts more than $9 billion annually on health care bureaucracy, making universal coverage affordable. But because the 2006 law deepened our dependence on private insurance, it can only add coverage by adding costs. Though politically feasible, this approach is already proving fiscally unsustainable. The next economic downturn will push up the number of uninsured just as the tax revenues needed to fund subsidies fall.

The lesson from Massachusetts is that we still need real health care reform: single payer, non-profit national health insurance.

Signed by Dr. Rachel Nardin and 250 other physicians in Massachusetts.

Newsweek JULY 30, 2007 ISSUE

Yes, We Can All Be Insured

By Jane Bryant Quinn

Prepare to be terrorized, shocked, scared out of your wits. No, not by jihadists or dementors (you do read "Harry Potter," right?), but by the evil threat of ... universal health insurance! The more the presidential candidates talk it up, the wilder the warnings against it. Cover everyone? Wreck America? Do you know what care would cost?

But the public knows the American health-care system is breaking up, no matter how much its backers cheer. For starters, there's the 46 million uninsured (projected to rise to 56 million in five years). There's the shock of the underinsured when they learn that their policies exclude a costly procedure they need—forcing them to run up an unpayable bill, beg for charity care or go without. And think of the millions who plan their lives around health insurance—where to work, whether to start a business, when to rretire, even whom to marry (there are "benefits" marriages, just as there are "green card" marriages). It shocks the conscience that those who profit from this mess tell us to suck it up.

I do agree that we can't afford to cover everyone under the crazy health-care system we have now. We can't even afford all the people we're covering already, which is why we keep booting them out. But we have an excellent template for universal care right under our noses: good old American Medicare. When you think of reform, think "Medicare for all."

Medicare is what's known as a single-payer system. In the U.S. version, the government pays for health care delivered in the private sector. There's one set of comprehensive benefits, with premiums, co-pays and streamlined paperwork. You can buy private coverage for the extra costs.

Health insurers hate this model, which would end their gravy train. So they're trying to tar single-payer as a kind of medical Voldemort, ready to destroy. Here are some of their canards, and my replies:

Universal coverage costs too much. No—what costs too much is the system we have now. In 2005, the United States spent 15.3 percent of gross domestic product on health care for only some of us. France spent 10.7 percent and covered everyone. The French comparison is good because its system works very much like Medicare-for-all. The other European countries, all with universal coverage, spent less than France.

Why are U.S. costs off the charts? Partly because we don't bargain with providers for a universal price. Partly because of the money that health insurers spend on marketing and screening people in or out. Medicare's overhead is just 1.5 percent, compared with 13 to 16 percent in the private sector. John Sheils of the Lewin Group, a health-care consultant, says that the health insurers' overhead came to $120 billion last year, of which $40 billion was profit. By comparison, it would cost $54 billion to cover all the uninsured.

Eeeek, your taxes would go up! Maybe not, if Sheils is right. Both the Congressional Budget Office and the General Accounting Office have testified that the United States could insure everyone for the money we're spending now. But even if taxes did rise, you might still come out ahead. That's because your Medicare plan would probably cost less than the medical bills and premiums you're paying now.

We get world-class care; don't tamper with it. On average, we don't. International surveys put France in first place. On almost all measures of health care and mortality, we lag behind Canada and Europe. Many individuals do indeed get superior care, but so do people in single-payer countries, and at lower cost.

They have long waiting times. No advanced country has waiting periods for emergency surgery or procedures that are urgently needed. The United States has shorter waits than Canada and England for elective surgery. Still, queues are developing here, at the doctor's door. In a study of five developed countries, the Commonwealth Fund looked at how many sick adults had to wait six days or more for an appointment. By this measure, only Canada's record was worse than ours. But waits depend on how well a system is funded, not with the fact that it's single-payer. Many countries that cover everyone, including France, Belgium, Germany and Japan, report no issue with waits at all.

There's no problem; people get care even if they're uninsured. They don't. They get emergency treatment but little else. As a group, the uninsured are sicker, suffer more from chronic disease and rarely get rehabilitation after an injury or surgery. They also die sooner—knowing that, withh insurance, they might have lived.

Right now, Congress is trying to bring 3.3 million uninsured children into the State Children's Health Insurance Program. President George W. Bush says he'll veto the expansion as "the wrong path for our nation." He objects to "government-run health care" (like Medicare?) and says that SCHIP "deprives Americans of ... choice" (like the choice to go uninsured?). Buzzwords like "government run" are supposed to summon up monsters like "socialized medicine" that apparently still lurk under our beds. If these terror tactics work, prepare for another 46 million uninsured.

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Data Update

UNINSURED AND UNDERINSURED

▶ The number of Americans without health insurance jumped by 2.2 million to 47.0 million people (15.8 percent of the population) in 2006 (the most recent year for which data is available). There are now more uninsured in the U.S. than at any time since the passage of Medicare and Medicaid in the mid-1960's.

The proportion of people covered by employer-sponsored private coverage fell from 69.0 percent in 2000 to 59.7 percent in 2006. Government employees account for about one-fourth of all people with employer-sponsored coverage.

The number of uninsured children rose by 611,000 to 8.7 million in 2006, 11.7 percent of all children. With private employer-sponsored coverage deteriorating rapidly, the number of uninsured children has fallen only 17 percent since SCHIP was enacted in 1997, from 10.74 million (adjusted to be comparable to current figures) to 8.66 million. Over 6.6 million children were covered by SCHIP in 2006.

15.3 million Hispanics (34.1 percent) were uninsured in 2006, up 1.3 million from 2005. 7.6 million Blacks (20.5 percent) were uninsured in 2006, up 600,000 from 2005. In Massachusetts, often cited as a model for health reform, the number of uninsured increased from 583,000 in 2005 (9.2 percent) to 657,000 in 2006 (10.4 percent). (The Massachusetts estimate predates full implementation of the 2006 health reform law).

90.9 million Americans (30.6 percent) were covered by government programs or the VA in 2006. This included 40.3 million people with Medicare (13.6 percent), 38.3 million with Medicaid (12.9 percent), 10.6 million (3.6 percent) with VA/military and 1.7 million in other programs (under 1 percent) (United States Census Bureau, "Health Insurance Coverage 2006").

Maine's widely-touted 2003 health reform plan has expanded the number of people with coverage by only 11,000, less than 10 percent of the 136,000 uninsured in Maine in 2002, according to a recent study. 83 percent of Maine businesses that don't insure their workers cite the high monthly cost of premiums for DirigoChoice, the state-subsidized plan which costs $336 per single employee, just $30 less than other plans in the state. In addition, revenues for subsidies for low-income families (which are supposed to come from fees paid by private insurers and providers based on their savings on uncompensated care) have fallen short of projections by over 50 percent. (Lipson et al, Mathematica, Commonwealth Fund, 12/05/07).

▶ Almost 40 million (20 percent) Americans can't afford or access needed health care according to a report from the Centers for Disease Control and Prevention (CDC). One-fifth of Americans can't afford one or more of the following services: medical care, prescription medicines, mental health care, dental care, or eyeglasses. Data were collected in a survey of roughly 100,000 individuals (Centers for Disease Control and the National Center for Health Statistics, 12/03/07).

89.6 million U.S. residents younger than age 65 (34.7 percent of the non-elderly population) lacked health insurance at some point during 2006-2007, according to data from the Census Bureau's annual Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP). Most uninsured individuals lacked coverage for many months: nearly two-thirds (63.9 percent) were uninsured for six months or more; and more than half (50.2 percent) were uninsured for nine months or more. The study also found that 79.3 percent of residents who lacked health insurance were from working families, with 70.6 percent employed full time and 8.7 percent employed part time. ("Wrong Direction: One Out of Three Americans Are Uninsured", Families USA, 9/21/07).

▶ 29 percent of low- and middle-income households with credit card debt report that medical bills are a contributor to their current balances. Households reporting medical debt have higher levels of credit card debt than those without medical debt - $11,623 versus $7,964. Researchers surveyed 1,150 adults with family incomes between 50 percent and 120 percent of local median income ("Borrowing to Stay Healthy: How Credit Card Debt Is Related to Medical Expenses", Access Project, 01/16/07).

▶ Forty percent of Americans are inadequately insured, according to a survey by Consumers Reports. The group surveyed 2,905 Americans aged 18-64 and found that 29 percent of those with health insurance coverage (24 percent of the total U.S. population) were underinsured, while 16 percent were uninsured.

The underinsured reported two or more (out of six) specific problems with their plans, such as inadequate prescription drug coverage (63 percent). In the past 12 months, many of the underinsured reported having to postpone needed medical care due to costs (56 percent), having to use their savings to pay medical expenses (33 percent), making job-related decisions based mainly on health care needs (21 percent), having outstanding medical debts to doctors or hospitals exceeding $5,000 (17 percent), or postponing home or car

repairs due to medical costs (38 percent). In addition, 71 percent said they are dissatisfied with their household's share of out-of-pocket medical expenses, 34 percent said their retirement decisions were adversely affected by health expenses, and only 37 percent reported being financially able to handle an unexpected major medical expense in the next 12 months. (Consumer Reports, August 6, 2007).

▶ Uninsured patients aged 18 to 64 years are 1.6 times more likely than patients with private insurance to die within 5 years of being diagnosed with cancer, according to a study by researchers with the American Cancer Society (ACS). The uninsured were less likely to receive timely screening tests and more likely to be diagnosed with advanced stage disease than patients with private coverage. Patients with Medicaid coverage also fared poorly, partly because many beneficiaries receive coverage only after diagnosis. (Ward et al, Association of Insurance with Cancer Care Utilization and Outcomes, CA Cancer J Clin, January, 2008).

▶ About 122,000 Medi-Cal beneficiaries in California will lose their health coverage and join the ranks of California's 6.8 million uninsured if Governor Schwarzenegger's proposal that patients be required to file eligibility forms four times a year passes. Medi-Cal is the state's Medicaid program. The plan, which would affect 4.5 million of the 6.5 million Medi-Cal beneficiaries, would allow the state to dump people who no longer meet eligibility requirements faster, shifting an estimated $92 million a year in medical bills to patients. Schwarzenegger proposes cutting another $1 billion from the program by reducing benefits and cutting payments to providers by 10 percent. Medicaid accounts for 22 percent of spending by state governments (Chorneau, San Francisco Chronicle, 02/25/08, National Governors Association, June 6, 2007).

▶ Safety-net hospitals are facing deep deficits and service cuts across the country. LA County is proposing to reduce services at its six outpatient centers, which provide about 400,000 patient visits per year, to close a $195 million deficit. Two-thirds of their patients are uninsured.

In Atlanta, Grady Hospital is in deep financial trouble, and its Joint Commission accreditation is at risk. Grady provides 850,000 outpatient visits and more than 30,000 hospitalizations a year (only 8 percent covered by private insurance), and trains one in four Georgia physicians. It has the region's only Level 1 trauma center and ambulance fleet. Yet besides owing $71 million to creditors, it faces a $53 million deficit this year and is $366 million behind in needed capital improvements, such as replacing the trauma ward x-ray machine (which broke two years ago), and equipment for cardiac catheterization and MRIs. The wait for elective orthopedic procedures is, according to one doctor, "infinity."

Cook County's Stroger Hospital (previously "Cook County") in Chicago is facing another $108 million in cuts after being forced to close clinics and lay off 1,000 doctors, nurses, and other health workers to save $100 million last year. Without new funding, the County will have to close a center that treats one-third of the area's HIV patients, all 12 neighborhood clinics, and two public hospitals, Provident and Oak Forest. Only Stroger Hospital and the facility that treats jail inmates will remain, and officials admit that there's "no way" they'll be able to take care of all the people who have "no insurance and no other means."

About 300 public hospitals have closed in the past 15 years, including LA's Martin Luther King Jr.–Harbor Hospital and Washington's, DC General Hospital. The nation's 1,300 public hospitals account for two percent of all hospitals but provide 25 percent of the nation's uncompensated care (New York Times, 1/8/08, Los Angeles Times, 2/14/08, Cain's Chicago Business, 2/8/08).

COSTS

▶ Health spending in the U.S. in 2006 was up 6.7 percent to $2.1 trillion, $7,076 per person, 16.0 percent of GDP. The Centers for Medicare and Medicaid Services projects that in 2008 health care spending will be $2.4 trillion, or $7,868 per capita, and consume 16.6 percent of GPD. (CMS, Health Affairs 2/26/08).

The average premium for family coverage in 2007 was $12,106, with workers paying an average of $3,281 of the cost. The average premium for individual coverage was $4,479 with workers paying an average of $694 of the cost. Health insurance premiums grew 78 percent between 2002 and 2007, compared with cumulative inflation of 17 percent and cumulative wage grow of 19 percent over the same period ("Employer Health Benefits, 2007" Kaiser Family Foundation, 9/07).

▶ The Center for Medicare and Medicaid Services (CMS) estimates that in 2017 health spending will be $4.3 trillion, and the share of health spending by federal and state government's will increase 3 percentage points, from 46 percent in 2006 to 49 percent in 2017 (these figures exclude coverage for government employees and tax subsidies to employers). Part of the increased spending by government will be due to an increase in enrollment in private Medicare plans, which cost 12 percent more than traditional Medicare (for details, see the Medicare section of the Data Update, below). (Health Affairs and Kaiser Daily Health Policy Report, 2/26/08).

▶ "Cherry picking" is profitable to insurers because 1 percent of the population accounts for over 20 percent of health spending, while the sickest 10 percent account for over 60 percent of health spending. In contrast, the half of the popu-

lation with the least health spending accounts for only three percent of spending (Trends in Health Care Costs and Spending, Kaiser Family Foundation, September 2007).

▶ The Federal Employees Health Benefit Program (FEHBP) is often cited as a model for health care reform. But representatives from the Government Accountability Office (GAO) testified to Congress that the apparent success of the program in holding premium increases under 2 percent in 2007 is misleading. Premiums would have risen an average of 9 percent if reserves had not been used to reduce premiums (accounting for 5 percentage points of the difference) and benefits had not been cut (Testimony by John Dicken, GAO, 5/18/07, Kaiser Daily Health Policy Report, 5/21/07).

Health care expenses that exceed 10 percent of pre-tax family income is one measure of "underinsurance." More than 61 million Americans are in families that will spend more that 10 percent of their pre-tax income on health care (up from 37.1 million in 1996) and 13.5 million are in families that spend over 25 percent of their pre-tax income on health care. More than four out of five people (82.4 percent) in families spending more than 10 percent of their pre-tax income on health care costs have health insurance. Similarly, three-fourths (75.8 percent) of those spending more than 25 percent of their pre-tax income on health care costs have health insurance, according to a Families USA report based on data from the Bureau of Labor Statistics' Consumer Expenditure Survey (Too Great a Burden: America's Families at Risk, Families USA 12/20/07).

▶ Eight percent of adults ages 19 to 64 who are privately insured all year, or 8.5 million people, are covered through the individual insurance market, according to a Princeton survey of 1,878 privately insured adults age 19-64. Only a third (34 percent) rate their coverage as excellent or very good, compared with 54 percent of those enrolled in employer plans. Two of five adults (43%) covered through the individual market spent more than 10 percent of their incomes on premiums and out-of-pocket medical expenses, compared with one of four (24%) of those insured through employer plans. (S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families, The Commonwealth Fund, September 2006)

11 percent of all applicants for individual insurance coverage in 2006, and 30 percent of those applicants between the ages of 60 and 64, were not offered a policy (at any price) after a review of their medical conditions, according to a survey by America's Health Insurance Plans (New York Times 12/19/07).

▶ Ford and General Motors have turned over responsibility for retirees' health care costs to the United Auto Workers. The corporations will pay a fixed amount in cash, stocks and assets into a Voluntary Employee Benefits Association (VEBA) trust under the supervision of the UAW to cover retirees' health care costs. Ford will pay off its estimated $31 billion in retiree health care liabilities with a lump sum of $23.7 billion and GM will pay off its estimated $46.7 billion in liabilities with a lump sum payment of $26.5 billion (Kaiser Daily Health Policy Report, 12/04/07, GM Expects Further Cost Cuts, AP, 01/17/08).

▶ Out-of-pocket costs for maternity care are higher in consumer-driven health plans than in traditional plans, according to a study by the Georgetown Health Policy Institute. The group modeled cost-sharing for different birth scenarios. For an uncomplicated delivery, out-of-pocket costs ranged from $1,455 in a traditional plan to $7,884 in a CDHC plan in the individual market. Similarly, out-of-pocket costs with a C-section ranged from $2,244 in the traditional plan to $9,818 in a CDHC plan. (Maternity Care and Consumer-Driven Health Care, Karen Pollitz, Mila Kofman, Alina Salganicoff, Usha Ranji, Kaiser Family Foundation, 6/12/07).

Single Payer Would Save Money in Colorado, Kansas, New Mexico

Three new fiscal studies of single payer at the state level show that it would be possible to cover everyone and save money on total annual health spending. Savings are projected for Colorado ($1.4 billion), Kansas ($869 million), and New Mexico ($178 million) by the consulting firms of Lewin, Schramm-Raleigh, and Mathematica, respectively. Each firm also evaluated several other options for reform; all cost more for less coverage.

SOCIOECONOMIC INEQUALITY

▶ Hospitals charged uninsured and "self-pay" patients 300 percent of their Medicare- allowable costs and 250 percent of the amount private insurers paid for the same services in 2004. The gap between rates charged to self-pay patients and those charged to other payers for hospital care has widened dramatically since the mid-1980's. Researchers looked at hospitals because there is better data on their charges, not because hospitals necessarily overcharge the uninsured more or less than other providers. (Anderson G, "From Soak the Rich to Soak the Poor: Recent Trends in Hospital Pricing" Health Affairs 26, No.3 2007).

▶ The Cleveland Clinic, Nebraska Medical Center, and other hospitals now require that patients pay out-of-pocket costs

before surgery. In a February, 2008 letter to physicians, Cleveland Clinic CEO Fred DeGrandis, wrote that the clinic "started this new "point-of-service" policy because it offers more convenience for patients and decreases the number of days that bills remain in receivables." "Scheduled patients are notified when they pre-register that applicable co-pays will be due at the time of service. In addition, signs regarding the new co-payment collection initiatives are posted throughout the hospital...We encourage your office staff to communicate the expectation of co-pays when instructing patient about upcoming tests and procedures." Although the memo notes that "no patient will be turned away or denied treatment for failure to make their co-payment," placing the hospital in the roll of toll-keeper undoubtedly causes many patients to forgo necessary care (Cleveland Clinic memo and Omaha World Herald, 3/26/08).

▶ For decades, Mississippi and neighboring states with large black populations and persistently high poverty rates made steady progress in reducing infant death. But, in recent years, the death rate has risen in Mississippi and several other states. In Mississippi, infant deaths among blacks rose from 14.2 per thousand in 2004 to 17.0 per thousand in 2005 and from 6.1 per thousand to 6.6 among whites. The national average in 2005 was 13.7 for blacks and 5.8 for whites (Eckholm, "Infant Deaths Rise in South" New York Times, 04/22/07).

PHARMACEUTICALS, INC

▶ Bristol-Myers Squibb will pay a $515 million fine to settle charges that it illegally inflated wholesale prices and promoted its products for unapproved uses. The U.S. government uses average wholesale prices, as reported by drug makers, to set reimbursement rates for medicines used by federal health programs, including Medicare and Medicaid (Bloomberg, 09/28/07).

Drug and insurance companies spent a combined $2.2 billion lobbying Congress between 1998 and 2007. Pharmaceutical companies and their trade associations spent $1.2 billion, more than any other industry. Insurance companies and their trade associations came in second in lobbying expenditures over the decade, at $978 million. Drug makers dispatch over a thousand agents to lobby congressional committees and administration offices each year. They succeeded in making Medicare Part D a windfall for the drug companies by prohibiting Medicare from negotiating drug prices, and in blocking drug re-importation. (OpenSecrets.com Lobbying Database, 02/11/08 and Ken Dilanian, Senators Who Weakened Drug Bill Got Millions from Industry, USA Today, 05/14/07).

▶ Marketing expenditures by drug companies grew from $11.4 billion in 1996 to $29.9 billion in 2005. Spending on direct-to-consumer advertising increased three-fold over the same period, to $4.2 billion, 14 percent of total marketing expenditures (New England Journal of Medicine, 08/06/07)

Drug companies have raised the prices on medications needed by low-income seniors, and on "unique" medications with no therapeutic substitute, in response to the passage of Medicare Part D, according to a study published in Health Affairs. Seniors who are "dual-eligible" for Medicaid account for about 29 percent of Part D enrollees, and a higher share of drug utilization. Previously, drug companies were required to give Medicaid their "best price" on medications for this population, but this is no longer the case now that low-income seniors have been shifted into private Part D drug plans. Several drug giants reported rosy gains based on this shift in their annual reports. Additionally, prices on unique brand-name drugs used disproportionately by the elderly had major price increases during the first half of 2006. "The enhanced market power of the manufacturer created by Part D" is a threat to Medicare's financial stability, concluded the report (Frank and Newhouse, Health Affairs, Jan/Feb 2008).

▶ Overall prescription drug prices rose 8.2 percent in 2006, slightly slower than in 2005. However, prices of some categories of drugs increased much faster. The cost of drugs used to treat diabetes went up 15.5 percent in 2006 - the second year of double digit increases for these products. One technique drug companies use to boost revenues and reduce generic substitution is to steeply hike the price of a drug that is about to go off patent, prompting patients to switch to a newer product made by the firm that still has a long patent life (St. Louis Post Dispatch, 04/26/07, Kaiser Daily Health Policy Report, 2/21/08).

▶ Prescription drug spending will increase to $1,537 per person by 2017, up from $761 per person in 2007. Out-of-pocket spending on prescription drugs will remain about 18 percent of total drug costs. The share covered by private insurance will shrink from about 41 percent to 33 percent over the decade, while the share covered by public insurance will increase from 40 percent to 49 percent in 2017 (Baltimore Sun, 2/26/07).

▶ AstraZeneca will pay a $215 million fine in Alabama for inflating prices to that state's Medicaid program. The Montgomery County Circuit Court jury found AstraZeneca liable for misrepresentation and fraudulent concealment (Kaiser Daily Health Policy Report, 2/28/08).

Eli Lilly faces a $1 billion fine to settle civil and criminal charges stemming from the company's marketing of the drug Zyprexa. Zyprexa has serious side effects including diabetes and death and is approved only to treat people with schizophrenia and severe bipolar disorder. But company documents show that from 2000-2003, Lilly encouraged physicians to prescribe the costly medication to people with age-related dementia as well as people with mild bipolar disorder and depression (New York Times, 1/31/08).

CORPORATE MONEY AND CARE

▶ Health industry CEO's were richly rewarded in 2006. According to firms' SEC filings, the insurance executives with the highest total compensation included Wellpoint's Larry Glasscock ($23.9 million), Cigna's Edward Hanway ($21.0 million), Coventry's Dale Wolf ($12.9 million), Aetna's Ronald Williams ($19.8 million), Unitedhealth Group's William McGuire ($12.0 million), and Health Net's Jay Gellert ($5.2 million). The highest compensated drug company CEOs included Miles White at Abbot Laboratories ($26.9 million) and Richard Clark at Merck ($10.3 million) (Executive PayWatch Database, AFL-CIO).

California's Health Net Inc. will pay $9 million in punitive damages for canceling the insurance policy of a woman battling breast cancer while she was in the middle of treatment. The firm claimed that the patient weighed more than she reported on her insurance application, and failed to report a heart condition. The firm will also pay a fine of $1 million for misleading the state about bonuses tied to policy cancellations or "rescission." The firm avoided payment of $35.5 million in medical expenses by revoking around 1,600 policies between 2000 and 2006, offering its senior cancellations analyst more than $20,000 in bonuses based, in part, on her meeting or exceeding annual targets for revoking policies. Health Net made more than $2 billion in profits in 2007 (LA Times, 11/09/07, ABC News, 2/25/08).

▶ Blue Cross and Blue Shield of Massachusetts' CEO William Van Faase received a whopping $16.4 million retirement package when he stepped down as CEO in 2006. Faase stayed on as chairman and received another $3 million the same year, including $500,000 in base pay and $2.46 million in bonuses (Boston Globe, 01/24/08).

▶ Tampa-based health insurer Wellcare is under investigation for Medicaid fraud in Florida and other states. Almost all of the firm's $4 billion in revenues comes from federal and state governments. The firm allegedly inflated its mental healthcare costs in Florida to defraud the state of $35 million over five years. The company is also under investigation by New York, Georgia and Connecticut officials. (Wall Street Journal, 11/3/07).

