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EXAMINING THE SINGLE–PAYER HEALTH CARE OPTION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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EXAMINING THE SINGLE–PAYER HEALTH CARE OPTION

Wednesday, June 10, 2009
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and Labor
Washington, DC

The subcommittee met, pursuant to call, at 10:36 a.m., in room 2175, Rayburn House Office Building, Hon. Robert Andrews [chairman of the subcommittee] presiding.

Present: Representatives Andrews, Wu, Hare, Kucinich, Fudge, Kildee, McCarthy, Holt, Sestak, Clarke, Courtney, Kline, Wilson, Price, Guthrie, Hunter, and Roe.

Also Present: Woolsey, Miller, Scott, Payne, Stark.

Staff Present: Aaron Albright, Press Secretary; Tylease Alli, Hearing Clerk; Jody Calemine, General Counsel; Carlos Fenwick, Policy Advisor, Subcommittee on Health, Employment, Labor and Pensions; David Hartzler, Systems Administration; Jessica Kahanek, Press Assistant; Therese Leung, Labor Policy Advisor; Alex Nock, Deputy Staff Director; Joe Novotny, Chief Clerk; Megan O'Reilly, Labor Counsel; Rachel Racusen, Communications Director; Meredith Regine, Junior Legislative Associate, Labor; James Schroll, Junior Legislative Associate, Labor; Michele Varnhagen, Labor Policy Director; Mark Zuckerman, Staff Director; Robert Borden, Minority General Counsel; Cameron Coursen, Minority Assistant Communications Director; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Senior Legislative Assistant; Richard Hoar, Minority Professional Staff Member; Alexa Marrero, Minority Communications Director; Jim Paretti, Minority Workforce Policy Counsel; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; Ken Serafin, Minority Professional Staff Member; Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel; and Loren Sweatt, Minority Professional Staff Member.

Chairman ANDREWS. We would like to welcome our colleagues who are present this morning, ladies and gentlemen who will be witnesses, and the members of the public and the press. It is great to have you with us.

The United States is spending more of our national wealth, more of our business firms' income, more of our family and individual income on health care than any of our industrial competitors anywhere in the world. And I do think that there is an emerging con-

sensus we are not getting what we are paying for. We are not getting the quality that everyone wants and deserves, and we are certainly not getting the coverage that everyone wants and, we believe, deserves. There are too many people left out of our system; there is too much money spent within our system on things other than providing health care to people, spent on what many of us feel are wasted expenditures.

At the President's urging, the country and the Congress have embarked upon a broad national debate about how to fix that problem. And I would like to commend Members of both parties in both the House and even the Senate—even the Senate—for moving beyond a simple recitation of the country's problems to a robust debate about the proposed solutions to those problems. It is long overdue. We believe that legislating on those solutions is long overdue as well.

This morning our subcommittee will mark an important milestone in debate, and one of the more broadly supported and interesting solutions to the problem will be considered by the subcommittee in the form of the legislation proposed by the very distinguished chairman of the Judiciary Committee, Mr. Conyers. He will be our first witness—you may applaud if you would like. He will be our first witness this morning and will summarize and advocate for his legislation, as I am sure he will do, forcefully and articulately.

We will then proceed to a panel of what I guess you might call "lay witnesses."

John, I guess that implies that you are a holy person.

But we will proceed to a panel of lay witnesses. And one thing I would ask our colleagues to consider out of courtesy to the lay witnesses is that once Chairman Conyers has concluded his statement, those who would like to ask him questions, obviously, under the rules are permitted to do so; I am not going to avail myself of that opportunity, and I believe Mr. Kline is not, either.

And we urge members to consider not questioning Mr. Conyers, not because he is beyond being questioned, but because the lay witnesses have traveled from far and wide to be here today. We would like them to have maximum opportunity to interact with the panel so we can hear their views as well.

So Mr. Conyers has proposed a solution to this problem. He argues it with great passion. It is a solution that, unlike some in the Senate, I believe belongs on the table for consideration and for vigorous and fair consideration. That is what the purpose of this hearing is this morning.

With that, I am going to ask my friend, the ranking member of the subcommittee, Mr. Kline, for his opening statement.

Mr. KLINE. Thank you, Mr. Chairman. Good morning to you all. Good morning, Mr. Chairman.

We are here today, as the title of this hearing implies, to examine single-payer health care. And we are certainly going to hear from Chairman Conyers and from that panel of experts that Chairman Andrews mentioned.

Single-payer is certainly among the most controversial approaches to health care reform, and frankly, Mr. Chairman, I am a little surprised to see it on this subcommittee's agenda. President

Obama and Democratic leaders, as I understand it, have been very clear and very public in rejecting the notion of single-payer; and, frankly, I am glad that they have.

Creating a new one-size-fits-all health care system modeled on Medicare, I believe is a recipe for disaster. It will balloon the deficit and add to our mounting debt. It would drive up taxes while driving down medical innovation. It would ration care while empowering bureaucrats.

All of my friends on the other side of the aisle have not included Republicans in their deliberations. I have been following their progress pretty closely in the news. The latest reports indicate that they could formally unveil their legislation as early as next week.

While their proposal reportedly does not include a single-payer scheme, it seems highly likely that we will see a government-run option. And I use that word "option" with some trepidation, because it seems clear to me that any government-run option is designed to undercut the private sector and eventually drive private participants out of the market.

So perhaps today's hearing is appropriate after all. If the Democrats are serious about including a so-called government-run option in their plan, and if a government-run option is designed to crowd out the private sector, then the reality is that we are only a few steps away from a single-payer system. How else can we explain the urgency with which this hearing was scheduled?

As you know, Mr. Chairman, committee rules require that Members be provided at least 7 days' notice before any hearing. Often, and thankfully, we used to receive even more. But today's hearing was announced last Thursday, just a day less than the customary 7 days, and required the schedule to be reissued nonetheless and requires this subcommittee to waive our longstanding rules to proceed.

Mr. Chairman, this hastily convened hearing epitomizes everything that is wrong with the majority's health care reform process. Our health care system is in serious need of reform. Republicans and Democrats alike recognize the shortcomings of the current system and the need for meaningful change. There is a bipartisan commitment to change, and that is why we should have a bipartisan reform process.

Health care reform is far too important to get wrong. It is more important that we do it right than simply do it fast. Unfortunately, the majority seems to have chosen a different path. The Speaker, after a partisan strategy session at the White House last month, announced an arbitrary deadline that calls for House passage of a comprehensive health care overall before the August district work period. Frankly, it is like deja vu all over again.

Just like the so-called economic stimulus package earlier this year, we face the prospect of complex and costly legislation that is crafted behind closed doors. Members of Congress did not even have the opportunity to review the stimulus before it was brought to a vote. And judging by the announcement made at the White House this week—essentially acknowledgement that the stimulus isn't delivering the jobs that were promised—a partisan package that doesn't receive a thorough review and vetting simply won't work.

Mr. Chairman, I will say it again: Health care reform is far too important to get wrong. I come to this debate in good faith, and I stand ready to work with you, but this hearing is at the wrong time. It is too fast. Let's slow down and do this right. Thank you.

I yield back.

[The statement of Mr. Kline follows:]

Prepared Statement of Hon. John Kline, Senior Republican Member, Subcommittee on Health, Employment, Labor, and Pensions

Thank you Chairman Andrews, and good morning. We're here today, as the hearing title suggests, to examine single payer health care.

Single payer is certainly among the most controversial approaches to health care reform, and frankly, I'm a little surprised to see it on this subcommittee's agenda. President Obama and Democratic leaders have publicly rejected the notion of single payer. And I'm glad they have.

Creating a new, one-size-fits-all health care system modeled on Medicare is a recipe for disaster. It would balloon the deficit and add to our mounting debt. It would drive up taxes while driving down medical innovation. It would ration care while empowering bureaucrats.

Although my friends on the other side of the aisle have not included Republicans in their deliberations, I've been following their progress closely on the pages of the newspaper. The latest reports indicate that they could formally unveil their legislation as early as next week.

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Unfortunately, the majority seems to have chosen a different path. The Speaker, after a partisan strategy session at the White House last month, announced an arbitrary deadline that calls for House passage of a comprehensive health care overhaul before the August work period.

It's like deja vu all over again. Just like the so-called economic stimulus package earlier this year, we face the prospect of complex and costly legislation that is crafted behind closed doors. Members of Congress did not even have the opportunity to fully review the stimulus before it was brought to a vote. And judging by the announcement made at the White House this week—essentially, an acknowledgement that the stimulus isn't delivering the jobs that were promised—a partisan package that doesn't receive a thorough review and vetting simply won't work.

Mr. Chairman, I will say it again: Health care reform is far too important to get wrong. I come to this debate in good faith. I stand ready to work with you.

This hearing is the wrong issue at the wrong time, but it's not too late. I hope we give health care reform the serious, bipartisan consideration it deserves before we go down a path from which we cannot return.

Thank you, and I yield back.

Chairman ANDREWS. I thank the gentleman. I also want to take the prerogative and introduce a friend and guest this morning, the chairman of the Health Subcommittee on Ways and Means; our good friend Pete Stark from California is present. My understanding, and we discussed with the minority, Mr. Stark will be an observer of the hearing and does not intend to ask any questions. And we appreciate your indulgence in having him here.

And I would just say to my friend, who I know approaches this in good faith, that Chairman Miller and I intend to meet, I think as early as today, with members of the minority caucus to talk about health care reform before there has been any markup or any bill filed, which we look forward to your participation in. And I realize that was scheduled, I think just this morning, but I just want to let you know it is happening and there will be that discussion.

Also, just about timing. I sat in this room 15 years ago on one of the lower daises, much lower; and there was an attempt to get something done about this problem, and it failed. And there wasn't a whole lot done after that, which I think was another failure.

So I understand that there are some questions about schedule. But I would simply say that I don't think the problem is that we have gone too quickly; I think we haven't gone quickly enough. So that is just something we might disagree about.

So we are going to turn to our chairman of the Judiciary Committee, someone I have always regarded as a model of integrity and dignity, who conducts himself in such an important way in this House. His jurisdiction touches everything from how we pay our credit cards to whether we have our rights in a court of law. He has been, I think, a Member's Member for a very long time, a person we have tremendous respect for.

And we are very happy to welcome to this subcommittee this morning the distinguished chairman of the Judiciary Committee. The gentleman from Michigan, Mr. Conyers, is recognized.

STATEMENT OF THE HON. JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. CONYERS. Thank you, Chairman Andrews, for that flattering introduction; Ranking Member Kline, and all of my colleagues here. It is so good to see Pete Stark back in the saddle again. And I am just so privileged to be here. I want to thank you very much.

The one thing we have to do in this discussion of health care and how it is reformed is that we have got to have a discussion about it. And so my brief comments, because I am so flattered to have with us Dr. Marcia Angell, the former Editor of the New England Journal of Medicine; and Dr. Walter Tsou, Dr. Stephanie Woolhandler from Harvard Medical School, and other witnesses that you have been so kind to bring here.

I just want to review with us what I think it is that we are in, and I want to extend an opportunity for our discussions to go far beyond the hearing today. And I want to make myself available to all of the Members.

First of all, we have got to discuss it. And the first thing that occurs to me, that there is some—and I concede this to my ranking member friend—that there is some notion that universal single-payer health care is off the table. Well, that raises a very impor-

tant question. If you take the most popular health care reform measure and take it off the table, heaven knows what it is, I guess, you think you are left with.

The one thing I commended the 44th President about when I met with him first after his election was, he said something that no sitting President in my experience had ever said. He said: I want you to keep in touch with me, to keep me advised. We want to know about what is happening and what you are thinking about. And so I praised him for that.

He made a lot of other important statements, but the fact that he wanted to keep in touch was very important to me.

And so we have been keeping in touch, and citizens have been keeping in touch. I know, because I have been invited around the country endlessly. To some people that would like me to travel less and stay in my district more, the fact of the matter is, we are dealing with—and the polls establish it—I have got something here that tells us through two polls that this is the most popular system in the minds of most Americans. Most Americans. And I am going to put all these things in the record. But here are more than 400 local unions, 20 international unions, 39 State AFL-CIO unions, all resolved around this question.

Now, I wish I could claim some creativity or imagination for this, but universal single-payer is not a new idea. As a matter of fact, every industrial country on the planet except one, us, already has some version of it. What we are doing is developing the American version. What we are doing—and we have examined all the systems on Earth, we are putting this all together, we are studying this, we are not turning this over to government. We have got another database of myths about the system that I won't try to go into now. But we want to examine these. We cannot examine them without a hearing.

So it is with some sadness that I report that it wasn't easy for me to get to that first summit that the President called. It was an enormous one. He has taken an enormous step here. We have got to help him.

Here is how I am going to help my President. He is getting some misadvice about health care. To think that this sad substitute about the Massachusetts Plan—and there are people from this State that can expound on it far more greatly than I can—is going to move us forward. We are at a point now where we are either going to take this opportunity and move forward and have everybody in as a matter of constitutional right to health care—not health insurance, not policies, but health care itself—from the moment they are born to the moment that they leave our Earth.

Now, hear what the essentials are. It is a 37-page bill, but we are not going back to the 1994 mistake of 1,200 pages. What we are saying is, number one, everybody is afforded health insurance. Number two, they would be paying—the rate would be about 3.5 percent of your income. It is not government run; it is privately administered. No one will be giving up their choice or doctor or hospital or how they want their health service rendered. It would break the employer connection, and it would create one health insurance system, one which would be devised. We would come to-

gether whether we want combinations of existing health insurance groups or whether we want to do something differently.

So I want everybody that is thinking about this to start off with number one: This is the most popular form. And it would be very unlike the party in the majority now to determine that the most popular system would not even be examined. I am asking for a hearing in every committee, every committee, and if they will let us into the Senate as well. That is very important.

Now, here is the closing, Members. Chairman, this is a great bill. Fantastic. I have some saying their father was a single-payer, it is wonderful.

Guess what? It is impossible. So we have got to go to the next best thing. What is the next best thing? Well, we are working on that. We will be back in touch with you. I have got a plan of a plan that we would like you to examine.

Okay, now let me close with this. This country, this is where we are going to test the mettle. And this is not a test, because bringing health care to 47 million people and 30 million that don't have anything—this country was founded on the basis that a third of the people wanted to be free, a third of them wanted to stay with England, and a third of them didn't give a darn what happened. It couldn't be done. It wasn't able to happen.

Nelson Mandela was supposed to be imprisoned for the rest of his life, and he ended up the President of the country that sentenced him to a life in a penitentiary. It couldn't be done.

Social Security was supposed to have been the worst thing that had ever happened. And I have got some of the debates, and you would not believe what some people said in opposition to Social Security. It couldn't be done. It wouldn't work.

And what about Medicare? Medicare was fought tooth and nail. I know because I was here.

And now we have Obama himself. You can't elect—please, folks. You can't elect a person of color to the highest, most powerful government position on Earth. It is impossible. Get a grip.

Well, it was all possible. It all could be done.

And I am asking you to consider the political necessity of bringing up a bill that they said was off the table. Then they say, Well, it couldn't pass. Well, I think the American people are watching very closely, and I am saying that now is the time.

And I thank you for allowing me to make this introduction and to include the papers that I would like to be part of the record as well. Thank you for this opportunity, ladies and gentlemen.

[The statement of Mr. Conyers follows:]

Prepared Statement of Hon. John Conyers, Jr., a Representative in Congress From the State of Michigan

Mr. Chairman, members of the Committee. I am Congressman John Conyers, Jr. and I have the distinct pleasure of representing Michigan's 14th Congressional District. My testimony here today is the culmination of years of work aimed at obtaining a hearing on my bill, H.R. 676. "The United States Health Care Act" would establish a non-profit, publicly-financed, privately-delivered health care system that would ensure that all Americans have meaningful access to the medical provider of their choice.

This legislation currently enjoys the support of 78 other Members of Congress—more than any other universal health care bill. It has also been endorsed by a diverse coalition of local governments, labor unions, civil rights organizations, medical

professional organizations, and communities of faith that represent over 20 million people.

Most importantly, my bill has been endorsed in the court of public opinion. An Associated Press/Yahoo News poll conducted in December of 2007 found that 65% of the American people believe that the "United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the government and financed by the taxpayers."

I want to leave plenty of time for the stellar panel of health care experts assembled here today to answer the committee's questions, but, first, I would like to briefly address some of the myths about single-payer reform that will surely be addressed by some Members today. It is my hope that, with this hearing, we can begin to remove the cloud of misinformation and disinformation that has, until recently, resulted in universal single-payer reform being "off the table" at both ends of Pennsylvania Avenue.

Opponents of single-payer argue that scarcity of care and long waiting lines will inevitably occur in universal single-payer systems. The facts show otherwise. Waiting lines exist when government invests too little in the medical professionals and equipment that make up our health care infrastructure. It is true that Canada and the United Kingdom have had waits for elective procedures, but that is because they spend 60% and 33% less than we do on health care. Waiting lines do not exist in countries that adequately fund national health care. As long as health care is a priority for our nation, this problem will never materialize.

Another argument utilized by those skeptical of single-payer reform is that we cannot afford a single-payer system where we insure every man, woman, and child in the United States. In fact, according Dr. Steffie Woolhandler of Harvard Medical School, implementing a single-payer system with non-profit delivery would save approximately $300 billion dollars per year and contain long-term costs. If we deliberately hold down costs with a cohesive and efficient public-private partnership, we can afford to provide true universal health care with the $2.5 trillion we already spend each year.

The naysayers will also argue that dismantling our employer-based health care system is politically and economically untenable. We have heard this argument before. This argument was initially raised when Medicare was debated in the Congress in the 1960s. Yet, Medicare was enacted in 1965 and fully implemented in 1966.

Additionally, the experience of the nation of Taiwan shows that such a transition is feasible. Until 1995, Taiwan had a private health insurance market remarkably similar to our own. Over the course of the next six years, the country seamlessly transitioned to a single-payer national health insurance system. Today, their system boasts a 70 percent approval rating from doctors and patients, while only spending 2 percent on administrative costs.

I would like to caution the committee about the dangers of enacting partial reforms that leave some individuals uninsured, grow the ranks of the underinsured, and do little to contain the out-of-control growth of health expenditures. The best example of such a legislative failure is the Massachusetts Health Reform Act, enacted by that state's legislature in 2006. The Massachusetts reform effort has failed to contain costs and provide universal coverage because it is built around our broken for-profit private insurance system.

Instead of pursuing a reform strategy that has been successful in developed nations around the world—namely, improving access to health insurance that emphasizes prevention, functions without a profit motive, has low administrative costs, has minimal financial barriers to care, and maximizes value for patients—lawmakers in Massachusetts instead created a government-sanctioned monopoly for an industry that has left thousands of state residents without health insurance due to escalating premiums, co-pays, and deductibles.

Not surprisingly, without the cost-containment measures that are integral parts of any public insurance plan, health care spending has exploded in Massachusetts. In fiscal year 2009, the reform cost taxpayers $1.3 billion dollars. As a result, Governor Deval Patrick has been forced to cut money from safety-net providers such as public hospitals and community clinics. If the goal of reform is to limit costs and improve access to care, I would respectfully submit that single-payer offers a far better model for reform than the incremental, private insurance giveaway pursued in Massachusetts.

I want to again thank the Chairman for providing this forum for the serious consideration of the single-payer concept at this critical juncture in our nation's history. We are the richest country in the world and our doctors and medical facilities are the envy of our neighbors. Yet, our broken private insurance system burdens our business community and allows many of our fellow citizens to die and be hurt un-

necessarily. Two thirds of our nation's personal bankruptcies can be attributed directly to an individual's inability to pay medical bills. A single payer system will allow us to cover everyone without spending any more money than we do now. The sooner we adopt a uniquely American single-payer system, the sooner we can start enjoying a healthier and more prosperous America.

Chairman ANDREWS. Thank you, Mr. Chairman. As usual, you have contributed a great deal of substance and given us an awful lot to think about, which we are going to think about right now with the witnesses we have coming up.

I can assure you that the principles you are putting forward will be very much a part of this committee's deliberations and thoughts. And we view this as the beginning of the process and not the end.

And I do want to acknowledge our colleague, Congresswoman Watson is with us in the audience from California. We are happy to have her with us as well.

Again, Mr. Chairman, so we can get to the lay witnesses I am going to forgo asking any questions. Is there a member on either side that would like to ask the chairman a question?

That is a very good decision. Thank you very much. We appreciate that.

Thank you, Mr. Conyers, for coming. We are going to get to our lay witnesses. Thank you very much. Thank you for being here.

If I can ask the witnesses to come forward. I am going to read biographies to save us a little bit of time to get right to the testimony.

There are a series of votes coming up. Do we know when this morning?

Shortly. So we want to get started so we are not interrupted.

Ms. Geri Jenkins is a registered nurse and a member of the Council of Presidents of the California Nurses Association/National Nurses Organizing Committee. She has over 30 years of experience as a surgical, ICU, and trauma R.N. with the University of California, San Diego Medical Center's Hillcrest Campus. She received her B.S.N. from San Diego University.

Ms. Jenkins, welcome. We are glad you are with us.

Dr. Walter Tsou is a nationally known consultant on public health and health care reform. Currently, he is on the visiting faculty of the University of Pennsylvania, after serving as the President of the American Public Health Association in 2005, and was Health Commissioner of Philadelphia from 2000 to 2002—under Mayor Rendell, I assume. Correct?

He received his medical degree from the University of Pennsylvania, his M.P.H. from the Johns Hopkins School of Hygiene and Public Health, and he has an honorary doctorate in medical sciences from Drexel University.

Welcome, Doctor. It is great to have you with us.

Dr. David Gratzer, a physician, is a Senior Fellow at the Manhattan Institute. His research interests include consumer-driven health care, Medicare and Medicaid, drug re-importation, and FDA reform. His writing has graced the pages of more than a dozen newspapers and magazines, including the Wall Street Journal, the Washington Post, the Los Angeles Times, and the Weekly Standard.

Dr. Gratzer has recently been cited in the New England Journal of Medicine—a well-known publication—New England Journal of Medicine, Health Affairs, as well as by major media outlets across the United States and Canada.

Dr. Gratzer holds a B.S. and an M.D. from the University of Manitoba.

And, finally, Dr. Marcia Angell is a Senior Lecturer in the Department of Social Medicine at Harvard Medical School. Dr. Angell writes frequently in professional journals and the popular media on a wide variety of topics, including health policy, the interface of medicine and the law, care at the end of life, and the relations between industry and academic medicine. A graduate of the Boston University School of Medicine, she trained in both internal medicine and anatomic pathology, and is a board certified pathologist.

Welcome.

What a distinguished panel.

For those of you who have not been here before, in front of you is a battery of lights; and the battery of lights will have a green light when you begin your testimony. Your written testimony is accepted without objection for the written record of the hearing, so your written testimony is fully in the committee record.

We would ask you to give us about a 5-minute synopsis of the written testimony orally. The reason we limit you to 5 minutes is so we can maximize time for questions and answers with the Members of Congress that are here on the dais.

A yellow light will appear when you are about a minute away from the end of your time period. We would ask you to try to wrap up your remarks.

And when the red light goes on, you will be finished and we will move on to the next witness.

So, Ms. Jenkins, welcome. It is good to have you with us. You are on.

