PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter Fall 2013

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Fiscal study of single payer finds large savings

Single-payer legislation sponsored by Rep. John Conyers Jr. (H.R. 676) would save $592 billion on administrative and pharmaceutical costs in 2014, enough to cover all the insured and eliminate co-pays and deductibles for everyone else without raising health spending, according to a fiscal study by professor Gerald Friedman of the University of Massachusetts, Amherst. H.R. 676 would also make the financing of health care more progressive, so that 95 percent of families would pay less for health care (see page 54). Meanwhile, two more state AFL-CIO federations – Idaho and New Hampshire – have endorsed H.R. 676.

PNHP in the news

Recent research studies by PNHP members have gained prominence in policy debate, thanks in part to PNHP's media outreach efforts. In addition, a steady stream of members' letters and op-eds in newspapers and specialty journals has kept the single-payer message in the public eye.

The majority of the 30 million people left uninsured under the Affordable Care Act (ACA) will be low-income whites, and 81 percent of them will be citizens, according to a study by Dr. Rachel Nardin and colleagues at Cambridge Hospital and Harvard Medical School published in the Health Affairs blog (see page 13). Sarah Kliff of the Washington Post cited the study as one of the "most in-depth analyses of the uninsured under Obamacare that I've seen."

The ACA is "making underinsurance the new normal," according to an editorial that appeared in the Journal of General Internal Medicine by Drs. Steffie Woolhandler and David Himmelstein (see page 19).

The New York Times, Wall Street Journal, Washington Post, USA Today, ABC News, NPR and many other news outlets gave prominent coverage to the Health Affairs study, "Immigrants contributed $115.2 billion more to the Medicare Trust Fund than they took out in 2002-2009" by Dr. Leah Zallman with PNHPers David Bor, Danny McCormick, David Himmelstein and Steffie Woolhandler (see page 30). The study provides a powerful argument for including immigrants in a universal coverage program.

PNHP also publicized research on psychiatrists' wasted time waiting for insurance company approval (Annals of Emergency Medicine, see article on page 27), the low overhead costs of traditional Medicare (Journal of Health Policy, Politics and Law, see article on page 28), the health impact of austerity in Greece (American Journal of Public Health, available on PNHP's website at www.pnhp.org/austerity), and the high cost of Medicare Advantage overpayments (page 29).

PNHP president speaks out to defend caregiving from the market

PNHP President Dr. Andrew Coates' recent grand rounds on the need for single payer to defend caregiving resonated deeply with audiences in Seattle, West Virginia, and Baltimore. He also does a popular weekly radio commentary on WAMC Northeast Public Radio, drawing on his clinical practice as a hospitalist to expose indignity and injustice in the health system. He frequently calls on the medical profession to defend the moral vision of caregiving, noting that single payer is the minimum reform necessary to protect patients and the profession. Dr. Coates was recently profiled in the ACP Internist (see page 23).

Register now: PNHP 2013 Annual Meeting November 2 in Boston

The PNHP 2013 Annual Meeting will be held in Boston on Saturday, November 2, at the Seaport Boston Hotel. It will be preceded by PNHP's popular leadership training course on Friday, November 1. RSVP at www.pnhp.org. To enroll in leadership training, contact Matthew Petty at (312) 782-6006.

In This Issue

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Board of Directors, 2013

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New student members elected to PNHP's national board

Five of the students who organized this year's Student Single-Payer Summit in Chicago (see page 43) will share the student seat on PNHP's board: James Besante (N.M.), Josh Faucher (Minn.), Scott Goldberg (Ill.), Victoria Powell (Va.), Jessica Reid (Calif.). Thanks and good luck to outgoing student board members Danielle Alexander and Richard Bruno!

Membership drive update

Welcome to 324 physicians and medical students who have joined PNHP in the past year! PNHP's membership is now up to 18,725. 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 an exhibit at the American Academy of Family Physicians meeting in San Diego, Sept. 26-28. If you can volunteer for a few hours, please drop a note to matt@pnhp.org, or just stop by.

What PNHP members can do

1. Meet, write or phone your national legislators and encourage them to endorse H.R. 676, national single-payer legislation. The Capitol switchboard is (202) 224-3121.
2. Deliver grand rounds at your hospital on health care reform, or invite another PNHP member to speak. Updated slides covering the new health law are available at www.pnhp.org/slideshows (password = coates). To invite another member to speak, call the PNHP national office at (312) 782-6006.
3. Arrange a session on health care reform at the next meeting of your medical society or specialty.
4. Write an op-ed or letter to the editor for your local newspaper, medical specialty journal, or alumni magazine. Samples are online under "Articles of Interest" on the PNHP website. Never written before? PNHP's communications director Mark Almberg is available to help edit and submit your work. First-time writers are especially encouraged!
5. Reach out to local and state labor unions and encourage them to endorse HR 676.

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, Suite 602, Chicago, IL 60602."

Health care crisis by the numbers:
Data update from the PNHP newsletter editors

UNINSURED AND UNDERINSURED

According to the latest estimate from the Congressional Budget Office, the Affordable Care Act (ACA) will leave 31 million Americans without insurance in 2023, about 5 million more than would have remained uninsured if the ACA's Medicaid expansion had not been made voluntary. The demographic composition of the uninsured won't change much under the ACA; most will be non-Hispanic, white, low-income working-age adults. The majority (around 80 percent) will be U.S. citizens. 4.3 million children and nearly 1 million veterans will remain uninsured (Congressional Budget Office, May 14, 2013; Nardin et al, "The Uninsured After Implementation Of The Affordable Care Act: A Demographic And Geographic Analysis," Health Affairs, 6/6/13, reprinted on page 13).

• In 2012, 84 million adults – 46 percent of those aged 19 to 64 – did not have health insurance coverage for the entire year or had such high out-of-pocket costs that they were considered underinsured, up from 61 million in 2003. Underinsurance was defined as being insured all year but experiencing one of the following: out-of-pocket expenses of 10 percent or more of income; out-of-pocket expenses equal to 5 percent or more of income if low income (<200 percent of poverty); or deductibles equal to 5 percent or more of income.

Three-fourths of working-age adults with incomes less than 133 percent of poverty (i.e. less than $14,856 a year for an individual or $30,657 for a family of four) – an estimated 40 million people – were uninsured or underinsured in 2012. Fifty-nine percent of adults earning between 133 percent and 249 percent of poverty (between $14,856 and $27,925 for an individual or between $30,657 and $57,625 for a family of four) – 21 million people – were uninsured or underinsured. People with incomes under 250 percent of poverty accounted for 72 percent of the total number of Americans who were uninsured or underinsured in 2012.

On the plus side, the proportion of young adults ages 19–25 who were uninsured fell from 48 percent to 41 percent between 2010 and 2012, due to a provision in the 2010 Affordable Care Act allowing young adults to stay on a parent's health insurance until age 26.

In 2012, 80 million people reported that, during the past year, they did not go to the doctor when sick or did not fill a prescription due to cost, up from 63 million in 2003. In 2012, 41 percent of working-age adults, or 75 million people, had problems paying their medical bills or were paying off medical bills over time, up from 58 million in 2005. In addition, an estimated 28 million adults used all of their savings to pay off bills and 4 million adults had to declare bankruptcy in the previous two years. (2012 Biennial Health Insurance Survey, Commonwealth Fund)

• High and rising deductibles are driving up underinsurance. Five years ago, 12 percent of workers faced a deductible of at least $1,000 for single coverage. Today more than one-third of workers do, according to the Kaiser Family Foundation's 2012 survey of employer-sponsored plans. Increasingly, a high-deductible plan is the only insurance offered on the job, even at big firms (Andrews, Kaiser Health News, 5/20/13).

In one of the largest studies of its kind, 36.3 percent of the uninsured reported problems with medical bills in the first half of 2012. Overall, 20.3 percent of families, 54.2 million people, had difficulty covering their medical expenses. (Cohen et al, "Problems Paying Medical Bills: Early Release of Estimates From the National Center for Health Statistics," June 2013).

• Fifty-eight percent of patients who use an out-of-network provider in the hospital do so involuntarily, according to a recent survey. A visit was considered involuntary if it was due to a medical emergency (68 percent of involuntary contacts) or the physician's out-of-network status was unknown at the time of contact (31 percent of involuntary contacts). Fifteen percent of patients who saw an out-of-network physician as an outpatient did so involuntarily, but this is likely an underestimate because it didn't include people for whom an in-network provider was unavailable. Out-of-network care is costly and is only minimally covered by private insurance, adding to already burdensome expenditures for high-deductibles and coinsurance (Kyanko et al, "Out-of-Network Physicians: How Prevalent are Involuntary Use and Cost Transparency," HSR, June 2013).

• Uninsured hospitalized neonates have mortality 2.6 times higher than their insured counterparts, according to a new study. Of 4,318,121 neonates discharged in 2006, 5.4 percent were uninsured. 9.5 percent of all neonates who died were uninsured. Not surprisingly, five serious conditions, low birth weight, intraventricular hemorrhage, hypoxia, necrotizing enterocolitis, and congenital malformation, were the strongest predictors of mortality (adjusted odds ratio from 13.7 – 3.1). Lack of insurance had an adjusted odds ratio of 2.6, greater than most other clinical conditions. Compared with insured neonates, uninsured neonates received significantly fewer inpatient resources. Similar death outcome results were observed using data from 2003 and 2009 (Morris, F. "Increased Risk of Death among Uninsured Neonates," Health Services Research, August 2013).

RACIAL AND SOCIOECONOMIC INEQUALITY

• Although black seniors live, on average, half as far from a high-quality hospital as white seniors, they are between 25 percent

and 58 percent more likely to receive surgery at lower-quality hospitals. Additionally, black seniors in the most segregated areas are between 41 percent and 96 percent more likely than white seniors to have surgery at the lower-quality hospitals, an analysis of Medicare data from 2005 to 2008 found. For coronary artery bypass, the odds were 48 percent higher; for lung cancer resection, 41 percent higher; and for abdominal aortic aneurysm repair, 96 percent higher. Blacks living in regions with more residential racial integration are no more likely than whites to receive care in low-quality hospitals. The authors note that lack of resources may cause low-quality and that policies such as pay-for-performance, bundled payments, and nonpayment for adverse events may divert resources away from low-quality hospitals, further reduce quality, and exacerbate racial disparities (Dimick et al, "Black Patients More Likely Than Whites To Undergo Surgery At Low-Quality Hospitals In Segregated Regions," Health Affairs, June 2013).

• A new measure of poverty that takes medical expenses and social programs into account – the Supplemental Poverty Measure (SPM) – found that seniors are much worse off than previously thought. The SPM poverty rate for seniors is 15 percent compared to the standard rate of 9 percent, mostly due to the shrinking proportion of seniors' health care costs covered by Medicare (Matthews, "Senior poverty is much worse than you think," Washington Post, 5/20/13).

• A study of Florida's "Welfare-to-Work" social experiment found a higher mortality rate among recipients whose welfare benefits were limited to 24-36 months than among recipients of traditional, non-time-limited welfare. Among the 1,611 participants in the group pressured to get jobs, 4.7 percent died by 2011 versus 4.2 percent among the 1,613 people who remained on traditional welfare, a statistically significant 20 percent difference. Earlier studies had reported that time limits led to higher employment but had not looked at health outcomes (Muennig et al, "Welfare Programs That Target Workforce Participation May Negatively Affect Mortality," Health Affairs, June 2013).

The U.S. poverty rate increased from 11.3 percent in 2000 to 15.1 percent (50 million people) in 2010. The federal poverty limit in 2012 was $11,170 for an individual and $23,050 for a family of four.

In 2011, 1.65 million U.S. households were living in extreme poverty, defined as less than $2 a day per person. Those households include 3.55 million children, and account for 4.3 percent of all non-elderly households with children, up from 1.7 percent in 1996. Increasing extreme poverty is a long-term trend ("Safety Net Hospitals at Risk Report," Alvarez & Marsal Healthcare, 4/16/13; Matthews, Millions of Americans live in extreme poverty. Here's how they get by," Washington Post, 5/13/13).

• Between 2000 and 2009, only 7.9 percent of unauthorized immigrants benefited from public-sector health care expenditures (receiving an average of $140 in benefits per person per year), compared to 30.1 percent of U.S. natives (who received an average of $1,385) (Stimpson et al, "Unauthorized Immigrants Spend Less Than Other Immigrants And US Natives On Health Care," Health Affairs, 6/12/13).

• Between 2009 and 2011, average real income per family grew modestly by 1.7 percent but the gains were uneven. The incomes of the top 1 percent grew by 11.2 percent while the incomes of the bottom 99 percent shrunk by 0.4 percent. This has troubling health implications because there is substantial evidence that income inequality is associated with worse population health (Saez, "Striking it Richer: The Evolution of Top Incomes in the United States," Econometric Laboratory Software Archive, 1/23/13).

COSTS

• Health spending for 2013 is projected to total $2.92 trillion, 18.2 percent of GDP, or $9,807 per capita, up 4.0 percent from 2012. Health inflation dropped to a historic low of 3.9 percent in 2009, and is expected to average 5.7 percent between 2014-2021 as the ACA is implemented (Keehan et al, "National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands And Economic Growth Accelerates," Health Affairs, June 2012).

The Milliman Medical Index estimated that the cost of health care services for a typical family of four with an employer-sponsored preferred provider plan, is $22,030 in 2013, up 6.3 percent since 2012. That includes an employee contribution to the premium of $5,544 and out-of-pocket expenses of $3,600, for a total employee share of $9,144, up 6.5 percent from 2012. It also includes an employer contribution of $12,886 which is indirectly paid by the employee through forgone wage increases ("Milliman Research Report," Milliman Medical Index, 5/23/13).

• For-profit hospitals typically submit higher bills to Medicare than do nonprofit facilities. In contrast, public hospitals typically bill Medicare less than either nonprofit or for-profit hospitals, according to data released by Medicare on the costs of hospital procedures at 3,300 hospitals (Meier, McGinty and Creswell, "Hospital Billing Varies Wildly, Government Data Shows," New York Times 5/8/13).

• Forty-three percent of the Massachusetts state budget is going to health care this year. The $15.1 billion health tab funds the Medicaid program, subsidized insurance under the 2006 health care reform law, premiums for state employees' health insurance, and public health programs (Norton, "Health care, education consume 63 percent of planned state budget," State House News Service, July 6, 2012)

MEDICARE

• A record 14.4 million Medicare beneficiaries, 28 percent of all beneficiaries, are enrolled in Medicare Advantage (MA) plans

in 2013, up nearly 10 percent from 2012. Since 2010, enrollment in Medicare Advantage plans has grown by 30 percent in spite of predictions that the payment reductions enacted under the ACA would reduce enrollment. Why didn't enrollment fall? CMS subsequent awarded "quality bonuses" to nearly all plans plus a 5.5 percent upward "adjustment" to MA payment rates. These actions have offset ACA mandated payment reductions and kept MA plans profitable (Kaiser Family Foundation, "Medicare Advantage 2013 Spotlight: Enrollment Market Update," 6/10/13).

• Medicare Advantage plans profit by selectively enrolling and retaining healthy beneficiaries and disenrolling the expensively ill ("cherry-picking and spitting out the pits"). A new study finds that disenrollment to traditional fee-for-service (FFS) Medicare from Medicare Advantage plans continues to occur disproportionately among high-cost beneficiaries. Disenrollees incurred $1,021 per month in Medicare payments, compared with $798 in predicted payments (ratio of actual/predicted=1.28, $p < 0.001$ (Riley, "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Service," Medicare & Medicaid Research Review, 2012: Vol. 2, No. 4).

• Insurers that sell Medicare Advantage plans received $5.1 billion in overpayments between 2010 and 2012 due to upcoding, according to a new report from the Government Accountability Office. The insurers receive higher payments for members with certain medical diagnoses, so Medicare Advantage plans have an incentive to maximize their members' diagnoses (Overland, "CMS overpaid Medicare Advantage plans by $5.1B," FierceHealthPayer, 3/6/13).

The ACA is cutting $36.2 billion in funding for safety-net hospitals over the next five years on the premise that the ACA will result in fewer individuals receiving uncompensated care. Medicaid Disproportionate Share Hospital (DSH) payments are the largest source of federal funding for uncompensated care, with fiscal year 2011 allotments totaling nearly $11.3 billion. The ACA cuts $14.1 billion from Medicaid DSH payments between 2014 and 2019, resulting in a 50 percent reduction by 2019 compared to the baseline.

Medicare DSH payments are somewhat smaller, totaling $10.8 billion in 2010. Between 2014 and 2019, Medicare DSH payments to hospitals are being cut by $22.1 billion, a 28 percent reduction. Hospitals qualify for Medicare DSH payments through a complex formula that assesses the share of a hospital's patients who are low income. Beginning in FY 2014, base Medicare DSH payments to hospitals are being cut by 75 percent. Hospitals that continue to treat large number of uninsured individuals are supposed to see smaller cuts (Davis, "Q & A Disproportionate Share Hospital Payments and the Medicaid Expansion," National Health Law Program, July 2012).

MEDICAID

• In 2008, Oregon held a lottery for uninsured low-income adults to determine eligibility for Medicaid coverage. It accepted only 10,000 out of 89,824 applicants on a waiting list, launching the first randomized controlled trial of Medicaid coverage. The most recent results show that Medicaid provides partial financial protection. The incidence of catastrophic expenditures (over 30 percent of household income) for families was reduced from 5.5 percent in the uninsured group to 1.0 percent in the Medicaid group, while the proportion having to borrow money to pay medical bills or to walk away from the bills was reduced from 24 percent to 10 percent. However, the proportion reporting any medical debt was only reduced from 57 percent to 44 percent. Those receiving Medicaid used more health care, especially preventive services, and had a 30 percent reduction in depression. Blood pressure was also reduced, although that improvement did not achieve statistical significance, perhaps because fewer than 400 hypertensives were in the study (Baicker et al, "The Oregon Experiment – Effects of Medicaid on Clinical Outcomes," New England Journal of Medicine, 5/2/13).

• The largest Medicaid managed-care operator in D.C., Chartered Health Plan, which was responsible for providing care for over 100,000 AmeriHealth enrollees, collapsed in May. The plan leaves more than $60 million of unpaid medical bills and leftover claims, about 70 percent of which is owed to hospitals. AmeriHealth enrollees and providers in Chartered are being shifted to a new plan, Thrive Health Plan. The city has proposed settling at around $18 million, meaning providers would receive less than 30 cents of every dollar owed (DeBonis, "D.C.'s Medicaid upheaval puts health-care providers in a tight spot," Washington Post, 5/25/13).

ACA WATCH

• HHS Secretary Kathleen Sebelius has been asking health industry executives for large donations to assist in the ACA's implementation. Operating on what officials have described as a "shoestring budget," HHS has given 11 states more than $1.5 billion to help set up their exchanges as well as invested, as of March 2013, $394 million in information technology services to run "federally facilitated exchanges" in 25 more states. The Congressional Budget Office estimates that federal agencies will need between $5 billion and $10 billion to get the law up and running over the next decade (Kliff, "Budget request denied, Sebelius turns to health executives to finance Obamacare," Kaiser Health News, 5/10/13. GAO-13-601 Federally Facilitated Health Insurance Exchanges; RWJ Health Policy Brief, "Federally Facilitated Exchanges," 1/13).

BIG BUSINESS MAY GET OFF THE HOOK FOR SOME ACA MANDATES

• Under pressure from the business community, a key feature of the ACA, the employer mandate (the requirement that employers with 50 or more employees provide health coverage

to employees who work 30 or more hours per week or pay a $2,000 per-employee fine) has been delayed until 2015. The Obama administration said the delay was necessary in order to simplify the complicated reporting requirements under the law, and give businesses more time to adjust coverage. During the delay, employers will also be exempt from the $3,000 per-employee fine for each worker who receives a subsidy to purchase coverage on the health exchanges. Although most large firms either self-insure or provide insurance already, workers at firms that don't provide coverage will be forced to apply for Medicaid or subsidies on the exchanges. The individual mandate, the requirement that individuals purchase coverage or pay a fine of $95 or 1 percent of income, whichever is greater, is still due to go into effect January 1, 2014 (The penalty rises to $695 or 2.5 percent of income in 2016). Since data on employment and insurance coverage will be unavailable in 2014, the government will not be able to verify applicants' incomes, needed to determine subsidies on the health exchanges, or tell if someone is being honest when they say they have employer sponsored health insurance on their taxes.

According to The Wall Street Journal, large employers are not subject to the ACA's requirement that employers offer "minimum essential benefits." According to a strict reading of the ACA, only policies sold on the health exchanges to individuals and small businesses must meet the minimum essential benefits requirement, leaving out 130 million of the more than 160 million people with private insurance. A few large firms in the restaurant, retail and hospitality industries are working with insurers to design inexpensive "skinny" plans, with premiums under $50 a month, to replace their old "mini-med" plans, which had benefit caps as low as $2,000. The new plans won't have caps but may only cover preventive services and a few doctors' visits, excluding coverage for hospitalization, emergency care, prescription drugs, and other essential benefits.

Though firms could still face a $3,000 per employee fee – starting in 2015 – if any employees opt-out of their employer plan to get subsidized coverage through the exchanges, the risk of massive opt outs is minimal because even with federal subsidies those policies are expensive. A full-time worker earning $9 an hour would have to pay as much as $70 a month for a "silver" plan, even with the subsidies, according to the Kaiser Family Foundation. At $12 an hour, the workers' share of the premium would rise to as much as $140 a month. At this point it is still unclear how many employers will try the "skinny plan" strategy and whether or not regulators will outlaw it (Weaver and Mathews, "Employers Eye Bare-Bones Health Plans Under New Law," The Wall Street Journal, 5/19/13).

• Another strategy that large employers could use to circumvent the mandate is to shift workers to part-time status (defined as working less than 30 hours a week). Already the nation's largest movie chain, Regal Entertainment Group, with more than 500 theaters in 38 states, is cutting back workers' hours to avoid paying for health care. Similarly, the state of Virginia mandated that all part-time state employees (many of whom teach in community colleges) work no more than 29 hours per week. Youngstown State University in Ohio recently announced a 29 hour per-week part-time limit and placed employees on notice that they would be fired if they worked more than the maximum (Pollack, "States Cutting Employee Hours To Avoid Obamacare Costs," Fox News, 2/9/13; Chiaramonte, "Nation's Biggest Movie Theater Chain Cuts Workweek, Blaming Obamacare," Fox News, 4/15/13).

In a letter to Democratic leaders, the presidents of three large unions, the Teamsters, the United Food and Commercial Workers, and UNITE HERE wrote that the ACA will destroy "the foundation of the 40 hour work week that is the backbone of the American middle class" and "the very health and well-being of our members." Union-run multi-employer insurance plans (also known as Taft-Hartley plans) provide continuity of coverage in industries where job turnover is high and employment is often intermittent. The plans, which cover about 26 million people, are at risk of destabilization if employers cut workers' hours to avoid the employer mandate or shift them into lower-cost, subsidized plans sold on the exchanges. Under the ACA's current provisions, multi-employer plans are not eligible for the subsidies for coverage available to working people (138 percent to 400 percent of poverty). Hence the union plans won't be able to compete to cover workers in their industry with incomes under 400 percent of poverty. Although their multi-employer plans aren't eligible for federal subsidies, they will be subject to the same taxes as other private plans, such as the $63 per-person tax to support the reinsurance pool for the exchanges (each year for three years) and the "Cadillac" tax (see below). Two more unions, the International Brotherhood of Electrical Workers and the Laborers' International Union of North America, are also speaking out about the need for an "equitable fix" to the ACA (Single Payer News, 7/17/13, www.unionsforsinglepayer.org; Bogardus, "Unions break ranks on ObamaCare," The Hill, 5/21/13).

• Beginning in 2018, a new 40 percent excise tax, the "Cadillac Tax" will be levied on employers that offer plans that cost more than $10,200 for an individual or $27,500 for a family. Citing the threat of the tax, large employers are cutting benefits and raising co-pays and deductibles. Since 2009, the percentage of workers in plans with a deductible of at least $2,000 has doubled to 14 percent. Now more than a third of workers are in plans with an annual deductible of at least $1,000. Although the tax doesn't begin until 2018, employees are starting to feel the squeeze with some deductibles as high $6,000. The Congressional Budget Office estimates that the government will collect $80 billion in taxes on high premium plans between 2018 and 2023 (Abelson, "High-End Health Plans Scale Back to Avoid 'Cadillac Tax,'" New York Times, 5/27/13).

• Meanwhile, the administration says the small business exchanges, which offer tax credits to qualifying companies, are still on schedule, although they have delayed a rule that required

the exchanges to offer more than one plan. Workers at small businesses were supposed to be able to select from two or more plans. (Mary Agnes Carey, KHN, 7/2/13).

MEDICAID EXPANSION WON'T REMEDY ACCESS PROBLEMS

Only 23 states are currently committed to expanding their Medicaid programs under the ACA (a 2012 Supreme Court ruling on the ACA made the Medicaid expansion optional). Arkansas received approval to use its Medicaid funds to buy private insurance policies for Medicaid beneficiaries on the exchange, a move that will divert funds to overhead and profits and away from care; several other states are interested in following suit. Some 5.7 million low-income residents in states that are not expanding their Medicaid programs won't be eligible for any assistance gaining health coverage. They make too much to qualify for their state's current Medicaid program and too little to qualify for a federal subsidy on the exchanges, available to people making 138 percent to 400 percent of poverty. A person supporting a family of four who works full time at a job that pays $14 hour will qualify for a subsidy, but if they make $10 an hour, under current law, they will not (Pear, "States' Policies on Health Care Exclude Some of the Poorest," New York Times, 5/24/13).

• The ACA was supposed to hike Medicaid primary care payments nationally by an average of 73 percent, to the same level as Medicare's, in 2013 and 2014. Due to administrative delays, only a handful of states, including Maryland, have begun paying doctors at the higher rates. However, the increase may not draw many new physicians into the program. In 2009, Washington, D.C., increased Medicaid rates to all doctors to the same level as Medicare but failed to see a major increase in participation, possibly because poor people are concentrated in neighborhoods where few doctors practice (Pugh, "Most doctors still reject Medicaid as program expansion nears," McClatchy News, 5/13/13; Galewitz, "Increase in doctors' pay for Medicaid services off to a slow start," Washington Post, 5/18/13).

EXCHANGES – FAILING TO FIX THE INSURANCE MARKET

• The majority of the $1.8 trillion cost of the ACA over the next decade, $1.1 trillion, is going to subsidize the purchase of private insurance (the rest is for the Medicaid expansion) (CBO, "May 2013 estimate of the effects of the Affordable Care Act on Health Insurance Coverage," Table 1 and Table 2).

• Twenty-seven percent of uninsured, non-elderly adults with incomes in the tax credit range (138 percent to 400 percent of poverty) lack checking accounts. But most health plans on the exchanges will only be able to accept electronic transfers to pay premiums, setting up an access barrier for the "unbanked." African Americans and Hispanic Americans are over 40 percent more likely to be without checking accounts relative to whites of similar income. Also, as many as 5 million veterans and other Americans who receive federal benefits on prepaid debit cards may not be able use those same cards to pay their premiums for federally subsidized insurance (Varney, "How Will The 'Unbanked' Buy Insurance On The Exchanges?" Kaiser Health News, 5/20/13).

The ACA is supposed to limit out-of-pocket costs to $6,350 for an individual and $12,700 for a family (excluding premiums and spending on uncovered services, e.g. more than a few visits of physical therapy). But many plans have separate administrators for pharmacy and other benefits, and they will not be required to combine their tallies of members' out-of-pocket spending until 2015. Plans with no drug spending limit – the norm – won't have to cap out-of-pocket drug costs at all (Andrews, "Federal Rule Allows Higher Out-Of-Pocket Spending For One Year," Kaiser Health News, 6/11/13).

• The three lowest-priced silver plans available on California's exchange will cost $321 monthly. The bronze plan's price is less steep (depending on where you live, see below) but it comes with a $5,000 deductible for an individual ($10,000 for a family) and very high (50 percent) cost-sharing for many services. For example, a person would have to pay 50 percent of the bill for an inpatient stay, even to have a baby; 50 percent for emergency care, unless it resulted in an admission; 50 percent for diagnostic tests like CT scans and MRIs; and $120 for an urgent care visit (Lieberman, "Obamacare Exchange Watch: Low Healthcare Costs or California Dreaming?" OpEd News, 6/7/13).

Premiums on the California exchange vary dramatically by location. For the same health coverage from the same insurer, a 40-year-old resident in rural Mono County will pay $150 a month more in premiums (nearly 60 percent more) than an individual in Los Angeles County. The cost of the lowest level of coverage, bronze, for a 25-year-old ranges from $147 to $274 per month depending on location (Sanders, "Geography affects premiums on California health insurance exchange," The Sacramento Bee, 6/5/13).

• Many plans sold on state health exchanges won't cover bariatric surgery or other treatments for weight loss. Although Medicare and two-thirds of large employers in the U.S. cover bariatric surgery, the states have signaled insurance companies in over two dozen states to exclude the treatment (Varney, "Obamacare Insurance Won't Cover Weight-Loss Surgery In Many States," Kaiser Health News, 5/27/13).

INTERNATIONAL

• In a recent poll, 65 percent of the Swiss population favored single payer over their current system in which about 60 highly regulated private insurers sell "basic coverage" on a nonprofit basis. A referendum on single payer is likely in 2014 or 2015 (Daily Kos, "Swiss voters want to ditch their ObamaCare, replace with single payer," 6/24/13).

• Per capita spending increased during 2000–10 by 1.2 percentage points of gross domestic product (GDP) in Germany, 1.5 percentage points in France, 2.6 percentage points in the U.K. and Canada, and 3.9 percentage points in the United States ("Health Care Cost Containment Strategies Used In Four Other High-Income Countries Hold Lessons For The United States," Health Affairs, April 2013).

• The Gini coefficient, which measures relative inequality within a nation (higher means greater inequality), was 0.499 for the U.S. before taxes and transfers, and 0.380 after taxes and transfers, in 2010. The average Gini coefficient for OECD countries after taxes and transfers (0.316) was substantially lower than in the U.S. but still alarming. Between 2007 and 2010, income inequality in OECD countries increased by more than it had in the previous 12 years. The welfare state cushioned the impact of the global economic crisis for many, but spending cuts on health and social programs risk causing greater inequality and poverty in the years ahead. ("Growing risk of inequality and poverty as crisis hits the poor hardest," OECD Publishing, http://bit.ly/18Kba0d, 5/15/13).

• An average of 73 percent of all health spending was publicly financed in EU member states in 2010. Public financing accounted for over 80 percent in Sweden, Denmark, Norway, the Netherlands, and the U.K. ("Health at a Glance: Europe 2012," OECD, 11/16/12, http://www.oecd.org/health/healthataglance/europe).

Over a lifetime, tax payments to fund the Canadian health system are modestly progressive, with the most affluent quintile paying a slightly higher share of their income (8 percent) than the least affluent quintile (6 percent). Only the highest income group pays substantially more in taxes than they receive in care (3 percent of average income). Taxes for care paid by middle- and upper-middle-income groups were very close to their health care utilization costs. Health care utilization costs for the lowest quintile were equivalent to 24 percent of average income, demonstrating that this group would face hardship paying for care without Canada's single-payer health program ("Publicly Financed Health Care in Canada: Who Pays and Who Benefits Over a Lifetime?" Canadian Institute for Health Information, May 2013).