UnitedHealth Group and Corporate Crime

Former UnitedHealth CEO William McGuire will pay $468 million to avoid trial on charges that he manipulated stock options. McGuire resigned in 2006 with stock options valued at $1.6 billion

UnitedHealth, the nation's largest private insurer with 27 million enrollees, faces fines up to $1.33 billion due to a failure to make timely payments on thousands of Pacificare claims in California. UnitedHealth bought Pacificare for $9.2 billion in 2006, adding three million subscribers. The California Department of Insurance uncovered 133,000 alleged violations of state laws after widespread complaints by patients and providers. Separately, the state department of Managed Health Care is seeking $3.5 million in fines for claims denials (Girion, LA Times, 1/2/08)

UnitedHealth Group is under investigation by the New York Attorney General for activity at its subsidiary Ingenix, which compiles the data that much of the insurance industry uses to determine "usual and customary" and "reasonable" charges. Because their limits are usually far below what providers actually charge, patients are financially liable for a high proportion of any out-of-network care. Ingenix is alleged to manipulate the data to artificially lower fees. 16 insurers have been subpoenaed in the probe, including Aetna, Cigna, Wellpoint, and other insurance giant (Wall Street Journal, 2/14/08).

▶ California regulators are seeking $12.6 million in fines from Blue Shield, one of the state's largest health plans, for 1,262 alleged violations of claims handling laws and regulations that resulted in more than 200 people losing their medical coverage. The charges are based on an investigation of the firm's "Life and Health" unit which covers about 167,000 people. California Insurance Commissioner Steve Polzner called the allegations "serious violations that completely undermine the public's trust in our healthcare delivery system and are potentially devastating to patients". The state's HMO regulator is conducting a separate investigation into the company's managed care unit with 2.3 million members (Lisa Girion, LA Times, 12/13/07).

▶ One reason U.S. corporations have not embraced single payer national health insurance is because they have health-industry executives on their boards. The AFL-CIO filed a report with the Security and Exchange Commission (SEC) alleging that Board members of 21 of the largest non-health related U.S. companies have "violated their fiduciary duties to shareholders by barring the purchase of generic drugs instead of name brands, and blocking companies whose boards they sit on from supporting

federal legislation that could have saved shareholders billions of dollars." The 21 firms have Board members who also serve on the boards of pharmaceutical and other health-related companies (e.g. United Health Group, Aetna, Tenet, Pfizer, Johnson and Johnson, PhRMA, Abbott, Eli Lilly, Merck, etc) (AFL-CIO release, 10/05/07).

MEDICARE

▶ Patients with diabetes or cardiovascular disease who are uninsured prior to gaining Medicare coverage need more costly and intensive care over subsequent years than if they have been previously insured, according to a study of 5,158 retirement-age adults between 1992 and 2004. Uninsured patients with a history of diabetes, hypertension, heart disease, or stroke diagnosed before age 65 required 13 percent more doctors visits and 20 percent more hospitalizations, and had 51 percent higher total medical expenditures, between the ages of 65 and 72 than did previously insured adults. (J M McWilliams et al, Use of Health Services by Previously Uninsured Medicare Beneficiaries, New England Journal of Medicine, July 12, 2007).

▶ Medicare coverage leads to a dramatic improvement in health for previously uninsured individuals according to a study of 5,006 adults with and without insurance coverage over 55 years of age. For every 100 uninsured adults with heart disease or diabetes before age 65, the researchers found that with Medicare coverage they had 10 fewer major cardiac complications, such as heart attack or heart failure, than would be expected by age 72 (McWilliams et al, Health of Previously Uninsured Adults After Acquiring Medicare Coverage, JAMA, 12/26/07).

▶ Median out-of-pocket spending among Medicare beneficiaries was 15.5 percent of income in 2003. The 25 percent of beneficiaries with the highest spending spent at least 29.9 percent of their income on health care, while 39.9 percent spent more than a fifth of their income on health care (Neuman et al, The Increasing Financial Burden of Health Care Spending 1997-2003, Health Affairs, Nov/Dec 2007).

▶ The average monthly premium for a Medicare Part D drug plan will increase 17 percent, from $27.39 in 2007 to $31.99 in 2008, if enrollees don't change plans. Nearly one in five enrollees will experience an annual increase of at least $120 (Changes Ahead for Medicare Drug Program, Kevin Freking, AP, 11/03/07).

Medicare Part D plans are reducing coverage for high-cost drugs. Since 2006, the number of Medicare Part D Prescription Drug Plans using "specialty tiers" that allow the insurers to charge co-insurance of 33 percent has increased more than five-fold, from four to 21. Over 3 million seniors with Medicare Part D fell into the "donut hole" in 2007. ("Medicare Part D 2008 Data Spotlight: Specialty Tiers," The Henry J. Kaiser Family Foundation, December 2007).

Private Plans Hurt Medicare

Medicare Advantage plans cost the government 12 percent more per beneficiary than traditional Medicare, according to a new report by the Government Accountability Office (GAO), an investigative arm of Congress. The report says, "Medicare spends more per beneficiary in Medicare Advantage than it does for beneficiaries in the original Medicare fee-for-service program, at an estimated additional cost to Medicare of $54 billion from 2009 through 2012." The GAO also found that many people in private plans face higher costs for home health care, in-patient hospital care, and certain cancer drugs and mental health services. Overhead in Medicare Advantage plans is 13 percent, compared to 3 percent in traditional Medicare (New York Times, 2/28/08).

About 20 percent of the 44 million Medicare beneficiaries - 9 million people - are now in private Medicare Advantage plans. Enrollment in private plans is expected to increase to 27.5 percent in 2017. A Congressional effort to curb the Medicare overpayment to private plans was defeated in the face of heavy lobbying from the insurance industry (Health Affairs and Kaiser Daily Health Policy Report, 2/26/08).

The Medicare Advantage program is dominated by two giant firms, UnitedHealth and Humana. UnitedHealth, the nation's largest insurance company, received roughly 15 percent of its projected pre-tax profit of $7.5 billion in 2007 from Medicare. Humana derives about two thirds of its profit from the Medicare Advantage program, with an annual gross margin of about $1,650 per Humana beneficiary (Goldstein, Bloomberg, 10/29/07 and Freudenheim, New York Times, 12/5/07).

Since mid-2007 Medicare has imposed fines of more than $770,000 on 11 Medicare Advantage insurers for marketing violations and failure to provide timely notice to beneficiaries about changes in costs and benefits. According to testimony from the Wisconsin Commissioner of Insurance, "states have consistently reported ... complaints of high-pressure sales tactics and tactics that could be considered unethical, at best, and fraud, at worse" (Congressional Testimony, Wisconsin Insurance Commissioner Sean Dilweg, 5/22/07 and Pear, New York Times, 10/7/07).

Medicare Advantage plans do not provide higher quality or more cost-effective care than traditional Medicare, according to the Congressional Budget Office. Additionally, the Medicare Payment Advisory Commission (Med-PAC) reports that beneficiaries in the traditional program are less likely to report problems in access to specialty care. (Testimony, Congressional Budget Office Director, Senate Committee on Finance, 4/11/07).

▶ Hospitals participating in a Medicare pay-for-performance pilot program were not significantly more likely than non-participating hospitals to provide better treatment for acute myocardial infarction, according to a three year study (Glickman et al, JAMA, 06/06/07).

POLLS/PUBLIC OPINION

Majority of Physicians Support Single Payer

A majority (59 percent) of physicians in the U.S. now support government legislation to establish national health insurance, up from 49 percent five years ago, according to a new national survey. Similarly, opposition by physicians to national health insurance has dropped from 40 percent in 2002 to under one-third (32 percent) of physicians in 2007, and fewer physicians are "neutral" (9 percent in 2007 vs. 11 percent in 2002). Only 14 percent of physicians who oppose national health insurance are in favor of more incremental reforms. Psychiatrists are the most supportive (83 percent), followed by emergency medicine doctors (69 percent), pediatricians (65 percent), internists (64 percent), family practitioners (60 percent), and general surgeons (55 percent). (Carroll and Ackermann, "Support for National Health Insurance among American Physicians: Five Years Later" Annals of Internal Medicine, 4/1/08).

▶ In New Hampshire, 67 percent of all physicians, and 81 percent of all primary care physicians, support single payer ("favor a simplified payer system in which public funds, collected through taxes, are used to pay directly for services to meet the basic healthcare needs of all citizen") (New Hampshire Medical Society, December 2007).

▶ A survey of small and mid-sized businesses by the National Small Business Association found that 60 percent favor a "federally-funded, government administered health care system financed through higher taxes" (National Small Business Association 4/07).

▶ The term "socialized medicine" has lost much of its stigma in the U.S., according to a recent Harris poll of over 2,000 adults. Of the 67 percent of Americans who say they at least "somewhat" know what "socialized medicine" means, 45 percent say it would make the U.S. health care system better, compared to 39 percent who say it would make it worse. Four-fifths (79 percent) say "socialized medicine" means that "government makes sure everyone has health insurance" and 73 percent say it means "government pays most of the cost of health care" Only one-third (32 percent) say it means "government tells doctors what to do." Politics matter: 70 percent of Democrats and 45 percent of Independents say that socialized medicine would be an improvement, while 70 percent of Republicans say it would worsen health care. There is a lack of agreement about what parts of the U.S. health system are "socialized medicine," such as Medicare (60 percent say they think of Medicare this way), the VA (47 percent) and "managed care plans such as HMOs" (30 percent) (LA Times, 2/25/08).

65 percent of Americans agree that the "United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the government and financed by taxpayers" according to a recent AP/Yahoo Poll. Although the term "single payer" is less well known than "Medicare", a majority, 54 percent, say they consider themselves "a supporter of a single-payer health care system, that is a national health plan financed by taxpayers in which all Americans would get their insurance from a single government plan." (AP/Yahoo poll, 12/28/07).

INTERNATIONAL

▶ The United States ranks last in preventable death rates among 19 industrialized countries, resulting in about 101,000 excess deaths per year. In addition, while other nations improved dramatically during the study period, 1997 to 2002, the US improved only slightly. The study compared "amenable mortality" rates, deaths before the age of 75 from causes that are potentially preventable with timely and effective healthcare, and found that if the United States had matched the rate achieved by the three top-performing countries (France, Japan, and Australia) it would have had 101,000 fewer deaths per year by the end of the study period. On average, "amenable mortality" in the 18 other countries fell by 16 percent, whereas it fell by only 4 percent in the United States (E. Nolte and C. M. McKee, "US Has Most Preventable Deaths Among 19 Nations," Heath Affairs, January/February 2008).

Despite much higher health spending per capita in 2004 ($6,102 vs. $2,552), the United States has fewer health care resources per capita than the international average for 30 industrialized nations in the Organization for Economic Cooperation and Development (OECD). The U.S. has fewer doctors (2.4 vs. 3.2 per thousand population), fewer doctor visits (3.9 vs. 6.1 per capita), fewer RNs (7.9 vs. 8.1 per thousand), fewer acute care beds (2.8 vs. 3.8 per thousand) and shorter hospital stays (6.5 vs. 8.2 days) than the OECD international average (Anderson et al, Health Affairs, Sept/October 2007).

▶ Japan has a larger proportion of seniors than the U.S. yet is more effective at controlling drug costs. The Japanese government trimmed prescription drug prices by an average of 5.2 percent in its latest drug price review. The government is also stepping up efforts to promote generic medications (Reuters, 12/18/07).

▶ More Canadian-trained physicians moved back to Canada in 2007 (192) than left the country (133), according to the latest data from the Canadian Institute for Health Information. Overall, 207 physicians left Canada in 2007, while 238 returned from abroad, for a net gain of 31 (CIHI, Canada's Health Care Providers, 2007).

International Evidence on Mandating Health Insurance Coverage

Switzerland and the Netherlands are sometimes cited as nations that successfully attained universal coverage by mandating that individuals buy private insurance. Yet, Switzerland's mandate program resulted in "only a minute increase in coverage from the period before the mandate, when 98-100 percent of the population held coverage." Additionally, "private health insurers" in Switzerland are nothing like American insurance companies. They are non-profit and do not set premiums, benefits, or fees to providers. Princeton economist Uwe Reinhardt describes them as de facto "quasi-governmental agencies."

Dutch researchers estimate that the 2006 reform that allowed their non-profit regional sickness funds to convert to for-profit status and new insurers to begin marketing private coverage in the Netherlands has left hundreds of thousands of Dutch uninsured. About 241,000 people are not enrolled in a health plan and another 240,000 have already defaulted on their premiums, including a higher proportion of seniors, the unemployed and single parent families, out of a population of 16.4 million. There was one positive outcome of the 2006 reform: The government negotiated generic drug prices with the pharmaceutical industry, and reported that "for the first time in decades, our expenditure on medicines has fallen thanks to this agreement." (Glied et al, Health Affairs Nov/Dec 2007, personal communication, Hans Maarse, 12/7/07).

▶ U.S. patients are more likely than patients in seven other industrialized nations to say they experienced medical errors, went without care because of costs, and that the health care system needs to be rebuilt completely. Among U.S. patients with 2 or more chronic medical conditions, 32 percent reported a medical error in the last two years, versus 24 percent of patients in the United Kingdom and 16 percent of German patients. Thirty-seven percent of all U.S. adults and 42 percent of those with chronic conditions had skipped medications, not seen a doctor when sick, or foregone recommended care in the past year because of costs-rates well above all the other countries surveyed. 34 percent of Americans said that the US health system needs to be "rebuilt completely," compared to 15 percent in the UK and 12 percent in Canada (Mahon et al, Commonwealth Fund, 11/01/07).

RECENT RESEARCH FINDINGS FROM PNHP'ERS
(press releases and full-text on-line at www.pnhp.org/press).

▶ Waits for emergency care nationwide increased 36 percent between 1997 and 2004. Among all patients, the average wait increased to 30 minutes. Even the severely ill are waiting longer. Waits for patients suffering heart attacks increased 150 percent, to 20 minutes, and a quarter of heart attack victims in 2004 waited 50 minutes or more before seeing a doctor ("Waits To See An Emergency Department Physician: U.S. Trends And Predictors, 1997-2004" Wilper A, Woolhandler S, Lasser K, McCormick, Cutrona, Bor D and Himmelstein DU, Health Affairs, March/April 2008; 27(2):w84-w95).

▶ Most free drug samples go to wealthy and insured patients, not to the needy. More than three-quarters of sample recipients were insured all year. Conversely, less than one-fifth were uninsured for all or part of 2003, and less than one-third had low incomes (under $37,000 for a family of four). Free drug samples are distributed according to marketing criteria, not as a safety-net for patients. There are also safety concerns. Vioxx and Celebrex were among the most widely distributed samples in 2002, and they turned out to have lethal side effects ("Characteristics of Recipients of Free Prescription Drug Samples: A Nationally Representative Analysis." Cutrona S, Himmelstein DU, Woolhandler S, et al, AJPH, Feb 2008).

▶ There is no evidence that "disease management" (DM) programs are effective in controlling health costs, according to a comprehensive review. The rush to embrace DM as a panacea is reminiscent of the rush into managed care in the 1990's, which was a dismal failure. There are two types of DM programs. The first is non-profit chronic care programs that are integrated with primary care. These can improve quality, but in many cases raise costs. The second type is the for-profit model of DM promoted heavily by pharmaceutical companies. There's scant evidence that commercial DM programs improve quality or save money after accounting for program costs ("Disease Management: Panacea, Another False Hope, or Something in Between?" Geyman J, Annals of Family Medicine, May/June 2007).

PNHP Past President Dr. John Geyman's new book, "The Corrosion of Medicine: Can the Profession Reclaim its Moral Legacy?" (Common Courage Press, 2008) is available from the PNHP national office for $20.

What's Wrong with Hacker's (and Clinton's, and Obama's) Health Plan?

Hacker considers single payer reform unrealistic (N Engl J Med 2007;357:733-5). Instead he'd make employers cover employees, with an expanded Medicare-like program competing with private insurers.

Unfortunately, his political calculus ignores economic reality. As we detailed in The Journal, single payer could cut administration from 31% of health spending to 16.7% - equivalent to savings of $324 billion in 2007, enough to cover the uninsured and upgrade coverage for most others. Hacker's plan - like all multi-payer plans - forfeits bureaucratic savings. It perpetuates private insurers whose overhead averages 14.1% (vs. 1.3% for Canada's program), and the wasteful eligibility and billing paperwork they foist on providers. Hence, his coverage expansion means increased costs. Incremental reform efforts in several states, though politically successful, have all foundered on this problem.

Hacker also naively assumes that insurers would allow fair competition with Medicare. For decades HMOs have cherry-picked healthy Medicare patients and gained subsidies that allow them to flourish despite costs 12% above traditional Medicare's.

Single payer reform is anathema to insurers but would benefit most Americans. Uniquely among reform options; it's affordable.

by David U. Himmelstein, M.D. and
Steffie Woolhandler, M.D., M.P.H.

HILLARY CLINTON ON SINGLE PAYER

▶ This February, fourth-year Yale medical student Liza Goldman questioned Hillary Clinton about her support for single payer on the rope line after a campus appearance. Goldman told Clinton, "I'm sure you know that single-payer would save billions of dollars and thousands of lives." Clinton responded in agreement but said, echoing her disastrous 1993 health reform effort, "It's not politically feasible." So Goldman offered her a hypothetical: "Would you sign it if it came across your desk?" "She said yes, and shook my hand," Goldman reports. (Goldman is the daughter of Dr. Sarah Huertas Goldman, chair of PNHP's Puerto Rico chapter.)

Candidates are followers, not leaders. If we build a powerful movement for single payer national health insurance, they will step to the head of it. In the meantime, having Democratic candidates like Clinton and Obama who acknowledge the superiority if not desirability of single payer is a very profound gain for advocates of fundamental health care reform. Our challenge is to move the debate in the direction that their own admissions are taking them (contributed by Quentin Young, MD, PNHP Volunteer National Coordinator).

IMMIGRANTS continued from **page 57**

make sure the resources are there for the right people," Mercado said. "Yet how can you deny someone health access? If we don't treat and prevent illness . . . our whole community is going to suffer."

Dr. Okie is a contributing editor of the *Journal*.

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Annals of Internal Medicine

Clinical Observations

Support for National Health Insurance among U.S. Physicians: 5 Years Later

Background: The increasing costs of health care and health insurance have concerned Americans for some time (1). The number of uninsured Americans increased by 2.2 million to 47 million in the most recent census. This is the largest increase reported by the U.S. Census Bureau since 1992 (2). In a 2002 survey of physicians, we reported that 49% supported government legislation to establish national health insurance (3).

Objective: To determine whether physician opinion has changed in the 5 years since the 2002 survey and assess physicians' support for government legislation to establish national health insurance and their support for achieving universal coverage through more incremental reform.

Methods: We randomly sampled 5000 physicians from the American Medical Association Masterfile. We sent each physician a survey asking 2 questions: 1) In principle, do you support or oppose government legislation to establish national health insurance? and 2) do you support achieving universal coverage through more incremental reform? Question 1 was identical to the one we used in our 2002 study (3). Respondents answered using a 5-point Likert scale. We also gathered data on physician membership organizations and demographic, personal, and practice characteristics.

Results: Of 5000 mailed surveys, 509 were returned as undeliverable and 197 were returned by physicians who were no longer practicing. We received 2193 surveys from the 4294 eligible participants, for a response rate of 51%. Respondents did not differ significantly from nonrespondents in sex, age, doctoral degree type, or specialty. A total of 59% supported legislation to establish national health insurance (28% "strongly" and 31% "generally" supported), 9% were neutral on the topic, and 32% opposed it (17% "strongly" and 15% "generally" opposed). A total of 55% supported achieving universal coverage through more incremental reform (14% "strongly" and 41% "generally" supported), 21% were neutral on the topic, and 25% opposed incremental reform (14% "strongly" and 10% "generally" opposed). A total of 14% of physicians were opposed to national health insurance but supported more incremental reforms. More than one half of the respondents from every medical specialty supported national health insurance legislation, with the exception of respondents in surgical subspecialties, anesthesiologists, and radiologists. Current overall support (59%) increased by 10 percentage points since 2002 (49%). Support increased in every subspecialty since 2002, with the exception of pediatric subspecialists, who were highly supportive in both surveys (**Figure**).

Conclusion: Most physicians in the United States support government legislation to establish national health insurance. Support is high among physicians in all but some of the procedural specialties.

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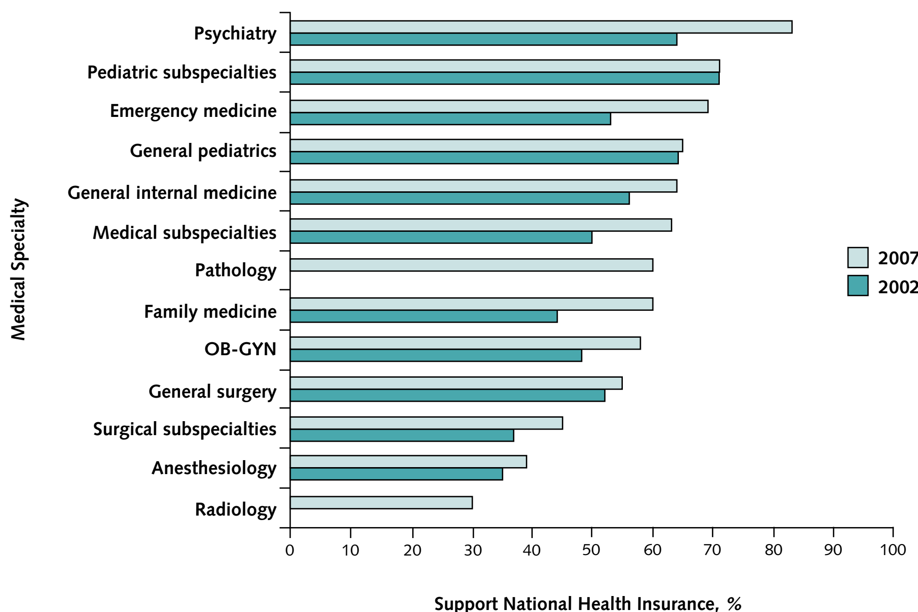
Potential Financial Conflicts of Interest: None disclosed.

Figure. **Support for government legislation to establish National Health Insurance in 2007 and 2002, by specialty.**



2002 data are not available for pathology and radiology because of lack of response in those categories. OB-GYN = obstetrics and gynecology.

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The Berkshire Eagle

Friday, February 15, 2008

Asking about single-payer

By Dr. Susanne King

I often talk with people about health care reform, advocating for single-payer health care as the only answer to problems that include 47 million uninsured people in the United States, and an even greater number of underinsured; the economic pressure on businesses; and the rising costs of health care for our country, states, towns and individuals. Here are the questions people most frequently ask.

1) What is single-payer health care?

"Single-payer" refers to the administration of the health care funds by one payer, rather than the current multiple insurance companies. This payer could be either the state or the federal government. Every other industrialized country in the world has national health insurance.

2) Is this socialized medicine?

No, because hospitals would still be privately owned, rather than owned by the government, and doctors would still be in private practice. "Single-payer" refers to the taking in and paying out of the health care dollars, which would replace the current role of private insurance companies. Traditional Medicare is a single-payer system that has been in place for many years.

3) Doesn't Medicare have big problems?

Traditional Medicare has worked very well for patients, and they have been happy with it. However, the intrusion of private insurance companies into the administration of Medicare, first with the introduction of private HMOs in the 1980s, and then by President Bush with subsidies to the insurance companies for drug plans, has wrought havoc with the program.

The insurance companies now see Medicare as a cash cow, creating an economic burden on the program, to the tune of billions of dollars per year. Subsequently payments to doctors, the actual providers of care, have been cut.

4) Can we afford single-payer, if that means covering 47 million uninsured people?

We already pay enough for comprehensive coverage for everyone. We just don't get coverage for everyone, because 31 percent of our health care spending goes for administration through the patchwork of private for-profit insurance companies. Potential savings from eliminating the waste and astonishing profits of insurance companies (like Massachusetts' Blue Cross/Blue Shield's 2006 compensation of over $16 million to its retiring CEO William Van Faasen), has been estimated at $350 billion per year.

5) Won't there be waiting lines or rationing with single-payer?

The United States currently rations care based on ability to pay, and 18,000 Americans die every year because they lack health insurance. Canada has a single-payer system, and their waiting times for care are shorter than commonly believed. In 2005, the median wait for specialists or elective surgery was four weeks. Canadians live longer and are more satisfied with their health care than Americans, while paying half as much per person.

6) Won't our aging population break the bank in a single-payer system?

Japan and Europe both have a higher percentage of elderly citizens, yet they spend much less on health care than we do, and have better outcomes. Universal access through a single-payer system prevents more advanced stages of illness, and will pay for long-term care rather than costly hospitalization.

7) Some people like their insurance; why should they change?

Our current system is tied to employment; people change or lose jobs, which disrupts their coverage. Others find their coverage fails when they get sick: 75 percent of the one million Americans experiencing medical bankruptcy each year were insured when they got sick. And insurance premiums go up every year, for policies that cover less and less.

8) How would single-payer be financed?

Currently about 60 percent of our health care system is financed by public money (our taxes), 20 percent by private employers, and 20 percent by individuals. With a state or national single-payer health program, the public money would be retained. One option for financing single payer would be a payroll tax on employers (approximately 7 percent) and an income tax on individuals (approximately 2 percent). The payroll tax would replace all other employer expenses for employee health care. The income tax would take the place of all current insurance premiums, co-pays, deductibles, and any other out-of-pocket payments.