STATEMENT OF GERI JENKINS, R.N., MEMBER, COUNCIL OF PRESIDENTS, CALIFORNIA NURSES ASSOCIATION

Ms. JENKINS. Thank you, Chairman Andrews and Ranking Member Kline, and the distinguished members of the subcommittee. I would like to thank you for this opportunity to support single-payer health care reform on behalf of the 86,000 members of the California Nurses Association/National Nurses Organizing Committee, the country's largest organization representing direct care registered nurses. I am proud to be a Co-President of CNA/NNOC, and I especially want to thank Education and Labor Committee Chair George Miller, who is a great champion of health care reform of R.N.s and of all working people.

In your consideration of changes to our health care system, you should know that registered nurses are the profession most trusted by the American public, as shown consistently in Gallup's annual poll on this question. Nurses are on the front lines of what I can only call a patient care crisis.

As a critical care nurse at the University of California, San Diego Medical Center, I see patients whose conditions are much worse because they avoided earlier treatment due to the high costs. Though they arrive sicker, they leave quicker than they should because

their insurance companies won't approve medically appropriate care.

I can tell you from my more than 34 years of experience, insurance companies ration care. The current systems ration care based on the ability to pay. Some patients, like 17-year-old Nataline Sarkysian, do not get the lifesaving treatment they need.

In Nataline's case, she needed a liver transplant, but CIGNA would not approve it until I and hundreds of others protested. During one of the protests, I was with Hilda, Nataline's mother, when she got the call that CIGNA had approved the transplant. But it was too late. Nataline died an hour later.

It doesn't have to be that way. We agreed with Presidential Candidate Obama, who called health care a basic human right; and we agree with now-President Obama who says health care reform is not a luxury, it is a necessity that cannot wait.

The same is true of health care itself. Right now, we are the only nation on Earth that barters human life for money. We need a guaranteed single standard of high-quality health care for all.

To make the change we need, let's have a real policy debate on the merits.

People talk about evidence-based practice. We need evidence-based policy. If we were to have a debate on containing costs, improving quality and universality, the single-payer advantage would be clear. Let's consider the principles President Obama has established.

First, reduced costs. In a survey of eight major industrialized countries, the U.S. fared the worst in out-of-pocket costs and the number of chronically ill adults forgoing care because of costs, even though the U.S. spends twice as much per capita on health care as the others. Twenty-five percent of Americans are skipping doctor visits because of cost, and that was before the recession.

According to another survey in October 2008, 38 percent of Americans who are insured delay care because of out-of-pocket costs. The reason? Premiums have been rising four times as fast as family income in the past decade, and copays, deductibles, and other transaction fees the insurance industry imposes that can run to thousands of dollars a year on top of premiums. That, along with denying claims, is how the for-profit insurance companies make money, which ultimately is their job for their shareholders, not authorizing care delivery.

Unless you can stop the insurance industry price gouging, we simply cannot make health care affordable, which means you either have price controls on the insurance industry or you take them out of the equation through a single-payer reform.

Cost controls are much better addressed under single-payer mechanisms like those contained in H.R. 676: global budgets to hospitals and clinics based on their patient care operations, negotiated reimbursements to providers, bulk purchasing, and negotiated prices for prescription drugs, incentives for preventive care, and reliance on primary care.

Second, guaranteed choice. How many Americans under 65 can go to any doctor of their choice without incurring additional costs, or at all? Very, very few. Certainly not those 94 percent of U.S. metropolitan areas that are served by one or two insurance compa-

nies, as shown in the AMA's 2008 study of insurance markets. Insurance coverage and companies now control patient choice of provider and treatment, often with terrible health results.

I often relay the story of a patient, seriously ill and in need of immediate intubation, who turned up in an emergency room in my community. He needed to be intubated, which is the insertion of a breathing tube, to save his life. Because he was so worried about cost, the patient looked up at his nurses and doctors caring for him and said, "Can you wait until next week? I will be 65 and have Medicare."

Respectfully, that is not the way my patients or their providers should be making their health care decisions, nor is it the way our Nation should force citizens to evaluate their health care decisions. One of the great advantages of single-payer is that it guarantees patients the ongoing choice of a doctor or other provider who will pay for providing treatment on the same basis.

Third, ensuring affordable care for all. Here again, single-payer has the advantage from a clinical point of view. Taiwan is the most recent country to have adopted single-payer, in 1995. The percentage of people with health insurance climbed from 57 percent to 97 percent, yet the expanded coverage produced little, if any, increase to overall health care spending beyond normal growth due to rising population income. Taiwan had a system much like ours, multipayer, dysfunctional, and broken. They made the switch just a decade ago, though some people said it could not be done, with great success for their people.

The U.S. ranks among 19 leading industrialized nations in preventable deaths—we rank last among 19 leading industrial nations in preventable deaths. We are last out of 19. If the U.S. matched the top three—France, Japan, and Australia—in timely and effective care, 101,000 fewer Americans would die every year.

In a study released earlier this year by CNA and which is included as an exhibit in my written testimony, it has been shown that extending Medicare to all would not only provide desperately needed medical care to millions, but would also result in the creation of 2.6 million new jobs in this Nation.

The evidence is clear. Single-payer works. It best meets the President's principles. And, most important, it best meets the needs of my patients for whom I have a professional responsibility to advocate.

Our history proves that with political leadership, any reform that benefits the American people as a whole is politically viable. Dare we waste this moment with a reform that will not adequately control costs, be truly universal, improve quality and guarantee choice of doctors and providers, or will we leave the American people feeling that the moment was wasted and that, once again, they cannot trust their government to genuinely act in their interests?

Let's enact single-payer and let's put patients first. Thank you very much.

Chairman ANDREWS. Thank you, Ms. Jenkins, very much. And, once again, your entire written statement will be made part of the record.

[The statement of Ms. Jenkins follows:]

Prepared Statement of Geri Jenkins, R.N., Co-President, California Nurses Association and National Nurses Organizing Committee

Chairman Andrews, Ranking member Kline and distinguished members of the Committee, thank you for this opportunity to support single-payer healthcare reform on behalf of the 86,000 members of the California Nurses Association/National Nurses Organizing Committee, the country's largest organization representing direct care Registered Nurses. I am proud to be a co-president of CNA/NNOC. I especially want to thank Education and Labor Committee chair George Miller, who is a great champion of healthcare reform, of R.N.s and all working people.

In your consideration of changes to our healthcare system, you should know that Registered Nurses are the profession most trusted by the American public, as shown consistently in Gallup's annual poll on this question.

Nurses are on the front lines of what I can only call a patient care crisis. As a critical care nurse at the University of California San Diego Medical Center, I see patients whose conditions are much worse because they avoided earlier treatment due to the high cost. Though they arrive sicker, they leave quicker than they should because their insurance company won't approve medically appropriate care.

I can tell you from my more than 34 years of personal experience, insurance companies ration care; the current system rations care based on ability to pay.

Some patients like 17 year old Nataline Sarkysian, do not get the life-saving treatment they need. In Nataline's case, she needed a liver transplant but CIGNA would not approve it until I and hundreds of others protested. During one of the protests, I was with Hilda, Nataline's mother, when she got the call of approval. But it was too late. Nataline died an hour later.

It doesn't have to be this way. We agree with Presidential Candidate Obama who called healthcare a basic human right and we agree with now-President Obama who says, "Healthcare reform is not a luxury. It's a necessity that cannot wait." The same is true for healthcare itself.

But right now we are the only nation on earth that barters human life for money.

To make the change we need, let's have a real policy debate on the merits. People talk about evidence based practice, we need evidence based policy. If we were to have a debate on containing costs, improving quality, and universality, the single-payer advantage would be clear.

Let's consider the principles President Obama has established:

• First, Reduce Costs

In a survey of eight major industrialized countries the US fared the worst in out-of-pocket costs and the number of chronically ill adults forgoing care because of costs—even though the US spends twice as much per capita on healthcare as the other seven (Health Affairs, Nov. 13, 2008). 25% of Americans are skipping docotrs visits because of costs (and that's before the recession). According to another survey in October, 2008, 38% of Americans who are insured delayed care because of out-of-pocket costs.

The reason? Premiums . . . which have been rising four times as fast as family incomes the past decade—and co-pays, deductibles, and other transaction fees the insurance industry imposes that can run to thousands of dollars a year on top of premiums. That, along with denying claims, is how the for-profit insurance companies make money, which, ultimately is their job for their shareholders, not authorizing care delivery. Unless you can stop the insurance industry price gouging, we simply cannot make healthcare affordable, which means you either have price controls on the insurance industry, or you take them out of the equation through single payer reform.

Costs controls are much better addressed under single-payer mechanisms like those contained in HR 676—global budgets to hospitals and clinics based on their patient care operations; negotiated reimbursements to providers; bulk purchasing and negotiated prices for prescription drugs; incentives for preventive care and reliance on primary care.

• Second, Guarantee Choice

How many Americans under 65 can go to any doctor of their choice without incurring additional costs, or at all? Very, very few, certainly not those in 94% of U.S. metropolitan areas that are served by one or two insurance companies, as shown in the AMA's 2008 study of insurance markets. Insurance coverage and companies now control patient choice of provider and treatment—often with terrible health results.

I often relay the story of a patient seriously ill and in need of immediate intubation—insertion of a breathing tube—to save his life. Because he was so worried about costs, the patient looked up at his nurses and asked, "Can't you wait until next week? I'll be 65 and I'll have Medicare."

Respectfully, that is not the way my patients or their providers should be making their healthcare decisions nor is it the way our nation should force its citizens to evaluate their healthcare decisions.

One of the great advantages of single-payer is that it guarantees patients the ongoing choice of a doctor or other provider, who are paid for providing treatment on the same basis.

• Third, Ensure Affordable Care for All

Here again, single-payer has the advantage from a clinical point of view. Taiwan is the most recent country to have adopted single-payer, in 1995. The percentage of people with health insurance climbed from 57% to 97% yet the expanded coverage produced little if any increase in overall healthcare spending beyond normal growth due to rising population and income. Taiwan had a system much like ours, multi-payer, dysfunctional, and broken; they made the switch just a decade ago, though some people said it could not be done, with great success for their people.

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Let's enact single-payer. Let's put patients first.

Chairman ANDREWS. Dr. Tsou, welcome to the committee.

STATEMENT OF WALTER TSOU, M.D., M.P.H., NATIONAL BOARD ADVISOR, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, AND FORMER HEALTH COMMISSIONER OF PHILADELPHIA

Dr. TSOU. Thank you. Congressman Andrews, Ranking Member Kline, and members of the Health Subcommittee, my name is Dr. Walter Tsou. I am a public health physician and former Health Commissioner of the City of Philadelphia.

If you believe that every American has the right to quality, affordable health care, then the only affordable means to achieve that goal is through a properly financed single-payer national health insurance program. Attempting to reconcile the dual imperatives of universal coverage and cost control through alternative methods besides single-payer is an exercise in futility. It is clear that cost controls means that someone's ox gets gored, either the taxpayers, physicians and hospitals or the private health insurance industry.

When some congressional leaders declare that, quote, "Single-payer is off the table," they are in effect saying that insurers will be protected, leaving the pain to patients, taxpayers, and health care providers. Let's examine each of these categories.

For the taxpayers, it is difficult to understand why we must endure an additional $1.5 trillion or more over the next decade in expenses at a time when our Nation already spends 50 percent more per capita on health care than any other country in the world. For physicians and hospitals, simply cutting reimbursements is counterproductive, especially at a time when we need to increase reim-

bursements for primary care and mental health services. And for the private insurance industry, well, they have dominated health care for the past 50 years, but it doesn't work.

Despite a supposedly competitive marketplace, health care costs have skyrocketed, nearly 50 million Americans are uninsured, and the quality of care for most Americans is, quote, "suboptimal." Choice is a total misnomer. Americans want to be able to choose their doctor and hospital, not their health plans.

A humane health care system should reinforce the safety net in the face of our Nation's worst recession since the Great Depression, but our profit-driven system kicks millions of Americans in the gut and leaves them both jobless and uninsured. We have saddled our Nation with an inefficient and exorbitantly expensive health care system that drives jobs overseas, where health benefit costs are low, and discourages entrepreneurs from striking out on their own for fear of losing their insurance coverage.

We need a far greater investment in community-based public health and preventive medicine, including home visitation for newborns and public health nurses doing chronic disease management in the community. But where will we get the funds?

Single-payer is the only reform that can control health care costs. It does so by cutting insurance firms' profits, streamlining the massive administrative apparatus that adds to the costs of hospitals and doctors' offices, using bulk purchasing, negotiating fee schedules for physicians, and putting hospitals on predictable global budgets.

The $19 billion that has been set aside for health information technology is doomed to fail because it is dependent on a complex, fragmented health care financing system.

In contrast, consider Taiwan, as Geri noted, where everyone has a smart card. Your smart card carries your medical history and can be viewed by any doctor in Taiwan. Their national database allows them to identify the few outliers who try to abuse the system rather than hassling millions of doctors and patients.

What the Internet had done to transform telecommunications across the world is what single-payer will do to transform how we deliver health care in America. A national public health database would allow us a direct resource to areas of greatest need. We can change the incentives of reimbursement to advance our national health goals embodied in Healthy People 2020 and reward communities that help achieve those goals. This would encourage health professionals and hospitals to work together with their local health department to advance national health objectives.

President Obama has stated that if he were to start over again, he would favor a single-payer system, but argues that moving to single-payer is too radical. Well, I come from Philadelphia where revolutionary ideas are celebrated, not dismissed.

Our most famous radical document begins with these words, "We the People," not "We the Insurers":

We the People of the United States, in Order to form a more perfect Union, to promote the general Welfare and secure the Blessings of Liberty to ourselves and our Posterity do ordain and establish this Constitution for the United States of America.

This Nation captured the world's imagination with bold ideas that put the people first. It is time for our own generation's revolution. Thank you.

Chairman ANDREWS. Thank you, Dr. Tsou. Thank you very much.

[The statement of Dr. Tsou follows:]

Prepared Statement of Dr. Walter Tsou, National Board Advisor, Physicians for a National Health Program

Congressman Andrews and members of the HELP subcommittee, my name is Dr. Walter Tsou. I am a public health physician and former Health Commissioner of Philadelphia.

If you believe that every American has the right to quality, affordable health care, then the only affordable means to achieve that goal is through a properly financed, single-payer, national health insurance program.

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Let's examine each of these categories:

For the taxpayers, it is difficult to understand why we must endure an additional $1.5 trillion or more[1] over the next decade in expenses at a time when our nation already spends 50% more per capita on health care than any other country in the world?

For physicians and hospitals, simply cutting reimbursements is counterproductive, especially at a time when we need to increase reimbursements for primary care and mental health services.

For the private insurance industry, they have dominated health care for the past fifty years, but it does not work. Despite a supposedly competitive marketplace, health care costs have skyrocketed, nearly 50 million are currently uninsured, and the quality of care for most Americans is "suboptimal."[2] Choice is a total misnomer. Americans want to be able to choose their doctor and hospital, not their health plans.

A humane health care system should reinforce the safety net in the face of our nation's worst recession since the Great Depression, but our profit-driven system kicks millions of Americans in the gut and leaves them both jobless and uninsured. We have saddled our nation with an inefficient and exhorbitantly expensive health care system that drives jobs overseas where health benefit costs are low, and discourages entrepreneurs from striking out on their own for fear of losing their insurance coverage.

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[1] *http://www.washingtontimes.com/news/2009/mar/18/health-care-reform-likely-15-trillion/*
[2] *http://www.ahrq.gov/qual/nhqr08/Key.htm*

health goals embodied in Healthy People 2020 and reward communities that help achieve those goals. This would encourage health professionals and hospitals to work together with local health departments to advance national health objectives.

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Chairman ANDREWS. We are privileged to welcome Dr. Gratzer. You are on.

STATEMENT OF DAVID GRATZER, M.D., SENIOR FELLOW, MANHATTAN INSTITUTE FOR POLICY RESEARCH

Dr. GRATZER. Thank you, Mr. Chairman, members of the committee, Members of Congress.

Mr. Chairman, I am particularly delighted to have received such a warm introduction. Listening to the fawning accomplishments you spoke of, I was reminded of a former colleague who had commented to me that, on paper, I seem quite interesting.

Mr. Chairman, and members, I have been here for a few moments, as have you, and I have had the opportunity to hear from a few of your colleagues, a few of my copanelists; and, curiously, I have yet to hear the name Claude Castonguay mentioned once. I suppose perhaps it is not so surprising, given that Mr. Castonguay has been out of elected office for three decades. And when he was in elected office, Mr. Castonguay, in fact, wasn't even American. He was a Quebecer, a Canadian.

But Mr. Castonguay's name jumps to mind today at these hearings because of his thoughts on government and health care; and as we move forward and Congress debates something much larger in the coming months, Mr. Castonguay, for those of us born and raised north of the 49th parallel like myself, is somewhat of a heroic figure.

In the 1960s, he was tasked by the Quebec government to consider what would be an appropriate way to organize health care. Mr. Castonguay's report called for a single-payer system. He is known as the Father of Quebec Medicare, as single-payer is known there, because of the report. And then, in an unusual twist and turn of career, he was actually elected to office and appointed minister of health and implemented his own report. Quebecers for decades thereafter referred to the government-issued health card as a Castonguette, in his honor.

Last year, he was tasked again by the Quebec government to review the system and recommend proposals for reform. Mr. Castonguay did not mince his words. He suggested that the system is, quote/unquote, "in crisis," that the days of simply throwing money into the system and rationing care ought to be over, and he argued for a more robust rule for private sector health care. He went so far as to advocate not just copays or user payments, but to suggest that public hospitals actually ought to lease out unused

office space in off hours to private physicians and thus stoke the fires of entrepreneurship. Mr. Castonguay has changed his mind.

To put that in perspective: When the father of Quebec Medicare changes his mind, it is as though—I don't know—John Maynard Keynes on his deathbed in 1946 in England suggests that maybe there is a problem with socialism.

Why would this gentleman change his mind on government-run health care? Well, let me just outline a couple of things in Canadian newspapers over the last couple of weeks—not reports I have written or right-wing think thanks or watchdog groups, just things that have appeared in the newspapers that I have picked. And you can Google this later if you doubt what I am suggesting.

There is a couple in Quebec that are entertaining a lawsuit against the government because, you see, at 5:00 in the morning in a hospital, in active labor, they buzz the nurse and no one came. They ended up delivering their own child without any medical assistance. This wasn't in a rural hospital. This is one of the largest hospitals in Quebec. I guess that is consumer-driven health care, Canadian style.

One is aware that, according to the Ontario government's own guidelines, three-quarters of patients requiring urgent cancer surgery don't get it in a timely manner—not according to my standards, according to the standards outlined by the Ontario government.

And, of course, there are the issues around value and quality where, in Quebec, there is an intense review going forward suggesting that maybe one in every four breast cancer test results was tainted and thus unreliable. One in four.

Mr. Castonguay has changed his mind, and certainly I can appreciate where he comes from. I was born and raised in Canada as well, from a little town smack dab in the middle of the prairies, Winnipeg. On a cold winter's day, it can drop to 40 below on the prairies. That is the same in Celsius as in Fahrenheit.

I guess I am a son of Castonguay. Not literally, but as somebody a generation younger than him, I grew up under socialized medicine, and I understand why people would believe in a single-payer system, why they believe it would be compassionate and more equitable than the system of the United States. But like Mr. Castonguay, I changed my mind because I saw the reality in Canada and in Britain and across Europe.

We will speak much of anecdote today, but we should also speak of statistics. Cancer outcomes are better in the United States than they are in Canada. Survival rates are better for low-birth-weight children. Even the income inequity health gradient is better in the United States than in Canada and in Britain.

I understand the temptation of single-payer because I used to believe in it. But as Congress moves forward and we discuss this option, but also a government public plan option which might swallow up 120 million people from the private insurance market, I would suggest to you that answers don't lie north of the 49th parallel or in Europe, but the United States needs a "Made in the U.S.A." solution.

Thank you, sir.

Chairman ANDREWS. Doctor, thank you for your participation.

[The statement of Dr. Gratzer follows:]

Prepared Statement of David Gratzer, M.D., Senior Fellow, Manhattan Institute for Policy Research

Thank you for the opportunity to testify today as Congress begins this critical debate. The decisions legislators may soon make will be critical, not only for the future of health care in the United States, but also for patients around the world who benefit from American innovations in health-care practice and medical technology.

My concerns about the option under discussion today are drawn from practical personal experience—as a physician born and trained in Canada, as the author of two books (and the editor of a third) on comparative health-care policy, and as a senior fellow at the Manhattan Institute. (For the record, the views I present are my own and do not necessarily represent those of the Manhattan Institute.)

The U.S. health-care system needs reform. But in the sincere search for a simple solution, many critics mistakenly believe the Canadian single-payer model represents a "magic bullet" alternative. Others believe a so-called "public plan option" will provide the benefits of a single-payer model without the usual disadvantages, ignoring the experience of other jurisdictions that learned that incrementally introducing publicly-administered insurance simply produces the same challenges at an incremental speed.

To understand the single-payer system, it is important to realize that in the Canadian model "single-payer" is really a polite euphemism for a government-funded, government-managed system. While American observers speak of Canadian medicare as if there is one federal insurance plan, in truth, ten balkanized provincial insurance systems make different decisions on care and coverage in response to a general federal mandate. Insurance is nominally portable between provinces, but gaps in coverage have appeared when Canadians moved from one province to another.

Each provincial insurance plan is funded partly by generous federal transfers. The White House hopes that health reform will reduce health costs without damaging quality, but the story of the Canadian system is the story of provincial governments struggling to manage health-care costs alongside other budget priorities. When budgets are insufficient, the provinces lobby for more federal transfers, go into deficit, and/or limit care by managing supply.

Critics of the American system note that it fails to provide universal coverage to its citizens. But Canada's single-payer system also denies care; instead of denying insurance coverage, Canada's public insurance plans simply limit the supply of costly medications and capital-intensive procedures.

Shortly before Oregon's referendum on a single-payer health-care system, a man wrote to his local paper, claiming that under a single-payer system, "you just send your doctor's bill to the government and they pay it." But it is not so simple. Canadian governments all have a strong interest in managing cost, and so the gentleman from Oregon ignored two problems: first, he would have to get in to see the right doctor in the first place. Then, there are limits to what that doctor would permitted to bill for.

Even now, after a decade of joint federal-provincial efforts to reduce waiting lists, wait times for some procedures are still rising. The Canadian Institute for Health Information is the designated reporting agency for health-care wait times, and in several categories in 2008, provinces did not even meet the benchmark standard for service. To put that in context, the benchmark for "timely" service for coronary, bypass, hip replacement or knee replacement surgery is 75% or more of patients receiving treatment within 182 days.

In Alberta, Canada's wealthiest province, 50% of outpatients in 2008 had to wait more than 41 days for an MRI scan. In Saskatchewan, 10% of patients awaiting knee replacement surgery had to wait 616 days or more. In Nova Scotia, 50% of patients needing hip replacement surgery waited 201 days or longer. These are the government's own numbers. Studies by the Fraser Institute and other health-care watchdogs often produce a more disturbing picture.

