

Testimony

**Public Hearing
Partnership for Coverage
NYS Insurance Department
NYS Department of Health
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**Leon N. Zoghlin MD
Physicians for a National Health Program
1132 West Ave.
Hilton, NY 14468-9101
585-392-9447
cyclist@rochester.rr.com**

I am Leon Zoghlin, medical school class 1955, University of Illinois. I have practiced family medicine for over 50 years. My financial relationships with patients span the direct fee for service and the HMO eras, and I am now a volunteer physician at the St. Joseph Neighborhood Center medical clinic for the uninsured.

I represent Physicians for a National Health Plan, which is an organization of 15,000 physicians and allied groups interested in universal health care. We are an organization which provides the public and government with research, education, and advocacy for a single payer universal healthcare plan.

We do not believe in the “building block” approach. An insurance based foundation for your building blocks is a base of quicksand. We believe that a single payer system can be implemented in a simple sweeping, universal plan. The savings lie in the elimination of the complex overhead of the insurance industry.

The implementation problems of other states stem from their utilization of the insurance industry. The costs that add no value to health care, are complexity, bureaucracy, profits, and outrageous salaries.

Cost also is the result of the “surfeit of riches” that the medical profession and allied industries have given society; endoscopy, and endoscopic surgery, and advanced imaging in the form of CT, MRI, and PET scanning. Alas, they all involve expensive technology that moves so fast that economy of scale has never been realized. This is also another reason why healthcare does not fit the market economy.

The evidence we present was developed for a national system, but we believe it is applicable to the state of NY. The Canadian system began in the single province of Saskatchewan .

As to the benefits to the economy, more cars are made in the province of Ontario than in the state of Michigan. I also place in evidence a letter signed by the CEOs of the Canadian division of our major auto companies, calling for a strengthening of the Canadian single payer health system.

I have the 23 questions you pose to witnesses. Since you already know I favor single payer I will start with question 19.

The Failure of the Health Care Industry (HMOs)

The health insurance industry has existed for 30 yrs. and has failed miserably to provide health care security. Premiums now exceed the grasp of the middle class. Physicians have been alienated by meddling of HMOs in professional decisions, and intrusion into the doctor patient relationship. The time and money required to deal with the complexity of multiple companies

with multiple panels, fee schedules, formularies precertifications, and guidelines that morph into instruments of pay for performance, has sapped their pride of profession. The sick are either refused coverage, or are rated at a level that the healthy cannot afford, much less the victim who has an illness that reduces his productivity.

This cauldron of complexity has been estimated to add \$350 billion/yr. to the 16% GDP Americans spend on health care. Half of the bankruptcies in this country are due to illness.

The Solution:

Proposal of the Physicians Working Group for Single Payer National Health Plan www.PNHP.org

I: Principles:

Access to health is a human right.

The right to choose a physician is fundamental.

The public should set health care policy, financing, and budget.

II. Eligibility:

A. All legal residents of the United States.

B. Reciprocity with other government health systems.

III. Governance:

A. Regional, State or local board or commission with representation from:

1. Government

2. Business

3. Labor

4. Consumers

5. Providers

B. Funds distributed from NHI on a per capita basis

IV. Coverage:

All medically necessary services as determined by a board of experts and community representatives.

1. Acute

4. Dental

2. Long term

5. Prevention

3. Mental

V. Hospital Payment:

A. NHI would pay each hospital a monthly sum to cover operating expenses negotiated

The basis of:

1. past budgets

3. demand for service

2. clinical performance

4. proposed programs

VI. Physician (provider) payment

A. Fee for service

B. Capitation

C. Salary

1. Hospital (as an item of their operational budget) 3. Capitated HMO

2. Group practices/clinics

VII. Long term care:

A. Eligibility determined by local agency:

1. Home aide
2. Nursing home
3. Respite care

B Global budget to local agencies who then contract with providers
Visiting nurses and aides

VIII. Capital spending.

Only nonprofit hospitals and agencies that receive NHI operating fund eligible.

New hospital construction, Expensive equipment (MRI)

Purchase of needed for-profit hospitals and nursing homes.

Administered by a regional board

XI. Funding

Income tax Philanthropy

Payroll tax Long term bonds

Cost of a Single Payer System:

We believe that elimination of the overhead of private insurance could pay for universal coverage in a single payer system. The partial basis of that belief is as follows.

June, 1991 General Accounting Office

“savings in administrative costs would be more than enough to offset the expense of universal coverage”

December 1991 Congressional Budget Office

“a single payer system that paid providers at Medicare rates, the population that is currently uninsured could be covered without dramatically increasing national spending on health.”

April, 1993 Congressional Budget Office

“Under a single payer system with co-payments... on average, people would have an additional \$54.00/yr. to spend.”

June 1998 Economic policy institute

“it is assumed that in the first year after implementing a universal single payer plan, total national expenditures are unchanged from baseline”The

Lewin Group, Washington D.C., an economic consulting firm offered these studies of saving to states that implement single payer.

1994 New Mexico, \$158 million/yr.

2000 Maryland, \$345 million in 1st yr.

2002 California \$7.6 billion/ yr.

2004 Georgia, \$716 million/yr

2005 California, \$343 billion over 10yrs.

Other studies have predicted savings in Delaware, Vermont, Missouri, Massachusetts, and Maine.

With the implementation of a single payer healthcare program, government in the state of New York could remove the cost of employee healthcare premiums from their budget. This would apply to the state, county, town, village, city and school districts. Those funds could be applied to a single payer system.

Endorsements:

- American Association of Community Psychiatrists
- American Medical Women's Association
- American Medical Student's Association
- National Medical Association
- American Nurses Association
- American Public Health Association
- Islamic Medical Association
- Americans for Democratic Action
- California Nurses Association/National Nurses Organizing Committee
- Church Women United
- Consumer Federation of America
- Consumers Union
- Just Health Care
- National Association of Social Workers
- National Council of Senior Citizens
- National Family Farm Coalition
- National Health Care for the Homeless Council
- Neighbor to Neighbor
- Older Women's League
- Screen Actor's Guild
- US Public Interest Research Group
- United Steelworkers Union
- NY Academy of Family Practice
- NY Democratic Party
- Public Employee Federation
- District of Columbia Chapter AMA
- AFL/CIO

You already have the testimony of Rebecca Elgie, who has been walking the state on behalf of single payer. To date she has obtained the endorsement of the legislatures of Albany, Cortland, Livingston, Rensselaer, Schuyler, Sullivan, Tompkins, and Ulster counties.

23 Questions:

My advocacy of a single payer health plan in response to question 19 renders questions 1,4-7,9-13, and 16-23 moot

Question 2:

The increased cost of health care is partially a function of riches the medical profession can deliver to society. We can solve more problems. There is no containing it. It will impose increasing ethical problems in the future. New York spends more money on public health care because we treat more people. I am proud of that. We have elected to use the federal contribution to Medicaid to the maximum, requiring us to match those funds. Our expenditure of \$50 billion brings \$50 billion federal dollars into our economy. It should be noted that Kentucky matches 70% federal and 30% state because the legislation views Kentucky more impoverished than NY. New Yorkers help pay for Kentucky's Medicaid.

Question 3:

Quality in healthcare has yet to be reliably defined. We have been rated on adherence to guidelines based on consensus rather than evidence with data from notoriously inaccurate claims administration. Elimination of paperwork involved in billing, precertification and appeals of rejected claims would make us more efficient and richer. My reaction to monetary rewards for good practice, or pay for performance, is best expressed by this publication from Don Berwick MD: "I do not believe that it is true that the way to get better doctoring or better nursing is to put money on the table in front of doctors and nurses. I think that's a fundamental misunderstanding of human motivation. I think people respond to joy and work and love and achievement and learning and appreciation and gratitude in a sense of a job well done. I think it feels good to be a good doctor and better to be a better doctor. When we begin to attach dollar amounts throughputs and to individual pay, we are playing with fire. The first and most important effect of that may be to begin to disassociate people from their work."

Question 6:

We must access federal monies for Medicare, Medicaid, VA, Indian Health etc. This is not likely to happen in this administration which has a penchant

for health savings accounts. I do not see single payer until 2009. Hopefully it will come as a National program. In any case, we can prepare for it and be ready for implementation as soon as federal funds are available.

Question 8 ERISA

The healthcare provisions of ERISA would be supplanted by single payer.

Questions 14, 15

There is evidence that co-pays reduce utilization. However there is also evidence that co-pays reduce appropriate as well as inappropriate utilization. Means testing to determine level of co-payment is not likely to be cost effective.

Leon N. Zoghlin MD

1132 West Ave.

Hilton, NY 14468

cyclist@rochester.rr.com

INSURANCE FAILURE

Getting the Facts Right: Why Hillarycare Failed

By Vincente Nacarro

Professor of Health and Public Policy

The John Hopkins University

10/24/07

In his article "The Hillarycare Mythology" (The American Prospect, October 2007, pp. 12-18), Paul Starr, a senior health policy advisor to President Bill Clinton and a leading figure in Hillary Rodham Clinton's White House task force on health care reform, analyzes the origins, development, and final outcome of the Clinton administration's health care reform — referred to by Republicans as "Hillarycare."

Starr dates the origins of Bill Clinton's commitment to health care reform to the special congressional election held in Pennsylvania in November 1991, when Harris Wofford won against all odds by making reform of the health care sector a major campaign issue. According to Starr, this event triggered a great deal of interest in health care reform; even the American Medical Association (AMA) and the Health Insurance Association of America (HIAA) supported some types of reform such as an employer mandate to provide health benefits coverage. As noted by the editor of JAMA, "there was an air of inevitability about health care reform." It was this surge of interest that candidate, and later President, Clinton tried to capitalize on by developing a proposal to provide universal health care coverage for all Americans (meaning all U.S. citizens and residents).

Once elected, Bill Clinton established the 500 member White House task force, led by Mrs. Clinton, to work on the details of a proposal developed within a framework defined by the President. According to Starr, the proposal failed when President Clinton presented it to the U.S. Senate after completion of, rather than before, the budget discussions. The Senate did not support the proposal, because it would require extra revenues (making senators susceptible to Republican charges of fiscal irresponsibility) and particularly because — again, according to Starr — the proposed benefits coverage was too extensive and too large for many senators to swallow. The final message of Starr's article is that it was President Clinton's fault, rather than Hillary's, that the reform proposal failed.

Starr reproduces a widely held interpretation of the failure of the Clinton health care reform that (limiting the analysis to the relationship between the President and Congress) attributes this failure to a calendar error — bad timing — and to the excessive generosity of the proposed health care benefits. I believe there is a need to correct such an interpretation of the events that led to the death of the reform proposal and to challenge the assumptions behind the interpretation. This is important because we might face a similar situation very soon. The majority of the U.S. population is dissatisfied with the funding and organization of the health care sector, and this dissatisfaction has reached unprecedented levels. Once again, all indicators show that people want change. But we could face another failure unless some major changes take place in the U.S. — changes that, I admit, are unlikely to occur with the current correlation of forces in the country and in the Democratic Party.

Let's start with some corrections to Starr's assumptions. The commitment of the Democratic Party and candidate Bill Clinton to universal health care coverage for all citizens and residents started much earlier than Starr suggests. It began in the presidential primary campaigns of 1988, when Jesse Jackson (for whom I was senior health advisor), running for the Democratic nomination, made a commitment to universal, comprehensive health care benefits coverage a central component of his platform. This proposal was dismissed by the Democratic Party

establishment as “too radical,” but it had already mobilized large sectors of the party’s grassroots (especially labor unions and social movements) to support Jackson, with more than 40% of the delegates at the Democratic Party Convention in Atlanta. This shook the Democratic establishment and stimulated responses from Governor Clinton, Senator Al Gore, and Congressman Richard Gephardt to block this rise of the left in the Democratic Party, which they did by establishing the Democratic Leadership Council, among other interventions. (Gore and Gephardt have changed since then; Bill Clinton hasn’t.) (I describe these effects of Jackson’s health proposals on the Democratic Party in “The 1988 Presidential Election,” in *The Politics of Health Policy: The U.S. Reforms 1980—1998*, Blackwell, 1994. pp. 99-110.) To control this growth of the left, something had to be done. And as liberals always have done when faced with the left, they recycled its progressive proposals, adopting much of their narrative but emptying them of their content. This is what Clinton did in his 1992 campaign. He used the title, narrative, and symbols of Jesse Jackson’s campaign, calling his platform “Putting People First” (the title used by Jackson in 1988) and including the call for universal health care benefits. As the perceptive *Financial Times* wrote, “Clinton [has borrowed] extensively from Jesse Jackson 1988. He sounds like a Swedish social democrat.” While borrowing the language and the symbols, however, Clinton changed the content dramatically.

Whereas Jackson had called for a single-payer program similar to that in Canada, Clinton chose the opposite pole of the political spectrum: managed care competition. Managed care competition basically meant the insurance companies exercised full control over health care providers, with doctors working in group practices called Health Maintenance Organizations (HMOs). As stated by Paul Elwood, a leading member of the White House task force, “insurers-controlled HMOs, under managed care competition will stimulate a course of change in the health care industry that would have some of the classical aspects of the industrial revolution — conversion to larger units of production, technological innovation, division of labor, substitution of capital for labor, vigorous competition and profitability as the mandatory condition of survival” (“Health Maintenance Strategy,” *Medical Care*, 9 (1971), p. 291). This industrial revolution in medical care would indeed have revolutionized the practice of medicine.

It is important to note that the idea of managed care competition was first proposed as a solution to the irrationality of the U.S. health care sector by Alain Enthoven, personal advisor to U.S. Secretary of Defense Robert McNamara during the Vietnam War. Enthoven was in charge of developing the “body count” as an indicator of military efficiency. After the Vietnam fiasco, Enthoven retired to the Rand Corporation, choosing to focus his intellectual efforts on the reform of U.S. health care. A strong ideologue and market fundamentalist, and completely ignorant of the mechanics of the medical care sector, Enthoven thought the best way to control out-of-control costs in the health sector was to increase competition in the sector, letting health insurance companies compete for consumers — meaning patients — based on the price of services. The problems with such a naïve and unrealistic scenario are many. First, patients do not determine the cost or price of medical care services. Second, patients have very little choice in the U.S. health care sector: employers choose which plans are available to employees. Third, the market does not exist in the health care sector. Fourth, the insurance industry’s financial viability depends on its ability to discriminate against heavy care-users. I could go on and on detailing just how wrong Enthoven’s proposals were.

Not surprisingly, managed care was the proposal chosen by the insurance industry and by employers. As Bill Link, Executive Vice President of Prudential and one of the highest-paid CEOs in the country, stated: “for Prudential, the best scenario for reform — preferably even to the status quo — would be enactment of a managed competition proposal.” Link envisioned the corporatization of U.S. medicine, breaking the long dominance of health care providers in

the medical care sector. As Enthoven wrote in an article co-authored with Richard Kronick, another leader of the White House health care reform, “what about traditional fee-for-services individual and single specialty group practices? We doubt that they should generally be compatible with economic efficiency. . . . Some would survive in private solo practice without health plan contracts, serving the well-to-do.” It could not have been put more clearly: managed care competition was corporate assembly-line capitalism for the masses and their health care providers, with free choice and fee-for-service medicine for the elites.

