



### Third annual student summit a success

Medical and other health professional students from 31 medical schools and six public health schools convened in Chicago on April 12 to build the student movement for single payer. The summit, held at Northwestern University’s Feinberg School of Medicine, featured sessions on health care financing reform, starting a student chapter of PNHP, writing an op-ed and other topics, along with a spirited rally in front of the Blue Cross and Blue Shield Illinois headquarters that was covered by Univision. Congratulations to PNHP student leaders and all the participants. Summit attendee Brad Zehr and 60 others have introduced a pro-single-payer resolution to the Student Section of the AMA (reprinted on page 27).

### Historic Senate hearing held on international health systems

Experts on single-payer health systems in Canada, Denmark, France and Taiwan testified at a first-ever U.S. Senate hearing in March chaired by Sen. Bernie Sanders, I-Vt., on what the U.S. can learn from other countries (see selected testimony, starting on page 11). The witnesses, including Taiwan’s former health minister, Dr. Ching-Chuan Yeh, provided compelling evidence on the benefits of single payer in terms of access, efficiency and costs. A video clip from the hearing featuring Dr. Danielle Martin vigorously defending the Canadian health system against GOP Sen. Richard Burr, R-N.C., has been viewed over 800,000 times.

Sen. Sanders is the sponsor of single-payer legislation in the Senate, S. 1782. PNHP members are encouraged to ask their senators to co-sponsor the bill by calling the Capitol switchboard at (202) 224-3121. On the House side, ask your congressman to co-sponsor Rep. John Conyers’ single-payer bill, H.R. 676.

### Nearly two-thirds of Maine physicians support single payer

A new survey by the Maine Medical Association (MMA) shows that 64 percent of its members support a single-payer system, up from 52 percent in 2008. The surveys asked, “When considering the topic of health care reform, would you prefer to make improvements to the current public/private system or a single-payer system such as a ‘Medicare for all’ approach?” Kudos to Maine PNHPers Drs. Janis Petzel, Richard Dillihunt and Julie K. Pease for shepherding the survey resolution through the MMA. See page 6 for more detail.

### Annual Meeting on Nov. 15, New Orleans

Plan now to attend PNHP’s 2014 Annual Meeting on Saturday, Nov. 15, in New Orleans at the Hampton Inn Convention Center. The meeting will feature a mix of plenary sessions and workshops. As in past years, it will be preceded by PNHP’s popular Leadership Training Institute, which is being revamped this year to focus on skill building, and followed by the annual meeting of the American Public Health Association. The hotel rate is \$249 double, (504) 566-9990.

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## Membership drive update

Welcome to over 488 physicians and medical students who have joined PNHP in the past year! PNHP's membership is now 19,129. We invite new (and longtime) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community.

PNHP will be hosting exhibits at meetings of the American Society of Clinical Oncology (Chicago, May 31-June 2) and the American Academy of Family Physicians (Washington, D.C., Oct. 23-25). If you can volunteer for a few hours, please drop a note to e.henkels@pnhp.org, or just stop by.

## What PNHP members can do

1. Subscribe to the "Quote of the Day" by Senior Health Policy Fellow Dr. Don McCanne to stay on top of the rapidly changing health reform landscape. Each day's quote highlights significant new research and analysis on the health care crisis and the evidence for single-payer reform. Subscribe at [www.pnhp.org/qotd](http://www.pnhp.org/qotd).
2. Arrange a session on health care reform at the next meeting of your medical society or specialty.
3. Introduce a resolution in support of single payer to your medical society or specialty association. A sample resolution is available online at [www.pnhp.org/sampleresolution.pdf](http://www.pnhp.org/sampleresolution.pdf).
4. Give a grand rounds at your hospital on health care reform, or invite another PNHP member to speak at a grand rounds or other hospital forum. Updated slides covering the new health law are available at [www.pnhp.org/slideshows](http://www.pnhp.org/slideshows) (password = coates). To invite another member to speak, call the PNHP national office at (312) 782-6006 or e-mail [info@pnhp.org](mailto:info@pnhp.org).
5. Write an op-ed or letter to the editor for your local newspaper, medical specialty journal, or alumni magazine.
6. Meet, write or phone your national legislators and encourage them to endorse the single payer bills H.R. 676 and S. 1782. The Capitol switchboard is (202) 224-3121.
7. Join or renew your membership in PNHP online today at [www.pnhp.org/join](http://www.pnhp.org/join). Encourage your colleagues to join PNHP; see the new form at [www.pnhp.org/refer](http://www.pnhp.org/refer).
8. Form a chapter of PNHP, or get involved in the one nearest you. To get started, call the PNHP national office at (312) 782-6006.

## It's easy to add PNHP to your will

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

# Health care crisis by the numbers:

## Data update from the PNHP newsletter editors

### UNINSURED AND UNDERINSURED

- 8 million people signed up for private coverage on the federal and state health exchanges during the open enrollment period that ended March 31, according to a report from the Department of Health and Human Services. Since as many as two-thirds of enrollees had prior coverage and 10-20 percent of people have yet to pay their first month's premiums, the net impact of the ACA's exchanges and federal subsidies on the number of uninsured won't be clear for several months (Pear, "Late rush to sign up for insurance," New York Times, 5/2/14).

In its most recent release, the Congressional Budget Office estimates that 42 million Americans will remain uninsured in 2014, 36 million in 2015, and 29-31 million between 2016 and 2024 (CBO, "Insurance Coverage Provisions of the Affordable Care Act," April 2014).

- In 2012, 31.7 million Americans under age 65 were underinsured, according to a conservative estimate by The Commonwealth Fund. The estimate was based on new Census Bureau data on household medical expenditures. An additional 47.3 million Americans were uninsured that year. "Underinsurance" in the study was defined as spending 10 percent or more of household income for medical care or, if under 200 percent of the federal poverty line, greater than 5 percent of household income. The estimate didn't include people who were insured but went without care due to cost, or were healthy but whose insurance was so skimpy they would have faced high costs in the event of illness (Schoen et al., "America's Underinsured," Commonwealth Fund, 3/14).

- Nearly 3.7 million low-income, uninsured people with a serious mental illness, serious psychological distress, or a substance use disorder will not receive coverage under the Affordable Care Act because they live in one of the 24 states that have refused to expand their Medicaid programs to people with incomes up to 138 percent of poverty. Three-quarters of these individuals (2.7 million) live in 11 Southern states, and over 1.1 million live in just two states – Texas (625,000) and Florida (535,000) (American Mental Health Counselors Association, 2/27/14).

Of an estimated 115,000 uninsured and low-income people with HIV/AIDS living in the U.S., over half (about 60,000 people) live in states that are not expanding Medicaid, according to an analysis of HIV surveillance data and data from the National Health Interview Survey (Snider et al., Health Affairs, March 2014).

- Many insurance plans - including both employer-based plans and those purchased through the health exchanges - include "source-of-injury" exclusions that preclude coverage of medical bills arising from suicide or attempted suicide, even when it stems

from a mental illness. Despite the federal mental health parity law (2008), insurers still discriminate in the fine print, claiming that parity only requires them to cover mental health benefits, not medical bills arising from an intentional overdose or injury (Andrews, "Some plans refuse to cover medical costs related to suicide despite federal rules," Kaiser Health News, 2/18/14).

### SOCIOECONOMIC INEQUALITY

- Women's life expectancy in McDowell County, W.Va., where average household income is around \$22,000, has fallen by two years since 1985, to 73 years. In contrast, women's life expectancy in Fairfax County, Va., where average household income is \$107,000, has risen over the same period by five years, to 85 ("Income Gap, Meet the Longevity Gap," New York Times, 3/16/14).

- Income inequality is rising around the world, not just in the U.S. The rate of return to capital has historically been higher than the rate of economic growth and wages, according to a new analysis of centuries of data by Thomas Piketty of the Paris School of Economics. The first half of the 20th century was an aberration due to the destruction of a huge amount of capital in two world wars. In 1913, at the end of the Gilded Age, the stock of the world's privately held capital amounted to about five years' worth of global income. In 1950 it had fallen to three, by 2010 risen to four, and will rise to seven by the end of the century. Future inequality in the U.S. will be driven by two forces: a rising share of income going to corporate profits and the owners of capital, and of the remaining labor income, a rising share going to top executives (Porter, "A relentless widening of disparity in wealth," New York Times, 3/12/14).

- The U.S. middle class is no longer the richest in the world, according to an analysis of data from the Luxembourg Income Study. After-tax median income in Canada is now higher than in the U.S., and Britain, the Netherlands, and Sweden are closing in. Also, poor U.S. families, at the 20th percentile of the income distribution, make significantly less than similar families in Canada, Sweden, Norway, Finland or the Netherlands. The findings are due to U.S. firms distributing a higher share of pay to top executives and lower top tax rates, and to Canadian and European government policies that redistribute income and subsidize health care, college, day care, paid maternity leave, and other benefits for their residents (Leonhardt, "U.S. middle class no longer world's richest," New York Times, 4/23/14).

### COSTS

- The cost of employer-sponsored health care among large employers (>1,000 employees) is expected to rise 4.4 percent, to \$9,560 per employee, in 2014, despite another round of benefit cuts (without this year's cuts the increase would have been 7

percent). Employees' share of premiums will increase an estimated 7 percent, to \$2,975. Employees will pay an estimated 37 percent of total health costs (premiums and out-of-pocket costs) in 2014, up from 34.4 percent in 2011. Nearly two-thirds of large (>1,000 employees) companies with employer-sponsored health coverage say they are likely to eliminate coverage in the next few years and steer their workers to public exchanges. They have already started with their under-age-65 retirees (Towers Watson, "Survey for the National Business Group on Health," 3/6/14).

- Maryland has received a waiver from CMS to transition its "all payer" hospital payment system, under which all insurers pay the same fees, to a global budget system, effective January 1, 2014. The goal is to reduce overutilization of inpatient care and shift resources to more appropriate settings. Whether it will control costs or just, in the absence of a single payer that can slash bureaucracy, restrict access to care, is unclear. The effort, led by the Maryland Health Services Cost Review Commission, is just getting under way. Details may be found at [www.hsrcr.maryland.gov](http://www.hsrcr.maryland.gov).

### **'Medicare for all' given to more victims of asbestos poisoning**

Sen. Max Baucus, D-Mont., who as chair of the Senate Finance Committee relied heavily on staffer Liz Fowler, a former WellPoint VP, to craft the private-insurance-based ACA, created an exception from his own bill and gave Medicare and supplementary benefits to residents of all ages in Libby, Mont., with asbestos-related disease caused by the operations of the W.R. Grace mining company. Instead of being required to buy private insurance on the health exchange, affected Libby residents received lifelong Medicare coverage and access to a new, permanent "Libby Pilot Program," which covers services "tailored to specific health needs resulting from asbestos exposure" not covered by Medicare, like long-term care, medications, and transportation. Now, affected residents of Libby who have moved to any of 18 other counties (including six counties in Idaho and seven in Washington state) will be able to access those services without charge under an expansion of the program approved by CMS (Gerstenecker, "Libby Montana program expands," The Western News, 2/4/14).

- Even a small unpaid medical debt can damage a person's credit rating, making it harder and more expensive to get a mortgage or other loan. Medical bills account for about half of all bills reported to collection agencies and affect the credit record of about 20 percent of the population, according to Richard Cordray, director of the federal Consumer Financial Protection Bureau. About 40 percent of a sample of 5,000 mortgage applicants to a Texas firm, Supreme Lending, had medical debt in collection, with the average around \$400. Most people were unaware of their debt. The problem is worsening with increasing deductibles and the rise of large physician and hospital groups, making it impossible for patients to negotiate debt with their physician (Rosenthal, "When Health Costs Harm Your Credit," New York Times, 3/8/14).

- Massachusetts' 2006 health reforms, the model for the ACA, did not solve the problem of unaffordable health care costs. In 2012, more than one-third (38.7 percent) of insured Massachusetts adults reported problems with health care costs. The proportion of adults reporting problems with costs rose to 41.6 percent for people with incomes below 138 percent of poverty, and to 49.5 percent for people with incomes between 139 and 399 percent of poverty. Over 40 percent of insured, low-income people had problems with costs despite the fact that Massachusetts' reform has stronger consumer protections against out-of-pocket costs (e.g. limited to \$1,000 for people below 200 percent of poverty) than the ACA (Long, "Health insurance coverage is just the first step: Findings from Massachusetts," Health Affairs blog, 3/26/14).

### **Congress boosts pay to private Medicare plans**

In response to a multimillion-dollar lobbying campaign by the insurance industry, HHS reversed its plans for a 1.9 percent cut in payments (about \$7 billion) to Medicare Advantage (MA) plans. Instead, the plans will receive a 0.4 percent raise in 2014. The plans were overpaid by 6 percent compared to the cost of taking care of similar enrollees in traditional Medicare in 2012, according to the Medicare Payment Advisory Committee. MA plan enrollment grew by 9 percent last year, to 14.4 million. According to a study by economists at the University of Pennsylvania, the excess payments to MA plans almost all go to marketing and profits, with only 17 percent going into benefits. Humana makes two-thirds of its total annual profit on MA plans (Hancock, "Decoding the high-stakes debate over Medicare Advantage cuts," Kaiser Health News, 4/7/14).

## **CORPORATE MONEY AND CARE**

### **For-profit hospital chains breed fraud, again**

- The Justice Department is investigating the giant hospital chain Health Management Associates (HMA) for Medicare and Medicaid fraud. HMA, which recently merged with Community Health Systems (CHS) in a \$7.6 billion deal to create the nation's second largest for-profit hospital chain with over 200 hospitals, is the target of eight separate whistle-blower (qui tam) lawsuits in six states and several investigations by states' attorneys general for using "sophisticated software systems, financial incentives, and threats" to inflate hospital admissions. HMA administrators used a customized software program called ProMed to monitor its physicians and drive admissions. For example, the software gave emergency department physicians daily scorecards on their progress towards meeting the firm's target of admitting 50 percent of all ER patients over age 65, regardless of clinical necessity. Physicians and administrators who questioned HMA's policies and procedures were threatened and fired. Former HMA CEO Gary Newsome, who received \$22 million in compensation in the three years before his departure last year, was a top executive at CHS prior to being hired by HMA; CHS faces similar accusations. In 2003, HCA (the biggest for-profit hospital chain) paid the then-largest health care

fraud settlement in U.S. history, \$1.7 billion, for Medicare fraud (Creswell and Abelson, "Hospital Chain Said to Scheme to Inflate Bills," New York Times, 1/23/14).

### CEOs at top insurers still getting outsize pay

CEO pay at the nation's biggest for-profit health insurers generally held firm, but in one case increased sharply between 2012 and 2013: Aetna's CEO, Mark Bertolini, saw his compensation more than double to \$30.7 million from \$13.3 million. UnitedHealth Group's Stephen Hemsley received \$12.1 million in 2013, WellPoint's Joseph Swedish received \$17 million, Humana's Bruce Broussard took in \$8.8 million, and Cigna's David Cordani received \$13.5 million. In the three years since the passage of the ACA, 32 executives of the nation's five biggest for-profit health insurance firms have received a total of \$548.4 million in cash and stock options ("The Irony of Obamacare," UNITE HERE, March 2014, and SEC schedules 14A in 2011, 2012, 2013).

CEOs at the nation's two largest Medicaid managed care insurers received huge pay raises. Centene CEO Michael Neidorff received \$14.5 million in compensation in 2013, up 71 percent from 2012. Centene runs Medicaid programs in nearly 20 states, including Missouri and Illinois. On top of his salary of \$1.2 million, Neidorff got a \$3 million bonus, \$10 million in stock, and \$82,798 of personal flights on a company plane, financial adviser fees, event tickets and security services. If Neidorff leaves Centene after a takeover, his golden parachute will be worth \$31.9 million. That includes \$24.2 million for unvested stock and \$7.7 million in severance, bonus and incentive payments. Molina Healthcare CEO Mario Molina's pay more than doubled, rising to \$12 million from \$5 million. Molina runs Medicaid programs in 11 states (David Nicklaus, "Centene CEO's pay jumps to \$14.5 million," St. Louis Post Dispatch, 2/25/14, and SEC filings).

- Two recent studies of Patient Centered Medical Homes (PCMH) found that most quality indicators did not improve and there were no significant cost savings compared with control practices. The first study, supported by The Commonwealth Fund, was a randomized controlled trial that compared 18 small adult primary care practices in New York that were randomly chosen to receive two years of support and financial incentives to redesign their practices into PCMHs (as recognized by the National Committee of Quality Assurance), with 14 control practices. Compared to controls, PCMH physicians performed better on just 2 of 11 quality indicators (blood pressure control and breast cancer screening) and 1 of 10 efficiency indicators (care visits leading to ED visits) but there were no significant cost savings. The second study, a large three-year RAND trial comparing performance on 11 quality measures, utilization, and costs at 32 PCMH's to 29 comparison practices in southern Pennsylvania, found significant improvement on only one quality measure (nephropathy screening in diabetes). No significant differences in utilization or costs of care were found other than a one-year increase in ambulatory care sensitive admissions in PCMH practices. Pilot practices accumulated bonuses averaging \$92,000 per physician over the three-year study (which were excluded from the cost calculations). The lack of savings

from PCMH's suggests that delivery system reform alone won't control costs (Fifield et al., JGIM, 6/1/13, and Friedberg et al., JAMA, 2/26/14).

### GALLOPING TOWARD OLIGOPOLY

- Just two health insurers controlled over 50 percent of the market for private health insurance in 45 states in 2011. In 15 states, a single insurer had more than 50 percent of the private insurance market, according to the AMA's most recent study of the lack of competition in the commercial health insurance market (AMA, "AMA Analysis Lists States Where One Private Health Insurer Rules," 11/7/13).

- Anthem, the giant for-profit Blues plan, is the only firm selling health insurance on the exchange in New Hampshire. Nationwide, in 515 mostly rural, low-income counties across 15 states, only a single insurer is offering coverage on the health exchange. Premiums in those counties can be hundreds of dollars more per month than in nearby metropolitan areas. Overall, monthly premiums for a silver plan for a 40-year-old individual range from \$154 in Minneapolis to \$461 in southwest Georgia and \$483 in Colorado's mountain resort region, where many permanent residents are low-paid service workers. Insurers are not supposed to deny coverage to patients with pre-existing conditions since the passage of the ACA, and risk adjustment for sicker patients is supposed to make "cherry-picking" obsolete, but for-profit insurers have found new methods to accomplish the same thing. Aetna's CEO, for example, admitted they were targeting areas with high employment and incomes to attract desirable customers (Martin and Weaver, "For many, few health plan choices," Wall Street Journal, 2/12/14, and Ehley, "Ten worst places to live for Obamacare," Fiscal Times, 2/20/14).

### Corporate 'finance people' closely monitor patient care – for profits

"The practice of medicine is moving more rapidly than ever from decision-making by individual doctors toward control by corporate interests. The transformation is being fueled by the emergence of large hospital systems that include groups of physicians employed by hospitals and others, and new technologies that closely monitor care. While the new medicine offers significant benefits, like better coordination of a patient's treatment and measurements of quality, critics say the same technology, size and power can be used against physicians who do not meet the measures established by companies trying to maximize profits. 'It's not a doctor in there watching those statistics – it's the finance people,'" said an attorney representing whistle-blowers (Creswell and Abelson, "Hospital Chain Said to Scheme to Inflate Bills," New York Times, 1/23/14).

- The Cleveland Clinic is contracting directly with national employers like Lowe's to perform cardiac and orthopedic surgery on their employees. Lowe's pays the cost of travel and waives deductibles and co-pays for its workers to have their surgery at the clinic for a set fee. While the Cleveland Clinic claims to have a lower-than-average readmission rate for cardiac patients,

patients who are able to travel for care are undoubtedly younger, healthier, and more stable than the average cardiac patient. The practice raises questions about the clinic “cream skimming” profitable patients, leaving more costly, sicker and less well-insured patients for local facilities (Daily Briefing, Advisory.com, “For Cleveland Clinic, employer deals have been a ‘win-win-win,’” 3/10/14).

## PHARMA

- Gilead is marketing its new hepatitis C drug, sofosbuvir, in the U.S. for \$84,000 for a three-month course (\$168,000 for six months of treatment that some patients need) or about \$1,000 per pill. Gilead’s first quarter sales of \$2.3 billion of sofosbuvir are the highest ever for a new drug. During the same period, UnitedHealth Group, the nation’s largest insurer, spent over \$100 million on sofosbuvir and other treatments for hepatitis C, some of which it attributed to pent-up demand for treatment by newly insured patients. Sofosbuvir, which costs less than \$1.62 per pill to produce, is sold for about \$350 per pill in the U.K. Gilead says it will sell the drug to low-income countries for \$2,000 for a 12-week course, but Médecins Sans Frontières says, based on their experience treating HIV, that diagnosis and comprehensive treatment costs must be limited to \$500 per patient in both middle- and low- income nations to be successful (Pollack, “Gilead revenue soars on hepatitis C drug” New York Times, 4/23/14, and “MSF responds to reports on Gilead pricing for hepatitis C drug sofosbuvir in developing countries,” Médecins Sans Frontières Access Campaign, 2/7/14).

As the price of specialty drugs soars, employers are shifting more of the cost onto patients. This year, 23 percent of employer-sponsored health plans and nearly all plans sold on the health exchanges have a separate tier with higher cost-sharing for specialty drugs, up from 5 percent of plans in 2006. Just 2.3 percent of prescriptions now account for 30 percent of all out-of-pocket costs. In 2012, U.S. regulators approved 39 drugs, the most since 1996. Of the 12 for cancer, 11 cost at least \$100,000 a year (“Hard pills to swallow,” The Economist, 1/5/14, and Thomas, “Prices Soaring for Specialty Drugs, Researchers Find,” New York Times, 4/15/14).

- Questcor has raised the price of a 60-year-old immune system drug, Acthar, from \$40 to more than \$28,000 a vial since acquiring the rights to the drug for \$100,000 in 2001. Acthar, made from the pituitary glands of pigs, was originally used to treat a rare disease in babies. Questcor has aggressively marketed the drug for more common conditions like multiple sclerosis and lupus, uses approved several decades ago when approval standards were low, and clinical trials were not needed. As a result, sales of Acthar topped \$761 million last year, and the firm is being bought out by another drug maker, Mallinckrodt Pharmaceuticals, for \$5.6 billion. Questcor’s promotional practices are under investigation by the Justice Department (Pollack, “Mallinckrodt pharmaceuticals to buy Questcor for \$5.6 billion,” New York Times, 4/8/14).

- A federal jury in Louisiana awarded \$6 billion in punitive damages against Takeda Pharmaceuticals, the manufacturer of the

diabetes drug Actos, and \$3 billion against Eli Lilly Inc., the U.S. distributor of Actos, for failing to disclose that the drug raises the risk of bladder cancer when used for more than one year. Regulators in France and Germany suspended sales of Actos over health concerns in 2009. (Li, Los Angeles Times, 4/8/14).

## POLLS

- Nearly two-thirds (64.3 percent) of Maine physicians and medical students favor a single-payer approach to health system reform, up from 52.3 percent in 2008, according to a recent survey by the Maine Medical Association. The survey asked the following question both years: “When considering the topic of health care reform, would you prefer to make improvements to the current public/private system or a single-payer system such as a ‘Medicare for all’ approach?” Support for “improvements to the current public/private system” fell to 35.7 percent in 2014 from 47.4 percent in 2008. There was no significant difference in response to the question based upon age, geographic location, or MMA membership status. Primary care physicians and psychiatrists were more supportive of single payer than other physicians, as were physicians who did not own their own practices. More details of the survey are available on the association’s website at [www.mainemed.com](http://www.mainemed.com).

Vermont residents favor single payer 55 percent to 42 percent after being read a brief description and rationale for reform. An even greater majority, 70 percent, say they favor a system that would have the government pay medical bills directly instead of through insurance companies. The margin of support drops but remains a majority (51 percent in favor, 43 percent opposed) when told it would mean “the largest tax increase in Vermont history.” Women, younger adults, people with college or graduate degrees, and Democrats are more likely to be supportive. Three-fourths of Vermonters say they would either favor or remain neutral towards a candidate supporting single payer; only one-quarter of respondents said they would oppose such a candidate. The poll of 502 Vermonters in mid-January, at the height of problems with the rollout of the Vermont health exchange, was conducted by Boston-based Kiley and Co. with funding from the National Education Association (True, “Single-payer advocacy group gets boost from NEA, poll shows support for health reform,” Vtdigger.com, 2/21/2014).

- Despite a \$27 billion investment by the federal government, nearly 70 percent of physicians think electronic health records have not been worth the effort, resources, and cost, according to a national survey of 1,000 physicians for Medical Economics. Sixty-nine percent of respondents said that coordination of care with hospitals has not improved, 67 percent dislike the functionality of their EHR system, and 66 percent of internists would not buy their current system. A qualitative study of 30 physician practices in six states by RAND found that a number of problems with EHR’s significantly worsened physician satisfaction. “Aspects of current EHRs that were particularly common sources of dissatisfaction included poor usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work

content, inability to exchange health information, and degradation of clinical documentation” (Verdon, “Physician outcry on EHR functionality, cost,” Medical Economics, 2/10/14, RAND 10/13).

## INTERNATIONAL

- A survey of 20,045 adults in 11 industrialized countries, intended to form a baseline for the impact of the ACA on the U.S. health system in an international context, found that U.S. adults are far more likely than people in other nations to go without health care, have trouble paying medical bills, and encounter time-consuming health insurance paperwork or disputes, or claims unexpectedly not paid. The other nations studied were Australia, Canada, France, Germany, the Netherlands, Norway, Sweden, Switzerland and the U.K. Even insured U.S. adults were more likely than adults in other countries to forgo care because of costs and to struggle with medical bills. Forty-two percent of insured Americans reported paying \$1,000 or more out-of-pocket for medical bills last year, compared to 2 percent of Swedes and 3 percent of people in the U.K.

Thirty-two percent of U.S. adults had to spend a lot of time on insurance paperwork or had an insurer deny a claim. Problems with insurers were also common in Switzerland (25 percent), the Netherlands (19 percent), and Germany (17 percent), the other three nations in the survey that use multiple payers (albeit highly regulated) for basic coverage in their systems. (Switzerland and the Netherlands use private insurance while Germany uses “sickness funds.”) There has been a steep increase in the proportion of people in the Netherlands forgoing care because of costs, rising from 8 percent in 2010 to 22 percent in 2013, a period in which the Netherlands implemented market-based reforms, along with austerity (Schoen et al., “Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries,” Health Affairs, December 2013).

## ACA WATCH

- Tom Scully, the former CMS chair who shepherded the Medicare drug bill – based on private, for-profit drug plans – through Congress in 2003, recently assured a group of hedge fund and private equity investment managers that “[Obamacare] is not a government takeover of medicine. It’s the privatization of health care” (Davidson, “The President wants you to get rich on Obamacare,” New York Times Magazine, 10/30/13).

## Early enrollment figures

- A net of about 9.3 million uninsured adults between the ages of 18 and 64 gained coverage during the first quarter of 2014, according to a mid-March survey of 2,425 adults by RAND. An expansion of employer-based coverage (to 8.2 million people, of whom 7.1 million were uninsured) and Medicaid (to 5.9 million people, of whom 3.6 million were uninsured), not enrollment through the exchanges, accounted for most of the new coverage among the uninsured, the survey found. RAND estimated that two-thirds of the people who enrolled via the health exchanges had prior coverage, along with all but about 500,000 of

the 7.8 million people who enrolled in individual plans directly through insurers. Overall, RAND found that the uninsured rate among 18-64 year olds dropped to 15.8 percent in 2014 from 20.5 percent in 2013. Because the data did not include the final two weeks of open enrollment, the actual uninsured rate for this group is likely to be slightly lower (Carman and Eibner, “Survey estimates net gain of 9.3 million American adults with health insurance,” RAND, April 2014).

A similar survey by the Urban Institute in early March estimated that 15.2 percent of adults aged 18-64 were uninsured. In states that are expanding their Medicaid programs, 12.4 percent of non-elderly adults were uninsured, compared with a rate of 18.1 percent in states not expanding Medicaid (Long, Urban Institute, 4/3/14).