CORPORATE MONEY AND CARE

• Aetna's CEO Mark Bertolini announced that the firm intends to reduce its already limited provider networks by one-half to three-fourths for plans they market on the exchanges. The firm will also continue to favor "margins over membership" and will pull out of the exchanges if they do not "develop favorably" or if "they ask for unreasonable rates" (Quote of the Day, Don McCanne, on 2013 Q1 Earnings Conference Call with Mark Bertolini - Chairman, CEO and President of Aetna, and Shawn Guertin - Chief Financial Officer of Aetna, 4/30/13).

• Private equity firms invested $4 billion in 2012 in health and medical services, including urgent care clinics, up from $3.5 billion in 2011. Urgent care clinics, one of the fastest growing areas of investment, generate average EBITDA (earnings before interest, tax, depreciation, and amortization) margins of about 20 percent (Abrahamian, "Analysis: Private equity funds rapid growth of walk-in clinic," Reuters, 5/21/13).

• The Department of Justice is suing Vitas Healthcare and Vitas Hospice, the nation's largest hospice chain, for submitting tens of millions of dollars in fraudulent Medicare claims over than a decade. In 2011, Vitas Hospice, founded by Florida Senate president Dan Gaetz, received $856 per patient per day from Medicare, compared to the usual rate of $652 per day (Kennedy, "Florida Senate president's former hospice company sued by feds for alleged Medicare fraud," Associated Press, 5/9/13).

In 2012, CEOs at the nation's six largest insurance companies received $83.3 million in pay. WellPoint's Angela Braly topped the list with $20.6 million, followed by UnitedHealth Group's Stephen Hemsley ($13.9 million), Aetna's Mark Bertolini ($13.3 million), Coventry Health Care's Allen Wise ($13 million), Cigna's David Cordani ($12.9 million), and Health Net's Jay Gellert ($10.2 million). Aetna also spent $201,093 on Bertolini's personal use of corporate aircraft and around $16,000 to upgrade the executive's home security system. The company said it did this "in light of concerns regarding the safety of Mr. Bertolini and his family as a result of the national health care debate" (AFL-CIO Executive Pay Watch, accessed on 6/25/13; Murphy, "Aetna Chairman CEO Compensation Climbs 26 percent," ABC News, 4/8/13).

Richard Bracken, the CEO of Hospital Corporation of America (HCA), a chain of 135 for-profit hospitals, was the second highest paid CEO in 2012. His compensation was $38.6 million ("The Highest Paid C.E.O.'s," New York Times, 4/5/13).

• For-profit hospices are twice as likely as nonprofit hospices to have at least one restrictive enrollment policy to avoid potentially high-cost patients. Patients with serious illnesses may need complex and expensive palliative treatments, but only one-third of hospices will enroll patients who are receiving palliative chemotherapy, and only one-half will enroll patients receiving total parenteral nutrition. (Carlson, "Unusual billing patterns spur probe of inpatient hospice care," Modern Healthcare, 5/6/13; Carlson et al, "Hospices' Enrollment Policies May Contribute to Underuse of Hospice Care in The United States," Health Affairs, December 2012).

BIG PHARMA

• The 11 largest global pharmaceutical companies made a combined $711 billion in profits over the last decade and paid their CEOs a total of $1.57 billion, according to corporate filings. In 2012 alone the drug companies' CEOs drew total compensation of $199.2 million. In 2006, the first year of the Medicare prescription drug law, the pay of the CEOs jumped by $58.9 million. The top earners in 2012 were Johnson & Johnson's

William Weldon, who took in $29.8 million, and Pfizer's Ian Read, who received $25.6 million. By comparison, half of all Medicare beneficiaries had less than $22,500 in annual income (Rome, "Big Pharma CEOs Rake in $1.57 Billion in Pay," Health Care for America Now, 5/8/13).

• The CEO of the giant drug distributor McKesson, John Hammergren, has a pension worth $159 million. The Wall Street Journal called it "almost certainly the largest in corporate America." Hammergren has been one of the highest-paid executives in the U.S. in recent years, receiving over $130 million in 2011 alone, and more than $355 million in cash and stock over the past seven years (Mark Maremont, Wall Street Journal, 6/24/13).

• Federal prosecutors have charged Novartis with providing illegal kickbacks to over 20 pharmacies to promote the use of Myfortic (mycophenolate sodium), an immune suppressant used to help prevent rejection of transplanted kidneys. Myfortic competes with the Roche drug CellCept (mycophenolate mofetil) and, since 2009, with generic versions of CellCept. Prosecutors say in their lawsuit that Medicare and Medicaid paid tens of millions of dollars in claims for Myfortic that were influenced by kickbacks. In one example, Novartis paid $650,000 to Bryant's Pharmacy in Batesville, Ark. Bryant's submitted 8,300 claims for more than $3.2 million to Medicare Part B. Myfortic sales in the United States were $239 million in 2012, up 20 percent from 2011 (Pollack, "U.S. Accuses Novartis of Providing Kickbacks," New York Times, 4/23/13).

• The U.S. Supreme Court ruled that drug companies that pay a competitor to delay marketing copies of their products to settle a patent dispute, a practice known as "pay for delay," can be sued for violating antitrust laws. The Federal Trade Commission estimates that pay-for-delay deals raise health care costs by $3.5 billion annually. There were 40 "pay for delay" deals over patent disputes in 2012, up from 28 the year before, involving brand-name drugs with over $8.3 billion in sales, according to the FTC. Patent disputes often arise when brand-name drug companies seek to extend their 20-year patent monopolies for another 20 years by obtaining "secondary" patents on slightly modified versions of the drug or a change in how the drug is administered (Savage, Los Angeles Times, 6/18/13; Norman, Politico, 3/12/13).

• The Office of Fair Trading in London has accused GlaxoSmithKline of market abuse in a "pay for delay" scheme. The firm is accused of making substantial payments to three generic drugmakers to delay introducing generic versions of its antidepressant paroxetine between 2001 and 2004. If convicted, the firm could be fined up to 10 percent of its worldwide sales of the drug, which amounted to 26.4 billion pounds in 2012 (Hirschler, "OFT accuses GSK over 'pay-for-delay' drug deals," Reuters, 4/19/13).

• Fraud by pharmaceutical firms is accelerating. In the first half of 2012, drug companies paid penalties of $6.6 billion to settle 19 cases of illegal marketing, price-gouging, and other violations. Between 2002 and 2011, drug manufacturers paid $22.1 billion to settle 202 allegations of illegal marketing, price-gouging of government programs and other violations, most of them in the past five years (Almashat S. and Wolfe S., "Pharmaceutical Industry Criminal and Civil Penalties: An Update," Public Citizen, 9/12).

BIG BROTHER HEALTH CARE

Workplace wellness programs, a $6 billion industry, are not effective either financially or clinically, according to an evaluation by RAND. Researchers analyzed data from about 600 large employers, and medical claims data from the Care Continuum Alliance. Participants in wellness programs lost an average of only 1 pound over three years, saw no significant reductions in cholesterol levels, and did not generate any significant reduction in health care costs. Nonetheless, under the ACA, employers can penalize workers up to 30 percent of premiums based on their lack of participation in a corporate wellness program. Penalties can rise up to 50 percent for smokers who don't participate in tobacco cessation programs (Munro, "RAND Corporation Briefly Publishes Sobering Report On Workplace Wellness Programs," Forbes, 5/28/13; Jost, "Implementing Health Reform: Workplace Wellness Programs," Health Affairs, 5/29/13).

Employees of CVS Caremark, the nation's largest drugstore chain, must disclose their weight, height, body fat and blood pressure or pay a $600-a-year fine. CVS says they need the information to improve their employees' health through preventive measures and providing incentives to be healthier, but critics fear that the data could be used to discriminate against unhealthy or disabled workers (Hamilton, "Report: CVS Caremark demands workers disclose weight and health info," Los Angeles Times, 3/20/13).

HOSPITALS AND ACOs, INC.

• As part of the ACO movement, health systems are increasingly buying or developing their own insurance plans to sell directly to employers. One of the nation's largest nonprofit hospital operators, Englewood, Colo.-based Catholic Health Initiatives (CHI), which operates over six dozen hospitals in 17 states, has acquired a majority stake in Soundpath Health, a Washington-state-based insurer for $24 million, and is looking for other insurers to acquire.

CHI is not alone in jumping into the insurance game. The Detroit Medical Center and its nonprofit parent Vanguard Health Systems recently acquired ProCare Health Plan, a Detroit-based Medicaid HMO, for $6 million. Massachusetts' largest (and most expensive) hospital and physician network, Partners HealthCare System, acquired Neighborhood Health Plan, a nonprofit insurer with 240,000 enrollees. Partners is providing grants to more than 50 community health centers affiliated with the insurer. Another Massachusetts health system, Steward Health Care System, is planning to sell a health

plan called "Steward Community Choice." The plan will be administered by a nonprofit HMO, Tufts Health Plans, and will target small businesses. Two of Atlanta's largest health care providers, Piedmont Healthcare and WellStar Health System, are planning to jointly launch an insurer by the end of 2013 (Evans, "Cutting out the middleman," Modern Healthcare, 3/25/13, Patricia Kirk, "As ACO movement gathers momentum, hospitals and health systems see opportunities in providing health insurance," Dark Daily.com, 7/13/13).

• The nonprofit Cleveland Clinic, which owns eight hospitals in Ohio along with several out-of-state facilities, is forming an "alliance" with one of the nation's largest for-profit hospital operators, the 135-hospital chain Community Health Systems Inc. (CHS), based in Franklin, Tenn. The Cleveland Clinic will help some CHS hospitals with their cardiovascular services – and allow CHS to use their famous name in advertising – while CHS will help the Cleveland Clinic with the "operational efficiency" of their nonprofit hospitals. The two companies said they will share data for research and also participate in future joint ventures that could include acquisitions. The Mayo Clinic created the Mayo Clinic Care Network in 2011 which now includes 16 member hospitals and health centers while the MD Anderson Cancer Center now has 11 members in an ever-growing network. It's a "health care version of the franchise arrangements common in other industries" according to The Wall Street Journal (Mathews, WSJ, 3/11/13).

• The Centers for Medicare and Medicaid Services flagship cost-control effort, the Pioneer Accountable Care Organization (ACO) Model, produced negligible savings in its first year. Of 32 participating organizations with 670,000 beneficiaries (out of 425 ACOs nationally), only 13 produced savings, 2 lost money, 2 dropped out, and 7 more are planning to switch to another Medicare program with no risk attached to it (the Medicare Shared Savings Program). Some quality gains were reported, such as improved cholesterol control for diabetes patients, but given that the organizations were told in advance about the 15 measures that would be used to determine if they met quality standards, they may simply represent teach-to-the-test gains. Cigna, Aetna and United, along with other insurers, have announced they expect to develop hundreds more ACOs in the future (Don McCanne, "Pioneer Accountable Care Organizations Disappoint," Quote of the Day, 7/16/13, archived at www.pnhp.org)

Tenet is acquiring Vanguard Health Systems for $4.3 billion, including the assumption of $2.5 billion in Vanguard debt. The acquisition will boost the number of Tenet hospitals from 49 to 79 and add new markets such as Chicago and Detroit as well as deepen its reach into Texas. Tenet, which paid nearly $1 billion in fines for fraud and patient abuse in the mid-1990s while operating as National Medical Enterprises, and paid another $1.7 billion in penalties between 2002 and 2006 to settle charges of improper Medicare billing, unnecessary cardiac procedures, kickbacks, and other claims, says it is going to step-up its acquisitions of hospitals in the coming period (Mathews, Wall Street Journal 6/24/13; "Lest We Forget: Tenet Healthcare Settlement Payments, 1994-2007," http://bit.ly/14ScVHi, accessed on July 18, 2013).

• Studies show that hospital mergers significantly increase hospital prices. According to a report by the Robert Wood Johnson Foundation, "the magnitude of price increases when hospitals merge in concentrated markets is typically quite large, most exceeding 20 percent." A chart of some recent studies is reprinted below. (Gaynor and Town, "The Synthesis Project, The Impact of Hospital Consolidation – Update," Robert Wood Johnson Foundation, 6/9/12).

Author/Year	Location of mergers	Time frame of analysis	Results
Dafny (2009)	US	1999–2005	Merging hospitals had 40% higher prices than non-merging hospitals.
Haas-Wilson and Garmon (2011)	Evanston, IL Mergers of Evanston-NW & Highland Park and St. Therese & Victory Memorial	1990–2003	Post-merger, Evanston-NW hospital had 20% higher prices than control group; no price effect at St. Therese–Victory.
Tenn (2011)	SF Bay Area, CA Sutter/Summit merger	1999–2003	Summit prices increased 28.4% to 44.2% compared with control group.
Thompson (2011)	Wilmington, NC New Hanover-Cape Fear merger	2001–2003	3 of 4 insurers experienced a large price increase; 1 insurer experienced a decrease in prices.

Sources: Dafny L. "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," Journal of Law and Economics 52:3, 2009; Haas-Wilson D. Garmon C., "Hospital Mergers and Competitive Effects: Two Retrospective Analyses," International Journal of the Economics of Business (IJEB) 18:1, 2011; Tenn S., "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," IJEB 18:1, 2011; Thompson E., "The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction," IJEB, 18:1, 2011).

WAMC NORTHEAST PUBLIC RADIO

April 12, 2013

Medicare and medicine as a profession

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

The following text is a slightly edited transcript of a radio commentary that Dr. Coates made on April 12, 2013. Dr. Coates is a regular contributor to WAMC's programming.

Medicare is the publicly-funded health benefit package that covers most necessary care for older Americans and people with disabilities.

Medicine (with education, law, and divinity) is one of the traditional professions. The American College of Physicians explains that our profession is characterized by its "specialized body of knowledge that its members must teach and expand, by a code of ethics and a duty of service that put patient care above self-interest." Elsewhere the ACP speaks of "the profession's collective responsibility to advocate for the health, human rights, and well-being of the public."

Medicare covers nearly 1 of every 6 people in the United States. When it was established in 1965 it opened new possibilities for physicians to treat patients. One of my retired physician friends recalls that before Medicare many of his elderly patients from a rural upstate village simply had no way to pay for care. Physicians would treat elderly patients of limited means for free. Often patients would bring homespun gifts or produce to the office as a tribute and a payment.

Today many patients remain unable to pay for care. Many physicians continue to volunteer their services (there are over 1,200 free clinics in the United States). Yet by its very existence, including that this popular public program has worked for 48 years, Medicare reminds us that there is really no excuse for anyone to be denied access to care.

Meanwhile medicine has been buffeted by an explosion of technology together with the steady infiltration of market forces in all aspect of caregiving.

This week Sen. Chuck Grassley, the Iowa Republican, asked Marilyn Tavenner, acting administrator of the Centers for Medicare and Medicaid Services (CMS), about a leak of information from CMS that caused health insurance stocks to soar.

The scandal was the leak of a decision by to raise federal payments to private insurance companies that run Medicare Advantage plans, publicly subsidized private benefit packages that are a private alternative to traditional public Medicare. The Obama administration, which once talked about cutting support to Medicare Advantage companies, reversed itself.

Forty minutes before the official CMS announcement health insurance stocks began trading furiously. In the 20 minutes between the official announcement and the market close, hundreds of millions of dollars of shares changed hands, driving the insurance company stock values skyward. Over the next few days the value of private insurance stocks rose by billions.

Dr. Andrew Coates

Because of the decision, UnitedHealth Group, the nation's largest insurer and the one with the greatest market share in Medicare Advantage, will receive an extra $1.49 billion from Medicare for its Medicare Advantage plans in 2014. On this news, UnitedHealth stock surged in value by over $5 billion – in just one week!

The larger scandal is that we have allowed profiteering into health care.

Medicare Advantage has been a means to privatize the public program of Medicare, a way to divert public resources to insurance company profits. Calling attention to cheating on stock trades neglects the larger scandal: resources meant to go to the care of the sick should not be the source of profits for anyone.

According to an analysis by Drs. Ida Hellander and David Himmelstein at Physicians for a National Health Program, the total taxpayer cost of the extra subsidy to Medicare Advantage insurers will be $71.5 billion to $104.5 billion over the next decade, depending on the number of Medicare beneficiaries who enroll in the private plans.

Within the Medicare population the healthy tend to be enrolled in Medicare Advantage, the sick tend to remain – or return – to traditional Medicare.

The trade-off works like this: patients with Medicare Advantage may enjoy the benefit of a free health club membership (something only the healthy can really enjoy), but after a hospitalization, for example, some patients with Medicare Advantage find out that daily co-pays for rehabilitation services, for example, are simply unaffordable. They have to forgo benefits that would have been covered under traditional Medicare.

Medicare Advantage works well for insurance company profits. For patients, not so much. As a program it should really be abolished and its resources redirected to traditional, public Medicare. Meanwhile bipartisan efforts to undermine the traditional, public Medicare program gain momentum.

Curiously this is happening a mainstream debate has again focused upon the insanity – and unaffordability – of health care. Steven Brill's Time magazine article "Bitter Pill" continues to gain readers. Just this week Bloomberg Businessweek ran an article by Jeffrey Pfeffer titled "The Reason Health Care Is So Expensive: Insurance Companies."

(continued on next page)

THE WALL STREET JOURNAL. June 16, 2013

Should Physician Pay Be Tied to Performance?

By Steffie Woolhandler, M.D.

Paying doctors for better care – not just more of it – seems like a no-brainer. Yet rigorous studies of pay-for-performance bonuses have found no health benefits and some unintended harms.

An exhaustive analysis of pay-for-performance research by the Cochrane Collaborative, an international group that reviews medical evidence, unearthed "no evidence that financial incentives can improve patient outcomes."

Consider these cases. In Britain's massive pay-for-performance program, family doctors earned almost perfect scores (and big bonuses) for hypertension treatment, but population surveys found no decrease in blood pressure or its main complication, strokes. Meanwhile, aspects of quality that didn't bring bonuses deteriorated.

The largest U.S. pay-for-performance experiment – Medicare's Premier Demonstration – also flopped. The 200 hospitals that offered bonuses scored slightly worse on patient death rates than other hospitals.

Proponents argue that programs like these were flawed in one way or another, and that the next trial – or the one after – will certainly do better. They also claim successes with other programs. But none of these claims rest on rigorous science, and all those that have subsequently been subjected to rigorous tests have failed.

No Easy Measurement

Why do these programs consistently fall short? Measurement is distorted once you pay doctors based on the data they themselves create. High scores may reflect real excellence, but can just as easily reflect cherry-picking or gaming the measurement system.

One Boston-area hospital we observed improved its quality score 40 percent just by getting doctors to change the words they wrote in patients' charts. Medicare gives hospitals more credit for saving patients with "acute respiratory decompensation" than those with "COPD exacerbations," although these terms are synonyms. That kind of practice is neither illegal nor unusual.

Beyond that, it's devilishly difficult to quantify doctors' performance in the first place. Hospital death rates seem, at first glance, an ideal measure of medical quality. Yet, four widely used algorithms yield completely different mortality rankings; a hospital rated outstanding in one often looks downright dangerous in another.

Even if – as some proponents argue – we find performance measures that work for one group of doctors, it's unlikely that they'll work for all providers in all patient populations. Moreover, many providers interact in providing care, and influence each other and patients' outcomes in complex ways. It's hard to imagine that incentives could optimize this as a system.

Ignoring Psychology

There's also psychology at work. Rewarding performance ignores the complexity of human drive, particularly the role of intrinsic motivation – the desire to perform an activity for its own inherent rewards. Offering your dinner-party host a $10 reward for cooking a wonderful meal isn't likely to motivate future invitations.

Studies have found that financial incentives often crowd out intrinsic motivation. For instance, college students will spontaneously play with interesting puzzles, but once they're paid to solve them, they lose interest in playing for nothing. When day-care centers in Israel imposed fines on parents for picking up children late, tardiness increased. Promptness transformed from a moral duty to a market transaction.

Pay for performance undermines the mindset required for good doctoring – the drive to do good work even when no one is looking. Moreover, it forces doctors to shift their attention from patients to computer screens – documenting trivial details useless for patient care but essential for compliance.

None can doubt medicine's grave quality problems. As a remedy, pay for performance suggests manipulating greed. This can certainly change medicine, but not necessarily in the ways that we would plan, much less hope for.

David U. Himmelstein and Dan Ariely contributed to this article.

(***Coates**, continued from previous page)*

Where are the doctors? We have an individual and a collective obligation to the duties of our profession. No longer should we allow the care of our patients to form a substrate for profiteering and enormous bureaucratic waste. We know what it means for our patients when we allow profit-seeking to direct the allocation of resources.

I believe we physicians have a professional duty to protect and expand Medicare as a public program. Medicare is far from perfect, but an expanded and improved Medicare-for-all finance system would not only help our patients. It would help restore our profession to a place where we can better meet our social obligations.

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

HealthAffairs Blog

June 6, 2013

The Uninsured After Implementation Of The Affordable Care Act: A Demographic And Geographic Analysis

By Rachel Nardin, Leah Zallman, Danny McCormick, Steffie Woolhandler, and David Himmelstein

The Affordable Care Act (ACA) proposed expanding health insurance coverage by: (1) requiring states to offer Medicaid to people with incomes up to 138 percent (133 percent plus a 5 percent income disregard) of the federal poverty level (FPL), with most of this expansion funded federally; and (2) offering subsidies to help those with incomes up to 400 percent FPL purchase private insurance through newly created insurance exchanges. The Congressional Budget Office (CBO) estimated in March 2012 that the ACA would newly insure 30-33 million people, leaving 26-27 million uninsured in 2016.

In June 2012, however, the Supreme Court ruled that states may opt-out of Medicaid expansion. Since then, the governors of 14 states have announced their intention to opt-out, 6 are undecided, 3 are leaning against, and 2 toward the expansion. Opt-outs will likely leave several million more uninsured, but little is known about who is likely to remain uninsured under the ACA.

To estimate the number and characteristics of U.S. residents who will remain uninsured in 2016, we analyzed data from the Census Bureau's 2012 Current Population Survey, a nationally representative survey of the non-institutionalized U.S. population.

Methods

We first categorized states as undeclared, opting in (or leaning toward opting in), or opting out (or leaning toward opting out) of Medicaid expansion. We then examined the projected demographic characteristics of the uninsured population under two scenarios: (1) that all undecided states opt-in and (2) that all undecided states opt-out.

Our projections assume that in opt-out states, 90 percent of currently uninsured people with incomes below 138 percent FPL will remain uninsured, along with 75 percent of uninsured people with incomes above 138 percent FPL. For opt-in states we assume that 40 percent of currently uninsured people with incomes less than 138 percent FPL will remain uninsured, along with 60 percent of uninsured people with incomes above 138 percent FPL. These assumptions are consistent with published take-up rates for public programs, prior publications, and CBO estimates regarding ACA implementation.

Results

We found that if all currently undecided states opt-in, 29.8 million people will remain uninsured, whereas if all opt-out, the number of uninsured will total 31.0 million, 1.2 million above the opt-in scenario.

Exhibit 1 displays the current number of uninsured in each state and the number who will likely remain uninsured under opt-in and opt-out. For states that are opting out, this choice will lead to a decrease in the number of uninsured of only approximately 17 percent, rather than the approximately 50 percent decrease had they opted in.

Exhibit 2 shows the demographic characteristics of the uninsured currently and post-ACA under our best and worst case scenarios. Overall, the ACA will minimally alter the demographic composition of the uninsured, regardless of whether undecided states opt-in or out. While Blacks and Hispanics will continue to be overrepresented among the uninsured, the majority will be non-Hispanic, white, low-income, working-age adults, many of them employed. The majority (around 80 percent) of the uninsured will be U.S. citizens, irrespective of states' acceptance of Medicaid expansion. More than 4.3 million children and nearly 1.0 million veterans will remain uninsured under either scenario.

Implications

The Supreme Court's decision to allow states to opt-out of Medicaid expansion weakens the ACA's impact. Because the ACA also reduces funding to safety-net hospitals, states' refusal to expand Medicaid will likely result in both medical and financial hardship for vulnerable Americans.

Our finding that, following the ACA, only 20 percent of the uninsured will be noncitizens (some of whom reside here legally) runs counter to the common perception that the ACA will cover virtually all legal residents.

The ACA will leave tens of millions uncovered. It will do little to alter racial disparities in coverage. It will also perpetuate disparities in access based on state of residence. The ACA, whatever its merits, will fall well short of its stated goal of providing affordable care for all Americans.

Exhibits 1 and 2 are on page 14.

Exhibit 1

	Thousands Uninsured Pre-ACA	Thousands Uninsured Post-ACA if State Opts *Out*	Thousands Uninsured Post-ACA if State Opts *In*
Opting in			
Arizona	1,137	930	579
Arkansas	508	420	253
California	7,425	6,100	3,746
Colorado	788	647	399
Connecticut	303	242	162
Delaware	90	74	46
District of Columbia	52	42	27
Florida	3,765	3,080	1,917
Hawaii	105	86	53
Illinois	1,873	1,523	967
Maryland	802	646	423
Massachusetts	219	180	112
Michigan	1,209	985	621
Minnesota	487	397	250
Missouri	877	723	440
Montana	180	149	91
Nevada	607	502	302
New Jersey	1,336	1,083	693
New Hampshire	163	130	88
New Mexico	399	328	201
North Dakota	61	50	32
Ohio	1,549	1,261	796
Oregon	532	433	274
Rhode Island	129	101	65
Vermont	53	42	29
Washington	986	806	503
Leaning toward opting in			
Kentucky	621	512	311
New York	2,355	1,917	1,211
Undeclared			
Indiana	764	623	391
Kansas	380	312	193
Tennessee	841	686	429
Utah	412	337	210
Virginia	1,066	865	552
West Virgina	273	223	140
Leaning toward opting out			
Alaska	130	104	68
Nebraska	225	182	118
Wyoming	100	80	54
Opting out			
Alabama	622	517	306
Georgia	1,862	1,541	924
Idaho	266	218	135
Iowa	303	245	159
Louisiana	938	772	471
Maine	133	107	70
Mississippi	476	395	236
North Carolina	1,550	1,268	790
Oklahoma	636	515	331
Pennsylvania	1,375	1,121	705
South Carolina	876	721	442
South Dakota	104	86	54
Texas	6,080	4,986	3,080
Wisconsin	589	482	300

Exhibit 2

	Pre- ACA adoption*	Post-ACA (all undecided states opt-out)	Post- ACA (all undecided states opt-in)
	% of uninsured (millions)	% of uninsured (millions)	% of uninsured (millions)
Age			
0-17	14.3 (7.0)	14.3 (4.4)	14.4 (4.3)
18-44	56.7 (27.6)	56.9 (17.6)	56.8 (17.0)
45-64	27.5 (13.4)	27.4 (8.5)	27.5 (8.2)
65+	1.4 (0.7)	1.3 (0.4)	1.3 (0.4)
Gender			
Male	52.6 (25.6)	52.5 (16.3)	52.7 (15.7)
Female	47.4 (23.0)	47.5 (14.7)	47.3 (14.1)
Race			
White	74.0 (36.0)	74.0 (22.9)	74.0 (22.1)
Black	15.9 (7.7)	16.4 (5.1)	16.4 (4.9)
Asian	5.6 (2.7)	5.2 (1.6)	5.2 (1.6)
Other	4.5 (2.2)	4.4 (1.4)	4.4 (1.3)
Ethnicity			
Hispanic	32.5 (15.8)	31.5 (9.8)	32.1 (9.6)
Non-Hispanic	67.6 (32.8)	68.5 (21.2)	67.9 (20.2)
Veteran **			
Yes	3.4 (1.4)	3.5 (0.9)	3.5 (0.9)
No	96.6 (40.7)	96.5 (25.6)	96.5 (25.0)
Nativity Status			
US Born	72.8 (35.4)	73.7 (22.8)	73.4 (21.9)
Foreign Born Citizen	7.1 (3.4)	7.2 (2.2)	7.3 (2.2)
Foreign Born Non Citizen	20.1 (9.7)	19.1 (5.9)	19.3 (5.8)
Income			
<100% FPL,	28.9 (14.0)	27.5 (8.5)	26.9 (8.0)
100-199% FPL	30.0 (14.5)	30.0 (9.3)	29.9 (8.9)
200-399% FPL	28.2 (13.7)	29.0 (9.0)	29.5 (8.8)
>399% FPL	13.1 (6.3)	13.4 (4.2)	13.7 (4.1)
Employment Status**			
Not in labor force	30.3 (13.1)	30.2 (7.9)	30.3 (7.4)
Employed	59.0 (25.5)	59.3 (15.5)	59.2 (14.4)
Unemployed	10.8 (4.6)	10.5 (2.7)	10.5 (2.6)
Total (millions)	100 (48.6)	100 (31.0)	100 (29.8)

From *The Uninsured After Implementation Of The Affordable Care Act: A Demographic And Geographic Analysis* on page 13.

Rachel Nardin, M.D., is chief of neurology at Cambridge Health Alliance and assistant professor of neurology at Harvard Medical School. For the biographies of Leah Zallman, M.D., M.P.H., Danny McCormick, M.D., M.P.H., Steffie Woolhandler, M.D., M.P.H., and David U. Himmelstein, M.D., visit bit.ly/1b8XbiK.

IN THESE TIMES

July 2013

Underinsured in the age of Obamacare

The Affordable Care Act does not make health care a right

By Adam Gaffney, M.D.

During the second presidential debate of 2008, Tom Brokaw asked Barack Obama and John McCain: "Is health care in America a privilege, a right or a responsibility?"

Obama, unlike McCain, did not hesitate to respond plainly that health care "should be a right for every American." He proceeded to make health care reform a major goal of his presidency.

Sadly, though, whatever its merits (and they are substantial), the Affordable Care Act (ACA) will not create a right to health care in America. Nor will it lead to a system of universal health care. Not because it will leave millions uninsured – though it will do that – for if uninsurance were the law's only flaw, with some combination of an expansion of subsidies and of Medicaid, the ACA could be transformed into a truly universal system.

The law has a more fundamental flaw: It fails to reverse a peculiarly American trend toward what is euphemistically called "underinsurance." We may have health insurance, in other words, but we cannot afford to become ill.

The ACA may actually exacerbate a practice that many of us face, in a limited and innocuous way, in our encounters with the health care system – a practice known as "cost-sharing."

Cost-sharing takes the form of co-pays, deductibles and other payments that are not covered by insurance and are often exacted at the point of service. In theory, cost-sharing decreases medical spending by giving us "skin in the game," as commentators frequently (and oddly) put it. The theory is that by forcing us to pay something out-of-pocket every time we "consume" health care, we are disincentived to utilize in excess, hence medical spending is controlled.

Many would ask whether the average person really needs to be disincentived from an invasive procedure or an unnecessary afternoon in the doctor's office. But in any event, it is clear that as cost-sharing eats up larger portions of our disposable income, we become "underinsured," forced to go broke or ration our health care.

The underinsured

Evidence suggests that underinsurance has been on the rise for years. A study published in the journal Health Affairs in 2008 found that in 2007, about 20 percent of Americans with insurance age 19-64 – about 25 million individuals – could be classified as underinsured (defined as having an exposure to out-of-pocket expenses above a certain threshold). This represents a striking 60 percent increase since 2003.

Along similar lines, according to a report from the Kaiser Family Foundation, the percentage of insured workers with a deductible of $1,000 or more increased from 10 percent in 2006 to 34 percent in 2012, while the percent with a deductible of $2,000 or more increased from 3 percent to 14 percent.

But more telling than these figures is what underinsurance means to those who must live with it day after day. In milder cases, it might simply mean another bill to be paid out of a paycheck stretched thinner and thinner. Or it might mean deciding to sacrifice certain medical services – deferring appointments, not filling prescriptions, or forgoing diagnostic tests. During my years of training in internal and pulmonary medicine, I have seen entirely reasonable patients of mine make exactly these sorts of decisions.