This proposal was actively promoted in the White House task force by the staff of Democratic Representative Cooper and members of the so-called Jackson Hole Group, who even distributed the group’s manuals on implementing managed care competition to task force members. They were particularly active in the Governance of the Health System (chaired by Richard Curtis, who had been an official of the HIAA) and Global Budgeting working groups. Outside the task force, managed care competition was actively promoted by the insurance companies. Mr. Weinstein, a disciple of Enthoven and a member of the editorial board of the New York Times (a third of the Times board members then had connections with insurance companies), wrote nine editorials in support of managed care competition.

Paul Starr sold managed care to candidate Bill Clinton. Of course, Starr and another leader of the White House task force, Walter Zelman, were aware of some drawbacks of this scheme, and they modified it to allow for some form of regulation of the ill-defined market forces — without specifying, however, who would do the regulating. They spoke of Health Alliances that would regulate the rate of growth of premiums and would allow, in theory, for consumer choice of health plans, with large employers operating on their own outside the regulatory process but still within the framework of managed care competition (with budget constraints); health insurers and health care providers could be integrated in the same organization, or Health Plans. While managed care competition was the proposal favored by insurers and large employers, it was not favored by health care providers. Providers had already had enough experience with insurance companies to know that they could be more intrusive, abusive, and nasty than government. And managed care was certainly not the choice of the grassroots of the Democratic Party — labor unions and social movements.

Concerned that managed care was not backed by the majority of the progressive base of the Democratic Party, Jesse Jackson, Dennis Rivera (then president of Local 1199, the foremost health care workers union), and I went to see Hillary Clinton. We complained about the commitment to managed care competition without due consideration of a single-payer proposal supported by large sectors of the left in the Democratic Party. We emphasized the need to include this proposal among those to be considered by the task force. Mrs. Clinton responded by asking Jackson and the Rainbow Coalition to appoint someone to the task force with that point of view. And this is how I became a member of the White House task force. I later found out that there was considerable opposition from senior health advisors, including Starr and Zelman, to my becoming part of the task force. According to a memo later made public and published in David Brock’s nasty book *The Seduction of Hillary Clinton*, Starr and Zelman disapproved of my appointment “because Navarro is a real left-winger and has extreme distaste for the approach we are pursuing”— which was fairly accurate about my feelings, but I must stress that my disdain for managed competition and the intellectuals who supported it did not interfere with my primary objective: to make sure that the views of the single-payer community would be heard in the task force. They were heard, but not heeded. I was ostracized, and I had the feeling I was in the White House as a token — although whether as a token left-winger, token radical, token Hispanic, or token single-payer advocate, I cannot say. But I definitely had the feeling I was a token something.

It was at a later date, when some trade unions and Public Citizen mobilized to get more than 200,000 signatures in support of a single-payer system, that President Clinton instructed the task force to do something about single-payer. From then on the battle centered on including a sentence in the proposed law that would allow states to choose single-payer as an alternative if they so wished. In Canada, after all, single-payer started in one province (Saskatchewan) and later spread to the whole nation. I have to admit that I made that proposal with considerable misgivings, since the insurance companies can also be extremely influential at the state level. For example, Governor Schaeffer (a Democrat) of Maryland had asked insurance companies to interview the various candidates for state insurance commissioner. Still, including this proposal was a step toward giving single-payer a chance in the U.S.

It is interesting that in my debates with Alain Enthoven, he dismissed my proposals with the comment that “the U.S. Political System is incapable of forcing changes in such powerful constituencies as the insurance industry.” Such candid admission of the profoundly undemocratic nature of the U.S. political system was refreshing. The splendid opening of the U.S. Constitution, “We the people . . . ,” should be amended with a footnote reading “and the insurance companies.” Actually, Enthoven’s statement came very close to Marx and Engels’ Communist Manifesto, which defines democracy as a class dictatorship in which the corporate class controls the state. Empirical support in the U.S. for that statement is strong. But the statement is not 100% accurate. I lived under a dictatorship in my youth (in Franco’s Spain) and I recognize a dictatorship when I see one. The U.S. is not a dictatorship. People in the U.S. do have a voice. Marx and Engels (and Enthoven) were not completely right: U.S. history shows that people’s mobilizations can win the day. But, while not a dictatorship, U.S. democracy is profoundly undermined by the enormous influence of the economic and corporate lobbies, components of the corporate class. I documented this in *Medicine Under Capitalism*, published in the 1970s. And things have become much worse during the Reagan—Bush Sr.—Clinton—Bush Jr. era. The huge limitations of U.S. democracy are evident in the difficulty with which the importance of people’s voice gets noticed. And this is why the Clinton proposal failed. He did not include in his plans any effort to mobilize people in support of the reform. Quite to the contrary. He allied himself with the major forces responsible for the sorry state of the U.S. medical care sector — the health insurance industry. The insurance companies ultimately opposed the final proposal because of its regulatory components, added by Starr and Zelman. But, apart from these components, the insurance companies would have continued to manage the health care system.

Starr’s explanation of why the reform failed is dramatically insufficient. The failure had little to do with timing, with when and where President Clinton presented the proposal. It had to do with how the Clintons related to the progressive constituencies, including labor and social movements. No universal, comprehensive coverage will ever be achieved in the U.S. without an active mobilization of the population (especially progressive forces) so as to balance and neutralize the enormous resistance from some of the most important financial lobbies in the nation. Starr’s social engineering approach, lacking any understanding of the dynamics of power, explains failure as a consequence of problems of the electoral calendar or the types of benefits offered.

In reality, the Clinton administration ignored the majority of the country’s progressive forces from the very beginning of its mandate. President Clinton made his first priority a reduction of the federal deficit (a policy not even included in his program), approved NAFTA (against the opposition of the AFL-CIO, the social movements, and even the majority of the Democratic

Party), and committed himself to perpetuation of the for-profit health insurance system — the primary cause of the country's inhumane medical care system. When NAFTA was approved, Clinton signed the death certificate for the health care plan, and for the Democratic majority in Congress. The number of people who voted Republican in 1994 was no larger than in 1990 (the previous non-presidential congressional election year). The big difference was in the Democratic vote. Abstention by working-class voters increased dramatically in 1994 and was the primary reason why Democrats lost their majority in Congress. This is a point that Starr ignores. The Gingrich Revolution of 1994 was an outcome of voter abstention, particularly among the working class, who were fed up with President Clinton. But NAFTA was also the death knell for health care reform. One could see this in the White House task force. NAFTA empowered the right, and weakened and demoralized the left.

A continuing shift to the right (erroneously called the center) has been the Democratic Party's strategy for the past 30 years, abandoning any commitment to the New Deal and the establishment of universal entitlements that make social rights a part of citizenship. David Brock writes in his book "that Navarro had told Mrs. Clinton that if the President went ahead with a managed care competition plan, it would cost the election to the Democratic Party." Brock's credibility as a reporter is extremely limited, but on that point he was right. I told Mrs. Clinton that the only way of winning, and of neutralizing the enormous power of the insurance industry and large employers, was for the President and the Democratic Party leadership to make the issue one of the people against the establishment. It was a class war strategy that the Republicans most feared. My good friend David Himmelstein, a founder of Physicians for a National Health Program, told Mrs. Clinton the same thing. And as I judged by her response, she seemed to think we did not understand how politics works in the U.S. The problem is, we understood only too well how power operates.

This, then, is why the Clintons failed. And unfortunately, Hillary Clinton will fail again if she lacks the courage to confront those responsible for the predicament in the nation's health care system. The insurance-controlled system imposes enormous pain on the population. It is not just that 46 million people are now without health insurance, but the system also fails the huge numbers of people who have insufficient coverage and don't discover this until they need it. This cruel system has been supported by large employers because it gives them oppressive control of the labor force. When workers lose their job, they lose not only their income but also health benefits coverage — for themselves and their families. The alliance of two of the most powerful forces in this country — insurance and large employers — is at the root of the problem.

A final observation. Love of country is measured by the extent to which one promotes policies that support the well-being and quality of life of the population and, most particularly, the working and middle classes that make up the vast majority of the population. Judged by this standard, most super-patriotic, right-wing forces fail miserably on the love-of-country front. People in this nation die due to lack of health care. The estimates vary from 18,000 to 100,000 a year, depending on how you measure preventable deaths. But even based on the most conservative number of 18,000 (from the conservative Institute of Medicine), this is six times the number of people killed on September 11, 2001, by Al Qaeda. And these deaths continue year after year. The deaths on 9/11 are rightly seen as the result of enemy action. But why do the 18,000 deaths each year go unnoticed? Why aren't they seen as the outcome of hostile forces, whose love for their country is clearly nil? Mark Twain said, "You cannot love people and then go to bed with those who oppressed them." Why is it so difficult to understand such a basic truth?

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Costs of Health Care Administration in the United States and Canada

Steffie Woolhandler, M.D., M.P.H., Terry Campbell, M.H.A.,
and David U. Himmelstein, M.D.

From the Department of Medicine, Cambridge
Hospital and Harvard Medical
School, Cambridge, Mass. (S.W., D.U.H.);
and the Canadian Institute for Health Information,
Ottawa, Ont., Canada (T.C.).

Address reprint requests to Dr. Himmelstein
at 1493 Cambridge St., Cambridge,
MA 02139.

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background

A decade ago, the administrative costs of health care in the United States greatly exceeded those in Canada. We investigated whether the ascendancy of computerization, managed care, and the adoption of more businesslike approaches to health care have decreased administrative costs.

methods

For the United States and Canada, we calculated the administrative costs of health insurers, employers' health benefit programs, hospitals, practitioners' offices, nursing homes, and home care agencies in 1999. We analyzed published data, surveys of physicians, employment data, and detailed cost reports filed by hospitals, nursing homes, and home care agencies. In calculating the administrative share of health care spending, we excluded retail pharmacy sales and a few other categories for which data on administrative costs were unavailable. We used census surveys to explore trends over time in administrative employment in health care settings. Costs are reported in U.S. dollars.

results

In 1999, health administration costs totaled at least \$294.3 billion in the United States, or \$1,059 per capita, as compared with \$307 per capita in Canada. After exclusions, administration

accounted for 31.0 percent of health care expenditures in the United States and 16.7 percent of health care expenditures in Canada. Canada's national health insurance program had overhead of 1.3 percent; the overhead among Canada's private insurers was higher than that in the United States (13.2 percent vs. 11.7 percent). Providers' administrative costs were far lower in Canada.

Between 1969 and 1999, the share of the U.S. health care labor force accounted for by administrative workers grew from 18.2 percent to 27.3 percent. In Canada, it grew from 16.0 percent in 1971 to 19.1 percent in 1996. (Both nations' figures exclude insurance-industry personnel.)

conclusions

The gap between U.S. and Canadian spending on health care administration has grown to \$752 per capita. A large sum might be saved in the United States if administrative costs could be trimmed by implementing a Canadian-style health care system.

abstract

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costs of health care administration

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In 1991, we reported that people in the United States spent about \$450 per capita on health care administration in 1987, whereas Canadians spent one third as much.

Subsequent studies reached similar conclusions, but all relied on data from 1991 or before.

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In the interim, organizational and technological changes have revolutionized health care administration. The ascendancy of managed care and competition has forced providers to adopt more businesslike approaches. Mergers between hospitals and between health maintenance organizations (HMOs) have centralized “back office” tasks. E-mail has displaced regular mail, and the Internet allows insurers to offer on-line verification of applicants’ eligibility, utilization review, and payment approval.

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By 1999, nearly two thirds of U.S. health insurance claims were filed electronically, including 84 percent of Medicare claims.

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Canada’s national health insurance system has also been subject to technological change and turmoil — strident debate over cost controls, the availability of medical technology, hospital closures, and the appropriate role of investor-owned providers. But its organizational structure has changed little. We evaluated whether the adoption of a more businesslike attitude, the proliferation of HMOs, and the automation of billing and clerical tasks have trimmed administrative costs in the United States and whether Canada’s administrative parsimony has persisted in the years since our earlier study. To estimate administrative costs, we sought data on insurance overhead, employers’ costs to manage benefits, and the administrative costs of hospitals, practitioners’ offices, nursing homes, and home care. Our estimates use 1999 figures, the most recent comprehensive data. We used gross-domestic-product purchasing-power parities

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to convert Canadian dollars to U.S. dollars, and we used SAS software for data analyses.

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insurance overhead

We obtained figures for insurance overhead and the administration of government programs from the Centers for Medicare and Medicaid Services

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and the Canadian Institute for Health Information.

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employers’ costs to manage health care benefits

For the United States, we used a published estimate of employers’ spending for health care benefits consultants and internal administration related to health care benefits in 1996.

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We used this figure to estimate 1999 costs on the basis of the growth in health care spending among employers in the private sector.

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No comparable figures are available for Canada. We assumed that employers' internal administrative costs plus the costs of consultants (as a share of employers' health care spending

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are the same in Canada as in the United States.

hospital administration

For the United States, we calculated the administrative share of hospital costs by analyzing data from fiscal year 1999 cost reports that 5220 hospitals had submitted to Medicare by September 30, 2001, using previously described methods.

14,15

For Canada,

we and colleagues at the Canadian Institute for Health Information analyzed cost data for fiscal year 1999 (April 1, 1999, through March 31, 2000) for all Canadian hospitals except those in Quebec (which use a separate cost-reporting system), using methods similar to the ones we used to calculate costs in the United States. When questions arose about the comparability of expense categories, we obtained detailed descriptions of the Canadian categories from Canadian officials and consulted U.S.

Medicare auditors to ascertain where such costs would be entered on Medicare cost reports. For both countries, we multiplied the percentage spent on administrative costs by total hospital spending.

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administrative costs of practitioners

We calculated the administrative costs of U.S. physicians by adding the value of the physicians' own time devoted to administration to estimates of the share of several categories of office expenses that are attributable to administrative work. We determined the proportion of physicians' work hours devoted to billing and administration from a national survey

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and multiplied this proportion by physicians' net income before taxes.

8,17

We calculated the costs of administrative work by nurses and other clinical employees in doctors' offices by assuming that they spent the same proportion of their time on administration as did physicians. We calculated the value of this time on the basis of total physicians' revenues

8

and survey data on doctors' payroll costs

from the American Medical Association.

17

We attributed all of physicians' expenses for clerical staff to administration.

17

Although administrative and clerical workers accounted for 43.8 percent of the work force in physicians' offices (unpublished data), we attributed only one third of office rent and methods

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n engl j med

349;8

www.nejm.org august

21

,

2003

The

new england journal

of

medicine

770

other expenses (excluding medical machinery and supplies)

17

to administration and billing. Accounting, legal fees (excluding the cost of malpractice insurance), the costs of outside billing services, and other such costs are subsumed in "other professional expenses,"

17

half of which we attributed to administration.

To estimate the administrative expenses of dentists (and other nonphysician practitioners), we analyzed data on administrative and clerical employment in practitioners' offices from the March 2000 Current Population Survey using previously described methods.

18

Administrative and clerical employees' share of office wages was 43 percent lower in the case of dentists' offices and 14 percent lower in the case of other nonphysician practitioners' offices than those of physicians' offices. We assumed that the administrative share of the income of dentists and other nonphysician practitioners mirrored these differences.

To calculate administrative costs in Canada, we obtained figures from a Canadian Medical Association survey on the proportion of physicians' time devoted to administration and practice management

19

and multiplied this proportion by physicians' net income before taxes.