- Nearly 83 percent of those signing up for private coverage through exchanges received a federal subsidy, but overall, only about 21 percent of people eligible for a subsidy actually enrolled, according to an early estimate by the Kaiser Family Foundation. A higher proportion – up to 40 percent – of those eligible enrolled in Washington, California, Connecticut and Rhode Island. Tragically, the ACA made no provisions for subsidies to people earning less than 100 percent of the federal poverty line because the authors assumed that all states would expand their Medicaid programs (Levitt, “How much financial assistance are people receiving under the Affordable Care Act,” Kaiser Family Foundation, 3/27/14).

The average federal subsidy for private health insurance premiums on the exchanges will be about \$4,250 per enrollee in 2014, rising to \$7,170 per enrollee in 2024, according to the Congressional Budget Office’s latest estimates. The CBO estimates that about 25 million people each year will purchase private insurance with federal subsidies between 2016 and 2024. Factoring in subsidized cost-sharing (\$167 billion), federal subsidies to the private insurance industry over the 10-year period 2015-2024 will total \$1.03 trillion (CBO, “Insurance Coverage Provisions of the Affordable Care Act,” April 2014).

- Several of the 14 state-based exchanges experienced major problems. Maryland, Massachusetts, Oregon, Nevada and Vermont replaced top officials, cancelled contracts with software companies and spent tens of millions of dollars on new contractors and fixes. Only about 63,000 people were able to sign up for private coverage in Maryland, far short of the state’s goal of 250,000 people. Maryland officials have decided to drop their exchange and start over with Connecticut’s exchange software. The software is free, but they’ll have to invest another \$50 million to adapt it for Maryland. Oregon officials are dumping their \$248 million exchange and switching to the federal exchange HealthCare.gov next year. The switch will cost about \$35 million to complete. The Massachusetts Connector, which received \$180 million in federal grant money to prepare for the transition to the ACA, was unable to sign people up for federally subsidized coverage. The state signed up about 30,000 people for unsubsidized coverage, and 138,000 people for “temporary coverage,” with many of the sign-ups occurring via paper applications. The state also asked HHS to allow 114,000 Massachu-

sets residents to stay in their current plans through September (“extended coverage”) due to their technical problems. Xerox and the Nevada health exchange are being sued for not passing on premiums and applications to insurers, leading to disputes among hospitals, patients, and insurers over medical bills (Chereb, “Bungling mars health care deadline in some states,” AP, 3/25/14; Walker, “MD votes to adopt health exchange software used in Connecticut,” Baltimore Sun, 4/2/14; Cassidy, “\$180 million Fed connector tab eyed,” Boston Herald, 4/1/14; and Chereb, “Xerox, Nevada health exchange subject of class-action filing,” Las Vegas Sun, 4/2/14).

- Several states are concerned that their exchanges aren’t financially sustainable. The Hawaii Health Connector, which cost \$54 million to build, only signed up 7,788 people, for a cost of \$6,934 per enrollee; it is expected to cost \$15 million annually to operate, but only bring in \$1 million in revenues from a 2 percent fee on the plans it sells. The Hawaii exchange would have needed to sign up 150,000 people to be sustainable; officials now admit this was an “unrealistic” expectation in a state with 100,000 people who are uninsured, half of them eligible for Medicaid (Consillo, “Hawaii health connector won’t be sustainable after 2014,” Honolulu Star-Advertiser, 2/26/14).

## Benefits

### Low actuarial value, ultra-narrow networks, high administrative costs

- As of April 1, 20 percent of policies purchased through the exchanges were bronze, 65 percent were silver, 9 percent were gold, and 5 percent were platinum. Bronze plans have lower premiums but are not eligible for federal subsidies for cost-sharing (available to those with incomes below 250 percent of poverty), so most people enrolled in silver plans that are eligible for these additional subsidies (Summary enrollment report, HHS, 5/1/14).

- Patients are responsible for up to 50 percent of the cost of specialty drugs in plans sold on the exchanges, a burden that will hit people with chronic illness especially hard, according to reviews by Milliman Inc. and Avalere Health. Milliman reported, in a study of plans in California, New York, Florida and Texas, that the latter two states have especially high drug coinsurance, of 40 percent to 50 percent. An analysis of plans in 19 states by Avalere found that 60 percent of bronze plans and 23 percent of silver plans had drug coinsurance rates of 30 percent or more (“Chronically ill facing high drug costs under U.S. health law,” Reuters, 2/28/14).

- Every insurer offering plans on the health exchanges restricts patients to its own network of doctors and hospitals. Even more expensive plans in the same market from the same insurer don’t necessarily grant access to a wider choice of providers, and out-of-network care can be costly. Federal subsidies for cost-sharing don’t apply for out-of-network care, and out-of-network care costs may not count toward the out-of-pocket maximums (\$6,350 for an individual, and \$12,700 for a family, excluding premiums), leaving patients on the hook for the entire cost. A McKinsey & Co. analysis of 120 silver-level exchange plans

found that 70 percent were narrow network, with at least 30 percent of the area’s largest hospitals excluded, or ultra-narrow, excluding at least 70 percent. While insurers can’t charge more for out-of-network emergency department care, patients placed on observation status or admitted to an out-of-network hospital are no longer shielded from uncovered costs (Andrews, “Warning, Opting Out of Your Insurance Plan’s Provider Network is Risky,” Kaiser Health News, 3/18/14).

- For the most part, patients were unable to verify if their doctors were covered by a particular plan on the exchange in advance of purchasing it. According to ZocDoc, an online appointment booking firm which tried to verify the accuracy of insurers’ directories, about half of the listings for in-network providers were wrong. The California exchange took down its directory in early February due to errors (Tozzi, “Obamacare limits choices under some plans,” Bloomberg Businessweek, 3/20/14).

- Individuals can keep coverage that doesn’t meet the minimum benefits standards of the ACA for another year, and in some cases until 2016, according to new rules from HHS. Insurance commissioners in 21 states and the District of Columbia have blocked the extension on the grounds that they need these people in the exchange risk pools to avoid premium increases (“Keeping Your Insurance Policy,” New York Times, 3/6/14).

Insurers will be allowed to spend more than the ACA’s limit of 20 percent of their premiums on overhead because of the rocky rollout of the exchanges. Insurers complain that it required them to hire more call-center staff, process applications manually, and, in some states, like Maryland, where the exchange hasn’t functioned at all, pay broker fees (Hancock and Appleby, “Insurers may get cost break thanks to rocky ACA rollout,” Kaiser Health News, 3/13/14).

- Insurers are also receiving more federal help in the form of new, lower, reinsurance rates. In 2014, reinsurance for high-cost cases will kick in at \$45,000 in claims for one individual, down from \$60,000, and extending to a cap of \$250,000. While reinsurance is a temporary \$10 billion program that, like the risk corridors (which limit gains or losses by insurers over 3 percent of premiums) is only in effect until 2016, risk adjustment is a permanent feature of the new law. Plans that can show they have enrolled a sicker population are supposed to receive payments from plans that have enrolled healthier people. But risk adjustment is easy to game (as repeatedly demonstrated in the Medicare Advantage program) by labeling patients with more diagnoses, known as “upcoding.” Insurers are already scrambling to find out about enrollees’ health conditions, which they say they need to know in order to reduce the cost of caring for those patients. Cigna is calling enrollees to ask about health conditions, medications, and other medical needs, while Florida Blue is encouraging enrollees to fill out health risk forms and get tests for cholesterol and blood sugar (Mathews, “Health plans rush to size up new clients,” Wall Street Journal, 2/27/14).

- The penalty for not having health insurance by March 1, 2014, will “almost always” be more than the \$95 figure often cited in news reports. The penalty is \$95 or 1 percent of adjusted gross

income, whichever is greater, minus some adjustments, up to the cost of the premium of a bronze plan. The penalty will rise to 2 percent of income or a minimum of \$325 in 2015, and 2.5 percent of income but at least \$695 in 2016. A “tax penalty calculator” is online at the Tax Policy Center (McKinnon, Wall Street Journal, 3/6/14).

- Insurers are required to keep people on their rolls for three months if payments are missed, but are only required to pay their medical bills for the first month, leaving providers on the hook for the other two months if payments are not forthcoming. (“Commenters say ACA grace period rule puts unfair burden on hospitals, providers,” Bloomberg BNA, 8/21/13).

### Medicaid expansion

- As of March 28, 21 states have decided to opt out of the Medicaid expansion and three are still debating their participation (Missouri, Pennsylvania and Utah). Most of the states opting out require parents to make less than 50 percent of the federal poverty level to be eligible for Medicaid. The Commonwealth Fund estimated that states opting out of the Medicaid expansion will forgo an estimated \$34.7 billion in federal funds between 2014 and 2022 (Advisory.com and Glied et al., Commonwealth Fund, December 2013).

#### States privatize, shrink Medicaid benefits

Arkansas, which was allowed by HHS to use its federal Medicaid funds to buy private insurance for 94,000 Medicaid-eligible residents this year, diverted anyone thought to be medically frail (about 10 percent of new enrollees) to traditional Medicaid, thereby selectively enrolling the healthy in four for-profit, “private option” plans, which receive \$476 per person, per month. Now Arkansas is seeking waivers to shift more costs onto patients by (1) expanding the use of co-pays to people with incomes as low as 50 percent of poverty (only enrollees with incomes between 100 and 138 percent of poverty are currently charged co-pays), (2) curtailing non-emergency transportation assistance, and (3) setting up health savings accounts for beneficiaries (without necessarily putting funds in them). The state’s Republican Party has threatened to end the expansion unless CMS approves these changes (DeMillo, “Arkansas officials eye changes to Medicaid plan,” AP, 3/5/14, and Goodnough, “In Arkansas, private option Medicaid plan could be derailed,” New York Times, 2/11/14).

Several other states are appealing to HHS to institute premiums or co-pays for Medicaid enrollees, including Arizona, Iowa, Michigan, Indiana, New Hampshire, Pennsylvania and Tennessee. Iowa wants to charge Medicaid enrollees premiums of \$30 a month that beneficiaries can “earn back” by quitting smoking or losing weight. Premiums discourage uninsured poor people from enrolling in Medicaid while raising little in new health funds. Similarly, co-pays penalize the sick, particularly those with chronic illness (Saloner et al., “Pinching the Poor,” NEJM, 3/27/14, and Vestal, “‘Private Option’ for Medicaid Expansion Would Cut Some Benefits,” KHN, 3/27/14).

- The number of long-term care residents enrolled in mandatory Medicaid managed care is projected to double this year to 1.2 million. Florida, New Jersey, Ohio, California, and Virginia are implementing statewide mandates this year, while some other states, including New York, Texas, and Rhode Island, are expanding the approach to additional counties. “The mandatory transition of large numbers of consumers who use long-term care ... is unprecedented,” according to Laura Summer at Georgetown (Galewitz, “States accelerate shift of nursing home residents into Medicaid managed care,” 2/11/14).

### Employer mandate delayed, cap on deductibles for employees of small business eliminated

- The employer mandate in the ACA was slated to begin January 1, 2014. Now, the large employer mandate (>100 employees) has been postponed for one year, and will be phased in, so that in 2015 employers only need to cover 70 percent of employees working 30 or more hours per week to avoid a penalty, rising to 95 percent of workers in 2016. The deadline for employers with 51-99 workers to provide coverage for their workers or pay a fine was also extended for an additional year, to 2016. Seasonal employees who work six months or less are not considered full-time employees.

- Businesses with 50 workers or less are not required to provide or report coverage, but the federal government and 16 states and the District of Columbia have set up separate exchanges for small businesses and their employees under a program called the Small Business Health Insurance Options Project (SHOP). In 14 states and D.C., SHOP exchanges are facilitating small business owners’ ability to shift costs onto their workers through defined contributions. Instead of covering a uniform set of benefits for every employee, employers are permitted to contribute a set percentage (typically 50 percent) of the cost of an index plan towards the cost of the policy of the employee’s choice, making the worker responsible for the difference. While the ACA required plans sold through SHOP to limit deductibles to \$4,000 for family policies and \$2,000 for individual coverage, the cap on deductibles was removed in the “doc fix” legislation passed in March (Dash, Commonwealth Fund, 3/14, and Lieberman, “Repeal on deductible caps marks another step in The Great Cost Shift,” Columbia Journalism Review, 4/11/14).

### Labor issues under the ACA

- Union-management-run health insurance plans (Taft-Hartley plans) are not eligible for subsidies under the ACA; subsidies are restricted to the private plans sold on the exchanges. As a result, firms hiring nonunion workers with access to subsidized plans have a competitive advantage over unionized firms. In addition, firms with employees working less than 30 hours per week are not required to provide coverage, so there is a strong incentive for employers to cut workers’ hours. Labor unions warn that the ACA will lead to cuts in wages and benefits for the middle class (Mark Dudzic, “Ten things unions need to look out for when bargaining under Obamacare,” www.laborforsinglepayer.org).

# U.S. Senate hearing: Learning from other nations' health care systems

On March 11, Sen. Bernie Sanders of Vermont chaired a Senate subcommittee hearing on what the health care system in the United States can learn from other countries, particularly Canada, Taiwan, Denmark and France. The title of this unprecedented session was "Access and Cost: What the U.S. Health Care System Can Learn from Other Countries." The hearing was held before the Subcommittee on Primary Health and Aging of the Senate Committee on Health, Education, Labor and Pensions. We reproduce some of the key testimony here.

## Canada's system promotes equity, cost-savings and quality

By Danielle Martin, M.D., M.P.P.

Chairman Sanders, Ranking Member Burr, distinguished members of the HELP Committee, and my fellow panelists, I deeply appreciate the opportunity to come before you today to discuss the common challenges faced by the health systems of the United States and Canada, and to shed light on some policy solutions offered by a comparative examination of both.

My name is Dr. Danielle Martin. I am a primary care family physician working in the Family Practice Health Centre at Women's College Hospital, an ambulatory care hospital located in downtown Toronto, Ontario. I have practiced family medicine in Canada for nine years in a variety of settings, including remote rural communities as well as in the heart of our biggest city. My practice has included office-based comprehensive care family medicine, obstetrics, minor surgical procedures, and rural emergency and inpatient medicine. I also serve in an administrative leadership position at Women's College Hospital as Vice President Medical Affairs and Health System Solutions. Women's College is a unique organization – a hospital without inpatient beds that focuses on advancing the health of women, improving ambulatory care for people living with complex chronic conditions, and health system solutions. Being an outpatient hospital means that we deliver treatments, diagnostic procedures and perform complex surgeries for patients who do not require overnight stays.

In addition to my clinical training I also hold a Masters in Public Policy from the University of Toronto where I am currently an assistant professor in the Department of Family and Community Medicine and in the Institute of Health Policy, Management and Evaluation at the Dalla Lana School of Public Health.

Prior to becoming a physician I worked in health care policy and I have held a wide variety of leadership roles throughout my clinical training and practice. From 2005 to 2011, I was privileged to sit on the Health Council of Canada, the national organization responsible for monitoring progress on health care reform across Canada and reporting to the public. My longstanding interest in promoting a Canadian health system that is equitable, sustainable, and that delivers quality care led me in 2006 to help found Canadian Doctors for Medicare, a national advocacy group dedicated to strengthening our public system. I continue to sit on the board of directors of CDM.



**Dr. Danielle Martin**

My writings on our health system have appeared in a variety of peer-reviewed publications including the Canadian Medical Association Journal, Canadian Family Physician, and Healthcare Papers. I have also published articles and op-eds on health care in major Canadian newspapers such as the National Post, Globe and Mail, Toronto Star and I am regularly cited as an expert in news reports related to health reform and the Canadian health system. I continue to speak and write about the future of health care in Canada.

Health system thinkers face many of the same health policy challenges and share many of the same goals regardless of the disparate systems in which we work. It is my strongly held belief that we have much to learn from each other. In the brief time available to me this morning, I hope to help you understand how and why we have developed and maintained a single-payer health care system in Canada, and what I think American policymakers can learn from our experience.

To that end, I will begin by providing some background on the structural elements of the Canadian single-payer system that I think are especially relevant to the American context. I will also outline the advantages the single-payer structure affords us as we tackle the significant challenges we face: namely, the ability to ensure equity of access to services; the ability to control administrative costs; and the ability to jointly pursue shared policy goals in a coordinated manner. Finally, I will speak briefly on the issue of access to care in the Canadian system, a topic

which I know frequently receives media attention in American markets.

## **The Canadian Single-Payer System: Key Elements**

I do not presume to claim that the Canadian system is perfect or that we do not face difficult systemic challenges. However I will put forth the argument that our challenges do not stem from the single-payer nature of our system, nor are they insurmountable within that essential structure. Quite the contrary, working within a single-payer insurance structure helps us to better address and tackle many of the health care challenges shared by all developed nations, including rising costs, variation in quality, and inequities of access.

### *1. Health insurance is provided at the level of the provinces*

Although media coverage on both sides of the border often talks about the “Canadian” health care system as a single monolithic entity, it will be of interest to the committee to learn that in fact the Canadian system is actually 13 separate provincial and territorial systems, each quite independent from the other, in large measure because the Canadian constitution clearly puts most health care matters in provincial jurisdiction. We have learned, as I think you are also experiencing, that different provinces have different appetites and needs when it comes to public health care insurance and what, or more to the point who, it should cover. Our system finds its origin in reform in a single province that gained popularity and caught on over decades across the country.

Prior to the 1940s, access to health care in Canada was based on the ability to pay – and quite often, losing one’s health meant losing the farm. In 1947, the Province of Saskatchewan introduced a public insurance plan to pay for hospital services. In 1962, at roughly the same time the United States was beginning to debate the creation of the Medicare and Medicaid programs, Saskatchewan extended public insurance to cover physician services as well. Public insurance became popular very quickly and other provinces soon followed suit with similar reforms.

As the Committee is now aware, the Canadian single-payer health system is actually a consortium of 13 systems (one for each province and territory) that together provide coverage for all Canadians. That is, each province mostly controls the provision of health insurance, with minimum standards set at the federal level. These standards do not speak to the details of health service provision; rather, they dictate that in order to receive federal funding support, health insurance plans within the provinces must be (1) Universal, (2) Accessible, (3) Comprehensive, (4) Portable and (5) Publicly administered. Beyond a federal requirement that insurance plans must provide coverage for medically necessary physician and hospital services, the provinces and territories enjoy quite a lot of flexibility in determining the “basket of services” covered.

### *2. Insurance is public, but health services delivery is private*

When discussing health system structures, it is critical to distinguish between who pays for services and who delivers them.

Contrary to what many Americans may believe, Canada does not have “socialized medicine” in the strict sense, since in spite of being paid for through public insurance, almost all services are delivered by private entities. This includes not only our hospitals, which are mostly independent private not-for-profit entities, but also our providers, most notably physicians, who are not employees of the state. In Canada medically necessary physician services are covered by provincial insurance for which all residents are eligible, but physicians are independent contractors. Speaking as a practicing family doctor, this is a key feature of our system well worth highlighting; and given the current structures in American health care I think it is of some salience to your deliberations.

## **Benefits of the Single-Payer Insurance Model in the Canadian Context**

It is my view that the single-payer structure of our provincial health insurance systems, while far from a panacea for all that ails us, is the best possible structure within which to address our challenges. Single payer promotes equity of access to services; it enables coordinated pursuit of shared health policy goals; and it allows us to deliver quality care at far lower costs than those seen in the United States. I will address each of these benefits in turn.

### *1. Equity*

Poll after poll has demonstrated the enduring popularity of the single-payer model among Canadians. When asked what features of our system are most salient, Canadians from all walks of life answer that it is this aspect of our system that gives them particular pride. There is a strong consensus across Canada that access to health care should be based on need rather than the ability to pay. This is a fundamental principle of our system, and pooling risk by having everyone in the system makes it possible. While of course we continue to struggle with inequity across other aspects of health care, we do not have significant equity problems with respect to insurance. We do not have uninsured or underinsured residents. We do not have different qualities of insurance depending on a person’s employment. We do not have an industry working to try to carve out different niches within the risk pool. At substantially lower cost than in the U.S., all Canadians have health insurance and need rather than wealth is what drives access to care. This is a very significant accomplishment and as we watch the debate unfold in the U.S. as to how to address the challenges you face, we are reminded of its significance daily.

### *2. Achieving Consensus Policy Goals*

One of the big challenges in a multi-payer system is the question of how to achieve policy reform with so many players in the game. In a single-payer framework there is a place where the providers and insurers can go to address challenges together, namely the bargaining table. This is as beneficial to providers as it is to insurers since it affords all groups a policy lever beyond legislation or self-regulation that is open and accountable. If

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government and providers identify a significant challenge in the health system that needs to be addressed, they can work together to try to align financial incentives to advance those shared policy objectives.

For example, across the political spectrum and between countries with disparate health systems, there is a shared consensus among both government and physicians that the

**Single payer promotes equity of access to services; it enables coordinated pursuit of shared health policy goals; and it allows us to deliver quality care at far lower costs than those seen in the United States.**

provision of quality primary care should be a key policy goal. The evidence on the importance of primary care as a determinant of population health is widespread from the work of Barbara Starfield and others. We all want to see a well-developed primary care system and enough primary care physicians to serve the needs of the population. But it has been difficult over the last several decades to convince medical students to choose primary care when the compensation has lagged behind that of our specialist colleagues and the greatest needs are in remote or underserved urban areas. Single payer

allows for a consolidated voice at the bargaining table to have this conversation. Without jeopardizing physician autonomy, Canadian provincial governments have been able to work with the provincial medical associations to negotiate aligning financial incentives to promote primary care – from higher compensation for primary care doctors to programs that help reduce medical school loans for young doctors who choose to work in underserved areas.

Furthermore, this system affords the patient a voice at the table through their democratically elected representatives. This stands in contrast to a multi-payer private system where private insurance companies are not accountable to their enrollees but rather to their shareholders.

### 3. Lower Administrative Costs

On a practical level, having one payer for health services requires a far smaller administrative footprint than that under a multi-payer system. Canadian doctors save time on paperwork and Canada's overall administrative spending is far lower than our neighbor to the south. In fact, a comparative study published in Health Affairs found that if U.S. physicians were to curtail administrative costs to the level of those in my home province of Ontario, the total estimated savings would be \$27.6 billion per year. Looking at overall costs, a 2003 study found that after exclusions, administration accounted for 31.0 percent of health care expenditures in the United States and 16.7 percent of health care expenditures in Canada. Even this figure can be deceptive, as the Canadian system includes private supplemental health insurance that often covers services that are not covered by the public plans. Total administrative costs include those for private plans, but when only the public single-payer insurance program is considered, the insurance overhead shrinks to just 1.3 percent.

The far lower administrative costs in the Canadian system are one factor in explaining our relatively lower overall costs. Canada's spending on health care as of 2011 is 11.2 percent of GDP placing it roughly within the middle of the pack of similarly developed countries, compared to the U.S.'s 17.9 percent. One key factor in this disparity is the distinction between the mix of multiple private, for-profit insurance companies which work alongside a patchwork of public providers in the United States in contrast to the Canadian system which relies mostly on public financing and not-for-profit delivery. It is not the distinctly Canadian system that produces these savings so much as the underlying principle of publicly accountable universal health care, a principle shared by all OCED countries excluding the United States.

### Access and Quality in the Canadian Model

A concern has been raised that cost savings, though laudable, are indicative of poorer quality of care, whether in terms of health outcomes or in access to care. On both points, this concern is unfounded. First, Canadians enjoy the same or better outcomes of health care as Americans. We see this in terms of overall health outcomes such as life expectancy and infant mortality, though as others have pointed out these outcomes are tied to larger social determinants of health and are not necessarily a proxy for understanding the outputs of a health system.

When we turn to outcomes that are more directly attributable to provision of health care services we see the same pattern of equal or better outcomes for Canadians. And a recent systematic review of Canada's single-payer system found that Canada achieved health outcomes that are at least equal to those in the U.S. at two-thirds the cost. Examples of comparative health outcomes between Canada and the States may be found in the Appendix to this testimony.

### Addressing Wait Lists

While socio-economic barriers to care regrettably exist in both countries, access to health insurance is unencumbered in Canada regardless of income. But what of wait lists for care? When it comes to urgent, necessary care, Canadians are not waiting substantially longer than our peers in other countries, including the United States. However, unfortunately this has not been the case for elective medical care, particularly diagnostic imaging, non-urgent specialist appointments and elective surgeries such as cataract surgery, and hip and knee replacement. In response to this challenge we have seen governments doing much work to reduce wait times in the past decade. The key to success has been to change the way that we deliver service, for example, through single common wait lists rather multiple queues. It is also important to bear in mind that Americans also face the problem of wait times to see specialists. Of the 40 percent of Americans who report difficulties in seeing a specialist, 40 percent cite long waiting times, 31 percent cite a denied referral, and 17 percent say they cannot afford private insurance. The Canadian system, which allows patients to see specialists on referral as well as directly, and in which private insurance is not tied to the ability to pay, does not burden patients with either of these problems.

One proposal that absolutely has not shown success has been to move from a public system such as the one in Canada to a two-tiered system where patients with the means are able to jump the queue. A study conducted before and after the move from single-payer to multi-payer insurance in Australia found that median waiting times were inversely related to the proportion of public patients. In other words, in those parts of the country where there was more privately insured care, waits in the public system were longer. Why was this the case? Because our health human resources are not infinite, and the doctors, nurses and others providing care have to come from somewhere. The drain on the public system from doctors exiting to the private sector creates longer waiting lists in public health care. Instead, our focus should be on reducing wait times in a way that is equitable for all. That has been the imperative of the reforms in Canada, and while the battle is

not yet over, it is in my view an exemplary example of how Canadian health policy thinkers work to improve our system while upholding our values.

### Conclusion

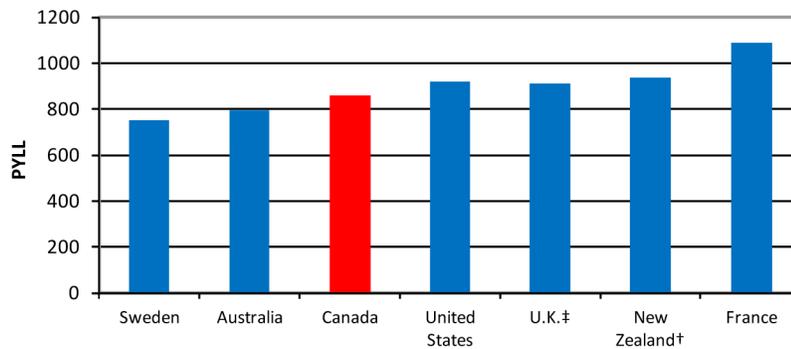
I want to reiterate my thanks to this Committee and to Chairman Sanders and Ranking Member Burr for giving me the opportunity to present this testimony today. It is truly an honor to exchange ideas about health system solutions on both sides of the border. I look forward to answering your questions and engaging in dialogue, as well as learning from my fellow presenters.

*Dr. Danielle Martin is vice president for Medical Affairs & Health System Solutions, Women's College Hospital, Toronto, Canada.*

## Outcomes



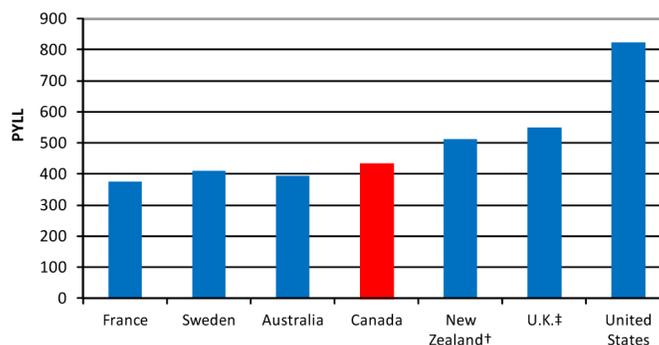
Cancer PYLL Comparison with OECD Countries, 2009



## Outcomes



Heart Disease PYLL Comparison with OECD Countries, 2009



*Editors note: PYLL = Potential years of life lost (ages 0-69) per 100,000*

# Key features of single-payer health systems

By **Tsung-Mei Cheng, LL.B., M.A.**

Today's hearing is focused on "international single-payer health system models that provide universal coverage of health care." I will tailor my remarks according to the three sub-themes the Committee wishes to explore, namely:

- Primary care access in single-payer systems
- Health care costs in single-payer systems, and
- Cross-country comparisons of health outcomes

Before proceeding with the Committee's agenda in more detail, however, I would like to provide the Committee with a summary of my main points:

1. If equity and social solidarity in access to health care and financing health care were fundamental goals of a health care system, the single-payer system provides an ideal platform for achieving these goals.

