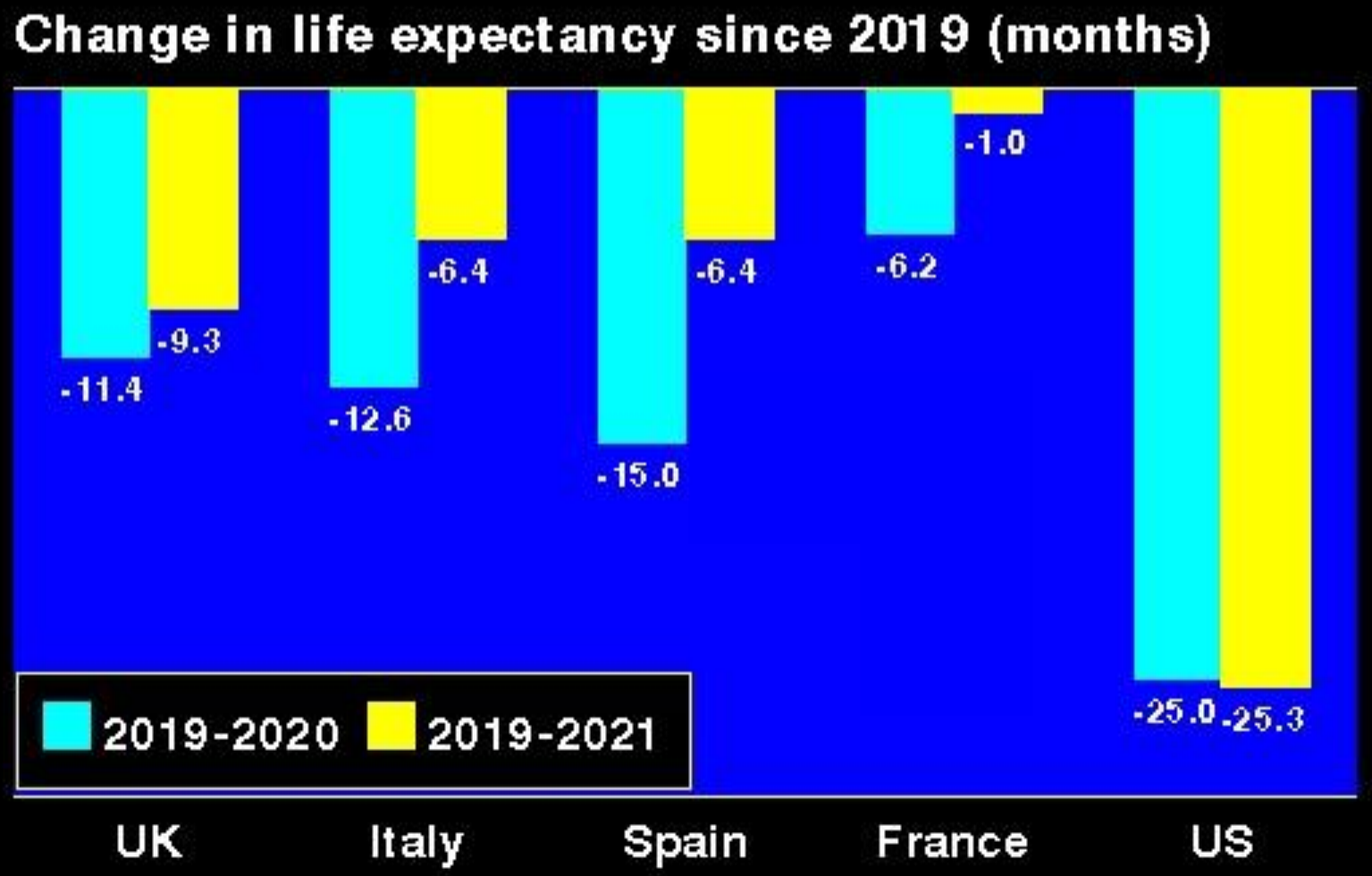
Slides prepared by Drs. Steffie Woolhandler & David Himmelstein, Faculty at the City University of New York at Hunter College and Harvard Medical School, and Research Associates, Public Citizen Health Research Group

Life Expectancy Rebounded From 2020 COVID-19 Drop in Other Nations, Not in US

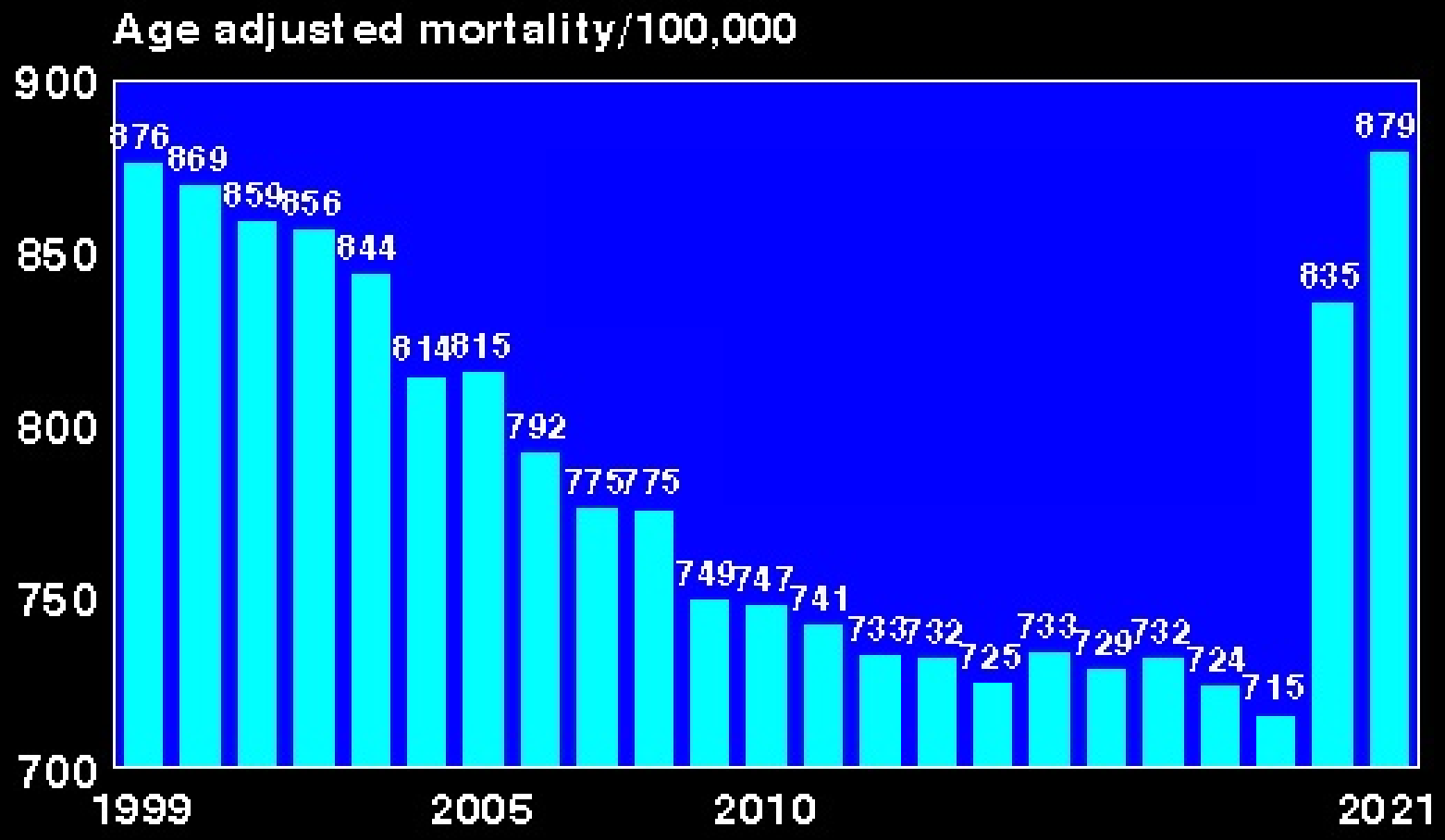


Source: Scholey et al. "Bounce back amid continued losses: Life expectancy changes since 2019"

Why was the U.S. so Vulnerable to COVID-19?

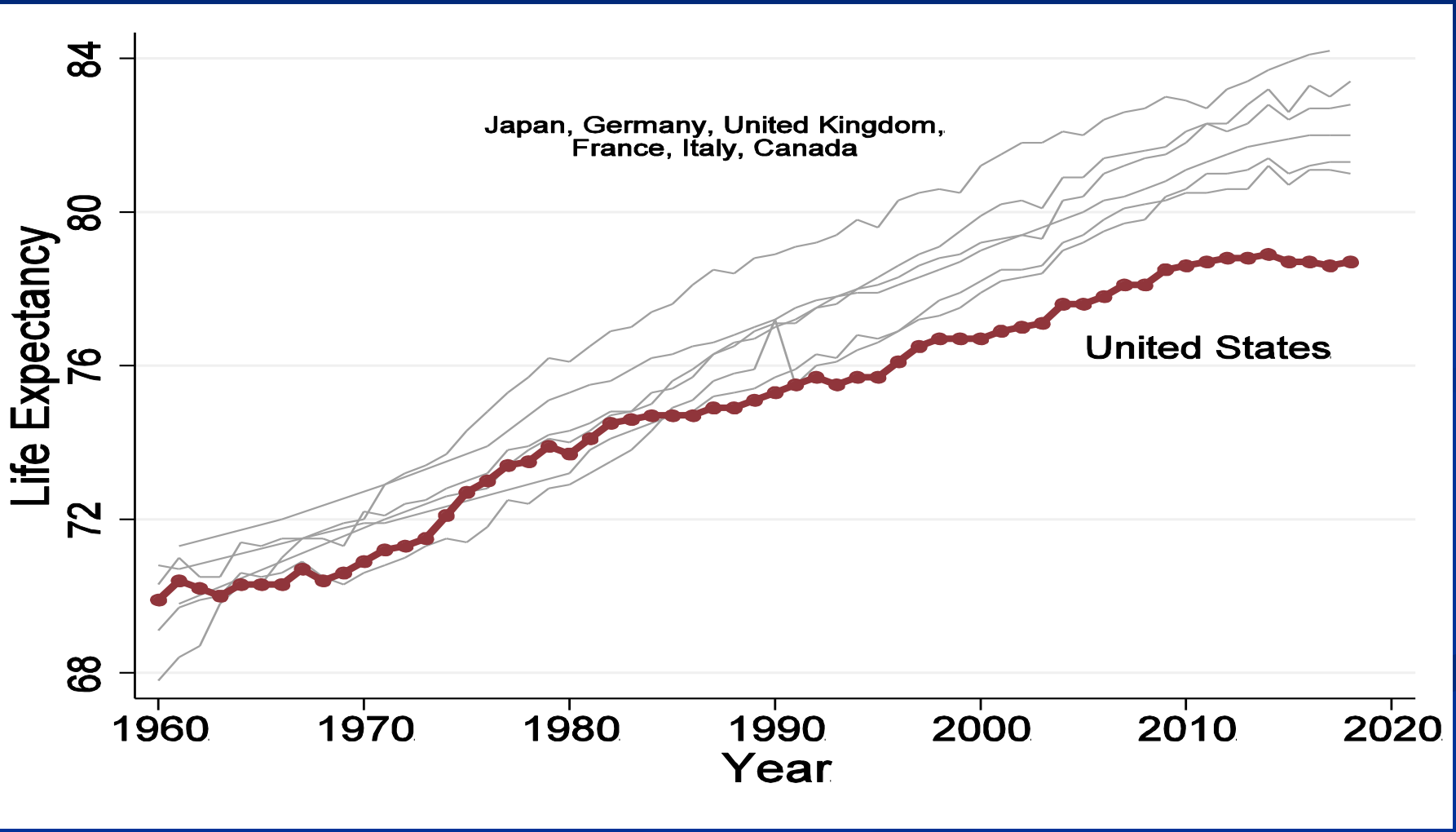
- Deteriorating health status.
- Weakened public health capacity.
- Increasing economic inequality.
- Racism that harms people of color and erodes support for safety-net programs.
- Wasteful health care system that prioritizes profitability over needs.

Progress on Mortality Slowed, Even Before COVID-19



Source: NCHS

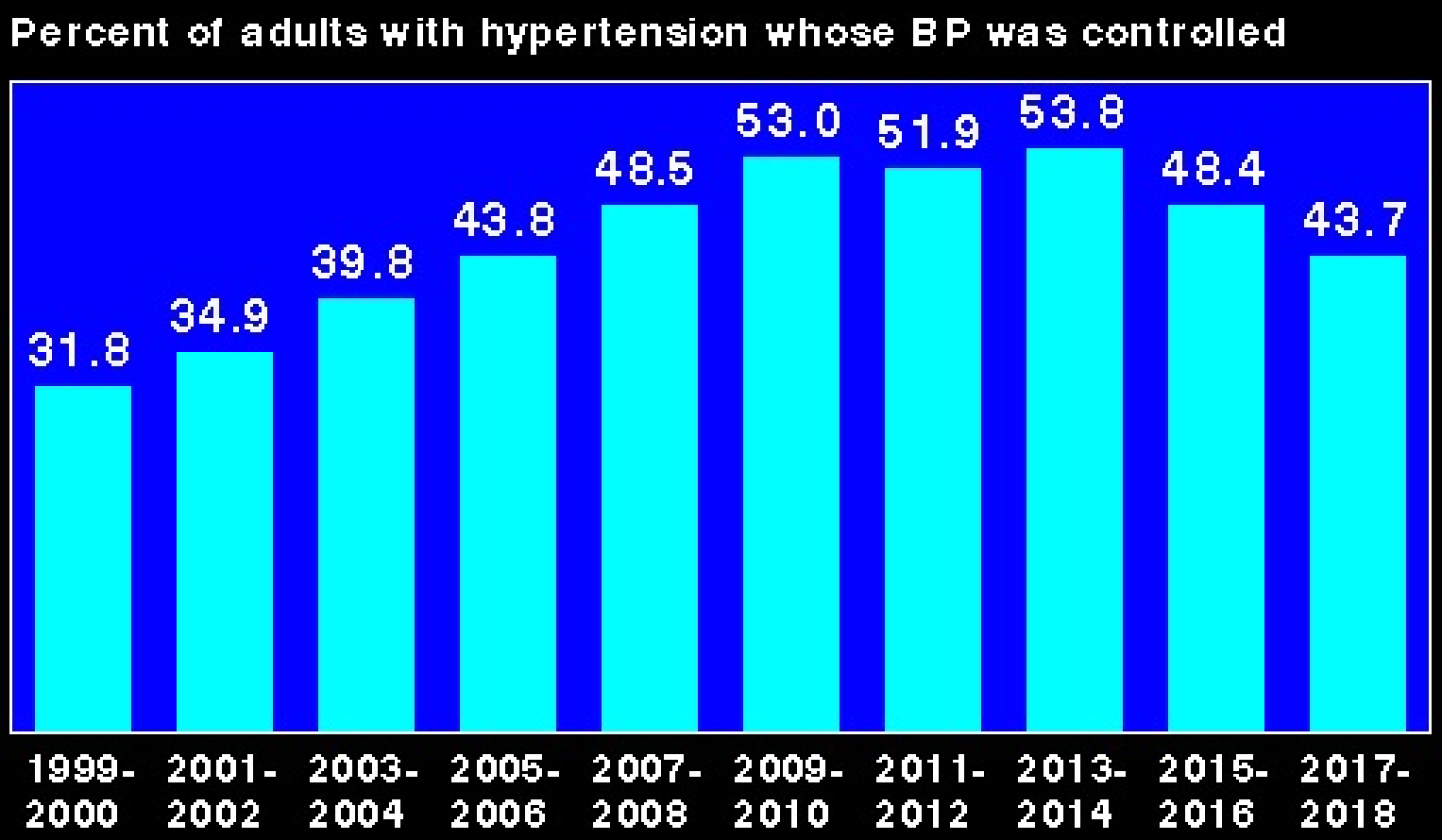
Life expectancy in the US and other G7 countries, 1960–2018



Source: J. Bor based on OECD 2020

Worsening Blood Pressure Control

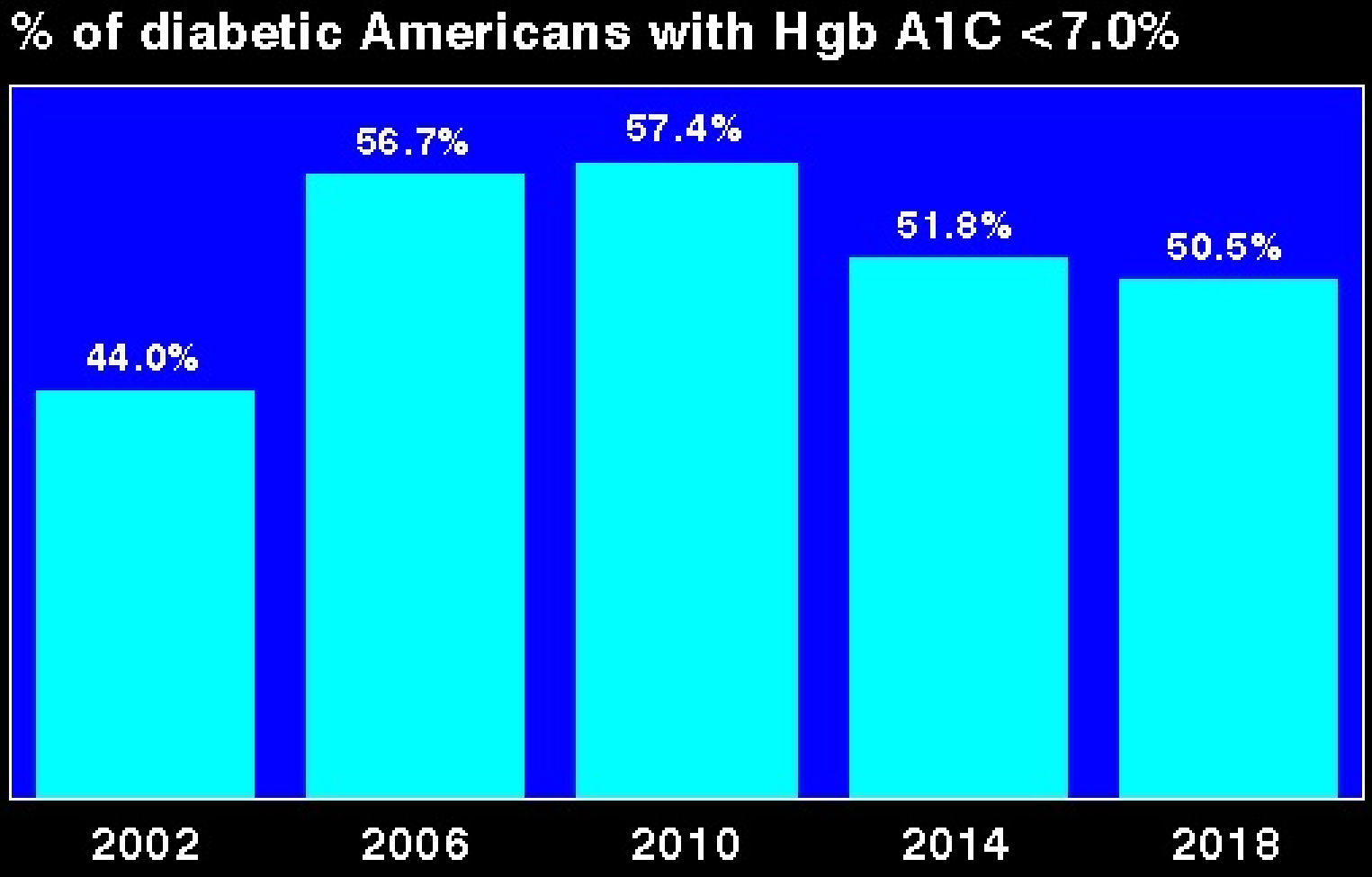
A Rising Share of US Adults Have Uncontrolled Hypertension



Source: JAMA 2020;324:1190 - Worsening control was seen in virtually every demographic group

Note: On average, 35.3% of US Adults had hypertension during the study period

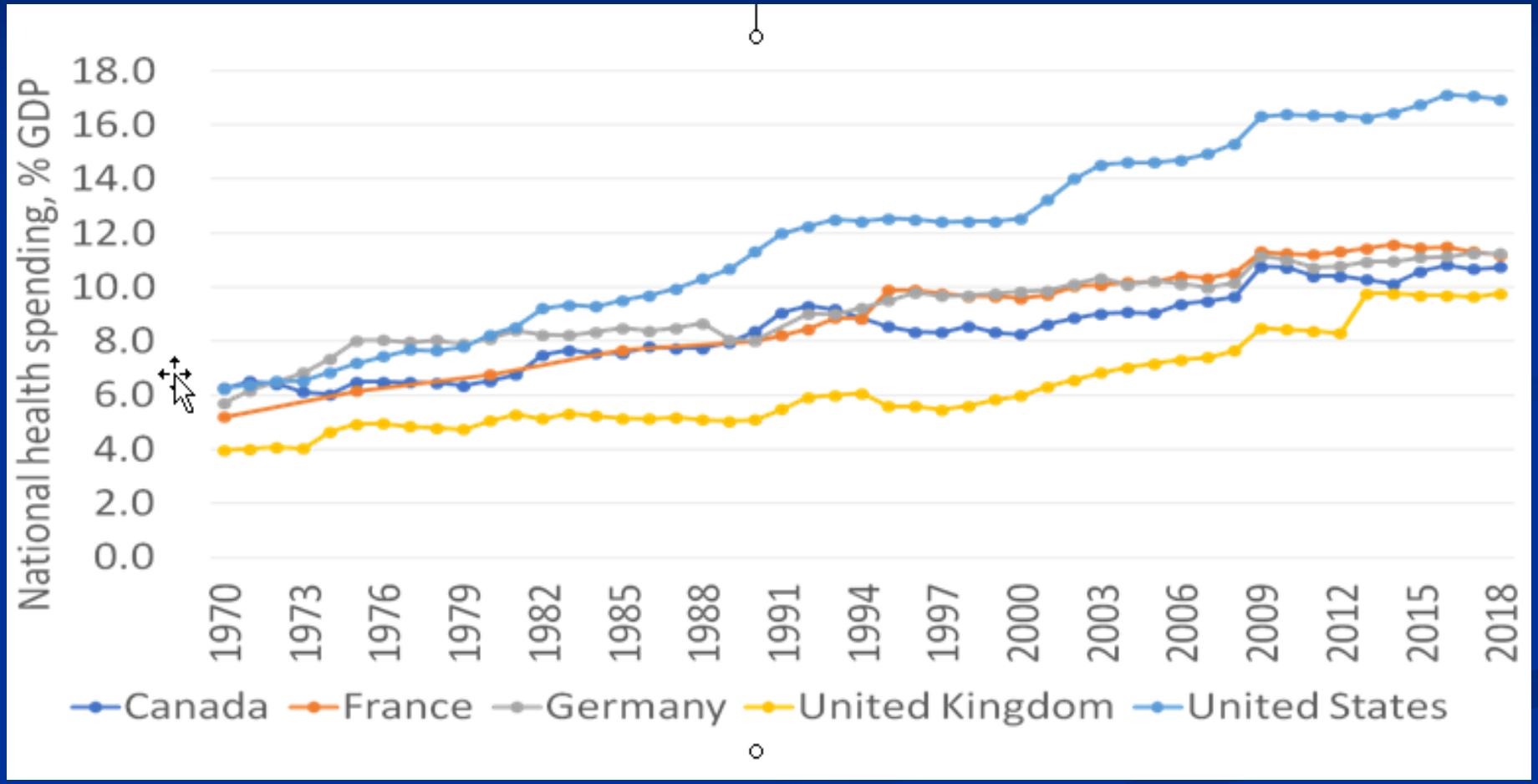
Diabetes Care is Deteriorating



Source: NEJM 2021;384:2219

Note: Data are 4 year averages ending in year shown

US Health Expenditures Started Diverging from Other Nations' ~1980



Source: A. Gaffney based on OECD data, 2020

Why Did US Longevity Stall and Health Costs Soar Starting in ~ 1980?

Neoliberalism

(AKA Market Fundamentalism)

- Markets regulate themselves
  - ❖ They give everyone what they deserve
  - ❖ Unions distort markets, impede formation of merit-based hierarchy
- Government is incompetent
  - ❖ Taxes and regulation should be cut
  - ❖ Public services should be privatized
- Seeking equality is counterproductive and morally corrosive

Background photo from The American Prospect

Corporate Social Responsibility?

"Few trends could so thoroughly undermine the very foundations of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their shareholders as possible."

Source: Milton Friedman - Capitalism & Freedom, 1962

Many Democrats Joined the Neoliberal Bandwagon

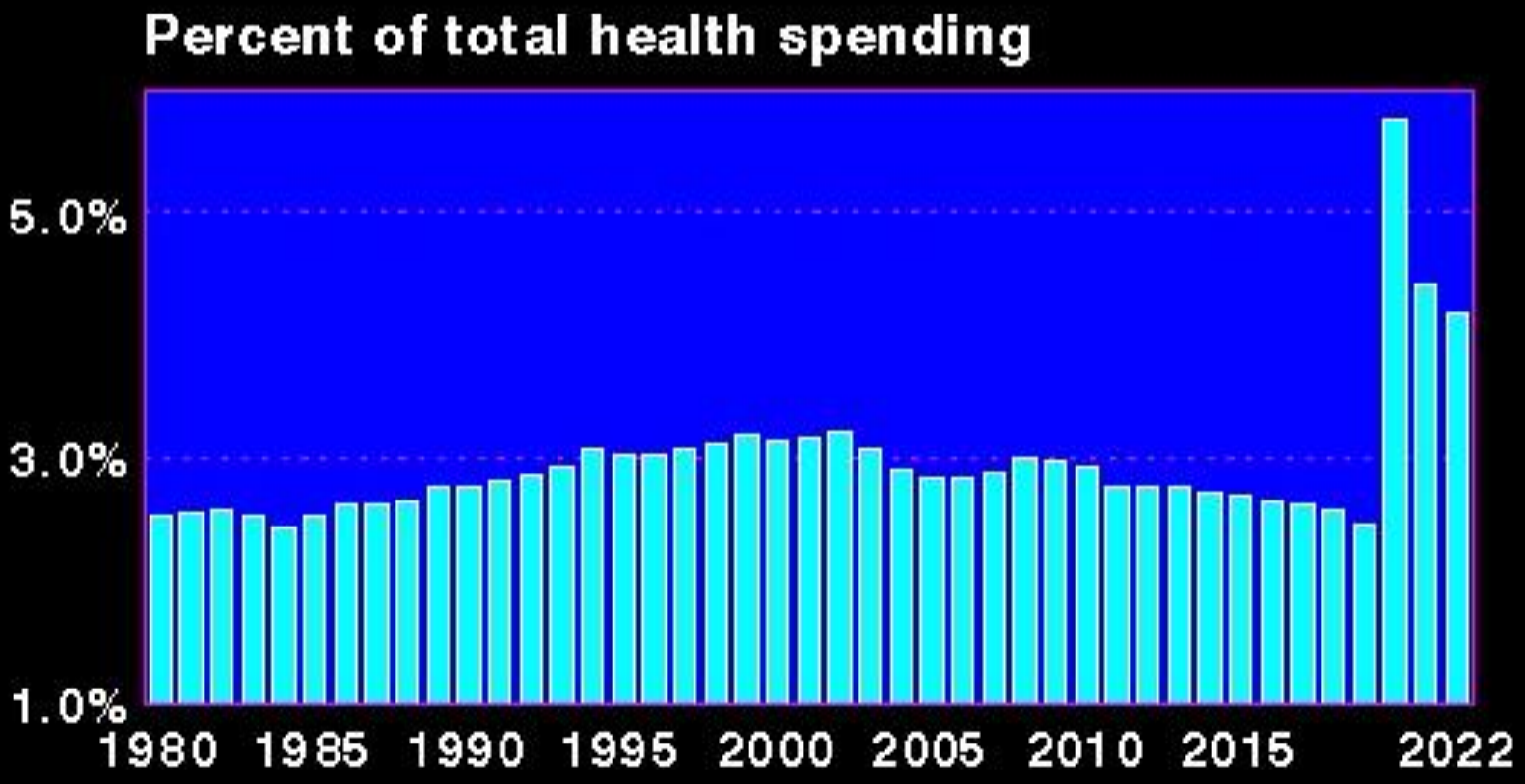
"The most terrifying words in the English language are: 'I'm from the government and I'm here to help' " Ronald Reagan

"The era of big government is over"

Bill Clinton

Weakened Public Health Capacity

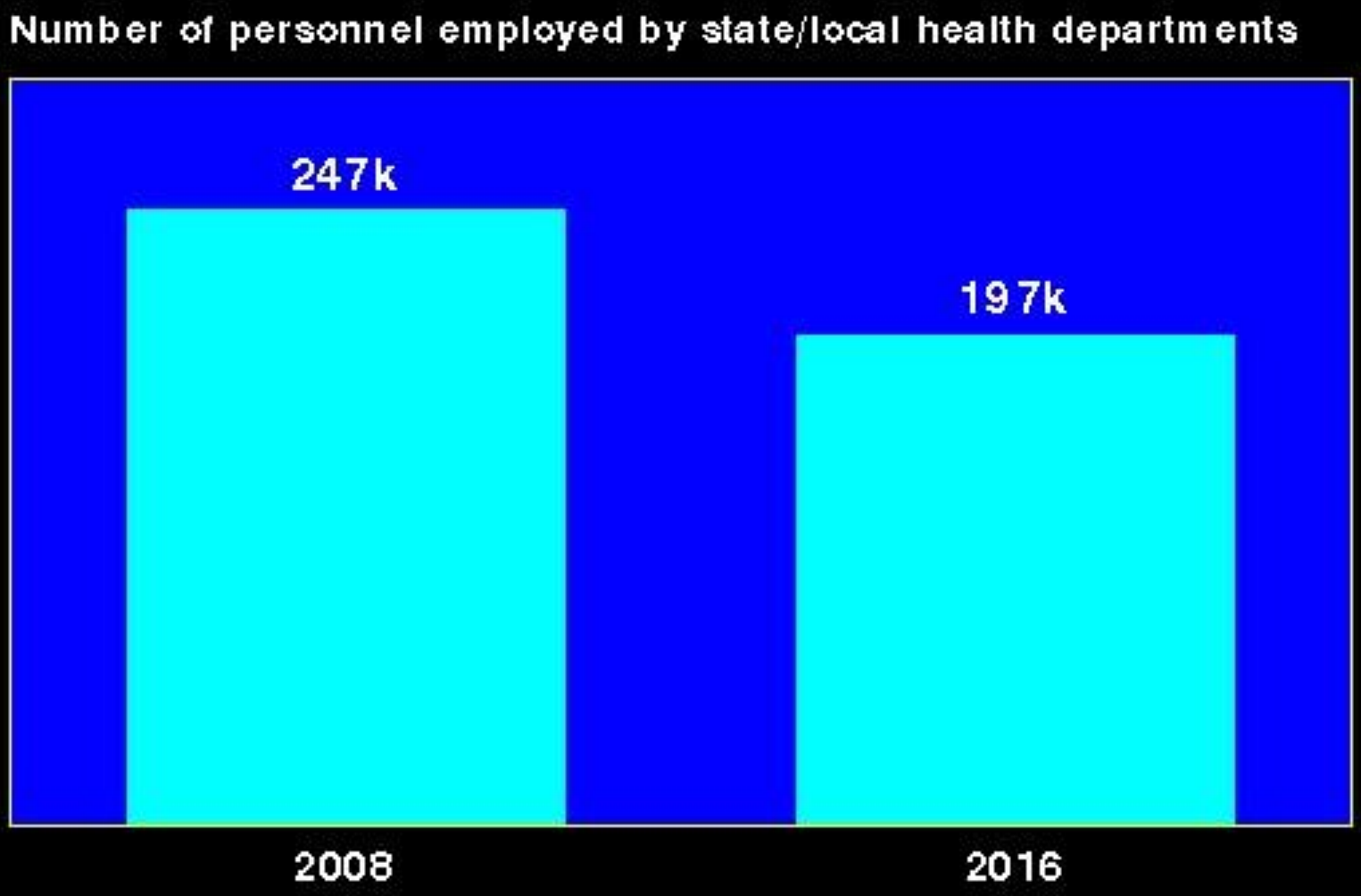
Public Health's Falling Share of Total Health Spending Left the US Vulnerable to COVID-19



Source: Woolhandler/Himmelstein - Am J Public Health 2016;106:56 (updated)
Note public health's share in Canada = 6.2%

Public Health Workforce Declined 20%

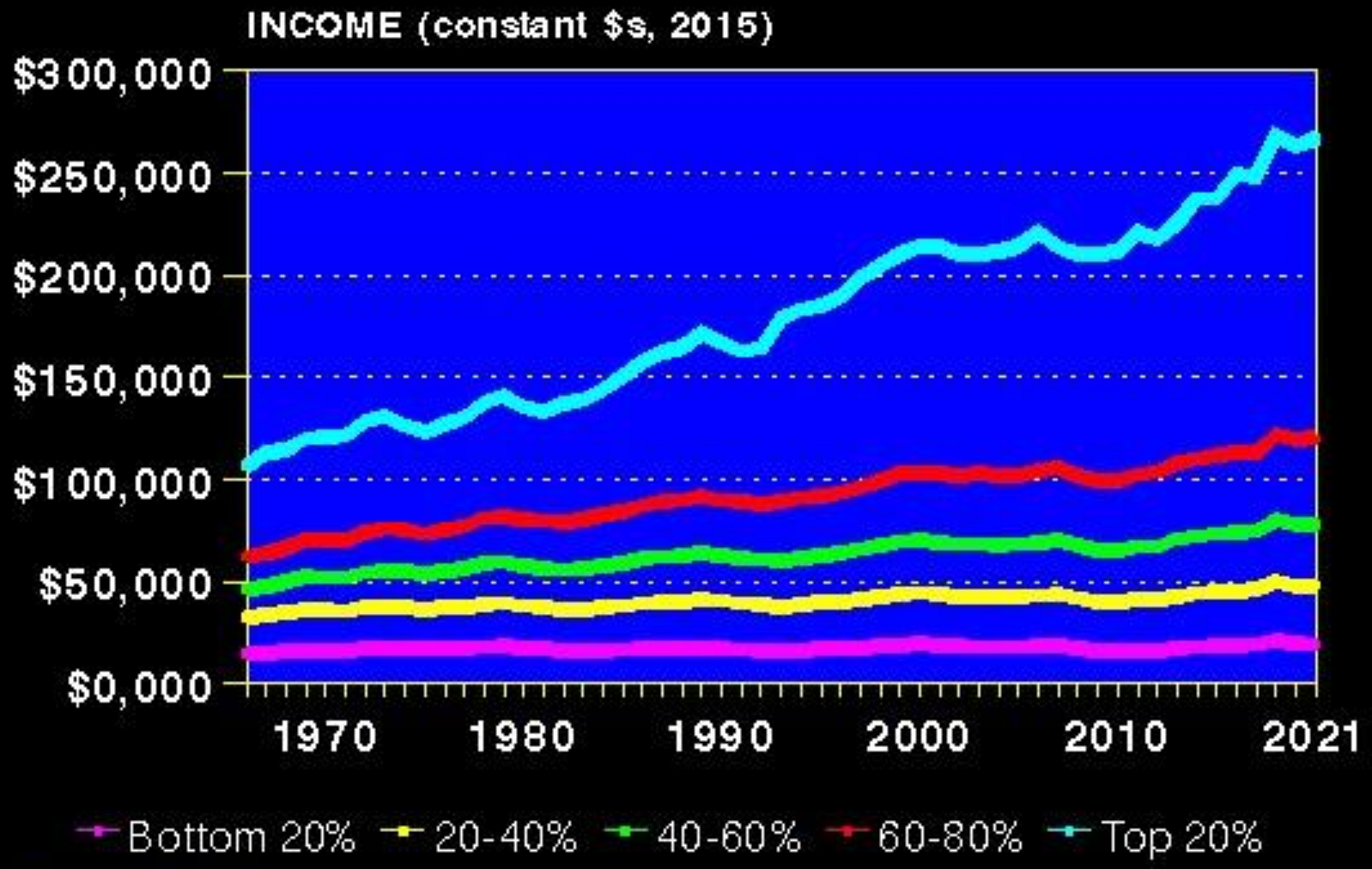
Frontline Personnel to Fight Epidemics



Source: Am J Preventive Med 2018;54:334

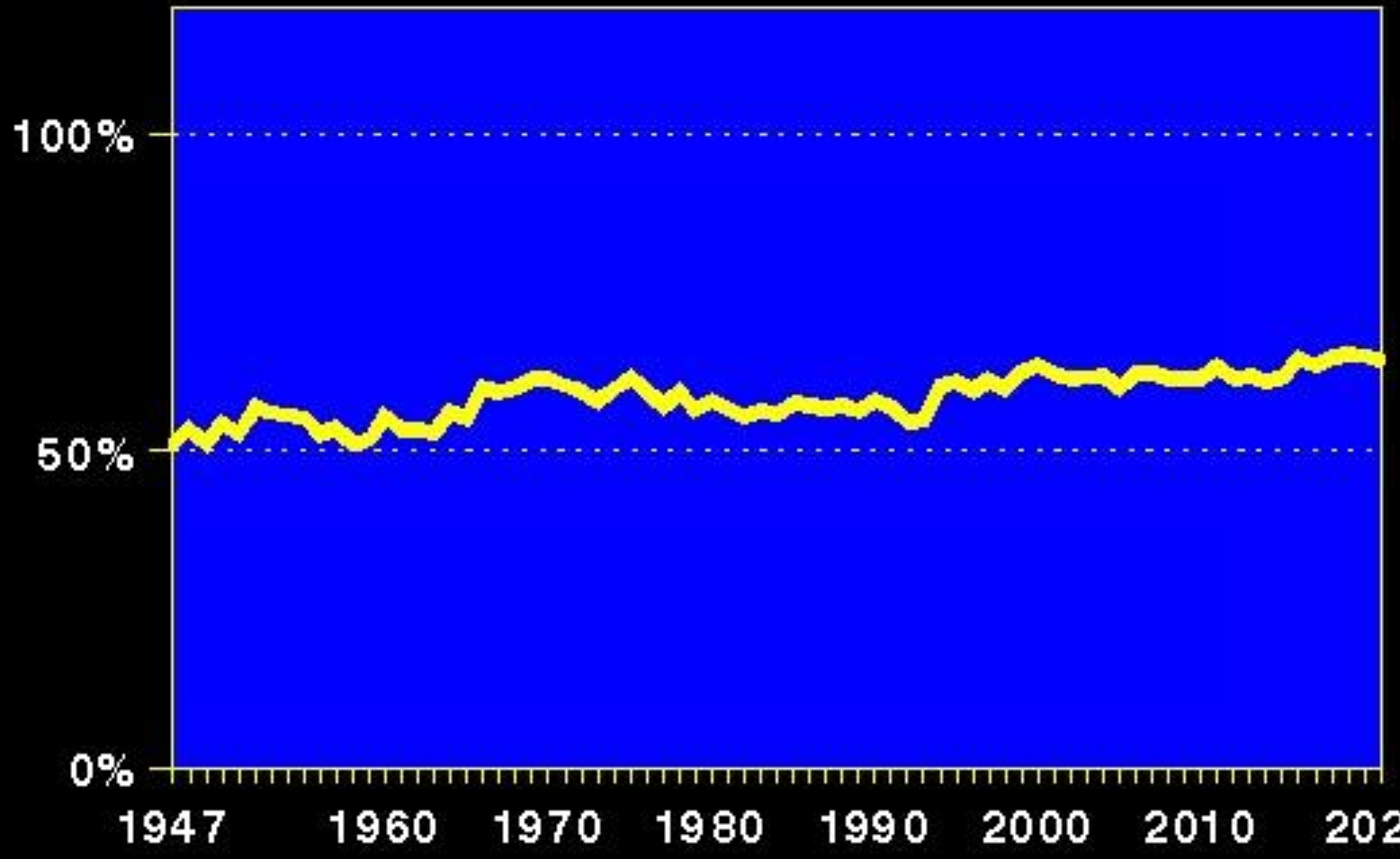
Increasing Economic Inequality

Mean Family Income for Each Fifth: 1966-2021 (Inflation Adjusted)



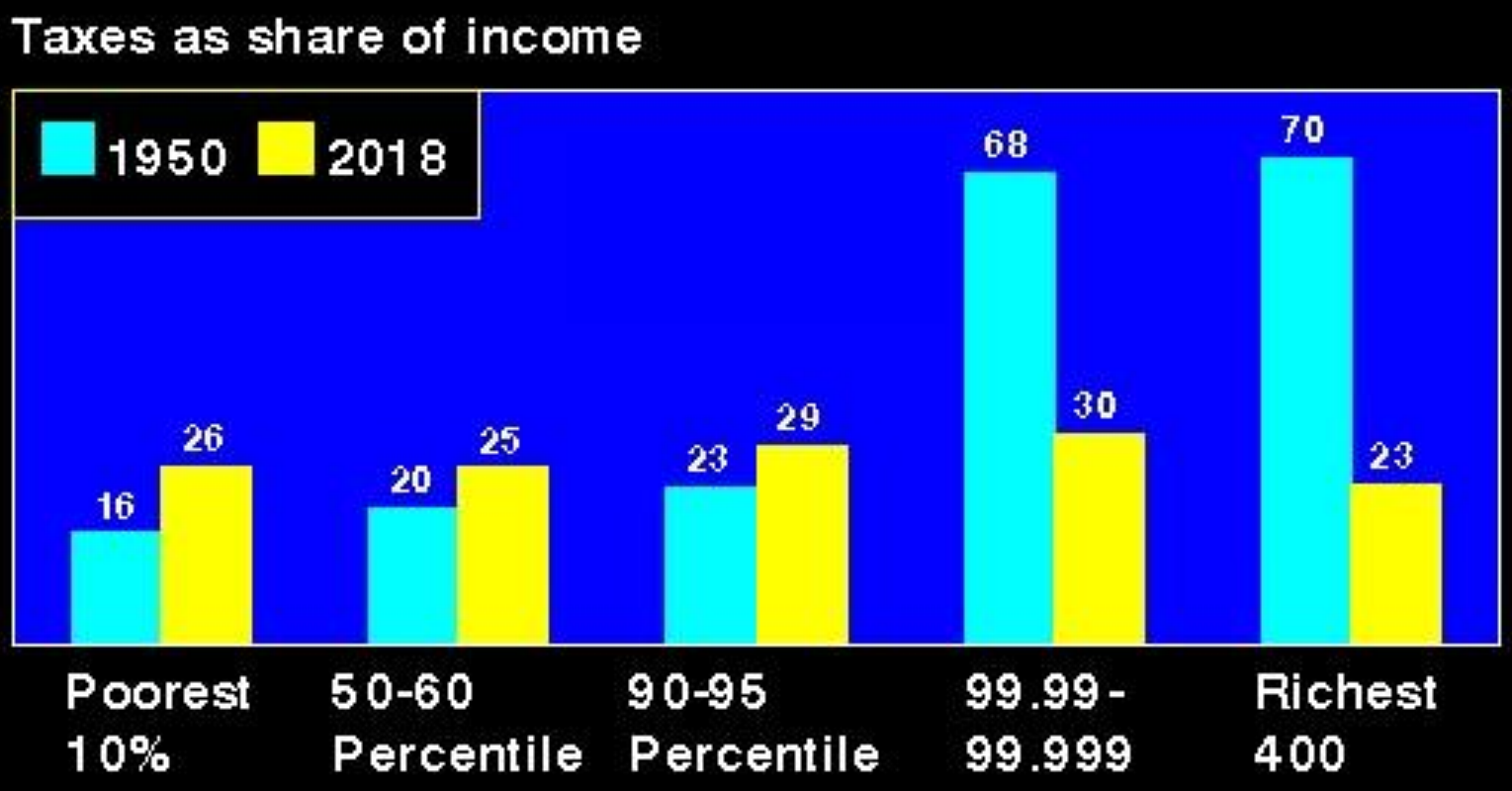
Source: Bureau of the Census

Black Families' Median Income as % of White Families', 1947-2020



Source: Bureau of the Census

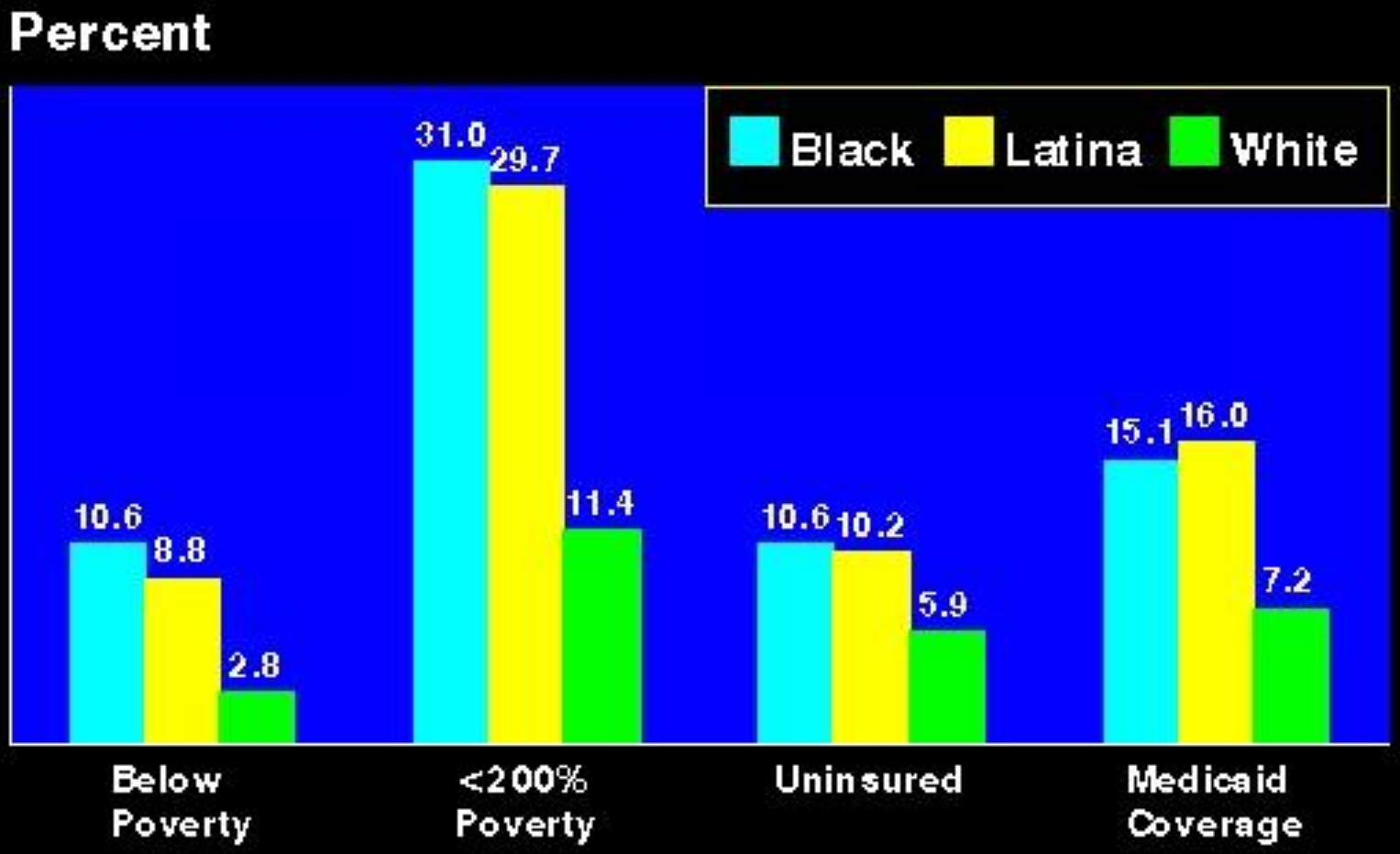
Tax Rate Has Fallen for the Super-Rich, Risen for Others



Source: Saez and Zucman (Saez's website, 2020)

Women Health Workers' Low Pay

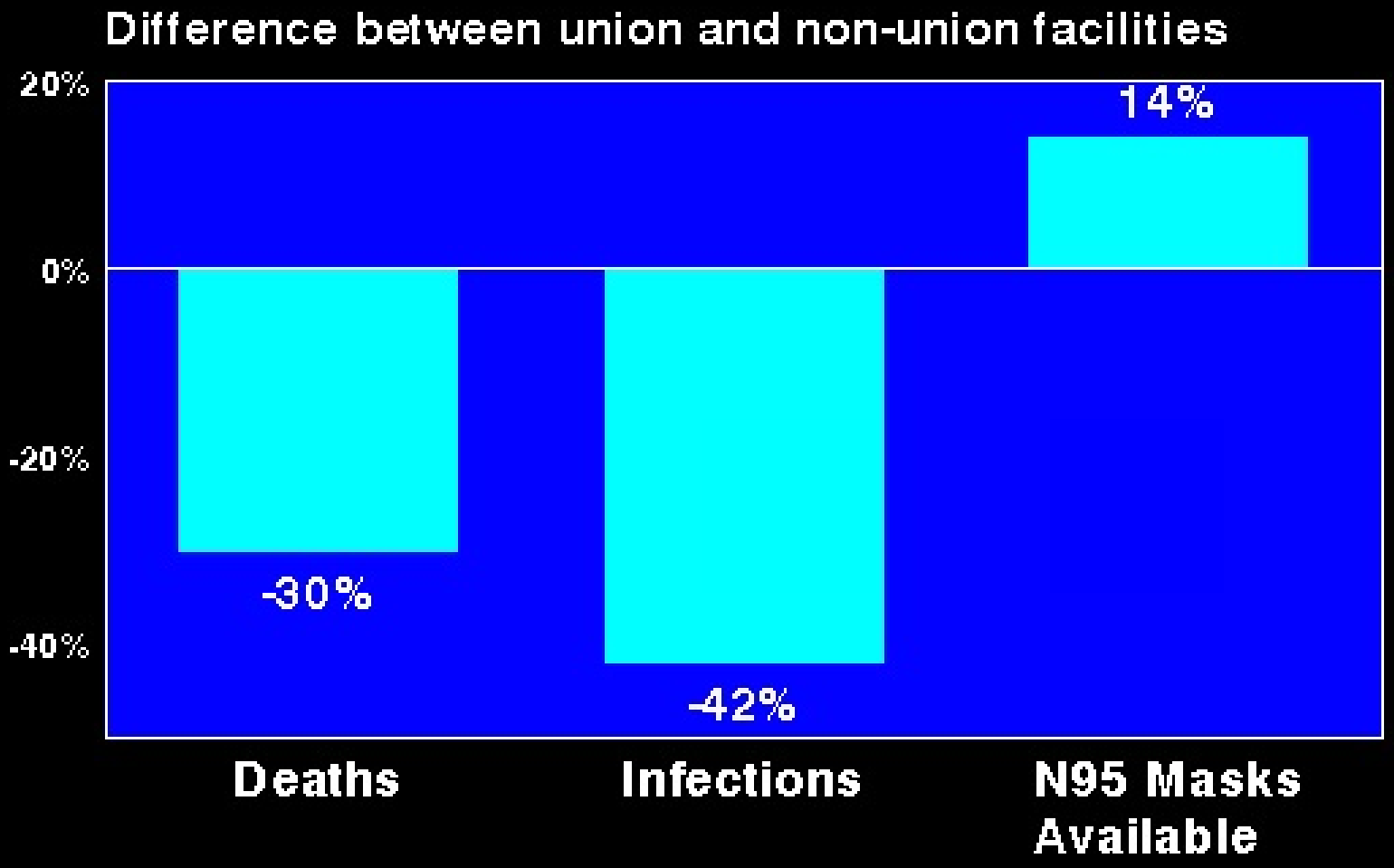
1.7 Million of Them and Their Children Live in Poverty



Source: Himmelstein K, Am J Public Health 2019;109:198

Note: 34.9% of the 14.1 million women health care workers earn < $15/hour.

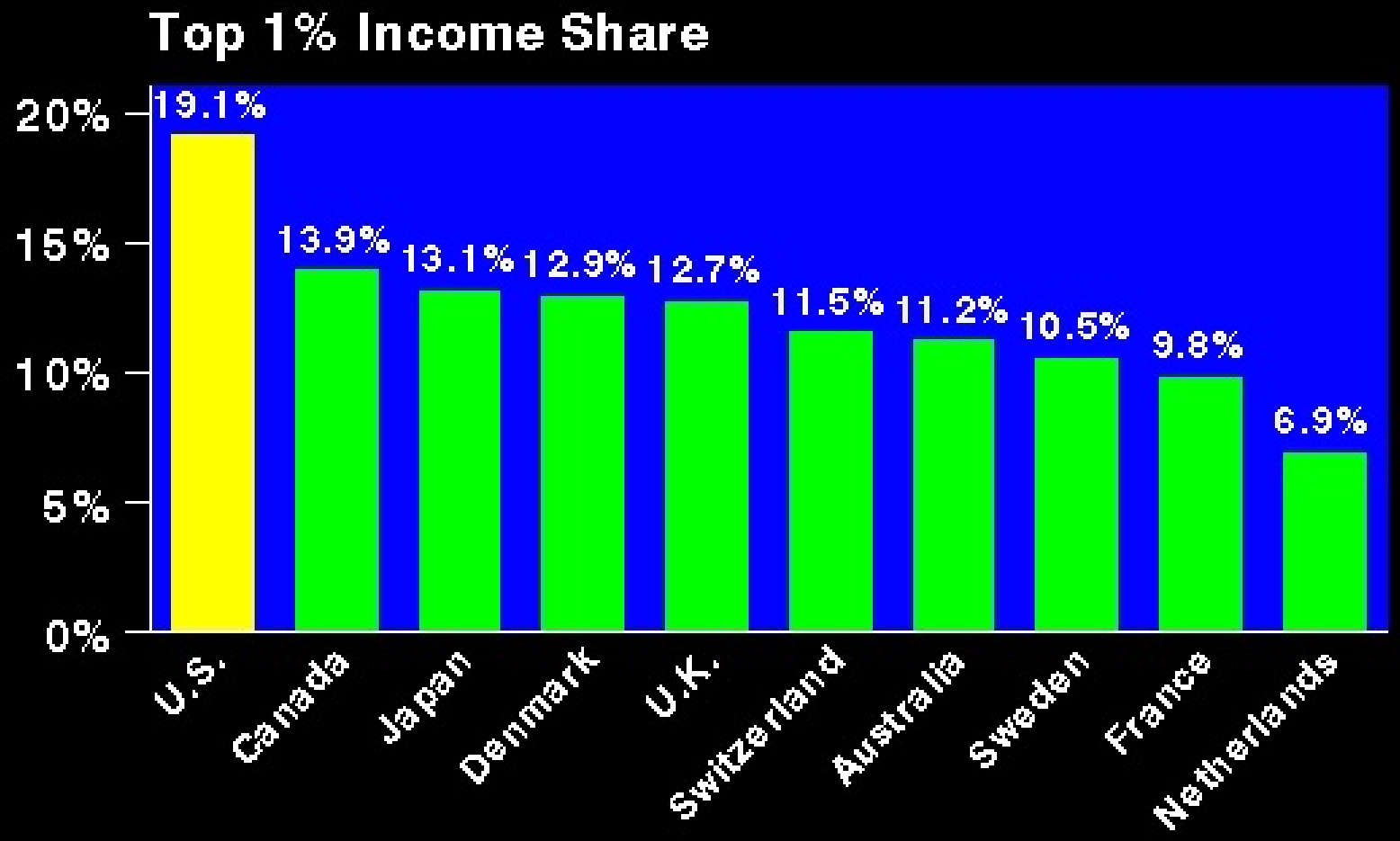
Unionized Nursing Homes: Fewer COVID-19 Deaths, Infections, PPE Shortages



Source: Dean, Venkataramani, Kimmel. Health Aff 2020;39:11:1

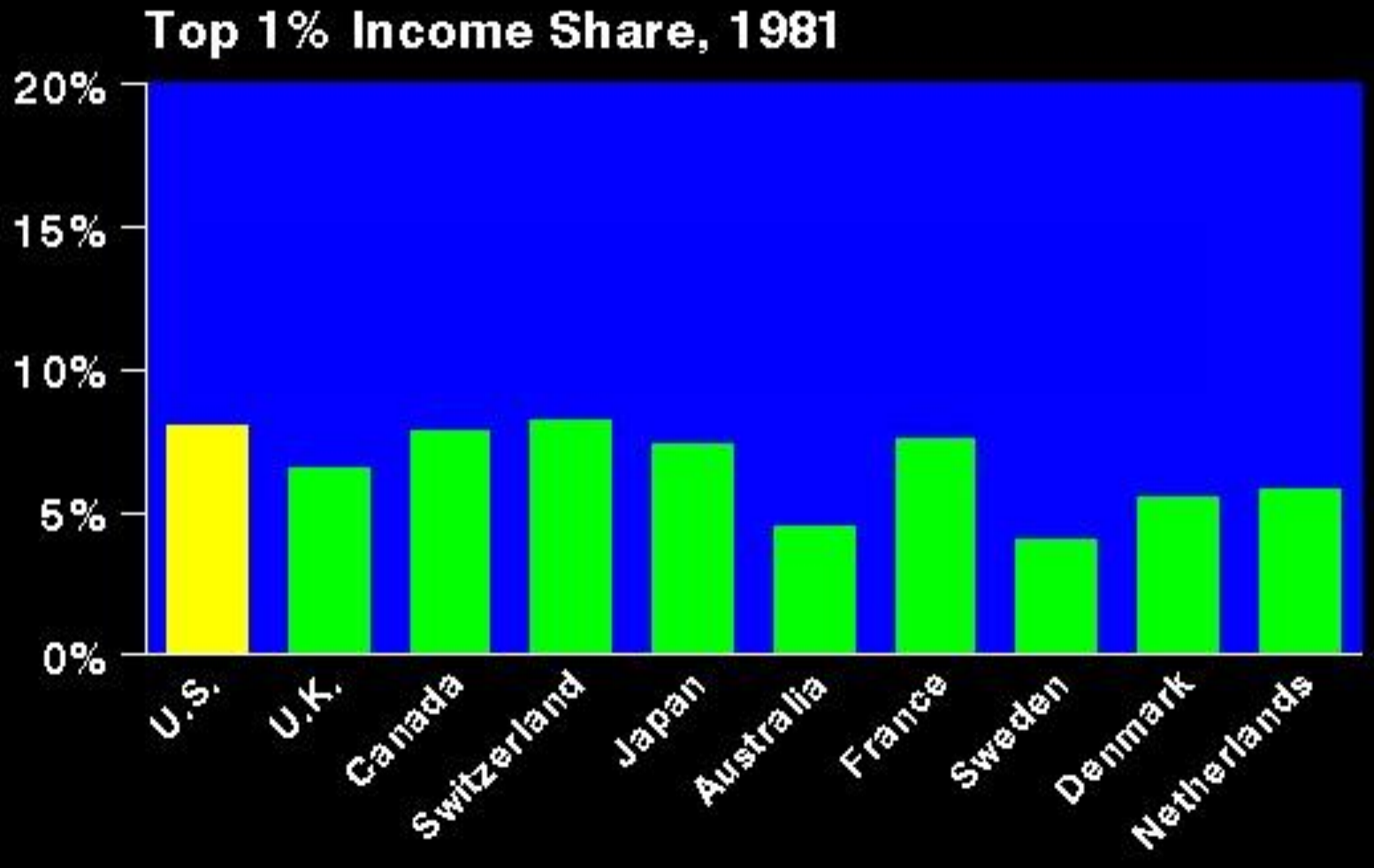
Note: Data are from nursing homes in NY State - adjusted for resident, NH & county characteristics,

Income Inequality Worst in U.S.



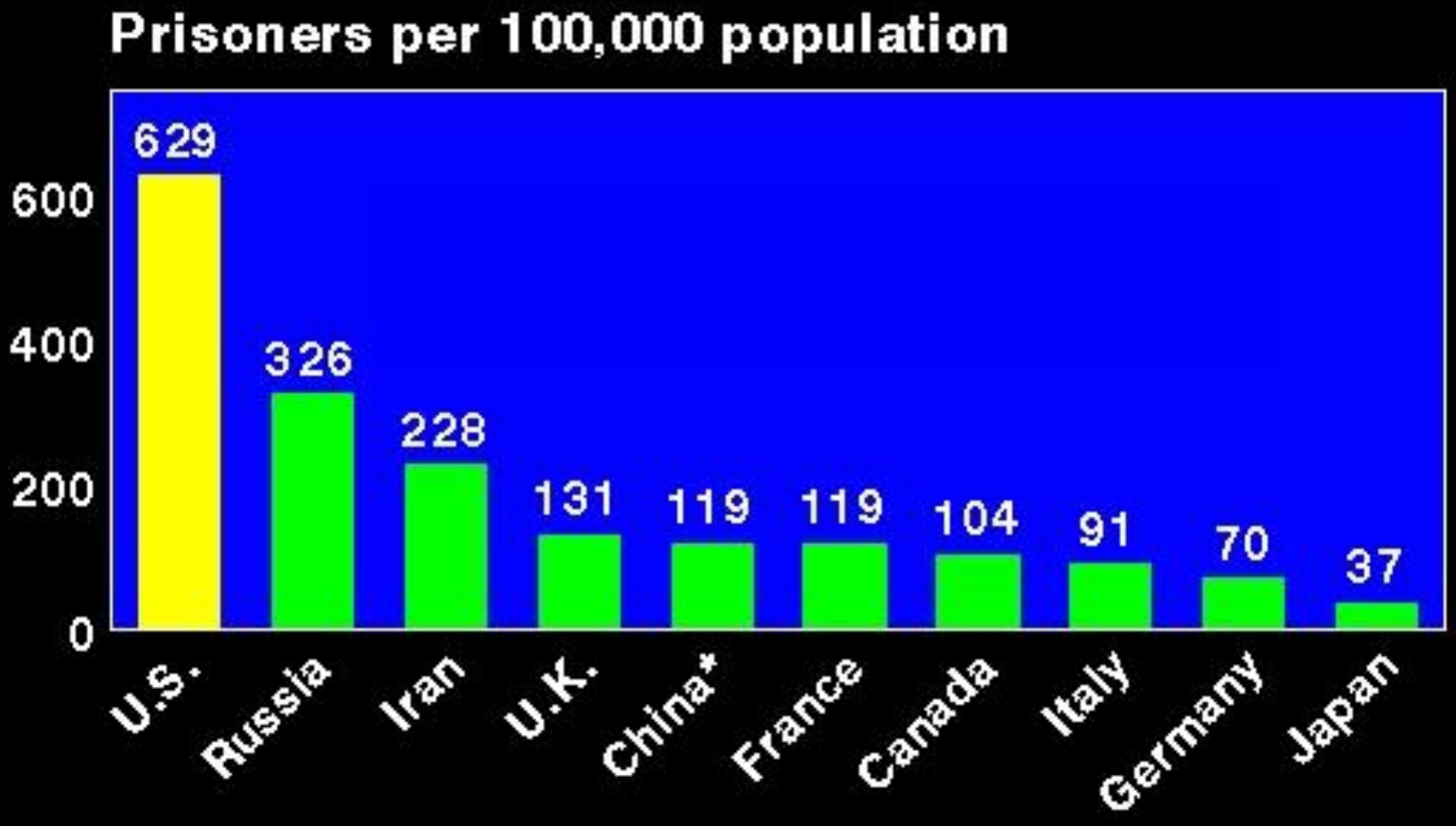
Source: World Inequality database - Data are for 2021 or most recent available

U.S. Income Inequality Was Less in 1981



Source: World Top Incomes database

Incarceration Rates



Source: Walmsley - World Prison Population List, 13th Ed.

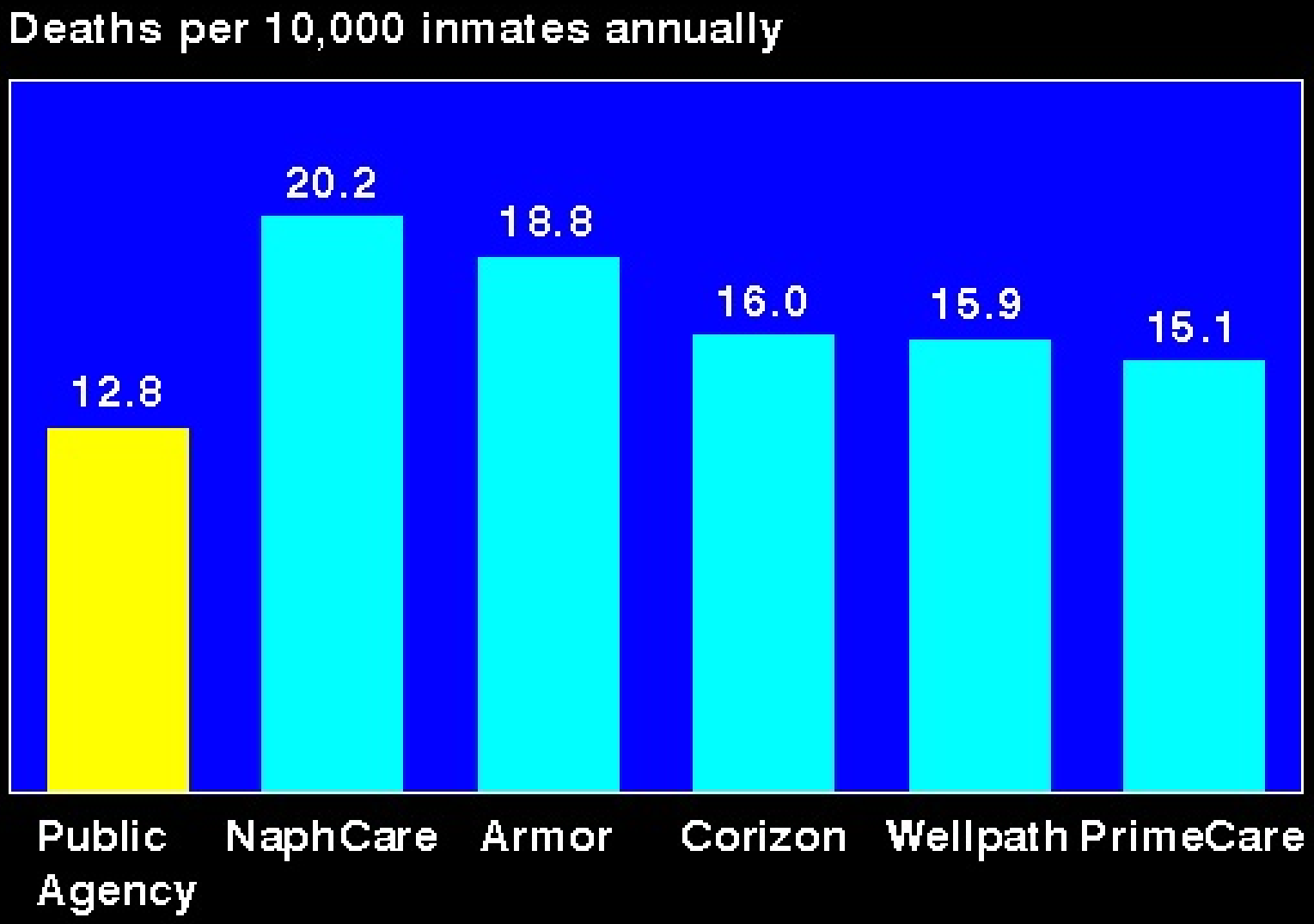
* Figure for China includes only sentenced prisoners

Prisoners Face Copays for Care

- 42 states + federal prison system charge copays for a visit.
- Average copay = $3.47/visit.
- In Oklahoma, prisoners earning 5 cents/hr. face a $4 copay (80 hours of work income, equivalent to $580 for a minimum wage workers.)

Source: The Marshall Project, May 30, 2018

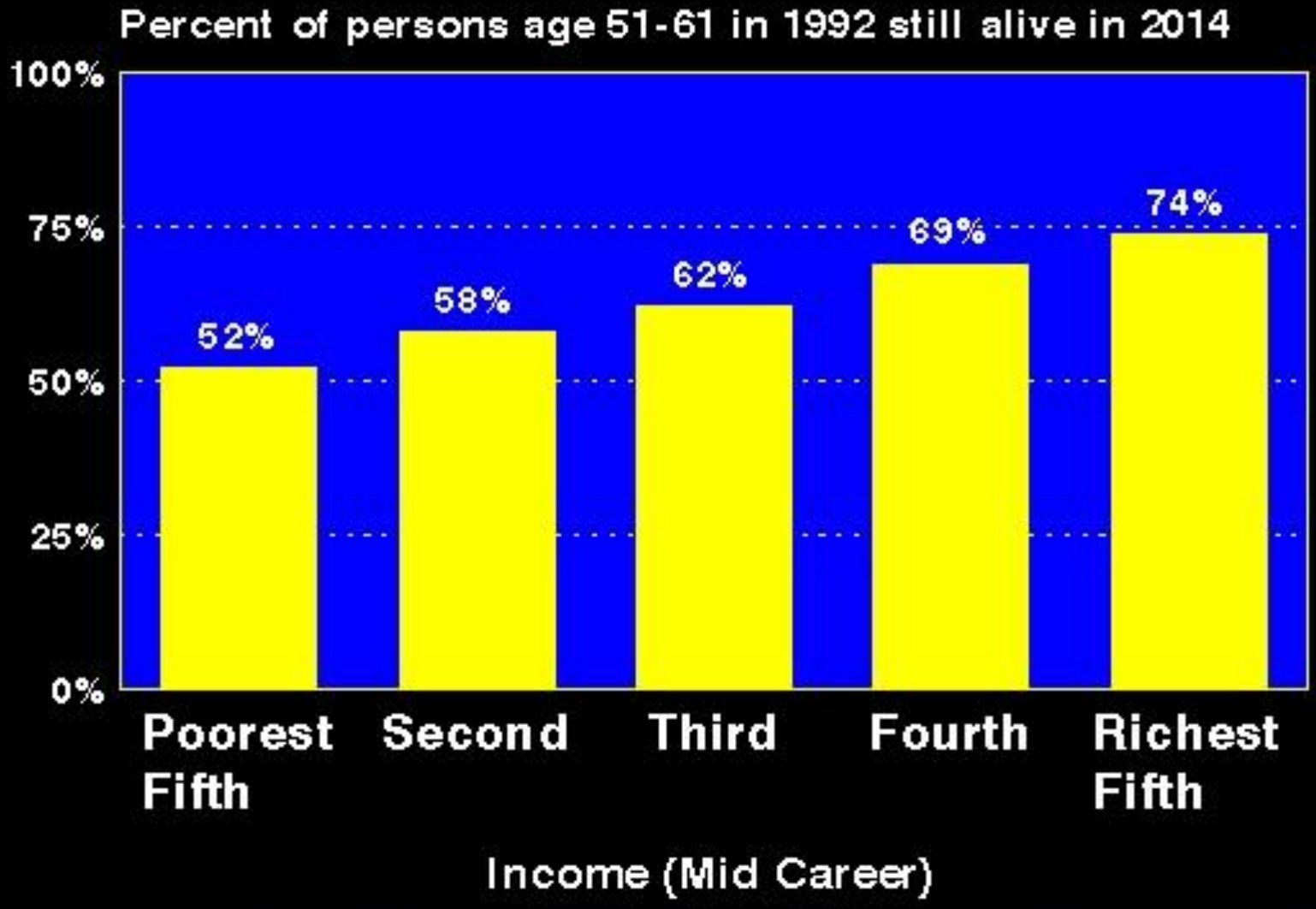
Outsourcing Jail Medical Care = More Deaths



Source: Szep J. Reuters, October 26, 2020

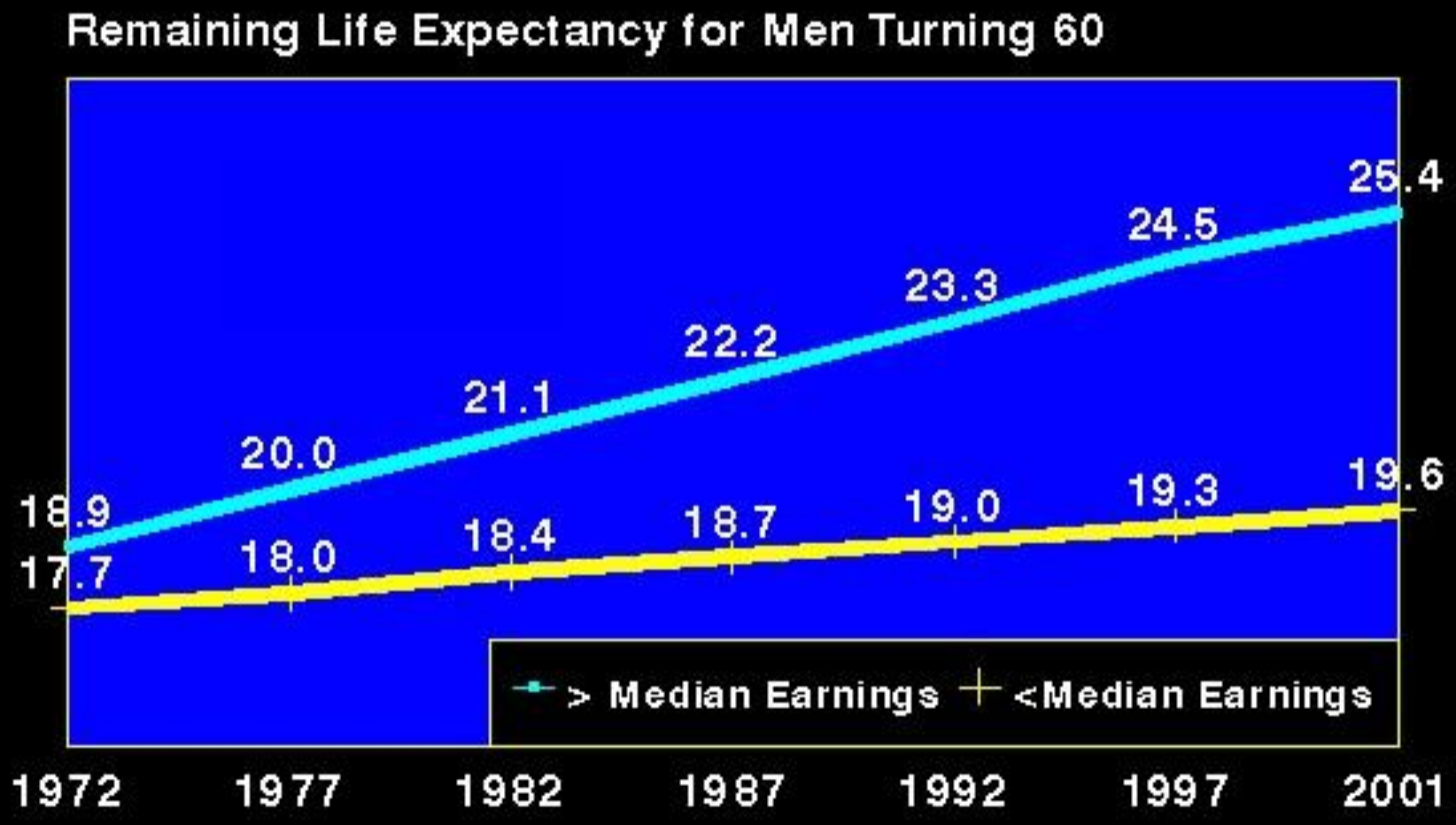
Increasing Economic Inequality Harms Health

Lower Income, Shorter Lives



Source: GAO - Income and Wealth Disparities Continue Through Old Age, August, 2019 (data from HRS)

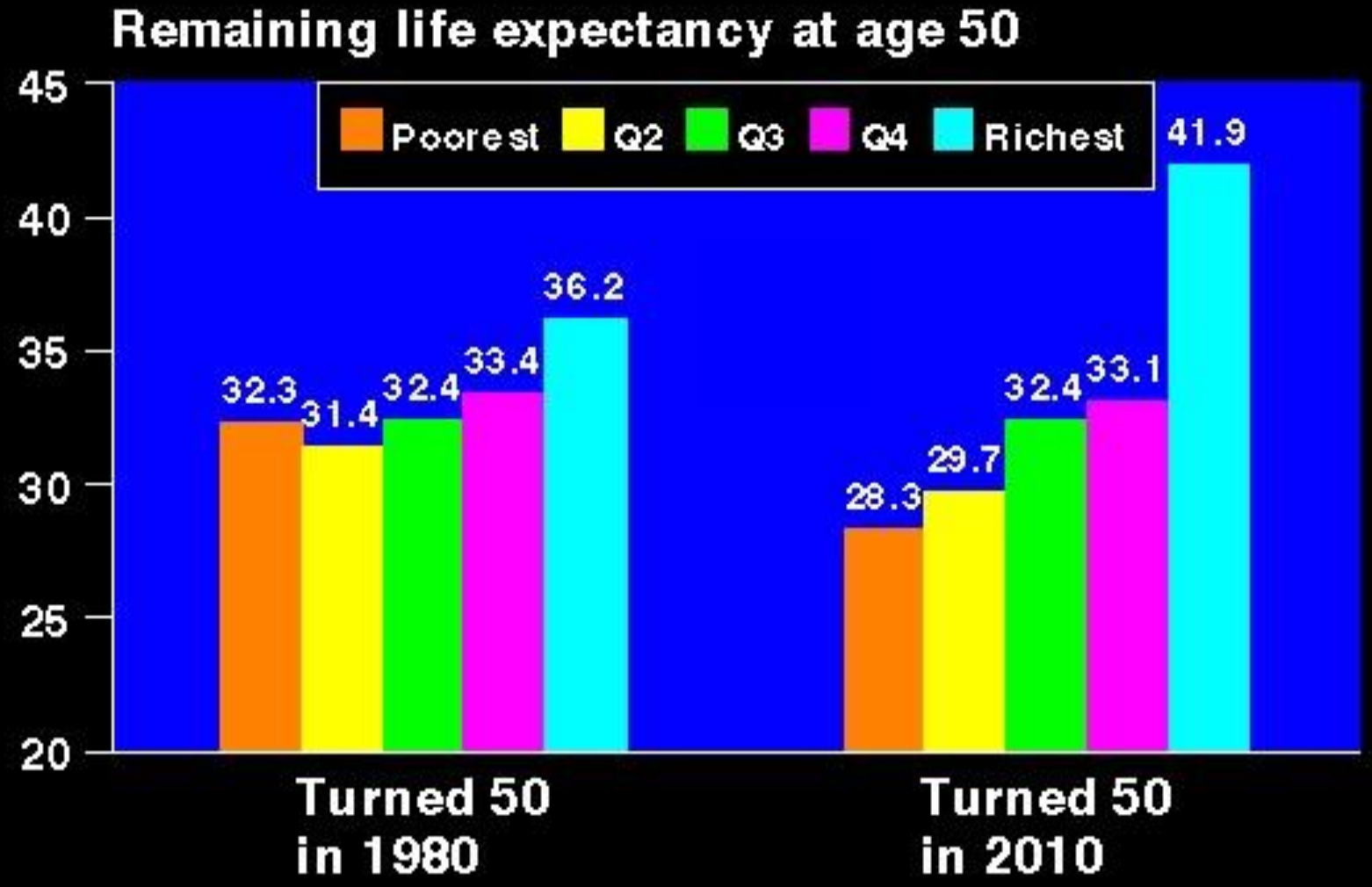
Widening Gap In Life Expectancy Between High and Low Earners



Source: Waldron. ORES, Social Security Admin, #108, 2007

Growing Gap in Life Expectancy by Income

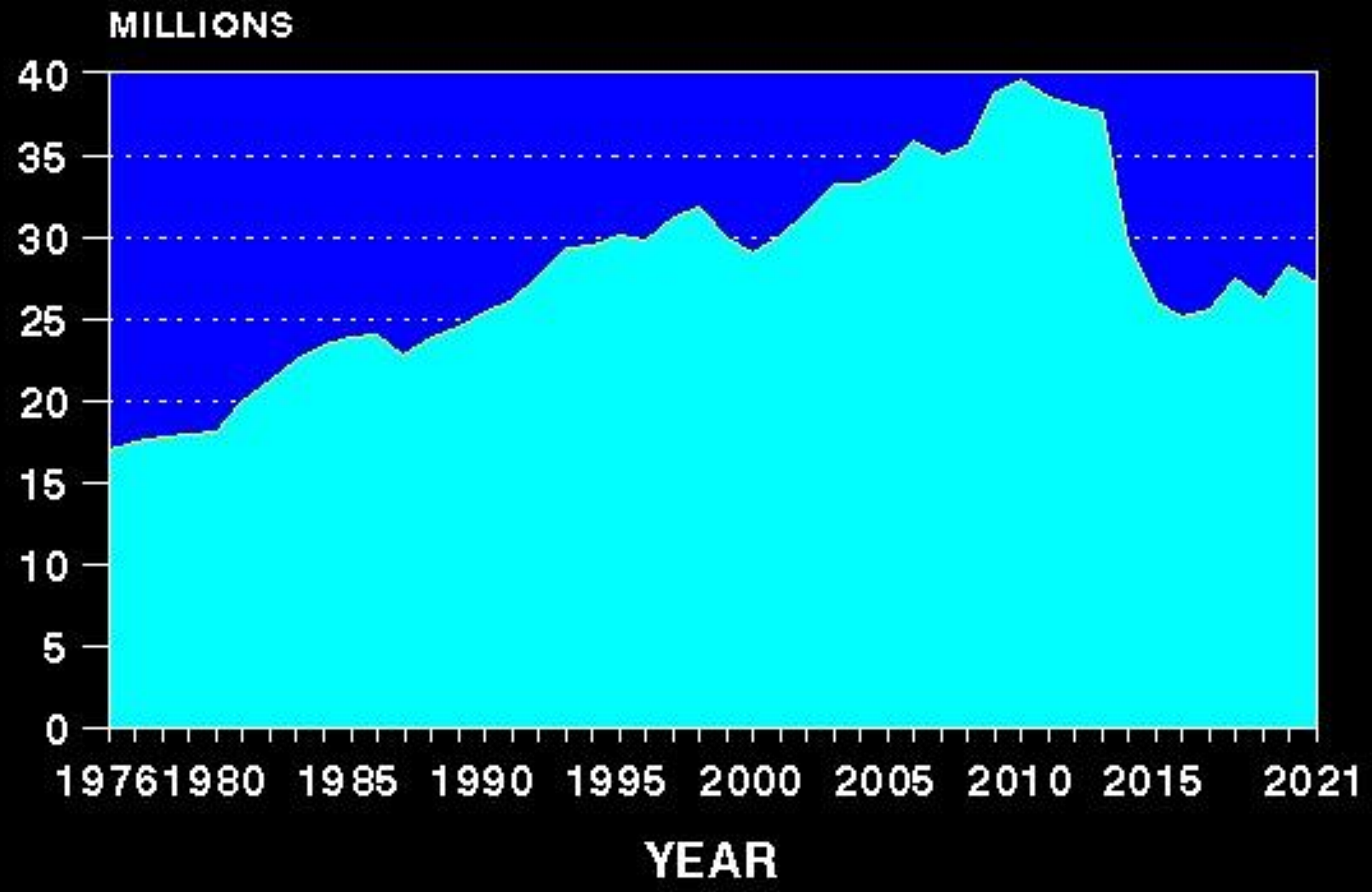
Dramatic Gains for the Wealthy, Losses for Lower Income