9,20

To calculate the cost of nonphysician staff time, we used figures from Canadian Medical Association surveys of physicians'

expenditures for office staff,

20,21

which did

not distinguish between clinical and administrative staff. We analyzed special 1996 Canadian Census tabulations to determine administrative and clinical workers' shares of total wages in doctors' offices.

18

We attributed all of the administrative workers' share to administration and assumed that nonphysician clinical personnel spend the same proportion of their time on administration as did physicians.

To calculate the costs of office rent and similar expenses, we attributed one third of physicians' office rent, lease, mortgage, and equipment costs

20,21

to administration and billing. We attributed half of other professional expenses

20,21

to administration.

To calculate the administrative expenses of nonphysician office-based practitioners in Canada, we used the same procedure that we used for the U.S. data and based the analysis on 1996 Canadian Census data.

nursing home administration

No published nationwide data on the administrative costs of U.S. nursing homes are available for 1999, and only Medicare-certified facilities (which are not representative of all nursing homes) file Medicare cost reports. However, California collects cost data from all licensed homes. Therefore, we analyzed 1999 data on 1241 California nursing homes,

22

grouping expenditures into three broad categories: administrative, clinical, and mixed administrative and clinical. We used methods similar to those employed in our hospital analysis

14,15

to

allocate expenses from the "mixed" category to the clinical and administrative categories. To generate a national estimate, we multiplied the administrative share of expenditures by total nursing home spending.

8

For Canada, we and colleagues at the Canadian Institute for Health Information analyzed data for fiscal year 1998 (April 1, 1998, through March 31, 1999) on administrative costs for homes for the aged (excluding Quebec) from Statistics Canada's Residential Care Facilities Survey, using methods similar to those we used for the U.S. data. We multiplied the share spent for administration by total nursing home expenditures in Canada.

9

administrative costs of home care

agencies

We analyzed data from fiscal year 1999 cost reports that 6633 home health care agencies submitted to Medicare. We excluded agencies reporting implausible administrative costs that were below 0 percent or above 100 percent and then calculated the proportion of expenses classified as “administrative and general.”

For Canada, we obtained data on administrative costs in Ontario; the categories used appeared similar to those used in the U.S. data.

23

We totaled the administrative costs of Community Care Access Centres,

24

which contract with home care providers; home care providers (White G, Ontario Association of Community Care Access Centres: personal communication); and provincial government oversight of home care. We multiplied the proportion spent for administration by total home care spending throughout Canada.

25

total costs of health care administration

To calculate total spending on health care administration, we totaled the administrative costs of all the categories detailed above. In analyzing the administrative share of health care spending, we excluded from both the numerator and the denominator expenditure categories for which data on administrative costs were unavailable: retail pharmacy sales,

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n engl j med

349;8

www.nejm.org august

21, 2003

costs of health care administration

771

medical equipment and supplies, public health, construction, research, and “other,” a heterogeneous category that includes ambulances and inplant services. These excluded categories accounted for \$261.2 billion, 21.6 percent of U.S. health care expenditures, and \$21.0 billion, 27.6 percent of Canadian health care expenditures.

trends since 1969

The analysis for 1999 relied on several sources of data that were not available for earlier years. To assess trends over time, using previously described methods,

18

we analyzed U.S. Census data on employment in health care settings from the March Current Population Survey for every fifth year since 1969 and the Canadian Census for 1971, 1986, and 1996.

insurance overhead

In 1999 U.S. private insurers retained \$46.9 billion of the \$401.2 billion they collected in premiums. Their average overhead (11.7 percent) exceeded that of Medicare (3.6 percent) and Medicaid (6.8 percent). Overall, public and private insurance overhead totaled \$72.0 billion — 5.9 percent of the total health care expenditures in the United States, or \$259 per capita (Table 1).

The overhead costs of Canada's provincial insurance plans totaled \$311 million (1.3 percent) of the \$23.5 billion they spent for physicians and hospital services. An additional \$17 million was spent to administer federal government health plans. The overhead of Canadian private insurers averaged 13.2 percent of the \$8.4 billion spent for private coverage. Overall, insurance overhead accounted for 1.9 percent of Canadian health care spending, or \$47 per capita (Table 1).

employers' costs to manage health benefits

U.S. employers spent \$12.2 billion on internal administrative costs related to health care benefits and \$3.7 billion on health care benefits consultants — a total of \$15.9 billion, or \$57 per capita (Table 1). Canadian employers spent \$3.6 billion for private health insurance and \$252 million to manage health benefits, or \$8 per capita.

hospital administration

The average U.S. hospital devoted 24.3 percent of spending to administration. Hospital administration consumed \$87.6 billion, or \$315 per capita (Table 1). In Canada, hospital administration cost \$3.1 billion — 12.9 percent of hospital spending, or \$103 per capita.

nursing home administration

California nursing homes devoted 19.2 percent of revenues to administration in 1999. Nationwide, U.S. nursing homes spent \$17.3 billion on administration, or \$62 per capita (Table 1). Administration accounted for 12.2 percent (\$882 million) of Canadian nursing home expenditures, or \$29 per capita.

administrative costs of practitioners

In the United States, administrative tasks consumed 13.5 percent of physicians' time, valued at \$15.5 billion. Physicians spent 8.3 percent of their gross income on clinical employees; the administrative portion (13.5 percent) of compensation of these employees was \$3.0 billion. Physicians' costs for clerical staff averaged 12.3 percent of physicians' gross income, or \$33.1 billion. The one third of physicians' office rent and expenses attributable to administration represented 4.6 percent of physicians' gross income, or \$12.4 billion. Finally, the half of "other professional expenses" (a category that includes accounting and legal fees) attributable to administration accounted for 3.2 percent of physicians'

income, or \$8.6 billion. In total, physicians' administrative work and costs amounted to \$72.6 billion — \$261 per capita, or 26.9 percent of physicians' gross income.

The administrative costs of dentists and of other nonphysician practitioners totaled \$8.6 billion and \$8.8 billion, respectively. Overall, U.S. practitioners' results

Table 1. Costs of Health Care Administration in the United States and Canada, 1999.

Cost Category Spending per Capita (U.S. \$)

United States Canada

Insurance overhead 259 47

Employers' costs to manage health benefits 57 8

Hospital administration 315 103

Nursing home administration 62 29

Administrative costs of practitioners 324 107

Home care administration 42 13

Total 1,059 307

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n engl j med

349;8

www.nejm.org august

21

,
2003

The

new england journal

of

medicine

772

administrative costs amounted to \$89.9 billion, or \$324 per capita (Table 1).

Canadian physicians devoted 8.4 percent of their professional time to practice management and administration, valued at \$592 million. They spent 6.1

percent of their gross income on clinical office staff.

The administrative portion (8.4 percent) of compensation of these employees amounted to \$53 million.

Physicians' costs for clerical staff averaged 6.9 percent of their gross income, or \$716 million. The one third of physicians' office rent and expenses attributable to administration totaled \$193 million. Finally, the 50 percent of "other professional expenses" attributable to administration cost \$116 million.

In total, physicians' administrative work and costs amounted to \$1.7 billion — \$55 per capita, or 16.1 percent of their gross income.

The administrative and billing costs of Canadian dentists and of other nonphysician practitioners totaled \$928 million and \$660 million, respectively.

Overall, the administrative expenses of Canadian practitioners totaled \$3.3 billion, or \$107 per capita (Table 1).

administrative costs of home care agencies

U.S. home care agencies devoted 35.0 percent of total expenditures to administration — \$11.6 billion, or \$42 per capita (Table 1). Administration accounted for 15.8 percent of Ontario's home care expenditures.

Throughout Canada, home care administration expenses totaled \$408 million, or \$13 per capita.

total costs of health care administration

In the United States, health care administration cost \$294.3 billion, or \$1,059 per capita (Table 1). In Canada, health care administration cost \$9.4 billion, or \$307 per capita. If the difference of \$752 per capita were applied to the 1999 U.S. population, the total excess administrative cost would be \$209 billion. After exclusions, administration accounted for 31.0 percent of health care expenditures in the United States, as compared with 16.7 percent of health care expenditures in Canada.

trends in administrative employment in health care

In the United States, 27.3 percent of the 11.77 million people employed in health care settings in 1999 worked in administrative and clerical occupations (Table 2). This figure excludes 926,000 employees in life or health insurance firms, 724,000 in insurance brokerages, and employees of consulting firms.

26

In 1969, administrative and clerical workers represented 18.2 percent of the health care labor force (Table 2). In Canada, administrative and clerical occupations accounted for 19.1 percent of the health care labor force in 1996, 18.7 percent in 1986, and 16.0 percent in 1971. (These figures exclude insurance personnel). Although the United States employed 12 percent more health personnel per capita than Canada, administrative personnel accounted for three quarters of the difference.

Administrators are indispensable to modern health care; their tasks include ensuring that supplies are on hand, that records are filed, and that nurses are paid. Many view intensive, sophisticated management as an attractive solution to cost and quality problems

27-29

; that utilization review, clinical information systems, and quality-improvement programs should upgrade care seems obvious. However, some regard much of administration as superfluous, born of the quirks of the payment system rather than of clinical needs.

How much administration is optimal? Does the high administrative spending in the United States relative to that in Canada (or to that in the United States 30 years ago) improve care? No studies have directly addressed these questions. Although indirect evidence is sparse, analyses of investor-owned HMOs and hospitals — subgroups of providers discussion

* Calculations exclude insurance-industry personnel.

Table 2. Administrative and Clerical Personnel

**as a Percentage of the Health Care Labor Force
in the United States, 1969 through 1999.***

Year Percentage of Health Care Labor Force

1969 18.2
1974 21.2
1979 21.9
1984 23.9
1989 25.5
1994 25.7
1999 27.3

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n engl j med

349;8

www.nejm.org august

21, 2003

costs of health care administration

773

with relatively high administrative costs — have found that for-profit facilities have neither higher-quality care nor lower costs than not-for-profit facilities.

15,30-38

Internationally, administrative expenditures show little relation to overall growth

in costs or to life expectancy or other health indicators.

39

Several factors augment U.S. administrative costs. Private insurers, which have high overhead in most nations — 15.8 percent in Australia, 13.2 percent in Canada, 20.4 percent in Germany, and 10.4 percent in the Netherlands

40

— have a larger role in the United States than in Canada. Functions essential to private insurance but absent in public programs, such as underwriting and marketing, account for about two thirds of private insurers' overhead.

40

A system with multiple insurers is also intrinsically costlier than a single-payer system. For insurers it means multiple duplicative claims-processing facilities and smaller insured groups, both of which increase overhead.

41,42

Fragmentation also raises costs for providers who must deal with multiple insurance products — at least 755 in Seattle alone

43

— forcing them to determine applicants' eligibility and to keep track of the various copayments, referral networks, and approval requirements. Canadian physicians send virtually all bills to a single insurer. A multiplicity of insurers also precludes paying hospitals a lump-sum, global budget. Under a global-budget system, hospitals and government authorities negotiate an annual budget based on past budgets, clinical performance, and projected changes in services and input costs. Hospitals receive periodic lump-sum payments (e.g.,

1

/

12

of the annual amount each month).

The existence of global budgets in Canada has eliminated most billing and minimized internal cost accounting, since charges do not need to be attributed to individual patients and insurers. Yet fragmentation itself cannot explain the upswing in administrative costs in the United States since 1969, when costs resembled those in Canada. This growth coincided with the expansion of managed care and market-based competition, which fostered the adoption of complex accounting and auditing practices long standard in the business world.

Several caveats apply to our estimates. U.S. and Canadian hospitals, nursing homes, and home care agencies use different accounting categories, though we took pains to ensure that they were comparable. The U.S. hospital figure is consistent with findings from detailed studies of individual hospitals.

44-47

The California data we used to estimate the administrative costs of U.S. nursing homes resulted in a lower figure (19.2 percent of revenues) than a published national estimate for 1998 (25.2 percent).

48

Our figures for physicians' administrative costs relied on self-reports of time and money spent. We had to estimate the time spent by other clinical personnel on administrative work and the share of office rent and expenses attributable to administration (together, these estimated categories account for 5 percent of total administrative costs in the United States). Physicians' reports and our estimates appear congruent with information from a time-motion study

45

and Census data on clerical and administrative personnel employed in practitioners' offices.

Our estimates of employers' costs to administer health care benefits rely on a consultant's survey of

* Data are from the Annual Reports filed with the Securities and Exchange Commission,

49

the Government of Saskatchewan,

50

and the Government of Ontario.

51

† Numbers include administrative-services-only contracts as well as Medicare, Medicaid, and commercial enrollees; numbers exclude recipients of pharmacy-benefit management, life, dental, other specialty, and nonhealth insurance products.

‡ The estimate is based on wage and salary expenses and on the assumption that the average annual wage is \$38,250.

Table 3. Number of Enrollees and Employees of Selected Major U.S. Private Health Insurers and Canadian Provincial Health Plans, 2001.*

Plan Name
No. of Enrollees†

**No. of
Employees
No. of
Employees/
10,000 Enrollees
U.S. plans**

Aetna 17,170,000 35,700 20.8
Anthem 7,883,000 14,800 18.8
Cigna 14,300,000 44,600 31.2
Humana 6,435,800 14,500 22.5
Mid Atlantic Medical Services 1,832,400 2,571 14.0
Oxford 1,490,600 3,400 22.8
Pacificare 3,388,100 8,200 24.2
United Healthcare 8,540,000 30,000 35.1
WellPoint 10,146,945 13,900 13.7

Canadian plans

Saskatchewan Health 1,021,288 145 1.4
Ontario Health Insurance
Plan
11,742,672 1,433 1.2

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n engl j med

349;8

www.nejm.org august

21

,
2003

The

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of

medicine

774

a limited number of U.S. firms. Though subject to error, this category accounts for only 5 percent of administrative costs in the United States.

Cross-national comparisons are complicated by differences in the range of services offered in hospitals and outpatient settings. For instance, many U.S. hospitals operate skilled-nursing facilities, whose costs are lumped with hospital costs in the national health accounts. Similarly, the costs of free-standing surgical centers, more common in the United States than in Canada, are lumped with practitioner costs. Although these differences shift administrative costs among categories (e.g., from nursing homes to hospitals), their effects on national totals should be small.

Price differences also affect international comparisons, a problem only partially addressed by our use of purchasing-power parities to convert Canadian dollars to U.S. dollars. (Using exchange rates instead would increase the difference between the United States and Canada by 27 percent.) Canadian wages are slightly lower than those in the United States, distorting some comparisons (e.g., per capita spending), but not others (e.g., the administrative share of health care spending or personnel).

Our dollar estimates understate overhead costs in both nations. They exclude the marketing costs of pharmaceutical firms, the value of patients' time spent on paperwork, and most of the costs of advertising by providers, health care industry profits, and

lobbying and political contributions. Our analysis also omits the costs of collecting taxes to fund health care and the administrative overhead of such businesses as retail pharmacies and ambulance companies. Finally, we priced practitioners' administrative time using their net, rather than gross, hourly income, conservatively assuming that when physicians substitute clinical for administrative time, their overhead costs rise proportionally; using gross hourly income would boost our estimate of total administrative costs in the United States to \$320.1 billion.

The employment figures used for our time-trend analysis exclude administrative employees in consulting firms, drug companies, and retail pharmacies, as well as insurance workers, who are far more numerous in the United States than in Canada

49-51

(Table 3).