2. Single-payer systems typically are financed by general or payroll taxes in a way that tailors the individual's or family's contribution to health care financing to their ability to pay, rather than to their health status, which until this year has long been the practice in the individual health insurance market in the U.S.

3. These systems protect individual households from financial ruin due to medical bills.

4. Single-payer health systems typically afford patients free choice of health care provider, albeit at the expense of not having a freedom of choice among different health insurers. Remarkably, in the U.S. households have some freedom of choice of health insurers – to the extent their employer offers them choice – but most Americans are confined to networks of providers for their insurance policy. In other words, Americans appear to have traded freedom of choice among providers for the sake of choice among insurers.

5. In single-payer systems "money follows the patient." Therefore providers of health care must and do compete for patients on the basis of quality and patient satisfaction, but not price.

6. In a single-payer health insurance system, health insurance is fully portable from job to job and into unemployment status and retirement. The "job-lock" phenomenon prevalent in the U.S. is unknown in those systems, contributing to labor-market efficiency.

7. Because all funds to providers of health care in a single-payer system flow from one payer, it is relatively easy to control total health spending in such systems. Indeed, total national health spending as a percent of GDP in countries with single-payer systems is lower than it tends to be in non-single-payer health systems. This does not mean providers are left without a voice.



Provider inputs are part of the formal negotiations over health care budgets.

8. For the most part, single-payer systems achieve their cost control by virtue of the monopsonistic market power they enjoy vis-a-vis providers of health care. It is a countervailing power that the highly fragmented U.S. health insurance system lacks vis-a-vis providers.

9. As part of their effort to control total health spending, however, and to avoid the waste of excess capacity that easily develops in health care, some single-payer systems (the U.K. and Canada) put constraints on the physical capacity of their health system (number of inpatient beds, MRI scanners, etc.). That approach can lead to rationing by the queue. The alternative to rationing by such administrative devices, of course, is rationing by price and ability to pay, an approach used by design or by default in the United States. Rationing by price or by non-price mechanism are just alternative forms of rationing.

10. A single-payer system is an ideal platform for a uniform electronic health information system of the sort, for example, used by our Veterans Administration health system (a single-payer system in its own right). There is a common nomenclature which enables 100 percent electronic billing and claims processing, thus yielding significant savings in administrative costs.

11. Because they conveniently capture information on all health care transactions, single-payer systems provide a database that can be used for quality measurement, monitoring and improvement, and also for more basic research on what drives health spending and what clinical treatments works and does not work in health care. It enables evidence based medicine and the tracking of efficacy and safety of new drugs and devices once they are introduced after approval by government based on results of clinical trials.

*Tsung-Mei Cheng is a health policy research analyst at the Woodrow Wilson School of Public and International Affairs, Princeton University.*

# Taiwan's two decades of experience with single payer

By Ching-Chaun Yeh, M.D., M.P.H.

## Universal coverage

Taiwan established universal national health insurance in 1995, bringing nearly 40 percent (about 9 million) uninsured under the umbrella of national health insurance (NHI). Before that, there were 12 different social health insurance and health service programs covering a population of 12 million. Currently, 99.6 percent of the population, about 23 million people, is enrolled in the NHI program. Taiwan is the only country in the last 30 years to reach universal coverage and a single-payer system at the same time. Nineteen years of experience with national health insurance have produced important results that other countries might find of interest.

## Equity

Taiwan has been one of the most egalitarian health systems in the industrialized world. Access to health care is an inalienable right in our constitution. Residents living in remote mountainous areas and offshore islands, and the poor, the disabled, the aged get pretty much the same access and health care as anyone else. A single-payer system has a single risk pool, since everyone is mandated to enroll. This enables cross-subsidization among diverse groups with not only different socioeconomic status but also different health status.

Studies show that the premium contribution compared to the health resources utilized are favorable to the low- and middle-income classes. Of course, this is the nature of a social health insurance program. Also, health care costs are much lower compared to most OECD (Organization for Economic Cooperation and Development) countries. National health spending grew from the pre-NHI three-year average of 4.87 percent of gross domestic product (GDP) to only 6.62 percent in 2012.

## Transition period

By the end of 1995, 10 months after NHI launched, only 92.3 percent of our population enrolled in the new program, and increased to 96.0 percent in 1996. In 2002, it finally reached 98 percent, the target we set in the planning stage. And now, 99.6 percent of our citizens covered by the NHI.

For the first two years, the percentage of health expenditure to GDP increased rapidly from 4.87 percent to 5.36 percent, then stabilized and gradually increased from 5.36 percent in 1996 to 6.62 percent in 2012.

The general public has been very satisfied with the NHI – although in the first half year of inception, satisfaction rates were as low as 25-40 percent, but by the end of the first year they



Dr. Ching-Chaun Yeh

rose to 60 percent, and after the end of the second year, they have always been between 70 and 80 percent up to the present.

## Single-payer system

Having a single-payer system is the main reason for our efficient services and also the low prices for health care we can achieve. Private delivery and highly competitive providers enable us to have efficient health services. The NHI Administration's contract with all of the hospitals and most of the private practitioners enable the insured to have an easy and equal access to health services. In addition, the single payer wields monopsonistic power in procuring services and products – hence low prices for health care.

A single insurance administration also has the benefit of a very low administrative cost, which was only 1.15 percent of total NHI spending in 2012. Although there is no choice of insurers, people enjoy complete free choice of providers. The latter compels the providers to be competitive and efficient. Doctors and hospitals must achieve very high productivity to survive. Providers in Taiwan must be mindful of patients' demands to stay competitive, and they do compete for patients. The NHI Administration set a uniform national fee schedule for all the providers. Price competition is limited to those services not covered by the NHI program. It is quality competition in nature, not price competition; but it certainly is competition.

Furthermore, the administration of the single-payer system is simple, as there is only one set of rules for everyone, whether it is regarding claim forms, clinical protocols, quality indicators, fee schedule, etc. The administration costs of hospitals and other providers are also much lower than those of a multi-insurer system.

(continued on next page)

## NHI benefits

NHI benefits are comprehensive: inpatient and outpatient care, drugs, dental care, traditional Chinese medicine, kidney dialysis, organ transplantation etc. Dental prostheses, dentures, cranes, wheelchairs, eyeglasses, cosmetic surgery, special nurses, long-term care, nursing home, etc., are not in the benefits list. Patients have to pay minimum co-payments either for hospitalization or outpatient services. The co-payment rates range from 5-20 percent for different services, and the average actual co-payment rate is 8 percent of the health costs because of the waiver scheme for serious illness, such as cancer, major operations, rare diseases, etc.

Patients stay in a single room or room with two beds must pay an extra room charge. About 60-75 percent of hospital beds are three and more beds in one room that are free of any room charge.

On average, hospitals received 80-85 percent of their revenues from the NHI Administration. The other 15-20 percent is from co-payments and other non-benefits health services.

## Public satisfaction

The NHI is the most successful public policy in Taiwan. The general public has been very satisfied with the NHI. One reason for the high satisfaction is that premium and co-payment rates are low. The premium rate is 4.91 percent of the payroll income, and total national health spending is only 6.62 percent of GDP, of which the NHI itself is 4 percent of GDP.

Easy accessibility is another reason. The NHI Administration contracts with 100 percent of hospitals and 93.5 percent of private practitioners in Taiwan (most of the non-contract practitioners are dentists, doctors of Chinese medicine and aged doctors). Free choice of providers is the key to the easy and equal access of health care.

Patients can carry the equivalent of cash as represented by their insurance cards to any provider of care, not just to a smaller network of providers, as under the U.S. private insurance system. Basically, there are no waiting list at all except for a few well-known medical centers and well-known doctors.

## Health performance and service quality

Some critics say at such low fees we must beget problems with our service quality. However, our life expectancy is comparable to that of the developed world. In 2012, it was 79.4 years old; for males 76.1, and for females 83.0. Taiwan's infant mortality rate is as low as 3.7 per thousand, maternal mortality was between 5.0 to 8.5 per 100,000 in the years from 2005 to 2012. Both of these rates are comparable to the developed world.

Before NHI, life expectancy increased 1.8 years from 1986 to 1996, and after NHI, it improved 2.9 years from 1996 to 2006.

Studies show that life expectancy improved more for low-ranked health classes.

As for the clinical service performance, cervical cancer mortality dropped 60 percent since NHI was launched. Stage-specific cancer survival rates are similar to developed countries, but this is not true with regard to the overall 5 years' survival for colon, breast, lung and oral cancer. That is due to the lack of preventive services and screening, not to the fact that our treatment is inferior. Fortunately, since 2009, the Ministry of Health has designated a special sum from the tobacco health tax revenue solely for screening of three major cancers in Taiwan: colon, oral, and breast. Of course, another part of the budget is designated for an antismoking campaign.

As for the survival after organ transplantation, we sometimes do better than the U.S. For example, because we do more liver transplantation in Taiwan, we have much better outcomes than does the U.S. Heart and kidney transplantation results are also comparable to the U.S. But since we rarely do lung or heart-lung transplants, our outcomes are much worse. Survival of the end-stage renal failure is also comparable to OECD countries.

## Premium increase

In its nineteen-year history, the NHI Administration only raised the premium rate two times: from 4.25 percent (of the payroll) to 4.55 percent in 2002, and to 4.91 percent in 2012. The Ministry of Health started a tobacco health tax in 2000 that gives NHI an additional 2 percent of the total NHI revenue.

In the year 2006 and 2009, the Ministry of Health raised the tobacco health tax again to yield more extra revenue (about 6 percent of total revenue now) for the NHI.

Before 2012, the premium collection was based on payroll income alone. In the year 2013, NHI Administration added another 2 percent of the non-payroll income to the premium base for the NHI as an additional source of funding. That is another 6 percent of the total revenue of NHI.

## Collection of premiums

The NHI's total premium revenue comes from three sources: government (36 percent), which will not default on premiums; employers (26 percent); and the public (38 percent). The NHI Administration is good at collecting premiums from the public. When people don't pay premiums on time, they send notices to them immediately. Our citizens are quite law-abiding, so the compliance rate is very high. The "bad debt rate" is just around 0.9 percent in 2011.

The government pays 100 percent of the premiums for low-income households – currently 1 percent of the population – and extends interest-free loans to the near-poor 2 percent of the population. Since 2009, the Ministry of Health has raised the tobacco tax from the NT\$10 per pack to NT\$20 per pack and has used part of the cigarette health tax revenue as a subsidy for the near-poor.

## Sectorial global budgets

Taiwan has used sectorial global budgets to control health spending successfully. Health policy experts generally believe that such an approach can be useful in the short run, to break an upward trend in health spending. But with more than 15 years of practice, Taiwan has confirmed that the global budget approach is not as bad as people imagine. We have five sectorial global budgets under one big overall global budget for the whole system: hospital, primary care, dental, traditional Chinese medicine, and kidney dialysis. Our hospital global budget includes hospital outpatient ambulatory care, and that part is almost 50 percent of the total cost of any hospital. So far this system has worked, even if not perfectly. Shifting patients from inpatient to outpatient care is effortless because both are under the same hospital global budget.

## New drug adoption

Taiwan spends roughly 25 percent of the NHI budget on drugs. However, multinational pharmaceutical companies often allege that prices paid by the NHI are too low. However, the NHI introduces forty to fifty new drugs every year. So spending for new drugs per total NHI expenditure continues to rise. About one percentage point of the 3-5 percent annual growth in spending of the NHI is for new drugs. Indeed, there are some delays in coverage for new drugs and new technologies. Adoption of new technology, including drugs, is often delayed by two to five years after adoption by U.S.

## Pay for performance

We have five Pay for Performance (P4P) programs using the disease management approach – diabetes, breast cancer, asthma, tuberculosis, and hypertension; other programs are based on fee-for-service or case payment. Diabetes management and tuberculosis control are relatively successful because there are good indicators to measure outcomes. For example, there is HbA1c for diabetes. Breast cancer P4P is considered so-so up to this point. There is no evidence as yet that P4P for asthma has made a big impact. Overall, however, the budget impact of these initiatives is still small. We need to take a much more aggressive approach to disease management. For that we need to overhaul our payment system, which is still largely based on fee-for-service payment to providers.

## Health IT

The NHI Administration issues every insured a credit card-size IC (integrated circuit) card for accessing health care. As all providers in Taiwan submit claims electronically based on the patient records they keep, we can do very detailed profiling of both patients and providers. All the data in our health IT system can be linked, so that we can analyze any data we choose to know about patients, their utilization, providers, and so on. We have complete profiles on utilization by patients'

income level, geographic location, number of visits, number of hospitalizations, etc. Thus, we are able to monitor our health system almost in real time.

At present, most hospitals have electronic medical records (EMRs) within their facilities. We are on the way to develop cross-system EMRs, and expect to accomplish this in the next few years. As there is a single insurer, one single standard has already been set up. We can go to a complete life-time e-record system within a few years.

An imaging switching center using a Picture Archiving and Communication System (PACS) has already functioned for years. All imaging done by the providers is electronically transferable within the entire Taiwan health system. Telemedicine for mountainous aboriginal communities and off-shore islands is a routine practice now.

Our policy decisions usually are based on quantitative evidence generated by our IT system. Taiwan invested heavily up front on health IT, and we have reaped the benefits of our powerful IT system ever since. The savings our IT system has generated have paid for the setup cost of that system many times over.

## Key to the successful implementation

First, we have a team of competent technocrats and dedicated leaders who can devise sound policy and then implement it. Second, in the initial stage, we had a reasonably stable political system. Third, we have a physical infrastructure capable of delivering on health policy. Fourth, we set up a good health IT system at the very beginning, to have the data capacity as a basis for policy making.

In addition, our country established NHI during a good economic period. It should be noted that there are associated cost increases in the initial few years in establishment of national health insurance. Fortunately, Taiwan had good economic growth for many years prior to and after the NHI was launched; so we were able to absorb the cost increases associated with its establishment.

*Dr. Ching-Chuan Yeh is the former minister of health for Taiwan. He is professor at the School of Public Health, College of Medicine, Tzu-Chi University, in Hualien City, Taiwan.*



# Denmark's single-payer system: strengths, structure, outcomes

By Jakob Kjellberg, M.Sc.

## Summary

The Danish health care system provides easily accessible, comprehensive and universal coverage for all citizens. The system is known as a “single-payer” system, in which funding for medically necessary care is provided by the regional governments through taxes – with guidance and some funding from the state and municipalities. Patients are free to choose among providers, and GPs serve as gatekeepers to specialist care.

The strengths of the Danish single-payer system can be summarized as follows:

- The system is simple and very easy to use
- All citizens have access to care; no one may be denied services on the basis of income, age, health or employment status
- Benefits are the same for all citizens
- Administrative costs are minimal as providers and insurers have no need to market themselves
- The regional governments are able to set and enforce overall budgetary limits
- Physician fee schedules are negotiated with the nation medical associations and are binding
- Co-payments are capped for pharmaceuticals and there are no co-payments for general practice, out-patient care or inpatient care
- A maximum 30 day waiting time guarantee is enforced for most elective surgery
- Patient satisfaction is very high – Consumer Powerhouse ranks the Danish health care system second in Europe.

## The structure of the Danish health care sector

The Danish health care sector has three political and administrative levels: the state, the regions and the municipalities (national, regional and local levels). The health care service is organized in such a way that responsibility for services provided by the health service lies with the lowest possible administrative level. In practice, this means that basic services, such as home nursing or non-specialized physical rehabilitation, are the responsibility of the municipalities, while more specialized care is taken care of by the regional level.

### The municipalities

The 98 municipalities are local administrative bodies run by democratically elected municipal councils. The municipalities have a number of tasks, and health care merely represents one of these. In the health field, the municipalities are responsible for home nursing, public health care, school health service, child dental treatment, prevention and rehabilitation. The municipalities are also responsible for most of the social



Jakob Kjellberg

services, for example nursing homes with care facilities and associated care staff for the elderly.

### The regions

Efficient provision of high quality hospital services requires a larger population than the average municipality, and this responsibility thus lies with the five regions. The regions run and own most of the hospitals. The regions are also responsible for the practice sector, including contracting with for instance general practitioners and private practice physiotherapists. The regions organize the health service for their citizens according to regional wishes and available facilities. Thus, the individual regions can adjust services within the financial and national legal limits. The regions are run by regional councils that are democratically elected.

### The state

The role of the state in health care provision is first and foremost to initiate, coordinate and advise. One of the main tasks is to establish the goals for a national health policy. The Ministry of Health and Prevention, in its capacity of principal health authority, is responsible for legislation on health care. This includes legislation on health provision, personnel, hospitals and pharmacies, medicinal products, vaccination, pregnancy health care, child health care and patients' rights.

### The health care system

The Danish health care system can be divided into two sectors:

- Primary health care
- The hospital sector

The primary health care sector deals with general health

problems and its services are available to all. Long-term nursing care, home care and preventive programs are organized by the municipalities. About 25 percent of the elderly around the age of 65 receive long-term care services at home, and 5 percent receive long-term care in institutions. There is no co-payment for home care but income-dependent co-payment for long-term care in institutions. The hospital sector deals with medical conditions requiring more specialized treatment, equipment and intensive care.

In the health care service, the general practitioners act as “gate-keepers” with regard to hospital and specialist treatment. This means that patients usually start by consulting their general practitioner. It is normally necessary to be referred by a general practitioner to a hospital for medical examination and treatment, except in cases of an accident or acute illness. In such cases, all residents have direct access to all hospitals.

Denmark had 3.5 practising physicians per 1000 population in 2009, higher than the OECD average of 3.1. Patients contact their general practitioner on average 6.6 times a year. Including other practicing specialist the primary sector handles approximately 90 percent of all patient contacts. The primary sector spends about 25 percent of the total health budget including primary sector pharmaceuticals. The number of hospital beds in Denmark is 3.5 per 1000 population, significantly lower than the OECD average (4.8 beds). The average length of stay in 2013 was 3.1 days. Table 1 provides an overview of the activity and spending in the regional health sector.

### Financing the Danish health care system

The Danish health care system is based on the principle of free and equal access for all citizens. Thus, the vast majority of health services in Denmark are free of charge for the users. In 2011, total health care expenditure in Denmark constituted 10.9 percent of GDP, which places Denmark above the OECD average of 10.6 percent of GDP. However, a new report questions these figures, since Denmark has a practice of reporting certain expenses for social care (such as nursing homes with care staff) to the

***The Danish health care system is based on the principle of free and equal access for all citizens. Thus, the vast majority of health services in Denmark are free of charge for the users.***

OECD as health care expenses. If these social care expenses are subtracted in line with the reporting practice used by most other countries, the Danish expenditure on health care drops from number 7 out of 34 OECD countries to number 19.

In 2012, the public expenditure constituted 85 percent of the total health expenditure, and private expenditure the remaining 15 percent. Private health care expenditure mainly covers out-of-pocket expenditure for pharmaceuticals and dentistry. The majority of regional and local health care expenditures are financed by tax on income, VAT etc. collected by the national government.

The regional health care services are financed by three kinds of subsidies: A block grant from the state (78 percent), a state activity-related subsidy (2 percent) and a local activity-related contribution (20 percent). In order to give the regions equal opportunities to provide health care services, the subsidy is distributed by a number of objective criteria that reflect expenditure needs (e.g. demography and social structure). Furthermore, part of the state financing of the regions is a state activity-related subsidy. The purpose of this is to encourage the regions to increase the activity level in hospitals.

The municipalities also contribute to financing of the regional health care. The purpose of the local contributions is to encourage the municipalities to initiate efficient preventive measures for their citizens with regard to health issues.

The administrative cost of the Danish health care system constitutes 4.3 percent of the total spending.

### The Hospital Sector

The hospital sector is the responsibility of the five regions. The regions are to provide free hospital treatment for the residents of the region and emergency treatment for persons who are temporarily resident. The obligation to provide citizens with hospital treatment is normally fulfilled by the individual region’s own hospitals.

The Ministry of Health and Prevention (through the National Board of Health) contributes to health care planning in the form of guidance and regulation regarding the definitions of basic and specialized treatments and functions in the hospital services. It also regulates how different forms of treatment should be organized, including coordination of the different levels of treatment.

The regions are required to make agreements among themselves regarding the use of highly specialized departments, in order to provide patients

*(continued on next page)*

Table 1: Number of contacts and regional spending (2009 data)<sup>2</sup>

Regional Health Care	1000 contacts	Visits Per capita per year	Regional spending 1000 mil DKK (%)
GP contacts	37,105	6.6	8.0 (8.3)
Practicing Specialists Doctors	5,028	0.9	3.0 (3.1)
Other practicing specialists	21,800	3.9	2.8 (2.9)
Primary sector pharmaceutical	n.a.	n.a.	6.9 (7.2)
Somatic discharges	1,257	0.2	} 75.5 (78.5)
Somatic outpatient visits	6,600	1.2	
Psychiatric discharges	46	0.01	
Psychiatric outpatient visits	792	0.14	
Total	72,628	12,969	96.3 (100%)

(Kjellberg, continued from previous page)

equal access to necessary specialized treatment irrespective of which region they live in. Furthermore, the regions may, upon authorization from the National Board of Health, refer patients to highly specialized treatment abroad, paid for by the state. The regions can also refer patients to approved hospitals abroad and pay for the services themselves. These options are primarily used for treatment of rare conditions or for highly specialized treatment that cannot be offered in a relatively small country like Denmark.

### Free choice of hospitals

Since January 1, 1993, citizens in need of hospital treatment have been free to choose, within certain limits, in which hospital they wish to be treated. Citizens may choose among all public hospitals offering basic treatment and a number of smaller, specialist hospitals owned by associations, which have agreements with the regions. If following a medical evaluation a citizen is judged to be in need of specialist treatment, he/she has a further choice between hospital departments in Denmark offering treatment on the same specialized level. Citizens may choose among private hospitals or clinics in Denmark or abroad, if the waiting time for treatment exceeds one or two months (depending on condition), and if the chosen hospital has an agreement with the region's association regarding treatment.

### Primary health care services

All residents in Denmark are entitled to public health care benefits in kind. Citizens do not pay any special contributions to this scheme, as it is financed through taxes. The Regions administer both the public hospitals and the primary health care scheme, whereas local administration of the primary health care service lies with the municipalities.

All general practitioners, specialists, dentists, physiotherapists, chiropractors, etc., are licensed by the state. The public health care scheme subsidizes treatment for persons. This treatment is provided by general practitioners, specialists, etc., who have made collective agreements with the public health care scheme. The Regions' Board for Wages and Tariffs enters into collective agreements with the organizations that represent the various professions. The tariffs are binding and are typically renegotiated every second year.

### General practitioners

Any person who is entitled to public health care benefits can choose between being covered in Group 1 or Group 2. Persons covered in Group 1 have to register with a specific general practitioner, and persons in Group 2 have the right, but not the obligation, to register with a specific general practitioner of their choice. Persons in Group 2 may visit any specialist without

visiting a general practitioner first. All Danes can freely choose their general practitioner, who is obliged to take on all new patients. If too many patients wish to be assigned to the same practitioner, he/she can temporarily stop accepting new patients on the list.

Persons covered in Group 1 have the right to free medical services from their general practitioner or specialist. Persons insured under Group 2 have to pay part of the cost of medical help from a general practitioner or specialist. The subsidy to persons insured under Group 2 corresponds to the cost of similar medical help from a specialist for persons in Group 1. About 98 percent of the Danish residents belong to Group 1.

### Dentists

All residents in Denmark are free to choose their own dentist. There are approximately 4,600 authorized dentists. Around 2,500 dentists are included in the collective agreement with the public health care scheme. The majority of the costs for dental treatments for adults are paid for by the users themselves as out-of-pocket payments. However, the public health care scheme pays a minor subsidy per visit for preventive and other dentistry treatments. Reference from a general practitioner is not required. Children under the age of 18 receive free dental care. Furthermore, there are special arrangements, with limited user payment, for those who have difficulties using the ordinary public dentistry services due to low mobility or mental or physical disability.

### Physiotherapists

There are approximately 2,100 physical therapists. The public health care scheme pays part of physiotherapy treatment, but persons with serious physical disabilities are entitled to physiotherapy free of charge. The treatment is only subsidized if prescribed by a general practitioner.

### Home nursing

The municipalities must provide home nursing free of charge, when it is prescribed by a general practitioner. Moreover, the municipalities are obliged to provide all necessary appliances free of charge. Home nursing provides treatment and nursing at home for people who are temporarily, chronically or terminally ill.

### Medicine

Most medicine is sold by pharmacies which are authorized by the state. The Ministry of Health and Prevention decides the number of pharmacies and where they may be situated. General reimbursement is granted for the costs of medicinal products which have been authorized for reimbursement by the Danish Medicines Agency. In general, reimbursement is granted

for medicinal products which have a certain and valuable therapeutic effect when used on a well-defined indication. Furthermore, the price of a given medicinal product must be proportionate to the effect of the product.

The reimbursement will be calculated on the basis of the price of the cheapest medicinal product among the different products with the same effect and the same active ingredients. The pharmacy is obligated to give patients the cheapest product. Chronically ill patients can be included in a special reimbursement scheme with a yearly ceiling of DKK 3,600 (US\$ 600) by the Danish Medicines Agency. Otherwise the patient pays 15 percent of the cost above the yearly ceiling. All pharmaceuticals prescribed as part of specialized hospital treatment are provided free of charge to the patient.

### Quality and patient safety

The Danish Institute for Quality and Accreditation in Healthcare and the National Indicator Project has been established to create Danish standards and indicators and to conduct the accreditation of Danish health care.

Data generated through the Danish Quality Model is made available to health professionals and the general public. The results are available on the integrated web portal for health matters in Denmark [www.sundhed.dk](http://www.sundhed.dk), serving both professionals and the general public. On the web portal citizens can view their own medical record (treatment at hospitals) and the prescription medication they have purchased, using their personal digital signature.

Every second year, the Danish Regions and the Ministry of Health and Prevention conduct a survey of patients' experiences in hospitals. The objective of the survey is to compare patient experiences at hospital level and at medical specialties level. The survey includes questions on, for instance, clinical services, patient safety, patient and staff member continuity, co-involvement and communication, information, course of treatment, discharge, inter-sectorial cooperation, physical surroundings, waiting time and free hospital choice.

The surveys generally show that the patients' overall impression of the hospitalization process is positive. They also identify areas in which the patients see a potential for improvement.

A national reporting system for adverse events was established in 2004. The reporting system aims to collect, analyze and communicate knowledge of adverse events, in order to reduce the number of adverse events in the health care system. Patients and relatives can report adverse events, and all health care professionals are required by law to report any adverse events they become aware of in connection with health care services.

Patients can seek compensation for injuries caused by examination or treatment in hospitals or by authorized health care professionals in private practice through the Patient

Insurance Scheme. According to the Act on the Right to Complain and Receive Compensation within the Health Service, compensation will be granted in the following situations: If it can be assumed that an experienced specialist would have acted differently in the given circumstances, thereby avoiding the injury; if the injury is due to the malfunction or failure of technical instruments; if the injury might have been avoided using another available and just as effective treatment technique or method; or if the injury occurred as the result of examination or treatment in the form of infections or other complications that were more extensive than the patient should reasonably have to endure. Patients may also receive compensation for injuries caused by medicinal products.

### Health outcomes

In an international perspective, health status in Denmark can generally be characterized as good. Surveys show that Danish citizens continue to consider their own health as being good. In a questionnaire survey from 2010, 85 percent of the population perceives their own health status as "excellent" or "very good."

The Danish life expectancy is rising again after a period of stagnation in the '80s. Since the mid '90s, the Danish life expectancy has been improving and at an average of 80.1 years is in line with the OECD average. Life expectancy for women

is 82.1 years, compared with 78.1 for men. Historically high smoking rates and high alcohol consumption are typically blamed for the relatively low life expectancy.

The proportion of regular smokers among adults has shown a marked decline over the past twenty-five years in most OECD countries. In Denmark, the percentage of adults who report to smoke every day has decreased by almost two-thirds, from 46.5 percent in 1985 to 17 percent in 2013.