For the vast majority of people, a 2 percent income tax is less than what they now pay for insurance premiums and out-of-pocket payments such as co-pays and deductibles, particularly for anyone who has had a serious illness or has a family member with a serious illness. Many small employers now have to pay 25 percent or more of payroll for health insurance, and large employers now pay roughly 8.5 percent. Everyone would have more comprehensive coverage: in addition to medical care and drugs, benefits would include mental health care, dental care, and long-term care.

9) Who would run a single payer plan?

It is a myth that with national health insurance the government will be making the medical decisions. The government would only be the administrator of the health care funds.

In a publicly financed, universal health care system, medical decisions are left to the patient and doctor, and the public has a say in how the system is run. Cost containment measures will be publicly managed by an elected and appointed body. This body, in consultation with medical experts in all fields of medicine, will decide on the benefit package, negotiate doctor fees and hospital budgets, and be responsible for health planning and the distribution of expensive technology. Right now, insurance companies make many health care decisions behind closed doors, and their interest is in profits, not

ASKING continued on **page 19**

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A slightly modified version of this article appeared in the Berkshire Eagle

COLORADO
Valley Courier

But I'um not dead yet!

By C. Rocky White, M.D.

The rising sun cut through the fog revealing a squalid little medieval English village. The undertaker was making his gruesome morning rounds collecting the victims of the Plague who had not survived the night.

He led his cart through streets shouting, "Bring out your dead!"

A door opened and a family tossed an old man onto the cart. The cart started again.

Suddenly the undertaker stopped.

"Be quiet and sit still back there," the undertaker barked.

"But I'um not dead yet!" the old man replied.

"I don't care, be still," said the undertaker.

"BUT I'UM NOT DEAD YET!" the old man repeated.

"Shut up!" the undertaker shouted.

Ok, it was just a Monty Python skit and I forgot what happens next (really, kids, this was humor in the 1970s), but this scene reminds us that our health care system isn't dead -- yet. Also, the medieval setting reminds us of just how far we have come since the dark ages and that medicine, like society, is evolving and constantly in a state of flux.

Thankfully, medicine has come a long ways and the medieval practice of bloodletting and using leeches has been assigned to the history books - sort of.

A leech is a water-dwelling parasite that attaches itself to another creature, sucking the host's blood for nourishment. Up until the last century, many physicians would attach leeches to their patients to "draw out the evil humors." They were applying modern science to the practice of medicine in light of what they knew. As the understanding of diseases changed, so did the treatments - thank God.

Likewise, as the practice of medicine has changed, our ideas about how to pay for it will have to change as well. The health insurance industry naturally evolved in the 20th century to protect people from the ever-increasing cost of modern medicine. With time, some very shrewd businessmen began to see that a lot of money was changing hands in this business. More and more health insurance companies became investor-owned, for-profit organizations that grew, merged and grew again, giving rise to the multi-billion dollar behemoths that dominate public health care policy today.

As I have said in the past, I'm a strong believer in a free market system and competition and there is nothing wrong with profit-motivating ingenuity. However, health care does not lend itself to Wall Street economics and human lives are not a commodity to be traded on the open market.

In the United States from 2000 to 2005, the real buying power income of primary care physicians fell about 5 percent, the number of people covered by employer-sponsored insurance fell from 69 to 60 percent of the workforce, and the uninsured rate went from 40 to 45 million.

Yet in that same timeframe, according to Weiss Ratings, the accumulated earnings of the 500 or so for-profit insurance companies that they track increased from $1 billion to $6.5 billion (by the second quarter of 2005) which, if annualized, would come to $13 billion by the end of 2005! That amounts to a 1,300 percent increase in profits at a time when many Americans had to declare bankruptcy because of medical bills and 2,700 people a day became uninsured!

When Bill McGuire, CEO of UnitedHealth Group, stepped down from his post last December amidst an investigation by the Securities Exchange Commission, he was collecting a salary of $8 million a year with accumulated United stock options of $1.6 billion.

For most for-profit insurance companies, anywhere between 15 and 30 cents of every dollar you spend on premiums is wasted on bureaucracy and multi-million dollar CEO salaries. While millions of Americans will be sitting at their kitchen tables tonight trying to decide between keeping their health insurance or paying for school lunch for their children, these guys will be trying to decide whether to panel their new yacht in Bermuda with Brazilian Mahogany or English Oak.

Despite the self-serving arguments of conservative Wall Street backers in Washington, the for-profit health insurance industry is not in the business of providing you with quality, equitable and affordable health care. They are in the business of making money -- and lots of it.

Just as doctors have learned that using leeches to "drain the evil humors" from a dying patient only hastened their demise, we must face the reality that our health care system (although not dead yet) is sick and pale and only the leeches are getting fat.

The way we finance health care will have to change -- it's only common sense for the common good.

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ASKING continued from **page 18**

our health care.

10) Won't doctors dislike a single-payer system?

Most doctors are very dissatisfied with the current system, because of its administrative burden, and because insurance companies create hurdles to providing care doctors think their patients need. Physicians would like to make medical decisions with their patients, without the intrusion of the profit-motivated insurance companies. In addition, doctors now provide care for which they don't get reimbursed, when patients are unable to pay because they are uninsured or underinsured. More and more physician groups are supporting single-payer. Physicians for a National Health Program now has 15,000 members.

11) How would we get to a single payer system?

There are bills in the state legislatures and in Congress. Single-payer legislation for our state is the Massachusetts Health Care Trust, Senate bill 703. Federal legislation is HR 676, now supported by 88 congressmen, including Rep. John Olver.

In Canada, single-payer health was introduced province by province, rather than at the national level. Support for single-payer health care is increasing as people learn about the benefits of this solution for our broken health care system.

If you wish to learn more, visit the Web sites www.pnhp.org, www.masscare.org, or www.sickocure.org.

Susanne L. King, M.D., is a Lenox practitioner.

The Washington Post
Thursday, June 21, 2007

Study Finds 1.8 Million Veterans Are Uninsured

Figure Has Grown by 290,000 Since 2000, Professor Tells House Veterans Panel

By Christopher Lee
Washington Post Staff Writer

As the nation struggles to improve medical and mental health care for military personnel returning from Afghanistan and Iraq, about 1.8 million U.S. veterans under age 65 lack even basic health insurance or access to care at Veterans Affairs hospitals, a new study has found.

The ranks of uninsured veterans have increased by 290,000 since 2000, said Stephanie J. Woolhandler, the Harvard Medical School professor who presented her findings yesterday before the House Committee on Veterans Affairs. About 12.7 percent of non-elderly veterans — or one in eight — lacked health coverage in 2004, the most recent year for which figures are available, she said, up from 9.9 percent in 2000. Veterans 65 and older are eligible for Medicare.

About 45 million Americans, or 15 percent of the population, were uninsured in 2005, the Census Bureau reports.

"The data is showing that many veterans have no coverage and they're sick and need care and can't get it," Woolhandler said.

Woolhandler's findings are based on data from two national surveys — the Current Population Survey administered by the Census Bureau and the National Health Interview Survey administered by the Department of Health and Human Services. Veterans who said they had neither health insurance nor veterans or military health care were counted as uninsured.

Woolhandler is a well-known advocate of guaranteeing access to health care for all Americans through a government-run national health insurance program. Republican lawmakers seized on that association to question whether she was trying to advance that goal with her study.

"The difficulty would be that because of your desire for universal health care, that could influence how you felt about veterans," Rep. Cliff Stearns (R-Fla.) said.

About 12.7 percent of non-elderly veterans — or one in eight — lacked health coverage in 2004, the most recent year for which figures are available

Woolhandler said the data are sound. She has firsthand experience with the issue as well, she said, because as a physician she has seen uninsured veterans with untreated high blood pressure, diabetes and other conditions.

"It breaks my heart," she said. "The VA should be an important safety net for my patients, and it's not."

Nearly 8 million veterans were enrolled in the VA health system in 2006. The focus of the hearing was whether to open VA hospitals' doors to so-called Priority 8 veterans, who have no service-connected disabilities and whose earnings generally are above 80 percent of the median income where they live. Doing so would add significantly to VA's caseload and costs — estimates range from $366 million to $3.3 billion annually — and some veterans groups and lawmakers are concerned that it would make it harder for veterans with serious service-related health problems to get timely care.

Only about half of the 1.8 million uninsured veterans are classified Priority 8, Woolhandler said. The rest may technically be eligible for some VA care but live too far from its facilities for it to be a real option, she said.

Rep. Steve Buyer (Ind.), the committee's ranking Republican, said Veterans Affairs should focus on its "core constituency" — veterans with service-related health problems, the indigent and those with "catastrophic" disabilities. "Some say the government is obliged to provide essentially free health care for life to anyone who served even a year or two," he said. "I intend to protect the core constituency first."

But Rep. Bob Filner (D-Calif.), the committee's chairman, said taking care of veterans is a continuing cost of war. "All veterans should have access to 'their' health-care system," he said. "This is rationing health care to veterans, those who have served our nation. And I think it's unacceptable for a nation of our wealth and our ability."

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The New York Times

LETTER TO THE EDITOR: APRIL 15, 2007

What´s the one Thing Big Business and the Left Have in Common?

Is this what our country has come to? Leading C.E.O.'s, despairing of their ability to limit rising health-care costs and unwilling to bear these costs themselves any longer, will now back legislation that would place every individual and family at the mercy of private insurance companies like UnitedHealth, Wellpoint and the other insurance giants. Do they think John and Jane Doe can achieve what Safeway and General Motors cannot, namely, affordable health care for all of us?

Instead of moving backward to the time before there was employer-based or group health insurance, when people were on their own to get health care any way they could, we should be moving forward, recognizing that health care is a necessary public good that should be treated as a public responsibility. We should be expanding and improving the Medicare program, which we know provides reliable, cost-effective coverage and has been doing so for more than 40 years. Public Medicare-for-All, not private for-profit insurance, is the only path to a future that will truly provide access to health care for all Americans.

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Leonard Rodberg, Ph.D
Flushing, N.Y.

(The authors are, respectively, chairman and research director of the New York chapter of Physicians for a National Health Program)

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SATURDAY, JUNE 2, 2007

ALBUQUERQUE JOURNAL

Single-Payer System a Bargain

Dr. David Scrase, the chief operating officer of Presbyterian Health Care Services, shows that he does not understand the Canadian single-payer system when he criticizes the findings of the Mathematica Policy Research Inc. report on New Mexico's options for universal health care.

The Journal quoted Scrase: "The Canadian system pays doctors a flat rate and owns hospitals, which means it does not incur the cost of negotiating and administering different payments from different sources."

This is not true. According to the Canadian Government Web site, "The majority of Canadian hospitals are operated by community boards of trustees, voluntary organizations, or municipalities." In other words, most Canadian hospitals are not-for-profit, just like Presbyterian Hospital.

Under a single-payer system, all hospitals are funded through a global budget. That means that the hospital receives an annual payment based upon the previous year's operating costs.

This is how we fund public schools, fire departments, and police departments. We don't pay the fire department on a per fire basis, so why should we pay hospitals based upon how many appendices they remove? By eliminating per patient billing, a huge amount of money is saved.

Under a single-payer national health insurance system, Scrase's Presbyterian Hospital would continue to operate as a non-profit hospital. The Presbyterian Health Plan, an insurance company, would no longer be allowed to sell insurance for the same services that are covered by the public insurance plan.

Having a system that combines a hospital (whose mission is to take care of sick patients) and a managed care insurance company (whose goal is to avoid insuring costly sick patients) poses a serious conflict of interest for the Presbyterian system.

In a single-payer statewide health insurance system, New Mexico's many skilled and dedicated physicians, clinicians, nurses and health workers would be freed from the time consuming, costly, and frustrating administrative hassles of a multi-payer system. They would be freed up to practice their professions and provide the best care for their patients.

The preliminary report from the Mathematica Policy Research Inc. shows that by reducing admininistrative overhead costs, a single-payer system can insure every New Mexican and actually save $178 million.

This is a bargain that New Mexicans should not pass up. We will never get a better offer!

BRUCE G. TRIGG, M.D.
Albuquerque

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THE WALL STREET JOURNAL. LETTERS SUNDAY, JULY 8, 2007

Canadian and U.S. Health Services – Let's Compare the Two

The introduction of private insurance or private-for-profit health care for medically necessary services is not the answer to challenges in the Canadian health-care system. In a systematic review of 38 studies published in Open Medicine in May, 17 leading Canadian and U.S. researchers confirmed the Canadian system leads to health outcomes as good, or better, than the U.S. private system, at less than 50% of the cost.

Unwanted side-effects of competitive health care include a drain of highly trained professionals from the public system and "cream skimming" of patients by private clinics who choose the healthiest patients, leaving the most complex to the increasingly overburdened public system.

In June 2006, the Canadian Medical Association reviewed all the evidence from other jurisdictions and concluded that private insurance for medically necessary physician and hospital services does not improve access to publicly insured services; does not lower costs or improve quality of care; can increase wait times for those who are not privately insured; and, could exacerbate human resource shortages in the public system.

Medicare is not only more equitable, but more efficient and produces higher quality health care than the alternatives. This conclusion is supported by the best national and international evidence, including reports from the World Health Organization and the Organization for Economic Co-Operation and Development.

So what should Canada do about patients who do not receive timely access to essential medical care? Numerous expert reports, including the 2002 Royal Commission on the Future of Health Care in Canada, have already told us we need to restore and strengthen Medicare, not decimate it.

In May the Canadian Centre for Policy Alternatives reported that successful initiatives in team-based care and improved administration produced dramatic cuts in waiting times for surgery in B.C. Alberta, Saskatchewan and Ontario, without any need for competition.

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The commentary by David Gratzer ("Who's Really Sicko?"editorial page, June 28) presents an extremely prejudicial view of the publicly funded Canadian health system. It highlights the unfortunate story of a man from Ontario who had difficulty accessing a head MRI scan for a malignant brain tumour. Undoubtedly there are similar anecdotes describing difficulties in accessing care experienced by the 44 million Americans who lack health insurance. However, in making a rational comparison of the Canadian and American health systems it is more reasonable to contrast service levels and costs of the systems rather than trading anecdotes.

Canadians pay about 9% of national GDP to insure 100% of citizens in our single-payer system, compared with more than 14% of GDP to insure 85% of Americans. The Kaiser Family Foundation reports that the average compound annual growth rate in U.S. health insurance costs has been 11.6% over the past five years. It is therefore not surprising that polling by Kaiser found that 75% of Americans were worried or very worried about the amount they would need to pay for health insurance in the future and that 63% were worried or very worried about not being able to afford health-care services.

There is no question that restriction of supply with sub-optimal access to services has contributed to the lower cost of health care in Canada. However, a new approach of targeting investments to reduce waiting times combined with transparent reporting of wait times is having a substantial impact on access in the Canadian system. Dr. Gratzer wrote about prolonged waits for treatment in Ontario but did not refer readers to the public Web sites that detail Ontario waiting times for cancer surgery, chemotherapy, radiation, cataract, heart, arthroplasty and imaging procedures:

(http://www.health.gov.on.ca/transformation/wait_times/wait_mn.html and http://www.cancercare.on.ca)

Canadians spend about 55% of what Americans spend on health care and have longer life expectancy, and lower infant mortality rates. Many Americans have access to quality health care. All Canadians have access to similar care at a considerably lower cost. In "Sicko," Michael Moore has apparently exaggerated the performance of the Canadian health system — there is no doubt that too many patients still stay in our emergency departments waiting for admission to scarce hospital beds. However, Mr. Moore's description of the advantages of the Canadian system in the film is more accurate than the jaundiced view of our system proposed by Dr. Gratzer.

Robert S. Bell, M.D.
President and CEO
University Health Network
Toronto

(The letter was also signed by Carolyn Baker, R.N., president and CEO, St. Joseph's Health Centre, Toronto, and Catherine Zahn, M.D., executive vice-president of Clinical Programs and Practice, University Health Network, Toronto.)

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SCIENTIFIC AMERICAN - MAY 03, 2007

WE'RE NUMBER TWO: Canada Has as Good or Better Health Care than the U.S.

By Christopher Mims

Whether it is American senior citizens driving into Canada in order to buy cheap prescription drugs or Canadians coming to the U.S. for surgery in order to avoid long wait times, the relative merits of these two nations' health care systems are often cast in terms of anecdotes. Both systems are beset by ballooning costs and, especially with a presidential election on the horizon, calls for reform, but a recent study could put ammunition in the hands of people who believe it is time the U.S. ceased to be the only developed nation without universal health coverage.

Gordon H. Guyatt, a professor of epidemiology and biostatistics at McMaster University in Hamilton, Ontario, who coined the term "evidence-based medicine," collaborated with 16 of his colleagues in an exhaustive survey of existing studies on the outcomes of various medical procedures in both the U.S. and Canada. Their work appears in the inaugural issue of the new Canadian journal Open Medicine, and comes at a time when many in Canada are debating whether or not to move that country's single-payer system toward for-profit delivery of care. The ultimate conclusion of the study is that the Canadian medical system is as good as the U.S. version, at least when measured by a single metric—the rate at which patients in either system died.

"Other people knew that Canadians live two to two and a half years longer than Americans," says Steffie Woolhandler, an author on the paper and an associate professor of medicine at Harvard Medical School, citing a phenomenon that many attribute to differences in lifestyle between the two countries. "But what was not known was once you got sick, was the quality of care equivalent in the two countries."

Americans Less Likely to Survive Treatment

According to Woolhandler, by looking at already ill patients, the researchers eliminated any Canadian lifestyle advantage and just examined the degree to which the two systems affected patient deaths. (Mortality was the one kind of data they could extract from a disparate pool of 38 papers examining everything from kidney failure to rheumatoid arthritis.)

Overall, the results favored Canadians, who were 5 percent less likely than Americans to die in the course of treatment. Some disorders, such as kidney failure, favored Canadians more strongly than Americans, whereas others, such as hip fracture, had slightly better outcomes in the U.S. than in Canada. Of the 38 studies the authors surveyed, which were winnowed down from a pool of thousands, 14 favored Canada, five the U.S., and 19 yielded mixed results.

Mortality Isn't the Only Measure That Matters

Not all experts agree with the implication that the Canadian system is better than the U.S. system, however, or with the researchers' methodology. Vivian Ho, who is the James A. Baker III Institute for Public Policy chair in health economics at Rice University in Houston and has spent time living and conducting research in both the U.S. and Canada, argues that the study's focus on mortality could be misleading.

"When we look at health systems we look at other things than death," Ho explains. In her own research on hip fracture, which was cited in Guyatt's study, she found that the time a patient had to wait before surgery—which was significantly longer in Canada than the U.S. because of a shortage of operating rooms—made only a 1 percent difference in terms of mortality.

"But certainly if you ask people waiting in the hospital," Ho notes, "They're going to say I'd rather have the U.S. system.... Waiting means there's a significant amount of distress for an elderly patient, and also higher complications for pneumonia because you have the patient immobile for so long."

Patti Groome, an epidemiologist at Queens University Cancer Research Institute in Kingston, Ontario, said she believes that overall the paper was balanced. "But when you get into [the] meat of [the] paper they can't sort out what's going on.... There's way too much heterogeneity in these studies to come to a conclusion about these systems." In meta-analyses such as this one, "heterogeneity" in results corresponds to variations in the size of an effect across the studies being reviewed.

In other words, of the studies surveyed, some showed slightly better outcomes for the Canadian system and some showed slightly better outcomes for the U.S. approach, making it hard to draw any conclusion other than that, on balance, the two systems seem to yield only slightly different outcomes.

Money Doesn't Necessarily Buy Health

The study's authors highlight the fact that per capita spending on health care is 89 percent higher in the U.S. than in Canada. "One thing that people generally know is that the administration costs are much higher in the U.S.," Groome notes. Indeed, one study by Woolhandler published in The New England Journal of Medicine in 2003 found that 31 percent of spending on health care in the U.S. went to administrative costs, whereas Canada spent only 17 percent on the same functions.

Ho believes, however, that there are also inefficiencies in the Canadian system. In her own work on hip fracture, she found that Canadian hospitals held patients for longer periods because there was no incentive to discharge them. "These patients are easier to take care of," she explains, "and that helps [hospital administrators] justify their budget.... I think there is room for economic incentives [in the Canadian system]."

"Personally," Ho adds, "my view is that the Canadian system is good for Canada and the American system is good for America. Neither side should switch, because the systems are a function of the population—the Canadian population believes much more in maintaining social safety nets."

This research may already be having an impact on policy debate: According to Woolhandler, Ohio democratic congressman and presidential candidate Dennis Kucinich has plans to circulate the results of this study to Congress. Woolhandler herself would like to see this study play a part in a slightly different debate—one over whether it it is better to be sick and insured in the U.S. or in Canada. "I'd like to see politicians giving up on this mythology that the quality of care for sick people in the U.S. is unique."

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the Charleston Gazette
THE STATE NEWSPAPER
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SUNDAY
February 10, 2008

UNIVERSAL HEALTH CARE:
U.S. could outdo Canadians

By Elizabeth Kurczynski and Allen Chauvenet

As physicians who treat children with blood diseases and cancer at Women and Children's Hospital, we frequently see families with either inadequate insurance coverage or no coverage at all. These are almost always working families with one or both parents who have a steady job.

These families are part of the 47 million Americans and the 322,000 in West Virginia with no health insurance coverage. Even families with "good" coverage are paying more per year with much higher co-payments and deductibles, since the cost of health insurance for a family is now over $12,000 per year.

Most Americans realize that our health-care system is in crisis. All of the presidential candidates propose incremental changes that would offer more people the opportunity to "buy" coverage, or offer families small grants to help them buy a cheaper insurance plan that provides only adequate coverage for those who are healthy. How many can afford $12,000 a year?

Dennis Kucinich is the only candidate who favors a nationwide single-payer health plan, which would provide coverage for everyone for all health-care needs, including drugs. Everyone who votes should know that this plan exists. It is an affordable alternative to more insurance. It could cover everyone for no more money than the $7,500 per person per year that we are currently spending for health care in the United States.

In the past, Barack Obama has said that a single-payer plan is the best health plan, but he now says that it is not politically feasible. In other words, our elected representatives feel that the insurance and drug lobbying interests are too powerful to fight. But these are the people we elect to support our interests nationally!

Thousands of physicians and many organizations such as the American College of Physicians and The Charleston Gazette have endorsed a single-payer universal health plan. Physicians for a National Health Plan is a national group that has been working for a single-payer plan for the past 20 years (PNHP.org). We have a Mountaineer Chapter of PNHP here in Charleston. Every other Western country covers everybody. We can do it, too.

Such a system would be similar to the Canadian health system, but better funded, since the Canadians pay less than $4,000 per person for health care. A single-payer system would be supported by tax dollars - about 6 percent for businesses, and about 2 percent for individuals, less than we currently pay. But the system would be privately run, and patients could choose their own physicians and hospitals. Everything would be covered, including doctors, hospital stays, long-term care, mental health, dental and vision care and prescription drugs. Hospitals would be given a lump sum for the year, and would not have to negotiate with and bill dozens of separate insurance companies. Physicians would be paid a set amount for specific services, and would no longer have to employ billing clerks to fill out many different complex insurance forms to receive reimbursement at a reduced rate.

Administrative costs in our current health-care system are between 30 and 40 percent of our total health-care costs, whereas a single-payer plan such as Canada's system, Medicaid, Medicare or the Veterans Administration health-care system, has only about 3 percent administrative costs. This dramatic savings would be enough to provide complete coverage for everyone in the United States.

Many polls have clearly shown that at least 65 percent of Americans want national health insurance, and over 97 percent of Canadians like their health-care system and would not want a U.S.-style system. How have we let our system get to the point where it is run by for-profit insurance companies whose goal is to deny care and to make more money for their Wall Street stockholders? Our Mountaineer chapter of Physicians for a National Health Plan would like all West Virginians to learn about a better alternative that can provide universal care, and eliminate the inequality and injustice in our current system.

Kurczynski and Chauvenet are both pediatricians and professors with WVU in Charleston.

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■ FINANCIAL TIMES TUESDAY JULY 3 2007

A future of public healthcare for all

Stephen Cecchetti

Economists believe in markets. Market-determined prices allocate scarce resources efficiently, encouraging individuals to put them to their best possible uses. This improves the welfare of everyone. But there are times when private markets break down, and insurance is one of them. When markets fail, the government inevitably has to step in to provide insurance. The future is one in which healthcare will fall into this same category. Even in countries like the US, the government, not the market, will ultimately control the level and cost of the medical care we will receive.

A single-payer, publicly run health-care system is the inevitable consequence of the nearly continuous scientific revolution in molecular genetics that began a half century ago. One day it is James Watson, one of the discoverers of the structure of DNA, being handed the complete genetic code inside his own cells. The next day researchers tie yet another chronic disease to the presence of specific patterns on individual chromosomes. Then, a few days after that, we find out that scientists are learning to make stem cells from skin cells.