Despite these imprecisions, the difference in the costs of health care administration between the United States and Canada is clearly large and growing.

Is \$294.3 billion annually for U.S. health care administration money well spent?

Supported by a grant (036617) from the Robert Wood Johnson Foundation.

We are indebted to Geoff Ballinger and Gilles Fortin for their invaluable assistance in securing and analyzing data on Canadian administrative costs and the comparability of U.S. and Canadian cost categories.

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Single solution

One universal health care system answers all the questions

Tim Joseph

Sunday, November 4, 2007

Gov. Eliot Spitzer has formed a task force to examine how to achieve universal health care access in New York. There are two fundamentally different approaches that can be taken to solve the problem.

One is to build on the current patchwork of employer-provided insurance, Medicare, Medicaid, Child Health Plus, Family Health Plus, individual pay as you go, indigent care provided by emergency rooms, etc. This approach involves making the health care system more complicated by adding patches to cover people currently left out.

The other approach is to replace the current system with a single government-managed health insurance system, sometimes called "single payer" or "Medicare for all."

As an elected county leader, I find that a tremendous amount of my time, and my county's budget, is devoted to one or another aspect of health care for some segment of our citizens. Nearly all of that time is devoted not to delivering health care, but to sorting out who will pay for it.

A big advantage of a single-payer system, compared with our current patchwork, is that it resolves this issue once and for all, and thus offers substantial savings in administrative costs.

Every estimate I've seen of those savings overlooks the myriad hidden costs associated with our current system. Here are just a few of those costs I encounter every day:

My county, like every county in the state, has an Office for the Aging. We have a 10-person staff. The largest part of their work consists of helping seniors navigate the health care system, find programs available to help them, and plan how they will manage health care costs now and in the future.

Our personnel department includes a full-time benefits manager who is mostly occupied with assisting employees in dealing with the health insurance program. Those employees lose productive work time consulting with the benefits manager and fighting insurance company denials, which can take hours from the workday.

When we negotiate with our employee unions, health care is always the biggest topic. We have a health care consultant on retainer to help us examine and cost out plan changes that we present to our unions in an attempt to control costs. At least two-thirds of the staff time devoted to collective bargaining is spent on health care issues.

We devoted hundreds of hours of staff time to developing and publicizing a discount prescription card available to all county residents to reduce drug costs for those without insurance.

We have a \$400,000 state grant to form a health insurance consortium among local governments to purchase employee health care as a larger group. We will hire a consultant to help us form that consortium and find a suitable plan. Various county staff devotes substantial time to this project.

We have staff in our mental health, public health and social services departments devoted to collecting fees from private insurers to reduce the public cost of programs that deliver various health services.

We have people waiting in jail whom judges are prepared to release to drug or alcohol treatment programs as soon as we can assure payment to the treatment center. Staff in local agencies and our Department of Social Services work on getting these inmates into health care programs, mainly Medicaid, that will cover treatment. Meanwhile, we pay the cost of incarceration.

Our economic development staff encounters aspiring entrepreneurs who would like to start their own businesses, but are tied to a job by the health insurance benefits. Meanwhile, new businesses often have trouble attracting the employees they need, because they cannot yet offer a health plan.

We have staff who don't like their jobs and perform at less than the desired level, but who remain because they need the health insurance.

Nurses and other health care professionals routinely leave direct service to take jobs in insurance companies, contributing to our severe shortage of nurses and physicians.

This is just a partial list of the many ways county government and local economies spend time and money dealing with the question of who will pay for health care.

None of these costs are ever included in comparisons between single-payer and other health care systems, but every one of them would go away if there was a single, simple and consistent answer to the question, "Who will pay?"

Only a single-payer system will accomplish that.

Nation's healthcare crisis gets personal

By David Lazarus

Los Angeles Times

October 7, 2007

I write a lot about healthcare reform. Now it's personal.

I was diagnosed this past week with diabetes. As of Friday, I was injecting myself with insulin, something I'll be doing four or five times a day, every day, for the rest of my life. Without the injections, I'll likely die.

Scared? You're damn right I'm scared. What's going to happen to me? What's going to happen to my family?

I got past the shock pretty quickly and am now stuck somewhere between denial and anger. Depression will soon arrive, followed eventually by acceptance. Something to look forward to.

This is an uncertain time for me, but I know this much: I'm more convinced than ever that our medical system is a mess and that a single-payer insurance program is the only realistic way we can achieve universal coverage, promote preventive treatment and make healthcare affordable to all.

And if contracting diabetes is frightening for a relatively well-insured person like myself, what must it be like for any of the 47 million Americans who lack health insurance?

According to the American Diabetes Assn., nearly 21 million U.S. adults and kids have the disease — 7% of the population. About 15 million of this number have been diagnosed. The rest have no idea that they're afflicted.

With obesity rates soaring, as many as 54 million others are strongly at risk of contracting diabetes in the future.

In my case, diabetes struck not because I stuff my face with Big Macs and fried chicken, which I don't. I take good care of myself and am not overweight — considerably less so since unexpectedly dropping about 15 pounds over the past couple of months.

No, it's almost certain I got nailed because a genetic time bomb finally exploded.

My father, Paul N. Lazarus III, who produced the movies "Westworld" and "Capricorn One," has Type 1 diabetes and is now nearly blind. My younger brother has Type 1 and is doing well enough. My aunt had Type 1 before it blinded and then killed her.

The doctors say diabetes — almost certainly Type 1 — has been lurking in my DNA since I was a child, waiting for its time to strike.

But why now? I've lived 46 fairly healthy years, except for certain pharmaceutical pursuits during college. I don't drink. I don't smoke. I exercise as regularly as I can. What did I do wrong?

Probably nothing. The stress of my recent move to L.A. and starting a new job didn't help, but it's not to blame. This was going to happen no matter what.

I had a good idea something was wrong when I noticed that my weight kept going down no matter what I ate, and that I was consumed with a thirst of biblical proportions (accompanied by a commensurate increase in bathroom breaks).

I visited my doctor and had a blood test. The bad news came just days later. I was immediately referred to a specialist, whom I'll call Dr. B.

Dr. B was great — knowledgeable, sensitive, empathetic. Problem was, Dr. B didn't take insurance.

Excuse me? I said.

Dr. B explained that it just wasn't cost-effective for him to seek reimbursement from insurance companies. It was too much hassle, he said, and he didn't get paid enough for his efforts. Dr. B said an increasing number of doctors were cutting ties with insurers for the same reasons.

If I wanted to see him at his private practice, which was most convenient to my home, each visit could cost me hundreds of dollars — not the most appealing prospect when one's facing a chronic disease.

Dr. B said I could try to deal with insurance reimbursements on my own, but that's the last headache I wanted to inflict on myself at this point.

So I had to quickly find a doctor who would take insurance. My insurer's website had a directory of possible choices, but you're essentially pulling a name out of a hat — not the best way to make decisions when your blood-sugar level is three or four times normal.

This led me to Dr. W, who was equally knowledgeable if perhaps a bit lacking in the empathy department. He also had what seemed to me unconventional ideas about how diabetes can be treated with certain drugs and a rigidly monastic diet of his own devising.

This ultimately led me to Dr. D at UCLA's Gonda (Goldschmied) Diabetes Center, whom I'm very fortunate to have found. Not only does he know what he's doing, but he also has the resources of a world-class medical facility that focuses exclusively on what's trying to put me under dirt.

It was Dr. D who finally made the call that I needed to start insulin injections, and it was he who made sure I knew how to handle that first, life-changing moment when needle touched skin.

Clearly I'm receiving the best available treatment, and I'd rather be here than anywhere in the world.

But the quirks and complexities of the insurance system border on madness. Through my employer, I have about as much insurance coverage as anyone. Yet that wasn't good enough for Dr. B.

I have to wonder where else my private-sector insurance will fail me in years ahead.

And what happens if I get fired tomorrow? With a preexisting condition, I'm virtually uninsurable in the individual insurance market. Will diabetes leave my family destitute?

In the past, I always wrote about the uninsured in a largely abstract way — a faceless mass of millions of people confronted with a broadly defined medical challenge. I know better now.

The terrifying possibility of my own loss of coverage gives me an acute sense of what the uninsured must deal with, the dreadful awareness that you and your loved ones are only one medical misstep from catastrophe.

That's unacceptable for any person who lives in the wealthiest, most advanced nation in the history of the world.

I'll have a lot more to say about this in the future, especially as my own situation takes shape. But this much at least is evident:

- Universal coverage must be our goal, and it must allow ready access to all aspects of the medical system at affordable prices.
- The emphasis must be on treatment, not bureaucracy. As it stands, researchers at Harvard University estimate that about a third of the \$2 trillion in annual healthcare spending is squandered on bureaucratic overhead.
- Employer-based healthcare is obsolete. As costs continue climbing, businesses can no longer meet their historical obligation of being the primary provider of coverage to American families.
- Quality medical treatment is a right, not a benefit.

Unfortunately, nearly all healthcare-reform proposals on the table center on expanding the existing system and pushing the uninsured into high-cost individual policies that will make private insurers even more profitable.

That can't be the answer.

Single-payer isn't perfect. Critics say it can involve long waits for treatment and can stifle innovation.

My belief is that Americans can get it right. We can learn from the examples of other nations and refine things so that our healthcare is second to none. It won't be easy. Then again, how much worse could it be than the way things are now?

As of this moment, I'm completely dependent on the U.S. healthcare system to keep me alive. I, and you, shouldn't have to settle for anything but the best.

We Have Seen the Enemy – And Surrendered

Barbara Ehrenreich

Bow your heads and raise the white flags. After facing down the Third Reich, the Japanese Empire, the U.S.S.R., Manuel Noriega and Saddam Hussein, the United States has met an enemy it dares not confront — the American private health insurance industry.

With the courageous exception of Dennis Kucinich, the Democratic candidates have all rolled out health “reform” plans that represent total, Chamberlain-like, appeasement. Edwards and Obama propose universal health insurance plans that would in no way ease the death grip of Aetna, Unicare, MetLife, and the rest of the evil-doers. Clinton — why are we not surprised? — has gone even further, borrowing the Republican idea of actually feeding the private insurers by making it mandatory to buy their product. Will I be arrested if I resist paying \$10,000 a year for a private policy laden with killer co-pays and deductibles?

It’s not only the Democratic candidates who are capitulating. The surrender-buzz is everywhere. I heard it from a notable liberal political scientist on a panel in August: We can’t just leap to a single payer system, he said in so many words, because it would be too disruptive, given the size of the private health insurance industry. Then I heard it yesterday from a Chicago woman who leads a nonprofit agency serving the poor: How can we go to a Canadian-style system when the private industry has gotten so “big”?

Yes, it is big. Leighton Ku, at the Center for Budget and Policy Priorities, gave me the figure of \$776 billion in expenditures on private health insurance for this year. It’s also a big-time employer, paying what economist Paul Krugman has estimated two to three million people just turn down claims.

This in turn generates ever more employment in doctors’ offices to battle the insurance companies. Dr. Atul Gawande, a practicing physician, wrote in *The New Yorker* that “a well-run office can get the insurer’s rejection rate down from 30 percent to, say, 15 percent. That’s how a doctor makes money. It’s a war with insurance, every step of the way.” And that’s another thing your insurance premium has to pay for: the ongoing “war” between doctors and insurers.

Note: The private health insurance industry is not big because it relentlessly seeks out new customers. Unlike any other industry, this one grows by rejecting customers. No matter how shabby you look, Cartier, Lexus, or Nordstrom’s will happily take your money. Not Aetna. If you have a prior conviction — excuse me, a pre-existing condition — it doesn’t want your business. Private health insurance is only for people who aren’t likely to ever get sick. In fact, why call it “insurance,” which normally embodies the notion of risk-sharing? This is extortion.

Think of the damage. An estimated 18,000 Americans die every year because they can’t afford or can’t qualify for health insurance. That’s the 9/11 carnage multiplied by three — every year. Not to mention all the people who are stuck in jobs they hate because they don’t dare lose their current insurance.

Saddam Hussein never killed 18,000 Americans or anything close; nor did the U.S.S.R. Yet we faced down those “enemies” with huge patriotic bluster, vast military expenditures, and, in the case of Saddam, armed intervention. So why does the U.S. soil its pants and cower in fear when confronted with the insurance industry?

Here's a plan: First, locate the major companies. No major intelligence effort will be required, since Google should suffice. Second, estimate their armed strength. No doubt there are legions of security guards involved in protecting the company headquarters from irate consumers, but these should be manageable with a few brigades. Next, consider an air strike, followed by an infantry assault.

And what about the two to three million insurance industry employees whose sole job it is to turn down claims? Well, I have a plan for them: It's called unemployment. What country in its right mind would pay millions of people to deny other people health care?

I'm not mean, though. If we had the kind of universal, single-payer, health insurance Kucinich is advocating, private health insurance workers would continue to be covered even after they are laid off. As for the health insurance company executives, there should be an adequate job training program for them — perhaps as home health aides.

Fellow citizens, where is the old macho spirit that has sustained us through countless conflicts against enemies both real and imagined? In the case of health care, we have identified the enemy, and the time has come to crush it.

THE PLAN

A National Health Program for the United States: A Physician's Proposal

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Abstract:

Our health care system is failing. Tens of millions of people are uninsured, costs are skyrocketing, and the bureaucracy is expanding. Patchwork reforms succeed only in exchanging old problems for new ones. It is time for basic change in American medicine. We propose a national health program that would (1) fully cover everyone under a single, comprehensive public insurance program; (2) pay hospitals and nursing homes a total (global) annual amount to cover all operating expenses; (3) fund capital costs through separate appropriations; (4) pay for physicians' services and ambulatory services in any of three ways: through fee-for-service payments with a simplified fee schedule and mandatory acceptance of the national health program payment as the total payment for a service or procedure (assignment), through global budgets for hospitals and clinics employing salaried physicians, or on a per capita basis (capitation); (5) be funded, at least initially, from the same sources as at present, but with payments disbursed from a single pool; and (6) contain costs through savings on billing and bureaucracy, improved health planning, and the ability of the national health program, as the single payer for services to establish overall spending limits. Through this proposal, we hope to provide a pragmatic framework for public debate of fundamental health-policy reform. (N Engl J Med 1989; 320: 102-8.)

Full Text:

OUR health care system is failing. It denies access to many in need and is expensive, inefficient, and increasingly bureaucratic. The pressures of cost control, competition, and profit threaten the traditional tenets of medical practice. For patients, the misfortune of illness is often amplified by the fear of financial ruin. For physicians, the gratifications of healing often give way to anger and alienation. Patchwork reforms succeed only in exchanging old problems for new ones. It is time to change fundamentally the trajectory of American medicine - to develop a comprehensive national health program for the United States.

We are physicians active in the full range of medical endeavors. We are primary care doctors and surgeons, psychiatrists and public health specialists, pathologists and administrators. We work in hospitals, clinics, private practices, health maintenance organizations (HMOs), universities, corporations, and public agencies. Some of us are young, still in training; others are greatly experienced, and some have held senior positions in American medicine.