But underinsurance can also translate into financial ruin. One study from 2009 found that 62 percent of all bankruptcies filed in 2007 had a medical cause. Particularly alarming, however, is the fact that three-quarters of these "medical debtors" had health insurance at the time of the illness that led to their bankruptcy. If health insurance does not prevent us from going bankrupt when we get sick, can we really call it "insurance"?

The ACA will reform the insurance industry to some extent, for instance by expanding Medicaid, eliminating lifetime limits on coverage, and preventing insurers from excluding us for pre-existing conditions. But the base model, so-called bronze plans on the ACA exchange, will only cover 60 percent of an individual or a family's health care expenses.

Although there are out-of-pocket limits as well as subsidies for the poor, families will be susceptible to as much as an estimated $12,500 in annual out-of-pocket expenses – after their premiums have been paid. Similarly, the administration has moved to allow state officials to charge Medicaid patients higher co-payments for such necessities as doctor's visits and prescriptions, though these individuals are less able than any to afford such fees.

The ACA, in short, will clearly not reverse – and in some cases, will worsen – the trend toward low-value health insurance that is increasingly relied upon – both by individuals and employers – in an age of soaring premiums and now, the required purchase of insurance.

The Massachusetts experience

As we peer into the future of health care in America, let's look at how the system on which the ACA was modeled – Mitt Romney's Massachusetts health plan – has fared. A 2012 report by the state's Division of Health Care Finance and Policy found

(continued on next page)

HEALTH AFFAIRS

May 2013

Some Families Who Purchased Health Coverage Through The Massachusetts Connector Wound Up With High Financial Burdens

By Alison A. Galbraith, Anna D. Sinaiko, Stephen B. Soumerai, Dennis Ross-Degnan, M. Maya Dutta-Linn, and Tracy A. Lieu

ABSTRACT

Health insurance exchanges created under the Affordable Care Act will offer coverage to people who lack employer-sponsored insurance or have incomes too high to qualify for Medicaid. However, plans offered through an exchange may include high levels of cost sharing. We surveyed families participating in unsubsidized plans offered in the Massachusetts Commonwealth Health Insurance Connector Authority, an exchange created prior to the 2010 national health reform law, and found high levels of financial burden and higher-than-expected costs among some enrollees. The financial burden and unexpected costs were even more pronounced for families with greater numbers of children and for families with incomes below 400 percent of the federal poverty level. We conclude that those with lower incomes, increased health care needs, and more children will be at particular risk after they obtain coverage through exchanges in 2014. Policy makers should develop strategies to further mitigate the financial burden for enrollees who are most susceptible to encountering higher-than-expected out-of-pocket costs, such as providing cost calculators or price transparency tools.

PNHP note: Exhibits 1 and 3 can be found on page 17.

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(***Gaffney**, continued from previous page)*

that Massachusetts employers increasingly choose insurance plans with fewer benefits, higher cost-sharing and lesser value. Between the years 2008 and 2010, the percentage of small group enrollees in the most risky, highest cost-sharing and seemingly least attractive plans (the bronze plans) increased from 2 percent to 27 percent, while those in the most comprehensive plans with less cost-sharing declined from 34 percent to 11 percent.

It may appear to make perfect sense for a healthy individual – or an employer – to favor low-premium, high-deductible plans. Why throw away thousands of dollars of much needed money every year for insurance premiums when using very little health care? Of course this is a gamble, but for those with significant competing expenses, choices have to be made.

The unfortunate reality, meanwhile, is that we all get sick, often when we least expect it. Insurance designed for the healthy is laughably absurd. And so underinsured individuals and families struck by unexpected illness constantly face choices between health care and other necessities.

In a poll conducted last year, 40 percent of sick Massachusetts adults reported problematic out-of-pocket medical costs, while 36 percent reported that the cost of medical care caused financial problems for their family, and 14 percent said there was a time during the previous year when they were unable to get needed care, usually for financial reasons. This is in spite of the fact that the Massachusetts health care system – like the ACA – requires insurance policies to offer certain minimum coverage. It is also supposed to be an example of universal health care.

Neither rational nor humane

It is bad enough to be sick; forcing the sick to be sick with worry over their medical bills is neither a rational nor humane approach toward health care in the 21st century. The idea that we need to force the sick – or the future sick, a category we all belong to – into categories of bronze, silver, gold and platinum benefits, as the ACA does, is simply unnecessary.

For the great irony of the situation is that what we in the United States call platinum care – health insurance in which 90 percent of our expenses are covered – is actually something more akin to bronze care in much of the developed world, where truly universal systems offer health care free (or nearly free) at the point of care. A single-payer system could accomplish the same here in the United States.

Let us turn back briefly to Brokaw's question in 2008. Obama went further than to merely declare health care a right in the abstract. "In a country as wealthy as ours," Obama argued, "for us to have people who are going bankrupt because they can't pay their medical bills – for my mother to die of cancer at the age of 53 and have to spend the last months of her life in the hospital room arguing with insurance companies because they're saying that this may be a pre-existing condition and they don't have to pay her treatment – there's something fundamentally wrong about that."

There is, of course, something very wrong with that. But the "pre-existing condition" is only one barrier to care. We will not have a "right" to health care until the other hazardous injustices of our system – persistent uninsurance and inadequate insurance among them – are also safely behind us, with a truly universal and comprehensive system in their place.

Adam Gaffney is a physician and a writer on issues of health care policy, politics and history.

EXHIBIT 1

Benefit Structure Of Commonwealth Choice Plans In Massachusetts, 2010

	Plan tier		
	Bronze	**Silver**	**Gold**
Percent of all Commonwealth Choice Connector enrollees[a]	57	34	9
Percent of HPHC Commonwealth Choice Connector enrollees	60	35[b]	4
Actuarial value[c] (all Commonwealth Choice plans)	40–50%	63–75%	80–85%
LOWEST MONTHLY PREMIUM (ALL COMMONWEALTH CHOICE PLANS)			
Individual	$225	$313	$390
Family	$794	$966	$1,393
ANNUAL DEDUCTIBLE (HPHC PLANS)			
Individual	$1,500–$1,750	None or $1,000	None
Family	$3,000–$3,500	None or $2,000	None
ANNUAL OUT-OF-POCKET MAXIMUM (HPHC PLANS)			
Individual	$5,000	$2,000	None or $2,000
Family	$10,000	$4,000	$4,000
SURVEY RESPONDENTS (%)			
Unweighted	36	56	8
Weighted	53	44	4
PERCENT OF STUDY FAMILIES WITH ANNUAL INCOME <400% OF POVERTY			
Unweighted	55	49	45
Weighted	51	50	45
NUMBER OF CHILDREN <18 YEARS IN STUDY FAMILIES (MEAN)			
Unweighted	0.9	0.9	0.4
Weighted	0.3	0.6	0.4

SOURCE Authors' calculations using Harvard Pilgrim benefits data, enrollment and survey data for Harvard Pilgrim Health Care members, and Commonwealth Choice Plan data for 2010 from: (1) Massachusetts Division of Health Care Finance and Policy, Massachusetts health care cost trends: premiums and expenditures (Note 12 in text); (2) Massachusetts Division of Health Care Finance and Policy. Health care in Massachusetts: key indicators [Internet]. Boston (MA): The Division; 2010 Nov [cited 2013 April 8]. Available from: http://www.mass.gov/chia/docs/r/pubs/10/key-indicators-november-2010.pdf; and (3) Massachusetts Health Connector, Connector monthly summary report—March 2010 (Note 13 in text). **NOTES** Percentages may not sum to 100 because of rounding. For weighted results, analyses were weighted to reflect oversampling of families with children and those in plans without deductibles. HDHP is high-deductible health plan. HPHC is Harvard Pilgrim Health Care. [a]Excluding Young Adult Plans. [b]14% non-HDHP; 21% HDHP. [c]The actuarial value is the percentage of health care expenses that the health plan will pay for a standard population.

EXHIBIT 3

Unadjusted Percentages Of Financial Burden And Higher-Than-Expected Out-Of-Pocket Costs, By Group, Massachusetts

Group	**Prevalence of financial burden among respondents**	**Prevalence of higher-than-expected out-of-pocket costs among respondents**
Overall	38	45
ANNUAL INCOME		
Less than 400% of poverty	56****	53**
400% of poverty or higher	24	39
PLAN TIER		
Bronze	31**	50**
Silver	47	43
Gold	34	13
PLAN TYPE		
HDHP	38	48***
Traditional	37	33

SOURCE Authors' calculations using enrollment and survey data for Harvard Pilgrim Health Care members. **NOTES** Analyses were weighted to reflect oversampling of families with children and those in plans without deductibles. "Financial burden" is problems paying medical bills; having to set up a payment plan with a hospital or doctor's office; or having trouble paying for basic needs such as food, heat, or rent because of medical costs, all within the prior twelve months. "Significance" is differences in outcome across a characteristic. HDHP is high-deductible health plan. **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

The New York Times

May 29, 2013

A Simpler, Better Solution

By David Himmelstein and Steffie Woolhandler

Gordon Schiff, an expert on medical quality, frequently admonishes: "Avoid workarounds." It's better to fix system defects than to force doctors and nurses to squander time and creativity (and to court disaster) by sidestepping problems like broken equipment, missing charts or computer bugs.

The Affordable Care Act is a giant workaround. Overwhelming evidence says that public insurers like Medicare (with overhead costs of 2 percent) are more efficient than private ones (overhead of private Medicare Advantage plans is 14 percent). And multiple insurers means multiple contracts, with varying coverage, billing procedures, documentation requirements, etc. – all of which force doctors and hospitals to waste billions more.

The obvious fix is to cut out the insurance middlemen and cover everyone under a single public program paid for by taxes – with equal coverage for all. But the insurance lobby blocked that, so instead the Affordable Care Act took the Rube Goldberg route.

The obvious solution is a single-payer system. Instead, the Affordable Care Act is a giant workaround, wasting time and money and ruining lives.

If your income is below $31,321 for a family of four (133 percent of the poverty line), you will get Medicaid (unless you live in a red state that declined the federal assistance, like Texas or Alabama). And "Medicaid" nowadays means a privately run Medicaid H.M.O. But make one dollar more (or if Junior moves out, leaving a family of three) and Medicaid disappears; now you're shopping for subsidized private insurance in the state-run exchange. That's not a rare occurrence: 28 million adults cross the 133 percent line annually.

In the exchange, "bronze" plans look cheapest – at first glance. But if your income is under 250 percent of poverty there are special discounts for copayments, but only in "silver" plans.

Move from 400 percent of poverty to 401 percent, and individual premiums rise $2,303. Can't quit smoking? Add $3,365.

Drs. Steffie Woolhandler and David Himmelstein

Stop paying your premium? You'll stay enrolled for three months, but your insurer only has to pay your medical bills for one month.

The health care law's consumer protections apply to everyone, except the 58.5 percent of private sector workers whose employers self-insure.

Employers who do not offer coverage must pay a fine, unless you work less than 30 hours a week, averaged over three months, or maybe 12 months.

Small employers can get help with premiums, unless they buy coverage through a Taft-Hartley Fund.

Got it? We don't either. And there's much more arcane detail that can mean life or death for thousands, penury or plenty for millions.

Government already pays two-thirds of total health costs, but much of that money takes a detour through a maze of private insurers. This manufactured complexity sows confusion and adds huge expense – the cost of a workaround.

David Himmelstein and Steffie Woolhandler are professors at the City University School of Public Health at Hunter College and visiting professors at Harvard Medical School. They are co-founders of Physicians for a National Health Program. This article appeared in "Room for Debate" section of The New York Times.

JGIM Journal of General Internal Medicine

April 2013

Life or Debt: Underinsurance in America

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

Life or debt.

Millions of our patients face that choice, including many with insurance. Health reform has focused on America's 50 million uninsured. But the predicament of the underinsured is also dire, and they will find less solace in the Affordable Care Act (ACA).

In this issue of JGIM, Magge et al.[1] cast welcome light on the plight of insured, low-income (0–125% of poverty) families. More than a third of them met criteria for "underinsurance"; 31.5% devoted more than 5% of their meager incomes to medical expenses, while many skipped or delayed needed care or medications because of costs.

Not surprisingly, Medicaid enrollees fared somewhat better than those with private coverage. Medicaid has generally been more comprehensive than private insurance, with minimal cost-sharing. However, Medicaid's low fees have caused many physicians and hospitals to shun Medicaid, compromising enrollees' ability to get appointments – a problem that wouldn't show up in Magge's analysis.

While among low-income insured individuals whites were at higher risk of underinsurance, a much higher share of all Blacks and Hispanics are uninsured or low-income. Hence, the low-income uninsured and underinsured account for a larger proportion of the total Black and Hispanic populations.

Paradoxically, the ACA may actually increase the number of underinsured.

Magge's research extends previous findings indicating a steady erosion of the financial protection offered by health insurance. Farley's analysis of the 1977 National Medical Expenditure Survey (NMES) found that 12.6% of individuals with private coverage had a 1% annual probability of incurring out-of-pocket medical expenses exceeding 10% of family income (one of several alternative definitions of underinsurance that she explored).[2] Using this same definition, underinsurance had increased to 29 million persons, 18.5% of those with private coverage by 1994.[3]

The NMES' successor – the Medical Expenditure Panel Survey (MEPS) – has not released the insurance benefit schedules needed to replicate Farley's definition. But more recent studies indicate that the ranks of the underinsured continue to grow.

Between 1996 and 2003, among individuals with employer-based coverage, the share with health expenditures (including premiums) exceeding 10% of family income increased from 14.2% to 18.2%.[4] The burden was especially heavy on the poor (among whom 33.3% spent >10 % of income); on those in fair or poor health (32.3%); and on those with chronic conditions such as diabetes (39.1%), hypertension (30.9%) or a mental disorder (29.2%).[4]

Using an alternative definition – inflation-adjusted out-of-pocket spending >$5,000 (excluding premiums) – underinsurance among households headed by a working age adult with full-year coverage increased from 2.6% to 4.5% between 1999 and 2006. Among households that included someone with a hospitalization, underinsurance rose from 7.2% to 11.6%.[5]

A series of surveys of non-elderly adults by the Commonwealth Fund estimated underinsurance at 9% in 2003, increasing to 16% in 2010;[6] the proportion spending >10% of income on out-of-pocket costs and premiums rose from 21% in 2001 to 32% in 2010.

Striking evidence of widespread underinsurance also comes from the bankruptcy courts. Nearly 1.2 million families seek bankruptcy protection annually; medical bills or illness contributed to 62% of filings in 2007 – a 49.6% increase since 2001.[7] Sixty percent of the medically bankrupt had private coverage at the onset of the bankrupting illness; only 22 % were uninsured.[7]

Several studies have shown that skimpy insurance menaces more than just financial health. In the Rand Health Insurance Experiment, the only randomized trial of cost sharing, high deductibles didn't harm affluent, healthy patients, but increased the risk of dying by 21% among lower income, sicker participants.[8] That study almost certainly understates the hazard of underinsurance, because it excluded the poorest and sickest individuals (i.e. those most likely to be harmed). Moreover, it predated widespread adoption of several life-prolonging therapies such as beta-blockers, ACE inhibitors, and statins, whose use is decreased by copayments.

In a large national survey in 2007, 29% of individuals with high-deductible plans vs. 16% with low deductibles reported delaying or avoiding care due to cost.[9] Disturbingly, in a study of patients hospitalized with acute myocardial infarction, underinsurance predicted pre-hospital delays (OR 1.21 compared to the well-insured).[10]

Many hope that the ACA will fix both uninsurance and underinsurance. Once fully implemented, it will expand coverage by about 26 million, eliminate lifetime benefit caps which have ensnared a few thousand families annually, and ban pre-existing condition exclusions.

But, paradoxically, the ACA may actually increase the number of underinsured. About 40% of those gaining coverage will get Medicaid. As Magge shows, many current Medicaid enrollees are woefully underinsured. Moreover, CMS looks set to allow state

(continued on next page)

(**Woolhandler and Himmelstein**, *continued from previous page)*

Medicaid programs to demand copayments and deductibles, even from the poorest of the poor. Several states have already reduced benefits, cut provider payments, and narrowed provider networks.[11] Hence, underinsurance among Medicaid recipients will probably increase. More ominously, the White House is encouraging state officials to use federal Medicaid expansion funds to purchase private insurance,[12] a shift likely to raise both taxpayers' costs and poor patients' copayments.

The new private coverage offered to near-poor and middle income individuals through insurance exchanges will also leave many underinsured. Bronze plans – the minimum coverage mandated by the ACA – will cover only 60% of average medical expenses; silver plans will cover 70%. That's far worse than the roughly 80% coverage under today's average job-based policy – equivalent to the ACA's Gold plans. (A complex system of sliding-scale discounts on copays and deductibles available to some of those with incomes 138%–250% of poverty will offset some, but not all, of the near-poor's cost-sharing.)

In concrete terms, a 56-year-old making $45,900 (399% of poverty, and hence eligible for premium subsidies) will pay an estimated $4,361 in premiums for individual Bronze coverage, and up to $4,167 in additional deductibles and copayments for covered services.[13] At 401% of poverty ($46,100) subsidies disappear; the mandatory premium would be $10,585, with out-of-pocket costs for covered services capped at $6,250. In effect, the federal government has lent its imprimatur to skimpy plans (long-promoted by private insurers) that offer scant protection from pauperization. Little wonder that expanded coverage under the Massachusetts reform (where Medicaid has remained comprehensive, and the Bronze plans' actuarial value is 70% vs. the ACA's 60%) yielded no reduction in medical bankruptcies.[14]

Unfortunately, both Massachusetts and the ACA eschewed the social insurance approach which makes care free at the time of use, puts the burden of health costs on those most able to pay – the healthy and wealthy – and relies on readily enforced global budgets for cost control. Instead, they embraced market-based policies that demand far more (percentage wise) from the middle class than the rich, and compound the misfortune of illness with financial penalties. Such policies conflate patients seeking care with price-sensitive consumers whose voracious appetites for excessive services must be curbed.

International evidence indicates that cost-sharing is neither necessary nor particularly effective for cost control; the U.S. has high cost-sharing and the highest costs. Canada, which outlawed copayments and deductibles in 1981, has seen both faster health improvement and slower cost growth.[15] Canadian provinces control costs by tax-based funding; global hospital budgeting; binding, negotiated physician fee schedules; and a simple unified single-payer structure that minimizes administrative burdens and costs. Scotland, which has eschewed market-based policies and patient payments – even going so far as to abolish parking fees – has costs about half those in the U.S. Scots view patients as owners of their health care system, not its customers.

Magge's sobering data remind us that wish-it-would-work health reforms such as the ACA won't end the unnecessary suffering that fragmented, market-oriented health financing inflicts on patients. Only thoroughgoing, evidence-based reform will do that.

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minnesota MEDICINE

April 2013

Beyond Obamacare: How a single-payer system can save health care in the United States

By Dave Dvorak, M.D., M.P.H.

As Minnesota's physicians, health care leaders and legislators grapple with the complex changes brought by the Affordable Care Act (ACA), many are concerned that even after the law is fully implemented, hundreds of thousands of people will remain uninsured while health care costs continue to spiral.

What if there were a simple, streamlined solution that would guarantee health coverage for every Minnesotan while saving the state billions of dollars? A growing number of Minnesota physicians are endorsing what they consider to be such a solution: single-payer health care. Weary of having to comply with hundreds of different insurance plans' administrative requirements while their patients are denied needed tests and treatments, these physicians are drawn to the simplicity, cost-effectiveness and truly universal coverage offered by a single-payer system.

Their views were supported by an independent analysis last year demonstrating that with a state-based single-payer system, every Minnesotan could have comprehensive coverage while the state would save billions annually.[1]

A deeply flawed system

The desire for meaningful reform comes in the face of the U.S. health care system's long-recognized dysfunction. Despite health care accounting for 18 percent of the nation's economy – twice that of other wealthy democracies – 48 million Americans lack health coverage.[2,3] Another 29 million are underinsured, having poor coverage that exposes them to unaffordable out-of-pocket expenses.[4] Health insurance premiums have doubled over the past decade, with the average annual cost for family coverage now exceeding $15,700;[5] and health care costs now account for two-thirds of personal bankruptcy filings in the United States.[6]

At the root of these problems is the fact that we have a fragmented, highly inefficient system. Employed Americans younger than 65 years of age have job-based insurance, if their employer chose to provide it; the elderly and disabled are covered through Medicare; the poor by Medicaid; military veterans through the Veterans Administration; and American Indians through the Indian Health Service. Persons who do not fall into any of those categories must try to purchase individual coverage in the private market, where it is often prohibitively expensive or unobtainable if they have a pre-existing health condition.

Owing largely to this fragmentation and inefficiency, a staggering 31 percent of U.S. health care spending goes toward administrative costs, rather than care itself.[7] Inefficiency exists at both the provider and payer level. To care for their patients and get paid for their work, physicians and hospitals must contend with the intricacies of numerous insurance plans – which tests and procedures they cover, which drugs are on their formularies, which providers are in their network. Meanwhile, private health insurance companies divert a considerable share of the premiums they collect toward advertising and marketing, sales teams, underwriters, lobbyists, executive salaries and shareholder profits. The top five private insurers in the United States paid out $12.2 billion in profits to investors in 2009, a year when nearly 3 million Americans lost their health coverage.[8,9]

The top five private insurers in the United States paid out $12.2 billion in profits to investors in 2009, a year when nearly 3 million Americans lost their health coverage.

The ACA of 2010, known widely as Obamacare, is expected to extend coverage to 32 million more Americans.[10] But it accomplishes this goal primarily by expanding the current fragmented, inefficient system and maintaining the central role of the private insurance industry in providing coverage. As a result, the ACA is expected to do little to rein in health care spending.[11] Furthermore, it will fall far short of achieving universal coverage, as tens of millions of Americans (including 262,000 Minnesotans) will remain uninsured after its full implementation.[1,10]

The solution

The central feature of a single-payer health care system would be one health plan that covers all citizens, regardless of their employment status, age, income or health status. Having a public fund that pays for care would slash administrative inefficiencies and eliminate profit-taking by the private insurance industry.

Under a single-payer system, the way society pays for health care would change, but the market-based health care delivery system would remain. Physicians and hospitals would continue to compete with one another based on service, quality of care and reputation. The chief difference is that they would bill a single entity for their services, rather than numerous insurers.

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(**Dvorak**, *continued from previous page)*

Individuals would benefit immensely by having continuous coverage that is decoupled from their employment. This would alleviate "job lock," in which people remain in undesirable employment situations in order to maintain coverage. In a single-payer system, individuals could choose to see any provider, in contrast to the current system in which choice is restricted to those who are in-network. Deductibles and copays would be minimal or eliminated, removing cost as a barrier to obtaining needed care.

A single-payer system would be funded through savings on administrative costs, along with modest taxes that would replace the premiums and out-of-pocket expenses currently paid by individuals and businesses. The cost savings to individuals, businesses and government would be considerable. The nonpartisan U.S. General Accounting Office concluded that single-payer health care would save the United States nearly $400 billion per year, enough to cover all of the uninsured.[7,12,13]

Physician support for a simplified, universal health care system is robust and growing. A 2008 survey published in Annals of Internal Medicine found that 59 percent of physicians supported a national health insurance system – up from 49 percent in 2002.[14] Physicians for a National Health Program, a national organization advocating for single-payer reform, reports a membership of 18,000.[15] In Minnesota, single payer has been formally endorsed by nearly 800 physicians, other providers and medical students.[16]

The Minnesota model

Recognizing the implausibility of achieving single-payer reform at the national level in the current political climate, many single-payer advocates have turned their attention to state-level reform. The ACA provides for "state innovation waivers" to be granted beginning in 2017, allowing states to implement creative plans they believe would work best for them. With this in mind, organized single-payer movements have taken root in states as varied as Colorado, Hawaii, Illinois, New York, California, Oregon and Vermont. Vermont's governor and Legislature passed a law in 2011 setting the path for the state to move toward single payer.[17]

In Minnesota, two advocacy organizations – Health Care for All Minnesota and the Minnesota chapter of Physicians for a National Health Program – are garnering public support for a single-payer system. Gov. Mark Dayton has expressed support for single payer,[18] and Sen. John Marty (DFL-Roseville) has authored legislation to establish such a system in Minnesota. Known as the Minnesota Health Plan, it would replace the current inefficient patchwork of private and public health plans with a single statewide fund that would cover the health needs of all Minnesotans – inpatient and outpatient services, preventive care, prescription drugs, medical equipment and mental health and dental care.[19] A 2012 study by The Lewin Group confirmed the feasibility of single payer in Minnesota. It concluded that adoption of a single-payer system would provide coverage to every Minnesotan, including the 262,000 left uncovered by the ACA, while saving the state $4 billion in the first year alone.[1] The average Minnesota family would save $1,362 annually in health costs, while the average Minnesota employer that currently provides insurance would realize savings of $1,214 per employee per year. The analysis showed these savings came primarily from administrative simplification; provider compensation remained unchanged.

Conclusion

With nearly 50 million uninsured people in the United States and skyrocketing health costs, the need for profound reform of our health system could not be more clear. The ACA is a start, but it will fall far short of achieving universal coverage, and it allows unsustainable spending growth to continue. Single-payer health care would eliminate administrative waste and inefficiency, thereby creating an opportunity to achieve truly universal, cost-effective health care.

Dave Dvorak practices emergency medicine at Fairview Southdale Hospital.

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ACP INTERNIST®

July 1, 2013

A doctor who embraces change, personally and politically

By Stacey Butterfield

In an era when even small changes to the health care system are highly controversial, leading a campaign for a single-payer system might seem like a daunting task to some. But Andrew D. Coates, MD, FACP, the new president of Physicians for a National Health Program (PNHP), has already tackled unusual challenges in his career.

Dr. Coates didn't start medical school until he was in his 30s. Prior to attending Columbia University College of Physicians and Surgeons in New York City, he worked in carpentry, factories and a feed mill. "I did hard jobs. ... I had a little bit of an adventure in terms of living in different cities and taking manual labor jobs," he said. "Then I went to graduate school in history."

Switching things up again, Dr. Coates turned down opportunities to turn his MA in history into a PhD and instead applied to medical schools. "When I was young I really wanted to be a doctor. I just assumed by the choices I made in college that after that it wasn't going to happen," he said. "I hadn't taken any science classes since 11th grade, so it was a winding road."

At the end of that road was internal medicine training, and then practice, in upstate New York. But even after settling down there, with children and lifelong connections, and attaining specializations in hospital medicine and palliative care, he grabbed an opportunity to mix things up.

"I took a temporary job at the Northern Navajo Medical Center in Shiprock, New Mexico, and we went as a family ... I needed an interpreter, a cultural interpreter as well as a language interpreter, when meeting specific patients," said Dr. Coates. "The cultural insights were inspiring. Overall I gained a deeper conviction about what medicine has to offer every human being."

Today, Dr. Coates offers his services as a community hospitalist in Troy, N.Y. "The needs are enormous and we often work over 200 hours a month. We also take turns doing nights, to make sure that one of our group is always available on the floors as well as to do the admissions. I went there because I wanted the experience of practicing the full spectrum of hospital medicine, and I love it," he said.

"There is no question that we could provide best-quality, comprehensive care to all patients...It's just a question of our consciousness."

Picking up another piece of the medical spectrum, he also serves as a medical director of a local public nursing home, which he describes as having great clinical care ("In recent years, no patient here has gotten a decubitus ulcer," he said) but crumbling infrastructure ("The roof leaks").

A recent proposal to privatize the nursing home holds the potential to damage the quality of care, he worries. "We have a great respiratory therapist and superb wound care and rehab nurses, for instance. For-profit nursing homes simply lack the kind of clinical depth that our patients count upon," he said. "The nursing home experience has raised my consciousness about why public care is superior to private, for-profit care."

Dr. Andrew D. Coates

In his newest role, at the helm of the nonprofit PNHP (his two-year term started Jan. 1), he hopes to raise physicians', patients' and policymakers' consciousness about making a clean break with what he characterizes as the "dysfunctional and wasteful" private health insurance model of financing care.

He sees the present costs faced by individuals as hazardous to health: "The evidence shows that co-pays, deductibles and co-insurance schemes cause our patients to avoid necessary care."

He doubts that reforms currently under way will reorganize how the profession interacts with society.

"If the goal remains to reduce costs and improve quality, I don't think these things will work. Eventually, we've got to deal with the evidence," he said. "The elements touted to save costs—electronic health records, accountable care organizations—these are not proven to save costs."

Dr. Coates and his colleagues in the education-oriented, 18,000-member PNHP advocate for a publicly financed, streamlined single-payer model that he says would reduce costs by slashing administrative waste.

"This would free physicians from a mountain of worry about how our patients' care will be reimbursed, and thus restore the physician-patient relationship," he said. "There is no question

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ACC in TOUCH blog
AMERICAN COLLEGE OF CARDIOLOGY

April 23, 2013

I am a Republican...can we talk about a single payer system?

By David May, M.D., Ph.D., F.A.C.C., BOG Chair

I am a Republican. For those who know me that is not a surprise. I live in a red state. I have never voted for a Democratic presidential candidate. I can field strip, clean and reassemble a Remington 12-gauge pump blindfolded. And on top of it, I think we should talk about having a single-payer national health care plan. The reason is quite simple. In my view, we already have one; we just don't take advantage of it.

Firstly, Medicare and the Center for Medicare and Medicaid Services (CMS) are de facto setting all of the rules now. They are a single-payer system. When we go to lobby the Hill, we lobby Congress and CMS. Talking to Blue Cross, Aetna, Cigna and United Healthcare is essentially a waste of time. All the third-party payers do is play off the Medicare rules to their advantage and profit. They have higher premiums, pay a somewhat higher benefit and have a significantly higher level of regulation which impedes the care of their customers. This is no longer consumer choice but effectively extortion, a less than hidden shake down in which the "choice" for a family of four is company A at $900 per month or company B at $1,100 per month. The payers are simply taking advantage of the system, playing both ends against the middle.

Secondly, in order to move forward with true health care finance we need complete transparency in cost and expense … and we need it now. As was noted in a recent Time magazine piece on the hidden cost of health care, our current system is a vulgar, less than honorable construct more akin to used car sales than medical care, cloaked under the guise of generally accepted accounting principles and hospital cost shifting.

Thirdly, with a single-payer system would potentially come real utilization data, real quality metrics and real accountability. The promise of ICD-10 with all of its difficulties is that of a much more granular claims-made data. We could use some granularity in health care data and we will never achieve it in big data quantities without a single-payer system.

Dr. David May

Lastly, I think that the physicians should be in charge of health care and not the insurance companies and hospital systems. With a single price structure, it becomes all about medical decision making, efficiency, the provision of care to our patients, and shared decision making, all of which we do well.

How, you might say, could a Republican come to such a position? The simple answer is I really think it is quite Republican. Oh, I know there will be many raised eyebrows and many critics. I accept that. I understand the fact that no single-payer system is perfect, that it is "socialist," that it is "un-American."

I would submit to you, however, that it is un-American to allow many of our citizens to be uninsured, that it is un-American to shunt money away from a strong military in order to support a bloated, inefficient and fraud-laden health care system, that it is un-American not to be open and above board with the cost of what we do, the expense of that service and the profit that we make. Mostly, it is un-American to let this outrageous health care injustice continue.

David May, M.D., Ph.D., F.A.C.C., began as the chair of the Board of Governors of the American College of Cardiology in March 2013. Dr. May currently works as a managing partner at his private practice, Cardiovascular Specialists, PA (CVS) in Lewisville, Texas.