Timely service is not the only casualty of rationed care. Diabetic Canadians have been denied insurance coverage for insulin pumps available under HMO plans in the United States. Newer medications or orphan drugs available to insured Americans are routinely excluded from provincial formularies, often after decisions made in closed-door hearings by Canada's Common Drug Review process. Finally, Canadians often turn to the United States for life-saving diagnostic exams or surgical procedures at private expense, either to outflank waiting lists or avoid outright denials of coverage by their provincial insurance plans. In one tragic case in the 1990s,

fifty Canadians died waiting for a basic cardiac test according to the Canadian Medical Association Journal in a 2002 article.

American advocates for a Canadian model repeatedly insist that "patients can choose any doctor they like." However, there is a shortage of doctors to choose from in Canada because governments forced medical faculties to reduce the supply of doctors graduating in the 1990s in an effort to contain costs. In June 2008, Statistics Canada reported that 4.1 million Canadians aged 12 and over were without a family doctor, rendering the freedom to choose a meaningless benefit.

Critics of the American system argue that health outcomes are unacceptable in part because Canada and other single-payer systems perform better on measures of life expectancy. But life expectancy is a product of a complex series of inputs, including wellness, fitness, and other environmental factors—like America's anomalously high homicide rate.

A better measure of health insurance outcomes is to compare outcomes for people who actually need insured care. And in a paper entitled Health Status, Health Care and Inequity: Canada versus the U.S. (2007), June O'Neill and Dave O'Neill made just such a comparison.

The O'Neills concluded that, and I quote, "direct measures of the effectiveness of health care show survival rates for individuals diagnosed with various types of cancer are higher in the U.S. than in Canada, as are infant survival rates of low-birth weight babies." Their study also found that despite "free" public insurance, Canadians in at-risk populations were significantly less likely to have had key preventative diagnostic procedures. Canadians in target groups were over 15% less likely to have ever had a mammogram than American patients, 10% less likely to have a PAP smear, 30% less likely to have had a PSA test for prostate cancer, and over 20% less likely to have ever had a colonoscopy test for colorectal cancers. The Canadian system is the best in the world, as long as you are not actually sick.

The limits of single-payer insurance are a consequence of a common political reality: if governments fund it, governments wear it. Once the so-called single-payer system is in place, government insurers are obliged to manage costs politically, making decisions about capital investments, technology, and even the supply of licensed medical professionals based on short-term budgetary or political priorities. So while Canada's health-care system was once supported by a healthy level of private capital investment, in many provinces, the politics of protecting the public system from the "threat" of competing market (e.g. patient) demands has led some governments to literally ban or buyout private providers wherever possible. For example, in 2004, the Ontario provincial government "repatriated" several privately-owned MRI clinics, despite the fact that all of them were providing publicly insured services. The reason given was ideology: it was unacceptable for a private firm to profit from diagnostic tests, even if the tests were provided at rates set by the government.

This cycle explains why Canada evolved from a universal insurance system delivered largely by private and non-profit care providers to a system that is largely publicly managed or administered in 2009. Pursuing a public option plan to provide single-payer service alongside private insurers is likely to lead inexorably to the same result as a pure single-payer model. The larger the public's share of the insurance system, the greater the demand on elected officials to wade in and control costs or deliver benefits directly.

These challenges appear in different forms across the single-payer world. Wait times, rationed care and inefficient public management is inevitable in single-payer systems because they all face the same health-care demands as the American system. No matter how tightly managed or rationed, Western health-care systems are all under pressure to cope with rising costs from aging, new technology and competition for health care professionals.

Health care's share of the provincial budget is approaching 40% of the provincial budget in Manitoba, a Canadian province that already prides itself on generous social welfare benefits, college subsidies and other social programs. The province of Ontario created a new health surtax in 2004—and the total budget for its single-payer health system is projected to grow by close to 6% annually in the next three years.

These are familiar stories in the United Kingdom and other single-payer systems. In the UK, the existence of a parallel private insurance system has not curtailed the explosive growth of the public system, nor the management problems that go hand in hand with public delivery. In 2007, a columnist for the Times of London quipped that "The [National Health Service] generates its own inflation as though it were a country in its own right." According to the NHS's own data, the Service's budget has on average exceeded inflation by 3% annually over the entire sixty-year lifetime of the Service. The 2009 NHS budget is over 56% larger than it was in the

fiscal-year ending 2003, even after a round of "efficiencies" were built into the 2009 budget plan.

With all of this investment, the UK's NHS has finally achieved its best wait list results since it began tracking wait times in 1948. But once again, success is relative; the standard for timely care in the NHS is that patient treatment must wait no more than 18 weeks for treatment once referred by a general practitioner.

Many in the United States Congress hope to quickly solve America's complex health care challenges either by embracing a single-payer model now, or moving incrementally to the Canadian system through the back door with a public insurance plan in the private marketplace. But experience shows that sooner or later, these alternatives risk destroying the best features of the American system in order to remedy the worst.

Congress can instead choose options that will fight cost escalation, preserve innovation and protect the high quality of American health care. But before these options will ever be properly considered, supporters of the single-payer model must honestly face up to the realities of the system in Canada and elsewhere. Single-payer models are far more complex and inefficient than their American supporters believe them to be. They are managed and rationed much more aggressively than their supporters believe them to be. And a careful review of those challenges, I believe, would convince most observers that the single-payer model is not the 'magic bullet' that American policymakers are hoping for.

Chairman ANDREWS. Dr. Angell, you are our wrap-up witness for this morning.

STATEMENT OF MARCIA ANGELL, M.D., SENIOR LECTURER, HARVARD MEDICAL SCHOOL, AND FORMER EDITOR – IN – CHIEF, NEW ENGLAND JOURNAL OF MEDICINE

Dr. ANGELL. Chairman Andrews, members of the subcommittee, thank you for inviting me and for your leadership on this important issue.

The reason our health system is in such trouble is that it is set up to generate profits, not to provide care. To pay for care, we rely on hundreds of investor-owned insurance companies that profit by refusing coverage to the sickest patients and limiting services to the others. And they cream roughly 20 percent off the top of the premium dollar for profits and overhead.

Our method of delivering care is no better than our method of paying for it. We provide much of the care in investor-owned health facilities that profit by providing too many services for the well-insured and too few for those who cannot pay. Most doctors are paid fee-for-service, which gives them a similar incentive to focus on profitable services, particularly specialists who receive very high fees for expensive tests and procedures. In sum, health care is directed toward maximizing income, not maximizing health.

Most current reform proposals would leave the present profit-driven and inflationary system essentially unchanged and simply pour money into it, an unsustainable solution. That is what is happening in Massachusetts, where we have nearly universal health insurance, but costs are growing so rapidly that its long-term prospects are bleak unless we drastically cut benefits and greatly increase copayments. We are learning that health insurance is not the same thing as health care. It may be too skimpy or too expensive to actually use.

Initiatives such as electronic records, disease management, preventive care, and comparative effectiveness studies may improve care, but experts agree that they are unlikely to save much money. Promises by for-profit insurers and providers to mend their ways

voluntarily are simply not credible. Regulation is also unlikely to modify profit-seeking behavior very much without a bureaucracy so large that it would create more problems than it solves.

Nearly every other advanced country has a largely nonprofit national health system that provides universal comprehensive care. Expenditures are, on average, less than half as much per person and health outcomes are generally much better.

Moreover, contrary to popular belief, these countries offer more basic services, not fewer, more doctor visits and longer hospital stays, more doctors and nurses. But they don't do nearly as many tests and procedures, because there is little financial incentive to do so.

It is true that there are waits for some elective procedures in some of these countries such as the U.K. and Canada, but that is because they spend far less on health care than we do. If they were to put the same amount of money into their systems as we do into ours, there would be no waits. For them, the problem is not the system, it is the money. For us, it is not the money, it is the system. We already spend more than enough.

Now, it is often argued that the first order of business should be to expand coverage and then worry about costs later. But it is essential to deal with both together to stop the drain on the rest of the economy and the further erosion of health care.

The only way to provide universal coverage and to control costs is to adopt a nonprofit single-payer system like that called for in H.R. 676. Anything else will either increase costs or decrease coverage inevitably.

Medicare is a single-payer system with low overhead costs, but it uses the same profit-oriented providers as the private system, so its costs are rising almost as rapidly. Setting up a Medicare-like public program to compete with private insurers, as advocated by the President, would have the same problem and, also, not realize the administrative savings of a true single-payer system. I also worry that the insurance industry would use its clout to underfund the public program and make it a dumping ground for the sickest, costliest patients, creaming off the profitable ones for themselves.

I am aware that phasing out the private insurance industry would mean a loss of jobs, but I believe the job loss in that sector would be more than offset by job gains in the rest of the economy which would no longer be saddled with the exorbitant cost of an industry that offers almost nothing of value. Thank you very much. And I look forward to your questions.

Chairman ANDREWS. Well, thank you, Dr. Angell, very much.

[The statement of Dr. Angell follows:]

Prepared Statement of Marcia Angell, M.D., Senior Lecturer in Social Medicine, Harvard Medical School, Former Editor-in-Chief, New England Journal of Medicine

The American health system is uniquely expensive and inflationary. Last year we spent about $2.5 trillion on health care, or some $8,000 per person, and costs keep growing much faster than the background inflation rate. What about comparably wealthy countries? If we look at the 30 members of the OECD, we find a startling disparity. In the most recent year for which figures are available, we spent two and a half times as much per person on health care as the median for the OECD countries. The other countries clustered fairly close together, while we stood clearly apart, and that gap is growing. Clearly, our health system is unsustainable.

As if that weren't bad enough, we don't get anywhere near our money's worth. By all the usual measures of health care—life expectancy, infant mortality, immunization rates, preventable mortality—we rank near the bottom of the OECD countries. Furthermore, contrary to conventional wisdom, we don't provide more basic services. On average, we have fewer hospital beds and fewer doctors and nurses per capita, we see our doctors less often and have shorter hospital stays. Canadians, for example, see their doctors nearly twice as often as we do. Worst of all, we're the only wealthy nation that does not provide comprehensive health care to all its citizens. Nearly 50 million Americans are uninsured—disproportionately the sick, the poor, and minorities—and many of the rest of us are underinsured, in the sense that we're not covered for every contingency. Loss of employment often means loss of health insurance, a particularly devastating problem in the current recession.

Our health care system, then, is outrageously expensive, yet inadequate and inequitable. How can we account for the paradox of spending more and getting less? The only plausible explanation is that there's something about the system itself—about the way we finance and deliver health care—that's enormously wasteful.

The underlying problem, I believe, is that we, alone among OECD countries, rely on a market-based system for health care. In fact, it's not a system at all, but a hodge-podge of different commercial arrangements that exist more or less independently from one another. The other countries all have national health systems. Some are single-payer arrangements, which means that all health care funds, whatever their source, are funneled through a single public agency, which then coordinates the distribution of resources. Some have multiple payers, but the system is tightly regulated so that everyone is covered, and prices and benefits are uniform.

Most of our other problems stem from that decision to treat health care like a market commodity instead of a social service. Thus, we distribute it not according to medical need, but according to the ability to pay. But there's a great mismatch between medical need and the ability to pay. In fact, those with the greatest need are precisely those least able to pay. So while markets are good for many things, they're not a good way to distribute health care. People who are well insured may get an MRI they don't need (and overuse of tests is a major contributor to cost inflation), while people without insurance may not get an MRI they do need.

Furthermore, successful markets expand; they don't contract. Businesses aim to increase revenues and maximize profits. Hospitals in the U.S., for example, often advertise their services. Like all businesses, they want more, not fewer customers. So each element in the health market is working to grow, even while the country as a whole presumably wants the system to contract.

Let's look more closely at how the health care market works. Most Americans receive tax-exempt health benefits from their employers, who pay insurers a portion of the insurance premiums—these days, a smaller and smaller portion. But not all employers offer benefits—it's strictly voluntary—and when they do, the benefits may not be comprehensive. Increasingly, employers cap their contributions, so that the burden of increasing costs falls entirely on workers. Workers, in turn, often turn down benefits, even when they're offered, because they can't afford their growing share.

The insurers with whom employers contract are mostly investor-owned, for-profit 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 the sickest patients at all; by limiting the coverage of those they do insure (for example, by excluding expensive services from the benefit package); and by passing costs back to patients as deductibles and co-payments and claim denials. We're the only nation in the world with a health care system based on dodging sick people. These practices add enormously to overhead costs because they require a great deal 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.

Now let's 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—on average about 20 percent—for their administrative costs, marketing, and profits. The remainder is then passed along a veritable gauntlet of satellite businesses that have sprung up around the health care industry. These include 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. They, too, siphon off some of the premiums, including enough for their administrative costs, marketing, and profits. Probably no more than 70 cents of the health care dollar actually reaches the providers—who themselves have high overhead costs to deal with the requirements of multiple insurers

often bent on avoiding payment. Cutting overhead in half would save the system about 350 billion dollars—more than enough to cover the uninsured.

In the past, there have been many attempts to reform the system incrementally. Mainly these have been efforts to counteract the harshest effects of the market by subsidizing care to people who would otherwise go without and discouraging demand by stratagems such as managed care. But all attempts to reform the system piecemeal have run into the following dilemma. If we expand coverage, then costs inevitably rise. And if costs are lowered, coverage is reduced. If the system stays essentially as it is and we tinker around the edges, coverage and costs have to move in the same direction. The only way both to increase health coverage and reduce costs is to change the system entirely.

With few exceptions, neither the Democrats nor the Republicans have advocated changing the system entirely. They have instead embraced different horns of the coverage/cost dilemma. Democrats generally favor increasing coverage, even though costs would rise still further, and Republicans favor controlling costs, even though coverage would surely shrink.

Many policymakers look to the Massachusetts plan, enacted in 2006, as a model. Through an individual mandate and subsidies for the poor, it has resulted in nearly universal insurance coverage. But it leaves the present profit-driven and highly inflationary system essentially unchanged, and simply pours more money into it. Already the plan is in deep trouble for that reason. The only way to control costs in such a system is to shrink the benefit package or increase deductibles and co-payments or both, and that's what Massachusetts is doing. The result is that people may have insurance that is inadequate or too expensive to actually use, because of high co-payments. Health insurance is not the same thing as health care—not by a long shot. People can have insurance that's of little use to them when they're sick. And there is no sense in enacting health reform if it will quickly become unaffordable.

I believe the only answer is a nonprofit single-payer system, as called for in HR 676. In some ways, this would be tantamount to extending Medicare to the entire population. Medicare is, after all, a government-financed single-payer program embedded within our private, market-based system. It's by far the most efficient part of our system, with overhead costs of less than 3 percent, and it covers virtually everyone over the age of 65, not just some of them. It also covers everyone for the full package of benefits, so it can't be tailored to avoid high-risk patients. But Medicare is not perfect, and was weakened by the Bush administration, which was hostile to it. Out-of-pocket costs are substantial and growing. Doctors' fees are skewed to reward highly paid specialists for doing as many expensive procedures as possible. Furthermore, because Medicare pays for care in a market-based entrepreneurial system, it experiences many of the same inflationary forces as the private insurance system. If Medicare were extended to everyone, it would have to be in the context of a nonprofit delivery system. Otherwise, we would not realize the advantages of a single-payer, coordinated financing system.

The main opposition to a single-payer system comes from two powerful industries—the private health insurance industry and the pharmaceutical industry. They in turn have inordinate influence over lawmakers and many economists and health policy experts, as well. These special interests propagate a number of myths.

Myth #1 is that we can't afford a single-payer system. The truth is that we can't afford not to have a national health care system. Our costs are exorbitant, premiums are rising rapidly, and the number of uninsured will undoubtedly swell as more employers drop health benefits or cap their contributions, and fewer workers find they can make up the difference. A single-payer system would be far more cost-effective, since it would eliminate excess overhead, 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 increasingly out-of-pocket. It makes more sense to pay only once. The most progressive way is through an earmarked health care tax on income.

According to Myth #2, innovative technologies would be scarce under a single-payer system, we would have long waiting lists, and maybe rationing. 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 spend 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. There's plenty of money in it.

Myth #3 is that a single-payer system would subject doctors and nurses and other providers to onerous, bureaucratic regulations. But nothing could be more onerous both to patients and providers than the multiple, intrusive regulations imposed on them by the private insurance industry. In fact, recent polls show that about 60 percent of doctors would prefer a national system to what we have now.

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 fairly well, and without considering the alternatives. I had a very conservative uncle who once asked me (rhetorically) to name three things the government does well. I said the NIH, the National Park Service, and the IRS. I might also have added Medicare, which as I've said is far better at funding health care than the private sector. We should remember that the government is elected by the public and is accountable to the public. In contrast, an investor-owned insurance company reports to its owners, not to the public.

According to myth #5, a single-payer system is a good idea, but unrealistic. I don't underestimate the special interests that would be arrayed against establishing such a system—they would be formidable, and it would take concerted pressure from the public and the medical profession to defeat them—but the fact remains that a national system is the only way to provide universal, comprehensive care, while providing a mechanism to contain costs. What is truly unrealistic is anything else.

I want to mention one final and very important reason for enacting a nonprofit single-payer health program. We live in a country that tolerates enormous and growing 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, marks a decent and cohesive society. It says that when it comes to vital needs, we are one nation, not 300 million individuals competing with one another.

Chairman ANDREWS. I think that each of the four of you has validated our optimism that you contribute substantially to the debate. Thank you. We are going to begin with the questions.

75 percent of health care costs in the United States are attributable to chronic disease and about 80 percent of that 75 percent is attributable to four chronic conditions and diseases: heart attacks and heart disease, cancer, diabetes and obesity-related problems, and asthma.

What I would like to ask the panelists to do is, for the single-payer advocates, tell me how we would approach solving that problem under single-payer. And then, Dr. Gratzer, for whichever system you would support, tell us how you think we could address these four very serious chronic disease problems.

And I want to be sure Dr. Gratzer gets some time. So we will ask one of the single-payer folks to go first, then Dr. Gratzer. I want to be sure we hear from him on this question. Dr. Angell, Dr. Tsou, who would like to?

Ms. Jenkins, maybe a nurse would be the best person since you do primary care.

Ms. JENKINS. I think inherent in the single-payer system is prevention, because if the government is the—if it is government funded, privately administered, the government has a vested interest in making sure you stay healthy and out of the system because it is more cost effective to prevent disease than to wait until people are sick and try to treat it.

So I think inherent in any single-payer system is a huge focus on prevention, because it is much more cost effective. So I think that is a big plus for single-payer. The whole focus in the single-payer system tends to be way more preventive.

Chairman ANDREWS. Dr. Gratzer, we will have you go second. Then we will go to the other two witnesses.

Dr. GRATZER. Maybe I should go last.

Chairman ANDREWS. No, you can go second.

Dr. GRATZER. Fair enough.

Mr. Chairman, you have hit the nail on the head. We are talking about rises of cost in American health care. As you know, CEA just came out with a report talking about what an extraordinary difference it would make to a middle-American family of four if we could hold back on the costs between——

Chairman ANDREWS. How do we do it?

Dr. GRATZER. Pardon me?

Chairman ANDREWS. How do we do it?

Dr. GRATZER. You know, I think that is a great question. To be totally——

Chairman ANDREWS. That is why I asked it.

Dr. GRATZER. To be totally blunt, I am not sure it has that much to do with health care system organization. I think that people who would advocate single-payer paint a magical picture that prevention is at the forefront, everyone gets to see a family doctor, hang out with the family doctor, pontificate on the importance of not smoking with their family doctor.

Look at Canada and Britain and Sweden. One finds actually less access to primary care, not more access. There are towns in Canada where, if you win the town lottery, you get your mortgage paid——

Chairman ANDREWS. I understand. But how do we do this? I mean, there is some evidence that shows that diabetics that get thorough and good nutrition counseling have better outcomes than those that don't.

How do we provide that kind of preventive service if we don't do single-payer?

Dr. GRATZER. I think we need to move money more to the individual, give him more control.

Chairman ANDREWS. But how can we do that if the insurance companies are unwilling to do it?

Dr. GRATZER. Well, I think we need to look at more consumer-driven plans. That doesn't necessarily mean just in private insurance.

In North Carolina they have a plan now that if you smoke or you are obese, you pay more financial penalties. I think that is part of it. I think part of this falls to public health care. I think also part of it falls to individual responsibility.

You know, I don't do primary care. But when I do primary care and I meet with a young smoker and I say, You know, tobacco is linked to cancer, never once—never once did that kid look back to me and say, Holy smokes, no one ever told me that before.

I think to simply say that we have problems in America due to obesity and diabetes and so on and that we are going to solve this with some sort of government solution is a terrible mistake.

Chairman ANDREWS. Dr. Tsou, what would your solution be?

Dr. TSOU. Thank you for the opportunity to address a very important and complex issue. People have thought about this. There is a guy, Ed Wagner, in Seattle who has thought a lot about organizing care. A lot of it comes down to, frankly, as Geri said before, setting up prevention.

There is something that is actually kind of missing in our health care system today, which I believe is a lot more community-based health care services.

If I were the king of the world, I would actually try to organize within neighborhoods, based on a database that was available to us, where we know what the prevalence of diabetes or high blood pressure or other major conditions is. We would organize neighborhood classes where we would teach people about salt restrictions, improving your diet, how to take your medicines properly, and we would try to have individuals, like public health nurses, who would check in on people who have some difficulty with compliance.

Chairman ANDREWS. And you think single-payer would facilitate that?

Dr. TSOU. I think the resources would be there, because we would actually have enough money to pay for something like that.

Chairman ANDREWS. I am going to give Dr. Angell a chance to answer. Then we will go to Mr. Kline.

Dr. ANGELL. Well, first of all, I am skeptical about your premise that 70 percent of health costs go to these chronic diseases.

Chairman ANDREWS. Well, it would be 56 percent. It is 80 percent of 75 percent.

Dr. ANGELL. Well, I know that at least 30 percent go to overhead, administrative costs, and profits. So all the rest don't go to these chronic diseases.

But still, to go to your point, we have, as I have said, a market-driven system that preferentially rewards specialists for doing highly paid tests and procedures. That is why we have more specialists than other countries, way too many specialists, and why we have too few primary care doctors.

A single-payer system could take care of that. It could change the fee schedule or change the way doctors are paid, so that we would have more primary care doctors who would do more to help people live with their chronic conditions if they have them or prevent them where that is possible.

So I think, here again, it is a matter of the market rewarding people for doing things. And that is exactly what they do, tests and procedures, curative procedures.

Chairman ANDREWS. Thank you very much.

We will turn to the ranking member from Minnesota, Mr. Kline.

Mr. KLINE. Thank you, Mr. Chairman. And I want to thank all of the witnesses. It is indeed a distinguished panel, with three medical doctors and a registered nurse. I am always glad to see a registered nurse. My wife spent her adult life as a registered nurse. She retired, but I feel like we are still doing our part. I have a niece who is a registered nurse in the field.

Dr. Gratzer, you were from Canada; I am from Minnesota. I know something about minus 40 degrees as well. And I also know about movement across that border for medical treatment.

Why do you think it is? Would you agree with me that there is travel from Canada to the United States for medical treatment? Minnesota is also sort of a destination State for medical care, with Rochester and the Mayo Clinic. Why do you suppose it is that there is that travel from Canada to the United States?

Dr. GRATZER. Because, like under the old Soviet system, everything is free and nothing is readily available. Canadians wait for practically any diagnostic test or specialist consult or procedure, and some of them opt out of the system by crossing the border. So they do that to the Mayo Clinic, but not exclusively so. I mean, if you were in downtown Toronto today, you would find an office for M.D. Anderson, you would find an office for the Cleveland Clinic. Medical tourism cuts across that border.