As physicians, we constantly confront the irrationality of the present health care system. In private practice, we waste countless hours on billing and bureaucracy. For uninsured patients, we avoid procedures, consultations, and costly medications. Diagnosis-related groups (DRGs) have placed us between administrators demanding early discharge and elderly patients with no one to help at home - all the while glancing over our shoulders at the peer-review organization. In HMOs we walk a tightrope between thrift and penuriousness, too often under the pressure of surveillance by bureaucrats more concerned with the bottom line than with other measures of achievement. In public health work we are frustrated in the face of plenty;

the world's richest health care system is unable to ensure such basic services as prenatal care and immunizations.

Despite our disparate perspectives, we are united by dismay at the current state of medicine and by the conviction that an alternative must be developed. We hope to spark debate, to transform disaffection with what exists into a vision of what might be. To this end, we submit for public review, comment, and revision a working plan for a rational and humane health care system - a national health program.

We envisage a program that would be federally mandated and ultimately funded by the federal government but administered largely at the state and local level. The proposed system would eliminate financial barriers to care; minimize economic incentives for both excessive and insufficient care, discourage administrative interference and expense, improve the distribution of health facilities, and control costs by curtailing bureaucracy and fostering health planning. Our plan borrows many features from the Canadian national health program and adapts them to the unique circumstances of the United States. We suggest that, as in Canada's provinces, the national health program be tested initially in statewide demonstration projects. Thus, our proposal addresses both the structure of the national health program and the transition process necessary to implement the program in a single state. In each section below, we present a key feature of the proposal, followed by the rationale for our approach. Areas such as long-term care; public, occupational, environmental, and mental health; and medical education need much more development and will be addressed in detail in future proposals.

COVERAGE

Everyone would be included in a single public plan covering all medically necessary services, including acute, rehabilitative, long-term, and home care; mental health services; dental services; occupational health care; prescription drugs and medical supplies; and preventive and public health measures. Boards of experts and community representatives would determine which services were unnecessary or ineffective, and these would be excluded from coverage. As in Canada, alternative insurance coverage for services included under the national health program would be eliminated, as would patient copayments and deductibles.

Universal coverage would solve the gravest problem in health care by eliminating financial barriers to care. A single comprehensive program is necessary both to ensure equal access to care and to minimize the complexity and expense of billing and administration. The public administration of insurance funds would save tens of billions of dollars each year. The more than 1500 private health insurers in the United States now consume about 8 percent of revenues for overhead, whereas both the Medicare program and the Canadian national health program have overhead costs of only 2 to 3 percent. The complexity of our current insurance system, with its multiplicity of payers, forces U .S. hospitals to spend more than twice as much as Canadian hospitals on billing and administration and requires U .S. physicians to spend about 10 percent of their gross incomes on excess billing costs.¹ Eliminating insurance programs that duplicated the national health program coverage, though politically thorny, would clearly be within the prerogative of the Congress.² Failure to do so would require the continuation of the costly bureaucracy necessary to administer and deal with such programs.

Copayments and deductibles endanger the health of poor people who are sick,³ decrease the use of vital inpatient medical services as much as they discourage the use of unnecessary ones,⁴ discourage preventive care,⁵ and are unwieldy and expensive to administer. Canada

has few such charges, yet health costs are lower than in the United States and have risen slowly.^{6,7} In the United States, in contrast, increasing copayments and deductibles have failed to slow the escalation of costs.

Instead of the confused and often unjust dictates of insurance companies, a greatly expanded program of technology assessment and cost-effectiveness evaluation would guide decisions about covered services, as well as about the allocation of funds for capital spending, drug formularies, and other issues.

PAYMENT FOR HOSPITAL SERVICES

Each hospital would receive an annual lump-sum payment to cover all operating expenses - a "global" budget. The amount of this payment would be negotiated with the state national health program payment board and would be based on past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and other costs, and proposed new and innovative programs. Hospitals would not bill for services covered by the national health program. No part of the operating budget could be used for hospital expansion, profit, marketing, or major capital purchases or leases. These expenditures would also come from the national health program fund, but monies for them would be appropriated separately.

Global prospective budgeting would simplify hospital administration and virtually eliminate billing, thus freeing up substantial resources for increased clinical care. Before the nationwide implementation of the national health program, hospitals in the states with demonstration programs could bill out-of-state patients on a simple per diem basis. Prohibiting the use of operating funds for capital purchases or profit would eliminate the main financial incentive for both excessive intervention (under fee-for-service payment) and skimping on care (under DRG-type prospective-payment systems), since neither inflating revenues nor limiting care could result in gain for the institution. The separate appropriation of funds explicitly designated for capital expenditures would facilitate rational health planning. In Canada, this method of hospital payment has been successful in containing costs, minimizing bureaucracy, improving the distribution of health resources, and maintaining the quality of care.⁶⁻⁹ It shifts the focus of hospital administration away from the bottom line and toward the provision of optimal clinical services.

PAYMENT FOR PHYSICIANS' SERVICES, AMBULATORY CARE, AND MEDICAL HOME CARE

To minimize the disruption of existing patterns of care, the national health program would include three payment options for physicians and other practitioners: fee-for-service payment, salaried positions in institutions receiving global budgets, and salaried positions within group practices or HMOs receiving per capita (capitation) payments.

Fee-for-Service Payment

The state national health program payment board and a representative of the fee-for-service practitioners (perhaps the state medical society) would negotiate a simplified, binding fee schedule. Physicians would submit bills to the national health program on a simple form or by computer and would receive extra payment for any bill not paid within 30 days. Payments to physicians would cover only the services provided by physicians and their support staff and would exclude reimbursement for costly capital purchases of equipment for the office, such as

CT scanners. Physicians who accepted payment from the national health program could bill patients directly only for uncovered services (as is done for cosmetic surgery in Canada).

Global Budgets

Institutions such as hospitals, health centers, group practices, clinics serving migrant workers, and medical home care agencies could elect to receive a global budget for the delivery of outpatient, home care, and physicians' services, as well as for preventive health care and patient-education programs. The negotiation process and the regulations covering capital expenditures and profits would be similar to those for inpatient hospital services. Physicians employed in such institutions would be salaried.

Capitation

HMOs, group practices, and other institutions could elect to be paid fees on a per capita basis to cover all outpatient care, physicians' services, and medical home care. The regulations covering the use of such payments for capital expenditures and for profits would be similar to those that would apply to hospitals. The capitation fee would not cover inpatient services (except care provided by a physician), which would be included in hospitals' global budgets. Selective enrollment policies would be prohibited, and patients would be permitted to leave an HMO or other health plan with appropriate notice. Physicians working in HMOs would be salaried, and financial incentives to physicians based on the HMO's financial performance would be prohibited.

The diversity of existing practice arrangements, each with strong proponents, necessitates a pluralistic approach. Under all three proposed options, capital purchases and profits would be uncoupled from payments to physicians and other operating costs - a feature that is essential for minimizing entrepreneurial incentives, containing costs, and facilitating health planning.

Under the fee-for-service option, physicians' office overhead would be reduced by the simplification of billing.¹ The improved coverage would encourage preventive care.¹⁰ In Canada, fee-for-service practice with negotiated fee schedules and mandatory assignment (acceptance of the assigned fee as total payment) has proved to be compatible with cost containment, adequate incomes for physicians, and a high level of access to and satisfaction with care on the part of patients.^{6,7} The Canadian provinces have responded to the inflationary potential of fee-for-service payment in various ways: by limiting the number of physicians, by monitoring physicians for outlandish practice patterns, by setting overall limits on a province's spending for physicians' services (thus relying on the profession to police itself), and even by capping the total reimbursement of individual physicians. These regulatory options have been made possible (and have not required an extensive bureaucracy) because all payment comes from a single source. Similar measures might be needed in the United States, although our penchant for bureaucratic hypertrophy might require a concomitant cap on spending for the regulatory apparatus. For example, spending for program administration and reimbursement bureaucracy might be restricted to 3 percent of total costs.

Global budgets for institutional providers would eliminate billing, while providing a predictable and stable source of income. Such funding could also encourage the development of preventive health programs in the community, such as education programs on the acquired immunodeficiency syndrome (AIDS), whose costs are difficult to attribute and bill to individual patients.

Continuity of care would no longer be disrupted when patients' insurance coverage changed as a result of retirement or a job change. Incentives for providers receiving capitation payments to skimp on care would be minimized, since unused operating funds could not be devoted to expansion or profit.

PAYMENT FOR LONG-TERM CARE

A separate proposal for long-term care is under development, guided by three principles. First, access to care should be based on need rather than on age or ability to pay. Second, social and community-based services should be expanded and integrated with institutional care. Third, bureaucracy and entrepreneurial incentives should be minimized through global budgeting with separate funding for capital expenses.

ALLOCATION OF CAPITAL FUNDS, HEALTH PLANNING, AND RETURN ON EQUITY

Funds for the construction or renovation of health facilities and for purchases of major equipment would be appropriated from the national health program budget. The funds would be distributed by state and regional health-planning boards composed of both experts and community representatives. Capital projects funded by private donations would require approval by the health-planning board if they entailed an increase in future operating expenses.

The national health program would pay owners of for-profit hospitals, nursing homes, and clinics a reasonable fixed rate of return on existing equity. Since virtually all new capital investment would be funded by the national health program, it would not be included in calculating the return on equity.

Current capital spending greatly affects future operating costs, as well as the distribution of resources. Effective health planning requires that funds go to high-quality, efficient programs in the areas of greatest need. Under the existing reimbursement system, which combines operating and capital payments, prosperous hospitals can expand and modernize, whereas impoverished ones cannot, regardless of the health needs of the population they serve or the quality of services they provide. The national health program would replace this implicit mechanism for distributing capital with an explicit one, which would facilitate (though not guarantee) allocation on the basis of need and quality. Insulating these crucial decisions from distortion by narrow interests would require the rigorous evaluation of the technology and assessment of needs, as well as the active involvement of providers and patients.

For-profit providers would be compensated for existing investments. Since new for-profit investment would be barred, the proprietary sector would gradually shrink.

PUBLIC, ENVIRONMENTAL, AND OCCUPATIONAL HEALTH SERVICES

Existing arrangements for public, occupational, and environmental health services would be retained in the short term. Funding for preventive health care would be expanded. Additional proposals dealing with these issues are planned.

PRESCRIPTION DRUGS AND SUPPLIES

An expert panel would establish and regularly update a list of all necessary and useful drugs and outpatient equipment. Suppliers would bill the national health program directly for the

wholesale cost, plus a reasonable dispensing fee, of any item in the list that was prescribed by a licensed practitioner. The substitution of generic for proprietary drugs would be encouraged.

FUNDING

The national health program would disburse virtually all payments for health services. The total expenditure would be set at the same proportion of the gross national product as health costs represented in the year preceding the establishment of the national health program. Funds for the national health program could be raised through a variety of mechanisms. In the long run, funding based on an income tax or other progressive tax might be the fairest and most efficient solution, since tax-based funding is the least cumbersome and least expensive mechanism for collecting money. During the transition period in states with demonstration programs, the following structure would mimic existing funding patterns and minimize economic disruption.

Medicare and Medicaid

All current federal funds allocated to Medicare and Medicaid would be paid to the national health program. The contribution of each program would be based on the previous year's expenditures, adjusted for inflation. Using Medicare and Medicaid funds in this manner would require a federal waiver.

State and Local Funds

All current state and local funds for health care expenditures, adjusted for inflation, would be paid to the national health program.

Employer Contributions

A tax earmarked for the national health program would be levied on all employers. The tax rate would be set so that total collections equaled the previous year's statewide total of employers' expenditures for health benefits, adjusted for inflation. Employers obligated by preexisting contracts to provide health benefits could credit the cost of those benefits toward their national health program tax liability.

Private Insurance Revenues

Private health insurance plans duplicating the coverage of the national health program would be phased out over three years. During this transition period, all revenues from such plans would be turned over to the national health program, after the deduction of a reasonable fee to cover the costs of collecting premiums.

General Tax Revenues

Additional taxes, equivalent to the amount now spent by individual citizens for insurance premiums and out-of-pocket health costs, would be levied.

It would be critical for all funds for health care to flow through the national health program. Such single-source payment (monopsony) has been the cornerstone of cost containment and health planning in Canada. The mechanism of raising funds for the national health program would be a matter of tax policy, largely separate from the organization of the health care

system itself. As in Canada, federal funding could attenuate inequalities among the states in financial and medical resources.

The transitional proposal for demonstration programs in selected states illustrates how monopsony payment could be established with limited disruption of existing patterns of health care funding. The employers' contribution would represent a decrease in costs for most firms that now provide health insurance and an increase for those that do not currently pay for benefits. Some provision might be needed to cushion the impact of the change on financially strapped small businesses. Decreased individual spending for health care would offset the additional tax burden on individual citizens. Private health insurance, with its attendant inefficiency and waste, would be largely eliminated. A program of job placement and retraining for insurance and hospital-billing employees would be an important component of the program during the transition period.

DISCUSSION

The Patient's View

The national health program would establish a right to comprehensive health care. As in Canada, each person would receive a national health program card entitling him or her to all necessary medical care without copayments or deductibles. The card could be used with any fee-for-service practitioner and at any institution receiving a global budget. HMO members could receive nonemergency care only through their HMO, although they could readily transfer to the non-HMO option.

Thus, patients would have a free choice of providers, and the financial threat of illness would be eliminated. Taxes would increase by an amount equivalent to the current total of medical expenditures by individuals. Conversely, individuals' aggregate payments for medical care would decrease by the same amount.

The Practitioner's View

Physicians would have a free choice of practice settings. Treatment would no longer be constrained by the patient's insurance status or by bureaucratic dicta. On the basis of the Canadian experience, we anticipate that the average physician's income would change little, although differences among specialties might be attenuated.

Fee-for-service practitioners would be paid for the care of anyone not enrolled in an HMO. The entrepreneurial aspects of medicine - with the attendant problems as well as the possibilities - would be limited. Physicians could concentrate on medicine; every patient would be fully insured, but physicians could increase their incomes only by providing more care. Billing would involve imprinting the patient's national health program card on a charge slip, checking a box to indicate the complexity of the procedure or service, and sending the slip (or a computer record) to the physician-payment board. This simplification of billing would save thousands of dollars per practitioner in annual office expenses.

Bureaucratic interference in clinical decision making would sharply diminish. Costs would be contained by controlling overall spending and by limiting entrepreneurial incentives, thus obviating the need for the kind of detailed administrative oversight that is characteristic of the DRG program and similar schemes. Indeed, there is much less administrative intrusion in day-

to-day clinical practice in Canada (and most other countries with national health programs) than in the United States.^{11,12}

Salaried practitioners would be insulated from the financial consequences of clinical decisions. Because savings on patient care could no longer be used for institutional expansion or profits, the pressure to skimp on care would be minimized.

The Effect on Other Health Workers

Nurses and other health care personnel would enjoy a more humane and efficient clinical milieu. The burdens of paperwork associated with billing would be lightened. The jobs of many administrative and insurance employees would be eliminated, necessitating a major effort at job placement and retraining. We advocate that many of these displaced workers be deployed in expanded programs of public health, health promotion and education, and home care and as support personnel to free nurses for clinical tasks.

The Effect on Hospitals

Hospitals' revenues would become stable and predictable. More than half the current hospital bureaucracy would be eliminated,¹ and the remaining administrators could focus on facilitating clinical care and planning for future health needs.