(***Butterfield**, continued from previous page)*

that we could provide best-quality, comprehensive care to all patients. We have all of the necessary resources—especially great health professionals—to do it. It's just a question of our consciousness."

Fast facts

Age: 51.

Something I wish I'd learned in medical school: Economics.

Personal hero: Rudolf Virchow, the 19th century pathologist and public health advocate.

Favorite ways to spend free time: Cooking for our family, hiking mountains.

Most recent book read: "Medicine and Public Health at the End of Empire" by Howard Waitzkin, MD, PhD.

Regret: Not showing as much kindness as I feel toward others.

If I weren't a physician, I would be: Working for a living (That's a joke, y'all).

Where ACP stands: The American College of Physicians published a position paper in the Annals of Internal Medicine on Jan. 1, 2008, in which it described the single-payer financing model as one pathway to achieving universal coverage. You can read the full text of the ACP's position paper here: bit.ly/12bKfUo.

THE UPTAKE

February 27, 2013

Fighting for health care that doesn't leave you broke and naked

A profile of Dr. Elizabeth Frost

By Jacob Wheeler

If Minnesota ever adopts a single-payer heath care system, the work of Dr. Elizabeth Frost will be remembered as one of the key reasons for its passage.

Together with her friend, Dr. Ann Settgast, Frost co-founded the Minnesota Chapter of Physicians for a National Health Program (PNHP) five years ago. The group holds rallies and speaks at hospitals across the state to recruit new members to its cause – and now boasts more than 1,000 members in Minnesota. Frost also has the ear of state lawmakers such as Sen. John Marty and Rep. David Bly, who hope to expand health care access in Minnesota.

Dr. Elizabeth Frost

"Single-payer" health care would make health care universal and ensure equal access to best treatment, expanding President Obama's Affordable Care Act. Under single-payer, everyone would be entitled to the best available care, no matter the size of their wallet. Citizens could keep their health insurance coverage even if they lost or changed jobs, and be allowed to retain their preferred doctor or caregiver. By encouraging preventative care, proponents say a single-payer system would significantly lower costs (as much as $350 billion a year, they estimate). Perhaps most importantly, a single-payer system would end health insurance industry meddling. Patients could make decisions based on health needs, not on what a billing department dictates.

Frost, 39, is a Washington, D.C., native who went to medical school at Case Western Reserve in Cleveland and serves as a family physician at the Hennepin County Medical Center's East Lake Clinic. She came to Minneapolis 11 years ago to live near her sister and her niece and nephew. One of the reasons she has stayed here is Minnesota's focus on improving health care services which, while far from ideal, offer better access to care than many other states do. Frost, who refers to herself as "something of a do-gooder," believes that her work as a physician extends beyond diagnosing defects or prescribing medicine.

Frost, who refers to herself as "something of a do-gooder," believes that her work as a physician extends beyond diagnosing defects or prescribing medicine.

Her tireless advocacy for single payer stems from her experience caring for her patients, and her concern that the present health system doesn't offer adequate care.

"I had a patient who came to see me who was 64 years old and had chest pains," Frost says when asked to illustrate the problem. "I recommended he go to the emergency room to get evaluated for his chest pains, and he refused because he didn't have health insurance. He said 'I'm gonna wait until I'm 65 to have this evaluated.'

"About a week later he went to the ER after having a massive heart attack. He died a few weeks later. If the Medicare age limit was 64 instead of 65, then that patient would be alive today."

The frustration in Frost's voice signals her impatience with a system in which patient outcomes often depend on arbitrary and unfair rules and requirements. She compares the current, broken system of health care to a skimpy hospital gown: The coverage looks fine, until you walk around and study it from behind.

Frost believes physicians have a duty to get involved in the health care debate that extends beyond caring for patients, a duty that should take them out of the clinic and into the public

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square: "Our goal is to figure out how to solve things on a grander scale," she says. Physicians who heed their own advice, Frost and Settgast joined together to found the local branch of PNHP five years ago. Today, it has over 1,000 members and supporters. Nationwide, Physicians for a National Health Program boasts 18,000 doctors.

Frost and Settgast organize an annual rally at the State Capitol to pressure lawmakers to push for single-payer health care in Minnesota. (This year's rally was held Feb. 7.) Perhaps no lawmaker has been more allied with their work than Sen. John Marty a DFLer from Roseville, who consults closely with Frost and Settgast on organizing strategy and bill drafting. The two physicians helped Marty craft language for a single-payer bill that Marty introduced last month as SF18. The bill, which is unlikely to win approval this year, would "guarantee that health care is available and affordable for all Minnesotans."

"Elizabeth is a perfect example of a doctor willing to advocate for the well-being of her patients," says Marty. "Her advocacy to make sure they have access to health care is consistent with the work she does in her clinic."

"I was impressed by her commitment to the issues, and commitment to really want to make change," echoes Rep. David Bly, DFL-Northfield. "It's really important that you have someone of her experience and stature step forward. I think they have had a tremendous impact in their effort to bring single payer to reality."

When she's not helping patients, speaking at hospitals to recruit new single-payer advocates or lobbying lawmakers, Frost often uses demonstrations to push her message that health insurance executives don't deserve to profit while her patients suffer. Every winter she takes part in a Protest on Ice, a bit of political theater performed on the frozen surface of Lake Minnetonka in front of UnitedHealth CEO Stephen Hemsley's house. Hemsley is one of the highest paid health industry executives in the country, taking home almost $50 million in 2011.

"You don't have to go far to find (family or community) efforts to raise money to cover someone's traumatic illness," he said. ..."Those days have to be numbered. We have to get beyond that. Health care should be seen as a right. It's a public good, like public schools or public safety."

"That $50 million is our money," said Frost. "He gets it off the backs of you and me."

Frost's message that adequate health care should be considered a basic right, not a privilege, resonates with lawmakers like Bly.

"You don't have to go far to find (family or community) efforts to raise money to cover someone's traumatic illness," he said, referring to common fundraisers at homes or at Legion Halls to help pay for health crises such as a family's cancer bills. "Those days have to be numbered. We have to get beyond that. Health care should be seen as a right. It's a public good, like public schools or public safety."

But is the public ready to support government-administered, single-payer health care of the kind advocated by Frost?

"If I could have a dollar for everyone who told me that single payer is not going to happen because it's not politically viable, I would be a millionaire," Frost admits. "(But) we all just need to close our eyes and jump. We need to get people in the streets demanding that health care is a human right."

"We want to push for single payer passing in Minnesota in 2015," says Frost.

Single payer – in which the government pays all medical bills, has been adopted in Canada and already exists, in limited form in the shape of Medicare in the U.S. Still, it was viewed by many politicians as a radical option during the health care reform debates before Congress passed the Affordable Care Act (ACA). Nevertheless, single-payer advocates may already have made their impact on U.S. history. Frost believes that the arguments of single-payer health care advocates helped prompt conservative Supreme Court Chief Justice John Roberts to cast his crucial vote in the Court's decision to uphold "Obamacare."

"I think that single-payer supporters might have been influential in him changing his mind to uphold the Affordable Care Act," says Frost. "A lot of people that I work with were protesting against ACA on the steps of the Supreme Court – alongside members of the Tea Party – because they wanted the Court to overturn the Affordable Care Act in order to pave the way for single payer. The threat of single payer, the threat of the progressives, may have encouraged (Roberts) to change his mind and uphold ACA."

Closer to home, Frost, Settgast and Physicians for a National Health Program are using a more grassroots approach to push for single payer in Minnesota. With 14,000 doctors in the state, they believe they can have strength in numbers. PNHP gives talks in hospitals, clinics and churches to reach those potential allies. They have presented at the Mayo Clinic in Rochester as part of the Grand Rounds forum, in which doctors discuss a topic once a week. Frost estimates the group added 15-20 converts from the 200 people who attended last year's Mayo speech.

Frost and Settgast also have a long-term hope that single payer will become more politically feasible, at least in Minnesota, in the next few years, perhaps as soon as 2015.

"We want to push for single payer passing in Minnesota in 2015," says Frost. "Gov. (Mark) Dayton would be in his second term (if he wins re-election in 2014), and he'll feel more liberal to push for something like this."

It may seem like a stretch now. But don't underestimate the effect that Frost, Settgast and the grassroots campaigning of Physicians for a National Health Program may be having on the debate. They are not going to quit anytime soon.

Psychology Today

May 14, 2013

Psychiatrists Waste Millions of Hours Obtaining Prior Authorizations

Health Insurers Require Time Consuming Prior Auths for Emergent Psych Admissions

By J. Wesley Boyd, M.D., Ph.D.

My colleagues and I recently tabulated how long psychiatric patients who were deemed in need of inpatient admission – overwhelmingly because of suicidal thoughts or plans – stayed in the emergency department prior to being hospitalized, as well as the amount of time that the emergency department psychiatrists spent obtaining authorization from the patient's insurer.

We found both lengthy waits for severely ill psychiatric patients in need of immediate hospitalization as well as time consuming prior authorizations required by insurance companies and published our findings in Annals of Emergency Medicine.

In our study psychiatric personnel spent, on average, 38 minutes on the telephone getting authorization. In 10 percent of cases it took more than one hour to obtain insurance authorization; in one case authorization took five hours of psychiatrist time. On top of the time required to obtain authorization, psychiatric patients who need admissions wait a long time for inpatient beds to open up. The total time that patients remained in the ER in our study averaged 8.5 hours.

Our data don't include a handful of patients who boarded in the ED over the weekend while waiting for an inpatient bed to become available for them and also excluded uninsured patients and those with Medicare, which doesn't require prior authorization.

A much larger study published just before ours found even longer wait times – more than 11 hours while awaiting placement into an inpatient facility.

Out of 53 requests, we had only one prior authorization request denied, so basically the process of calling the insurance company, relaying patient information, and obtaining her authorization to pay for admission, is a needless, time consuming process given that the end result – namely, the insurance company saying they will in fact pay for the admission – is a foregone conclusion provided I jump through the proper hoops.

Imagine if women in labor required this kind of authorization or if children with ruptured appendices did? There would be a public outcry and the practice would end immediately.

Given that there are approximately 2.5 million inpatient psychiatric admissions annually in the U.S., if two-thirds of them require some form of prior authorization (which is likely an underestimate), then roughly a million hours of time annually is wasted by psychiatric clinicians obtaining these authorizations. Add to that the many day hospital admission and psychiatric medication requests that also require prior authorization from insurance companies, and the total number of psychiatric clinician hours spent on the phone asking for authorization of service is staggering.

Just today, for example, I spent 25 minutes on the phone obtaining authorization for a psychiatric medication I prescribed for a 50-ish-year-old professional male. Knowing the call would take a chunk of time, I thought about not making the call and just having him pay out of pocket for the medication instead of taking my time to make the call, but I just couldn't bring myself to concede defeat to his insurance company so, ultimately, I made the call.

This is a travesty. It is demoralizing to psychiatric clinicians. For me to have to calculate whether my time is worth it for an insurer to pay for medications it is supposed to pay for is pathetic.

It also testifies to the fact that psychiatric patients are singled out for this kind of scrutiny because they are vulnerable and often unwilling to publicly advocate for themselves, the way that pregnant or pediatric patients and their allies might. I'd wager that insurance companies hope to profit off this vulnerability, given that overworked clinicians might opt to, if they are on the fence about how to proceed, do something other than admitting their patients given the hassle of seeking authorization. My co-authors and I call this "rationing this by hassle factor."

The humanity of societies is judged by how well they take care of their most vulnerable, and we undoubtedly need to do better. Health insurance needs to provide real coverage and assurance to those in need, not set up roadblocks to needed care that deter clinicians from seeking care when it is life-saving.

If we had a health care system that was not profit driven – an improved Medicare for all would be ideal – then I'd wager such impediments to urgent care would not be present and patients could receive the care they need without unnecessary hurdles for healthcare clinicians to jump through, set up only to generate greater profit for insurers.

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J. Wesley Boyd is on faculty at Harvard Medical School and is an attending psychiatrist at Cambridge Health Alliance and Children's Hospital Boston. This article appeared at the Psychology Today blog.

BECKER'S Hospital Review

February 27, 2013

4 things to know about Medicare's overhead costs

By Bob Herman

Many statistics and numbers are thrown around when health care policymakers and leaders discuss Medicare's administrative costs, but an article set to appear in June's Journal of Health Politics, Policy and Law attempts to alleviate the confusion associated with Medicare's overhead costs.

Kip Sullivan, J.D., part of the Minnesota Chapter of Physicians for a National Health Program, wrote the article to examine the debate over Medicare's administrative expenditures and how CMS' figures should be used.

Here are four things to know, based on the article.

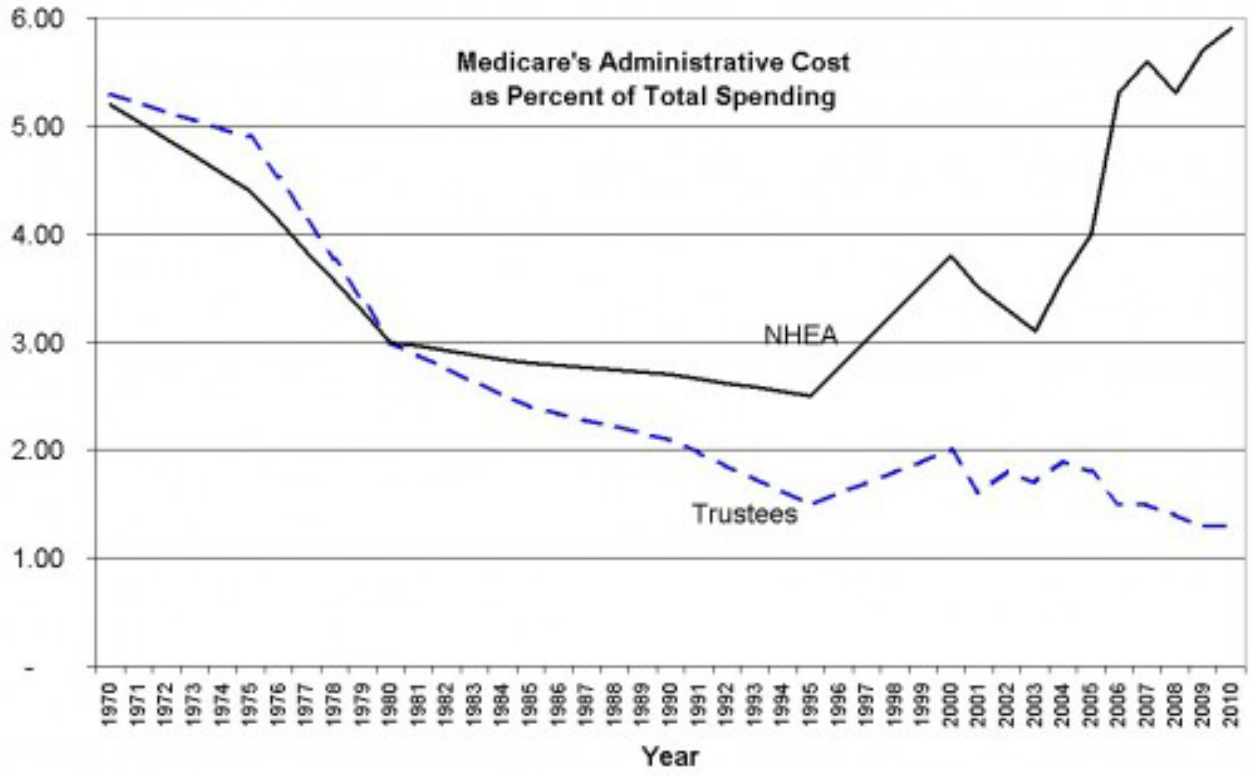
1. There are two different measures of Medicare's administrative costs. One figure comes from the Medicare Board of Trustees' annual report, while the other comes from CMS' National Health Expenditure Accounts. According to the latest trustees' report, Medicare's overhead represented 1.4 percent of its total expenditures. According to the latest NHEA, Medicare's overheard was 6 percent of expenditures.

2. The discrepancy between the two figures is due to Medicare Parts C and D. Mr. Sullivan wrote that the difference between the trustees' measure of overhead and the NHEA measure "is due almost entirely to the fact" that the NHEA figure includes administrative expenses incurred by health insurers that participate in Medicare Advantage (Part C) and Medicare's prescription drug program (Part D). In essence, the overhead associated with the private insurers involved with Medicare raise the program's overhead by almost 5 percent, or $24 billion in 2010.

3. All groups across the political spectrum have been confused about, or misused, Medicare's administrative costs. According to the article, conservative think tanks, liberal authors, health insurance lobbyists and others have all misrepresented Medicare's administrative costs.

4. The Medicare Board of Trustees and NHEA figures are comprehensive. Some have criticized the government's definition of Medicare's overhead, but Mr. Sullivan writes that both governmental figures include other expenditures incurred by CMS, the IRS, Social Security and others to administer Medicare. When it comes to "traditional" Medicare, the trustees' measure is the more accurate one, according to the report.

Chart from Austin Frakt of The Incidental Economist, February 18, 2013



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Private insurers' Medicare Advantage plans cost Medicare an extra $34.1 billion in 2012

Instead of being more efficient, private insurers have cost Medicare almost $300 billion more over the life of the program

FOR IMMEDIATE RELEASE, May 10, 2013

A study published online today finds that the private insurance companies that participate in Medicare under the Medicare Advantage program and its predecessors have cost the publicly funded program for the elderly and disabled an extra $282.6 billion since 1985, most of it over the past eight years. In 2012 alone, private insurers were overpaid $34.1 billion.

That's wasted money that should have been spent on improving patient care, shoring up Medicare's trust fund or reducing the federal deficit, the researchers say.

The findings appear in an article published in the International Journal of Health Services by Drs. Ida Hellander, Steffie Woolhandler and David Himmelstein titled "Medicare overpayments to private plans, 1985-2012: Shifting seniors to private plans has already cost Medicare US$282.6 billion."

Hellander is policy director at Physicians for a National Health Program (PNHP), a nonprofit research and advocacy group. Woolhandler and Himmelstein are professors at the City University of New York School of Public Health, visiting professors at Harvard Medical School and co-founders of PNHP.

Medicare has contracted with private insurance plans – previously referred to as Medicare HMOs and now called Medicare Advantage plans – since 1985. Such plans, most of them for-profit, currently cover about 27 percent of Medicare enrollees and have been growing at a fast clip. UnitedHealth and Humana are among the largest players in this market, and together operate about one-third of such plans.

Medicare pays these privately run plans a set "premium" per enrollee for hospital and physician services (averaging $10,123 in 2012) based on a prediction of how costly the enrollee's care will be.

The authors find that private insurers have four strategies that make them more costly than the traditional Medicare program.

1. Private plans cherry-pick healthier beneficiaries who cost less to care for, guaranteeing large profits. Although private plans must accept all seniors who choose to enroll, they cherry-pick by selectively recruiting the healthiest seniors through advertising, office location, etc. They also induce sicker ones to disenroll by making expensive care inconvenient.

2. They recruit otherwise healthy seniors with very mild (and inexpensive) cases of sometimes serious conditions – automatically triggering higher premiums for these beneficiaries from the risk-adjustment scheme implemented in 2004, but escaping payments for expensive care. For instance, many seniors have very mild cases of arthritis, heart failure and bronchitis that require little or no treatment.

3. They enroll patients who get most of their care free at the Veterans Administration.

4. They heavily lobby Congress to raise their reimbursement. The insurance industry successfully induced Congress and the Bush administration to add bonus payments to Medicare Advantage premiums beginning in 2003.

Since the study was completed, the industry has again successfully lobbied the administration to raise payments to Medicare Advantage plans, reversing a planned cut of 2.2 percent in reimbursement rates and instead obtaining a 3.3 percent increase. Stock prices of private insurers soared over the announcement.

"We've long known that Medicare has been paying private insurers more than if their enrollees had stayed in traditional fee-for-service Medicare, but no one had added up the total extra cost to the taxpayer since contracting with private insurers began 27 years ago," said Dr. Ida Hellander, lead author of the study. "Nor has anyone systematically examined the many ways that private insurers have gamed the system to maximize their bottom line at taxpayers' expense."

"In 2012 alone, private insurers are being overpaid $34.1 billion, or $2,526 per Medicare Advantage enrollee," Hellander said.

Co-author Dr. Steffie Woolhandler said: "It's clear that having Medicare Advantage programs compete with Medicare doesn't save us money. In fact the opposite is the case. The private plans only add waste, and the aggregate waste is staggering – enough to be a significant drag on the economy.

"It's time we look to proven, cost-effective ways of providing high-quality care to Medicare's beneficiaries and to the entire population," Woolhandler said. "That means taking a fresh look at the single-payer model of reform."

"Medicare overpayments to private plans, 1985-2012: Shifting seniors to private plans has already cost Medicare US$282.6 billion." Ida Hellander, M.D., Steffie Woolhandler, M.D., M.P.H., David U. Himmelstein, M.D. International Journal of Health Services, May 10, 2013 (online first), Vol. 43, No. 2. DOI: 10.2190/HS.43.2.g

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Immigrants heavily subsidize Medicare's Trust Fund: Health Affairs study

Harvard Medical School and Hunter College School of Public Health researchers find immigrants generated surplus contributions of $115.2 billion in 2002-2009, $13.8 billion in 2009

FOR IMMEDIATE RELEASE: May 29, 2013

Immigrants, particularly noncitizens, pay billions more into Medicare's Hospital Insurance Trust Fund than they withdraw in health benefits each year, according to researchers at Harvard Medical School and Hunter College School of Public Health. The study is being released today as a Web First by Health Affairs, and will also appear in the journal's June issue.

In 2009 alone, immigrants paid $33.1 billion into the Trust Fund but used only $19.3 billion in health care paid for by the Trust Fund, yielding a surplus of $13.8 billion. About three-quarters of this surplus, $10.1 billion, came from noncitizens. The article concludes that reducing immigration would worsen Medicare's financial health.

Payroll taxes are the major source of revenues for the Trust Fund, which mostly pays hospital bills. The overwhelming majority of immigrants are working age, have high rates of labor force participation, and hence pay substantial payroll taxes. Moreover, even undocumented immigrants often pay these taxes, usually under a borrowed or false Social Security number.

Trust Fund outlays for immigrants are low for several reasons. Few are elderly. Moreover, even some elderly immigrants are ineligible for Medicare because they have not worked the required 40 quarters in the U.S. under a valid Social Security number, lack legal status, or, if legal residents, do not meet the five-year (legal) residency requirement. Even among eligible immigrants, some may not use Medicare because they retire to their country of origin. Those who do enroll in Medicare use relatively little care, which probably reflects problems in access to care.

The study authors examined Trust Fund contributions and expenditures for each year between 2002 and 2009. They analyzed data from the Census Bureau's Current Population Survey to determine tax contributions, and used the Medical Expenditure Panel Survey to examine medical expenses.

They found that immigrants contributed a surplus of between $11.1 billion and $17.2 billion per year, or a total of $115.2 billion dollars from 2002-2009. During the same years, U.S.-born persons generated a net deficit of $28.1 billion. In 2009 immigrants provided an average per capita surplus of $368, while native-born Americans generated a per capita deficit of $113. Noncitizen immigrants contributed a net subsidy of $466 per person.

"For years I have seen my immigrant patients be blamed for driving up health care costs," said lead author Dr. Leah Zallman, an instructor in medicine at Harvard Medical School and staff physician at Cambridge Health Alliance, "and yet few acknowledge their contributions. Our study demonstrates that in one large sector of the U.S. health care economy, immigrants actually subsidize the care of native-born Americans."

"The numbers completely contradict the widely held misperception that immigrants are a drain on the health system," said Dr. Steffie Woolhandler, professor at Hunter College School of Public Health, visiting professor of medicine at Harvard, and co-founder of Physicians for a National Health Program. "Reducing immigration would worsen Medicare's financial woes."

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"Immigrants contributed an estimated $115.2 billion more to the Medicare Trust Fund than they took out in 2002-09," Leah Zallman, M.D., M.P.H., Steffie Woolhandler, M.D., M.P.H., David Himmelstein, M.D., David Bor, M.D., M.P.H., Danny McCormick, M.D., M.P.H. Health Affairs, June 2013. Web First, May 29, 2013.

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Physicians for a National Health Program is a nonprofit research and educational organization of more than 18,000 doctors who support single-payer national health insurance, an improved Medicare for all. PNHP had no role in funding or otherwise supporting the study described above.

Cambridge Health Alliance (CHA) is an integrated health care system that serves Cambridge, Somerville, and Boston's metro-north communities, and is a Harvard Medical School teaching hospital. With three hospital campuses, an extensive primary care network, and an employed physician model, CHA provides high-quality, culturally competent care to a large, diverse patient population.

The Hunter College School of Public Health, located in Manhattan, works with communities, nonprofits, private groups and government agencies to help people live healthier lives. It conducts research and creates new models of public health education and practice to solve urban health problems. Hunter College is the largest college in the City University of New York (CUNY) system.

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May 21, 2013

Some unions protest Obamacare's impact on multiemployer health plans

By Kay Tillow

The Affordable Care Act (ACA) of 2010, also known as Obamacare, presents challenges to the multiemployer plans through which some unions bargain collectively to provide health care insurance for their members. These plans, often called Taft-Hartley plans, currently cover about 26 million workers, families, and retirees. Unless there is a major regulatory change made by Health and Human Services, these union negotiated plans will be struck a harsh blow once the exchanges go into effect in 2014.

A quiet effort by many unions to persuade the Obama administration to make this change is now becoming very public.

In an op-ed published in The Hill, Joseph T. Hansen, president of the United Food and Commercial Workers (UFCW), said:

"But as currently interpreted, the ACA would block these plans from the law's benefits (such as the subsidy for lower-income individuals and families) while subjecting them to the law's penalties (like the $63 per insured person to subsidize Big Insurance). This creates unstoppable incentives for employers to reduce weekly hours for workers currently on our plans and push them onto the exchanges where many will pay higher costs for poorer insurance with a more limited network of providers. In other words, they will be forced to change their coverage and quite possibly their doctor. Others will be channeled into Medicaid, where taxpayers must pick up the tab.

Kay Tillow

"In addition, the ACA includes a fine for failing to cover full-time workers but includes no such penalty for part-timers (defined as working less than 30 hours a week). As a result, many employers are either reducing hours below 30 or discontinuing part-time health coverage altogether. This is a cut in pay and benefits workers simply cannot afford. For example, a worker making $10 an hour that has his or her schedule cut by six hours a week would lose $3,100 a year in income. With millions of workers impacted, this would have a devastating effect on our economy."

The effort of unions to persuade the Obama administration to change the regulations in order to resolve the problems was reported in the Jan. 30 edition of The Wall Street Journal.

"Top officers at the International Brotherhood of Teamsters, the AFL-CIO and other large labor groups plan to keep pressing the Obama administration to expand the federal subsidies to these jointly run plans, warning that unionized employers may otherwise drop coverage."

"We are going back to the administration to say that this is not acceptable," said Ken Hall, general secretary-treasurer for the Teamsters, according to the WSJ article.

Many unions have been working through the National Coordinating Committee for Multiemployer Plans (NCCMP) to find a solution. In a memorandum to the Department of Health and Human Services, the NCCMP stated:

"If subsidies are available only for plans purchased through Exchanges, employers contributing to multiemployer plans will face tremendous economic pressure to stop contributing to multiemployer plans. … Many employers will feel the need to drop coverage and access the subsidies to remain competitive."

On April 16, the United Union of Roofers, Waterproofers and Allied Workers International President Kinsey M. Robinson issued a statement calling for a repeal or complete reform of President Obama's Affordable Care Act. He stated that the union has supported President Obama for both terms in office but that the union's concerns "over certain provisions in the ACA have not been addressed, or in some instances, totally ignored.

"In the rush to achieve its passage," Robinson continued, "many of the Act's provisions were not fully conceived, resulting in unintended consequences that are inconsistent with the promise that those who were satisfied with their employer sponsored coverage could keep it. These provisions jeopardize our multiemployer health plans, have the potential to cause a loss of work for our members, create an unfair bidding advantage for those contractors who do not provide health coverage to their workers, and in the worst case, may cause our members and their families to lose the benefits they currently enjoy as participants in multiemployer health plans."

This growing crisis underlines the need for unions to press for passage of H.R. 676, Expanded and Improved Medicare for All, national single-payer health insurance. This real solution awaits a dynamic, massive, in-the-streets movement that makes sound health policy also politically feasible.

Such a solution would improve the lives of all workers by assuring that everyone has all medically necessary care with no co-pays and no deductibles. Even dental care and long-term care are covered.

Kay Tillow is coordinator of the All Unions Committee for Single Payer Health Care, which builds union support for H.R. 676. She lives in Louisville, Ky.

Conflicts of interest

By Marcia Angell, M.D.

Dr. Marcia Angell is a senior lecturer in social medicine at Harvard Medical School and former editor of The New England Journal of Medicine. The text below served as the basis of her keynote address to the national convention of the American Student Medical Association in Washington, D.C., on March 15, 2013.

In May of 2000, shortly before I stepped down as editor-in-chief of the New England Journal of Medicine, I wrote an editorial titled "Is Academic Medicine for Sale?" It was prompted by a clinical trial of an antidepressant called Serzone that was published in the same issue of the Journal.

The authors of that paper had so many financial ties to drug companies, including the maker of Serzone, that a full disclosure statement would have been about as long as the article itself, so it could appear only on our website. The lead author, who was Chairman of the Department of Psychiatry at Brown University (presumably a full-time job), was paid more than a half million dollars in drug company consulting fees in just one year.

Although that particular paper was the immediate reason for the editorial, I wouldn't have bothered to write it if it weren't for the fact that the situation, while extreme, was hardly unique.

Among the many letters to the editor I received in response to my editorial, one was particularly pointed. It asked rhetorically, using my title, "Is academic medicine for sale? And answered, "No, the current owner is very happy with it."

In this lecture, I'll make the argument that the boundaries between academic medicine and the pharmaceutical industry are dissolving, and the important differences between their missions are becoming blurred – with harmful effects on medical research, education, and clinical practice.

Let's remind ourselves of what the missions of academic medical centers and the pharmaceutical industry are: Academic medical centers are charged with educating the next generation of doctors, conducting scientifically important research, and taking care of the sickest and neediest patients. That's what justifies their tax-exempt status.

In contrast, drug companies – like other investor-owned businesses – are charged with increasing the value of their shareholders' stock. That's their fiduciary responsibility. All their other activities are merely means to that end.

For the companies, the point is to develop profitable drugs, not necessarily important or innovative ones (and paradoxically enough, the most profitable drugs are the least innovative – a subject for another lecture). Nor do drug companies aim to educate doctors, except as a means to the primary end of selling drugs. Drug companies don't have education budgets; they have marketing budgets from which their ostensibly educational activities are funded.

This profound difference in missions is often deliberately obscured – by drug companies because it's good public relations to portray themselves as primarily research and educational

Dr. Marcia Angell

institutions, and by academics because it enables them not to face up to what's really going on.

Clinical trials

Let's begin with clinical trials, then I'll talk about medical education. First, some background: Most clinical trials are funded by the pharmaceutical industry. That's because drug companies are required to have their new drugs tested in human subjects before they can get the approval of the FDA to sell them. They must show the FDA that a new drug is reasonably safe and effective, usually as compared with a placebo.

The results of drug trials (there may be many) are submitted to the FDA, and if one or two are positive – that is, they show effectiveness without serious risk – the drug is usually approved, even if all the other trials are negative.