The time is fast approaching when we will have an inexpensive test that is capable of revealing a person's genetic propensity to contract a broad array of chronic diseases. That means that we will be able accurately to assess the cost of treatment over their lifetime.

I grant that there are a number of things about my medical future that I would rather not know. For example, I am not anxious to learn about my genetic predisposition to develop Alz-heimer's disease or my propensity to contract heart disease or type two diabetes.

While I may shy away from knowing the details, I am interested in the medical equivalent of my credit score – call this my "health score". Without revealing the specifics of any future diseases I am likely to contract, a health score will summarise my overall healthcare risks. Each year, with new information on my weight, blood pressure and the like, my score will be refined.

The fact that we will all have health scores has profound implications for insurance; or, more accurately, for the failure of market-based insurance. If I have the information revealing that I am likely to be healthy, living a long life with a low cost of medical care, then I am going to forgo insurance for everything except treatments arising from accidents that are completely unforecastable.

Alternatively, if my insurance company can obtain my health score, then, in the same way that lenders use my credit score to calibrate the interest rate they might offer on a loan, they will adjust my health insurance premium based on their precise estimate of the cost of my future medical care. And, importantly, a clever insurance company that is precluded from learning my health score directly will find a pricing scheme that leads me to reveal it to them through the choices that I make.

A single-payer, publicly run health-care system is the inevitable consequence of the nearly continuous scientific revolution in molecular genetics that began a half century ago

The fact that private insurers can accurately compute customer premiums to reflect expected future payouts means that the insurance market will break down. Insurance is about shifting risk, pooling large groups of undifferentiated individuals. When either the insurer or the insured can forecast future events, accurately distinguishing one person from another, the rationale for insurance disappears.

In thinking about the provision of medical care, it is important to realise that we view it differently from other goods and services. When it comes to housing, cars, vacations and the like we are fairly tolerant of disparities between rich and poor. Our focus is on equal opportunities, not on equal outcomes.

Granted, Americans accept greater inequality than the citizens of many other countries do. Not so for healthcare. Members of wealthy societies share the view that their members are entitled to high-quality medical care. Social justice demands that the rich and poor among us all receive roughly comparable treatment.

Over the past decade there have been several attempts to reform the American healthcare system. The US spends nearly 15.5 per cent of gross domestic product on medical care, roughly 50 per cent more than countries such as France, Germany and the Netherlands. And, as measured by life expectancy and infant mortality, Americans' health outcomes are worse than those in much of the industrialised world. Something has to change. But change is politically and socially difficult, so in designing the new system we should make changes that are likely to last.

Looking into the future, we see that technology will force private health insurance to disappear at the same time that the social pressure to provide equal access to care will remain. This makes it inevitable that healthcare systems everywhere will provide universal coverage and be publicly run. Governments will replace markets, ensuring that the poor and uninsurable receive medical treatment at the same time that the healthy are forced to participate in a comprehensive system.

Unfortunately, we shall be forced to restrict access to the most expensive treatments, but even so everyone is going to receive adequate healthcare. The operation replacing my disintegrating brain and overworked liver with the new ones grown from my skin cells may not be covered; but then again, maybe it will.

Regardless, I am off to my wine cellar to ponder the best way to design a publicly run, single-payer healthcare system.

The writer is a professor of global finance at the Brandeis International Business School and a co-director of the US Monetary Policy Forum

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U.S. should have Medicare for all ages

By Robert Gumbiner

There is a somewhat illogical argument being made against expanding Medicare to include all citizens and taxpayers in the U.S., which is that Social Security and Medicare are going to go broke. This argument makes no sense. For one thing, if this were true, how could the federal government keep borrowing from Social Security and Medicare? The fact is, Medicare has the money and the federal government doesn't.

Another argument used to muddy the waters is that health care costs more than Medicare can afford to pay. The answer to this problem is simple: collect more money. When the cost of living goes up, we expect to pay more for goods and services. Twenty years ago, a house might cost $50,000 or $150,000; that same property now costs $800,000. So why should we expect to pay the same amount of money for Medicare health care that we were paying 20 years ago?

In addition, let's pay more attention to controlling the costs and better education of the providers in the cost of their procedures. Give the providers, i.e. doctors and hospitals, some responsibilities for cost control.

True, when 80 million baby boomers join the 40 million people currently covered by Medicare, the budget may be stretched thin. But since Medicare will be spreading the risk over 120 million people, in the future it will work. Remember, a lot of those new people are accessing Medicare at 66 years of age and those are winners for the Medicare program because they are healthier than the average. These younger people will be feeding in over the next 20 to 30 years, and using less care initially. Actually, Medicare may work better; it's the increasing number of people in their late 80s and 90s that we have to worry about.

By the same token, we could expand Medicare to provide health care to everyone, using a simple payroll deduction (from employees) and contribution (from employers). We know that people will agree to pay more if they get more. In the Scandinavian countries people are willing to pay more because they get more social services, including health care coverage. People in this country can understand this simple equation. They would be agreeable to pay another 4 percent payroll deduction if it meant 100 percent coverage and no financials worries.

This is a simple plan that can work, but the public is being led down the garden path by a bunch of unknown, talking heads. The propaganda machines for the insurance and pharmaceutical companies are trying their old-fashioned scare techniques on the American public, claiming that Medicare is going broke, so forget about using it to establish national universal health care.

Garbage!

It will just take another three or four percentage points - whatever it costs - out of payroll. People will be delighted to pay it in order to get full coverage.

The biggest opponents to expanding Medicare are the insurance and pharmaceutical companies. Insurance companies are parasitical. They get paid for doing nothing. In fact, they create their work. Having managed two insurance companies in addition to a large HMO, I can tell you that it costs at least 15 percent or more to market your product and another 10 percent to run the company, even if you are fully funded and spreading the risk. This means 25 percent to 30 percent of "health care cost" is going directly to the insurance companies and is not contributing anything to health care. Right now, Medicare avoids this added 25 to 30 percent, paying something like 4 to 6 percent, all in, for claims adjustments outsourced to companies like Blue Cross. It is time for insurance companies to get out of the health care business.

Having managed two insurance companies in addition to a large HMO, I can tell you that it costs at least 15 percent or more to market your product and another 10 percent to run the company. This means 25 percent to 30 percent of "health care cost" is going directly to the insurance companies.

We brought the tobacco companies under control for the greater good of the American public; we can do the same with the insurance and pharmaceutical companies that shamelessly exploit the American public.

How is it that American pharmaceutical companies can sell their same product for 30 percent, 40 percent or 50 percent less in Canada and Mexico and make money? Doesn't that mean they are making 30 percent, 40 percent or 50 percent more than they need to make off the American public? It is a crime. It's ridiculous. Why doesn't Congress do anything about it?

Robert Gumbiner, M.D., is founder and former CEO of FHP International.

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The New York Times

MONDAY, JULY 16, 2007

The Waiting Game

PAUL KRUGMAN

Being without health insurance is no big deal. Just ask President Bush. "I mean, people have access to health care in America," he said last week. "After all, you just go to an emergency room."

This is what you might call callousness with consequences. The White House has announced that Mr. Bush will veto a bipartisan plan that would extend health insurance, and with it such essentials as regular checkups and preventive medical care, to an estimated 4.1 million currently uninsured children. After all, it's not as if those kids really need insurance — they can just go to emergency rooms, right?

O.K., it's not news that Mr. Bush has no empathy for people less fortunate than himself. But his willful ignorance here is part of a larger picture: by and large, opponents of universal health care paint a glowing portrait of the American system that bears as little resemblance to reality as the scare stories they tell about health care in France, Britain, and Canada.

The claim that the uninsured can get all the care they need in emergency rooms is just the beginning. Beyond that is the myth that Americans who are lucky enough to have insurance never face long waits for medical care.

Actually, the persistence of that myth puzzles me. I can understand how people like Mr. Bush or Fred Thompson, who declared recently that "the poorest Americans are getting far better service" than Canadians or the British, can wave away the desperation of uninsured Americans, who are often poor and voiceless. But how can they get away with pretending that insured Americans always get prompt care, when most of us can testify otherwise?

A recent article in Business Week put it bluntly: "In reality, both data and anecdotes show that the American people are already waiting as long or longer than patients living with universal health-care systems."

A cross-national survey conducted by the Commonwealth Fund found that America ranks near the bottom among advanced countries in terms of how hard it is to get medical attention on short notice (although Canada was slightly worse), and that America is the worst place in the advanced world if you need care after hours or on a weekend.

Debunking another health care myth.

We look better when it comes to seeing a specialist or receiving elective surgery. But Germany outperforms us even on those measures — and I suspect that France, which wasn't included in the study, matches Germany's performance.

Besides, not all medical delays are created equal. In Canada and Britain, delays are caused by doctors trying to devote limited medical resources to the most urgent cases. In the United States, they're often caused by insurance companies trying to save money.

This can lead to ordeals like the one recently described by Mark Kleiman, a professor at U.C.L.A., who nearly died of cancer because his insurer kept delaying approval for a necessary biopsy. "It was only later," writes Mr. Kleiman on his blog, "that I discovered why the insurance company was stalling; I had an option, which I didn't know I had, to avoid all the approvals by going to 'Tier II,' which would have meant higher co-payments."

He adds, "I don't know how many people my insurance company waited to death that year, but I'm certain the number wasn't zero."

To be fair, Mr. Kleiman is only surmising that his insurance company risked his life in an attempt to get him to pay more of his treatment costs. But there's no question that some Americans who seemingly have good insurance nonetheless die because insurers are trying to hold down their "medical losses" — the industry term for actually having to pay for care.

On the other hand, it's true that Americans get hip replacements faster than Canadians. But there's a funny thing about that example, which is used constantly as an argument for the superiority of private health insurance over a government-run system: the large majority of hip replacements in the United States are paid for by, um, Medicare.

That's right: the hip-replacement gap is actually a comparison of two government health insurance systems. American Medicare has shorter waits than Canadian Medicare (yes, that's what they call their system) because it has more lavish funding — end of story. The alleged virtues of private insurance have nothing to do with it.

The bottom line is that the opponents of universal health care appear to have run out of honest arguments. All they have left are fantasies: horror fiction about health care in other countries, and fairy tales about health care here in America.

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CHICAGO SUN-TIMES

APRIL 30, 2007 COMMENTARY

Eliminating private health insurance our only good option

BY NICHOLAS SKALA
AND QUENTIN YOUNG, M.D.

Rod Blagojevich wants to be remembered as Illinois' "health care governor," and his focus on our state's millions of uninsured and underinsured is commendable. Unfortunately, he has come up with the wrong prescription. Blagojevich would hike taxes to pay insurance companies for meager benefits. But eliminating private insurers altogether would save enough to provide health care for all Illinoisans for no more than we're spending now.

Illinois has only two options for health reform: preserve private insurance companies (and the huge systemic waste they generate), or scrap them and use the savings to cover everyone. Sadly, Blagojevich has joined President Bush, former North Carolina Sen. John Edwards, Massachusetts Gov. Mitt Romney and California Gov. Arnold Schwarzenegger in offering the private insurance route.

The better approach would be to replace insurance companies with Medicare-like universal public health insurance, a system that has afforded the rest of the industrialized world better health for half our per-capita cost (or less).

The Blagojevich approach has little hope of remedying our state's health crisis: Decent coverage would remain unaffordable for most Illinoisans while costs would continue to rise. Despite the governor's promises of affordable insurance, the only way to get inexpensive policies is to strip them down with huge co-payments and deductibles. In Massachusetts, the first state to experiment with such a scheme, a 56-year-old making $30,000 annually will have to spend $7,164 in premium and deductible payments before insurance kicks in, and still pony up 20 percent of hospital costs after that.

Such skimpy plans are insurance in name only. Beleaguered Illinois families would remain unable to get care and as costs continue to rise, employers will push more and more middle-class families from more comprehensive plans into the new, paper-thin coverage.

The only way to simultaneously expand coverage and lower costs is through a single-payer system: "Medicare for All Illinois." The state single-payer bill (HB 311) introduced by Representatives Mary Flowers and Mike Boland has garnered considerable support. But this plan would terminate, rather than sustain, private health insurers.

Every other developed nation has some form of public health insurance, yet most spend less than half per person than we do. Nearly a third of our $2.3 trillion in health spending this year will go for administration. In their drive to enroll healthy (and therefore profitable) patients and screen out the sick, private insurers waste vast sums on marketing, billing, underwriting, utilization review and other activities that enhance profits but divert resources from care. The paperwork they inflict on doctors and hospitals costs hundreds of billions more each year. In contrast to the roughly 20 percent overhead of insurance companies, Canada's single-payer program runs for 1 percent overhead. And Canada's hospitals and doctors face little paperwork burden.

Illinoisans get scant return for our outsized spending. Brits and Canadians have lower rates of nearly every chronic disease. Americans have higher infant mortality and shorter life expectancy than people in most other industrialized countries.

Harvard researchers have shown that streamlining our health finances through a single public payer -- a kind of "Improved Medicare for All" -- could save Illinois more than $13 billion a year, enough new money to provide comprehensive benefits for all the people in Illinois. Through rational planning and the elimination of wasteful duplication, it also would establish a stable, long-term cost control mechanism, ensuring that the new benefits are sustainable in the future.

A single-payer system is the only economically viable reform option. Yet opposition from insurance and drug industry giants continues to intimidate lawmakers and even aspirants to the presidency. We need leaders committed to the health of all people of Illinois.

Nicholas Skala is co-founderof Health Care for All Illinois; Dr. Quentin Young is national coordinator of Physicians for a National Health Program.

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SOUTHTOWNSTAR CHICAGO SUN-TIMES TUESDAY APRIL 1, 2008

Dr. Quentin Young, a Chicago legend, to retire

By PHIL KADNER

His patients have included Martin Luther King Jr., Mike Royko, Studs Terkel and members of the Chicago 7 conspiracy trial, but after 61 years in private practice, Dr. Quentin Young is hanging up his stethoscope.

Young, a physician in Chicago's Hyde Park community who from 1972-81 was chairman of the Department of Medicine at Cook County Hospital, was King's doctor during the civil rights leader's ill-fated stay in Chicago.

He was with him when King was hit in the head with a rock while marching through Gage Park and also visited King in his Chicago home when he came down with a respiratory infection.

"I stretched a 15-minute visit for a cold into an all-afternoon affair just so I could talk to the man," Young recalled. "It was a unique opportunity."

I have done the same whenever I've had the chance to talk to Young, a liberal renegade who has lived by the credo: "If the majority agrees with you, you are probably in the wrong."

Young, for the first time in his 20-year fight for national health insurance, finds himself in the majority.

A survey to be published today in the Annals of Internal Medicine, a medical journal, indicates that a majority of U.S. physicians (59 percent) support national health insurance, 32 percent oppose it, and 9 percent are neutral.

The findings, according to a news release, reflect a 10-percentage-point increase in physician support for national health insurance since 2002, when a similar survey was conducted.

Surveys were randomly mailed to 5,000 doctors, and 2,103 were returned.

Psychiatrists (83 percent), pediatric subspecialists (71 percent), emergency medicine physicians (69 percent) and general pediatricians (65 percent) seemed to be the most enthusiastic about national health insurance, while those practicing radiology (30 percent) and anesthesiology (38 percent) registered the lowest amount of support for such a program.

Young, 84, is a founding member of the Chicago-based Physicians for a National Health Program and believes the results signify an important shift in the public debate.

"People trust their doctors," Young said. "If their doctor tells them that national health insurance is not a good thing, they tend to believe that's probably true. If their doctor now starts saying it is something that would be good for the country, then average people will be more likely to support it."

The survey, conducted by researchers at Indiana University, is being touted as the largest ever among doctors on the issue of health care financing reform.

An estimated 47 million Americans have no health insurance, and another 50 million are believed to be underinsured.

At the same time, health insurance costs are rising at a rate of about 7 percent a year, twice the rate of inflation.

Employers are struggling to pay health insurance premiums for their employees, often reducing coverage or asking workers to pick up more of the cost.

Local governments, such as Cook County and the state of Illinois, find themselves cutting other costs to meet the public's health care needs.

The amount of money budgeted for Medicaid in Illinois is now larger than the amount of money budgeted for public education, although about half of that cost is picked up by the federal government.

Young contends that while other industrialized countries control medical costs through single-payer universal health care plans, the profiteers here (primarily health insurance companies) continue to drive up costs. Because their primary motive is to make money, not to provide the best health care for patients, insurers' decisions often are detrimental to policyholders.

Yet many Americans still believe health care here is better than anyplace else in the world. But they seem to be living in denial, ignoring the fact that health care here is not going to remain as it is.

Costs will continue to rise. Employers, facing a potential recession, are going to have to cut their costs.

Health insurance companies will continue to make a profit through higher premiums and by taking control of patient treatment out of the hands of family doctors.

Young, who is giving up his medical practice, will devote all of his energies to reforming health care.

"I tell people that I will refuse to die until there is national health care," he laughed.

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ON HEALTH CARE REFORM:

Long Waits Are Really SiCKO

By DEBORAH BURGER

What country endures such long waits for medical care that even one of its top insurers has admitted that care is "not timely" and people "initially diagnosed with cancer are waiting over a month, which is intolerable?"

If you guessed Canada, guess again. The answer is the United States.

Scrambling for a response to the popular reaction to Michael Moore's "SiCKO" and a renewed groundswell for a publicly financed, guaranteed single-payer health care solution, such as SB840, the big insurers and their defenders have pounced on Canada, pulling out all of their old tales of people waiting years in soup kitchen-type lines for medical care.

But, here's the dirty little secret that they won't tell you. Waiting times in the United States are as bad as or worse than Canada. And, unlike the United States, in Canada no one is denied needed medical care, referrals or diagnostic tests due to cost, pre-existing conditions or because it wasn't pre-approved.

U.S. waiting times are the elephant in the room few critics care to address. But, listen to what the chief medical officer of Aetna had to say in March.

Speaking to the Aetna Investor's Conference 2007, Troy Brennan let these pearls drop:

The U.S. "health care system is not timely."

Recent statistics from the Institution of Healthcare Improvement document "that people are waiting an average of about 70 days to see a provider."

"In many circumstances, people initially diagnosed with cancer are waiting over a month, which is intolerable."

In his former stint as an administrator and head of a physicians' organization,

Paul Lachine/NewsArt.com

he spent much of his time trying "to find appointments for people with doctors."

Brennan's comments went unreported in the major media. But some reports are now beginning to break through, spurred by the debate "SiCKO" has spawned.

Business Week reported (www.businessweek.com/technology/content/jun2007) that "as several surveys and numerous anecdotes show, waiting times in the United States are often as bad or worse as those in other industrialized nations -- despite the fact that the United States spends considerably more per capita on health care than any other country."

A Commonwealth Fund study of six highly industrialized countries (www.commonwealthfund.org), the United States and five nations with national health systems (Britain, Germany, Australia, New Zealand and Canada) found waiting times were worse in the United States than in all the other countries except Canada .

There's something else you probably don't hear about Canada. Substantial progress is being made.

Most of the wait-time problems derive from funding cuts by conservative national or provincial governments, or from the siphoning off of resources by private providers. But precisely because the Canadian system is publicly administered, Canadians are able to force their elected officials to fix problems, or get voted out of office.

Throughout Canada, there are multiple pilot programs that have succeeded in slashing wait times. Canada's latest statistics show that median wait times for elective surgery in Canada is now three weeks -- that's less time than Aetna's chief medical officer says Americans typically wait after being diagnosed with cancer.

Canada also has no waits for emergency surgeries. It also doesn't have 44 million people who are uninsured because everyone has a national health-care card guaranteeing health care from any doctor or hospital they choose. And it doesn't burden those with insurance with rising deductibles or co-pays. A study reported by Health Affairs, a policy journal, for example, found that out-of-pocket costs to U.S. consumers jumped 76 percent this year over last year alone.

Canada also surpasses the United States in a broad array of health barometers, including life expectancy, infant mortality rates, adult mortality rates, deaths due to HIV/AIDS, mortality rates for cardiovascular diseases and years of life lost to injuries and diseases, according to data from the World Health Organization and the Organization of Economic Co-operation and Development.

No wonder some people are so afraid we'll learn the real comparative story about Canada's system -- and our own.

Deborah Burger, R.N., is president of the California Nurses Association.

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ABSTRACT

Canada-trained pediatric surgeons: a cross-border survey of satisfaction and preferences

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Objectives: The American and Canadian health care delivery systems impact pediatric surgical practice differently. We conducted a survey of Canada-trained pediatric surgeons practicing in the United States and Canada to compare their levels of satisfaction and to assess their health care system preferences.

Methods: Pediatric surgeons who graduated from Canadian training programs between 1983 and 2002 were invited to complete a web-based questionnaire. They rated their satisfaction on a scale ranging from 1 (most) to 5 (least) with issues pertaining to quality of life, compensation, work environment, academics, and patient care. Surgeons who had experience in both the American and Canadian systems marked their preferences for each system as it impacted the same areas.

Results: Sixty surgeons (65% practicing in the United States and 35% in Canada) of 94 eligible participants (64%) responded to the survey. Surgeons in the United States were more satisfied with their overall workload and patient care issues, whereas those in Canada were more satisfied with the system of health care reimbursement and the medicolegal environment. Among 38 surgeons who had experience in both systems, 26% had an overall preference for the Canadian system, 24% did for the American system, and half had no preference.

Conclusions: Canada-trained pediatric surgeons practicing in the United States are more satisfied with patient care issues, whereas those practicing in Canada are more satisfied with the medicolegal environment and the system of health care reimbursement. There is no overwhelming preference for either system among surgeons who had experience in both.

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Table 1 Satisfaction levels of pediatric surgeons practicing in the United States and Canada[a]

	United States	Canada	*P*
Quality of life			
I am satisfied with my overall workload.	**2.1**	2.6	**.049**
I am satisfied with the amount of time I have for my family.	2.6	3.2	NS
I am satisfied with my overall quality of life.	2.1	2.4	NS
Financial compensation and reimbursement			
I am satisfied with the opportunity I have for financial advancement.	2.3	2.6	NS
I am satisfied with the overall system of health care reimbursement.	3.8	**2.6**	**<.001**
I am satisfied with my net after-tax income.	2.4	2.7	NS
I am satisfied with the amount of paperwork required for fee and salary collection.	3.4	**2.3**	**<.001**
Work environment			
I am satisfied with the amount of administrative responsibilities.	2.6	2.4	NS
I am satisfied with the medicolegal environment.	3.9	**2.0**	**<.001**
I am satisfied with the opportunity I have for professional advancement.	2.0	2.0	NS
I am satisfied with my work environment.	2.1	2.2	NS
Academic activities			
I am satisfied with my academic status.	2.2	2.0	NS
I am satisfied with my academic progress.	2.3	2.5	NS
I am satisfied with the amount of teaching I provide.	2.1	2.2	NS
I am satisfied with the amount of clinical research I perform.	2.6	3.0	NS
I am satisfied with the amount of basic science research I perform.	2.6	2.9	NS
I am able to obtain research funding if needed.	3.0	2.9	NS
I am able to find researchers to collaborate with if needed.	2.3	2.6	NS
Patient care			
I am satisfied with the quality of surgical care children receive in the system.	1.7	1.9	NS
I am satisfied with the quality of surgical care I am able to provide my patients.	**1.4**	1.9	**.017**
I am satisfied with the amount of technological resources available to me.	**1.6**	2.5	**<.001**
I am able to provide my patients emergency services without impediment.	**1.5**	2.6	**<.001**
I am able to provide my patients elective services without impediment.	**1.7**	3.0	**<.001**
My patients are able to undergo elective operations within a reasonable period.	**1.5**	2.8	**<.001**
I feel patients are treated equitably without regard to their financial status.	1.8	**1.4**	**.028**
I feel patients and their families are satisfied with the health care system.	2.3	2.3	NS
Overall			
I am satisfied with the overall system of health care delivery.	2.8	2.5	NS
I prefer the system in which I practice to that of Canada/the United States.	2.6	2.2	NS

NS indicates not significant.

[a] Respondents rated their level of agreement with each statement on a scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*), with a lower value denoting a higher level of agreement with the statement.

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Modern Healthcare

SEPTEMBER 17, 2007

The $150 billion swindle

The case against Medicare Advantage is overwhelming; when will D.C. get wise?

By Todd Sloane

If it is hard to argue an indefensible proposition, the Bush administration is showing no obvious signs of distress. It continues to vow that it will go to the mat to protect the Medicare Advantage program, even in the face of overwhelming evidence that it mainly serves the needs of shareholders and health insurance executives, at a breathtaking cost to taxpayers.

In another era this would have astounded conservatives, who prized fiscal restraint over everything else. This White House has made a religion out of the concept of privatizing Medicare and rewarding its business cronies.

As of this writing, it seems that some House Democrats are signaling retreat on using major cuts in this managed-care boondoggle to finance an array of changes to the Medicare program, part of their broader plan to extend the State Children's Health Insurance Program. As we have argued, this retreat is not a bad thing—for now. Better to send Bush a clean SCHIP bill—financed by an increase in tobacco taxes and backed by a bipartisan, veto-proof majority—than to see a veto sustained, harming children in the process.