Smoking rates among adults in Denmark is now slightly below the OECD average (20.9 percent in 2011). At the same time, obesity rates have increased in recent decades in all OECD countries. In Denmark, the obesity rate among adults was 13.4 percent in 2010, up from 9.5 percent in 2000. The average for the OECD countries was 15.0 percent.

The Euro Health Consumer Index (EHCI) ranks 35 national European health care systems on 48 indicators, covering six areas that are essential to health consumers: Patients' rights and information, Accessibility of treatment (waiting times), medical outcomes, range and reach of services provided, and pharmaceuticals and prevention. In 2013 Denmark, was ranked second among the 35 countries. Denmark scores especially high on patient rights, information and range and reach of services provided. Denmark scores relatively low in the prevention and health outcomes subdisciplines.

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## The Twilight of the British Public Health System?

By Adam Gaffney, M.D.

Less than two years after the fall of Nazi Germany, a bankrupt Britain – reeling from the most destructive war in history and living under conditions of stark austerity – elected to create an extraordinary system of universal health care, the National Health Service (NHS). Aneurin Bevan, the Labour Party minister of health who played a crucial role in its creation, famously remarked that the NHS would “last as long as there are folk left with the faith to fight for it.” Subsequent developments, it seems, have put his challenge to the test.

In 2012 David Cameron’s Conservative-led government passed the Health and Social Care Act, legislation that opens the NHS to privatization like never before. Building on a series of neoliberal health care “reforms” dating back to the Thatcher era and coinciding with the dictates of our age of austerity, Cameron’s law could very well mark the beginning of a slow end for the English NHS (the largely autonomous Scottish NHS has been going in a much different direction). To be clear, the law is not meant to privatize the system entirely; after all, caring for a whole population – including its poor, elderly, and chronically ill – is messy, complex, and frequently unprofitable, and so historically uninteresting from a commercial perspective. Instead, the law will allow – indeed, it will require – the competitive “tendering” of health care services to corporate providers, which can then pick off the profitable parts, bit by bit. Its provisions end the fundamental legal requirement that the secretary of state ensure comprehensive care throughout the country. The law encourages NHS facilities to provide uncovered services for cash, while at the same time reductions in funding force cuts in covered services. The law may even ultimately open new opportunities for fees to be charged at the point of service, in direct contradiction of the service’s founding principles.

The Health and Social Care Act, in other words, will not end the NHS. It will fragment and commercialize it, while the demands of austerity will continue to stretch it thin. At some point, though the NHS will continue to exist, we may no longer be able to recognize it.

### I. 1948–1980: “It Is Not a Charity”

Shortly after the NHS went into effect in 1948, a leaflet was distributed to all homes to explain the function and purpose of the new system:

“It will provide you with all medical, dental, and nursing care. Everyone – rich or poor, man, woman or child – can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a charity. You are all paying for it, mainly as taxpayers, and it will relieve your

money worries in times of illness.”

Though its organizational structure may have been considerably complex, such a simple and straightforward summary spoke to the truly radical – and fundamentally universal – nature of the new service.

Its first few years in action revealed the great, unmet medical needs of the country, with the sudden surge in the use of health care resulting in substantial initial over-spending. This precipitated, in the early 1950s, the introduction of fees for medications, eyeglasses, dentures, and eventually all dental treatment. Still, other care remained free at the point of service, and the NHS’s general structure remained largely intact over the next few decades, protected by strong public support and by a consensus between Labour and Conservatives on the importance of the welfare state. Yet at the same time, the NHS was often starved of resources.

The NHS is frequently touted for its success at keeping the cost of health care low, easily beating not only the United States but also most of its continental peers with respect to efficiency. (In 2008, for instance – after a period of historically high spending – the UK was still only spending \$3,129 annually per capita on health care, compared with \$3,737 in Germany, \$4,079 in Canada, and \$7,539 in the United States.) Yet its frugality has time and time again gone too far, and the end of the 1970s – when the United Kingdom was facing anemic growth, marked inflation, and persistent deficits – was one such time.

### II. 1980–1997: “Safe with Us”

By the time Margaret Thatcher came to power, therefore, the NHS was in a state of neglect. What was needed was more attention and more money, on par with that of other industrialized nations. But the modern neoliberal era was just beginning, both in Britain and in the United States; the Thatcherite prescription was, unsurprisingly, a dose of austere market medicine.

Still, she moved slowly on the NHS. In 1982, for instance, Thatcher distanced herself from a leaked internal cabinet think tank report that all but called for gutting the NHS (and the welfare state with it). “It is ... worth considering,” an early version of the report read, “aiming over a period to end the state provision of healthcare for the bulk of the population, so that medical facilities would be privately owned and run, and those seeking healthcare would be required to pay for it.” The public was outraged by the leaked report, and in response Thatcher declared in her 1982 Conservative Party conference speech that the NHS was “safe with us,” an assurance repeated

*At some point, though the NHS will continue to exist, we may no longer be able to recognize it.*

by Conservatives ever since.

It appears, however, that Thatcher and her cabinet may not have been quite as horrified by such bold proposals as they claimed. Indeed, as the Guardian reported on the basis of cabinet documents released last year, Thatcher and her chancellor Sir Geoffrey Howe had actually commissioned and encouraged the report and discussed its recommendations at a special cabinet meeting. Howe, meanwhile, continued to defend the report even after the rest of the cabinet went the other way.

But Thatcher understood that the Conservative stance on the NHS remained an ongoing political liability, so over the decade her administration moved slowly, but surely, in changing the service. Non-clinical hospital activities (like laundry and cleaning) were outsourced to private companies. Fees for dentistry, eye care, and prescriptions were raised again and again. Spending on new facilities was kept low. NHS long-term nursing care facilities were mostly closed, progressively replaced by private facilities. Hospital management was corporatized, with new “chief executives” replacing consensus management and the number (and pay) of business-trained managers throughout the system rising dramatically.

However, Thatcher’s administration is best known for endeavoring to create an “internal market” within the NHS. Based in part on recommendations from the American managed care advocate Alain Enthoven, the reforms were meant to create a pseudo-marketplace within the NHS by splitting the system into “purchasers” and “providers.” The former, composed of health authorities and some general practitioners (GPs), were to “buy” health services “sold” by newly created “trusts” (composed of hospitals and specialists). The system was costly, didn’t produce much in terms of efficiency gains, and was rather unpopular. The GPs, some of whom now functioned as “fundholders” charged with “buying” services for their patients, didn’t seem to particularly like the additional job, while the split between GPs who became fundholders and those who didn’t risked establishing a two-tier system.

The move was, in any event, politically ill-advised, and Labour was quick to capitalize on this. In the 1997 elections they ran directly against the “internal market”: “Our fundamental purpose,” read their manifesto from that year, “is simple but hugely important: to restore the NHS as a public service working cooperatively for patients, not a commercial business driven by competition.”

### III. 1997–2010: “To Restore the NHS”

On this platform, Labour won the 1997 elections by a landslide, gaining the biggest majority held by any government since 1935. Its health care mandate, therefore, could hardly have been clearer. Yet Blair’s “Third Way” would prove in most respects – save one – a continuation of Conservative neoliberal health care policy.

Despite Labour’s fierce election-time criticism of the “internal market,” for example, the division into buyers and sellers was

more or less maintained. Labour also passed legislation in 2003 that allowed NHS hospitals and care groups to apply for “foundation” status, whereby they would no longer be under the direction of the department of health and could essentially function as nonprofit organizations. These “foundation trusts” could then borrow on financial markets, enter into ventures with private companies, and go bankrupt like other corporations. Along similar lines, in 2000 the government signed a “Concordat” with the private sector, promising a closer relationship between the NHS and private providers. Such reforms are evidence of the “essential continuity,” as the historian Charles Webster put it, between Conservative and Labour health care policy.

But with the so-called Private-Finance Initiative (PFI), Labour outdid the market zeal of Conservatives. Under this system, the government allowed consortia of banks, construction companies, and management companies to build and manage public service buildings like hospitals; the “trusts” would then sign long-term leases of these buildings from the private sector. PFIs never really took off under the Conservatives given a lack of investor enthusiasm, and like the “internal market,” PFIs were sharply criticized by Labour during the election year. Once in power, however, the party abruptly reversed course: Blair passed legislation protecting investors from financial risk in hospital PFI deals, and a rush of profitable NHS PFI contracts followed in short order.

The PFI experience ended up proving much more expensive in the long term than traditional hospital construction through public financing. PFIs allowed the rapid construction of new capital stock at low initial cost, presenting a veneer of improvement while funneling NHS dollars into the private sector. By pushing costs decades down the road, however, they left hospital trusts with poisonous obligations, later resulting in cuts in services and requiring government bailouts. In February 2012, for instance, the government bailed out some seven PFI-encumbered NHS trusts to the tune of £1.5 billion. “Labour left some parts of the NHS with a dismal legacy of PFI,” the Conservative health secretary Andrew Lansley rightly (if hypocritically) put it.

One thing, however, that Labour did right was to begin to adequately fund the NHS. Though Labour came into office with a tight budget plan for the NHS, toward the end of the 1990s it began promising a new course. Indeed, the government all but agreed that it would need to lessen the spending gap between it and other industrialized nations: by 2000 NHS spending was growing at nearly twice its historic average rate.

With this increased funding, the NHS was able to make substantial improvements in the quality of care. Polling data from 2010, for instance, revealed that 70 percent of the public was either “very” or “quite” satisfied with the NHS, up from 35 percent when Labour took power in 1997. Cameron’s 2010 Conservative-led coalition government, on the other hand, was less content: two decades of neoliberal reform had not, apparently, gone far enough.

(continued on next page)

#### IV. 2010–2012: “Putting Patients First”

Needless to say, the Conservative-led coalition didn’t come to power on an anti-NHS platform. “We will stop the top-down reorganisations of the NHS,” the coalition government blandly promised, “that have got in the way of patient care.” When the new health secretary Andrew Lansley released his important NHS White Paper in July 2010, many of his declarations – “[making] the NHS more accountable to patients” and “putting patients first” – sounded pretty unobjectionable.

Yet this was no ordinary year. The global financial crisis was in full swing, and anti-Keynesian macroeconomic policy had become the reigning paradigm in Europe. Austerity was the order of the day in the United Kingdom, and the NHS was not spared. In part on the basis of a 2009 McKinsey report that claimed the NHS in England could save between 15 percent and 22 percent in spending over three to five years through improved efficiency alone, hospitals and other health trusts had their funding frozen or cut. Reductions in spending, the government argued, were to come through improved productivity, but in light of the reality of health care inflation and ever-rising demand, such a mandate has been tantamount to a spending squeeze unprecedented in NHS history.

However, it wasn’t until January 19, 2011, that Lansley’s Health and Social Care bill hit Parliament. Totalling some 354 pages, it laid out a radical reconfiguring of the entire NHS and quickly precipitated widespread alarm. The government responded with an unusual “listening pause” so as to (it claimed) hear out the concerns of the public. The honesty of this exercise was called into question by a leaked confidential memo that revealed that the government “drew a red line” under most of the fundamental parts of the bill. The pause ended in June, and the bill returned to Parliament, made its way through the Lords and the Commons, and became law in March 2012. Although there were pockets of resistance, they were insufficiently powerful, united, headstrong, and prompt to derail the law, which was pushed forward by far more powerful political and corporate interests.

#### V. 2012–present: “A Convenient Logistical Base”

The implications of the law took some time to work out, its dense legalese obscuring (for some) what would be its inevitable consequences. And in truth – as the Conservative-led government frequently and fairly argued – many of its provisions were extensions of what had already been initiated (or continued) under Labour governments. A case in point is the new Clinical Commissioning Groups (CCGs) that the law created. The CCGs are led by GPs and are required to “commission” tax-funded health services, a task that dates back to the “internal market.” More novel is the fact that – under new regulations issued under Section 75 of the act – the CCGs will not have the option of preferentially commissioning services from the NHS: they are now legally required to put all services

up for competitive tender, including to corporate providers.

There are several reasons to predict that commercial entities could take over more and more of the provision of care as a result. First, GPs are busy enough with the task of taking care of patients; the complex process of commissioning was, from the outset, going to rely on assistance from outside corporate consulting groups. Second, the motives of some of the GPs involved in commissioning have been called into question. An investigation performed by the British Medical Journal recently revealed that more than a third of GPs on the boards of the CCGs have conflicts of interest arising from involvement in private companies, ranging from directorships of local for-profit health care service companies to stock ownership in large national health care corporations. Third, by exposing the CCGs to the influence of corporate lawyers and to the rules of European Union competition law, the law will further limit the GPs’ ability to slow privatization. CCGs “will think twice before invoking the wrath of one of the large corporations now moving into healthcare,” as an editorial in the BMJ put it. “With legal and contracting teams many times larger than those available to the commissioners, it is they who will be the ultimate arbiters of the shape of healthcare.”

And no doubt, health care corporations – both national and international – are chomping at the bit. A variety of U.S. corporations have, for instance, been buying up international health care services for years. “There has been what seems like blockbuster deal after blockbuster deal,” the UK industry magazine Health Investor reported last year. For these U.S. corporations, the magazine gushed, “the UK also provides a convenient logistical base from which to expand. Setting up offices in a country that speaks the same language, has a respected legal system and isn’t far from mainland Europe provides the ... ideal platform [for expansion].”

Last July the NHS announced that it was embarking on the single largest outsourcing deal in its history, inviting bids for a billion-pound contract to provide health care for the elderly, including end-of-life care. Leading corporate contenders were said to include the Virgin, Circle, and Serco corporations, though the latter was still embroiled in a fiasco relating to data manipulation on the quality of care at one of the general practices it runs.

The point is not that corporate interests can, will, or even want to privatize most or much of the NHS; the concern is that they will poach the choice cuts – the self-contained, profitable services – and then leave the unprofitable care, the catastrophes, the poor patients, and the complications to the nearby NHS. As an article in Health Investor frankly admits, “there are many obvious benefits for patients, consultants and providers of a unit co-located with a major NHS hospital. ... Proximity to Level 2 Intensive Care Units gives greater peace of mind should something go seriously wrong.” It’s hard to imagine a better arrangement – for the company, of course.

The NHS has had significant issues with care quality at times. But under austerity and with the resultant service cuts and hospital closures, the quality of the NHS may very well deteriorate – a situation that commercial interests will be

ready to exploit. One private insurer, for instance, recently blamed some 13,000 deaths on the “tragic consequence of negligence” by the NHS, which it contrasted with its own private health insurance that provides patients with “the peace-of-mind they need for their health.” Private insurers also received a boost by way of another provision of the law: in addition to enabling the creeping commercialization of health care through “competitive tendering,” the law also weakens restrictions on how much private medical treatment can be provided in NHS facilities, allowing “foundation trusts” to make up to 49 percent of their annual revenue in private, non-NHS care. As an analysis by the BMJ revealed last year, NHS hospitals are already offering and marketing more and more private medical services to patients for cash, at the same time that cost cutting has forced them to reduce the availability of NHS services. The emergence of a two-tier system seems almost preordained under such circumstances.

Yet do these changes truly constitute a revolution, or are they simply part of an evolutionary process of privatization that began during the Thatcher years? Allyson Pollock, professor of public health at the University of London, has made a persuasive case for the former. Though the law may further the siphoning of NHS funds into the private sector, she has argued that its largest impact may be elsewhere. By repealing sections 1 and 3 of the NHS Act, the 2012 law ended the duty of the secretary of state to provide comprehensive and equitable health services, allocated on the basis of need, throughout the country. Pollock and her colleagues have concluded that this could endanger one of the most essential, and most treasured, elements of the NHS – free care. Now, it will be up to the individual CCGs to determine which health services will be provided and free, and which will not. “NHS hospitals, built with public money, [are] charging people for treatments that used to be free,” the Labour shadow health secretary Andy Burnham railed at his party’s annual conference, “and [are] still free to people living elsewhere.”

The law, in sum, is both something old and something new. Developments over three decades have moved the NHS – if ever so slowly, unevenly, incompletely, and at times ambiguously – away from the “comprehensive health service” called for by the 1946 act and toward the vision of the 1982 policy memo that even Thatcher had disowned. In the case of undocumented immigrants, in fact, this change has already occurred: in 2011 charges were introduced for prenatal care for immigrants, and in late 2013 charges were instituted for all emergency care. Whether such measures actually succeed in saving money – or whether the revenues are consumed by the administrative apparatus needed to collect and process the fees – remains to be determined. Either way, some of the most vulnerable individuals in English society will now be discouraged from seeking health care.

This transformation must be understood not only in the context of British history, but also against the background of parallel



Andrew Worthington

**Activists and health professionals from the Lewisham branch of the “Keep our NHS Public” campaign were among those who marched in London on Oct. 20, 2012, to resist the privatization drive of the British government and to protest cuts in essential services.**

developments occurring internationally. From this perspective, it seems that the travails of the NHS are but one more instance of a global neoliberal phenomenon (if uneven and incomplete) in health care. The demands of austerity in continental Europe are, for instance, limiting the scope of universal health care in countries ranging from Spain to Greece, raising “user fees” for care at a time when people are less able to pay than ever, while simultaneously furthering the privatization of the health care sector. Spain, just like England, has also moved to restrict the ability of undocumented immigrants to access the health care system. In the United States, meanwhile, the largest health care reform in a generation has critically subsidized the private insurance industry in an effort to stem rising uninsurance, while abetting historic rises in “cost sharing” that may eventually make this nation a “copay country.” The transformation of the NHS, therefore, though in some ways a local problem, is also a part of a much larger dynamic in the global political economy of health care. The challenge of maintaining, improving, and expanding universal health care, it is becoming increasingly clear, must therefore be met on both the national and the international stage.

The NHS – like all health care systems – is, and always has been, imperfect. Yet replacing it with a semi-privatized, commercialized, corporatized, and fragmented body – still funded by general taxation but otherwise a pale reflection of its former self – will only exacerbate its weaknesses, while hollowing out its universal, moral core.

*Adam Gaffney is a physician and writer with a focus on health care politics and history. His last article for Dissent dealt with austerity and health in continental Europe, and he has also written for Salon, In These Times, and Truthout.*

## The urgency for health reform returns

By Andrew D. Coates, M.D., F.A.C.P.

This week New York State of Health, also named The Official Health Plan Marketplace, put out a press release to celebrate a milestone.

“800,333 New Yorkers have completed their applications and 501,205 have enrolled for coverage since the launch of the Marketplace on October 1, 2013,” the statement read, adding, “Seventy percent who have enrolled to date were uninsured at the time of application.”

The press release went on to report that “New York is on track to meet or exceed its enrollment goal of 1.1 million people by the end of 2016.”

The New York State of Health is the state-run insurance exchange established by the Affordable Care Act, President Obama’s signature social reform.

An arm of the state health department, the Marketplace is a public agency. Its public servants help private insurance companies sell their product and help those eligible receive government subsidies toward the cost of the insurance. (The Affordable Care Act also aims to lower the number of uninsured by expanding Medicaid enrollment, thus the exchange also helps identify those who qualify for Medicaid.)

The cost of private health insurance with comprehensive coverage has, for many years in a row, risen much faster than wages. Private health insurance premiums have become simply unaffordable. Recognizing this, the Affordable Care Act did two things.

First, it put in place a system of tax credit subsidies for people not eligible for Medicaid, Medicare or employer-sponsored insurance. For those eligible (for example if your employer doesn’t offer health insurance) and whose incomes are below 400 percent of the poverty level (about \$45,000 in annual income for a single-person household), the Official Health Plan Marketplace is the official way to obtain subsidies toward insurance premiums.

Second, it established minimum coverage at 60 percent of expected costs of care, while planning to tax plans deemed to provide “too much” coverage – for example, truly comprehensive coverage earned through union struggles with large employers.

When people shop for health insurance on the exchanges they can choose among plans that cover 60 percent, 70 percent or 80 percent of anticipated costs. The most affordable premiums come with high deductibles and other large out-of-pocket costs. Because employer-sponsored plans in general covered about 87 percent of expected costs, underinsurance will become the new normal.

The Albany Times Union reported that “Of the total 501,205 people enrolled, the state said 276,681 chose private insurance plans, while 224,524 qualified for coverage under Medicaid,

the government-sponsored health insurance program for low-income Americans.” We should note here that about 150,000 of the 500,000 people who enrolled through the marketplace already had some kind of health insurance.

New York state has about 2,270,000 people who lack health insurance. The goal of the state marketplace is to reduce this to nearly half as many by 2017.

So far, establishing the N.Y. State of Health, The Official Health Plan Marketplace, has cost \$429,065,407. That’s about \$536 per user thus far – or about \$856 per newly insured person.

If the exchanges are something of a rescue plan for an industry peddling an unaffordable product, they come at a significant cost. Curiously, the insurance marketplace idea has become a profoundly bipartisan one. It not only that the Democratic president took the idea from the Republican governor’s health reform. Prominent Republican legislators would like to see vouchers for the purchase of Medicare – on an official insurance marketplace.

Most striking is the fact that selling insurance by itself does little to change our health system. For some individuals obtaining coverage, including Medicaid, will prove to be a godsend.

Yet getting insurance or Medicaid does not guarantee access to necessary or comprehensive care. Not only are our health outcomes mediocre, but the experience of going to the doctor, the emergency room, the hospital is too often undignified.

The Affordable Care Act is reducing the number of uninsured, yet at the end of the day it is not a program of universal access to care. Because the major failings of the U.S. system still persist – avoidable death and bankruptcy, racial and socioeconomic disparities, the perverse incentives of profiteering, burgeoning costs – the urgency for thoroughgoing health reform has returned.



Dr. Andrew Coates

*Dr. Andrew Coates practices internal medicine in Upstate New York. He is president of Physicians for a National Health Program.*

## AMA's student section considers single-payer resolution

*PNHP note: The resolution below was submitted to the American Medical Association's Medical Student Section (AMA-MSS) on April 17 by 61 medical students from 18 schools, primarily from the Northeast and Midwest but with several co-authors in the West. The lead signer was Bradley Zehr of the Boston University School of Medicine. The resolution will be under discussion by AMA-MSS members nationwide in the run-up to the organization's June 5-7 annual meeting in Chicago, where it is expected to be voted upon. In the interest of conserving space, we have removed the resolution's 25 footnotes and other back matter.*

### Resolution on Advocacy for Single-Payer Health Insurance

Whereas, 48 million Americans lacked health insurance in 2012, and an estimated 31 million Americans will remain uninsured in 2024 despite advances made by the Patient Protection and Affordable Care Act; and

Whereas, Underinsurance is expanding as many patients are forced into private health insurance plans with high deductibles (> \$1,000) and narrow provider networks; and

Whereas, 28 million low-income Americans will cross between Medicaid and the subsidized private health insurance exchanges annually, an effect called "churning", which erodes continuity of care; and

Whereas, The United States ranks last out of 19 high-income countries in preventing deaths amenable to medical care before age 75; and

Whereas, The United States ranks last out of 7 wealthy nations in health care access, patient safety, coordination, efficiency, and equity; and

Whereas, The United States spends twice as much per capita on health care compared to the average of wealthy nations that provide universal coverage; and

Whereas, Medicare overhead costs are less than 2%, and private health insurance overhead costs range from 7% to 30%, with an average of 12%;

Whereas, Providers are forced to spend tens of billions more dollars dealing with insurers' billing and documentation requirements, bringing total administrative costs to 31% of U.S. health spending, compared to 16.7% in Canada; and

Whereas, The United States could save more than \$380 billion annually on administrative costs with a single-payer system, enough to cover all of the uninsured and eliminate or dramatically reduce cost-sharing (deductibles, co-payments, co-insurance) for everyone else; and

Whereas, A single-payer Medicare-for-All national health insurance system would fundamentally simplify the financing of health care in the United States; and

Whereas, A single-payer system would cover every American from birth for all necessary medical care and would virtually eliminate health uninsurance and underinsurance in the United States; and

Whereas, A single-payer system would increase patients' freedom to choose among health care providers and not be constrained by arbitrary private insurance networks; and

Whereas, A single-payer system would protect the physician-patient relationship from interference by for-profit health insurance companies whose purpose is to maximize profit; and

Whereas, A single-payer system would facilitate regional health system planning, directing capital funds to build and expand health facilities based on evidence of need, rather than being driven by the dictates of the market, which increases geographical inequality; and

Whereas, Hospitals and clinics could remain private not-for-profit organizations under a government-financed single-payer system, in contrast to the government-operated hospitals of the Veterans Administration; and

Whereas, A single-payer system would control costs through proven-effective mechanisms such as negotiated global budgets for hospitals and negotiated drug prices, thereby making health care financing sustainable; and

Whereas, Support among physicians for government legislation to establish national health insurance increased from 49% in 2002 to 59% in 2007; and

Whereas, Support among the general United States population for a single-payer health care system climbed from 28% in 1979 to 49% in 2009; and

Whereas, There is single-payer legislation in both houses of Congress, H.R. 676 and S. 1782, that outlines the transition to an expanded and improved Medicare for all, including re-training programs for private health insurance workers whose jobs would be lost; and

Whereas, Vermont passed legislation in 2011 to create a "pathway to single-payer" in that state starting in 2017, the soonest allowed under Section 1332 of the Affordable Care Act, and many other state legislatures are considering similar legislation; therefore be it

RESOLVED, That our American Medical Association shall advocate for legislation to implement a single-payer health insurance system.

## Nine Questions About My New Medical Home

By Matthew Anderson, M.D.

Sometime in the past five years – it’s hard for me to say exactly when – I suddenly found myself living in a new home. I must admit I am still a bit disoriented by how this happened. But it did. People keep telling me that everything will be OK but I am not entirely sure.

For example, in my old home we had occasional family meetings; things are different now. We now have weekly (and monthly) meetings. The many new administrators ask us to complete personality surveys. Once we had to figure out what items we should take from a sinking yacht in the South Pacific (hint: the \$100 bill will be useful). Another time we had to decide if we were a “Wow” or a “Thinker.” We are asked to figure out how we can do a better job for them. I guess, like all forms of therapy you don’t get better unless you change.

Despite all these meetings there are a series of things I still don’t understand. I am afraid to raise my hand at the meetings and give the impression I’m a bad sport so I have written my questions down. Please, please don’t think I am a Luddite who wants to go back to the old home. In fact, what I dislike most about the new home is precisely the way – even in its differences – it resembles the old home.

### 1. Is this a home or is it a hostel?

One of the things that drew me to family medicine was the desire to build long-term relationships with families. I went to weddings and graduations; I was asked to be a godfather. I was there when babies were born and came into bedrooms to declare deaths. I could meet my patients on the street. I had families where I cared for five generations. At the time insurance companies didn’t generally dictate to people whom they could or could not choose as their doctors. Patients who liked me stayed and those who didn’t went to other doctors. All of this felt something like a home.

All that has changed now. Pretty much everyone will be on a managed care plan that will limit their choice of providers. If the system runs as intended, decisions about which doctors patients can see will be made every two years by the rational economic decisions of their employers. There will be nothing special anymore about the relationship between the doctor and the patient. As this has been explained to me, it is not really a problem “because you are a member of a team.”

I’ve already lost patients because of this system. And I’ve seen the orphans of other doctors when they come into my practice; they can no longer see their old family doctor because he or she isn’t in their new plan. I console them and then spend time reconstructing their health and social histories. I repeat labs, perhaps even vaccines given by the other physician. It’s hard to see that this makes clinical, emotional, or economic sense. And when will they have to leave my panel?

In a system where physician choice is guided by the commercial interests of employers and insurers, is it really possible to speak of a medical home?

### 2. Will my old friends still be welcome in my new home?

One of the things that most worries me is “Pay for Performance,” or P4P. Mind you, I don’t think it’s wrong to evaluate physician performance, although I wonder if the metrics being used are the right ones. I am not sure, for example, that the skill that best characterizes me is my ability to order flu shots. It’s also not at all clear that paying doctors for hitting targets actually improves any outcomes. Nonetheless, my income will increasingly depend upon hitting targets dictated by the insurance companies. But to be honest, I am not even sure who generates the targets. It isn’t us. And in this patient-centered home, it is not the patients.

P4P is very worrisome. Many of my patients are not necessarily what we, as residents, used to call “citizens.” Many of them have drug histories, some have done time, a good proportion don’t read or write. They are often skeptical of my brand of medicine, and many are struggling with mental illness. Their insurance status is often precarious; even if they wanted to get care, it is often unavailable to them. Experience would suggest that this group will not have excellent clinical outcomes. Are my old friends now going to cost me money?