Mr. KLINE. And so we are sort of—the United States and I am thinking in terms of Minnesota right now. We are sort of a safety valve. If you can't get it, if the single-payer system in Canada doesn't provide the service, you just cross the border and get help in Minnesota.

Dr. GRATZER. If you can afford it, sure.

Mr. KLINE. And the question is, what would happen if we are now Canada, we have the Canadian system? Where do they go?

Dr. GRATZER. Your compassion for Canadians is outstanding.

Mr. KLINE. Well, when they come south for health care, medical care, sometimes they stop at the Mall of America, and we are always glad to have them for that as well.

Dr. GRATZER. You know, it is not just that Canadians come because of the safety valve. People from all over the world come to the United States because there is medical excellence here.

I think as we move forward and have debates in the United States about how to reform this system, it is important not just to look at the bad, but to remember the good and not to lose it. Mayo is an outstanding leader. If you are the King of Jordan and you have a health problem, you go there, too.

But, yes, when Canadians need MRIs, Canada having a third of the MRIs per capita as the United States, they cross the border. When Canadians need to see an internist, they cross the border. Very often when Canadians need a quadruple bypass, they cross the border.

Mr. KLINE. So you outlined a system that has some pretty serious shortcomings, and we do see that because of the border crossing.

And yet, we have heard here today, and other critics say, that the American health care system scores low on measures such as life expectancy, and others. And single-payer systems do a whole lot better.

Can you address that issue for me?

Dr. GRATZER. I would be delighted to, sir.

Look, when you try to do an international comparison, it is very complicated. I think all too often we tend to be overly simplistic. We look at crude indicators.

One example of that would that be life expectancy. Now, health care obviously has import on life expectancy or influence on life expectancy, but it also reflects a mosaic of other factors: genetics,

whether a person smokes, whether a person exercises, a person's diet.

In fact—and it pains me to say this as a physician—probably one of the less important things is health care in that overall equation. One finds that Americans smoke too much, they drink too much, and they eat too much, especially compared to their northern neighbors.

And America is an unusual place in other ways. Let me just give you one example.

There are eight times more murders per capita in the United States than there are in France. If you were to take out accidental and intentional death from life expectancies statistics—you factor out murders as one example, you factor out MVAs—one would discover that Americans live longer than people in any other Western nations. So, careful about those crude statistics.

Mr. KLINE. Thank you very much.

We have several medical doctors on the panel who are looking forward to their chance to ask questions, so I will yield back the balance of my time, Mr. Chairman.

Chairman ANDREWS. Thank you very much, Mr. Kline.

Mr. Wu, the gentleman from Oregon, is recognized for 5 minutes.

Mr. WU. Thank you very much, Mr. Chairman. I just have a couple of questions.

Some of the studies that I have read indicate that technologic drive is a significant contributor to cost increases, and also the increase in administrative costs; and that technologic drive is perhaps 50 percent of cost increases, and the majority of the other 50 percent may be administrative costs, including marketing expenses. I would just like the different witnesses on the panel to address how you all think that a single-payer plan would handle those two different types of expenses, technologic drive versus administrative costs, including marketing costs.

Dr. Angell, should we begin with you?

Dr. ANGELL. If you start with the administrative costs, there is no question that a single-payer system would have much lower administrative costs. As I mentioned, the administrative costs of the biggest insurers average roughly 20 percent—that is administrative costs, marketing, profits—compared with 3 percent in Medicare. So there is no question we would realize great savings in administrative costs.

If you look at the use of technology, it is not the technology itself. All advanced countries have the same technologies. We have no secrets here; it is how we use the technologies. We use them much more widely because it is profitable to do so.

Many of the technological tests and procedures are done in freestanding imaging centers, laboratories, outpatient centers, and they are paid handsomely for using them. So it is a matter of generating income, not targeting medical need.

In this country if you are well insured, if you can afford it, you may get an MRI you don't need. You may get many MRIs you don't need because it is profitable for someone to do that. But if you aren't well insured, you may go without an MRI you really do need. So it is the mismatch between the technology and the need for that technology that is so bad in this country.

Dr. GRATZER. An excellent question. I am not as technologically phobic as perhaps some of my copanelists are. Let me just give you one example: Death by cardiovascular disease has fallen by two-thirds in the United States in the last 60 years. Part of that is because drugs likes beta blockers have changed cardiac care. But part of it is because of high-expense medical interventions. I mean, to put things in perspective, the revolution that has occurred in health care, Robert E. Lee on the battlefield in 1864 had a heart attack, and state-of-the-art cardiac care at the time was 2 weeks of bed rest. Nearly a century later, 90 years later, when President Eisenhower had a heart attack, state-of-the-art cardiac care at the time was 6 weeks of bed rest. Today we do a hell of a lot more for you than bed rest.

So we have paid more for technology, and let us not forget the incredible advantages that come with it. But I think we would all agree that we are not getting value for dollar; that too many tests are ordered, and there is a quality difference amongst the tests amongst different providers. The question is ultimately what are we going to do about that? The administration says we ought to set up a committee, and they ought to help guide doctors in determining who need tests and when to pay for it. I am skeptical of that, but I am open to that argument. But I think ultimately we will address this by people paying 13 cents on every consumer dollar spent on health care, having people more involved in their decisions.

I also think, though, that we need government to provide us with more transparency and more accountability and more information. That is the way to move away from the high-expense, not necessarily high-quality, care that we have.

Mr. WU. Thank you.

Dr. TSOU.

Dr. TSOU. I think it is ridiculous to think that Mrs. Jones down the street can evaluate technology on something as complicated as medicine today.

The truth is we have to have a responsibility in government to actually do comparative effectiveness and figure out what things work and which don't. And if we don't know what technologies are effective, we should do clinical trials to determine that. That is one of the potential advantages that single-payer has. It creates a large database that allows you to look at health outcomes, and you can see which ones actually work and which ones don't. So I think single-payer helps advance the decisionmaking around whether technology is advantageous or not.

Mr. WU. My time has expired; but, Ms. Jenkins, would you care to comment also?

Ms. JENKINS. I am not an M.D., and I don't have all of the statistics off the top of my head, but anecdotally I know that what Dr. Tsou said is very true. I think we need best practices and evidence-based practice. And I have been a nurse long enough to see things done routinely just because that is what we have always done, and new innovations that are more cost-effective overlooked because of habit.

So I think he is right. And I think he is right when he says that when you have a single-payer system, you have one uniform sys-

tem to evaluate, to look at, and if you see deficiencies and you have one system, you can fix it. When you have 1,300 different health care providers with 1,300 different systems, you run into a problem.

So I would reiterate what Dr. Tsou said: It is going to be much easier with a single-payer system to track efficiencies in the system and what works and what doesn't.

Chairman ANDREWS. The gentleman's time has expired.

The bell you just heard go off is a series of floor votes. There are three of them, so Members are going to have to leave to go vote on the floor. Here is how we are going to proceed. We are going to go to Dr. Price's questions, and then we are going to adjourn the hearing temporarily. After the three floor votes are over, which I would estimate would be in the 12:20 to 12:30 range, we will reconvene and proceed with Members' questions.

Dr. Price is recognized for 5 minutes.

Mr. PRICE. I appreciate you holding this hearing.

I ask unanimous consent that an article entitled "Medicare, Not the Model for Reform" be included in the record.

Chairman ANDREWS. Without objection.

[The information follows:]

Medicare Not the Model for Reform

By REP. TOM PRICE (R-Ga.), M.D., April 16, 2008

"Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided * * *"

Those were the words written into law when Congress established our health insurance for seniors program—or Medicare—some 40 years ago. As a surgeon for nearly a quarter century, however, I can attest that there may be no greater negative impact on the "manner in which medical services are provided" than the federal government's intrusion into health care, primarily through Medicare. Yet, many prominent Democrats dangerously see Medicare as the model for national healthcare reform.

Today, we are at a healthcare crossroads. Our broken medical delivery structure is in dire need of meaningful reform. There is no disagreement that a system with up to 47 million uninsured at some point annually requires fundamental change. The great debate will be how we achieve full access to quality healthcare in a way that ensures patients receive the treatment they believe best for themselves.

Having spent my career caring for patients and having to work with the federal healthcare system, it is clear to me and the vast majority of my former medical colleagues that Medicare must not be the model for our nation's health system reform. Its fundamentally broken structure fails many seniors and requires its own patient-centered improvements, not broad expansion. Our focus for positive transformation must be cost of care, access to care, and quality of care. And Medicare comes up short on all three counts.

Medicare was surely created with the greatest of intentions—a way to ensure that those often with the most challenging needs receive high quality healthcare—and that goal remains. The structure of the program, however, has led to dwindling access to doctors, a deteriorating standard of care and an uncontained cost structure.

When Medicare was created in 1965, the long-term budget estimate for 1990 (the furthest year predicted) was roughly $9 billion. In actuality, 1990 spending on Medicare Part A was nearly $67 billion. This year, we will spend more than $450 billion on the program, 12.3 percent of all federal revenue, with that percentage expected to double in the next 15 years.

Skyrocketing costs coupled with onerous regulations have led directly to shrinking access to care.

Patients are often told which doctors they may see and how frequently. Doctors, in turn, are told which procedures or tests they may—and may not—order or provide. It erodes the ability of patients and their doctors to make independent healthcare decisions—some of the most personal and important decisions we make. A once-sacrosanct institution, the doctor-patient relationship, is being trampled by

coverage rules, inflexible regulations, one-size-fits-all policies and a flawed payment system.

The constant battle between government insurers and American doctors over permissible procedures and reimbursement levels is leading to a dangerous shortage of qualified new physicians. Most medical practices, including some of the largest and most respected institutions in the nation, find it necessary to limit the number of Medicare patients they see. This is not a healthy system.

To paint a responsible face on the damaging effects to care, Medicare tracks quality indicators that may have, in fact, nothing to do with quality healthcare. A punitive enforcement program creates perverse incentives leaving some of our sickest citizens without qualified providers. Put simply, federal healthcare policy has lost its vision of what quality healthcare means.

Thankfully, there is a positive alternative that would allow access to quality care for all Americans.

By restoring our focus to those most intimately affected by healthcare decisions—patients—we can transition to a financing and delivery system which will accomplish insurance coverage for all without sacrificing quality and access.

Using my experience as a physician, I have authored legislation, the Comprehensive Health CARE Act, H.R. 2626, to positively and fundamentally reform American healthcare. Two pillars are necessary to move us in the right direction. First, our tax policy should ensure that it makes financial sense for all Americans to be insured. Second, that insurance should be owned and controlled by the patient. Regardless of who is paying the bill—government, employer or individual—patients should be able to decide what coverage and care is best suited for their individual or their family's needs.

Such a system will provide the accountability, responsiveness, and flexibility needed to ensure quality care, individual access, and contained cost.

Restoring the power of patients in our health care system is the best way to ensure we will have quality care throughout the 21st century. It will only occur if we remember and re-establish a process that best serves those most affected—patients!

Prior to being elected to Congress, Price practiced orthopaedic surgery for more than 20 years.

Mr. PRICE. I want to thank Congressman Conyers for coming and commend him for his commitment to health care reform, and I was struck by one of his comments. As a physician, I am a strong advocate for appropriate health system reform, what I call patient-centered reform. I would suggest candidly that a single-payer system is not patient centered. By its very definition, it is government centered, and that is the real concern that I have.

The comment you made, and I think it was very enlightening, the Chairman said we need too determine whether, quote, "we want a combination of our current system or we want something else." And the question is: Who is the "we"? I would suggest if the "we" is us here in Congress, or within the bureaucratic nature of the Federal Government, then we have the wrong "we." The "we" that we need are the patients, the American people. Unless we concentrate on patients, we will not get to the right answer, and I believe real reform comes when we empower patients.

I have been struck by the testimony about how awful American health care is, just struck by it. The statistics don't bear that out at all. In fact, Dr. Tsou, one of your quotes was, "By and large, the quality of care is suboptimal." That is astounding. I think the American people will be astounded to know that the care they receive is suboptimal. In fact, if you look at disease-specific criteria, what you find is that the care provided in America, across all demographic quadrants of our society, is second almost to none. Almost to none.

We have principles that we ought to adhere to in the area of health care. Everybody has access, affordability and quality. I add

three to that: responsiveness, innovation and choice. I would suggest to everyone who is listening that none of the principles of your health care that you provide are improved by the intervention of the Federal Government. None. Not access. Access is being limited in the programs that are run by the Federal Government. Not affordability. All of the cost overruns that occur in the four systems that are run by the Federal Government, Medicare, Medicaid, Indian Health Service, the veterans health care. Certainly not quality when you see the limitation of care that is imposed by the Federal Government. Responsiveness and innovation in the same sentence as the Federal Government is rarely used, and rightly so. And then choices. Choices are always limited by governmental intervention.

And to the end of the cost, which I think is incredibly important to address, Dr. Gratzer, would you comment on what is included in our estimation of health care costs that may not be included in another estimation, other nations' estimations of their health care costs?

Dr. GRATZER. Well, Dr. Price, I fully agree with your comments. With regard to what does American medicine do that one doesn't find so much elsewhere in the world, research and development would be a great example of that. There is more spent at one facility in the United States, M.D. Anderson, on research and development than there is in the entire country of Canada. America is the leader in medical technology and development and implementation. When people talk about a new drug coming to market, it is almost surely an American drug. When people talk about innovations going on in the United States, as you know Health Affairs rated the top 10 greatest innovations of the 20th century, and 7 of them were invented within these borders. More Nobel Prizes go to Americans than nationals of other countries combined. This is a country that excels in medicine. We shouldn't forget that as we look at reform.

Mr. PRICE. My understanding is that much of the long-term care, the nursing home care and the like, is included in our costs for health care in the determination of what we spend on health care, and that is not the case in other nations. Do you know that to be true?

Dr. GRATZER. I am not an expert on such comparisons. I know for sure that capital costs are not accounted for the same way. Canadians spend money less per capita; but I would suggest it is not quite the huge gap that American experts might put forward.

Mr. PRICE. Mr. Chairman, I would suggest that a right to health care in other nations that have a single-payer system is a right to get in line, and that is the concern that so many of us have. The last thing we want is just to simply pass something here in Washington that is, under the guise of giving people the right to health care, we give them the right to get in line for a lesser quality of care than is currently been provided.

There is positive reform that is on the table, and I would suggest that we ought to look at that as well as a committee.

I thank the Chairman.

Chairman ANDREWS. The gentleman's time has expired. At this time the committee will temporarily adjourn. If you turn around, you can see the floor voting schedule. There will be three votes. We

will come back as soon as we have cast our third vote and resume the hearing at that time.

[Recess.]

Chairman ANDREWS. We are going to resume the hearing. The gentleman from Illinois Mr. Hare is recognized for 5 minutes.

Mr. HARE. Thank you, Mr. Chairman. Thank you for holding this hearing, which I consider to be extremely important.

I am amazed at some of the things that I have heard. Dr. Gratzer, let me say a couple of things. It is my understanding that when the Canadian people were polled, 97 percent of the people in Canada said they wouldn't trade their health care plan for the United States plan on a bet. So if it is crisis, only about 3 percent of your Canadian friends would be in agreement with you.

We have heard a lot about lines, lines for health care, having to wait for health care. Here we don't have lines, we just get rejected. I have had constituents who have had C-sections with their insurance companies, and they go in later and are told they are denied because of preexisting conditions. Here we don't have lines, we have people who, if they lose their job because of no fault of their own, that leave and don't have portable health care.

I know of a 31-year-old man who worked part-time jobs, temporary jobs, to try to get health care coverage, and they found him dead in the shower of a heart attack. And his father and mother, who were very hardworking people, said, when the press asked them, are you mad that God took your son, he said, God did not take my son; He made a special place for my son to go. He said, this government took my son because it didn't have the courage to pass health care that would cover my son when he lost his job.

I think when you take a look at where we are at today, if Mr. Castonguay said it is in crisis, I would like him to come take a look at this system. We have a CEO of an insurance company making $200,000 a day. You have insurance companies giving people a letter in one hand that approves the surgery; the person has the surgery, and then they get a denial paper after they get home from the hospital from the same wonderful, benevolent insurance company.

Now, I am a card-carrying capitalist here, but I believe in the single-payer system. If this system isn't broken, then I don't know what the definition of broken is. I will tell you, I am a fundamental believer that health care—and I think this was mentioned before by the Chairman—health care is a right, it is not a privilege in this Nation. Everybody ought to have it. We don't pay doctors. I went to my hospitals in my districts, we are 243 days late paying health care providers, and pharmacists are not getting reimbursed and have gone out of business.

While we may not have the lines, what we have is—and all of these statistics that are mentioned here today—these are real people with real problems, and I lay this at the foot of greedy insurance companies who care more about the bottom line of making profits than they do about keeping people well. The whole question about the wellness situation is to blame people. Yes, we have to take part of the responsibility, but that is like saying if your next-door neighbor's house catches on fire because he was smoking, we should do nothing about it because it was his fault, he was smok-

ing. So we are not going to go put the fire out, we are just going to watch it burn.

I will tell you, to that man that works today repairing gasoline motors for lawn mowers at $8 an hour—and, by the way, when his wife came in and saw her son dead on the gurney in the hospital, she had a heart attack, and he ended up with $200,000 worth of bills. And he had to borrow $8,000 to bury his own son. And I will tell you, that is not what this country is about.

Some people say, why are we having this hearing? We have to have this hearing. The vast majority of the American people—and when are we ever going to get it—they support this system. So here we are once again debating whether or not this is doable or not doable and who has the best system.

I know one thing, in my district when I did town hall meetings—and, by the way, I had counties that carried not for George McGovern, but for George Wallace, so this is not liberal land that I come from. And every one of the six town hall meetings that I had, the vast majority of the people supported single-payer health care. And I didn't even ask them, they brought it to my attention.

So we have to fix this system. We have heard about the Medicare system and the government can't do anything right. Ask a veteran if they would be willing to give up their VA health care. And the government can't do anything right, ask a senior citizen if they want to stop receiving a Social Security check. Ask somebody on Medicare, since we can't ever do anything right, if they don't like the Medicare system.

I am not saying that they are perfect, but what I am saying is that we have an opportunity here to change the way we do business. And quite frankly, if you don't have a public option, who is going to go in competition with the insurance companies? They are competing against themselves. They are not even covered under Federal antitrust legislation.

We need to get real here, from my perspective. And all of the statistics that we hear, and the lines of people flooding into Minnesota and other States to get health care, I don't know about the floods. I am from Illinois, and I know about floods on the river, but I do know this, that we have a flood of people every single day who are worried to death that their children or themselves are going to get sick, and if they lose their jobs, they don't have portability of health care. We have to fix that. This bill will do it.

If I sound a little bit agitated, it is because I am.

Chairman ANDREWS. The gentleman's time has expired.

I note that the Chairman of the full committee Mr. Miller is here. I do want to obviously welcome him and see if he would like to add any remarks at this time.

Mr. MILLER. Thank you, Mr. Chairman. Just quickly, I wanted to ask Ms. Jenkins a question.

We seem to rerun this argument all of the time about how we are rationing medicine between Canadians and Americans and what have you. What I am witnessing in my congressional district at this time, if you have insurance, I think it is something close to three out of four people have Kaiser because of the history of the program started in the Bay area.

What I now see in the public institutions is they are absolutely being flooded by individuals who have serious medical problems, but no longer have insurance because they have lost their jobs. If I go to my regional medical center or go to the community clinics, we now see this huge inflow of people who bring no resources to this medical necessity that they have.

Scheduling times have become far more difficult than in the past. I am not familiar with what is happening in the private sector in the hospitals, but certainly what we now see in the public facilities in the Bay area is that obviously your medical condition doesn't know whether you are employed or unemployed; you need help or your children or spouse does, whatever your situation is with your family.

This standing in line and postponement of appointments and delay times and wait times is happening in the current system because of the structure of this system; is that your understanding? Correct me if I am wrong, but as I have traveled around and visited the facilities, it is stunning.

Ms. JENKINS. I work in a public facility, the University of California, and public facilities are under assault. The public health care system in this country has been under assault for a long time. And it was pointed out with the swine flu concerns we haven't funded public facilities anywhere very well, and they have been constantly underfunded.

Mr. MILLER. I understand that, but I am talking about people who find themselves in situations where they need immediate attention.

Ms. JENKINS. They come through the emergency room, which is the most costly way to access the health care system, so we are spending more money to deal with those crises than with a single-payer system. The most costly way to access the system is through an emergency room, and people have to be seen in an ER. So as we see this employment crisis and people losing their employee-based health care, you can see a huge flood of people who are going to be accessing the most expensive way into the system, which is through an emergency room.

Mr. MILLER. When people come from Canada to receive medical care here, are they doing that on their own hook?

Ms. JENKINS. People do come from Canada for care, but a lot of those people are sent by the Canadian Government to get care here that they can't get or there is an access problem. And the Canadian Government also sends a checkbook with them because they pay for it. If there is medical necessity that is urgent, and the access is not available in Canada, they do send people to this country for care, but they pay for it. So it is not like these people are here because they don't have any other recourse. The Canadian Government looks at it, and if they have a situation that they deem is emergent and needs critical care that they can't get there, they will send them here, and they pay for their care.

Mr. MILLER. We send people to UC San Francisco, but in most instances we send them with whatever insurance they have. Or we send them to Stanford. That is the usual business practice. And I assume that is not interrupted because of national boundaries in this case. We are not adversaries.

Ms. JENKINS. I think that is a misconception.

Mr. MILLER. Thank you.

Chairman ANDREWS. Thank you, Mr. Chairman. Obviously as Minority Members return, they will reclaim their time.

The gentleman from Ohio Mr. Kucinich, who has been one of the most fierce and articulate advocates of single-payer, is recognized for 5 minutes.

Mr. KUCINICH. Gentle, not fierce.

There has been a lot of talk here, Mr. Chairman, about rationing. And during war, people have rations. Imagine if during wartime if one out of six Americans who were getting rations during a critical period during the war, imagine if one out of six were not able to get rations, and they just starved. Well, you have one out of six Americans starving for health care; 50 million Americans can't get any health care at all.

Now, Dr. Gratzer, you have tried to make the case that rationing in Canada is worse than it is in the U.S. Do you know what statistics Canada, the analog to the U.S. census, says the median wait time is across Canada for elective surgery?

Dr. GRATZER. Why don't you inform us, sir?

Mr. KUCINICH. It is 4 weeks.

Dr. GRATZER. What did they——

Mr. KUCINICH. And what does Canada say the median wait time for diagnostic imaging, like MRIs, is?

Dr. GRATZER. I can tell you that the Ontario government recently looked at that for answers, was 6 months.

Mr. KUCINICH. It is 3 weeks.

How many uninsured are there in Canada?

Dr. GRATZER. Probably relatively few.

Mr. KUCINICH. That is right. None or very few.

How many medical bankruptcies are there in Canada?

Dr. GRATZER. It depends how you define a medical——

Mr. KUCINICH. None or very few.

How many insured Americans go without needed care due to the high cost of health care which is due to health insurance companies?

Dr. GRATZER. Am I allowed to answer, or are you just going to continue to——

Mr. KUCINICH. Well, if you have an answer, you can answer. But if you don't, I will answer it.