But down the road, probably when there is a different balance of power in Washington, scrapping Medicare Advantage will be to the advantage of almost everyone. In 2003, we were sold a bill of goods on how handing some extra money to insurers in the short term would produce long-term savings to the program, while allowing insurers to deliver more services at lower premiums.

A new analysis by the Congressional Budget Office gives the lie to that notion. It shows that the Medicare Advantage payment structure would preclude any such savings unless insurers can deliver services at half the cost of fee-for-service Medicare. In the dry language of CBO Director Peter Orszag, such an outcome is "implausible."

Instead, the CBO projects that extra payments to Medicare Advantage would amount to $150 billion over the next decade.

For this, what do we get? An American Medical Association survey found that more than half of physicians said their Medicare Advantage patients had been denied coverage of services that fee-for-service Medicare routinely picks up. The Medicare Rights Center finds that access to needed care is often hindered by overly strict rules on pre-authorization by the private plans. A Kaiser Family Foundation report found that seniors in poor health may be charged more for coverage. Medicare Advantage fee-for-service plans—which are the fastest-growing segment of the program and receive the highest rate of extra payments—don't provide care coordination, often charge higher copayments and don't offer much in the way of extra benefits.

The CMS admits it has failed to keep track of extra benefits offered to beneficiaries and, according to a recent report from the Government Accountability Office, it also has failed to adequately keep track of much of anything else. The CMS is required each year to audit one-third of Medicare Advantage plans to see if they are providing the benefits they say they are, but the GAO found the percentage of plans audited has been going down sharply, to just 14% in 2006.

In one year of audits they performed, the CMS identified about $34 million in government payouts that could have been used by the plans to provide extra benefits to beneficiaries. And that was in 2003, before the huge additional payments mandated by the Medicare Modernization Act of 2003. The CMS told the GAO it had no plans to pursue financial recoveries because the agency lacked authority to do so. The GAO said the law clearly spells out such power.

One could joke that maybe the CMS could privatize its enforcement activity, but with $77 billion being wasted on the program this year alone, it is no laughing matter.

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The NEW ENGLAND JOURNAL of MEDICINE

Perspective
FEBRUARY 7, 2008

Market-Based Failure — A Second Opinion on U.S. Health Care Costs

Robert Kuttner

U.S. health care expenditures rose 6.7% in 2006, the government recently reported. According to the Centers for Medicare and Medicaid Services, total health care expenditures exceeded $2.1 trillion, or more than $7,000 for every American man, woman, and child.[1] Medicare costs jumped a record 18.7%, driven by the new privatized drug benefit. Total health care spending, now amounting to 16% of the gross domestic product, is projected to reach 20% in just 7 years.

Relentless medical inflation has been attributed to many factors — the aging population, the proliferation of new technologies, poor diet and lack of exercise, the tendency of supply (physicians, hospitals, tests, pharmaceuticals, medical devices, and novel treatments) to generate its own demand, excessive litigation and defensive medicine, and tax-favored insurance coverage.

Here is a second opinion. Changing demographics and medical technology pose a cost challenge for every nation's system, but ours is the outlier. The extreme failure of the United States to contain medical costs results primarily from our unique, pervasive commercialization. The dominance of for-profit insurance and pharmaceutical companies, a new wave of investor-owned specialty hospitals, and profit-maximizing behavior even by nonprofit players raise costs and distort resource allocation. Profits, billing, marketing, and the gratuitous costs of private bureaucracies siphon off $400 billion to $500 billion of the $2.1 trillion spent, but the more serious and less appreciated syndrome is the set of perverse incentives produced by commercial dominance of the system.

Markets are said to optimize efficiencies. But despite widespread belief that competition is the key to cost containment, medicine — with its third-party payers and its partly social mission — does not lend itself to market discipline. Why not?

The private insurance system's main techniques for holding down costs are practicing risk selection, limiting the services covered, constraining payments to providers, and shifting costs to patients. But given the system's fragmentation and perverse incentives, much cost-effective care is squeezed out,

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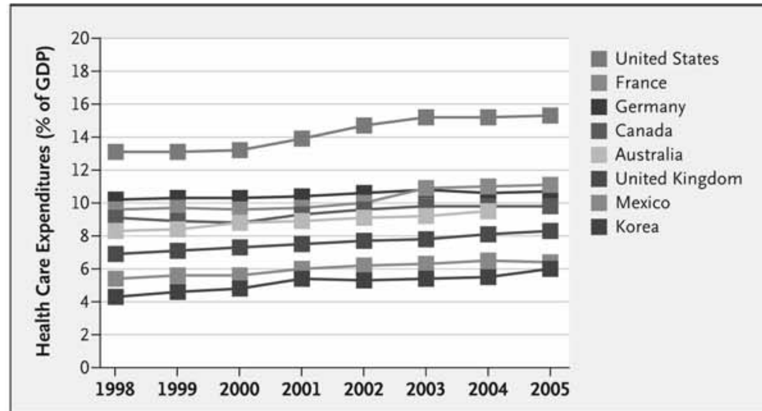
resources are increasingly allocated in response to profit opportunities rather than medical need, many attainable efficiencies are not achieved, unnecessary medical care is provided for profit, administrative expenses are high, and enormous sums are squandered in efforts to game the system. The result is a blend of overtreatment and undertreatment — and escalating costs. Researchers calculate that between one fifth and one third of medical outlays do nothing to improve health.

Great health improvements can be achieved through basic public health measures and a population-based approach to wellness and medical care. But entrepreneurs do not prosper by providing these services, and those who need them most are the least likely to have insurance. Innumerable studies have shown that consistent application of standard protocols for conditions such as diabetes, asthma, and elevated cholesterol levels, use of clinically proven screenings such as annual mammograms, provision of childhood immunizations, and changes to diet and exercise can improve health and prevent larger outlays later on. Comprehensive, government-organized, universal health insurance systems are far better equipped to realize these efficiencies because everyone is covered and there are no incentives to pursue the most profitable treatments rather than those dictated by medical need. Although the populations of most countries that belong to the Organization for Economic Cooperation and Development are older than the U.S. population, these countries have been far more successful at containing costs without compromising care (see graph).



Health Care Expenditures in Selected Countries.

The growth rate of medical expenditures has been slowest in nations with universal health insurance systems. Data are from the Organization for Economic Cooperation and Development. GDP denotes gross domestic product.

Many U.S. insurers do reward physicians for following standard clinical practices, but these incentives do not aggregate to an efficient national system of care. After more than three decades of managed care — and the same three decades of studies by Wennberg and colleagues identifying wide variations in practice patterns — consistent practices are still far from the norm.[2] Commercial incentives are not fixing what's broken.

Instead, cost-containment efforts have fallen heavily on primary care physicians, who have seen caseloads increase and net earnings stagnate or decline. A popular strategy among cost-containment consultants relies on the psychology of income targeting. The idea is that physicians have a mental picture of expected earnings — an income target. If the insurance plan squeezes their income by reducing payments per visit, doctors compensate by increasing their caseload and spending less time with each patient.

This false economy is a telling example of the myopia of commercialized managed care. It may save the plan money in the short run, but as any practicing physician can testify, the strategy has multiple self-defeating effects. A doctor's most precious commodity is time — adequate time to review a chart, take a history, truly listen to a patient. You can't do all that in 10 minutes. Harried primary care doctors are more likely to miss cues, make mistakes, and — ironically enough — order more tests to compensate for lack of hands-on assessment. They are also more likely to make more referrals to specialists for procedures they could perform more cost-effectively themselves, given adequate time and compensation. And the gap between generalist and specialist pay is widening.[3]

A second cost-containment tactic is to hike deductibles and copayments, whose frank purpose is to dissuade people from go-

ing to the doctor. But sometimes seeing the doctor is medically indicated, and waiting until conditions are dire costs the system far more money than it saves. Moreover, at some point during each year, more than 80 million Americans go without coverage, which makes them even less likely to seek preventive care.[4]

The system also has inflationary effects on hospitals' revenue-maximization strategies. Large hospitals, which still have substantial bargaining power with insurers, necessarily cross-subsidize services. The emergency department may lose money, but cardiology makes a bundle. So hospitals fiercely defend their profit centers, investing heavily in facilities for lucrative procedures that will attract physicians and patients. For the system as a whole, it would be far more cost-effective to shift resources from subspecialists to primary care. But in an uncoordinated, commercialized system, specialists might take their business elsewhere, so they have the leverage to maintain their incomes and privileges — and thereby distort cost-effective resource allocation.

Defenders of commercialized health care contend that economic incentives work. And indeed they do — but often in perverse ways. The privately regulated medical market is signaling pressured physicians to behave more like entrepreneurs, inspiring some to defect to "boutique medicine," in which well-to-do patients pay a premium, physicians maintain good incomes, and both get leisurely consultation time. It's a convenient solution, but only for the very affluent and their doctors, and it increases overall medical outlays.

Other doctors opt out by becoming proprietors of specialty hospitals, usually day surgeries. In principle, it is cost-effective to shift many procedures to outpatient settings that are less expensive but still offer high-quality care. In a government-organized universal system, the cost savings can be usefully redirected elsewhere. But in our system, the savings go into the surgeons' pockets, and their day hospitals often have a parasitic relationship with community hospitals, which retain the hardest cases and give up the remunerative procedures needed to subsidize those which lose money.

A comprehensive national system is far better positioned to match resources with needs — and not through the so-called rationing of care. (It is the U.S. system that has the most de facto rationing — high rates of uninsurance, exclusions for preexisting conditions, excessive deductibles and copayments, and shorter hospital stays and physician visits.) A universal system suffers far less of the feast-or-famine misallocation of resources driven by profit maximization. It also saves huge sums that our system wastes on administration, billing, marketing, profit, executive compensation, and risk selection. When the British National Health Service faced a shortage of primary care doctors, it adjusted pay schedules and added incentives for high-quality care, and the shortage diminished. Our commercialized system seems incapable of producing that result.

Despite our crisis of escalating costs, dwindling insurance coverage, and deteriorating conditions of medical practice, true national health insurance that would not rely on private insurers remains at the fringes of the national debate. This reality reflects the immense power of the insurance and pharmaceutical industries, the political fragmentation and ambivalence of the medical profession, the intimidation of politicians, and the erroneous media images of dissatisfied patients in universal systems.[5]

Sometimes, we Americans do the right thing only after having exhausted all other alternatives. It remains to be seen how much exhaustion the health care system will suffer before we turn to national health insurance.

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Mr. Kuttner is co-editor of the *American Prospect* and a senior fellow at Demos, a New York–based public policy research and advocacy organization.

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Competition in a publicly funded healthcare system

Are the UK and other countries right to adopt a market based model for improving their health services? **Steffie Woolhandler** and **David Himmelstein** believe that the appropriate response to the US experience with such policies is quarantine, not replication

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Why would anyone choose to emulate the US healthcare system? Costs per capita are about twice the Organisation for Economic Cooperation and Development average. Forty seven million people are completely uninsured. Many others with insurance face high out of pocket costs that hinder care and bankrupt more than a million annually.[1] Mortality statistics lag behind those of most other wealthy countries, and even for the insured population, clinical outcomes and patient satisfaction are mediocre.[2 3]

This dismal record arises, we contend, from health policies that emphasise market incentives. Even as the public share of health spending in the US has risen to 60% (box) investor owned firms have eclipsed the public, professional, and charitable bodies that previously managed the financing and delivery of care. The development and effect of US policies that mix public funding and private management has wider relevance because politicians in Europe and beyond are pushing analogous schemes.

Failure of private contracting in Medicare

The combination of tax funding and market oriented delivery is exemplified by the US Medicare programme, which has a budget more than double that of the entire NHS. Until 1965, many US employers offered private health cover, but elderly, poor, and disabled people were mostly uninsured and forced to rely on threadbare government institutions or charity. In 1965, Congress established the Medicare social insurance programme for elderly people. Private hospitals gained a vast new market, and investors soon took note, launching for-profit chains that now account for 15% of US acute care hospitals. Similarly, for-profit dialysis firms rushed in after the government made everyone with end stage renal disease eligible for Medicare in 1972.

Until the 1970s, private insurers (mostly founded and controlled by doctors and hospitals) and Medicare exerted minimal oversight of care and payment rates. But soaring costs prodded employers and government to assert more control. In the private sector, managed care and health maintenance organisations (HMOs)—most of which were controlled by investors rather than health providers and vigorously intervened in clinical care—rapidly gained a foothold.

In the mid-1980s, Medicare also began encouraging elderly people to enrol in private HMOs. Government paid the private plans a fixed monthly premium for each person who switched from traditional (fee for service) Medicare, with the HMO taking over responsibility for purchasing (or, rarely, providing) care. This arrangement was touted as a means to bring market efficiency to the public programme and to broaden patients' choices.

Unfortunately, the first crop of Medicare HMOs yielded mainly scandal–for example, a major political donor whose plan enrolled thousands of aged patients in Florida (and collected tens of millions of government dollars) but neglected to contract with doctors or hospitals to care for them. He fled prosecution, eventually seeking refuge in Spain.[4]

Subsequently, Medicare applied stricter regulations. The government set the HMOs' payment at 95% of the average monthly cost of care for a patient in traditional Medicare, with the expectation of 5% savings through improved efficiency. Patients who chose an HMO–attracted by free spectacles, lower copayments, and other benefits not covered under traditional Medicare—were free to return to traditional Medicare whenever they wished.

HMOs recognised an opportunity in the skewed distribution of health costs. Most patients use little care—indeed 22% of elderly people cost Medicare nothing at all each year—while the fraction who are severely ill account for the lion's share of expenditures. Astute HMO executives quickly realised windfall profits through cherry picking–recruiting healthier than average older people who brought hefty premiums but used little care—and returning sick patients, and their high medical bills, to the traditional Medicare programme–disrupting care for millions.[5]

HMO marketing departments devised selective

Tax financed health spending in US

- Official figures for 2005 peg government's share of total health expenditure at 45.4%, but this excludes:
  Tax subsidies for private insurance, which cost the federal treasury $188.6bn (£92bn; €129bn) in 2004 and predominantly benefit wealthy taxpayers
  Government purchases of private health insurance for public employees such as police officers and teachers. Government paid private insurers $120.2bn for such coverage in 2005: 24.7% of the total spending by US employers for private insurance
- Government's true share amounted to 9.7% of gross domestic product in 2005, 60.5% of total health spending or $4048 per capita (out of total expenditure of $6697)
- By contrast, government health spending in Canada and the UK was 6.9% and 7.2% of gross domestic product respectively (or $2337 and $2371 per capita)
- Government health spending per capita in the US exceeds total (public plus private) per capita health spending in every country except Norway, Switzerland, and Luxembourg

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recruitment schemes to attract healthy people. These included free fitness club memberships, complementary recruiting dinners at times and places inaccessible to frail elderly people, and advertisements painted on the bottoms of swimming pools. HMOs used financial incentives to encourage doctors to persuade sick patients to leave the HMO—for example, deducting payments to specialists from the primary care doctor's own capitation payment. Hence, a general practitioner could raise her income by advising patients needing hip replacement to leave the HMO, and even convince herself that such advice might benefit patients by freeing them of HMO restrictions on the choice of surgeon and hospital.

HMOs concentrated on ensuring convenient and attractive care for the modest needs of healthy (and profitable) older people. Meanwhile, expensive, ill patients fared poorly. Stroke patients, those needing home care, and others with chronic illnesses got skimpy care, had bad outcomes, and fled HMOs.[5-8] And when all else failed and an HMO found itself saddled with too many unprofitably ill patients in a particular county, executives simply closed up shop in that area and returned the patients to traditional Medicare.

By the late 1990s, private HMOs' selective enrolment of healthy elderly people and removal of sick people had raised annual Medicare costs by about $2bn.[9] Yet despite this subsidy, HMOs couldn't effectively compete with traditional Medicare. The burden of administrative costs—about 15% in the largest Medicare HMO[10] compared with 3% in traditional Medicare—was too great to overcome. Many HMOs couldn't sustain the extra benefits they had offered at the outset to attract members.

As enrolment fell, HMOs lobbied hard for government rescue, and Congress upped their payments. Currently, Medicare pays private plans $77bn annually; the cost of caring for the eight million Medicare members who have switched to HMOs is 12% above the cost of caring for comparable patients in traditional Medicare.[11]

Medicare's HMO contracting programme, originally touted as a market based strategy to improve the public programme's efficiency, has evolved into a multibillion dollar subsidy for private HMOs. Moreover, the massive financial power amassed by these firms (largely at government expense) is a political roadblock to terminating this failed experiment.

Is private really better?

Other US experiments in using public money to buy care from private firms have also disappointed. Costs for the private insurance that government purchases for public employees have risen even faster than Medicare's.[12] According to comprehensive meta-analyses, investor owned renal dialysis centres (funded almost entirely by the special Medicare programme that covers everyone needing long term dialysis) have 9% higher mortality than non-profit centres despite equivalent costs[13]; and investor owned hospitals—which receive most of their funding from public coffers—have

By the late 1990s private health plans were selectively enrolling healthy people and removing sick ones

2% higher death rates and 19% higher costs than non-profit hospitals.[14 15] Despite spending less on nurses and other clinical staff, investor owned hospitals spend more on managers.[16]

If the failings of private contracting in the US are underappreciated, so is the major success story of recent US health policy: the Veterans Health Administration system. This network of hospitals and clinics owned and operated by government was long derided as a US example of failed Soviet-style central planning. Yet it has recently emerged as a widely recognised leader in quality improvement and information technology. At present, the Veterans Health Administration offers more equitable care, of higher quality, at comparable or lower cost than private sector alternatives.[17]

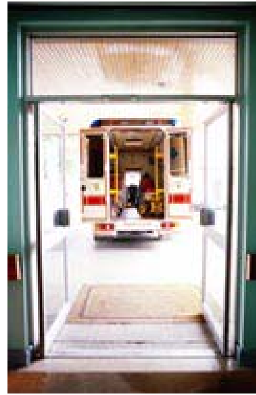
Costs of market forces

Health care's shift from a public service to a business model has raised costs, partly by stimulating the growth of bureaucracy. The proportion of health funds devoted to administration in the US has risen 50% in the past 30 years and now stands at 31% of total health spending, nearly twice the proportion in Canada.[18] Meanwhile, administration has been transmogrified from the servant of medicine to its master, from a handful of support staff dedicated to facilitating patient care to a vast army preoccupied with profitability.

Recent trends elsewhere indicate that the US experience is not unique. The advent of internal markets sharply increased administrative costs in the UK[19] and New Zealand.[20] The overheads of Canadian private insurers are 10 times higher than those of public provincial health insurance programmes.[18] In Australia, tax subsidies for private insurance have directed money through private firms, whose overhead is 12% (versus 3.5% in the public programme)[21]; the private hospitals favoured by current policies are about 10%

costlier than public ones.[22] As Germany's insurance plans have adopted an increasingly business-like mode of operation, administrative costs have soared, rising 63.3% between 1992 and 2003; meanwhile doctors complain about an avalanche of paperwork.[23]

Two factors are at work. Firstly, fragmenting the funding stream, with multiple payers rather than a single government one, necessarily adds complexity and redundancy. Secondly, high administrative costs are intrinsic to the commercial mode (in medical care as elsewhere). Each party to a business transaction must maintain its own detailed accounting records, not primarily for coordination but as evidence in case of disputes.[24] Moreover, investors and regulators demand verification by independent auditors, generating yet another set of records. Thus the commercial record replicates each clinical encounter in paper form before, during, and after it takes place in the examining room. The sense of mutual obligation and shared mission to which medicine once aspired becomes irrelevant, even a liability. Hence, the decision to unleash market forces is, among other things, a decision to divert healthcare dollars to paperwork.



Overcrowded US emergency departments turn away an ambulance once a minute, on average

Market failure

Market theorists argue that although competition increases administration, it should drive down total costs. Why hasn't practice borne out this theory?

Investor owned healthcare firms are not cost minimisers but profit maximisers. Strategies that bolster profitability often worsen efficiency. US firms have found that raising revenues by exploiting loopholes or lobbying politicians is more profitable than improving efficiency or quality. Columbia/Hospital Corporation of America (HCA)—the biggest US private hospital operator—deliberately submitted inflated bills and expenses to the government, structured business deals so that Medicare picked up the cost of corporate expenses, and paid doctors in return for patient referrals.[25] Tenet, the second largest hospital firm, has a long history of legal problems. In the 1980s (when the firm was known as National Medical Enterprises) it gave doctors kickbacks to boost referrals and improperly detained psychiatric patients in order to fill beds, resulting in legal settlements totalling nearly $700m.[26] More recently, Tenet paid hundreds of millions of dollars in fines to resolve claims that it offered kickbacks for referrals; claimed excessive sums from Medicare; and that its hospitals performed hundreds of unnecessary cardiac procedures.[27-29]

For-profit executives' incomes also drain money from care. When Columbia/HCA's chief executive officer resigned in the face of fraud investigations into the company, he left with $324m in company stock. Tenet's chief executive exercised stock options worth $111m shortly before resigning under pressure from investors in 2003. The head of HealthSouth (the dominant provider of rehabilitation care, mostly paid for by Medicare) made $112m in 2002, the year before his indictment for fraud (charges of which he was later acquitted) and four years before his conviction on unrelated bribery charges.[30]

Even chief executives of untainted firms have reaped enormous rewards. Former Harvard geriatrician John Rowe earned $225 000 a day (including Sundays and holidays) in his 65 months running Aetna health insurance company.[31] Bill McGuire made $1.6bn after giving up pulmonary medicine to run UnitedHealthcare.[32]

While private contracting has benefited executives and shareholders, it has increased costs and worsened quality because health care cannot meet the fundamental requirements for a functioning market. It is fashionable to view patients as consumers, but seriously ill people (who consume most care) cannot shop around, reduce demand when suppliers raise prices, or accurately appraise quality. They necessarily rely on their doctor's advice on which tests and treatments to "purchase."

Even for sophisticated buyers like government, the "product" of health care is notoriously difficult to evaluate, particularly since doctors and hospitals create the data used to evaluate and reward them. When Tenet hospitals did heart surgery on healthy patients, the surgical outcomes appeared first rate. Even for honest firms, careful selection of lucrative patients and services is the key to success. Conversely, meeting community needs often threatens profitability and hence institutional survival. In the past decade 425 emergency departments—magnets for both very sick and uninsured patients unable to pay—have closed. Overcrowded US emergency departments turn away an ambulance once a minute, on average.[33]

Finally, a real market would require multiple independent sellers, with free entry into the marketplace. Yet many hospitals exercise virtual monopolies; half of Americans live in regions too sparsely populated to support real medical competition.

Hallmarks of market based reforms

- Market reforms aim to bring medicine into the realm of commerce, where commodities (homogeneous goods or services) are bought and sold for profit
- The first stage of this process is to divide the medical enterprise into discreet, saleable units (commodities), creating buyers and sellers—for example, separating responsibility for financing and providing care or moving from global hospital budgets to fixed payment for a specific procedure
- Once medical commodities are defined, the sellers (medical providers) are forced to compete, giving rise to financial winners and losers
- Because most medical commodities are heterogeneous (patients differ) providers can gain advantage by market segmentation—for example, caring for a relatively healthy subgroup of patients with a particular diagnosis
- Profitable providers attract investors and amass the financial (and political) power to expand their opportunities, while unprofitable ones are driven from the market

What's driving privatisation?

Evidence from the US is remarkably consistent; public funding of private care yields poor results. In practice, public-private competition means that private firms carve out the profitable niches, leaving a financially depleted public sector responsible for the unprofitable patients and services. Based on this experience, only a dunce could believe that market based reform will improve efficiency or effectiveness. Why do politicians—who are anything but stupid—persist on this track?

Such reforms offer a covert means to redistribute wealth and income in favour of the affluent and powerful. Privatisation trades the relatively flat pay scales in government for the much steeper ones in private industry; the 15-fold pay gradient between the highest and lowest paid workers in the US government gives way to the 2000:1 gradient at Aetna.

But even more important, privatisation of publicly funded health systems uses the public treasury to create profit opportunities for firms needing new markets. US private insurers used to focus on selling coverage to employer sponsored groups and shunned elderly people as uninsurable. Now, with employers cutting health benefits, insurers have turned to public treasuries for new revenues. And why stop at selling insurance? Why not tap into the trillions spent annually on care in hospitals and doctors' offices?

Lessons for other countries

Market fundamentalists conjure visions of efficient medical markets partnered with government oversight and funding to assure fairness and universality. But regulation is overmatched. Incentives for optimal performance align imperfectly, at best, with the real goals of care. Matrices intended to link payment to results instead reward entrepreneurs skilled in clever circumvention. Their financial and political clout grows; those who guilelessly pursue the arduous work of good patient care lose in the medical marketplace.