Source: Growing Gap in Life Expectancy by Income, National Academy of Sciences, 2015

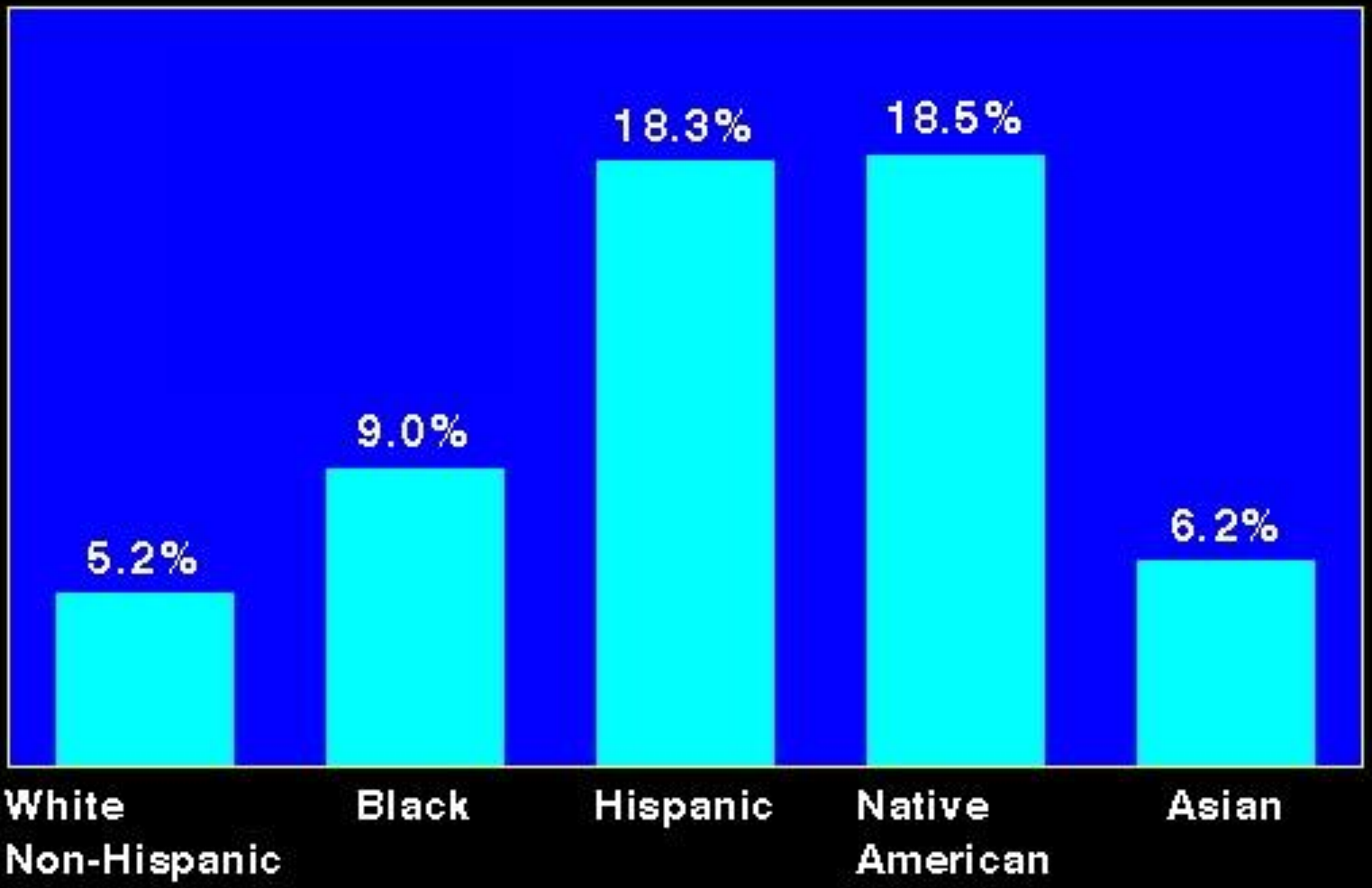
The Uninsured

Americans Uninsured All Year, 1976-2021



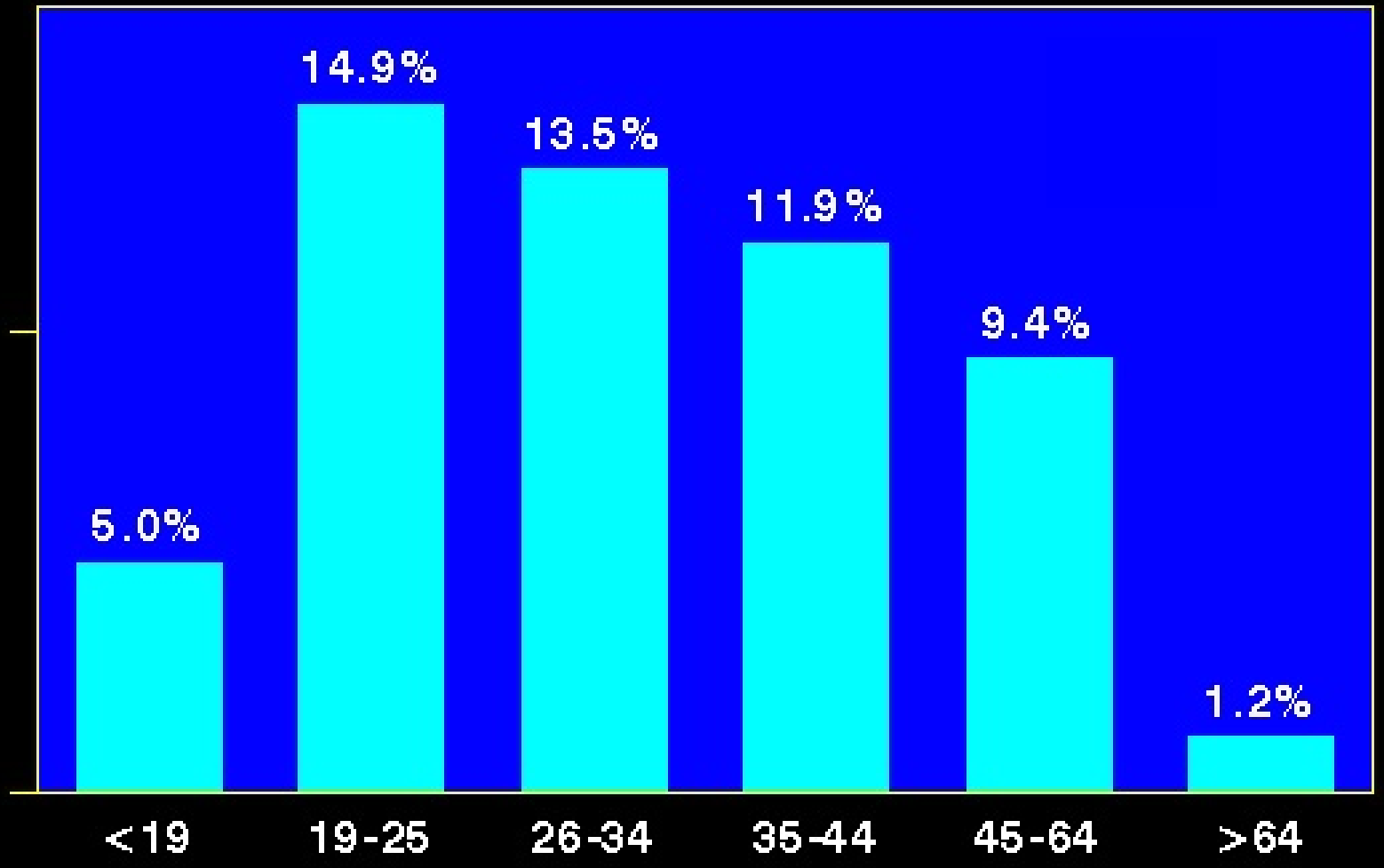
Source: Himmelstein & Woolhandler - Tabulation from CPS, ACS & NHIS Data
Note - At time of survey, an additional 2 to 3 million are uninsured

Percent Uninsured by Race/Ethnicity, 2021



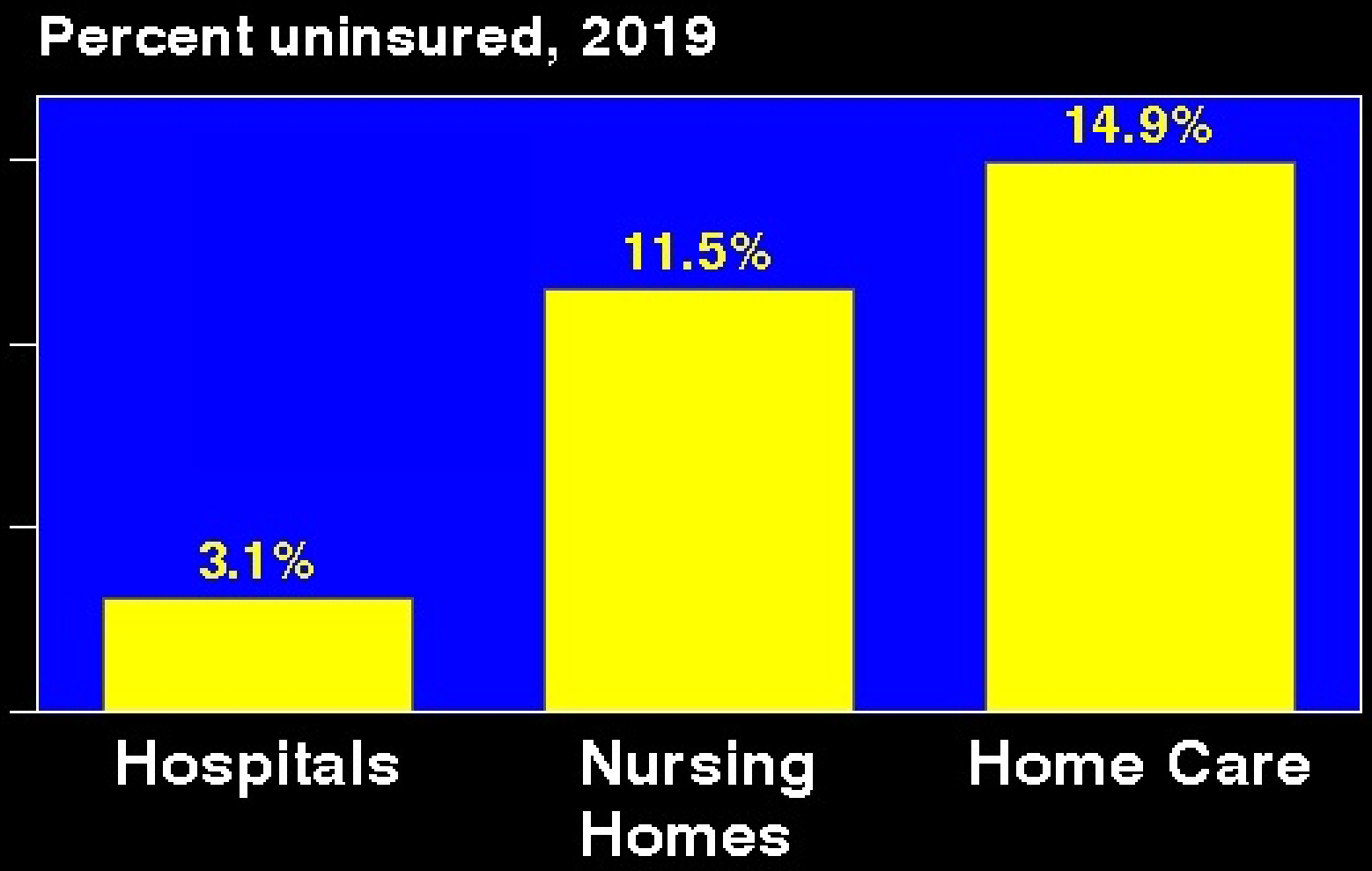
Source: CPS

Percent Uninsured by Age Groups, 2021



Source: CPS

Many Frontline Health Workers Are Uninsured



Source: Himmelstein & Woolhandler, Analysis of data from 2019 Current Population Survey
Note: 663,000 hospital, nursing home and home care workers were uninsured
70% of New York home care agencies do not provide PPE to employees

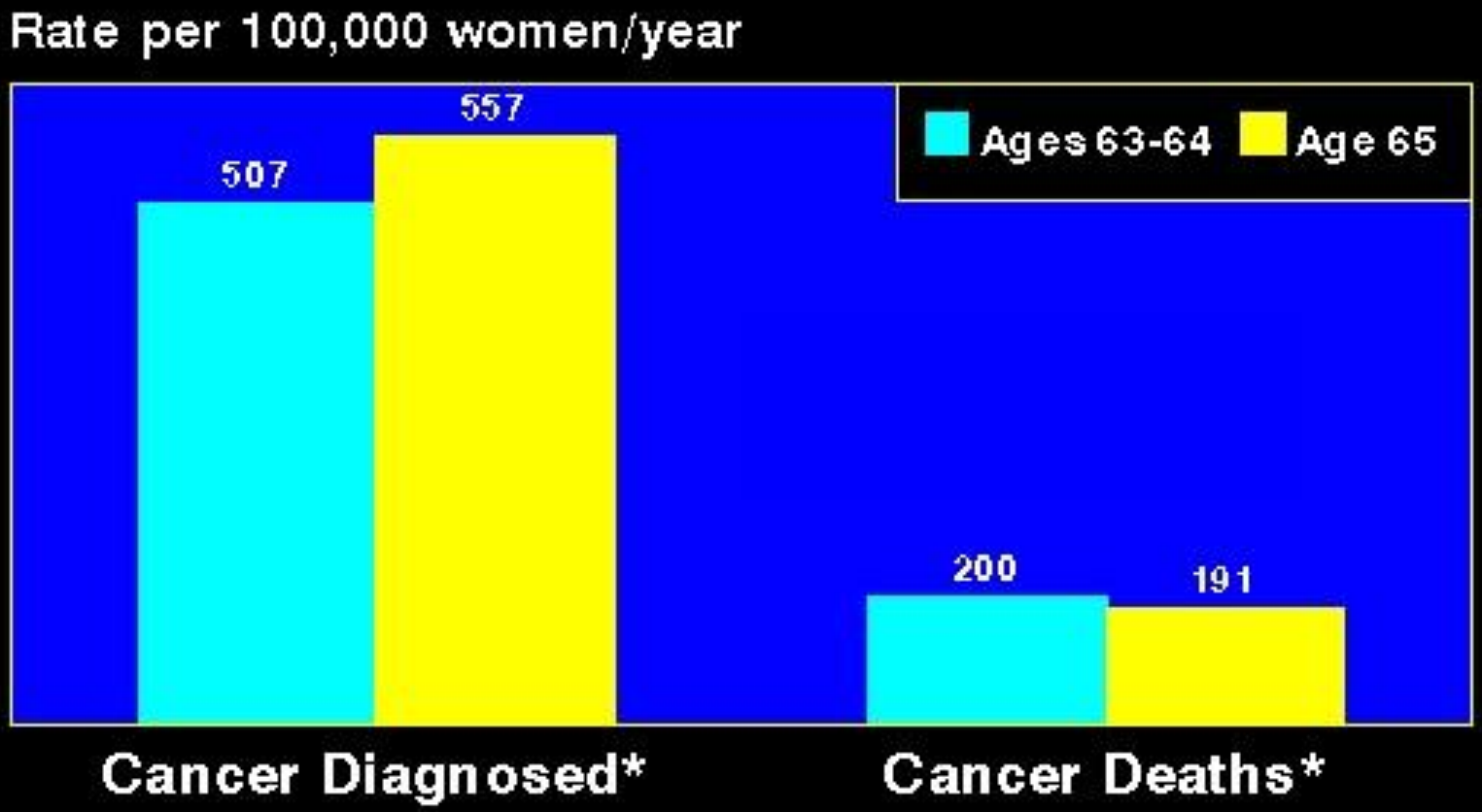
36,355 Deaths During 2021 Due to Uninsurance

State	% Uninsured	Excess Deaths
Texas	18.0	6,793
California	7.0	3,528
Florida	12.1	3,378
Georgia	12.6	1,741
North Carolina	10.4	1,402
New York	5.2	1,325
U.S.	8.6%	36,771

Source: Woolhandler & Himmelstein, Ann Int Med 2017;167:424
Based on best estimate from multiple studies of 1 death per 769 uninsured/year, and # uninsured at time of survey

Medicare Coverage Improves Cancer Detection and Outcomes

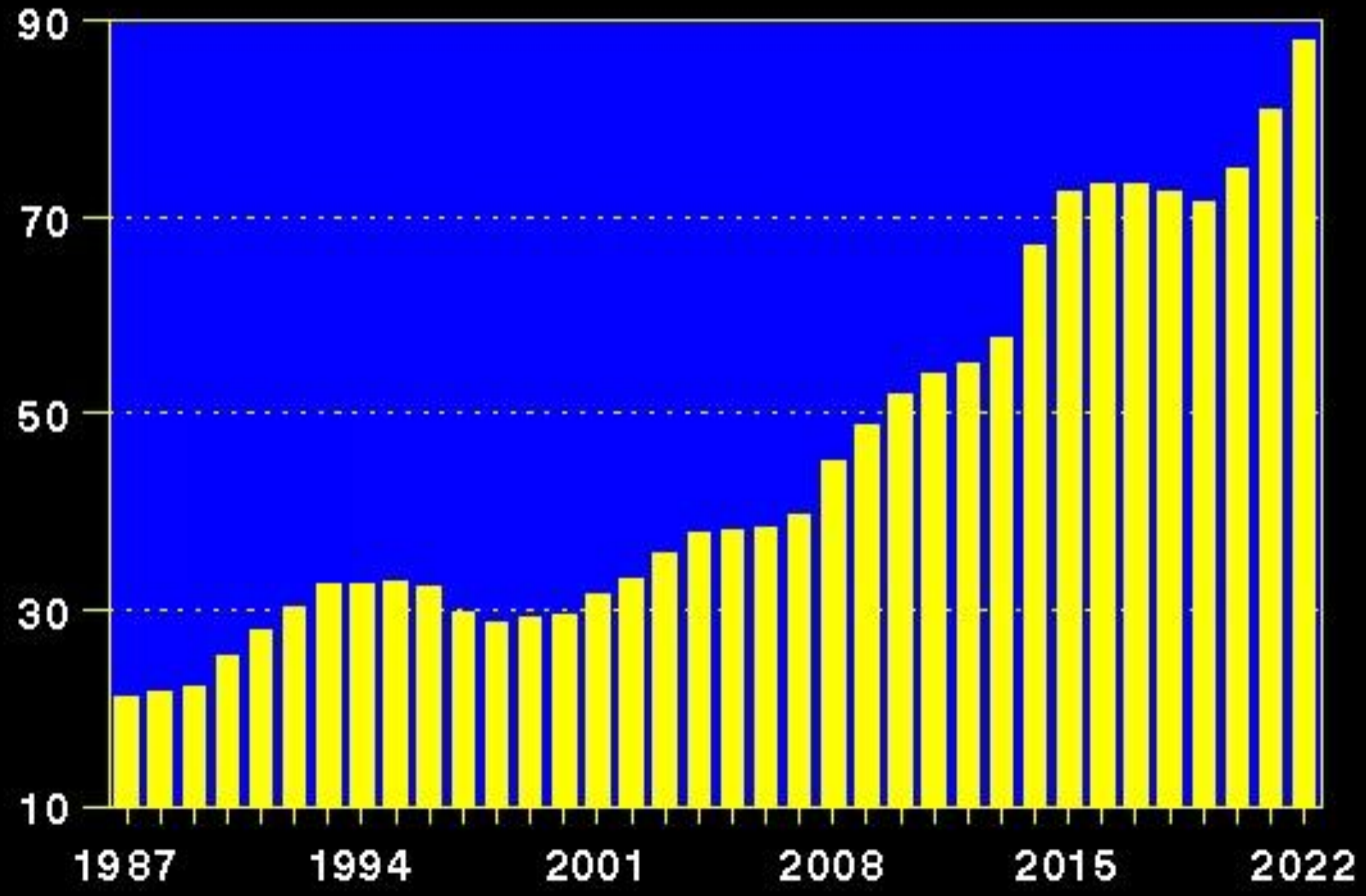
Diagnoses Rise, Deaths Fall at Age 65



Source: NBER Working Paper 26292, September, 2019
* Breast, colorectal or lung cancer

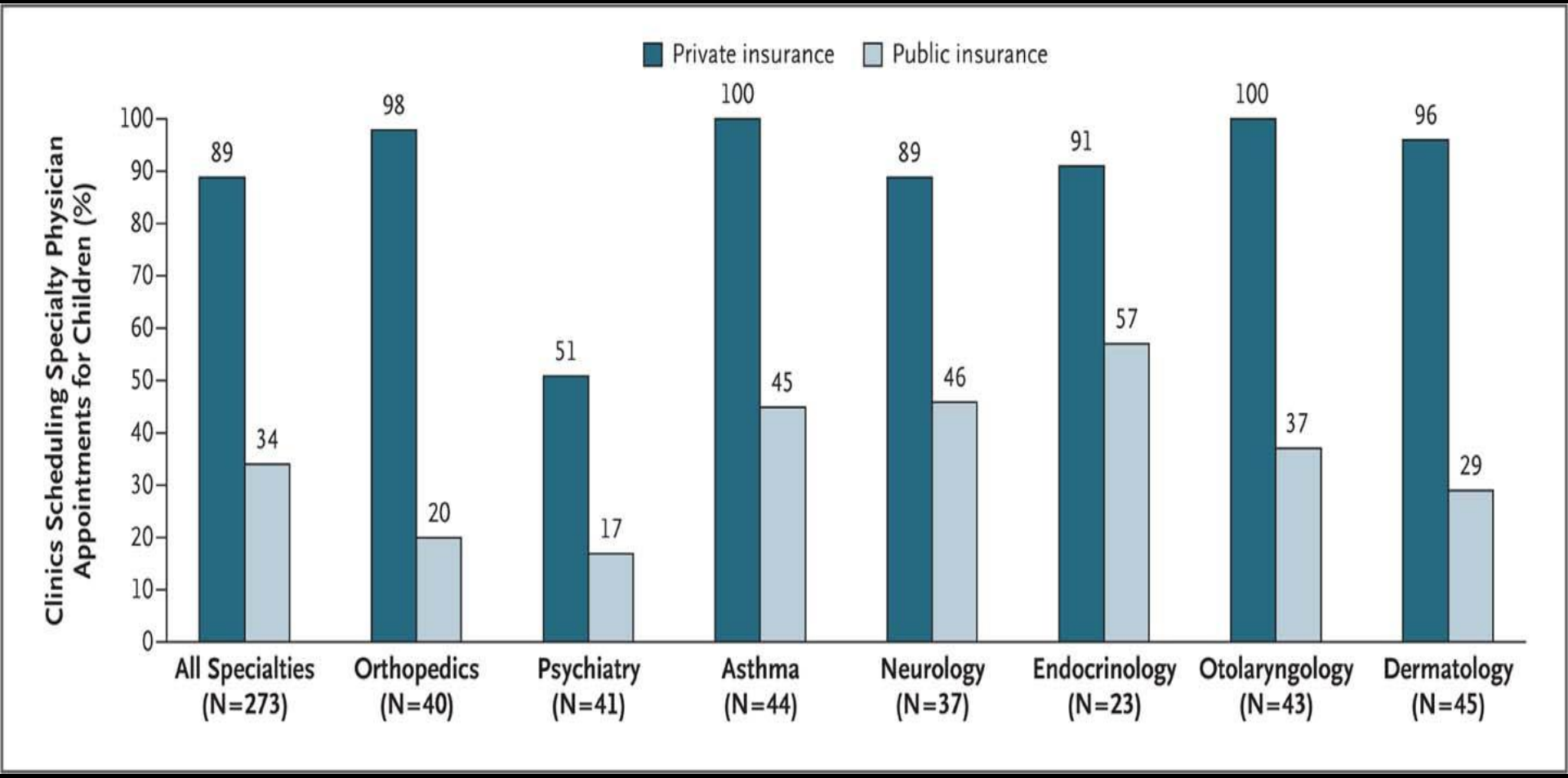
Medicaid: Poor Access, But Better Than Nothing

Medicaid Enrollment, 1987-2022



Source: Kaiser Foundation - Figures are for mid year

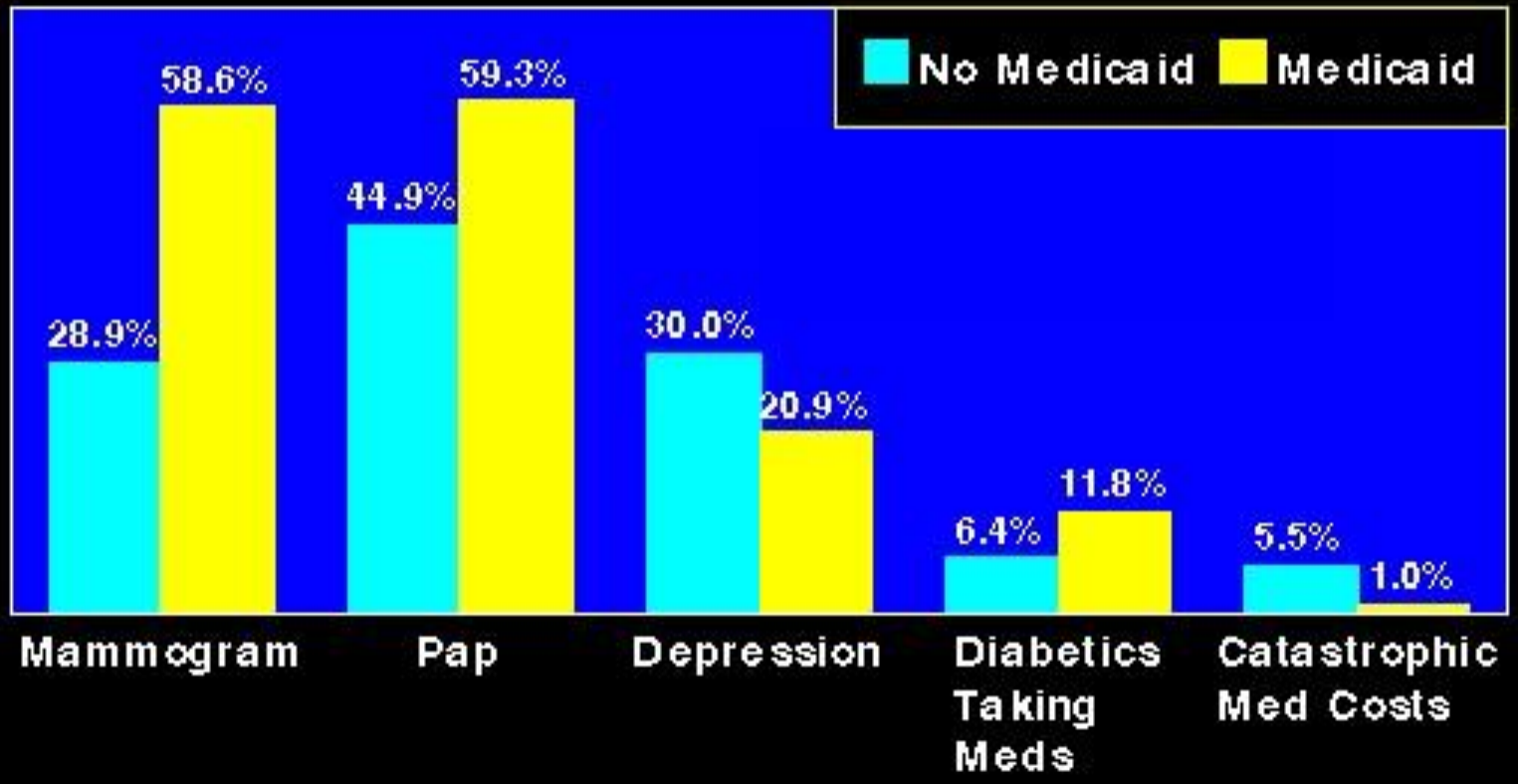
Many Specialists Won't See Kids With Medicaid



Bisgaier J, Rhodes KV. N Engl J Med 2011;364:2324-2333

Medicaid Helps

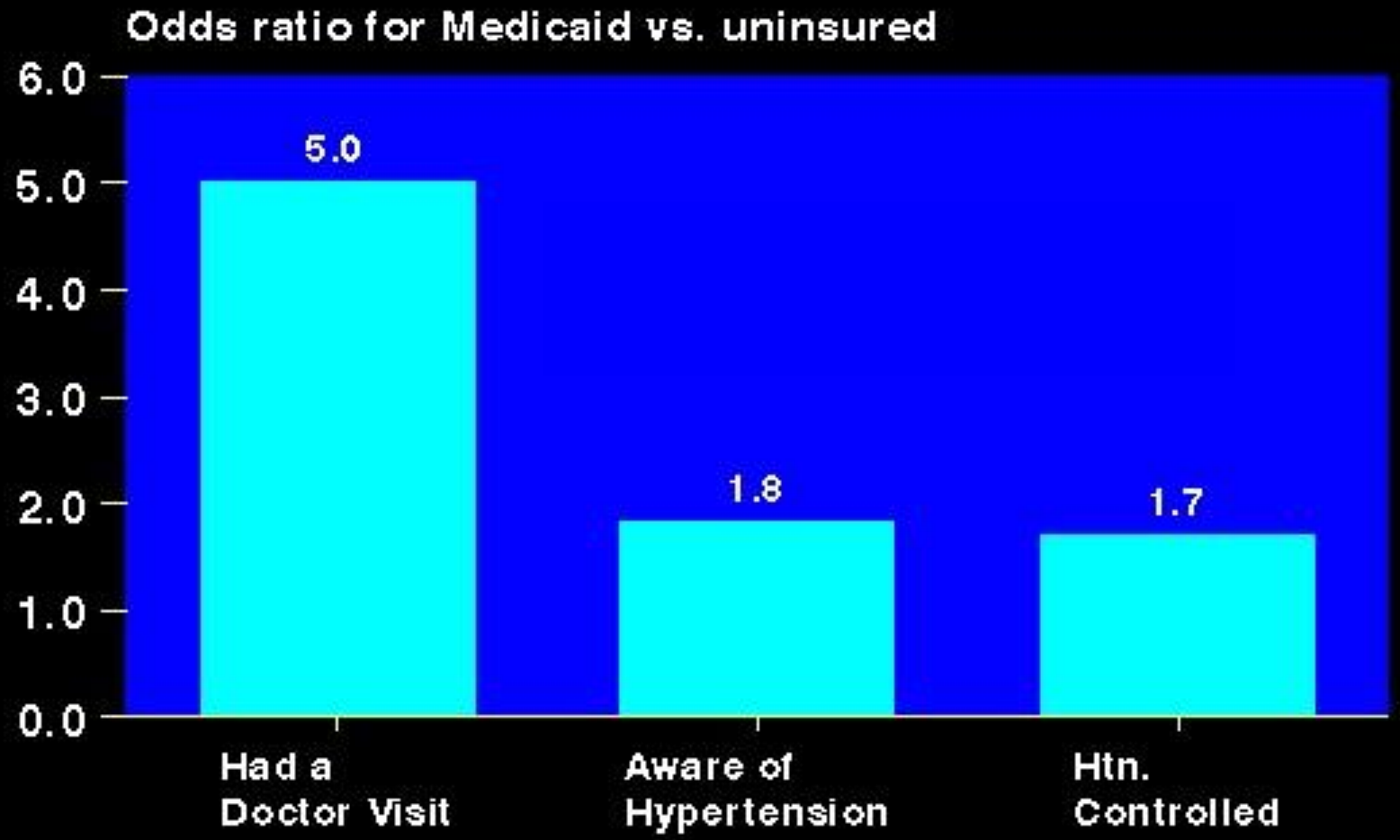
An RCT in Oregon



Source: NEJM May 2, 2013

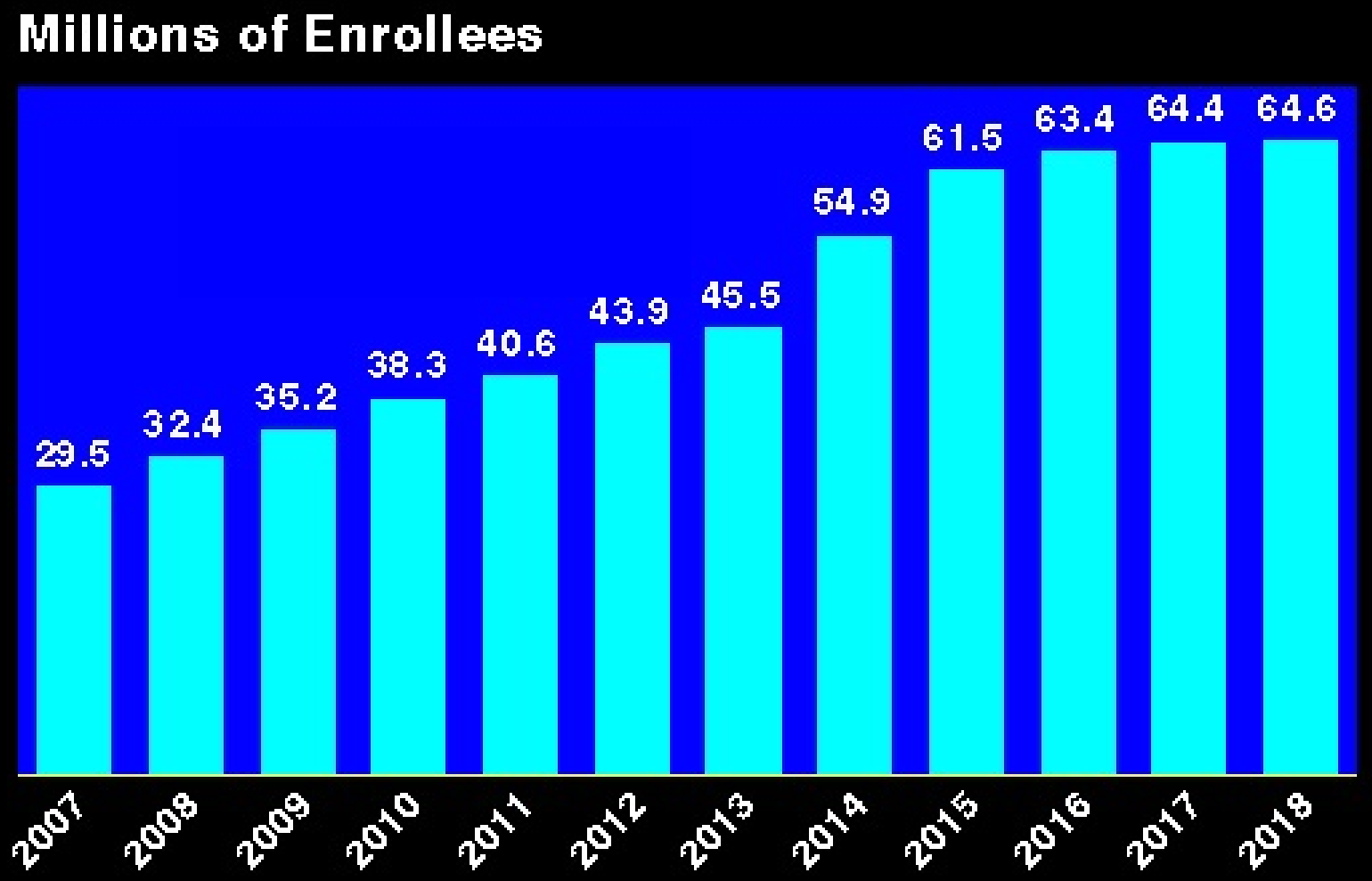
Note: Catastrophic medical costs = out-of-pocket spending >30% of income
Depression = screened positive for depression using PHQ8

Medicaid Improved Access & Hypertension Control for the Poor



Source: Christopher, Wilper, Himmelstein, Woolhandler, McCormick - AJPH 2015
Odds ratios are adjusted for sex, age, race/ethnicity, presence of chronic condition, disability

Medicaid Managed Care Enrollment Soaring

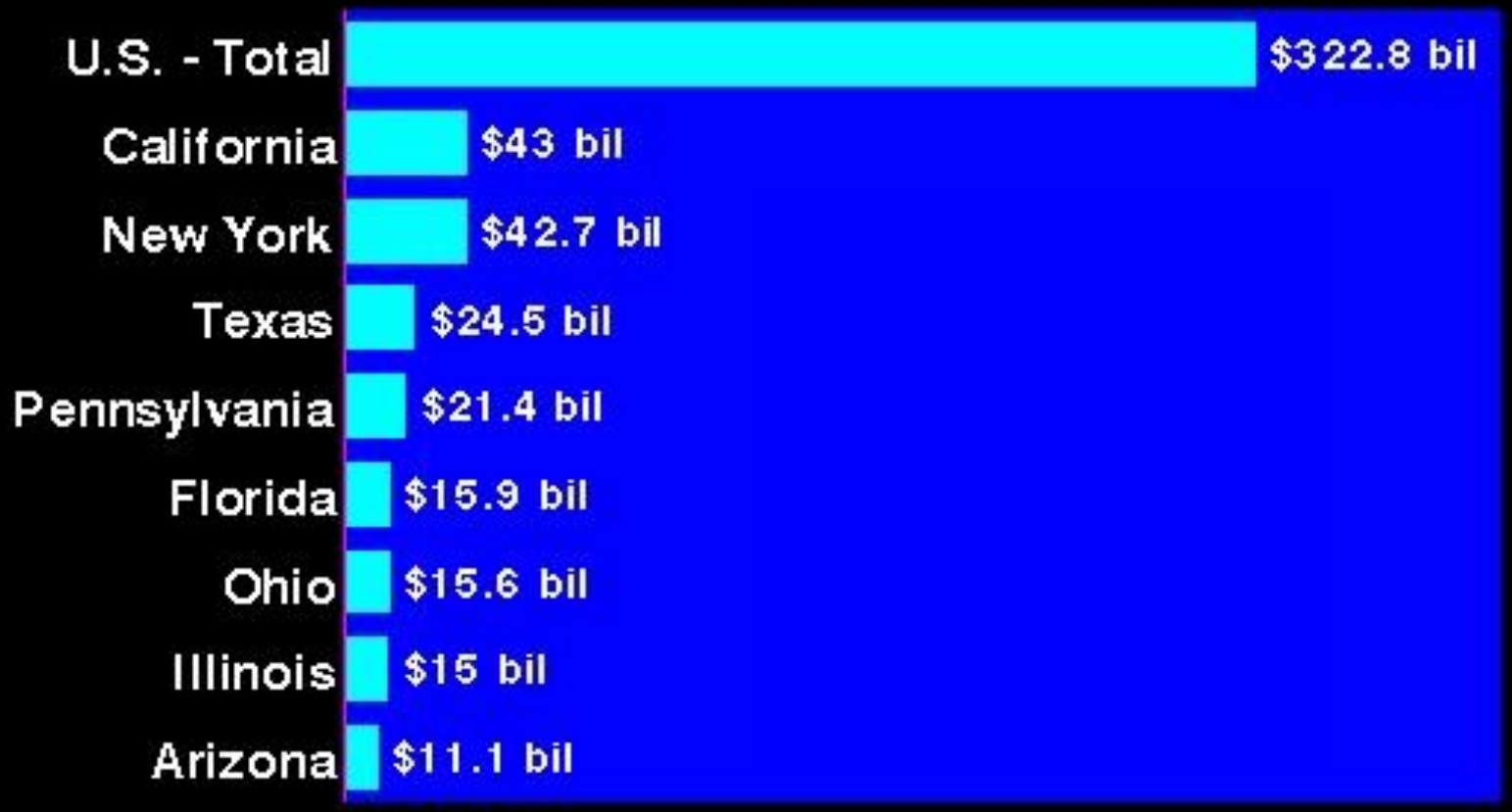


Source: Sanofi Public Payer Digest, 2016 and 2020

Note: Medicaid payments to mgd. care firms, 2019 = $279.1 bil., MLR = 88.6(overhead = $9 bil.)

No evidence of cost savings, some evidence of worse quality

Medicaid Managed Care: A Major Revenue Source for Insurers



Medicaid Managed Care Spending, 2020

Source: Kaiser Family Foundation, 2022
Note: Per Milliman, average overhead + profit = 11.4% of revenues (~ $37 billion)

Medicaid Managed Care Patients Can't Get Appointments

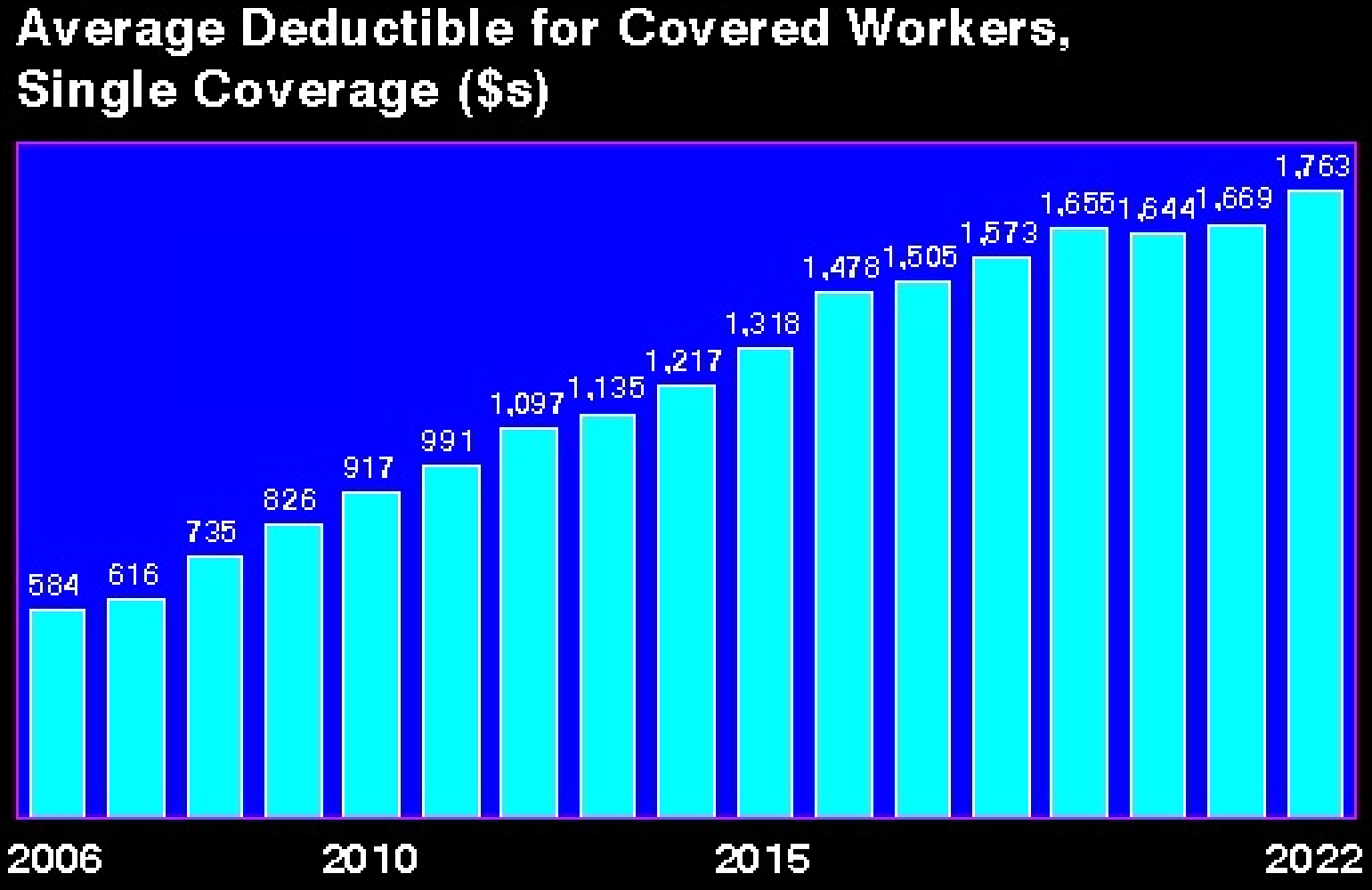
HHS OIG Survey of 1800 MDs Listed on Managed Care Rosters Finds Majority are Unavailable

Appointment Availability

Source: HHS Inspector General's Report, 12/2014 - OEI-02-13-00670

Under-Insurance

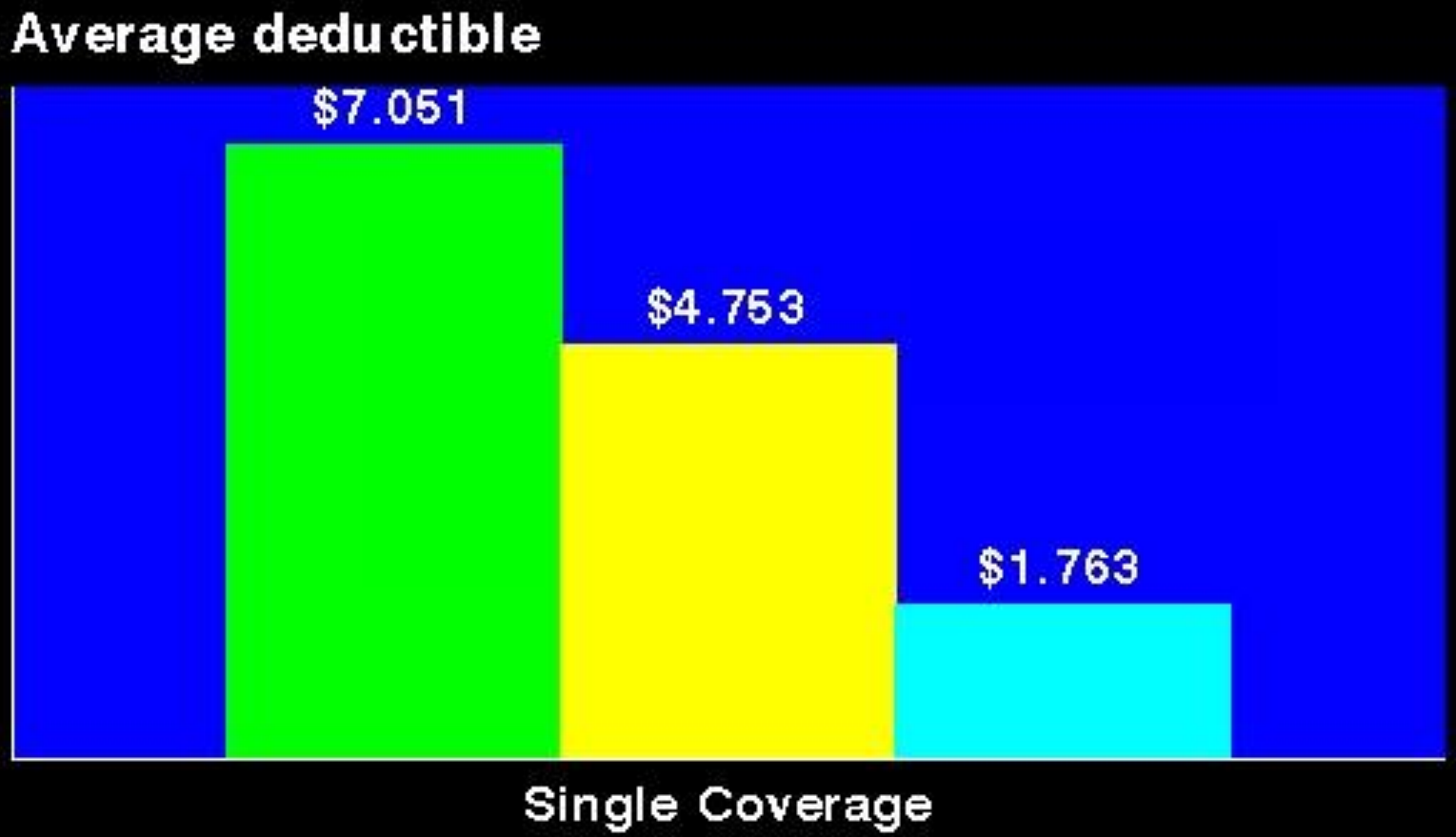
Average Deductible Rising



Source: Kaiser/HRET Survey of Employer-Sponsored Benefits

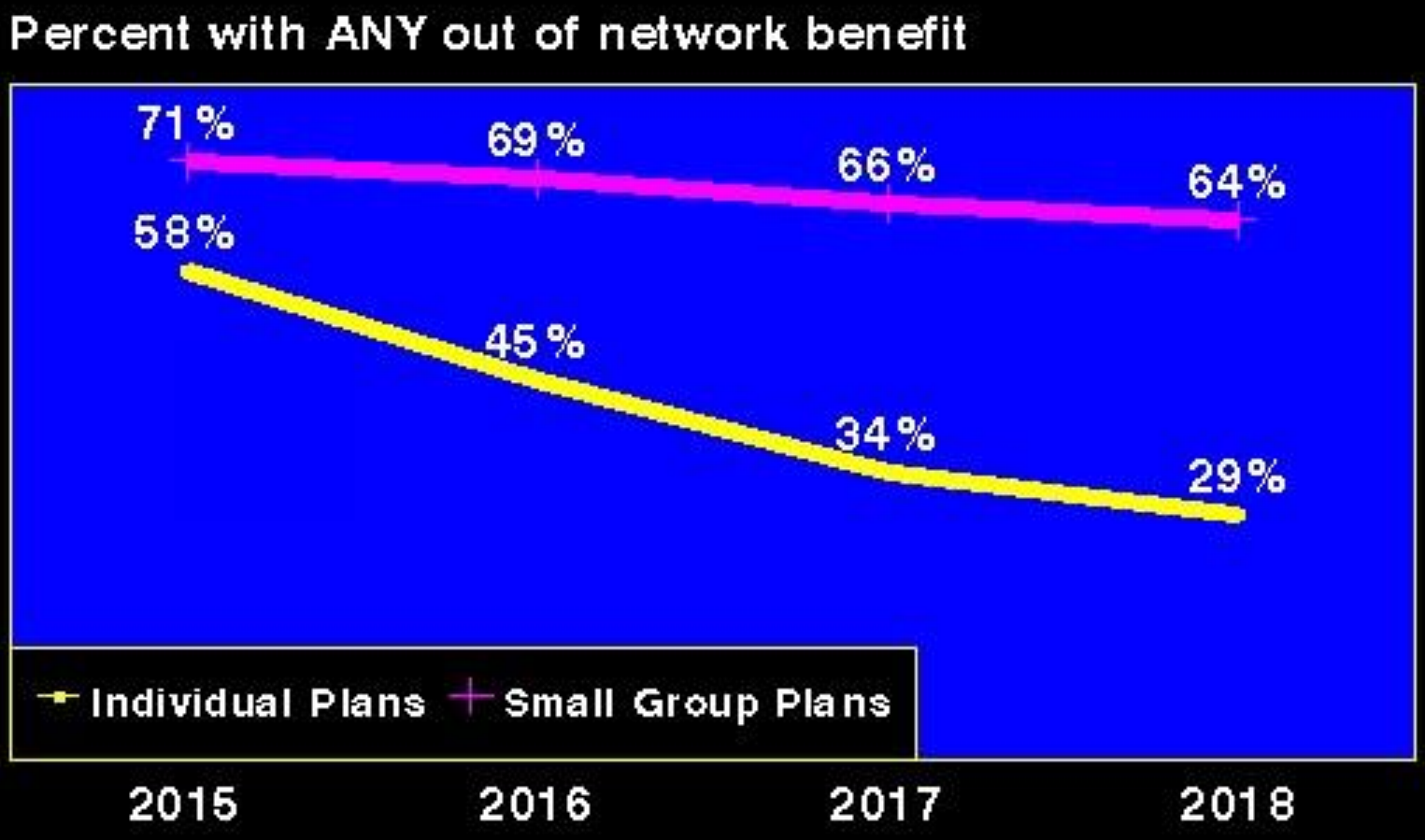
ACA Exchange Plans' Deductibles

Higher Than Average Job-Based Plan



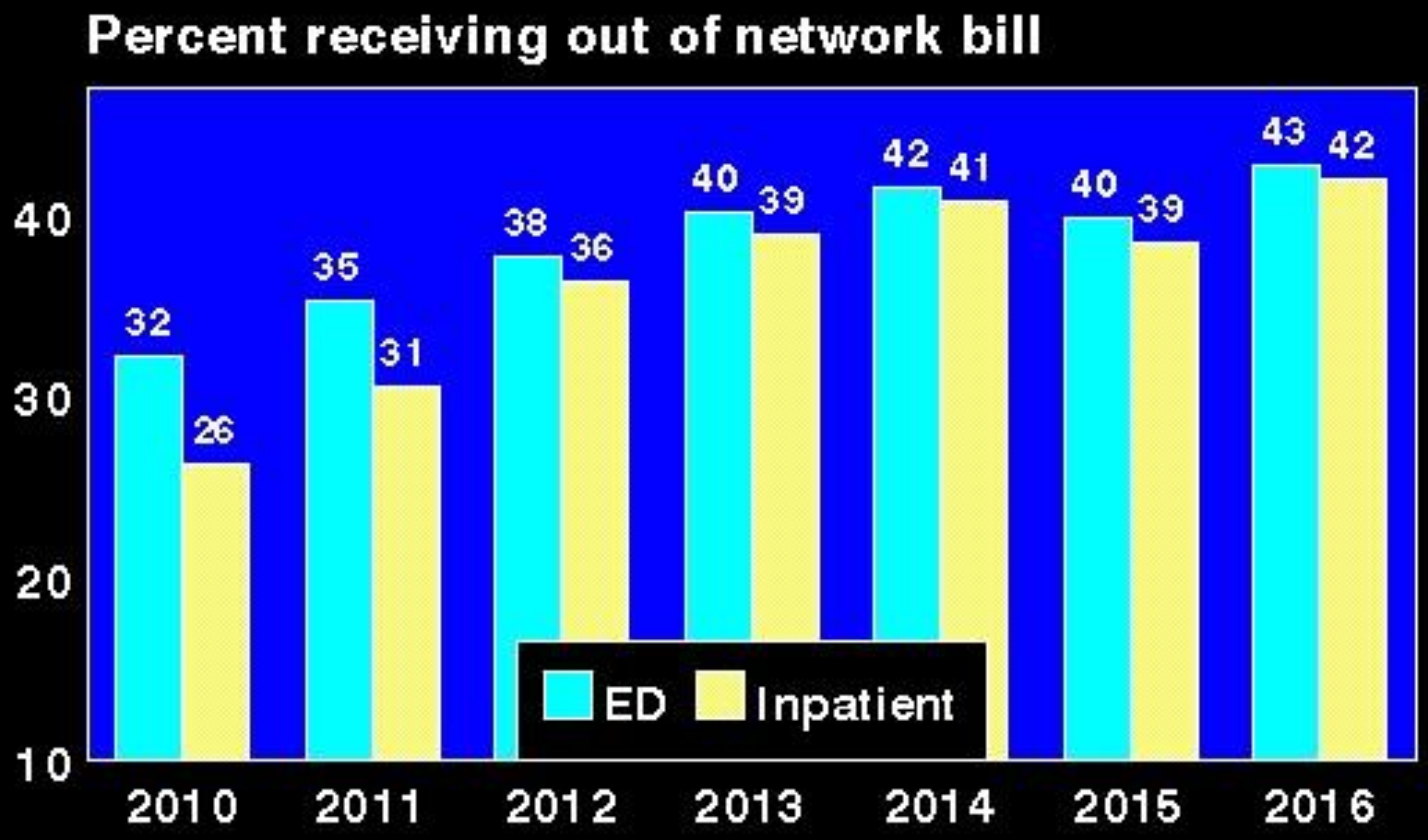
Source: KFF and Kaiser Foundation 2022 Employer Health Benefits Survey

Many Plans Now Pay NOTHING for Out Of Network Care



Source: RWJF 10/4/2018

Out of Network Bills Rising



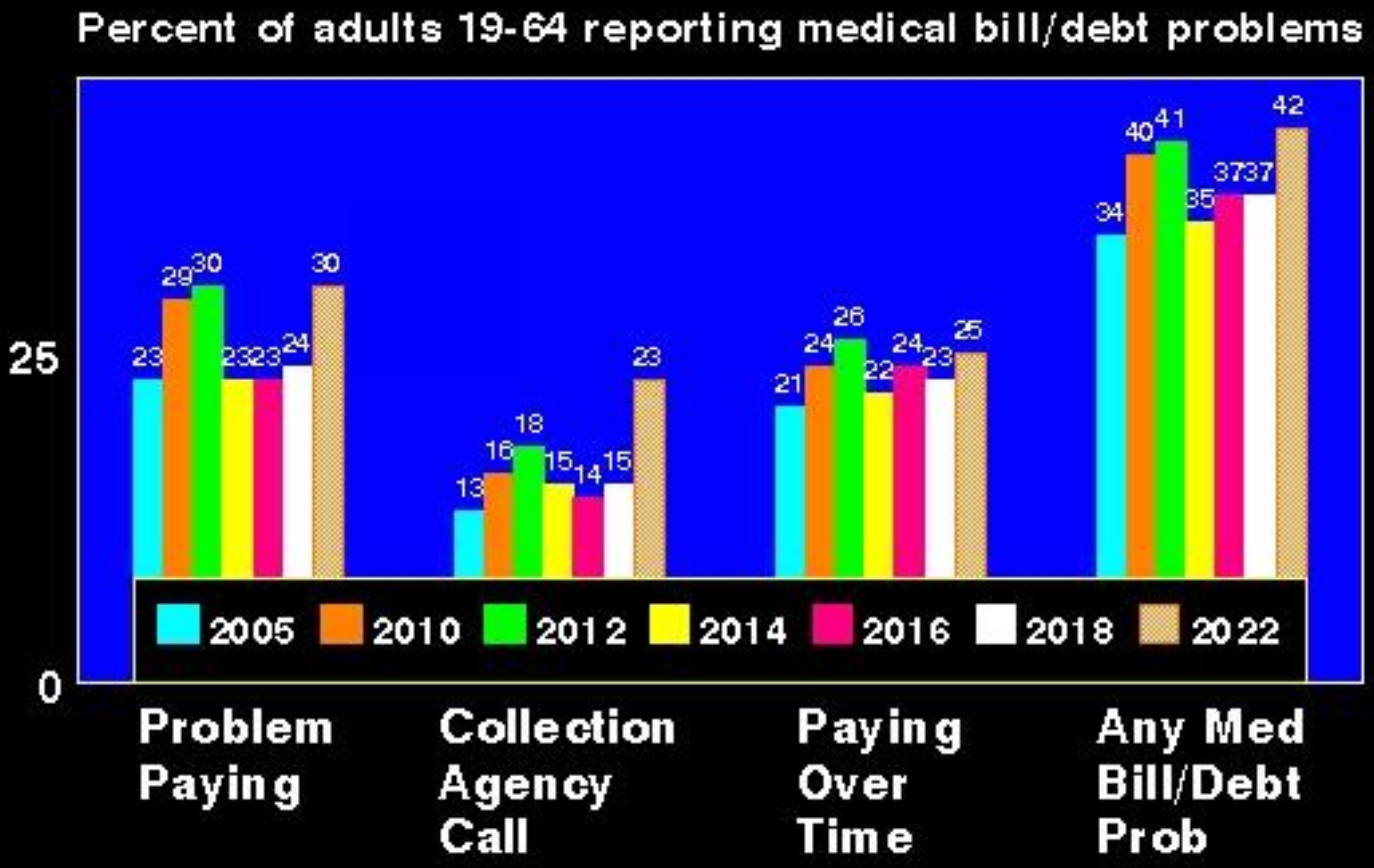
Source: JAMA IM 2019;179:1543

Mean out of network bill for ED care rose from $220 to $628

Mean out of network bill for inpatient stay rose from $804 to $2040

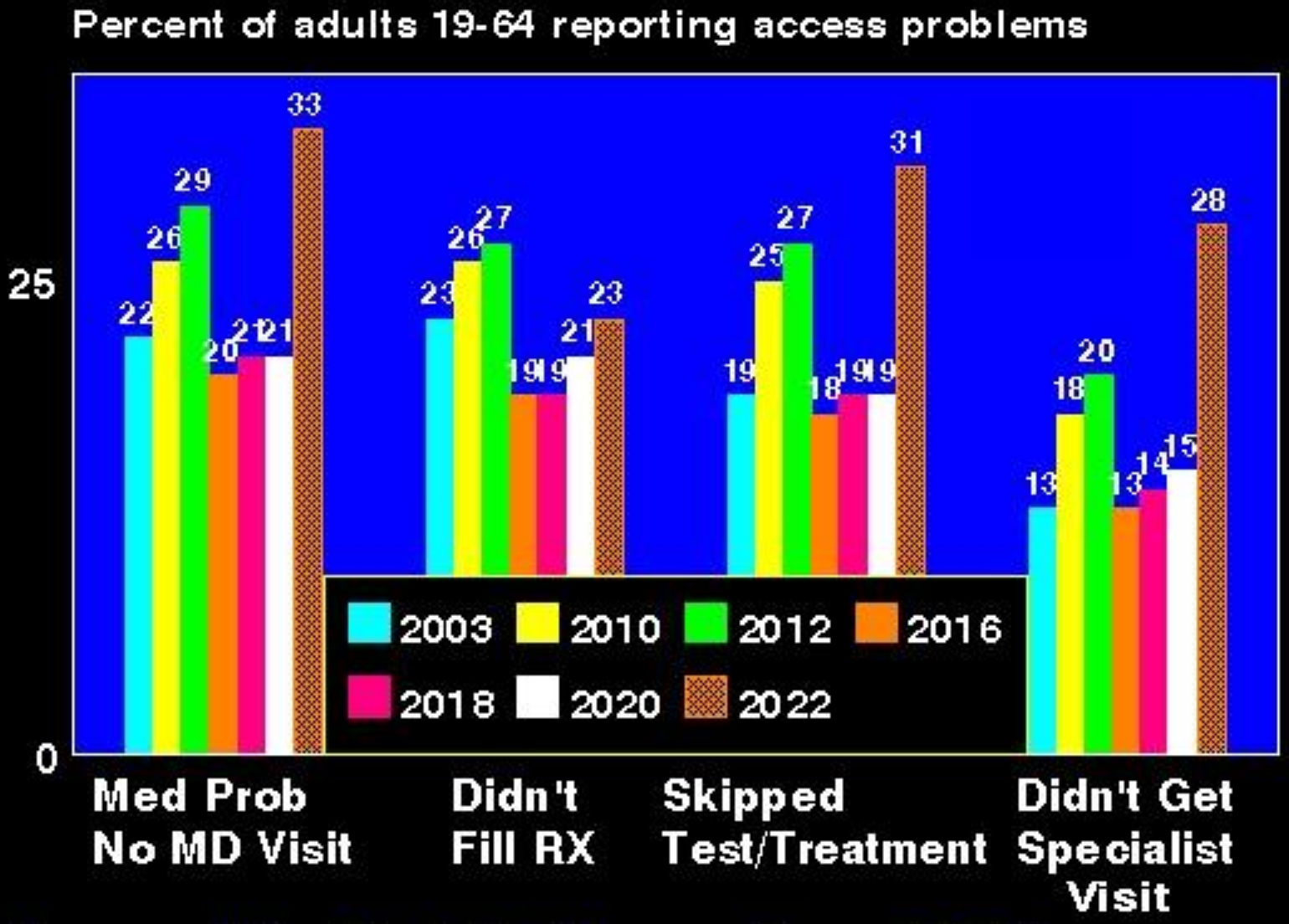
Medical Bill and Debt Problems

Now Worse Than in 2005



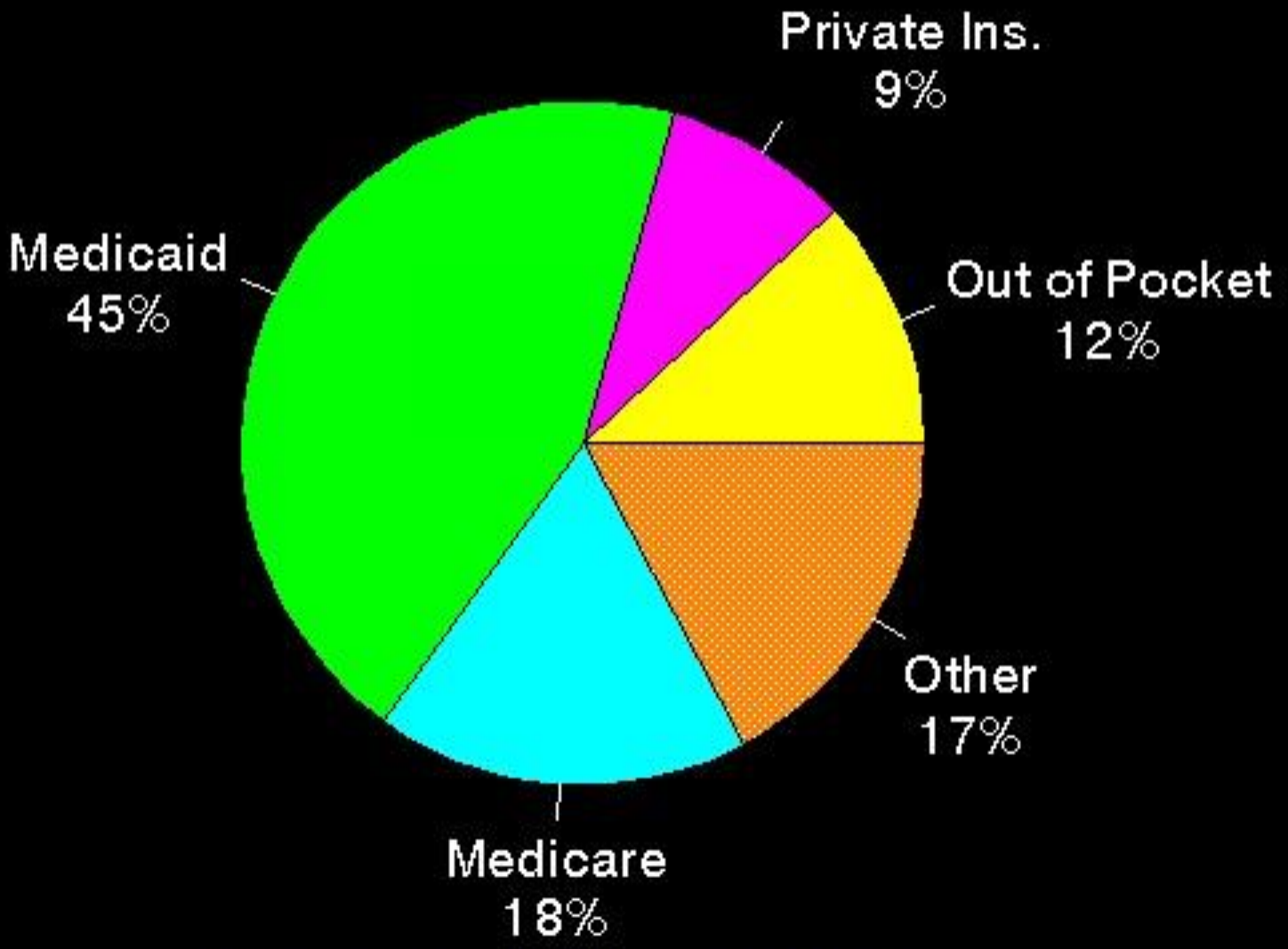
Source: Commonwealth Fund Biennial Health Insurance Surveys 2005, 2010, 2012, 2014, 2016, 2018, 2021

Access to Care Problems Increasing



Source: Commonwealth Fund Biennial Health Insurance Surveys 2003-2022

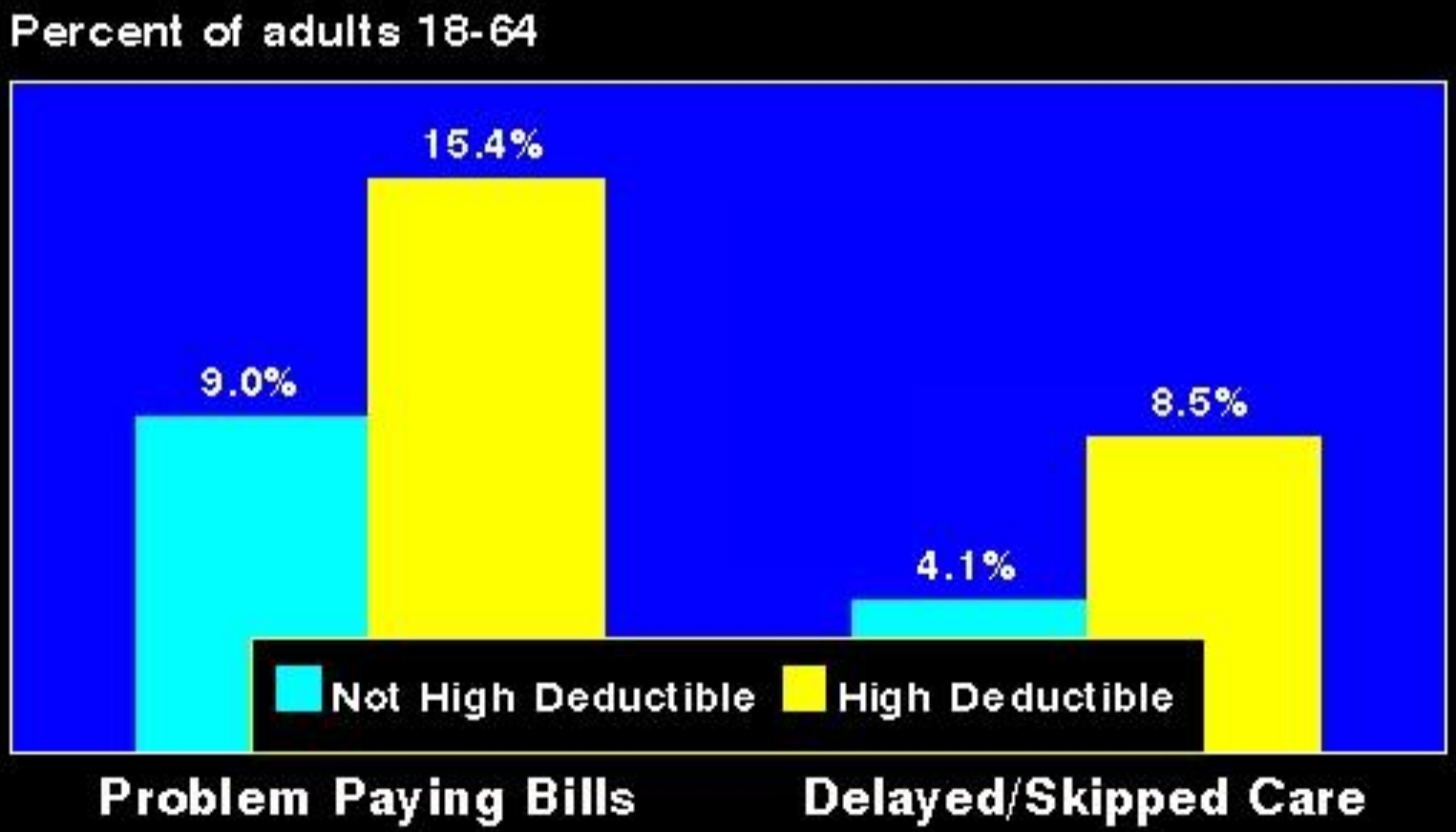
Who Pays for Long Term Care?