Dr. GRATZER. Go for it, sir.

Mr. KUCINICH. What is your answer?

Dr. GRATZER. Why don't you answer your question, sir?

Mr. KUCINICH. What is your answer? How many insured Americans go without needed care due to the high cost of health care which is due to health insurance companies?

The witness isn't responding.

Dr. GRATZER. The witness is delighted to speak further on those statistics and other statistics, but you keep cutting me off, sir.

Mr. KUCINICH. You respond if you have an answer. You didn't give an answer.

Dr. GRATZER. I am not going to be led down a garden path. If you would like to ask me a question, I would be delighted to answer.

Mr. KUCINICH. You have showed a garden here to members of this committee and to the audience. There is another side of the picture that you don't seem to be aware of, even though you want to be an expert on Canada. Can you provide us with an answer on this one about America?

Dr. GRATZER. But my position is respectable, and I dislike your comments, sir.

Mr. KUCINICH. Do you have an answer? How many insured Americans, insured, go without needed care due to high cost of health care which is due to health insurance companies?

He has no answer. The answer is that it is one out of every four.

So we are trying to make a case here that somehow Canada is in a mess, but we are not focusing on the fact that in the United States there are people who aren't getting needed care. And this gentleman has expected us to believe that rationing is worse in Canada. I don't know how we can buy that. Now, if single-payer is so bad, maybe the gentleman, the doctor, can explain to us why 60 percent of U.S. doctors want it, according to the peer-reviewed Annals of Internal Medicine of 2008.

Mr. PRICE. Are you going to let him answer this one?

Mr. KUCINICH. He can answer it if he can answer it.

Dr. GRATZER. I would suggest that many physicians in the United States are unsatisfied with the system, and rightly so. I would suggest that many physicians are looking for reform, and rightly so. But I would suggest that many physicians are unaware of what really goes on in single-payer systems, perhaps illustrated well by some of the comments that you have already made.

It is easy for an American audience to look north, but I would ask you then: What do you make of studies like the O'Neill paper, published by the National Bureau of Economic Research, that showed that Americans have better access in terms of chronic care management, that cancer outcomes are better south of the 49th parallel, that low-income baby mortality rates are lower in the United States?

I would not suggest to you for a moment that the United States is a perfect system. Goodness, I have written an entire book on the problems south of the 49th parallel, but I would suggest to you that looking to a government-rationed system and a government-managed system, because inevitably those two things are the same, would be a mistake for Members of Congress.

Thank you.

Mr. KUCINICH. And I am glad that we have other witnesses here.

Ms. Jenkins, the California nurses found that a single-payer system would act as an economic stimulus not only by eliminating the underinsurance problem, but also by several other means, including the creation of 2.6 million new jobs. Could you please describe how you think a single-payer health care system would act as a stimulus?

Ms. JENKINS. Well, we would be insuring another 47 million people, so there would be an economic stimulus there in the creation of jobs. We did an econometric study where you look at the ripple effect of what is spent in health care and how it translates into other areas of the economy, the wages workers make, how they spend them and how that stimulates the economy, and we not only

found that a single-payer system would create a net gain of 2.6 million jobs, it would increase business and public revenues by $317 billion. Additional employee compensation with those new jobs would be $100 billion, which would generate $44 billion in more tax revenues, and these people would go out and spend that money in the economy. So there is huge economic stimulus in doing this, besides the obvious ethical and moral issue of actually providing care for everyone in this country.

Chairman ANDREWS. The gentleman's time has expired.

The Chair recognizes the gentlelady from New York Mrs. McCarthy for 5 minutes.

Mrs. MCCARTHY. Thank you, Mr. Chairman.

Ms. Jenkins, before I came to Congress, I was a nurse for over 32 years. A lot of things that we have been able to do on this committee, especially on the higher education bill that we got passed, was basically trying to help nurses get more nurses into the system. We have plenty of people that want to be nurses. Unfortunately, we don't have the faculties that want to hire professors to be able to teach nursing. The good news is nurses are getting good pay now. Back in the 1960s, we certainly got terrible pay.

No matter which way we go—and I believe we have a good health care system. Our problem is we have too many people that are not receiving health care. That is what we are trying to fix. And I think it is important for everyone to know that. But we are not going to be able to do that unless we have enough primary care doctors out there, and we need a whole ton of nurses out there because we also have to look to the future. We are not preparing ourselves at all for the baby boomers because they are not going to go to a nursing home, I can tell you that right now. They are going to want to have care in their house. They want to stay in their home, as the majority of patients do.

So whatever we do, whether it is single-payer, whether it is going to be a public—however we come up with something, nursing and physicians have to be a part of that. And hopefully the physicians will get paid a better price. I have Blue Cross/Blue Shield, and I go and have my tests done, and I see what the doctors get. It is nowhere near what it should be. I think it is embarrassing the pay we give them.

You have worked many nights. You are the one who calls the doctor at 2 or 3 o'clock in the morning, as I did. People forget that. People think that they roll in and just take care of people. What do you think we need to do even more so to make sure that we have more nurses coming into the system?

Ms. JENKINS. Well, we do have to fund nursing education to create more slots for people. I know in California, all of the nursing programs have huge waiting lists waiting for slots. I think there needs to be education investment to train nurses. Senator Boxer has put forth a bill that invests in nursing education.

And we have to look at the working conditions. Nurses have one of the highest incidence of musculoskeletal injuries of any work group because of the kind of work that they do.

Part of her bill would be safe patient handling. We need to create safe work environments for patients as well as nurses. It is very frustrating as a nurse to go home and worry about what you

missed because you didn't have the time to give the care you need. So we do have to make an investment in creating staffing standards, better working conditions.

Most of us didn't go into nursing to make a million bucks, we went into nursing to take care of people. I think it is important to understand as nurses, we take very seriously our role of being the advocate for the patient. We are the last line of defense for the patient at the bedside. We need to invest in nursing education, as you say.

Mrs. MCCARTHY. Hopefully we will be doing that.

One more thing I will say is unfortunately across the country, we have seen a high incidence of infections in our hospitals, which cause sometimes death to a lot of patients. I happen to believe strongly that if we had more nurses and a better nursing ratio on the floors, that we would not see the kind of infections that are out there mainly because they would have the time to actually do the work that they need to do.

We used to have—back in the 1960s, we might have 1 nurse to every 10 patients, but I have to say about 4 of them would be self care, and the others would be a lot more care being given. We didn't have the infections then. We basically were fairly well staffed. But when nurses were starting to be called in on mandatory overtime, they left the profession. My sister left the profession, unfortunately. We need to address those things.

Ms. JENKINS. We absolutely do. You are right, there has been a huge speed-up on the delivery of care in hospitals, and a lot of it is driven by this profit motive that says let us save some money, and let us cut some staff. I think that drives some of that. That does lead to an incidence of increased infections in hospitals. There are other factors, too, but that is a big one. You have to have the time to provide safe care, which means you have to have some realistic staffing ratio of nurses to patients in hospitals.

Mrs. MCCARTHY. I agree with you. I hope through this committee, because that is what we will be working on, I will be working on the nursing issue on this committee as we debate what else we are going to do for health care. I thank you.

Chairman ANDREWS. We thank the gentlelady for her contributions. She talks about nursing, and she is a very valuable Member for that reason.

The gentleman from New Jersey Mr. Holt is recognized for 5 minutes.

Mr. HOLT. Mr. Chairman, thank you, and I thank the witnesses for coming.

Let me begin with Dr. Angell. You have outlined a number of the advantages of a single-payer system. I was impressed by an article that I read earlier this year by Dr. Atul Gawande in the New Yorker where he looked at other countries and how they got to their universal coverage. For example, Britain created the National Health Service based on the wartime health system; and France created a system based on a prewar, independent local insurance program.

Single-payer systems have some advantages. Have you thought about how we could get to that, if you see that as the ideal, from our fragmented system of today?

Dr. ANGELL. Yes, I have. In fact, I was on the writing committee that published an article in the Journal of the American Medical Association, August 13, 2003, that goes through how we would convert in considerable detail. There is no time to do that here, obviously.

Mr. HOLT. Could I ask that you provide that to the committee and that it be made part of the record?

Chairman ANDREWS. Without objection.

[The article follows:]

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Proposal of the Physicians' Working Group for Single-Payer National Health Insurance

*The Physicians' Working Group for Single-Payer National Health Insurance**

ABSTRACT

The United States spends more than twice as much on health care as the average of other developed nations, all of which boast universal coverage. Yet more than 41 million Americans have no health insurance. Many more are underinsured. Confronted by the rising costs and capabilities of modern medicine, other nations have chosen national health insurance (NHI). The United States alone treats health care as a commodity distributed according to the ability to pay, rather than as a social service to be distributed according to medical need. In this market-driven system, insurers and providers compete not so much by increasing quality or lowering costs, but by avoiding unprofitable patients and shifting costs back to patients or to other payers. This creates the paradox of a health care system based on avoiding the sick. It generates huge administrative costs that, along with profits, divert resources from clinical care to the demands of business. In addition, burgeoning satellite businesses, such as consulting firms and marketing companies, consume an increasing fraction of the health care dollar. We endorse a fundamental change in US health care—the creation of an NHI program. Such a program, which in essence would be an expanded and improved version of traditional Medicare, would cover every American for all necessary medical care. An NHI program would save at least $200 billion annually (more than enough to cover all of the uninsured) by eliminating the high overhead and profits of the private, investor-owned insurance industry and reducing spending for marketing and other satellite services. Physicians and hospitals would be freed from the concomitant burdens and expenses of paperwork created by having to deal with multiple insurers with different rules, often designed to avoid payment. National health insurance would make it possible to set and enforce overall spending limits for the health care system, slowing cost growth over the long run. An NHI program is the only affordable option for universal, comprehensive coverage.

INTRODUCTION

The US health care system is rich in resources. Hospitals and sophisticated equipment abound, with even many rural areas boasting well-equipped facilities. Most physicians and nurses are superbly trained, and dedication to patients is the norm. Our research output is prodigious, and we fund health care far more generously than any other nation.

Yet despite medical abundance, health care is too often meager because of the irrationality of the current health care system. More than 41 million Americans have no health insurance, including 33% of all Hispanics, 19% of African Americans and Asians, and 10% of non-Hispanic whites.[1] Many more, perhaps most of us, are underinsured. The world's richest health care system is unable to ensure basics like prenatal care and immunizations, and we trail most of the developed world on such indicators as infant mortality and life expectancy. Even the well-insured may find care compromised when health maintenance organizations (HMOs) deny expensive

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medications and therapies. Fear of financial ruin often amplifies the misfortune of illness for patients.

For physicians, the gratifications of healing give way to anger and alienation in a system that treats sick people as commodities and physicians as investors' tools. In private practice we waste countless hours on billing and bureaucracy. For the uninsured, we avoid procedures, consultations, and costly medications. In HMOs we walk a tightrope between thrift and penuriousness, under the surveillance of bureaucrats who prod us to abdicate allegiance to patients and to avoid the sickest who may be unprofitable. In academia, we watch as the scholarly traditions of openness and collaboration give way to secrecy and assertions of private ownership of vital ideas—the search for knowledge displaced by a search for intellectual property.

For 9 decades, opponents have blocked proposals for national health insurance (NHI), touting private sector solutions. Reforms over the past quarter century have emphasized market mechanisms, endorsed the central role of private insurers, and nourished investor ownership of care. But promises of greater efficiency, cost control, and responsiveness to consumers are unfulfilled; meanwhile, the ranks of the uninsured have swelled. Health maintenance organizations, launched as health care's bright hope, have raised Medicare costs by billions[2] and fallen substantially in public esteem. Investor-owned hospital chains, born of the promise of efficiency, have been wracked by scandal, their costs high and their quality low.[3-12] Drug firms, which have secured the highest profits and lowest taxes of any industry, price drugs out of reach of many who need them most.

Many in today's political climate propose pushing on with the marketization of health care. They would shift more public money to private insurers; funnel Medicare through private managed care; and further fray the threadbare safety net of Medicaid, public hospitals, and community clinics. These steps would fortify investors' control of care, squander additional billions of dollars on useless paperwork, and raise barriers to care still higher. Instead, we propose a fundamental change in US health care—a comprehensive NHI program.

Four principles shape this vision of reform:

1. Access to comprehensive health care is a human right. It is the responsibility of society, through its government, to ensure this right. Coverage should not be tied to employment.

2. The right to choose and change one's physician is fundamental to patient autonomy. Patients should be free to seek care from any licensed health care professional.

3. Pursuit of corporate profit and personal fortune have no place in caregiving. They create enormous waste and too often warp clinical decision making.

4. In a democracy, the public should set health policies and budgets. Personal medical decisions must be made by patients with their caregivers, not by corporate or government bureaucrats.

We envision an NHI program that builds on the strengths and rectifies the deficiencies of the current Medicare system. Coverage would be extended to all age groups and expanded to include prescription medications and long-term care. Payment mechanisms would be structured to improve efficiency and ensure prompt, fair reimbursement, while reducing bureaucracy and cost shifting. Health planning would be enhanced to improve the availability of resources and minimize wasteful duplication. Finally, investor-owned facilities would be phased out. These reforms would shift resources from bureaucracy to the bedside, allowing universal coverage without increasing the total costs of health care.

Key features of the proposal [in italics] followed by the rationale for our approach are presented below.

ELIGIBILITY AND COVERAGE

A single public plan would cover every American for all medically necessary services, including long-term care, mental health and dental services, and prescription drugs and supplies. Unnecessary or ineffective services, as determined by boards of experts and community representatives, would be excluded from coverage. As in the Medicare program, private insurance duplicating the public coverage would be proscribed. Patient co-payments and deductibles would also be eliminated.

Abolishing financial barriers to health care is the sine qua non of reform. Only a single comprehensive program, covering rich and poor alike, can end disparities based on race, ethnicity, social class, and geographic region that compromise the health care of the American people. A single-payer program is also key to minimizing the complexity and expense of billing and administration.

Private insurance that duplicates the NHI coverage would undermine the public system in several ways. First, the market for private coverage would disappear if the public coverage were fully adequate. Hence, private insurers would continually

lobby for underfunding of the public system. Second, if the wealthy could turn to private coverage, their support for adequate funding of NHI would also wane. Why pay taxes for coverage they don't use? Third, private coverage would encourage physicians and hospitals to provide 2 classes of care. Fourth, a fractured payment system, preserving the chaos of multiple claims databases, would subvert quality improvement efforts, eg, the monitoring of surgical death rates and other patterns of care. Fifth, eliminating multiple payers is essential to cost containment. Public administration of insurance funds would save tens of billions of dollars each year.

Private health insurers and HMOs now consume 12% of premiums for overhead,[13] while both the Medicare program and Canadian NHI have overhead costs below 3.2%.[14]

Our multiplicity of insurers forces US hospitals to spend more than twice as much as Canadian hospitals on billing and administration; forces US physicians to spend vast amounts on billing; and nourishes a panoply of business consultants, coding software vendors, and other satellite businesses.[14,15] Only a true single-payer system would realize large administrative savings. Perpetuating multiple payers would force hospitals to maintain expensive cost-accounting systems to attribute costs and charges to individual patients and payers. In the United Kingdom, market-based reforms that fractured hospital payment have swollen administrative costs.[16,17]

Co-payments and deductibles discourage preventive care, decrease the use of essential care, are expensive to administer, and especially endanger the most vulnerable patients—the poor and those with chronic illnesses.[18] Many nations with NHI have effectively contained costs without resorting to such charges.

Coverage decisions would doubtless be difficult and sometimes hotly contested. Even the fairest and best-informed board would confront costly choices where evidence was sparse and passions abundant. Yet we are encouraged by Medicare's generally open and reasoned approach. Moreover, in both Medicare and NHI, the inclusion of the affluent in the same program with others creates a powerful lobby for maintaining adequate coverage. For these reasons, we believe NHI provides a framework for replacing the confused and often unjust dictates of insurance companies with rational, evidence-based decision making.

HOSPITAL PAYMENT

The NHI program would pay each hospital a monthly lump sum to cover all operating expenses. The hospital and the regional NHI office would negotiate the amount of this payment annually based on past budgets, clinical performance, projected changes in demand for services and input costs, and proposed new programs. Hospitals would not bill for services covered by NHI.

Hospitals could not use any of their operating budgets for expansion, profit, excessive executives' incomes, marketing, or major capital purchases or leases. Major capital expenditures would come from the NHI fund and would be appropriated separately based on community needs. Investor-owned hospitals would be converted to not-for-profit status and their owners compensated for past investment.

Global budgeting would simplify hospital administration by virtually eliminating billing, thus freeing up resources for enhanced clinical care. Prohibiting the transfer of operating funds to capital projects or shareholders would eliminate the main financial incentive for both excessive interventions (under fee-for-service payment) and skimping on care (under capitated or diagnosis related group systems), since neither inflating revenues nor limiting care could result in institutional gain. Separate and explicit appropriation of capital funds would facilitate rational health care planning. These methods of hospital payment would shift the focus of hospital administration away from lucrative services that enhance the bottom line and toward providing optimal clinical services according to patients' needs.

PAYMENT FOR PHYSICIANS AND OUTPATIENT CARE

Physicians and other practitioners could choose from 3 payment options: fee-for-service, salaried practice in institutions receiving global budgets, and salaried practice in group practices or HMOs receiving capitation payments. Investor-owned HMOs and group practices would be converted to not-for-profit status. Only institutions that actually deliver care could receive NHI payments, excluding most current HMOs and some practice management firms that contract for services but don't own or operate clinical facilities.

(1) Fee-for-service: The NHI and organizations representing fee-for-service practitioners (eg, medical associations) would negotiate a simple, binding fee schedule. As in Canada, physicians would submit bills on a simple form or via computer and would receive interest for bills not paid within 30 days. Physicians accepting pay-

ment from the NHI program could not bill patients for covered services, but they could bill for excluded procedures such as cosmetic surgery.

(2) Salaries within institutions receiving global budgets: Hospitals, group practices, clinics, home care agencies, and the like could elect to be paid a global budget, which could include funding for items such as education, community prevention programs, and patient care. Regulations regarding capital payment would be similar to those for inpatient hospital services, as would the budget setting process.

(3) Salaries within capitated groups: Group practices and nonprofit HMOs could opt to receive capitation payments to cover all physicians and other outpatient care. Regulation of payment for capital would be similar to that for hospitals. The capitation payment would not cover most inpatient services, which would be included in hospital global budgets. However, a capitated group could elect to provide and be compensated for physician services to inpatients. Enrollment would be open to any patient, and efforts to selectively enroll those at low risk would be prohibited. Patients could disenroll with appropriate notice. Health maintenance organizations would pay physicians a salary, and bonuses based on the utilization or expense of care would be prohibited.

The proposed pluralistic approach to health care delivery would avoid unnecessary disruption of current practice arrangements. All 3 proposed options would eliminate profiteering and uncouple capital from operating costs, features essential to cost containment and health planning.

The fee-for-service option would greatly reduce physicians' office overhead by simplifying billing. Canada and several European nations have developed successful mechanisms for controlling the inflationary potential of fee-for-service practice.[19] These include limiting the supply of physicians, monitoring for extreme practice patterns, and setting overall limits on regional spending for physicians' services (thus requiring the profession to monitor itself). Because of the administrative advantages of single-source funding, these regulatory options have been implemented without extensive bureaucracy. Similar cost-constraint mechanisms might be needed in the United States. We also recommend capping expenditures for the regulatory and reimbursement apparatus; the Canadian experience suggests that 2% to 3% of total costs should suffice.[14]

Global budgets would allow institutions to virtually eliminate billing, while assuring them a predictable revenue stream. Such funding could also stimulate the development of community prevention programs whose costs cannot be attributed (or billed) to individual patients.

LONG-TERM CARE

The NHI program would cover disabled Americans of all ages for all necessary home and nursing home care. Persons unable to perform activities of daily living would be eligible for services. A local public agency in each community would determine eligibility and coordinate care. Each agency would receive a single budgetary allotment to cover the full array of long-term care services in its district. The agency would contract with long-term care providers for the full range of needed services, eliminating the perverse incentives in the current system that often pays for expensive institutional care but not the home-based services that most patients would prefer.

The NHI program would pay long-term care facilities and home care agencies a lump sum budget to cover all operating expenses. For-profit nursing homes and home care agencies would be converted to not-for-profit status. Physicians, nurses, therapists, and other individual long-term care providers would be paid on either a fee-for-service or salaried basis.

Since most disabled and elderly people would prefer to remain in their homes, the program would encourage home- and community-based services. The 7 million unpaid caregivers, the family and friends who currently provide 70% of all long-term care,[20] would be assisted through training, respite services, and in some cases, financial support. Nurses, social workers, and an expanded cadre of trained geriatric physicians would assume leadership of the system.

Few Americans have private coverage for long-term care. For the rest, only virtual bankruptcy brings entitlement to public coverage under Medicaid. Universal coverage must be combined with local flexibility to match services to needs.

Our proposal borrows features from successful long-term care programs in some Canadian provinces[21] and in Germany. The German program, in particular, demonstrates the fiscal and human advantages of encouraging rather than displacing family caregivers, offering them recompense, training, and other supports.[22]

CAPITAL SPENDING, HEALTH PLANNING, AND PROFIT

The NHI budget would fund the construction of health facilities and the purchase of expensive equipment. Regional health planning boards would allocate these capital funds. These boards would also oversee capital projects funded from private donations when they entailed any increase in future publicly supported operating costs.

The NHI program would compensate owners of investor-owned hospitals, HMOs, nursing homes, and clinics for the loss of their clinical facilities, as well as any computers and administrative facilities needed to manage NHI. They would not be reimbursed for loss of business opportunities or for administrative capacity not used by NHI.

Capital spending drives operating costs and determines the geographic distribution of resources. Capital funds must go to excellent and efficient projects in areas of greatest need. When operating and capital payments are combined, as they are currently, prosperous hospitals can expand and modernize while impoverished ones cannot, regardless of need or quality. National health insurance would replace implicit mechanisms of capital allocation with explicit ones. Insulating these crucial decisions from lobbying and other distorting influences would be difficult and require rigorous evaluation, needs assessment, and active participation by providers and the public. The consistently poor performance of investor-owned facilities precludes their participation in NHI.

Investor ownership has been shown to compromise quality of care in hospitals,3-5 nursing homes,[23] dialysis facilities,[24] and HMOs;[25] for-profit hospitals are particularly costly.6-12 A wide array of investor-owned firms have defrauded Medicare and been implicated in other illegal activities.[26] Investor-owned providers would be converted to nonprofit status. The NHI program would issue long-term bonds to amortize the one-time costs of compensating investors for the appraised value of their facilities. These conversion costs would be offset by reductions in payments for capital that are currently folded into Medicare and other reimbursements.

MEDICATIONS AND SUPPLIES

The NHI program would pay for all medically necessary prescription drugs and medical supplies, based on a national formulary. An expert panel would establish and regularly update the formulary. The NHI program would negotiate drug and equipment prices with manufacturers based on their costs, excluding marketing or lobbying. Where therapeutically equivalent drugs are available, the formulary would specify use of the lowest-cost medication, with exceptions available in specific cases. Outpatient suppliers would bill the NHI program directly for the negotiated wholesale price, plus a reasonable dispensing fee, for any item in the formulary that is prescribed by a licensed practitioner.