Health systems in every nation need innovation and improvement. But remedies imported from commerce consistently yield inferior care at inflated prices. Instead we prescribe adequate dosing of public funds; budgeting on a community-wide scale to align investment with health priorities and stimulate cooperation among public health, primary, and hospital care; encouragement of local innovation; explicit empowerment of patients and their families; intensive audit for improvement, not reward or blame; a system based on trust and common purpose; and leadership not by corporations but by "imaginative, inspired, capable and . . . joyous people, invited to use their minds and their wills to cooperate in reinventing the system, itself . . . because of the meaning it adds to the lives and the peace it offers in their souls."[34]

We thank Howard Waitzkin for useful comments.

Contributors and sources: SW and DUH work as primary care doctors at an urban public hospital. Stimulated by their patients' difficulties in obtaining care, they began research into the inadequacies of US health care. In 1986 they cofounded Physicians for a National Health Program (**www.PNHP.org**), which advocates non-profit national health insurance in the US. Both authors participated equally in all aspects of this work, which draws on their research, experience as clinicians in the US healthcare system, and extensive literature review. Both serve as guarantors.

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SUMMARY POINTS

The US has long combined public funding with private healthcare management and delivery

Extensive research shows that its for-profit health institutions provide inferior care at inflated prices

US experience shows that market mechanisms undermine medical institutions unable or unwilling to tailor care to profitability

Commercialisation drives up costs by diverting money to profits and fuelling growth in management and financial bureaucracy

The poor performance of US health care is directly attributable to reliance on market mechanisms and for-profit firms and should warn other nations from this path

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(**Editor's note:** *The following entry from Dr. Don McCanne's single payer "Quote of the Day" concerns the negative impact a decade of private health plans has had on Australia's single payer national health insurance system. In 2007 the government spent $3 billion in taxpayer funds to subsidize 1/3 of the cost of private health insurance, but claimed penury when it came to adequately funding public hospitals. To subscribe to the "Quote of the Day," drop a note to to Dr. McCanne via e-mail Don@McCanne.org.*

Australia's Medicare and Private Health Plans:

A Model of Two-Tiered Care

The private life of health care

By Ruth Pollard and Mark Metherell
The Sydney Morning Herald
April 6, 2007

In just 10 years, the health system many were dreading has arrived. Spurred by the Federal Government's campaign to push Australians into private health insurance and exacerbated by difficulties in finding care in public hospitals, the balance has tipped in favour of private hospitals. Our system is now a genuinely two-tiered model: the wealthy and privately insured get timely health care and the rest, unless they are critically ill, can wait.

In the past decade, a clear division of labour has evolved: public hospitals are now dominant in emergency surgery and medicine, while private hospitals rule in elective surgery, accounting for 55.7 per cent of all operations.

"Since 1982-83, Australia's hospital system has witnessed a massive shift of activity to the private sector," Bill Nichol, an assistant director in the federal Department of Health, writes in the study.

"The private sector's role has increased to dominant player" in several categories of care, including eye, cancer, ear, nose and throat and the male and female reproductive systems, Nichol says.

The worrying thing is that many seem to have thrown up their arms in despair, a kind of "Oh, well" about the death of equity in the health system.

Bruce Armstrong, the director of research at the Sydney Cancer Centre and a professor of public health at the University of Sydney, believes there has been no attempt to prevent a two-tier health system from developing.

"Equity is a real issue – a proportion of the Australian population which is not inconsequential is not going to get that care because if you go to a private hospital you need private health insurance and even then, there [are] always going to be gap payments."

A disturbing trend to emerge despite the establishment of Medicare in 1983 is the widening disparity between the well-off and the poor in mortality rates from avoidable diseases. The Australian way of death means the prosperous are significantly less likely to die from avoidable disease than those on low incomes.

In 1986 the rate of death from "avoidable" causes such as treatable and preventable conditions like heart disease among the have-nots was 50 per cent higher than for the haves. By 2002 that difference had stretched to a twofold gap, according to research published in the International Journal of Epidemiology.

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Commentary by Don McCanne, MD

Australia's experiment with a public Medicare program and private insurance plans has provided a very important policy lesson for the United States: Establishing policies that encourage the purchase of private insurance while simultaneously limiting the funding of public insurance will inevitably result in a two-tiered system. More affluent individuals will have the best care money can buy, whereas those remaining in an underfunded public program will have impaired access and impaired health outcomes. Keep in mind that impaired health outcomes means chronic suffering and death.

The private Medicare Advantage insurance options in our Medicare program are intended to reproduce this same two-tiered system in the United States. Currently the Medicare Advantage plans are provided with more taxpayer funds so that they can attract individuals by providing better benefits. Once the private plans are well established, the government can start reducing the funding of both the traditional program and the private plans. But the private plans will be able to continue to offer greater benefits merely by increasing premiums and cost sharing. Thus more affluent individuals will select the private plans whereas individuals with more modest means will be relegated to the underfunded public program. Without a surge in political activism, this outcome is inevitable.

There is an even more important lesson from the Australian experience. We now have a consensus that we must reform health care in America. The two main options are to either establish an equitable national health insurance program, or build on the current fragmented system to achieve universality. Numerous attempts at patching our current system have fallen short, so some politicians and policymakers are now supporting a public Medicare-like program as a safety-net alternative. Because health care costs are a leading concern of virtually everyone, efforts will be made to keep the funding of the Medicare-like option to a minimum. Imagine a minimally funded program that attracts people with low incomes and with significant health care needs; talk about stretching resources. Anyone who can buy their way out of that program will. Like Australia, a two-tiered system would be inevitable.

As Professor Braithwaite says, "The real question is, is this the health system that we want, that people desire?"

AUSTRALIA continued from **page 42**

The report concludes that "advantaged people have obtained a disproportionate benefit of health care, contributing to widening relative health inequalities".

"A universal health-care system does not guarantee equality in health-care-related outcomes," says the article, whose lead author was Rosemary Korda of the National Centre for Epidemiology and Population Health at the Australian National University.

The Health Minister, Tony Abbott, having presided over multibillion-dollar infusions into the private sector through Medicare payments to private doctors and the private insurance rebate, acknowledges states are bearing a larger share of public hospital costs.

But he says that if there is an equity problem, it's for state governments to fix. "It may sound like I am playing the blame game, but state governments are responsible for public hospitals," Abbott says.

He would welcome further growth in private insurance, which he suggests many more people could afford given that more than 1 million people on incomes of less than $20,000 pay for cover.

"No doubt having private health insurance confers additional benefits [like avoiding public waiting lists], but you do have to pay for it," Abbott says.

It was inevitable that we would end up at this point, says Professor Jeffrey Braithwaite, the director of the Centre for Clinical Governance Research at the University of NSW.

"This is a health system responding to policy measures - those measures are the caps in the public hospital system and the incentives provided in the private system," he says.

"The real question is, is this the health system that we want, that people desire?"

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Canada's health care system and the sustainability paradox

Irfan Dhalla MD

Physician leaders,[1] newspaper columnists,[2,3] representatives of the business community[4] and even some health policy analysts[5] have all expressed concerns that publicly funded health care is unsustainable. The current federal health minister has even gone so far as to say that "both the Prime Minister and I have indicated that the status quo won't be sustainable in terms of demands on our system."[6]

Not everyone holds this view. For example, in his report on health care in Canada,[7] Roy Romanow concluded that our health care system was "as sustainable as we want it to be." Despite this countervailing argument, concerns about unsustainability have provided an impetus for proposed reform.[1]

In this article, I will argue that Canada faces a sustainability paradox: despite ever-increasing expenditures, both in absolute dollars and as a percentage of the national income, increases in overall spending on health care in Canada are sustainable for the foreseeable future.

Are increases in government spending on health care sustainable?

One view maintains that our publicly funded health care system is unsustainable because health care expenditures are accounting for an ever-increasing share of government spending. In Ontario, for example, health care spending accounted for just over 30% of the provincial government's expenditures in 1981/82, but 45% in 2004/05. Assuming that current trends will continue, the Ontario government has projected that the share will increase to 55% by 2025.[8]

One major flaw with this line of reasoning is the assumption that the percentage of government expenses devoted to health care depends primarily on how much governments spend on health. When measured by percentage of government expenses, health spending also depends on 2 other key factors: how much governments spend on non-health-related items (e.g., education, police services, social assistance) and how much governments collect in taxes. If a government reduces its spending on non-health-related items or cuts taxes, the percentage of expenditures devoted to health care will increase automatically.

A closer look at the Ontario data described earlier reveals that other trends are hidden amid the seemingly inexorable rise in health care spending. For example, starting in 1988, the share of Ontario's expenditures devoted to health care actually decreased for almost 10 years, from 38% to just over 35%. After 1997, the share began to grow, but the increase was due in large part to reductions in spending on non-health-related items, tax cuts and reductions in transfers from the federal government.[8]

Arguments that our publicly funded health care system is unsustainable because it accounts for an ever-increasing share of government funding often depend on the premise that tax rates must be fixed or continually declining. This as-

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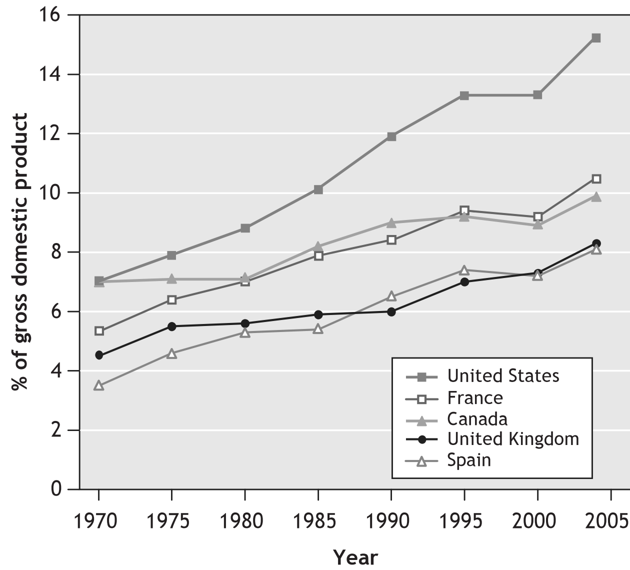

Figure 1: Health care expenditures as a percentage of the gross domestic product in 5 selected countries.

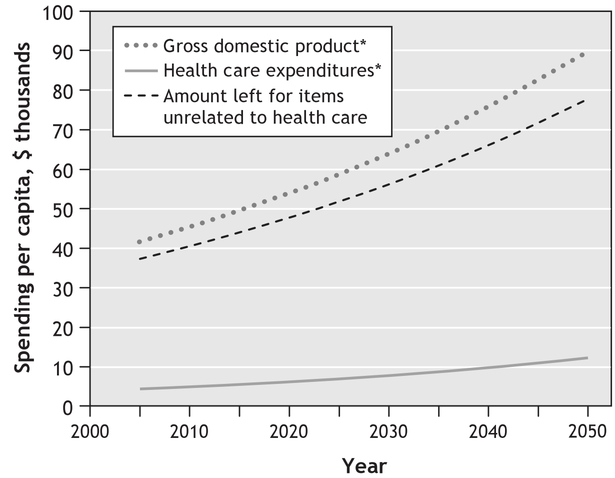

Figure 2: Long-term projections for per capita spending on health care and other non-health-related items in Canada. *The projections assume an annual growth rate per capita of 2.3% in health care spending and of 1.7% in gross domestic product.

sumption, however, is open to challenge. Over the last 20 years, although the share of government tax revenue in Canada as a proportion of our gross domestic product (GDP) has remained essentially constant at 33%, many other economically advanced countries have quietly been increasing taxes. In 1985, members of the Organisation for Economic Co-operation and Development (OECD), a group of 30 countries "committed to democracy and the market economy," collected taxes at an average rate of 30% of their respective GDPs. By 2004, these countries were collecting taxes at an average rate of 36% of GDP.[9] Although some might argue that the overall taxation level in the United States is a more appropriate benchmark for Canada than the OECD average, others would argue that comparing ourselves exclusively to the United States leads to an artificially constricted range of policy options for Canadian decision-makers. Had our taxes increased at even half the rate of those among the OECD countries, the argument that health care expenditures are unsustainable because they account for an ever-increasing share of government spending would be far less viable.

For the reasons I have described, it is problematic to assess sustainability on the basis of health care spending as a share of government expenditures. Would it be better to consider health care spending as a share of GDP instead?

Is the increasing economic burden of health care sustainable?

The prevailing view that health care spending is rising faster than both inflation and the growth of the economy is correct. However, the difference between health care spending and economic growth is smaller than many assume. Health care spending (in both the private and public sectors) accounted for 7% of Canada's GDP in 1970, and 9.9% in 2004.[10] Contrary to popular belief, the larger part of the increase actually occurred over the first half of the last 35 years. Similar increases have occurred in other countries, and in many cases they have been even larger than those in Canada. For example, health care spending in Spain was 3.5% of the GDP in 1970 and 8.1% in 2004; in the United States, the corresponding numbers were 7% and 15.3% (Figure 1).[10]

Moreover, to measure health care spending as a percentage of GDP obscures an extremely important fact: over the last 35 years, the economy in all economically advanced countries has been growing. This growth has allowed us to spend more, not only on health but on a variety of other goods and services as well. In terms of sustainability, spending on health care itself is unimportant; what matters is how much we have left to spend on our other needs and desires. In other words, growth in health care spending is sustainable provided it does not reduce the average Canadian's ability to purchase non-health-related goods and services.

Over the last 35 years, despite the phenomenal growth in health care spending, we have still had enough left to spend ever-increasing amounts on non-health-related goods and services. How is this possible? Imagine a country where spending on health care is $1 per capita and the GDP is $100 per capita. If, over 50 years, health care spending increases by 100 times, to $100, and the GDP increases 10 times, to $1000, the amount of money left for non-health-related spending has still increased from $99 to $900. In other words, the citizens of this imaginary country would have seen their health care spending increase from 1% of GDP to 10% of GDP and would still have almost 10 times as much money left for non-health-related spending. Some would call this the miracle of economic growth.

From 1992 to 2004, real per capita spending on health care (i.e., after exclusion of the effects of inflation) in Canada increased at a rate of 2.3% per year.[10] During the same period,

real per capita economic output (GDP) increased at a rate of 1.7% per year.[11] If these growth rates were to continue indefinitely (and these numbers are similar to those forecasted by at least one provincial government[8]), the amount of money left for non-health-related spending would continue to increase for well over a century (Figure 2).

Conclusions

Is our health care system unsustainable? I have argued that increases in health care spending are sustainable as long as growth in non-health-related spending can still occur. From the evidence I have presented here, one can see that non-health-related spending can continue to increase even if health care expenditures grow at a faster rate than that of the GDP, provided the economy continues to grow over the long term.

Governments might argue that our health care system could still be unsustainable, if it were to crowd out other important government priorities, such as spending on child care or the environment. This argument would be true only if governments were incapable of increasing taxes.

An obvious and important question remains: *Should* health care spending continue to grow at current rates? To answer this question would require an analysis of whether we are obtaining value for the money we spend. Evidence on this point is limited; however, one recent analysis of health care spending in the United States (where costs are significantly higher than in Canada) concluded that overall increases in spending have provided "reasonable value."[12] Given the limited strength of this evidence, it might be reasonable to argue that society has an interest in limiting further growth in health care expenditures. However, arguments that health care spending *cannot* grow at current rates are, because of the sustainability paradox, unsound.

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Private health insurance and access to health care in the European Union

Sarah Thomson and Elias Mossialos

Private or voluntary health insurance (VHI) does not play a significant role in many health systems in the European Union (EU), either in terms of funding or as a means of gaining access to health care. In most EU member states it accounts for less than 5% of total expenditure on health and covers a relatively small proportion of the population (see Table 1). The exceptions to this trend are France, Germany and the Netherlands.

VHI fulfils different roles in different contexts. In the EU context it can be classified according to whether its role, in relation to statutory health insurance (SHI), is substitutive, complementary or supplementary. Substitutive VHI provides cover that would otherwise be available from the state. It is purchased by those who are excluded from participating in some or all aspects of the SHI scheme – for example, Dutch residents with an annual income over 30,700 a year and their dependants (around a quarter of the population) – or by those can choose to opt out of that SHI scheme, such as German employees with annual earnings over 45,900 and their dependants (about 5% of the population). Complementary VHI provides cover for services excluded or not fully covered by the state, particularly cover for statutory user charges, as in Croatia, Denmark, France and Slovenia. Supplementary VHI provides cover for faster access and increased consumer choice and is available in most EU member states.

Table 1
Levels of VHI coverage as a percentage of the total population in the EU, 2000 or latest available year

Country	Substitutive	Complementary	Supplementary
Austria*	0.2%	18.8% (inpatient 12.9%)	
Belgium	7.1%	30–50%	
Denmark*	None	28%	
Finland***	None	None	Children <7: 34.8% Children 7–17: 25.7% Adults: 6.7%
France**	Marginal (frontier workers)	85% (2000 estimate 94%)	
Germany*	9%	9% (mainly)	
Greece	None		10%
Ireland	None	45%	
Italy*	None	15.6%	
Luxembourg	None	70% (mainly)	
Netherlands*	24.7% (+ 4.2% WTZ)	>60%	Marginal
Portugal**	None		12%
Spain*	0.6%	11.4%	
Sweden*	None		1.0–1.5%
UK	None		11.5%

* 1999, ** 1998, *** 1996

Source: Mossialos and Thomson (2004)[1]

VHI may increase access to health care for those who are able to purchase an adequate and affordable level of private cover. At the same time it is likely to present barriers to access, particularly for older people, people in poor health and people with low incomes. The greater the role of VHI in providing access to effective health services that are a substitute for or complement to those provided by the government, the larger the impact it will have on access to health care.

Access to health care within VHI markets is heavily dependent on the regulatory framework in place and the way in which insurers operate. It may be affected by how premiums are rated, whether they are combined with cost sharing, the nature of policy conditions, the existence of tax subsidies to encourage take up or cross-subsidies to the statutory health care system and the characteristics of those who purchase it. It may also be affected by whether or not benefits are provided in cash rather than in kind, the way in which providers are paid and the extent to which policies are purchased by groups – usually employers – rather than individuals.

Due to information failures in VHI markets, insurers need to find ways of assessing an individual's risk of ill health in order to price premiums on an actuarially fair basis. However, accurate risk assessment is technically difficult and expensive to administer. Consequently, insurers have strong incentives to select risks – that is, to attract people with a lower than average risk of ill health and deter those with a higher than average risk. Some regulatory measures will increase insurers' incentives to select risks – for example, requiring insurers to offer community-rated premiums – while others, such as risk adjustment mechanisms, aim to reduce these incentives.

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Table 2
Conditions usually excluded from VHI cover in the European Union, 2001

Country	Usual exclusions
Austria	*Individual*: pre-existing conditions usually excluded (but not from group policies); insurers cannot reject applications but may charge higher premiums and/or introduce cost-sharing arrangements for people with chronic illnesses
Belgium	*Mutual*: psychiatric and long-term care (lump sum) *Mutual*: psychiatric care (co-payment) *Commercial*: pre-existing conditions, infertility treatment, sporting injuries
Denmark	Pre-existing conditions
Finland	Pregnancy and childbirth, infertility treatment, alcoholism, herbal remedies, treatment covered by statutory health insurance
France	Excluding any disease is forbidden by law, although it can be authorized in individual policies under certain conditions: the disease has to be clearly stated and the insurer has to prove that the patient had the disease before purchasing the policy
Germany	Pre-existing conditions are excluded if they were known at the time of underwriting and were not disclosed by the insured; declared pre-existing conditions are covered but generally result in higher premiums
Greece	Pre-existing conditions
Ireland	Open enrolment
Italy	*Individual*: pre-existing conditions, chronic and recurrent diseases, mental illness, alcohol and drug addiction, cosmetic surgery, war risks, injuries arising from insurrection, natural disasters etc; also often excludes dental care not caused by accident/illness *Group*: pre-existing conditions such as diabetes, drug and alcohol addiction, HIV/AIDS, severe mental health problems such as schizophrenia, voluntary termination of pregnancy and war risks
Luxembourg	*Mutual*: open enrolment (but no cover for treatment excluded from Statutory Health Insurance) Commercial: pre-existing conditions
Netherlands	Some dental plans may require people to have their teeth restored before acceptance
Portugal	*Individual*: pre-existing conditions, long-term chronic illnesses (such as diabetes, multiple sclerosis and asthma), HIV/AIDS, haemodialysis, self-inflicted injuries, psychiatric treatments, check-ups, dental care, outpatient drugs, alternative medicine and non-evidence based treatment; dental care, delivery costs and outpatient drugs are only covered by the most expensive policies
Spain	HIV/AIDS, alcoholism and drug addiction, dental care (often available for a supplementary premium), prosthesis, infertility treatment, orthopaedics etc; some insurers do not have general restrictions but may reject certain conditions; most insurers offer extra benefits for a supplementary premium eg organ transplants, second opinion, family planning, assistance during trips, treatment abroad, certain prosthesis; only one insurer offers homeopathy or spa treatment
Sweden	Emergency care, long-term care, HIV/AIDS, some other communicable diseases, diseases and injuries as a result of the use of alcohol or other intoxicating substances, pre-natal care, child birth (normal or with complications), termination of pregnancy, infertility treatment, vaccinations
UK	Pre-existing conditions, GP services, accident and emergency admission, long-term chronic illnesses such as diabetes, multiple sclerosis and asthma, drug abuse, self-inflicted injuries, outpatient drugs and dressings, HIV/AIDS, infertility, normal pregnancy and child birth, cosmetic surgery, gender reassignment, preventive treatment, kidney dialysis, mobility aids, experimental treatment and drugs, organ transplants, war risks and injuries arising from hazardous pursuits

***Source*: Mossialos and Thomson (2004)[1]**

However, even if explicit risk selection is prohibited by requiring insurers to offer open enrolment and to cover pre-existing conditions, insurers may engage in covert forms of risk selection.

Insurers in European VHI markets are generally subject to a low level of regulation. In most non-substitutive VHI markets regulation is exclusively concerned with ensuring that insurers remain solvent rather than issues of consumer protection. Ireland is the only country in which insurers are required to offer open enrolment, community-rated premiums and lifetime cover and are subject to a risk equalization scheme (see the article on Ireland). Elsewhere insurers are permitted to reject applications for cover, exclude or charge higher premiums for pre-existing conditions, rate premiums according to risk, provide non-standardized benefit packages and offer annual contracts. Benefits are usually provided in cash – that is, insurers reimburse individuals for their health care costs. In loosely regulated VHI markets older people, people in poor health and people with low incomes are likely to find it difficult to obtain affordable coverage. People in poor health may not be able to purchase any cover (see Table 2).

Governments intervene more heavily in markets for substitutive VHI in Germany and the Netherlands where, as a result of risk selection by insurers, older people and people with chronic illnesses have not been able to purchase sufficient cover. Risk selection by insurers has also contributed, to some extent, to the financial instability of the SHI scheme, which covers a disproportionate amount of older people in both countries. Changes in regulation to prevent further destabilization of SHI in the Netherlands in 1986 and in Germany in 1994 and 2000 mean that some people with relatively low incomes no longer have access to statutory coverage and must rely on substitutive VHI. For this reason insurers in both countries are required to provide older people with standardized benefit packages – providing similar benefits to statutory coverage – for a premium regulated by the government. Insurers in Germany are also required to offer lifetime substitutive VHI cover. In the

Table 3
A comparison of administrative costs among voluntary and statutory insurers, 1999

Country	Voluntary (% of premium income)	Statutory (% of public expenditure on health)
Austria	22% (early 1990s)	3.6% (2000)
Belgium	25.8% (commercial individual) 26.8% (commercial group)	4.8%
France	10–15% (mutuals) 15–25% (commercial)	4–8%
Germany	10.2%	5.09% (2000)
Greece	15–18% (commercial life insurers)	5.1%
Ireland	11.8% (Vhi Healthcare 2001) 5.4% (Vhi Healthcare 1997)	2.8% (1995)
Italy	27.8% (2000)	0.4% (1995)
Luxembourg	10–12% (mutuals)	5.0%
Netherlands	12.7%	4.4%
Portugal	About 25%	-
Spain	About 13–15%	5.0%
UK	About 15%	3.5% (1995)
United States	About 15%	About 4.0%

***Source*: Mossialos and Thomson (2004)[1]**

Netherlands younger people with substitutive VHI are required to cross-subsidize the premiums of older people and all policy holders must make an annual contribution to the SHI scheme.

Complementary VHI covering cost sharing is likely to present barriers to access for people with low incomes, particularly those with incomes just above the threshold for any exemptions from cost sharing that may exist. It is both inequitable and inefficient for governments to establish a price mechanism through cost sharing and then negate the effect of price for those who can afford to purchase complementary VHI. Complementary VHI is most prevalent in France, where it covered 85% of the population in 1998. Research shows that the likelihood of being covered by complementary VHI is highly dependent on social class, income levels, employment status, level of employment and age. Furthermore, the quality of coverage provided by complementary VHI increases significantly with income. In order to address the inequalities in access to health care arising from unequal access to complementary VHI, the French government introduced a law on universal health coverage (CMU) in 2000, extending free complementary VHI coverage to people earning less than 550 (US$ 645) per month (see the article on page 4).