The capital budget requests of hospitals would be weighed against other priorities for health care investment. Hospitals would neither grow because they were profitable nor fail because of unpaid bills - although regional health planning would undoubtedly mandate that some expand and others close or be put to other uses. Responsiveness to community needs, the quality of care, efficiency, and innovation would replace financial performance as the bottom line. The elimination of new for-profit investment would lead to a gradual conversion of proprietary hospitals to not-for-profit status.

The Effect on the Insurance Industry

The insurance industry would feel the greatest impact of this proposal. Private insurance firms would have no role in health care financing, since the public administration of insurance is more efficient^{1,13} and single-source payment is the key to both equal access and cost control. Indeed, most of the extra funds needed to finance the expansion of care would come from eliminating the overhead and profits of insurance companies and abolishing the billing apparatus necessary to apportion costs among the various plans.

The Effect on Corporate America

Firms that now provide generous employee health benefits would realize savings, because their contribution to the national health program would be less than their current health insurance costs. For example, health care expenditures by Chrysler, currently \$5,300 annually per employee,¹⁴ would fall to about \$1,600, a figure calculated by dividing the total current U.S. spending on health by private employers by the total number of full-time-equivalent, nongovernment employees. Since most firms that compete in international markets would save money, the competitiveness of U.S. products would be enhanced. However, costs would increase for companies that do not now provide health benefits. The average health care costs for employers would be unchanged in the short run. In the long run, overall health costs would rise less steeply because of improved health planning and greater efficiency. The funding mechanism ultimately adopted would determine the corporate share of those costs.

Health Benefits and Financial Costs

There is ample evidence that removing financial barriers to health care encourages timely care and improves health. After Canada instituted a national health program, visits to physicians increased among patients with serious symptoms.¹⁵ Mortality rates, which were higher than U.S. rates through the 1950s and early 1960s, fell below those in the United States.¹⁶ In the Rand Health Insurance Experiment, free care reduced the annual risk of dying by 10 percent among the 25 percent of U.S. adults at highest risk.³ Conversely, cuts in California's Medicaid program led to worsening health.¹⁷ Strong circumstantial evidence links the poor U.S. record on infant mortality with inadequate access to prenatal care.¹⁸

We expect that the national health program would cause little change in the total costs of ambulatory and hospital care; savings on administration and billing (about 10 percent of current health spending) would approximately offset the costs of expanded services.^{19,20} Indeed, current low hospital-occupancy rates suggest that the additional care could be provided at low cost. Similarly, many physicians with empty appointment slots could take on more patients without added office, secretarial, or other overhead costs. However, the expansion of long-term care (under any system) would increase costs. The experience in Canada suggests that the increased demand for acute care would be modest after an initial surge^{21,22} and that improvements in health planning⁸ and cost containment made possible by single-source payment⁹ would slow the escalation of health care costs. Vigilance would be needed to stem the regrowth of costly and intrusive bureaucracy.

Unsolved Problems

Our brief proposal leaves many vexing problems unsolved. Much detailed planning would be needed to ease dislocations during the implementation of the program. Neither the encouragement of preventive health care and healthful life styles nor improvements in occupational and environmental health would automatically follow from the institution of a national health program. Similarly, racial, linguistic, geographic, and other nonfinancial barriers to access would persist. The need for quality assurance and continuing medical education would be no less pressing. High medical school tuitions that skew specialty choices and discourage low-income applicants, the underrepresentation of minorities, the role of foreign medical graduates, and other issues in medical education would remain. Some patients would still seek inappropriate emergency care, and some physicians might still succumb to the temptation to increase their incomes by encouraging unneeded services. The malpractice crisis would be only partially ameliorated. The 25 percent of judgments now awarded for future medical costs would be eliminated, but our society would remain litigious, and legal and insurance fees would still consume about two thirds of all malpractice premiums.²³ Establishing research priorities and directing funds to high-quality investigations would be no easier. Much further work in the area of long-term care would be required. Regional health planning and capital allocation would make possible, but not ensure, the fair and efficient allocation of resources. Finally, although insurance coverage for patients with AIDS would be ensured, the need for expanded prevention and research and for new models of care would continue. Although all these problems would not be solved, a national health program would establish a framework for addressing them.

Political Prospects

Our proposal will undoubtedly encounter powerful opponents in the health insurance industry, firms that do not now provide health benefits to employees, and medical entrepreneurs.

However, we also have allies. Most physicians (56 percent) support some form of national health program, although 74 percent are convinced that most other doctors oppose it.²⁴ Many of the largest corporations would enjoy substantial savings if our proposal were adopted. Most significant, the great majority of Americans support a universal, comprehensive, publicly administered national health program, as shown by virtually every opinion poll in the past 30 years.^{25,26} Indeed, a 1986 referendum question in Massachusetts calling for a national health program was approved two to one, carrying all 39 cities and 307 of the 312 towns in the commonwealth.²⁷ If mobilized, such public conviction could override even the most strenuous private opposition.

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*This proposal was drafted by a 30-member Writing Committee, then reviewed and endorsed by 412 other physicians representing virtually every state and medical specialty. A full list of the endorsers is available on request. The members of the Writing Committee were as follows: David U. Himmelstein, M.D., Cambridge, Mass. (cochair); Steffie Woolhandler, M.D., M.P.H., Cambridge, Mass. (cochair); Thomas S. Bodenheimer, M.D., San Francisco; David H. Bor, M.D., Cambridge, Mass.; Christine K. Cassel, M.D., Chicago; Mardge Cohen, M.D., Chicago; David A. Danielson, M.P.H., Newton, Mass.; Alan Drabkin, M.D., Cambridge, Mass.; Paul Epstein, M.D., Brookline, Mass.; Kenneth Frisof, M.D., Cleveland; Howard Furnkin, M.D., M.P.H., Philadelphia; Martha S. Gerrity, M.D., Chapel Hill, N.C.; Jerome D. Gorman, M.D., Richmond, Va.; Michelle D. Holmes, M.D., Cambridge, Mass.; Henry S. Kahn, M.D., Atlanta; Robert S. Lawrence, M.D., Cambridge, Mass.; Joanne Lukomnik, M.D., Bronx, N. Y.; Arthur Mazer, M.P.H., Cambridge, Mass.; Alan Meyers, M.D., Boston; Pauick Murray, M.D., Cleveland; Vicente Navarro, M.D., Dr.P.H., Baltimore; Peter Orris, M.D., Chicago; David C. Parish, M.D., M.P.H., Macon, Ga.; Richard J. Pels, M.D., Boston; Leonard S. Rodberg, Ph.D., New York City; Jeffrey Scavron, M.D., Springfield, Mass.; Gordon Schiff, M.D., Chicago; Isaac M. Taylor, M.D., Boston; Howard Waitzkin, M.D., Ph.D., Anaheim, Calif.; Paul H. Wise, M.D., M.P.H., Boston; and William Zinn, M.D., Cambridge, Mass.

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Statement of Dr. Marcia Angell introducing the U.S. National Health Insurance Act

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Concurrent with the publication of the Physicians' Proposal for National Health Insurance in the *JAMA*, the proposal was adapted into legislative form by Congressmen John Conyers (D-MI), Dennis Kucinich (D-OH) and Jim McDermott (D-WA).

The U.S. National Health Insurance Act (also known as the Expanded and Improved Medicare for All Act), HR 676, was introduced on February 4, 2003. The following is the statement made at the introduction ceremony by Physicians' Working Group member and former *NEJM* editor Dr. Marcia Angell.

(A printable handout of this document is available by [clicking here](#))

February 4, 2003
Washington D.C.

We are here today to introduce a national health insurance program. Such a program is no longer optional; it's necessary.

Americans have the most expensive health care system in the world. We spend about twice as much per person as other developed nations, and that gap is growing. That's not because we are sicker or more demanding (Canadians, for example, see their doctors more often and spend more time in the hospital). And it's not because we get better results. By the usual measures of health (life expectancy, infant mortality, immunization rates), we do worse than most other developed countries. Furthermore, we are the only developed nation that does not provide comprehensive health care to all its citizens. Some 42 million Americans are uninsured — disproportionately the sick, the poor, and minorities — and most of the rest of us are underinsured. In sum, our health care system is outrageously expensive, yet inadequate. Why? The only plausible explanation is that there's something about our system — about the way we finance and deliver health care — that's enormously inefficient. The failures of the system were partly masked during the economic boom of the 1990's, but now they stand starkly exposed. There is no question that with the deepening recession and rising unemployment, in the words of John Breaux, "The system is collapsing around us."

The underlying problem is that we treat health care like a market commodity instead of a social service. Health care is targeted not to medical need, but to the ability to pay. Markets are good for many things, but they are not a good way to distribute health care. To understand what's happening, let's look at how the health care market works. Most Americans receive tax-free health benefits from their employers, who pay insurers a portion of the premiums for health coverage. But not all employers offer benefits, and when they do, the benefits may not be comprehensive. It's entirely voluntary. When employers are competing for workers, they offer good benefits; when unemployment rises, they drop them.

The insurers with whom employers do business are mostly investor-owned, for-profit managed care businesses. They try to keep premiums down and profits up by stinting on medical services. In fact, the best way for insurers to compete is by not insuring high-risk patients at all; limiting the coverage of those they do insure (for example, by excluding expensive services, such as heart transplantation); and by passing costs back to patients by denying claims or as deductibles and co-payments. We are the only nation in the world with a health care system based on dodging sick people. These practices add greatly to overhead costs because they require a mountain of paperwork. They also require creative marketing to attract the affluent and healthy and avoid the poor and sick. Not surprisingly, the U. S. has by far the highest overhead costs in the world.

It's instructive to follow the health care dollar as it wends its way from employers toward the doctors and nurses and hospitals that actually provide medical services. First, private insurers regularly skim off the top a substantial fraction of the premiums — anywhere from 10 to 25 percent — for their administrative costs, marketing, and profits. The remainder is then passed along a veritable gauntlet of satellite businesses that feed on the health care industry, including brokers to cut deals, disease-management and utilization review companies, drug-management companies, legal services, marketing consultants, billing agencies, information management firms, and so on and so on. Their function is often to limit services in one way or another. They, too, take a cut, including enough for their own administrative costs, marketing, and profits. I would estimate that no more than 50 cents of the health care dollar actually reaches the providers — who themselves face high overhead costs in dealing with multiple insurers.

What are the signs of the imminent collapse of this system? Private health insurance premiums are now rising at an unsustainable rate of about 13 percent per year, and as much as 25 percent in some areas of the country. Coverage is shrinking, as more employers decide to cap their contributions to health insurance and workers find they cannot pay their rapidly growing share. And finally, with the rise in unemployment, more people are losing what limited coverage they had. This is not a system that can be tinkered with. It needs to change.

The program we are introducing today is the very soul of simplicity and efficiency, compared with our private health care system. It is a single-payer system, that is, health care funds would be distributed by a single, public entity, so that health care could be coordinated to eliminate both gaps and overlap. In many ways, our program would be

tantamount to extending Medicare to the entire population. Medicare is, after all, a government-financed single-payer system embedded within our private, market-based system. It's by far the most efficient part of our health-care system, with overhead costs of less than 3 percent, and it covers virtually everyone over the age of 65, not just some of them. Medicare is not perfect, but it is by far the most popular part of the U. S. health care system, and in my opinion its problems would be relatively easy to remedy — but that is another subject.

What are the usual objections to the sort of national program we are calling for today? They are mostly based on a number of myths.

Myth #1 is that we can't afford a national health care system, and if we try it, we will have to ration care. My answer is that we can't afford not to have a national health care system. A single-payer system would be far more efficient, since it would eliminate excess administrative costs, profits, cost-shifting and unnecessary duplication. Furthermore, it would permit the establishment of an overall budget and the fair and rational distribution of resources. We should remember that we now pay for health care in multiple ways — through our paychecks, the prices of goods and services, taxes at all levels of government, and out-of-pocket. It makes more sense to pay just once.

According to Myth #2, innovative technologies would be scarce under a single-payer system, we would have long waiting lists for operations and procedures, and in general, medical care would be threadbare and less available. This misconception is based on the fact that there are indeed waits for elective procedures in some countries with national health systems, such as the U. K. and Canada. But that's because they spend far less on health care than we do. (The U. K. spends about a third of what we do per person.) If they were to put the same amount of money as we do into their systems, there would be no waits and all their citizens would have immediate access to all the care they need. For them, the problem is not the system; it's the money. For us, it's not the money; it's the system.

Myth #3 is that a single-payer system amounts to socialized medicine, which would subject doctors and other providers to onerous, bureaucratic regulations. But in fact, although a national program would be publicly funded, providers would not work for the government. That's currently the case with Medicare, which is publicly funded, but privately delivered.

As for onerous regulations, nothing could be more onerous both to patients and providers than the multiple, intrusive regulations imposed on them by the private insurance industry. Indeed, many doctors who once opposed a single-payer system are now coming to see it as a far preferable option.

Myth #4 says that the government can't do anything right. Some Americans like to say that, without thinking of all the ways in which government functions very well indeed, and without considering the alternatives. I would not want to see, for example, the NIH, the National Park Service, or the IRS privatized. We should remember that the

government is elected by the public and we are responsible for it. An investor-owned insurance company reports to its owners, not to the public.

Some people say that a single-payer system is a good idea, but politically unrealistic. That is a self-fulfilling prophecy. In my opinion, the medical profession and the public would be enthusiastic about a single-payer system if the facts were known and the myths dispelled. Yes, there would be powerful special interests opposing it and I don't underestimate them, but with courageous leadership, such as Representative Conyers is providing, and the support of the medical profession and public, I believe there is nothing unrealistic about a National Health Insurance Program.

I want to mention one final and very important reason for enacting a national health program. We live in a country that tolerates enormous disparities in income, material possessions, and social privilege. That may be an inevitable consequence of a free market economy. But those disparities should not extend to denying some of our citizens certain essential services because of their income or social status. One of those services is health care. Others are education, clean water and air, equal justice, and protection from crime, all of which we already acknowledge are public responsibilities. We need to acknowledge the same thing for health care. Providing these essential services to all Americans, regardless of who they are, helps ensure that we remain a cohesive and optimistic country. It says that when it comes to vital needs, we are one community, not 280 million individuals competing with one another. In seeking to ensure adequate health care for all our citizens, we have an opportunity today to reassert that we are indeed a single nation.

Marcia Angell, M. D.

*Senior Lecturer, Department of Social Medicine, Harvard Medical School
Former Editor-in-Chief, New England Journal of Medicine*

FINANCE

Single Payer System Cost

How Much Would a Single Payer System Cost?

Editors' Note: With the recent resurgence of interest in controlling health care costs, we thought a review of some of the state and national fiscal studies performed on single payer over the years might be useful.

(Updated through February 2005. If you know of a study we have missed, please contact Dr. Ida Hellander at (312) 782-6006 or info@pnhp.org)

National Studies

June, 1991 General Accounting Office

"If the US were to shift to a system of universal coverage and a single payer, as in Canada, the savings in administrative costs [10 percent of health spending] would be more than enough to offset the expense of universal coverage" ("Canadian Health Insurance: Lessons for the United States," 10 pgs, ref no: T-HRD-91-35. Full text available online at <http://www.gao.gov/>).