National health insurance could simultaneously address 2 pressing needs: providing all Americans with full drug coverage and containing drug costs. As a single purchaser with a disproportionate influence on the market, the NHI program could exert substantial pressure on pharmaceutical companies to lower prices. Similar programs in the United States and other nations have resulted in substantial drug price reductions.[27-29]

Additional reforms are needed to improve prescribing practices, minimize medication errors, upgrade monitoring of drug safety, curtail pharmaceutical marketing, ensure that the fruits of publicly funded drug research are not appropriated for private profit, and stimulate real innovation while ameliorating current incentives to develop "me-too" drugs that add little to the therapeutic armamentarium.[30]

FUNDING

The NHI program would pay for virtually all medically necessary health services, with total expenditures set at approximately the same proportion of the gross domestic product as in the year preceding the establishment of NHI.

While it is critical that the vast majority of funds flow out to providers from a single payer in each region, the mix of taxes used to raise these funds is a matter of tax policy, largely separate from the organization of health care per se.

Single-source payment is the sine qua non of administrative simplification and the cornerstone of cost containment and health planning. Government expenditures, including payments for public employees' private health coverage and tax subsidies to private insurance, already account for about 60% of total health spending in the United States.[31] This would increase under NHI, to perhaps 80% of health costs with the remainder used for such items as nonprescription drugs, cosmetic surgery, and other excluded services. The public money now routed through private insurers

would be used to fund public coverage. The additional funds could be raised in a number of ways, including earmarked income taxes, payroll taxes, or required employer contributions. During a transition period, it seems reasonable to require that employers transfer money earmarked for health benefits under existing labor pacts to the NHI program. In the long run, we believe that funding based on income or other progressive taxes is fairest. Federal funding would attenuate inequalities among the states in financial and medical resources. The increase in government funding would be offset by reductions in premiums and out-of-pocket costs. The total costs of the NHI program would be no greater (and eventually less) than those of the current fragmented system.

COMMENT

Under an NHI program, the financial threat of illness to patients would be eliminated, as would current restrictions on choice of physicians and hospitals. Taxes would increase, but except for the very wealthy, would be fully offset by the elimination of insurance premiums and out-of-pocket costs. Most important, NHI would establish a right to health care.

Clinical decisions would be driven by science and compassion, not the patient's insurance status or bureaucratic dictum. National health insurance would offer physicians a choice of payment options and practice settings. Nurses and other personnel would also benefit from the reduction in paperwork and a more humane clinical milieu.

National health insurance would curtail the entrepreneurial aspects of medicine, including both the problems and the possibilities. All patients would be insured, with a uniform fee schedule. Physicians who work harder would make more. Billing would be simplified, saving each practitioner thousands of dollars annually in office expense. Based on experience in Canada, NHI would have little impact on physicians' average incomes, although differences among specialties might be attenuated.

National health insurance would contain costs by enforcing overall budgets and eliminating profit incentives and not by detailed administrative oversight of utilization. Since hospitals and HMOs could not transfer monies for patient care to shareholders or divert them to institutional expansion, pressure to skimp on care would be minimized.

National health insurance would eliminate many administrative and insurance worker positions, necessitating a major effort at job placement and retraining. Many of these displaced workers might be deployed as support personnel to free up nurses for clinical tasks; others might be retrained to staff expanded programs in public health, home care, and the like.

Clinical departments would see only modest changes, eg, the elimination of billing-related work. However, hospitals' and nursing homes' administrative departments would shrink, and their financial incentives would change. Responsiveness to community needs, quality of care, and efficiency would replace financial performance as the bottom line. Operating revenues would become stable and predictable; capital requests would be weighed against other priorities for health care investment. Facilities would not grow or shrink based on their financial performance, although rational health planning would mandate that some expand and others close. Investor-owned providers would be converted to not-for-profit status.

The insurance/HMO industry's role would be virtually eliminated. Most of the funds to expand care under NHI would come from eliminating insurance company overhead and profits, as well as the administrative expense they impose on health professionals and hospitals.

Private employers now fund 19% of health spending.[31] Even if new NHI taxes on employers fully replaced this spending, firms would achieve savings on their employee benefits departments, which currently cost billions of dollars to administer. Hence, for the average business, reform would likely yield at least modest short-term savings. Over the longer term, enhanced cost containment under NHI would spare firms from rapid and erratic health care cost growth. Many firms would undoubtedly choose to continue current wellness programs and workplace safety initiatives.

Covering the uninsured would save thousands of lives annually.[32] Upgrading coverage for those who are currently insured (eg, by adding full prescription drug benefits) would yield additional health benefits.

Independent estimates by several government agencies and private sector experts indicate that NHI would not increase total health care costs.[33-37] Savings on administration and billing, which would drop from the current 30% of total health spending to perhaps 15%, would approximately offset the costs of expanded services.

Over the long run, improvements in health planning and cost containment made possible by single-source payment would slow health care cost escalation.

This article presents a framework for the urgently needed reform of our health care payment system. We do not pretend to address the full range of health care problems or even to provide the detailed transition plan that will be needed to minimize dislocations during reform of the financing system. The need for quality improvement would remain urgent. National health insurance would not, in itself, encourage healthy lifestyles or upgrade environmental and public health services. Nonfinancial barriers to care—racial, linguistic, and geographic—would persist. Many issues in medical education would remain, including medical students' debt burden that skews specialty choices and discourages low-income applicants, the underrepresentation of minorities, and the appropriate role for commercial firms in supporting research and education. Some patients would still seek unnecessary services, and some physicians would still yield to financial temptation to provide them. The malpractice crisis would be partially ameliorated—the 25% of jury awards designated as compensation for future medical costs would be eliminated. However, our society would probably remain litigious, and legal and insurance fees would still consume about three fifths of malpractice premiums.[38] The aging of our population and the development of costly new technologies would present a continuing challenge to affordability.

Finally, while we propose a central role for government in financing care, we hold no illusions about government's shortcomings. Many of us disagree with government policies and priorities and are concerned by the influence of powerful special interests. Yet only a public NHI program can streamline our system and garner the savings needed to make universal coverage affordable. Ultimately, we prefer the democratic process, however flawed, to the boardroom decision making of private insurance firms.

ALTERNATIVES TO NHI

The mounting crisis in health care has called forth a variety of incremental reform proposals discussed below. All share one critical liability: because they would retain the role of private insurers, they would perpetuate administrative waste, making universal coverage unaffordable. Most would augment bureaucracy. Proponents' assertions that private insurers would achieve large savings through computerized bill processing are not credible; most claims processing is already automated.

"Defined Contribution Schemes" and Other Mechanisms to Increase Patients' Price Sensitivity

These plans cap employers' premium contributions at a fixed amount, pressuring employees to choose lower-cost insurance options. Many cite the Federal Employees Health Benefit Program as a model for such reform, even though premiums in this program are rising faster than in Medicare or for private employers.[39] Hence, such programs are more likely to shift costs from firms to employees than to slow overall cost growth. Moreover, defined contribution schemes ensure a multitiered insurance system, with lower-income workers forced into skimpy plans, and the uninsured remaining uncovered.

Tax Subsidies and Vouchers for Coverage for the Uninsured

These proposals would offer tax credits to low-income families who purchase private coverage. While promises of new government funding to expand coverage are attractive, the proposed subsidies (eg, $3000 per family under President Bush's proposal) fall far short of the cost of adequate insurance, requiring low-income families to pay thousands of dollars out of their own pockets. Hence, few of the uninsured would actually purchase coverage, even with the subsidy. Instead, most of the tax credits would subsidize premiums for low-income people who already have coverage. As a result, large outlays for tax subsidies would buy little new coverage. For instance, outlays of $13 billion annually would cover only 4 million of the uninsured.[40]

Expansion of Medicaid, State Children's Health Insurance Program (SCHIP), and Other Public Programs

Some proposals would expand Medicaid eligibility. Others would allow states to buy stripped-down HMO coverage for Medicaid recipients, with the savings ostensibly used to enroll more beneficiaries. Several problems bedevil these strategies. First, Medicaid already offers second-class coverage. Such programs that segregate the poor virtually ensure poor care and are more vulnerable to funding cuts than public programs that also serve affluent constituencies. In most states, Medicaid payment rates are so low that many physicians resist caring for Medicaid patients.

As a result, access to care for Medicaid enrollees is often little better than for the uninsured.[41,42] Further cuts to benefits, as envisioned in some Medicaid HMO schemes, would leave Medicaid recipients with coverage in name only. Moreover, the disempowered Medicaid population is particularly vulnerable to exploitation by profit-seeking HMOs, as evidenced by past scandals in California, Florida, Tennessee, and other states.[43,45] Promises (eg, in Oregon[46,47] and Tennessee[48]) that savings from Medicaid coverage cuts would lead to universal coverage have proven empty.

Second, even large Medicaid expansions in the past have failed to keep pace with the erosion of private coverage.[49] Moreover, Medicaid funding is most endangered when it is most needed; any economic downturn depletes states' tax revenues, reducing funds for Medicaid just as rising unemployment rates deprive many of private coverage.

While few can argue with proposals to cover more of the poor and near-poor, Medicaid expansion without systemwide reform is a stopgap measure unlikely to stem future increases in the number of uninsured. It does not lead to universal coverage.

Employer Mandates

This approach would require most employers to offer private coverage for their workers, with employees paying part of the premiums. The proposed mandates are usually coupled with a plan to expand Medicaid-like public programs. Some versions would offer employers the option of paying into a public program rather than providing the coverage themselves. Such programs can only add coverage by adding cost, leaving premiums unaffordable to many. In states where such plans have been passed, they have achieved neither universal coverage nor cost control.[1,50,53] Hawaii's program has left many uncovered because of loopholes in the law, and costs in that state have continued to spiral upward. A 1988 Massachusetts employer mandate law was passed but later abandoned when costs soared.[51]

The Medicare HMO Program and Medicare Voucher Schemes

Under Medicare's HMO program, private HMOs have already enrolled millions of senior citizens. Prominent proposals would expand Medicare's use of private insurers by offering seniors a voucher to purchase private coverage in lieu of traditional Medicare. These strategies assume that private plans are more efficient than Medicare, that seniors can make informed choices among health plan options, and that private insurers' risk avoidance can be thwarted. All 3 assumptions are ill-founded. Traditional Medicare is more efficient than commercial insurers; costs per beneficiary have risen more slowly and overhead is far lower.

An American Association of Retired Persons survey of seniors found that few had adequate knowledge to make informed choices among plans.[54] Despite regulations prohibiting risk selection in the current Medicare HMO program, plans have successfully recruited healthier than average seniors. Hence HMOs have collected high premiums for patients who would have cost Medicare little had they remained in fee-for-service Medicare. Moreover, HMOs have evicted millions of seniors in counties where profits are low, while continuing to enroll Medicare patients in profitable areas.[55] As a result, HMOs have increased Medicare costs by $2 billion to $3 billion each year2 and disrupted the continuity of care for many patients.

A voucher program for Medicare would also push low-income seniors into skimpy plans similar to the defined contribution approach to employee coverage discussed above. Moreover, Congress is unlikely to increase the value of the voucher to keep pace with the rising costs of private plans. Over time, seniors' out-of-pocket costs for coverage would likely rise.

CONCLUSION

Health care reform is again near the top of the political agenda. Health care costs have turned sharply upward. The number of Americans without insurance or with inadequate coverage rose even in the boom years of the 1990s. Medicare and Medicaid are threatened by ill-conceived reform schemes, and middle-class voters are very concerned about the abuses of managed care. Other wealthy countries manage to provide universal health care at half the cost we pay. Their problems stem mainly from inadequate funding, not the structure of their systems. In contrast, the problems in the United States are systemic. Incremental changes cannot solve them; further reliance on market-based strategies will exacerbate them. What needs to be changed is the system itself.

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This article has been endorsed by 7784 additional physicians and medical students (names available at *http://www.pnhp.org/signers/).*

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Dr. ANGELL. While I have the floor here, I wonder if it would be possible for me to comment on three issues raised earlier, and maybe the fourth issue, the nursing situation.

Mr. HOLT. Yes, you may. You may use my time for that.

Dr. ANGELL. The nursing problem, the staffing problem in general, is something that can only be handled in a single-payer system because then you would have the ability to coordinate and dis-

tribute resources and make manpower decisions that you can't do in a fragmented system or nonsystem. We really don't have a system; it is a nonsystem. So you need some kind of a system to make these kinds of decisions. That is another reason for doing it, and that would include manpower decisions.

The other comments I would like to make, earlier it was suggested that somehow a government-administered system would be less responsive to patients' needs and desires. I would like to explore that by comparing Medicare, our Medicare, which is a government-administered, publicly financed system, with our employment-based private system that relies on investor-owned insurance companies.

Medicare insures almost everyone over the age of 65 whether they have preexisting conditions or not, all of them, and it insures them for the full benefit package. It can't tailor that package according to whether someone actually needs care or not, and recipients of Medicare have free choice of doctors, completely free choice. Compare that with the insurance system, the private insurance system, where you may not get insurance if you have a preexisting condition. If you do get the insurance, you may have certain things covered, but other things not covered.

Mr. HOLT. I have a close, in fact, the closest possible, relationship with the medical profession.

Chairman ANDREWS. He is married to a physician, that is what he means.

Mr. HOLT. And indeed if most doctors had to choose between Medicare's rules and restrictions and that of any number of private insurance companies, it would be Medicare hands down.

Dr. ANGELL. And most patients, too.

It is the most popular part of our health care system.

Something was said earlier about cancer outcomes being better in this country than in some other countries. Cancer is a disease of older people, and I suspect what we are seeing is the success of the Medicare part of our system and not the private employment-based part.

So I think the notion that somehow a government-administered system is less responsive to patients is quite the opposite of the case in this country.

Second, the flight from Canada. First of all, I am not aware of droves of people coming, but we have now about 50 million.

Mr. HOLT. I should warn you, our time is running out.

Dr. ANGELL. I will be fast. We have 50 million Americans with no insurance at all. They would love to go to Canada for health care if they could afford it. That would be droves going in the other direction.

If the King of Jordan can come here and get health care, that is a sad commentary on both of our countries; that he can't get health care in his country that is adequate, and that he can jump the queue, and 50 million people here don't have health insurance, but he can buy his way in.

Chairman ANDREWS. The gentleman's time has expired.

I want to add a word of appreciation and thanks to the witnesses and also make a request of them. The appreciation is obvious. You prepared thoroughly for this morning. You have endured the delay

in the middle of the hearing, for which I apologize, when we had the floor votes, and we very much appreciate the very substantive contribution that you have made.

The committee and the Congress are at the onset of our deliberations on passing a bill that we hope will address the problems that you very articulately have identified today. To summarize them, I think it includes the fact that we pay too much and get too little, the fact that there is too much interference with the relationship between a patient and a provider, and the fact that the problems seem to be escalating rather than being resolved.

I would ask each of the four witnesses to continue to have dialogue with the committee as the process goes forward, and I would invite you to do that. We are accessible through all the different modes of communication, and we would like to hear from each one of you.

I would like to ask if the substitute Ranking Member has any comments before we conclude.

Mr. PRICE. I would like to echo our appreciation for the witnesses, and especially for Chairman Conyers, who has labored long in an effort to try to reform the system.

I think a couple of points that I would like to make. One is that those of us on our side of the aisle do not believe that the status quo is acceptable. Reform is absolutely imperative for all of the reasons that all of us have grave concerns about the situation that we find ourselves in, whether it is on the provider side as physicians and hospitals and nurses and others who are working as diligently as possible to care for patients, or whether it is on the patient side where they are having difficulty gaining access.

I would respectfully suggest that an honest and sober reflection of what has gone on before in other systems would be appropriate, and in our system. If one is a new Medicare patient in this Nation, access to care is markedly limited because it is difficult to find a physician who is taking new Medicare patients. The Mayo Clinic is limiting the number of Medicare patients that it is taking in Jacksonville. That is a frightening, frightening statement about—an indictment of our current system.

The limitation of care under our Medicare system I know very well and firsthand as a physician practicing under that system, and Medicare limits the ability of physicians to care for patients in a remarkable number of ways.

So I would join the Chairman in hoping that we would have a very thoughtful, sober, reflective, honest debate and discussion. If we do that, I have great faith we will come up with a system that will reflect the ideals of Americans.

Chairman ANDREWS. I thank the gentleman.

I would just conclude with this comment. An American President stood up and said that the country needed a law to be sure that every person had access to quality health care and health insurance, and he said that if we did not take steps to achieve that objective, that the economy of the country would suffer greatly, and, more importantly, individuals and families would suffer greatly. That President was Harry Truman, and his words were repeated by various other Presidents since then.

In 1971, Richard Nixon proposed a system of universal health care through an employer mandate. I see Chairman Conyers shaking his head. He remembers that. Mr. Chairman, I was in high school then, but I do remember the proposal. Obviously there have been attempts, most recently in 1994, and in other iterations since then.

There is one common thread I hope is running through Members of both parties and through both Houses. I know it exists in the White House. This time there is going to be a law, not a discussion. We are going to do our very best to make sure that it is a law that works and can pass. I think today's discussions have been very fruitful and constructive in helping us get to that point. As I said to the Chairman at the outset, we hope this is the beginning of our interaction with you, not the end.

With that, I thank the Members.

Without objection, Members will have 14 days to submit additional materials or questions for the hearing record.

[Questions for the record and their responses follow:]

[VIA EMAIL],
U.S. CONGRESS,
Washington, DC, June 16, 2009.

Dr. MARCIA ANGELL, *Senior Lecturer in Social Medicine,*
Harvard Medical School, FXB Building, 6th floor, 651 Huntington Avenue, Boston, MA 02115.

DEAR DR. ANGELL: Thank you for testifying at the June 10, 2009, Committee on Education and Labor Subcommittee on Health, Employment, Labor, and Pensions Hearing on "Examining the Single Payer Health Care Option."

Committee Members had additional questions for which they would like written responses from you for the hearing record.

Congressman Kucinich asks the following questions:

1. I asked a question of Dr. David Himmelstein when he gave testimony a number of weeks ago in this subcommittee and I'll ask it of you too. In the event that a national single payer plan is not brought to a vote by this Congress, what would be your top legislative health care priority that would get us closer to a system that would control costs, grant health care as a right, and improve quality?

2. We know single payer will eliminate a lot of excessive costs at the outset by getting rid of the unnecessary middleman, the health insurance companies. But the real cost problem is that costs are rising every year faster than inflation. How will single payer control the rate of cost growth? What evidence do we have for that?

3. Why is the Massachusetts health care plan failing?

4. We have heard over and over that polls show that people want to keep the health care they have. And yet polls show people have extremely low approval ratings for the health insurance industry. How would you reconcile those two polls?

5. Why does it make a difference if the system is for-profit or not-for-profit? What is the difference in cost, quality and access?

6. Why is FEHBP, the health plan for federal employees, including Members of Congress, not a good model for health care reform?

7. I believe that health care is a human right, that it is just as important as water, food, education, housing or any other human right. Can you please describe the range of health care finance options that would make health care a human right?

Please send your written response to Subcommittee staff by COB on Wednesday, June 24, 2009—the date on which the hearing record will close. If you have any questions, please contact the Subcommittee. Once again, we greatly appreciate your testimony at this hearing.

Sincerely,

ROBERT ANDREWS, *Chairman,*
Subcommittee on Health, Employment, Labor, and Pensions.

Dr. Angell's Responses to Questions Submitted

DEAR CHAIRMAN ANDREWS: Thank you for your letter of June 16 and for sending me the additional questions posed by Congressman Kucinich. Before answering them, I would like to make two general observations, as background for my specific responses.

First, nearly everyone agrees that the central problem in our health system is runaway costs. Yet we've chosen to leave the system largely in the hands of for-profit businesses whose primary goal is to grow. Even on the face of it, that makes no sense.

Second, it's important to distinguish the insurance system from the delivery system, which consists of the facilities and providers who deliver the care. To control costs, reform needs to address both.

Now I'll address Congressman Kucinich's perceptive questions as you numbered them in your letter. I would also refer him to the written testimony I submitted for the record at the June 10th hearing.

1. Question: In the event that a national single-payer plan is not brought to a vote by this Congress, what would be your top legislative health care priority that would get us closer to a system that would control costs, grant health care as a right, and improve quality?

Answer: There are two possible incremental approaches that would be helpful. We could allow individual states to institute single-payer systems within their borders (I assume they would need federal waivers to include Medicare and Medicaid recipients.) Unless health facilities and providers became nonprofit, however, savings would be limited. But it would be a start and give us some experience with single-payer health care. The second incremental approach would be to lower the Medicare age nationally a decade at a time. Here, too, savings would be limited if we retained our profit-driven delivery system. Moreover, unlike a true single-payer system within a state, there would still be hundreds of private insurers driving up administrative costs. So I would prefer a state-by-state approach.

2. Q. How will single-payer control the rate of cost growth? What evidence do we have for that?

A. I agree that runaway cost is the central problem. Converting to a single-payer system would help enormously. Since overhead is one of the fastest growing parts of the system, cutting it in half would be more than a one-time saving; savings would carry over year after year. In addition, a single-payer system permits the rational distribution of resources according to medical need. But costs would still rise too rapidly, because of the for-profit delivery system. Most specialty hospitals and many general hospitals are for-profit, as are most nursing homes, home health care agencies, dialysis units, psychiatric facilities, and freestanding imaging and testing centers. The more they do, the more they are paid; costs to the system are their profits. Another reason costs would continue to rise is that most physicians are paid fee-for-service, and the fees are badly skewed to reward specialists extravagantly for doing high-technology tests and procedures. As for evidence, I would refer you to Atul Gawande's recent article in the New Yorker and to an excellent book by Shannon Brownlee, titled Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer, published in 2007 by Bloomsbury Press.

To realize the full savings of a single-payer system, we would need a three-pronged reform: (1) a single-payer insurance system, (2) a nonprofit delivery system, and (3) putting physicians on salaries, or adjusting fees to reward primary care physicians much more and specialists less. You might want to refer to an article I wrote for the Canadian Medical Association Journal, October 21, 2008, comparing the Canadian system with ours since they adopted their system in 1972.

3. Q. Why is the Massachusetts health care plan failing?

A. It is simply unaffordable for the state and for individuals. It requires residents to buy, or the state to subsidize, private insurance at whatever price the industry wants to charge. Handing private companies a captive market was a recipe for steep price increases. About a quarter of those required to purchase insurance out-of-pocket have been granted waivers because they can't afford it, and the required benefit package has been stripped down (for example, the requirement for prescription drug coverage was dropped). Even so, it's doubtful whether the program can limp along much longer. Deductibles and co-payments will have to increase, and required benefits will probably be reduced still further. Massachusetts is learning that health insurance is not the same thing as health care.

4. Q. We have heard over and over that polls show that people want to keep the health care they have. And yet polls show people have extremely low approval ratings for the health insurance industry. How would you reconcile those two polls?

A. Everything would depend on the wording of the questions in the polls. I think people are worried that they may lose what they have, as inadequate as that may be, and so they may be reluctant to advocate scrapping the system altogether. They don't want to end up with even less than they have now. But I've never met anyone who had a kind word for the practices of the insurance companies, or who thought it was OK for people to lose their health care if they lost their jobs.