Source: Woolhandler/Himmelstein Analysis of NCHS Data

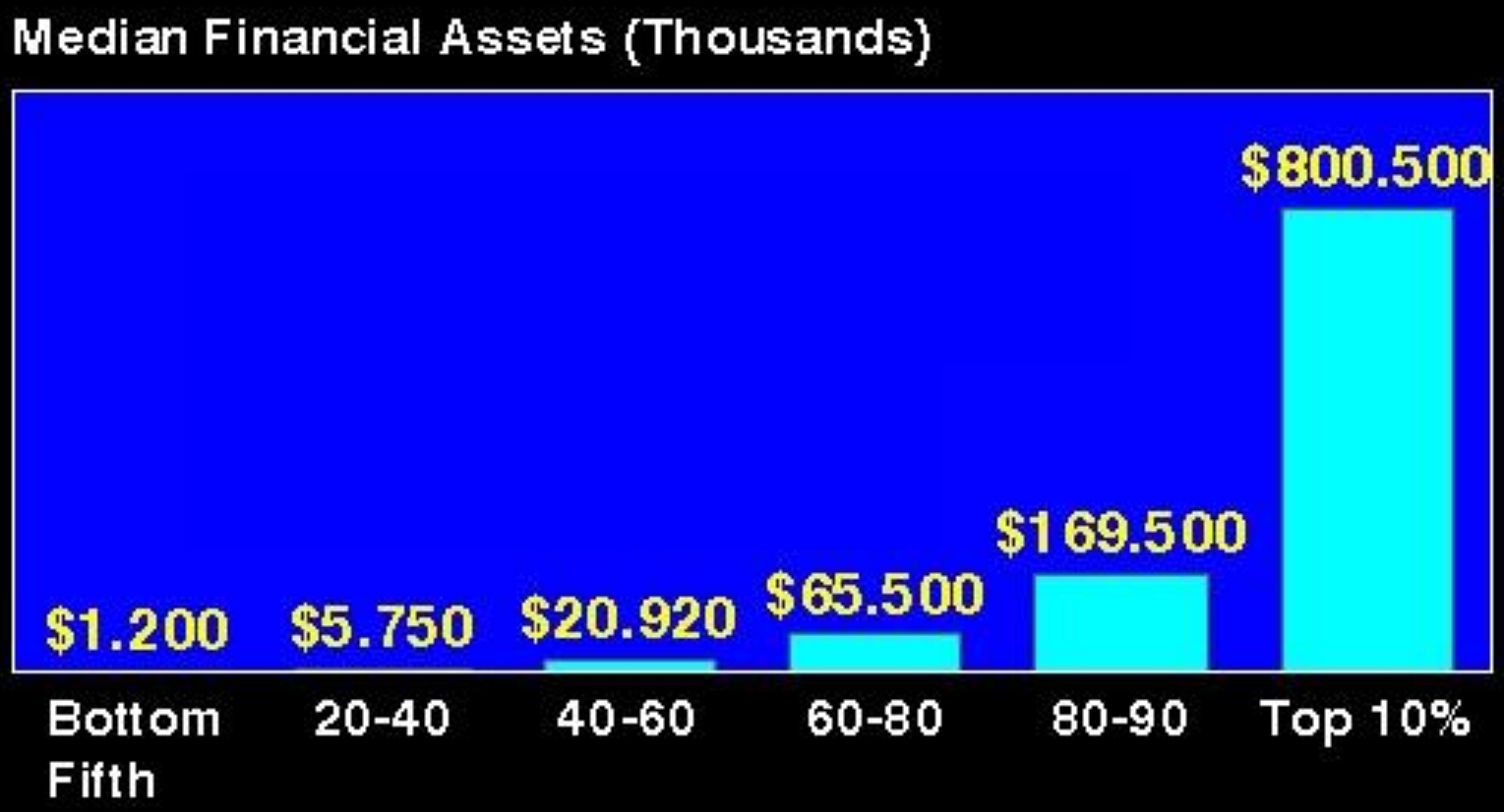
Under-Insurance Impedes Care, Worsens Health

High Deductible Coverage (HDHP) Compromises Finances and Access



Source: Cohen & Zammitti, NCHS, June, 2017 - Based on 2016 NHIS data
Note: Of people with job-based coverage, 26.9% had HDHP in 2011, rising to 39.6% in 2016
Note: HDHP = >$1200/$2400 single/family deductible in 2011, $1300/$2600 in 2016

Many Families Lack Assets to Pay High Deductibles

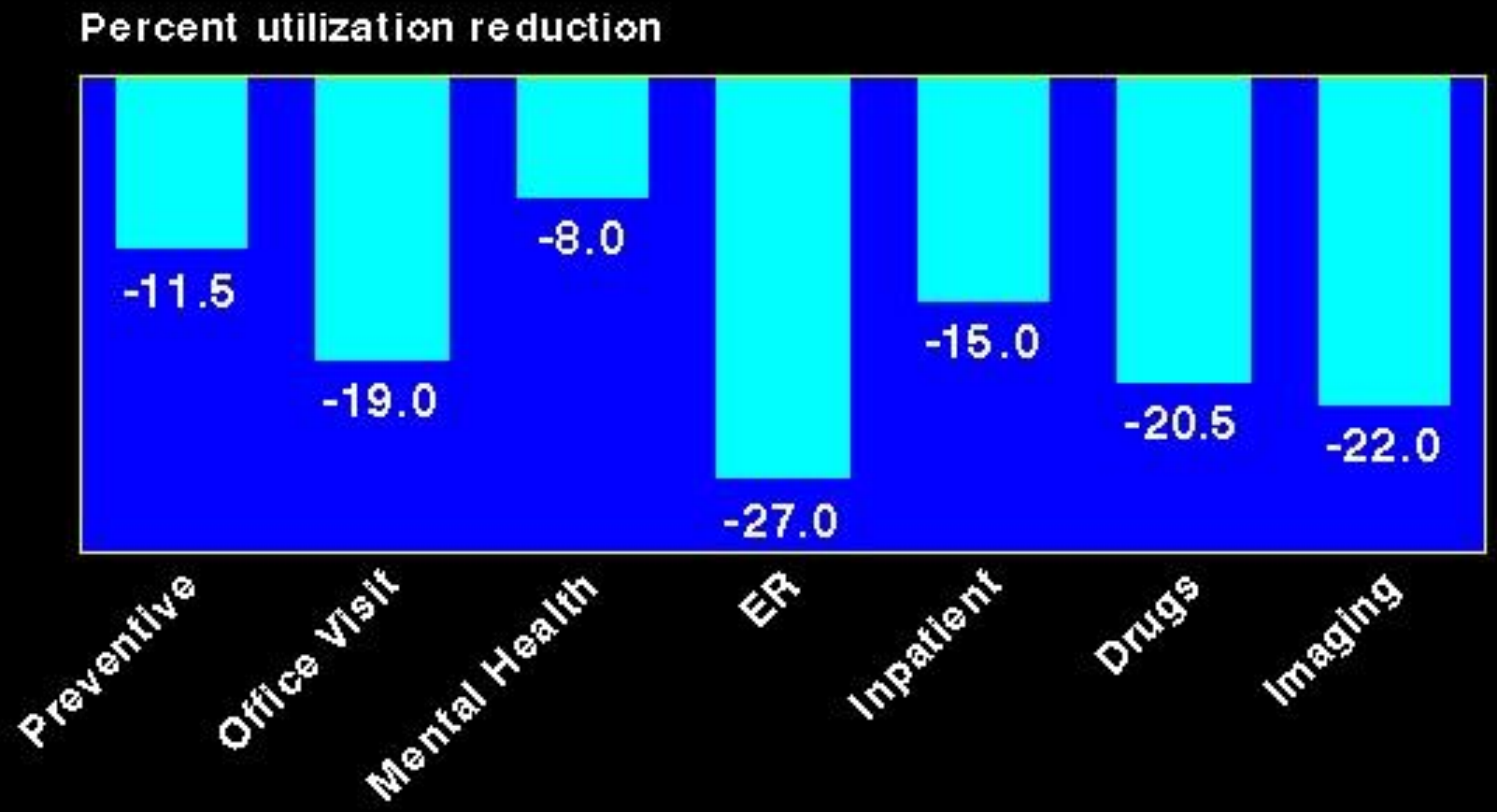


Source: Federal Reserve Survey of Consumer Finance 2019

High Deducticles Cut All Kinds of Care

150,000 Employees Lost "Cadillac" Coverage

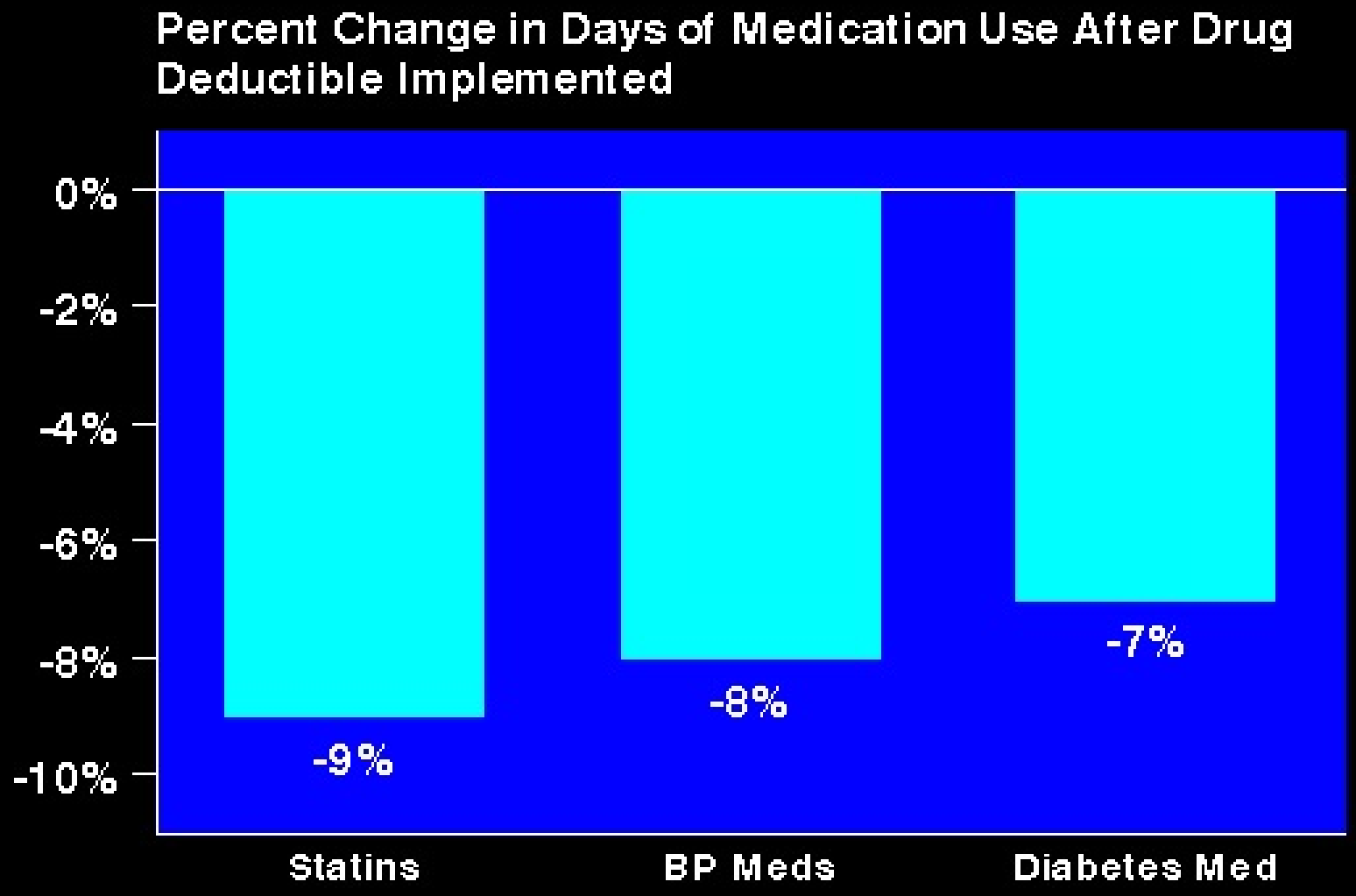
No Evidence that Patients Shifted to "Higher Value" Care



Source: Brot-Goldberg et al, 6/2015 - http://eml.berkeley.edu/~bhandel/wp/BCHK.pdf
Note: Findings closely resemble those of Rand Health Insurance Experiment
Note: Study found no evidence that patients shopped for lower prices

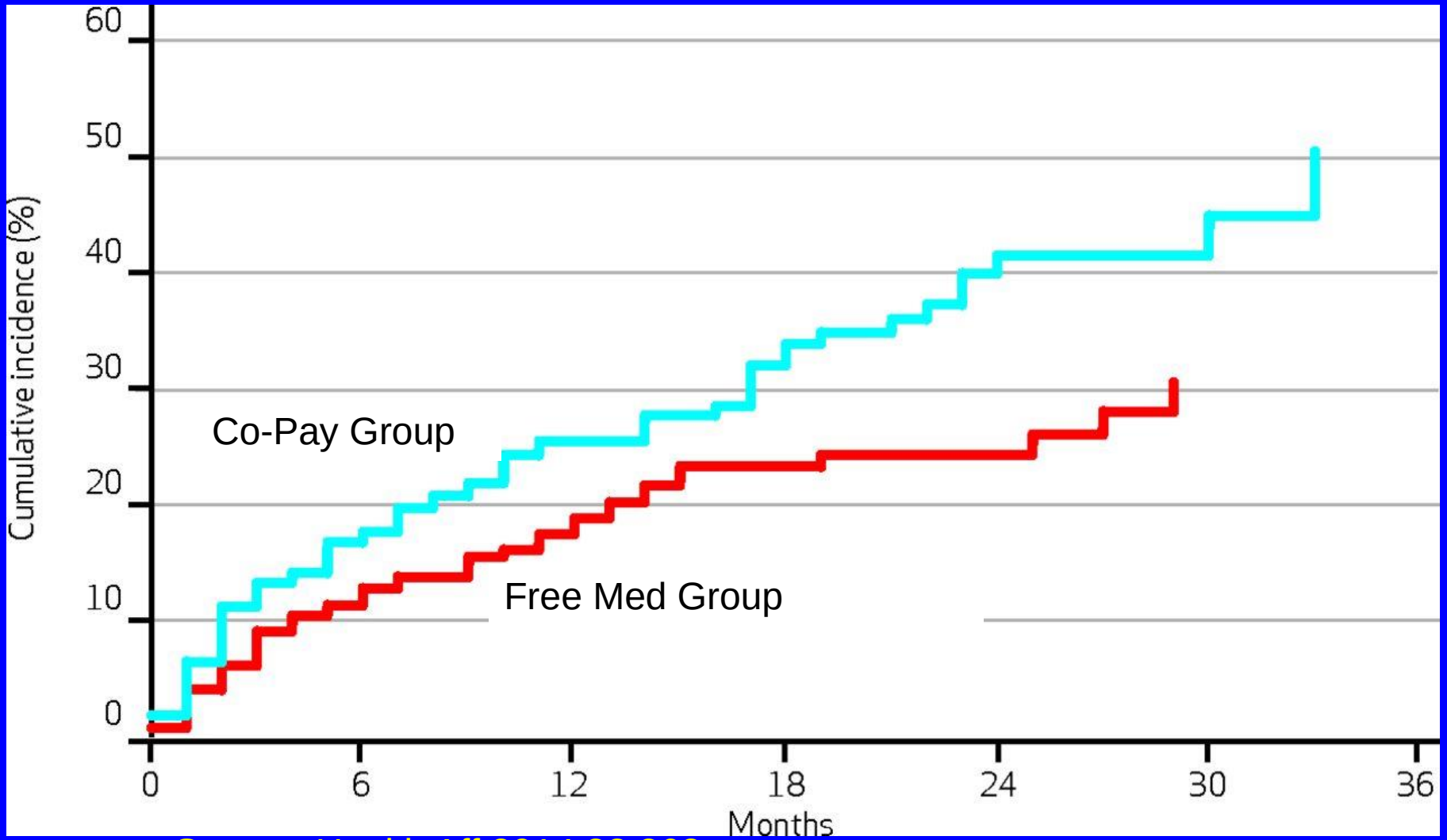
Drug Deductible Reduced Needed Medication Use

Comparison at Firms That Added vs. Didn't Add Drug Deductible



Source: Huckfeldt etl al. NBER W20927 - 2/2015

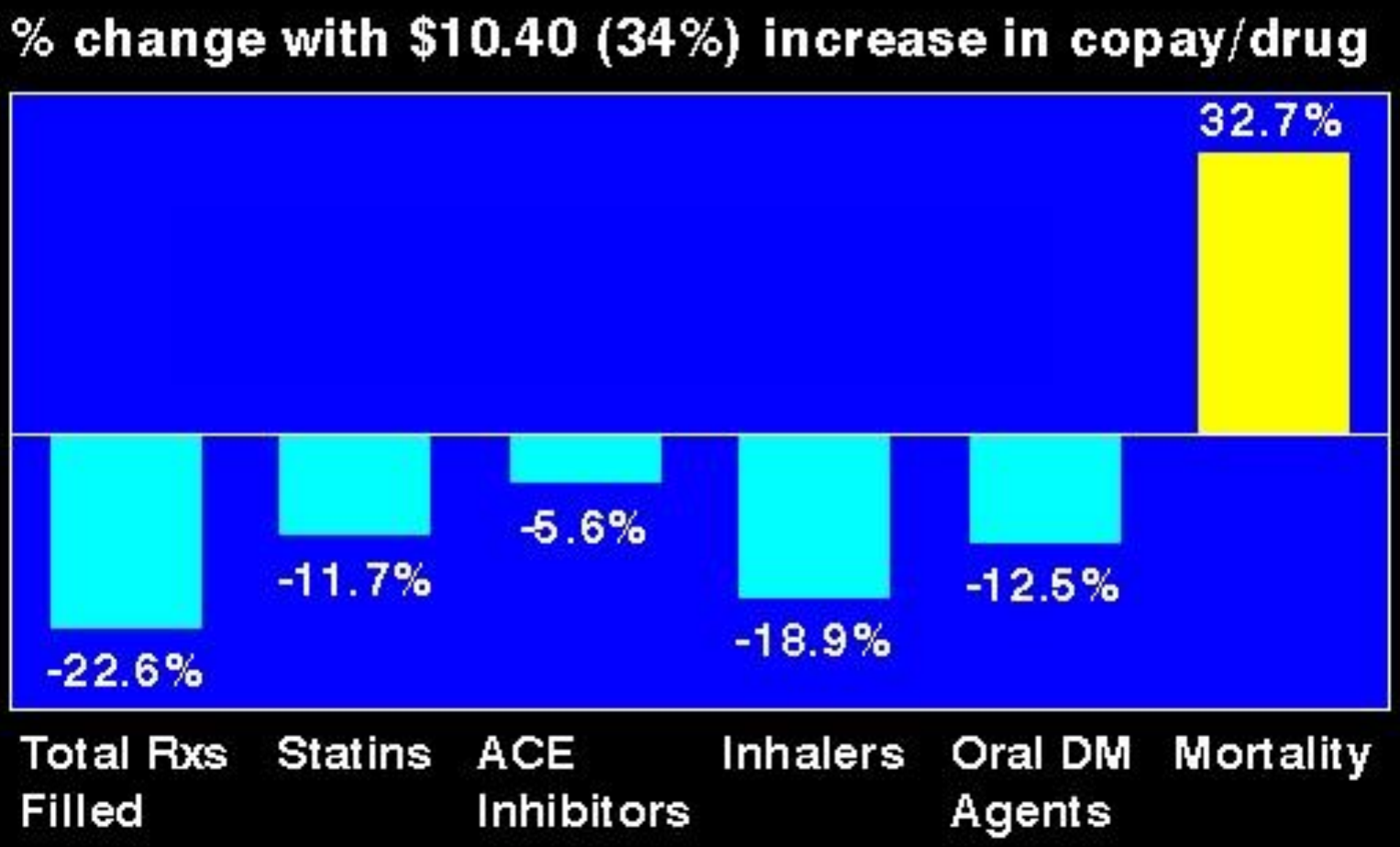
Medication Co-pays Increased Post-MI Vascular Events in Minorities – An RCT



Source: Health Aff 2014:33:863

Drug Copayments Kill

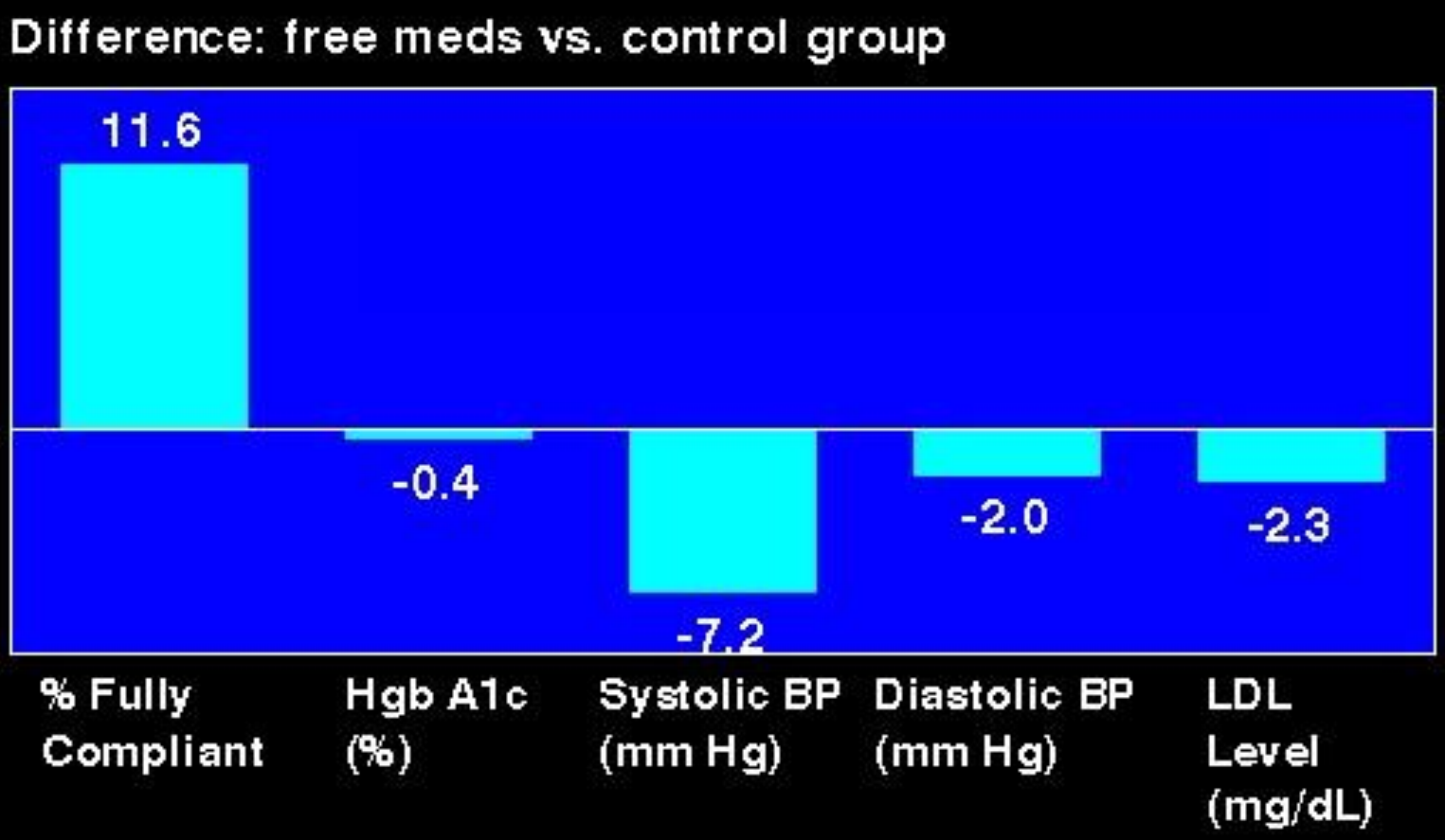
Quasi-Experimental Analysis of Medicare Part D Copays



Source: "The Health Costs of Cost Sharing) NBER #28439, February, 2021

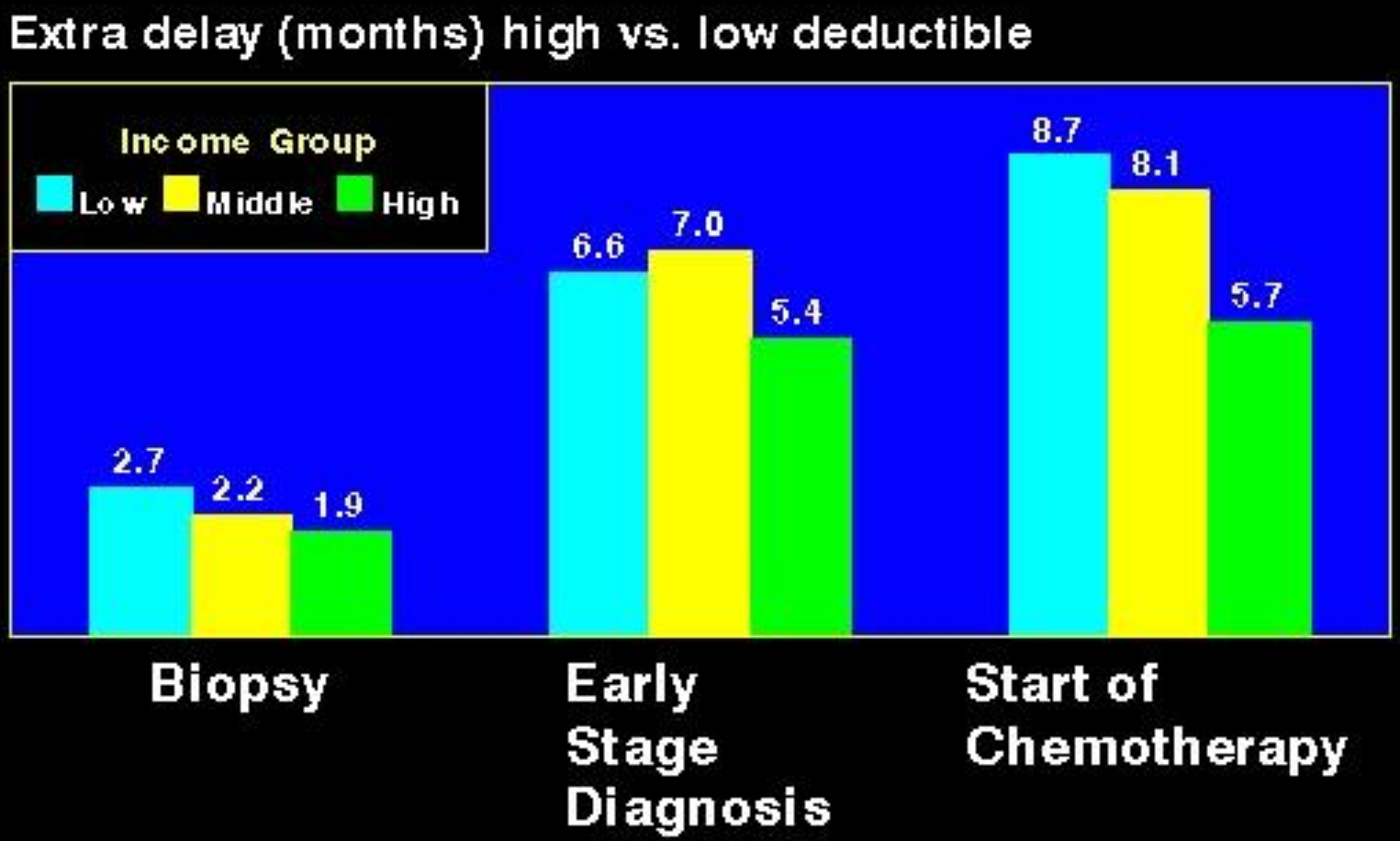
Many patients stopped all drugs; Reductions in use largest in patients on many drugs

RCT: Free Meds Improved Compliance and Outcomes



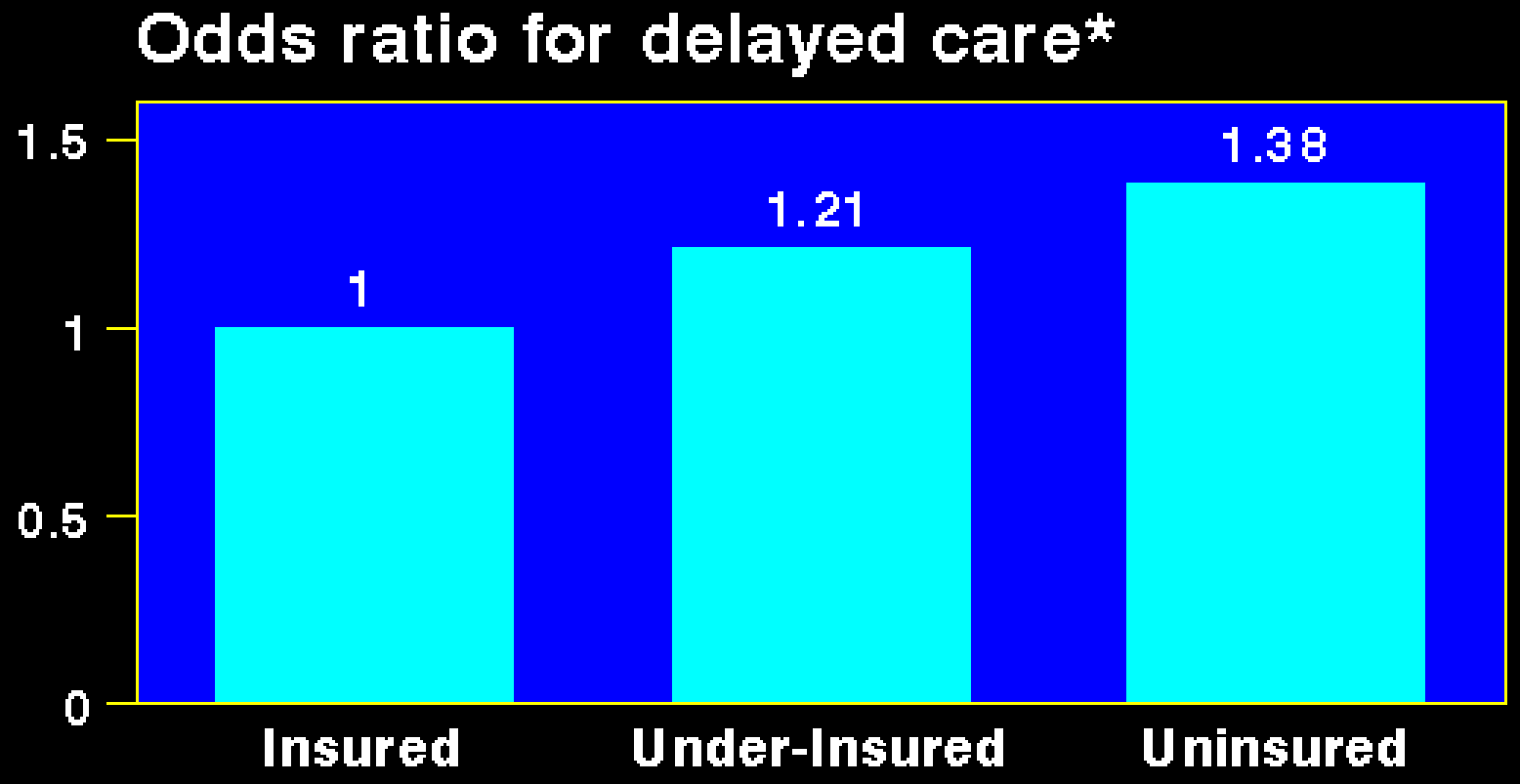
Source: JAMA IM 2020;180:27

High Deductible Plans Delayed Breast Cancer Care



Source: Health Affairs 2019;38:408

Uninsured and Under-Insured Delay Seeking Care for Heart Attacks



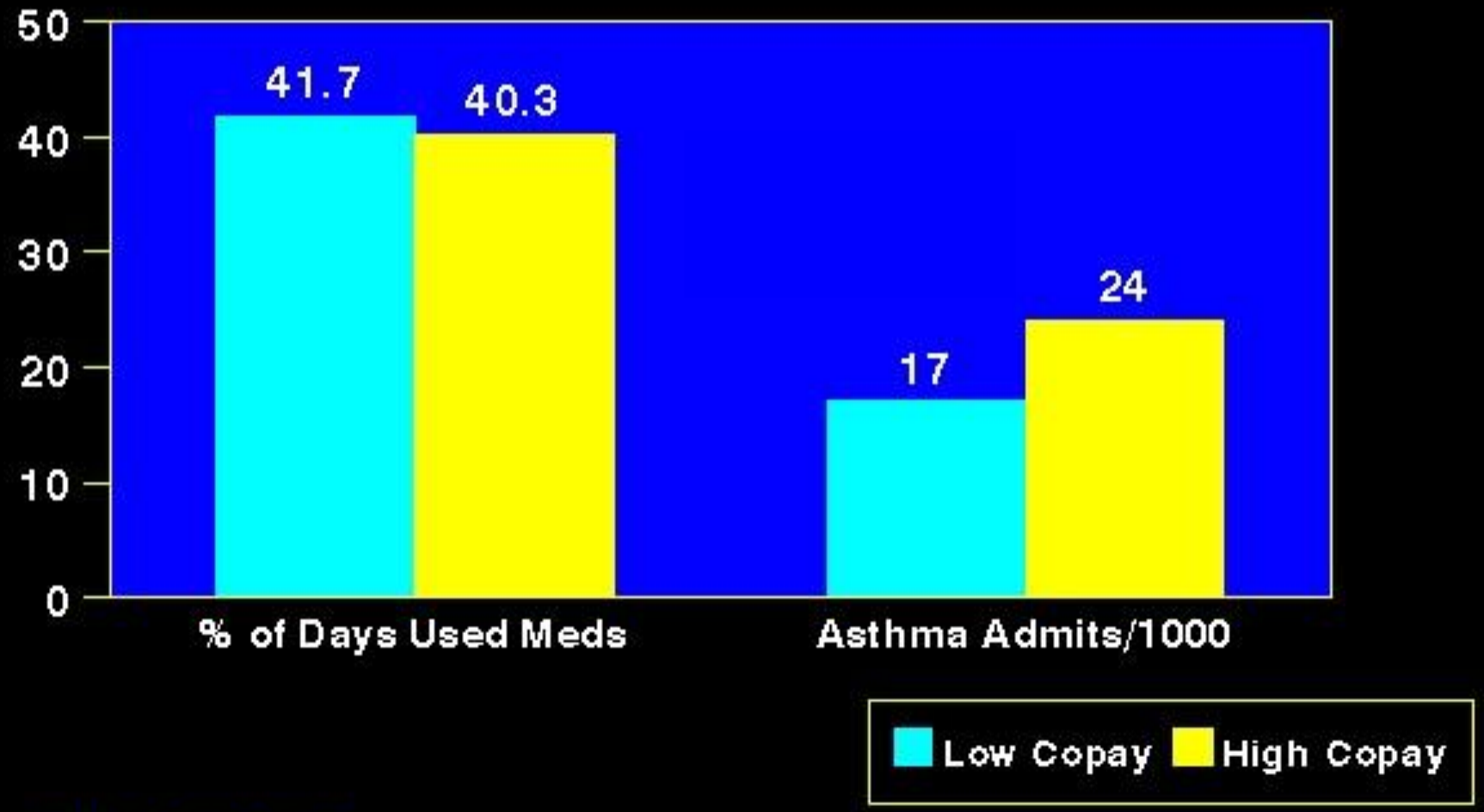
Source: JAMA April 15, 2010:303:1392

*Adjusted for age, sex, race, clin. characteristics, hlth status, social/psych factors,urban/rural

Under-insured = Had coverage but patient concerned about cost

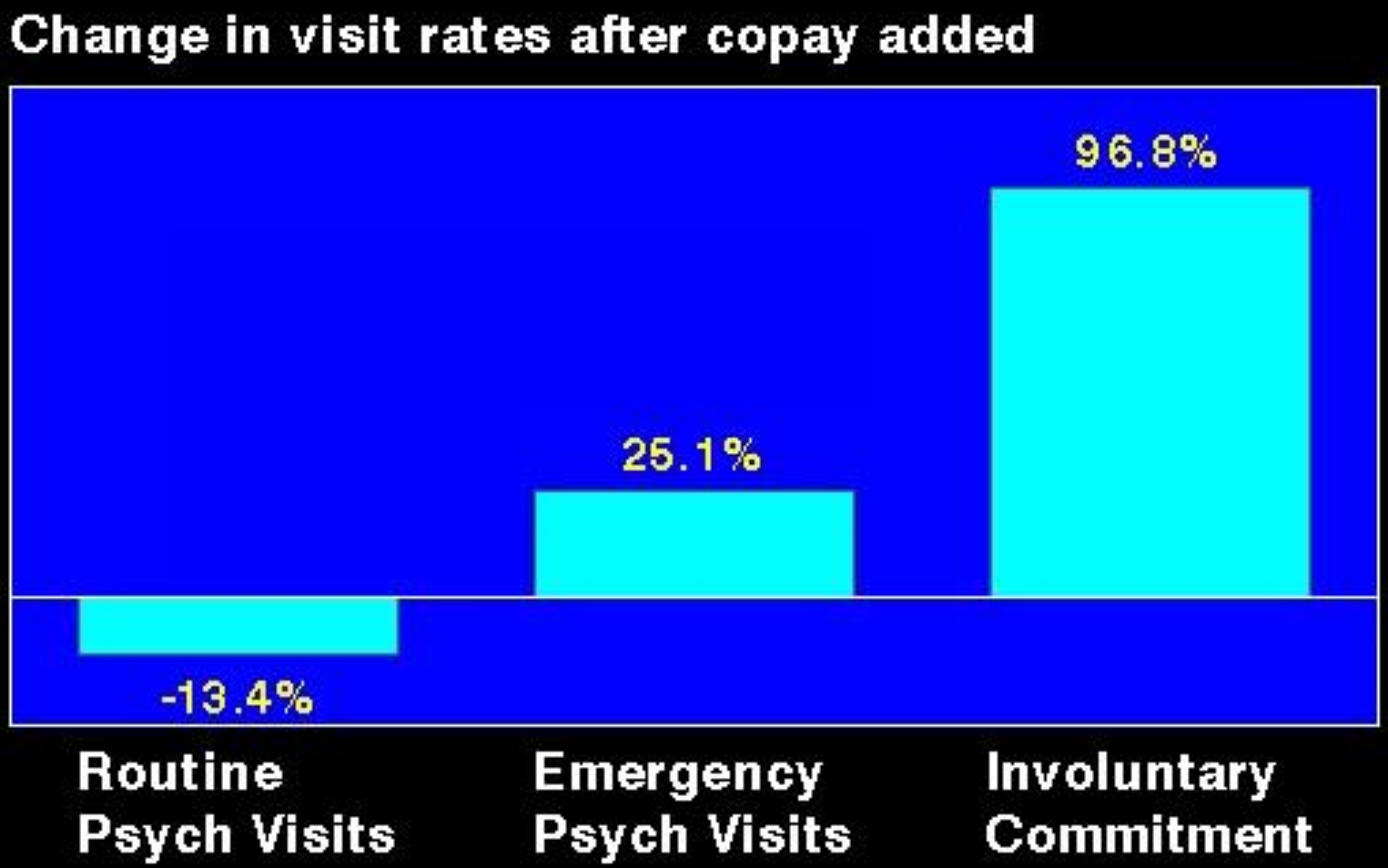
Higher Medication Co-Pays = Worse Asthma Outcomes

Children Age 5-18



Source: JAMA 2012;307:1284

200 Euro Copayment Cut Routine Psych Visits, Increased Crisis Care in Holland

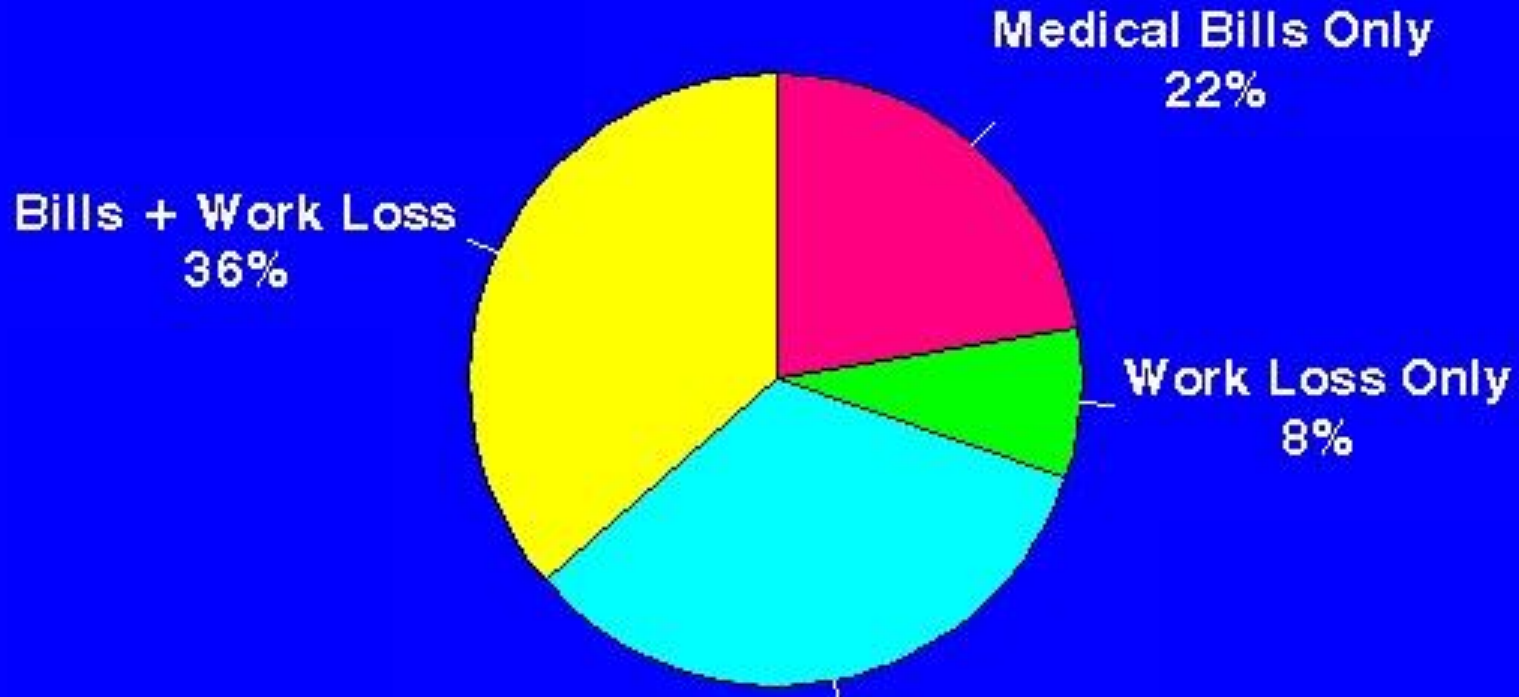


Source: JAMA Psychiatry 2017;74:932
Note: Copay was not applied to children, whose use rates remained stable

Under-Insurance: A Leading Cause of Financial Distress and Ruin

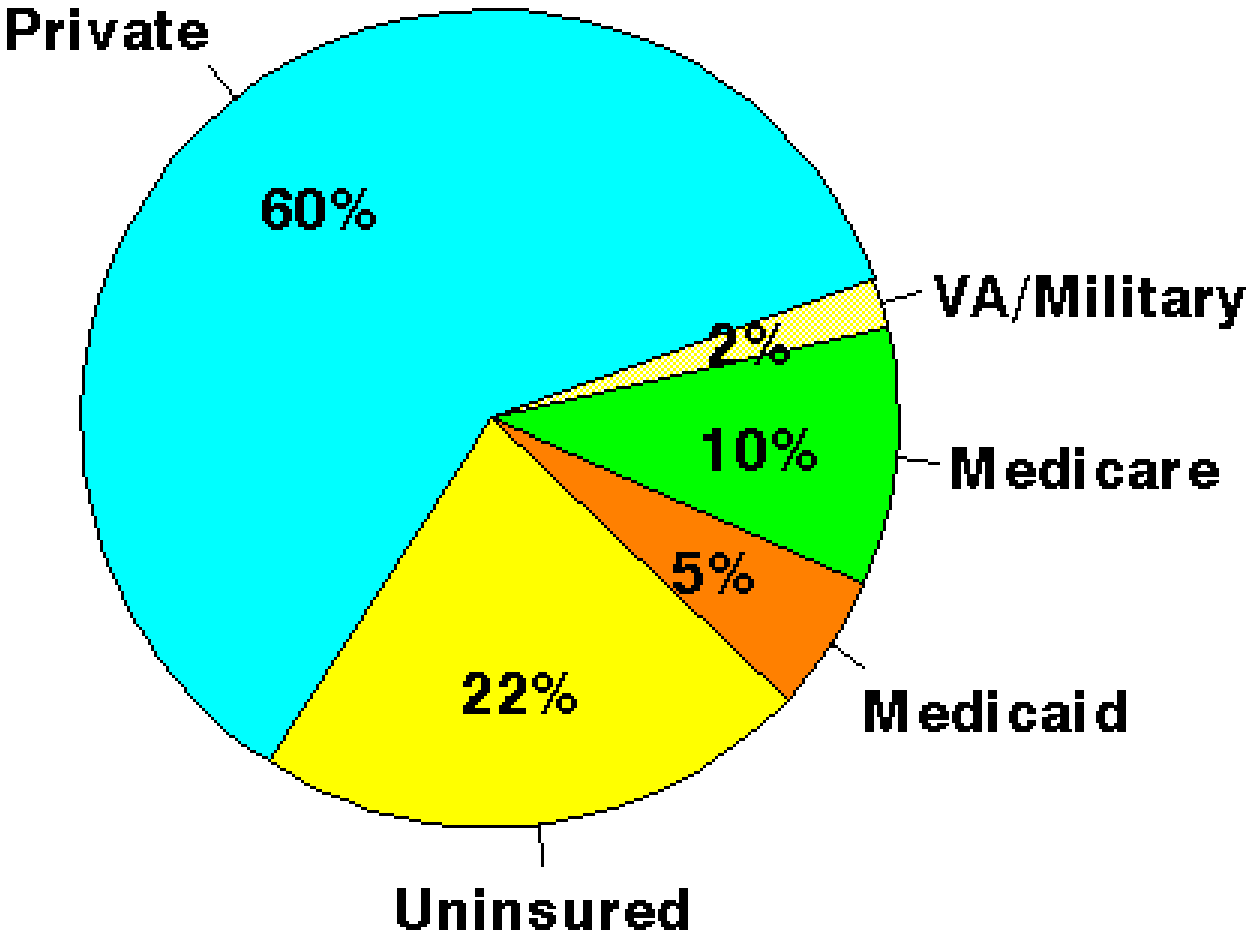
2/3 of Bankruptcy Filers Cite Medical Bills or Illness-Related Work Loss as a Cause

National Survey of Debtors, 2013-2016



Source: Himmelstein, Thorne, Lawless, Foohey, Woolhandler - AJPH 2019;109:431
Work loss = "work loss due to illness"

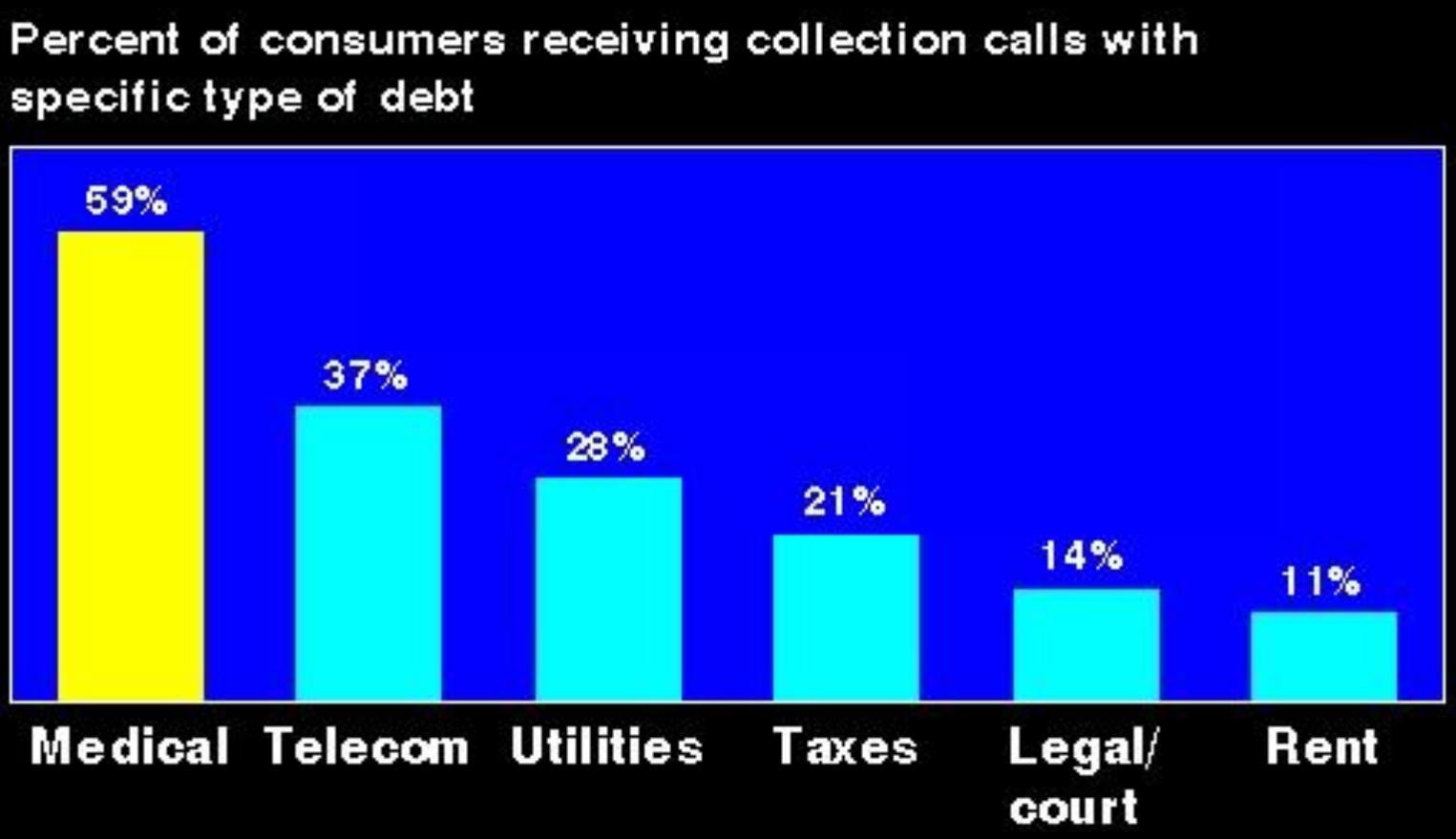
Most of the Medically Bankrupt Had Coverage



Insurance at Illness Onset

Source: Himmelstein et al. Am J Med; August, 2009

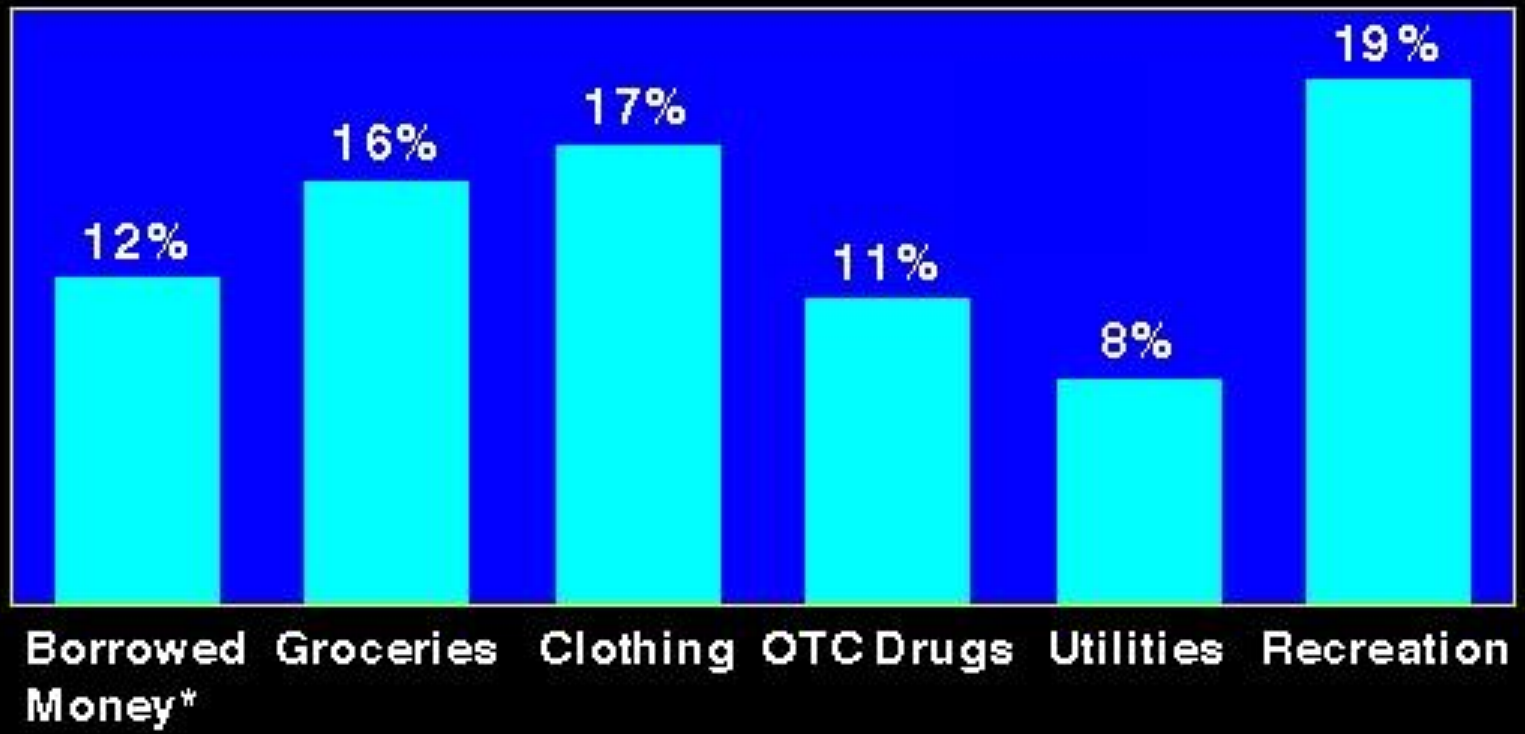
Medical Bills are Most Common Reason for Collection Calls



Source: Consumer FInancial Protection Bureau, January, 2017
Note: Medical collection calls were the only category which did not differ by income

Health Costs Force Millions into Debt and to Forego Other Essentials

Percent of adults who have borrowed money or reduced spending due to health care costs



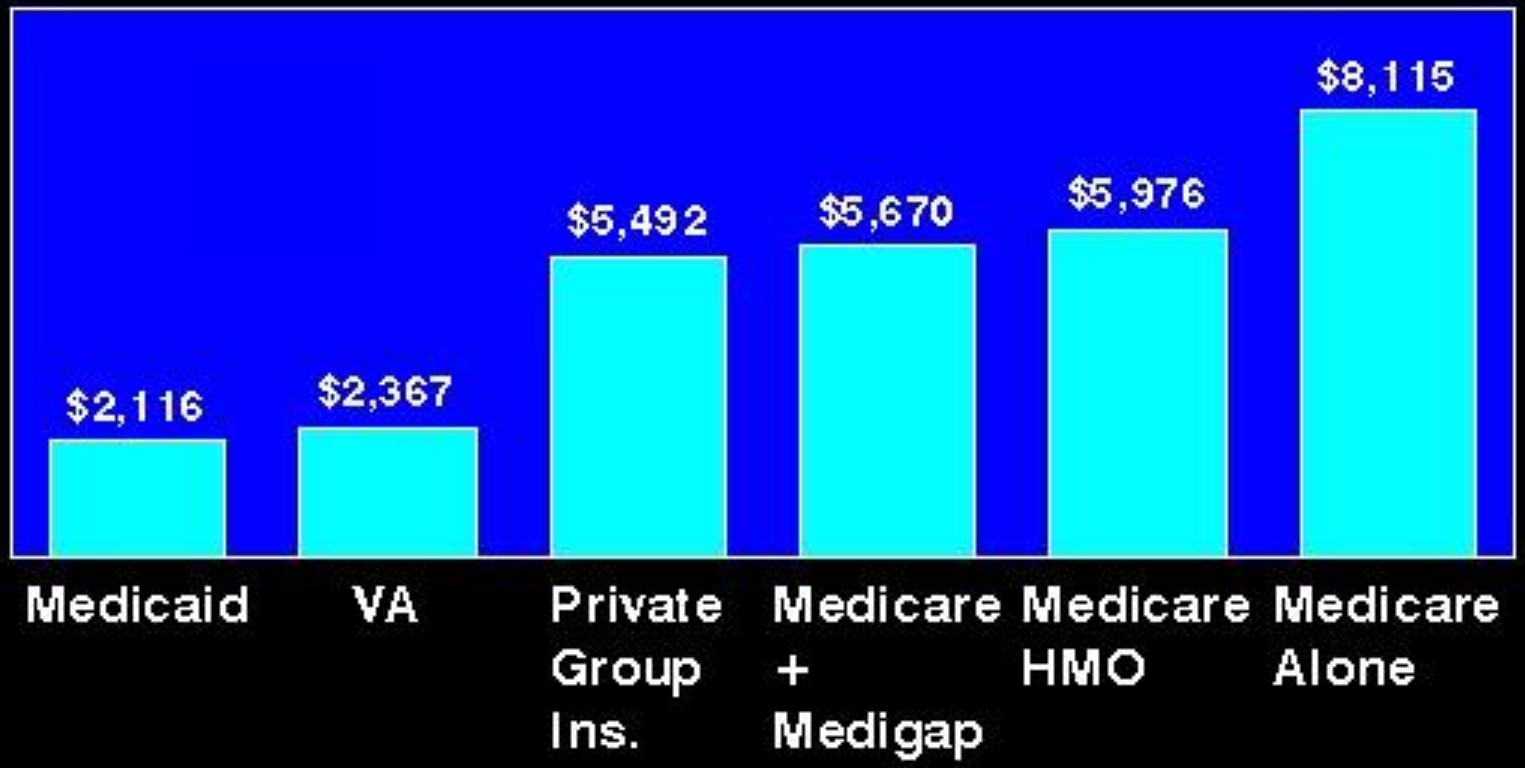
Source: Westhealth/Gallup - Public Perceptions of the U.S. Healthcare System - 2019

* Total borrowing to pay health costs = **$88 Billion**

Insured Cancer Survivors' High OOP Costs

A study of 1,409 Cancer Survivors Over 50

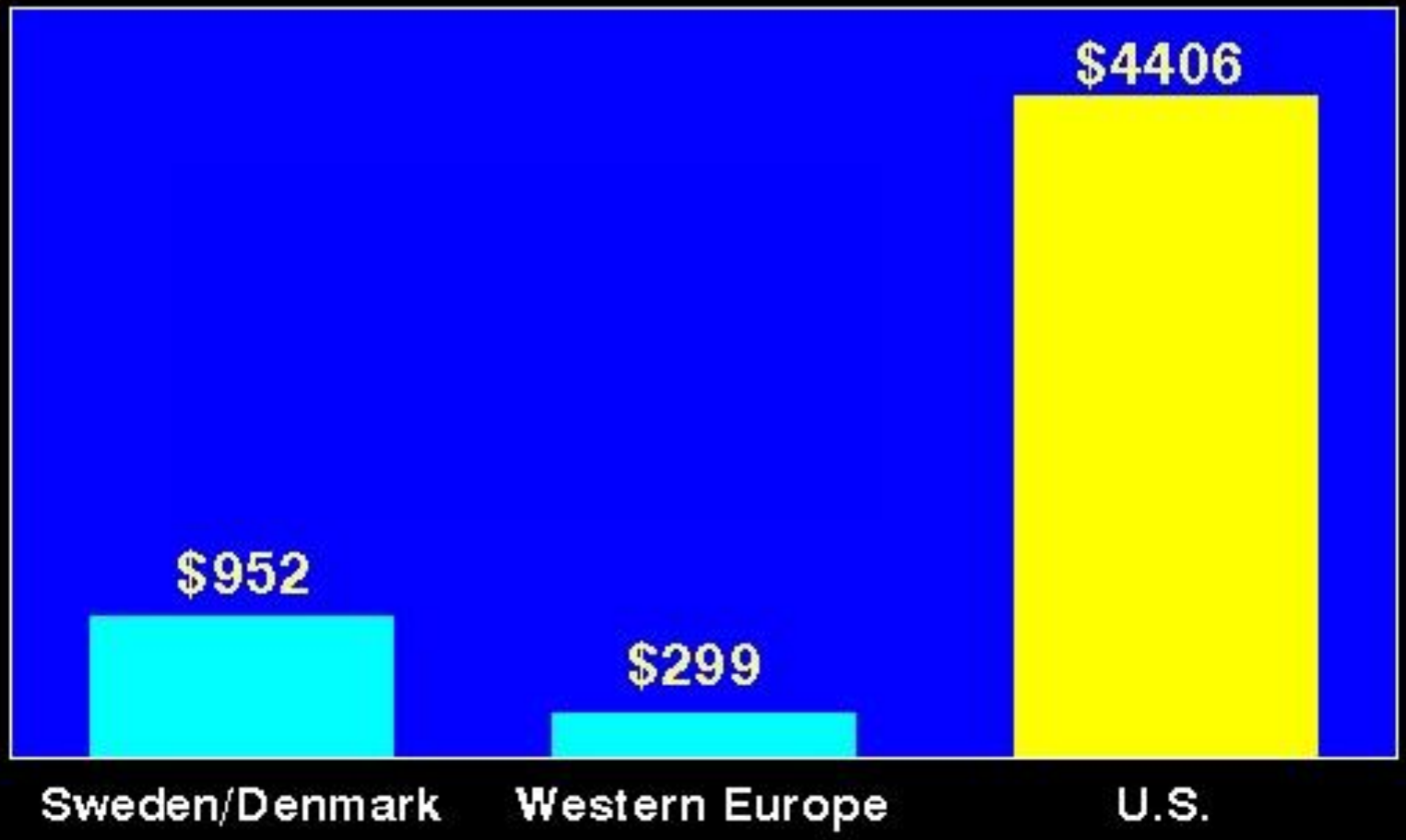
Mean annual out-of-pocket medical costs



Source: JAMA Oncology 2017;3:753 - Based on analysis of data from Health and Retirement Study
Note - Median household income was $51,371

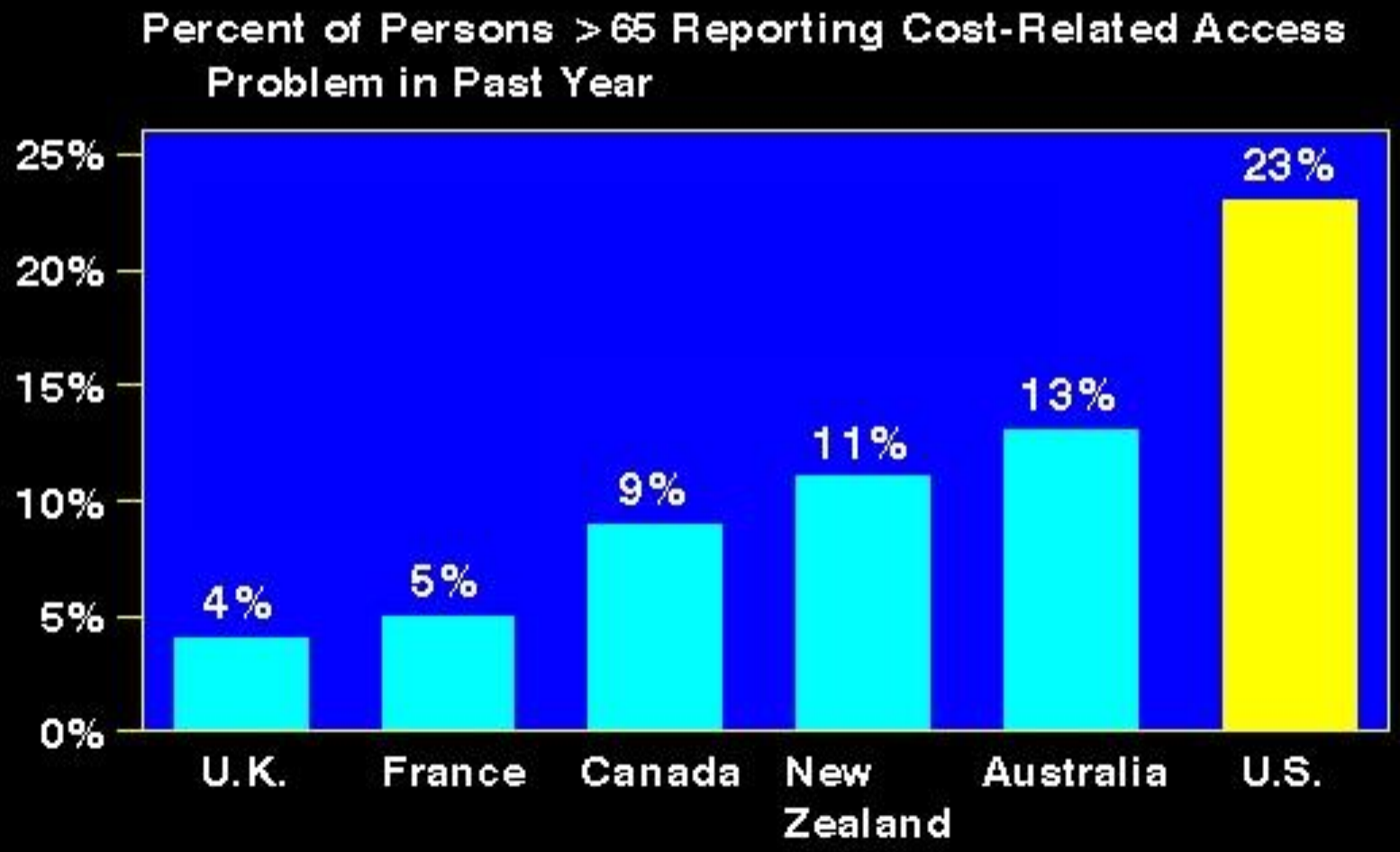
Dementia in US = High Out-of-Pocket Costs

Average annual out-of pocket spending by persons with dementia



Source: Medical Care 2021;59:543

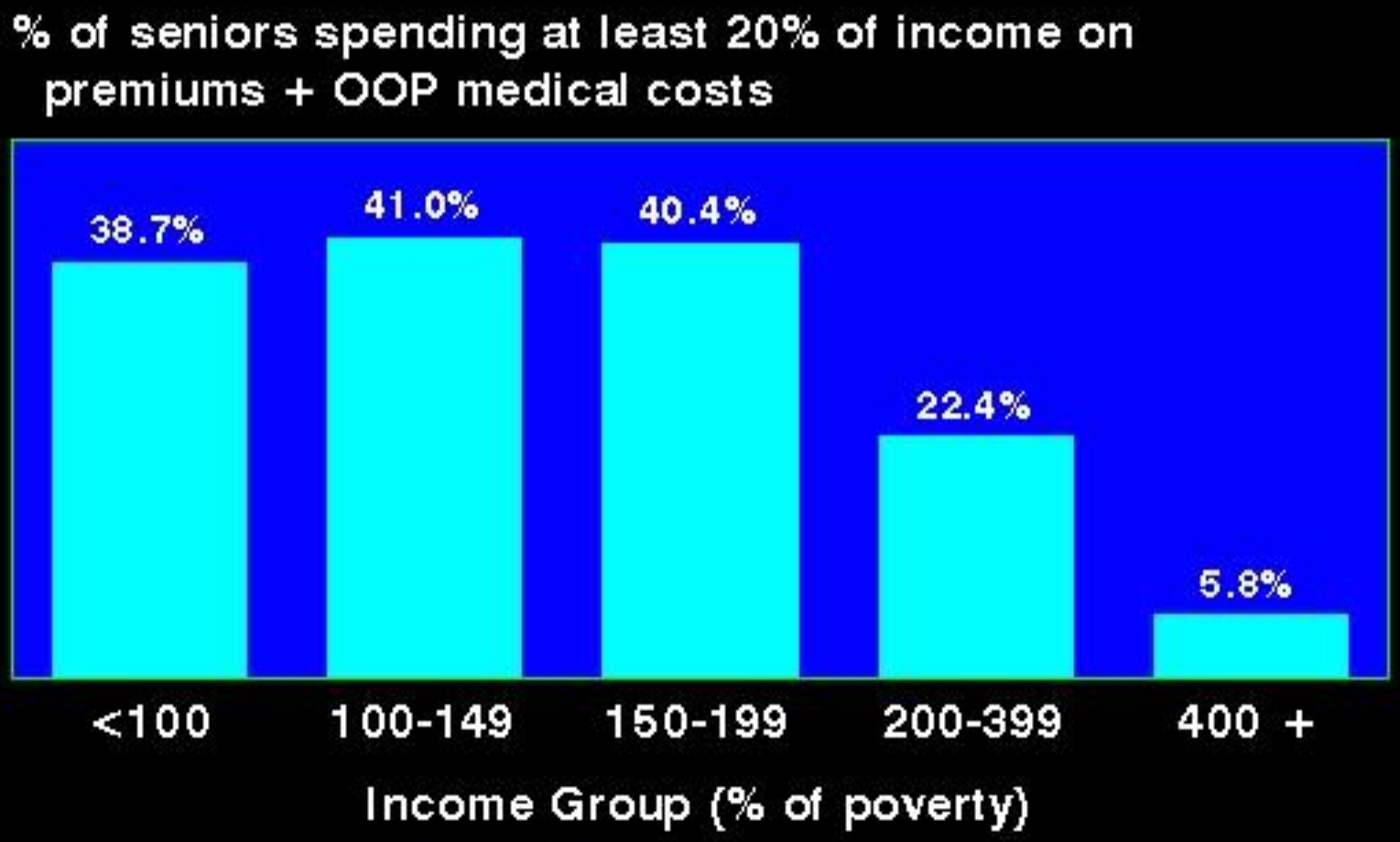
Despite Medicare, U.S. Seniors Have More Cost-Related Access Problems



Source: Health Affairs 2017; 36:2123

Medicare Needs Improvement

For Many Seniors, Medical Costs Consume More Than 1/5th of Income

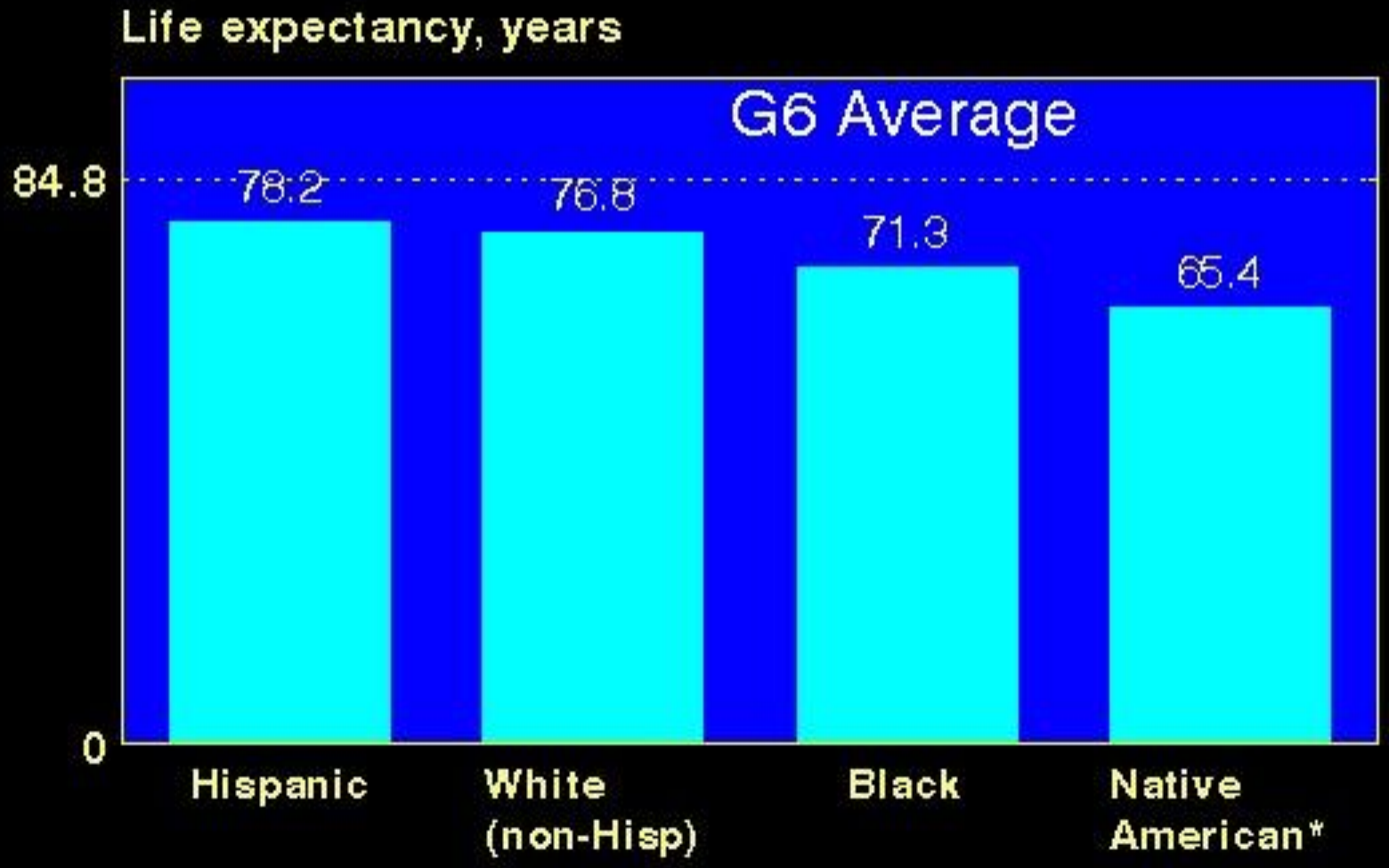


Source: Commonwealth Fund May 12, 2017

Racism Harms Health

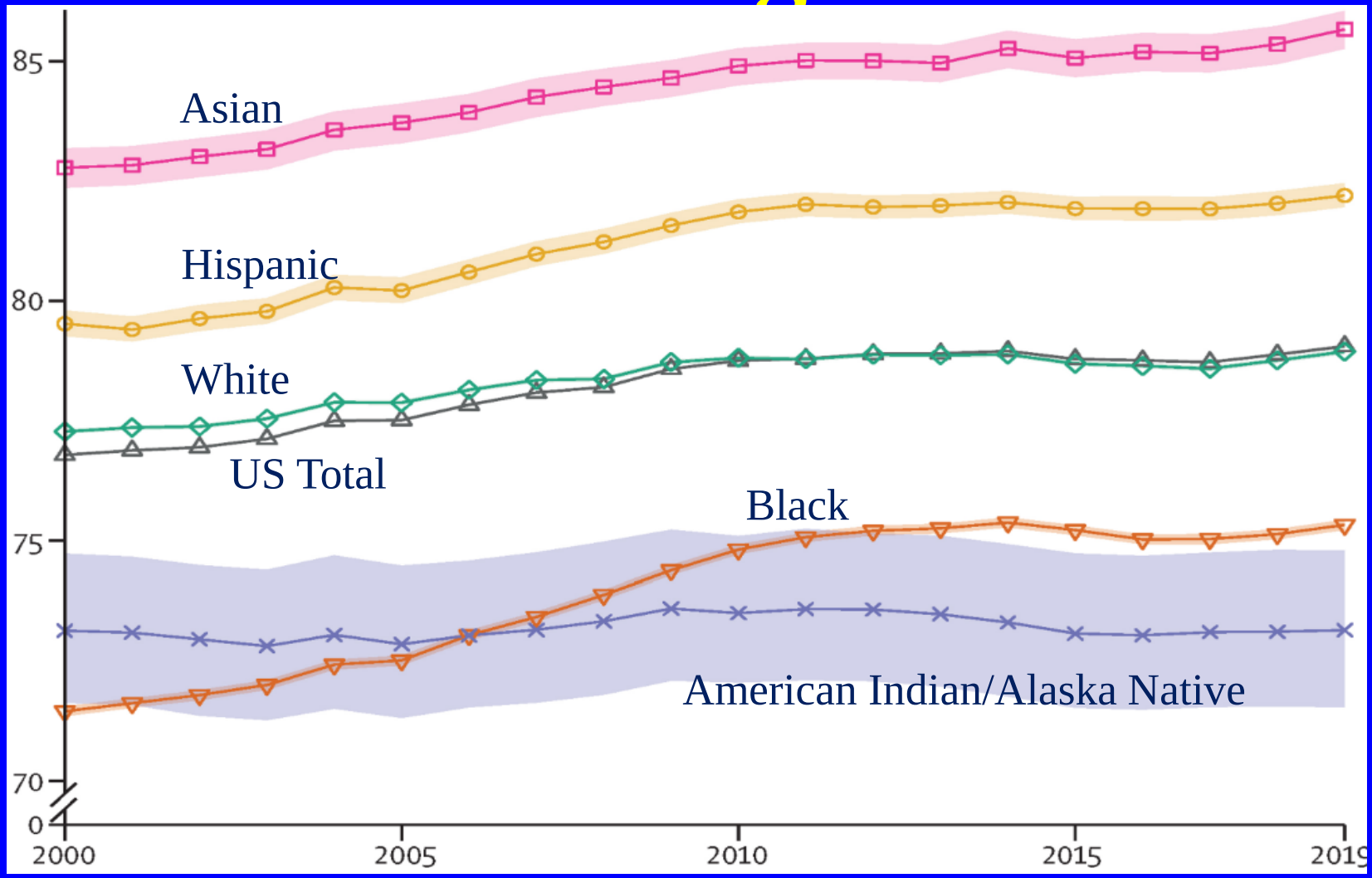
Black and Native Americans Die Younger

But Life Expectancy for Every Group is Shorter Than Other G7 Nations

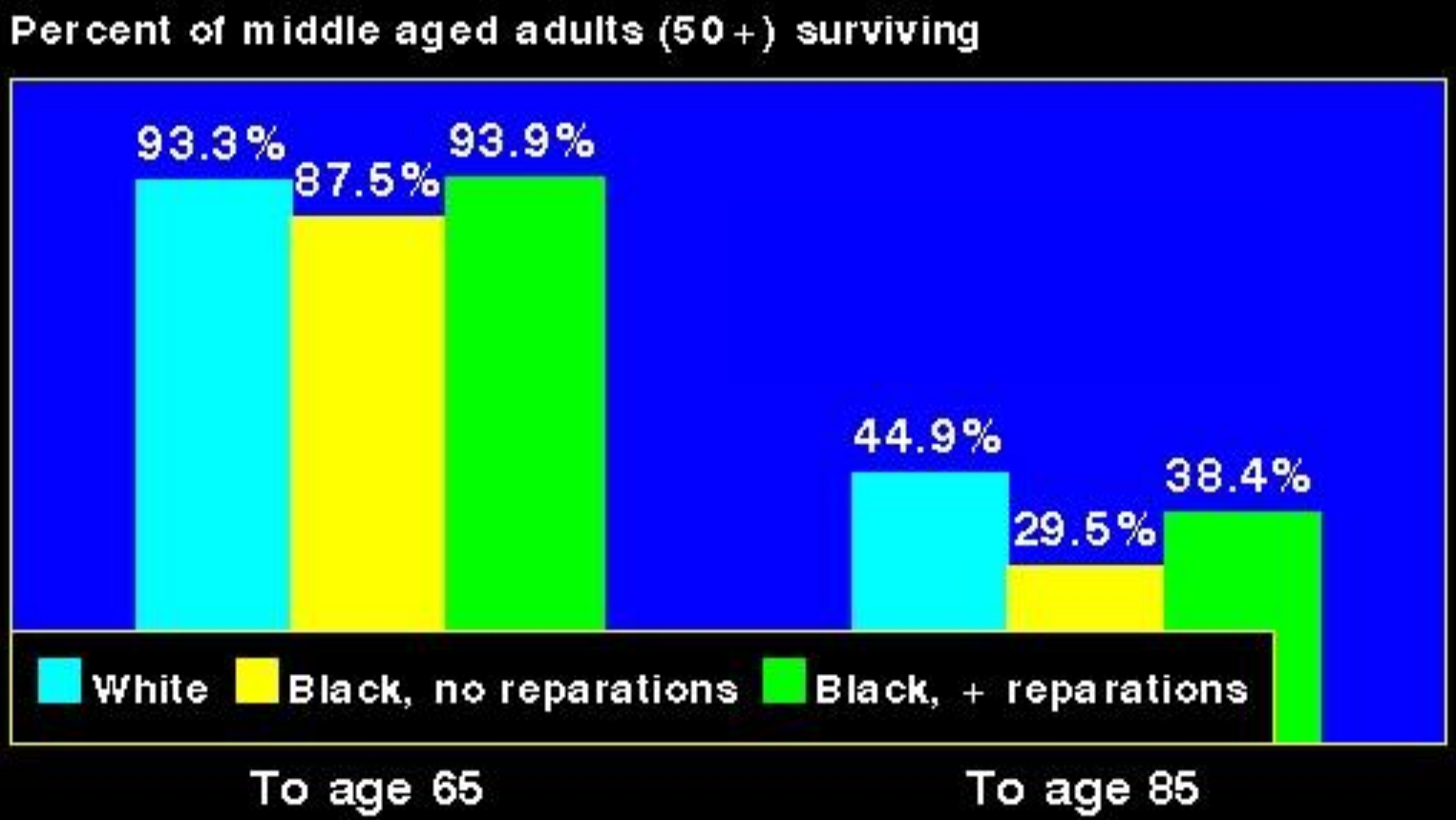


Source: Andrasfay and Goldman Demographic Research 7/27/22 and MedRxiv presprint July 19, 2022
Other G7 nations = Canada, France, Germany, Italy, Japan, UK

Native Americans Die Youngest



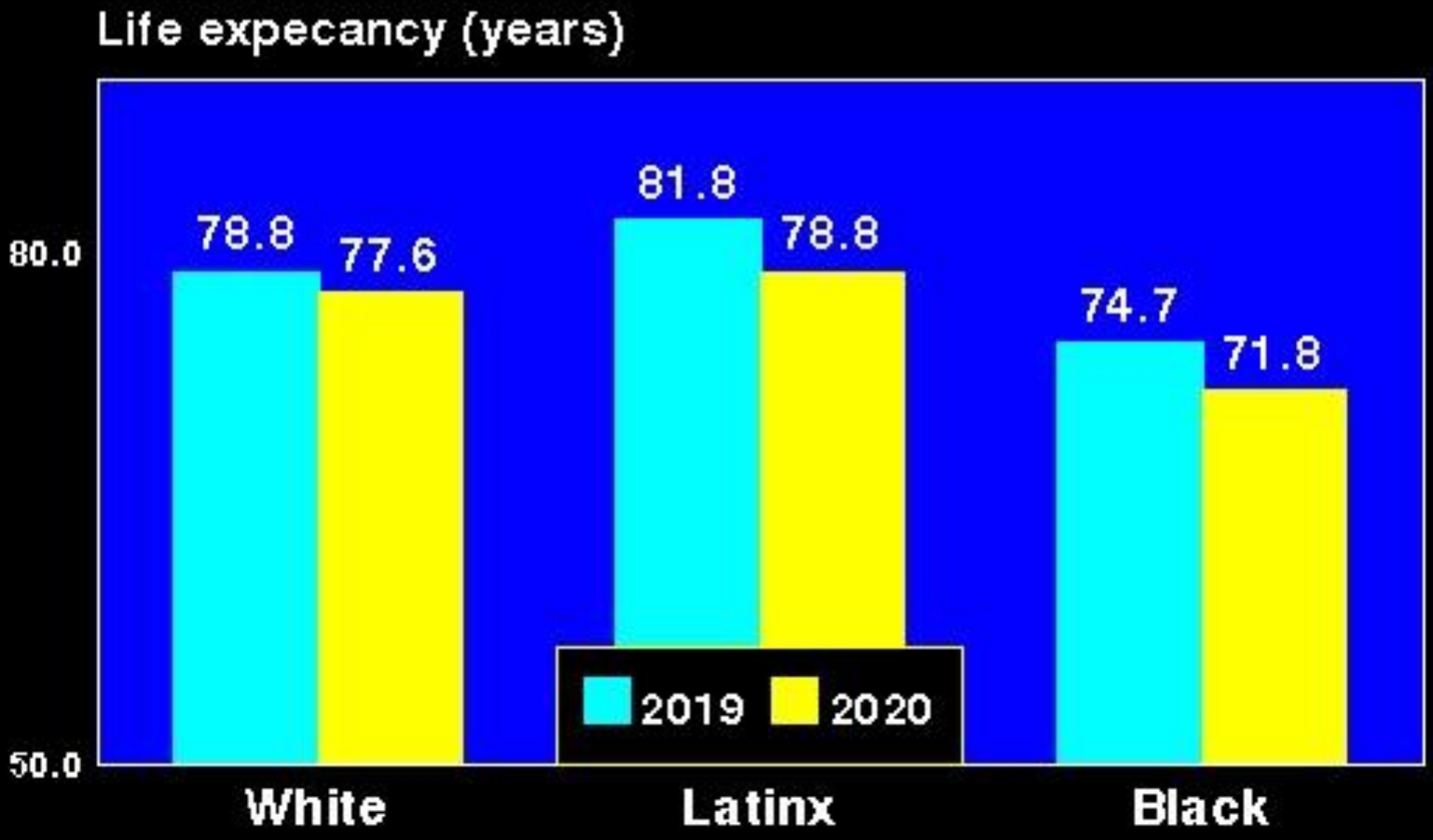
Reparations Payments Could Close the Racial Life Expectancy Gap



Source: K. Himmelstein et al - JAMA Network Open 2022

Survival analysis based on Health & Retirement Study data, with modeling of reparations equal to mean White wealth

COVID-19 Has Sharply Reduced Black and Latinx Life Expectancy

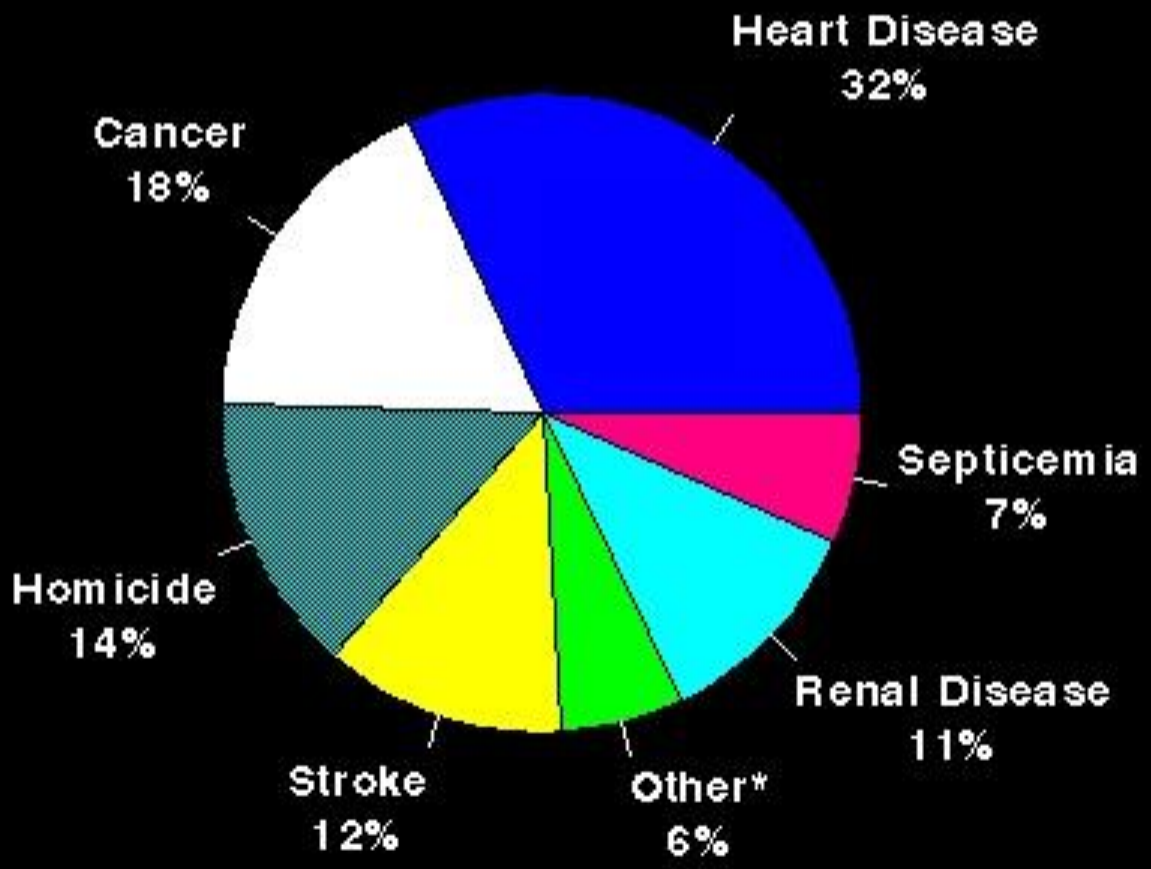


Source: NCHS, 2021

Native Americans' Life Expectancy Plummetted During COVID-19 Pandemic

Source: Goldman and Andrasfay, Demographic Research July 27, 2022

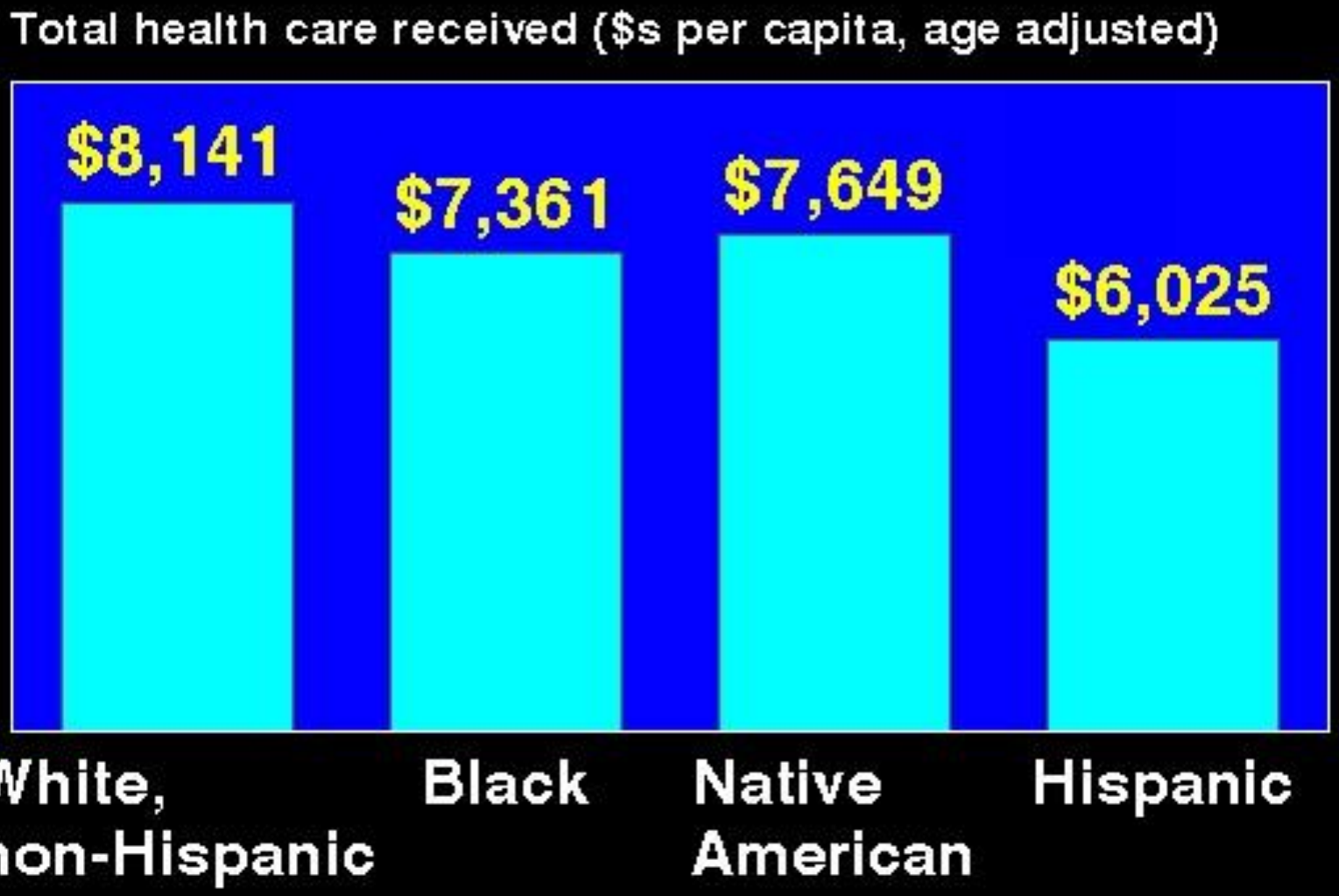
Causes of Black/White Disparity in Adult Mortality



Source: MMWR May 2, 2017

* Includes conditions (e.g. diabetes) for which Black death rates are higher and some (e.g. COPD, cirrhosis) for which Black death rates are lower

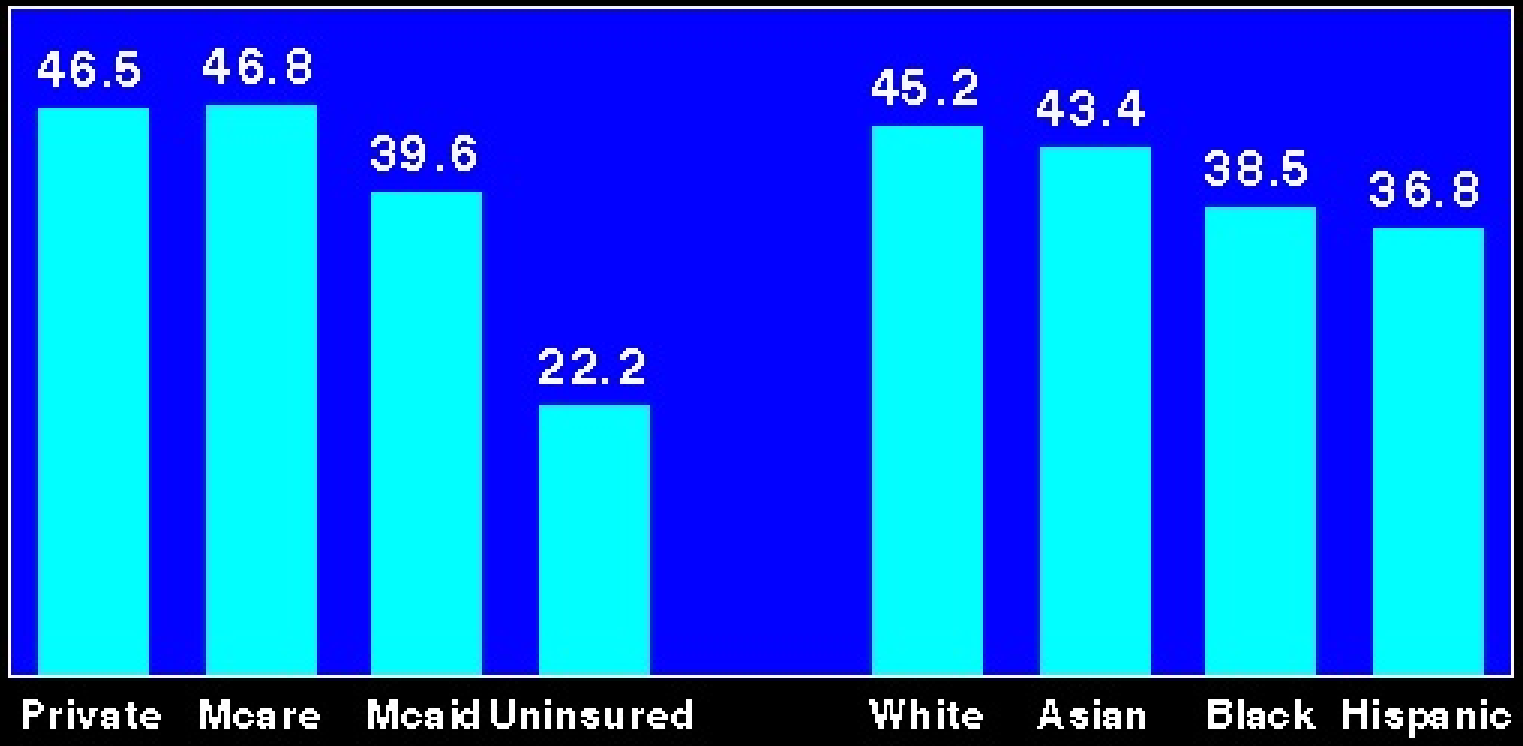
People of Color Get Less Care



Source: JAMA 2021;326:649-59

Uninsured and People of Color Have Worse Blood Pressure Control

Percent of adults with hypertension whose BP was controlled, 2016-2017

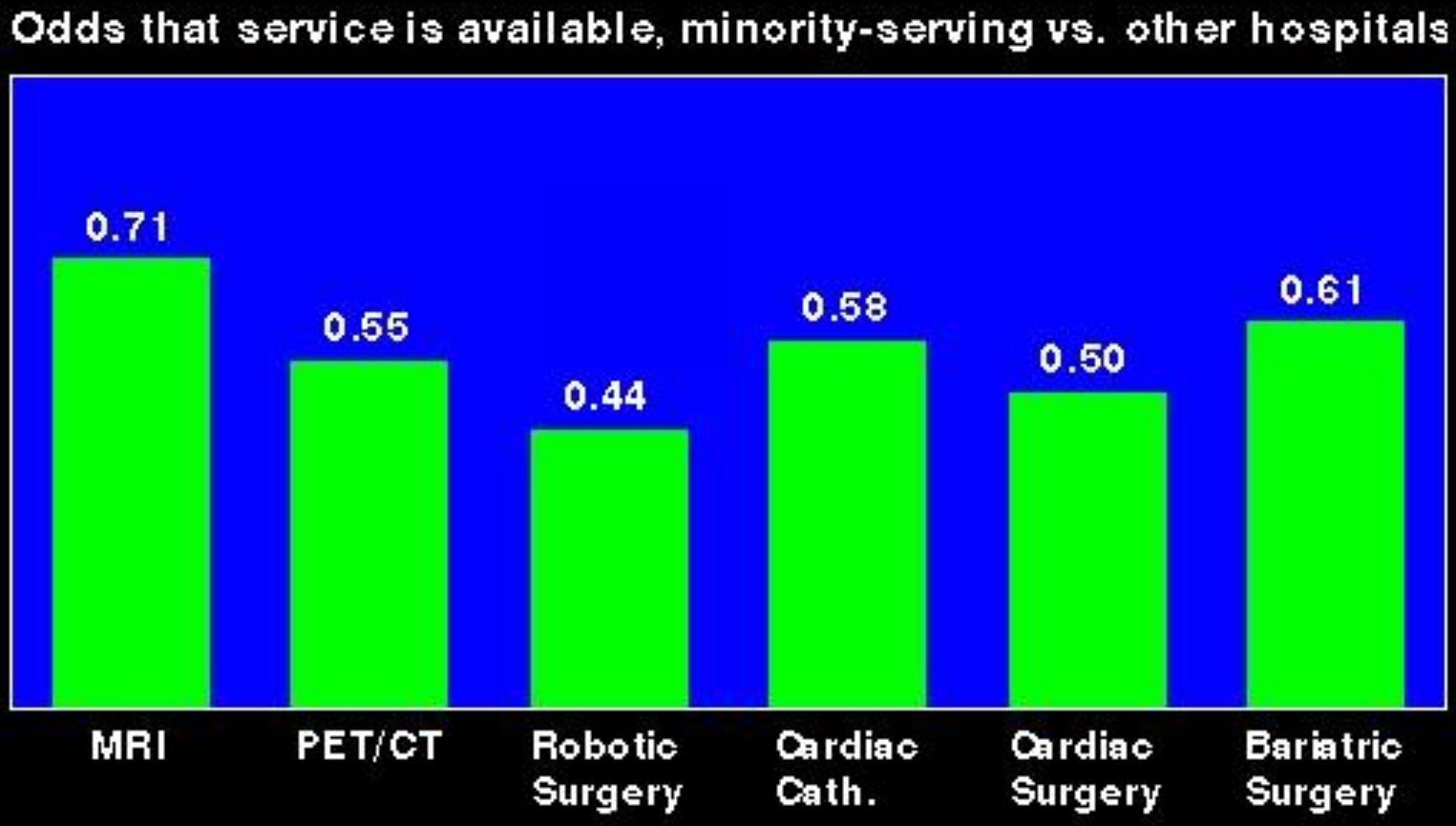


Source: JAMA 2020;324:1190

Black- and Latinx-Serving Hospitals Have Less Funding for Buildings and Equipment

Source: Gracie and Kathryn Himmelstein, Int J Health Services 2020
Black- and Latinx-serving = 10% of US hospitals with highest percent of Black/Latinx pts.