Supplementary VHI often provides faster access to health care by enabling people to bypass waiting lists in the public sector. It can also provide access to a wider range of providers. However, if supplementary VHI does not operate independently of the statutory health system, it may distort the allocation of public resources for health care, which may restrict access for those who are publicly insured. This could happen if boundaries between public and private provision are not clearly defined, particularly if capacity is limited, if providers are paid by both the public and the private sector and if VHI creates incentives for health care professionals to treat public and private patients differently. Governments in some countries, for example, Ireland, have found that the existence of VHI can reduce access for publicly funded patients and are taking steps to clarify the boundaries between public and private provision of health care.

VHI tends to incur higher management and administrative costs than SHI, partly because pool size is smaller, but mainly due to the extensive bureaucracy required to assess risk, set premiums, design benefit packages and review, pay or refuse claims (see Table 3). Insurers also incur additional expenses through advertising, marketing, distribution, reinsurance and the need to generate a profit or surplus. Within the EU context, these additional costs cannot be justified on the grounds that insurers are innovative in devising mechanisms to contain costs. In practice, EU insurers are more likely to compete on the basis of risk selection than through competitive purchasing. Most attempts to contain costs operate on the demand side, through cost sharing. Transaction costs have not been lowered as a result of increased liberalization of VHI markets in the EU since 1994. In Ireland higher levels of advertising following liberalization have actually increased transaction costs.

Overall, VHI requires careful regulation to ensure access to health care, guarantee consumer protection and stimulate efficiency gains. The existence of VHI is likely to create barriers to access and may reduce equity and efficiency in the health system as a whole. Furthermore, unless there are clear boundaries between the public and the private sector, VHI may distort the allocation of public resources for health care, to the detriment of those who are insured by statutory health insurance.

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Yes, We Can! Can We?

THE NEXT FAILURE OF HEALTH CARE REFORM

By VICENTE NAVARRO

A major problem–if not the major problem–for many people living in the U.S. is the difficulty of accessing and paying for medical care when they are sick. For this reason, candidates in the presidential primaries of 2008–the Democrats more often than the Republicans–have been recounting stories about the health-related tragedies they have encountered in meetings with ordinary people around the country (an exercise conducted in the U.S. every four years, at presidential election time). These stories tell of the enormous difficulties and suffering faced by many people in their attempts to get the medical care they need. I have been around long enough–I was senior health advisor to Jesse Jackson in the Democratic primaries of 1984 and 1988–to know how frequently Democratic candidates, over the years, have referred to such cases. The only things that change are the names and faces in these human tragedies. Otherwise, the stories, year after year, are almost the same.

In the Democratic Party primaries of 1988, for example, candidate Michael Dukakis talked about a young single mother who had two jobs and still could not afford medical insurance for herself and her children. In 1992, Bill Clinton did the same, changing the story only slightly. This time it was the case of a woman with diabetes who could not get health insurance because of her chronic condition. And now, in the 2008 primaries, Hillary Rodham Clinton (whom I worked with on the White House Health Care Reform Task Force in 1993) describes a similar case. This time it is a single woman, with two daughters, who cannot pay her medical bills because her congenital heart defect makes it impossible for her to get medical insurance coverage. And Barack Obama describes similar cases, with the eloquence that characterizes all of his speeches. He frequently refers to his own mother, who had cancer and had to worry not only about her illness but about paying her medical bills.

All these cases are tragic and are representative of a situation faced by millions of people in the U.S. every year. But, I am afraid that unless the winning Democratic candidate, once elected president (and I hope he or she will be), develops a more comprehensive health care proposal than any of those put forward in the primaries so far, we will see the same situation continue. Democratic candidates in the 2012 primaries, and in the 2016 primaries, will still be referring to single mothers with chronic health conditions who cannot pay their medical bills. The proposals put forward by Obama and Clinton underestimate the gravity of the problem in the U.S. medical care sector. The situation is bad and is getting worse: the number of people who are uninsured and underinsured has been growing since 1978.

Let's start with the uninsured, those people who do not have any form of health benefits coverage. There were 21 million uninsured people in the U.S. in 1972. By 2006, that number had more than doubled to 47 million. And this increase has been independent of economic cycles. The number of uninsured grew by 3.4 million from 2004 to 2006, even as a resurgent economy raised incomes and lowered poverty rates. Meanwhile, during those years, the Democratic Party establishment distanced itself from any commitment to resolving these problems. Even though the 1976, 1980, 1984, 1988, and 1992 Democratic Party platforms included calls for health care benefits coverage for everyone (what is usually referred to as "universal health care"), that call was usually made without much conviction. In the primaries of 1988, when I was involved in preparing the Democratic platform, Dukakis (the winner of the primaries) resisted including universal health care in the party platform. He was afraid of being perceived as "too radical." He had to accept it, however, because Jesse Jackson agreed to support Dukakis (Jackson had 40% of the Democratic delegates at the Atlanta convention) only if the platform included this call for universal care.

Then, in 1992, Bill Clinton (who borrowed extensively from Jackson's 1988 proposals) put the call for universal health care at the center of his program. But, once president, his closeness to Wall Street and his intellectual dependence on Robert Rubin of Wall Street (who became his Secretary of the Treasury) made him leery of antagonizing the insurance industry. It was President Clinton's unwillingness to confront the insurance companies that led to his failure to honor his commitment to work toward a universal health care program (see my article "Why HillaryCare Failed" http://www.pnhp.org/hillarycare,

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November 12, 2007). The type of reform President Clinton called for was a health insurance-based model called "managed care," in which insurance companies remain at the center of health care. An alternative approach could have been to establish a publicly funded health care program (which was favored by the majority of the population) that would cover everyone, providing medical care as an entitlement for all citizens and residents. This could have been achieved, such as by expanding the federal Medicare program to cover everyone. To do so, however, would have required neutralizing the enormous power of the insurance companies with a massive mobilization of the population against them and in favor of a comprehensive and universal health care program.

But President Clinton's loyalty to Wall Street prevailed. His administration's top priorities were reduction of the federal deficit (at the cost of reduced public social expenditures) and approval of NAFTA (without amending President George H. W. Bush's proposal, which Clinton had inherited, and refusing to address the concerns of the labor and environmental movements). These actions antagonized and demoralized the grassroots of the Democratic Party. Clinton lost any power to mobilize people for the establishment of a universal health care program. This frustration of the grassroots, and especially the working class, also led to the huge abstention by the Democratic Party base in the 1994 congressional elections and the consequent loss of the Democratic majority in the House, the Senate, and many state legislatures. At the root of this disenchantment with the Clinton administration was its unwillingness to confront the insurance companies and Wall Street. Could that happen again?

The health care mess (Nixon dixit)

Before addressing this question, let's look at the problems people face in the U.S. But first, I should stress that the country has sufficient resources to provide comprehensive, high-quality medical care to everyone who needs it. The U.S. spends 16% of its GNP on medical care, almost double the percentage spent by Canada and most countries of the European Union (E.U.) on providing universal, comprehensive health care coverage to their populations. We in the U.S. spend $2.1 trillion on medical care, making the medical care sector one of the largest economies in the world (if the medical care sector were a country, rather than a massive sector within a country). And it has been estimated that this spending will reach 20% of GNP in a few years (7 years according to some, 12 years according to others). Lack of money is not the root of the medical care problem in the U.S. We spend far, far more than any other developed country, and far more than what we would need to provide comprehensive health care coverage for everyone. The frequently heard argument that the U.S. cannot afford universal, comprehensive care has no credibility. It is a poor rationale for keeping the situation as it is.

Despite the huge amount of money spent on medical care, the situation of the U.S. medical care sector is a disgrace. Even Richard Nixon, in an unguarded moment, defined it as a mess. And as noted above, it has gotten much worse since Nixon was president: in 2006, 47 million Americans did not have any form of health benefits coverage, and 108 million had insufficient coverage. And people die because of this. Estimates of the number of preventable deaths vary, from 18,000 per year (estimated by the conservative Institute of Medicine) to a more realistic level of more than 100,000 (calculated by Professor David Himmelstein of Harvard University). The number depends on how one defines "preventable deaths." But even the conservative figure of 18,000 deaths per year is six times the number of people killed in the World Trade Center on 9/11. That event outraged people (as it should), but the deaths resulting from lack of health care seem to go unnoticed; these deaths are not reported on the front pages, or even on the back pages, of the New York Times, Washington Post, Los Angeles Times, or any other U.S. newspaper. These deaths are so much a part of our reality that they are not news. How can this be tolerated in a country that claims to be a civilized nation?

The Democratic candidates´ proposals

The proposals put forward by the current Democratic candidates for president, Barack Obama and Hillary Clinton, will improve the situation. They will diminish somewhat the number of those not covered by health insurance and will reduce the level of undercoverage. But the major problems will remain unresolved, including the problems the candidates have referred to during their campaigns. People will still experience incomplete coverage, and many millions will continue to be uninsured and underinsured. Not even the mandatory health insurance called for by Hillary Clinton will resolve these problems. Her plan proposes that, just as a car driver in the U.S. must have car insurance, so a citizen or resident will have to have health insurance. The problem with this mandate is not only—as Obama has pointed out—the matter of enforcement (note that according to some estimates, up to 20% of car owners drive without car insurance), but the assumption behind the policy. The assumption is that most people who are not insured are "free-riders," people who could afford to buy insurance but choose not to, and choose to let someone else pay for their care when they get sick. But the vast majority of people who are uninsured are people who cannot afford to pay for it. It's as simple as that. Massachusetts passed a mandate of this sort (under Governor Mitt Romney), but 198,000 people still remain uninsured. The subsidies and tax incentives proposed to help the uninsured pay for health insurance premiums under plans of this type are insufficient.

Another proposed mandate (put forward by Clinton more strongly than by Obama) is that all employers must provide insurance coverage to their employees—a policy proposed by President Nixon back in the 1970s. But with this proposal, unless you force employers to

provide comprehensive coverage at an affordable cost to everyone, the problem will still not be resolved. An even greater problem with the employer mandate, however, is that it continues to tie health benefits to employment, which is a perverse system and a nasty one. The reason employers, in 1948, pushed to make health care benefits dependent on employment (in the nefarious Taft-Hartley Act) was that this was a way of controlling workers. The Taft-Hartley Act forced the labor force to get health care benefits through collective bargaining agreements that are highly decentralized and are negotiated at the place of employment. In the U.S., workers who lose their jobs lose not only wages, but also health benefits coverage for themselves and their family. And if these workers want to keep their insurance, they have to pay prohibitive premiums. So, a worker will think twice before striking. This is one reason why the U.S. has fewer working days lost to strikes than other developed countries. Until recently, employers have been the major force—besides the insurance companies—for keeping the current system of funding and managing health care. This system, then, is based on an alliance between employers and the insurance industry.

It is this alliance that is responsible for the biggest problem of health care benefits: undercoverage. Most people believe that because they have health insurance, they will never face the problem of being unable to pay their medical bills. They eventually find out the truth—that their insurance is dramatically insufficient. Even for families with the best health benefits coverage available, the benefits are much less comprehensive than those provided as entitlements in Canada and in most E.U. countries. And paying medical bills in the U.S. is a serious difficulty for many people. In fact, inability to pay medical bills is the primary cause of family bankruptcy, and most of these families have insurance. Furthermore, 20% of families spend more than 10% of their disposable income on insurance and medical bills (the percentage is even higher for those with individual insurance: 53%). In 2006, one of every four Americans lived in families that had problems in paying medical bills. And most of them had health insurance.

The inhumanity of this situation is made evident by the fact that nearly 40% of people in the U.S. who are dying because of terminal illness are worrying about paying for care—how their families are going to pay the medical bills, now and after they die. No other developed country comes close to these levels of insensitivity and inhumanity. Meanwhile, the federal government parades around the world as the great defender of human rights, ignoring the fact that among the developed democratic nations, the U.S. is the most deficient in human rights. The basic right of access to health care in time of need does not exist in the U.S. The United Nations Human Rights Declaration includes this right in a prominent position, but this is a declaration that the U.S. Congress has never signed. It should come as no surprise that the world's people do not believe the U.S. government is a great defender of human rights abroad, since it does not guarantee even basic rights at home.

And here again, things are getting worse. The percentage of uninsured and underinsured has been increasing. The proportion of people with employer-based health benefits coverage declined from 67.8% among the non-elderly in 2000 to 63% in 2006—even though the economy was booming during those years. In the same period, the number of adults without coverage increased by 8.7 million, and from 2004 to 2006 the number of children without coverage increased by 1 million.

Why does this situation persist in the U.S.?

For any society, medicine is a mirror of the power relations in that society. And nowhere is the lack of human rights more evident than in the house of medicine. In the U.S., insensitivity toward human needs goes hand-in-hand with enormous profits made from that suffering. The root of the problem, as noted earlier, is not lack of money but the channels through which that money is managed and spent. The problem is the privatization of the funding of medicine that allows profits to boom. The insurance and pharmaceutical industries enjoy the highest rates of profit in the U.S. Just last year, insurance industry profits reached $12 billion, and pharmaceutical industry profits $49 billion, the highest in the U.S. and in the world. According to Fortune Magazine, health-related industries are among the most profitable industries in the country. A lot of money is being made from people's suffering. This scandalous situation is easy to document. For example, lanzoprasol, a gastric secretion-reducing medicine widely used in the U.S., costs $329 in Baltimore, U.S.A.; the same medicine (same number of doses) costs $9 in Barcelona, Spain! And the current Bush administration signed legislation for a program that, in theory, covers drug costs for elderly people, but in practice this is an enormous rip-off. It forbids the government to negotiate with the drug industry on the cost of drugs—that is, the price of their products. What this means is that the federal government pays the prices dictated by pharmaceutical companies.

Now, one might well ask, Why does this continue? Why hasn't our government done something about it? Is it that the government could not provide comprehensive health benefits coverage? It certainly could. All E.U. governments do so. All provide publicly funded, comprehensive health care coverage to their entire population. And on this side of the Atlantic, Canada (which once had a system identical to ours, health insurers included) also provides this entitlement to all its citizens. In Canada in the 1960s, a social democratic government in Saskatchewan did a very logical thing. My good friend, Dr. Samuel Wolfe, who was then Chief Health Officer of Saskatchewan, proposed to the province's social democratic government that rather than paying premiums to insurance companies, people would pay earmarked taxes to a public trust fund, controlled by their representatives. This trust fund would negotiate

with doctors and hospitals for the payments they would receive for the care they provided. This saved a lot of money by bypassing the insurance companies. The Saskatchewan Health Plan provided comprehensive care to everyone in the province at a much lower cost than before. Soon, the other provinces adopted similar plans, establishing Canada's nationwide health plan that now covers everyone. The overhead for the public system in Canada is only 4%, compared with 30% in the U.S. insurance industry–30% that goes to marketing, administration (a lot of paper shuffling goes on in U.S. health care), and the salaries of extremely well-paid executives and insurance lobbyists. One of the best-paid individuals in this country is William McGuire, CEO of an insurance company–United. He makes $37 million a year, plus $1.7 billion in stock options. And all of this money comes from premiums paid by people, many of whom have insufficient coverage.

The insurance companies have enormous power, both in Washington and in most state legislatures. In Maryland, for example, a former governor arranged for candidates for Insurance Commissioner to be interviewed by the insurance associations before he made his final selection. But, insurance industry influence is strongest in Washington. In the U.S., money is the milk of politics. The electoral process is also privatized. And the insurance companies pay a lot of money to candidates. According to the Center for Responsive Politics, the insurance industry has contributed $525,188 to Hillary Clinton, $414,863 to Barack Obama, and $274,724 to John McCain. As a consequence, not one of the candidates is asking for a publicly funded system. The major players in medical care in the U.S.–insurance companies, drug companies, professional associations, etc. (the list is long)–have given a lot of money to the candidates. The splendid document called the U.S. Constitution, which begins "We the people " should have a footnote "and the insurance companies, the drug companies, " The U.S. Congress is indeed the best Congress money can buy (for a further discussion of how money corrupts the electoral system, see my article "How to Read the U.S. Primaries: Guide for Europeans," Counterpunch, February 13, 2008). The privatization of the electoral process (with most of the money that pays for campaigns coming from economic, financial, and professional interests, and from 30% of the nation's highest-income earners) corrupts the democratic process. I am not implying that politicians are corrupt (although some are). I am willing to admit that most are honorable persons. But the need to constantly raise funds for their campaigns (election and re-election) corrupts the democratic system. And the unwillingness of most members of Congress to change this situation makes them accomplices in that corruption. Such practices are illegal in most democratic countries.

And people know all about this. In surveys, 68% of people believe the U.S. Congress does not represent their interests, but the interests of the financial and economic groups that fund political campaigns. But the establishments, including the political, media, and academic establishments, want everyone to believe that the reason we don't have a universal health program is that people don't want it. They would like people to believe that Congress legislates what people actually want. Meanwhile, the long list of public policies that people want but do not get from their government is growing: 65% of people want a publicly funded health care system similar to that in Canada, a system that in academic language is called single-payer. In a single-payer system, the government, rather than the insurance companies, negotiates with providers–doctors, hospitals, nurses, etc.–for the provision of medical care. We already have a system of this type in Medicare (with an administrative overhead of only 4%, compared with the 30% in the insurance system). By eliminating the huge administrative expenses, we could provide comprehensive health care coverage for everyone without spending an extra penny.

The possibilities for major change

Obama and Clinton are ready to admit that single-payer may be better than any other alternatives. Obama spoke out in favor of it at one time:

> "So the challenge is, how do we get federal government to take care of this business? I happen to be a proponent of a single payer health care program. I see no reason why the United States of America, the wealthiest country in the history of the world, spending 14% of its Gross National Product on health care cannot provide basic health insurance to everybody. And that's what Jim is talking about when he says everybody in, nobody out."
>
> "A single payer health care plan, a universal health care plan. And that's what I'd like to see. And as all of you know, we may not get there immediately. Because first we have to take back the White House, we have to take back the Senate, we have to take back the House." (Barack Obama in 2003 before the Illinois AFL-CIO)

But, something happened on the way to Washington. The train derailed. Now Obama claims that his declaration was taken out of context. And Hillary Clinton, in 1993, told me that while single-payer might be the most logical model, it was politically infeasible.

I hope both candidates will reconsider. At this time, neither candidate's proposal will resolve the health care crisis we are facing. And in 2012, candidates will still be talking about single mothers who cannot pay for medical care for themselves or their children. The candidates of 2008 should be asking for government mandates rather than individual mandates. It is not people who should be mandated to get insurance. It is the government that should be mandated to provide insurance for everyone as an entitlement.

The need to mobilize

Obama has been able to capitalize on the anti-establishment mood in the country. And he has inspired many. While I believe that large numbers of people–the grassroots of the Democratic Party who support him–do want change and are firmly anti-establishment, I am concerned that they are putting too much faith in one individual. Without diminishing what candidate Obama has achieved, the fact is that he has already shown himself to be adaptable to the political context. He was once against the war in Iraq. But, in Congress, his votes on Iraq have been indistinguishable from those of Hillary Clinton. And in health care, his rather disappointing proposal will not resolve the problems. I am very worried that once in power, he will not have the courage to confront the extremely powerful lobbies primarily responsible for the lack of health care coverage and the undercoverage of the American people. It happened with Bill Clinton's administration and it may happen again. Contrary to what Obama and others have said, the main problem with Hillary Clinton's Task Force in 1993 was not its secrecy (although secrecy was indeed a problem) but a conceptual framework based on an insurance model–managed care–that was pushed on the political, media, and academic establishments by the insurance companies. The ideologues of managed care were clearly in charge of the Task Force. It could happen again.

To prevent this, there is a need to mobilize. History is not made by extraordinary figures but by ordinary people who can move mountains when they believe in a cause and get organized. It has happened all over the world, and it has happened in the U.S. We saw it in the establishment of the New Deal, Social Security, unemployment insurance, job creation, minimum wage, and subsidized housing, among other programs. These were not just the outcome of President Roosevelt's position, but the result of huge social agitation and mobilization. As usually happens in historical moments of societal change, government leaders were not so much leading as trying to catch up with what millions of people were demanding. Similarly, the Great Society Programs–Medicare, Medicaid, Environmental Protection Agency, NIOSH, OSHA, and many other examples of progressive legislation–were the outcome of massive mobilizations. Candidate John Kennedy's proposals for change were rather moderate, and his domestic policies, once he was elected, were also disappointing. But the mobilization triggered by his election was followed by many more, such as Appalachian coal miners' strikes against their working conditions, the splendid civil rights movement led by Martin Luther King, and the anti-Vietnam War movement led by student groups. They all established a political climate in which progressive legislation could occur. History, indeed, does not repeat itself. But it offers us pointers on where to go. And it should be obvious that change will not occur unless there is a huge mobilization to complete the unfinished agenda of civil rights: a full development of social rights, with the human right to access to health care at the center.

To achieve that right, we need reforms more substantial than those put forth by either Democratic candidate. The splendid slogan first used by the great trade union leader Cesar Chavez, founder of the United Farm Workers of America, was Yes, We Can! This should guide the call for establishing the right to health care. But, for that to happen, the current holders of the slogan must heighten their expectations and become more ambitious in their proposals. This is what the electorate expects from them in their promises of change

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Dr. Vicente Navarro is Professor of Health Policy, Public Policy, and Policy Studies at the Johns Hopkins University. He has written extensively on economics, health, and social policy, and has been advisor to many governments and international agencies. His books have been translated into many languages. He was the founder and president of the International Association of Health Policy (http://www.healthp.org/), and for almost forty years has been Editor-in-Chief of the International Journal of Health Services. He is also a founding member of Physicians for a National Health Program.

See also "Why Hillarycare Failed" http://www.pnhp.org/hillarycare

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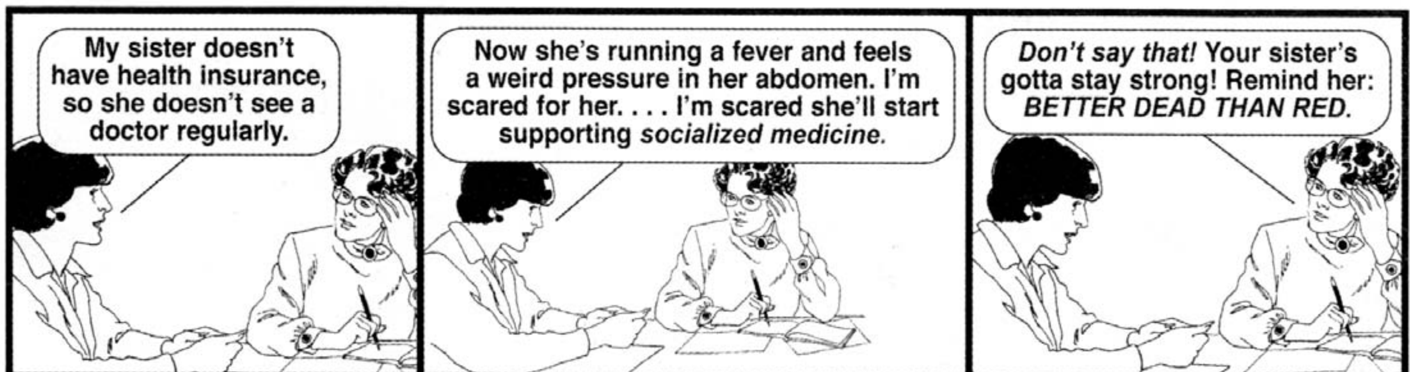

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

AUGUST 9, 2007

Immigrants and Health Care — At the Intersection of Two Broken Systems

Susan Okie, M.D.

At a primary care clinic in Montgomery County, Maryland, where I volunteer, the patients are uninsured immigrants from Latin America or West Africa. Many are day laborers, house cleaners, or construction workers; most do not speak English. Several months ago, I saw a middle-aged Hispanic baker with profound weakness, fatigue, limb swelling, and severe muscle pain, who had to be hospitalized for myxedema. Fortunately, a local charity agreed to pay most of her hospital costs, and she's now receiving thyroid hormone–replacement therapy — but with regular care, her hypothyroidism could have been diagnosed earlier and hospitalization averted. Another day, I tried to persuade a reticent West African man who had been tortured in prison that psychological counseling might help his chronic pain. However, mental health services for uninsured immigrants are sparse, and the man was reluctant to venture to a distant part of Washington, D.C., to a program for torture survivors. A third patient, a man in his 40s, came in with a nearly empty bottle of eyedrops, which he had brought from Ghana to take for glaucoma. The disease had already blinded him in one eye, and the vision in his other eye had been fluctuating. He needed a complete eye exam and visual-field testing, but arranging timely referrals to specialists is often difficult for caregivers treating the uninsured. I wrote him a prescription, and we managed to set up an appointment at a hospital-based ophthalmology clinic that accepts a limited number of uninsured patients.