5. Q. Why does it make a difference if the system is for-profit or not-for-profit? What is the difference in cost, quality and access?

A. The purpose of investor-owned businesses is to increase the value of their shareholders' stock by maximizing profits. Health care is distributed like a market commodity according to the ability to pay, not according to medical need. In economic terms, this is a highly successful industry—profitable and growing—but it's a huge drain on the rest of the economy and a staggeringly inefficient way to deliver health care. If we want to reduce the nation's health costs, why would we leave the job to an industry that by its nature seeks to expand? Comparisons of for-profit with nonprofit facilities and providers have clearly shown that for-profits almost always cost more than comparable nonprofits, and usually deliver poorer quality care. For a full review of this subject, please see Chapter 2 (The Consequences of Commercialized Care) of Arnold S. Relman's book, A Second Opinion: Rescuing America's Health Care, published in 2007 by Public Affairs.

6. Q. Why is FEHBP, the health plan for federal employees, including Members of Congress, not a good model for health care reform?

A. Costs of the FEHBP are rising extremely rapidly, because there is no mechanism for controlling them. As in the case of the Massachusetts model, it doesn't make sense to enact health reform if it will quickly become unaffordable.

7. Q. I believe that health care is a human right, that it is just as important as water, food, education, housing or any other human right. Can you please describe the range of health care finance options that would make health care a human right?

A. I certainly agree with you. Health care is a vital need, like fire and police protection, clean water and air, equal justice, and education. There is no reason to single it out to be left to the vagaries of the market. Imagine if a 5th grader were turned away from school because his parents hadn't purchased education insurance! The fairest way to finance health care is through an earmarked tax on income. Income taxes would increase somewhat, but the savings in premiums and out-of-pocket costs in a more efficient system would more than offset the increase in taxes.

Thank you for giving me the opportunity to respond to these questions.

[VIA EMAIL],
U.S. CONGRESS,
Washington, DC, June 16, 2009.

Ms. GERI JENKINS, *R.N., Co-President,*
California Nurses Association/National Nurses Organizing Committee, 2000 Franklin Street, Oakland, CA 94612.

DEAR MS. JENKINS: Thank you for testifying at the June 10, 2009, Committee on Education and Labor Subcommittee on Health, Employment, Labor, and Pensions Hearing on "Examining the Single Payer Health Care Option."

Committee Members had additional questions for which they would like written responses from you for the hearing record.

Congressman Kucinich asks the following questions:

1. A number of states have commissioned health care experts from the Lewin Group and other expert organizations to produce studies comparing the cost effectiveness of different ways of delivering health care to their citizens, including single payer. What did those studies find?

2. I asked a question of Dr. David Himmelstein when he gave testimony a number of weeks ago in this subcommittee and I'll ask it of you too. In the event that a national single payer plan is not brought to a vote by this Congress, what would be your top legislative health care priority that would get us closer to a system that would control costs, grant health care as a right, and improve quality?

3. We know single payer will eliminate a lot of excessive costs at the outset by getting rid of the unnecessary middleman, the health insurance companies. But the real cost problem is that costs are rising every year faster than inflation. How will single payer control the rate of cost growth? What evidence do we have for that?

4. Why is the Massachusetts health care plan failing?

5. We have heard over and over that polls show that people want to keep the health care they have. And yet polls show people have extremely low approval ratings for the health insurance industry. How would you reconcile those two polls?

6. Why does it make a difference if the system is for-profit or not-for-profit? What is the difference in cost, quality and access?

7. Why is FEHBP, the health plan for federal employees, including Members of Congress, not a good model for health care reform?

8. I believe that health care is a human right, that it is just as important as water, food, education, housing or any other human right. Can you please describe the range of health care finance options that would make health care a human right?

Please send your written response to Subcommittee staff by COB on Wednesday, June 24, 2009—the date on which the hearing record will close. If you have any questions, please contact the Subcommittee. Once again, we greatly appreciate your testimony at this hearing.

Sincerely,

ROBERT ANDREWS, *Chairman,*
Subcommittee on Health, Employment, Labor, and Pensions.

Ms. Jenkins' Responses to Questions Submitted

DEAR CONGRESSMAN ANDREWS: Thank you for allowing me the opportunity to testify at the subcommittee on Health, Employment, Labor, and Pensions Hearing on "Examining the Single Payer Health Care Option."

I have enclosed my responses to Congressman Kucinich's questions along with a study prepared by the Institute for Health & Socio-Economic Policy titled "Single Payer/Medicare for All: An Economic Stimulus Plan for the Nation."

Thank you again for the opportunity and I will gladly answer any questions you may have.

Sincerely,

GERI JENKINS, *R.N., Co-President,*
California Nurses Association/National Nurses Organizing Committee.

Responses to Congressman Kucinich's questions

1. A number of states have commissioned health care experts from the Lewin Group and other expert organizations to produce studies comparing the cost effectiveness of different ways of delivering health care to their citizens, including single payer. What did those studies find?

Response: Over the last 15 years, 13 states have used expert consulting firms to look at various options for the provision of health care for their residents. The states which commissioned the studies and the advantages demonstrated by single payer are:

State/firm	Annual single payer savings	Year
New Mexico/Lewin	$151,800,000	1994
Delaware/Sol.for Prog.	229,000,000	1995
Minnesota/Lewin	718,000,000	1995
Mass./Lewin/SFP/BUSPH	1,800,000,000	1998
	3,600,000,000	
Maryland/Lewin	345,000,000	2000
Vermont/Lewin	118,000,000	2001
California/Lewin	7,500,000,000	2002
Maine/Mathmentica Policy	0	2002
Rhode Island/SFP/BUSPH	270,000,000	2002
Missouri/MFH	1,700,000,000	2003
Georgia/Lewin	716,000,000	2004
California/Lewin	8,000,000,000	2005
Colorado/Lewin	1,400,000,000	2007
Kansas/Lewin	869,000,000	2007

Twelve of the thirteen states showed very significant savings in health care costs while at the same time eliminating all the uninsured. Maine was the exception, showing no increase/decrease in state health spending under single payer but providing health care to an additional 150,000 residents. More information on these reports is available at info@pnhp.org

All of the firms used very conservative estimates of how much money would be saved by using a single payer system versus multiple payers.

2. I asked a question of Dr. David Himmelstein when he gave testimony a number of weeks ago in this subcommittee and I'll ask it of you too. In the event that a national single payer plan is not brought to a vote by this Congress, what would be your top legislative health care priority that would get us closer to a system that would control costs, grant health care as a right, and improve quality?

Response: Elimination of the Medicare Advantage Program, increasing the level of Medicare benefits and lowering the age at which people are eligible for Medicare would mark important steps in meeting the goals of controlling costs, granting health care as a right, and increasing quality. Absent a national single payer plan, enabling the states to enact their own single payer plans without any federal barriers and to receive any and all moneys they would have otherwise receive from the federal government is a top priority for CNA/NNOC.

3. We know single payer will eliminate a lot of excessive costs at the outset by getting rid of the unnecessary middleman, the health insurance companies. But the real cost problem is that costs are rising every year faster than inflation. How will single payer control the rate of cost growth? What evidence do we have for that?

Response: Primarily by applying a national health care budget, negotiating prices with providers and pharmaceutical companies, and changing the government's compensation for health care from fee for service to payment based on patient wellness and outcomes. Several decades ago health care in the U.S. and Canada consumed about the same percentage of the GDP in both countries. Today, we are spending 50% more of our GDP than does our northern neighbor. The difference of course is that Canada adopted single payer 40 years ago.

4. Why is the Massachusetts health care plan failing?

Response: The Massachusetts Plan individual mandate, costs continue to escalate far more than initially projected, private insurance plans are costly for many who are not subsidized, community health clinics and hospitals are severely disadvantaged. Without continuing federal largess, it is economically unsustainable as has proven to be the case with other state reforms.

5. We have heard over and over that polls show that people want to keep the health care they have. And yet polls show people have extremely low approval ratings for the health insurance industry. How would you reconcile those two polls?

Response: By and large people want to keep their doctors and other health care providers. The large majority of people understand that health insurance companies do not provide health care. In many instances these companies limit a person's choice of doctors, change the doctor they already have, and deny or modify the care their doctor prescribes, thus the very negative ratings for such companies.

If the statement, "People should have the right to go to the physician of their choice, just like people on traditional Medicare do, and no insurance company has a right to interfere with the decisions me and my doctor make about my health care" were polled, we believe the results would show a very large majority in support.

6. Why does it make a difference if the system is for-profit or not-for-profit? What is the difference in cost, quality and access?

Response: In a for-profit system, too much focus is directed and too many resources are directed toward the primary objective: making a profit for the insurance, pharmaceutical, healthcare equipment and large provider corporations and all the entities up and down the line that may build in some way to make money off the system. Measures of quality are often obscured or non-existent as individual profit centers measure their success by the impact on the bottom line and not of the health and well-being of patients or communities.

Beginning with a non-profit focus allows far better motivation for public health outcomes and helps control costs currently swelled by profits to shareholders and CEOs alike. In addition to the obvious costs built into the current system for the profit margins, all the activities that support the maximization of profit—underwriting, policy rescissions, large billing operations and administrative waste all funnel money away from the delivery of healthcare. Under a non-profit system, a far higher percentage of our healthcare dollars would actually be used for healthcare services.

Under the current multi-payer, for-profit system, access issues have forced more than 47 million people to go without health insurance of any kind and millions of others to make critical healthcare decisions based on access limited by financial concerns. The cost of those access issues has been 22,000 American lives lost every year due to a lack of access to care and a much higher number of preventable deaths which are at least in part attributable to access issues.

7. Why is FEHBP, the health plan for federal employees, including Members of Congress, not a good model for health care reform?

Response: The Federal Employee Health Benefit Pool is a large "connector" for the purchase of for-profit health insurance plans. As such, it offers not greater health or financial security to federal employees than any other large employer group benefit package. Members of Congress—and high ranking federal employees—do have access to higher level plans with better coverage than do the lower ranking staff members and many employees of other federal agencies. So even within the FEHBP there are wide disparities in access and quality of care available for these individuals and their families. The FEHBP is simply a large health insurance marketplace. Some are able to afford great coverage while others cannot.

8. I believe that health care is a human right, that it is just as important as water, food, education, housing or any other human right. Can you please describe the range of health care finance options that would make health care a human right?

Response: Health care as a human right can be financed by increasing the payroll tax as proposed in H.R. 676. Or, as proposed in H.R. 1200 by a combination of a small income tax increase with an increase in the employers' payroll tax. Some countries finance a substantial amount of their national health care from a value added tax. The progressive income tax can be part of the financing as well.

Other nations finance their systems at least in part from their general revenue.

Presumably, when Congress voted to financially bail out Wall Street and the big banks and AIG by adding $trillions to the liabilities of the country's taxpayers it anticipated that the costs would be paid from the Treasury. Should not financing the health care of the American people receive the same consideration?

[To access the study, "Single Payer/Medicare for All: An Economic Stimulus Plan for the Nation," use the following Internet address:]

http://www.calnurses.org/research/pdfs/ihsp—sp—economic—study—2009.pdf

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[VIA EMAIL],
U.S. CONGRESS,
Washington, DC, June 16, 2009.

Dr. WALTER TSOU, M.D., M.P.H., *National Board Advisor,*
Physicians for a National Health Program, 325 E. Durham Street, Philadelphia, PA 19119.

DEAR DR. TSOU: Thank you for testifying at the June 10, 2009, Committee on Education and Labor Subcommittee on Health, Employment, Labor, and Pensions Hearing on "Examining the Single Payer Health Care Option."

Committee Members had additional questions for which they would like written responses from you for the hearing record.

Congressman Kucinich asks the following questions:

1. I asked a question of Dr. David Himmelstein when he gave testimony a number of weeks ago in this subcommittee and I'll ask it of you too. In the event that a national single payer plan is not brought to a vote by this Congress, what would be your top legislative health care priority that would get us closer to a system that would control costs, grant health care as a right, and improve quality?

2. We know single payer will eliminate a lot of excessive costs at the outset by getting rid of the unnecessary middleman, the health insurance companies. But the real cost problem is that costs are rising every year faster than inflation. How will single payer control the rate of cost growth? What evidence do we have for that?

3. Why is the Massachusetts health care plan failing?

4. We have heard over and over that polls show that people want to keep the health care they have. And yet polls show people have extremely low approval ratings for the health insurance industry. How would you reconcile those two polls?

5. Why does it make a difference if the system is for-profit or not-for-profit? What is the difference in cost, quality and access?

6. Why is FEHBP, the health plan for federal employees, including Members of Congress, not a good model for health care reform?

7. I believe that health care is a human right, that it is just as important as water, food, education, housing or any other human right. Can you please describe the range of health care finance options that would make health care a human right?

Please send your written response to Subcommittee staff by COB on Wednesday, June 24, 2009—the date on which the hearing record will close. If you have any questions, please contact the Subcommittee. Once again, we greatly appreciate your testimony at this hearing.

Sincerely,

ROBERT ANDREWS, *Chairman,*
Subcommittee on Health, Employment, Labor, and Pensions.

Dr. Tsou's Responses to Questions Submitted

Thank you so much for the opportunity to speak to your subcommittee on June 10 on the subject, "Examining the Single Payer Health Care Option." You have kindly sent me seven additional questions which I have answered below. I am happy to answer any further questions which you or your committee members may have.

Yours truly,

WALTER TSOU, M.D., M.P.H.

1. In the event that a national single-payer plan is not brought to a vote by this Congress, what would be your top legislative health-care priority that would get us closer to a system that would control costs, grant health care is a right, and improve quality?

A. J. Muste (1885-1967), the well-known peace activist, once stated, "there is no way to peace, peace is the way." So it probably is not surprising that I believe that there is no way to quality affordable health care that makes health care a right except for a properly financed, single-payer, national health insurance program. Hence, I believe that the current national aversion by members of Congress to single-payer is totally misguided. For example, instead of trying to reassure people that a robust public option is not a slippery slope to single-payer, we should be upfront and say that our national goal is to move toward a single-payer plan and that we intend to take a series of steps that move us toward that goal. As I stated in my testimony and illustrated by this past week's CBO estimate of the Senate HELP committee's draft reform legislation, trying to find the funds in order to expand access to health care for all Americans while keeping the private health-insurance industry intact is an exercise in futility. The New York Times poll published on June 20 showed that 72% of Americans support a government administered health insurance plan. Equally striking is that 85% of Americans believe that our healthcare system needs either fundamental changes or should be completely rebuilt. Americans want major health care reform and they want government to assume the lead role. I believe there is a major disconnect between what Americans outside of the Beltway want and what politicians within the Beltway are discussing. Again, the June 20 NY Times poll notes that two of the major design issues being discussed:

a. mandating that employers provide insurance or that all Americans must purchase insurance (good idea only 26%)

b. taxing employer benefits (good idea only 20%)

There is wisdom in what Americans are asking for and Congress would be wise to change course and listen.

Medicare was passed in 1964 and implemented in 1965. The original authors, Wilbur Cohen, Nelson Cruikshank and others, intended to have a single payer national health insurance program, but were stymied by special interest groups. They were met with the same warnings that you can't change the health care system so dramatically. Now 44 years later, Medicare and Medicaid remain robust and dramatic examples of the essential role of a government funded insurance plan that has served tens of millions of Americans. The unfinished dream of the Medicare authors remains unmet. It is time to help realize that dream.

Not passing single payer means that you will waste hundreds of billions of dollars in order to pursue a woefully inefficient system of insurance. As noted above, Medicare and Medicaid were implemented within a year, because for most Americans, they care about picking their doctor or hospital and not as much about who pays their bill.

If you don't do single payer, several steps could be taken to move us toward a single payer plan. For example, we could put all hospitals on global budgets based on their previous year's expenditures, new capital expenses, new community initia-

tives that advance our nation's health objectives and adjusted by the rate of inflation.

Another initial step would be to insure all residents within a given age range such as all children under age 18 or all early retirees between ages 50-65. The younger age cohort could be cheaper to insure and offer significant advantages which will pay off for our nation in the future. The older early retiree cohort is more expensive to fund, but is likely to address a huge problem for businesses and local governments—the problem of retiree health care costs which is rapidly disappearing in America (witness the auto industry). A major problem is that insuring cohorts still maintains the duplicative billing systems and administrative waste in our system, so it does not have the savings needed to cover all Americans. However, it would be an acknowledged step toward true universal coverage and would be a first step toward single payer.

2. We know single-payer will eliminate a lot of excessive costs at the outset by getting rid of the unnecessary middleman, the health insurance companies. But the real cost problem is that costs are rising every year faster than inflation. How will a single-payer control the rate of cost growth? What evidence do we have for that?

If you squeeze a balloon, one end always expands while the squeezed end contracts. This is very similar to what happens in our health care system where we've tried a variety of price controls and other methods to control health care costs only to find that other areas grow exponentially.

The beauty of single-payer is that it offers the greatest variety of choices for controlling health care costs and because it is the dominant payer of health services, squeezing the balloon can effectively control costs. In fact, it is the only method that can work. Believing that 1,300 private health insurers in a competitive marketplace can control costs belies what fifty years of experience tells us. They cannot do it.

Our proposals for funding single-payer health care begins with spending what we will spend as a nation on health care in 2010, namely $2.7 trillion. We create our budget estimates within the confines of this dollar amount that we adjust annually based on the rate of inflation.

Kaiser Family Foundation has recently reviewed HR 676, the US National Health Care Act (USNHC) which would implement a single payer plan across this nation. They identified the following methods of cost containment in the bill:

1. Establish annual budgets for health care professional staffing, capital expenditures, reimbursement for providers, and health professional education

2. Pay institutional providers, including hospitals, nursing homes, community or migrant health centers, home care agencies, and other institutional and prepaid group practices, a monthly lump sum to cover operating expenses

3. Pay physicians and other non-institutional providers based on a simplified fee scheduled or as a salaried employee in an institution receiving a global budget or in a group practice or HMO receiving capitation payments. (The fee schedule should be negotiated by the government with the various specialty societies since the specialty societies know best what the respective services are "worth". As new procedures are introduced, new fee schedules can be negotiated.)

4. Establish a uniform electronic billing system and create an electronic patient record system. (The uniformity of a single payer system allows us to pick one robust system using "smart card" technology which can be read by any health professional across America. Currently, only the VA has such capability. The information technology would allow us to create a sophisticated database as well as complete state, local, and even neighborhood database which could be used to most properly identify areas of need and the most judicious placement of resources.)

5. Allow only public or not-for-profit institutions to participate in USNHC. Private physicians, clinics, and other participating providers may not be investor owned (see answer to question #5)

6. Require USNHC program to negotiate annually prices for drugs, medical supplies, and assistive equipment

7. Establish a prescription drug formulary that encourages best practices in prescribing and promotes use of generics and other lower cost alternatives.

A single-payer financing system would generate hundreds of billions of dollars of savings in duplicative, wasteful administrative spending which is now simply used to determine eligibility or prior authorization requirements.

Finally, a single payer system is only obligated to pay the best price for a quality service. The great advantage that a single payer database could create is not only to better match resources with needs at the local and neighborhood level, but to negotiate the best price for services rendered on behalf of the American patient. In other words, I support the "Republican" perspective that we need price competition, but the competition comes at the delivery end of health care, not the financing end.

(see answer to Question #4). This is a longer discussion which I would be happy to discuss if of interest to the committee.

How do we know that such single-payer systems can work? Perhaps the best evidence can be found in other countries that have adopted single-payer financing. Taiwan has the lowest administrative costs in the world—1.6%! Taiwan spends only 6% of their GDP on health care. Compare that to the 17%, soon to be 20% that we spend here in America. Canada has managed to balance its federal budget because of their single-payer health plan for the past decade—something that we can only dream about. And finally consider this story: I gave a lecture to the students at Penn medical school and in the front row were some hospital executives. After my lecture they told me that their health system had approximately 650 people who did nothing else except work in billing. Another way of looking at this, is that this hospital did not hire doctors, nurses, or social workers or purchase new equipment, but rather were forced to hire hundreds of billing personnel to cope with the complex health-care financing system we have created in America. This is a monstrosity. Multiply that by all the other competitive hospitals in Philadelphia and you realize that there are literally hundreds of thousands of people who do nothing else except push paper around—and for what reason? Toronto General Hospital in Canada has a billing department of approximately 6 people who do nothing except to process the bills of Americans who happen to have the misfortune of getting sick in Canada.

We have a desperate need for people who can work in direct patient care. It is also one of the most rewarding things we can do in our society. We should be hiring more doctors, nurses, social workers and other health professionals and we need a single-payer financing system to help support them. HR 676 offers a two year retraining plan for displaced workers so that they can be put to use helping with direct patient care or public health.

3. Why is the Massachusetts health care plan failing?

The Massachusetts health plan was created by a Democratic legislature and signed by a Republican governor. It carries both the best and worst aspects of this bipartisan agreement. It reminds me of the saying that a camel is a horse created by a committee.

While Massachusetts has been successful in reducing the number of uninsured largely through subsidies for low-income individuals enrolled in Commonwealth Care (their version of Medicaid), the costs of these subsidies is bankrupting the state. Without a mechanism for cost-containment, the Massachusetts plan is unsustainable.

In addition, Massachusetts residents are increasingly finding that the insurance premiums offered through the Connector are unaffordable and still leave them with somewhere between $2-$4000 in deductibles. Those unable to afford the premiums must pay a fine when they file their state taxes which this year will exceed $1000—and they remain uninsured. In addition, some 70,000 individuals have been exempted from the individual mandate to purchase health insurance because they have been deemed uninsurable by the Connector. Those individuals are probably the ones who most need insurance, yet they remain uninsured under the Massachusetts plan.

While the Massachusetts plan has been discussed as a model for national health reform, it is little more than an expensive transfer of public dollars into the hands of private insurers who skim off 15-25% for their own administrative costs and return the reduced amount to pay for medical bills.

The Massachusetts Connector adds approximately 4% to the cost of health care in the state and is faced with the impossible task of continuously means testing Massachusetts residents to see if they qualify for subsidies or if they should have their subsidies removed. The sheer cost of means testing every Massachusetts residents is an administrative disaster and would be unnecessary under a single-payer system.

In summary, the Massachusetts plan has high costs that are unsustainable, and transfers public dollars into a wasteful private health insurance model, leaves the most vulnerable still uninsured, and is increasingly unaffordable for its residents. It should not be the model for health care reform for this country.

4. We've heard over and over that polls show that people want to keep the health care they have. And yet polls show people have extremely low approval ratings for the health insurance industry. How would you reconcile these two polls?

The confusion about people's perception of healthcare is related to the duel use of the word healthcare in our lexicon. Healthcare can mean both how we deliver medical services and how we finance medical services. Americans, by and large, love and appreciate their doctors and nurses and want to make sure that the trusting relationship that they have built with them continues in any health-care reform. This deals with how we deliver our medical and prevention services.

Americans, however, fundamentally hate the bureaucracy and discriminatory nature of the private health insurance model. It is why the June 20 New York Times poll shows that 85% of the American people want a fundamental or complete change in how we finance healthcare in this country.