It wouldn’t be hard to figure out ways to get this group of people off my panel and to get more “citizens” on it. It would make me look good. It would make the clinic look good. And it’s what the rational economic incentives offered me would dictate. Why, then, don’t I want to do it? Is there something wrong with my attitude?

### 3. Does Mommy love me or is she just paid to say so?

Recently a patient asked me if he should get a flu shot or not. I told him I was getting flu shot and that I thought he should too. I thought this was the right answer despite my (ever deepening) skepticism about vaccines and their regulation.

Behind my patient’s question was the implicit assumption that I would be providing him with unbiased, expert advice that was not influenced by commercial considerations. I think he would have felt less sure of my answer had he known that part of my salary depended upon his getting a flu shot. Is it fair for me to have given him any advice on this matter without disclosing my economic interest in the answer? I must admit, sadly, that P4P makes me feel more than ever like a poorly paid pimp for the medical-industrial complex. And I wonder how I will feel the next time I go see my doctor and ask for his or her advice. Should I ask him if he is being paid to get me to do something Aetna has decided is important?

The problem is that once communication is purchased (in secret) it becomes impossible to trust anyone.

#### **4. Why are we playing computer games during family time?**

The moments I used to enjoy most were those when I sat down in front of a patient and we talked. This was the time to enjoy the immense privilege of entering into another person's reality and engaging with it.

The EMR has fundamentally altered this relationship in ways that I am still struggling with. There is much less eye contact with my patients since I am writing on a keyboard, often sitting crosswise to him or her. Sometimes I even have to sit with my back to the patient. The content of the interview is dictated by a series of menus whose logical progression is unclear to me; I can't imagine what my patients conjecture.

Like many large medical systems we have several EMRs and they don't talk to one another. During a typical encounter I am switching back and forth on the computer between software A and software B (perhaps even opening C & D), all the while trying to maintain a conversation with someone in English (or in their own language). It may be just my inability to multi-task and I am sure that someday we will have (one) good EMR. But right now it seems to me that the multiple EMRs are a massive barrier between my patients and me. They feel very unsafe. Wouldn't it have been better to have thoroughly tested these systems first? Or was this another rational, economic decision?

#### **5. Are there any family secrets left?**

In my old home medical information was relatively isolated in a paper chart located in one physical space; I must say I hated running up and down to the chart room and longed for an EMR. But nowadays when I type something into the computer literally thousands of people across the medical center can access it. My notes are sent to insurance companies to provide verification of need. The pharmaceutical companies mine (and have mined) all our prescription data. They know more about what I have prescribed than our EMR does.

I think about this when I go to visit my own doctor who belongs to a different hospital. How many people – either strangers or acquaintances – will now be able to read everything I have told him? It has made me circumspect. Paper charts are so 20th century, but I do wish that there were real protections for patient information including my own. Remember that your colleague or clinic supervisor can – with a few strokes of their fingers – open your EMR. Wouldn't it have been better to discuss this matter thoroughly first? Or is private patient data just one more commodity to be bought and sold by billion-dollar corporations?

#### **6. Everyone tells me how important I am, so why is my allowance being cut?**

This is the part that puzzles me the most. At a recent Grand Rounds we were told that everyone thought primary care providers were the backbone of the health care system.

President Obama said so. Orin Hatch said so. The ACA said so. The Republicans said so. Even IBM loves family doctors and IBM points out that they are buying the care so they should be able to get what they want.

Yet when I look at my paycheck now it is less today – in real terms – than it was when I was hired in 1995. I worked hard in 1995 and I work hard now. I regularly work two or more weeks without a day off. This is the life I love, but I can easily understand why medical students would decide upon a different career. They see how hard we family doctors work, they hear about our salaries, and they are socialized in a medical culture that values technical expertise and knowing more and more about less and less. It almost seems like all this talk about the importance of primary care is just that: happy talk designed to keep us working. I suspect medical students are smart enough to figure this out and continue to avoid our specialty.

We are not flourishing as a specialty and our leadership is far too busy talking about the promised land of the PCMH.

#### **7. Do I have to go to Church now?**

One of the things I like best about medicine is that – despite its very imperfect realization – medicine aspires to be a scientific pursuit based on evidence. But the current crop of Administrators (MDs freshly minted with their MBAs or a course at Harvard Business School) subscribe to a different religion: the compelling anecdote dressed up as a case study. Advanced Access came to our clinic five years ago on the basis of a case study series in JAMA. Would we give a new hypertensive drug based on a case series? Why are management decisions not held to the same level of careful scrutiny we give to clinical interventions? Why are we told that P4P will be implemented despite the lack of good evidence “because insurers are paying for it”?

I see that same problem in the enthusiastic and relentless pursuit of better patient satisfaction scores. Patients are constantly reminded that “we strive for five” and managers are rewarded when satisfaction scores are high. This passes for good administrative practice or even as hardheaded business thinking. But basic research principles tell us that if you want an honest answer to a question you don't begin by suggesting the responses. What would we think of a clinical trial where the Principal Investigator met weekly with his or her evaluation team to review blood pressure readings and told them that he wanted better results? Or where the PI offered money to the research team that could produce the best results? We would consider such behavior highly unethical. Why? Because research strives to produce honest results, not those that favor the hypothesis of the investigator.

When Administrators tell staff to tell patients that we strive for five, what are they doing? Both being dishonest and biasing the results to serve their own interests. This is not science; this is hucksterism.

Of course, it is not really the administrators' fault. They are good people. I like the place I work because there are so many good people there. The problem doesn't lie with the people, it lies with the system.

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## Apprehensive, Many Doctors Shift to Jobs With Salaries

By Elisabeth Rosenthal

American physicians, worried about changes in the health care market, are streaming into salaried jobs with hospitals. Though the shift from private practice has been most pronounced in primary care, specialists are following.

Last year, 64 percent of job offers filled through Merritt Hawkins, one of the nation's leading physician placement firms, involved hospital employment, compared with only 11 percent in 2004. The firm anticipates a rise to 75 percent in the next two years.

Today, about 60 percent of family doctors and pediatricians, 50 percent of surgeons and 25 percent of surgical subspecialists – such as ophthalmologists and ear, nose and throat surgeons – are employees rather than independent, according to the American Medical Association. “We’re seeing it changing fast,” said Mark E. Smith, president of Merritt Hawkins.

Health economists are nearly unanimous that the United States should move away from fee-for-service payments to doctors, the traditional system where private physicians are paid for each procedure and test, because it drives up the nation's \$2.7 trillion health care bill by rewarding overuse. But experts caution that the change from private practice to salaried jobs may not yield better or cheaper care for patients

“In many places, the trend will almost certainly lead to more expensive care in the short run,” said Robert Mechanic, an economist who studies health care at Brandeis University's Heller School for Social Policy and Management.

When hospitals gather the right mix of salaried front-line

doctors and specialists under one roof, it can yield cost-efficient and coordinated patient care. The Kaiser system in California and Intermountain Healthcare in Utah are considered models for how this can work.

But many of the new salaried arrangements have evolved from hospitals looking for new revenues, and could have the opposite effect. For example, when doctors' practices are bought by a hospital, a colonoscopy or stress test performed in the office can suddenly cost far more because a hospital “facility fee” is tacked on. Likewise, Mr. Smith said, many doctors on salary are offered bonuses tied to how much billing they generate, which could encourage physicians to order more X-rays and tests.

Mr. Mechanic studied 21 health systems considered good models of care – including the Mayo Clinic and the Palo Alto Medical Foundation – and discovered that many still effectively rewarded doctors for each procedure. “It doesn't make any sense,” he said.

Hospitals have been offering physicians attractive employment deals, with incomes often greater than in private practice, since they need to form networks to take advantage of incentives under the new Affordable Care Act. Hospitals also know that doctors they employ can better direct patients to hospital-owned labs and services.

“From the hospital end there's a big feeding frenzy, a lot of bidding going on to bring in doctors,” Mr. Mechanic said. “And physicians are going in so they don't have to worry – there's a lot of uncertainty about how health reform is going to play out.”

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*(Anderson, continued from previous page)*

### 8. Can we get some family therapy?

We are told that the new home is “patient centered.” But what does that mean? Patients certainly weren't involved in setting it up, nor are they involved in its management. The main way they can provide feedback is via surveys, but these surveys are conducted in a way that biases results. Indeed, by almost any measure the patient seems to be the last one taken into consideration.

### 9. Can't we afford a better home?

It may sound like I am a bit homesick but this is not true. In fact, I am concerned that the new medical home has all the defects of the old home: balkanization of information, over-reliance on

technology, medicalization, disrupted care, waste, inefficiency, values that favor the privileged, the rigid hierarchies that keep people from working well together, inattention to the needs of patients – except now it's all electric. It's like giving steroids to someone on acne. The problems just get uglier.

There was a time when family medicine saw itself as a counter-culture in medicine with a mission to incorporate a different set of values. Our job should be to improve the well-being and health of our patients and their communities, not the bottom line of the corporations who thrive off our labor.

Such a dream will not happen until health care is seen as a public good instead of a private commodity. A national health system, it seems, is the only economically rational and humane way forward.

*Matthew Anderson practices family medicine in New York City.*

(Rosenthal, continued from previous page)

In addition, Medicare had reduced its set doctors' fees over the last decade, while insurers have become more aggressive in demanding lower rates from individual practices that have little clout to resist. Dr. Robert Morrow, a family doctor in the Bronx, said he now received \$82 from Medicare for an office visit but only about \$45 from commercial insurers.

Dr. Cathleen London practiced family medicine for 13 years outside Boston, but recently took a salaried job at a Manhattan hospital. She said she accepted a pay cut because she could see that she was losing ground in her practice. "I think the days of what I did in 1999 are over," she said. "I don't think that's possible anymore."

The base salaries of physicians who become employees are still related to the income they can generate, ranging from under \$200,000 for primary care doctors to \$575,000 in cardiology to \$663,000 in neurosurgery, according to Becker's Hospital Review, a trade publication.

Because of the relatively low salaries for primary care doctors, Dr. Suzanne Salamon said that for the last two years she has had trouble filling a prestigious Harvard geriatrics fellowship she runs.

Dr. Howard B. Beckman, a geriatrician at the University of Rochester, who studies physician payment incentives, said reimbursements for primary care doctors must be improved to attract more people into the field. "To get the kinds of doctors we want, the system for determining salaries has to flip faster," he said.

Doctors can become employees by practicing in a hospital building, or by selling their multispecialty practice to a hospital, so their office becomes part of a network. That has attracted specialists, including many cardiologists who took up such offers several years ago after Medicare reduced physician payments for cardiac procedures like the placement of stents to hold open clogged arteries. The fraction of cardiologists employed by hospitals rose to 35 percent in 2012, up from 11 percent just five years earlier, according to the American College of Cardiology.

Dr. Joel Jacowitz, a cardiologist in New Jersey, and his 20 or so partners decided to sell their private practice to a hospital. In addition to receiving salaries, that meant they no longer had to worry about paying malpractice premiums themselves or finding health insurance for their staff members.

Dr. Jacowitz said that the economics drove the choice and that the only other option would have been to bring in more revenue by practicing bad medicine – ordering more heart tests on patients who did not need them or charging exorbitant rates to people with private insurance. He said he knew of one cardiologist in private practice who charges more than \$100,000 for a procedure for which Medicare pays about \$750.

"Some people are operators and give the rest of us a bad name," he said, adding that he had changed his opinion about America's fee-for-service health care system. "I'm fed up – I want a single-payer system."

Dr. Kirk Moon, a radiologist in private practice in San Francisco, also sees advantages for the nation when doctors

become employees. "I think it's pretty clear that sooner or later we're all going to be on salary," he said. "I think there'll be a radical decrease in imaging, but that's O.K. because there's incredible waste in the current system."

Various efforts to change incentives for doctors and hospitals are being tested. An increasing number of employers or insurers, for example, pay health systems a yearly all-inclusive payment for each patient, regardless of their medical needs or how many tests are dispensed. If doctors order unnecessary tests, it costs the hospital money, rather than bringing it in.

And instead of offering bonuses for productivity – doctors cite pressures from hospital employers to order physical therapy for every discharged patient or follow-up M.R.I. scans on every patient who got an X-ray – some hospital systems are beginning to change their criteria. They are providing bonuses that reward

doctors for delivering high quality and cost effective care, such as high marks from patients or low numbers of patients with asthma who are admitted to the hospital.

"The question now is how to shift the compensation from a focus on volume to a focus on quality," said Mr. Smith of Merritt Hawkins. He said that 35 percent of the jobs he recruits for currently have

such incentives, "but it's pennies, not enough to really influence behavior."

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## Why are physicians becoming hospital employees?

By Don McCanne, M.D.

*PNHP note: Dr. McCanne, PNHP's senior health policy fellow, wrote the following commentary on the article above at his "Quote of the Day" listserv and blog on Feb. 17. You can subscribe to his regular messages about current health policy matters at [www.pnhp.org/qotd](http://www.pnhp.org/qotd).*

Follow the money. Hospitals consolidate to increase market power, moving more patients into higher priced hospital out-patient services. Doctors have joined hospitals because "economics drove the choice." Current national policies encourage physicians and hospitals to organize in order to provide "accountability," but this oligopolistic power grab results in "accountability" that only their chief financial officers would admire, certainly not the people who pay the medical bills.

Under a well-designed single-payer system, excess spending would diminish by improving pricing and by reducing incentives to use worthless or harmful health care services. Many physicians have grown weary of having to attend to the business side of their practices when what they really want is simply to take care of their patients.

More and more physicians will be echoing the words of Dr. Jacowitz, "I'm fed up — I want a single-payer system." When the patients start repeating those words, the politicians will have to follow.

## With Hippocratic Oath, doctors pledge allegiance to patients, not profits

By Philip Caper, M.D.

The Maine Medical Association recently updated a 2008 poll of their members that asked the question, “When considering the topic of health care reform, would you prefer to make improvements in the current public/private system (or) a single-payer system, such as a ‘Medicare-for-all’ approach?” In 2008, 52.3 percent favored the Medicare-for-all approach. In the updated poll, released last week, that number had risen to 64.3 percent.

It’s pretty unusual for two-thirds of a group of doctors to agree on something as controversial as a single-payer health care system. Until recently, doctors formed the core resistance to “government-run” health insurance in the U.S.

A number of factors account for this impressive change, but the huge administrative burden on practicing physicians created by our plethora of private insurance schemes is certainly near the top of the list.

The other day, I spoke with a Maine physician nearing retirement and looking forward to it. She was recently returning home after a long day in her practice, carrying her “homework,” a pile of administrative paperwork several inches high. Her husband asked her how she got so far behind in her paperwork. “I wasn’t behind at all,” she replied. She did this much paperwork, mostly insurance forms, at least twice a week.

American physicians spend at least three times as much time, money and effort on administrative work related to payment and insurance coverage as our Canadian brethren, with their single-payer system. Administrative hassle is a major factor driving more and more American doctors to sell our practices to large corporations that take care of the back-office work. The Affordable Care Act has only added to that burden. Sixty percent of doctors now work for corporations, and that number is growing.

Working for a corporate provider of health care services is a mixed bag. He who pays the piper calls the tune. As both for-profit and nonprofit health care corporations have become increasingly focused on the bottom line, doctors working for them have come under increasingly subtle and not-so-subtle pressures to generate revenue for their employers.

Some tests and procedures are more profitable than others. Increasingly, doctors’ “productivity” is measured by the amount of profitable revenue we produce rather than by the results we get for our patients. But in health care, profitability is a very unreliable measure of value because doctors’ fees and other health care prices are often set arbitrarily.

When we graduate from medical school, most of us take the Hippocratic Oath, swearing our primary allegiance to our patients. Young doctors tend to take their oath very seriously.

Most doctors truly want to do what’s best for patients, not their insurance company or our employers’ bottom line.

But in today’s corporatized and increasingly monetized health care environment, the demands for generation of profit often directly conflict with our clinical judgment. The belief that doctors and other healers act as stewards for our patients’ welfare has long earned us a special place

in society and the trust of our patients. That position and that trust, so critical to healing, is now threatened.

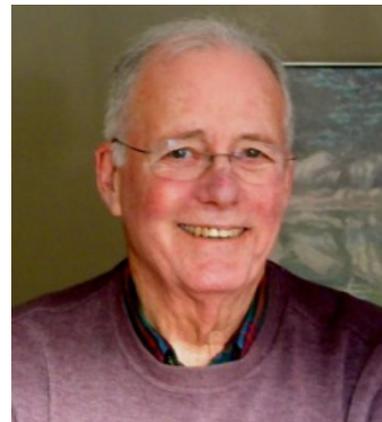
This conflict has made many doctors very angry. Practicing a profession that has traditionally been a calling has become a business. Doctors today are caught in a system corrupted by an excessive focus on money that is forcing us to behave in ways that conflict with our professional ethics. We are growing very tired of being told how to practice medicine by insurance company bureaucrats and corporate MBAs.

This is another major cause of the burnout experienced by increasing numbers of doctors. Many older doctors are now simply looking for a way out. Others are calling for systemwide reforms that will allow them to return to focusing on the welfare of their patients. Hence the results of the recent MMA poll.

In an excellent new book called “What Matters In Medicine,” longtime Maine family doctor David Loxterkamp points out that medical care, while often using scientific jargon, methods and tools, is at its core a profession about relationships, not profits. That’s something the bean-counters and policy wonks who have become increasingly influential in determining the nature of our corporatized health care system seem unable to understand.

It’s time to remove corporate profit from the financing of health care, and perverse financial incentives from the direct provision of services. It’s time for improved Medicare-for-all.

*Physician Philip Caper of Brooklin is a founding board member of Maine AllCare, a nonpartisan, nonprofit group committed to making health care in Maine universal, accessible and affordable for all.*



**Dr. Philip Caper**

## The 'No Free Health Care' Tax

We all pay when the 'undeserving' have to grovel for treatment

By Philip Caper, M.D.

How much tax would you be willing to pay to make sure somebody who can't afford health care has to grovel to get it?

I have watched the fight about whether to expand Maine's Medicaid program (sometimes referred to as "welfare") going on in Augusta during the past year or so with increasing bewilderment. Many Mainers, including Gov. LePage, seem to be really angry at the idea that "those people" (you know who they are) may get something they don't "deserve" at taxpayer expense. Yet these angry people seem unwilling to take the step that would really save money by just letting those who can't pay for medical care die.

Why? I suspect it's because the overwhelming majority of us still value human life. But they don't seem to mind making "undeserving welfare takers" grovel.

We all end up paying the bill for their care one way or another anyway, in higher health insurance premiums and hospital and doctors' charges. That bill is much higher than it needs to be.

Adding it all up, the price of unnecessary administration, avoidable illness, and lack of more effective control of costs that are avoided in the Medicare-for-all-like systems in other countries easily amount to 20 percent of our total health-care spending.

Many people are unwilling to believe you can cover everybody for less than the cost of covering just some, and probably can't be persuaded otherwise. But it's still worth trying.

Deciding who is or is not "worthy" of dignified health care turns out to be very expensive. It's been persuasively shown in dozens of other countries that it costs far less to cover everybody than to spend lots of money, energy and political capital deciding who the "undeserving" are, and then figuring out how not to cover them.

For example, doctors in Maine, required to deal with scores of health insurance plans, spend about three times as much on administration as Canadian doctors with their much simpler single-payer financing system.

Hospitals spend even more, requiring large billing departments, often with hundreds of employees. Insurance companies have large underwriting departments in order to create dozens or hundreds of "risk pools."

Credible estimates of the money wasted on such unnecessary administration run to about \$1,500 per year for every person in the state.

Then there's the cost of avoidable illness. It's a well-known fact that people without health insurance often delay seeing a doctor if they think they can't afford it. This results in many delayed diagnoses that then end up requiring treatments that are far more difficult and expensive than need be.

Uninsured people tend to use emergency rooms that do their best to stabilize patients, but cannot prevent illnesses and injuries from happening in the first place and are not required or equipped to provide adequate follow-up care. Such pent-up demand is most likely what underlies the recent finding that the use of ERs surged among newly insured Medicaid enrollees, who are less likely to have a regular doctor. I expect that it will level off as they begin to receive regular care.

A single pool of funds is much easier to control than our current fragmented system of financing health care. Constraining the flow of money into our current system is like trying to control the flow of a river by building a dam in its delta rather than upstream.

As governments and employers try to restrain their payments into the health-care system, the latest rivulet to expand is direct out-of-pocket payments (co-pays and deductibles) by patients. They too will soon become a flood.

Out-of-control health care costs are eroding our ability to do lots of other important things in both public and private sectors. The complexity of the Affordable Care Act will only make these unnecessary administrative costs grow even more. The tax just went up.

Is it really worth \$1,500 every year and rising – to you and every member of your family – to make sure some "undeserving" person doesn't get "free" medical care?

That's something worth thinking about.

*Physician Philip Caper of Brooklin is a founding board member of Maine AllCare, a nonpartisan, nonprofit group committed to making health care in Maine universal, accessible and affordable for all.*

## Sunday Dialogue: Medicine as a Business

*Dr. Howard Corwin's letter to the editor of the New York Times on how the drive to increase profits has compromised doctors' ethics and their treatment of patients prompted several responses. Dr. Corwin's original letter, two of the responses, including one by the former editor of the New England Journal of Medicine, Dr. Arnold Relman, and Dr. Corwin's response are below. The full selection of responses is posted online.*

To the Editor:

Recent accusations against the for-profit hospital chain Health Management Associates ("Hospital Chain Said to Scheme to Inflate Bills," front page, Jan. 24), including that it put pressure on doctors to admit patients to increase profits, demonstrate the destructive power of the corporatization of medicine on the practice of medicine. The ethical base is lost when businesspeople take over and destroy the traditions of medical practice. Hospital Corporation of America, the nation's largest for-profit hospital chain, is under investigation for similar practices.

Leaders of corporate America care little about the credo that established medicine as a noble profession, operated not for profitability but for the good of the patients. Sadly, doctors within the corporate system who have opposed fraudulent and illegal practices designed to maximize profitability are punished and terminated. Meanwhile, the white-collar criminal behavior of corporate executives is not adequately punished.

Such practices have a corrosive effect on independent doctors as well. This leads many to game the system and find loopholes to maximize profits. Costs soar. Hospitals and medical schools are often complicit.

Many decent doctors deplore the changes in health care delivery systems that foster such abuses. But I find it hard to be heard when I speak of accountability. I call on our current and next generation of medical school graduates to have the vision and courage to take back the leadership of medicine and restore its right to be considered a noble profession.

HOWARD A. CORWIN

Naples, Fla., Feb. 3, 2014

*The writer was a clinical professor of psychiatry at Tufts University School of Medicine.*

### Readers React

As a physician myself, I have often shared Dr. Corwin's lament. But on further reflection I can no longer blame either the corporations or the profession itself.

First, we as a society have decided that medicine and capitalism are a suitable match. We have done so despite the fact that almost no other developed nation considers this a way to dispense

health care. Doctors have been not so subtly influenced to make decisions that do no harm, but also maximize income.

Second, when physicians have banded together to form corporate entities or hospitals, they have eventually found themselves out of their depth. None of us learn anything about managing a business in medical school. Enter the management consultant, accompanied by his band of trusted executives with large salaries and a new vocabulary. They have sometimes provided good advice, but unlike the physicians they put profits first and patients next.

Asking new graduates to take back medicine is not the solution. Instead, we must open up a debate in America about whether we consider health care a basic right rather than a commodity. If so, then we must move toward some sort of universal single-payer system.

If not, we should resign ourselves to further encroachment by the corporations and invite the executives into bedside rounds each morning.

PRAMEET SINGH

Bronxville, N.Y., Feb. 5, 2014

*The writer is a psychiatrist.*

What needs to be added to Dr. Corwin's grim but accurate description of the commercialization of our health system is that physicians have compounded the problem by choosing in large numbers to become employees of hospitals. Hospitals, whether for profit or nonprofit, usually behave like business corporations seeking more income. To this end, they expect help from their physician-employees in referring patients and ordering hospital services.

This corruption of the independent professional practice of medicine could be avoided if physicians chose to join nonprofit doctor-managed groups, and with their patients actively supported the kind of basic reform advocated by Physicians for a National Health Program.

ARNOLD S. RELMAN

Cambridge, Mass., Feb. 5, 2014

*The writer is professor emeritus of medicine at Harvard Medical School and former editor in chief of The New England Journal of Medicine.*

### The Writer Responds

The heart of the doctor is the soul of medicine. Historically the doctor-patient relationship has earned medicine recognition as a noble profession. Corporatization keeps doctors from practicing that time-honored tradition. It is demoralizing to the

*(continued on next page)*

## Doctor favors a single-payer health care system

By Ed Weisbart, M.D.

I am a proudly patriotic, fiscally prudent, family physician. For those three reasons, I support a national health insurance program.

Patriots like me prefer to think that America leads the world. Unfortunately, statistics show that we lag far behind in health care. Our diabetics are more likely to get an amputation, our maternal and infant mortality rates are among the worst, and our life expectancy ranks 51st in the world.

We have many of the world's best doctors and hospitals. So how do we explain our poor health outcomes?

It's our deeply flawed way of paying for care.

We should demand an explanation for why we continue to spend double any other nation per person on health care, despite our dreadful results.

Nearly two-thirds of that spending comes from our tax dollars. Our public funds for health care are already higher than the total health spending in any other nation. We're paying more than enough for universal comprehensive health care, but we're not getting it.

Even more striking, 31 percent of what we spend on health care has nothing to do with actual care. That 31 percent goes to the paperwork and administration inherent in an insurance model designed to be confusing to patients and profitable for big insurance companies.

In contrast, all other nations spend less than 10 percent on overhead. Our own Medicare program has overhead of roughly 2-5 percent.

Thirty-one percent. That means that of my \$1,300 monthly premium, \$403 dollars is squandered every month just to prop up the bureaucracy inflicted on us by the health insurance industry.

As a practicing physician, I see the ravages of living with inadequate insurance. I've seen my diabetics take their insulin every other day, my hypertensives choosing between prescription and eviction, and my 64-year-old stroke patients choosing to wait until they turn 65, get Medicare, and can afford

what they need to stay alive.

This is not the United States I was brought up to believe in.

Yes, we have emergency rooms as a last resort. But patients often defer or forgo care, sometimes with fatal consequences. Further, by limiting universal access to the ER means that we pay the \$48,000 average cost of a stroke, but we refuse to pay for a \$4 bottle of pills to prevent that stroke. This is both terrible health care and fiscal imprudence. It is inconsistent with our nation's alleged culture of life.

The good news is that there is a solution, hiding in plain sight. Most seniors love their Medicare program, despite its limitations. Many seniors purchase a wrap or supplement to fill Medicare's gaps. We could simply embed those supplements into the Medicare program and provide that to all Americans, not just seniors.

Every serious economic analysis shows that the savings from an "improved Medicare for all," otherwise known as single-payer national health insurance, would more than outstrip its new expenses.

By slashing the administrative waste and redirecting that money to care, and by eliminating premiums, copays and deductibles, 95 percent of Americans would spend less, not more, on health care.

For businesses, these savings would spill over into reductions in workers comp, liability, and even auto insurance. Such a system would also provide more predictable future costs.

Only through a single-payer model can we establish a business case for improving the health of all Americans. With everyone (including Congress) in the same program, we would reap the benefits of timely, effective care, treating hypertension and diabetes rather than continually courting preventable medical disasters.

What are we waiting for?

*Ed Weisbart, M.D., is chair of the Missouri chapter of Physicians for a National Health Program.*

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*(Corwin, continued from previous page)*

profession and unsatisfactory for the patients.

I agree with Dr. Singh that America must decide if health care is a basic right rather than a corporate commodity. Dr. Relman decries commercialization in both for profit and nonprofit settings and advocates for single-payer health insurance.

Most doctors believe that receiving adequate medical care should be a human right. Medicine was not meant to be corporatized on a profit-and-loss balance sheet. Capitalism is right for many fields, but not for medicine.

The next generation of sophisticated and caring doctors will

have multidisciplinary skills and perspectives that include training in economics, business, public health and public policy. They can be the engine of change and take back medicine from business domination. Their vision, courage and idealism can lead us to well-managed, government-sponsored, single-payer universal health care. Doctors long to return to a system that understands and values doctors and patients, and a code of ethics that ennobles, not degrades, their calling.