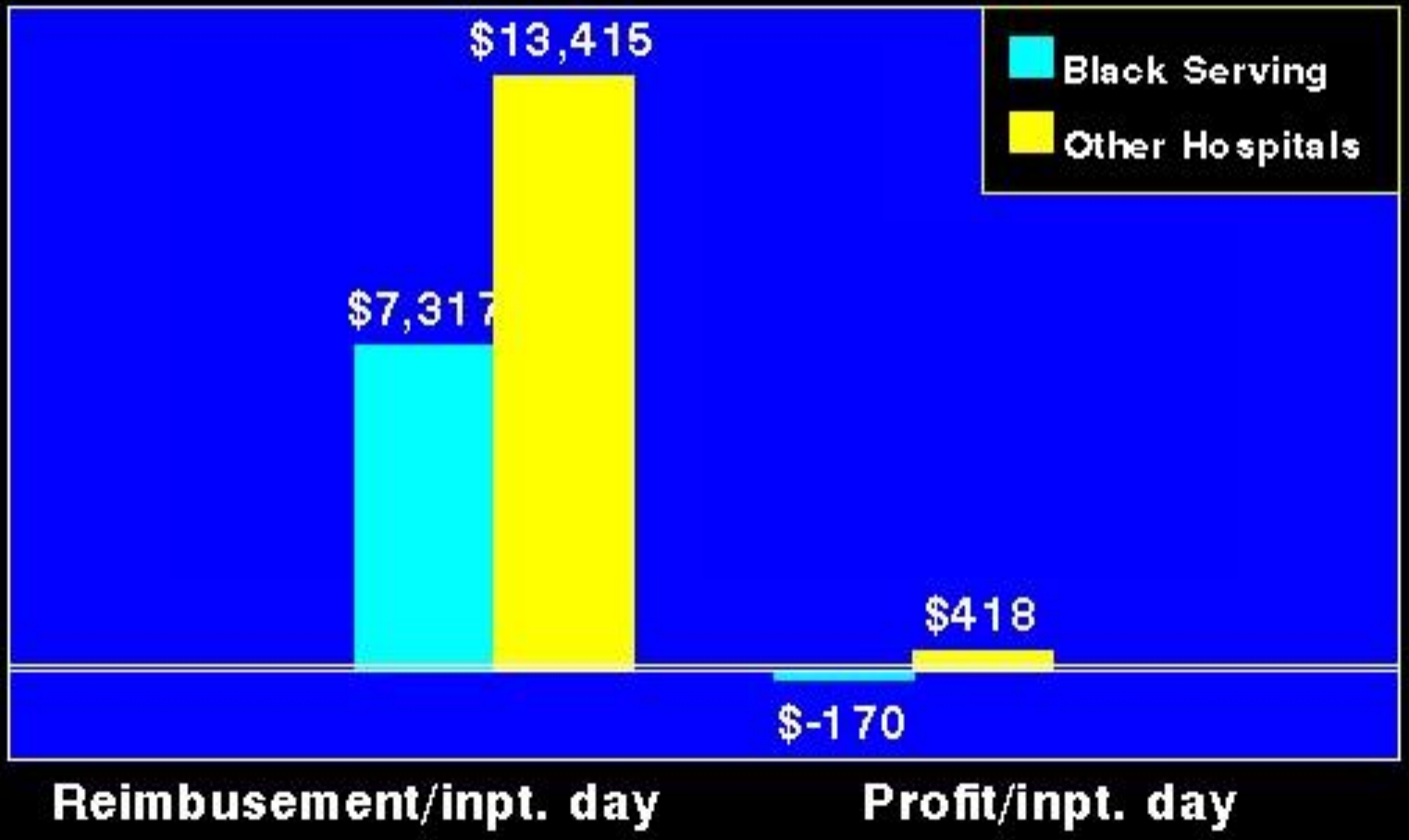
Black- and Latinx-Serving Hospitals Offer Fewer High Tech Services



Source: Gracie and Kathryn Himmelstein, Int J Health Services 2020
Black- and Latinx-serving = 10% of US hospitals with highest percent of Black/Latinx pts.
Odds ratios are adjusted for size, location, teaching status and ownership

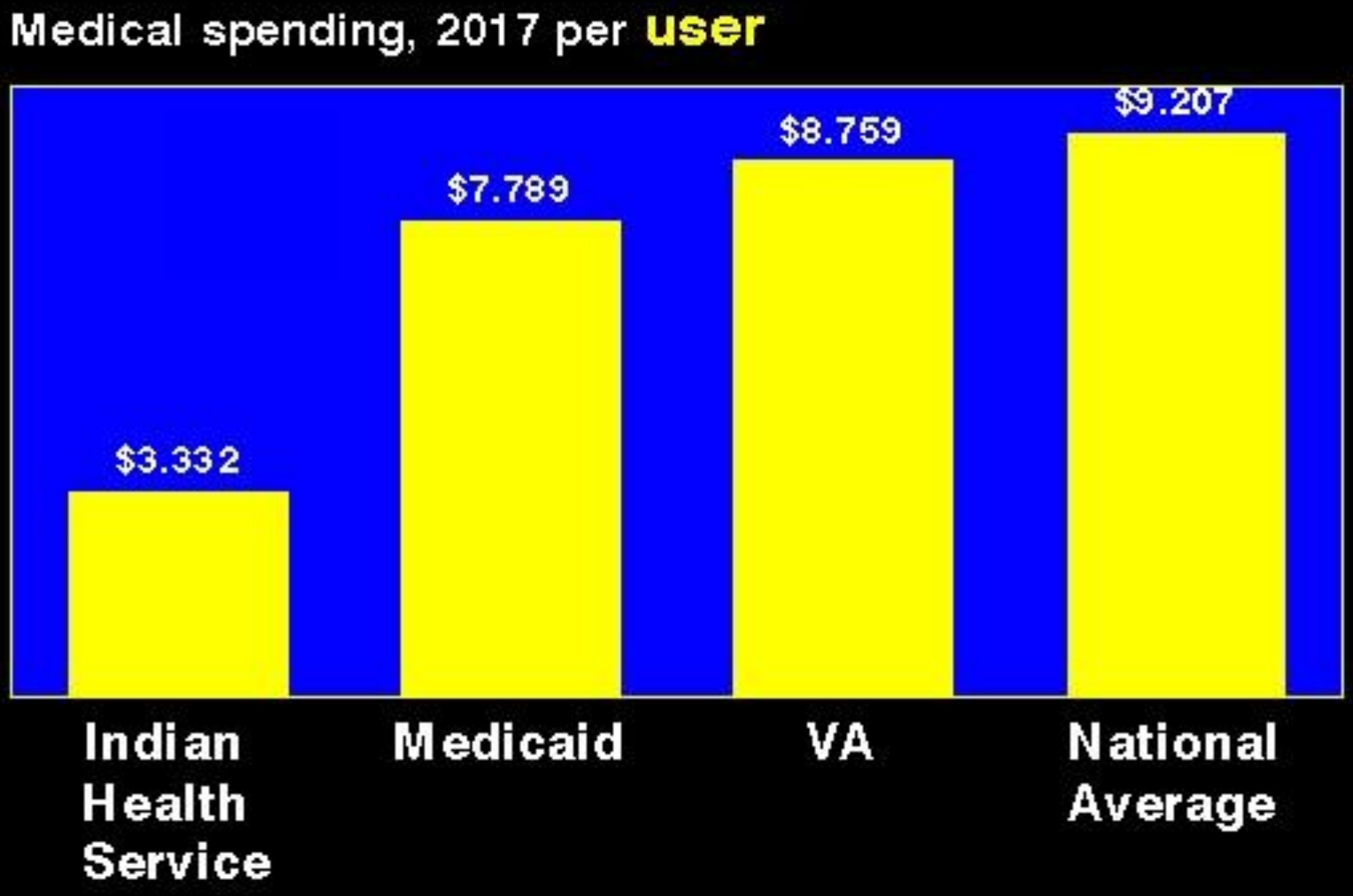
Black Serving Hospitals Get Paid Less

Structural Racism in Hospital Financing



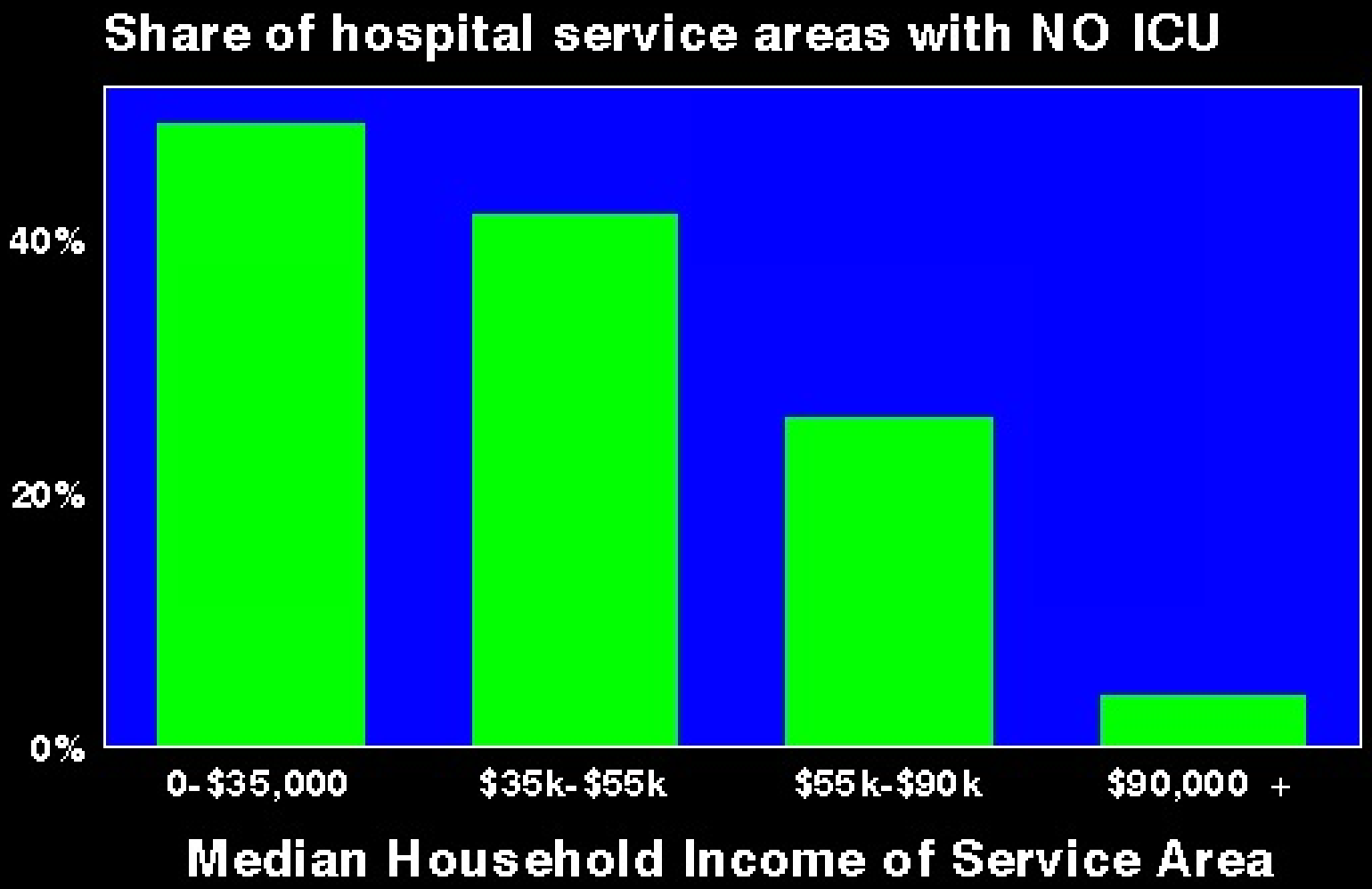
Source: Gracie & Kayty Himmelstein and Joniqua Ceasar - submitted for publication
Note: "Black Serving" = 10% of hospitals with largest proportion of Black patients (i.e. >25.8%)
Note: Data are means, 2016-2018

Indian Health Service, Grossly Underfunded



Source: National Tribal Budget Formulation Workgroup, April, 2018
Note: Estimated spending shortfall, including facility upgrades = $36.83 billion

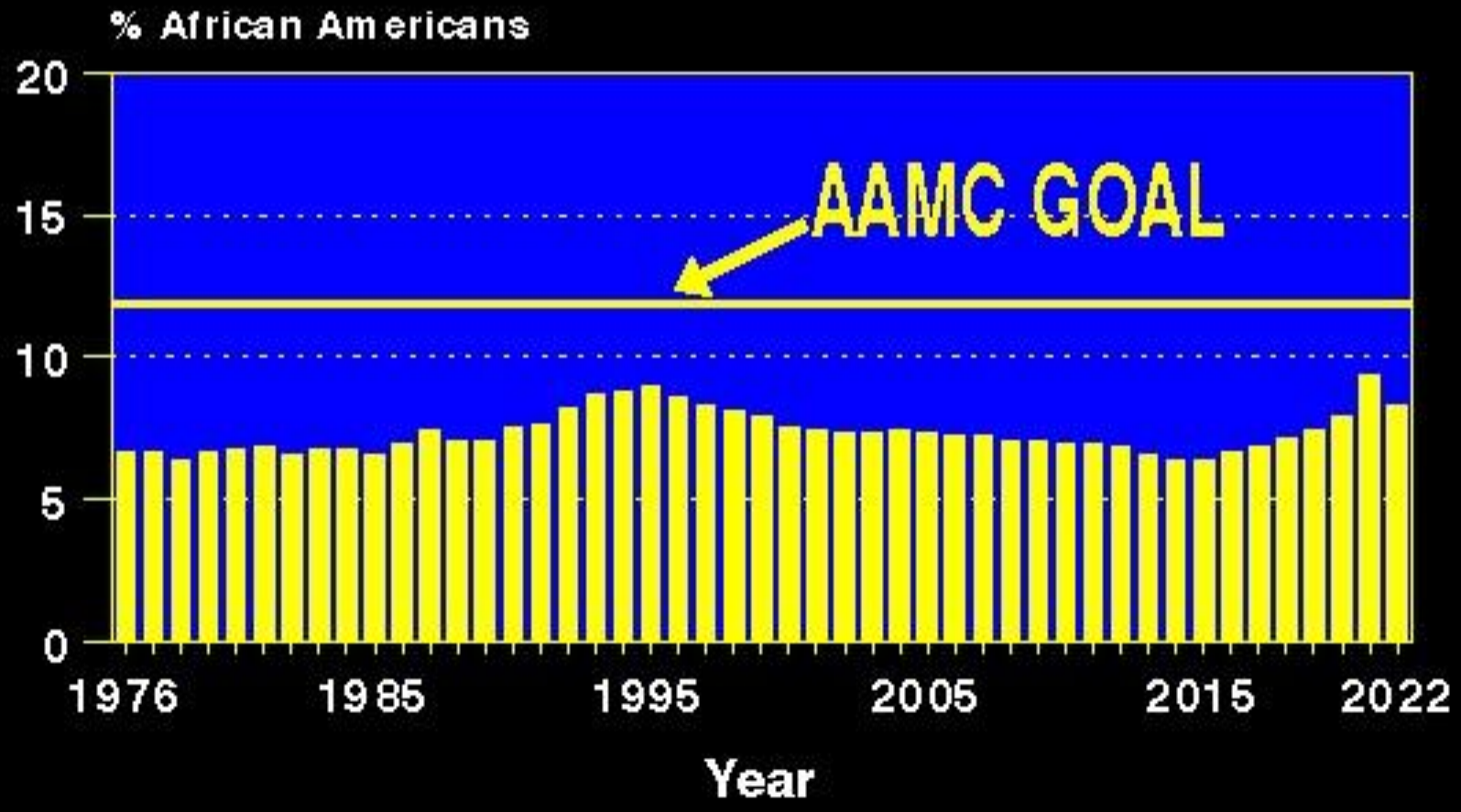
Poorer Regions, Fewer ICU Beds



Source: Health Aff 2020;39:1362

Note: A $10,000 increase in median income was associated with a 11.8% increase in ICU beds

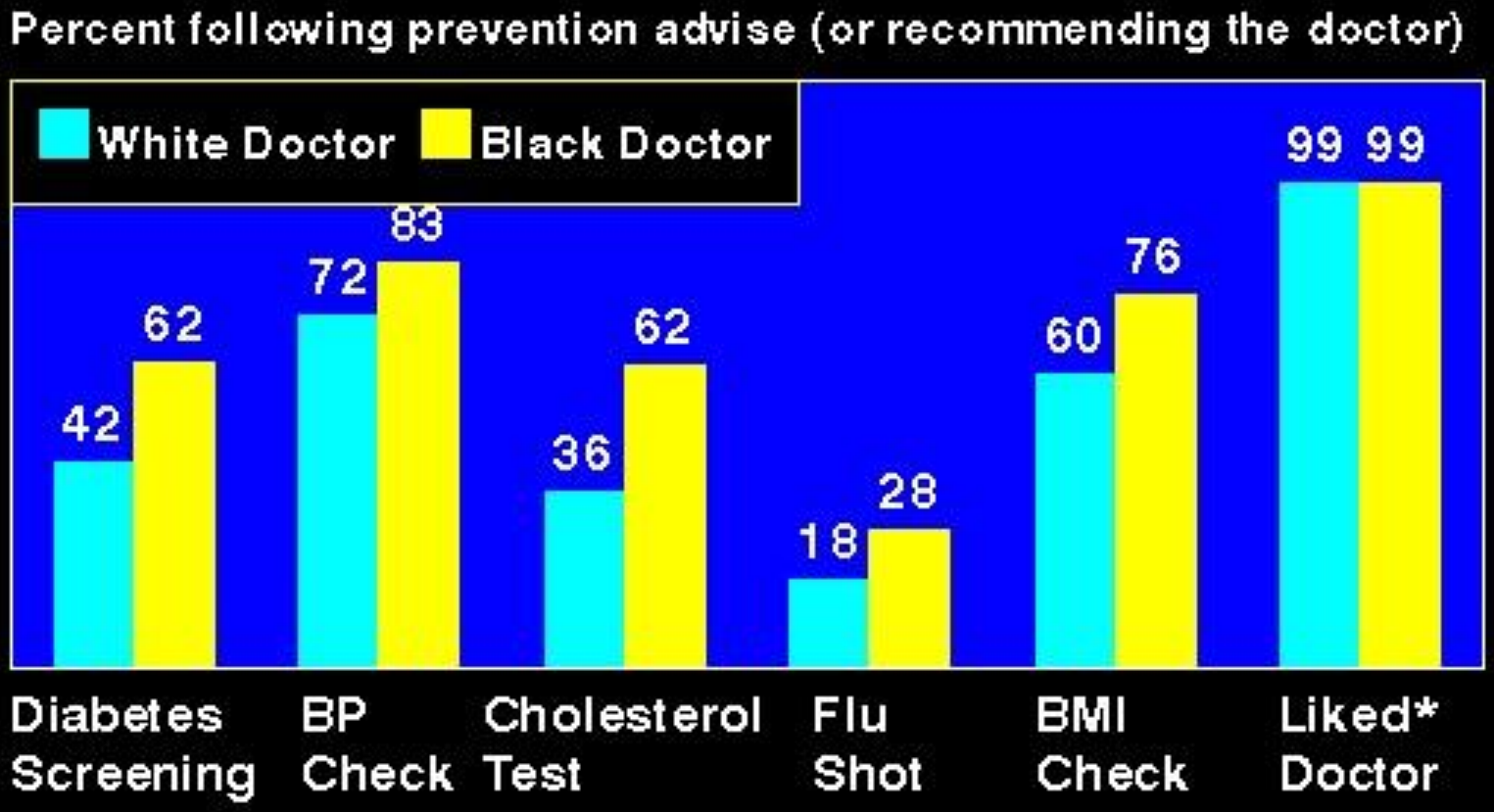
Black Enrollment in U.S. Medical Schools, 1976-2022/23



Source: RWJ Fdn. 1987; AAMC; & JAMA Annual Medical Education Special Issue

Black Men More Often Followed a Black Doctor's Advise: An RCT

Even Though They Gave Black and White Doctors Same Ratings

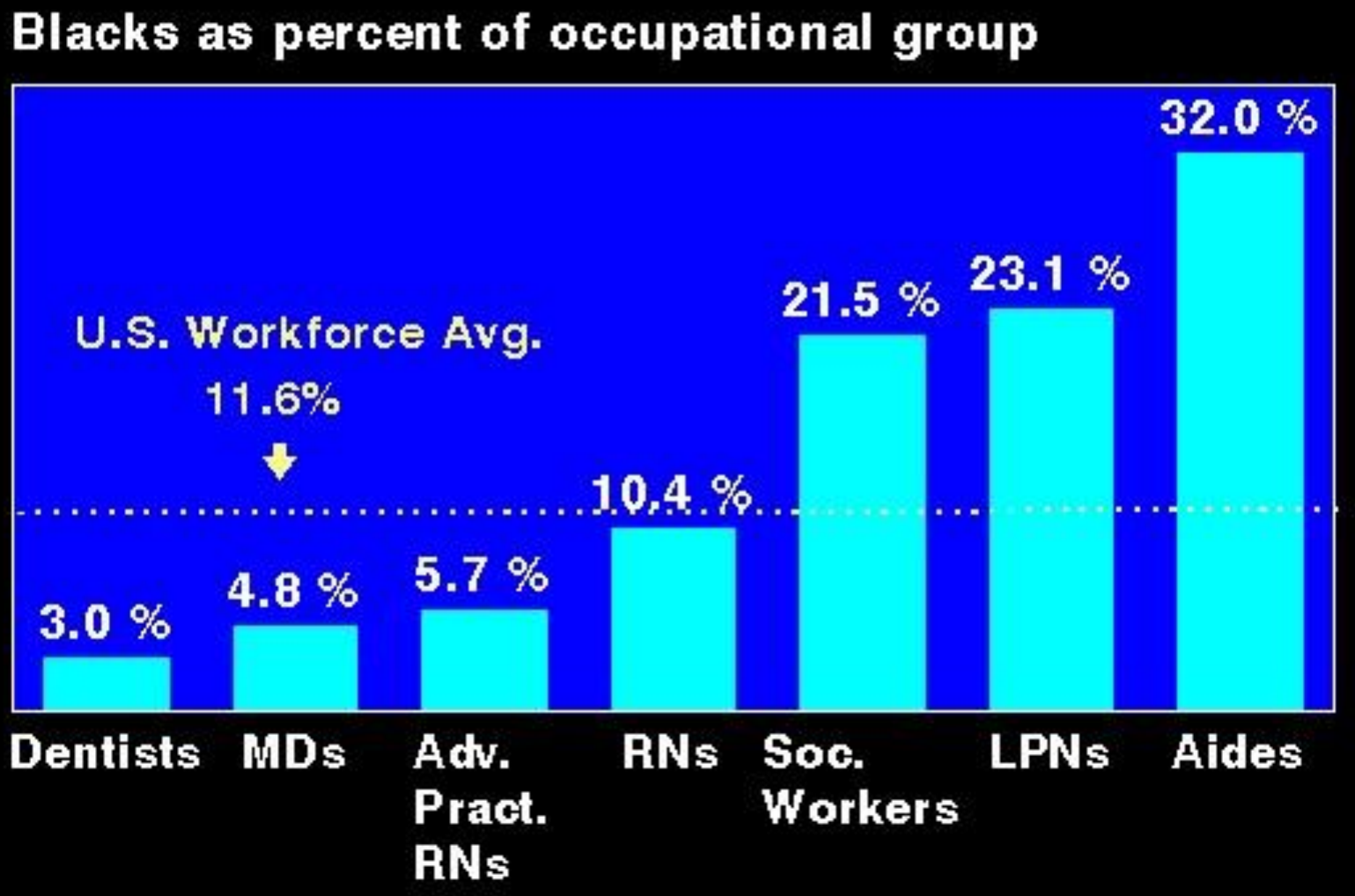


Source: American Economic Rev 2019;109:4071

Authors estimate that universal availability of Black doctors could cut B:W CV mortality gap by 19%

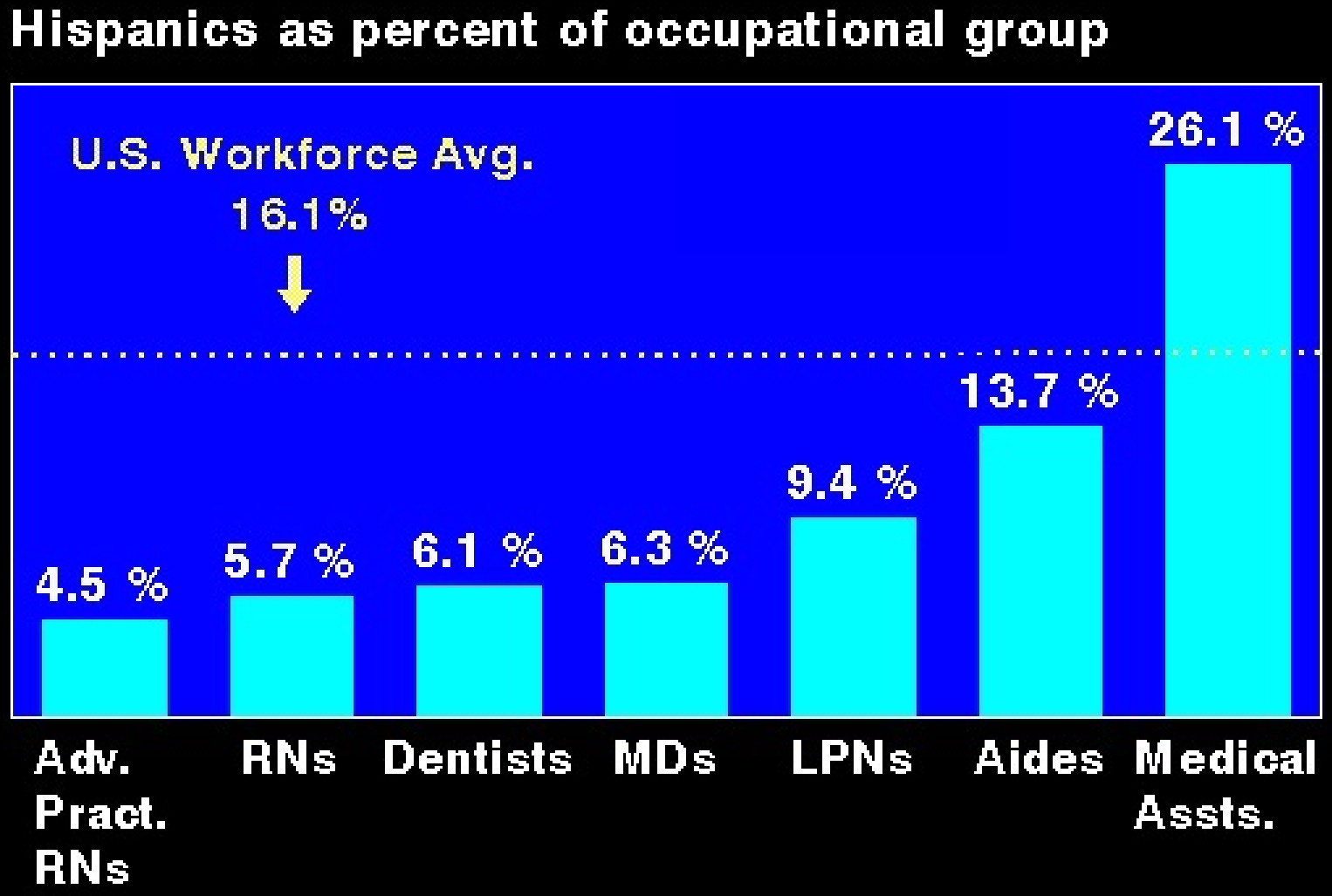
* Liked = would recommend doctor to others

Blacks in Health Occupations



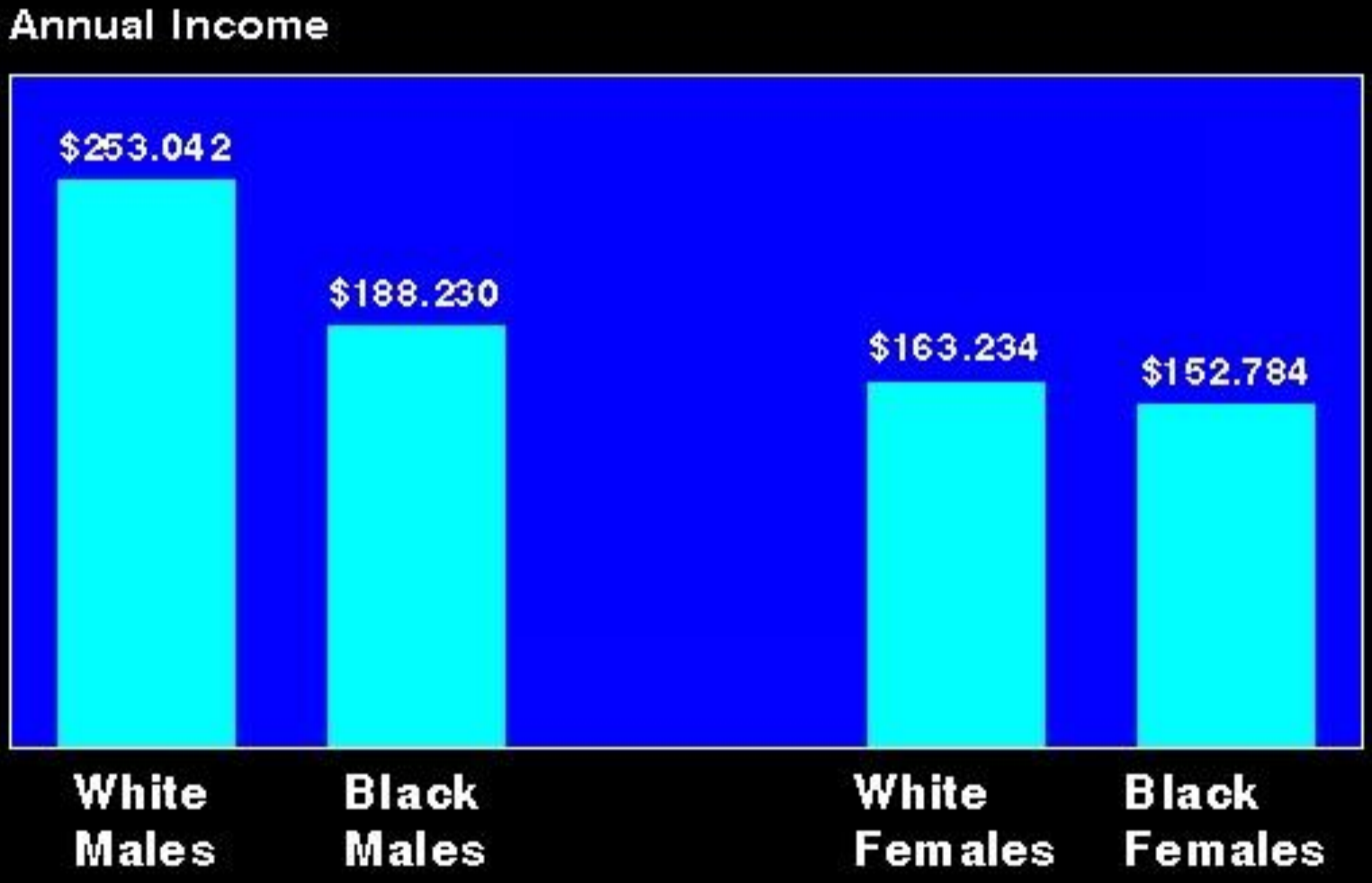
Source: HRSA based on data from American Community Survey 2011-2015

Hispanics in Health Occupations



Source: HRSA based on data from American Community Survey 2011-2015

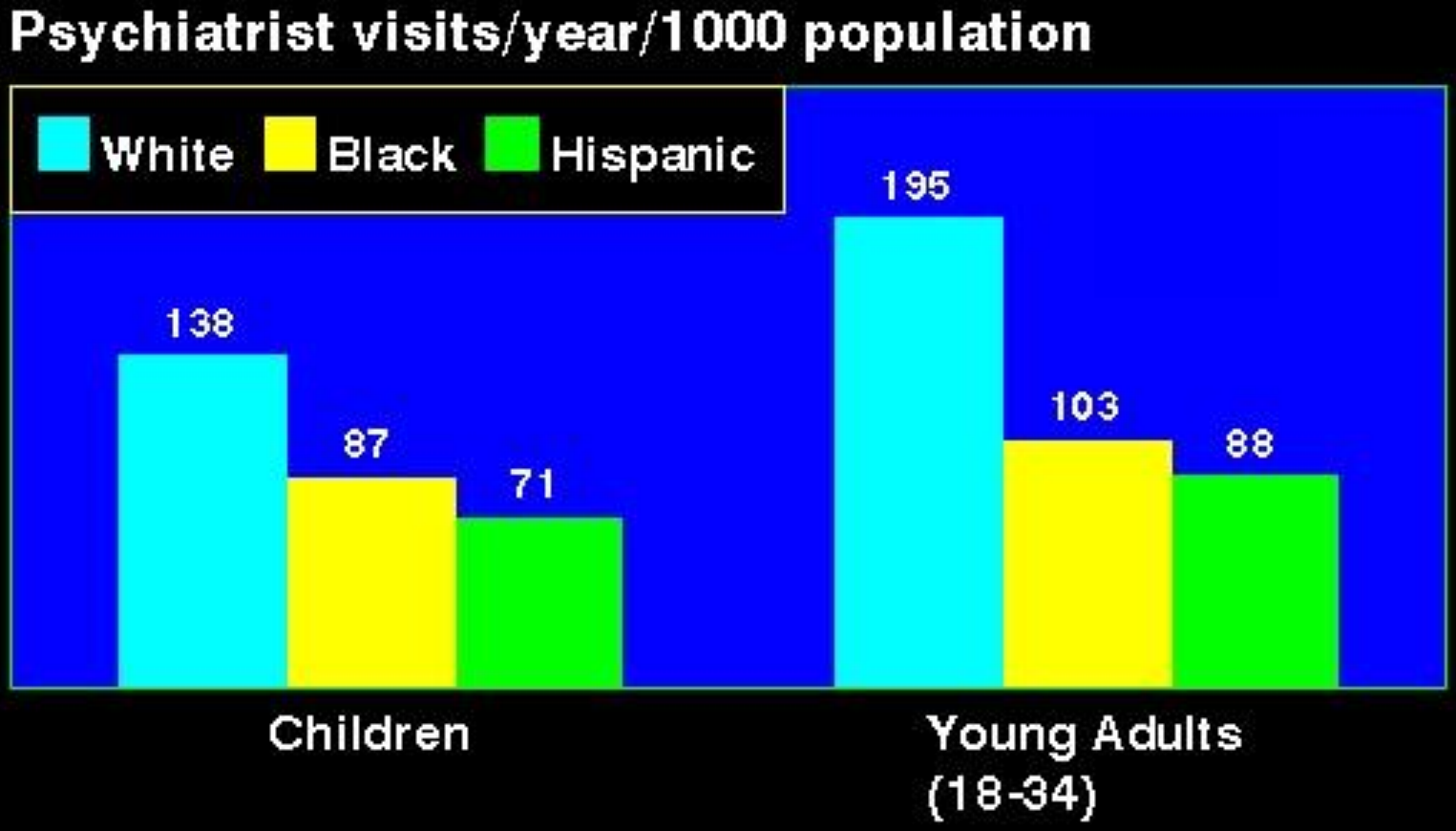
Black and Female Physicians Earn Less



Source: Ly et al. BMJ 2016;353:2923

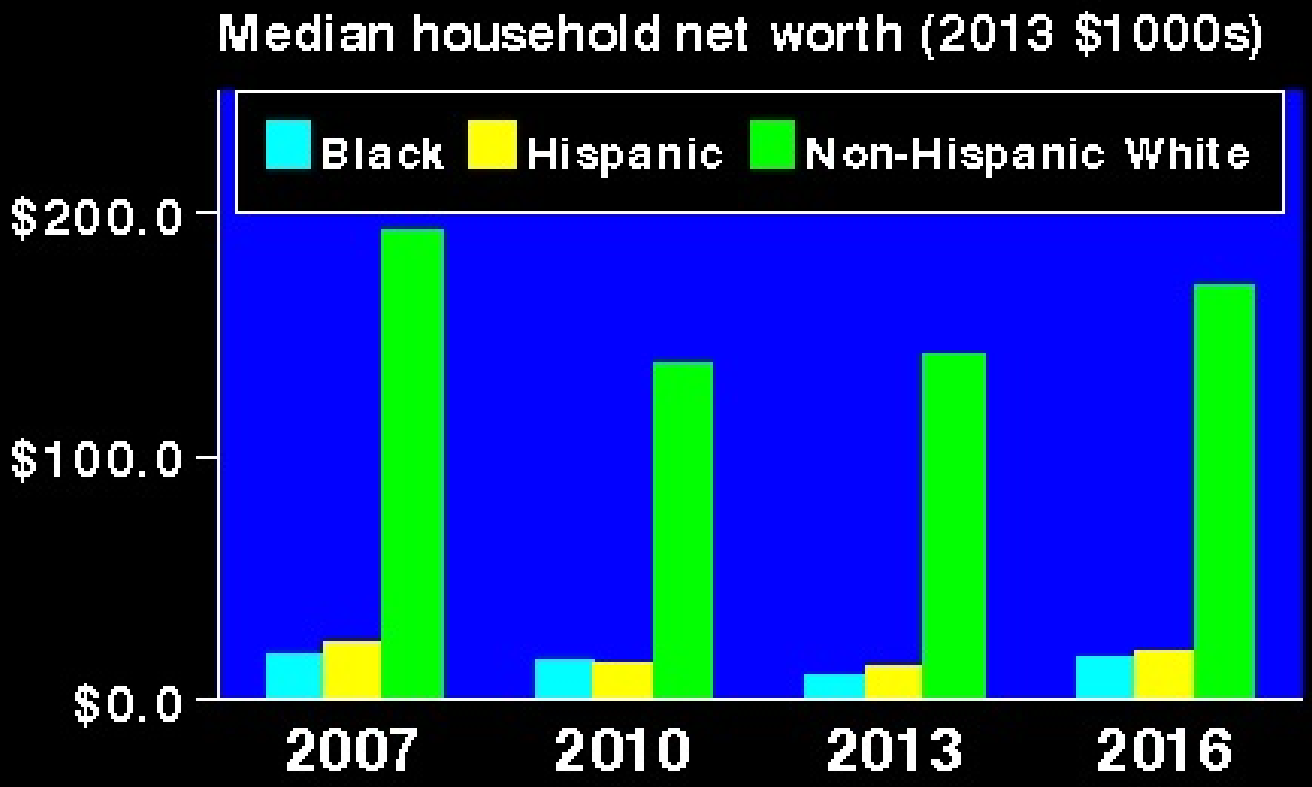
Note: Figures are adjusted for hours worked, specialty, age, years in practice, practice type, % of revenue from Medicare/Medicaid

Minority Children & Youth Get Few Psychiatrist Visits



Source: Marrast, Himelstein & Woolhandler - Int J Hlth Serv 2016

Growing Wealth Gap for Minorities

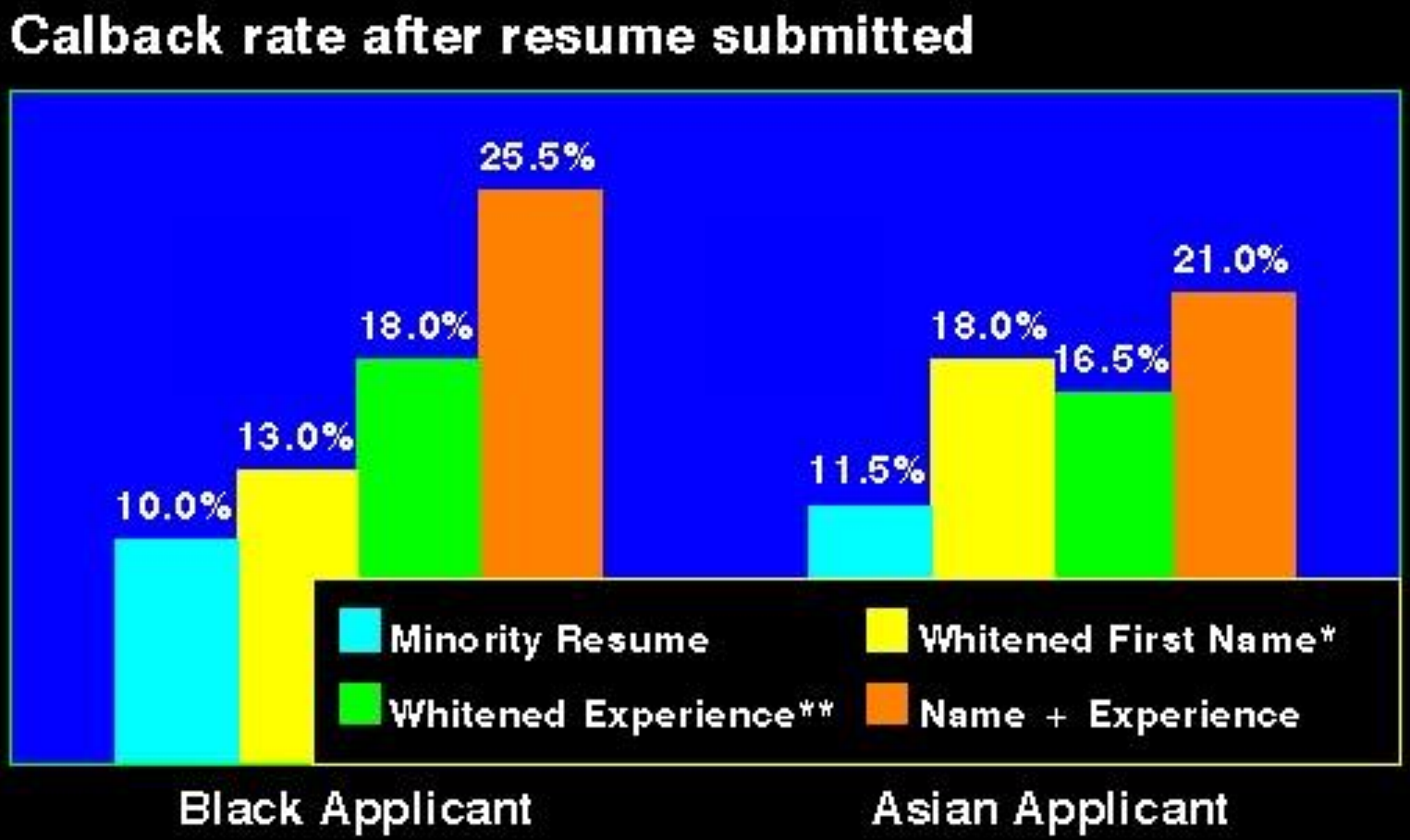


	2007	2010	2013	2016
Black	$19.2	$16.6	$11.0	$17.6
Hispanic	$23.6	$16.0	$13.7	$20.7
Non-Hispanic White	$192.5	$138.6	$141.9	$171.0

Source: Kochhar - Pew Research Center, 12/12/14 - Based on Federal Reserve Data

Job Discrimination Persists

Experimental Study of the Impact of "Whitening" Resumes



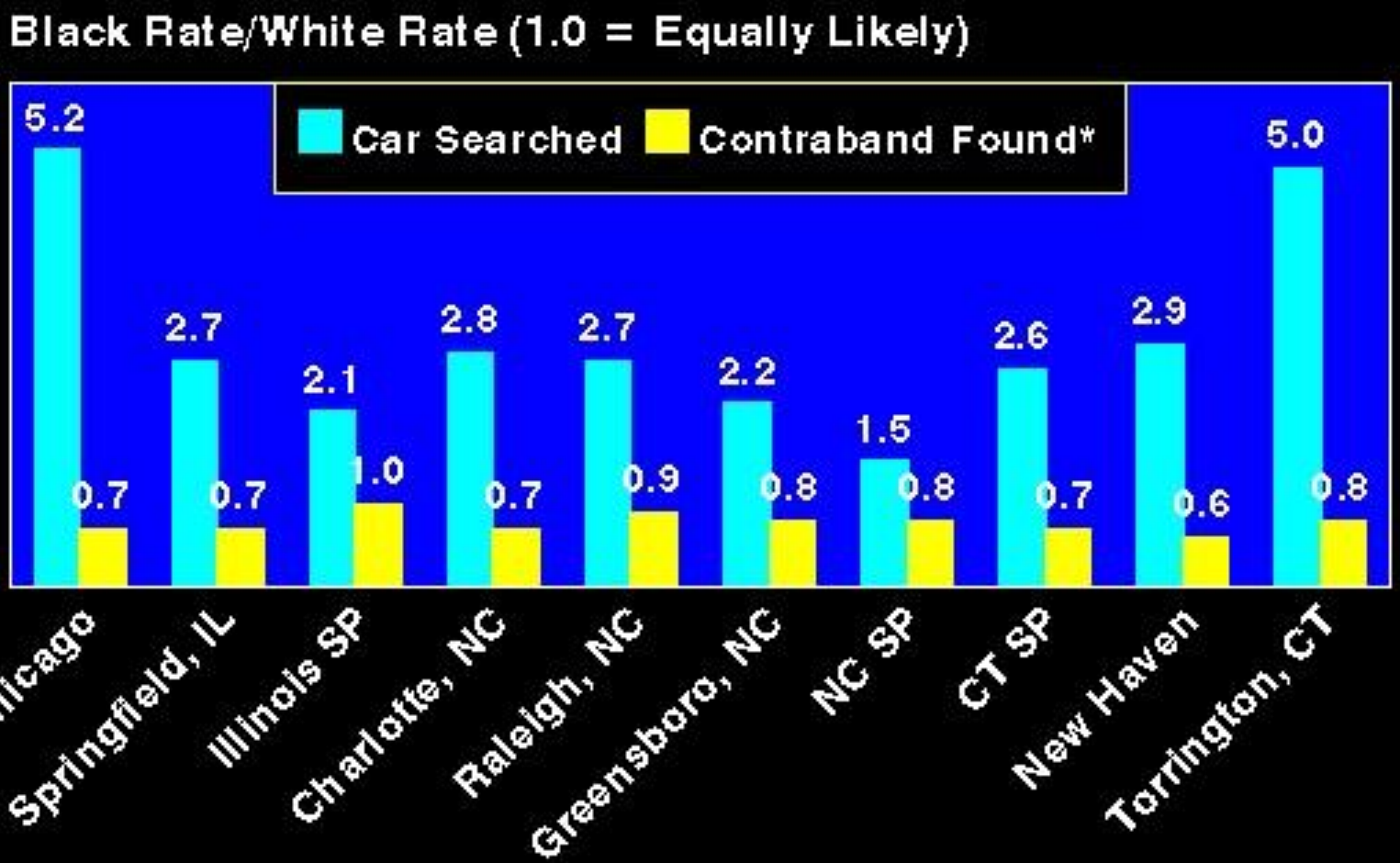
Source: Kang SK, et al. Admin Sci Q, 2016 - Job ads with pro-diversity language yielded same result

* e.g. change "Lamar J. Smith" to "L. James Smith" or "Lei Zhang" to "Luke Zhang"

** e.g. change "Aspiring Asian Business Leaders" to "Aspring Business Leaders"

Driving While Black

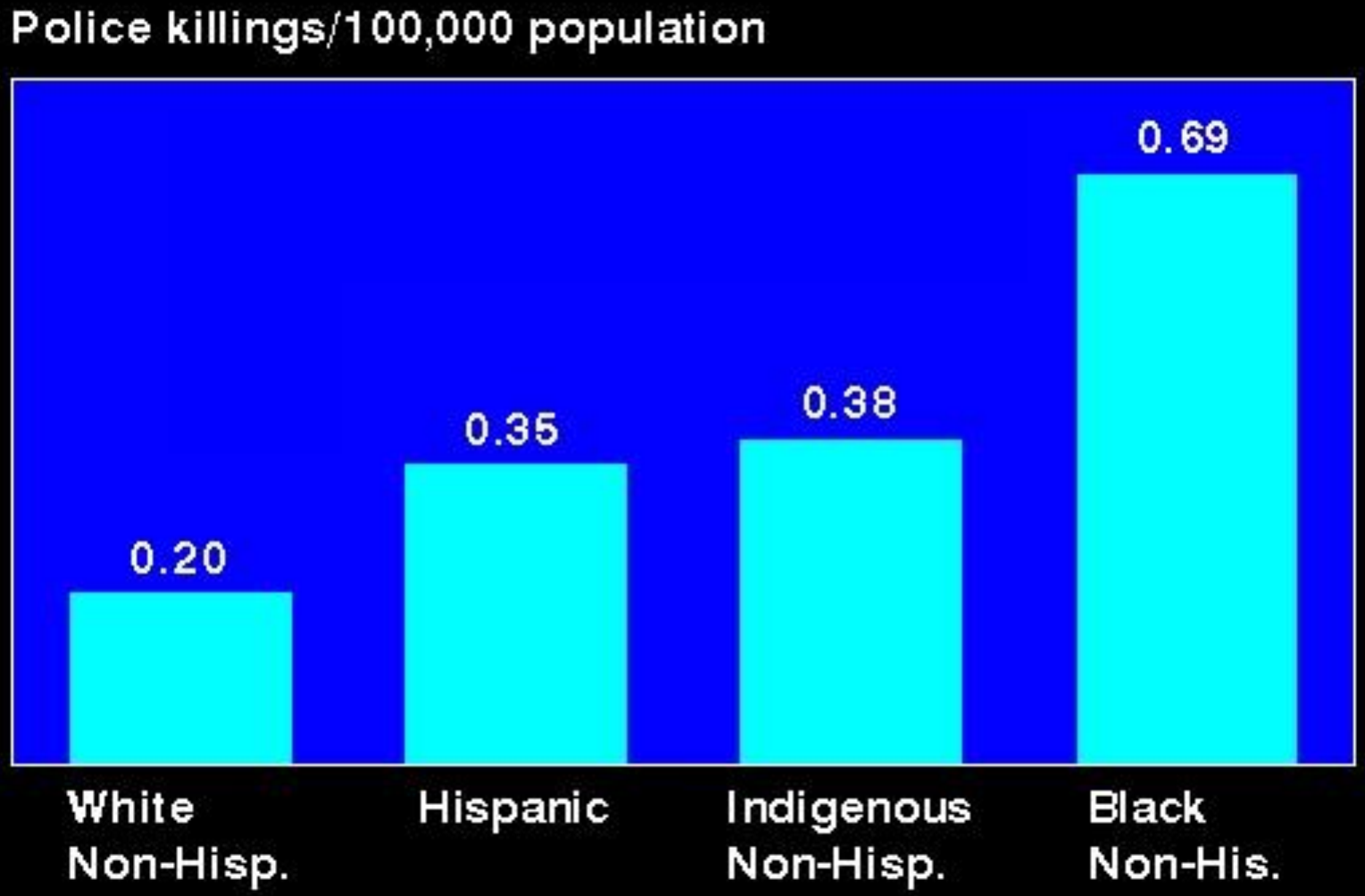
More Likely to Be Searched, Lsss Likely to be Found With Contraband



Source: NY Times 10/25/15

* Contraband found among those searched

Police Killings Target People of Color

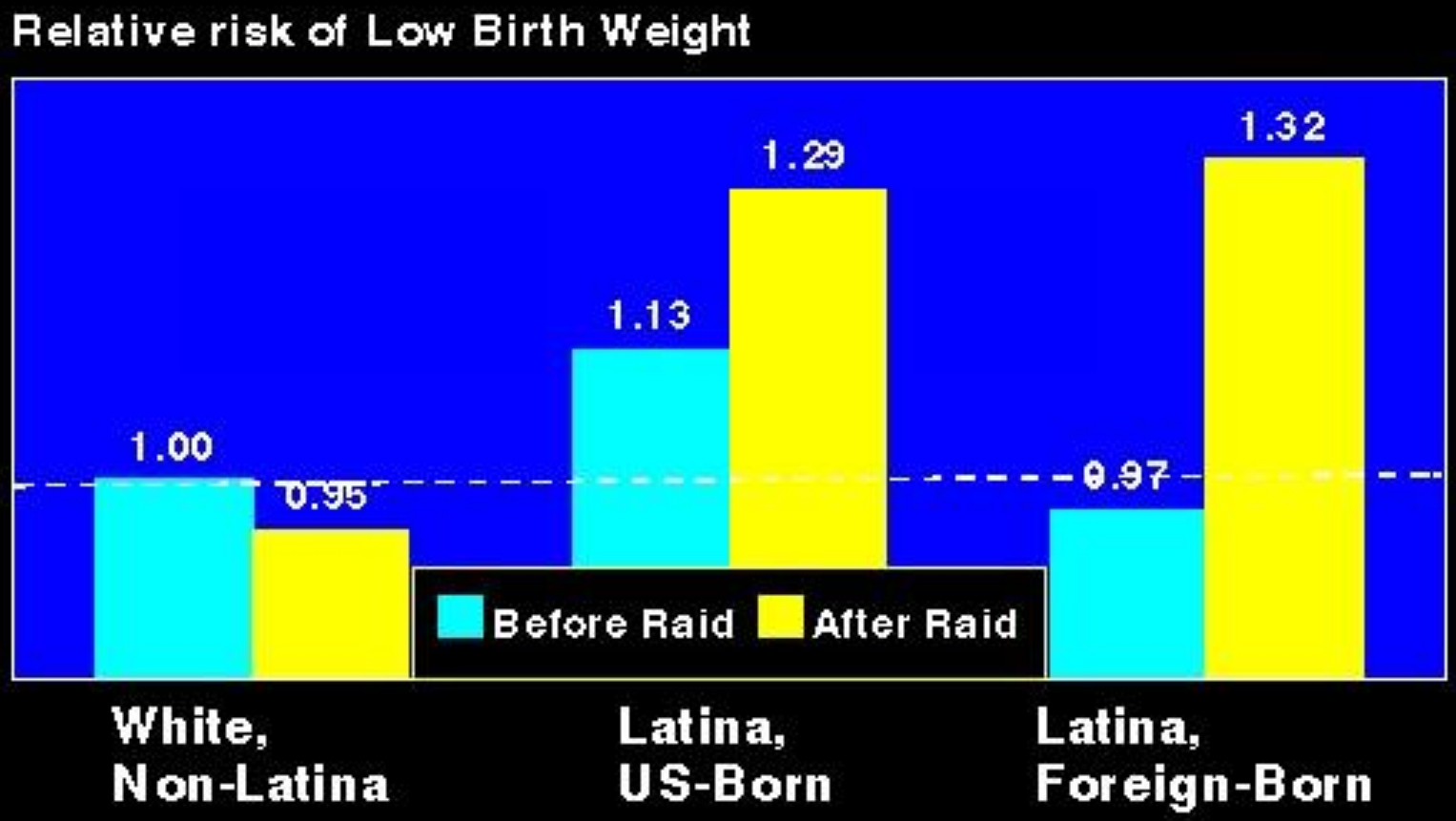


Source: Lancet 2021;398:1239

Note: The rate of police killings rose 38.4% between the 1980s and 2010s

Protecting Immigrants' Right to Health Care

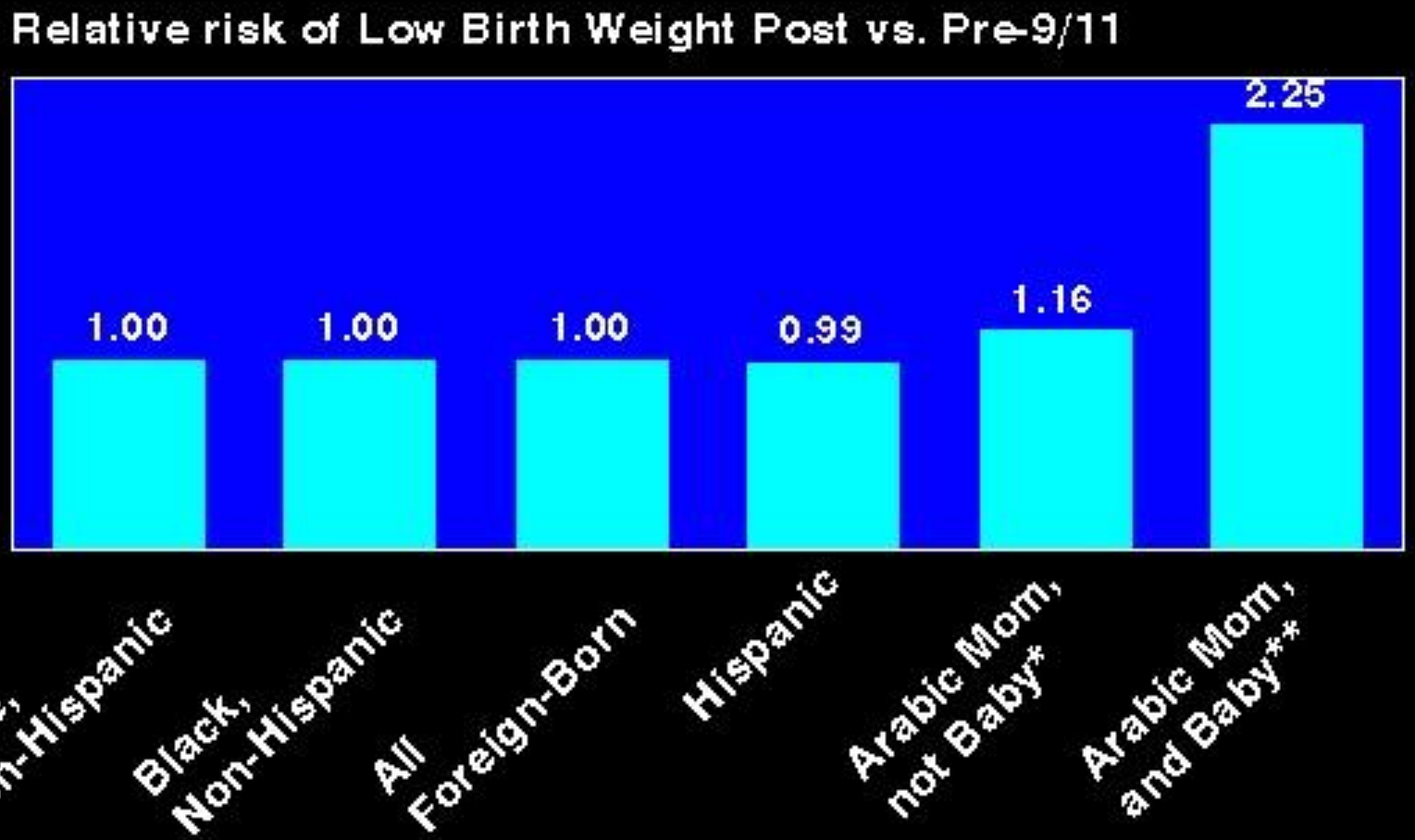
Low Birth Weight Increased In Iowa After A Massive Immigration Raid



Source: Int J Epidemiol 2017;839

Note: 2008 Postville, Iowa raid was largest single-site immigration raid in history. 900 agents handcuffed and chained all Latinos at meatpacking plant

Low Birth Weight Rose Among Arabic-Named Women in California After 9/11



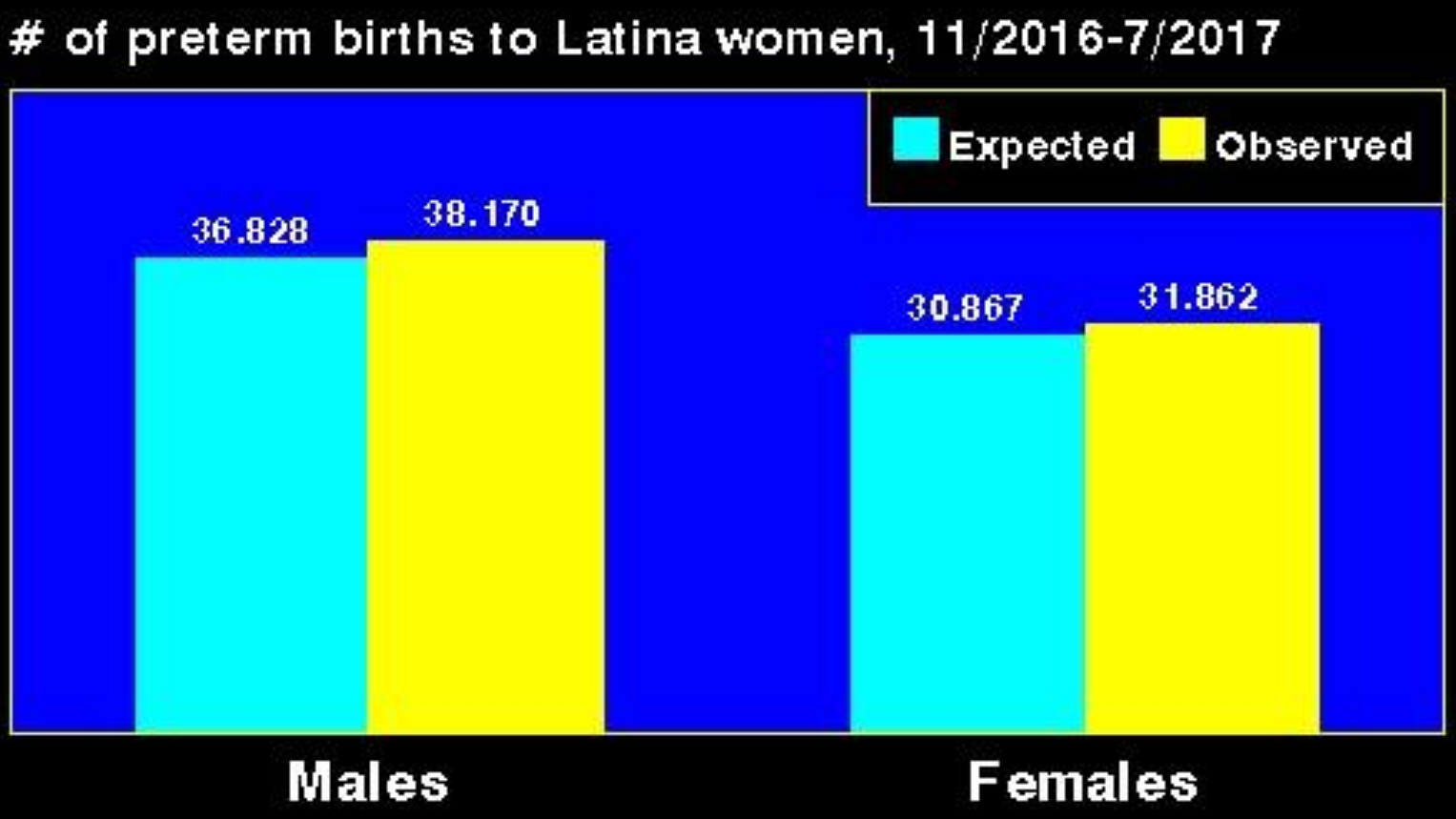
Source: Demography 2006;43:185

* Mother's name Arabic, infant's name not ethnically distinctive

** Mother's name Arabic, infant's name ethnically distinctive

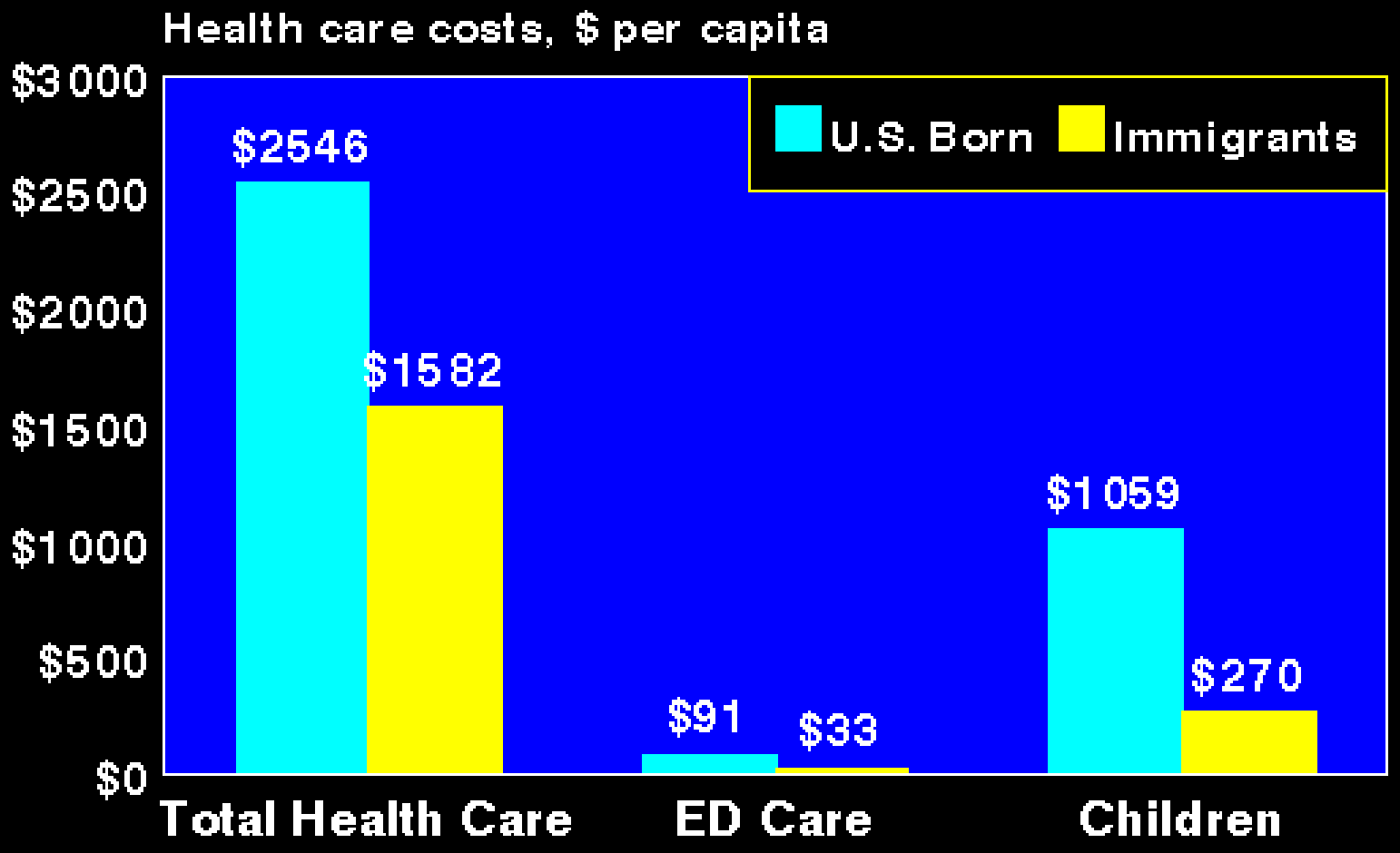
Preterm Latinx Births Increased After Trump's Election

2337 Excess Preterm Births During 9 Months Post-Election



Source: Gemmill et al, JAMA Network Open July 19, 2019
Note: Expected number calculated based on trends, 2009-October, 2016

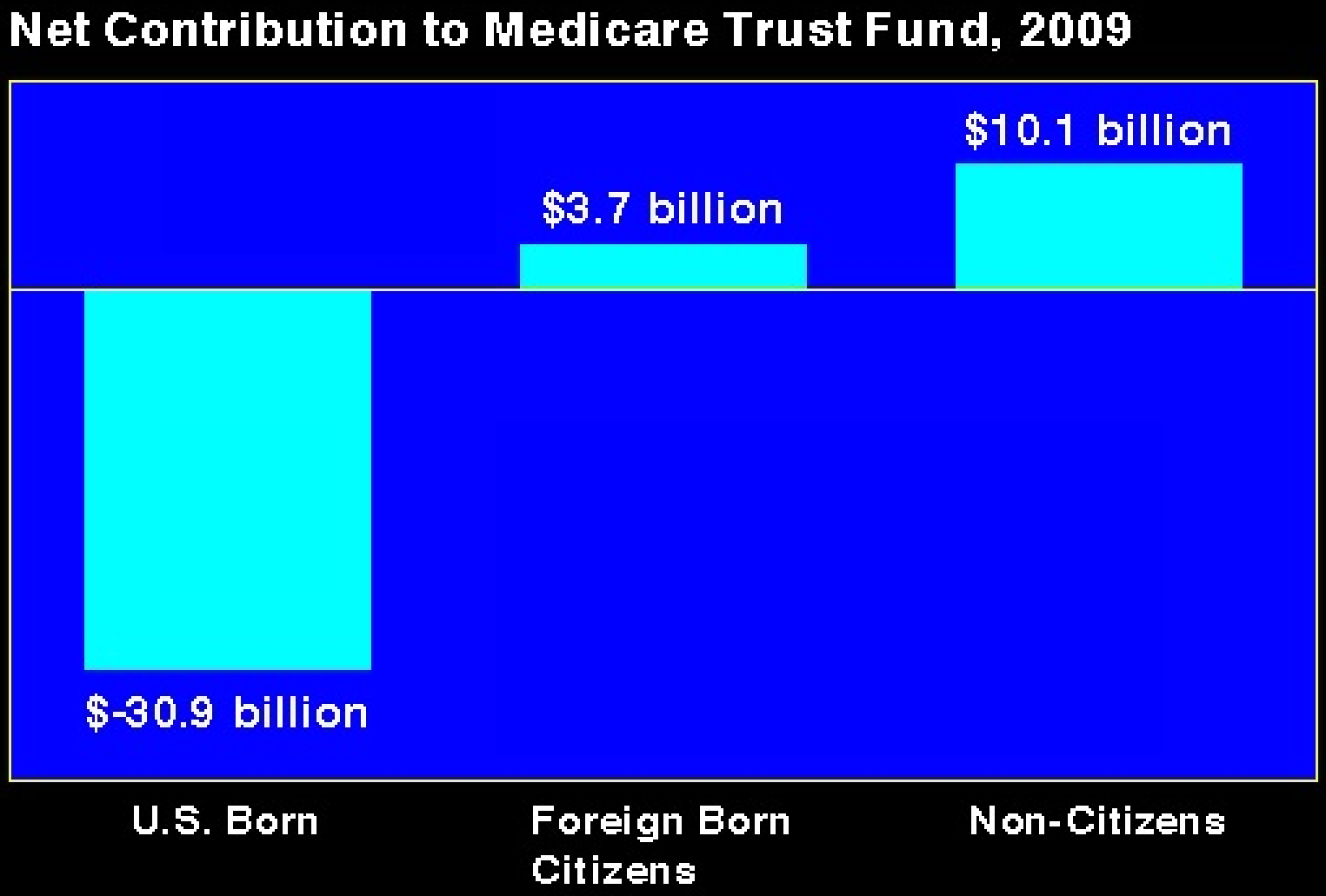
Immigrants Get Little Care



Source: Mohanty et al Am J Public Health 2005;95:1431

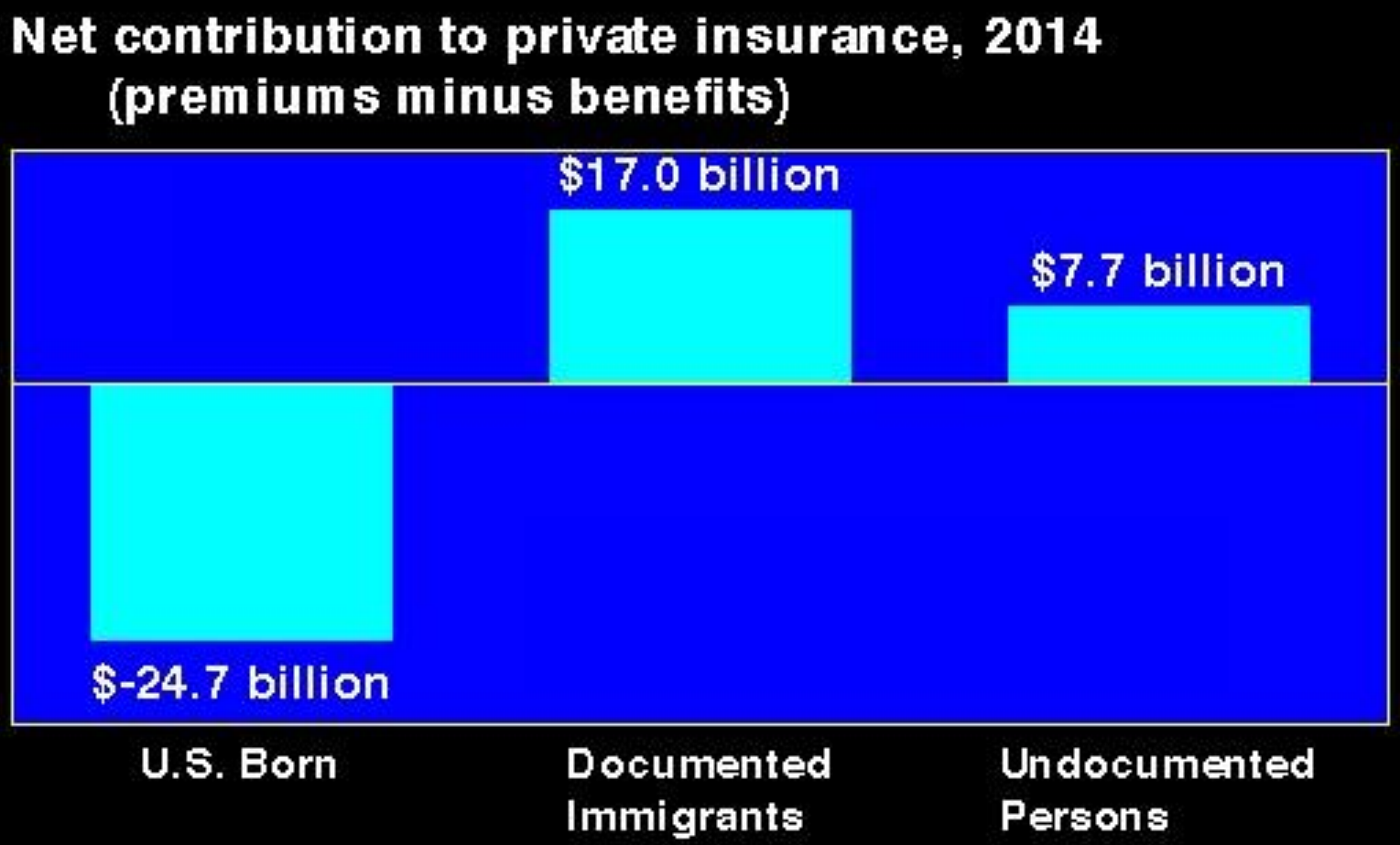
* Adjusted for ethnicity, poverty, age, insurance status, patient/parent-reported health status