The FDA approves a drug only for a specified use at a specified dose – for example, to treat lung cancer – and it's illegal for companies to promote them for any other use. But physicians may prescribe an approved drug "off label" – i.e., for other than the approved use.

Since drug companies don't have direct access to human subjects, they've traditionally contracted with academic researchers to conduct the trials on patients in teaching hospitals and clinics. That practice continues, but over the past couple of decades the terms and conditions have changed.

Until the mid-1980s, drug companies simply gave grants

to medical centers for researchers to test their products, then waited for the results and hoped their products looked good. Sponsors had no part in designing or analyzing the studies, they did not claim ownership of the data, and they certainly didn't write the papers or control publication. Grants were at arm's length. That is no longer true.

Drug companies now design studies to be carried out by academic researchers who are little more than hired hands supplying the human subjects and collecting data according to instructions from the company. Often, the sponsors keep the data, analyze it, write the papers, and decide whether and when and where to submit them for publication.

The deference shown by the academic centers to the drug industry is intensified by competition from a fairly new industry that does clinical research for the drug companies by organizing doctors in private practice to enroll their patients in clinical trials. Although these companies – called contract research organizations (CROs) – are geared to provide fast service to their clients, drug companies still often prefer working with academic medical centers, in part because it increases the chances of getting the work published, but mainly because it gives them access to highly influential faculty physicians – referred to by the industry as "thought-leaders" or "key opinion leaders" (KOLs).

These are the people who write textbooks and medical journal articles, issue practice guidelines, sit on FDA and other governmental advisory panels, head professional societies, and speak at the innumerable meetings and dinners that take place every day to teach clinicians about prescription drugs. Having KOLs on the payroll is worth every penny a drug company spends.

Drug companies now design studies to be carried out by academic researchers who are little more than hired hands supplying the human subjects and collecting data according to instructions from the company. Often, the sponsors keep the data, analyze it, write the papers, and decide whether and when and where to submit them for publication.

In addition to grant support, academic researchers may now have a variety of other financial ties to the companies that sponsor their work, something that used to be prohibited. They serve as consultants to the same companies whose products they're evaluating, join advisory boards and speakers' bureaus, enter into patent and royalty arrangements, agree to be the listed authors of articles ghostwritten by interested companies, promote drugs and devices at company-sponsored symposia, and allow themselves to be plied with expensive gifts and trips to luxurious settings.

To be sure, some institutional conflict-of-interest rules would preclude some of this, but the rules are highly variable, generally quite permissive, and loosely enforced.

Besides, schools now have their own manifold deals with industry and are hardly in a moral position to object to their faculty behaving in the same way. A recent survey found that about two-thirds of academic medical centers hold equity interest in companies that sponsor research within the same institution. A study of medical school department chairs found that two-thirds received departmental income from drug companies and three-fifths received personal income. Academic leaders, chairs, and even deans sit on boards of directors of drug companies.

The impact of Bayh-Dole

Much of the rationalization for the pervasive research connections between industry and academia rests on Congress's Bayh-Dole Act of 1980, which has acquired the status of holy writ in academia – held up to critics of academic/industrial relations like a cross before vampires.

To review Bayh-Dole briefly: This legislation permits – but does not require – universities to patent discoveries that stem from government-funded research, and then to license them exclusively to companies in return for royalties. In this way, academia and industry are partners, both benefiting from public support.

Until Bayh-Dole, all government-funded discoveries were in the public domain. The original purpose of Bayh-Dole was to speed technology transfer from the discovery stage to practical use. It was followed by changes in patent law that loosened the criteria for granting patents.

As a consequence, publicly funded discoveries of no immediate practical use can now be patented, and then handed off to start-up companies for early development. The start-up companies are often founded by the researchers and their institutions, and they usually either license their promising products to larger companies or are bought by large companies outright.

The result of Bayh-Dole was a sudden, huge increase in the number of patents – if not in their quality – and the most prestigious academic centers now have technology transfer offices and are ringed by start-up companies.

An often overlooked result of Bayh-Dole is that drug companies no longer have to do their own creative, early-stage research; they can rely on universities and start-up companies for that. In fact, the big drug companies now concentrate mainly on the late-stage development of drugs they've licensed in from other sources, as well as on producing variations of top-selling drugs already on the market – called "me-too" drugs. There is now very little innovative research in the modern pharmaceutical industry, despite its pretenses to the contrary.

Harmful 'collaboration'

So far, I've described an academic world in which, over just the past two or three decades, the intertwining of academia and industry has become virtually complete, and even though quite recent, largely accepted as inherent to medical research. So what's wrong with that? Isn't it just the sort of collaboration that leads to the development of important new medical treatments?

Here are just a few of its harmful effects:

Increasingly, industry is setting the research agenda in academic centers, and that agenda has more to do with industry's mission than with the mission of the academy. Researchers and their institutions are focusing too much on targeted, applied research,

mainly drug development, and not enough on non-targeted, basic research into the causes, mechanisms, and prevention of disease.

Moreover, drug companies often contract with academic researchers to carry out studies for almost entirely commercial purposes. For example, they sponsor trials of drugs to supplant virtually identical ones that are going off patent. And academic institutions are increasingly focused on striking it rich through Bayh-Dole.

In addition to distorting the research agenda, there's overwhelming evidence that drug company influence biases the research itself. Industry-supported research is far more likely to be favorable to the sponsors' products than NIH-supported research. There are many ways to bias studies – both consciously and unconsciously – and they are by no means always obvious.

Probably the main cause of bias is the suppression of negative results. A review of 74 clinical trials of antidepressants, for example, found that 37 of 38 positive studies – that is, studies that showed effectiveness – were published. But of the 36 negative studies – those that failed to show effectiveness – 33 were either not published or published in a form that conveyed a positive outcome. Many drugs that are assumed to be effective are probably little better than placebos, but there is no way to know because negative results are hidden.

Clinical trials are also biased through research protocols that are designed to yield favorable results for sponsors. For example, the sponsor's drug may be compared with another drug administered at a dose so low that the sponsor's drug looks more powerful. The standard practice of comparing a new drug with a placebo, when the relevant question is how it compares with an existing drug, is also misleading.

The pharmaceutical industry devotes much, if not most, of its vast marketing budget to what it calls the "education" of doctors. The reason is obvious: doctors write the prescriptions, so they need to be won over.

In short, it's often possible to make clinical trials come out pretty much any way you want, which is why it's so important that investigators have no financial stake in the outcome of their work. There is simply no substitute for that. It's often claimed that attempts to regulate conflicts of interest will slow medical advances. The truth is that conflicts of interest distort medical research, and advances occur in spite of them, not because of them.

Medical education

I'd like now to turn to medical education. The pharmaceutical industry devotes much, if not most, of its vast marketing budget to what it calls the "education" of doctors. The reason is obvious: doctors write the prescriptions, so they need to be won over.

Drug companies support educational programs even within our best medical schools and teaching hospitals, and are given virtually unfettered access to young doctors to ply them with gifts and meals and promote their wares. They also support roughly half the continuing medical education or CME that doctors in practice are required to have, often indirectly through private investor-owned medical education companies whose only clients are the drug companies. CME is supposed to be free of drug-company influence, but incredibly enough, these private education companies have been accredited to provide CME by the AMA's Accreditation Committee for Continuing Medical Education – a case of the fox not only guarding the chicken coop, but living inside it.

If drug companies and medical education companies were really providing education, doctors and academic institutions would pay them for their services. That's what you do when you take, say, piano lessons. You pay the teacher, not the other way around. But in this case, the money flows in the other direction. Industry pays the academic institutions and faculty, and they even pay the doctors who take the courses. That's a sure-fire indicator of the real nature of the transaction.

The companies are simply buying access to medical school faculty, and to doctors in training and practice. This is really marketing masquerading as education. In fact, it's self-evidently absurd to look to companies for critical, unbiased education about products they're selling. It's like asking a beer company to teach you about alcoholism, or a Honda dealer for a recommendation about what car to buy.

Doctors recognize that truth in other parts of their lives, but they've convinced themselves that drug companies are different. Underscoring the absurdity of the pretense is the fact that some of the biggest Madison Avenue ad agencies, hired by drug companies to promote their products, also own their own medical education companies and contract research organizations. It's one-stop shopping for the drug companies.

But doctors do learn something from all the ostensible education they're paid to receive. They learn to practice a very drug-intensive style of medicine. Even when changes in lifestyle would be more effective, doctors and their patients come to believe that for every ailment and discontent there's a drug. Doctors are also led to believe that the newest, most expensive brand-name drugs are superior to older drugs or generics, even though there's seldom any evidence to that effect, because sponsors don't usually compare their drugs with older drugs at equivalent doses. In addition, physicians, swayed by prestigious medical school faculty who are paid by drug companies, learn to prescribe drugs for off-label uses without good evidence of their effectiveness.

Drug companies are not charities; they expect something in return for the money they spend on the profession, and they evidently get it or they wouldn't keep paying. I'm not suggesting that there's necessarily an explicit quid pro quo. The situation is more subtle than that.

It's human nature to feel warmly toward people with whom one collaborates closely, particularly when they're so generous. One author referred to the "food, friendship, and flattery" that are bestowed on key opinion leaders, and of course, the money's not bad, either. Doctors are not immune to human nature, including the natural desire to return favors.

What can be done?

What should be done about all of this? So many reforms would be necessary to restore integrity to medical research, education, and practice that they can't all be summarized here. Many would involve congressional legislation and changes in the FDA, including its drug-approval process. But there is also a need for the medical profession to wean itself from industry money almost entirely. Although industry-academic collaboration can make important scientific contributions, it does not necessitate the personal enrichment of researchers and teachers. To claim that it does is a self-serving excuse.

I would suggest these three key reforms:

First, members of medical school faculties who conduct clinical trials should not accept any payments from drug companies except research support, and that support should have no strings attached, including control by drug companies over the design, interpretation, and publication of research results. Medical schools and teaching hospitals should rigorously enforce that rule, and should not themselves enter into deals with companies whose products members of their faculty are studying.

Conflicts of interest in academic medicine have serious consequences, and we need to stop making excuses for them.

Second, doctors should not accept gifts from drug companies, even small ones, and they should pay for their own meetings and continuing education. Other professions pay their own way, and there is no reason for the medical profession to be different in this regard.

And third, academic medical centers that patent discoveries should put them in the public domain or license them inexpensively and non-exclusively. The Bayh-Dole Act has become more a matter of seeking windfalls than of technology transfer. Indeed, an argument has been made that it actually impedes technology transfer because of the thicket of licenses on early discoveries that encumber downstream research. It has certainly done nothing to ensure that drugs licensed from academic institutions are made "available on reasonable terms" to the public, as called for in the legislation; that provision has been totally ignored by both industry and academia.

I believe medical research was every bit as productive before Bayh-Dole as it is now, despite the lack of patents. I'm reminded of Jonas Salk's response when asked in an interview whether he had patented the polio vaccine. He seemed amazed at the very notion, then explained that the vaccine belonged to everybody, and asked, "Could you patent the sun?"

After much unfavorable publicity, professional organizations, and even industry have begun to wring their hands about the problem of conflicts of interest. So far, however, the response has been to appoint committees and issue guidelines, most of which are strictly voluntary and full of loopholes.

They usually refer to "potential" conflicts of interest, as though that were different from the real thing, and they focus on disclosing or managing them, not prohibiting them. Disclosure is better than nothing, but it does not eliminate the conflicts. It only passes the burden to someone else to decide whether the conflicts biased the work, and that is not easy to do.

I'm aware my proposals might seem radical. That's because we're now so drenched in market ideology that any resistance is considered quixotic. But academic medical centers are not supposed to be businesses. They now enjoy great public support, and they jeopardize that support by continuing along the current path. Conflicts of interest in academic medicine have serious consequences, and we need to stop making excuses for them.

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PUBLIC CITIZEN
Protecting Health, Safety and Democracy

November/December 2012

Holding Big Pharma's Feet to the Fire

By Jake Parent

A new Public Citizen report shows state and federal governments, more than ever, are holding the drug industry accountable for fraudulent behavior

Pharmaceutical companies are still the largest defrauders of the federal government, but states are now collecting a record amount in fines levied against such companies, a new Public Citizen study has found.

In an era of ever-tighter Medicaid budgets, many states have recovered just as much, if not more, money from this litigation as they spent on all Medicaid fraud enforcement since 2006.

According to the report, "Pharmaceutical Industry Criminal and Civil Penalties: An Update," more settlements are being announced between state and federal governments and the drug industry than ever before, with financial penalties on the rise. Already, 2012 has seen the highest financial penalties assessed against the pharmaceutical industry in a single year, with $6.6 billion recovered through mid-July by both the federal government and states.

The federal government also has settled almost as many cases and recovered more in financial penalties from the drug industry in the past three and a half years as it had in the previous 18 years combined. Three pharmaceutical companies – GlaxoSmithKline (GSK), Johnson & Johnson and Abbott – were responsible for two-thirds of the financial penalties paid to the federal and state governments during the most recent period (Nov. 2, 2010, through July 18, 2012) covered by the report.

In Public Citizen's findings, overcharging health programs – mainly in the form of drug pricing fraud against state Medicaid programs – was the most common violation, while the unlawful promotion of drugs was associated with the largest penalties.

Reaching settlements, recouping funds for cash-strapped states

Medicaid fraud cases against pharmaceutical companies have been on the rise over the past two decades. Public Citizen's original, landmark 2010 study on pharmaceutical fraud found that such cases had skyrocketed since 1990 as prescription drug spending in the U.S. increased from $40 billion in 1990 to more than $234 billion by 2008.

The rise in settlements is likely due both to an increase in the scale of fraud committed by the drug industry and, more importantly, increased enforcement of current laws, such as the False Claims Act, to crack down on the wrongdoing. Since 1991, 239 settlements have been reached between pharmaceutical companies and federal or state governments, for a total of $30.2 billion.

During that time, 27 states have prosecuted companies on their own and reached at least one settlement with a pharmaceutical company. Kentucky has had the most such single-state settlements (17) while Texas has had the highest number of single-state settlements resulting from actions initiated by private whistleblowers (six). In just the past two years, state governments have collected more than $2 billion from Medicaid fraud cases.

Seventeen states recouped the equivalent or more of their entire Medicaid fraud enforcement budgets with money from these settlements.

Arkansas, South Carolina, Alabama and Hawaii recovered the most relative to their enforcement budgets, recouping between $12 and $84 for every dollar spent on Medicaid fraud enforcement.

"What this new report unequivocally shows is that those states that have chosen to hold the pharmaceutical industry accountable have largely seen their enforcement efforts pay for themselves," said Dr. Sammy Almashat, a researcher with Public Citizen's Health Research Group and the study's author.

This uptick in settled federal cases was largely a product of increased use of provisions in the False Claims Act, which is meant to hold companies responsible for defrauding the federal government. In 2012, GSK agreed to pay $3 billion to the federal government to resolve allegations that it had illegally marketed multiple medications and had offered paid incentives, or kickbacks, for doctors to prescribe their drugs. It was the largest single fine paid by a drug company to settle health fraud allegations.

Investigations initiated by whistleblowers were responsible for most federal settlements (75 percent) and financial penalties (78 percent) during the most recent period studied.

In fact, almost half the whistleblower-prompted federal and state settlements during this time were made possible by a single whistleblower, Ven-A-Care pharmacy in Key West, Fla. Ven-A-Care's owners tipped off the government after realizing that several of the drug manufacturers they did business with were selling the medications with unjustifiably high markups.

Changing the industry's perception of fraud

Although some of these settlement amounts seem astronomical, many drug companies may consider the settlements a cost

of doing business; the total amount paid in fraud cases by pharmaceutical companies over the past 20 years represents just two-thirds of the profits made by the 10 largest drug companies in 2010 alone.

Stronger federal legislation could help make companies think twice before committing fraud, Almashat said. At this point, however, only a few lawmakers have sought to take on the powerful pharmaceutical lobby and increase sanctions for defrauding the government.

One attempt was an amendment proposed by Sen. Bernie Sanders (I-Vt.) to a Food and Drug Administration bill in May that would have taken away exclusive marketing rights – potentially worth billions of dollars – if a company was found to be at fault for fraud involving a particular drug.

The amendment fell victim to what Sanders labeled the muscle of the pharmaceutical industry, ultimately receiving only nine votes.

"The bottom line is that the pharmaceutical industry is making money hand over fist while it systematically defrauds taxpayers, all the while individuals in the United States (let alone the developed world) are not getting the medicines they need because they cannot afford them," Sanders said in a statement regarding the proposed amendment.

One other legislative path suggested by the report is to create a blacklist for companies that commit fraud.

Any firm on this list could be barred from receiving payments from Medicare and Medicaid, thus preventing access to large portions of the market for their products. So far, no such legislation has been introduced.

Finally, Public Citizen recommends that criminal charges be levied against executives who knowingly allow fraudulent activities to occur. Until some additional level of enforcement is put into place, it's likely that drug companies will continue to see the cost of paying out fraud settlements as worth it.

"It's obvious these companies will continue their fraudulent practices as long as it makes business sense for them to do so," said Dr. Sidney Wolfe, director of Public Citizen's Health Research Group. "Legislation and more rigorous enforcement are needed to protect taxpayer money and patient safety."

To read the report, please visit bit.ly/UwHWrO.

Pharmaceutical Company Penalties: Worst Offenders, 1991-2012*

Company	Total Financial Penalties	Percent of Total	Number of Settlements
GlaxoSmithKline	$7.56 billion	25.1%	20
Pfizer	$2.96 billion	9.8%	15
Johnson & Johnson	$2.33 billion	7.7%	14
Merck	$1.86 billion	6.2%	27
Abbott	$1.82 billion	6.0%	12
Eli Lilly	$1.71 billion	5.7%	13
Schering-Plough	$1.34 billion	4.4%	7
AstraZeneca	$954 million	3.2%	7
TAP Pharmaceutical Products	$875 million	2.9%	1
Novartis	$793 million	2.6%	12
Bristol-Myers Squibb	$789 million	2.6%	12
Mylan	$707 million	2.3%	19
Serono	$704 million	2.3%	1
Purdue	$620 million	2.1%	2
Allergan	$600 million	2.0%	1
Daiichi Sankyo	$500 million	1.7%	3
Cephalon	$425 million	1.4%	1
Boehringer Ingelheim	$329 million	1.1%	14
Forest Laboratories	$315 million	1.0%	4
Sanofi	$313 million	1.0%	10
Other	$1.88 billion	6.2%	108
Total	**$29.38 billion**	**97.3%**	**303**

Source: Public Citizen's "Pharmaceutical Industry Criminal and Civil Penalties: An Update"

**Information is through July 18, 2012. The total number of settlements listed here is greater than the total number of settlements during this period of time (239), because some settlements involved more than one company. Also, the percent of the total, which is based on $30.174 billion in overall penalties, does not equal 100 percent because of the inability to determine an individual company's share in a settlement, in some cases. If a listed parent company is nonexistent now, the name at the time of the most recent settlement was used.*

DISSENT

April 12, 2013

Austerity and the Unraveling of European Universal Health Care

By Adam Gaffney, M.D.

A great human disaster is now unfolding in the many Eurozone countries that have agreed to slash spending, wages, and living standards to meet the demands of fiscal austerity. One facet of this story that has received far too little attention, however, is the effect of these measures on the health of these nations.

Austerity derives from the Greek *austeros*, for harsh or severe; but, in the area of health care, it has veered into the cruel: health expenditures dwindle, hospital budgets shrink, health care needs rise, and human suffering worsens. Suicide is on the rise; basic hospital supplies are missing; potentially life-saving surgeries are delayed; the rate of new HIV infections increases; drug shortages are ubiquitous; the prevalence of mental illness spikes. And these are just the obvious results.

The effects of austerity on health care are both immediate and long-reaching. Deep cuts in public health spending clearly exacerbate the suffering caused by the prolonged economic depression. At the same time, the cuts contribute to a more pernicious, slow-moving, and decidedly political process.

For austerity is being wielded to initiate the unraveling of one of the great and humane achievements, indeed inventions, of modern Europe: the universal health care system. To understand why this is the case, let us take a brief look at how Europe came to have what it has today, before we return to the dangers of the present course.

Although the idea that all human beings, whether rich or poor, deserve health care can in some senses be traced to antiquity, it was only in the late nineteenth century, under the combined economic and political pressures of industrialization, working-class organization, and left-wing mobilization, that governments enacted forms of "social insurance."

Under the government of Otto von Bismarck, Germany was the first to set up a system of "compulsory" health insurance, which obligated industrial employers to provide insurance for their low-paid workers. The health insurance system was funded and administered by workers and employers through the so-called "sick funds." The Bismarckian system is typically credited with initiating the European tradition of universal health care, and it certainly provided a model for other countries, as with Britain in 1911 and France in 1928.

The truly universal health care system, however, was in general a post–Second World War development and was usually the consequence of the work of labor and left-wing parties. Most Western European nations took one of two paths: gradual expansion of coverage until the system could fairly be called universal or the more abrupt creation of a truly socialized national health service. In Great Britain, the 1946 passage of the National Health Service Act brought about the British National Health Service. Financed through general taxes, it provided health care as a right, with medical services free at the point of service.

Dr. Adam Gaffney

Most other nations, however, took a more incremental path. France, for instance, built upon its 1928 National Health Insurance system, passing successive pieces of legislation that covered larger and larger proportions of the population until, in 2000, the remaining 1 percent of the nation that was uninsured received coverage. Germany likewise built upon its nineteenth-century Bismarckian system to create a system of truly universal coverage.

Greece was relatively late to the game. In 1934, it established a Social Security Organization that covered urban and industrial workers, which was expanded to agricultural workers in 1961. But it was the 1983 legislation of the newly elected Socialist Party that put into place a National Health Service (NHS), founded on the principles of universal access. Along similar lines, Spain built upon a 1942 health insurance law with successive expansions of coverage. This culminated in the 1980s, when through a number of measures the Spanish Socialist Party converted the health care system to a tax-based system with universal access and a largely public provision of care.

No doubt, as they entered the twenty-first century, all of these systems had their own flaws, their own inefficiencies, even their own inequities and injustices. But for the first time in human history, the poorest individuals could avail themselves of some of the most advanced medical care in the world without worry that their illness would bankrupt their family, and without the stigma of charity. A true right to health care had been legislated into existence. Universal health care, from this perspective, represented a truly massive and historical achievement.

Needless to say, there has been resistance to these initiatives and programs from the time of their enactment. Margaret Thatcher tried to introduce market-based reforms into the NHS in the 1980s with so-called "managed competition," in which health authorities were to function as buyers of care from competing groups of providers. Overall, however, this was quite unpopular, and during the 1997 elections the Labour Party promised an end to managed competition and other Thatcherite reforms.

Similar efforts occurred elsewhere. In the 1990s, for example, a conservative government in Spain managed to legislate certain "reforms" that, among other things, raised co-payments for care.

Still, the overall success of the universal model of health care was difficult to deny. It was clear that the United States, which lacked a universal system and which had worse outcomes despite paying much more, was not the model to emulate. And in 2000, when the World Health Organization issued its first ever ranking of the world's health care systems (albeit with controversial methodology), the two top spots went to France and Italy, with Spain in seventh and Greece in fourteenth.

Although cost control was (and certainly remains) everywhere an issue, it was clear that those nations with a more market-based health care system, such as the United States, saw costs rise far faster. It was, in short, difficult to argue with success, and universal health care remained very popular among voters.

Crisis and Opportunity

The economic crisis of 2008 opened a historic window of opportunity for those who would move away from universalism. The long-growing and clearly unsustainable housing bubble – and all the economic distortions it had created – popped, to consequences worse than most had imagined, with punishing recessions and sky-high unemployment that have yet to resolve in such nations as Greece and Spain.

These less competitive Eurozone nations, tied to a single currency whose masters had not read, or did not believe in, John Maynard Keynes's theory on the fundamental importance of monetary and fiscal expansion in times of crisis, were particularly crippled. Although Greece had had significant budgetary problems even prior to the crash, most other nations didn't. Indeed, despite all the later talk about the unsustainability of its welfare state, Spain was actually running a budget surplus before the crash.

Developing nations seeking "bailouts" are accustomed to the International Monetary Fund's "conditionality" demands for fiscal contraction, and in particular, for reduced social and health care spending. But now it was the newly indebted nations of Western Europe that were being asked to slash their public sector and undergo internal devaluation, this time by the so-called "troika" – the European Central Bank, the European Union, and the IMF. Those who had never been inclined to universal health care in the first place, and who had sought to chip away at it even when it seemed to be working reasonably well, had a new and powerful ally. The attack on the European welfare state began in the "periphery."

Spain Steps Away

In Spain, talk about the "unsustainability" of universal health care rose in the early years of the crisis. While some cuts were going to be inevitable given the demands of the troika, the conservative "People's Party," elected to power in the Spanish parliament in November of 2011, went further. In the face of the demands of the troika to slash health care expenditures, the party proceeded to pass, by royal decree (thereby avoiding parliamentary debate), a new health care law that represented perhaps one of the largest changes in Spain's national health service since its establishment in the 1980s.

The law did several things, such as increase co-payments and limit the ability of illegal immigrants to access the health care system. Most radically, however, it quietly shifted the nation away from a truly universal scheme, financed through taxation, to a contributory one. Pensioners, for instance, could have access to the system only if they had contributed to it, while those over age twenty-one who had not contributed to the social security system needed to demonstrate an absence of income to obtain access to health care.

In fairness, the system remained by and large a universal one, particularly if compared to, say, the United States. But the meaning of what had transpired was clear enough. "Spain's public health service is to shift from one that provides universal coverage through general taxation," reported Aser García Rada in the British Medical Journal, "to a system funded through social security contributions."

Crucially, however, these changes were carried out in conjunction with huge global spending cuts in health care. In Catalonia, for instance, as García Rada reported, the nationalist party, after its victory in the 2011 regional elections, moved quickly to reduce the health care budget by 10 percent, to cut the salaries of some forty thousand public health professionals, and to close a third of its hospital beds and 40 percent of its operating rooms. Waiting times for care rose, and the situation became so bad that surgeons at one university hospital offered to operate on cancer patients for free. Hospital management, however, citing the various other associated costs of operations, denied them this opportunity.

Although cost control was (and certainly remains) everywhere an issue, it was clear that those nations with a more market-based health care system, such as the United States, saw costs rise far faster. It was, in short, difficult to argue with success, and universal health care remained very popular among voters.

Mark Weisbrot at the Center for Economic and Policy Research estimated that in the United States these cuts would be comparable to a 25 percent reduction in total Medicaid spending. The reduced clinical activity, delays in payments, long waiting lists, and reduced health care investment will have two effects. First, the health of the population is likely to worsen. But second, these cuts have a certain self-fulfilling logic: as quality deteriorates, public support for the system declines, the system becomes more vulnerable to further attacks, and the cycle can restart. Universal health care in Spain has not been undone; its unraveling, however, has begun.

'Humanitarian Crisis' in Greece

Greece entered the crisis in worse budgetary shape than Spain, and also with a less advanced health care system. The health

of its population was therefore all the more precarious when austerity hit.

The cuts came hard and quick. With each bailout there were further demands for deep reductions in health care spending, with the IMF requesting a cut in public health spending from 10 percent of GDP to less than 6 percent. Health care spending – from both private and public sources – fell from $25 billion in 2010 to $16 billion in 2011. In 2011, the minister of health called for a 40 percent reduction in hospital budgets, despite a 24 percent rise in public hospital admissions between 2009 and 2010. And by 2012, Greece was estimated to be spending more on interest payments on its debt than on education and health care combined.

The results were soon evident. Doctors have reported shortages of basic hospital supplies, ranging from gloves to cotton wool. Nurses have complained about huge increases in their patient loads. Waiting times increased, with one physician telling the New York Times that breast cancer patients were waiting three months to have their tumors excised. Despite large increases in the rates of depression, spending on mental health actually fell by 45 percent. Significant reports of drug shortages came in from across the country. Co-payments for drugs were increased, while at the same time hospitals and pharmacies began demanding cash payments for drugs, so as to avoid the risk and wait for reimbursement.

Simultaneously, access to public health services was sharply limited. The loan agreements that Greece has signed with international lenders have resulted in major changes to the health care system. Greece had not had a fully universal system of health care even prior to the crash. Individuals and their employers would contribute to a government-supported fund, and these individuals thereby received access to the public health system. Those who lost their jobs received benefits for a year and thereafter could still receive some treatment if unable to afford health care. But under the new deal, Greeks had to start paying for more of their health care costs out of pocket once their benefits expired. At the same time, the ranks of those without benefits swelled, creating a dangerous situation.

Reliance on "street clinics" and charitable care, which previously had been used primarily by illegal immigrants without access to the public system, became more common. One charitable clinic, as reported in the medical journal Lancet, described a rise in the proportion of Greeks that utilized its services from 3 percent to 30 percent. Reuters carried a story about another clinic that relied on donated drugs, run by volunteer doctors and nurses who saw sixty patients a day.

Waiting times increased, with one physician telling the New York Times that breast cancer patients were waiting three months to have their tumors excised.

This, of course, was all occurring at time when the social, medical, and mental health needs of the population were expanding rapidly. A 2012 study suggested a more than doubling in the rate of major depression in Greece between 2008 and 2011, particularly among the young and those, not surprisingly, in financial distress. Reports of rising suicide rates in 2011 were particularly concerning given Greece's traditionally low rate. The government's public health agency reported significant increases in new HIV infections. Illegal drug use became more prevalent. The deputy health minister described a large "new category" of homeless – those unemployed by the crisis and evicted thereafter.

Other European countries made similar, if less dramatic, cuts. Portugal, for instance, pushed through a large increase in co-payments as part of an agreement with the troika. Co-payments were also introduced in Italy, while the Italian Health Pact of 2011–2012 required a reduction in the number of hospital beds and admissions.

The common factor to all these reforms is that they take these nations' health care systems away from universalism, both in letter and spirit. Even more frightening, particularly for nations such as Greece and Spain, has been the fact that they haven't worked. Slashing public sector spending has, as widely predicted, merely intensified the recession. Unemployment thus remains at Great Depression levels. As GDP falls further, so too does tax revenue. With no headway made in deficit reduction, countries need more bailouts, the troika demands more cuts, and social services such as health care deteriorate further.

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Austerity has been both an economic and human disaster, and it only remains to be seen how many lives are ruined – or indeed, lost – before the responsible parties recognize it.

Although universal health care was a relatively recent achievement, it quickly came to be considered an intrinsic feature of the European welfare state. It is not, however, immutable. Universal health care everywhere arose through the process of political struggle, and it can be similarly unmade. It was generally the creation of parties of the Left, and was more likely to emerge, and to emerge earlier, in those countries with a strong tradition of labor unionism. As the balance of power shifts, it is not only possible, but indeed probable, that those elements that were fundamentally opposed to universal health care from its very conception will emerge to challenge it.

The greatest bulwark against these challenges remains its broad popularity, and it is for this reason that the attacks do not come head on. The best analogy in the United States is with Medicare and Social Security, also popular programs entirely discordant with the political philosophy of the Right. The right wing uses the cause of cost-containment and deficit reduction, combined with allegations of inefficiency, to chip away at the margins of these programs, to promote privatization and reductions in benefits, while at the same time avoiding a frontal rhetorical attack.

Similarly, those who would undo universal health care in Europe begin by increasing the barriers to access (such as increased user fees or the denial of care to illegal immigrants), by cutting expenditures and reducing quality, by subtly changing the system away from universalism with changes in financing or benefit eligibility. Not to recognize that such measures could amount to the first step in a long process of unwinding the right to health care would be a dangerous mistake.