HOWARD A. CORWIN  
Naples, Fla., Feb. 6, 2014

## As Vermont Goes, So Goes the Nation?

By Molly Worthen

When most liberals hear the words “third party,” they have nasty flashbacks to Ralph Nader’s spoiler campaign in 2000. The history buffs among them might think of the populist Greenback Party’s feckless protests against the gold standard in the 19th century or the five presidential campaigns of the Socialist Eugene V. Debs – the last of which, in 1920, he ran from prison.

Third parties seem out of touch with reality, the refuge of idealists with dreams too fragile for the trenches of major party politics. But Democratic skeptics, at least, shouldn’t be too quick to judge. One state is now on the way to single-payer health care, and a third party deserves much of the credit.

Three years ago, Peter Shumlin, the governor of Vermont, signed a bill creating Green Mountain Care: a single-payer system in which, if all goes according to plan, the state will regulate doctors’ fees and cover Vermonters’ medical bills. Mr. Shumlin is a Democrat, and the bill’s passage is a credit to his party. Yet a small upstart spent years building support for reform and nudging the Democrats left: the Vermont Progressive Party. The Progressives owe much of their success to the oddities of Vermont politics. But their example offers hope that the most frustrating dimensions of our political culture can change, despite obstacles with deep roots in American history.

Green Mountain Care won’t begin until at least 2017, but Vermont liberals are optimistic. “Americans want to see a model that works,” Senator Bernie Sanders told *The Atlantic* in December. (Mr. Sanders is an independent, but a longtime ally of the Progressives.) “If Vermont can be that model it will have a profound impact on discourse in this country.”

Before you dismiss that prospect as wishful thinking, consider: That’s how national health care happened in Canada. A third party’s provincial experiment paved the way for national reform. In 1946, the social-democratic government of Saskatchewan passed a law providing free hospital care to most residents. The model spread to other provinces, and in 1957 the federal government adopted a cost-sharing measure that evolved into today’s universal single-payer system.

It seems natural that America’s experiment in Canadian-style health care should begin in Vermont, a state with a long history of cross-border contact. In Derby Line, Vt., the border runs through the town library. Decades ago, pregnant women from Quebec often drove to Vermont to give birth, preferring American hospitals. Not anymore. When it comes to health care, two countries that share so much have diverged profoundly.

Between 1870 and the Great Depression, Americans and Canadians both worried about the growing gap between the mega-rich and the poor. Their disillusionment fueled the rise of dissenting parties. In Canada, the most successful of these, the social-democratic Cooperative Commonwealth Federation, won control of Saskatchewan in 1944. Canada never passed

reforms to match the New Deal, and the C.C.F. capitalized on voters’ frustration with the federal government’s inaction – just as liberals in Vermont are now doing.

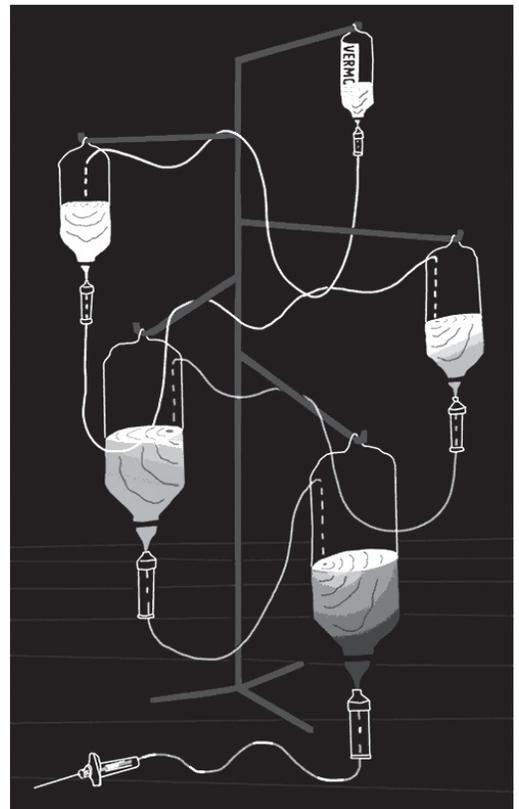
It’s risky to compare 1940s Saskatchewan to Vermont today, but “Vermont has some of the features that Saskatchewan had in the 1940s and 1950s. It’s a rural state in which voices from the left have been more legitimate

than in other parts of the country,” said Antonia Maioni, a professor of political science at McGill University in Montreal. “Saskatchewan was the last place where you would have expected to have this bold innovation. It was the poorest, most rural, most sparsely populated province. And yet it was the mouse that roared.”

The Vermont Progressives have only eight seats in the State Legislature, but they played a decisive role in the 2010 gubernatorial election. They promised not to play spoiler if the Democratic candidate supported single-payer health care. “Shumlin was very clear on his stance, and it pulled him through a narrow primary – a lot of Progressives were volunteers on that – and then he narrowly won,” Chris Pearson, a Progressive state representative from Burlington, told me. “He kept his promise.”

What explains the success of the Progressive Party? Vermont is small, and “it was expected that I’d knock on every door in my district,” Mr. Pearson said. “Progressives are dedicated to that style of campaigning. It’s also affordable. You can run a House race for \$5,000.”

Despite their urban origins in Burlington, the Progressives have won crucial support from rural, traditionally conservative parts of the state, where lifelong Republicans have responded



Alexander Glandien

to the same argument that the Populists once used: Without regulation and a public safety net, capitalism will grind the independent farmer into the ground.

The trouble is that the Progressives have no national colleagues pressuring President Obama from the left. The Saskatchewan social democrats and their national successor, the New Democratic Party, forced the ruling Liberals to move left in the 1950s and 1960s as other provincial governments came to favor national reform.

American third parties face many obstacles in national elections, not least financial disadvantages and the ability of the major parties to co-opt dissenters by forming factions (in Canada, rules requiring tight party discipline mean insurgents like the Tea Partiers would probably have to form their own organizations).

But there is a deeper ideological reason. Canada inherited something else from Britain besides the Westminster system. It retained the full spectrum of English politics. This includes the socialist left and the Tory right – both traditions that, despite their differences, call for a strong central government and the restraint of individual liberty in the interest of the community.

The United States, by contrast, is a revolutionary state. The founders feared both kingly tyranny and the rule of the mob, and they bequeathed to us a political spectrum that is the narrowest in the Western world. With few exceptions, even left-wing dissenters have preached some version of free market ideology. The Vermont Progressives' promise to "promote cooperative, worker-owned and publicly owned enterprises" is a far cry from Debs's demand that "the capitalist system must be overthrown."

***Green Mountain Care won't begin until at least 2017, but Vermont liberals are optimistic. "Americans want to see a model that works," Senator Bernie Sanders told The Atlantic in December. "If Vermont can be that model it will have a profound impact on discourse in this country."***

In times of crisis – during the Civil War, the Great Depression and World War II – Americans have tolerated a radical expansion of the role of government. Harry Truman tried to seize the moment in 1945 by pushing for universal health care, only to be stymied by conservative opponents and the American Medical Association.

American doctors succeeded where Canadian doctors failed (despite multiple doctors' strikes) because the American political system left individual politicians vulnerable to lobbying. They capitalized on the rhetoric of the Cold War, insisting that "socialized medicine" was one step short of Soviet tyranny. There is also no denying the ugly role that race played in this story: Too many

white Americans have rejected reforms for fear that their tax dollars would help black Americans.

Yet the main lesson that Americans can learn from Canada is that political cultures can change. In 1950 Canada was, in many respects, a more conservative country than America, and each step of reform was hard-won. But as Canadians watched new policies produce results, skeptics became supporters. "Many policies that emerged in postwar Canada have changed Canadians' conception of their relationship to the state," Professor Maioni told me. "Policies feed political culture." If the Vermont experiment works, other states will follow. American pragmatism will trump ideology.

*Molly Worthen is an assistant professor of history at the University of North Carolina, Chapel Hill, and the author, most recently, of "Apostles of Reason: The Crisis of Authority in American Evangelicalism."*

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## Michigan State Medical Society authorizes single-payer study

*The following resolution was adopted by the House of Delegates of the Michigan State Medical Society at its meeting on April 27. It was written by Larry R. Junck, M.D., and introduced by Dr. Junck, Fred W. Whitehouse, M.D., and Mildred J. Willy, M.D.*

### Single-Payer National Health Insurance: MSMS Board Review

Whereas, the Affordable Care Act (ACA) has significant limitations including incomplete coverage of the population, complex bureaucracy, individual mandate, and allowable overhead within plans of 15-20 percent, and

Whereas, Medicare receives high satisfaction ratings from patients and, when adequately funded, is a model for an efficient single-payer system with low overhead of 1-3 percent, and

Whereas, nearly all advanced countries have a well-functioning single-payer system that is embraced by their citizens, and

Whereas, a single-payer system has advantages to medical

practices including simplicity of billing and administration, and Whereas, a single-payer system can help American businesses to be more competitive by eliminating their involvement in paying for health care for their employees, and

Whereas, a single-payer system provides the opportunity to improve medical care according to themes of the MSMS Future of Medicine report, including "Universal Coverage," "Prevention and wellness," and "Partnering with patients"; therefore be it

RESOLVED: That the MSMS Board of Directors investigate supporting the adoption of a single-payer financing mechanism for health insurance that does not impede the choice of physician or other provider, and that the Board report back to the MSMS House of Delegates in 2015 regarding its investigation.

WAYS AND MEANS COMMITTEE FISCAL NOTE: \$50,000 for a health care consulting firm to research, analyze and write a report.

## The unfinished work of health care for all

By Rita Valenti, R.N.

ATLANTA – A lot of people are tangled up defending the indefensible mess of the Affordable Care Act, also known as “Obamacare,” and its rollout.

Behind the frustrations stemming from the technical problems that inevitably come with enshrining the commodification of health care lies a deep-seated, popular hope for real access to quality, comprehensive and compassionate health care.

It is that vision of what is now possible, free universal comprehensive health care for all, regardless of immigration status, that needs articulation. History is the great teacher for the responsibilities of the present.

The summer of 2013 marked the eve of the 50th anniversary of the Mississippi Freedom Summer. Throughout the South, numerous assemblies, marches and rallies brought forward that history to help shape the future.

In 1963, the southern Medical Committee for Human Rights (MCHR) was forged out of the bloody struggle against Jim Crow and for liberation. African American physicians in Mississippi that supported the struggle lost segregated hospital privileges, had their student loans recalled and were generally forced to leave the state in order to practice medicine.

Dr. Robert Smith didn't leave. He came together with others and formed southern MCHR. They began to document the brutalities unleashed on civil rights workers, treat injuries and initiate free clinics.

Very quickly the social movement for equality and the burning need for equal access to quality health care merged and remained so until the neoliberal onslaught of the 1970s.

One of the most telling points of that history was the 1968

political platform of the independent Mississippi Freedom Democratic Party (MFDP). Two points of that program bear witness to the unfinished matter of health care today:

- “Place the present Medicaid problem on a national basis with national standards, like Medicare, instead of having it optional for the states.”
- “Every person shall receive free and complete medical care from the day he is born until the day he dies.”

What was true then is truer now, and more necessary and possible.

Nearly every Southern state has declined to expand the Medicaid program under the ACA, leaving nearly 5 million people who would otherwise be eligible to enroll excluded from coverage in a region that has proportionally the most uninsured.

The medical and technological advances of the past 50 years have laid the basis for the distribution of health care based on need, not money. In the 1960s, health care was only midway in its transformation from a cottage industry to the corporate entity it is today.

The heart of the MFDP platform of 1968 was its independent political position. Neither the Southern states' Democratic parties then, nor the national Democratic Party now, support a program for a publicly run and accountable national health system.

The veterans of the fight for equality did not compromise their dreams then, why should our working class settle for less now?

*Rita Valenti, R.N., is a board member of Healthcare-Now and a former Georgia state legislator.*

### The ‘medical presence’ during Freedom Summer

Another important service provided by Medical Committee for Human Rights during Freedom Summer was that of “medical presence.” Whether it was a demonstration or a march to the courthouse, MCHR volunteers were on the scene, easily identifiable by the Red Cross emblem on their sleeves and their professional appearance. (“We always wore a suit,” one doctor recalled, “no matter how hot it was.”) Their presence seemed to diminish the level of violence during a confrontation.

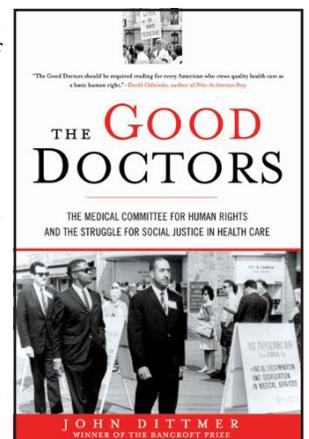
“The police got nervous when they saw medical people or a car with a Red Cross band,” observed one medical volunteer. “It was a bit of a deterrent to their brutality.”

This was also true when MCHR doctors were into the jails to examine civil rights workers who had been arrested. After such a visit, an activist was less likely to be beaten by the jail-

ers, who knew the physician could testify to the previous condition of the inmate. ...

The summer of 1964 in Mississippi was the most violent since the last days of Reconstruction. There were thirty-five shooting incidents and sixty-five homes and other buildings burned or bombed, including thirty-five churches. One thousand movement people were arrested, and eighty activists suffered beatings. There were at least six murders.

*Excerpted from “The Good Doctors” by John Dittmer.*



# Congratulations on Match Day!

PNHP congratulates its student members who have matched into residency programs. PNHP members are encouraged to welcome these incoming residents to their new institutions. Contact Emily Henkels at [e.henkels@pnhp.org](mailto:e.henkels@pnhp.org) for information on how to connect with these incoming residents at your institution.

The following is a partial list of our student members who have matched into residency programs.

**Ian Bett** will be starting a Family Medicine residency at Grant Medical Center in Columbus, Ohio.

**Matt Bewley** will be starting a Psychiatry residency in Miami, Fla.

**Nikhil Desai** will be starting a Family Medicine residency at MedStar Franklin Square Medical Center in Baltimore.

**Shokoufeh Dianat** will be starting a Family Medicine residency at Brown University in Providence, R.I.

**Amy Edelstein** will be starting an Internal Medicine/Primary Care residency at Lenox Hill Hospital in New York.

**Alexander Friedman**, will be starting an Internal Medicine residency at UC Riverside in California.

**Meghan Geary** will be starting an Internal Medicine residency at Brown University in Providence, R.I.

**Irmina Haq** will be starting a Family Medicine residency at Harbor - UCLA in Los Angeles.

**Alicia Kepich** will be starting a Family Medicine residency at Jackson Memorial Hospital in Miami, Fla.

**Abhishek Kulkarni** will be starting an Emergency Medicine residency at the University of Arizona.

**Jillian Landeck** will be starting a residency at United Family Medicine in Minneapolis.

**Vishes Mehta** will be starting a General Surgery residency at Montefiore Medical Center in New York.

**Rachel Mehendale** will be starting a preliminary year residency in Internal Medicine at Baylor College of Medicine in Houston, followed by an advanced residency in Neurology at Columbia University Medical Center in New York.

**Jennifer Perkins** will be starting a Family Medicine residency at the University of Wisconsin.

**Victoria Powell** will be starting an Internal Medicine and Urban Health residency at Johns Hopkins University in Baltimore.

**Jessica Allyn Reid** will be starting an Oncology/Gynecology residency at the University of Southern California.

**Lucia Somberg** will be starting an Emergency Medicine residency at Jacobi/Montefiore at Albert Einstein College of Medicine in New York.

**Hari Vasu** will be starting an Internal Medicine residency at NYP Weill Cornell in New York.

## PNHP Mentoring Program

This spring, PNHP launched a new Mentoring Program aimed at developing medical student leadership. Mentors, who were previously involved with single-payer advocacy as students and are now residents or early career physicians, are helping their student counterpart to develop semester-long goals for chapter building, research, and legislative advocacy. The program will be accepting new student and mentor applications for the fall 2014 semester beginning in August. Contact Emily Henkels at [e.henkels@pnhp.org](mailto:e.henkels@pnhp.org) for more information about the Mentoring Program.

The inaugural pairs of mentors-mentees are:

**Phil Verhoef, M.D., Ph. D.**, University of Chicago - **Rachel Stones**, University of Chicago Pritzker School of Medicine

**Richard Bruno, M.D.**, Johns Hopkins University - **Abigail Navarro**, University of Wisconsin School of Medicine

**Danny Lugassy, M.D.**, New York University - **Keri Ann Shalvoy**, SUNY Downstate

**Parker Duncan, M.D., M.P.H.**, Santa Rosa Community Health Center - **Henry Schwimmer**, UC Berkeley

**Danielle Alexander, M.D.**, UC Davis - **Eric Jackson**, Mayo Medical School

## On Obamacare: a med student's view

By Jawad Husain

I voted for Barack Obama in 2008 because he promised to sign a universal health care law. This aligned with my ambitions to become a doctor who treats patients based on their medical need, not their ability to pay. Finally, the time had come for us to fix our inequitable system and offer our citizens the human right to health.

Six years later, most of the provisions of the Patient Protection and Affordable Care Act have been implemented. However, it's apparent that political pressure from the private insurance industry and the big drug companies has thwarted the goal of the universal health care.

Obamacare is expected to help an additional 20 million Americans obtain health insurance, mostly through Medicaid expansion and subsidized private insurance, but about 30 million Americans will remain uninsured. According to the American Journal of Public Health, this translates to approximately 30,000 preventable deaths a year.

Mandating Americans who don't qualify for Medicaid and who don't have employer-based coverage to buy private insurance policies benefits insurance companies, but does little to make health care affordable.

For example, those enrolling in an exchange-based Bronze Plan will have only 60 percent of their actual health care costs covered by insurance. According to a report by the Kaiser Family Foundation, even after paying premiums, a family may have to spend up to \$12,700 out of pocket.

When patients have "more skin in the game," e.g. higher co-pays and deductibles, they often forgo necessary medical care. Medical costs caused 37 percent of Americans to forgo seeing a doctor or skip filling a prescription in 2013, according to findings by The Commonwealth Fund.

The private insurance industry's profit-making incentive makes health care a commodity that is unaffordable for the poor. However, there are promising solutions currently being proposed at the state level.

Vermont is already in the process of setting up a statewide single-payer health insurance system.

Vermont's legislature has declared health care a "public good" and assumes the responsibility to, "ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters." This is not "socialized medicine;" doctors and hospitals will remain independent. All medical

***Six years later, most of the provisions of the Patient Protection and Affordable Care Act have been implemented. However, it's apparent that political pressure from the private insurance industry and the big drug companies has thwarted the goal of the universal health care.***



Jawad Husain with Dr. Art Chen at the SNaHP Summit, which was held at Northwestern's Feinberg School of Medicine in Chicago, on April 12, 2014.

needs are covered for everyone, and patients are free to choose their doctor.

Canada's single-payer system has resulted in high-quality universal coverage at a cost that is about half of what the United States spends on health care. Risk is shared across the entire population, administrative costs drop and zero profits go to insurance companies.

If Vermont's approach succeeds, we can expect other states to follow. Massachusetts gubernatorial candidate Dr. Donald Berwick intends to establish a single-payer system if elected. Congressional Representative John Conyers, Jr. has sponsored a single-payer bill in the House and Senator Bernie Sanders has a similar bill in the Senate.

Single-payer national health insurance is not impossible. Canadians did not always have a single-payer health care system – they demanded it. Their single-payer movement started with a single province.

How many more "unprofitable" Americans have to die or go bankrupt before we too demand our human right to health?

*Jawad Husain is a medical student at the Boston University School of Medicine.*

## Medical school students lobby Albany for single-payer health plans

By Kyle Hughes

ALBANY, N.Y. – A group of 70 medical school students held their first-ever Capitol lobbying day Tuesday, calling for universal health care, medical marijuana and reining in insurers that now account for a third of the cost of health care here.

One of the organizers of Medical Student Advocacy Day, Albany Medical College student Ajay Major, said he was inspired by the problems he saw firsthand among backstretch workers at Saratoga Race Course.

“When I was in college I volunteered as a public health worker and an interpreter at the race track up in Saratoga,” Major said. “These workers, most of whom were shipped up with the horses, (who are) from Central America, live in small concrete cubes with minimal pay, long hours and a dangerous job. They have no formal health care in this country for their acute or their chronic conditions.”

“Local physicians, public health workers and social workers created a two bed clinic run out of an old double-wide trailer,” the Indiana resident added. “The clinic, supported by donations from local hospitals, was entirely free of charge to its patients. The clinic provided the entire spectrum of care ... I’m here today because I was inspired by my colleagues at the race track who understood that it was their duty as healers to provide for their patients.”

He said those kinds of selfless acts of providing health care is viewed as extraordinary when it should be the norm.

“Not only is the U.S. the only developed country without universal health care, we’re also paying twice as much per capita on health care as other industrialized nations,” said student Xin Guan, who came to study at Albany Med from California. “Does this mean we provide better care? No, in fact we are falling behind in all measures of morbidity and mortality.”

She said medical bills are the reason behind 62 percent of all personal bankruptcies, and noted that even with Obamacare, about 30 million people in the U.S. will lack health insurance. “Thirty-one percent of every health care dollar goes into private insurance bureaucracy,” she said.

Another student, Phyllis Ying of Seattle, said when she volunteered at farmers markets, doctors organized to bring

***“Not only is the U.S. the only developed country without universal health care, we’re also paying twice as much per capita on health care as other industrialized nations,” said student Xin Guan, who came to study at Albany Med from California. “Does this mean we provide better care? No, in fact we are falling behind in all measures of morbidity and mortality.”***

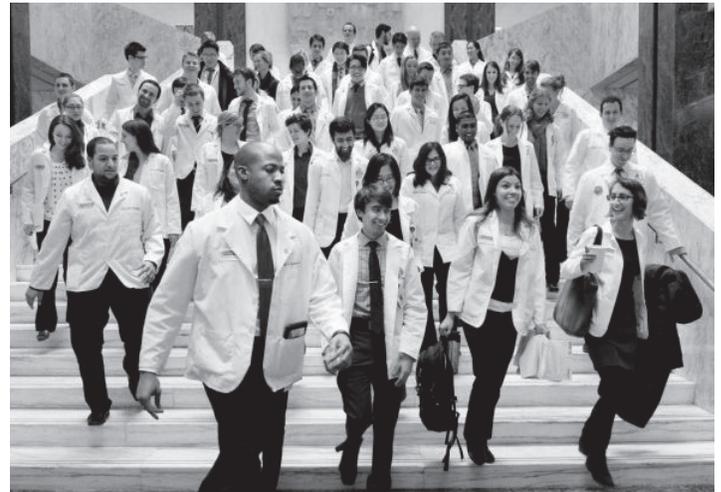


Photo: John Carl D’Annibale / Albany Times Union

**Medical students walk down the staircase of the Legislative Office Building during Medical Student Advocacy Day at the Capitol, Jan. 28, 2014, in Albany, N.Y.**

healthy food to poor residents of Albany’s South End. “For our patients, being their advocate is essential,” she said. “As one of the South End parents said to me, ‘We need this.’”

The bills the group lobbied in favor of Tuesday included:

- A5389/S2078: Establishes the New York Health program, a comprehensive system of access to health insurance for New York state residents. The bill “would create a universal single-payer health plan – New York Health – to provide comprehensive health coverage for all New Yorkers.” It would replace private insurance and be financed by a combination of state funds and payroll taxes. “Every New York resident

would be eligible to enroll, regardless of age, income, wealth, employment, or other status. There would be no premium, deductibles, or co-pays. Coverage would be publicly funded.”

*Kyle Hughes writes for NYSNYS News, a news service about government and politics based in the New York State Capitol, Albany.*

## Opting Out of Medicaid Expansion: The Health and Financial Impacts

By Sam Dickman, David Himmelstein, Danny McCormick, and Steffie Woolhandler

The Affordable Care Act (ACA) was designed to increase access to health insurance by: (1) requiring states to expand Medicaid eligibility to people with incomes less than 138 percent of the Federal Poverty Level (FPL) (\$19,530 for a family of three in 2013), with the cost of expanded eligibility mostly paid by the federal government; (2) establishing online insurance “exchanges” with regulated benefit structures where people can comparison shop for insurance plans; and (3) requiring most uninsured people with incomes above 138 percent FPL to purchase insurance or face financial penalties, while providing premium subsidies for those up to 400 percent of FPL.

Recent studies suggest that Medicaid expansion will result in health and financial gains. Older studies also found salutary health effects of expanded or improved insurance coverage, particularly for lower income adults. These studies also document an increase in utilization of most health care services. Most recently, the Oregon Health Insurance Experiment (OHIE) found a striking increase in emergency department use as well as other outpatient care.

The Supreme Court ruled in June 2012 that states may opt out of Medicaid expansion, and as of November 2013, 25 states have done so. These opt-out decisions will leave millions uninsured who would have otherwise been covered by Medicaid, but the health and financial impacts have not been quantified.

In this post, we estimate the number and demographic characteristics of people likely to remain uninsured as a result of states’ opting out of Medicaid expansion. Applying these figures to estimates of the effects of insurance expansion from prior studies, we calculate the likely health and financial impacts of states’ opt-out decisions.

### The Consequences of Opting Out

The Supreme Court’s decision to allow states to opt out of Medicaid expansion will have adverse health and financial consequences. Based on recent data from the Oregon Health Insurance Experiment, we predict that many low-income women will forgo recommended breast and cervical cancer screening; diabetics will forego medications, and all low-income adults will face a greater likelihood of depression, catastrophic medical expenses, and death. Disparities in access to care based on state of residence will increase. Because the federal government will pay 100 percent of increased costs associated with Medicaid expansion for the first three years (and 90 percent thereafter), opt-out states are also turning down billions of dollars of potential revenue, which might strengthen their local economy.

The ACA’s tax subsidy for insurance purchase on the Exchange is only available to persons with incomes above 100 percent

of FPL. People below this threshold in opt-out states (the so-called low-income “coverage gap”) will see no benefit as the law goes into effect. They may even see harm because the ACA cuts disproportionate share (DSH) funding to safety net hospitals, reducing the resources available to care for the remaining uninsured.

Despite the widely held belief that almost all Americans will be insured under the ACA, more than 32 million people will remain uninsured after the law goes into effect. Even in states that opt in to Medicaid expansion, millions will remain without coverage.

Low-income adults in states that have opted out of Medicaid expansion will forgo gains in access to care, financial well-being, physical and mental health, and longevity that would be expected with expanded Medicaid coverage.

### Examining the numbers

The number of uninsured people in states opting in and opting out of Medicaid expansion is displayed in Exhibit 1. Nationwide, 47,950,687 people were uninsured in 2012; the number of uninsured is expected to decrease by about 16 million after implementation of the ACA, leaving 32,202,633 uninsured. Nearly 8 million of these remaining uninsured would have gotten coverage had their state opted in. States opting in to Medicaid expansion will experience a decrease of 48.9 percent in their uninsured population versus an 18.1 percent decrease in opt-out states.

Predicted national-level consequences of states opting out of Medicaid expansion are displayed in Exhibit 2. We estimate the number of deaths attributable to the lack of Medicaid expansion in opt-out states at between 7,115 and 17,104. Medicaid expansion in opt-out states would have resulted in 712,037 fewer persons screening positive for depression and 240,700 fewer individuals suffering catastrophic medical expenditures. Medicaid expansion in these states would have resulted in 422,553 more diabetics receiving medication for their illness, 195,492 more mammograms among women age 50-64 years and 443,677 more pap smears among women age 21-64. Expansion would have resulted in an additional 658,888 women in need of mammograms gaining insurance, as well as 3.1 million women who should receive regular pap smears.