Immigrants Keep Medicare Afloat



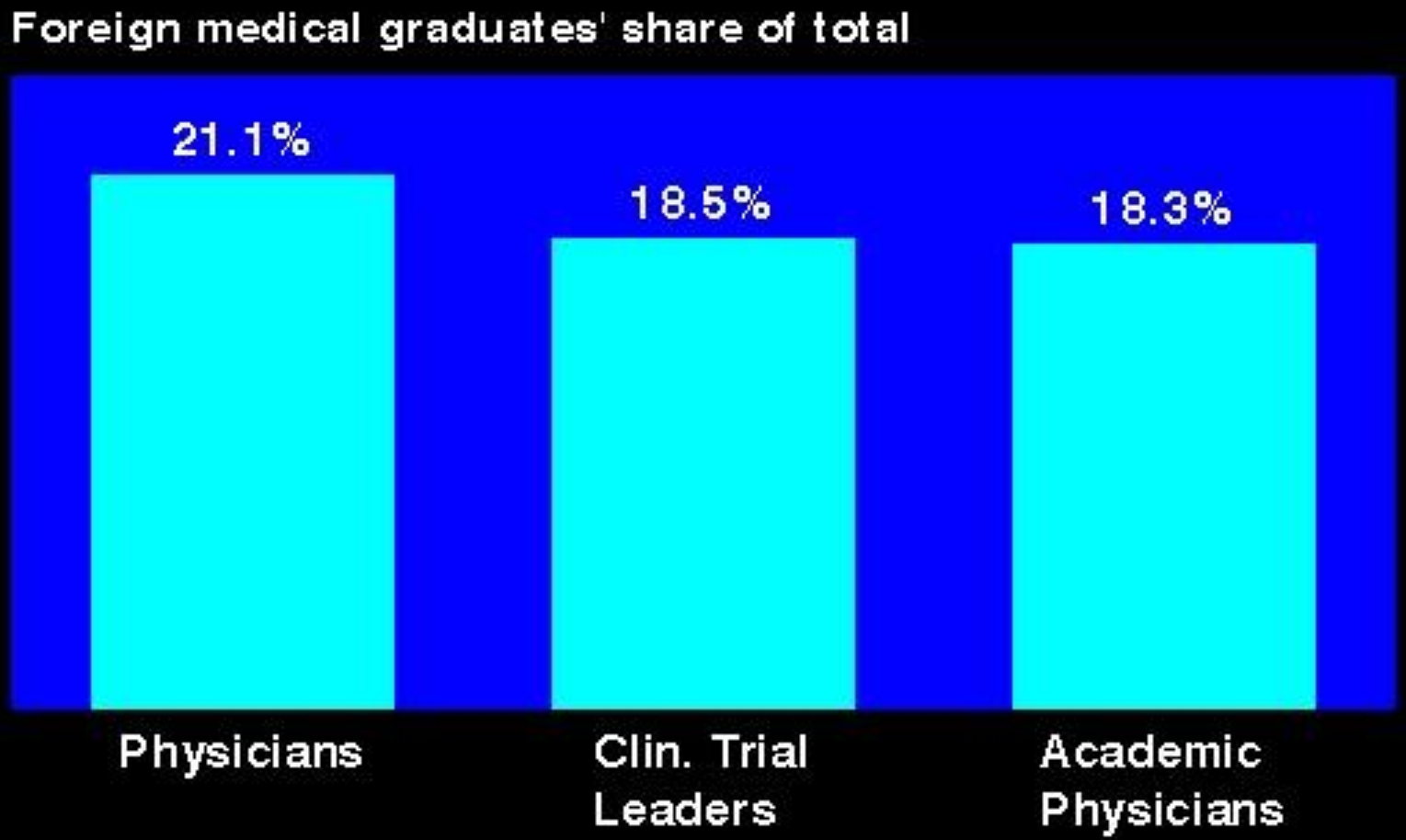
Source: Zallman et al, Health Affairs 2013; 32:1153

Immigrants Subsidize Native-Born in Private Insurance



Source: Zallman et al, Health Affairs October, 2018

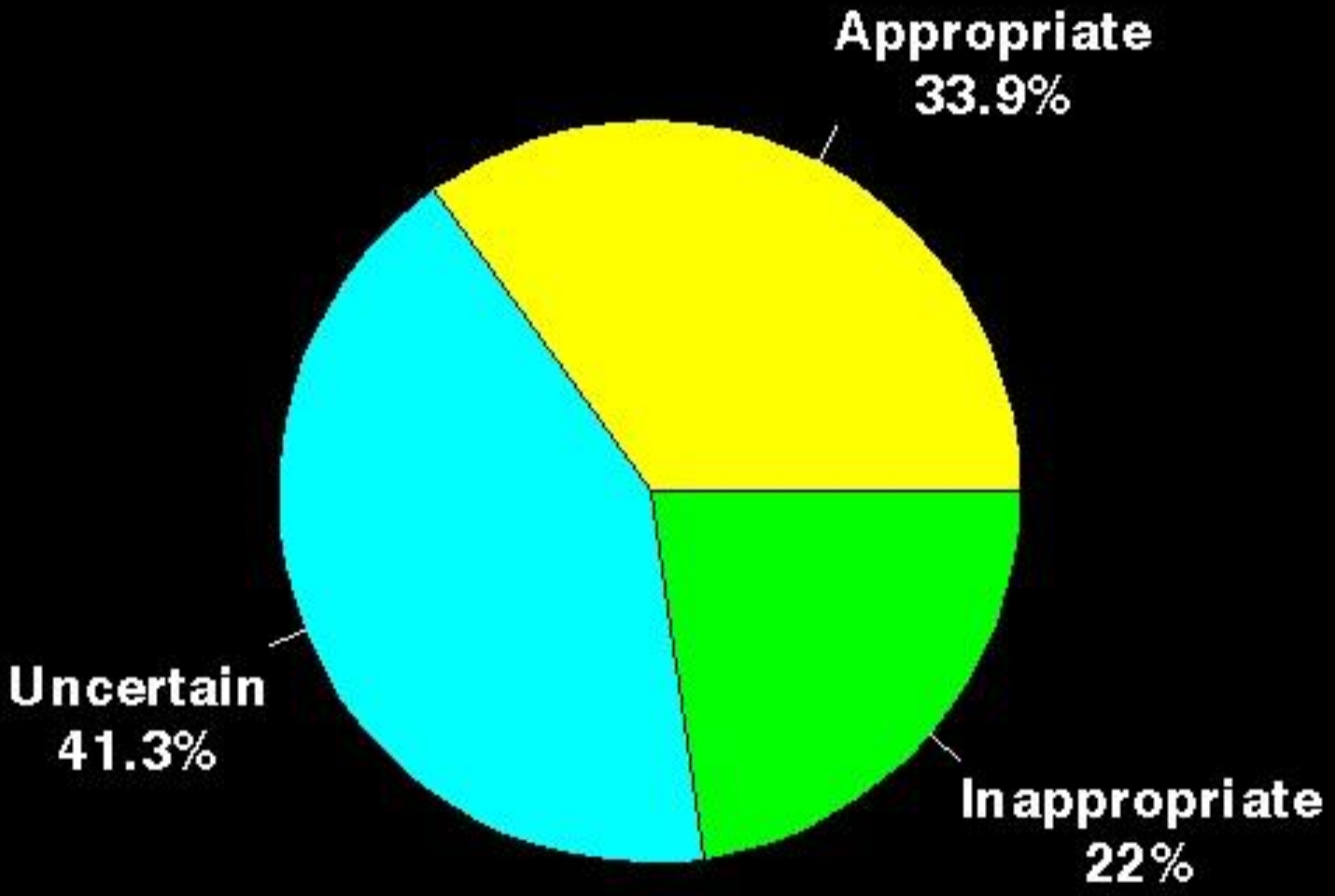
Immigrants Play Vital Roles in U.S. Care, Science and Education



Source: Ann Int Med 2017;157:584

While Many Go Without Vital Services, Others Get Low- or No-Value Care

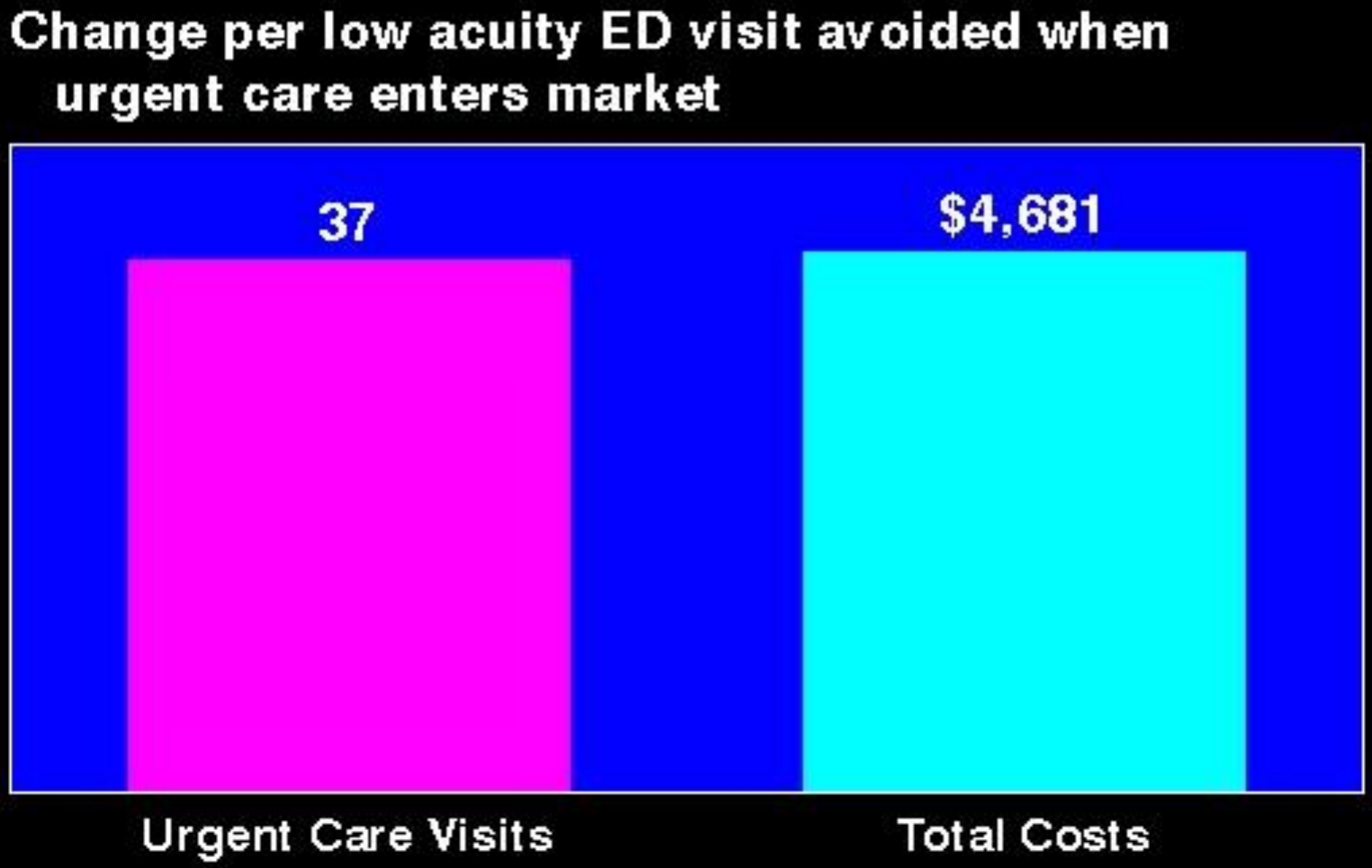
Many Elective PCIs Are Inappropriate



Source: JAMA IM 2014;174:1630 - Based on 1,225,562 patients in PCI Cath registry

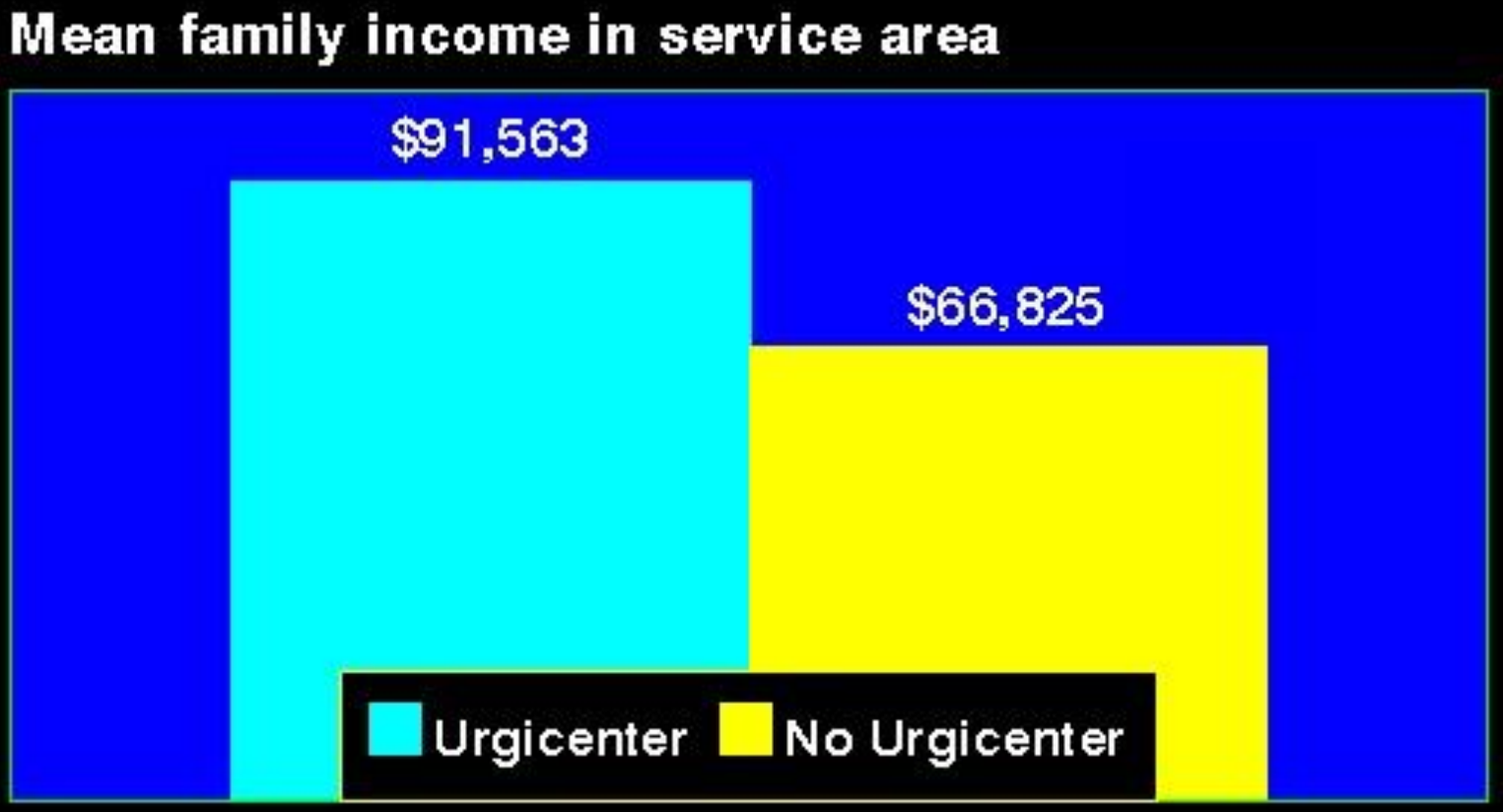
Urgent Care Centers Raise Costs

Extra Urgent Care Visits Outweigh Decreased ED Visits



Source: Health Affairs 2021;40:587

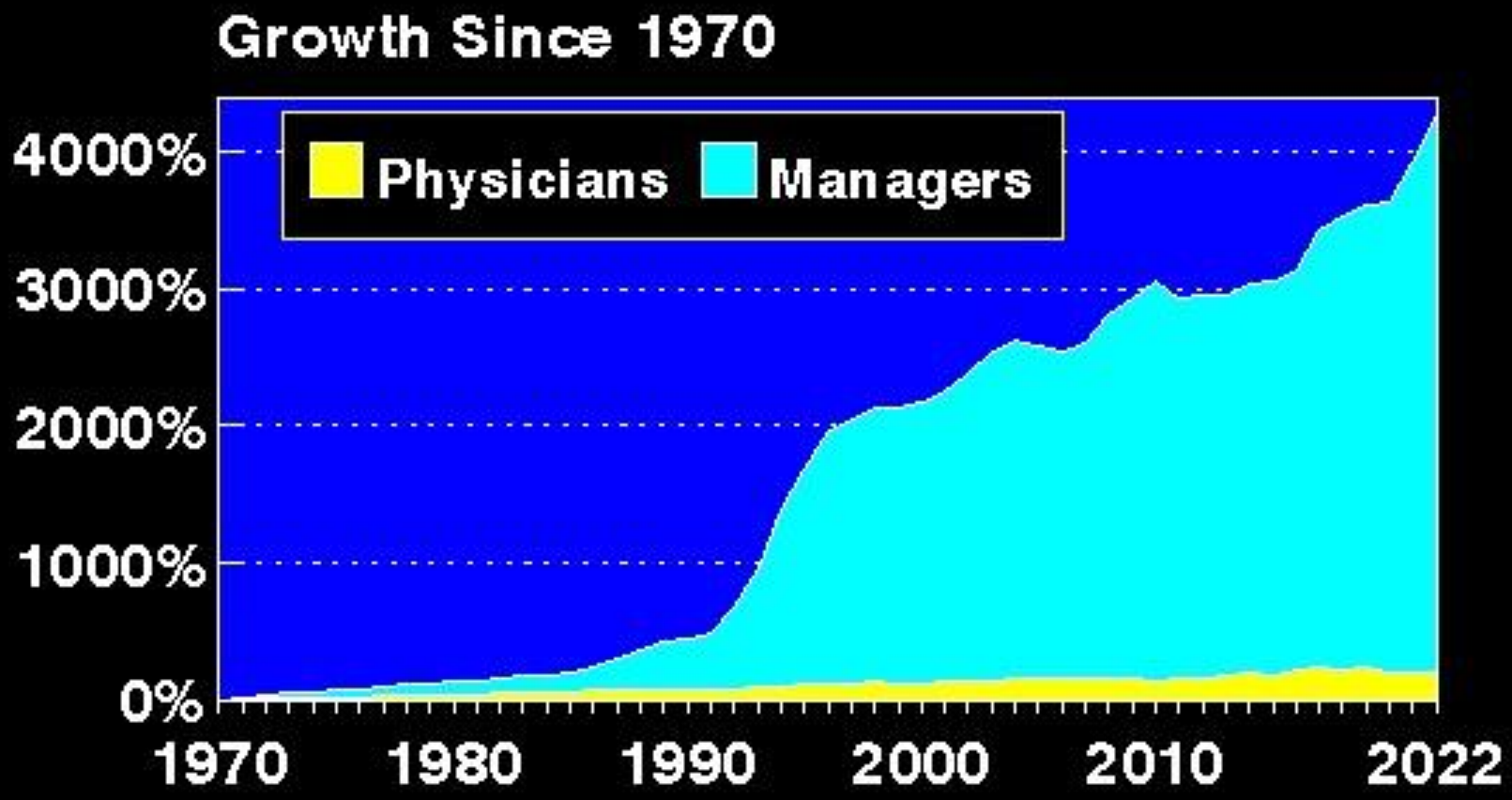
Free Standing ERs in Texas Avoid Areas of Greatest Need



Source: Health Affairs 2017;36:1712 -
Note: Urgicenters were also more likely to locate in areas with more private insurance (70% vs. 57%) less Medicaid (14% vs. 21%) and uninsured (13% vs. 19%). Presence of hosp. ED not predictive

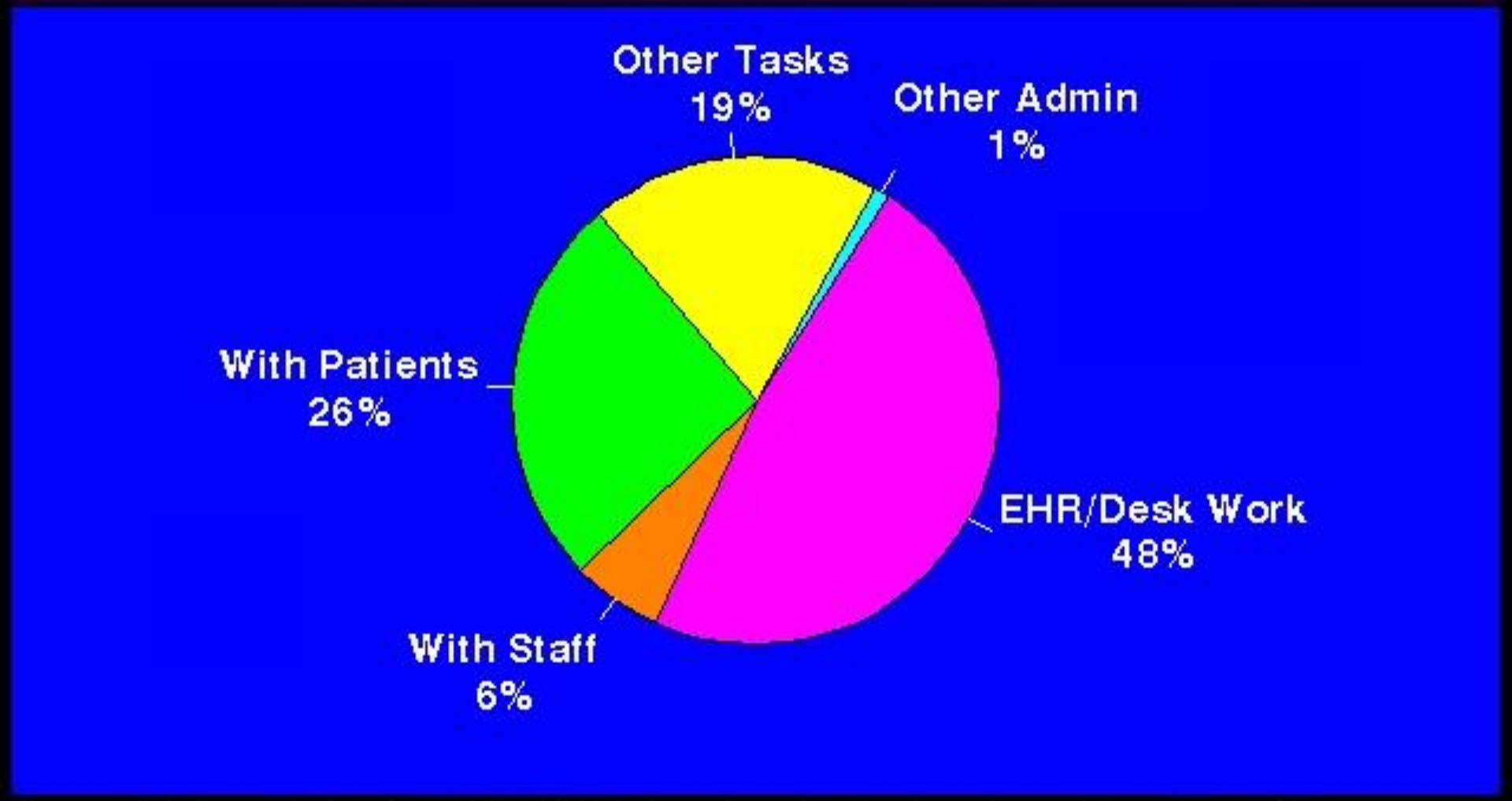
Administrative Overhead Rising

Growth of Physicians and Administrators 1970-2022



Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS
Note - Managers are shown as 3 year moving average

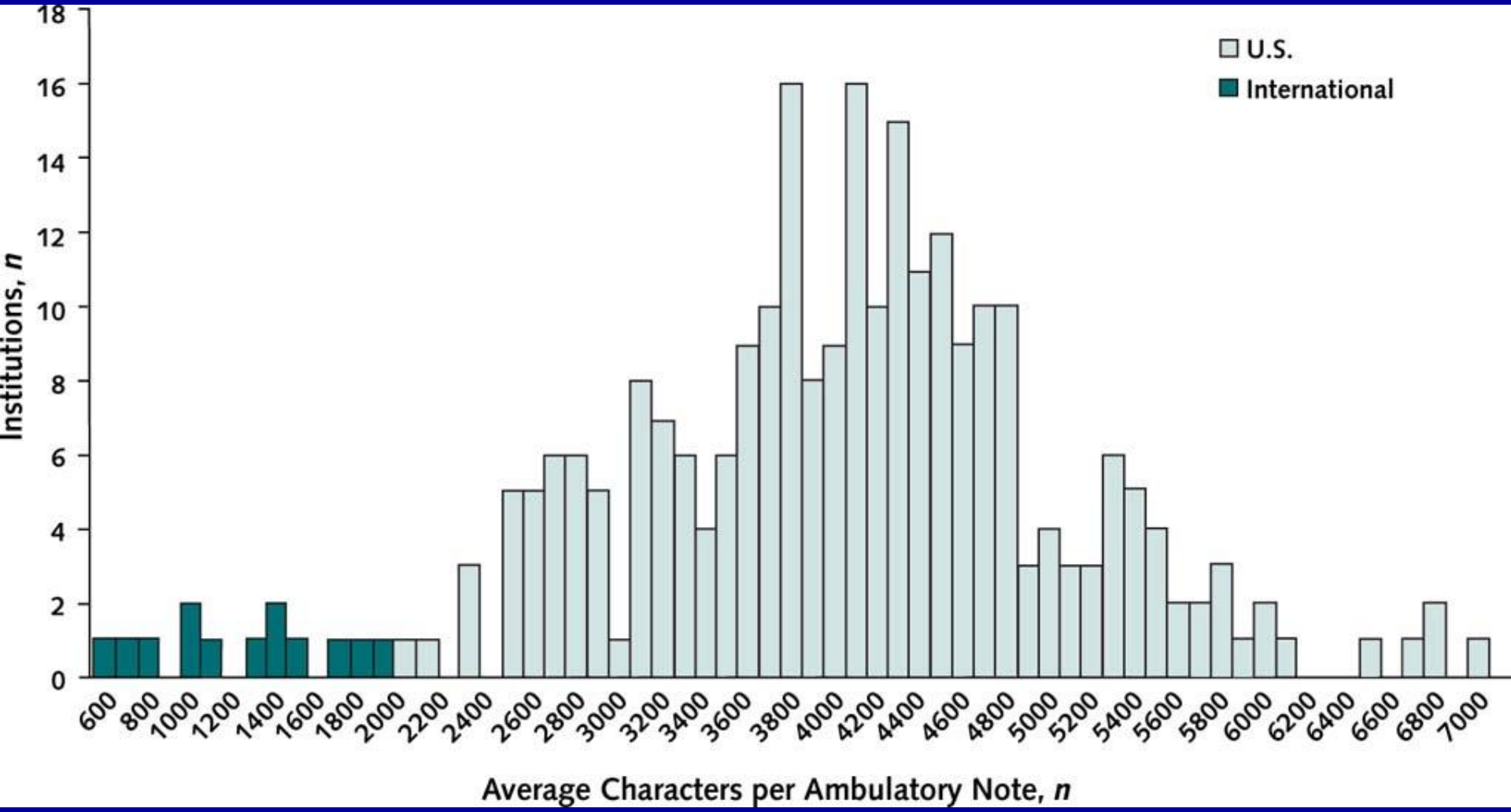
Doctors Spend Twice as Much Time on EHR/Desk Work as With Patients



Source: Sinsky et al. Ann Int Med 9/6/2016 - based on time/motion observation + home diary
Note: Figures are percent of office hours - exclude the 1-2 hrs/night of home EHR/desk work

EPIC EHR Notes 4x Longer in US

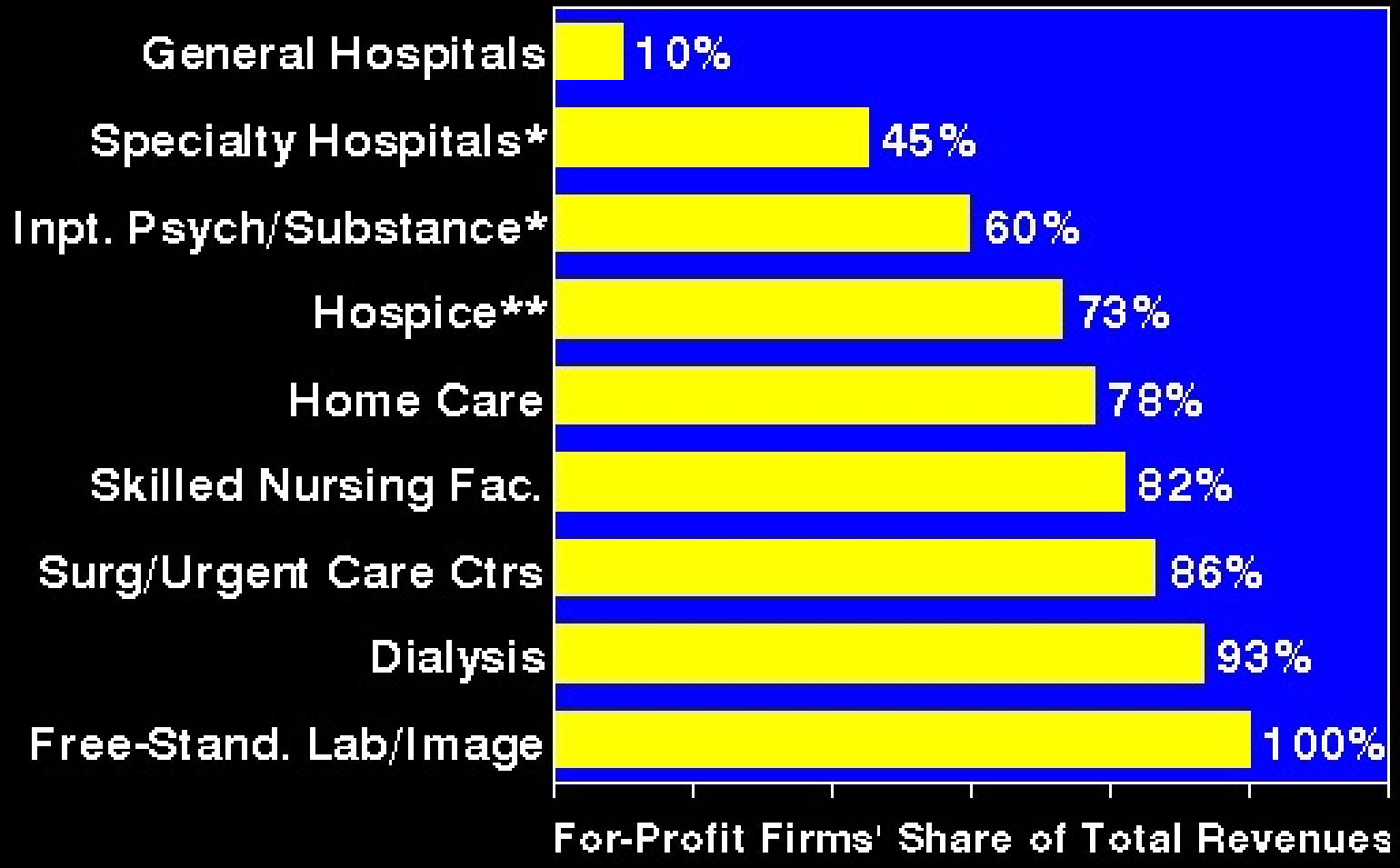
Documentation Driven by Payment Complexity



Source: Ann Intern Med 2018; 169:51

Investor-Owned Care: Inflated Costs, Inferior Quality

Extent of For-Profit Ownership



Source: Commerce Dept. Service Annual Surveys & MedPac. Data are for 2020 or most recent available

* Data are for non-government-owned hospitals

** Data are for share of establishments

Health Industry Profits, 2021

Pharmaceuticals	$117.1 bil
Insurers	$28.3 bil
Equipment/Supplies	$20.3 bil
Pharmacy/Lab/Benefit Mgr.	$18.6 bil
Providers	$10.1 bil

Source: Fortune 500, 2022
Note: Excludes firms not in Fortune 500 which account for substantial pharma profits

Health Care CEO's Pay, 2020

CEO	Firm	Total Pay
Leonard Schleifer	Regeneron	$453 mil
Joe Hogan	Align Technology	$113 mil
Mike Pykosz	Oak Street Health	$92.5 mil
David Cordani	Cigna	$91.2 mil
David Schlanger	Progyny	$80.4 mil
Michael Mussallem	Edwards Life Sci.	$76.7 mil
Helmy Eltoukhy	Guardant Health	$75.6 mil
Tim Walbert	Horizon Therapeutics	$70.1 mil
Steve MacMillan	Hologic	$68.5 mil
Neil Kumar	BridgeBio Pharma	$62.8 mil

Source: Herman et al, STAT+ 7/18/2022

Health Insurer CEO Compensation 2012-2021

Firm	Total Pay
Cigna	$365,959,592
UnitedHealth	$349,470,281
Centene	$322,619,510
CVS-Aetna	$265,741,187
Humana	$187,880,631
Anthem/Wellpoint	$166,515,815
Molina	$112,148,401

Source: Stat News 5/12/22

Note: Excludes UnitedHealth's severance pay of $142 million to Dave Wichmann in 2021

The Profits of "Non-Profit" Health Systems

Health System	2020 Profit	2019 Profit
Kaiser	$2,217 mil.	$2,732 mil.
UPMC	$836 mil.	$27 mil.
Intermountain	$743 mil.	$506 mil.
Mayo	$728 mil.	$1,063 mil.
AdventHealth	$694 mil.	$829 mil.
Indiana U. Health	$656 mil.	$679 mil.
Baylor Scott & White	$558 mil.	$725 mil.
Houston Methodist	$402 mil.	$651 mil.

Source: Modern Healthcare July 19, 2021:44

"Non-Profit" Health Systems Becoming Speculative Investors

Organization	Hedge Fund Investments	Private Equity	Total Investments
Kaiser	2.820 bil.	10.180 bil.	35.486 bil.
Ascension	1.357 bil.	3.424 bil.	22.002 bil.
Mayo	3.421 bil.	3.869 bil.	14.320 bil.
MGH/Brigham	NA	1.140 bil.	12.914 bil.
Cleveland Clinic	3.335 bil.	2.061 bil.	12.880 bil.
Advocate Aurora	2.115 bil.	1.959 bil.	12.192 bil.
Indiana U. Health	1.218 bil.	0.802 bil.	7.839 bil.
Sutter	1.132 bil.	0.414 bil.	7.812 bil.

Source: Modern Healthcare 5/3/2021

Non-Profit Leaders Collecting Big Paydays From Pharma

Name	Position	Company	Board Pay 2017	Share Value
Robert Alpern	Dean, Yale	AbbVie	$335,929	$4.3 mil
Peter McDonnell	Dir, Hopins/Wilmer Eye	Allergan	$449,941	$0.7 mil
Tyler Jacks	Dir, MIT Koch Inst.	Amgen	$343,998	$1.1 mil
Julia Haller	Chief, Wills Eye Hosp.	Celgene	$525,470	$86.5 mil
Marschall Rung	Dean, U Mich.	Lilly	$279,000	$1.1 mil
Kevin Lofton	CEO, Catholic Hlth Init.	Gilead	$415,803	$1.8 mil
Laurie Glimcher	CEO, Dana Farber	Glaxo	$101,000	$0.1 mil
Mary Beckerle	CEO, Huntsman Cancer	J&J	$324,893	$0.7 mil
Mark McClellan	Dir, Duke Hlth Pol	J&J	$284,893	$1.2 mil
A E Washington	CEO, Duke	J&J	$284,893	$2.3 mil
John Noseworthy	CEO, Mayo	Merck	$234,167	$0.3 mil
Chares Sawyers	Chair, MSKCC	Novartis	$367,000	$0.7 mil
Dennis Ausiello	Dir, MGH Ctr.	Pfizer	$375,000	$1.9 mil
Joseph Goldstein	Chair, U Tx Southwest	Regeneron	$1,307,211	$4.2 mil

Source: BioPharma Dive - "Directors who hold board seats and lead non-profits"

For-Profit Hospitals Cost 19% More

Source: CMAJ 2004;170:1817

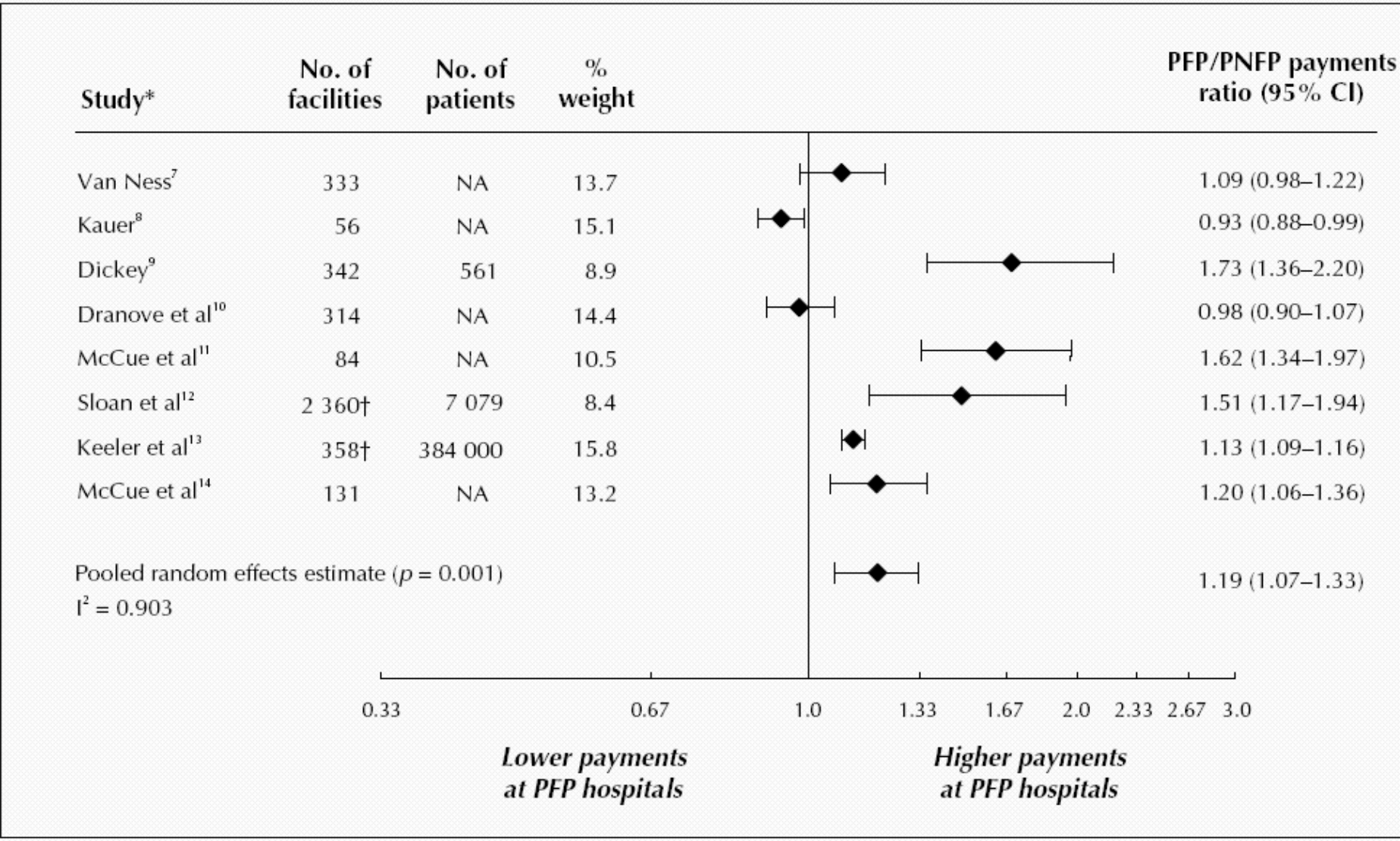
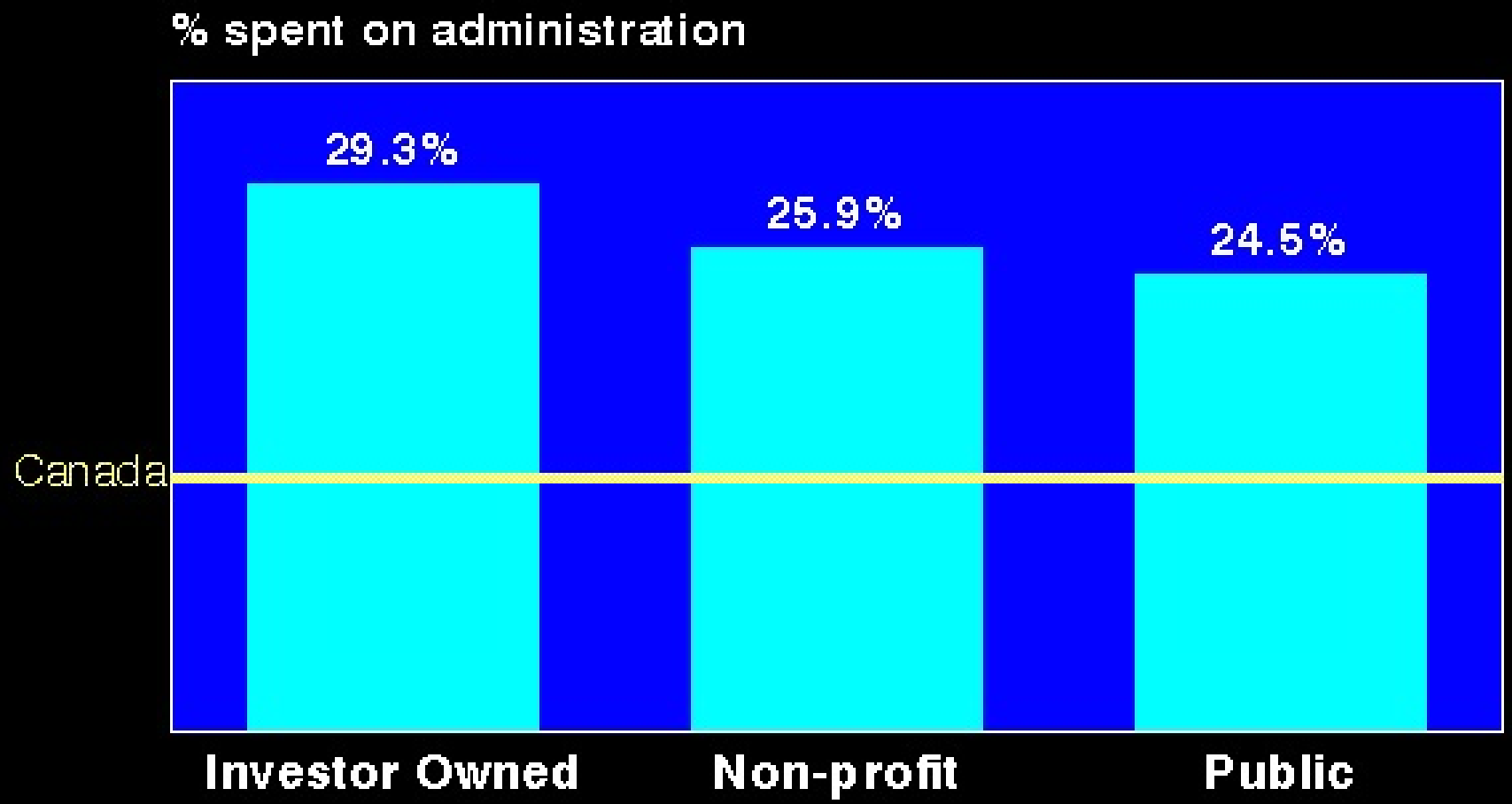


Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.
*The studies are in chronological order by midpoint of the data collection period. †Approximation from investigator.

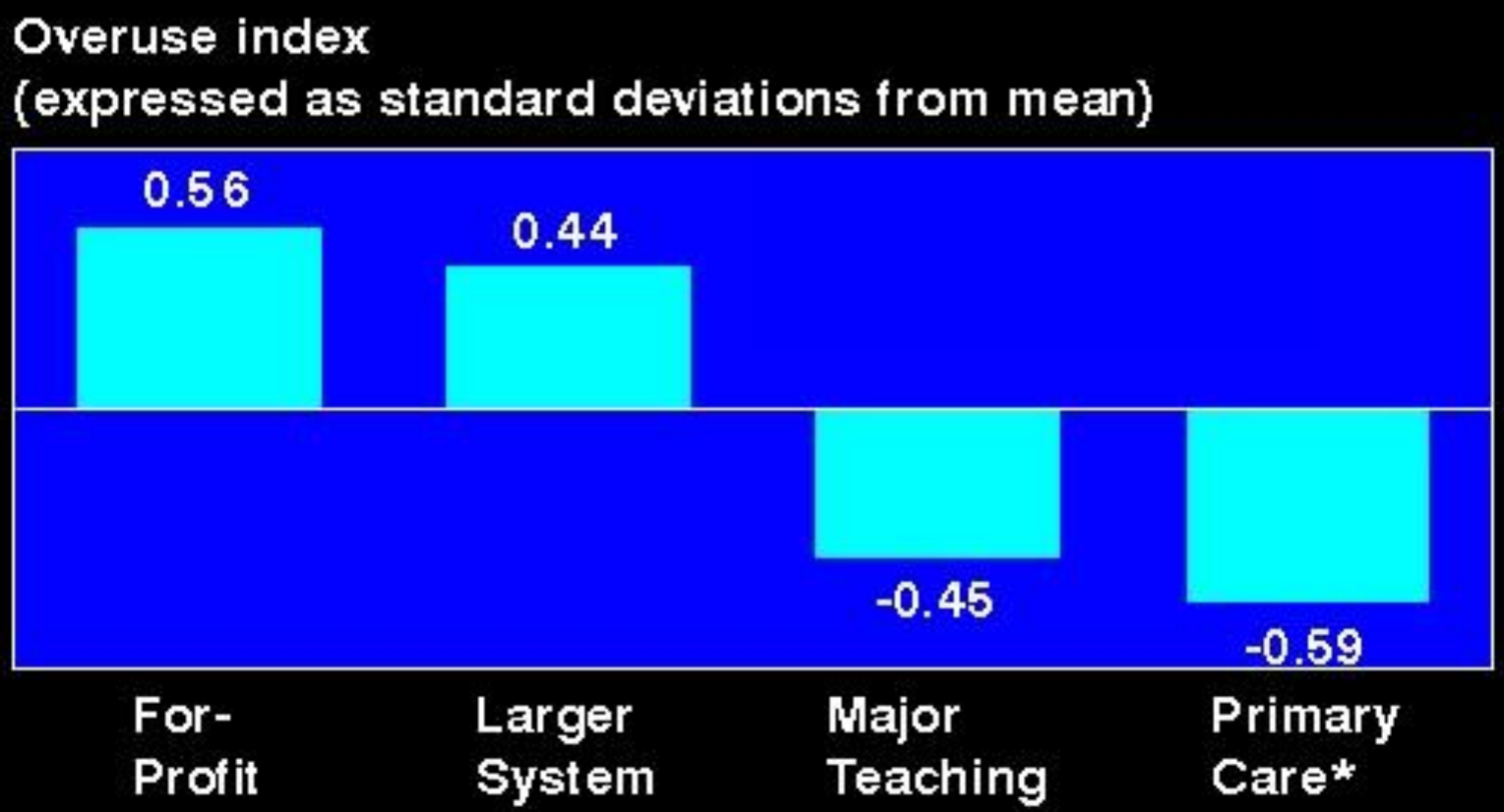
For-Profit Hospitals' Administrative Costs are Higher



Source: Woolhandler & Himmelstein analysis of Medicare Cost Reports + Ann Int Med 2020

For-Profit Hospitals, Larger Systems Deliver More Low/No-Value Care

Teaching Hospitals and Those With More Primary Care Deliver Less



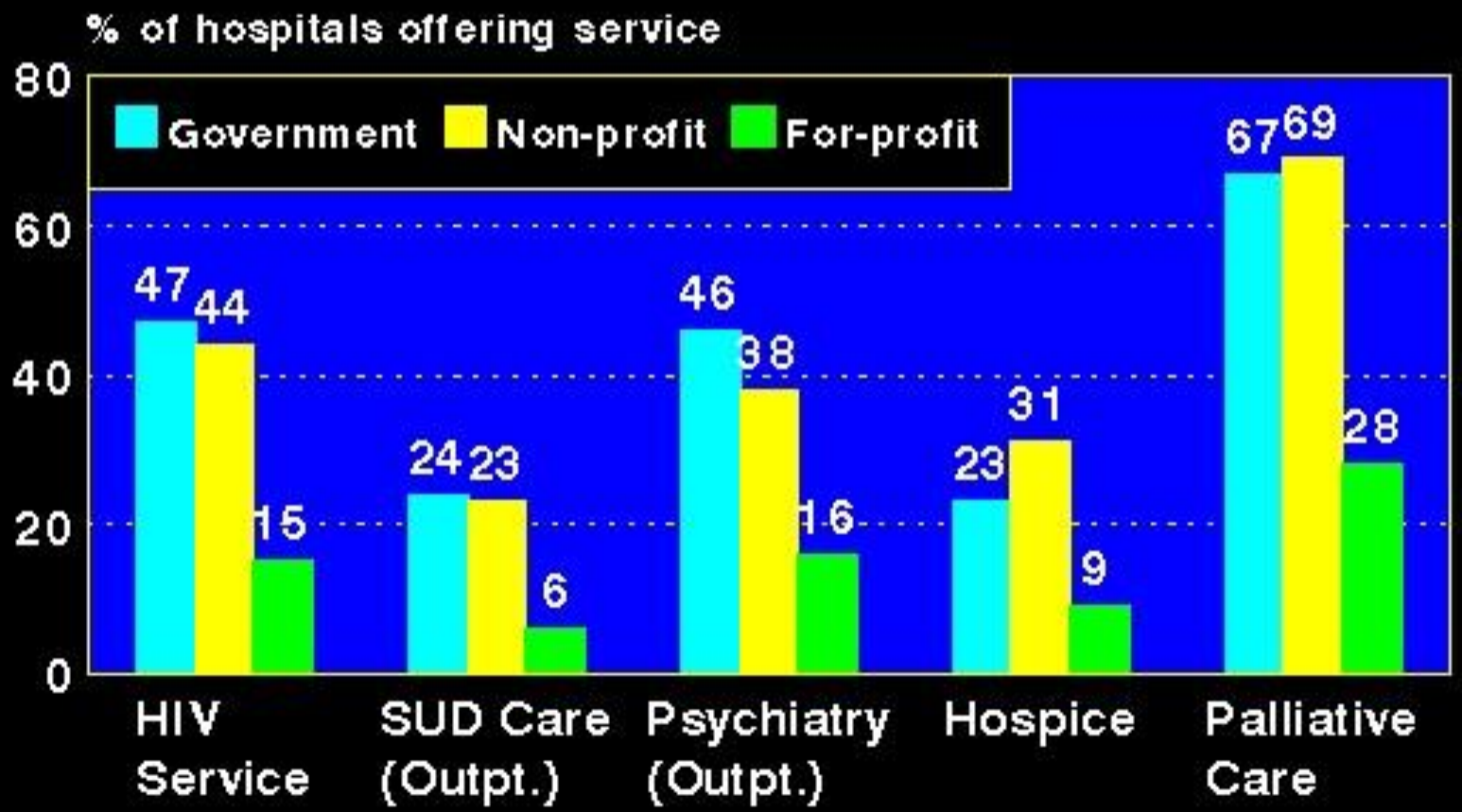
Source: JAMA Health Forum 2022;3:e214543
Note: Overuse index is summary measure based on volume of 17 low/no value services
* Highest tertile of primary care physician supply

Doctors at For-Profits Take More Pharma Money

Proportion of doctors receiving drug company payments

Source: Pro Publica 6/29/2016

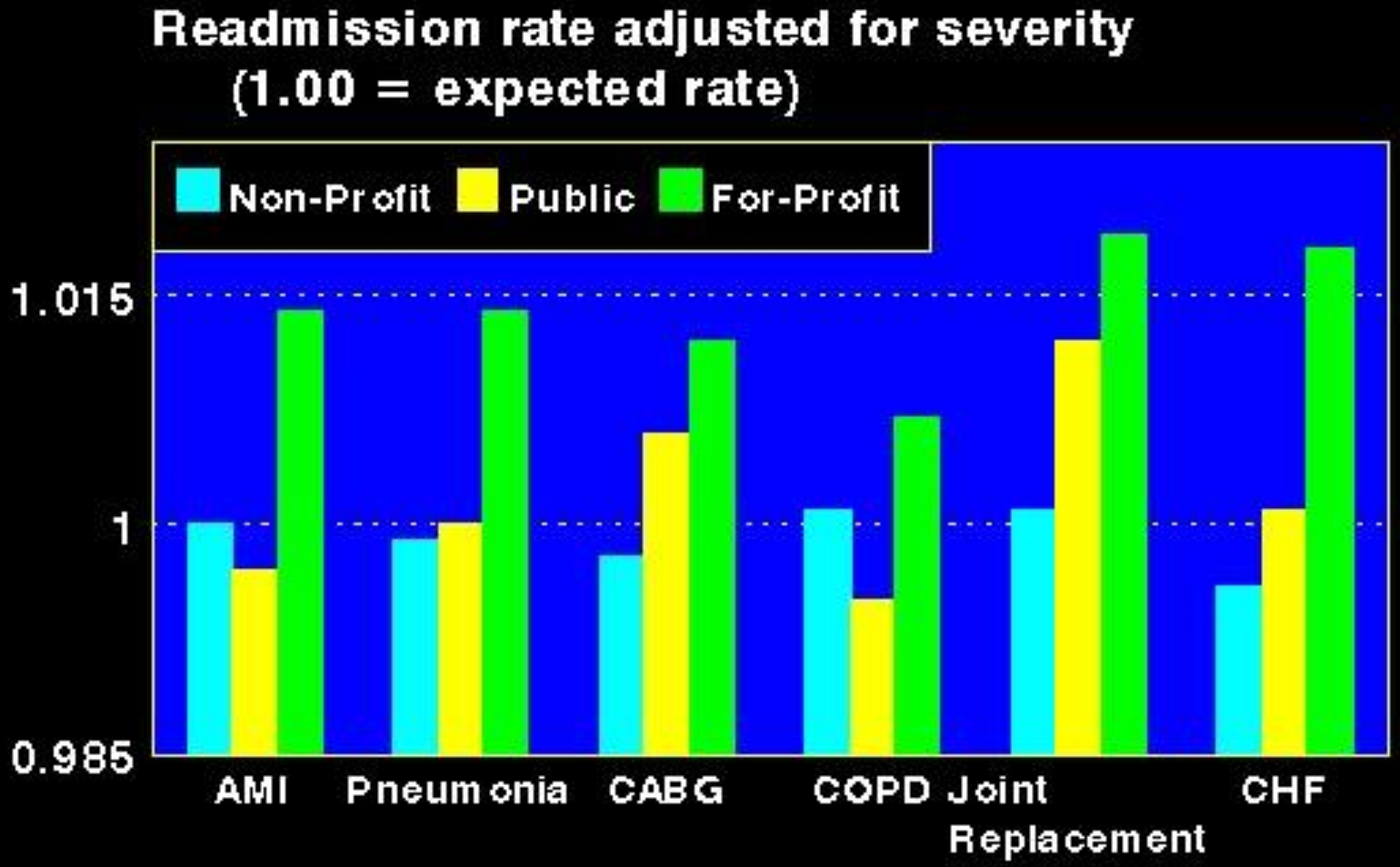
For-Profit Hospitals Avoid Vital but Unprofitable Services



Source: JAMA 2022;327:2145

Other unprofitable services showed similar pattern; for-profits were more likely to offer profitable Services. Differences persisted afte adjustment for multiple hospital and community characteristics.

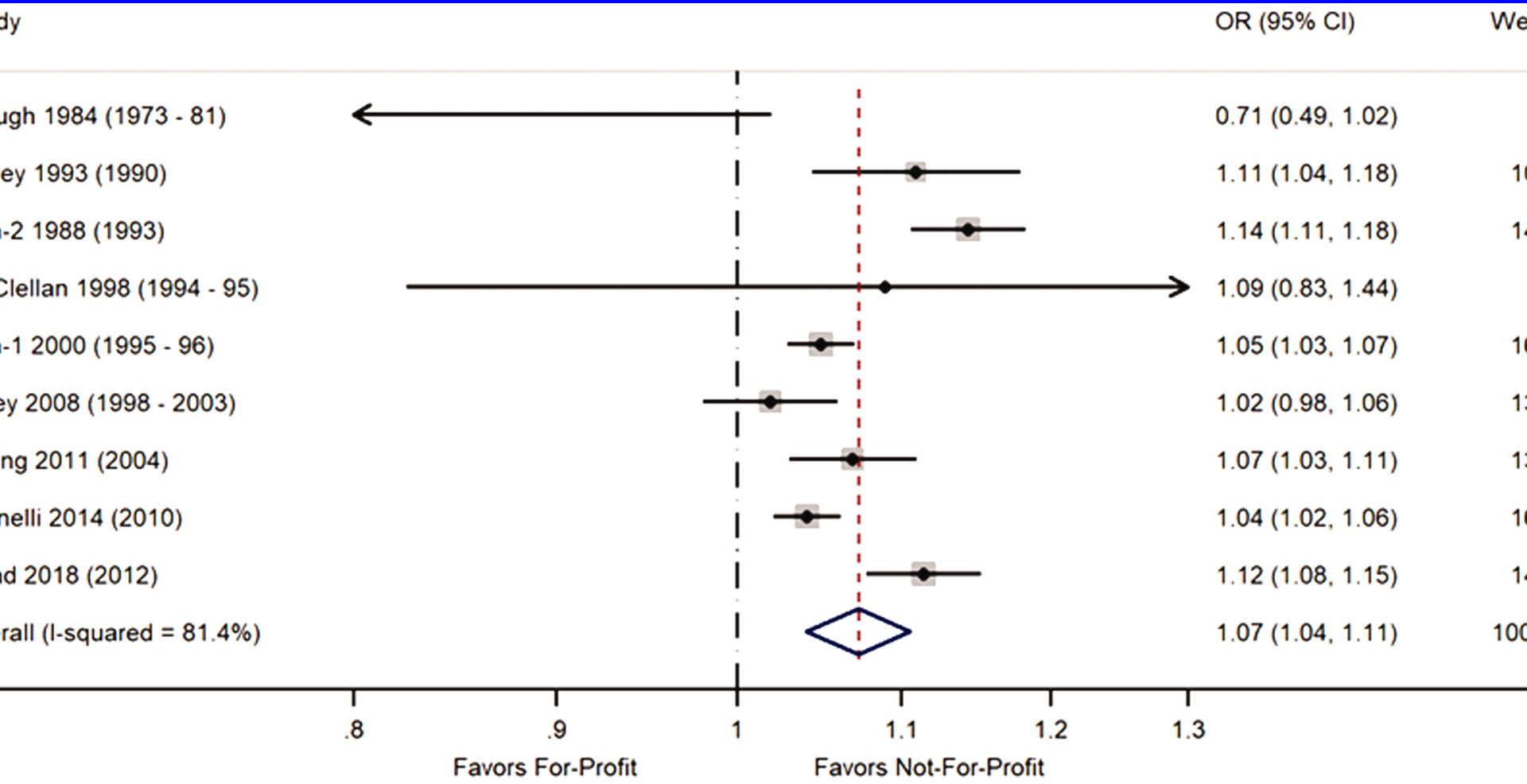
For Profit Hospitals Have Highest Readmission Rates for EVERY Condition



Source:PLOS One 9/18/2018 - based on Medicare data 2012-2015

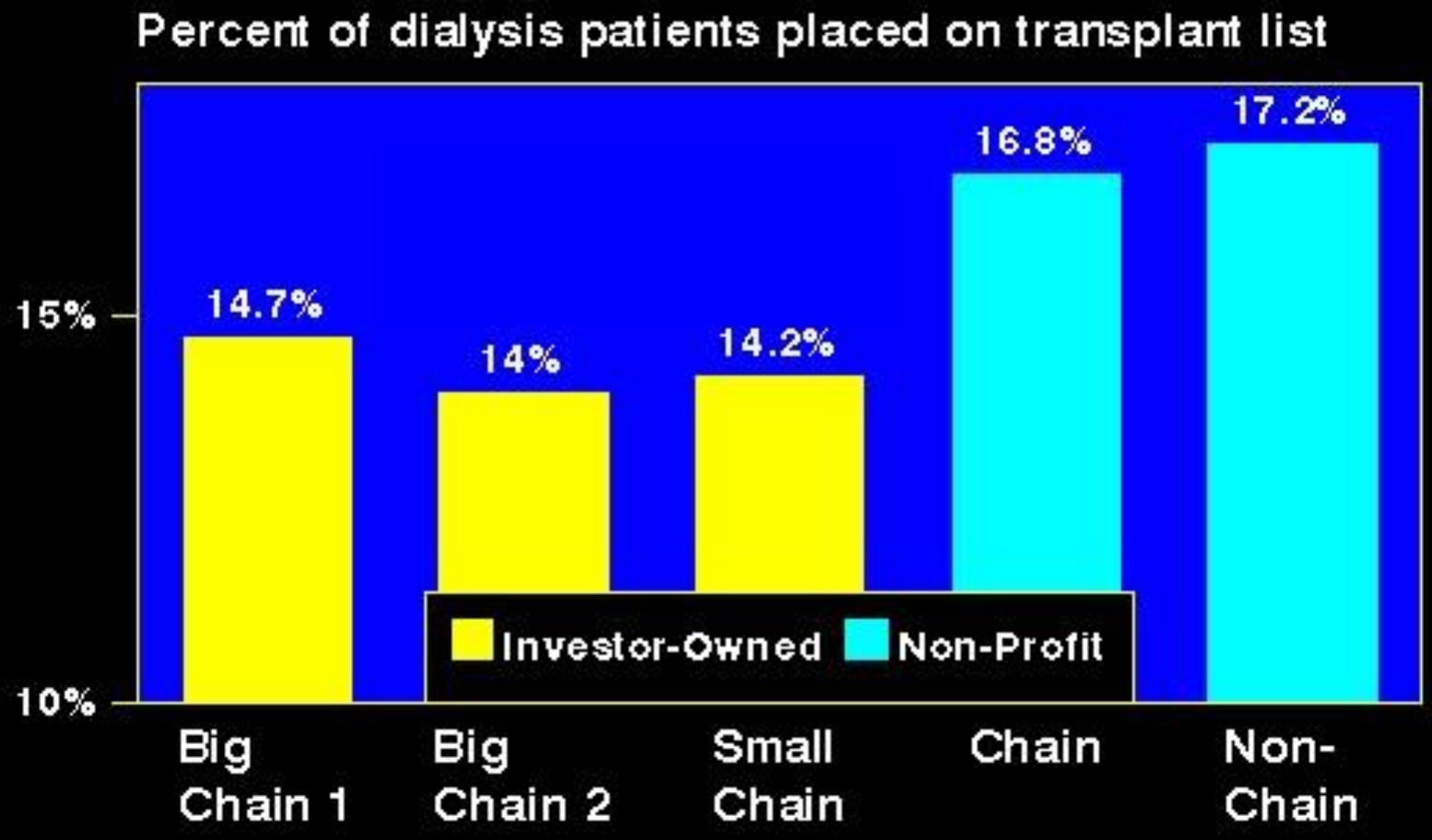
For-Profit Dialysis Clinics' Death Rates are 7% High

3800 Excess Death Annually



Source: Dickman, Mirza et al. Int J Health Serv 2021;51:371

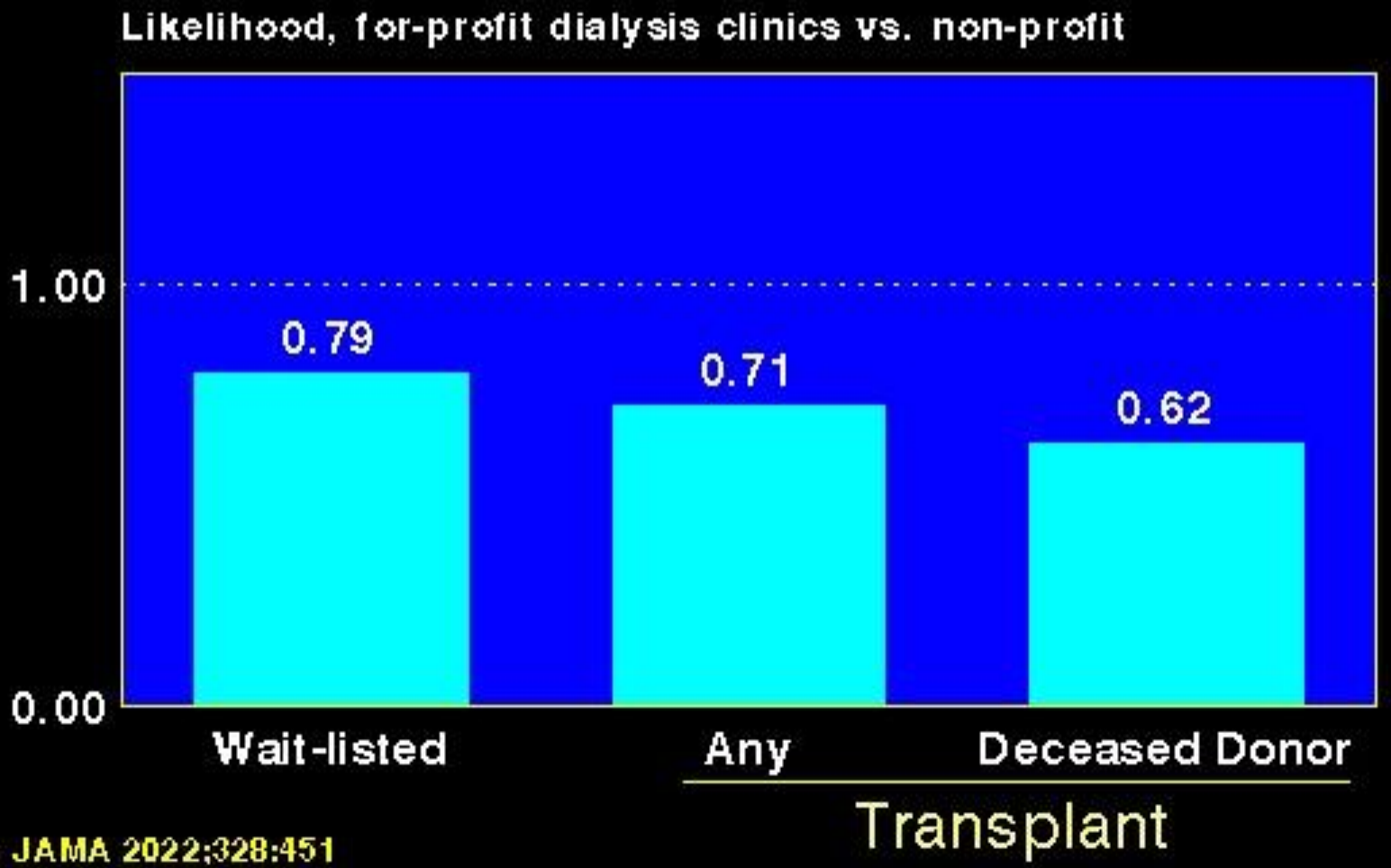
Investor-Owned Dialysis Clinics Discourage Transplants



Source: JAMA 2019;322:957 (article corrected 4/21/2020)

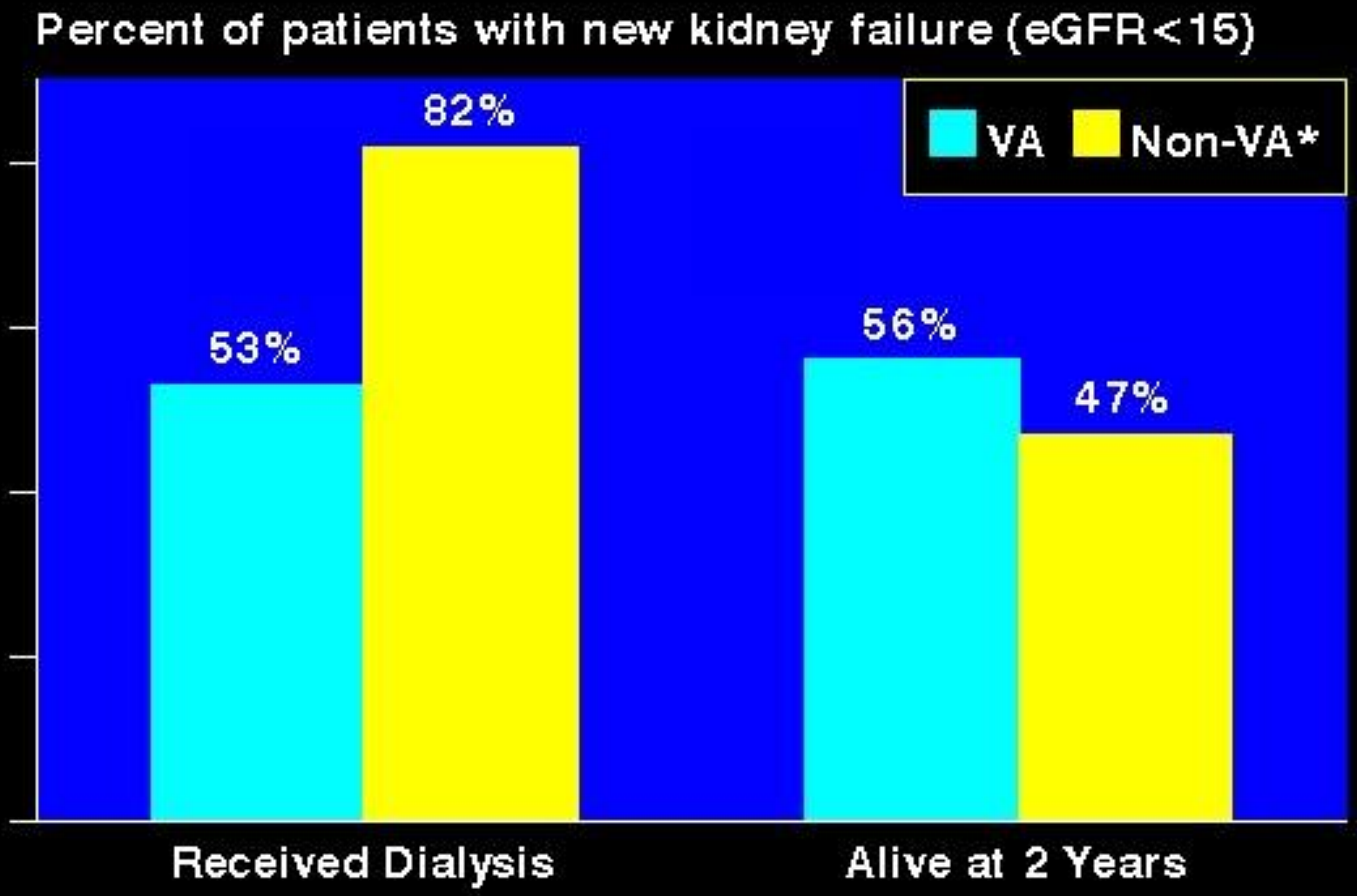
Kids at For-Profit Dialysis Centers Less Likely to Get Transplants

Transplant = Lost Customer



So urce: JAMA 2022;328:451

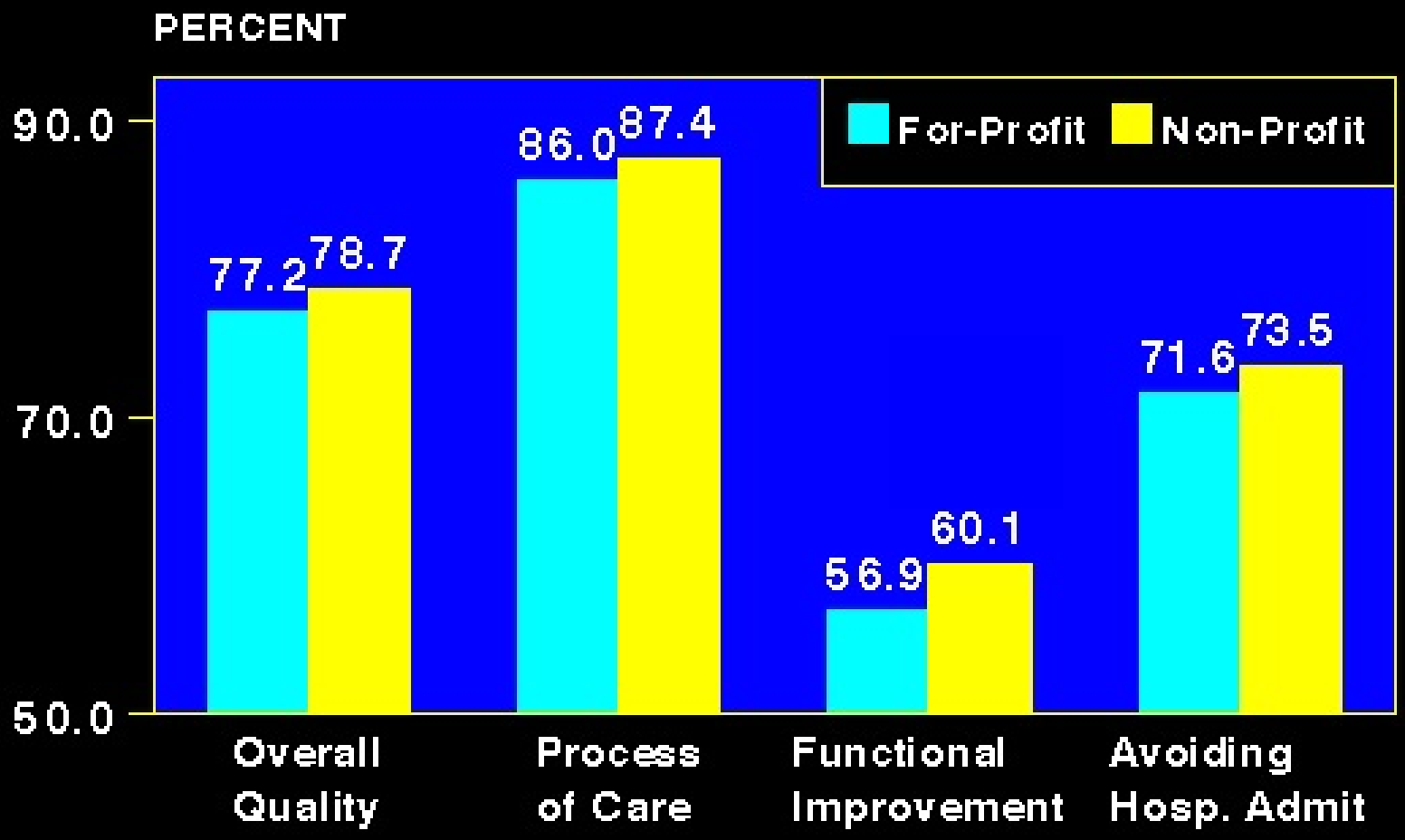
VA Kidney Care: Less Dialysis, Better Survival



Source: JAMA IM 2018;178:657

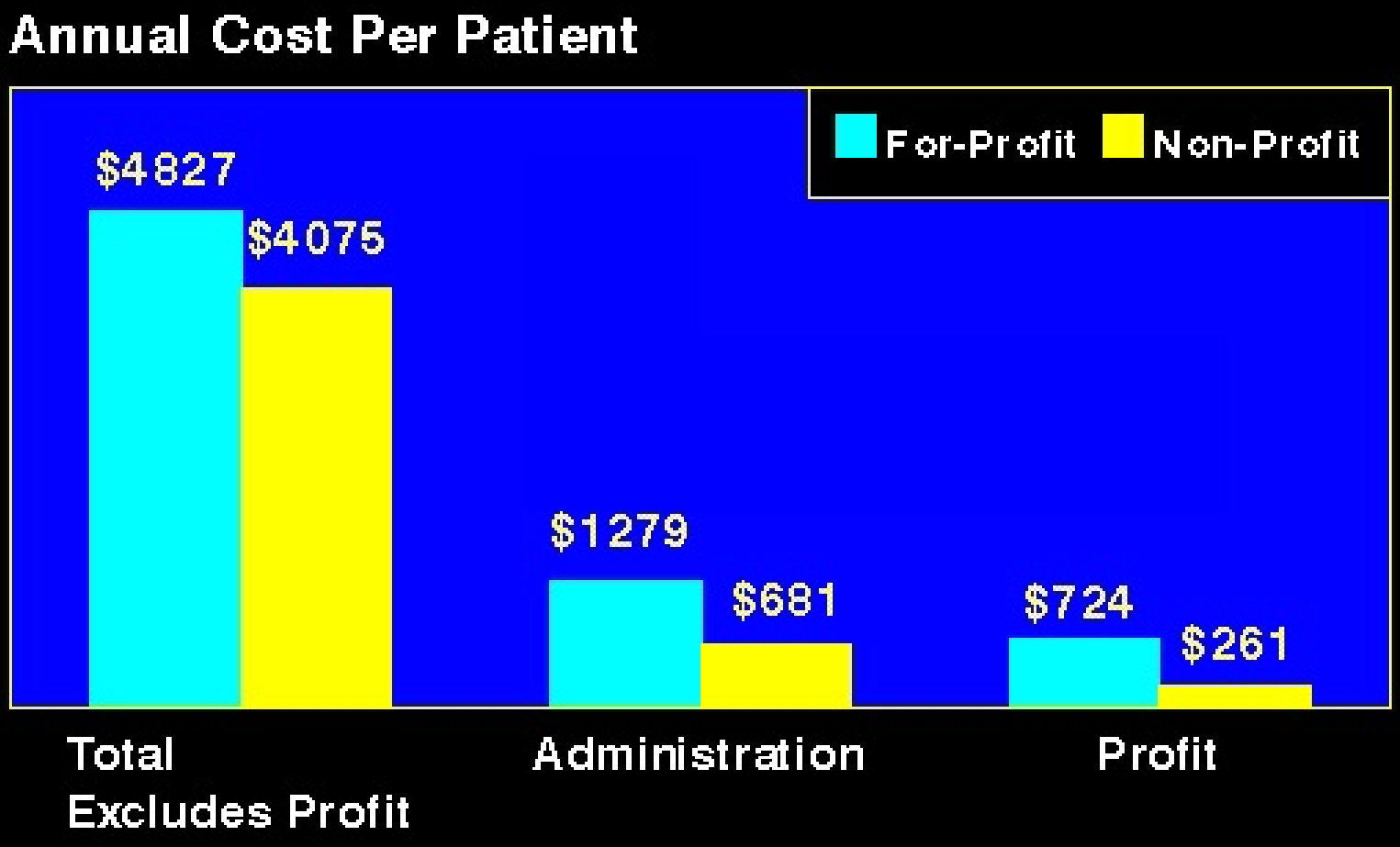
*Non-VA = Medicare-paid, mostly delivered by investor-owned facilities