There is yet another mistake that we must avoid. Perhaps because we wish to avoid self-congratulation or complacency with the status quo or perhaps because every system has faults and inefficiencies and imperfections, we can sometimes fail to recognize a true advance or accomplishment. Even as we try to improve it, we should accept the historical importance of universal health so that we can understand what we would lose were it to end.

You don't need a doctor to know that there are not many things worse than suffering from a serious illness or injury. One thing that is worse, though, is suffering while knowing that effective care for that condition exists, but is inaccessible or unaffordable; or suffering and receiving some treatment, but at the cost of bankruptcy; or suffering while knowing that the illness could actually have been prevented with better, or earlier, care. True universal health care confers an individual right to be protected from these terrible eventualities. It is therefore all the more urgent that we both protect and expand it.

Adam Gaffney is a board-certified internist, a fellow in pulmonary and critical care medicine, and a member of Physicians for a National Health Program.

Report from the second annual Student Summit

By Victoria Powell, MS3

The second national Student Summit was held at PNHP headquarters in Chicago on Saturday, May 11. Forty-two students were in attendance, from fourteen different medical and other health professional schools.

During an introductory session, each student described why they are working for single payer and what they would like to achieve at the summit. Answers reflected a diversity of backgrounds and experiences, yet many students affirmed the need to restructure the current system of health care as a commodity to one of health care as a human right. Students desired to form relationships with like-minded people from around the country in order to strengthen resolve, build momentum, and further deepen their knowledge and understanding. This introductory session set an optimistic tone that persisted throughout the day.

The student-organized conference featured diverse programming carefully created to help participants expand knowledge; share and develop skills; motivate and energize each other; and form lasting relationships. Above all, organizers wanted to encourage participation of attendees and impart a sense of shared ownership of the movement. Many attendees gave presentations and led sessions, several for the first time.

The opening presentation covered an evidence-based rationale for converting our fragmented, inefficient system into a single-payer, universal syste. It explained why the ACA has key inadequacies. Next, a presentation about the legacy of health professional activism emphasized that we are joining a long and bold tradition of those who saw the need for social change and acted. The final large group session of the morning was a detailed look at HR 676.

Breakout sessions provided a chance for students to discuss strategies, share skills, learn what other student chapters and social groups have accomplished, and deepen their understanding of healthcare economics and policy. These included a presentation on heroism vs. evil in medicine; transitioning from sympathizers to activists; and a summary of healthcare economics with an emphasis on refuting the "iron triangle" of cost, quality, and access.

Interactive skill-building workshops included effective communication skills, responding to difficult questions about single payer, and a lesson in successful organizing given by a student familiar with Southside Together Organizing for Power (STOP), a group focused on building the power of residents on the Southside of Chicago. Students were given opportunities to meet in geographically based groups to discuss previous and future chapter events, how to grow the movement and collaborate to avoid "binge advocacy" that results in burnout.

Our keynote speaker, Dr. Paul Song, spoke about California's efforts to achieve a state-based single payer system, ways that students can help, and employing diverse tactics such as forming coalitions with other groups, working to elect progressive politicians who will fight for single payer, and disseminating fact-based material about single payer benefits over the current system.

Finally, we asked students to consider how they envision the role of students in the fight for Medicare for All. The feeling was unanimous that health professions students have a unique opportunity and role.

theguardian

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Britain's NHS: Section 75 of the health act is an engine for destruction

Section 75 of the health act is the mechanism that locks in privatization of the health service: the Lords must amend it

By Kailash Chand

LONDON – Andrew Lansley's Health and Social Care Act, which came into effect on 1 April, had a troubled passage through parliament, including an unusual legislative "pause." This was to allow the government time to "listen" to its many critics, including most health care professionals and a majority of the public, who believed the plans would create and lock in rights for private providers to make a profit from the National Health Service.

Lansley gave assurances that these voices had been heard, and that clinical commissioning groups would be able to decide "when and how competition should be used."

However, concerns about privatization return to centre stage this week, when the regulations governing procurement and competition are debated in the Lords. As Lucy Reynolds, a research fellow at the London School of Hygiene and Tropical Medicine, puts it, if the act itself was the aircraft of privatization, the structure that gave the idea the potential to fly, section 75 of the regulations is the engine that will allow take off.

The wording of section 75 requires commissioners to put out to tender everything that could be provided by an organization other than the NHS. Private contractors are more likely to win these tenders than doctors, many of whom will never have even seen a tender notice.

The regulations would create rights for commercial providers under rules originally devised by U.S. corporations to promote their commercial interests. If implemented, they will drag the NHS into a competition law regime which creates obligations for governments to compensate private providers in the event of services being brought back into public provision.

The British Medical Association, along with many other health organizations including the Royal College of General Practitioners, are calling for the regulations to be withdrawn, as is the Labour party. The BMA says they must be replaced with new regulations that "unambiguously reflect previous government assurances that commissioners will not be forced to use competition when making their commissioning decisions," and explicitly state this principle.

As contracts are lost by public sector bidders, the teams that would have delivered them will be made redundant because funds will not be available to pay them. Under the proposed regulations, the government is not permitted to rescue such a service unless all other competitors are equally subsidized, in the interests of non-discrimination.

The competitive tendering forced by the current draft of the regulations requires a large amount of administration, which will divert funds away from frontline care. Thanks to market-driven changes that have already taken place administrative costs have risen to at least 16 percent, in contrast to the pre-1980 figure of less than 5 percent.

These regulations will act as the motor of the NHS privatization by giving companies a mechanism to force their way into NHS service provision for the patients, procedures and places wherever they see profits. The likes of Care UK or Virgin Care will try to cherry-pick easy and profitable services – diagnostics, routine elective surgery, and simple treatments, for example – leaving behind A&E [emergency departments], care of the elderly, mental health services and anything that is unpredictably expensive.

There is no evidence to support the idea that competition breeds excellence in health care. According to Robert Evans, professor of economics at the University of British Columbia, market innovations in the NHS over the last 40 years have led to greater inequity, increased inefficiency, cost inflation and higher levels of public dissatisfaction.

Seeking the withdrawal and replacement of these regulations is not scaremongering; there is plenty of evidence that market-driven health services lead to limited choice, escalating costs, and reduced quality.

There is no evidence to support the idea that competition breeds excellence in health care. According to Robert Evans, professor of economics at the University of British Columbia, market innovations in the NHS over the last 40 years have led to greater inequity, increased inefficiency, cost inflation and higher levels of public dissatisfaction.

It is time to reject the market ideology that has plagued the NHS for more than a quarter of a century, wasting billions of pounds in the process.

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Issues in International Health Policy

Health Care for Undocumented Migrants: European Approaches

Bradford H. Gray and Ewout van Ginneken

ABSTRACT: European countries have smaller shares of undocumented migrants than does the United States, but these individuals have substantial needs for medical care and present difficult policy challenges even in countries with universal health insurance systems. Recent European studies show that policies in most countries provide for no more than emergency services for undocumented migrants. Smaller numbers of countries provide more services or allow undocumented migrants who meet certain requirements access to the same range of services as nationals. These experiences show it is possible to improve access to care for undocumented migrants. Strategies vary along three dimensions: 1) focusing on segments of the population, like children or pregnant women; 2) focusing on types of services, like preventive services or treatment of infectious diseases; or 3) using specific funding policies, like allowing undocumented migrants to purchase insurance.

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OVERVIEW

An estimated 6.7 million—or 57 percent—of the 11.8 million undocumented migrants in the United States lacked health insurance in 2007, accounting for 14.6 percent of the nation's 46 million uninsured.[1] As the Affordable Care Act is implemented, determining whether and how to meet the medical needs of undocumented migrants will be challenging. This issue brief examines how undocumented migrants' access to care is handled in European health systems. Policies and practices vary greatly across countries and have become issues of intense debate.[2]

Undocumented migrants include people who have entered a country without documentation, as well those whose visas have expired. In Europe, this does not include regularized "temporary or guest workers" in guest worker programs with appropriate documentation who are covered by the national health system. Guest workers can become undocumented migrants if they overstay their work permits.

There is concern in policy circles in Europe that terminology—particularly words such as "illegal aliens"—can have a negative, inflammatory effect on thinking and arguments. A variety of terms are used in the European context, including undocumented or unauthorized migrants, people without papers, irregular or clandestine immigrants, and undocumented third-country nationals (i.e., referring to people who are neither from the European Union country in which they are staying nor any other country in the E.U.). For the purposes of consistency, we will use the term "undocumented migrant" for the remainder of this issue brief.

This paper focuses on health care arrangements for undocumented migrants, but it is important to recognize that in addition to challenges arising from their legal status, undocumented migrants also face language, cultural, and economic barriers to care that are common among immigrants. Whether such problems should be addressed by health systems (e.g., through translation services and efforts to increase cultural awareness) or by immigrants' making needed adaptations is a highly politicized issue.

Care providers in several European countries report that undocumented migrants' most common health care problems involve mental health, infectious and sexually transmitted diseases, and reproductive health.[3] According to a project called "Health Care in Nowhereland," which works to improve services for undocumented migrants in the E.U., barriers to care include fear of being reported, lack of information about their rights, lack of legal entitlements, costs of services, and discriminatory attitudes among health professionals.[4]

The U.S.–European Comparison

The U.S. and European Union differ in terms of the scale of their undocumented migrant populations. The total population of the 27 E.U. countries is more than 500 million, substantially exceeding the U.S.'s 300 million. Yet in the E.U., the estimated number of undocumented migrants ranges from 1.9 million to 3.8 million,[5] far fewer than the U.S.'s estimated 11 million to 12 million. In both the U.S. and the E.U., health care for immigrants—particularly those who lack documentation—is debated passionately.

In the U.S., attention is largely focused on migrants from Mexico and Central America and on a heavily policed border. The European immigrant population comes from many different countries, with a heavy concentration on countries in Africa, the Middle East, and the former Soviet Union. External borders of the European Union involve different countries with varying immigration policies. Concerns about trafficking, particularly of women and children, for commercial sexual exploitation or forced labor or slavery are more prominent in Europe, but policy regarding asylum-seekers and refugees is important in both the E.U. and the U.S. The human rights advocacy community is more prominent in policy discussions in the E.U. where health care is viewed as a human right rather than as a market good. The tradition of charity care by hospitals, physicians, and community health centers is more prominent in the U.S.

Undocumented Migrants: Ethical, Public Health, and Other Issues

Providing medical care for undocumented migrants in the E.U. involves several interrelated issues or concerns, including:[6]

- *Humanitarian/ethical issues:* The International Covenant on Economic, Social, and Cultural Rights, which has been ratified by most countries—although not the U.S.[7]—states that health care is a human right that should be available to everyone within the jurisdiction of a state, without discrimination.[8] According to this argument, society should treat the poor or those who are vulnerable for a variety of reasons (e.g., age, fear, war trauma, language barriers), particularly when workers in many immigrant households do society's dirty work.
- *Public health issues:* Public health concerns underlie policy decisions in some countries to provide services such as vaccination and prenatal care, as well as to provide treatment for communicable diseases. Providing such services to undocumented migrants also benefits population as a whole.

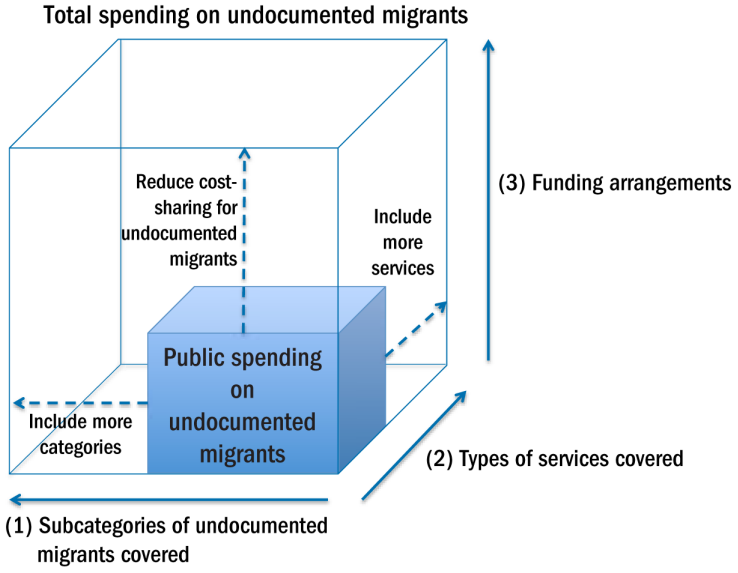
- *The "magnet" concern:* One objection to providing access to care for undocumented migrants is that doing so will attract more migrants. Little evidence is available. Similar arguments have been made in the U.S. about allowing immigrants (and immigrant children) access to education or other services.
- *The "free rider" concern:* Another argument against providing care to uninsured immigrants—particularly if they lack means to pay—is that they should not benefit from a system that others have paid for.
- *Health system concern:* In some countries, like England, that have queues for service, concerns have arisen that providing care to undocumented migrants will reduce access for others. Additionally, all countries have concerns about health care costs, which arguably would increase if services are provided to migrants. Little is known about the relative costs of different policies—allowing no access, access only to emergency services, or access to preventive services, primary care, or secondary care.

Policies Regulating Care of Uninsured Migrants in the European Union

Although undocumented migrants are accorded a right to health care under legal conventions adopted by the European Union, there is substantial room for interpretation. Specifically, there are considerable country-to-country variations regarding: 1) subcategories of the undocumented migrant population—for example, detained undocumented migrants, asylum seekers, children, victims, refugees; 2) the types of services, ranging from emergency care to a full range of services; and 3) types of funding arrangements—for example, separate funding, full coverage by the national health system, or allowing individuals to purchase insurance coverage in the statutory system. The higher the coverage in each of these three dimensions, the more comprehensive the care is in a given country (Exhibit 1).

The International Covenant on Economic, Social, and Cultural Rights and the Council of Europe have defined the provision of emergency care as a basic human right. In addition, a policy that requires screening the immigration status of people needing emergency services is not practical. However, beyond emergency care, there is great variation among European countries

Exhibit 1. Three Dimensions of Health Care Coverage Policy for Undocumented Migrants



Source: Adapted from the World Health Organization, *The World Health Report 2008: Primary Health Care—Now More Than Ever* (Geneva: World Health Organization, 2008); and R. Busse and S. Schlette, eds., *Focus on Prevention, Health and Aging, New Health Professions* (Gutersloh: Verlag Bertelsmann Stiftung, 2007).

regarding the provision of health care to undocumented migrants.[9]

The Nowhereland project grouped the European Union countries, plus Switzerland and Norway, into three categories based on a public health perspective.[10] Twenty countries provide access only to emergency care, four allow access to some health services beyond emergency care, and five allow undocumented migrants that meet certain conditions—for example, proof of identify or length of residence—access to the same range of services as nationals (Exhibit 2).

To illustrate the variation in coverage among countries, this issue brief explores several countries in more depth: four countries that provide full access under certain conditions and three countries that provide access to certain services or certain categories of undocumented migrants (Exhibit 3).

COUNTRIES PROVIDING FULL ACCESS TO UNDOCUMENTED MIGRANTS UNDER SPECIFIED CONDITIONS

France

The French experience illustrates the practical challenges when a country tries to establish and implement policies to give undocumented migrants access to medical care while also trying to discourage the illegal immigration of people seeking free care from the public system. The estimated 400,000 undocumented migrants in France come mainly from Asia, Central Africa, West Africa, Algeria, Morocco, Turkey, and Chechnya,[11] and have a variety of infections, chronic illnesses, and mental health conditions.

France's Universal Health Coverage Act provides publicly financed insurance coverage to all residents of the country, but there are separate laws and regulations regarding health care for undocumented migrants. The State Medical Assistance (AME) system allows a major subset of undocumented migrants to become eligible for publicly subsidized, free physician and hospital care. Undocumented migrants can apply for coverage at various health or social service centers, hospitals, and nongovernmental organizations. Applications must include an identification document (e.g., passport, birth certificate, or expired residency permit), an address, evidence of in-country residence for at least three months, and proof that household income is under the threshold (€631/month as of 2009). Successful applicants receive a one-year coverage certificate that the undocumented migrant can present to care providers who can invoice the state for reimbursement. Some services (e.g., dental prostheses and corrective lenses) are excluded and there is variation within the country regarding access to services. An estimated 180,000 undocumented migrants receive AME coverage.

Undocumented migrants who do not meet AME requirements are nevertheless entitled to: care in life-threatening situations; treatment of contagious diseases, but not other chronic diseases; all types of health care for children; maternity care; and abortion for medical reasons. Undocumented migrants who have been living in France for at least three years are eligible for

Exhibit 2. Undocumented Migrants' Access to Medical Care in European Countries

Degree of access	Countries
Access only to emergency services	Austria, Bulgaria, Cyprus, Czech Republic, Denmark, Germany, Greece, Estonia, Finland, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Malta, Poland, Romania, Slovak Republic, Slovenia, Sweden
Greater access to some services or for some categories of undocumented migrants	Belgium, Italy, Norway, and the United Kingdom
Full access under specified conditions	France, the Netherlands, Portugal, Spain, Switzerland

Source: The Nowhereland Project, Center for Health and Migration/DUK, and Malmo Institute for Studies of Migration, Diversity, and Welfare, *Two Landscapes of Nowhereland: Fact Sheet Policies, 2010.*

Exhibit 3. Health Care Access to Undocumented Migrants in Seven European Countries

Country	Undocumented migrants as percentage of population	Main vehicle for covering undocumented migrants	Benefits	Additional notes
England	1.2%	National Health Service (NHS)	Emergency care and certain infectious diseases with public health hazard. NHS requires hospitals to confirm the ability to pay of patients not covered by the NHS.	Cost must either be covered by the patient or taken out of the hospital's budget, which creates a barrier
France	0.6%	State Medical Assistance (AME)	Full range as provided in the public system	Undocumented migrants without AME eligibility are entitled to emergency care, pediatric care, and maternity care
Germany	0.6% to 1.8%	Separate tax-funded scheme where providers can receive reimbursement for the costs of emergency treatment	All emergency care. Several categories of "planned care," only accessible with a medical card.	Undocumented migrants face a high barrier when applying for a medical card in the welfare office because the office must report the individual to the authorities, which could lead to deportation
Italy	0.3% to 1.6%	Undocumented migrants can apply to a local national health service office for a temporary (i.e., six-month) health card	Health card entitles urgent care, essential care, preventive care (including maternity care), and diagnosis/treatment of infectious diseases.	There are local differences in interpretation of the law and willingness to provide services. There are reports of many people without access.
Netherlands	0.4% to1.4%	Separate tax-funded scheme in which the government pays providers for undocumented migrant care at 80% of normal fees for costs that cannot be recovered from the patient	Full range as provided in the public system	The requirement that patients be billed and the limited number of contracted providers for services provided on referrals may create barriers to care
Spain	0.8%	Undocumented migrants are covered by the national health service if they have registered as residents of the municipality	Full range as provided in the public system	The requirements for registration with a municipality (valid passport, a proven residency) and the fact that police have access to registers constitute the greatest barriers
Switzerland	1.0 % to 1.3%	Undocumented migrants are required to purchase insurance in the statutory health insurance system provided by private insurers. There are income-related subsidies.	Full range as provided in the public system	High premiums, cost-sharing requirements, and administrative procedures may seriously hamper undocumented migrants' ability to purchase insurance. Undocumented migrants mostly rely on basic health care provided by the cantons.

Source: Country-specific reports from the Nowhereland Project and the Platform for International Cooperation on Undocumented Migrants (PICUM).

"home medical assistance," which is less comprehensive than the AME but that nevertheless allows them to see general practitioners without charge. The Platform for International Cooperation on Undocumented Migrants (PICUM) has observed that documenting three years of continuous residence can be difficult.

People who become undocumented when their status as legal immigrants expires can remain insured for up to four additional years.

Even with these systems in place, undocumented migrants face many practical difficulties in getting care. According to PICUM, thousands of undocumented migrants do not have AME coverage for which they appeared to be entitled.[12] The main reasons cited include: 1) uneven interpretation and implementation of the law across agencies and cities, 2) undocumented migrants' lack of awareness of the program, and 3) lack of acceptable identification documents or adequate evidence regarding residency requirements. Some doctors and pharmacies reportedly refuse to serve people with AME coverage.

The Netherlands

In the Netherlands, arrangements for care of undocumented migrants—an estimated 0.4 percent to 1.4 percent of the population—have changed in recent years. Under reforms initiated in 2006, all citizens and legal residents are obliged to purchase private insurance coverage, as are nonresidents who pay income tax.[13] Separate arrangements were made under which providers were paid by the government for their service to undocumented migrants.

In 2009, a new scheme defined the terms under which government would pay providers for care to undocumented migrants. It distinguishes among types of care and, to a certain extent, types of undocumented migrants. Providers are paid on a fee-for-service basis—generally at 80 percent of normal fees—for "medically necessary care" to undocumented migrants, if the providers previously tried to recover the costs from the patient but were unsuccessful. The scheme distinguishes between services that are directly accessible and those that require a referral or prescription. For directly accessible services—which involve general practitioners; midwives; dentists, for patients up to age 18; physiotherapists; and hospital emergency departments—all providers can be reimbursed for service to undocumented migrants. For services requiring a referral—those provided by hospital departments other than the emergency room, specialist physicians, nursing homes, and dispensaries—reimbursement is available only to specifically contracted providers.

The requirement that patients be billed for some services and the limited number of contracted providers for services provided on referrals may create barriers to care.[14] Even so, the Dutch arrangements go further than do those of most other countries in regularizing access for undocumented migrants.[15]

Spain

There were an estimated 354,000 undocumented migrants living in Spain in early 2008, mostly individuals who overstayed their visas.

In theory, Spain provides some of the broadest health coverage to undocumented migrants in Europe. Since the mid-1990s, several regularization programs have granted legal status to approximately 1 million undocumented migrants in Spain.[16] The regionally organized, tax-funded National Health Service provides universal coverage with free health care at the point of delivery. Undocumented migrants are included if they have registered as residents of the municipality, thereby obtaining a health card. Undocumented migrants who are not registered in a municipality are entitled to emergency treatment free of charge. Interpretation and practice may vary across Spain's 17 regions. For example, Madrid has provided health cards to undocumented migrants without requiring them to register. Some Spanish authorities and providers have organized information campaigns aimed at undocumented migrants and have distributed printed materials to inform and facilitate their access to health care.

Nevertheless, undocumented migrants face many practical obstacles accessing the health system. The requirements for registration with a municipality (i.e., valid passport, proven residency) and the fact that police have access to registers constitute the greatest barriers.

Recently the situation has worsened. Spain's conservative government approved a law that denies undocumented migrants full access to the public system. From September 2012, undocumented migrants only have access to emergency, maternity, and pediatric care. More than 1,300 Spanish doctors and nurses have vowed to continue treating undocumented migrants.[17]

Switzerland

A 2005 study estimated the number of undocumented migrants in Switzerland at 80,000 to 100,000. Most are believed to be former seasonal workers from non-European Union countries who overstayed their residence permits. Article 12 of the Swiss constitution gives every person the right to basic health care, but Switzerland's 26 cantons are responsible for incorporating article 12 into their respective bodies of law.

Undocumented migrants, like any person present in Switzerland for more than three months, have the obligation and the right to purchase statutory health insurance provided by private companies. There are income-related subsidies. Insurers are obliged to accept all applicants for the basic package of benefits, regardless of individual risk. Applicants have to provide their full name, date of birth, a contact address, and a bank or post office address.

The process may be complicated for undocumented migrants. Expensive insurance premiums and cost-sharing requirements, as well as complex administrative procedures and requirements for subsidies, may seriously hamper their ability to purchase insurance. As a result, undocumented migrants often rely on their right to basic health care as implemented by the cantons, which can vary in scope. Most cantons provide only emergency care. In practice, undocumented migrants may bear the full costs of nonemergency health services, effectively making such care unaffordable.[18]

COUNTRIES PROVIDING ACCESS TO NONEMERGENCY SERVICES OR PROVIDING CARE TO CERTAIN CATEGORIES OF UNDOCUMENTED MIGRANTS

Italy

Italy is one of the largest immigrant countries in Europe, with foreign-born individuals representing almost 6 percent of the population. Estimates of the number of undocumented migrants range from 200,000 to 1 million people.[19] Most entered the country legally on tourist or work visas and remained after they expired. The main countries of origin are Romania, Albania, Morocco, Ukraine, China, Tunisia, and Poland.

Italy's tax-funded health system covers all citizens and regular immigrants who register with a local health administration and receive a health card that entitles them to primary, inpatient, and emergency care that is free at the point of service. There are copayments for most other services, though there are exemptions for senior citizens and people with low incomes or with chronic diseases, as well as pregnant women and prisoners.

Undocumented migrants cannot register in the mainstream health system. However, they can apply to a local office of the national health system for a six-month health card that entitles them to urgent care, as well as essential care for diseases that could become dangerous. Undocumented migrants are also entitled to preventive care, including maternity care, and diagnosis and treatment of infectious diseases.

There may be barriers to access related to knowledge, culture, and language, as well as fear. Physicians and office staff are prohibited from reporting undocumented migrants to authorities, but legislation to require reporting has been publicly debated in recent years.[20] The allowable copayments may also create financial barriers.

There are also local differences interpreting what the law requires and in willingness to provide services. However, a number of nongovernmental organizations and charitable health care providers serve undocumented migrants regardless of whether they have gone through the process to gain an entitlement.[21]

England

In England, the National Health Service (NHS) is funded from general taxes and care is largely free at the point of service to all "ordinary residents." Visitors and undocumented migrants have access only in emergencies and for certain infectious diseases that constitute a public health hazard.[22] Hospitals are owned by the NHS, and the specialist physicians based therein are salaried employees. General practitioner (GP) physicians receive an annual capitation payment for registered patients. This structure creates barriers to care for undocumented migrants.

NHS regulations require hospitals to ascertain the status of all patients and, for patients not covered by the NHS, to confirm the ability to pay. If a medical professional determines that a treatment is immediately necessary, it must be provided, but the cost must either be covered by the patient or taken out of the hospital's budget. However, hospitals are reimbursed by the NHS for accident and emergency services and treatment of certain communicable diseases provided to non-NHS patients. HIV/AIDS is not on the list of communicable diseases eligible for free care. Undocumented migrants with HIV or AIDS may be admitted if critically ill and in immediate danger, but they will not be eligible for further services after discharge.[23] For routine primary care, unless non-NHS patients have the means to pay, their access to care depends upon finding a provider willing and able to provide service without additional compensation. Patients without proper documentation may be unable to get beyond the receptionist in a practice.[24]

Germany

Estimates of the number of undocumented migrants in Germany range from 500,000 to 1.5 million. A complicated regulatory framework for immigrants has led to a great deal of uncertainty for undocumented migrants, health professionals, and administrators. Rules for emergency care differ from those for planned services.

Hospitals and GPs are obliged to provide emergency care to undocumented migrants. Health workers and administrators in health establishments are not required to report undocumented migrants to authorities, but other public officials are. Providers can receive reimbursement for the costs of emergency treatment from the tax-funded social welfare office. Under such circumstances, the social welfare office does not have to report the undocumented migrant because the provider, who is applying for funding, has professional confidentiality protections which are extended to the office.

In case of planned care for serious illness or acute pain, improvement or relief of illnesses and their consequences, postnatal care, preventive care, and infectious and sexually transmitted diseases, undocumented migrants are entitled to the same publicly subsidized health care benefits as asylum seekers residing in Germany but they must have a medical card.

Undocumented migrants must personally apply for a medical card in the welfare office. Since the application comes from the undocumented migrant, not the provider, the welfare office is obliged to report the undocumented migrant to the immigration office. This deters applications since the process could eventually lead to deportation unless the undocumented migrant successfully applies for a temporary residence permit, known as Duldung. However, applying for Duldung only temporarily suspends a potential deportation. Special rules exist for children and pregnant women and traumatized persons, but access to maternity and child care is only possible after a successful application for a Duldung.

Consequently, as a practical matter, undocumented migrants have difficulty accessing planned care and many obtain such services only if they can pay out-of-pocket or providers are willing to forgo their fees.

In addition, the Law for Infectious Diseases provides for anonymous counseling and check-ups for patients with tuberculosis and sexually transmitted diseases. Such services are provided at public health offices.

For most of their care needs, undocumented migrants rely on professionals' willingness to offer free treatment or on the ability of charitable, religious, or aid organizations to provide assistance. The number of such charitable activities has been increasing. Most provide direct treatment and medication or pay for treatments from providers willing to treat undocumented migrants.

Berlin is aiming to regularize medical treatment for undocumented migrants and has proposed increasing access through anonymous health insurance cards, anonymous payments, and guaranteed doctor's fees.[25,26]

CONCLUSIONS AND OPPORTUNITIES FOR CROSS-NATIONAL LEARNING

There is no standard European approach to care for undocumented migrants. It is difficult to pinpoint the reasons why countries differ in their policies but factors such as the history and magnitude of a country's experience with immigration probably play a role, as well as the overall political climates and prevailing attitudes toward migrants and immigration.[27]

In addition to the legal complexities presented by undocumented migrants, they also create moral dilemmas for providers who may have to choose between providing care that is against national regulations or violating recognized human rights and their own moral standards.[28] Some adopt a strategy termed "functional ignorance,"[29] where the legal status of a care seeker is not ascertained by providers.

In many European countries, health care access for undocumented migrants is as much of a policy and political problem as it is in the United States. Although undocumented migrants have the right to health care under legal conventions adopted by the European Union, these regulations leave substantial room for interpretation. In most countries, the right to health care is interpreted as access to emergency care. But even in countries that provide full access, barriers remain because of the vulnerable position of the undocumented migrant. A right to care does not necessarily equate to full access to the health system. Gaps between policy and practice exist, although there is a lack of good data to describe the extent of the problem. Most available evidence is patchy and anecdotal.

Even so, the experience of several European countries shows it is possible to substantially improve access to care for undocumented migrants. Options to cover undocumented migrants can vary along three dimensions: 1) particular segments of the undocumented population, 2) particular types of services, or 3) funding arrangements. Examples of various strategies include Switzerland's policy of allowing undocumented migrants to obtain insurance coverage in the national system, Spain's former strategy of providing undocumented migrants with coverage in the national health service even without their financial contributions, and the Netherlands' plan to provide an additional source of funding to ensure that physicians and hospitals receive compensation for providing services to undocumented migrants. Policies to provide undocumented migrants with access to care may be more feasible in countries that have universal health insurance coverage because that coverage negates arguments that undocumented migrants are getting privileges not available to citizens. But even in countries with universal coverage, providing access to undocumented migrants requires explicit policy efforts.

The challenge of covering undocumented migrants is arguably more urgent in the U.S. than in the E.U., given the size of the U.S.'s undocumented migrant population and the implementation of the Affordable Care Act, which explicitly excludes them. There is little solid evidence regarding the cost-effectiveness and public health benefits of providing care to undocumented migrants. And despite economic arguments against providing coverage to undocumented migrants, evidence shows that the number of undocumented migrants in the U.S. has leveled off or declined, that many pay taxes and have insurance coverage, and that they do not cost more to cover or utilize more services than U.S.-born citizens.[30] The myriad policies in Europe could provide a tool box for the U.S., but experience in Europe shows that even with supportive policies, undocumented migrants often face formidable language, legal, cultural, and bureaucratic barriers to obtaining care.

Note: *Endnotes can be found on the PNHP website at: http://bit.ly/10P50sy*

Funding HR 676: The Expanded and Improved Medicare for All Act

How we can afford a national single-payer health plan

By Gerald Friedman, Ph.D.