Because of the confusion of the dual use of the word healthcare, political leaders need to be clear in distinguishing the delivery of healthcare from the financing of health care. And we should be educating the American people that while we strongly support the private delivery of healthcare in America as one of the crown jewels of our health care system, our efforts at health-care reform deal directly and only with how we finance healthcare. Because of that, single-payer health care can be implemented much easier than most politicians believe. As long as Americans can continue to see their private doctors and nurses, who pays their bills is of less concern to almost all Americans. Single payer means public financing and private delivery marries what the polling data suggests what Americans want. The great fear of politicians is the reaction of the insurance and pharmaceutical industry, but that should not obscure doing the "right" thing for Americans.

5. Why does it make a difference if the system is for-profit or not-for-profit? What is the difference in cost, quality and access?

I do not object to profit in a health care system as long as everyone is in the system and is offered decent health care.

What I object to is having 50 million Americans without health insurance while others literally make billions of dollars in profit within the same system. That is morally and socially corrupt.

How has the for-profit system corrupted our values? Private health insurance companies actively practiced adverse risk selection by shunning the sake and ensuring only the healthy. They regularly deny insurance because of pre-existing conditions. They've even gone as far as practicing "recission" where investigators are given expensive patients and asked to comb through their medical records to see if there are potentially even trivial health conditions which were not claimed on the application form as an excuse for canceling their policies. Insurers who unfortunately are stuck with expensive patients can create numerous bureaucratic roadblocks in order to make such patients want to leave their insurance plan which of course means that they become someone else's problem.

For-profit private insurance companies are simply not allowed in virtually all other countries except the Netherlands and our own. And in the Netherlands, the insurance companies are highly regulated. We can begin a health-care reform by insisting that for-profit private health insurance companies must convert to nonprofit status.

The great sadness is that the "profit" motive in health care has permeated and contaminated the entire health care system so that even "not for profit" systems are increasingly behaving and acting as "for profit" institutions. So the conversion to nonprofit status is not sufficient alone.

Private insurance companies under a single-payer system would be allowed to cover benefits (e.g., cosmetic surgery) if it's not covered by the national program. These companies actually do very well in countries like Canada because of their limited scope of benefits are predictable and profitable. But we should eliminate most of the private insurance companies in our country and replace them with a single-payer, national health insurance program because of the great potential advantages for giving every American quality, affordable health care as noted in question #2.

6. Why is FEHBP, the health plan for federal employees, including members of Congress, not a good model for health care reform?

Federal employees under FEHBP, still have all of the flaws of private health insurance including high co-pays and deductibles, medical underwriting, and complex paperwork.

Members of Congress actually receive benefits closer to what a single-payer plan would offer including comprehensive benefits, no co-pays or deductibles, and free choice of the best medical facilities in the country. Congress also has something though that most Americans do not have, namely a House physician. It is doubtful that members of Congress have the same problems of seeking referrals, waiting weeks to see a primary care doctor, or shopping around for the cheapest office or procedure which many federal employees must endure under HSAs under FEHBP.

If we were to have all Americans into the FEHBP program, it would dramatically raise the pricing of insurance premiums until there was better underwriting experience. It would do nothing about reducing the enormous administrative bureaucracy inherent in our current system. It would not have the ability to do bulk purchasing in order to reduce the costs of medicines and supplies. Data gathered by the private insurance companies would become proprietary and would deprive the country of

the advantages of a national database similar to Medicare which is the basis for the Dartmouth Atlas on health care costs and the US Renal Data System.

In short, forcing Americans into the private health insurance FEHBP program offers no advantages and continues the current bureaucratic and wasteful system, except on a larger, national scale.

7. I believe that health care is a human right, that it is just as important as water, food, education, housing or any other human rights. Can you please describe the range of healthcare finance options that would make health care a human right?

I posed this question with Dr. Anja Rudiger, who is the Human Rights to Health Program Director.

I copy her response to me below:

I suggest you draw on three publications, which I attach:

NESRI/NHeLP's Human Rights Principles for Financing Health Care;

NESRI/NHeLP's Human Rights Assessment of Single Payer Plans;

and Amnesty International USA's statement of principles (and petition) on the human right to health care. Of course you're welcome to circulate all documents to the committee if you like.

The NESRI/NHeLP financing principles are based on an interpretation of the relevant international treaties and human rights law, and include references to those documents in the footnotes.

If you think the questioner is open to international perspectives, you could refer to the International Covenant on Economic and Social Rights, because it also mentions all the other rights listed in the question, in addition to the right to health. The Covenant doesn't set out specific financing principles, however—this is mostly done by another UN Committee tasked with providing a detailed interpretation of the treaty (this is also quoted in our footnotes).

To summarize our arguments in the financing principles document (see intro):

"A society disposed to protect both bodily and financial health requires the collective provision of health care on a guaranteed and sustainable basis. In such a society, health care is treated as a public good, rather than as a commodity sold in a marketplace dominated by private interests. The following ten principles for financing health care emerge from human rights standards recognized in the United States and around the world. They are intended to guide the design of a sustainable, cost-effective system that secures comprehensive health care for all."

The 10 financing principles are based on the basic human rights principle that everyone must be able to get the health care they need, regardless of their ability to pay. And while the international legal framework does not mandate whether healthcare financing should be private, public or a combination of both, it makes very clear that governments have an obligation to respect, protect and fulfill the right to health, and to step in if the private sector fails to provide comprehensive (not just emergency) health care to everyone, on an equal basis, based on needs. From this we conclude that health care financing in the U.S. has to be public—given the private sectors' widely documented failures to meet this human rights obligation.

You will see this conclusion also reflected in the statement from Amnesty International USA. Here's an abbreviation of Amnesty's argument:

The human right to health care requires universality, i.e. that every person has access to comprehensive, quality health care. It requires equity in financing and access, which means that benefits and contributions should be shared fairly to create a system that works for everyone. Health care is a public good, not a commodity. Publicly financed and administered health care should be expanded as the strongest vehicle for making health care accessible and accountable. Human rights require the government to be ultimately responsible for ensuring that both public agencies and private companies make health care decisions based on health needs, not on profit margins or other factors.

Finally, you'll see in the attached single payer analysis that we've taken those ten human rights financing principles and measured single payer bills, notably HR 676 and S 703, against them. The detailed results are on pages 7 and 8, and they show that single payer plans are well-placed to meet human rights principles for financing health care. And because we've previously prepared human rights analyses of market-based plans, we can compare those and conclude that single payer plans are vastly superior to market-based plans in meeting human rights principles.

I hope this helps. Please let me know if you'd like more information or clarifications.

Best,

ANJA RUDIGER, PH.D., *Human Right to Health Program Director, National Economic and Social Rights Initiative/National Health Law Program.*

The Human Right to Health Program, run jointly by NESRI and NHeLP, is developing human rights tools to support community organizations and coalitions across the U.S. in their efforts to achieve rights-based health is acare reform at the local, state, and federal level.

Subscribe to the Human Right to Health listserv:

https://lists.mayfirst.org/cgi-bin/mailman/listinfo/human—right—to—health

If you are interested in this area of health and human rights, I have permission from Dr. Rudiger to contact her directly for her input. I attach her articles to this letter.

Human Rights Principles for Financing Health Care

Ten Health Care Financing Principles to Ensure Universality, Equity, and Accountability

The goal of a healthy society is at the core of human rights principles, which place a duty on government to protect everyone's health. In the United States, this requires urgent health care reform to end the needless loss of life, health, and well-being of millions of people. Although current reform plans are primarily driven by a sense of economic necessity, based on cost concerns, they do implicitly share a common understanding of health as a social goal. Where those proposals fall short is in assuming that these shared social and financial goals can be realized as by-products of fragmented, market-based services.

Whether it is the systematic denial of coverage and care in the private insurance system, the price-inflated private Medicare plans, the poor results of privatized Medicaid administration, or the costly Massachusetts health reform, in no instance has the market succeeded in providing equitable access to quality care at a cost affordable to individuals and society as a whole. Indeed, as a market good, health care is by definition exclusionary, sold only to those who can pay, and readily exhaustible, depleted by private interests that literally "take their cut" from available resources through profit, leaving less for the public at large.

A society disposed to protect both bodily and financial health requires the collective provision of health care on a guaranteed and sustainable basis. In such a society, health care is treated as a public good, rather than as a commodity sold in a marketplace dominated by private interests. The following ten principles for financing health care emerge from human rights standards recognized in the United States and around the world. They are intended to guide the design of a sustainable, cost-effective system that secures comprehensive health care for all.

The 10 Principles

Health care financing must create a system that is:

1. Focused on health
2. Universal and unified
3. Publicly administered
4. Free at the point of access
5. Equitable
6. Centered on care
7. Responsive to needs
8. Rewarding quality
9. Cost-effective
10. Accountable

NESRI National Economic & Social Rights Initiative

nesri.org
healthlaw.org

NHeLP NATIONAL HEALTH LAW PROGRAM

1

Focused on health	Health care financing must be completely aligned with the central purpose of a health system: protecting people's health.

The goal of a healthy society must take precedence over factors such as market imperatives, profit motives, and the vagaries of policy and budget cycles. A health care system should be financed in a way that guarantees and secures comprehensive health care for everyone, consisting of all preventive care, screening, information, treatments, therapies, and drugs needed to protect people's health, including mental health, dental and vision care, and reproductive services.[1]

2

Universal and unified	Health care financing must secure automatic access to care for everyone and avoid separating people into different tiers.

How health care is financed must not lead to differences in how people receive health care, either with regard to access, quality, or outcomes. Everyone must be included and get automatic access to equal high quality health care, guaranteed throughout their lives and appropriate to their needs. Financing mechanisms should produce a unified health care system and not give rise to different tiers of access or coverage. When everyone is part of the same system, and can access and use it in the same way, the system itself is stronger and more sustainable since everyone benefits from supporting it.[2]

3

Public	Health care is a public good that should be publicly financed and administered.

Health care is a public good that belongs to all of us, and burdens and benefits must be shared equitably by all. The government has a duty to guarantee everyone equal and easy access to public goods. It can best meet this obligation through public financing and administration of health care, as this minimizes the disincentives to providing care that characterize the business model of private insurers. Steps toward a public system may include expanding public programs such as Medicaid and Medicare, establishing a strong public insurance plan option, and effectively regulating the private insurance sector.[3]

4

Free	At the point of access, health care services must be provided without any charges or fees.

When visiting a doctor, clinic or hospital, patients should not have to pay. Health care funds should be collected independent of the actual use of care, to avoid creating a barrier to care. Services must be provided based on clinical need, not payment, regardless of the financing mechanism used.[4]

5

Equitable	Health care financing must be equitable and non-discriminatory.

Finances for health care provision must be raised and spent in an equitable way. General progressive taxation constitutes the most equitable mechanism, followed by sliding scale social insurance contributions. Whichever model the government adopts, financial contributions from individuals must be according to ability to pay, in order to be affordable for all (e.g. on a sliding scale starting at zero). They must be assessed in a non-discriminatory way, i.e. they cannot differ on grounds of health status, gender, age, employment or any other status except income. In a similar fashion, corporations should be required to contribute to the costs of the health care system.[5]

6

Centered on care	**Care should be financed as directly as possible, without intermediaries. Insurance coverage, if used as a vehicle for financing care, works only if based on the principle of risk and income solidarity**.

The key function of a health care system is to provide care, not coverage. If insurance coverage is used as a vehicle for financing care, this can only benefit all if those who happen to enjoy better health or higher incomes contribute at a level that helps support the whole system, including those in poorer health or with low incomes. This grounds the system in the principles of risk and income solidarity and means that insurance must include everyone (guaranteed issue), spread costs and risk across society as a whole (community ratings, large pool), guarantee comprehensive benefits to all, and collect contributions based on ability to pay.[6]

7

Responsive to needs	**Resources must be allocated equitably, guided by health needs.**

Health care spending must be guided by health needs and rectify existing disparities in resource allocation and infrastructure development. Resources must be used equitably for the benefit of all, while recognizing that some communities and individuals may need more care or different services than others. Communities should be involved in determining how their needs are met, and their participation should be fully funded.[7]

8

Rewarding quality	**Financing mechanisms must reward the provision of quality, appropriate care and the improvement of health outcomes.**

Health care spending must reward quality, appropriate care, and improved health outcomes, rather than profit-seeking, marketing, unnecessary medical procedures, poor coordination, or other interests or effects not linked to protecting health. If care is financed through private insurance, regulation must ensure (through measures such as medical loss ratios) that resources are not diverted away from quality care. On the provider side, we should reward doctors, clinics, and hospitals who focus on quality and outcomes rather than volume, deliver primary care, provide medical homes, and serve communities and areas in need.[8]

9

Cost-effective	**Resources must be used effectively and sustainably to protect the health of all.**

Financial resources in the health care system must be used for the benefit of the whole society, leaving no one behind and investing in communities whose health has not kept up with that of the rest of the population. Wasteful or uncontrolled spending in some areas restricts opportunities for protecting health in others, so the cost-effectiveness of interventions should be taken into account (e.g. through needs assessments, global budgets for hospitals, control of capital expansion and technology projects, etc.).[9]

10

Accountable	**Financing mechanisms and procedures must be accountable to the people.**

Whether public or private, all financing mechanisms and procedures must be transparent and accountable to the people for whose benefit they exist. The people have a right to participate in the oversight of financing structures, and the government has a duty to ensure that financing decisions are based on the human rights principle of universal, equitable health protection. To ensure that this is the case, monitoring and evaluation systems, as well as appropriate public and private remedies, must be put in place to enable the public to measure and oversee progress toward meeting human rights standards.[10]

How Reform Can Realize Our Human Right to Health Care

Human rights principles illuminate the social, economic, and moral aspects of our health care crisis and offer guidance for developing a holistic solution.

If we agree on the common goal of a healthy society, we need to create a robust and sustainable system of collective health care provision that guarantees that everyone can get the health care they need, regardless of their ability to pay.

If we agree on the need to contain the health care costs faced by families, businesses, and government, we need to use our limited resources as effectively as possible, accountable to all of us. We cannot afford to waste them on insurance middlemen and other corporate interests that inflate prices and deplete resources through bureaucracy, marketing, and profit-making.

If we agree on the moral obligation conferred by human rights, which entails treating every person as our equal, endowed with dignity and an equal opportunity to pursue a healthy life, then we cannot exclude anyone from health care, or give them inferior care, or force them to pay private gatekeepers to access care.

Our social goal of universal health protection requires that we pursue cost containment by turning a volatile market good into a sustainable public good. And only a public good can be distributed equitably and thereby help us meet our moral obligation for equal treatment.

Health care reformers who take into account these basic principles will be able to develop a sustainable system that is universal, equitable, and accountable to the people.

References

1 International Covenant on Economic, Social and Cultural Rights, entered into force in 1976 (hereinafter ICESCR), Art. 12; The Committee on Economic, Social and Cultural Rights, *The Right to the Highest Attainable Standard of Health: 11/08/200 E/C.12/2000/4 (General Comment 14)* (hereinafter GC 14) at pars. 8, 9, 17, 34, 51 & 53.

2 ICESCR, Art. 12; GC 14 at pars. 12 (b) & 34. States must afford "equal access" to care for all persons (GC 14, pars. 34 & 35), which is threatened in a system with different access tiers — where, for example, poorer patients, in part due to different insurance options, see different doctors than wealthier patients — but strengthened significantly in a unified system that affords the same access route to all.

3 The international framework allows a public, private or mixed system (GC 14 at par. 36), provided that governments fulfill their obligation to protect against private actors, such as insurers, undermining the right to health care (GC 14 at par. 33). Given the breadth of evidence that private or privately administered financing has led to inequities and disincentives to providing appropriate coverage and care, a mixed system seems more suited to reaching human rights goals in the United States, with full and equal access to private doctors and hospitals that are publicly administered and financed. *See generally* GC 14 at pars. 33, 35, 36, 50 & 51.

4 The right to health requires the removal of all barriers interfering with access to health services (GC 14 at par. 21), and payment at the point of access, however small, has been proven to deter the uptake of health care especially by poor people (*see* RAND Corporation, "The Health Insurance Experiment," RAND Research Highlights 2006). *See generally* GC 14 at pars. 21 & 50.

5 *See* GC 14 at pars. at 12, 18, 19, 21, 30, 34, 43(a), 43(e) & 51; International Convention on the Elimination of All Forms of Racial Discrimination, ratified by the United States in 1994, Article 5 (e) (iv).

6 *See* GC 14 at pars. 12, 35 & 51.

7 *See* GC 14 at pars. 12, 17, 37 & 43.

8 *See* GC 14 at pars. 12, 35, 51 & 55.

9 *See* GC 14 at pars.18, 19, 47 & 51.

10 *See* GC 14 at pars. 17, 54, 55, 56, 57, 58 & 59.

The Human Right to Health Program, run jointly by the National Economic and Social Rights Initiative (NESRI) and the National Health Law Program (NHeLP), develops human rights tools to support organizations and advocates in their efforts to advance the human right to health care in the United States. The program is carried out in collaboration with the FXB Center on Health and Human Rights at the Harvard School of Public Health, Ipas, the Opportunity Agenda, and the Human Rights Implementation Project. Special thanks to the U.S. Human Rights Fund, the Moriah Fund, and the Herb Block Foundation for their support.

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We believe . . . health care is a human right, not a commodity!

In October 2008, President Obama affirmed that health care should be a right, not a privilege. In so doing, he echoed the values of the Universal Declaration of Human Rights, which holds that every human being has the right to health care.

Elected officials in the United States—especially President Obama, his administration, and the current Congress, but also policymakers at the state and local levels—have a historic opportunity to make good on the president's affirmation by recognizing and treating health care as a right, and not a commodity.

We believe that health care is a right, not a privilege or a commodity. To fulfill the human right to health care, the U.S. health care system must meet these principles:

1. Universality: This means that everyone in the United States has the human right to health care. Reform measures should ensure that every person has access

to comprehensive, quality health care. No one should be discriminated against on the basis of income, health status, gender, race, age, immigration status or other factors.

2. Equity: This means that benefits and contributions should be shared fairly to create a system that works for everyone. Health care is a public good, not a commodity. Gaps in the health care system should be eliminated so that all communities, rich and poor, have access to comprehensive, quality treatment and services. Publicly financed and administered health care should be expanded as the strongest vehicle for making health care accessible and accountable.

3. Accountability: This means that the U.S. government has a responsibility to ensure that care comes first. All players in the health care system, whether public or private, have human rights obligations, and must be accountable to the people. The U.S. government is ultimately responsible for ensuring that both public agencies and private companies make health care decisions based on health needs, not on profit margins or other factors.

Bring human rights to the health care debate!

Sign the petition at *amnestyusa.org/healthcare*

[Addition submission of Mr. Kline follows:]

Prepared Statement of the Steering Committee of the National Coalition on Benefits (NCB)

Dear Madam Speaker, Senator Reid, Senator McConnell and Representative Boehner: The National Coalition on Benefits (NCB) is comprised of over 185 employers, associations and other organizations representing employers that offer health benefits to their employees and other beneficiaries. Voluntarily providing health care to more than 170 million Americans, employers are leading the way in helping to improve our health care system. While firmly committed to helping workers and their families meet their health care needs, employers are also struggling with health care costs, especially in this economically challenging time. The NCB supports health care reform that improves health care quality and reduces costs. We believe that individuals should have the responsibility to obtain health insurance and the health care delivery system should be improved through measures such as value purchasing, wellness and prevention, health information technology, and comparative effectiveness research that does not result in rationed care. Healthcare reform must have at its foundation an effective a strategy to control costs. As President Obama has said, "Soaring health care costs make our current course unsustainable. "We completely agree. Unfortunately, we are concerned that emerging legislative proposals do not provide meaningful cost savings for the overall health care system, especially in the near term. In a well intentioned effort to expand coverage, cost containment has not received the priority it demands. Over the course of the past two years, employers have worked to make clear the five fundamental issues that health care reform must properly address to preserve the employment-based system and lead to our support. To date, we have not seen legislative proposals where each of these core issues has been adequately resolved.

As Congress moves closer to formal consideration of legislation, we want to continue to work with all Members of Congress to enact reforms that not only allow Americans to keep the coverage they have today if they like it—and for most Americans, that means their employer-based coverage—but makes it possible for them to count on it being there tomorrow when they need it. ERISA We continue to strongly support the flexibility that ERISA provides in the offering of employer-sponsored health insurance coverage. If the objective is to build upon the employer-based system that successfully covers more than 170 million Americans, then employers must have the ability to determine how best to meet the needs of their employees and retirees. Additionally, allowing states or localities to require employers to comply with various mandates would further raise employer costs, stifle innovation in employer-sponsored coverage and result in unequal benefits for employees. But simply retaining the federal framework is not sufficient if onerous or impractical requirements are added to ERISA itself. Since a fundamental tenet of health care reform is to allow Americans to keep the coverage with which they are satisfied, legislation should not include changes to ERISA or other laws that would risk hurting those who are highly satisfied with the health care coverage that they currently receive. Employer Mandate We are gravely concerned about proposals that would limit the flexibility of employers at a time when our country needs employers to create jobs and invest in future growth. Employer mandates of any kind, including requirements to "pay or play" are not the answer to the healthcare problem because they

undermine our ability to address two key goals of health reform: coverage and affordability. In fact, mandates limit the flexibility and innovation that serves as the foundation of voluntary employer provided health care. This voluntary and flexible system has worked for over six decades and today provides the backbone of the coverage model for over 170 million Americans. Weakening this system would undermine the very goal we are trying to accomplish—making insurance more accessible and affordable for those who do not have health insurance. Most significantly to employers—mandates fail to address the shared problem facing all employers—the soaring cost of health care Mandated Minimum Benefit Any minimum standards for benefits need to be affordable for individuals and taxpayers. Individuals should be able to determine the level of benefits they need and can afford for their family. Employers must also be able to continue to design the benefit plans that make sense for their workforce and consider the full range of health plan options available in a reformed health care market.

The Public Plan A public plan, particularly combined with the impact of Medicare, Medicaid, and other public plans, cannot operate on a level playing field and compete fairly if it acts as both a payer and a regulator. The public plan's unfair competitive position, both by its size and regulatory authority, will merely shift additional costs to the private sector and employees covered by private plans. A public plan that would use government mandated prices would directly result in a cost-shift to other payers and thus would do nothing to address the underlying problems that make health coverage unaffordable for many. Improving the cost, quality and the efficiency of health delivery are key imperatives for reform. We already experience that cost-shift today as Medicare, the largest payer in the United States, consistently underpays providers. Employers and our covered employees and families also see higher price tags in their medical plans because Medicare and Medicaid payment rates are set by law and are comparatively lower than rates for employer-sponsored group health plans. It is no secret that providers receive much higher payments from private insurance plans than from public plans. Tax Exclusion Changes to the taxation of employer-provided health care are also not the answer to health care reform. These policies would increase employer and employee costs and could have a chilling impact on the part of our health care system that provides coverage to all-comers at a community rated premium irrespective of health risk or preexisting conditions. Moreover, it is important to recognize that employers and employees are already paying the largest share of health care costs in this country. As a result, we believe that savings achieved lowering health care costs and improving quality should continue to be the first and foremost sources of financing for health care reform. In summary, we remain concerned about any provisions that would make health care more costly for employers and employees, destabilize our employer-based system of health coverage, or restrict the flexibility of employers to provide innovative health plans that meet the needs of their employees. We look forward to working with you to advance health care reform this year.

Chairman ANDREWS. Without objection, the hearing is adjourned.

[Whereupon, at 1 p.m., the subcommittee was adjourned.]

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