For recent immigrants — especially the estimated 12 million who are here illegally — seeking health care often involves daunting encounters with a fragmented, bewildering, and hostile system. The reason most immigrants come here is to work and earn money; on average, they are younger and healthier than native-born Americans, and they tend to avoid going to the doctor. Many work for employers who don't offer health insurance, and they can't afford insurance premiums or medical care. They face language and cultural barriers, and many illegal immigrants fear that visiting a hospital or clinic may draw the attention of immigration officials. Although anti-immigrant sentiment is fueled by the belief that immigrants can obtain federal benefits, 1996 welfare-reform legislation greatly restricted im-

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migrants' access to programs such as Medicaid, shifting most health care responsibility to state and local governments. The law requires that immigrants wait 5 years after obtaining lawful permanent residency (a "green card") to apply for federal benefits. In response, some states and localities — for instance, Illinois, New York, the District of Columbia, and certain California counties — have used their own funds to expand health insurance coverage even for undocumented immigrant children and pregnant women with low incomes. Other states, however, such as Arizona, Colorado, Georgia, and Virginia, have passed laws making it even more difficult for noncitizens to gain access to health services.

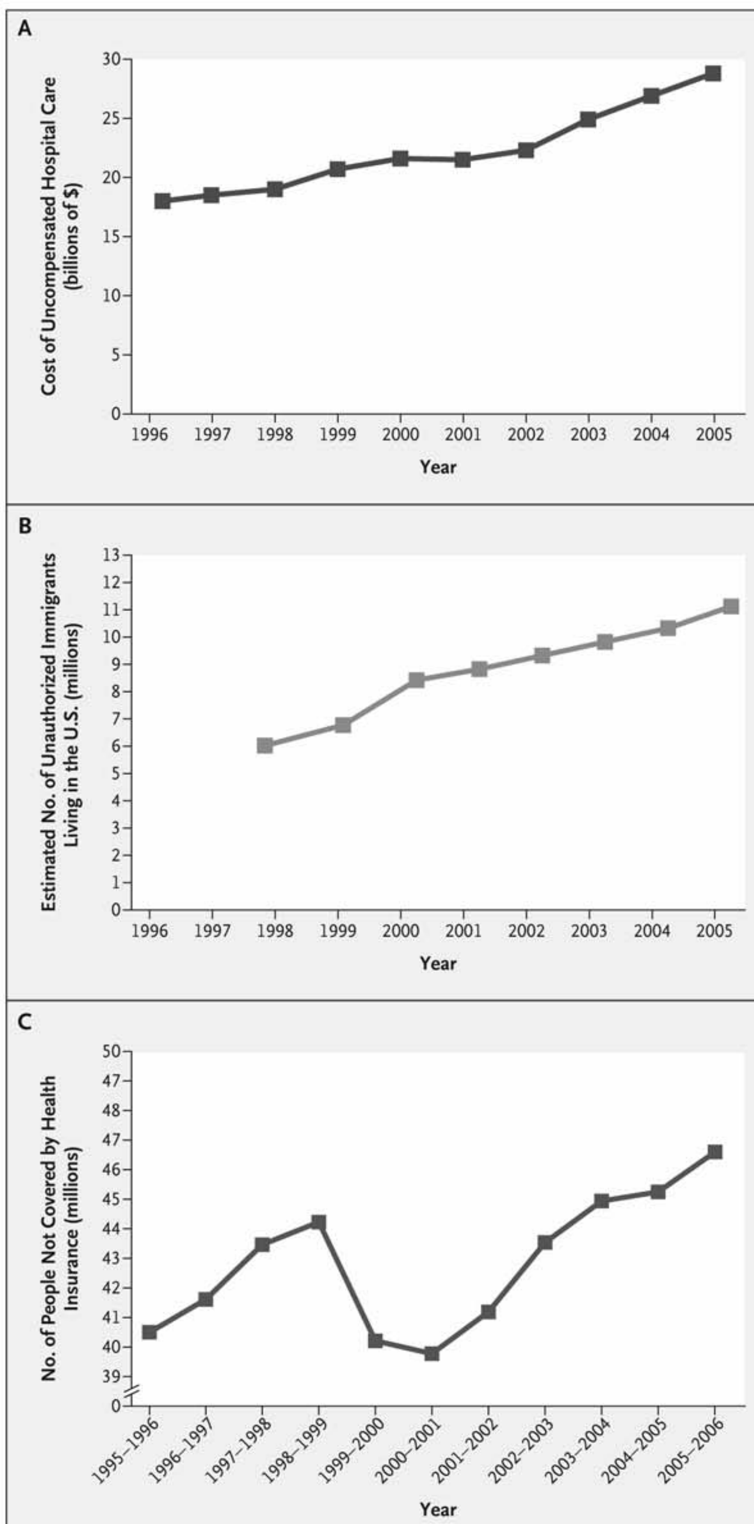
Whether or not they have health insurance, immigrants overall have much lower per capita health care expenditures than native-born Americans,[1] and recent analyses indicate that they contribute more to the economy in taxes than they receive in public benefits. In a study from the RAND Corporation, researchers estimated that undocumented adult immigrants, who make up about 3.2% of the population, account for only about 1.5% of U.S. medical costs.[2] Many immigrants do not seek medical treatment unless they are injured or acutely ill; at our clinic, patients with type 2 diabetes often have florid symptoms and even incipient renal damage by the time their disease is diagnosed.

One study found that annual per capita expenses for health care were 86% lower for uninsured immigrant children than for uninsured U.S.-born children — but emergency department expenditures were more than three times as high.[1] Although U.S. hospitals must provide emergency care without first asking about income, insurance, or citizenship, early diagnosis and treatment in a primary care setting are both medically preferable and a better use of resources. "If people keep postponing medical care because they're so concerned about being sent back over the border," noted Elizabeth Benson Forer, executive director of the Venice Family Clinic, a venerable free clinic in Los Angeles that serves many immigrants, "then you can end up with some pretty horrendous health situations."

Immigrants live, work, and attend school in communities throughout the country; laws and bureaucratic barriers that reduce their use of key preventive health services, such as immunizations and screenings for infectious disease, make for bad public health policy, and denying immigrants primary care ultimately increases health care costs for everyone. For example, labor and delivery costs for undocumented immigrant women are covered under the federal and state emergency Medicaid program, but most states do not cover prenatal care, and there is no coverage for family planning. Some of my patients say they would like to use oral contraceptives or an intrauterine device or undergo a tubal ligation, but they can't afford it. And immigrants, like native-born Americans, are vulnerable to chronic diseases; as my colleague, nurse practitioner Lois Wessel, notes, "Even the 25-year-old day laborers are eventually going to become 45-year-olds, probably still undocumented, with hypertension and diabetes. . . . Life in America is going to make them become not so healthy."

Recently, a bipartisan group of U.S. senators, with White House support, introduced an immigration bill that offered the best chance in years of achieving substantial reform of a dysfunctional system. However, the bill met with opposition from both conservatives and liberals and was killed in the Senate this past June, quashing all hope of immigration reform during the current administration. State legislatures this year are considering a record number of anti-immigrant measures, and the Senate bill's demise heightens their chances of passage. "You will see the states and cities scrambling to pass their own laws and regulations, and you're going to get a completely contradictory set of policies," Senator John McCain (R-AZ) predicted in a *Washington Post* article on July 8. In many areas of the country, one consequence is likely to be reduced access to health care for immigrants.

Noncitizens make up about 20% of the 46 million uninsured people in the United States. Hospitals generally do not collect information on patient immigration status, and there are no reliable national figures on hospital costs for undocumented immigrants. Nevertheless, the soaring cost of uncompensated care (see graph A) has made the problem of providing care for uninsured immigrants a hot political issue, particularly in border states and those (such as the southeastern states) whose immigrant populations have grown rapidly in recent years. Some uninsured immigrants needing emergency treatment (including pregnant women, children, adults



Cost of Uncompensated Care (Panel A), Number of Unauthorized Immigrants (Panel B), and Number of Uninsured People (Panel C) in the United States.

The annual cost to U.S. hospitals of uncompensated care (charity care plus bad debt) has been rising, although the fraction of total hospital expenses represented by such care has remained relatively constant at about 5 to 6% since 1980. The number of unauthorized immigrants present in the United States has also been increasing, although the estimates are uncertain. Treatment of unauthorized immigrants contributes to uncompensated care costs, but the main reason such costs are increasing is the rise in the number of people who lack health insurance. Immigrants represent only about 20% of the uninsured. Data on uncompensated care are from the American Hospital Association; data on unauthorized immigrants are from the Pew Hispanic Center; data on the uninsured are from the U.S. Census Bureau.

with dependent children, and elderly, blind, or disabled patients with incomes below Medicaid thresholds) qualify for emergency Medicaid coverage. In many other cases, hospitals receive no payment for their care, although in 2003 Congress appropriated $250 million per year for 4 years (starting in 2005) to partially compensate hospitals for treating undocumented immigrants.

A recent study found that although emergency Medicaid spending for immigrants in North Carolina grew by 28% between 2001 and 2004, it still represented less than 1% of the state's Medicaid budget.[3] More than 80% of that spending was for childbirth and complications of pregnancy, and major injuries accounted for nearly one third of the rest. In California, emergency Medicaid spending for uninsured immigrants for fiscal year 2007 exceeded $941 million, according to Kim Belshé, secretary of the California Health and Human Services Agency. "Clearly, there are medical needs faced by this population," said Belshé, "and the emergency room is not the most cost-effective place for [addressing] them." In addition, undocumented immigrants may account for as much as $750 million annually of the cost of uncompensated care in California hospitals — about 10% of the annual total — since they represent about 10% of the

state's emergency department patients, according to Jan Emerson, vice president of external affairs for the California Hospital Association. "Almost half of the hospitals in California are currently operating in the red," she said. "It would not be fair to place the blame solely on undocumented immigrants, but certainly, they are a contributing factor."

The chief sources of outpatient care for uninsured immigrants are public clinics and community health centers. Such clinics are often sparse in suburban and rural areas that have recently faced an influx of immigrants. Even in cities with strong community-clinic networks and a long history of serving immigrants, access to care is uneven. For example, at the Venice Family Clinic, a bilingual nurse educator runs health and exercise classes in Spanish and English for patients with diabetes, pregnant women receive free state-subsidized prenatal care, and there are regularly scheduled clinic sessions for victims of torture and human trafficking. Yet arranging specialty referrals is a constant challenge — it usually entails sending patients to outpatient clinics at county hospitals, where some have to wait as long as a year for an appointment. In the Washington, D.C., area uninsured women, including undocumented immigrants, can get free annual mammograms and Pap smears through subsidized cancer-screening programs, but follow-up treatment for abnormal findings other than cancer is usually not included, and many clients have no source of primary care, as noted by nurse practitioner Wessel, who works monthly at one such program. "Patients come in year after year" for Pap smears — "but they've never had their blood pressure checked," she said. "We don't check it, because all we're financed to do is cervical- and breast-cancer screening."

In states seeking to expand insurance coverage, the question of including undocumented immigrants is a thorny one. About 1 million of California's 4.8 million uninsured residents are undocumented adults, and about 136,000 are undocumented children.[4] As part of a proposal for comprehensive health care reform, Governor Arnold Schwarzenegger is seeking to provide health insurance coverage (through Medicaid and the State Children's Health Insurance Program, or SCHIP) to all children with family incomes at or below 300% of the federal poverty level, regardless of immigration status. Although there is considerable public support for insuring undocumented immigrant children, Republican state legislators "do not believe that state general fund revenues should be invested in people who are here illegally," said health secretary Belshé — "and that extends to children."

The federal Medicaid program has always been restricted to U.S. citizens and legal residents, but recent federal and state laws designed to strengthen enforcement of eligibility rules have created new barriers, even for infants and children who are citizens, and have had a chilling effect on other programs providing health services for immigrants. The 2005 Deficit Reduction Act requires all persons applying for or renewing Medicaid coverage to provide proof of identity and U.S. citizenship. Since that law went into effect, at least eight states have reported dramatic declines in Medicaid enrollment, and some Medicaid-eligible infants and children have gone without immunizations and needed medical care because of delays in coverage.[5]

In Georgia, which last year passed a law requiring immigrants to show proof of legal residency in many situations, "we've started seeing a lot of kids not going to the doctor," said Flavia Mercado, a pediatrician who runs the International Medical Center at Atlanta's Grady Memorial Hospital. "A lot of my clients are leaving and going to other states, and a couple are even going back to their country. Everyone is very fearful." She said that Atlanta organizations are scaling back health services for Hispanics and have stopped sponsoring Hispanic health fairs, fearing that they will be raided by police or immigration officials. Meanwhile, faced with rising health care costs and increasing numbers of uninsured persons, the state's Medicaid program has sharply reduced benefits: it recently stopped paying for prenatal care for high-risk women and for nonemergency hemodialysis. Although immigrants make up a minority of the uninsured, Mercado said media reports regularly blame illegal immigrants for the worsening problems of the state's health care system. Anger over high medical costs and reduced access to care no doubt contributes to anti-immigrant sentiment; the remedy, however, is not immigrant bashing, but health care reform.

"As an American citizen, I understand that you want to

IMMIGRANTS continued on **page 16**

PNHP Chapter Reports

In **Alabama**, Dr. Wally Retan and other PNHP'ers are active in speaking, outreach to labor and other groups, and building the state's PNHP chapter, "Healthcare for Everyone". The group is working with the local labor council of the AFL-CIO, and a PNHP spokesperson will give the keynote address in an upcoming forum with the Dean of the School of Public Health and Alabama Blue Cross and Blue Shield. To get active or invite a speaker to your group, contact Dr. Wally Retan at HealthCareForEveryone@charter.net.

Arizona PNHP has been mobilizing support for both HR 676 and a HB2677, a state single-payer bill sponsored by PNHP member Phil Lopes, the Arizona House Minority Leader. PNHP members met in Phoenix with nurses from the National Nurses Organizing Committee (NNOC) to form a new state coalition, "Arizona Medicare for All." They plan to team up with other groups to help promote single payer in the state. Contact Dr. George Pauk at gpauk@earthlink.net.

PNHP's **California** chapter, the California Physicians Alliance (CaPA) is active in speaking to health professionals and the public, in lobbying for SB 840 (Keuhl's bill) and HR 676, in recruiting new members at academic medical centers, in chapter-building, and in media outreach. 400 medical students participated in a lobby day for SB 840 in January. PNHP National Coordinator Dr. Quentin Young testified against the flaws in governor Schwarzenegger's individual mandate proposal, ABX 1, before Sen. Keuhl's committee; he delivered a letter from 250 physicians in Massachusetts about the problems with that state's individual mandate plan and the need for single payer. Dr. Claudia Chaufan's article about ABX 1 is available on-line at www.capa.pnhp.org. Activists are developing local chapters in Humboldt County, Los Angeles, Fresno and other areas. The Los Angeles group is active in outreach to business (including county and city government), including to the Business Caucus of the California Democratic Committee in Anaheim. Contact CaPA's new staffer, Roberto Ramos, at capa13@sbcglobal.net ~ capa.pnhp.org

PNHP Senior Health Policy Fellow Dr. Don McCanne is a frequent speaker to California medical and grassroots groups and to the media. His influential and widely-read "Health Policy Quote of the Day" is archived at www.pnhp.org/quote_of_the_day, or sign-up by dropping a note to don@mccanne.org.

In **Colorado**, PNHP'ers are active in speaking, writing, outreach to legislators, and in coalition-building. Dr. Elinor Christiansen and Dr. Rocky White are leaders in Health Care for All Colorado and in promoting single payer at the state level. A fiscal analysis by Lewin found that single payer would cover all the uninsured and save $1.4 billion annually. Dr. White is running for a seat in the state House (District 62) on a pro-single payer, pro-education platform. Contact Dr. Christiansen at echris7doc@gmail.com.

The **Washington, DC** chapter of PNHP is active in speaking, outreach to physician and other groups, media outreach, and acting as national PNHP's liaison to the Congress and Washington-based organizations. Activists met with members of the Congressional Black Caucus (garnering 3 new co-sponsors for HR 676), discussed single-payer with national leaders of the AFL-CIO, and hosted a single payer booth at the Take Back America conference. Dr. David Rabin is a frequent speaker to both medical and grassroots groups. Drs. Harvey Fernbach and Robert Zarr have been featured in the local media and are active in meeting with medical student and other groups. Contact Dr. Robert Zarr at rlzarr@yahoo.com.

Georgia PNHP members 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. Chapter 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.

In **Hawai'i**, Dr. David Friar in Oahu is starting a new chapter of PNHP. PNHP activist Dr. Leslie Hartley Gise recently spoke to the Tripler Army Medical Center and the medical school in Honolulu. She also participated in events with Rep. Mazie Hirono (D-HI, a new co-sponsor of HR 676) and Rep. Neil Abercrombie (D-HI). For a speaker or to become active, contact Dr. Leslie Hartley Gise on Maui at leslieg@maui.net or David Friar on Oahu at davidfriar@hawaii.rr.com.

Indiana's PNHP chapter, Hoosiers for a Commonsense Health Plan (HCHP), has been active in outreach to physicians, coalition building and statewide outreach. HCHP has chapters in Indianapolis and Bloomington, and four new chapters in Fort Wayne, Terre Haute, New Albany, and Evansville. The group received the Indiana Public Health Association's "Citizens Advocacy Award." HCHP is active in outreach to garner co-sponsors for HR 676 as well as working on legislation to study single payer at the state level (SB 218). Contact Dr. Rob Stone at rstone@hchp.info ~ www.hchp.info

In **Illinois**, PNHP'ers are active in speaking, grassroots outreach, press work, and supporting HB 311, a bill for a single payer plan in Illinois (full text on-line at www.healthcareforallIllinois.org). Dr. Quentin Young and Dr. Claudia Fegan are active in speaking to physicians at grand rounds and other conferences. Dr. Fegan spoke at the annual meeting of the Student National Medical Association. Dr. Anne Scheetz and her husband Jim Rhodes are active in outreach to grassroots groups and other public audienceWiscons across the state. Since Dr. Gordon Schiff moved to Boston, the chapter is in need of more speakers for physician audiences. If you are willing to give grand rounds on behalf of PNHP (we'll provide slides and other materials), please drop a note to Ida@pnhp.org.

PNHP members in **Kansas** are working with medical students from the University of Kansas, labor, church, and other groups to form "Heartland Healthcare for All". First year medical student Elizabeth Stephens and others are active in speaking using the PNHP slide show. The Kansas Legislature is studying health care reform options. The fiscal analysis by the consulting firm of Schramm-Raleigh found that single payer would cover everyone and reduce health spending by $870 million annually. For a speaker or to become active, contact Dr. Joshua Freeman at jfreeman@kumc.edu.

Kentucky PNHP members are active in outreach to faith and civic groups and to legisla-

tors at both the state and federal level. Kay Tillow continues to spearhead the effort to garner labor support for single payer. Dr. Garrett Adams participated in a widely-covered press conference when Sicko premiered and is frequently interviewed on local radio. Dr. Syed Quadri, Dr. Ewell Scott and Harriette Seiler are active in speaking and writing letters to the editor. Contact Garrett Adams at kyhealthcare@aol.com.

In **Massachusetts'** PNHP members have been leading critics of the state's health reform, and continue an active campaign for single payer. Chapter Chair Dr. Rachel Nardin's Op Ed appeared in the Boston Globe, and she crafted a statement calling for more thoroughgoing health reform in the state, which garnered the signatures of 250 Massachusetts' physicians. Dr. Nardin is also active in speaking to professional and community groups. Dr. Susanne King's pro-single payer column regularly appears in the Berkshire Eagle, the largest paper in the western part of the state. Dr. Michael Kaplan's Op Ed critical of the health reform appeared in the Boston Globe. Students in PNHP sponsored a showing of SiCKO and follow-up forum for Boston-area medical students. Dr. Pat Berger brought a pro-single payer resolution to the Massachusetts Medical Society. The MMS agreed to "include single-payer health care reform as an option for achieving universal, comprehensive, equitable, patient-centered, sustainable, and affordable health care for our patients." Contact Dr. Rachel Nardin at rnardin@bidmc.harvard.edu.

In **Michigan**, PNHP member Dr. Jim Mitchiner has been active in speaking, media outreach, and discussion of single payer within his specialty society, the American College of Emergency Physicians. He spoke to the Michigan State Medical Society House of Delegates, the Washtenaw County Medical Society, and WMU's Center for the Study of Ethics in Society. His pro-single payer op-ed appeared in the Ann Arbor News, and he was interviewed by the local NPR affiliate in Kalamazoo. Contact Dr. Mitchiner at jmitch@umich.edu.

Minnesota PNHP members are active in speaking, lobbying, outreach to grassroots groups and collecting physician endorsements for a resolution in support of HR 676. Chapter members are working with Sen. John Marty and the Minnesota Universal Health Care Coalition on the new Minnesota Health Care Act, the state's single-payer bill, which already has 57 co-sponsors and passed out of the Senate Health Policy Committee in February. Dr. Morrison Hodges, Dr. Lisa Nilles, Dr. Elizabeth Frost, and Kip Sullivan have been active in speaking to community groups and in forums with Rep. Keith Ellison, a sponsor of HR 676. The chapter is holding a speaker's training in February and is seeking additional opportunities to speak to physicians. Contact Dr. Ann Settgast at settg001@umn.edu, Dr. Lisa Niles at eanilles@comcast.net, or Dr. Elizabeth Frost at libbess@gmail.com.

PNHP'ers in the **New York-Metro** chapter of PNHP are active in speaking, outreach to physicians and medical students, press work, and sponsoring a popular monthly forum on health policy and politics. PNHP President-Elect Dr. Oliver Fein is a frequent speaker both locally and nationally. Dr. Fein, medical student David Marcus, Martha Livingston and others led a speakers' training for 43 medical students on March 8. A new book on single payer,"10 Excellent Reasons for National Health Care" edited by Dr. Mary O'Brien and Martha Livingston is being published by The New Press this summer. (http://www.pnhpnymetro.org/)

In **Albany**, PNHP'ers are frequent speakers to physician and grassroots groups. Chapter chair Dr. Paul Sorum and Dr. Andy Coates led a well-attended speaker's training in October. Activists are involved in outreach to unions, medical students, the League of Women Voters, the NY branch of the American College of Physicians, and other groups. Contact Dr. Coates at esquincle@earthlink.net.

The newly formed **Finger Lakes** PNHP Chapter (Rochester, New York) has been active in speaking, media outreach, and lobbying. The chapter hosted four screenings of SiCKO followed by panel discussions, and participated in a meeting with Rep. Louise Slaughter (NY-28). Chapter chair Dr. Larry Jacobs' pro-single payer op-eds appeared in the Rochester Democrat & Chronicle and the Santa Fe Times (Jacobs' winter home). Chapter members have published letters supporting single-payer in the Syracuse Post Standard and other local press. Drs. Leon Zoghlin, Larry Jacobs and Emily Queenan spoke at a seminar for medical students at the University of Rochester. Contact Larry Jacobs at lsjacobsnynm@msn.com.

In **North Carolina**, PNHP members are active in speaking, media outreach, leadership training, and coalition-building with Health Care for All North Carolina. Members who are active in speaking include Dennis Lazof, Dr. Gary Greenberg, Dr. Trevor Craig, Dr. Ernesto de la Torre and Dr. Jonathan Kotch. State Rep. Verla Insko participated in panel discussions on SiCKO and other events. Staffer Emily Taylor and Dr. Claudia Prose developed useful materials for the group. The chapter co-sponsored three fall forums with the Pediatrics Society, the Nurses' Association, and the Community Health Center Association, and received two grants to fund additional outreach and training. Contact Dr. Jonathan Kotch at jkotch@email.unc.edu.

Activists resurrected an **Ohio** chapter of PNHP in January. They plan to give grand rounds, do outreach to the media, legislative work, and participate in public debates and forums. A state bill for single payer, the Health Care for all Ohioans Act, was re-introduced in the legislature in 2007. PNHP'ers educated state legislative leaders and their aides about single payer, and used SiCKO as an organizing tool. Letters to the editor and op-eds by PNHP members have appeared in publications statewide. For a speaker or to become active, contact Dr. Jonathon Ross at drjohnross@ameritech.net.

PNHP's **Western Washington** chapter is very active in speaking, outreach to the public, and lobbying for single payer on the national (HR 676/HR 1200) and state level (Washington Health Security Trust). The chapter is pushing for a fiscal analysis of WHST to show that single payer is the only affordable option for universal coverage. In addition to participating in nearly a dozen panels on healthcare reform, PNHP'ers have presented to the King County Medical Society, a residency program in family medicine, on radio and at rallies. The chapter hosted a booth at the Washington State Medical Association's annual meeting, is making a brochure for physicians' waiting rooms, and is supporting a medical student studying in Cuba. The chapter's annual meeting in February focused around "The Community Effects of Uninsurance." Contact Dr. David McLanahan at pnhp.westernwashington@comcast.net.

PNHP members Drs. Linda and Gene Farley are very active in the Coalition for Wisconsin Health (CWH), the **Wisconsin** affiliate of PNHP. Canadian labor leader James Clancy spoke in Milwaukee about the advantages of single payer in December; an excellent recording of his talk is available at www.grassrootsnorthshore.org/?page_id=19. For a speaker or to become active, contact esfarley@wisc.edu.

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