For Profit Home Care: Lower Quality



Source: Cabin, Siman, Himmelstein & Woolhandler, Health Affairs 8/2014

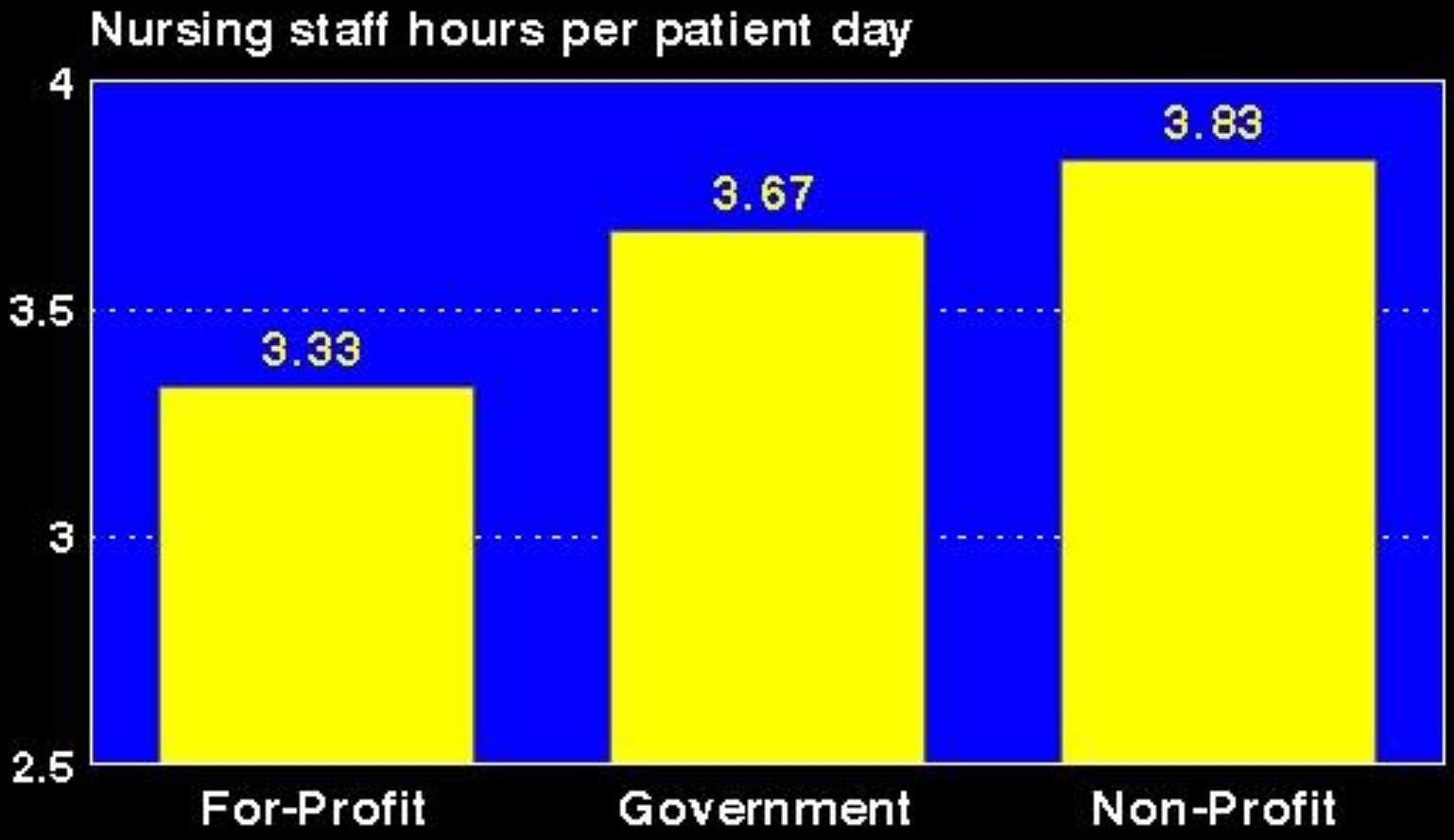
For Profit Home Care: Higher Cost



Source: Cabin, Siman, Himmelstein & Woolhandler, Health Affairs 8/2014

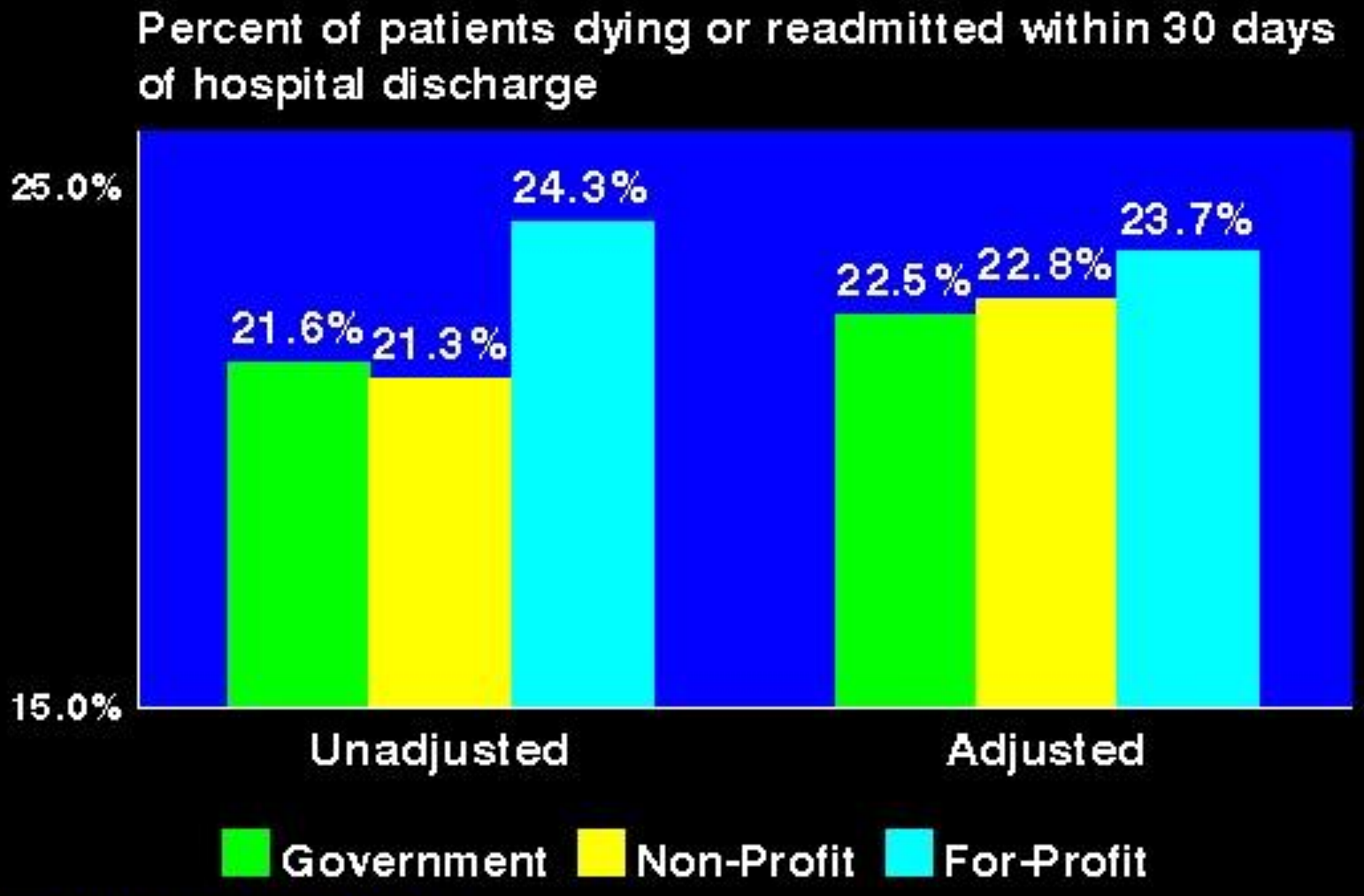
For-Profit Nursing Homes: Less Nursing Care

A National Study



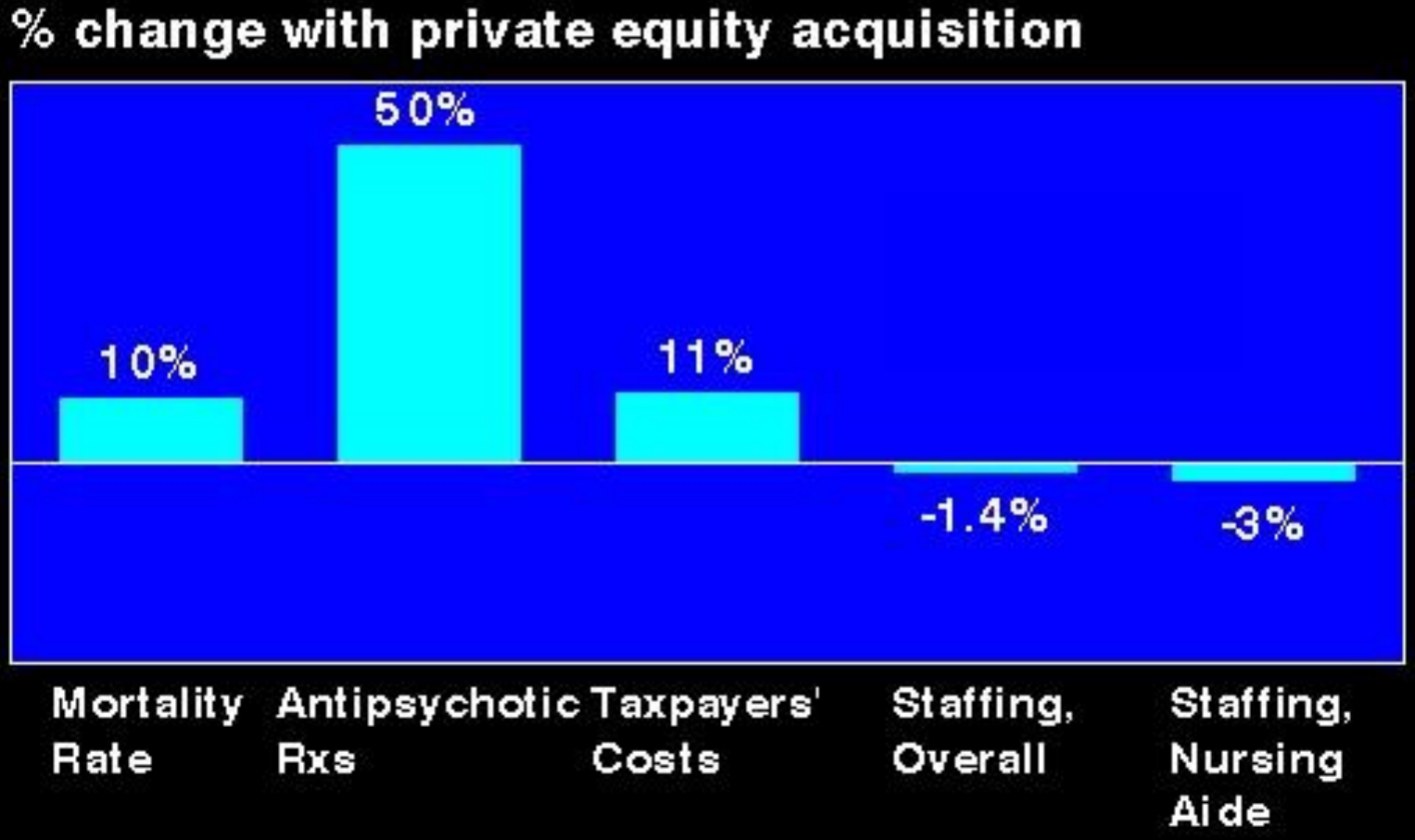
Source: Health Affairs 2019;38:1095

For-Profit Nursing Homes (SNFs): More Deaths and Hospital Readmissions



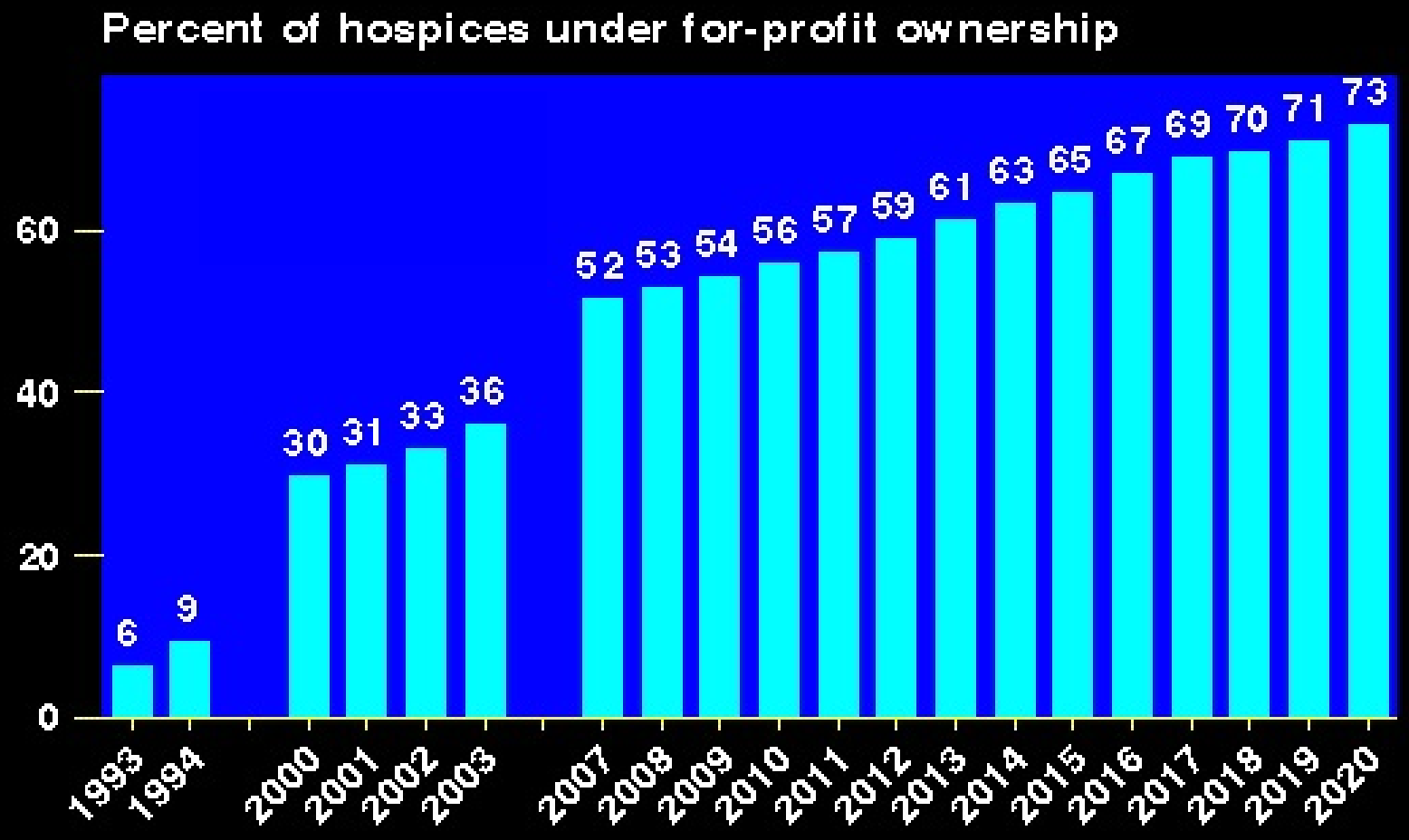
Source: JAMA 2014;312:1552

Private Equity Nursing Home Takeovers Harm Patients, Raise Costs



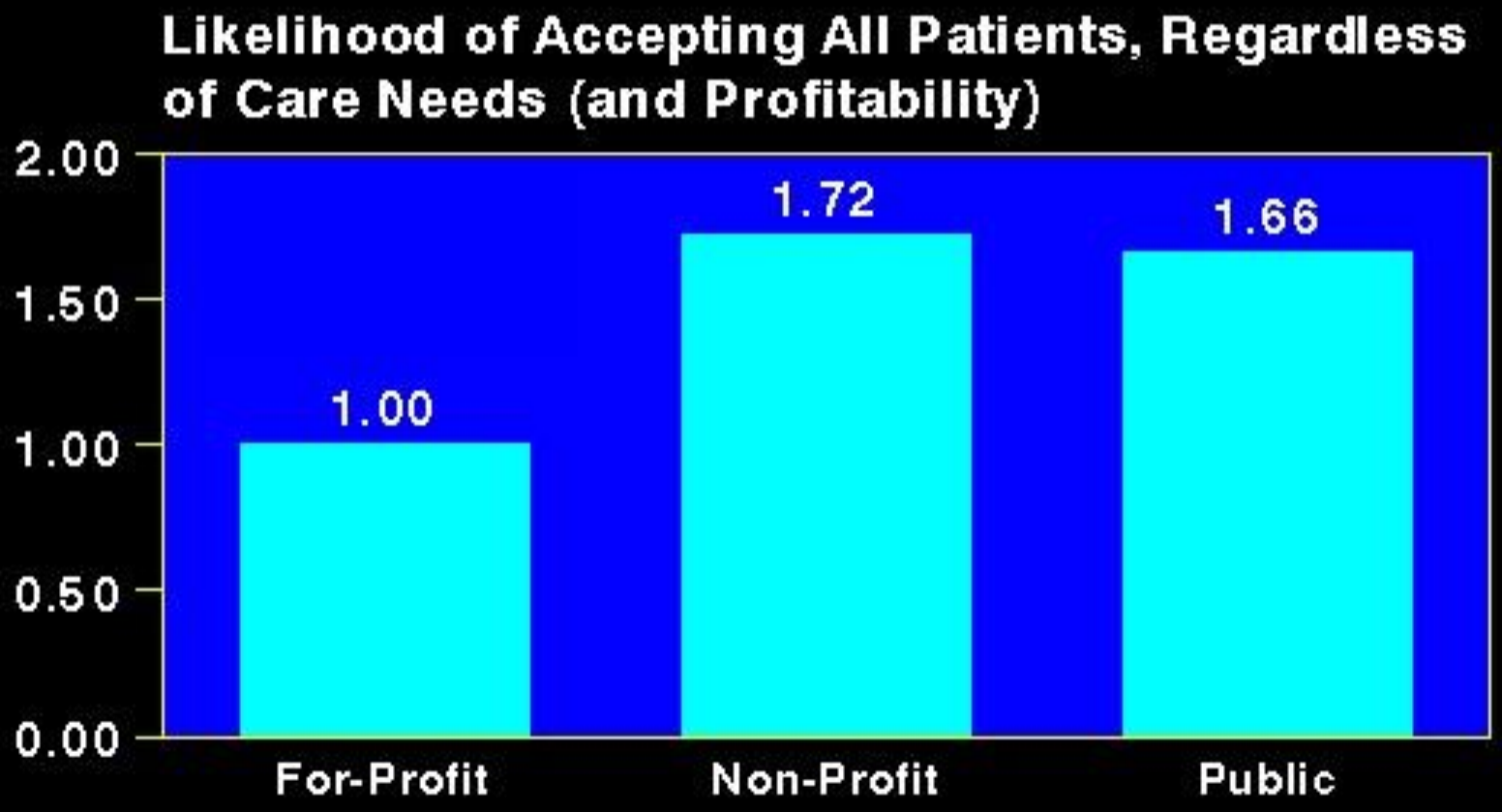
Source: "Does Private Equity Investment in Healthcare Benefit Patients" NBER #28474, February, 2021
Note: Study used a within-facility DinD analysis + instrumental variable control for pt. factors

Hospice Goes For-Profit



Source: MedPac Annual Report, 2022 and previous
Note: Profit rate: for-profits = 19.2%; non-profits = 6.0%
Mean LOS: for-profits = 115 days; non-profits = 73 days

For-Profit Hospices Avoid Unprofitable Patients



Source: Health Affairs 2012;31:2690

Note: Based on accepting pts. on chemo, TPN, transfusions, tube feeds, intrathecal cath, palliative radiation, or living alone

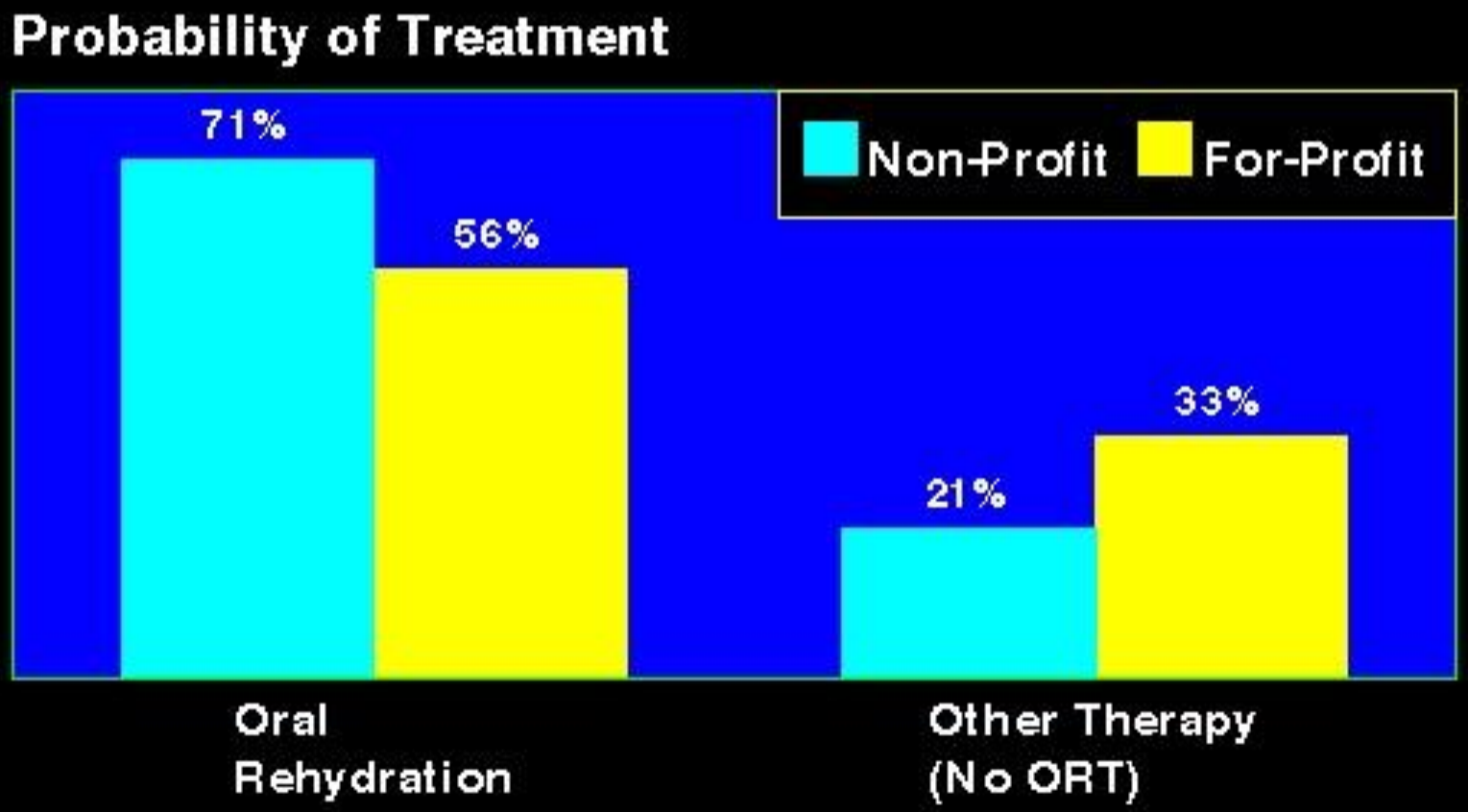
For-Profit Hospices Minimize Care, Maximize Payment

- Offer narrower range of services
- Employ less skilled staff
- Choose patients needing less care + longer life expectancy
- More complaints and deficiencies
- Less charity care, research, training
- More ED and hospital use
- More D/C's of demented patients
- Account for 90% of hospices with lowest spending on care

Source: JAMA IM 2021;181:1113

For-Profits in Africa Less Likely to Give Children Appropriate Dehydration Treatment

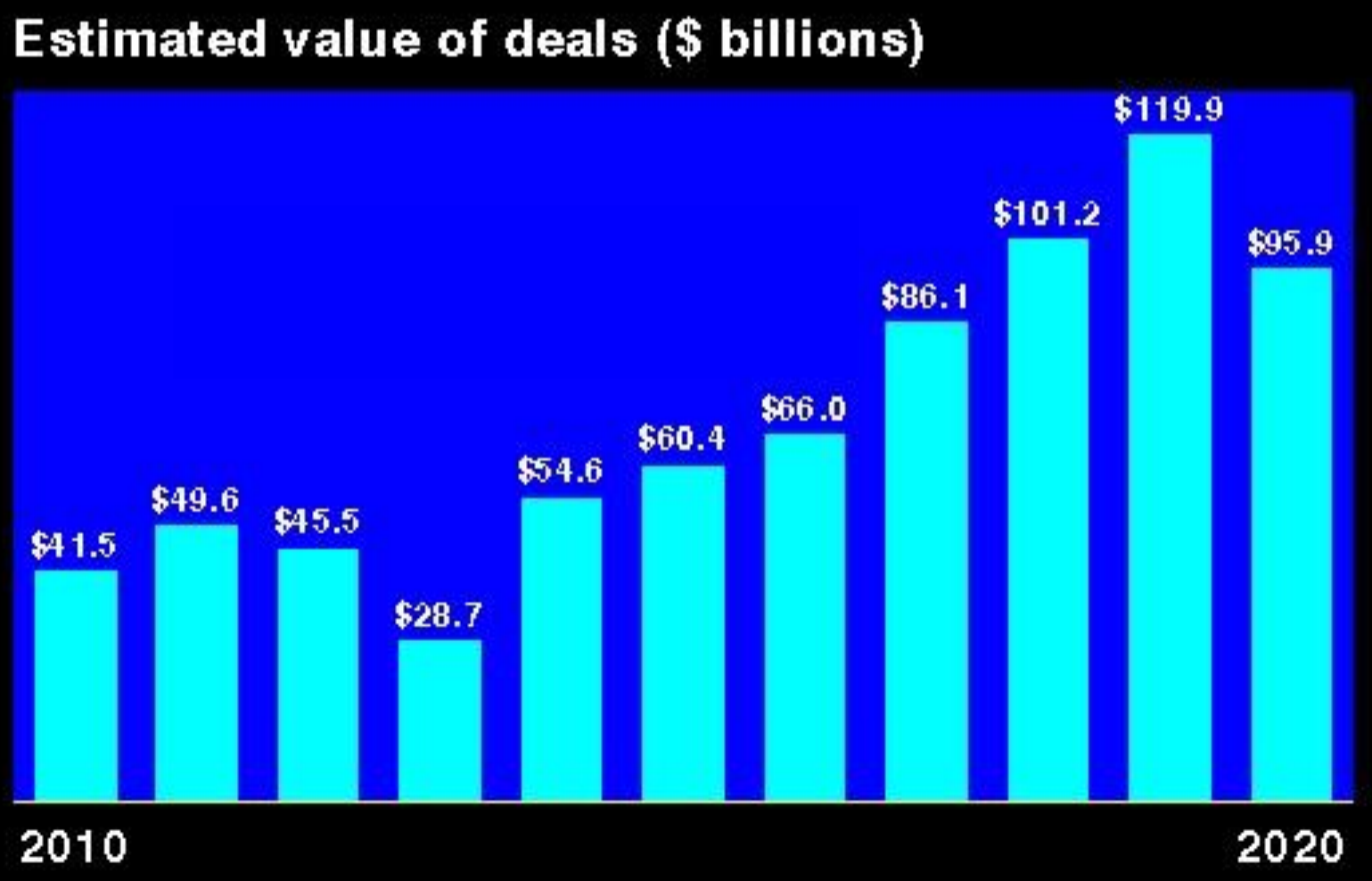
More Likely to Give Ineffective Treatments



Source: Am J Trop Med Hyg 2014;90:939
Note: Study included treatment at any health/pharmacy facility
Note; Over 700,000 children die from diarrhea annually, ORT is life-saving

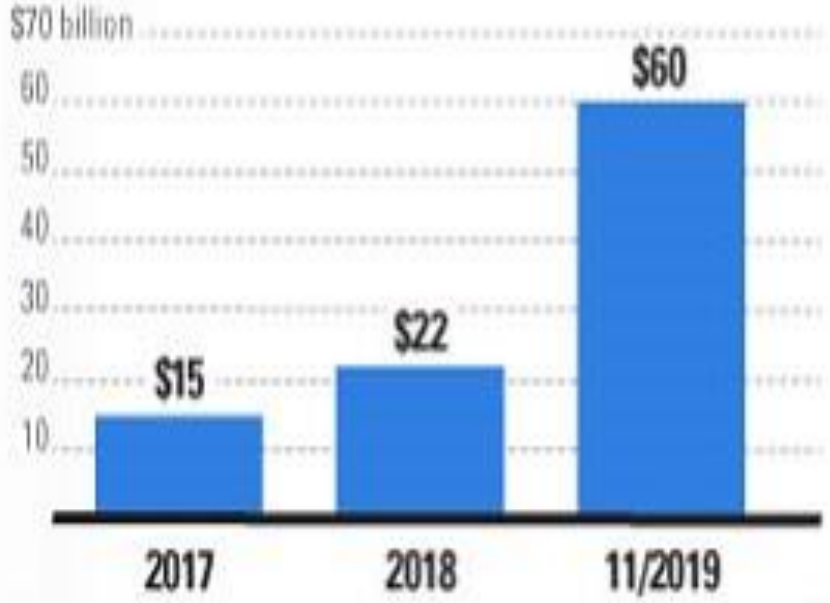
Private Equity Health Care Takeovers

$749 Billion, 2010-2020



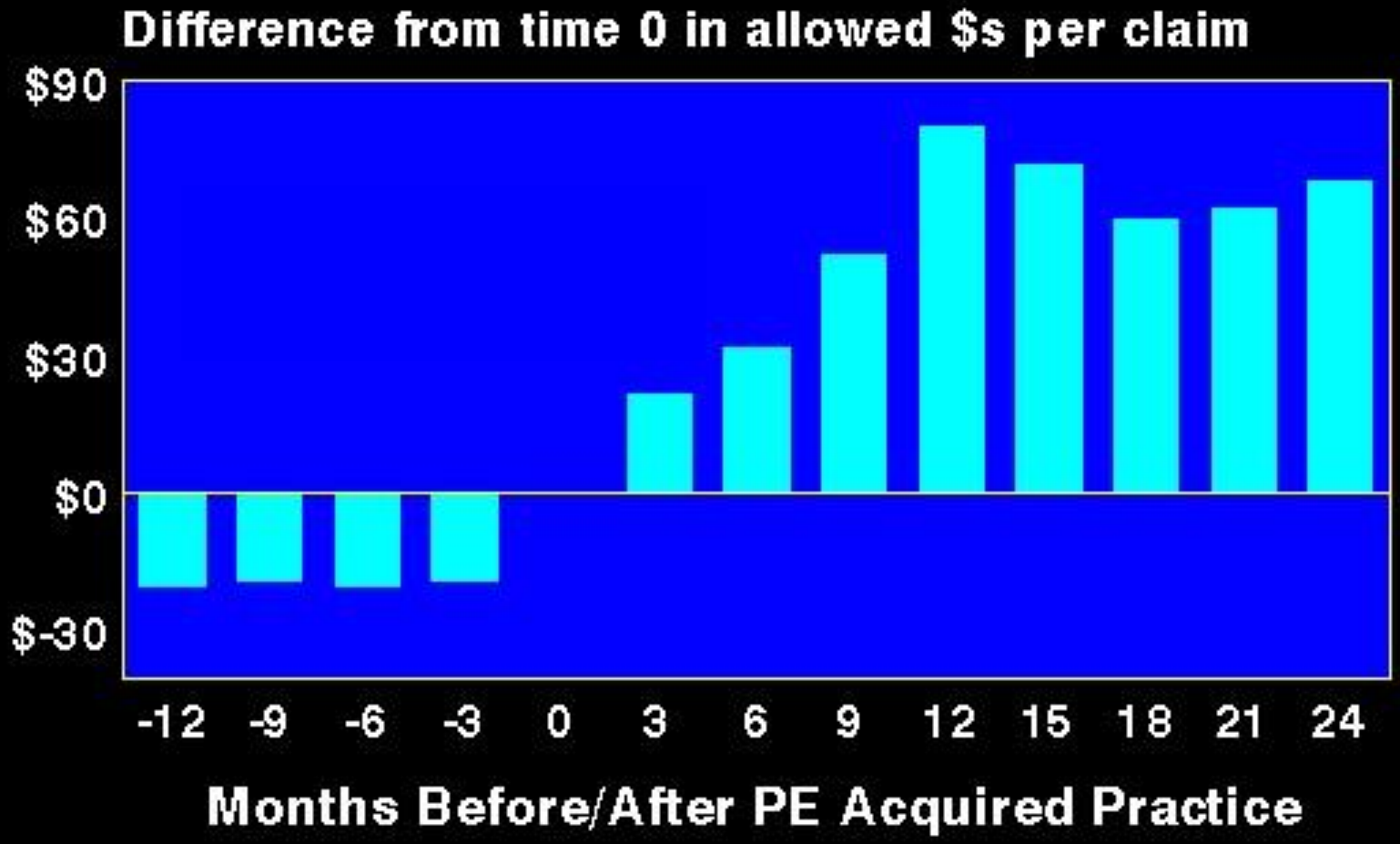
Source: Scheffler et al. "Soaring private equity investment in the healthcare sector" 5/18/2021

Private equity and venture investment in physician practices



Source: "Private equity in healthcare," Medical Economics, Nov. 12, 2019

When Private Equity Buys Practices, Prices (and Costs) Rise



Source: JAMA Health Forum 2022;2886
Note: Number of patient visits and total billings/revenues also increased after acquisition

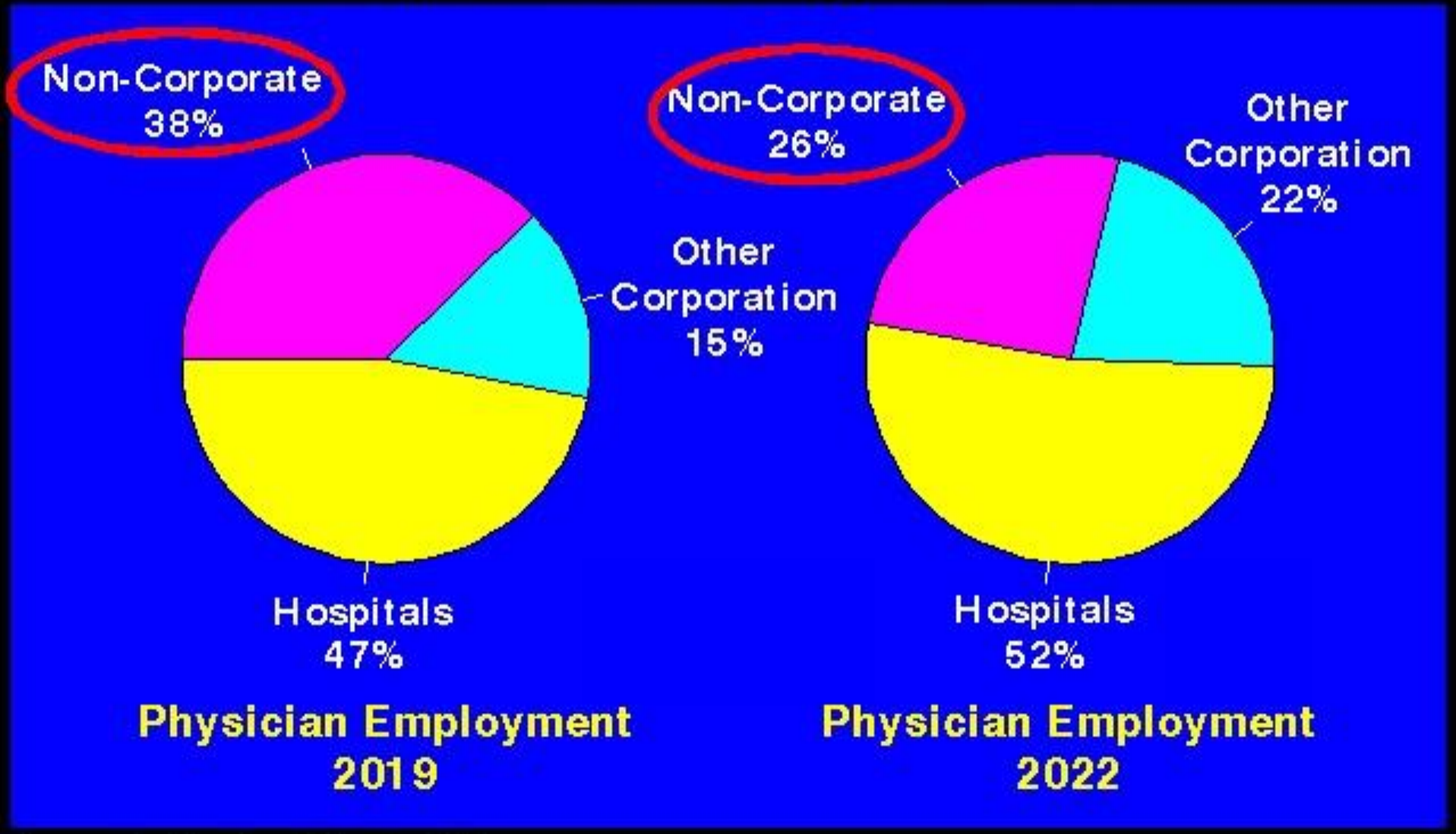
What Happens When PE Buys a Dermatology Practice?

- Push sales of cosmeceuticals.
- Offer bonuses for increasing elective procedures (and continued elective procedures throughout pandemic).
- Pushed MDs to increase (e.g. double) visit #s.
- Mobile clinicians do frequent skin check and biopsies on demented nursing homes patients.
- Bring dermatopathology services “in house”, increasing biopsy rates and likely false positive melanoma Dxs.
- Extensive use of poorly-supervised PAs and NPs for skin checks and procedures.
- Skimp on supplies.
- Increase Medicare billings/taxpayer costs.

Sources: Bloomberg Law 5/20/2020; NBC News 12/20/2021; NY Times 10/26/2018 & 11/20/2017

Most Physicians Are Corporate Employees

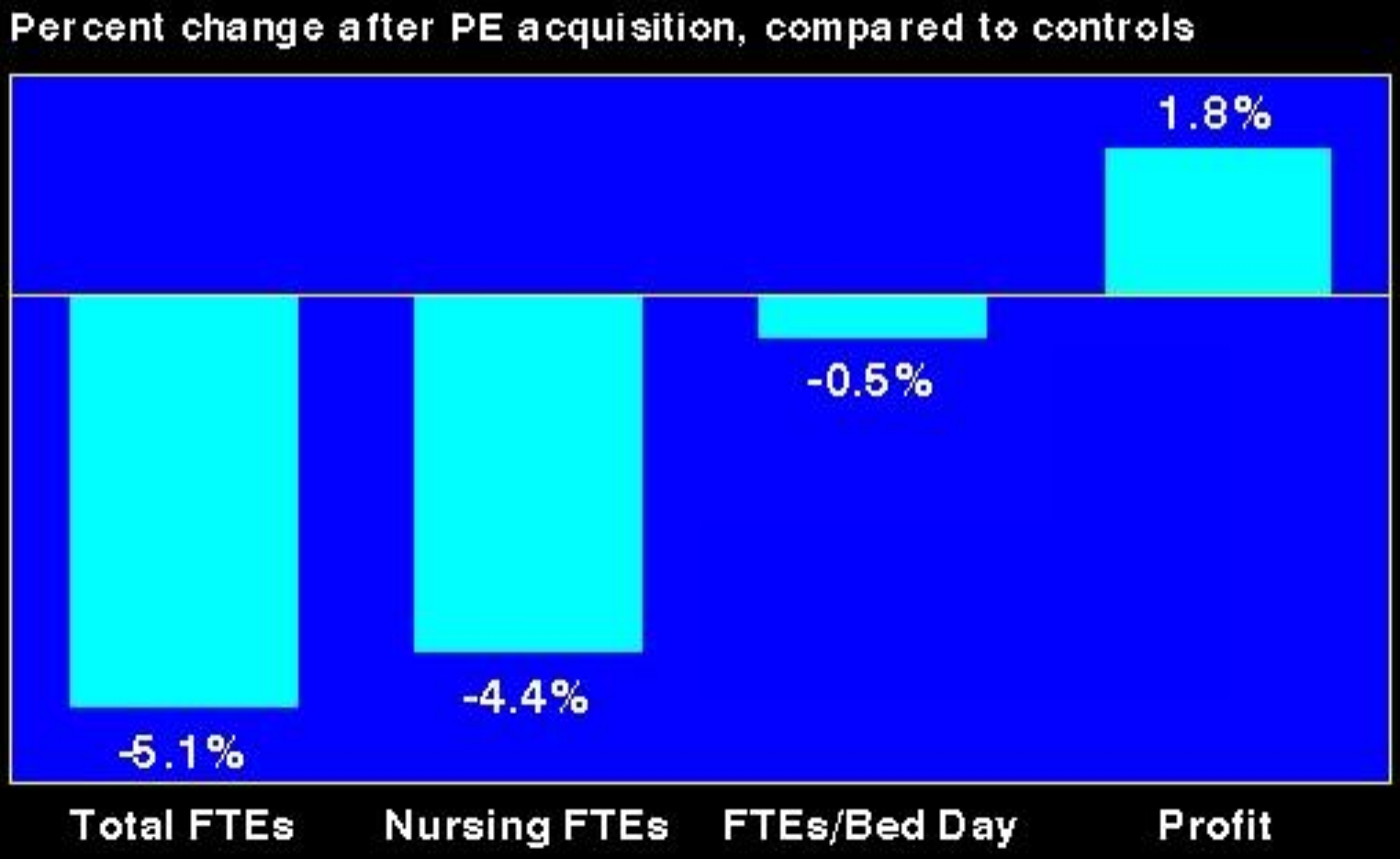
Rapid Growth During Pandemic



Source: Avalere Health April, 2022

Note: Data are for Medicare-participating physicians

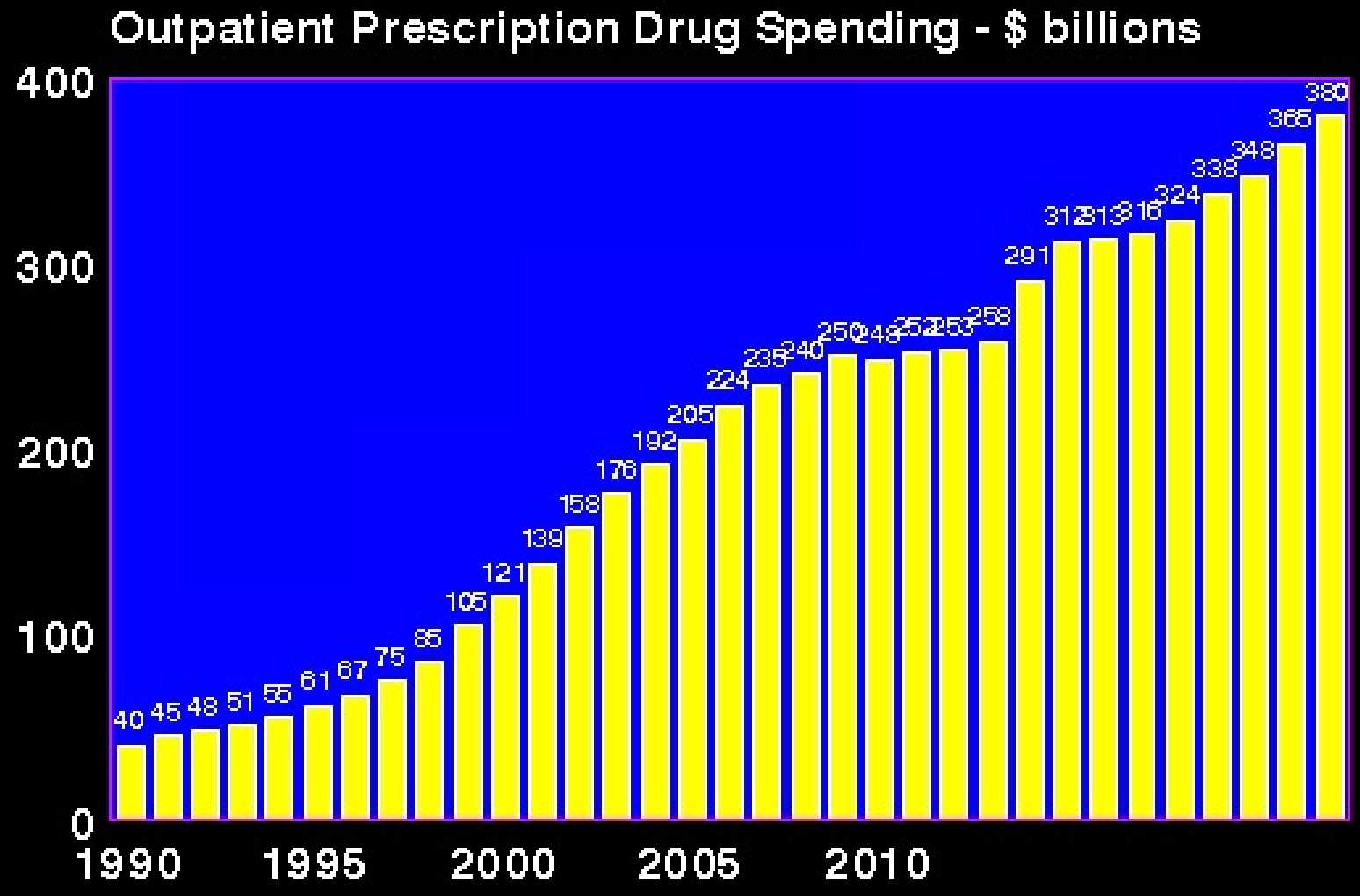
Private Equity Hospital Takeovers: Falling Care, Rising Profits



Source: Health Affairs 2022;41:523

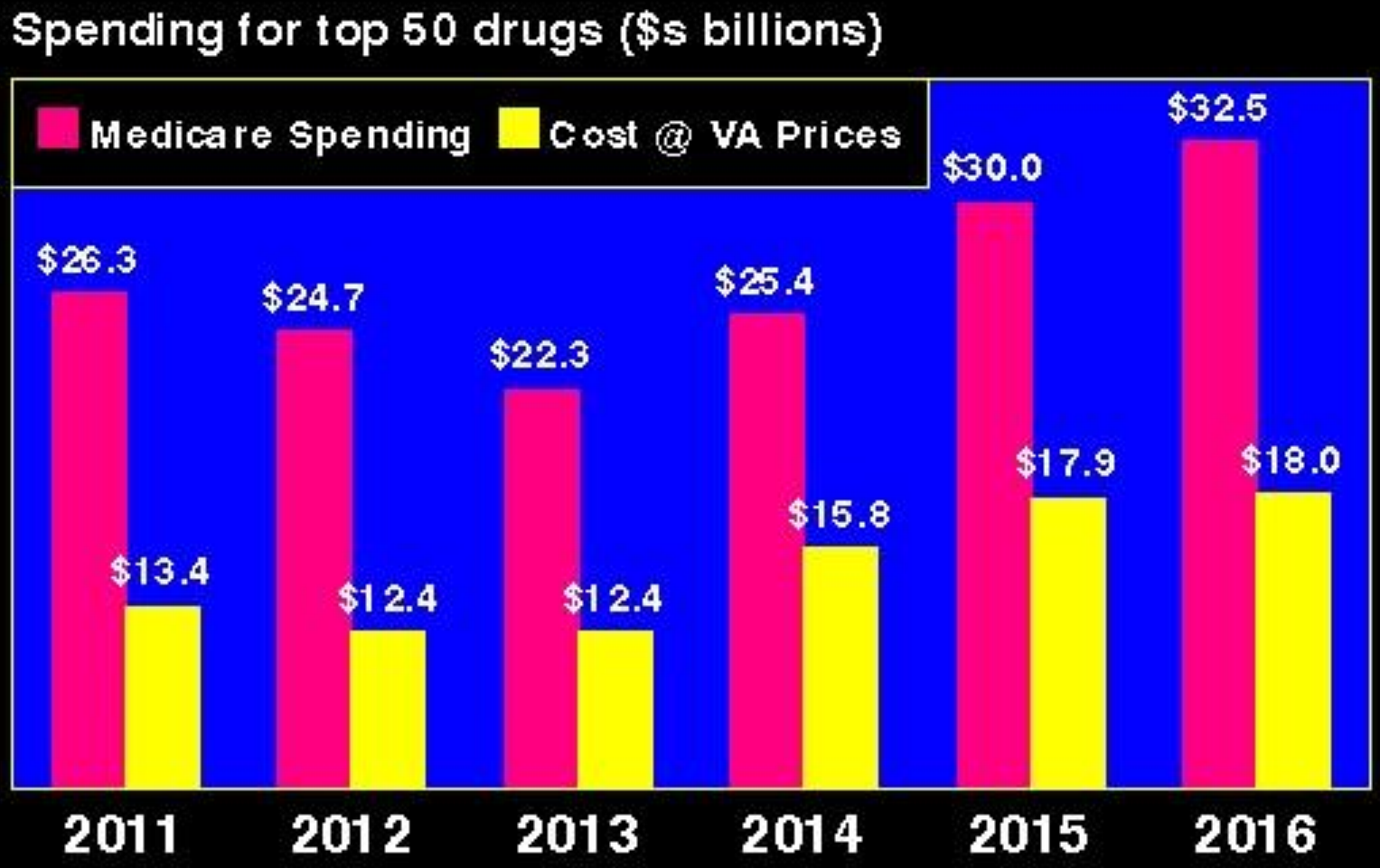
Drug and Device Firms Inflate Prices, Distort Priorities

U.S. Drug Spending, 1990-2022



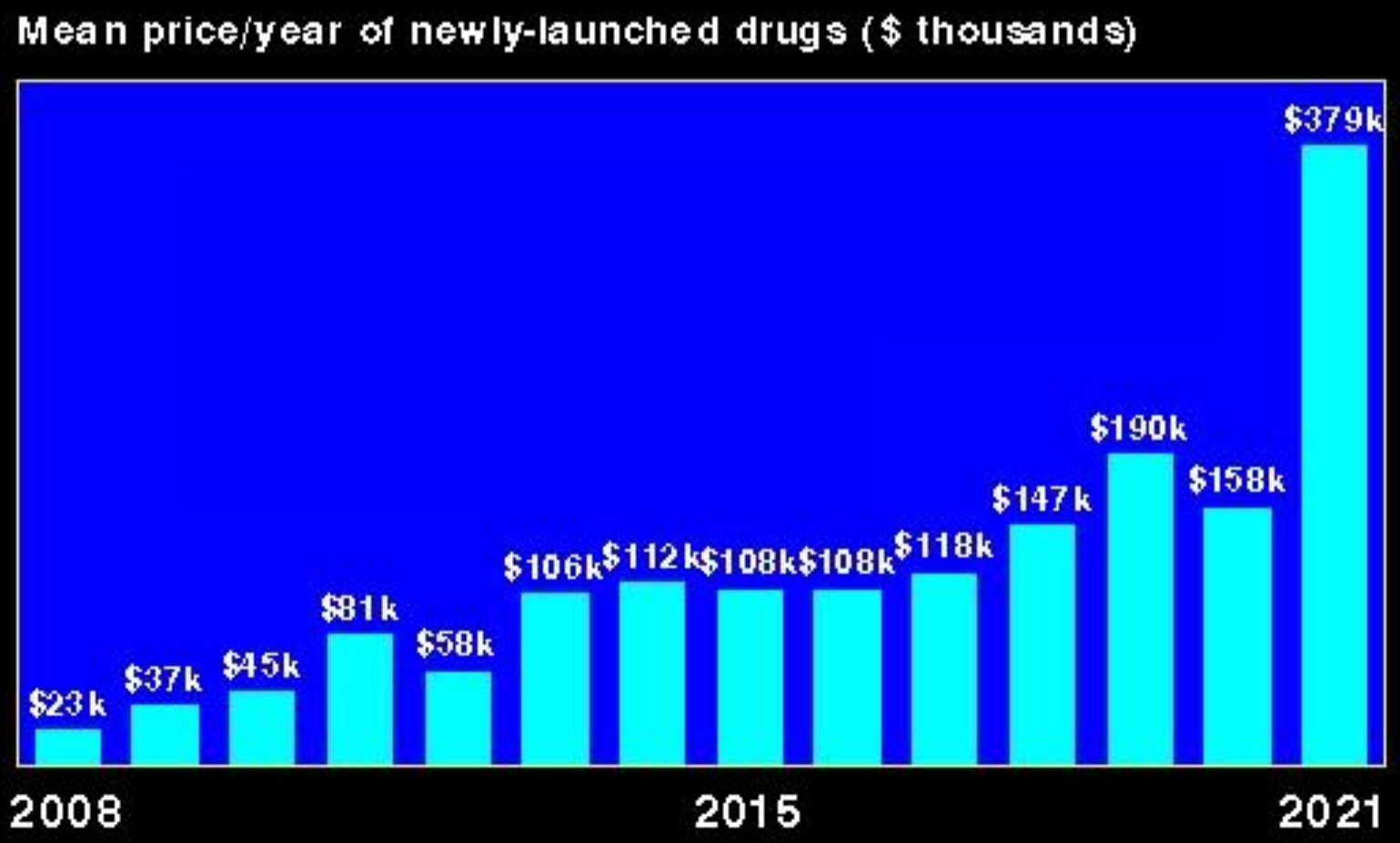
Source: CMS, Office of the Actuary - Note: 2021 - 2022 estimated

Medicare Would Have Saved $71 Billion Over 6 Years if it Paid VA Prices



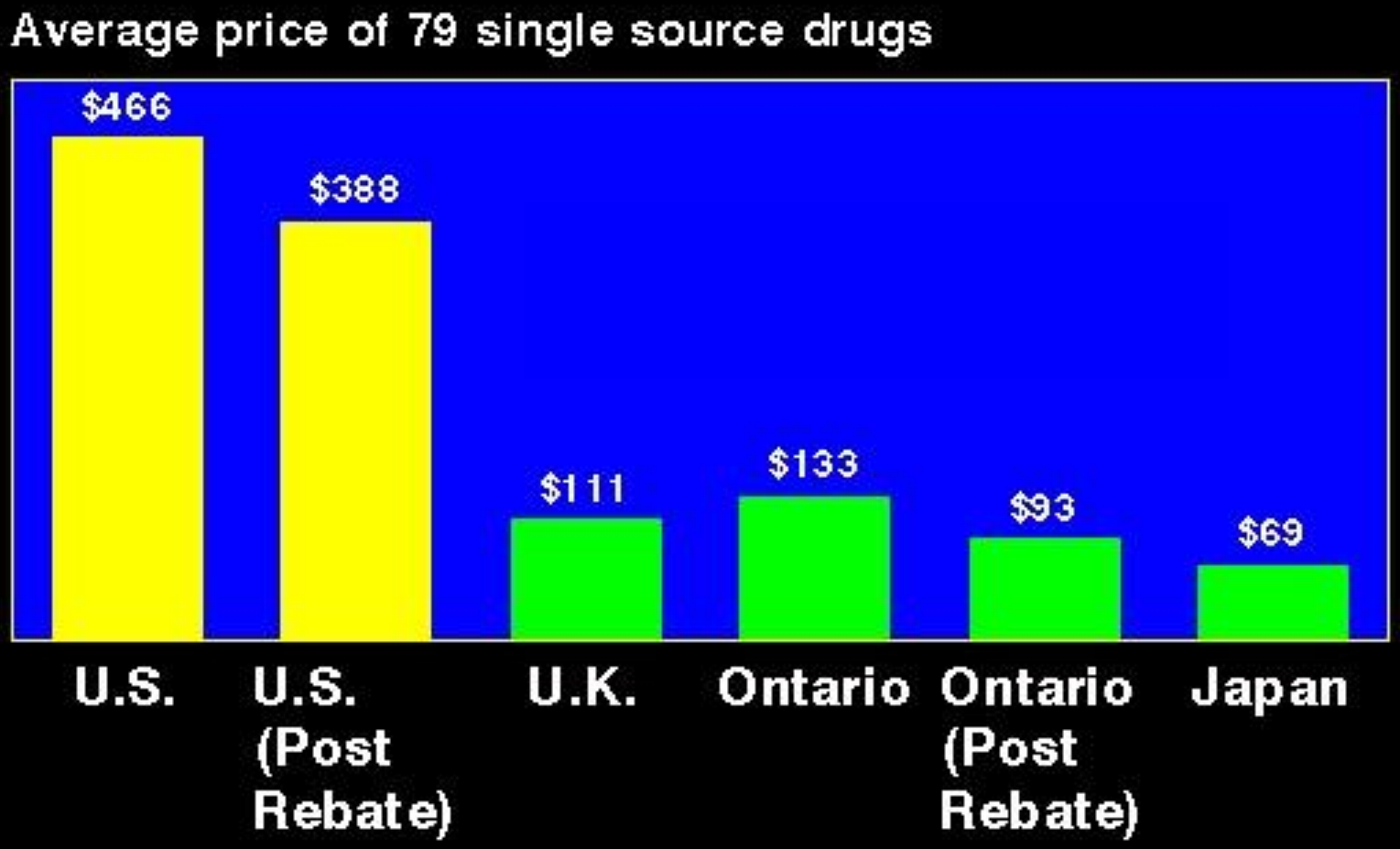
Source: JAMA IM 2019;179:431

Prices of Newly-Launched Drugs Have Skyrocketed



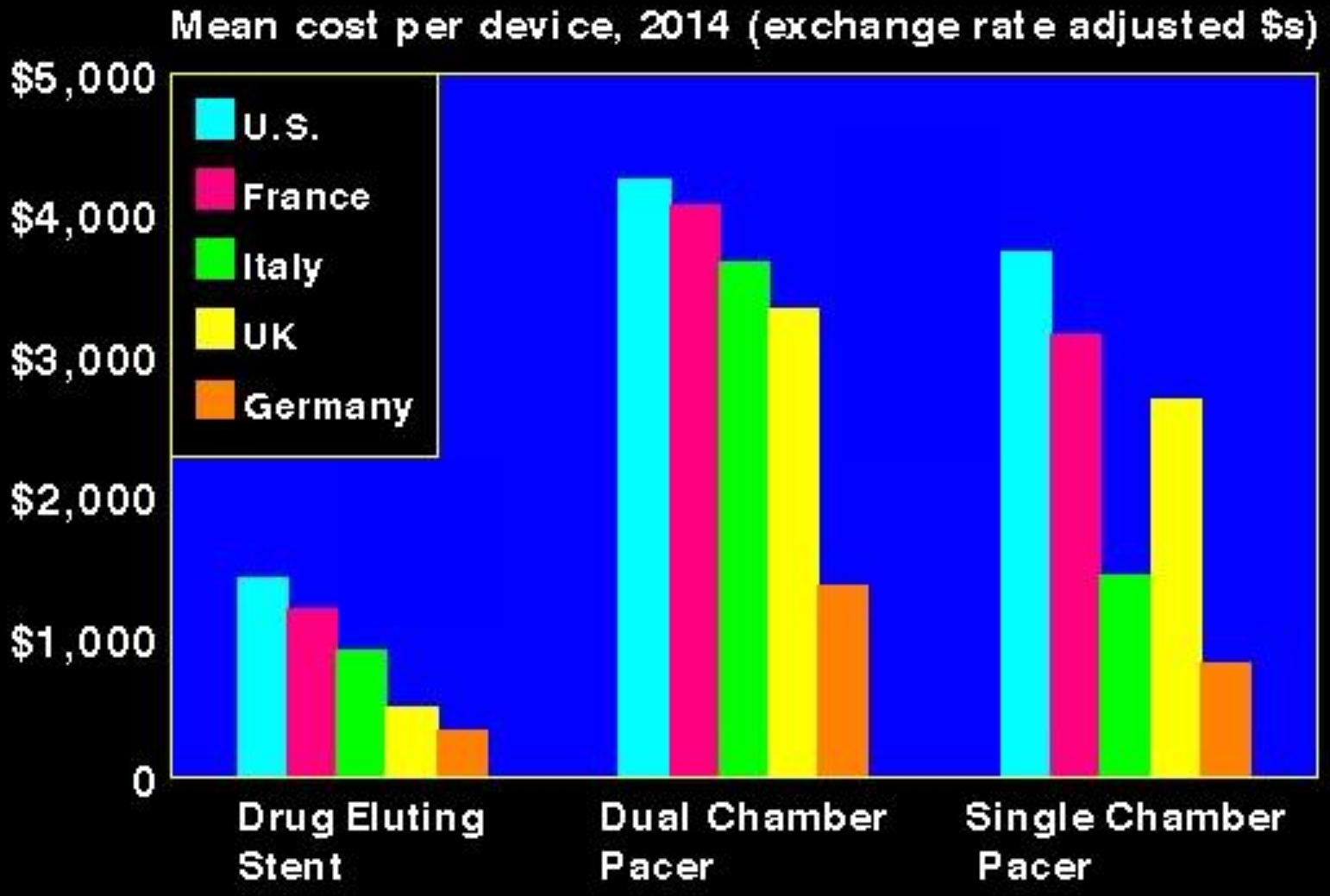
Source: JAMA 2022;327:2145

Medicare Part D Drug Prices are Several-Fold Higher than in Other Nations



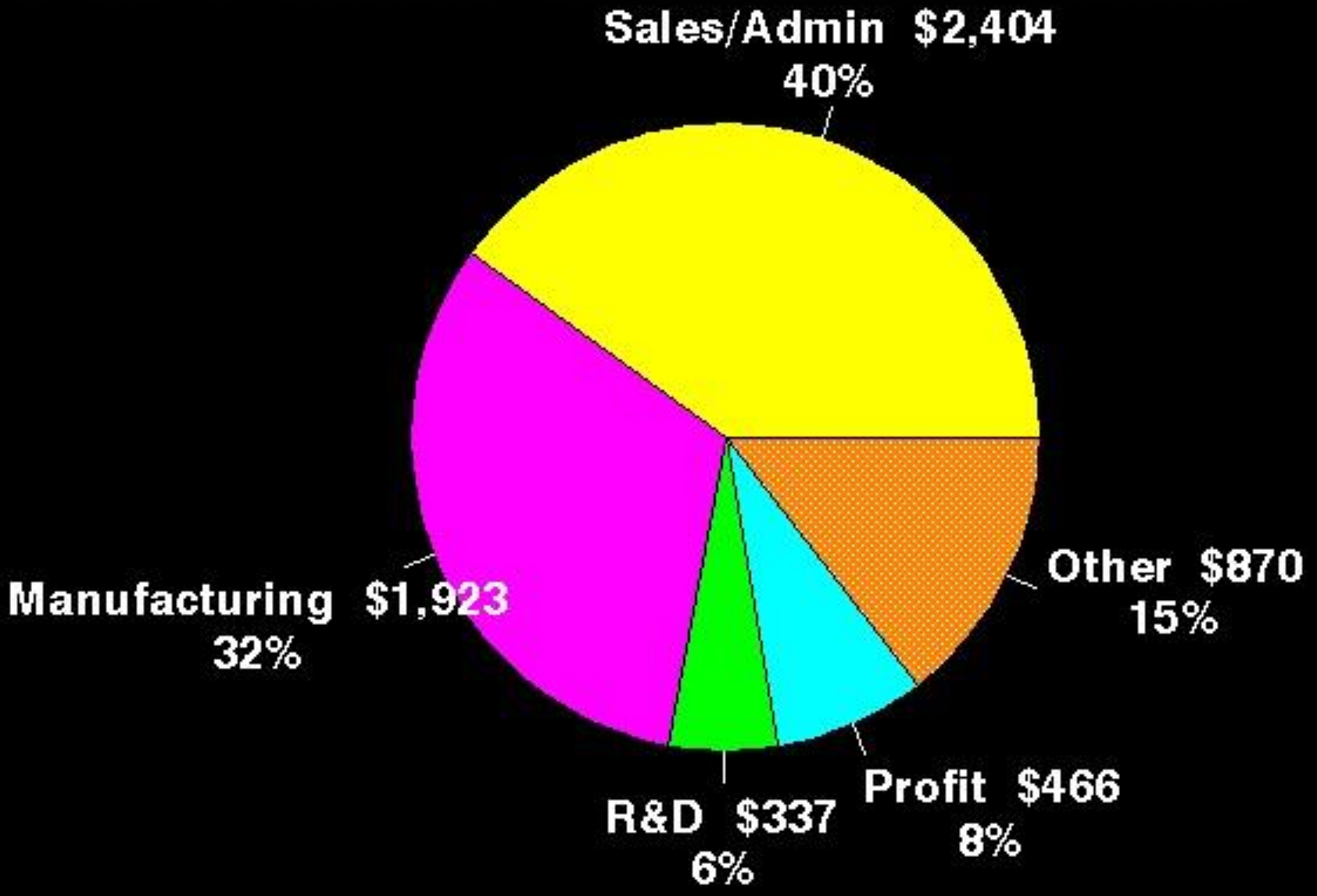
Source: Health Affairs 2019;38:804
Note: Purchasing these 79 drugs at the UK price would have saved Medicare $41 bil. in 2018

As With Drugs, Devices Price are Highest in U.S.



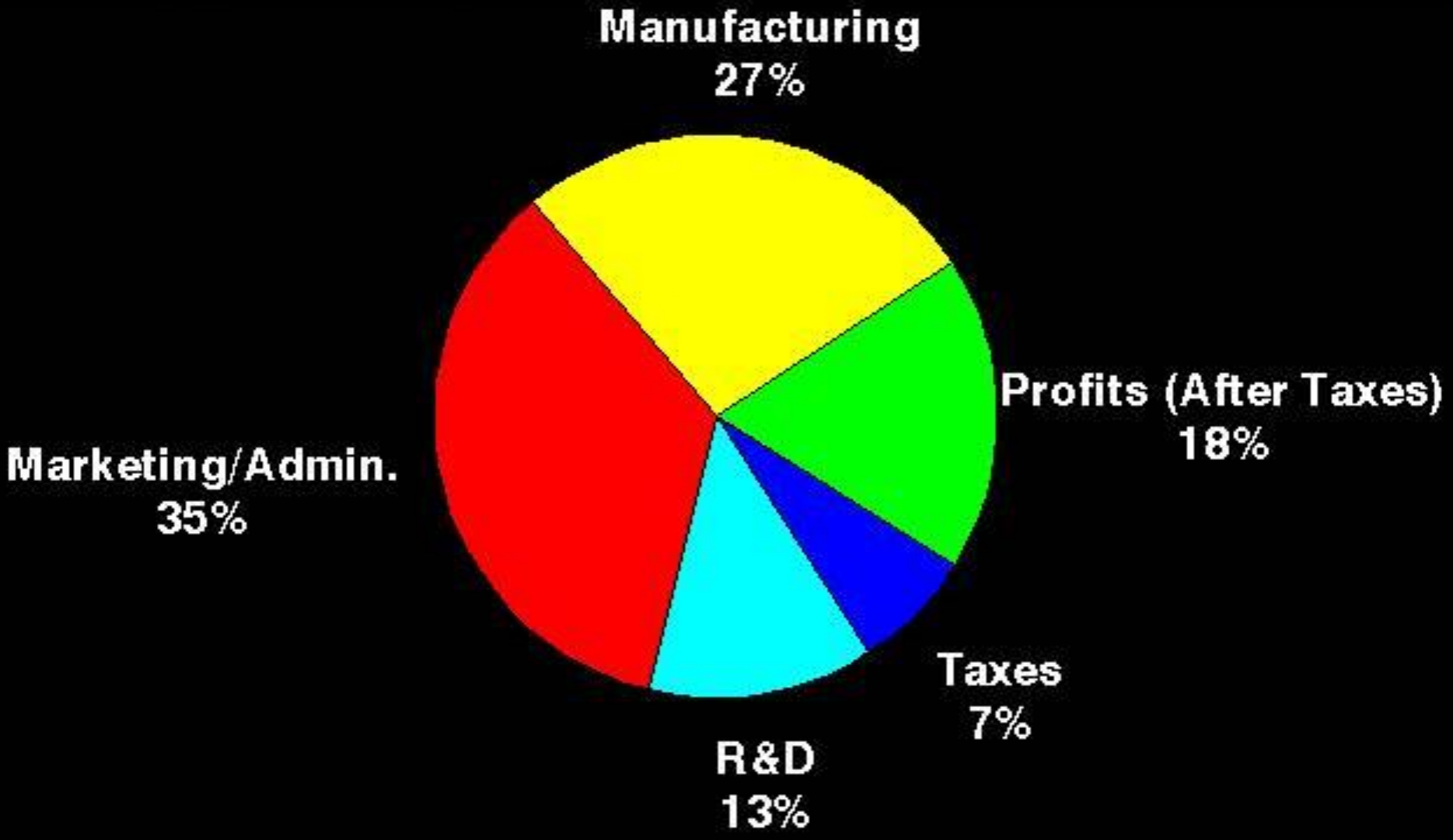
Source: Health Affairs 2018;37:1570
Note: Devices account for 6% of U.S. health expenditures

What Goes Into a $6000 Orthopedic Implant



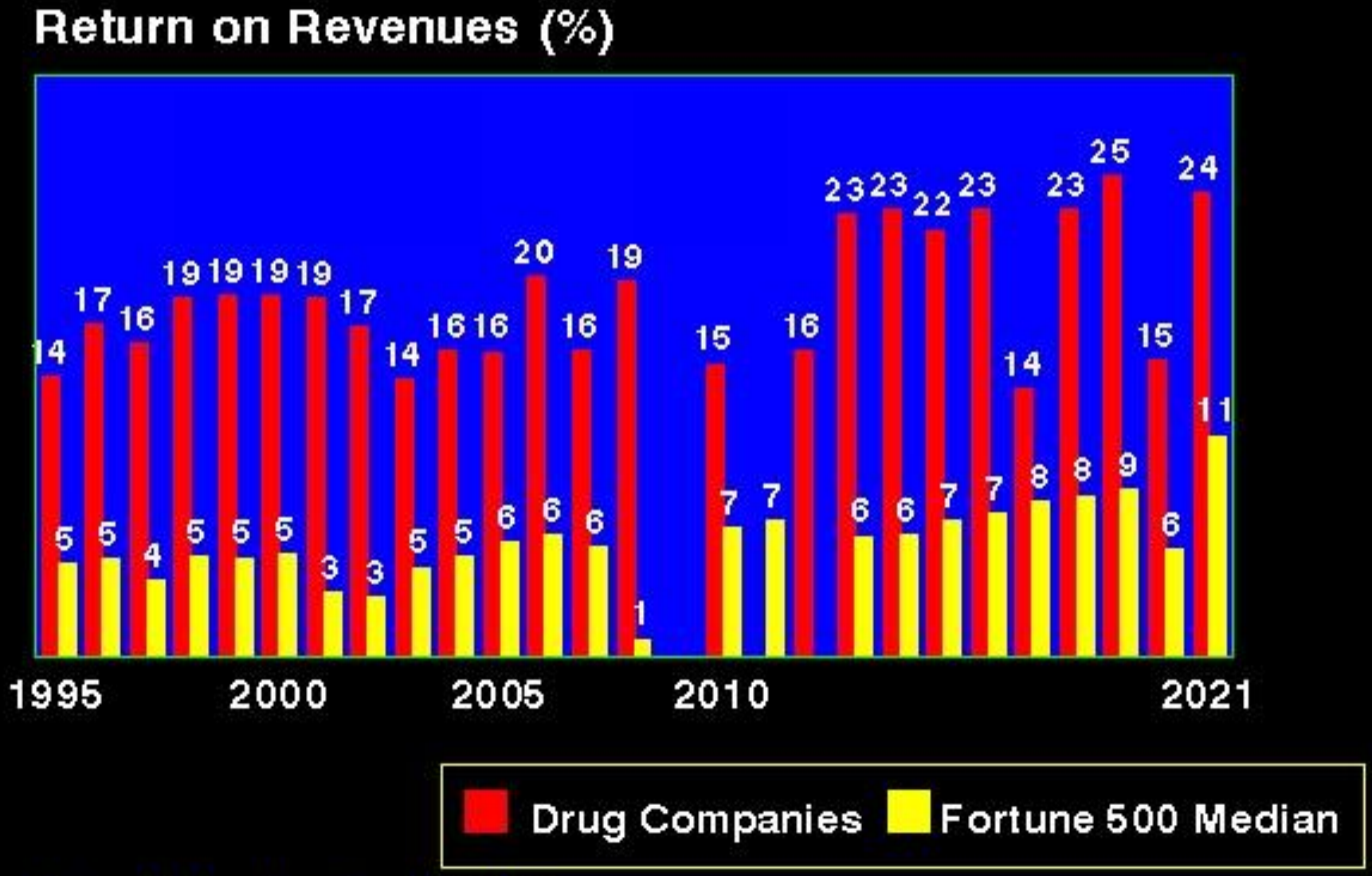
Source: Modern Healthcare 2/5/2018

Drug Companies' Cost Structure



Source: Health Affairs 2001; 20(5):136

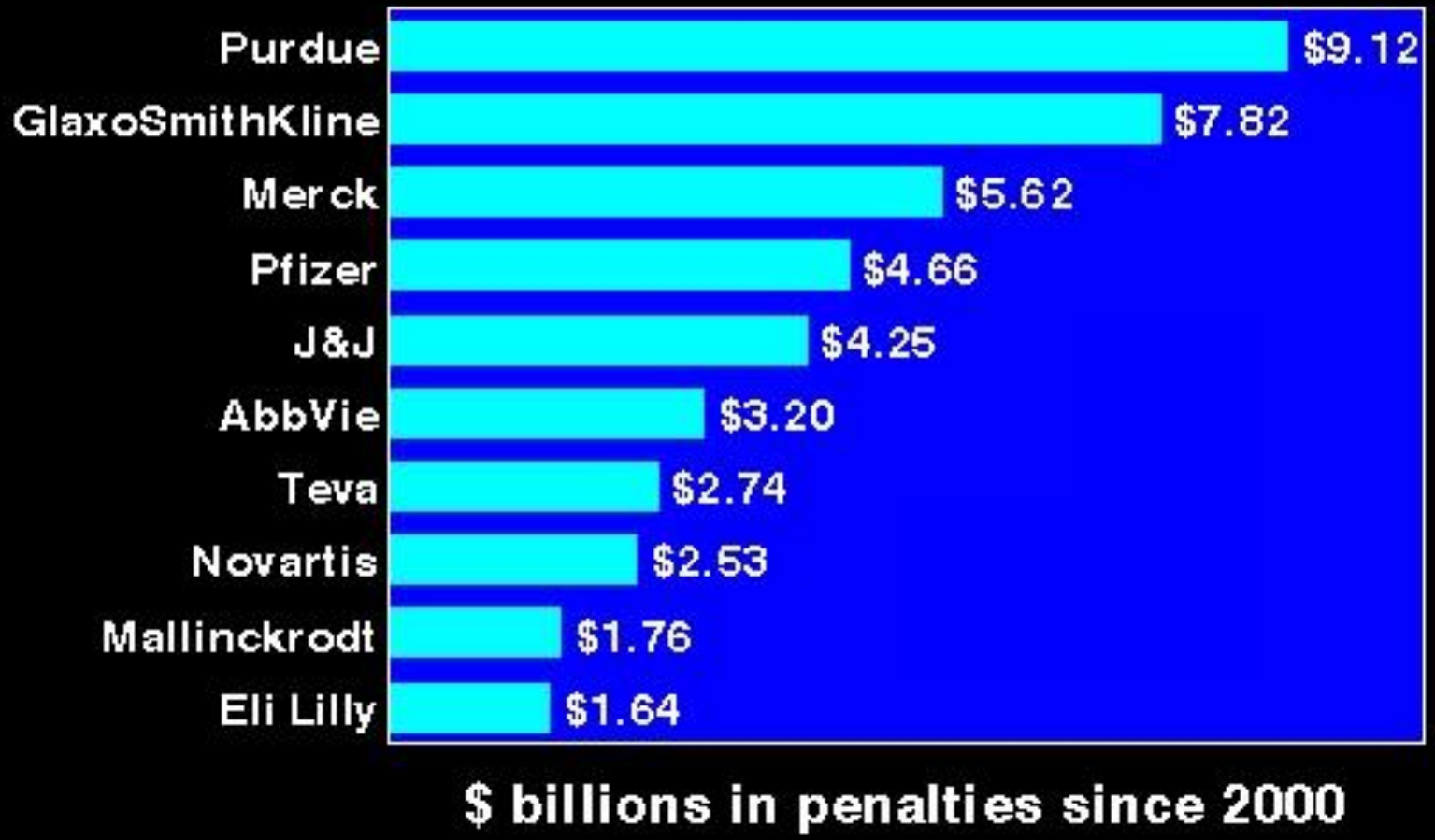
Drug Company Profits, 1995-2021



Source: Fortune 500 rankings for 1995-2022

Pharma Firms Have Paid $43.33 billion in Penalties Since 2000

Despite Fines, Profits Totaled ~ $2 Trillion



Source: GoodJobsFirst Violation Tracker - 8/2021 and JAMA 2020;323:834

INVESTING

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Goldman Sachs asks in biotech research report: 'Is curing patients a sustainable business model?'

Tae Kim | @firstadopter

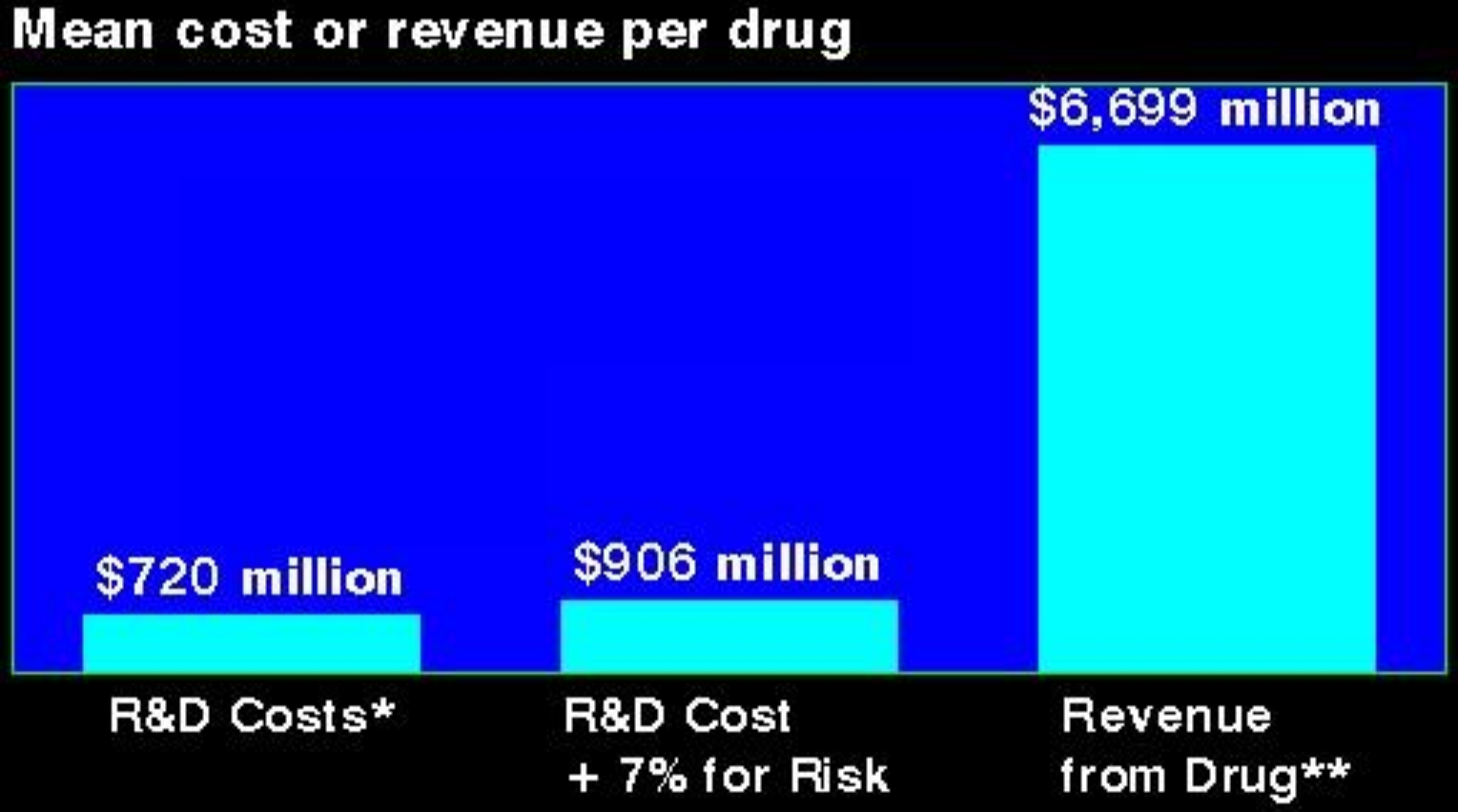
Published 3:15 PM ET Wed, 11 April 2018 | Updated 7:20 PM ET Wed, 11 April 2018

CNBC

"The success of its [Gilead's] hepatitis C franchise has gradually exhausted the available pool of treatable patients. . .In the case of infectious diseases such as hepatitis C, curing existing patients also decreases the number of carriers able to transmit the virus to new patients."