December, 1991 Congressional Budget Office

"If the nation adopted...[a] single-payer system that paid providers at Medicare's rates, the population that is currently uninsured could be covered without dramatically increasing national spending on health. In fact, all US residents might be covered by health insurance for roughly the current level of spending or even somewhat less, because of savings in administrative costs and lower payment rates for services used by the privately insured. The prospects for controlling health care expenditure in future years would also be improved." ("Universal Health Insurance Coverage Using Medicare's Payment Rates")

April, 1993 Congressional Budget Office

"Under a single payer system with co-payments ...on average, people would have an additional \$54 to spend...more specifically, the increase in taxes... would be about \$856 per capita...private-sector costs would decrease by \$910 per capita.

The net cost of achieving universal insurance coverage under this single payer system would be negative."

"Under a single payer system without co-payments people would have \$144 a year less to spend than they have now, on average...consumer payments for health would fall by \$1,118 per capita, but taxes would have to increase by \$1,261 per capita to finance this plan." ("Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates" ref : CBO memorandum, 60 pages)

July, 1993 Congressional Budget Office

"Enactment of H.R. 1300 [Russo's single payer bill] would raise national health expenditures at first, but reduce spending about 9 percent in 2000. As the program was phased in, the

administrative savings from switching to a single-payer system would offset much of the increased demand for health care services. Later, the cap on the growth of the national health budget would hold the rate of growth of spending below the baseline. The bill contains many of the elements that would make its limit on expenditures reasonably likely to succeed, including a single payment mechanism, uniform reporting by all providers, and global prospective budgets for hospitals and nursing homes." ("Estimates of Health Care Proposals from the 102nd Congress" ref: CBO paper, July 1993, 57pages)

December, 1993 Congressional Budget Office

S491 (Senator Paul Wellstone's single payer bill) would raise national health expenditures above baseline by 4.8 percent in the first year after implementation. However, in subsequent years, improved cost containment and the slower growth in spending associated with the new system would reduce the gap between expenditures in the new system and the baseline. By year five (and in subsequent years) the new system would cost less than baseline. ("S.491, American Health Security Act of 1993")

June, 1998, Economic Policy Institute

"In the model presented in this paper, it is assumed that in the first year after implementing a universal, single-payer plan, total national health expenditures are unchanged from baseline. If expenditures were higher than baseline in the first few years, then additional revenues above those described here would be needed. However, these higher costs would be more than offset by savings which would accrue within the first decade of the program."

Universal coverage could be financed with a 7 percent payroll tax, a 2 percent income tax, and current federal payments for Medicare, Medicaid, and other state and federal government insurance programs. A 2 percent income tax would offset all other out-of-pocket health spending for individuals. "For the typical, middle income household, taxes would rise by \$731 annually. For fully 60% of households, the increase would average about \$1,600...costs would be redistributed from the sick to the healthy, from the low and middle-income households to those with higher incomes, and from businesses currently providing health benefits to those that do not.

"Even more important, greater efficiency and improved cost containment would become possible, leading to sizable savings in the future. The impediment to fundamental reform in health care financing is not economic, but political. Political will, not economic expertise, is what will bring about this important change."

"Universal Coverage: How Do We Pay For It?" — Edie Rasell, M.D. PhD).

State Studies

November 1994: New Mexico

Single Payer could save \$151.8 million and cover all the uninsured

The Lewin consulting group was hired to perform a fiscal study of alternative reform plans for the state of New Mexico. The study looked at single payer, managed competition, and an individual and employer-mandate.

The study concluded that a single-payer system with modest cost-sharing was the only plan that would cover all the uninsured and save over \$150 million per year (estimates given for 1998). Such a plan could be financed with a payroll tax of 7.92 percent (employer 80 percent/employee 20 percent) and a 2 percent tax on family income. If patient cost sharing was eliminated, the single payer program would cover all the uninsured for a net increase in costs of \$9.1 million.

The group's estimates of administrative savings were very conservative, about half of what other estimates have found. Thus, it is likely that a single payer program in the state of New Mexico could provide coverage for all the uninsured with no increase in current health resources.

Source : ("The Financial Impact of Alternative Health Reform plans in New Mexico" by Lewin-VHI, Inc. November 14, 1994.)

April 1995: Delaware

Single Payer would save money in Delaware

A fiscal study of single payer in Delaware by Solutions for Progress found that Delaware could save \$229 million in the first year (1995). In ten years, the cumulative savings would exceed \$6 billion, over \$8,000 for every person in Delaware. "The benefit package for the single-payer system modeled in the report will cover all medically necessary health services" with "virtually no co-payments nor any out-of-pocket health expenditures for any covered benefit."

The study's authors' note that they used a low estimate for administrative savings while using a high estimate for increased costs for utilization in order to assure a high margin for error and adequate funding.

Source: ("Single-payer financing for Universal Health Care in Delaware: Costs and Savings" prepared for the Delaware Developmental Disabilities Planning Council, April 1995 is 11 pages. Solutions for Progress, 215-972-5558. Two companion papers are also available: "Health Expenditures in Delaware Under Single-Payer Financing" and "Notes for Delaware Health Care Costs and Estimates for the Impact of Single Payer Financing.")

February 1995: Minnesota

Single Payer to save Minnesota over \$718 million in health costs each year

A March 1995 study conducted by Lewin-VHI for the Minnesota legislature found that single-payer with modest co-pays would insure all Minnesotans and save Minnesota over \$718 million health costs each year. The projected savings are conservative since Lewin-VHI global budgets or fee schedules to control costs.

Source: Program Evaluation Division, Office of the Legislative Auditor, State of Minnesota pg 68. "Health Care Administrative Costs" February 1995.

December 1998: Massachusetts

Two fiscal studies of single payer for the Massachusetts Medical Society show savings & benefits:

Lewin Group Solutions for Progress/Boston University School of Public Health (SFP/BUSPH)
"In early 1997, the Massachusetts Medical Society retained the services of two consulting teams to independently analyze the relative costs of a Canadian style single-payer system, and the current multi-payer health care system in Massachusetts."

"While Lewin and SFP/BUSPH reports differed in their orientations and methodologies, they reached similar conclusions. First, a single-payer system would achieve significant administrative savings [between \$1.8 and \$3.6 billion] over the current multi-payer system. Secondly, these savings are of such a magnitude that the available funds would be sufficient to insure universal coverage in the state and provide comprehensive benefits including outpatient medications and long-term care and eliminate all out-of-pocket payments (co-payments, deductibles)."

"The major difference in the studies findings had to do with the timing of achieving the cost savings. SFP/BUSPH estimated that the savings could be in the first year of implementation of the system. Lewin felt the savings would begin in year six."

Source: (Massachusetts Medical Society House of Delegates Report 207, A-99 (B)).
Full text of the studies are available online at: <http://www.massmed.org/pages/lewin.asp>

December, 2002: Massachusetts

Single Payer only plan to cover all and save money in Massachusetts

In the summer of 2001, the legislature allocated \$250,000 to develop a plan for "universal health care with consolidated financing" for Massachusetts. The pro-HMO consulting firm LECG studied three options; only the single-payer option met the study criteria. Despite their industry bias LECG reported 40 percent of every health care dollar spent in the state of Massachusetts goes to administrative costs.

The initial LECG report had two major flaws: It did not include the costs of taking care of the uninsured in the non-single-payer plans, and it did not take into consideration the huge administrative savings possible under single-payer. If these factors are taken into account, single payer is the only plan to cover everyone and save money.

Source: (To get the full report e-mail: UHCEF@aol.com)

June, 2000: Maryland

Single Payer Would Save Money in Maryland

A single-payer system in the state of Maryland could provide health care for all residents and save \$345 million on total health care spending in the first year, according to a study by the D.C. based consulting firm Lewin, Inc. The study also found that a highly regulated "pay or

play" system (in which employers either provide their workers with coverage or pay into a state insurance pool) would increase costs by \$207 million.

Editors' Note: The pro-business Lewin group probably underestimated the administrative savings from single payer and overestimated the administrative savings (and hence understated the costs) of their "pay or play" model. Data from hospitals in Hawaii, where there are only a few major insurers, suggest that if you have more than one payer, there are few administrative savings. However single-payer systems in Canada, the U.K., Sweden and other countries have garnered administrative savings substantially larger than assumed by Lewin. Hence the estimate by Lewin that single-payer universal coverage would cost \$550 million less to implement in the first year than "pay or play" is high.

Source: ("Full text of the study available online at: <http://www.healthcareforall.com>")

August 2001: Vermont

Universal Health Care Makes "Business Sense"

Single-payer universal health coverage could save Vermonters more than \$118 million a year over current medical insurance costs and cover every Vermonter in the process, according to a study paid for by a federal grant and prepared for the Office of Vermont Health Access by the Lewis Group. "Our analysis indicates that the single payer model would cover all Vermont residents, including the estimated 51,390 uninsured persons in the state, while actually reducing total health spending in Vermont by about \$118.1 million in 2001 (i.e., five percent). These savings are attributed primarily to the lower cost of administering coverage through a single government program with uniform coverage and payment rules"

Source: ("Analysis of the Costs and Impact of a Universal Health Care Coverage Under a Single Payer Model for the State of Vermont", The Lewin Group, Inc. Full text of the study is available on-line at: www.dsw.state.vt.us/districts/ovha/spgappendixf.pdf)

April 2002: California

State Health Care Options Project

A study of nine options for covering California's seven million uninsured by the conservative D.C.- based consulting firm of Lewin, Inc found that a single payer system in California would reduce health spending while covering everyone and protecting the doctor-patient relationship.

Three of the nine options analyzed by Lewin for their fiscal implications included single payer financing.

1.) A proposal by James Kahn, UCSF, Kevin Grumbach, UCSF, Krista Farley, MD, Don McCanne, MD, PNHP, and Thomas Bodenheimer, UCSF, would cover nearly all health care services including prescription drugs, vision and dental for every Californian through a government-financed system while saving \$7.6 billion annually from the estimated \$151.8 billion now spent on health care.

2.) A second proposal by Ellen Shaffer, UCSF- national health service- Would reform both financing of and the delivery system so that every Californian has a "medical home", that is, a primary care physician with an ongoing relationship with that patient. Like the Kahn et al proposal, it saves about \$7.5 billion through various efficiencies.

3.) The third by Judy Spelman, RN, and Health care for All, covers care for every Californian in a manner similar to the Kahn et al proposal but eliminates all out-of-pocket costs. Its cost savings are estimated at \$3.7 billion.

All three proposals stabilize the health care system, reduce paperwork, and protect the doctor-patient relationship by eliminating the role of for-profit HMOs and insurers. The Kahn et al proposal envisions that the not-profit Kaiser Permanente, the state's largest integrated health system, would continue.

Source: (Contact Sandra (916)654-3454 to get a copy of the full report)

(See also February 2005 report)

December 2002: Maine

Single Payer an economically feasible option for Maine

The June 2001 Maine legislature created a nineteen member Health Security Board to develop a single payer system for Maine. In July, the Board contracted with the consulting firm Mathematica Policy Research, Inc, (MPA) firm to study the feasibility of single payer in the state. The firm found that single payer would cost about the same amount as the current system, while covering all 150,000 uninsured residents. Depending on the benefits provided by the system, single payer would cost the same as current state health spending, or increase health spending by 5 percent. (Note, the consultants were very conservative when estimating administrative savings, which could more than offset the 5 percent increase).

"Estimates from the model indicate that, under current policy, health care spending in Maine will continue on a path of steady increase—rising by 37 percent between 2001-04 and by 31 percent between 2004-08. The model projects that a single-payer health system would produce a net increase in total health care spending under most benefit designs that MPA estimated, but this increase in spending would decline over time as the system realizes savings through global budgeting, reductions in administrative costs, and enhanced access to primary and preventive care."

"By reducing administrative spending and increasing overall demand for health care, a single payer system would generate some change in employment in Maine... However a single payer plan would improve health sector productivity by redistributing jobs from administrative to clinical positions."

"In summary, a single payer system appears to be economically feasible for Maine."

Source: (Mathematica Policy Research, Inc, "Feasibility of a Single-Payer Health Plan Model for the State of Maine" Final report 12/24/03/, MPR Ref No: 8889-300, 80 pages.

<http://www.mathematica-mpr.com/PDFs/mainefeasibility.pdf>

November 2002: Rhode Island

Single Payer would save \$270 million in Rhode Island

A study of single-payer in Rhode Island by analysts with Boston University School of Public Health and the consulting firm Solutions for Progress found that current health spending in Rhode Island is 21.5 percent above the national average and that incremental reforms cannot solve the state's health problems.

Solutions for Progress studied two models of single payer reform one with consolidated financing alone, and one with consolidated financing combined with "professionalism within a budget." They found that without health care reform, Rhode Island's costs would continue to rise, while both models of single-payer could provide universal coverage while saving an estimated \$270 million in the first year.

At first, the administrative and bulk purchasing savings have the largest impact. But over time, slowing the rate of inflation to 4 percent by making health professionals responsible for using resources prudently, ("professionalism within a budget") has a larger impact. Over six years, they estimate that consolidated financing alone would save \$4.4 billion, while single payer with "professionalism within a budget" delivery system reform would save over \$6.6 billion. Again, both models of single payer would provide coverage for all the uninsured and improve coverage for all Rhode Islanders.

Source: ("Rhode Island Can Afford Health Care for All: A Report to the Rhode Island General Assembly" On-line at www.healthreformprogram.org. For copies of this report, please contact Alan Sager or Deborah Socolar or phone the Health Services Department at (617) 638-5042.)

October 2003: Missouri

Single Payer Would Save \$1.3 billion in Missouri

Missouri Foundation for Health conducted a study on "health care expenditures and insurance in Missouri".

A single payer health care plan in the state of Missouri would reduce overall spending by about \$3 billion. "Assuming the universal health care plan adopted a benefit package typically found in the state, spending among the uninsured and underinsured would rise by nearly \$1.3 billion when fully implemented. On the other hand, the use of a streamlined single claims and billing form (electronically billed) would reduce overall spending by about \$3 billion. As a result health care spending would decline by approximately \$1.7 billion."

"Even if the state would adopt a more generous benefit package-one more generous than 75 percent of all private insurance benefits in the state-overall spending would decline. Overall health care spending would likely decline by \$ 1.3 billion under the streamlined administrative structure."

Source: ("A Universal Health Care Plan for Missouri", the full report can viewed at <http://www.mffh.org/ShowMe3.pdf>)

June 2004: Georgia

Single Payer in Georgia would reduce healthcare spending

A fiscal study by the Virginia-based Lewin Group found that Single Payer health would cover all Georgia residents and save \$716 million annually.

The "SecureCare" program would offer residents a comprehensive benefits package that includes long-term care and prescription drug coverage. It would be financed by replacing health insurance premiums with a combination of payroll and income taxes as well as modest new tobacco, alcohol and sales taxes. " Nearly all Georgia families would pay less for health care than they are today for much better coverage.

Source: (The Lewin Group, Inc. "The Georgia SecureCare Program: Estimated Cost and Coverage Impacts" Final report 10/21/03)

(Full text of the study available online at:

<http://www.pnhp.org/news/lewinanalysis.pdf>)

February 2005: California

California could save \$344 billion over 10 years with single payer

A study by the Lewin Group, finds that singlepayer would save California \$343.6 billion in health care costs over the next 10 years, mainly by cutting administration and using bulk purchases of drugs and medical equipment.

The bill's author, Sen. Sheila Kuehl, D-Santa Monica, said the report "demonstrates that we can do it. We need the will to do it. It makes insurance affordable for everybody."