State-level estimates for post-ACA effects of opting out of Medicaid expansion are displayed in Exhibit 3. In Texas, the largest state opting out of Medicaid expansion, 2,013,025 people who would otherwise have been insured will remain uninsured due to the opt-out decision. We estimate that Medicaid expansion in that state would have resulted in 184,192 fewer depression diag-

*(continued on next page)*

Exhibit 1: Uninsured Population by State, Pre- and Post-ACA

State	Number currently uninsured	Predicted number uninsured post-ACA
<b>Opting in</b>		
AR	534,965	262,117
AZ	1,198,325	599,767
CA	6,787,453	3,444,629
CO	704,533	360,757
CT	283,631	152,564
DC	49,735	25,487
DE	97,334	50,387
HA	104,845	51,460
IA	305,640	157,475
IL	1,731,845	878,954
KY	682,218	339,374
MA	272,126	145,020
MD	732,544	383,423
MI	1,059,696	547,897
MIN	443,002	232,193
ND	79,739	42,223
NJ	1,223,216	640,020
NM	453,215	227,023
NV	642,493	329,945
NY	2,185,195	1,122,130
OH	1,401,784	1,148,496
OR	596,865	304,183
RI	127,703	66,831
VT	42,836	22,830
WA	932,584	481,870
WV	264,287	135,790
<b>Opting out</b>		
AK	133,848	107,010
AL	711,302	588,500
FL	4,116,399	3,365,447
GA	1,856,223	1,535,835
ID	252,948	209,156
IN	848,573	694,153
KS	358,399	298,923
LA	819,410	678,529
ME	126,202	101,234
MO	793,925	646,589
MS	443,685	370,177
MT	181,221	147,851
NC	1,658,330	1,350,588
NE	245,418	199,693
NH	157,199	125,790
OK	639,834	520,267
PA	1,520,611	1,229,171
SC	665,287	554,044
SD	118,760	98,143
TN	892,107	744,665
TX	6,425,592	5,268,845
UT	411,349	329,867
VA	997,665	808,966
WI	549,798	442,318
WY	88,797	70,998
<b>Total</b>	<b>47,950,687</b>	<b>32,202,633</b>

Exhibit 2: Effects of Medicaid Expansion on Health and Financial Outcomes, and National Estimates of Adverse Outcomes Avoided or Appropriate Screening/ Treatment Provided If Current Opt-out States Accepted Medicaid Expansion

Outcome	Population Prevalence of Outcome in Control Group of Reference Studies at Baseline	Effect Estimate of Medicaid Expansion percent (95 percent CI)	Number Needed to Insure	Number of Persons with Adverse Outcomes Avoided or Appropriate Screening/ Treatment Provided If Medicaid Expanded in Opt-out States
Depression	30.0 percent*	-9.15 percent (-1.60 to -16.70)*	10.9	-712,037 (-124,509 to -1,299,565)
Use of diabetes medications	6.4 percent*	5.43 percent (1.39 to 9.48)*	18.4	422,553 (108,167 to 737,717)
Mammogram in past 12 months (age 50-64)	28.9 percent*	29.67 percent (11.96 to 47.37)*	3.4	195,492 (78,803 to 312,115)
Pap smear in past 12 months (age 21-64)	44.9 percent*	14.44 percent (2.64 to 26.24)*	6.9	443,677 (81,116 to 806,239)
Catastrophic medical expenditures	5.5 percent*	-4.48 percent (-0.69 to -8.26)*^	32.2****	-240,700 (-32,098 to -384,241)
Mortality (high estimate)	320 per 100,000 adults 20-64***	-19.6 (-11.9 to -27.3) per 100,000 adults 20-64**	455	-17,104 (-10,384 to -23,823)
Mortality (low estimate)	320 per 100,000 adults 20-64***	-91.4 (-18.1 to -146.1) per 100,000 uninsured population***	1,094	-7,115 (-1,410 to -11,368)

\* Source of estimate: (1)

\*\* Source of estimate: (2)

\*\*\* Source of estimate: (3)

\*\*\*\* All income levels

^ Effect size for persons with income < 100 percent FPL. Effect size is lower in higher income persons. See text for detail.

**Exhibit 3: State Estimates of Adverse Outcomes Avoided or Appropriate Screening /Treatment Provided If Current Opt-out States Accepted Medicaid Expansion**

	Number of Uninsured who would have been Insured if State had Opted In	Number of Individuals with Depression	Number of Diabetic Individuals Using Diabetes Medications	Number of Women a Mammogram in Past 12 Months (age 50-64)	Number of Women with a Pap Smear in Past 12 Months (age 21-64)	Number of Individuals with Catastrophic Medical Expenditures	Number of Deaths (high estimate)	Number of Deaths (low estimate)
AK	35,534	-3,251	1,929	941	1,849	-919	-91	-32
AL	235,084	-21,510	12,765	6,083	14,804	-7,732	-562	-215
FL	1,266,471	-115,882	68,769	37,639	73,890	-38,344	-2,221	-1158
GA	613,658	-56,150	33,322	17,778	37,234	-20,250	-1,176	-561
ID	83,314	-7,623	4,524	1,037	4,808	-2,581	-179	-76
IN	261,973	-23,971	14,225	5,893	14,246	-8,164	-758	-240
KS	124,048	-11,350	6,736	2,123	7,189	-4,092	-330	-113
LA	272,177	-24,904	14,779	7,628	16,769	-8,880	-542	-249
ME	34,289	-3,137	1,862	1,055	1,886	-953	-157	-31
MO	238,427	-21,816	12,947	4,086	14,134	-7,770	-700	-218
MS	153,849	-14,077	8,354	4,194	9,169	-5,256	-343	-141
MT	55,031	-5,035	2,988	1,674	3,252	-1,645	-117	-50
NC	498,045	-45,571	27,044	12,051	27,840	-14,776	-1,145	-455
NE	73,282	-6,705	3,979	1,414	3,584	-2,117	-212	-67
NH	41,993	-3,842	2,280	1,757	2,417	-1,143	-159	-38
OK	190,224	-17,405	10,329	3,569	11,052	-5,683	-439	-174
PA	435,088	-39,811	23,625	12,484	23,881	-12,780	-1,491	-398
SC	228,311	-20,890	12,397	7,715	13,046	-7,362	-551	-209
SD	38,985	-3,567	2,117	449	1,977	-1,252	-95	-36
TN	310,180	-28,381	16,843	9,744	18,042	-10,211	-759	-284
TX	2,013,025	-184,192	109,307	40,562	109,648	-62,610	-3,035	-1840
UT	111,531	-10,205	6,056	1,647	5,737	-3,186	-316	-102
VA	291,325	-26,656	15,819	9,155	17,788	-8,164	-987	-266
WI	152,399	-13,944	8,275	4,068	8,190	-4,193	-671	-139
WY	23,586	-2,158	1,281	743	1,245	-638	-69	-22
<b>Total</b>	<b>7,781,828</b>	<b>-712,037</b>	<b>422,553</b>	<b>195,492</b>	<b>443,677</b>	<b>-240,700</b>	<b>-17,104</b>	<b>-7,115</b>

noses, 62,610 fewer individuals suffering catastrophic medical expenditures, and between 1,840 and 3,035 fewer deaths.

**Methods**

We categorized states as opting in or opting out of Medicaid expansion using the Kaiser Family Foundation’s “Status of State Action on the Medicaid Expansion Decision,” which was updated on November 22, 2013. We used the Census Bureau’s 2013 Current Population Survey, a nationally representative survey of the non-institutionalized US population, to determine the number of uninsured people in each state before implementation of the ACA. We then projected the number of uninsured people in each state after implementation of the ACA depending on whether the state is opting in or opting out of Medicaid expansion. Based on previously published estimates of take-up rates and estimates from the Congressional Budget Office, we assumed that in states opting out, 90 percent of currently uninsured people with incomes below 138 percent of FPL will remain uninsured, as will 75 percent of uninsured people with incomes above 138 percent FPL. In states opting in, we assume that 40 percent of currently uninsured people with incomes below 138 percent FPL will remain uninsured, as will 60 percent of uninsured people with incomes above 138 percent FPL. These estimates incorporate the assumption that enrollment of people with incomes above 138 percent FPL through the ex-

changes will be higher in states that opt to expand Medicaid.

We used data from three sources to estimate the effects of Medicaid expansion: The Oregon Health Insurance Experiment; and two widely cited estimates of the impact of coverage expansion on mortality. The OHIE is a randomized study that examined the effects of expanding public health insurance for low-income (less than 100 percent FPL) adults on health, financial strain, health care use, and self-reported well-being. It found that after an average of 17 months of exposure to Medicaid coverage, improvements occurred in rates of depression (based on the eight-question version of the Patient Health Questionnaire (PHQ-8)), and catastrophic medical expenditures. In addition, the OHIE found that acquisition of coverage led to increased utilization of most types of health care, including several types of care that has been linked to improved outcomes such as diabetics receiving medication to treat their diabetes and clinically indicated mammograms and cervical pap smears (in the past 12 months). An estimate of the number needed to insure was calculated by dividing the number of newly insured persons by the number of outcomes achieved.

To estimate the effect of Medicaid expansion on catastrophic medical expenditures (i.e. medical expenditures greater than 30 percent of annual income), we used the observed effect size from OHIE for adults up to 100 percent FPL. In order to extrapolate this financial impact finding from the OHIE to near-poor and middle income persons, we assumed that the effect

size of Medicaid expansion among adults between 100 percent and 138 percent FPL would be only half as large, and among adults between 138 percent and 400 percent FPL, only one quarter as large as the effect size observed in the OHIE. To estimate the number of women eligible for cervical cancer screening and mammography, we used the age ranges for screening suggested by national consensus guidelines (21 to 64 years for pap smears and 50 to 64 years for mammograms), and applied the increase in pap smear and mammogram rates observed in the OHIE.

We estimated the range of likely mortality effects of Medicaid expansion. For our high estimate, we used the recent study by Sommers and colleagues that compared trends in mortality rates in states with Medicaid expansions (New York, Maine, and Arizona) to trends in states without such expansions. The Medicaid expansions were associated with a 6.1 percent decrease in mortality, or 19.6 deaths per 100,000 non-elderly adults. We conservatively used this population-based estimate, rather than their number-needed-to-insure figure of 176, because, as Sommer et al. pointed out, the latter figure reflects the fact that in their study, Medicaid preferentially enrolled sicker than average adults. For our low estimate, we used a study based on mortality follow-up of participants in the National Health and Nutrition Examination Study, which found a 40 percent increase in death rates among the uninsured, an effect size approximately 42 percent that found by Sommers.

### Limitations

Several caveats apply to our findings. Our figures, which use the number of uninsured in 2012 as the baseline, differ slightly from Congressional Budget Office figures based on projections of the numbers who would have been uninsured in several future years had the ACA not been passed. We could not take into account several factors that might influence the impact of Medicaid expansion. For instance, both the OHIE and Sommers estimates are based on Medicaid expansions that paid doctors pre-ACA reimbursement rates. Since the ACA will provide a two-year increase in Medicaid rates for primary care services, it is possible that access to care will improve more than was observed in those studies if more providers start accepting Medicaid. In addition, Oregon's health costs (and presumably its rates of catastrophic medical expenditures) are slightly lower than national average.

The patients studied in the OHIE were slightly older than the uninsured poor in opt-out states, and more often female. While we were able to adjust for these demographic differences in estimating cancer screening rates, it was not possible to do so for other effects. Similarly, we did not attempt adjustment for regional differences in depression prevalence, in the uninsured population, although such differences are probably small. If any-

thing, the adjusted prevalence of major depression in Oregon appears slightly below the national average. An older sample population in the OHIE may have resulted in greater improvements in health and screening following Medicaid expansion, leading to a slight overestimate of effects in states with a younger uninsured population, whereas the female predominance in

the OHIE may have resulted in a slight underestimate of effects in other states because males are more likely to have diabetes and other chronic conditions. In the OHIE, a relatively small number of persons were covered by the Medicaid expansion. The broader expansion under the ACA may put greater strain on the limited capacity of providers who accept Medicaid patients, curtailing utilization. Finally, participants in the OHIE had been uninsured for at

least six months, and were concentrated in the Portland area. Impacts elsewhere might differ.

We used data from the Sommers and Wilper studies to calculate mortality impacts because the OHIE was underpowered to detect changes in death rates. Although small improvements in hypertension prevalence (-1.3 percent) and Framingham risk score (-0.2 points) were observed in the OHIE, these did not achieve statistical significance.

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### 'Medicaid opt-out' study draws keen interest

Paul Krugman of The New York Times and journalists at the Philadelphia Inquirer, Kaiser Health News, Fox News, the Birmingham News and the St. Louis Post-Dispatch were among the many media professionals who cited the "Medicaid opt-out study" reprinted above.

In a subsequent news story at the Health Affairs Blog, the editors wrote the following: "Given their recent mention in Paul Krugman's New York Times' column, it's not surprising that Sam Dickman, David Himmelstein, Danny McCormick, and Steffie Woolhandler's discussion of the health and financial impacts of opting out of Medicaid expansion was the most-read Health Affairs Blog post from January 1 to March 31, 2014."

## Why drug prices are out of control, or money well spent by Big Pharma

By A.W. Gaffney, M.D.

Nowadays, it's not only radicals who are recognizing the rising problem of inequality. Between Bill de Blasio's mayoral inauguration, Obama's pointed speech early last month, and Pope Francis' critique of trickle down economics in November, the rhetoric of Occupy Wall Street seems to be going mainstream. Newly emerging statistics – for instance, that the top 0.01 percent of earners now seem to take home a bigger percentage of the national income than in any other year for which we have the numbers – seemingly rubs more and more Americans the wrong way.

To be fair, however, perhaps this increasingly skewed distribution of income and wealth should be interpreted as nothing more than the fair return on a prudent investment strategy. With enough money devoted to government lobbying, one could argue, any of us could be the beneficiary of upward wealth redistribution. But while some contributing factors to inequality – say the failure of the minimum wage to keep up with inflation (much less with productivity growth) – can be concisely displayed in numbers and graphs, acts of direct upward wealth redistribution require demonstration by way of a specific case study. Here, I consider the illustrative (and evolving) case of the transfer from taxpayers to pharmaceutical companies through Medicare Part D.

When Medicare was crafted in 1965, a drug benefit had strong Democratic Congressional support; at the same time, it wasn't a political priority for either party, and so given concerns about costs, it was dropped from the final bill. Growing pressure from seniors over subsequent decades, however, ultimately made a drug benefit an important political issue. Prescription drug coverage for seniors could have been created over these years with relative ease: A benefit could have been affixed to traditional Medicare, which would then have administered the program, and could have negotiated with pharmaceutical companies over prices (as other capitalist democracies, and even our own Veteran's Administration, already do).

However, the drug benefit that ultimately emerged – “Medicare Part D” – with President George W. Bush's 2003 Medicare Modernization Act (MMA) was the result of a much stronger power than common sense: corporate lobbying. Indeed, as argued in the 60 Minutes exposé, “Under the Influence,” the pharmaceutical industry all but wrote the law. Former congressmen and senators who had registered as lobbyists for the industry then endeavored to get it passed. Thomas Scully, a former hospital industry lobbyist who was appointed by Bush to run Medicare, was the primary negotiator with Congress over the MMA. He managed to obtain a waiver of federal ethics rules that allowed him to negotiate for lobbying jobs while still running Medicare, and in the lead up to the law's passage, actually threatened to fire his chief actuary if he revealed a higher cost estimate for the program. Meanwhile, the main

proponent of the bill in the House – Congressman Billy Tauzin, who had received significant campaign funding from the pharmaceutical industry – was actually already looking for lobbying jobs while the legislation was under consideration. Within weeks of its passage, he was in negotiations with the Pharmaceutical Research and Manufacturers of America (PhRMA), the chief lobbying group for the industry, for a position.



A.W. Gaffney

The profound generosity of the 2003 Act – not in terms of benefits for seniors, but with respect to profits – should therefore come as little surprise. First, the bill created an entirely privatized, administratively wasteful, and unnecessarily complex system of Pharmaceutical Dispensary Programs (PDPs) to administer the benefit. Under this system, seniors must choose from dozens of plans with various costs and differing formularies: Given the complexity of aggregating prices, premiums, and deductibles together with a universal human incapacity for predicting future illnesses, seniors succeed in choosing the cost-optimal plan (according to a 2012 report by the National Bureau of Economic Research) less than 10 percent of the time.

But the real prize of the law lay elsewhere: By explicitly outlawing Medicare from involving itself in “negotiations between drug manufacturers and pharmacies and PDP sponsors,” the bill ensured that Medicare would pay richly for the drugs it purchased. Notably, when it comes to all other healthcare – including physician services, hospitalizations, lab tests, and so forth – Medicare essentially has a “take-it-or-leave-it” approach to pricing. When it comes to prescription drugs, however, Medicare isn't even allowed to use its purchasing power to try to get a better deal for U.S. taxpayers, which is particularly problematic because many prescription drugs are patent-protected, giving the seller monopoly-power in determining prices.

Perhaps the industry, however, is simply getting what it pays for: In 2013, for instance, it led all other industries with \$171 million spent on government lobbying. Similarly, the various other actors crucial to the bill's passage have also earned strong dividends on their legislative investment, allowing some to quickly catapult into the highest echelons of the rich. Billy Tauzin, for instance, accepted a \$2 million a year offer to head PhRMA. Scully similarly soon joined the ranks of the drug lobbyists. In

fact, according to 60 Minutes, at least 15 congressional staffers, officials, and congressman who worked on the bill subsequently took positions with the industry.

Nor has the situation changed in more recent years. PhRMA predicated its support of President Barack Obama's Affordable Care Act on, among other things, maintaining the prohibition on Medicare drug price negotiation. Tauzin, still president of PhRMA, visited the White House some half dozen times after the 2008 election, and the industry ultimately got what it wanted: no price negotiations or drug imports. In that same year, Tauzin took home a bonus of \$2.3 million in addition to his \$2.1 million salary, and the following year he cashed out of the organization for a cool \$11.6 million. Who knew public service could be so rewarding?

But such payouts are miniscule in comparison with the predictable, and predicted, upward transfer of wealth effected by these lobbying efforts. When comparing the prices of the top 20 drugs prescribed to seniors, the organization Families USA found nearly a 60 percent markup in median drug prices (by comparing the lowest Part D prices with the lowest VA prices). The aggregate size of the wealth transfer that results from such differences was estimated in a January 2013 report by the Center for Economic and Policy Research, which argued that if Medicare spent as much as other industrialized nations on prescription drugs, it would save the federal government between \$229.7 billion and \$541.3 billion over the coming decade. The report also estimated that such a move would save state governments between \$30.8 and \$72.7 billion and beneficiaries directly between \$47.7 and \$112.4 billion over this same period. What's a cool half trillion between friends? Clearly, Big Pharma's annual lobbying expenditures are a downright pittance in the context of such rewards.

***When it comes to prescription drugs, however, Medicare isn't even allowed to use its purchasing power to try to get a better deal for U.S. taxpayers.***

The massive annual salaries of the CEOs of the pharmaceuticals companies – \$25 million in 2012 for the head of Pfizer alone, for instance, and about \$200 million for the big 11 that year collectively – cannot, in other words, be construed as simply the natural result of anarchical market forces. On the contrary, much of the wealth accumulation at the apex of the economic pyramid over the last few decades has had little to do with some miraculous, collective upsurge in the work ethic, intelligence, prudence, inspiration, perspiration, thrift, or math-and-science skills of a tiny class of mega-rich: instead, it has more to do with the rest of us being out-manuevered in the political arena. The absurd fact that financiers pay much less in taxes on money made on the stock market than what many others pay on money earned through actual work is yet another example of crude upward wealth redistribution via political action.

Conservatives frequently argue that inequality is a fact of life, or the price of doing business in a market economy; liberals often argue that we could do a better job of ameliorating the consequences of inequality through a stronger safety net. No doubt we need a stronger social welfare system, real universal health care, a more progressive tax code, a world-class system of education, and much more. But if we are to understand the reasons why ours is an increasingly unequal society, we can't neglect to trace the green strings of power back to the corporate puppeteers.

*A. W. Gaffney is a board-certified internist, a fellow in pulmonary and critical care medicine and a member of Physicians for a National Health Program whose writing deals with issues of health care and health policy from a progressive perspective. He is involved in progressive health activism and is researching a book on the idea of health care as a human right in history.*

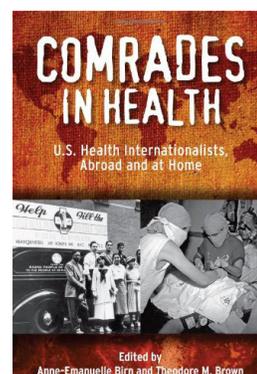
## **Comrades in Health: U.S. Health Internationalists, Abroad and at Home**

Edited by Anne-Emanuelle Birn and Theodore M. Brown  
Rutgers University Press, 2013  
Softcover, 350 pp., \$29.95

By presenting a combination of historical accounts and first-hand reflections, this collection of essays aims to draw attention to the long-standing international activities of the American health left and the lessons they brought home. The involvement of these progressive U.S. health professionals is presented against the background of foreign and domestic policy, social movements, and global politics.

“Everybody who cares about health and social justice, internationally and in the U.S., should read this book!” – *Amy Goodman, host of “Democracy Now!”*

“This wonderful book offers a deeply reflective look at the motivations, ideology, and outcomes of this critical work, telling the stories of true heroes and heroines of American medicine and public health. It is must reading for anyone contemplating international health activism today.” – *Dr. David Himmelstein and Dr. Steffie Woolhandler, cofounders, Physicians for a National Health Program*



## A 'pause' to reflect: Quentin Young tells his story

By Rick Kogan

It seems impossible that the life and times and accomplishments of Dr. Quentin Young might be able to fit into fewer than 250 pages, but there it is, colorful and passionate, between the covers of "Everybody In, Nobody Out: Memoirs of a Rebel Without a Pause."

As Young, in collaboration with Steve Fiffer, writes, "When you get to be my age, there's no shortage of stories to tell about things you've done, people you've met, and places you've been. Whether those stories are interesting enough to fill a book is for you, the reader, to decide."

Well, I have read and I have decided, and the answer is a resounding "Yes."

Young was born in 1923 and raised on the South Side, where he still lives. He enrolled in the University of Chicago at 16, volunteered for the U.S. Army, went to war and served in the medical corps, came back, earned his medical degree at Northwestern University, went to work at Cook County Hospital, where he eventually rose to chairman of the Department of Medicine from 1972 to 1982. He spent more than 60 years in private practice in Hyde Park.

Though on one level this book is about health care and the decades Young has been an articulate and indefatigable advocate for a single-payer national health care system, Young's passions and interests extend beyond his life's work. He attended his first protest as a teenager in support of steelworkers' efforts to unionize. He helped organize the Freedom Summers in Mississippi. Through the decades Young could be found front and center of so many good causes, social justice matters and civil rights issues.

For instance, when Dr. Martin Luther King Jr. brought his fight for open housing and an end to segregation in the public school system to Chicago in 1966, Young was there. After King was hit in the head with a rock during the horrific open-housing march in Marquette Park, Young tended that wound. "We stopped the blood loss and transported him to the hospital," Young writes. "The event had the capacity to kill him. He was my medical responsibility. In that moment, I was his doctor."

And he was the doctor for many others, including columnist Mike Royko, the Beatles when the band was making concert visits here, and his lifelong friend and fellow activist Studs Terkel. "I was fortunate to be kind of Zelig to a number of accomplished and well-known Chicagoans and outsiders," Young writes.

Politicians pepper these pages: the powerful Daleys on the fifth floor of City Hall, neighbor/friend Harold Washington, legendary 5th Ward Alderman Leon Despres, but not Gov. Pat

Quinn, who last year nominated Young to the board of the Illinois Sports Facilities Authority. The current occupant of the White House? "I'll get into my relationship with President Obama and my profound disappointment in Obamacare shortly," he writes – and he does, very frankly.

This book is the story of a life well and courageously lived. It is an essential for any Chicago book collection. His recall is solid and his style (with Fiffer) compelling.

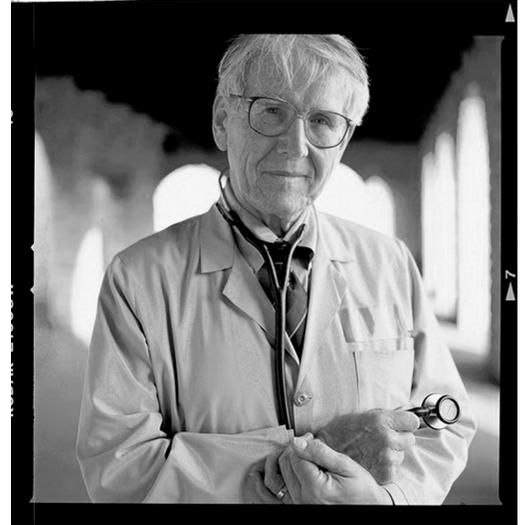
He is grateful for being able to mine the many newspaper stories that charted his life and career, and the recall of his family members (including his five grown children, two stepchildren and their families) and colleagues, "the thousands I have worked with." He slyly tips his hat to "(a)nother organization (that) also kept an almost daily diary of my activities during the 1960s and 1970s, the Federal Bureau of Investigation."

Near the end of this fine, fine book, he writes, "As you've no doubt noticed in the preceding pages, my views and actions have also propelled me into sharp conflict with institutions and persons who would perpetuate injustice. That was true yesterday; it remains true today. My work is unfinished."

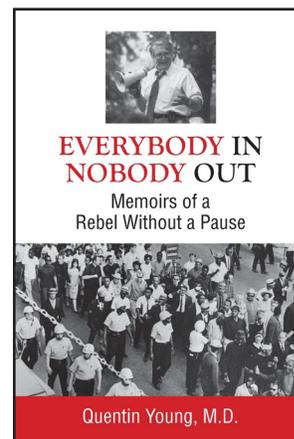
Ever busy, Young might take a moment to be proud – of his work, his life, this book.

**"Everybody In, Nobody Out"**  
By Quentin Young, Copernicus Healthcare, 254 pages, \$18.95

*Rick Kogan is a Tribune senior writer and columnist.*



Milbert Orlando Brown/Chicago Tribune



## How can the physician workforce be diversified?

By Lyndonna Marrast, M.D., and Danny McCormick, M.D., M.P.H.

The Affordable Care Act (ACA) will increase insurance coverage for the poor, uninsured and minorities, but will it improve access to care and population health? The answer depends critically on whether or not physicians are available to care for the newly insured. Many health policy experts fear there may not be.

While the ACA contains some modest pay increases for doctors willing to see patients with Medicaid (the means-tested joint federal-state program that the ACA will expand), these incentives are likely to be too small to dramatically boost physicians' willingness to care for disadvantaged patients or to affect the underlying national shortage of primary care physicians.

How then can we help ensure that the health care needs of disadvantaged patients are better met as ACA implementation proceeds? In the Feb. 1, 2014, print issue of JAMA Internal Medicine we reported the results of a study that may provide part of the answer: train more minority physicians.

Our study analyzed data from a federal survey of 7,070 patients and found that compared to other patients, the disadvantaged were more likely to be cared for by a minority physician. This was true regardless of how "disadvantaged" was defined, i.e. by low income, minority race/ethnicity, having Medicaid, being uninsured, being non-English speaking, or being in less-than-good health. For instance, patients with Medicaid were one and a half to two times more likely to be cared for by a minority physician than a white physician. Black, Hispanic and Asian patients were 19-26 times more likely to be cared for by a minority physician of the same race. And patients in fair to poor health were 20-44 percent more likely to see a minority physician.

We hope to one day live in a fully integrated society where everyone has the same, comprehensive health coverage, race and ethnicity matter less, and everyone has access to high quality health care professionals. However, until that day comes, we need to recognize the disproportionate role of minority physicians in meeting the health care needs of the poorest and sickest Americans.

Organizations such as the Institute of Medicine, the American Medical Association and the Association of American Medical Colleges have affirmed a need to train more minority physicians. In spite of this, African-Americans, who represent 12 percent of the population, only account for 6.3 percent of U.S. physicians. Hispanics make up 16 percent of the population but account for just 5.5 percent of physicians. These proportions have changed little in 20 years.

How can the physician workforce be diversified? Increased efforts to identify talented minority students and help prepare them for medical careers are needed. In addition, decreasing



Lyndonna Marrast, M.D., and Danny McCormick, M.D., M.P.H.

the exorbitant tuition costs of medical schools would disproportionately benefit minority students.

However, the change that would have the most direct impact is a revamping of medical school admissions priorities. Although a recent Supreme Court decision requires admissions committees to show that diversity could not be achieved by other means before resorting to race-conscious selection criteria, it nonetheless affirmed a compelling government interest in achieving diversity. All medical schools should set diversity as an explicit institutional priority and adopt admissions criteria that give preference to students (of any race/ethnicity) who bring diversity to the profession. Such policies might also favor students with a history of volunteering or working in underserved communities and those who seek careers serving disadvantaged patients.