July 31, 2013

Executive Summary

The Expanded and Improved Medicare for All Act, HR 676, introduced into the 113th Congress by Rep. John Conyers Jr. and 37 initial co-sponsors, would establish a single authority responsible for paying for medically necessary health care for all residents of the United States.

Under the single-payer system created by HR 676, the U.S. could save an estimated $592 billion annually by slashing the administrative waste associated with the private insurance industry ($476 billion) and reducing pharmaceutical prices to European levels ($116 billion). In 2014, the savings would be enough to cover all 44 million uninsured and upgrade benefits for everyone else. No other plan can achieve this magnitude of savings on health care.

Specifically, the savings from a single-payer plan would be more than enough to fund $343 billion in improvements to the health system such as expanded coverage, improved benefits, enhanced reimbursement of providers serving indigent patients, and the elimination of co-payments and deductibles in 2014. The savings would also fund $51 billion in transition costs such as retraining displaced workers and phasing out investor-owned, for-profit delivery systems.

Health care financing in the U.S. is regressive, weighing heaviest on the poor, the working class, and the sick. With the progressive financing plan outlined for HR 676 (below), 95% of all U.S. households would save money.

HR 676 (Section 211, Appendix 2) specifies a financing plan for single-payer that includes

- Maintaining current federal financing for health care
- Increasing personal income taxes on the top 5% of income earners
- Instituting a modest tax on unearned income
- Instituting a modest and progressive tax on payroll, self-employment
- Instituting a small tax on stock and bond transactions

The following progressive financing plan would meet the specifications of HR 676:

- Existing sources of federal revenues for health care
- Tax of 0.5% on stock trades and 0.01% tax per year to maturity on transactions in bonds, swaps, and trades
- 6% high-income surtax (applies to households with incomes > $225,000)
- 6% tax on unearned income from capital gains, dividends, interest, profits, and rents
- 6% payroll tax on top 60% of income earners (applies to incomes over $53,000, tax paid by employers)
- 3% payroll tax on the bottom 40% of income earners (applies to incomes under $53,000, tax paid by employers)

HR 676 would also establish a system for future cost control using proven-effective methods such as negotiated fees, global budgets, and capital planning. Over time, reduced health cost inflation over the next decade ("bending the cost curve") would save $1.8 trillion, making comprehensive health benefits sustainable for future generations.

Section I: Financing needs for single payer

Regressive and obsolete funding sources to be replaced by progressive taxation

Health expenditures under the existing health care system are projected to total $3.13 trillion in 2014, plus $32 billion in spending by employers for administering employer-based health insurance plans.[1] Health care financing in the U.S. is highly regressive, with low-income households and those dealing with serious illness or injury paying larger shares of their incomes towards health care than high-income and healthy households.

Under HR 676, progressive federal taxes (i.e. taxes that reduce the proportion of income paid by low-income households and those faced with a serious illness for medical care) would replace current regressive, income-invariant sources of health care financing such as spending by businesses and 80% of out-of-pocket spending by individuals.[2]

Progressive federal taxes would also replace regressive and obsolete funding sources including federal, state, and local government spending on private health insurance for government employees, and state and local government spending on Medicaid and other health programs. According to data from the Centers for Medicare and Medicare Services (CMS), these expenditures will total $1,723 billion in 2014. See Table 1.

Current spending on federal government programs to be applied to funding HR 676 amounts to $1,344 billion.[3] This includes federal spending for the Medicare program, the Medicaid program, and the Children's Health Insurance Program. Other funding sources include $47 billion in revenue from new Medicare taxes included in the Affordable Care Act of 2010, and the remaining 20% of out-of-pocket spending by individuals. Together, these funding sources amount to $1,454 billion of spending retained for funding HR 676 in 2014.

Table 1. Regressive and obsolete funding sources to be replaced by progressive taxation (in billions of dollars)

Private business	
Employer contribution to private health insurance premiums	414.2
Workers compensation and worksite health care	35.7
Household	
Employee contribution to private health insurance premiums and individual policy premiums	311.5
Premiums paid by individuals to Medicare Supplementary Medical Insurance	67.4
80% of out-of-pocket health spending	254.2
Other private revenues	167.3
Governments	
Federal	
Employer contribution to private health insurance premiums	34.7
State and Local government	
Employer contribution to private health insurance premiums	158.0
Health program expenditures (including Medicaid)	124.8
Other	155.3
Total current spending to be replaced with progressive financing	$1,722.9

Source: http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf; and http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/sponsors.pdf.

Estimated cost of system improvements and transition costs

A single-payer program would improve the health system in many ways. It would extend coverage to all uninsured Americans.[4] It would reduce barriers to access for the currently insured by eliminating burdensome co-payments, deductibles and other out-of-pocket spending for medical care. It would offer improved benefits by covering services like dental and long-term care. It would eliminate inequity in the treatment of less-affluent patients by paying providers the same fee for each patient regardless of income or employment.[5] These improvements would cost an estimated $343 billion annually.

Transition costs of implementing HR 676 would include the cost of unemployment insurance and retraining of displaced insurance and provider administrative personnel.[6] In addition, the cost of converting investor-owned health care facilities to non-profit status would be incurred and is spread out over 15 years.[7] Including transition costs of $51 billion in the first year, the estimated cost of expanding and improving Medicare is $394 billion. See Table 2.

Section II: Single-payer system savings as a source of financing

Savings on provider administrative overhead and drug prices

For decades, health care costs have risen much faster than income in the United States. As a result, total health care spending has risen from 5% of Gross Domestic Product in 1960 to nearly 18% today. While some of the increase in costs in the United States is due, as in other countries, to improvements in care, innovative technologies and greater longevity, costs have risen much faster in the United States than elsewhere because of the growing administrative burden of our private health insurance system.

Because of the large number of separate insurance programs and the fragmented billing system, American physicians and hospitals incur much greater costs for billing and insurance-related activities than do their foreign counterparts. Compared with doctors in Ontario, Canada, for example, Americans spend nearly four times as much on billing and insurance related

Table 2. Estimated cost of health system improvements and transition costs under HR 676 (in billions of dollars)

Increased utilization	144
Cost of expanded coverage including added government administrative costs	110
Cost of Medicaid rate adjustment	89
Transition cost of unemployment insurance and retraining for displaced workers	31
Transition cost of capital buy-out of private health care facilities	20
Total	$394

Note: The cost of coverage expansion includes overhead on all new coverage under the single payer ($25 billion) as well as $85 billion to cover the estimated 44 million who will be uninsured in 2014. It assumes the uninsured spend 55% as much on health care as the insured and would spend 80% with insurance; the lower spending is based on the age distribution of the uninsured. It is assumed that the ACA would have lowered the share without insurance by 11 million from 2013 to 2014, to 16% of the nonelderly population in 2014.[8] Utilization expansion assumes a 3% increase for most activities with a 20% increase for dental care (currently not provided for many insurance plans), a 20% increase in nursing home care, and a 40% increase in home health care. Current Medicaid physician rates are 34% below those paid under Medicare, and the ACA provides for an increase in rates for primary care to Medicare levels; this adjustment assumes that they will be equalized for all physician services.[9]

Table 3. Savings on provider administrative overhead and pharmaceutical costs (in billions of dollars)

	Health care spending with ACA	Savings rate	Savings w/ H.R. 676
Hospital care	983	9.4%	91.9
Physicians and clinical services	602	10.7%	64.2
Other professional services	84	9.0%	7.6
Dental services	120	9.0%	10.9
Home health care	88	19.2%	17.0
Nursing home care	172	7.0%	12.0
Other personal health care	164	10.7%	17.5
Subtotal savings on provider overhead			221.0
Subtotal savings on pharmaceuticals	309	37.5%	115.8
Total savings on provider overhead and drug costs under HR 676			$336.9

Sources: Administrative savings are the difference between overhead costs in the United States and Canada in 1999 from Steffie Woolhandler, Terry Campbell, and David Himmelstein, "Cost of Health Care Administration in the United States and Canada," New England Journal of Medicine no. 349 (2003); relative drug prices are from McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States," January 2007; projected spending under the ACA in 2014 is from Centers for Medicare and Medicaid Services.

Table 4. Savings on administrative costs of insurers, Medicaid, and employers (in billions of dollars)

Insurer overhead (excluding costs to providers)	197.4
Medicaid overhead	26.0
Employers' costs to manage employer-sponsored health coverage	31.7
Total	$255.1

activities ($83,000 per physician versus $22,000 in Ontario), and nursing staff, including medical assistants, spent 20.6 hours per physician per week interacting with health plans – nearly ten times that of their Ontario counterparts.[9]

In addition to the administrative savings within provider offices, a single payer system could lead to dramatic savings by negotiating reduced prices for pharmaceuticals which cost approximately 60% more in the U.S. than in Europe.[10] See Table 3. Today, Medicare is the only entity in the world excluded from negotiating lower prices on medications for its beneficiaries.

Savings on the administrative costs of private insurers, Medicaid, and employers

In addition to reducing the overhead of providers like doctors and hospitals, eliminating private insurance plans would also generate administrative savings on insurance overhead. Currently, private insurers have a "medical loss ratio" (the share of health care spending going for medical services) of barely 88%. The 12% administrative cost average includes the cost of advertising, enrollment, collecting premiums, paying claims, bureaucratic red-tape designed to discourage the submission of claims, inflated executive compensation, and profit, as well as relatively high administrative cost due to the small scale of many companies. A single-payer system would eliminate most of these costs, raising the share of spending going to providers up to the 98% rate for Medicare. With almost a trillion dollars in premiums paid into private health insurance, lowering the administrative ratio to the Medicare rate would save over $197 billion.[11]

Figure 1. Single-payer system savings from reduced administrative costs and drug prices (in billions of dollars)

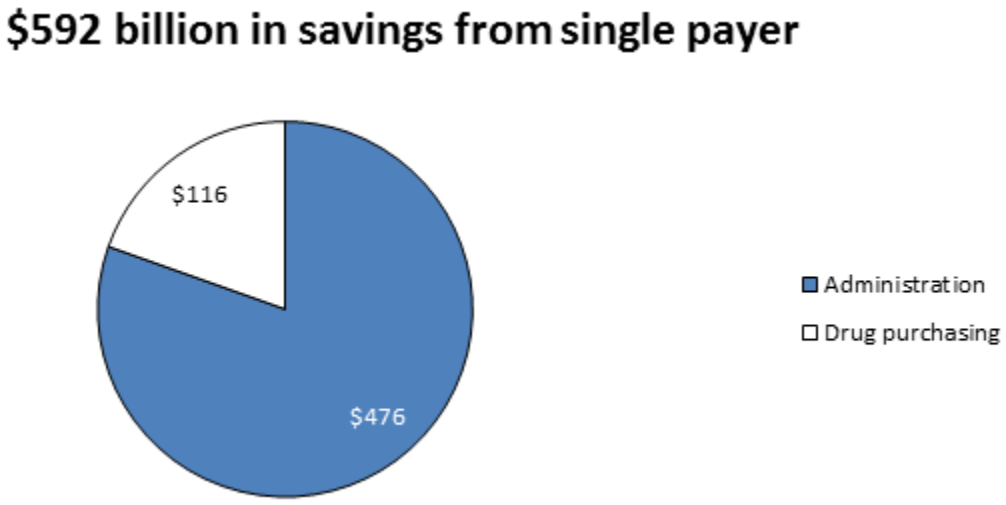


Table 5. Savings on federal tax expenditures for health care (in billions of dollars)

Exclusion of employer contribution for health insurance premiums from income tax	211.5
Exclusion of employer contribution for health insurance premiums from Medicare payroll tax	16.0
Self-employed medical insurance premiums	7.7
Medical Savings Accounts	2.2
Deductibility of medical expenses	11.2
Exclusion of interest on hospital construction bonds	5.5
Special Blue Cross/Blue Shield deduction	0.5
Distributions from retirement plans for premiums for health insurance	0.4
Credit for employee health insurance expenses of small business	4.5
Total federal income tax expenditures	$259.5

Sources: Government Printing Office, Analytical Perspectives, Budget of the United States, 2012, 243. Estimates for 2010 have been adjusted for 2014 at the rate of increase in general health care expenditures 1991-2009 from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/sponsors.pdf.

Further savings of $26 billion would come from the reduction in the administrative expenses of running Medicaid as a joint federal-state means-tested program. Currently, 5.7% of Medicaid expenses go for administration, including the cost of checking eligibility and operating a payment system separate from Medicare and other insurance systems.[12]

In addition, employers will save $32 billion on the direct costs of managing their employer-provided health insurance systems, including the costs of collecting and processing payments as well as consultant charges for choosing an insurance carrier. See Table 4.

Altogether, administrative savings from the single-payer system, on providers' overhead costs, and on administrative expense among insurers, Medicaid, and employers, come to $476 billion in 2014. Adding in the savings on prescription drugs of $116 billion brings the total savings to $592 billion. See Figure 1. Moreover, a single-payer system would slow the growth in health care spending from year to year, greatly reducing the burden of health care costs over the long term.[13]

HR 676 would eliminate the need for federal subsidies for the purchase of private health insurance by business and individuals. Along with deductions for medical savings accounts, medical expenses and some smaller tax breaks associated with the private insurance system, eliminating tax subsidies would save $260 billion (Table 5).

Section III: A progressive funding plan for HR 676

The health care improvements and transition costs of a single-payer system ($394 billion, Table 2), including expanding coverage to 44 million uninsured Americans and upgrading coverage for everyone else, would be funded under HR 676 by $592 billion in savings on administrative costs and reduced pharmaceutical prices. As a result of implementation of HR 676, health spending in the first year would fall by $198 billion to $2,964 billion (Table 6).

Table 6. National Health Expenditures with and without Implementation of HR 676 (in billions of dollars)

Baseline projected NHE 2014	3,130
Employers' costs to manage health coverage	32
Expenditures without single-payer reform	3,162
Single-payer system improvements and transition costs	394
Single-payer savings on administrative and drug costs	(592)
Expenditures with single-payer reform	$2,964

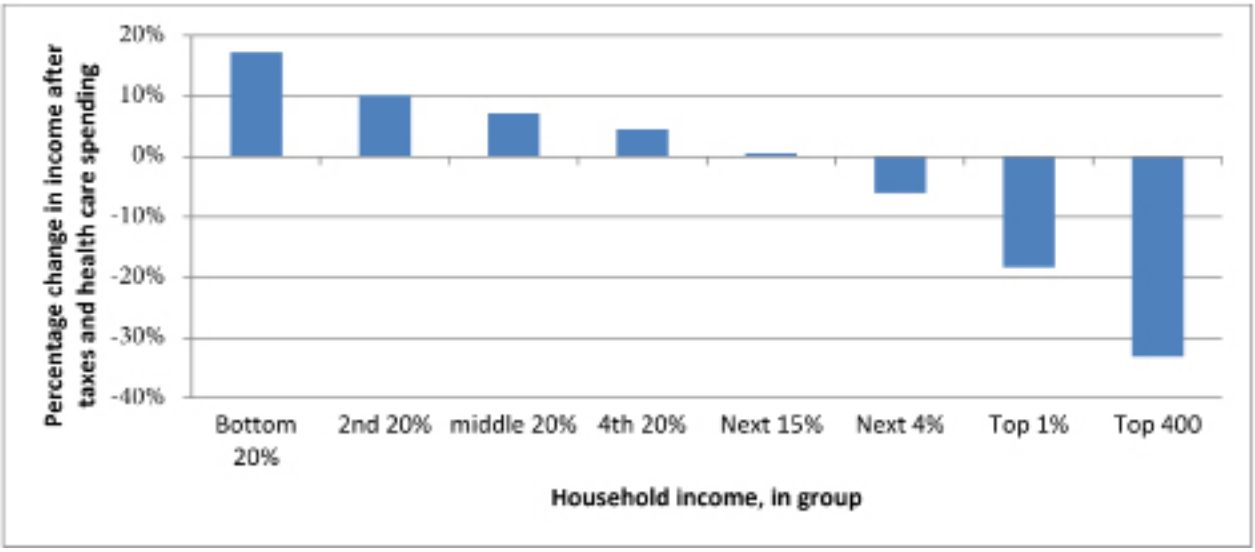
Table 7. A progressive financing plan for HR 676 that replaces regressive funding sources and improves and expands comprehensive benefits to all (in billions of dollars)

New progressive revenue sources	
Tobin tax of 0.5% on stock trades and 0.01% per year to maturity on transactions in bonds, swaps, and trades.	442*
6% Surtax on household incomes over $225,000	279
6% tax on property income from capital gains, dividends, interest, profits,	310
6% payroll tax on top 60% with incomes over $53,000	346
3% payroll tax on bottom 40% with incomes under $53,000	27
Total new progressive sources	1,404
Tax expenditure savings	260
Federal Medicare, Medicaid, and other health spending, and 20% of current out-of-pocket spending (maintained from current system)	1,454
Total Revenues	3,118
Savings for deficit reduction	$154

Sources: Revenue from the Tobin Tax from Dean Baker, et al., "The Potential Revenue from Financial Transactions Taxes." The Baker et al. estimates are for 2011 and I have extrapolated assuming revenue will grow at the same pace as the GDP; this conservative assumption leads to an understatement of revenue. Income distribution is from the updated background tables for Thomas Piketty and Emmanuel Saez, "Income Inequality in the United States."[16] Revenue is calculated by applying the tax rates to the reported income; since Piketty and Saez use IRS income data, I am assuming the same rate of noncompliance as under the current tax law. I have extrapolated from 2006 assuming that all income groups and all income types grew equally with the GDP; this conservative assumption leads to an understatement of revenue.

* Without Tobin tax, tax rates rise from 3% to 4%, and 6% to 8%.

Figure 2. Change in after-tax household income due to adoption of progressive financing for HR 676: 95% of Americans are better off under a single-payer system



Note: The percentages shown here are the difference between the share of income spent on health care now and the amount that would be spent under the proposed single-payer plan including the taxes proposed to replace the current regressive funding system. The taxes included here are a Tobin tax (described in the text), a 6% surtax on the richest 5% of households, a 6% tax on unearned income (including capital gains, dividends, interest, profits, and rents), a 6% tax on the top 60% of wages and salaries, and a 3% tax on the bottom 40%. The first four bars from the left represent the income of the bottom four quintiles of the population; the next bar (for an average income of $216,922) represents the next 15% (from the 80th to the 95th percentile); the next bar represents the next 4%; the next bar (for an average income of $2,994,817) represents the mean income of the richest 1% of the population; and the final bar (with an average income of $166,592,800) represents the wealthiest 400 American households based on their tax returns.[17] Note that the only groups in the population who would pay more for care are the richest 5%.

With the progressive funding plan outlined in Table 7, regressive and obsolete funding sources would be replaced by progressive taxes, including a new tax on financial transactions (a so-called Tobin Tax[14]), a progressive payroll tax and tax on unearned income, and surtax on high income individuals. Under the plan developed here, revenues would exceed expenditures by $154 billion in the first year, generating funds that could be invested in health professional education or used for deficit reduction.[15]

The proposed taxes would be highly progressive, especially compared with current health care spending which falls most heavily on lower-income households. On average, only 5% of Americans would pay more under this proposal, which would mean savings for Americans with household incomes up to well above $200,000. See Figure 2.

Conclusion: Single payer covers more, costs less than current system for 95% of Americans

This analysis shows that it is possible to reform the U.S. health financing system to make it more efficient and equitable. Universal health care with comprehensive benefits could be achieved under a single-payer system as embodied in HR 676. Improved Medicare for All would cost less for 95% of households and reduce the deficit by $154 billion in the first year.

Progressive financing of HR 676 is possible using a Tobin or "Robin Hood" tax as one of the funding sources. Although the Tobin tax is desirable for a number of reasons, HR 676 single payer may be financed without the Tobin tax if necessary. See Appendix 1.

This analysis is done for one point in time, 2014. Over time, the health care system in the United States has become more expensive both relative to the cost of providing equivalent services in the past and relative to other countries.[18] Under the federal reform law of 2010, it is projected that health care costs will continue to grow, creating growing pressure to cut costs by reducing access and quality of care.

In contrast, HR 676 would establish a system for future cost control using proven-effective methods such as negotiated fees, global budgets, and capital planning. Over the next decade, savings from reduced health inflation ("bending the cost curve") would equal $1.8 trillion. On top of the enormous administrative savings of single payer, the savings from effective cost-control would make it possible to provide universal coverage and comprehensive benefits to future generations[19] at a sustainable cost.

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Appendices are available online at http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf

Notes

1. Centers for Medicare and Medicaid Services, National Health Expenditure Projections, 2011-2021 (Washington, D.C.: Department of Health and Human Services, Center for Medicare and Medicaid Statistics, n.d.) Table 2; employer expenditures administering health insurance plans came to 4.2% of health insurance spending in Steffie Woolhandler, Terry Campbell, and David Himmelstein, "Cost of Health Care Administration in the United States and Canada," New England Journal of Medicine no. 349 (2003): 768–75. This ratio has been applied to employer-based health insurance in 2014.

2. While the largest components of out-of-pocket expenditures, prescription drugs and co-payments and deductibles, will be covered under HR 676, other medically-optional expenditures, such as some dental procedures or luxury eyeglasses, would not be covered, nor would most vitamins and some alternative medical practices. For the breakdown of out-of-pocket spending, see Ann Foster, "Out-of-pocket Health Care Expenditures: a Comparison," Monthly Labor Review (February 2010): 3–20.

3. HR 676 does not incorporate the Indian Health Service for the first five years, or the Veterans Administration for the first ten years (Sec 401). For this study, however, these have been included both on the revenue and the expenditure side.

4. The Congressional Budget Office estimates that there will be 44 million uninsured in 2014 after the Affordable Care Act goes into effect; Congressional Budget Office, "February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," February 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf.

5. Physicians who accept Medicaid patients are paid far less than those who serve other patients. Raising rates would be a transfer to providers who would be paid more for services they are currently performing. It would also improve access by allowing providers to perform services better, by spending more time with each patient; and it would encourage more providers to provide services for less-affluent patients.

6. In Section 303, HR 676 provides for up to two years of unemployment insurance and priority in retraining for "clerical, administrative, and billing personnel in insurance companies, doctors' offices, hospitals, nursing facilities, and other facilities whose jobs are eliminated due to reduced administration." One percent of health spending is set aside for unemployment and retraining annually.

7. In Section 103, HR 676 provides that over a fifteen year period, investor-owners shall be compensated for the actual appraised value of converted facilities used in the delivery of care. A reserve fund of $20 billion annually is created for this purpose.

8. Congressional Budget Office, "February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage."

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11. No savings have been assumed from reduced fraud despite the great capacity of a single-payer system to reduce or even to eliminate fraudulent billing. Fraudulent billing, including duplicate billing and billing for services not rendered, accounts for between 3% and 10% of health care spending in the United States, including an error rate in federal programs of over 9%. See "Testimony of the National Health Care Anti-Fraud Association" (Harrisburgh, PA., House Insurance Committee, Hourse of Representatives, Commonwealth of Pennsylvania, January 28, 2010), http://www.legis.state.pa.us/cfdocs/legis/TR/transcripts/2010_0017_0014_TSTMNY.pdf; General Accounting Office, Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments (Washington D.C., March 9, 2011), http://www.gao.gov/new.items/d11409t.pdf; William Hsiao, Steven Kappel, and Jonathan Gruber, "Act 128: Health System Reform Design. Achieving Affordable Universal Health Care in Vermont," January 21, 2011, 34, http://www.leg.state.vt.us/jfo/healthcare/FINAL%20VT%20Draft%20Hsiao%20Report.pdf.

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13. Since Canada established a single-payer system in 1971, real health care costs have risen by 1.1 percentage points less per year than in the United States. Over half of this difference can be explained by the greater inflation in administrative costs in the United States. Karen Davis et al., Slowing the Growth of U.S. Health Care Expenditures: What Are the Options, Commonwealth Fund Commission on a High Performance Health System (Commonwealth Fund, January 2007), http://www.commonwealthfund.org/usr_doc/Davis_slowinggrowthUShltcareexpenditureswhatareoptions_989.pdf; Woolhandler S Himmelstein DU, "Cost Control in a Parallel Universe: Medicare Spending in the United States and Canada," Archives of Internal Medicine (October 29, 2012): 1–2, doi:10.1001/2013.jamainternmed.272; McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States."

14. Originally proposed by the Yale economist and Nobel-laureate James Tobin, the United States taxed financial transactions from 1914 till 1966. A financial transactions tax has been endorsed by 11 Eurozone member states where it is scheduled to go into effect in 2014. The National Nurses United is campaigning for such a tax in the United States. Called the "Robin Hood Tax", a proposal for a financial transactions tax has been sponsored in Congress by Representative Keith Ellison in HR 6411; see the discussion at http://robinhoodtax.org/latest/robin-hood-tax-bill-introduced-congress; James Tobin, "A Proposal for International Monetary Reform," Eastern Economic Journal 4, no. 3–4, Eastern Economic Journal (1978): 153–159; Dean Baker et al., The Potential Revenue from Financial Transactions Taxes, Political Economy Research Institute Working Paper Series (Amherst, MA.: Political Economy Research Institute, University of Massachusetts at Amherst, December 2009).

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- **References can be found on page 71.**

By Brian Hutchison and Richard Glazier

Ontario's Primary Care Reforms Have Transformed The Local Care Landscape, But A Plan Is Needed For Ongoing Improvement

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ABSTRACT Primary care in Ontario, Canada, has undergone a series of reforms designed to improve access to care, patient and provider satisfaction, care quality, and health system efficiency and sustainability. We highlight key features of the reforms, which included patient enrollment with a primary care provider; funding for interprofessional primary care organizations; and physician reimbursement based on varying blends of fee-for-service, capitation, and pay-for-performance. With nearly 75 percent of Ontario's population now enrolled in these new models, total payments to primary care physicians increased by 32 percent between 2006 and 2010, and the proportion of Ontario primary care physicians who reported overall satisfaction with the practice of medicine rose from 76 percent in 2009 to 84 percent in 2012. However, primary care in Ontario also faces challenges. There is no meaningful performance measurement system that tracks the impact of these innovations, for example. A better system of risk adjustment is also needed in capitated plans so that groups have the incentive to take on high-need patients. Ongoing investment in these models is required despite fiscal constraints. We recommend a clearly articulated policy road map to continue the transformation.

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Canada's ten provincial and three territorial health systems operate within a national legislative framework, the Canada Health Act of 1984. Under the act, provinces and territories receive health care funding to provide universal, public, first-dollar coverage of medically necessary physician and hospital services. Because the act requires coverage of only physician and hospital services, the extent of public coverage of other health services, such as prescription drugs, vision care, home care, and long-term care, varies among the provinces and territories.

In 2010, 71 percent of Canada's health spending was publicly funded.[1] However, Canada's health care delivery system is largely private. Most physicians are independent contractors who are reimbursed by the provincial or territorial health plan on a fee-for-service basis. Almost all hospitals are owned and operated by private not-for-profit entities.

With more than thirteen million residents, Ontario is Canada's most populous province. Historically, primary care in Ontario was delivered predominantly by solo and small-group practices owned and managed by physicians. Physicians are paid by the Ontario Ministry of Health and Long-Term Care and may not bill patients or third parties for services covered by the public health insurance plan. Ontario has the second-lowest ratio of primary care physicians to population among Canada's ten provinces: 92 per 100,000.[2]

Canada's Health System Performance

During the 1980s and 1990s many industrialized countries invested heavily in strengthening primary care. Canada did not, and its primary care infrastructure and patient access to primary care suffered. A recent survey of primary care physicians in ten wealthy industrialized countries[3] showed that Canadian physicians ranked second-lowest on use of electronic medical records; were least likely to offer online appointment scheduling or to respond via e-mail to patients' medical questions or concerns; and were less likely than primary care physicians in all but one other country to work with nurses, therapists, or other nonphysician clinicians.

In the early 2000s a new policy environment emerged in Canada in response to an improved fiscal climate, growing public and professional dissatisfaction with the country's primary care status quo, and national reviews[4,5] that highlighted the importance of primary care to overall health system performance. Policy makers began to embrace a gradual approach to reforming primary care.[6,7]

Five national reform objectives were established. These were increasing access to primary care organizations that would provide a defined set of services to a defined population; increasing emphasis on health promotion, disease and injury prevention, and chronic disease management; expanding all-day, every-day access to essential services; establishing interdisciplinary primary care teams; and facilitating coordination and integration with other health services. To pay for the reforms, the federal government committed substantial funds to advancing primary health care, home care, and catastrophic prescription drug coverage.

Ontario's Primary Care Reform Strategy

Ontario moved swiftly to develop a variety of new care delivery and payment models[8] that were responsive to the new national goals. The Ministry of Health and Long-Term Care worked closely with major stakeholders, including physician groups such as the Ontario Medical Association, to develop diverse primary care models that were voluntary for both providers and patients. From 2002 to 2007 a number of new primary care organizational and funding models were initiated, having different characteristics to suit diverse provider and patient communities (Exhibit 1). These models are described more fully in the online Appendix.[9]

Voluntary participation by patients and providers in these new models of care provided opportunities for those ready to embrace innovation to do so without requiring universal participation or adoption. Physicians were attracted to the new models by the promise of increased income under the new arrangements;[10] improved infrastructure, such as electronic medical records; additional clinical and administrative staffing; sharing of after-hours on-call work; and the positive experience reported by early adopters. Patients readily accepted the new models because they preserved the continuity of physician-patient relationships.

Key Policy Initiatives

Since 2000 Ontario has pursued three major, interconnected policy initiatives: new physician reimbursement and organizational models, patient enrollment with a primary care provider, and support for interprofessional team-based care.[8]

NEW MODELS Physicians practicing in the new organization and payment models are reimbursed through various blends of payment types, including capitation, which is payment per patient per month; fee-for-service; salary; and pay-for-performance.

In two of the reimbursement models, the Family Health Organization and the Family Health Network, capitation is the principal component. Capitation payments are adjusted for the age and sex of enrolled patients. In 2012, 39 percent of Ontario's family physicians participated in these models. In two other models, Family Health Group and Comprehensive Care, fee-for-service is the main element. Twenty-nine percent of Ontario's family physicians participated in these two models in 2012.

Physicians working in Community Health Centres, described below, are salaried employees. In two additional models, the Rural and Northern Physician Group Agreement and the model for physicians working in community-governed Family Health Teams, reimbursement is salary based with additional incentive payments. Physicians working in Family Health Teams with physician governance or mixed community and physician governance are paid through one of three remuneration models: Family Health Organization, Family Health Network, or Rural and Northern Physician Group Agreement.

All blended reimbursement models include special fees or premiums, which vary across models, for providing priority services such as reproductive care, palliative care, and home visits. They also include graduated pay-for-performance for achieving specified levels of preventive care coverage among enrolled patients and incentive fees for the management

EXHIBIT 1

Primary Care Organizational And Funding Models In Ontario

Characteristic	Model (year introduced)						
	Community Health Centre (1979)	Family Health Network (2002)	Family Health Group (2003)	Rural and Northern Physician Group Agreement (2004)	Comprehensive Care Model (2005)	Family Health Team (2005)	Family Health Organization[a] (2007)
Physician reimbursement	Salary	Blended capitation	Blended fee-for-service	Blended salary	Blended fee-for-service	Blended capitation or blended salary	Blended capitation
Targeted financial incentives	No	Yes	Yes	Yes	Yes	Yes	Yes
Formal patient enrollment	No	Yes	Yes	Yes	Yes	Yes	Yes
Minimum group size (physicians)	None	3	3	1	1	3	3
Governance	Community board	Physician-led	Physician-led	Physician-led	Physician-led	Physician-led, community board, or mixed	Physician-led
Interprofessional team members	Yes	Limited	Limited	No	No	Yes	Limited
After-hours care requirements	Yes	Yes	Yes	Yes	Optional	Yes	Yes

SOURCE Ontario Ministry of Health and Long-Term Care. **NOTE** A fuller version of this table is available in the Appendix (Note 9 in text). [a]Created through the harmonization of two preexisting models: Health Service Organizations (introduced in 1978) and Primary Care Networks (introduced in 1999).

of patients with diabetes and congestive heart failure and for smoking cessation.