Profits Dwarf Cancer Drug R&D Costs

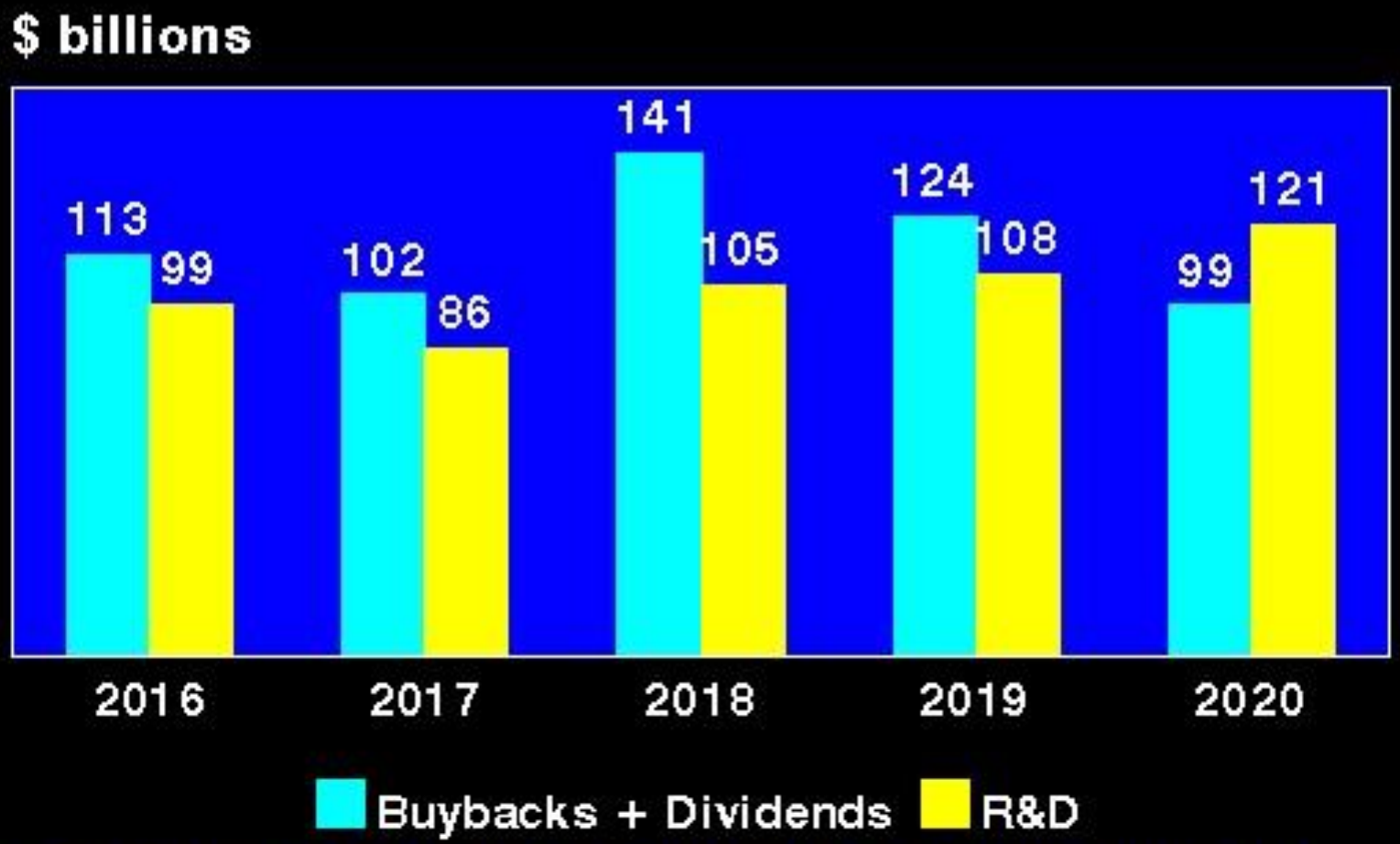
Analysis of All Drugs Approved 2006-2015
From Firms With Only 1 Approved Drug



Source: Prasad et al. JAMA IM, online 9/11/2017
* Costs of all company R&D, including their non-approved agents
** Total revenue from sales since approval - mean of 3.8 years

Drug Firms Spent More on Stock Buybacks and Dividends Than on R&D

$578 bil. for shareholders, $522 bil. for R&D

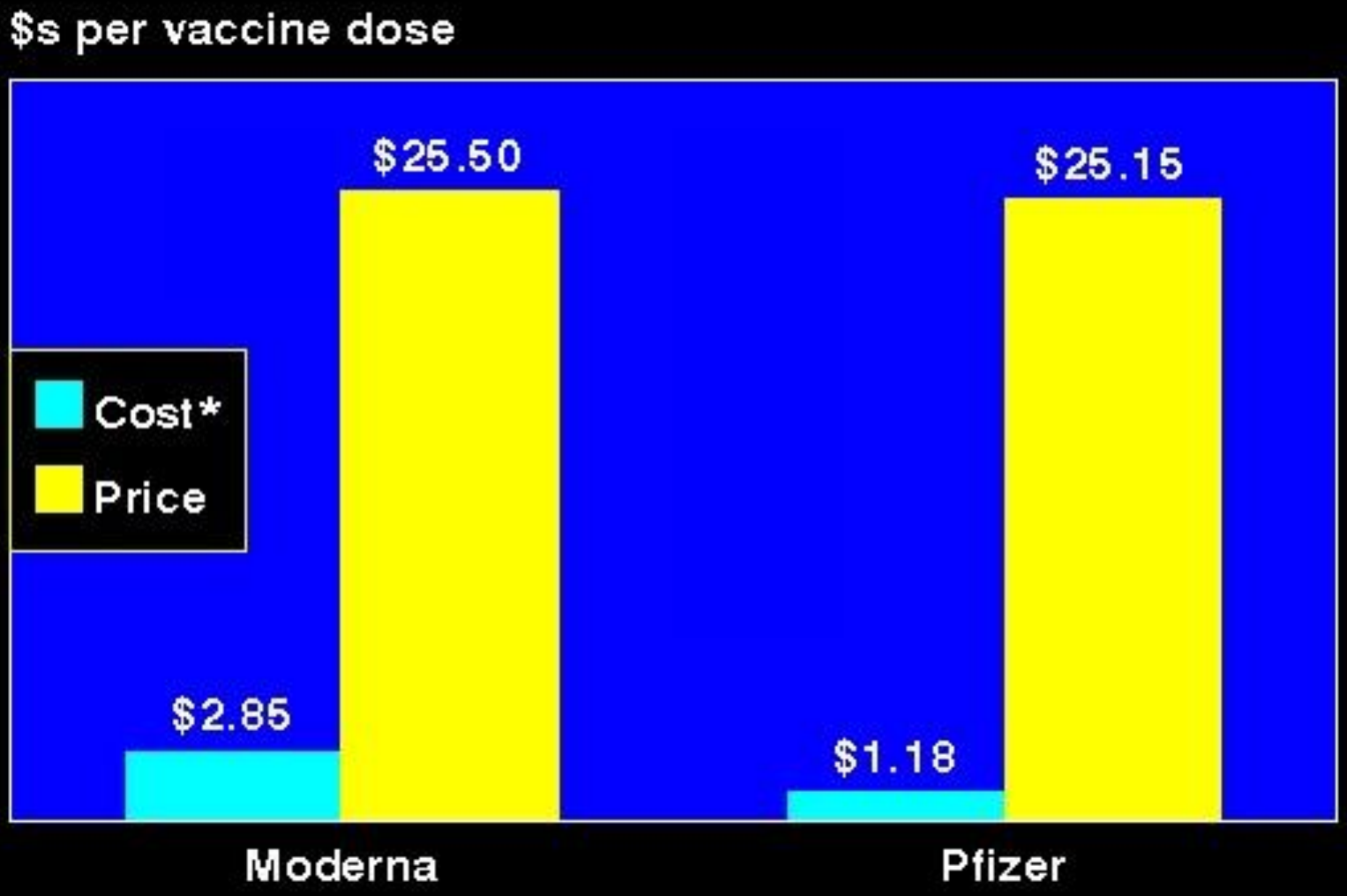


Source: Congressional Committee on Oversight and Reform - July, 2021

Government Paid Twice for Vaccines

- Funded most of the basic science research underlying mRNA vaccines and that characterized the spike protein.
- Spent at least $18 billion subsidizing vaccine makers' research and production, purchased all doses used in US.
- Firms refused to share vaccine recipe, limiting global production capacity and leaving billions unprotected.
- Cost to manufacture mRNA vaccine: ~$2/dose for Moderna, ~$1/dose for Pfizer. Sale price ~$25/dose. (J Royal Soc Med 2021;114:502)
- "Pfizer, BioNTech and Moderna will make pre-tax profits of $34 billion this year between them, which works out as over a thousand dollars a second." (Peoples Vaccine Alliance)

COVID-19 Vaccine Makers Jack Up the Price

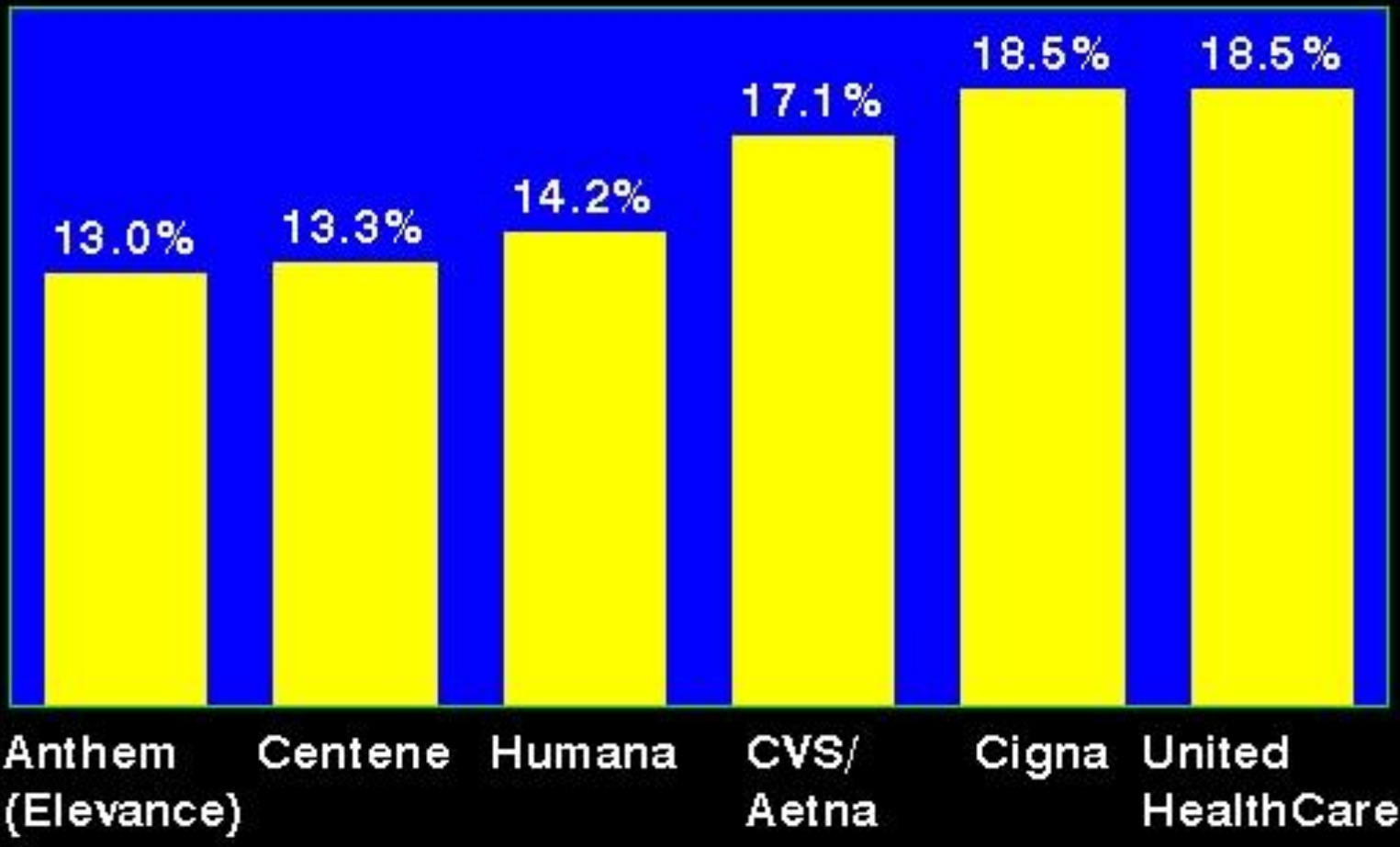


Source: Light & Lexchin. J Royal Soc Med 2021;114:502

*Cost figure includes estimated cost of materials + capital + personnel

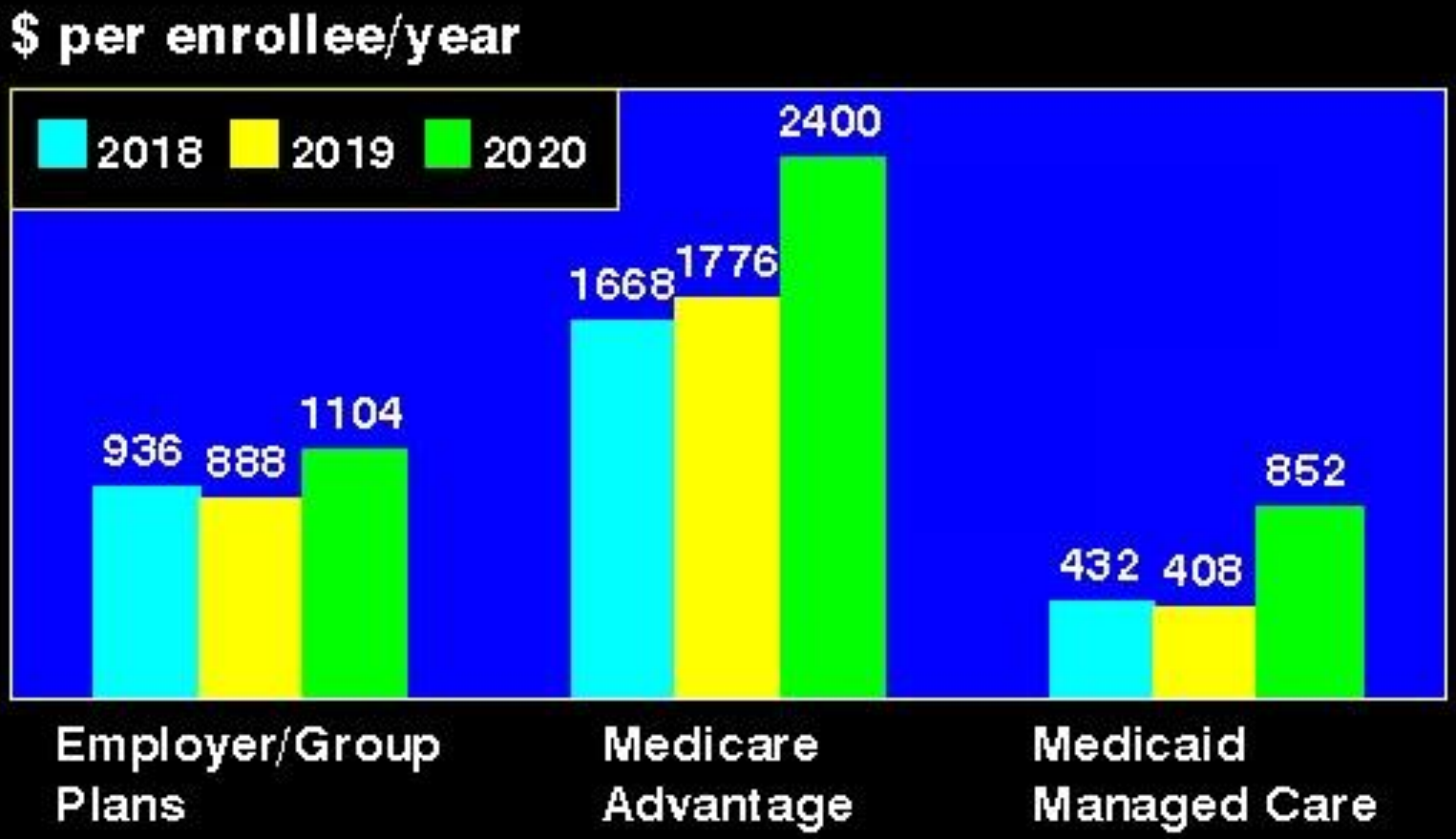
Private Insurers: Middlemen Who Add Costs But Not Value

Insurance Overhead, 2022



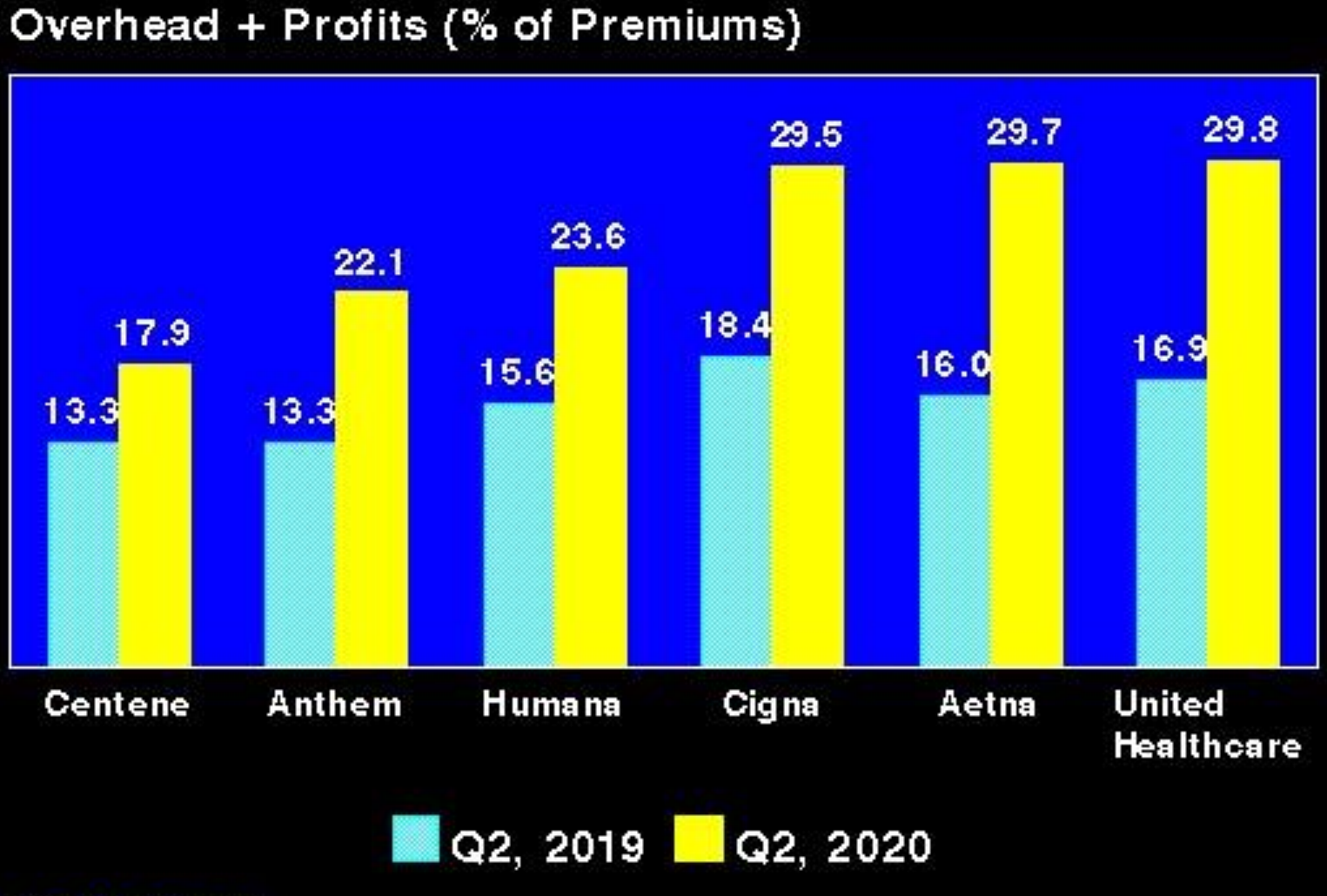
Source: SEC filings for second quarter, 2022
Note: Overhead = percent of premiums not spent on medical services
Note: Figure for Cigna is for first quarter, 2022

Private Insurers' Overhead/Profit Per Enrollee, 2018-2020



Source: Kaiser Family Foundation analysis of National Assoc. of Insurance Commissioners' data
Note: Data are for January 1 - September 30, annualized

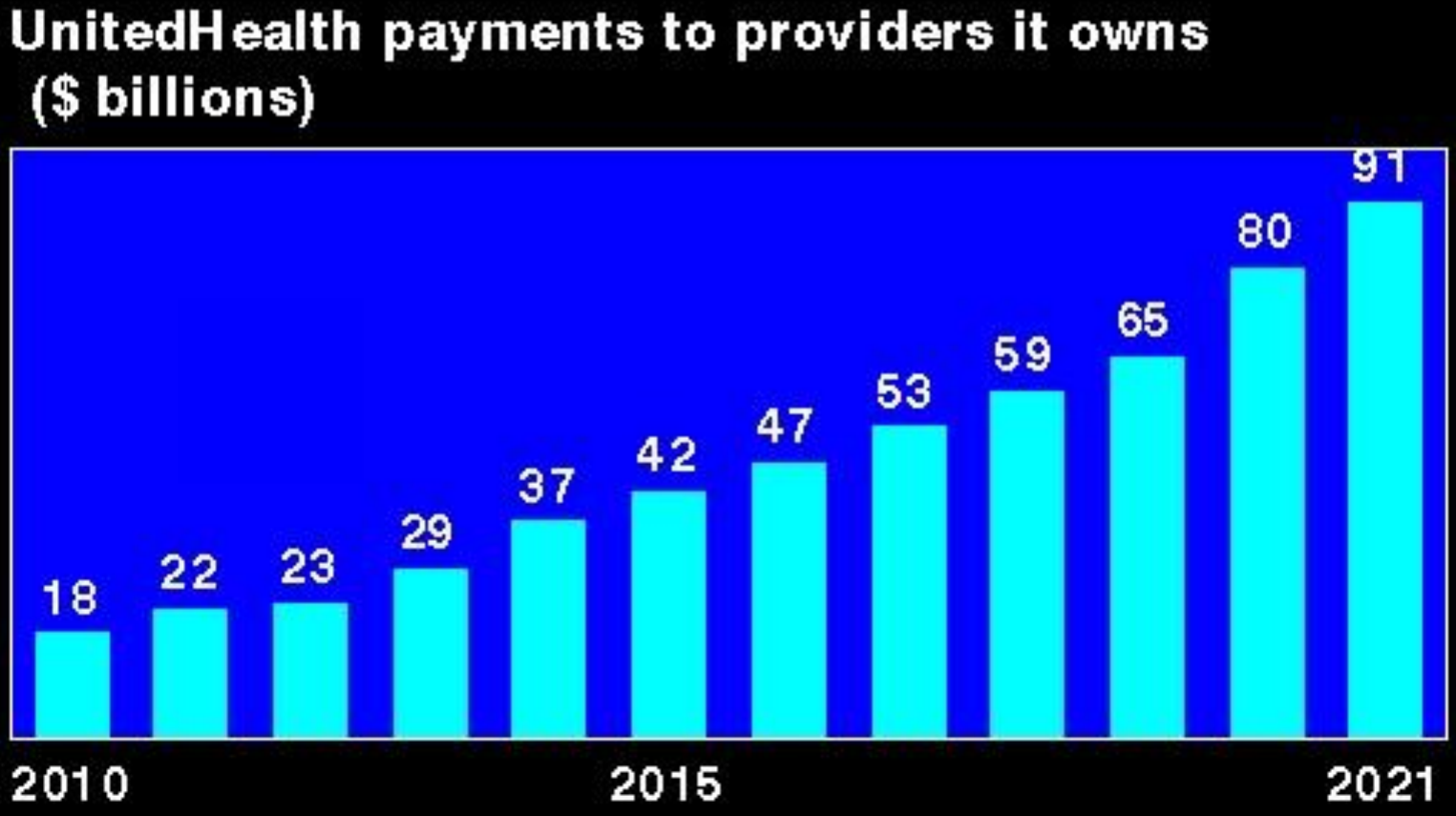
COVID-19 Boosted Insurers' Profits



Source: SEC Filings

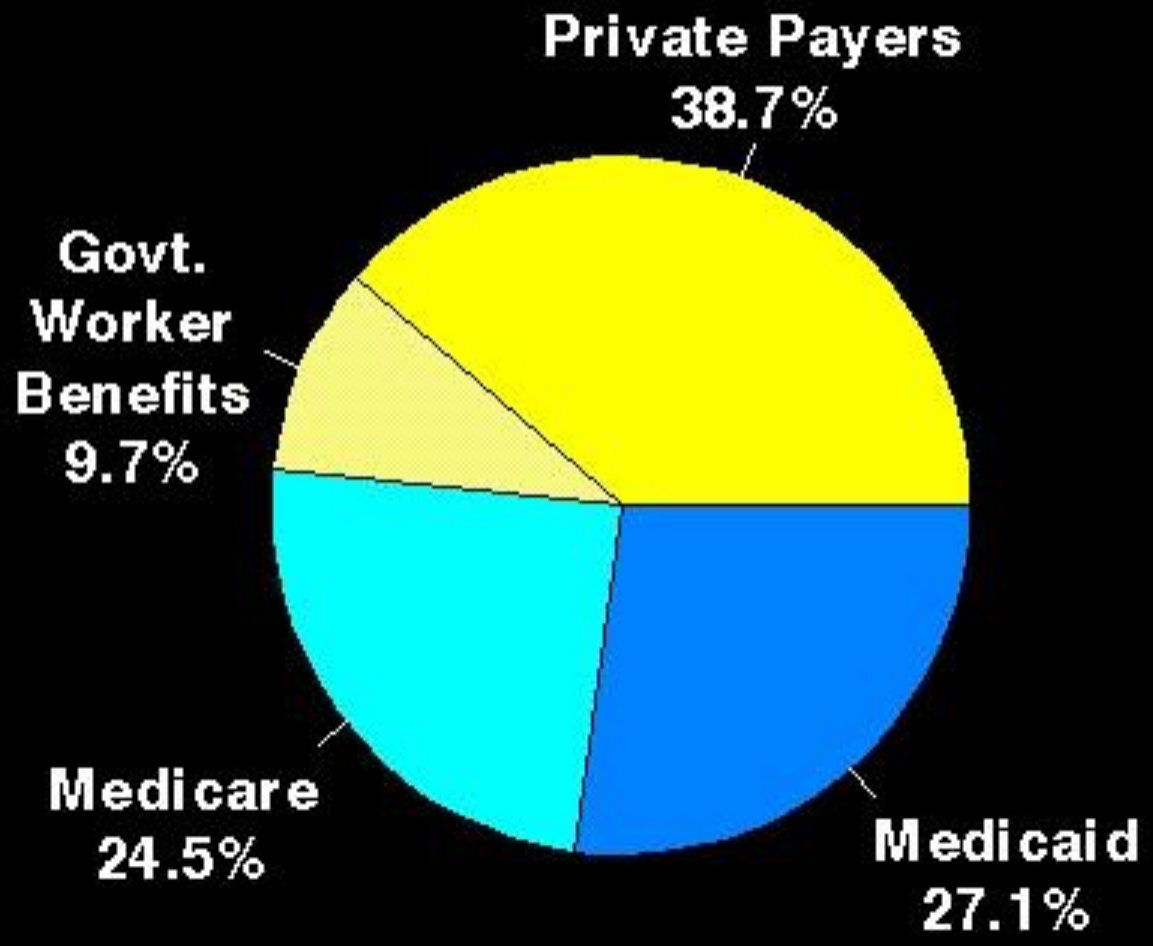
Insurers "Double Dip" to Skirt Medical Loss Ratio Limits

"Profits swell when insurers are also your doctors"



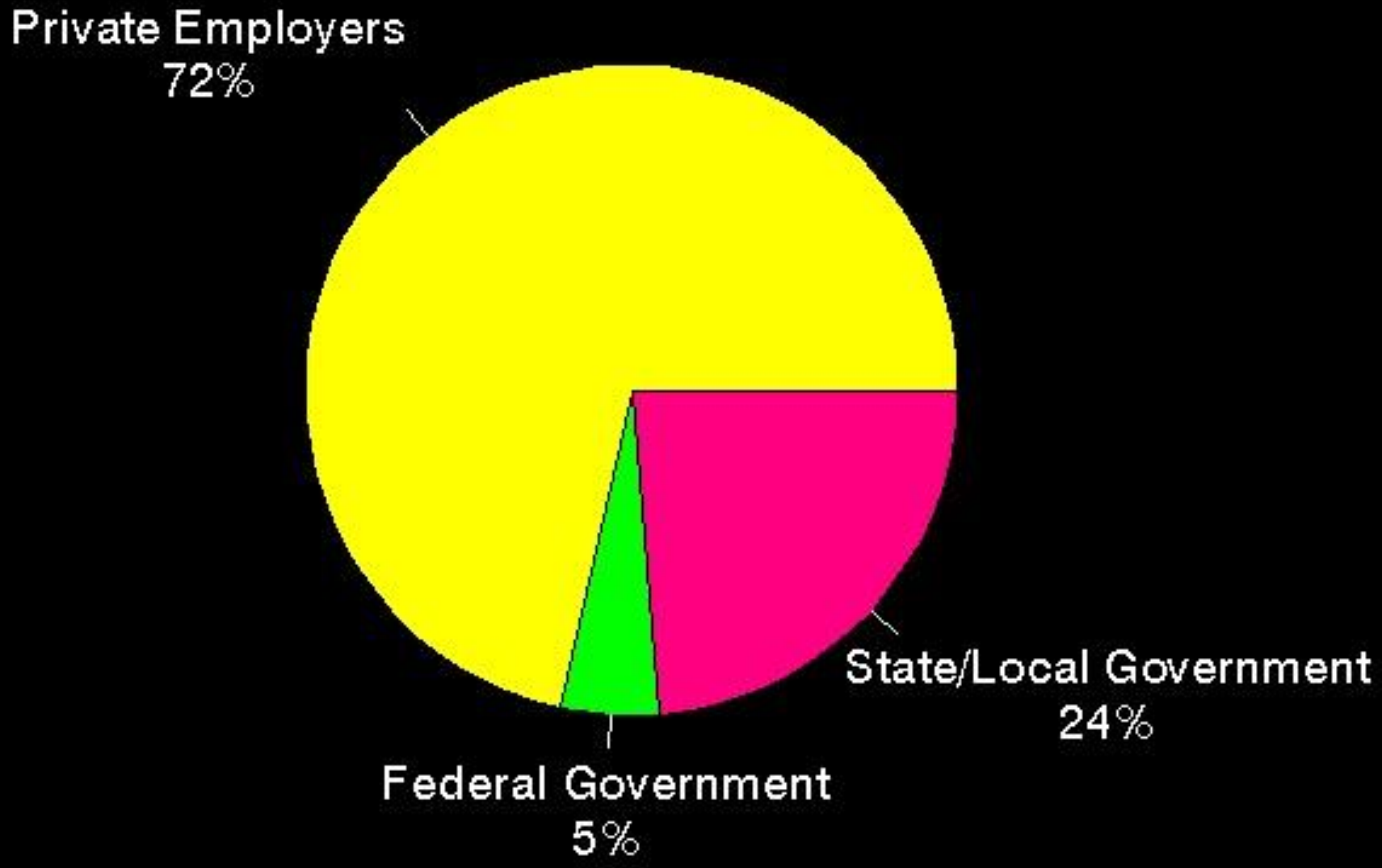
Source: Bob Herman, Axios July 16, 2021

61% of Private Insurers' Revenues Come From Government Payers



Source: AM Best 8/13/2018 - Government workers' benefit costs estimated from CMS data

Employer Payments for Private Insurance, 2020



Source: NCHS 2020

Insurers Risk Select Via Formulary Design

Put Generics Needed by Sicker Patients in High Co-Pay Tier

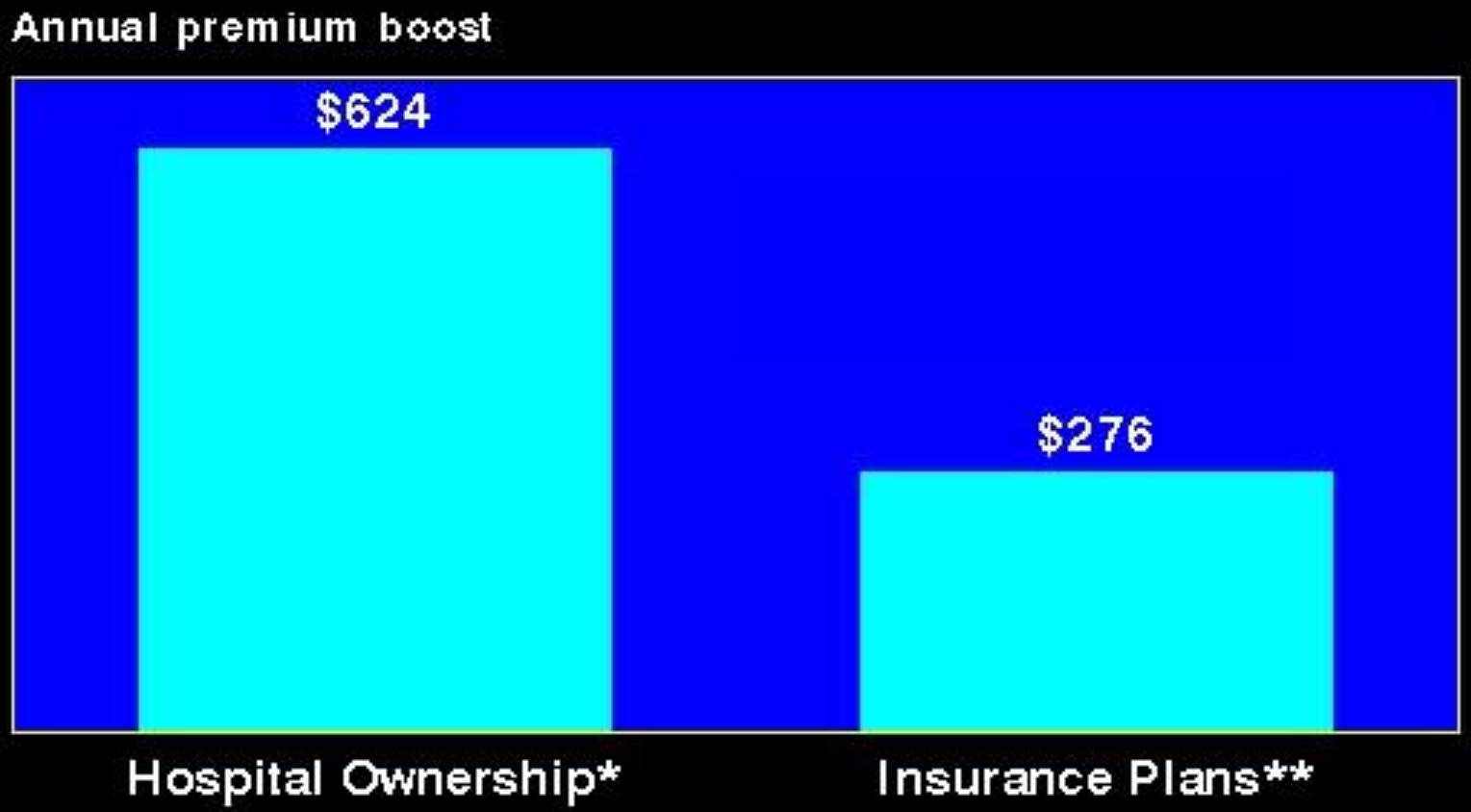
Drugs of Choice	Illness	Plan 1	Plan 2	Plan 3*
Anti-Retrovirals	HIV	No	No	No
Triptans	Migraine	No	No	No
Anti-Psychotics	Schizophrenia	No	No	No
Macrolides	Pneumonia	Yes	No	No
L-Dopa	Parkinson's	Yes	No	No
Anti-Convulsants	Seizure	Yes	No	No
ACE Inhibitors	Hypertension	Yes	Yes	No
Metformin	Diabetes	Yes	Yes	No

Source: Oster & Fendrick, Am J Managed Care 2014; 9:693-4

* Harvard Pilgrim

"No" = No drug of choice available in Tier 1 (lowest co-pay)

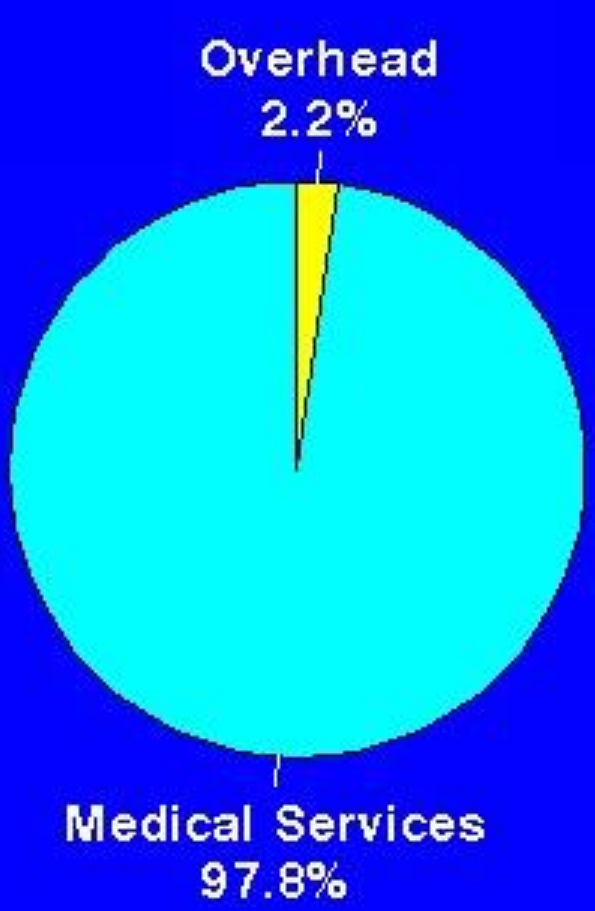
Both Hospital and Insurer Consolidation Raise Premiums



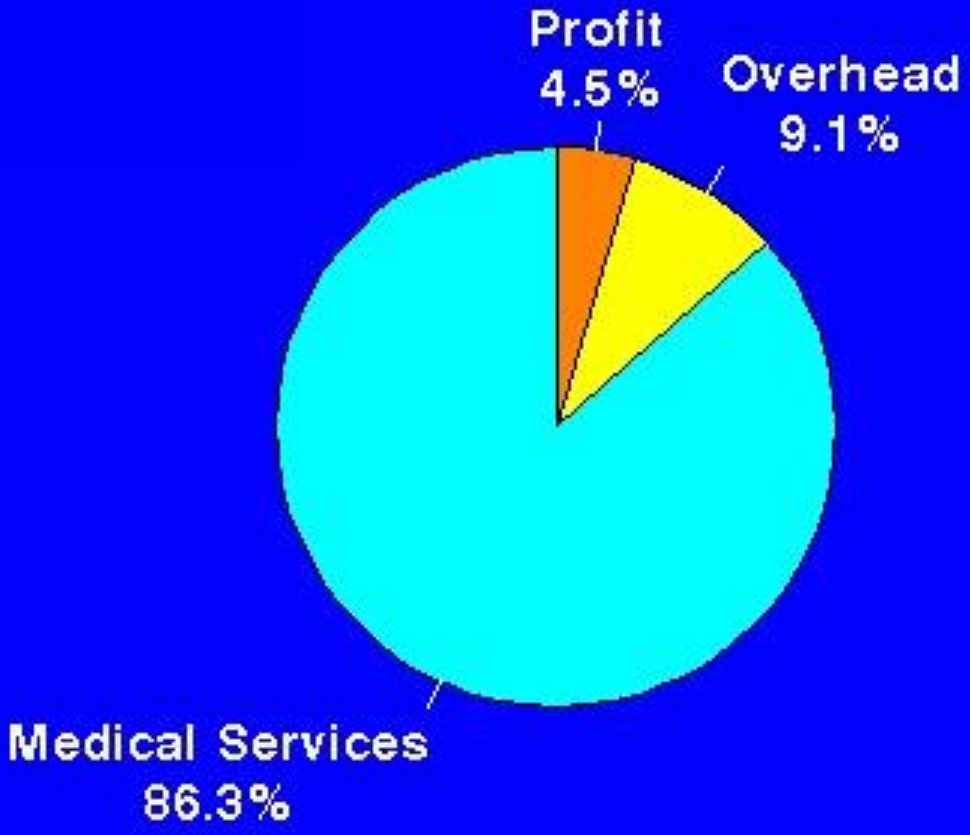
Source: Health Affairs 2019;34:668
* Difference between regions with most and least concentrated tertiles of ownership
** Difference associated with the presence of one fewer insurer in region

Medicare Advantage: The Only Working Model of Competing Private Plans and a Public Option (Traditional, FFS Medicare)

Medicare Advantage Plans' High Overhead



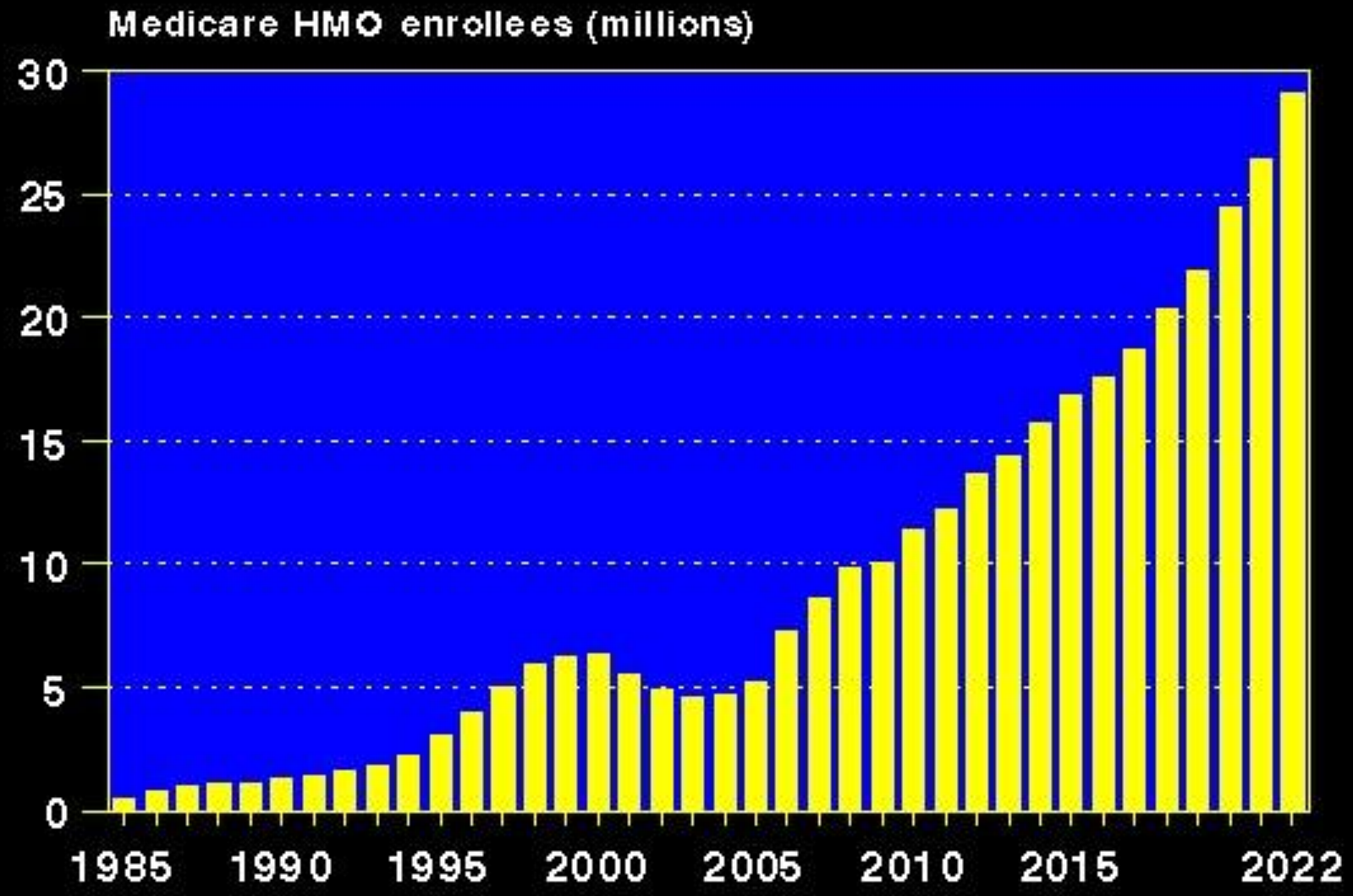
Traditional Medicare



Medicare Advantage Plans

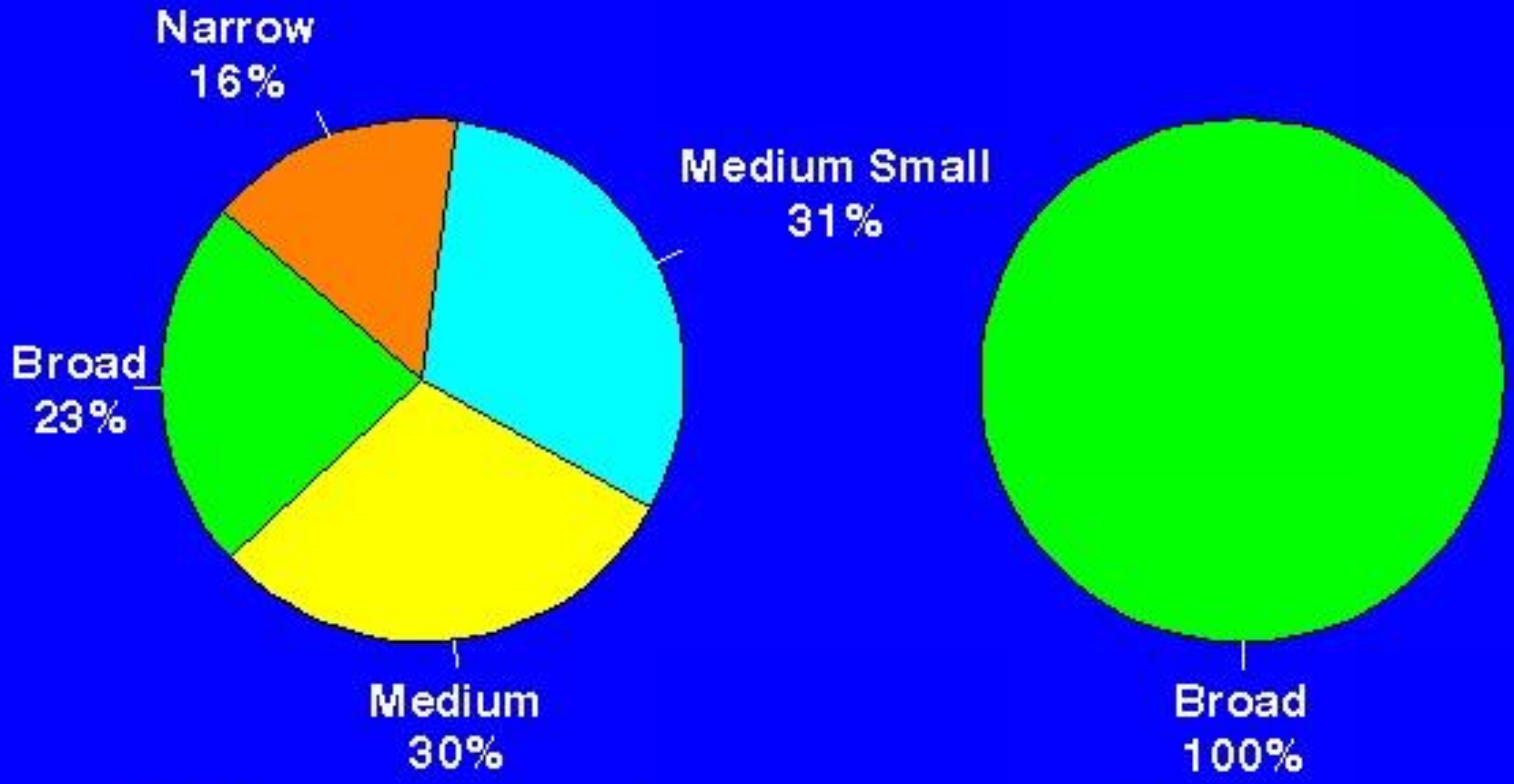
Source: GAO 12/2013 and Medicare Trustees report 2012 - Figures are for 2011
Note: MA overhead = $905/enrollee; profit = $447/enrollee; total profit = $3.3 billion

Medicare HMO Enrollment, 1985-2022



Source: CMS & Kaiser Foundation

Medicare Advantage Plans' Narrow Networks



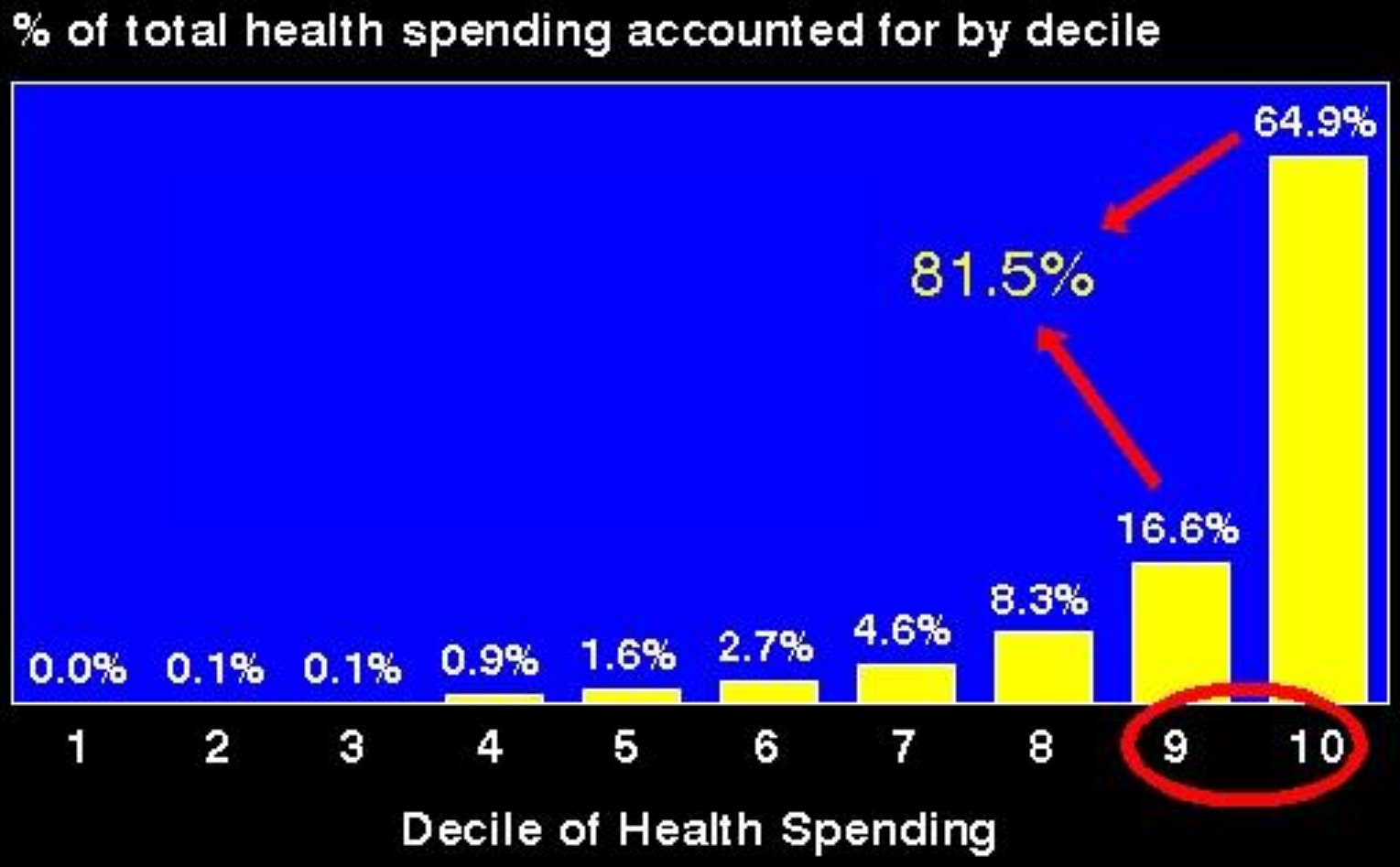
Source: Kaiser Family Foundation June, 2016
Note: Narrow = <30% of hospitals; Medium small = 20-49%; Medium = 50-69%; Broad = >69%
Note: >1/3 of all plans lack an NCI cancer ctr.; 49% of narrow networks exclude academic med centers

How do Medicare Advantage Plans Outcompete Traditional Medicare?

- Cherry-picking + Lemon-dropping
  - Exclude hospitals/doctors attractive to high-cost patients
  - Benefit/formulary design
  - Hassle factor
- Upcode + over-diagnose to game risk adjustment
- Outright cheating

A Few Sick People Account for Most Health $s

Percent of Total Spending for Each Decile Among Non-Institutionalized Americans



Source: JAMA 2016;316:1348

Medicare Advantage Plans' Strategies: 1- Cherry Picking

Marketing, network manipulation, benefit design

Medicare Advantage Enrollees Cost $1,253/year Less Before Enrolling

MA plans selectively recruit low-cost enrollees within each diagnosis

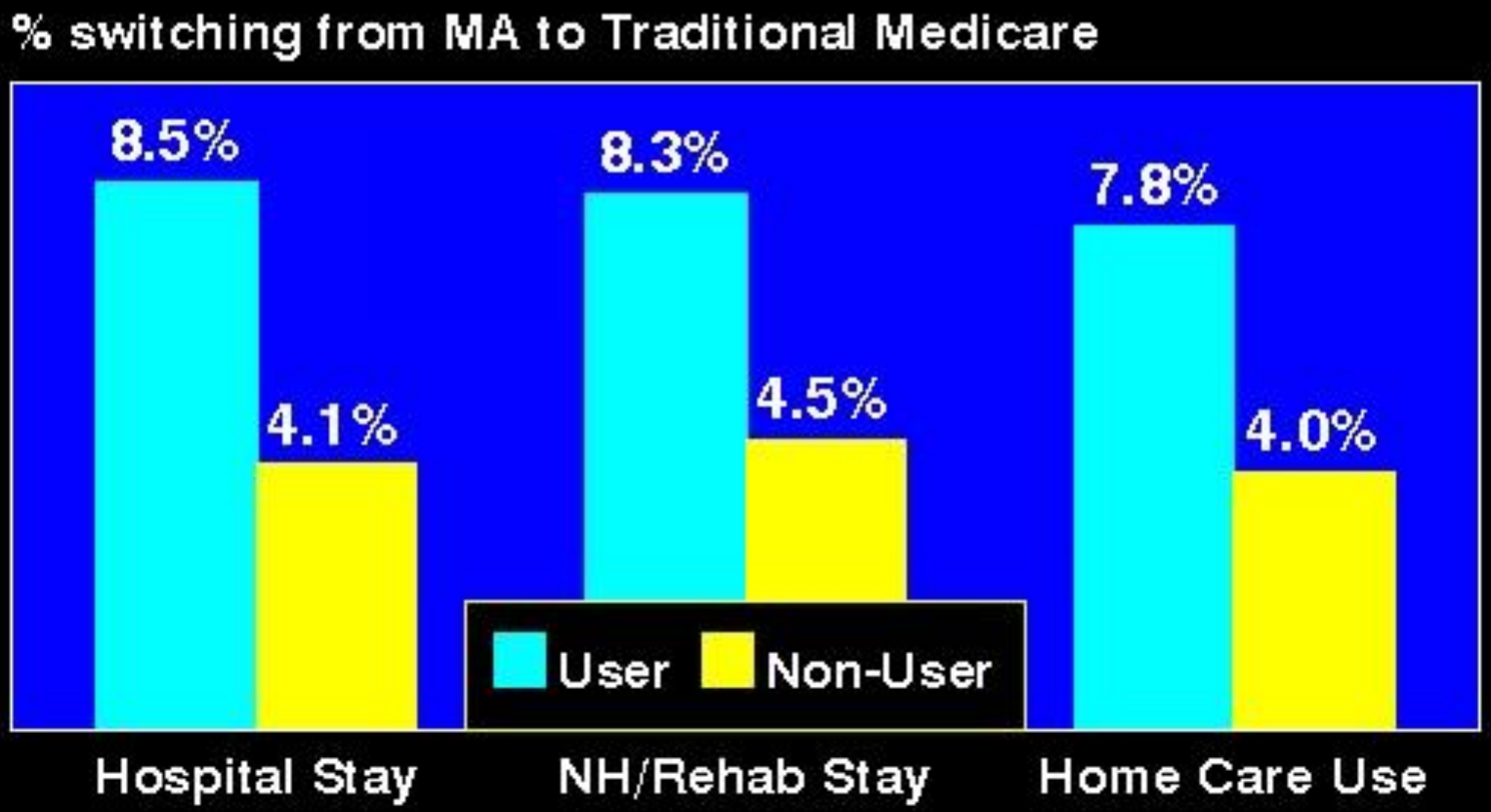
Source: Kaiser Foundtion May, 2019

Note: For example, difference for pts. with asthma = $1410; depression = $1198; arthritis = $1371

Medicare Advantage Plans' Strategies: 2 - Lemon Dropping

Network manipulation, benefit design, hassle factor

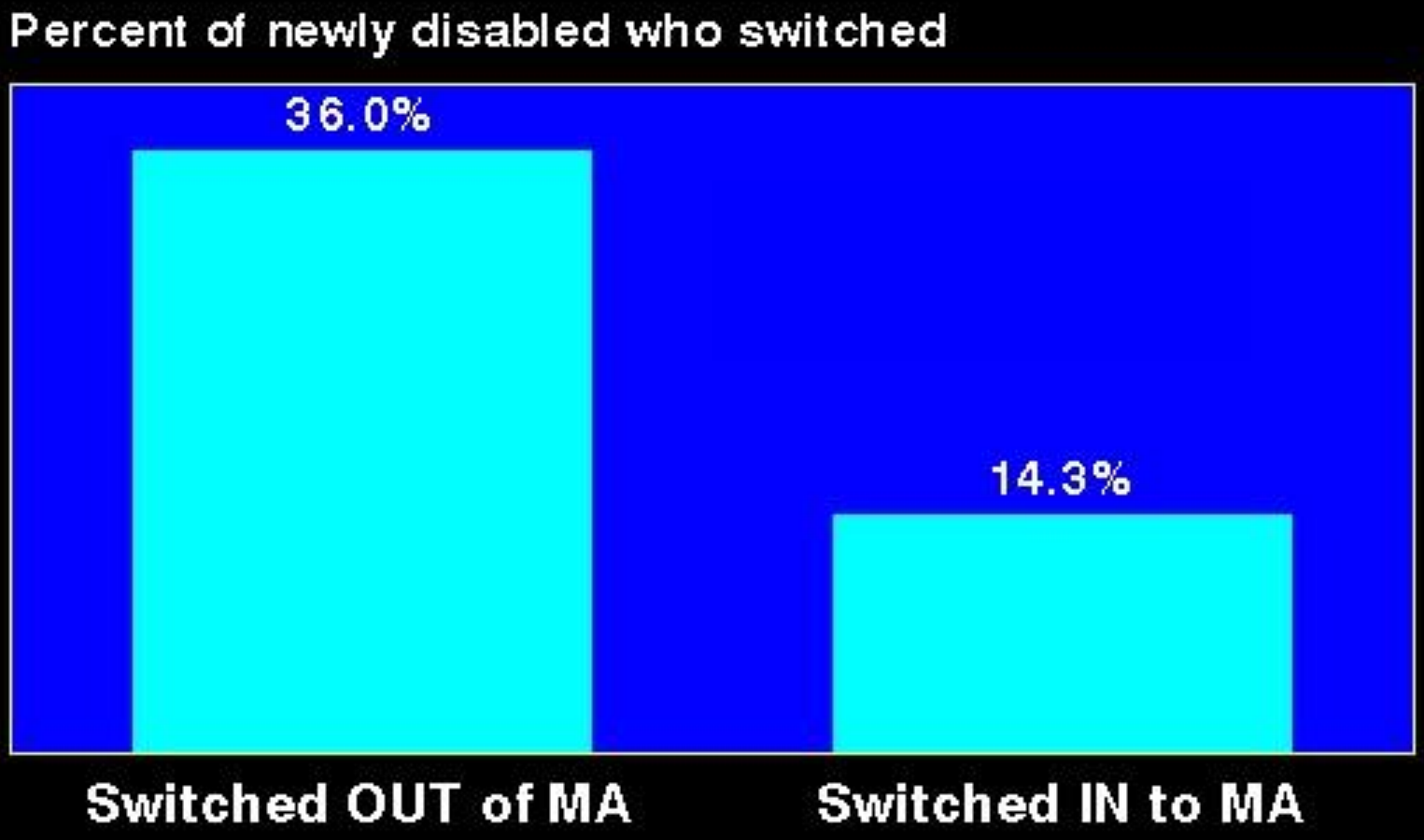
MA Plans Eject Patients Using Expensive Care



Source: Health Affairs 2021;40:469

Note: Data shown are for non-rural enrollees. Differences were similar for rural enrollees

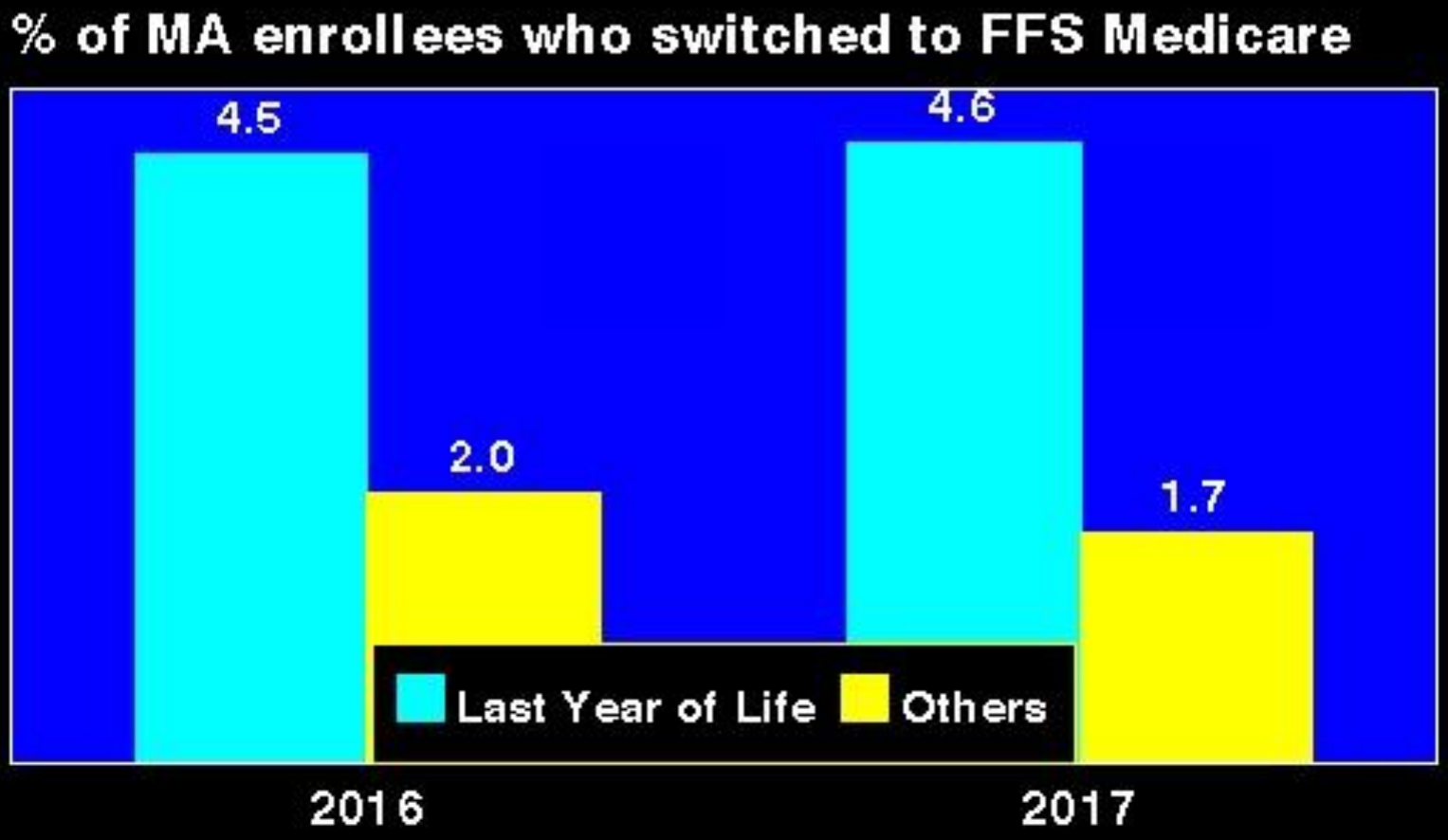
Patients Acquiring New Disabilties Switch Out of Medicare Advantage



Source: Health Aff 2020;39:809
Note: New functional disability = needs assistance with >1 ADL

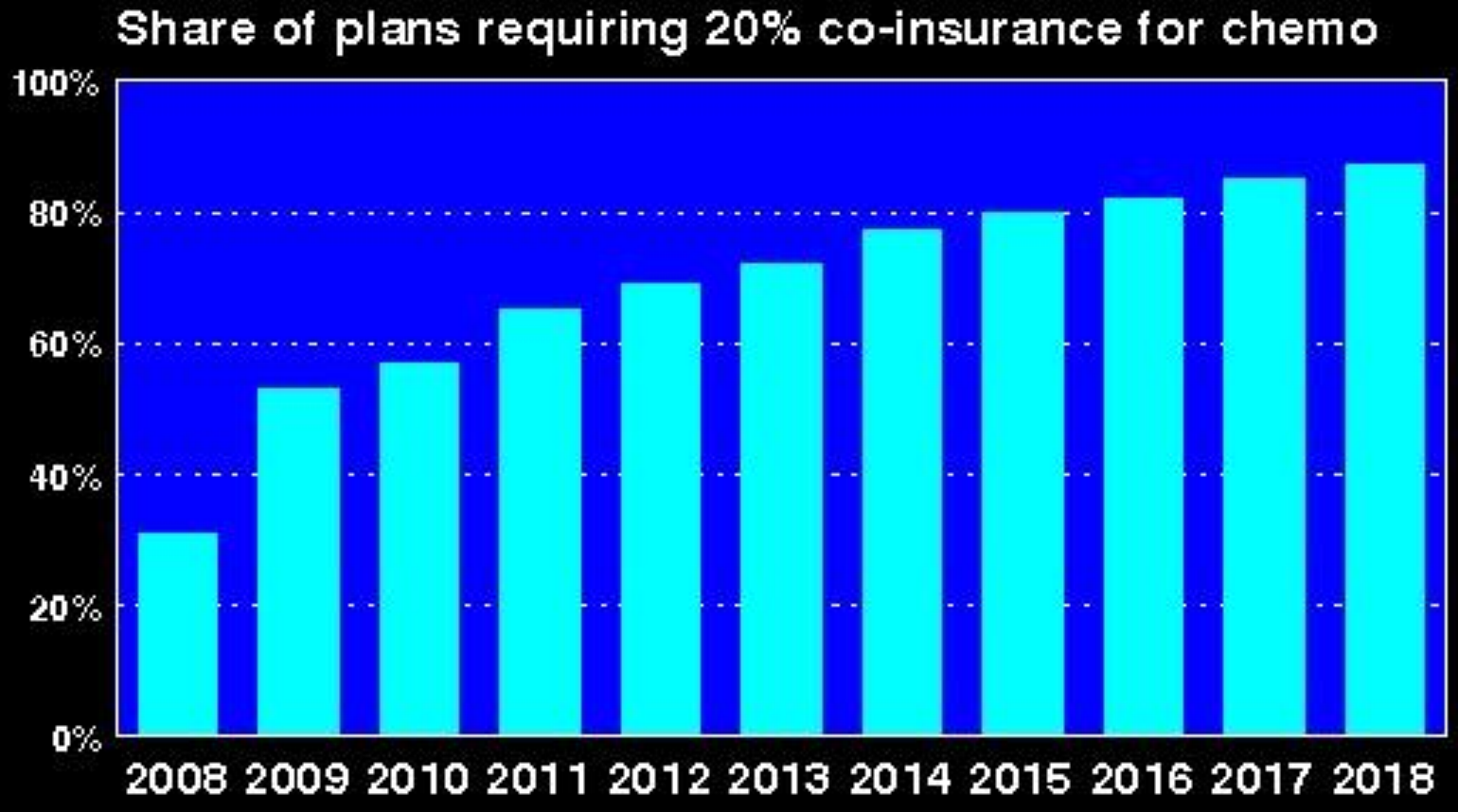
Medicare Advantage Plans Disenroll Dying (Expensive) Enrollees

Last-Year-of-Life Switches Raised Taxpayers' Costs by $912 Million



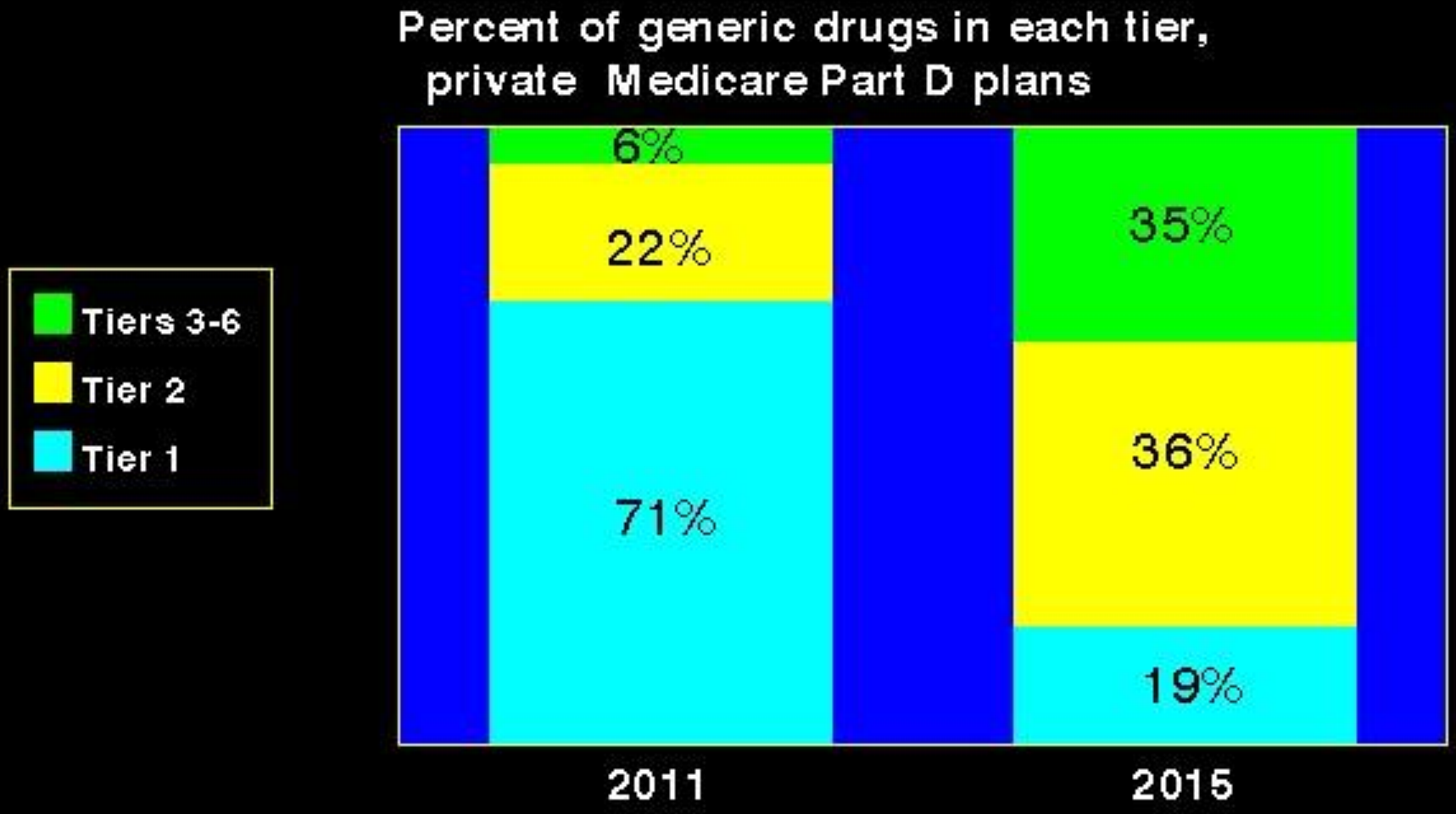
Source: GAO June 28, 2021

Medicare Advantage Plans Push Cancer Patients Out by Imposing 20% Co-Insurance for Chemotherapy



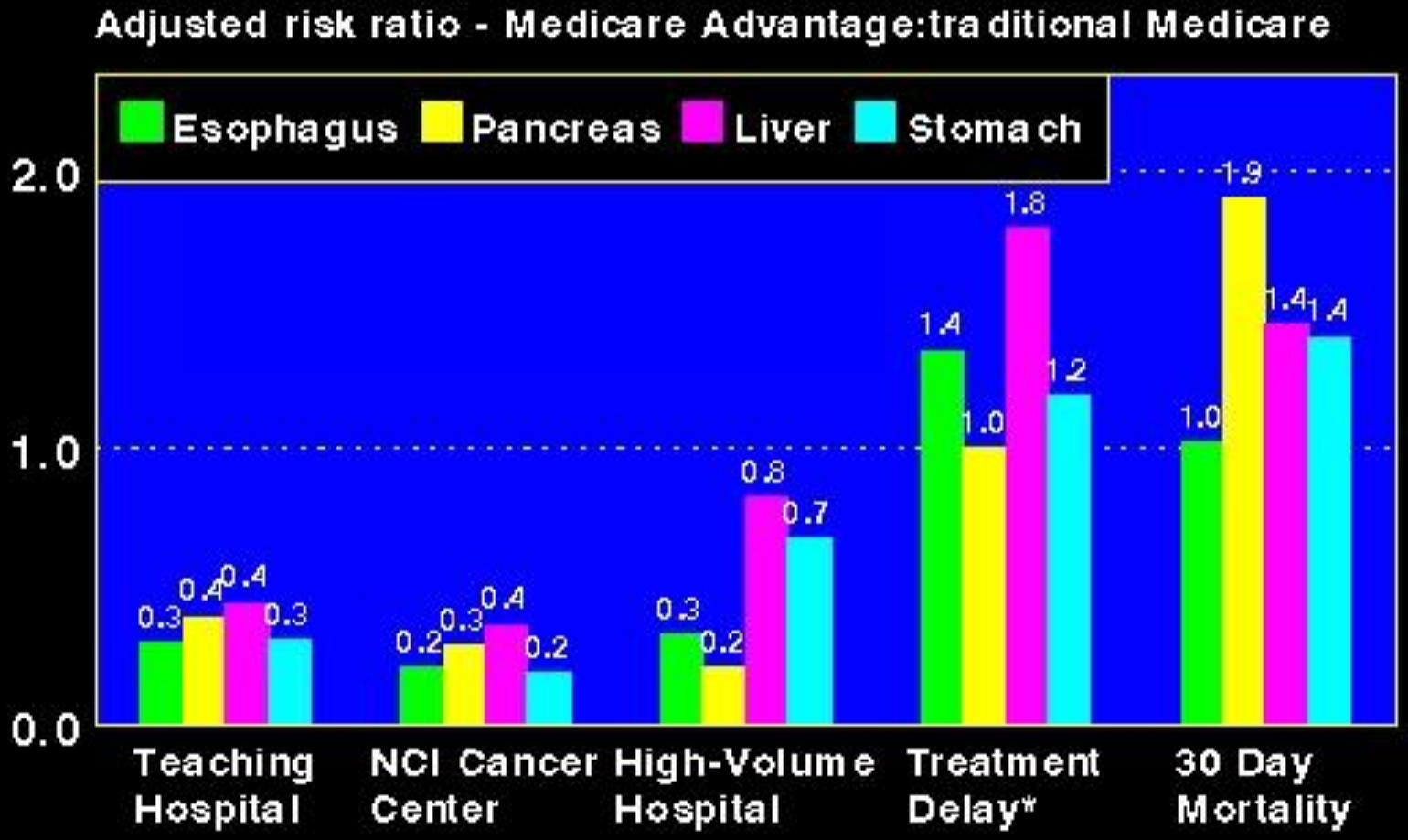
Source: JGIM 2019;34:1119

Medicare Plans Put Generics Into Higher "Tiers", Boosting Copays by $6.2 bil.