In the United States today, the poor die six years younger than the affluent, blacks die nearly four years younger than whites, and patients from most ethnic minorities have markedly worse access to needed medical care. Medical schools need to do more than bemoan these grim realities; they should act to change them. America's medical schools have just completed another application cycle and have decided who will or will not become a physician. In the next few years, they must be willing to commit to training more high-quality minority health care providers. By changing the complexion of the nation's physician workforce, medical schools prepare a physician workforce to better meet the needs of all Americans.

*Lyndonna Marrast is a primary care physician, Cambridge Health Alliance. Danny McCormick is an associate professor, Harvard Medical School and a primary care physician, Cambridge Health Alliance.*

## The French way of cancer treatment

By Anya Schiffrin

When my father, the editor and writer Andre Schiffrin, was diagnosed with stage four pancreatic cancer last spring, my family assumed we would care for him in New York. But my parents always spent part of each year in Paris, where my father was born, and soon after he began palliative chemotherapy at Memorial Sloan Kettering my father announced he wanted to stick to his normal schedule – and spend the summer in France.

I humored him – though my sister and I didn't want him to go. We felt he should stay in New York City, in the apartment where we grew up. I could visit him daily there, bringing takeout from his favorite Chinese restaurant and helping my mother.

I also didn't know what the French healthcare system would be like. I'd read it was excellent, but assumed that meant there was better access for the poor and strong primary care. Not better cancer specialists. How could a public hospital in Paris possibly improve on Sloan Kettering's cancer treatment?

After all, people come from all over the world for treatment at Sloan Kettering. My mother and I don't even speak French. How could we speak to nurses or doctors and help my father? How would we call a taxi or communicate with a pharmacy?

But my dad got what he wanted, as usual. After just one cycle of chemo in New York, my parents flew to Paris, to stay in their apartment there. The first healthcare steps were reassuring: my parents found an English-speaking pancreatic cancer specialist and my dad resumed his weekly gemcitabine infusions.

My parents were pleasantly surprised by his new routine. In New York, my father, my mother and I would go to Sloan Kettering every Tuesday around 9:30 a.m. and wind up spending the entire day. They'd take my dad's blood and we'd wait for the results. The doctor always ran late. We never knew how long it would take before my dad's name would be called, so we'd sit in the waiting room and, well, wait. Around 1 p.m. or 2 p.m. my dad would usually tell me and my mom to go get lunch. (He never seemed to be hungry.) But we were always afraid of having his name called while we were out. So we'd rush across the street, get takeout and come back to the waiting room.

We'd bring books to read. I'd use the Wi-Fi and eat the graham crackers that MSK thoughtfully left out near the coffee maker. We'd talk to each other and to the other patients and families waiting there. Eventually, we'd see the doctor for a few minutes and my dad would get his chemo. Then, after fighting New York crowds for a cab at rush hour, as my dad stood on the corner of Lexington Avenue feeling woozy, we'd get home by about 5:30 p.m.

So imagine my surprise when my parents reported from Paris that their chemo visits couldn't be more different. A nurse would come to the house two days before my dad's treatment day to take his blood. When my dad appeared at the hospital, they were ready for him. The room was a little worn and there

was often someone else in the next bed but, most important, there was no waiting. Total time at the Paris hospital each week: 90 minutes.

There were other nice surprises. When my dad needed to see specialists, for example, instead of trekking around the city for appointments, he would stay in one room at Cochin Hospital, a public hospital in the 14th arrondissement where he received his weekly chemo. The specialists would all come to him. The team approach meant the nutritionist, oncologist, general practitioner and pharmacist spoke to each other and coordinated his care. As my dad said, "It turns out there are solutions for all the things we put up with in New York and accept as normal."

One day he had to spend a few hours at Cochin. They gave him, free of charge, breakfast and then a hot lunch that included salad and chicken. They also paid for his taxi to and from the hospital each week.

"Can't you think of anything bad about the French healthcare system?" I asked during one of our daily phone calls. My mom told me about a recent uproar in the hospital: It seems a brusque nurse rushed into the room and forgot to say good morning. "Did you see that?" another nurse said to my mom. "She forgot to say *bonjour!*"

When the gemcitabine stopped working, the French oncologist said he would put my dad on another drug – one my dad's U.S. insurance plan had refused to approve in New York.

By this time, I had become a French healthcare bore. Regaling my New York friends with stories of my dad's superb care in Paris, I found people assumed he was getting VIP treatment or had a fancy private plan. Not at all. He had the plain vanilla French government healthcare.

I had read many articles about the French healthcare system during the long public debate over Obamacare. But I still hadn't understood fully, until I read an interview in the New York Times that revealed the French system is basically like an expanded Medicaid. Pretty much everyone has insurance, it explained, and the French get better primary care and more choice of doctors than we do. It also turns out, as has been much commented on, that despite all this great treatment, the French spend far less on healthcare than Americans.

In 2011, France's expenditure on health per capita was \$4,086, compared to \$8,608 in the United States, according to the World Health Organization. Spending as a percentage of gross domestic product was 11.6 percent in France while in the United States it was a far higher 17.9 percent.

Last fall, my mother asked me to come and see their general practitioner in Paris so we could plan ahead for my father. My mom got an appointment for the next morning and we walked to the office, five minutes from my parents' apartment. We

*(continued on next page)*

## Spanish health advocates foil hospital privatization scheme

‘Sea of white coats,’ allies send privatizers packing – at least for now

By Marciano Sánchez Bayle and Hixinio Beiras Cal with Andrew D. Coates

MADRID – In a stunning turnaround, the regional government of Madrid recently abandoned plans that would fully privatize six privately managed hospitals together with more than 40 primary care clinics.

The policy reversal has been widely attributed to the large, high-profile and sustained demonstrations by doctors and nurses. The white coats worn by these caregivers prompted many to name the mobilizations “The White Tide.” The protest wave helped lead the general public to support an end to the privatization of health care.

This dramatic defeat for the would-be privatizers, followed by the abrupt resignation of the regional health minister who supported them, Javier Fernandez-Lasquetty, shows that privatization policies and initiatives can be reversed, even if only partially. It is a lesson that applies not just to Autonomous Region of Madrid, but throughout Spain and perhaps worldwide. In Spain, other regions, including Castilla La Mancha, Aragon and Extremadura, also repudiated privatization proposals.

In Madrid, privatization of the health system was spearheaded by the conservative government, starting in October 2011. Its resounding defeat took place in January of this year, 15 months after the government began the privatization initiative.

### ‘Whoever resists, wins’

We would like to offer some observations about this turn of events.

First, it’s obvious that the proximity of elections, specifically the impending May 25 vote for the European Parliament, has been a fundamental factor in this policy reversal.

The eve of an election campaign created an acute political moment. The prospect of mass protests opposing the proposal to weaken one of the government’s basic public services, especially one that serves the majority of the electorate gave the candidates pause. With a majority of voters seriously questioning the government’s health policies, full-throated support for privatization became impossible. Many voters were convinced that elected officials sought intentionally to damage and mutilate the region’s health care system.

We want to stress the tenacity of health care professionals, who publicly supported and joined citizens marching in the streets. Our colleagues significantly reinforced the strength of public opinion against the privatization of health care.

Second, judicial processes played an important role in foiling the privatization drive. Some 20 legal appeals, lodged by op-

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waited for a half-hour on a comfortable couch, chuckling over the very French selection of magazines on the coffee table (Elle and Vogue) and admiring the lush garden view. The waiting room was quiet. I realized what was missing: There was no billing department.

We spoke with the doctor for about 45 minutes. My mom wanted to know what would happen when my dad was no longer able to walk. “Oh,” said the doctor, speaking in English. “I prescribe a wheelchair and it’s delivered to your house. Shall I do it now?”

When I asked the price, she looked surprised. No charge. She asked if we wanted someone to come to the house every day and it was my turn to look surprised. What would they do? For example, someone could come and give my dad a massage to alleviate his neck pain. Again, no charge.

At the end of the appointment, my mom pulled out her French insurance card. Total cost of the visit? 18 euros.

When my dad began to get worse, the home visits started.

Nurses came three times a day to give him insulin and check his blood. The doctor made house calls several times a week until my father died on December 1.

The final days were harrowing. The grief was overwhelming. Not speaking French did make everything more difficult. But one good thing was that French healthcare was not just first rate – it was humane. We didn’t have to worry about navigating a complicated maze of insurance and co-payments and doing battle with billing departments.

Every time I sit on hold now with the billing department of my New York doctors and insurance company, I think back to all the things French healthcare got right. The simplicity of that system meant that all our energy could be spent on one thing: caring for my father.

That time was priceless.

*Anya Schiffirin is a Reuters blogger and the author of “Bad News: How America’s Business Press Missed the Story of the Century.”*

(Sanchez Bayle, continued from previous page)

ponents of the scheme, not only challenged privatization within the courts, but slowed the process, giving opponents of privatization more time to organize.

Third, health care professionals, across a spectrum of caregiving roles, lent a unified and dignified character to the mobilizations to keep health care out of the privatizers' hands. The demonstrations achieved wide participation of professionals from all categories of caregivers. Prominent participants included professionals from Primary Health Clinics and hospitals with the unanimous support of professionals and even their scientific societies, and schools. (Although the College of Nurses had a reluctant attitude at the beginning that changed after the occupation of its headquarters by nurses.) Citizens and patients joined the caregivers, whose unions also officially joined the fight.

Such unanimous support was unprecedented. The movement was not only very broad but sustained over a long period. Following the initial mobilization by professionals, participation dropped off somewhat. But the day-to-day conflicts in the health care facilities kept rekindling the movement. Health care workers and citizens with a keen awareness of the issues raised by privatization of health care found a willing response in their communities.

### Unity, not uniformity

A remarkable variety of initiatives and actions characterized the mobilizations, which were frequently spontaneous and uncoordinated. Actions ranged from traditional strikes and demonstrations to sit-ins and occupations of hospitals and clinics. Henares Hospital was occupied for 131 days. There were petition campaigns, a public referendum, music and poetry performances, flash mobs, dramatizations, photographic exhibitions and many other forms of protest – too many to describe here. They flourished throughout the region.

From January 2013 onward, the mobilization mainly took the form of mass convergences. *Mareas Blancas*, “Seas of White,” took place on the third Sunday of each month. But everyone remained focused on stopping the privatization of the six hospitals involved. Far from tiring people, the diversity of actions seemed to strengthen their involvement. A coalition emerged in which any initiative against privatization was supported by nearly all participants.

Obviously not everything was idyllic. There were occasionally tensions between the participating groups. But in the end, common sense prevailed: The disagreements were kept at a low profile and never spilled over into the demonstrations or public discourse.



Barcex

Physicians, nurses, other health workers and patients march in a “White Tide” demonstration against the privatization of public hospitals and clinics in Madrid on Oct. 27, 2013.

Groups and individuals who, in the past, might not have sought one another out, came together in coalition. No matter who had an idea, no matter who took the initiative, it was understood that the continuity of effort against privatization was paramount. There was an implicit pact of “non-interference,” an effort to respect every contribution. Trade unions and opposition parties accepted this approach – which allowed some other groups to take the lead. The movement grew stronger and more unified even though there were anti-union sentiments and party loyalties among specific sections of the coalition.

### Winning hearts and minds

During the previous 13 years, administration of health care in Spain devolved to the level of regional administrations. Efforts to thwart the move toward privatization have thus remained regional. Opponents of privatization have done a great deal of consciousness-raising about its dangers among the grassroots. The impact of this educational work, although largely unnoticed, led to several local actions against other privatization measures.

Another reason for the success of the effort against privatization was its impact on the mass media. The mainstream media took notice of the conflict from the start. The media coverage won even more public support and inspired publication of a number of anti-privatization opinion pieces in newspapers and magazines. This was very important for the sustaining the struggle.

Especially in the initial the news coverage, media coverage noted the leadership of doctors in the movement, although in truth the entire spectrum of health care personnel were involved. Mass mobilizations received further media attention – social media as well as mainstream mass media – and in turn the movement grew even larger.

## Social science in the struggle

Opponents of the privatization drive offered scientific evidence to show that privatization of health care leads to inferior health outcomes. To these factors we should add yet another: the research and documentation carried out, or publicized, by opponents of the privatization drive. Studies on the outcomes of privatization measures elsewhere demonstrated, in an irrefutable way, that such schemes not only resulted in no improvements in health care, but in many cases led to an actual deterioration of such services.

These findings were important in rebuffing claims that the privatization would save money while preserving the public's health. In fact, had the hospitals and clinics been privatized, the cuts in their services would have jeopardized the regional health care system for years to come.

The arguments against privatization were further strengthened when research exposed the economic links of two former regional health ministers to corporations benefiting from privatization measures under their administrations, and the discovery of a great number of irregularities in the agreements to privatize the six hospitals under the Private Finance Initiative.

## The special nature of health care

The background of this important struggle is the role that health care and physicians play in society. Health care is one of the basic public services affecting the population directly. In Spain, individuals are usually born and die in public hospitals. Everybody has experienced, some time or another, contact with hospitals and clinics as a patient or as a relative or friend of a patient. Health care forms part of daily conversation for many people, and is an issue about which everyone is concerned.

Many Spaniards still remember their experiences under the disastrous health system that was in place prior to the 1970s, and therefore appreciate the current National Health Service. Younger Spaniards now travel abroad and have been able to compare the advantages of the Spanish NHS with the problems of more privatized systems.

And of course there is a substantial international bibliography that compares health care systems, in which the Spanish NHS is always listed in a very good position. (In 2013, Bloomberg ranked it as the most efficient system in Europe, and placed it the fifth most efficient worldwide.)

## Doctors rise to the occasion

The prominent role of doctors in the demonstrations has been a big surprise, and a most welcome one. They've helped strengthen the movement considerably.

Why a surprise? Physicians are poorly organized. In addition, they are generally reluctant to take action because – rightly or wrongly – they see themselves as members of a social and professional elite. Many doctors still cling to this notion even though they confront working conditions similar to those of other workers worldwide: low salaries, precarious working agreements, job insecurity, and so on. On top of this they have seen, firsthand, the incompetence and poor qualifications of politically appointed hospital managers and other health care

authorities.

These circumstances have created a fertile breeding ground for chronic dissatisfaction among doctors, contributing to the recent explosion.

Doctors are still considered by society as a social class with a distinct professional prestige, empowered with a halo of near-magical powers. Although relations between doctors and patients have improved due to a greater degree of patient autonomy under the National Health Service, the reality is that there is still a certain amount of dependency of patients on their doctors. As a result, physicians' opinions about health care and the NHS exert an outsized influence on the public.

In addition, doctors generally belong to the middle class, and a confrontation between physicians and a conservative government is quite unusual. A number of doctors remarked, "I have voted Popular Party [the conservative party] all my life," thereby revealing their deep frustration with the government's indiscriminate cuts and privatizations, and giving the movement added legitimacy.

## Government arrogance and the struggle ahead

Finally it should be noted that the attitude of the government of the Autonomous Region of Madrid, and especially of its health minister, clearly spurred on the mobilizations. Mr. Lasquetty, in a show of great arrogance, disregarded any dialogue with the public. Moreover, when questioned, Lasquetty was unable to coherently explain the supposed advantages of his plans. His only answer was to repeat his simplistic slogans and to deny the evidence, behavior that was a monument to failure. He was unable to win over even his own supporters.

While the defeat of this particular privatization scheme is a victory, we should not be naïve: the Popular Party's drive to privatize health care will continue. This may lead to other, minor privatizations, both in quantity and quality, so as to remain unnoticed by the public, at least until after the next general election.

The big victory of the White Tide is actually twofold: it not only put a halt to privatization the six hospitals and the primary care clinics, but it also created a new atmosphere – an ideological hegemony – against the privatization of health services. In other words, the immense majority of the population and professionals of the Autonomous Region of Madrid are now convinced that such privatizations are unjustified and actually lead to harm.

The big question is, can the experience of the White Tide be replicated elsewhere? When it comes to health policies and the NHS in other regions of Spain, the answer may very well be positive. As we indicated previously, there have been modest victories elsewhere. On the other hand, if we look at other sectors of the economy, the answer remains uncertain. The health care sector, thanks to nature of the NHS, has some very special characteristics that set it apart from other parts of the economy.

*Drs. Marciano Sánchez Bayle and Hixinio Beiras Cal are leaders of the Federation of Associations for the Defense of Public Health (Spain). Dr. Andrew D. Coates is president of Physicians for a National Health Program.*

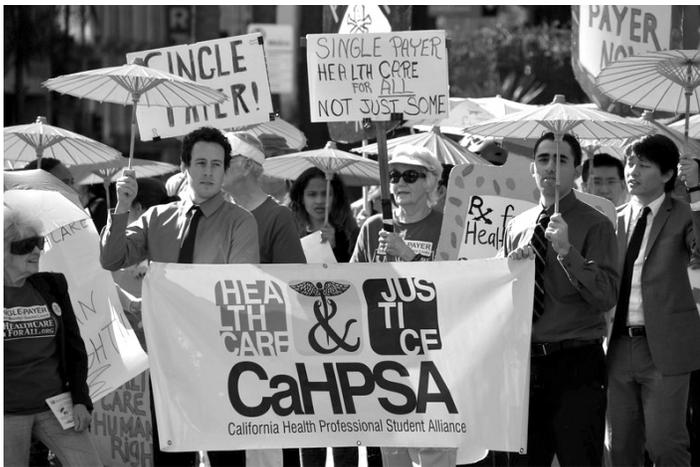
## Chapter Reports

**In Alabama**, Dr. Pippa Abston presented at a community forum on Jan. 2 titled “Better than the ACA.” Over 50 community members participated in an engaging exercise to explore an ideal health care delivery system. Group consensus by the end of the event was to have a single-payer system. Contact Dr. Abston to learn more about this creative event at [pabston@aol.com](mailto:pabston@aol.com).

**In California**, the California Health Professional Student Alliance (CaHPSA) organized two local lobby days this spring, which covered different parts of the state. The first, held in Los Angeles at USC, consisted of a training followed by a march to City Hall, where they met with members of the city council and the county board of supervisors, some of whom had never heard of single payer. Their goal is to build a larger movement across California in anticipation of a single-payer bill being reintroduced in 2015.

CaHPSA leader Jessica Reid participated at the third annual Students for a National Health Program (SNaHP) Summit in Chicago, serving on a panel about legislative advocacy. Shearer Student Fellow Keyon Mitchell also participated, leading a workshop on “Advocating for Single Payer in the Era of the ACA.”

Finally, PNHP President Dr. Andrew Coates was the keynote speaker at Single Payer Now’s annual meeting in San Francisco. He met and spoke with local PNHP members and activists while in town. Contact Cindy De La Cruz at [cindy@pnhpcalifornia.org](mailto:cindy@pnhpcalifornia.org) for information about California PNHP events.



Participants in CaHPSA’s Southern California Lobby Day in Los Angeles march to City Hall.

**In Illinois**, Dr. Anne Scheetz and medical students tabled at the Midwest student conference of the Latino Medical Student Association (LMSA) at Northwestern University. Additionally, the Illinois Single Payer Coalition (ISPC) shared a table with the Labor Campaign for Single Payer at the April 4-6 Labor Notes conference in Chicago, where they also presented at a workshop titled “Healthcare Justice: State by State” and participated in the Healthcare Workers Meeting. The ISPC, PNHP Illinois, and National Nurses United teamed up to co-sponsor a presentation by Dr. Andy Coates aimed toward building up labor support for single payer titled “Beyond Obamacare: Why Labor Deserves

Better” in Chicago on May 8.

On April 12, the third annual Students for a National Health Program (SNaHP) Summit occurred at Northwestern Feinberg School of Medicine. Over 80 medical and health professional students from more than 30 institutions turned out for the summit, more than doubling last year’s attendance. The student-led conference featured skill-building workshops, such as “White Coat Organizing Conversations,” a panel on legislative advocacy, and “Methods to Affect Social Change.” Dr. Art Chen, board member of PNHP California, gave a keynote presentation called “Activism: Transforming Ideals into Action.” Culminating the day, the students marched down Michigan Avenue and rallied against private health insurance greed at Blue Cross Blue Shield of Illinois. The summit and rally was covered by WGN Radio and Univision.

PNHP **Kentucky** held its annual meeting on April 12 with special guests Dr. Ed Weisbart of PNHP Missouri and Drs. Art Sutherland and Carol Paris of PNHP Tennessee. Dr. Weisbart gave several presentations around Louisville leading up to the daylong Saturday meeting on the theme, “Building Single Payer Support in Kentucky – Responding to the Healthcare Crisis.” To connect with PNHP Kentucky, contact Dr. Garrett Adams at [kyhealthcare@aol.com](mailto:kyhealthcare@aol.com).

**In Louisiana**, Drs. Rade Pejic and Elmore Rigamer have organized a new chapter of PNHP in New Orleans. Dr. Pejic, a recently retired surgeon, and Dr. Rigamer, who is the medical director of Catholic Charities New Orleans and a psychiatrist, decided to organize the chapter when Dr. Steffie Woolhandler visited New Orleans to speak at the annual American Medical Student Association (AMSA) convention this spring. For the new chapter’s first event, they hosted Dr. Woolhandler for a presentation at her alma mater, Louisiana State University. To get involved in the New Orleans chapter of PNHP, contact Dr. Pejic at [rpejicmd@gmail.com](mailto:rpejicmd@gmail.com).

**In Maine**, four PNHP members successfully moved the Maine Medical Association (MMA) to pass a resolution to repeat a membership poll on attitudes toward single payer. The results of this year’s poll showed that 64 percent of the respondents favor a “Medicare for all” approach, up from 52 percent in 2009. This new information is being used in lobbying and media efforts. Learn more about the survey and other efforts happening in Maine by contacting Dr. Julie Pease at [jkpeasemd@gmail.com](mailto:jkpeasemd@gmail.com).

The **Minnesota** chapter of PNHP has a brand new website at [www.pnhpminnesota.org](http://www.pnhpminnesota.org). Check out the 1-minute video on their home page, an upbeat introduction to what life would be like under single payer. PNHP Minnesota is also pleased to welcome its new full-time executive director, Taina Maki, who is a former Minnesota legislative staffer. The chapter has been busy giving talks to medical residents and pre-med students, and have been meeting with lawmakers including Sen. Al Franken and Rep. Betty McCollum. McCollum is a new co-sponsor of H.R. 676. They are also working with a growing coalition, including Minnesota Nurses Association and SEIU Healthcare, to pass single payer in Minnesota. Get involved by contacting Inge DeBecker at [ingepnhp@gmail.com](mailto:ingepnhp@gmail.com).

**In New York**, over 70 medical students from around the state participated in the first-ever Medical Student Advocacy Day, which was organized by Albany Medical College students Xin Guan, Ajay Major, and Phyllis Ying. The Advocacy Day was covered by the Times Union and other media, and led to new co-sponsors of the New York Health bill. The student chapter organized a follow-up event titled “The Great Healthcare Debate” with Dr. Paul Song from PNHP California and Dr. Mitchell Heller from Benjamin Rush Society. Dr. Song won the debate handily.

Thanks to the advocacy of PNHP New York Metro members, there have been several new endorsements of the New York Health bill, including by the Working Families Party and SEIU 1199. The Metro chapter hopes that the bill will pass the New York State Assembly in June, and is organizing a lobby day for one final push on May 6. To get involved with organizing efforts in New York, contact [info@pnhpnymetro.org](mailto:info@pnhpnymetro.org).

Finally, PNHP congratulates New York Metro board member Dr. Mary Bassett for her appointment as NYC Health Commissioner under the new De Blasio administration.

**In Oregon**, the PNHP chapter has begun circulating a statement of support for single payer online, and hopes to circulate it to all physicians in the state. To sign on to the statement, Oregon physicians can visit [www.pnhporegon.org](http://www.pnhporegon.org). For more information on this effort, contact Dr. Mike Huntington at [mchuntington@comcast.net](mailto:mchuntington@comcast.net).



**David Ball, RN and leader of Health Care for All South Carolina, being interviewed during Truthful Tuesday protests in Charleston, S.C.**

**In South Carolina**, a dozen activists, including PNHP South Carolina leader David Ball, were ticketed in a civil disobedience action on March 11 protesting the state’s decision to block Medicaid expansion. The “Truthful Tuesday” protests were organized by South Carolina Progressive Network, of which the local PNHP chapter, Health Care for All South Carolina, is a part. The protests were covered by several news outlets, including The State and the Charleston Post Courier. To learn more about the Truthful Tuesday protests or to get involved in South Carolina, contact Dr. David Keely at [dfkeely3@gmail.com](mailto:dfkeely3@gmail.com).

**In Tennessee**, a new PNHP chapter had its inaugural meeting under the leadership of Dr. Laura Helfman in Chattanooga. The new chapter had a vibrant discussion about the basics of H.R. 676, the shortfalls of the Affordable Care Act, the continuing prevalence of underinsured, and the particular challenges of organizing for single payer in the South. The next Chattanooga meeting will be held in May; please contact Dr. Helfman at [riverdoc@blomand.net](mailto:riverdoc@blomand.net) to learn more. PNHP is also excited to welcome a new medical student chapter at Quillen School of Medicine at East Tennessee State University under the leadership of medical students Anand Saha and Annie Kolarik. The new student chapter was formed shortly after Saha learned about PNHP while attending the American Medical Student Association convention in March.

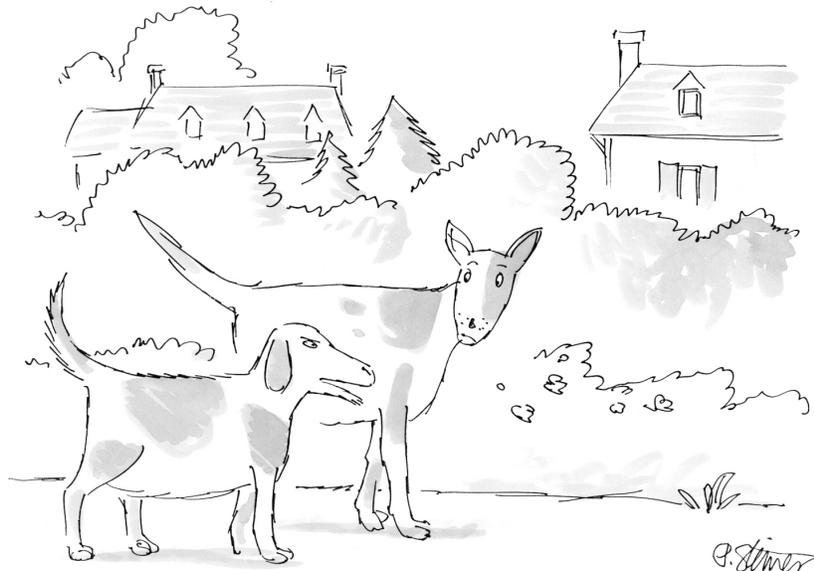


**Rachel Stones, first-year medical student at Pritzker School of Medicine and participant in PNHP Mentoring Program, giving a presentation to undergraduates at Rice University in Texas.**

**In Texas**, medical student Rachel Stones spoke to a group of 100 undergraduate students at Rice University on the topic of single payer. The event was co-sponsored with Health Care for All Texas. The chapter is working with Healthcare-NOW! to organize the first-ever “Everybody INstitute,” a daylong conference to train community members to become advocates for single payer. The INstitute is scheduled for May 17, contact [info@hcfat.org](mailto:info@hcfat.org) for more details. Contact Ben Day at Healthcare-NOW! if you are interested in learning more about Everybody INstitutes at [ben@healthcare-now.org](mailto:ben@healthcare-now.org).

### **Tim Carpenter, single-payer advocate, dies at 55**

Physicians for a National Health Program was deeply saddened to learn that Tim Carpenter, co-founder and executive director of Progressive Democrats of America, died on April 28 at his home in Florence, Mass., after a long battle with cancer. He was 55. Tim was a relentless advocate for single-payer national health insurance, and worked closely with PNHP members across the country to build support for H.R. 676, Rep. John Conyers’ single-payer bill. Tim’s dedication to coalition work was encapsulated in his favorite motto: “Teamwork!” We will miss him.



**"They talk about universal health care,  
but they don't really mean universal."**



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