The introduction of these new organization and remuneration models has transformed the primary care landscape in Ontario. In 2012, 76 percent of Ontario's family physicians participated in one of the new primary care reimbursement models, with the other 24 percent remaining in traditional fee-for-service arrangements. This constitutes a dramatic change from 2002, when 94 percent of Ontario's family physicians were in traditional fee-for-service arrangements and just 6 percent in some other kind of reimbursement arrangement (Exhibit 2).

Of the primary care physicians who continued to be reimbursed through traditional fee-for-service arrangements in 2012, about half were in "focused" or specialized practice—for example, emergency department, psychotherapy, hospital medicine, sports medicine, or long-term care.

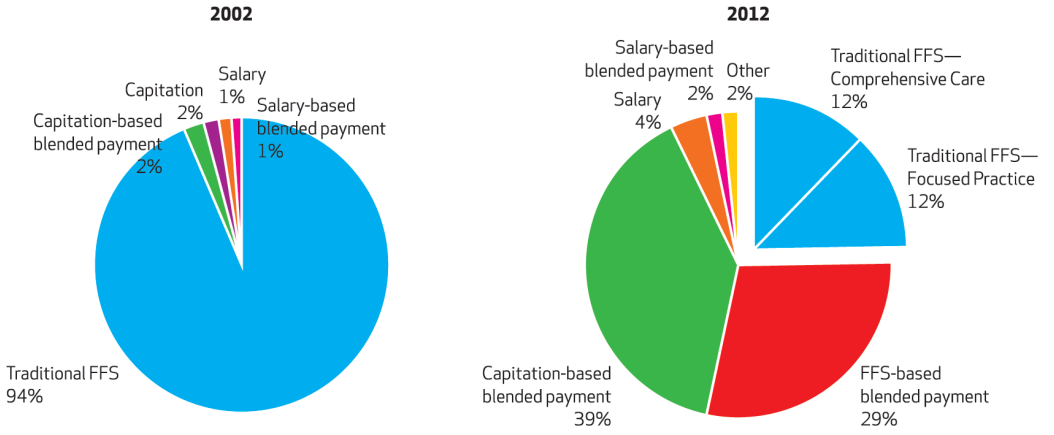
With limited exceptions, the new primary care reimbursement models required participating physicians to be part of a group practice or practice network of three or more physicians. Partly as a result, the proportion of Ontario primary care physicians who self-identified as solo practitioners declined from 37.4 percent in 2001 to 24.9 percent in 2010.[11,12] Participating practices were also required to provide a minimum number of weekend and evening office hours that varied by group size. Apart from these requirements, the new reimbursement mechanisms support and reward, but do not require, changes in the organization and delivery of care.

Total payments to primary care physicians increased by 32 percent between fiscal year 2006–07 and fiscal year 2009–10, related in large part to the introduction of new reimbursement models.[13] Additionally, average payments to primary care physicians increased at a higher rate than did payments for specialist physicians.[14] The proportion of Ontario primary care physicians who reported overall satisfaction with the practice of medicine increased from 76 percent in 2009 to 84 percent in 2012.[3,15] More Ontario medical school graduates now choose family medicine as their first choice for postgraduate training compared with ten years ago—a shift from 26 percent in 2003 to a percentage that fluctuated between 34 percent and 39 percent during 2009–11.[16]

PATIENT ENROLLMENT Under Ontario's reformed primary care models, patients are not required to enroll, even if their regular physician participates in one of the reimbursement models and offers enrollment in it. Additionally, physicians cannot refuse to enroll a patient because of

EXHIBIT 2

Distribution Of Ontario Family Physicians, By Payment Model, 2002 And 2012



SOURCES Ontario Ministry of Health and Long-Term Care and Institute for Clinical Evaluative Sciences. **NOTE** FFS is fee-for-service.

the patient's health status or level of need for services. When a patient chooses to enroll with a participating primary care practice, the patient agrees to seek treatment first from the enrolling physician (or group) unless the patient is traveling or experiencing a health emergency. The enrolling physician or group commits to providing comprehensive primary care services to the patient.

Ontario's new primary care practice models are proving popular: The number of patients enrolled with a primary care physician grew from fewer than 600,000 in 2002 to 9.9 million in August 2012, representing 73 percent of the Ontario population (Phil Graham, Ontario Ministry of Health and Long-Term Care, personal communication, August 10, 2012).

PRIMARY CARE TEAMS Expanding interprofessional primary care teams was a key goal of Ontario's primary care reforms. These teams are "groups of professionals from different disciplines who communicate and work together in a formal arrangement to care for a patient population in a primary care setting."[17] They typically include primary care physicians and nurses or nurse practitioners, or both, and a provider from at least one other clinical discipline, such as a social worker, dietitian, or pharmacist. In contrast, traditional primary care practices usually include only physicians, medical office assistants, and—commonly but not always—nurses.

Ontario's emphasis on interprofessional primary care teams is addressed through a network of 75 Community Health Centres, 200 Family Health Teams, and 26 Nurse Practitioner–Led Clinics. The total number of primary care physicians working in interprofessional teams increased from 176 in 2002 to more than 3,000 in 2012 (Graham, personal communication, August 10, 2012, and July 20, 2012). Ontario's Community Health Centres deliver care to socially disadvantaged and hard-to-serve populations and employ almost 400 primary care physicians and more than 300 nurse practitioners.

The province's Family Health Teams serve as patient-centered medical homes, where people can access care from multiple health care providers—most commonly nurses, nurse practitioners, dietitians, mental health workers, social workers, pharmacists, health educators, and occupational therapists—in one setting. They now include more than 2,400 primary care physicians and more than 1,700 other primary health care professionals (Graham, personal communication, July 20, 2012). Ontario's Nurse Practitioner–Led Clinics are similar in concept to Family Health Teams, but in these clinics physicians function mainly in a consulting capacity.

To support the development of interprofessional primary care teams and increase access to primary care, the provincial government has expanded medical, nurse practitioner, and midwifery education programs; increased the number of family medicine residency positions; established educational programs for physician assistants; and expanded the scope of practice of nurse practitioners, midwives, and pharmacists.[18–21] Interprofessional primary care teams now serve close to one-fifth of the province's population.

Additional Initiatives

In addition to the initiatives described above, Ontario embraced other programs to improve

access to primary care and strengthen primary care infrastructure.

LINKING UNATTACHED PATIENTS TO A PRIMARY CARE PROVIDER In a further attempt to address the sizable number of Ontarians without a regular primary care provider, the Ministry of Health launched Health Care Connect. This program was designed to help unattached patients obtain a regular primary care provider using nurses known as "care connectors," who attempt to identify a primary care provider willing to accept the patient. A priority focus was patients with high needs for care. Primary care physicians who accepted a high-needs patient received bonus payments for enrolling the patient and also for the patient's first year of care.

By September 2012, 226,371 patients had registered with the program. Of these, 165,328 patients, 16,138 of whom were high-needs, were matched by care connectors with a primary care provider who agreed to accept them as a patient.[22]

FUNDING ADMINISTRATIVE PERSONNEL Except for Community Health Centres, primary care in Ontario has been notable for its lack of administrative infrastructure at the practice level. Family Health Teams are eligible for funding for administrative purposes, including an administrator or executive director. The agreements governing the Family Health Organization and Family Health Network reimbursement models described above allow for "office practice administration" funding to employ an administrator.

ADOPTING ELECTRONIC MEDICAL RECORDS The Ministry of Health has historically subsidized the purchase and implementation of approved clinical management systems, such as electronic medical records, in Family Health Networks and Family Health Organizations and to a lesser extent in other new primary care reimbursement models. However, beginning in 2010 subsidies and technical support were made available to all family physicians, no matter what care model they were a part of. The proportion of Ontario family physicians who reported using an electronic medical record increased from 44 percent in 2009 to 65 percent in 2012.[3,15]

INTEGRATING QUALITY IMPROVEMENT TRAINING AND SUPPORT Efforts to integrate quality improvement methods in Ontario's primary care sector, a recognized need, are ongoing but insufficient given the size of the sector. Learning collaboratives based on the Institute for Healthcare Improvement Breakthrough Series model[23] lead to new hands-on and virtual training that has reached approximately 500 practice-based teams. The Ministry of Health supports this work through Health Quality Ontario, a ministry-funded government agency.

Challenges And Shortcomings

Despite substantial system-level changes, the impact of Ontario's primary care reforms on processes and outcomes of care is yet to be determined. A time lag in realizing the benefits of policy initiatives is to be expected, particularly for complex innovations such as the implementation of interprofessional teams. Substantial gains in access, quality, or effectiveness of care require reshaping roles and care processes.

However, even at this stage of implementation, several policy shortcomings and missing elements have become apparent. These need to be addressed to ensure that Ontarians reap the full benefit of recent investments in strengthening primary care.

LOCAL PRIMARY CARE GOVERNANCE Ontario's primary care sector continues to be severely fragmented. In all but a few communities, numerous—mainly small—primary care practices and organizations operate independently, lack a common voice, and rarely share resources and expertise. In this environment, effective coordination and integration of primary care with other specialized health and social service sectors is virtually impossible.

Local, appropriately resourced primary care organizations are needed that could assume collective responsibility for clinical performance and service delivery. Such organizations could respond to community needs; negotiate relationships with other health and social services; and coordinate and support the sharing of resources, performance measurement activities, and quality improvement efforts to improve population health.

ONGOING PERFORMANCE MEASUREMENT AND FEEDBACK Ontario lacks a coherent system for ongoing primary care performance measurement and feedback at the practice, organization, and system (community, regional, and provincial) levels. A performance measurement system that taps health administrative data, clinical data from electronic medical records, and patient experience data could regularly provide actionable information to identify strengths and shortcomings, guide service and system planning, and track the impact of policy innovations and quality improvement efforts.

SYSTEMWIDE QUALITY IMPROVEMENT TRAINING AND SUPPORT Several hundred practice-based primary care teams have participated in quality improvement initiatives. However, this number represents a small fraction of the province's primary care practices. A strategy is needed to spread quality improvement training

and support across the entire sector, perhaps using provincially supported local primary care organizations as the locus of quality improvement expertise and activity.

Financial incentives targeting improved outcomes will be effective only if primary care providers and managers have the capacity to measure and improve health care processes and outcomes.

IMPROVED ELECTRONIC MEDICAL RECORDS Although the provincial government has made sizable investments in primary care information technology, the current systems have limited interoperability and performance measurement, disease management, and registry capability.

ALIGNMENT OF INCENTIVES WITH HEALTH SYSTEM NEEDS Several elements of current primary care physician payment arrangements require review in light of emerging evidence. Blended payment schemes based on capitation are more conducive to interprofessional team-based care than is fee-for-service remuneration. However, age- and sex-adjusted capitation does not adequately capture the variation in need for primary care services in practices serving sicker, often socially disadvantaged, populations.

Until the capitation-based blended payment rates are risk-adjusted, physicians serving these populations are likely to remain in fee-for-service practice. This reality leaves these providers and their vulnerable patients unable to access the enhanced clinical and administrative resources that are available to those in Family Health Teams, for example, thereby perpetuating and deepening health care inequities. Current evidence indicates that less healthy, low-income, and immigrant Ontarians are underrepresented in the practice populations of capitation-based physicians.[24] Risk-adjusted capitation is needed to address this issue.

Current pay-for-performance incentives also need to be reviewed given their modest or, in some cases, nonexistent impact.[25,26] The "access bonus" component of capitation-based blended payment models is administratively cumbersome; penalizes physicians serving marginalized populations; and, because the access bonus is unaffected by enrolled patients' use of emergency departments, fails to discourage unnecessary emergency department use. This fact may help explain why rates of emergency department visits—after demographics, urban-rural location, and case-mix are controlled for—are higher in the capitation-based models, including Family Health Teams, than in fee-for-service–based models and have not changed appreciably over time.[24,27] Same-day or next-day access to primary care also has not improved over time.[27]

EFFECTIVE MANAGEMENT OF PERFORMANCE CONTRACTS Contractual agreements between the Ministry of Health and Long-Term Care and physicians participating in patient enrollment models specify the range of services that physicians are required to provide and the terms and conditions under which they must deliver those services. However, contract monitoring has been lax. Not surprisingly, some participating practices have failed to meet their contractual obligations.[13,28]

SYSTEMATIC EVALUATION OF INNOVATION The Ministry of Health frequently commissions evaluations of major policy and health system innovations that identify successes that need to be reinforced and spread and shortcomings that need to be addressed. However, these commissioned evaluations are often inadequately resourced, not subject to scientific review, and begun too late for relevant baseline data to be collected. Moreover, the findings are rarely made public. The results of publicly funded evaluations need to be made publicly available if they are to be effective.

Moving Forward

Many of the continuing needs discussed above are being addressed, at least in part, by the Ministry of Health. For example, a pilot program, Health Links, will support collaborations among primary care providers, specialist physicians, hospitals, home care, and long-term care in nineteen communities to improve care for high-needs patients.[29]

A multistakeholder initiative to develop a comprehensive primary care performance measurement system is under way. The initiative includes the Ministry of Health, data holders, organizations representing primary care providers, patient advocacy groups, and regional health authorities.

Beginning this year, the Ministry of Health will require Family Health Teams, Community Health Centres, and Nurse Practitioner–Led Clinics to prepare and submit annual quality improvement plans to Health Quality Ontario and to report performance measures, including measures of timely access to care.

The latest negotiated agreement between the Ministry of Health and the Ontario Medical Association includes provisions to introduce an "acuity modifier" to address variation in health care need beyond that captured by age and sex adjustment of capitation payments and to review the access bonus. If appropriately designed, the acuity modifier would address the need for risk adjustment of primary care capitation payments

identified above. The agreement also includes increased fees and performance incentives for house calls to homebound and frail elderly patients and criteria-based funding for interprofessional health care providers in non–Family Health Team patient enrollment models.[30]

Independent evaluations of Health Quality Ontario's primary care quality improvement collaboratives and learning community are in progress and will be publicly released. A five-year external evaluation of the Family Health Team initiative, commissioned by the Ministry of Health, is in its fourth year. However, the government has not yet committed to making the results public.

Conclusion

The past several years have seen profound changes in the funding and organization of primary care in Ontario. However, budgetary constraints arising from government deficits incurred during the recent recession pose a threat to the ongoing process of transformation, which requires continuing investments. To sustain the transformational momentum, a clearly articulated policy road map that commands the support of the public and key stakeholders is needed. Given the fiscal climate, primary care stakeholders—including the public—will need to mobilize to ensure that Canada's federal and provincial governments stay the course of primary health care renewal. ■

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Note: *Full endnotes can be found on the PNHP website at: http://bit.ly/1aTt6Wr*

THE LANCET

Offline: Four principles of social medicine


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Although officially classed as an upper-middle-income country, the American embargo against Cuba continues, punishing not only a government but also an entire people. (Article 33 of the Fourth Geneva Convention states that "No persons may be punished for an offense he or she has not personally committed. Collective penalties…are prohibited.") The Cuban Assets Control Regulations were established 50 years ago this month (on July 8, 1963) under the US Trading With The Enemy Act. It is a violation of those regulations if an American citizen travels to Cuba, engages in any kind of trade with Cuba, or even brings back goods of Cuban origin. There is a complex bureaucracy around the supply of medical products, which limits their supply and use. 50 years of trying to hurt 11 million people enough to encourage an insurrection to overthrow their government has taken its toll. Infrastructure in Cuba is fragile. Incomes are low. The Castro regime—Fidel or Raul, it is the same party that has been in power since the Revolution of 1959—is struggling to open up an economy without suffering the depredations that plunged its one-time banker, the Soviet Union, into criminal mayhem. (When the Soviet Union imploded, the GDP of Cuba collapsed by a third within 24 hours, a moment Cubans, with seemingly wry humour, call the "Special Period".) Yet, despite Cuba's problems, there are few public protests. The government does not fire rubber bullets at its citizens. It does not need tear gas. Why? Could it at least partly be thanks to universal health coverage?

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Cuba was the first Latin American country to implement a comprehensive primary health care system. The vice-minister for health spoke last week in Havana of her government's priorities. Her first concern was "user satisfaction", followed by quality and efficiency. Reducing maternal mortality was her overriding objective. Could universal health coverage be a political instrument for national peace, order, and stability? That is certainly the explicitly stated objective of China's health reforms. But the reason the Cuban people do not riot, the reason they endure the American embargo without condemning their government, and the reason they seem to accept the absence of freedoms usually seen as litmus tests for legitimate political regimes elsewhere goes beyond the health system (although it is linked to it). Ever since the 1950s, when the USA exploited Cuba as a playground for gambling and corruption, and for over 400 years of colonial rule before that, the goal of Cuba's leaders has been to restore the dignity of their people by winning independence and autonomy. Cuba's Government is certainly imperfect. But its imperfections are considerably fewer than its successes. Castro won independence and autonomy. He restored dignity. He established highly effective health and education systems. Under his brother, Raul, Fidel's victory must now meet the challenge facing all nations (and health systems)—sustainability.

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Within that challenge lies one approach to health that does make Latin America distinct from other regions of the world. As part of a symposium to review the hidden contributions of Latin America to our understanding of health, Nila Heredia, a former Minister of Health in Bolivia, set out a view of social medicine that makes western notions of public health seem anaemic by comparison. Heredia described four principles of social medicine, all of which one can see intimately connected to Cuba's success under the Castros. First, health is a fundamental right. Second, health is socially determined. Third, health can only be achieved through universal (non-discriminatory) policies. Fourth, health can only be achieved through social participation at all levels. These four principles are influenced by four additional forces—interculturality (how rarely we take culture seriously in western medicine), gender, labour, and the environment. At the heart of this notion of social medicine lies our attitude to health—is health a good to be traded and exchanged or is health a right? Here is the most important lesson of all from Latin America—it was the only region of the world that took the 1978 Declaration of Alma Ata seriously. 35 years after Alma Ata, and after 50 years of American sanctions against Cuba, perhaps it is time to look again at *why* universal health coverage is the most powerful force to achieve human dignity, equity, and self-realisation.

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Chapter Reports

In **California**, PNHP is helping form a new state single-payer coalition, the AllCare Alliance. PNHP chapters in Chico, Sonoma, San Francisco and the East Bay hosted talks by Donald Light, Ph.D., on Big Pharma. Dr. Gerald Kominski, director of the UCLA Center for Health Policy Research, was a guest at PNHP-California's annual retreat. The chapter's student affiliate, the California Health Professional Student Alliance (CaHPSA), welcomed 18 new student leaders; they are already starting to plan educational activities and the January 2014 Lobby Day in Sacramento. Former Shearer Fellow Joseph Foy will serve as the CaHPSA legislative officer for 2013-2014. For details, contact Dr. Bill Skeen at bill@pnhpcalifornia.org.

In **Colorado**, Dr. Tom Gottlieb and other PNHP members are in the process of reorganizing the chapter with the help of Donna Smith, the new executive director for Health Care for All Colorado (HCAC). PNHP national board member Dr. Diljeet Singh and economist Gerald Friedman, Ph.D., spoke at HCAC's successful annual gala this spring. PNHP members helped kick off a summer of single-payer action on June 1 with a visit from Rep. John Conyers Jr., primary author and sponsor of H.R. 676. Dr. Vince Markovchick hosted a gathering for PNHPers at his home and is offering to teach classes on single payer this fall at schools and colleges along with Smith. PNHPers are also supporting HCAC's citizens' ballot initiative that would establish health care as a human right and a public good in Colorado. For more information, contact Donna Smith at smith4025@comcast.net.

In the **District of Columbia**, PNHP national board member Dr. Robert Zarr has been working with two medical student interns. The interns are creating a 20-30 minute movie about single payer based on a monologue by Dr. Zarr. Stay tuned! For details, contact Dr. Zarr at rlzarr@yahoo.com.

In **Hawaii**, PNHPer Dr. Stephen Kemble is engaged in outreach to the governor's office about the need for single payer and to eliminate Medicaid managed care. Dr. Kemble is the president of the Hawaii Medical Association, which is critical of the implementation of the ACA and has passed a pro-single-payer resolution. For details, contact Dr. Kemble at skemblemd@hawaii.rr.com.

The New York Metro chapter at their lobby day in Albany, in support of the New York Health bill.

In **Illinois**, Dr. Ray Drasga hosted a meeting with PNHPer Dr. Steve Kemble, president of the Hawaii Medical Association, to discuss single-payer work and the fight against Medicaid managed care. New student chapters of PNHP have formed at the University of Chicago, Northwestern, and University of Illinois. Local single-payer activists are working to garner an endorsement of single payer from the Illinois AFL-CIO. Dr. Claudia Fegan recently spoke at the National Organization for Women's national conference in Chicago. Drs. Pam Gronemeyer and Philip Verhoef and intern Brandon Sandine have been speaking, tabling, and getting letters to the editor published, including a letter by Sandine in the Rockford Register-Star. For details, contact Dr. Anne Scheetz at annescheetz@gmail.com.

In **Kentucky**, past PNHP President Dr. Garrett Adams and Dr. Ewell Scott are active in giving talks to health professionals and civic groups (e.g. Rotary clubs), speaking with public officials and on the radio, publishing letters, and working with Kentuckians for Single-Payer Healthcare. Dr. Adams delivered grand rounds in Chattanooga, Tenn., as part of an effort to build a PNHP chapter there. For details contact Dr. Adams at kyhealthcare@aol.com.

PNHPers in the **Maine** AllCare chapter are active in giving presentations on the health care crisis and single payer across the state, often using "The Healthcare Movie" to facilitate discussion. The chapter is making plans for a referendum on single payer in 2016. PNHP board member and chapter chair Dr. Phil Caper has had many op-eds published in the Bangor Daily News. For details, contact Dr. Caper at pcpcaper21@gmail.com.

In **Mississippi**, Drs. John Bower and Art Sutherland were instrumental in setting up several speaking engagements for former PNHP President Dr. Claudia Fegan in mid-April, including the University of Mississippi's Medical Center's Health Equity Lecture, a multidisciplinary grand rounds, and a talk at a "Bias in Healthcare" conference at Tougaloo College. Dr. Fegan also participated in a public radio interview and a discussion after a community screening of "The Deadliest Disease in America," a film on racism in medicine. For details contact Dr. John Bower at jbower564@aol.com.

The **New York Metro** chapter of PNHP held a lobby day in Albany with about 200 participants in support of state Rep. Richard Gottfried's single-payer New York Health bill. The legislation now has enough co-sponsors to pass in the Assembly, and nearly enough to pass in the Senate. Dr. Oliver

Fein and New York Metro chapter executive director Laurie Wen met with the Doctors Council (a physicians' union), regarding a possible endorsement of HR 676 and the New York Health bill. Steven Brill, author of the article "Bitter Pill" in Time magazine, spoke to a large crowd at the chapter's regular monthly forum. On the anniversary of Medicare's passage, local activists delivered Medicare birthday cupcakes to congresspeople who have not yet endorsed H.R. 676. For details contact Laurie Wen at laurie@pnhpnymetro.org.

In **Charlotte, N.C.**, a new PNHP chapter of, Health Care Justice, hosted a kickoff event in May with Gerald Friedman, Ph.D., an economist at University of Massachusetts at Amherst. Friedman noted that North Carolina could cover all of the uninsured and save $18.7 billion annually with a single-payer system. The kickoff, which was covered by the Charlotte Business Journal, was attended by over 100 people and co-sponsored by the League of Women Voters. The chapter is using an information sheet with an attached resolution as a membership recruiting tool. The communications committee, recently infused with new volunteers, is drafting new short and long presentations, and an FAQ for speakers. They plan to celebrate the 48th birthday of Medicare with op-eds and letters to the editor, and to hold quarterly educational "get to know you" meetings for new volunteers and prospective members. For details contact chapter founder Dr. Jessica Saxe at jsaxe@earthlink.net.

In **St. Louis, Missouri**, PNHPers in white coats participated in a demonstration with the United Mine Workers (UMWA) against Peabody Coal. The firm is trying to drop retiree health and other benefits for 22,000 miners and their spouses by declaring bankruptcy. The president of the UMWA, Cecil Roberts, thanked them for their support from the podium, while the group's banner was displayed on the main stage. The St. Louis chapter of PNHP has more than doubled in size, with over 400 people now on their local list. Tom Flanagan, a recently retired medical device salesperson, is helping the chapter garner speaking engagements, including grand rounds at two of the major academic centers in St. Louis this fall. The chapter is active in media outreach and in the drive for Missouri to expand Medicaid under the ACA. Dr. Ed Weisbart writes that the chapter has been able "to strike a dialogue that advocates unequivocally for the expansion of Medicaid while framing it in the larger context of Improved and Expanded Medicare for All. The messages seem to resonate well." The chapter is also grateful to PNHP national office staffer Dustin Calliari for creating their website, www.pnhpstl.org, even as they take steps toward going statewide. For details, contact Dr. Ed Weisbart at edweisbart@gmail.com.

Doctors from PNHP St. Louis at a demonstration with the United Mine Workers in May.

In **New Hampshire**, Dr. Donald Kollisch and other PNHP members are drafting a state single-payer bill for use as an organizing tool at the local level. Stay tuned. For details, write to donald.o.kollisch@dartmouth.edu.

In **Oregon**, activists hosted their second annual "Inner City Blues Festival - Healing the Health Care Blues." The event was well attended and raised money for the statewide coalition, Health Care for All Oregon. The state's single-payer bill has 23 cosponsors this session, up from 11 last year. The Legislature has passed a bill for an economic study on health care financing options, including single payer. State Rep. Michael Dembrow, D-Portland, reached across the aisle to convince his fellow representatives to back the study. In the Senate, four Republicans, including Sen. Jeff Kruse of Roseburg, joined all Democrats in support. The bill calls for a privately funded comprehensive study of health care financing in Oregon, analyzing at least four reform options, including a single-payer system. For details contact Paul Gorman at gormanp@me.com.

In **South Carolina**, Dr. David Keely and other single payer activists met recently in Charleston to discuss plans for building their chapter, Healthcare for All - South Carolina. They are reaching out to physicians in the Palmetto Health Association and to faith and civic groups like the Providence Presbytery and the League of Women Voters on the heels of PNHP national board member Dr. Art Sutherland's successful chapter visit in mid-March. They are also involved in planning this fall's Healthcare-NOW! meeting which will focus on organizing for single payer in Southern states. Activists plan took birthday cakes to their local representatives and HCFA-SC met on July 30 to celebrate Medicare's birthday. For details, contact Dr. David Keely at davidkeelymd@comporium.net.

In **Tennessee**, Dr. Roger LaBonte is working to interest medical students in single payer. Middle Tennessee PNHP Chapter Coordinator Dr. James Powers is a frequent speaker on Medicaid, Medicare, and single payer. In April he spoke to Vanderbilt medical students and delivered grand rounds at Meharry Medical College during Health Disparities Week to very supportive audiences. Dr. Arthur Sutherland is active in speaking, publishing letters to the editor, and pushing the governor to expand the state's Medicaid program, TennCare. He is also helping to launch new chapters of PNHP in Chattanooga and Knoxville-Oak Ridge. He emphasizes the ACA is only "insurance reform" and that meaningful reform, Improved Medicare for All, is still needed. For details, contact Dr. Jim Powers at james.powers@vanderbilt.edu or Dr. Art Sutherland at asutherland523@gmail.com.

In **Vermont**, opponents of single payer are working to conflate all of the Affordable Care Act's (ACA) unpopular features – the individual and employer mandates and the health exchanges in particular – with single payer. In speaking engagements and through the media, especially the print media, Vermont PNHP members are working to distinguish these two types of reform, and correcting misconceptions emanating from both opponents and the media. They are focused on keeping reform on track to transition to a single-payer system in 2017, the soonest allowed under the ACA. Vermont PNHP members also recently testified about their concerns with the Accountable Care Organization model before the legislature and Green Mountain Care Board. For details, contact Dr. Marvin Malek at mmalek66@gmail.com.

In **Washington State**, PNHP members held their 8th annual meeting at the University of Washington campus. Featured speakers included PNHP President Dr. Andy Coates, economist Gerald Friedman, Ph.D., and state Sen. Karen Kaiser, who is the ranking Democrat on the Health Committee in the Legislature. Kaiser is committed to getting a federal waiver for Washington to adopt a single-payer plan as soon as allowed under the ACA. Dr. David McLanahan and other chapter activists have met with 11 statewide organizations in preparation for their statewide "health care is a human right" campaign kickoff. For details, contact Dr. McLanahan at mcltan@comcast.net.

In **West Virginia**, Drs. Jim Binder and Hedda Haning organized a successful speaking tour for PNHP President Dr. Andy Coates to Charleston and Morgantown, featuring him at grand rounds, a lecture at the University of West Virginia School of Public Health, a tour of a rural clinic, and a reception at Dr. Binder's house. Activists are following up on Dr. Coates' visit by doing outreach to other organizations that might support single payer. The chapter also hopes to host a speakers training session for members willing to give talks to churches and other organizations. For details, contact Dr. Jim Binder at jbinder2@suddenlink.net.

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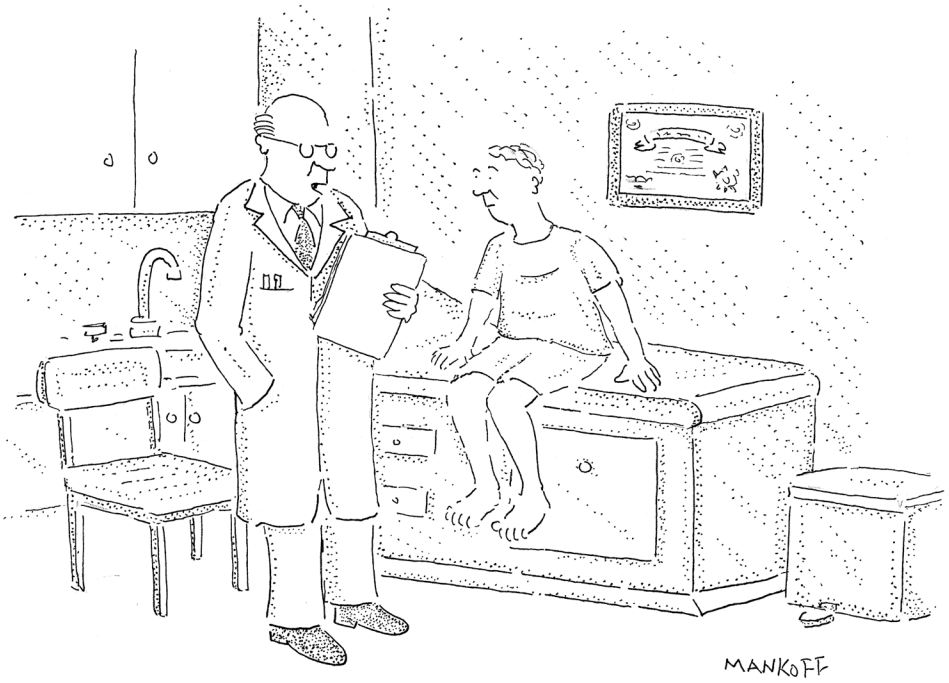

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