Lewin Group Report

The Health Care for All Californians Act: Cost and Economic Impacts Analysis

January 19, 2005

Fact Sheet

* The Lewin report, prepared by an independent firm with 18 years of experience in healthcare cost analysis, affirms that we can create a fiscally sound, reliable state insurance plan that covers all Californians and controls health cost inflation.

* The Lewin report shows that all California residents can have affordable health insurance; and that, on average, individuals, families, businesses and the state of California, all of whom are now burdened with rising insurance costs, will save money.

* In February, State Senator Sheila Kuehl (D-23) will introduce the California Health Insurance Reliability Act (CHIRA), based on these findings. CHIRA, based on the Lewin Report model will insure every Californian and allow everyone to choose his or her own doctor.

Savings Overall

The Lewin report model would achieve universal coverage while actually reducing total health spending for California by about \$8 billion in the first year alone. Savings would be realized in two ways:

1. The Act would replace the current system of multiple public and private insurers with a single, reliable insurance plan. This saves about \$20 billion in administrative costs.
2. California would buy prescription drugs and durable medical equipment (e.g., wheelchairs) in bulk and save about \$5.2 billion.

Savings for State and Local Governments

* In addition, state and local governments would save about \$900 million, in the first year, in spending for health benefits provided to state and local government workers and retirees.

* Aggregate savings to state and local governments from 2006 to 2015 would be about \$43.8 billion.

Savings for Businesses

* Employers who currently offer health benefits would realize average savings of 16% compared to the current system.

Savings for families

* Average family spending for health care is estimated to decline to about \$2,448 per family under the Act in 2006, which is an average savings of about \$340 per family.

* Families with under \$150,000 in annual income would, on average, see savings ranging between \$600 and \$3,000 per family under the program in 2006.

Cost Controls

* By 2015, health spending in California under the Act would be about \$68.9 billion less than currently projected. Total savings over the 2006 through 2015 period would be \$343.6 billion.

* Savings to state and local governments over this ten-year period would be about \$43.8 billion.

Comprehensive Benefits

* The Lewin Report assumes an insurance plan that covers medical, dental and vision care; prescription drug; emergency room services, surgical and recuperative care; orthodontia; mental health care and drug rehabilitation; immunizations; emergency and other necessary transportation; laboratory and other diagnostic services; adult day care; all necessary translation and interpretation; chiropractic care, acupuncture, case management and skilled nursing care.

Efficiencies

* The Lewin Report shows that efficiencies in the system make these superior benefits available while generating savings.

Freedom to Choose

*The Lewin Report model assumes the consumer's freedom to choose his or her own care providers. This means that each Californian will be free to change jobs, start a family, start a business, continue education and or change residences, secure in the knowledge that his or her relationships with trusted caregivers will be secure.

For more information please go to the below link:

<http://democrats.sen.ca.gov/senator/kuehl/>

August, 2005

The National Coalition on Health Care

Impacts of Health Care Reform: Projections of Costs and Savings

By Kenneth E. Thorpe, Ph.D.

This fiscal analysis of the impact of four scenarios for health care reform found that the single payer model would reduce costs by over \$1.1 trillion over the next decade while providing comprehensive benefits to all Americans. The other scenarios would be improvements over the status quo, but would not reduce costs as dramatically or provide the same high-quality coverage to all.

Summary of the Coalition's Specifications:

1. Health Care Coverage for All
2. Cost Management
3. Improvement of Health Care Quality and Safety
4. Equitable Financing
5. Simplified Administration

Reform Models studied:

- Scenario 1: employer mandates (supplemented with individual mandates as necessary)
Scenario 2: expansion of existing public programs that cover subsets of the uninsured
Scenario 3: creation of new programs targeted at subsets of the uninsured (FEHBP model)
Scenario 4: establishment of a universal publicly financed program (single payer)

Colorado, August 2007

The Lewin Group

Technical Assessment of Health Care Reform Proposals (Proof Report)

August 20, 2007

Prepared for: The Colorado Blue Ribbon Commission for Health Care Reform

The Lewin Group was engaged by the Colorado Blue Ribbon Commission for Health Reform to assist in developing and analyzing alternative proposals to expand health insurance coverage and reform the Colorado health care system.

Single Payer Results, Excerpt:

COLORADO HEALTH SERVICES SINGLE PAYER PROGRAM

The Colorado Health Services (CHS) Program is a single payer plan that would provide coverage to all residents of the state, including state and local workers, and residents currently covered under Medicare, Tricare, Veteran's Health, Indian Health Services and Federal Health Benefits programs. The program would provide all people with comprehensive health care benefits that cover the same list of services now covered by the Colorado Medicaid benefits package. Consumers would have their choice of providers and hospitals within the state.

0 - number remaining uninsured

\$1.4 billion - decline in health spending

All Other Plans, Results, excerpt:

BETTER HEALTH CARE FOR COLORADO

Better Health Care for Colorado provides a path to universal health care through a public program expansion and access to private insurance coverage with low-income subsidies through a Health Insurance Exchange. Individuals eligible for public programs would receive benefits under those programs, and individuals who purchase private coverage would have access to a limited core set of benefits, with premiums copays.

467,200 - number remaining uninsured

\$595 million - increase in health spending

SOLUTIONS FOR A HEALTHY COLORADO

Solutions for a Healthy Colorado provides coverage to all Colorado residents under a Core Limited Benefit Plan in the private sector and expands coverage under Medicaid and Child Health Plus (CHP+). People who are low income but who would not be eligible for the government programs would receive a premium subsidy.

133,400 - number remaining uninsured

\$271 million - increase in health spending

A PLAN FOR COVERING COLORADO

A Plan for Covering Coloradans provides coverage to Coloradans through a public program expansion and a mandatory private pool for all residents not eligible for the public program. It provides a minimum benefits package in a private pool and premium assistance based on income for those who cannot afford insurance. All plans would provide a comprehensive minimum benefits package, and differ mainly on cost-sharing amounts.

106,500 - number remaining uninsured

\$1.3 billion - increase in health spending

Source:

Lewin's Technical Assessment of Health Care Reform Proposals (230 page report):

<http://www.colorado.gov/cs/Satellite?c=Page&childpagename=BlueRibbon%2FRIBBLayout&cid=1178305890619&p=1178305890619&pagename=RIBBWrapper>

Comment by Dr. Don McCanne, PNHP Senior Health Policy Fellow:

Once again, fiscal analysis shows that the models of reform that build on our highly flawed, fragmented system of financing health care actually increase health care spending while falling far short on the goals of reform. In contrast, the single payer model would provide truly comprehensive care for absolutely everyone while significantly reducing health care spending.

Major fiscal consulting groups:

The Lewin Group, Washington DC (703) 269-5500

Mathematica Policy Research Group (609) 799-3535

Health Reform Program, Boston University (617) 638-5042

Solutions for Progress (215) 972-5558

****Compiled and updated by Padma Alavilli, February 2005***

ENDORSEMENTS

November 2002

Joint Letter on Publicly Funded Health Care

Canada's publicly funded health care system provides essential and affordable health care services for all Canadians, regardless of their income. Publicly funded health care also enhances Canada's economic performance in several important ways.

The auto industry is Canada's most important export industry; it directly employs over 150,000 Canadians in high-wage jobs, supports hundreds of thousands of other spin-off jobs, produces \$90 billion worth of shipments per year, and generates billions of dollars in tax revenues for all levels of government in Canada. The success of this industry has been crucial to Canada's economic progress over the past decade. Canada's health care system has been an important ingredient in the auto industry's performance.

Workers in the auto industry, and in the many manufacturing and service industries which supply automakers, benefit directly from access to public health care services. Thanks to this system, they are healthier and more productive. Employers in the auto industry, meanwhile, enjoy significant total labour cost savings because most health care services are supplied through public programs (rather than through private insurance plans).

The public health care system significantly reduces total labour costs for automobile manufacturing firms, compared to the cost of equivalent private insurance services purchased by U.S.-based automakers; these health insurance savings can amount to several dollars per hour of labour worked. Publicly funded health care thus accounts for a significant portion of Canada's overall labour cost advantage in auto assembly, versus the U. S., which in turn has been a significant factor in maintaining and attracting new auto investment in Canada.

Canada's publicly funded health care system is now facing demographic, technological, and fiscal pressures. The erosion of publicly funded health care through measures such as the delisting of currently-covered services, the imposition of user fees, the failure of the public system to keep up with the changing nature of health care, and new costs such as prescription drugs and home-care, will impose significant costs on automotive employers and undermine the attractiveness of Canada as a site for new automotive investment.

For both employers and workers in the auto industry, it is vitally important that the publicly funded health care system be preserved and renewed, on the existing principles of universality, accessibility, portability, comprehensiveness, and public administration. The system needs a secure multi-year funding base from government, and must be expanded to cover an updated range of services (including prescription drugs and home care services) that reflects both the evolving nature of medical science and the emerging needs of our population.

To this end, Ford Motor Company and CAW-Canada jointly urge the federal and provincial governments to take appropriate actions to preserve the public health care system, secure its funding base, and modernize the range of services which it covers. In addition to reinforcing the quality and accessibility of health care for Canadians, these measures would also help to ensure the long-run success of Canada's auto industry.



Alan Batty

Alan Batty
President and Chief Executive Officer
Ford Motor Company of Canada, Limited

Basil "Buzz" Hargrove

Basil "Buzz" Hargrove
National President
CAW-Canada



Michael G. Smith

FOR THE COMPANY

DAIMLERCHRYSLER

E. O. Smith

FOR THE COMPANY

Partnership with government can provide health care for all

By JIM McDERMOTT

The Atlanta Journal-Constitution

Published on: 10/29/07

The fundamental role of government is to protect and serve the people and the fundamental role of business is to produce a profit and serve its shareholders. When it comes to providing health care, we can fuse the best of both worlds to provide health care to the American people.

Let's look briefly at where we are. The number of uninsured Americans is rising while the number of U.S. companies offering a health care benefit to employees is falling. Health care premiums have risen 78 percent in the last six years but wages have risen only 19 percent. The financial health of the American middle class deteriorates every month because of soaring health care costs.

Up against this harsh reality, more Americans have been forced to accept reactive care in an emergency room, because they can't afford access to preventive care. This costs more in dollars and in health. And make no mistake, everyone pays. You may not be the person forced to seek medical treatment in the emergency room, but you are paying for that visit through higher premiums.

For years we've been told the answer to this crisis rests solely with the private sector. Special interests have funded multimillion-dollar fear and smear campaigns to frighten the American people into accepting hype instead of health care. But let's recognize just three facts left out of all those ads: SCHIP, Medicaid and Medicare.

The ads don't tell you that these and other programs of care and dignity were created by the government because the private sector failed to provide care for millions of people because it wasn't profitable. Does anyone think we ought to cancel Medicare and let senior citizens go it alone, or not care for poor kids or vulnerable families?

Government led the way before and government must lead the way again. We know from history that good and decent programs like SCHIP and Medicare had to be created by government.

If anyone tells you that you can't trust government, ask them who they trust to protect America from terrorist threats, protect consumers from unsafe products in the marketplace, protect airline travelers by ensuring we have safe skies.

Government can provide the leadership and free the private sector to provide the services, innovation and efficiency. A universal plan would cover every American's care, financed publicly, but implemented privately.

In any insurance program, rates are determined by the risk pool — fewer people in the pool equates to higher risk — and higher prices since companies have a duty to make a profit.

Today, risk is divided into thousands, if not millions of individual segments across America, which drives up prices and drives people out of the system as rates soar.

But an American health care program would create a national risk pool including every American — driving risk down to the lowest possible point. The efficiencies and savings would be enormous.

The irony is that the more people we cover, the lower the cost per person to provide health care. The system would eliminate uncompensated care, which every private provider faces today — and the rest of us pay for through higher rates. By providing a national risk pool, we bring enormous clout to the marketplace that benefits everyone.

Under a universal plan we don't interfere with the delivery of health care services by the private sector, but we do provide the financial support to drive the system to achieve maximum efficiencies and lower costs. Public and private sectors working together actually work. We do it in time of war. We do it in time of national crisis. We need to do it now, because health care has become a national crisis.

Most Physicians Endorse Single-Payer National Health Insurance

EMBARGOED UNTIL 4:01 PM, EST
February 9, 2004

Contacts: Danny McCormick, M.D., M.P.H.
Tel (617) 665-1032
Beeper (617) 546-9422
Steffie Woolhandler, M.D., M.P.H.
Tel (617) 665-1032 or 497-1268
Beeper (617) 546-0577

Most Physicians Endorse Single-Payer National Health Insurance
According to Harvard Study

Nearly two-thirds (64%) of physicians favor single-payer national health insurance, far more than support managed care (10%) or fee-for-service care (26%) according to a Harvard Medical School study published today in the Archives of Internal Medicine. National health insurance (NHI) received majority support from physicians of virtually every age, gender and medical specialty – even among surgeons, a plurality supported NHI. The breadth of physician support for NHI was highlighted by the fact that even most members of the American Medical Association and the Massachusetts Medical Society favor the single payer approach. Despite this high level of support, however, only about half (51.9%) of physicians studied were aware that a majority of their fellow physicians support NHI.

The researchers surveyed a random sample of 904 Massachusetts physicians drawn from the AMA's Master File of all doctors. The survey included questions about views on health care financing and medical practice issues. Eighty-nine percent believed that it is the responsibility of society, through its government, to provide everyone with good medical care, regardless of their ability to pay. Physicians also favored physician payment under a salary system (56.8%), and would be willing to accept a reduction in fees for a reduction in paperwork (67.1%). Doctors overwhelmingly (70.3%) rejected allowing the insurance industry to continue playing a major role in the delivery of medical care.

"The perception that physicians oppose national health insurance often serves to reinforce political barriers to health care reform. Our finding that a large majority of physicians actually support single-payer national health insurance could provide the impetus for national health insurance, particularly if physicians began to publicly advocate for their views" said Dr. Danny McCormick, a study author and researcher at Harvard Medical School.

Dr. David Bor, a study co-author who is an Associate Professor of Medicine at Harvard Medical School and Chair of the Department of Medicine at The Cambridge Health Alliance commented: "At first I was surprised at our results. But when I reflected on my own clinical experience with publicly funded programs like Medicare, I realized that I and many other doctors are convinced that the government can do an excellent job administering health insurance. The plain fact is Medicare works better for patients-and for doctors-than most private insurance plans."

"Most doctors are fed up with the health care system. It's not just the paperwork and insurance hassles, but knowing that many of our patients can't afford to fill the prescriptions we write for them. And millions of people who are uninsured avoid care altogether until they're desperately ill. That's why more than 10,000 physicians have endorsed a proposal for national health insurance that appeared in the JAMA last August. This survey shows that the overwhelming majority of doctors now support NHI.." said Dr. Steffie Woolhandler, another study co-author and Associate Professor of Medicine at Harvard Medical School.

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Physicians for a National Health Program (PNHP) is a research and education organization with more than 12,000 physicians representing every state and specialty. PNHP was founded in 1987 and has physician spokespeople across the country. For a local spokesperson, call the national headquarters at 312-782-6006. Visit us online at <http://www.pnhp.org/>

McCormick D, Himmelstein, DU, Woolhandler S, Bor DH, "Single-Payer National Health Insurance: Physicians' Views", Archives of Internal Medicine. 2004 February 9; 164:300-304