Source: Avalere 5/22/2018

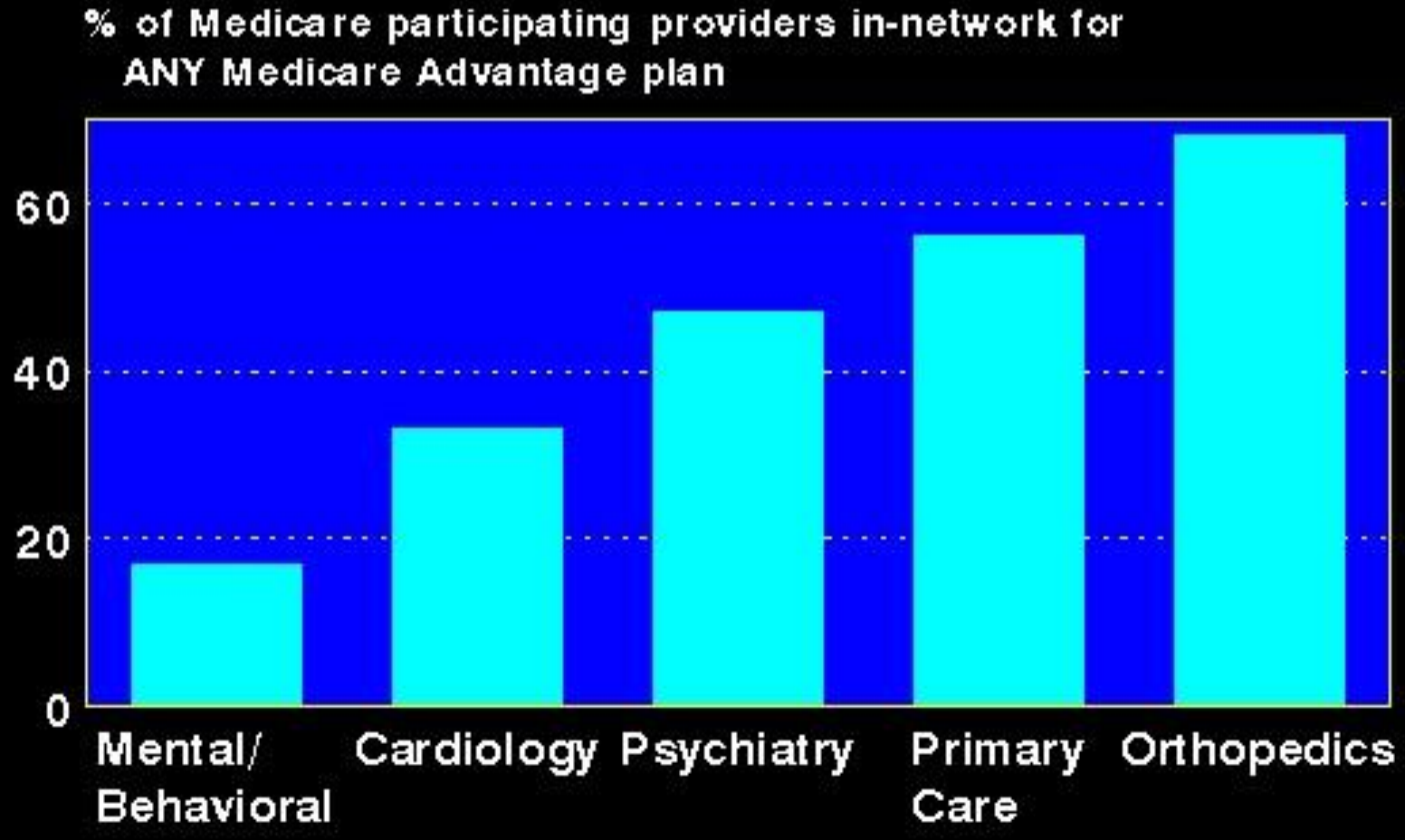
Medicare Advantage Cancer Patients: Inferior Surgical Care



Source: J Clin Oncol - Published online 11/2/2022

* >2 weeks between Dx and Rx

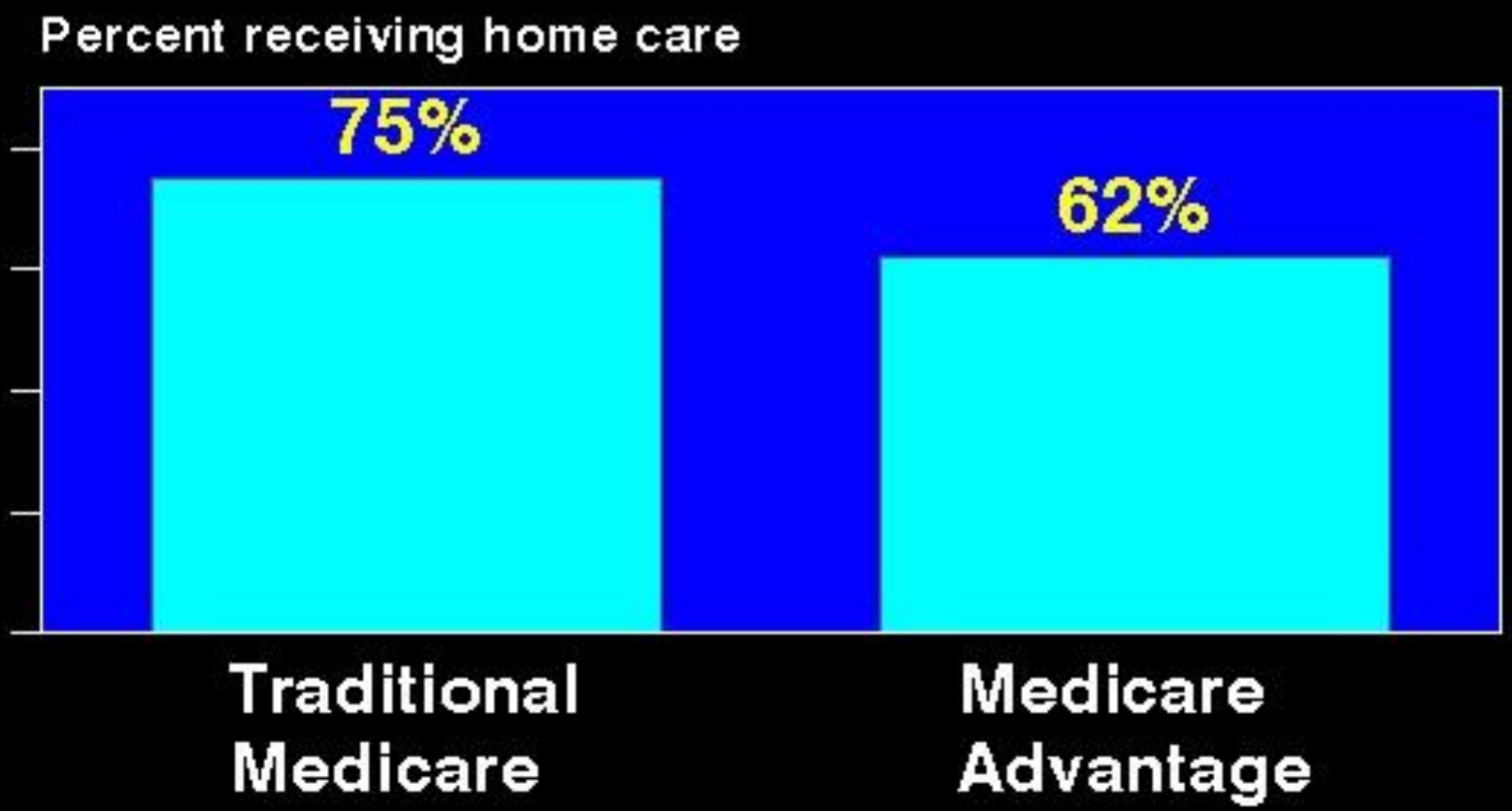
Medicare Advantage Plans' Narrow Patients' Choice of Provider



So urce: JGIM 2021;37:488

Medicare Advantage Plans Deny Needed Home Care

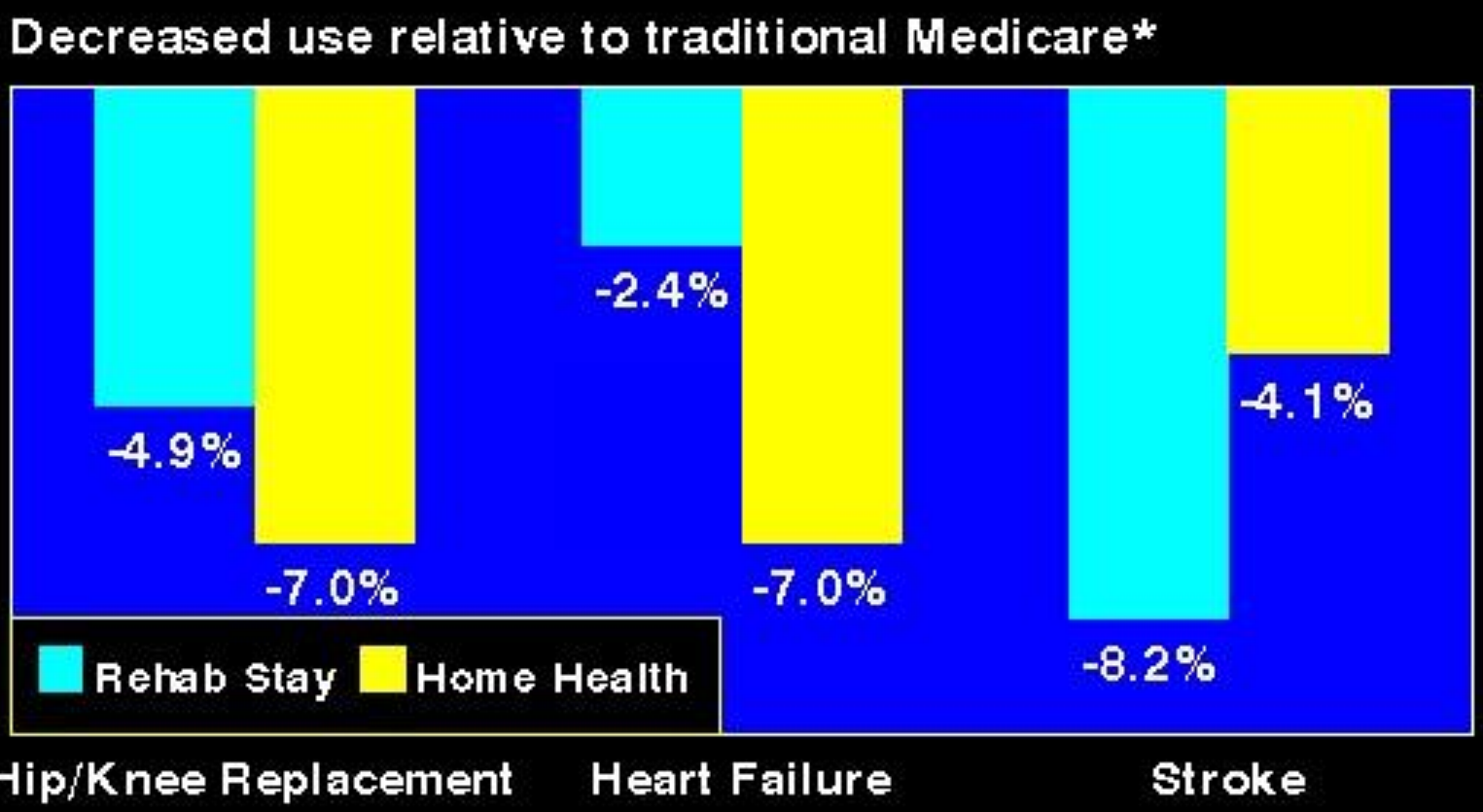
Pushing Out Unprofitably Ill Patients



Source: JGIM 2021;36(8):2323-31

Receipt of home care among those whose hospital record indicated "discharged with home care"

Medicare Advantage Plans Skimp on Rehabilitation and Home Care



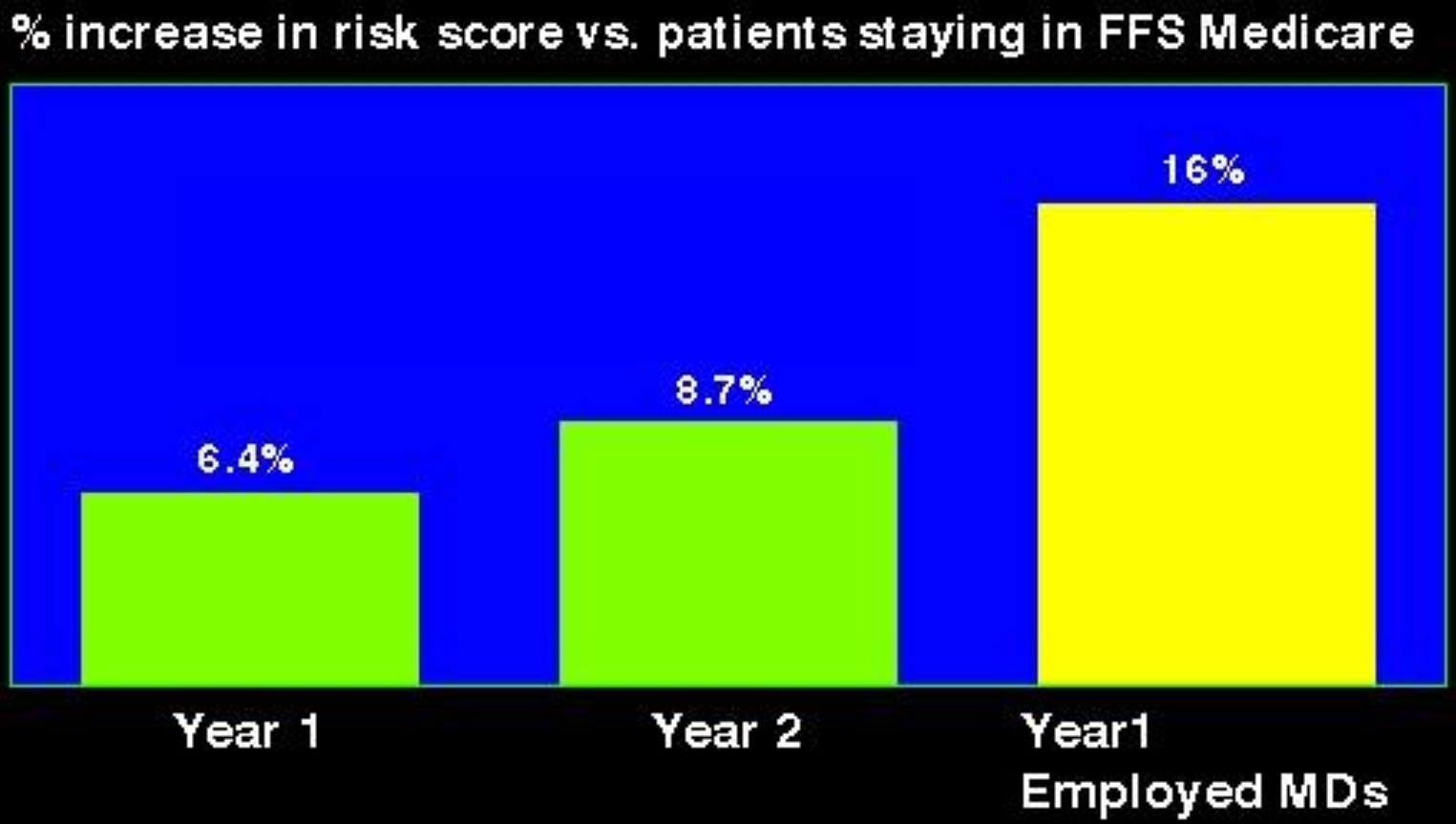
Source: Health Aff 2020;39:837

* Difference in share of patients receiving service in 90 days after discharge, adjusted for demographic, clinical and hospital characteristics

Medicare Advantage Plans' Strategies: 3 - Cheating

Medicare Advantage Plans "Upcode"

Risk Scores Spike Immediately After Patients Enroll; Biggest Jump in HMOs that Employ Doctors

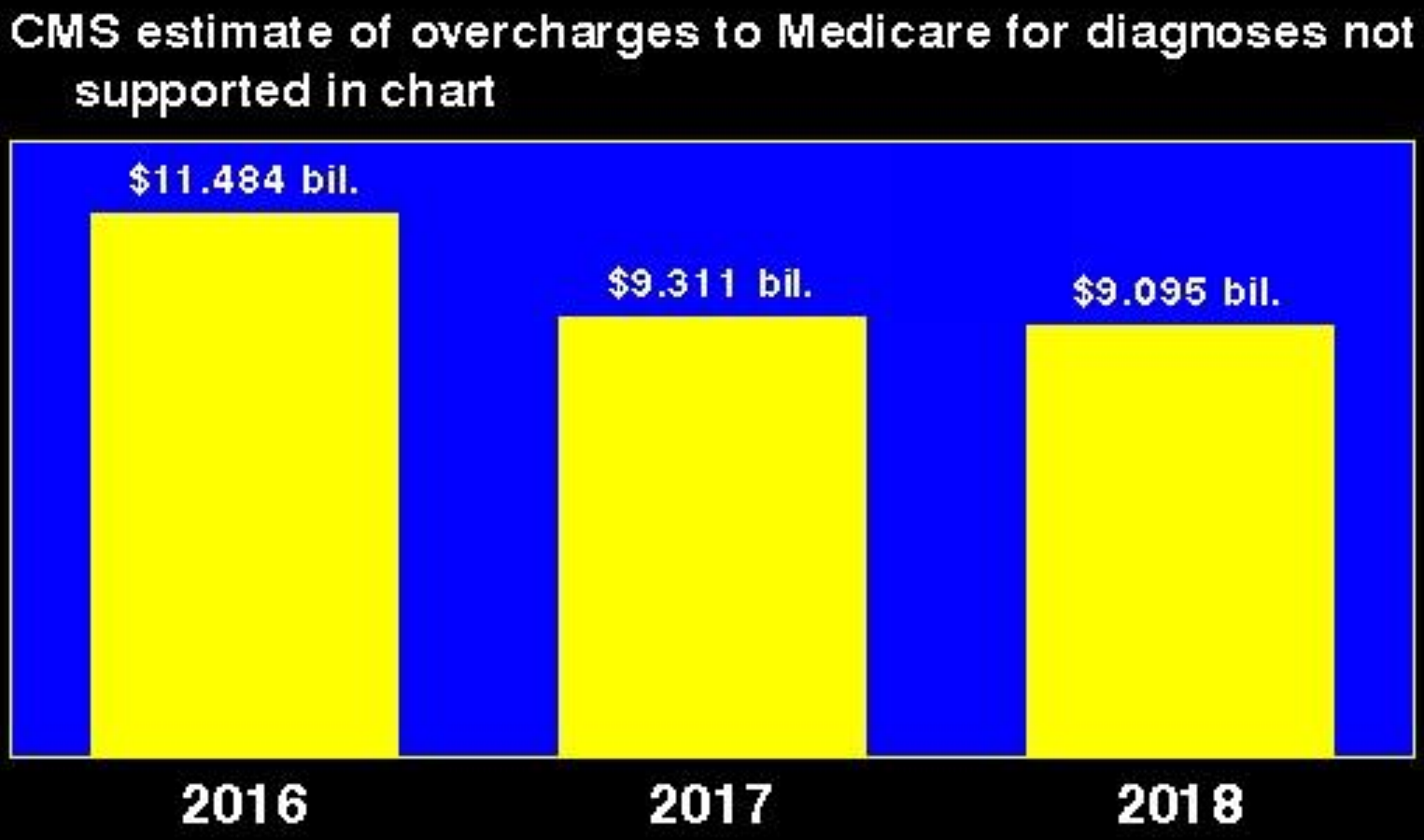


Source: NBER Working Paper # 21222

The 6.4% coding increase ups MA plans' payments from Medicare by $10 billion/yr, ~$650/enrollee. It is equivalent to 6% of all enrollees becoming paraplegic or 39% becoming diabetic.

Medicare Advantage Plans' Claims for Unsupported Diagnoses

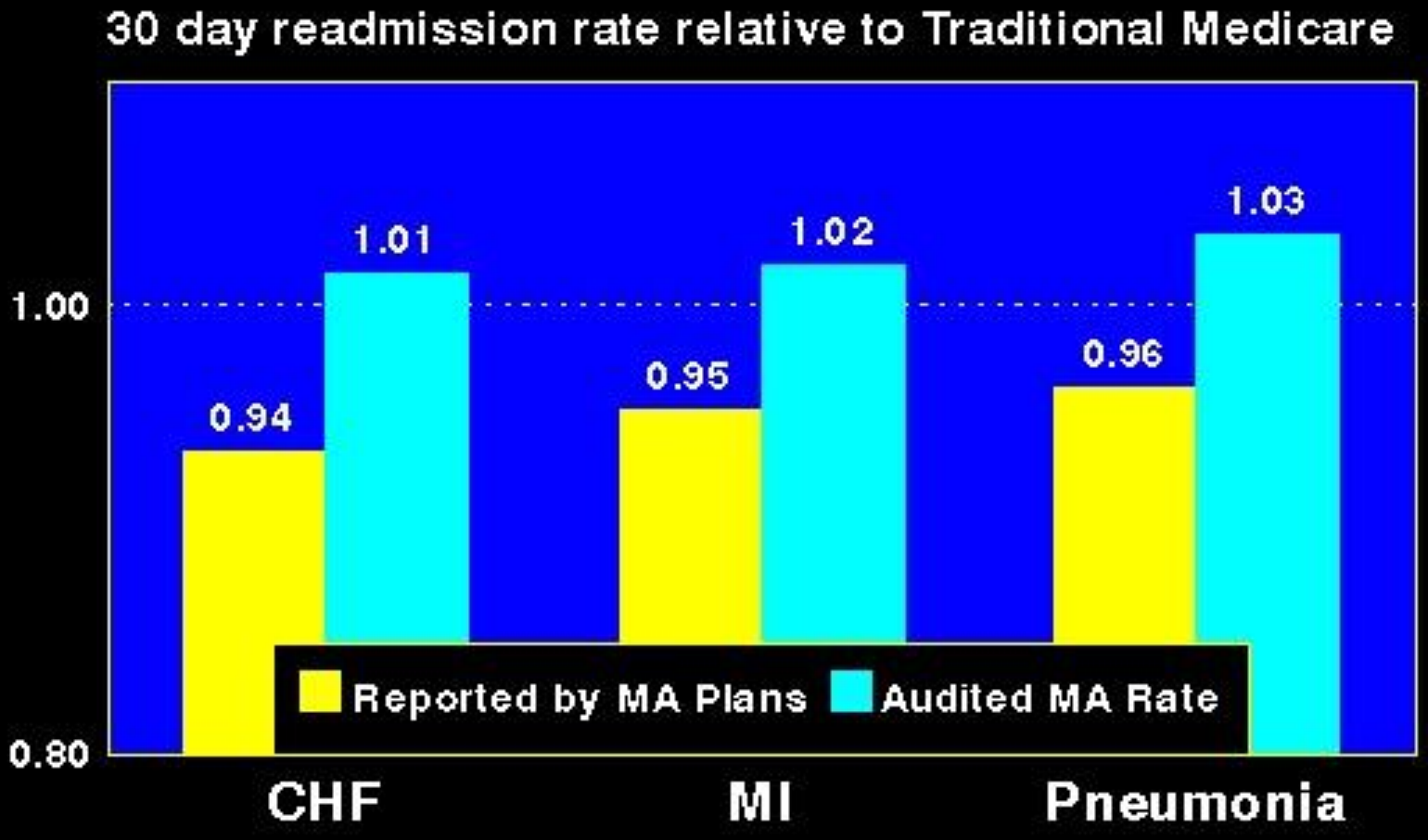
CMS Chart Audit (But CMS Only Pursued Recovery for 0.2% of Projected Overcharges)



Source: Kaiser Health News 7/16/2019

M.A. Plans Lie About Quality

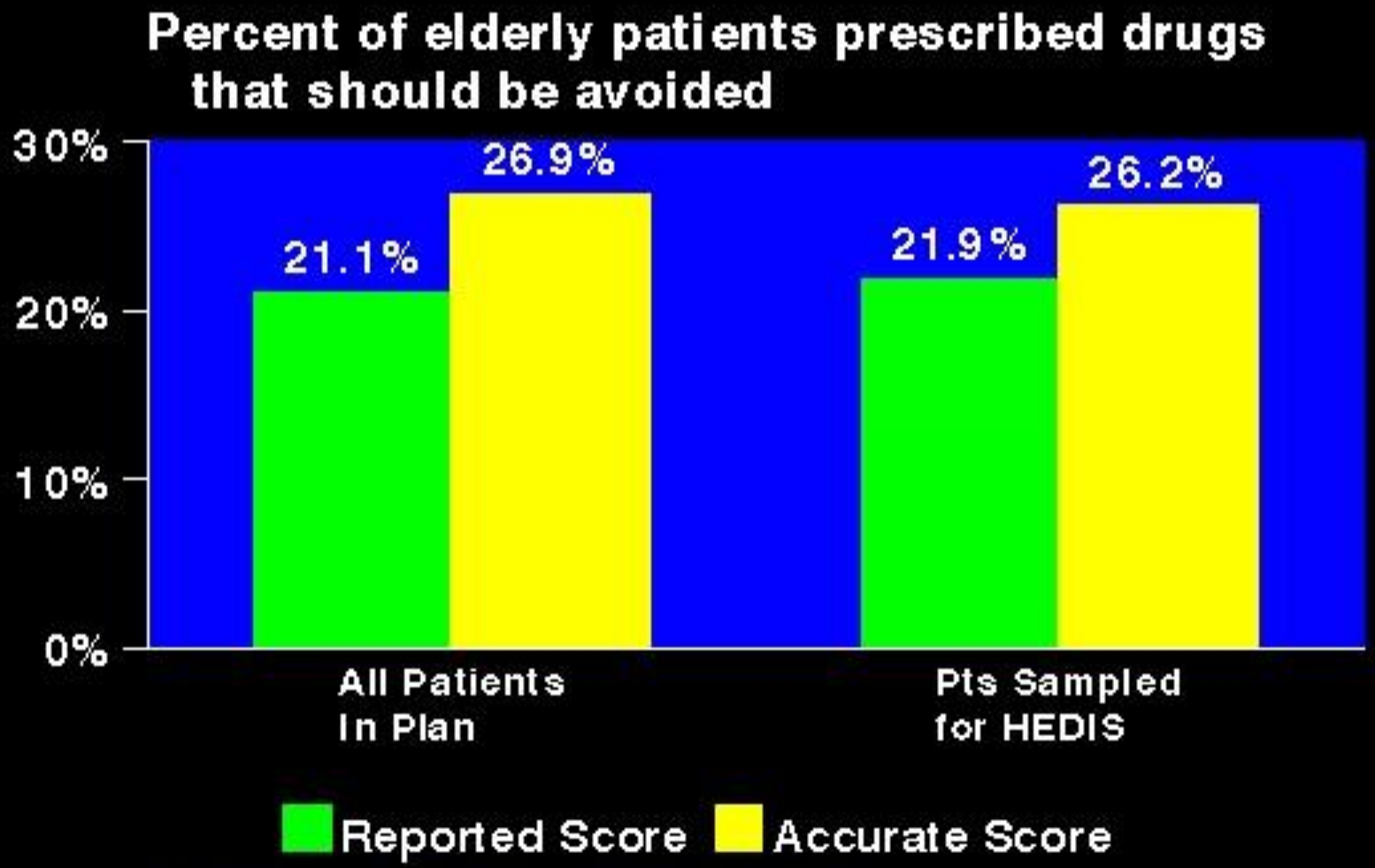
Advantage Plans Report few Readmits
But Audit Shows Rates Higher Than FFS Medicare



Source: Annals of Internal Medicine 2019; 171:99

95% of Plans Cheat on HEDIS Quality Scores

Medicare Advantage Plans Failing to Cheat Fall in Rankings



Source: Annals of Internal Medicine 2013;159:456

Researchers compared reported HEDIS scores for high risk prescribing to actual Medicare Part D payment records for all enrollees, and for enrollees sampled for the HEDIS scoring

HMO "Housecalls" A New Upcoding Scam

- **HMOs send it "housecall" doctor – or one from Mobile Medical Examination Services Inc.**
- **Doctor seeks out unimportant diagnoses, e.g. mild arthritis**
- **No treatment offered**
- **Extra diagnoses allow HMOs to upcode - adding > $3 billion/yr to Medicare Advantage payments**
- **Efforts to outlaw upcoding "housecalls" were scrapped after industry lobbying blitz**

Source: Schulte, Center for Public Integrity, 2014

Profit-Driven Upcoding Makes Accurate Risk Adjustment Impossible:

High Cost Providers Inflate Both Reimbursement and Quality Scores by Making Patients Look Sicker on Paper

- Dr. Smith sees Ms. Jones, a 76 year-old Medicare beneficiary as a FFS patient and simply submits the one or two diagnoses treated during any visit.

Dr. Smith diagnoses sent to CMS	HCC Risk Score
Demographic Score	.448
Obesity	0
Type 2 diabetes, exudative retinopathy	.104
Major depress disorder, 1 episode, unspec	0
CHF	.323
Asthma	0
Pressure ulcer of right heel, unspecified	0
HCC Score: 1.029	
FFS Expected Cost: $9,000	

Source: https://downloads.healthcatalyst.com/wp -content/uploads/2019/04/HCC -coding.png

Ms. Jones joins an MA Plan which sends a nurse to her home, reviews her charts, suggests Dr. Smith record other diagnoses: Cost to CMS increases 350%

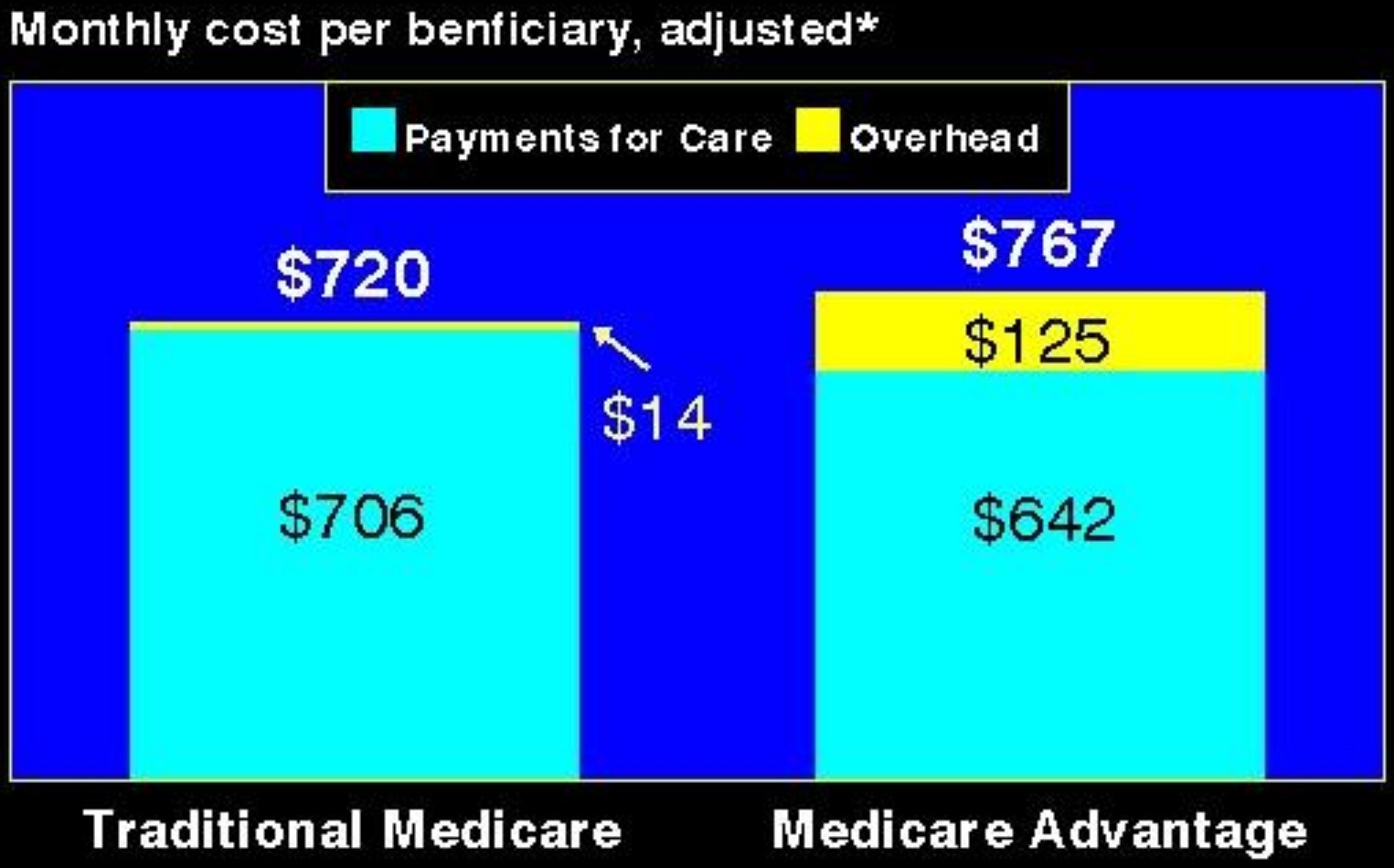
Dr. Smith's Coding	HCC Risk Score
Demographic Score	.448
Obesity	0
Type 2 diabetes, exudative retinopathy	.104
Major depress disorder, 1 episode, unspec	0
CHF	.323
Asthma	0
Pressure ulcer of right heel, unspecified	0
HCC Score: 1.029	
Expected CMS Annual Cost: $9,000	

Medicare Advantage Coding	HCC Risk Score
Demographic Score	.448
Type 2 diabetes w/ diabetic retinopathy	.318
Major depress. disorder, 1 episode, mild	.395
CHF, class 3	.323
COPD	.328
Pressure ulcer of right heel, stage 3	1.204
CHF*DM; CHF*COPD	.154,.19
RAF Score: 3.633	
MA Plan Annual Payment: $32,000	

Source: https://downloads.healthcatalyst.com/wp -content/uploads/2019/04/HCC -coding.png

Medicare Advantage Plans Raise Costs

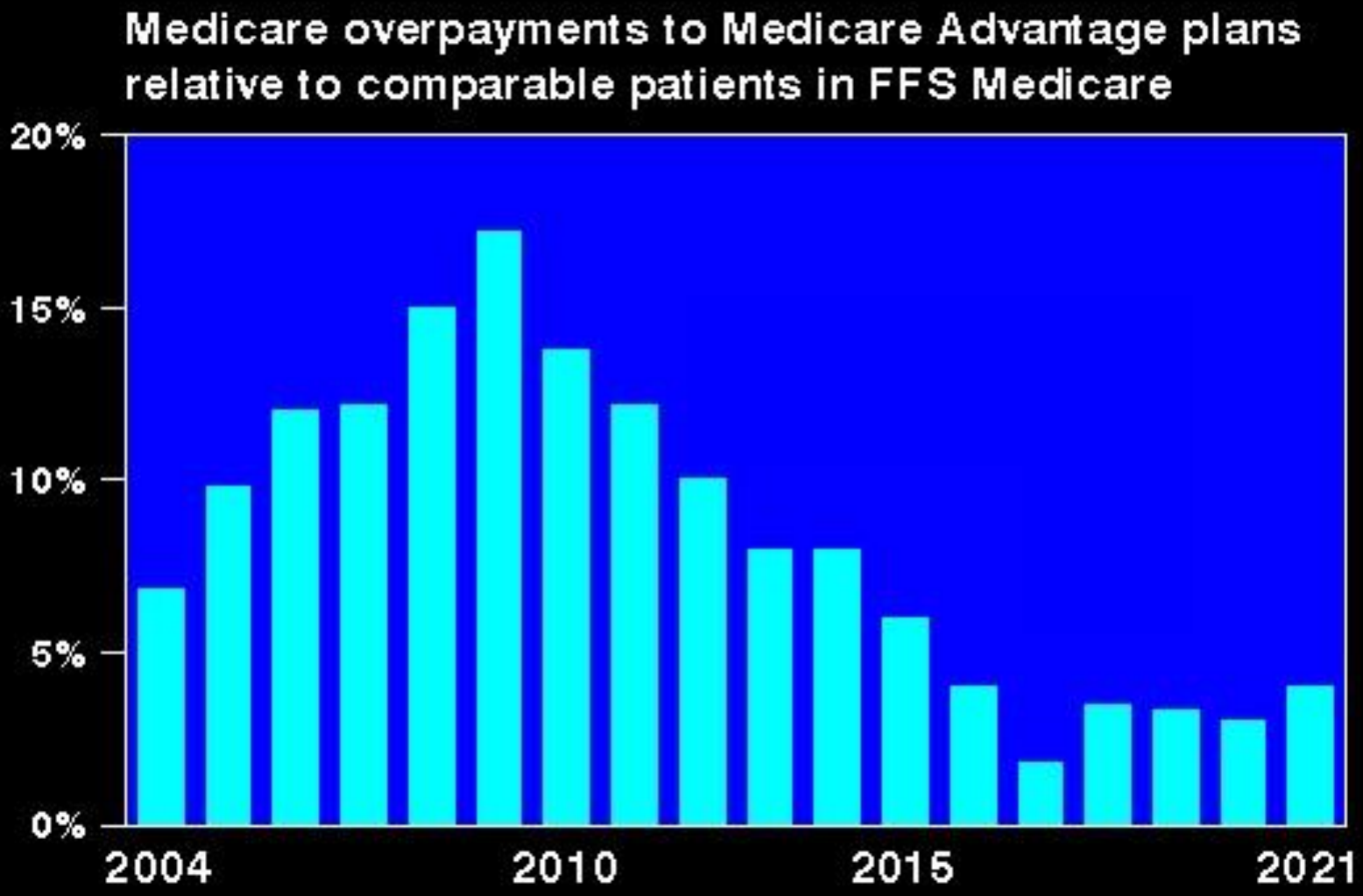
Less Spending on Care, More on Overhead



Source: Am. Econ. J. Applied Econ 2019;11:302 - Data are for 2010

* Health status adjustment based on diagnoses + mortality risk

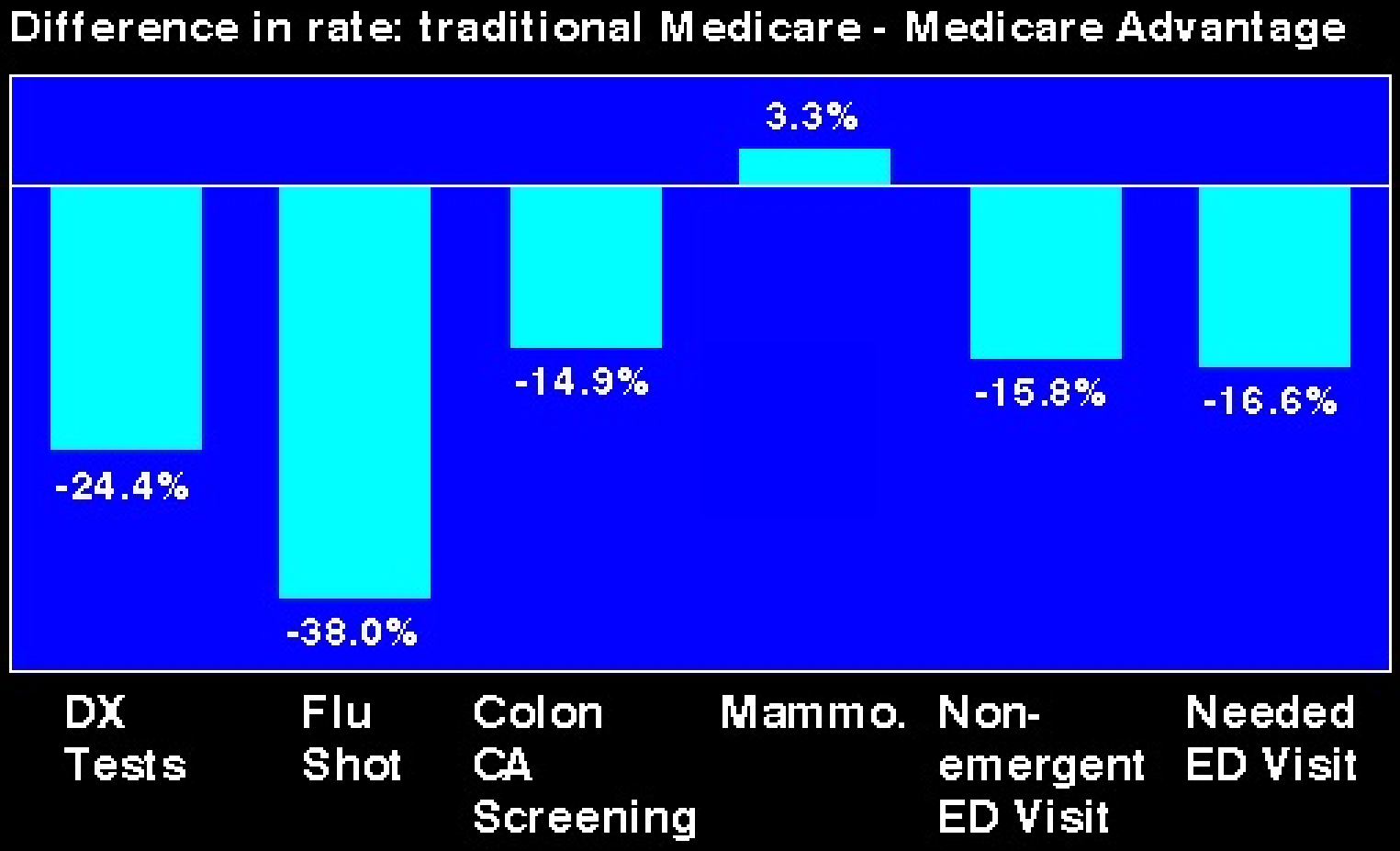
Medicare Advantage Raises Taxpayers' Costs



Source: MedPAC Blog March 3, 2021

Note: 2021 overpayment = $13.9 billion.

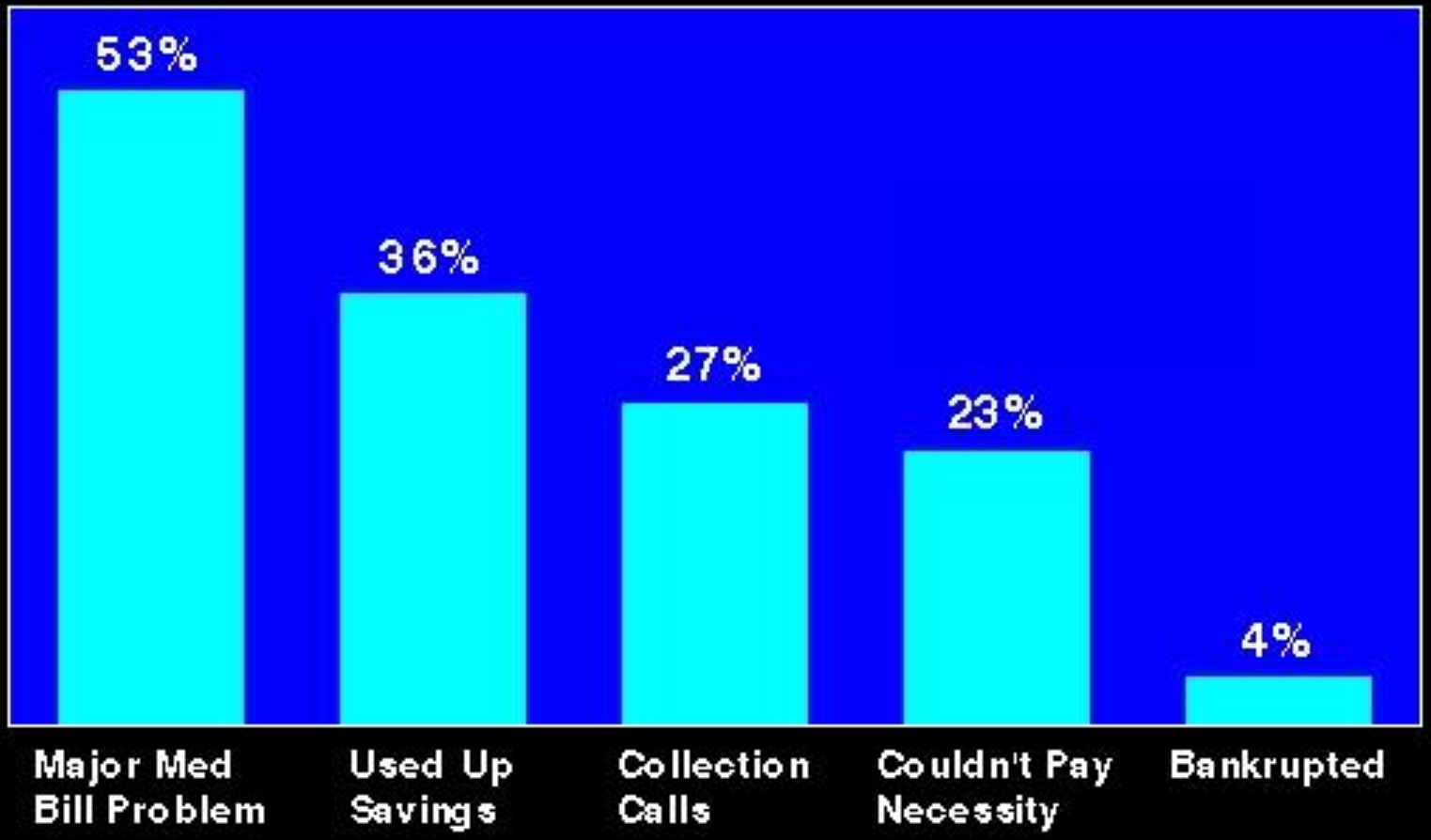
Medicare Advantage Plans Cut Both Needed and Unneeded Care



Source: NBER Working Paper #23090, January, 2017

Medicare Needs Improvement

Financial Problems of Seriously Ill Enrollees



Source: Health Aff 2019;38:1801

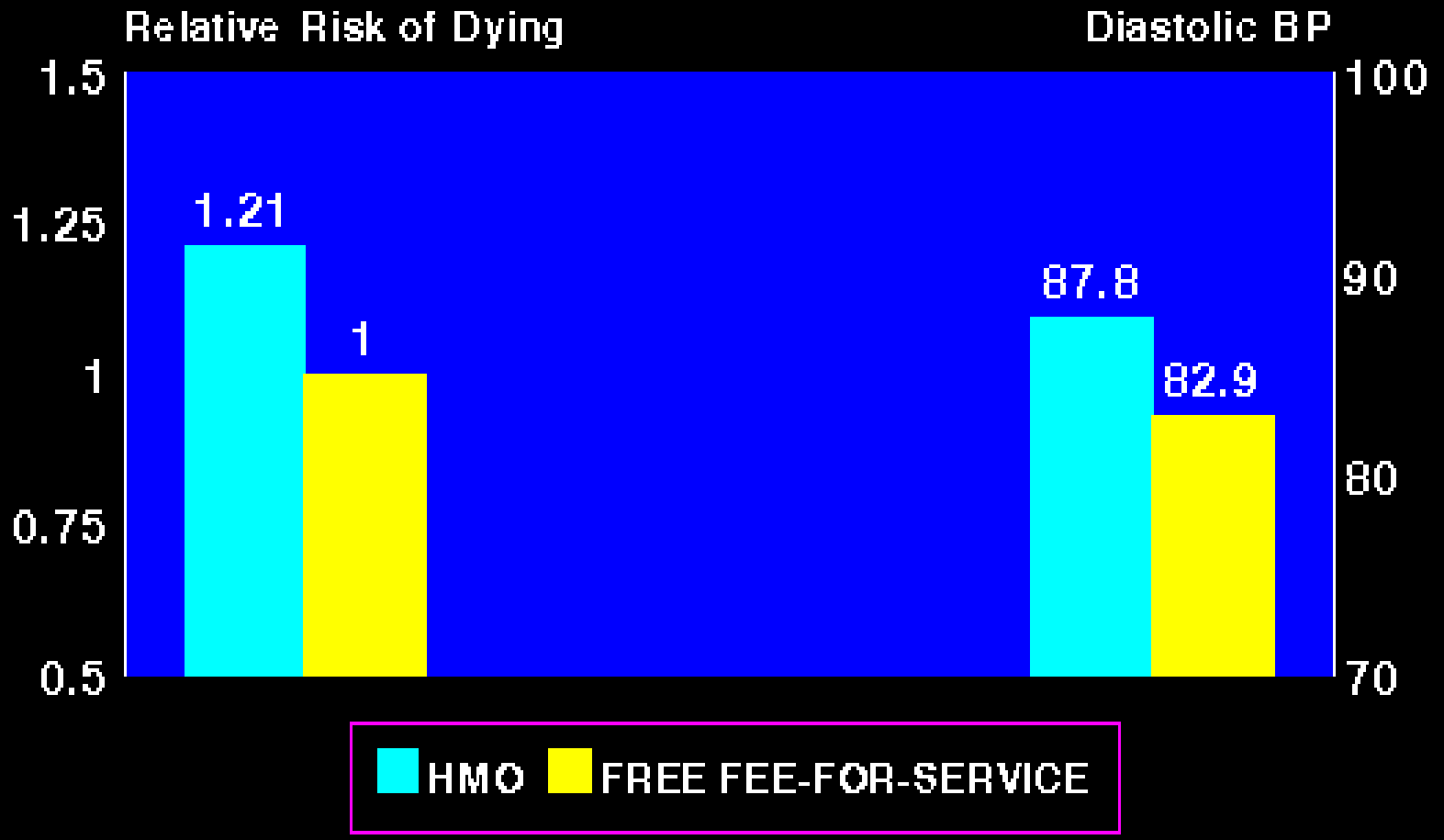
Note: "Necessity" = Food, heat, housing

ACOs
Warmed Over Managed Care

"IT'S LIKE DEJA VU ALL OVER AGAIN."

YOGI BERRA

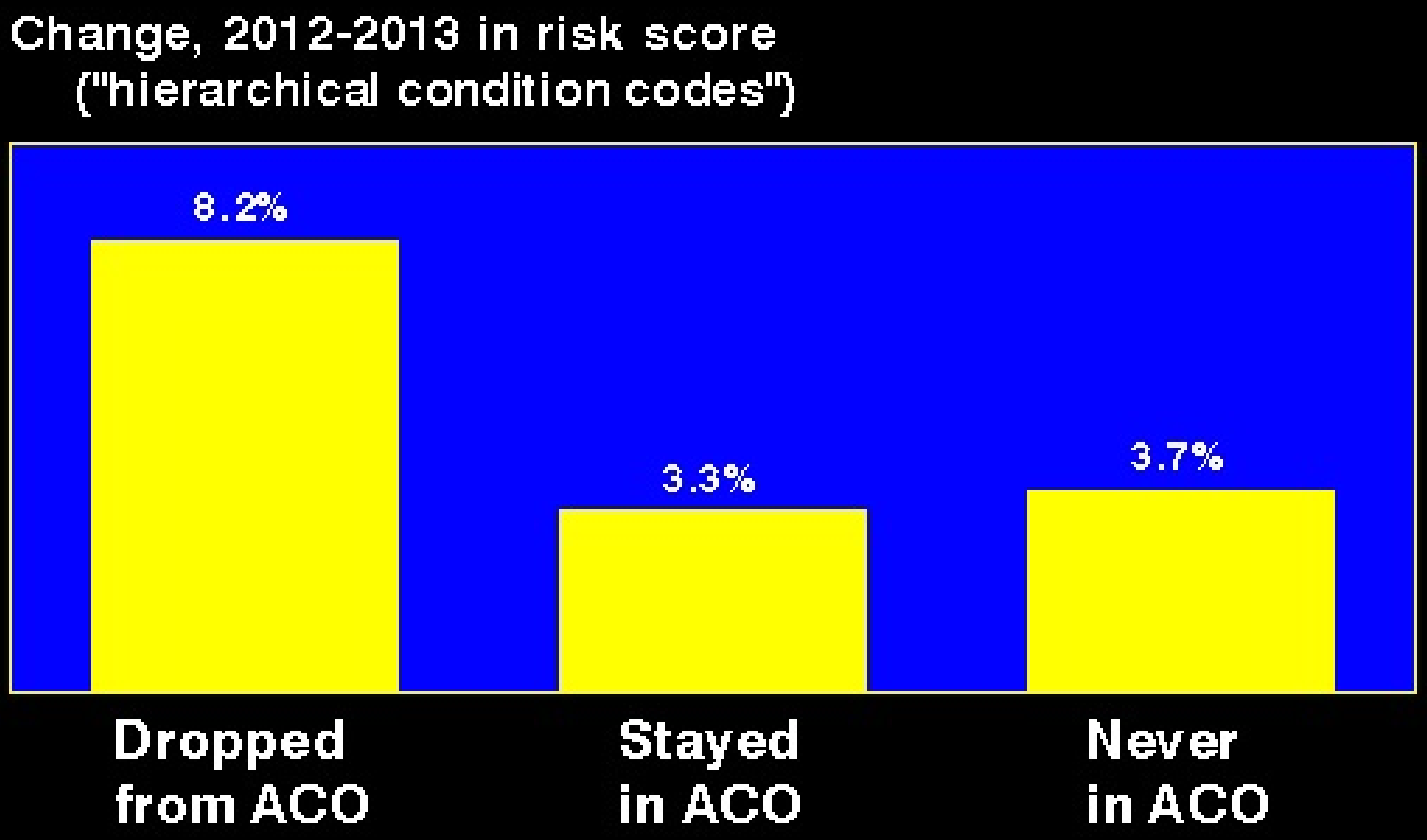
High Risk HMO Patients Fared Poorly in the Rand Experiment



Source: Rand Health Insurance Experiment, Lancet 1988; i:1017
Note: High Risk = 20% of population with lowest income + highest medical risk

ACOs Got Rid of Patients in Deteriorating Health

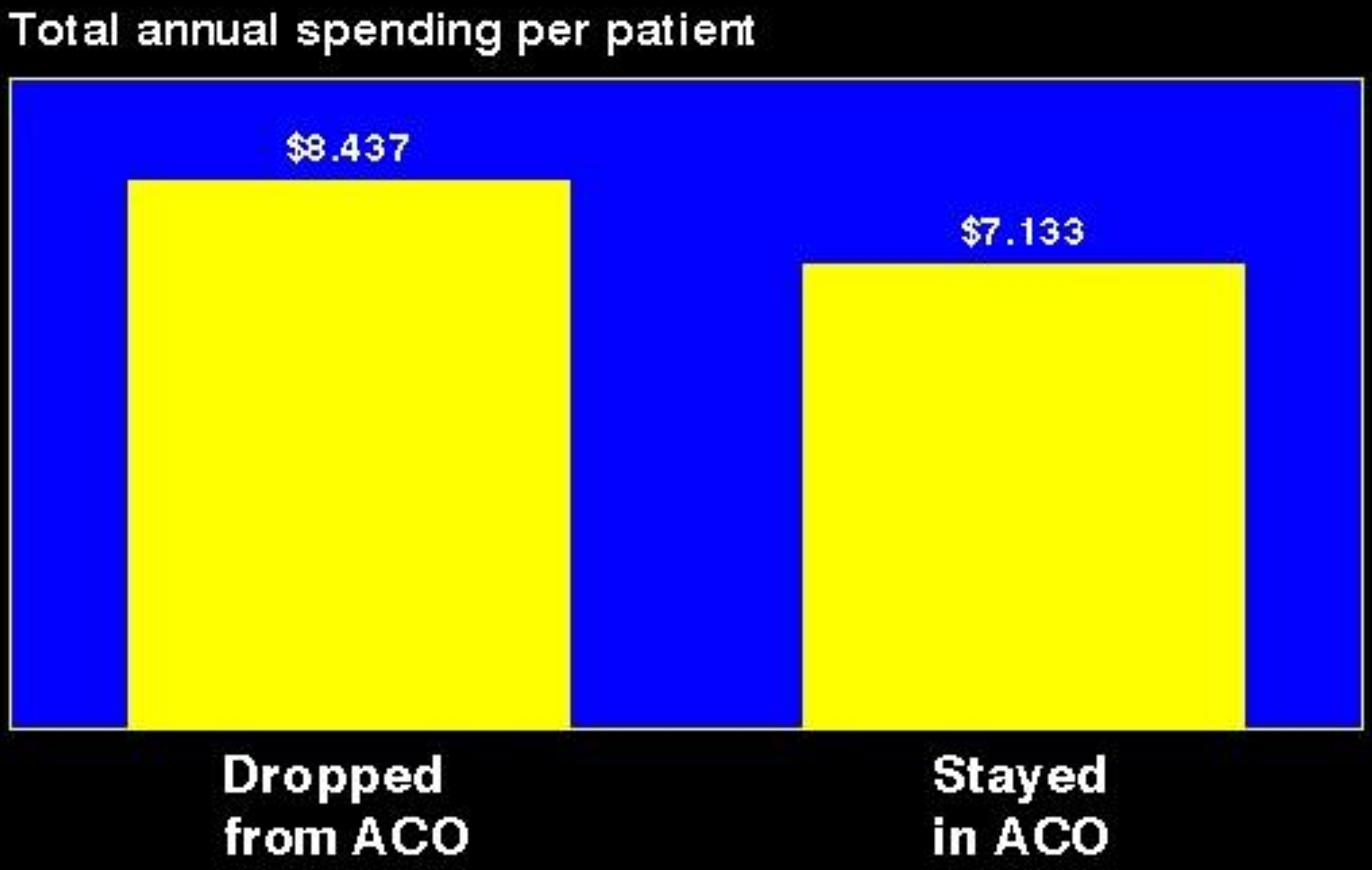
For Patients Already Enrolled in ACO, Upcoding Doesn't Boost Risk-Adusted Payments So ACOs "Lemon-Drop" With Increasing Care Needs



Source: Health Affairs 2019;38:253

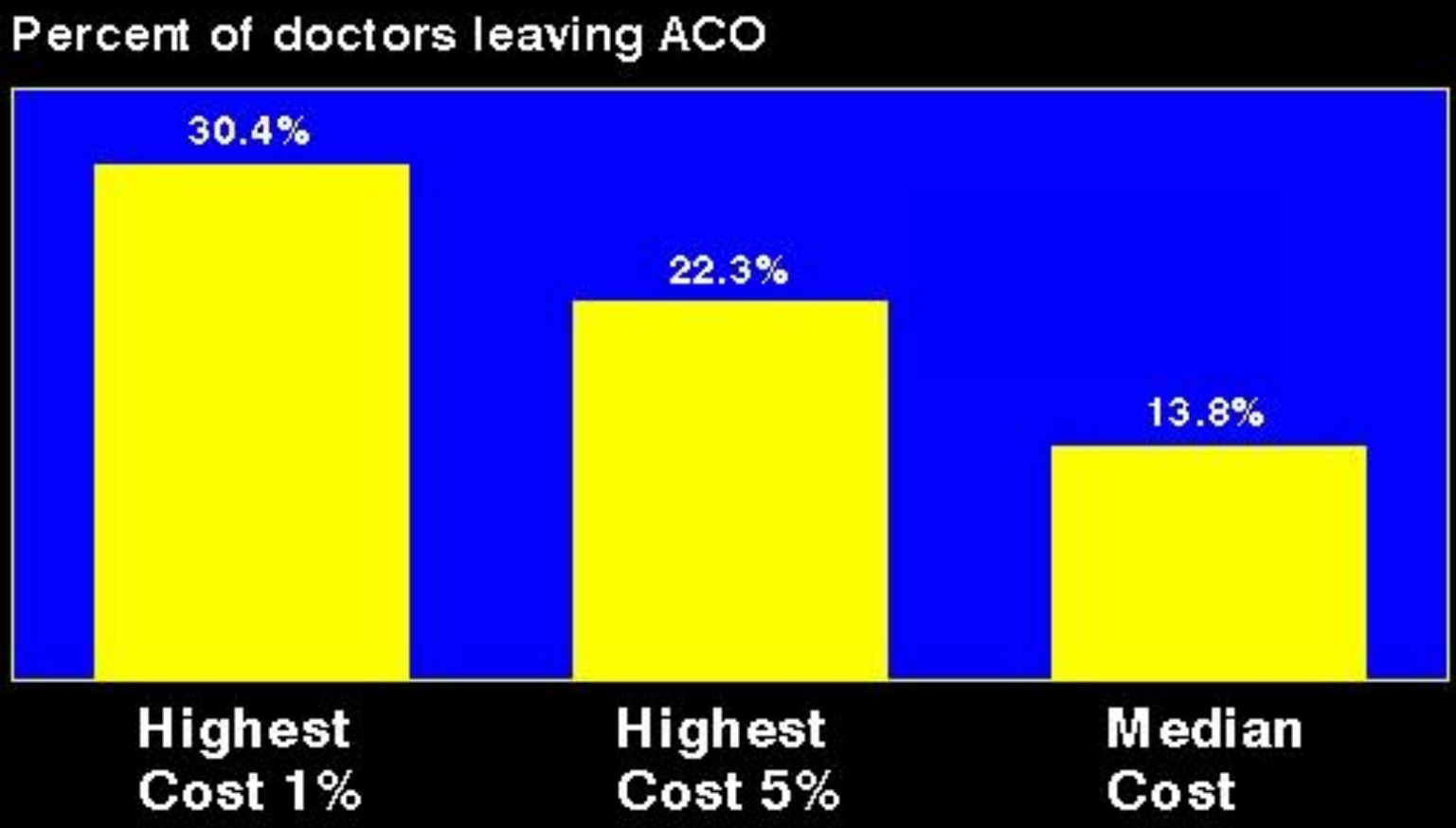
ACOs Got Rid of High Cost Patients

For Patients Already Enrolled in ACO, Upcoding Doesn't Boost Risk-Adjusted Payment
So ACOs "Lemon-Drop" High Cost Patients to Generate Bonuses from Fake Savings



Source: Health Affairs 2019;38:253

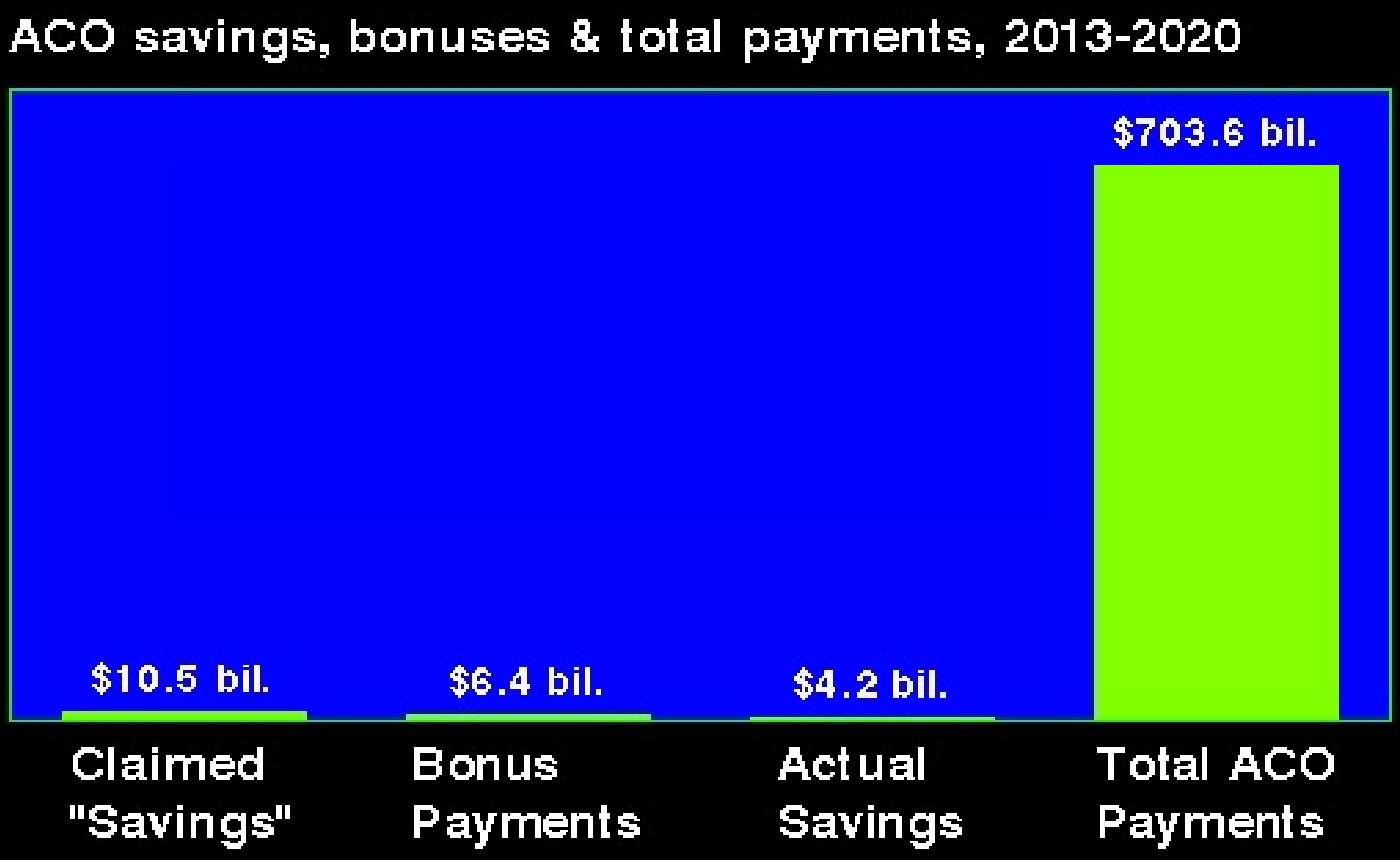
ACOs Get Rid of High Cost Patients By Ejecting Their Doctors



Source: Ann Intern Med 2019;171:27

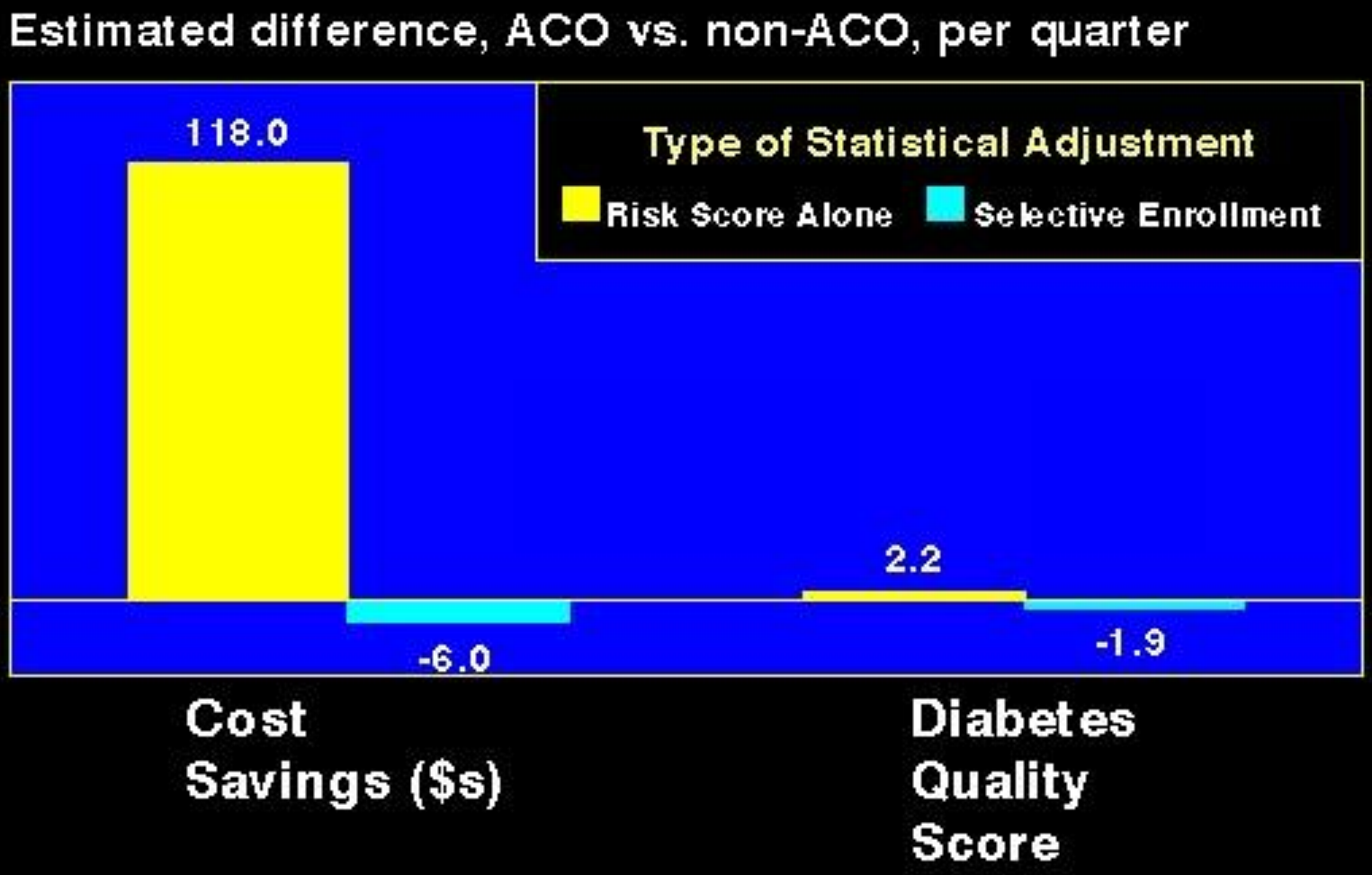
ACO Savings: $4.2 bil. Over 8 Years =0.59% of Spending on ACOs

MEDPAC Estimate: ACOs Increased Administrative Costs by $12.8 bil.



Source: Himmelstein & Woolhandler analysis of CMS ACO Public Use Files, 8/2022 + MEDPAC staff est.

ACOs: No Savings, No Quality Improvement After Control for Selective Enrollment



Source: Ann Intern Med 2019;171:27

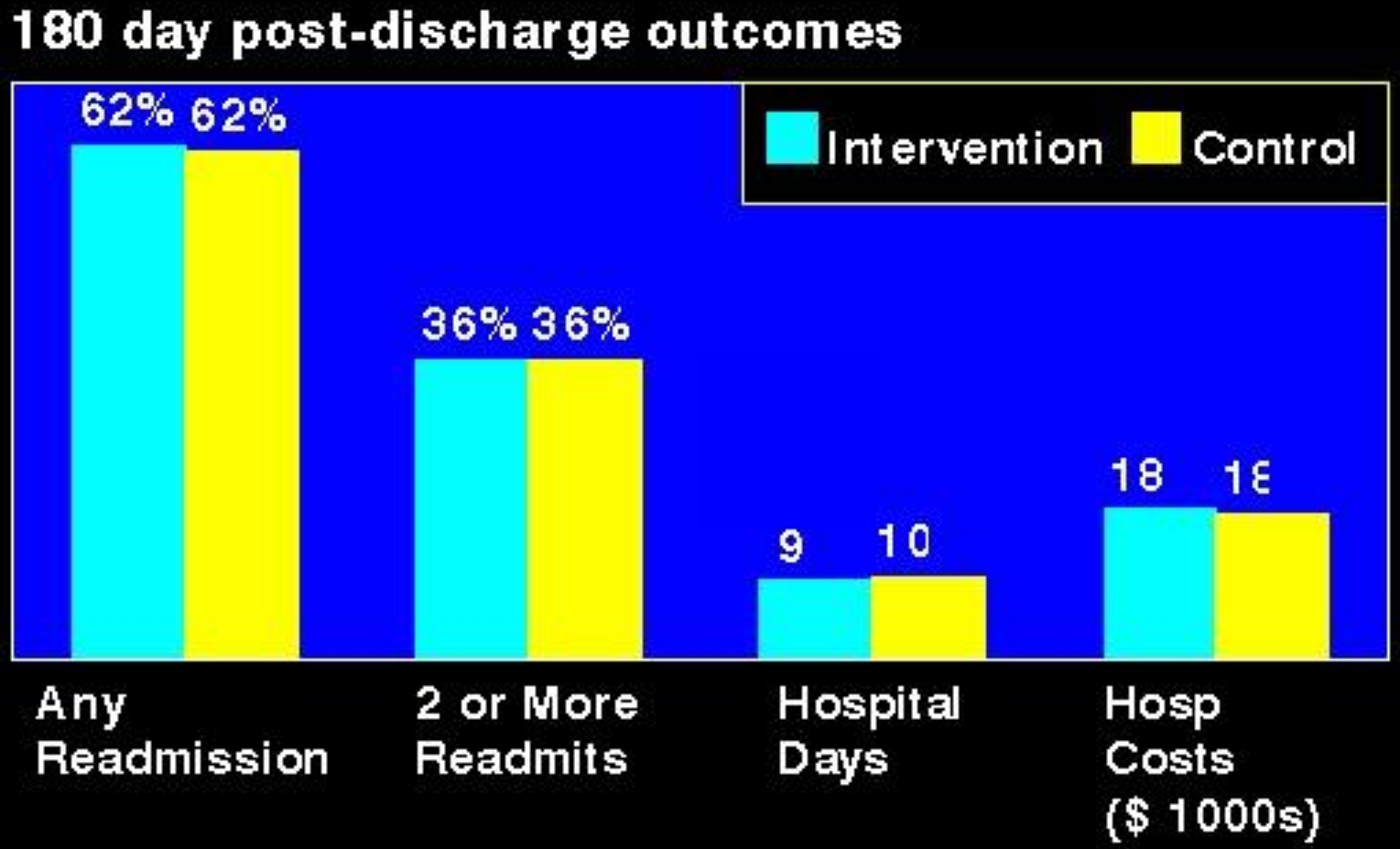
McKinsey: "The Math of ACOs"

- ~$9 million/year/ACA spent on new data/analytics
- ~1.25% of total revenues for care management: Success depends on curtailing patients' use of care and steering enrollees to lower-price providers, NOT managing chronic conditions.
- Additional costs for "executive director, head of real estate, head of care management, and lawyers and actuaries"

Source: McKinsey & Co.. August 2020

Hotspotting Didn't Work - RCT

Much Touted Camden Model Failed



Source: N Engl J Med 2020;382:152

Failure of Medicare HMO Risk Adjustment: Implications for ACOs

- Despite decades-long effort, CMS has failed to stop cherry-picking
- Intensive coding makes patients appear sicker on paper, ups risk-adjusted capitation fee and factitiously raises quality scores
- ACOs that fail to cherry pick/upcode get low payments, and factitiously poor quality scores
- Implications:
    - No net savings, probable increased costs
    - Resources transferred from sick to healthy
    - Biggest cheaters are biggest winners
    - ACOs that embrace problem patients driven from the market

The Toxicity of Pay for Performance (P4P)

Assumptions Implicit in P-4-P

1. Performance can be accurately ascertained
2. Individual variation is caused by variation in motivation
3. Financial incentives will add to intrinsic motivation
4. Current payment system is too simple
5. Hospitals/MDs delivering poor quality care should get fewer resources

Medicare Quality Scores Penalize Doctors Caring for Poor Seniors

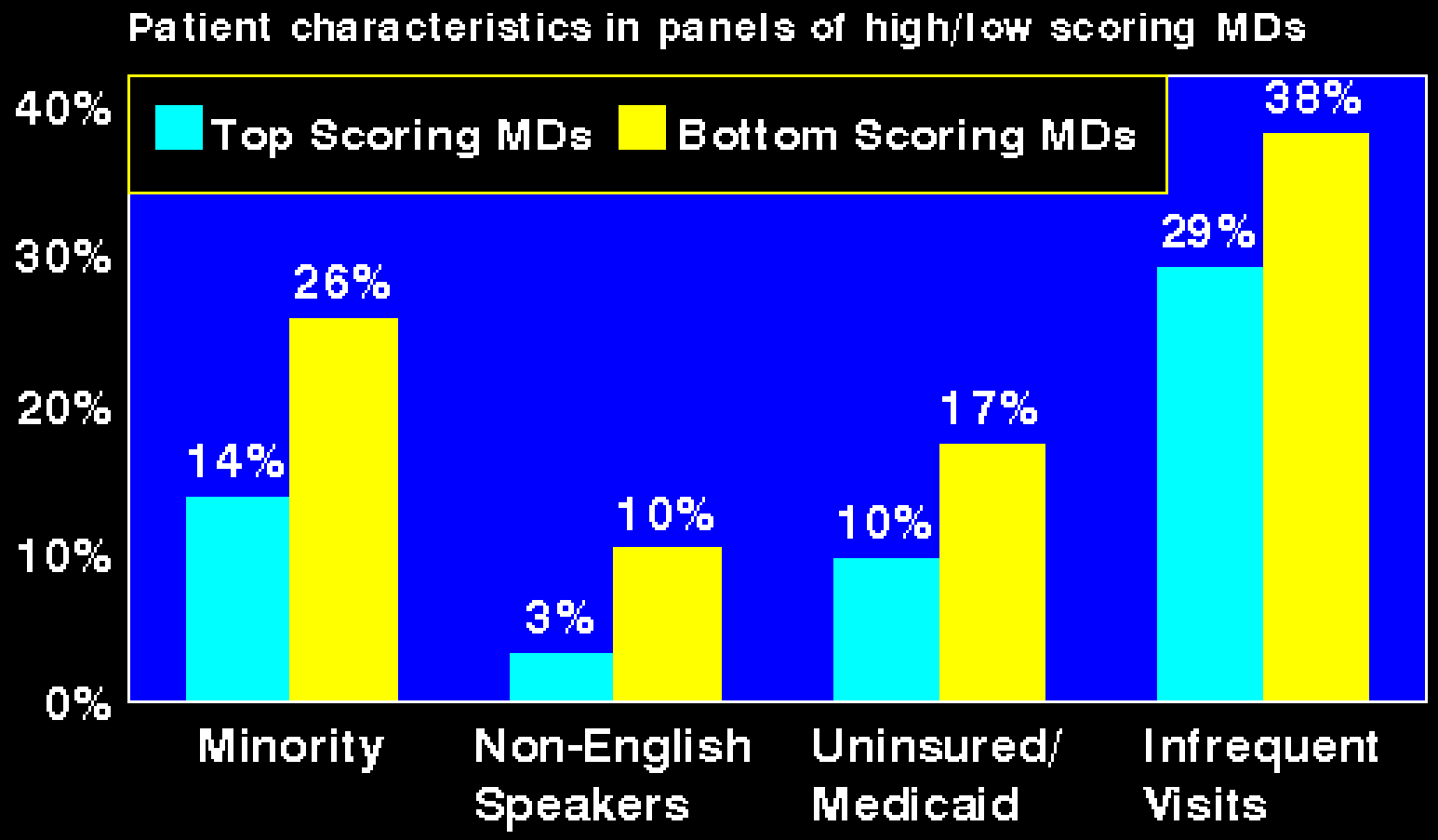
Score Difference = $15,000 Lower Medicare Payments

Source: JAMA 2020;324:975

Note: Poor is defined as dual (i.e. Medicaid) eligible

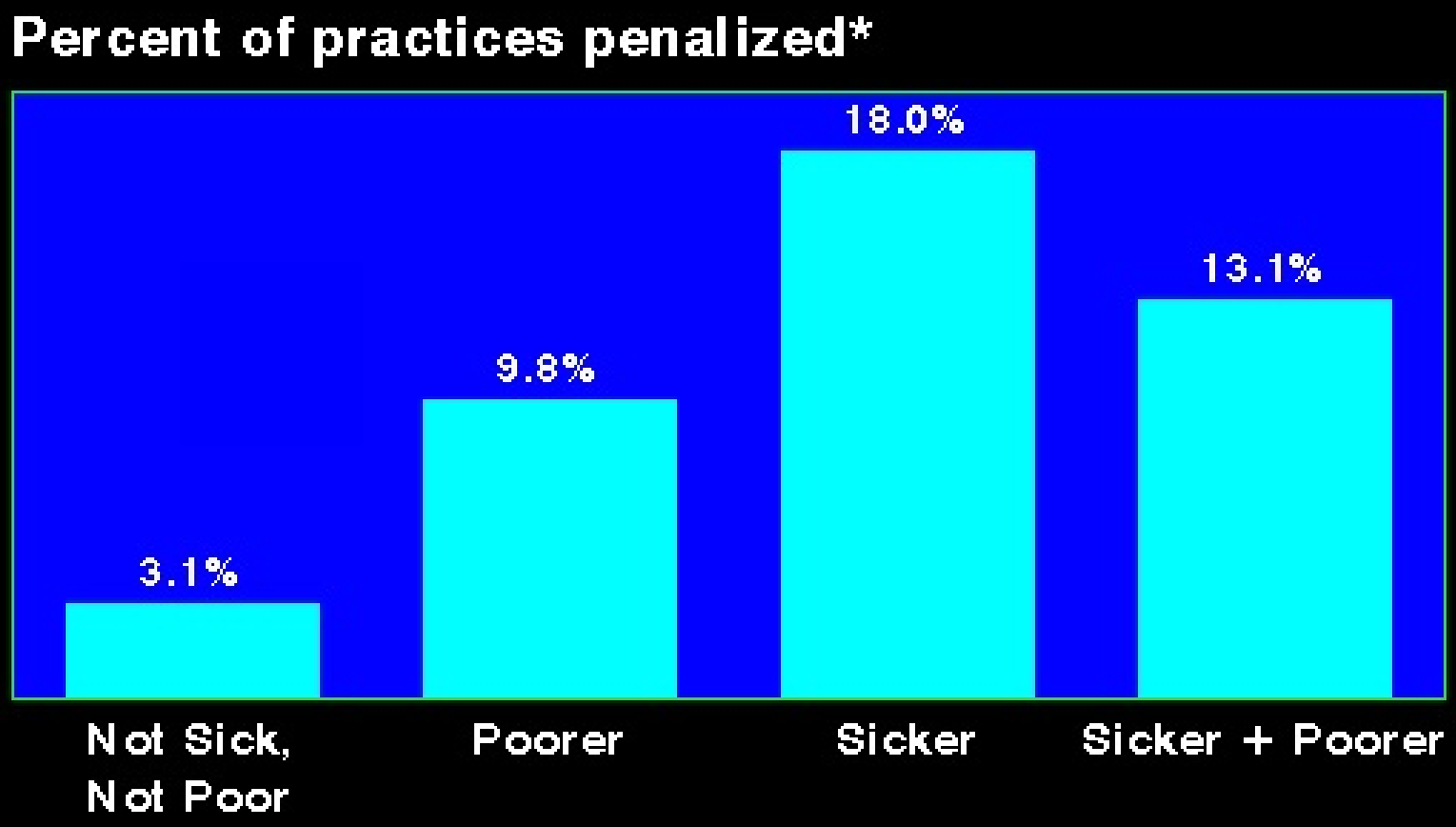
Quality Scores Tell More About Patients Than Doctors

Harvard Docs with Poorer/Minority Patients Score Low



Source: JAMA 9/8/2010:1107

Medicare's Value-Based Payment Program Penalizes Doctors Caring for High-Needs Patients



Source: JAMA 2017;318:453

*Note: Estimate based on simulation of penalties under mandatory Physicians Value-Based Payment Modifier Program

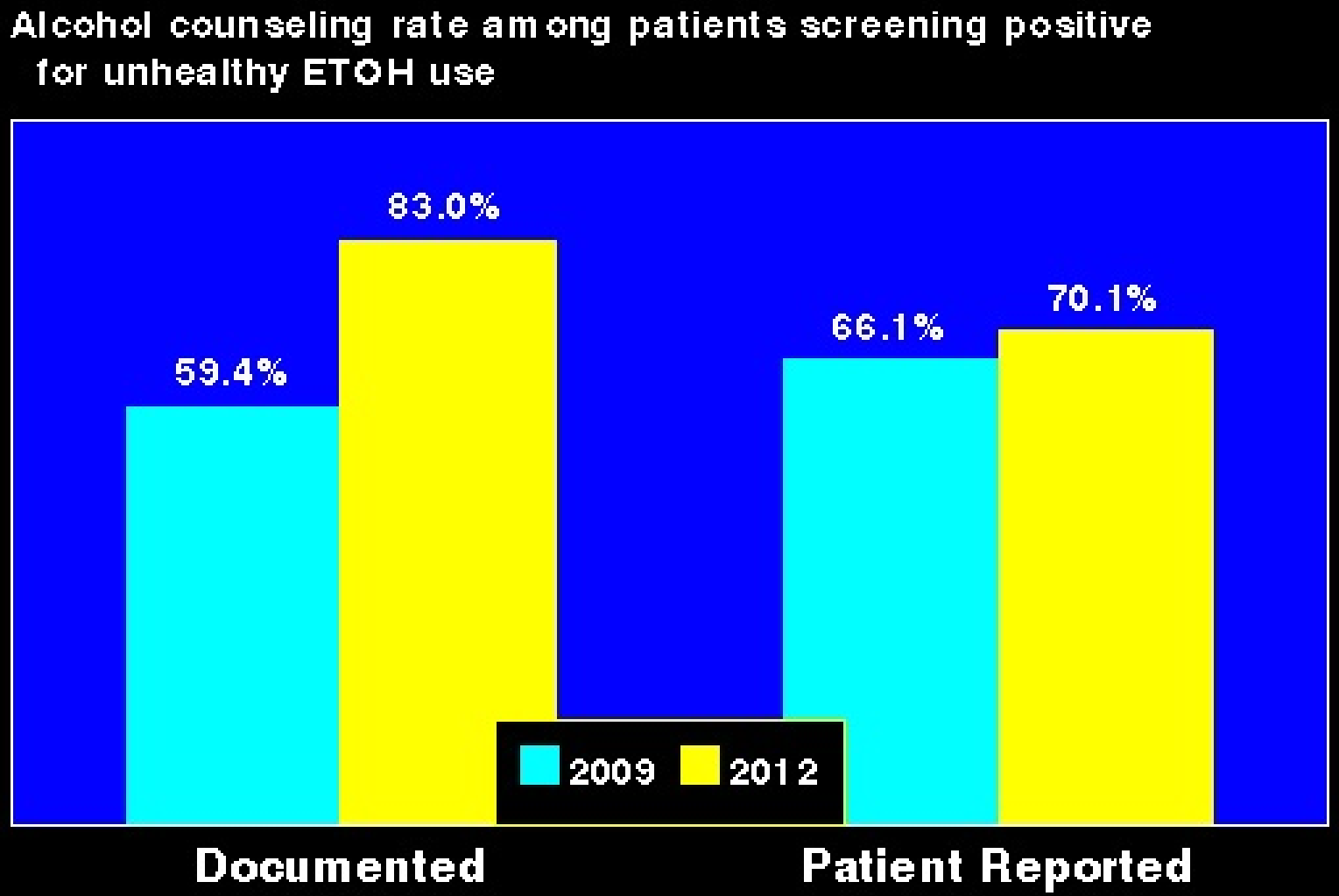
Pay for Performance

"I do not think its true that the way to get better doctoring and better nursing is to put money on the table in front of doctors and nurses. I think that's a fundamental misunderstanding of human motivation. I think people respond to joy and work and love and achievement and learning and appreciation and gratitude - and a sense of a job well done. I think that it feels good to be a doctor and better to be a better doctor. When we begin to attach dollar amounts to throughputs and to individual pay we are playing with fire. The first and most important effect of that may be to begin to dissociate people from their work."

Don Berwick, M.D,

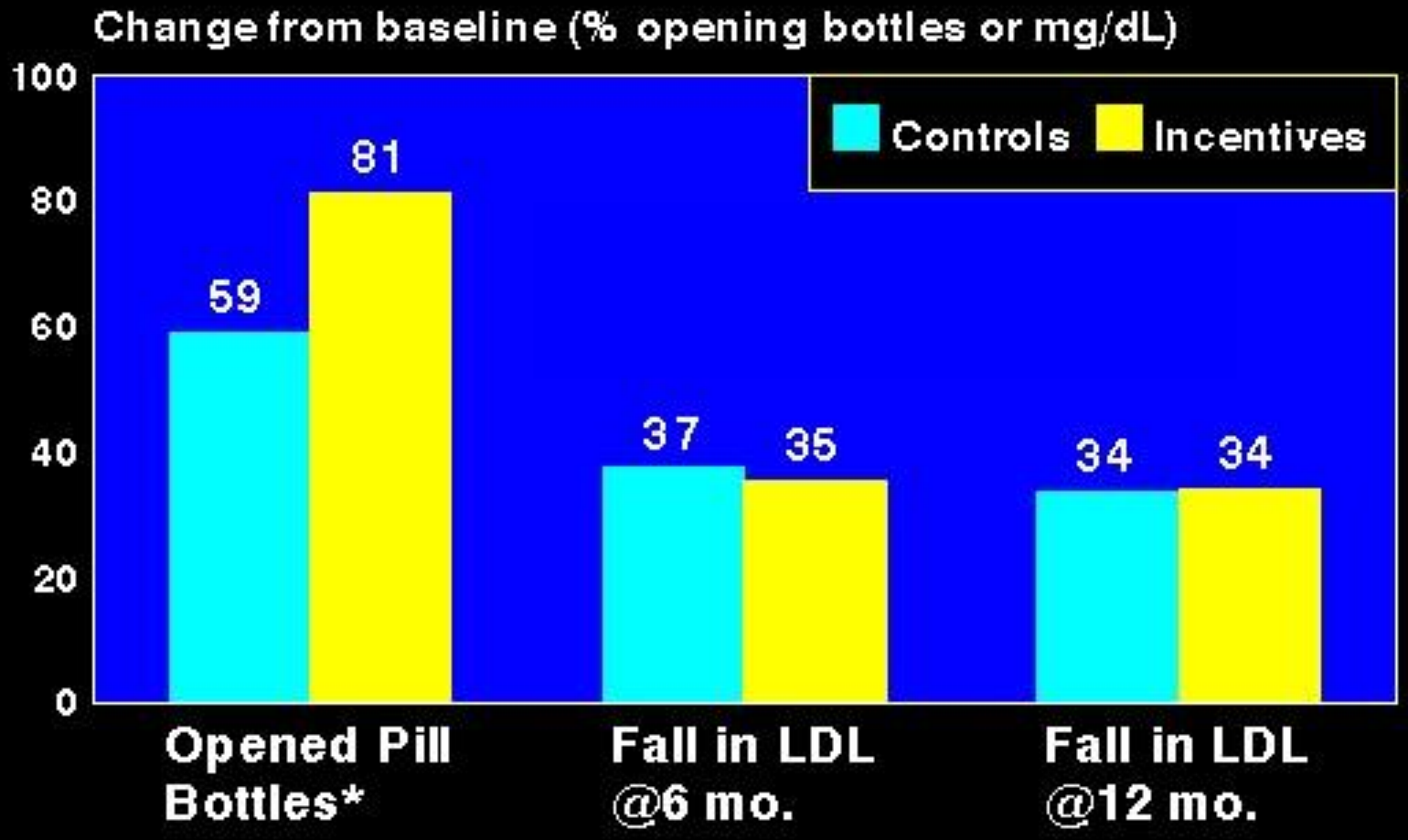
Source: Health Affairs 1/12/2005

Performance Monitoring Increased Documentation of Alcohol Counseling, But Not Real Counseling Rate



Source: JGIM 2017;33:268

$450 Incentive to Take Statins Improved Pill Bottle Openings But Not LDL-C Levels

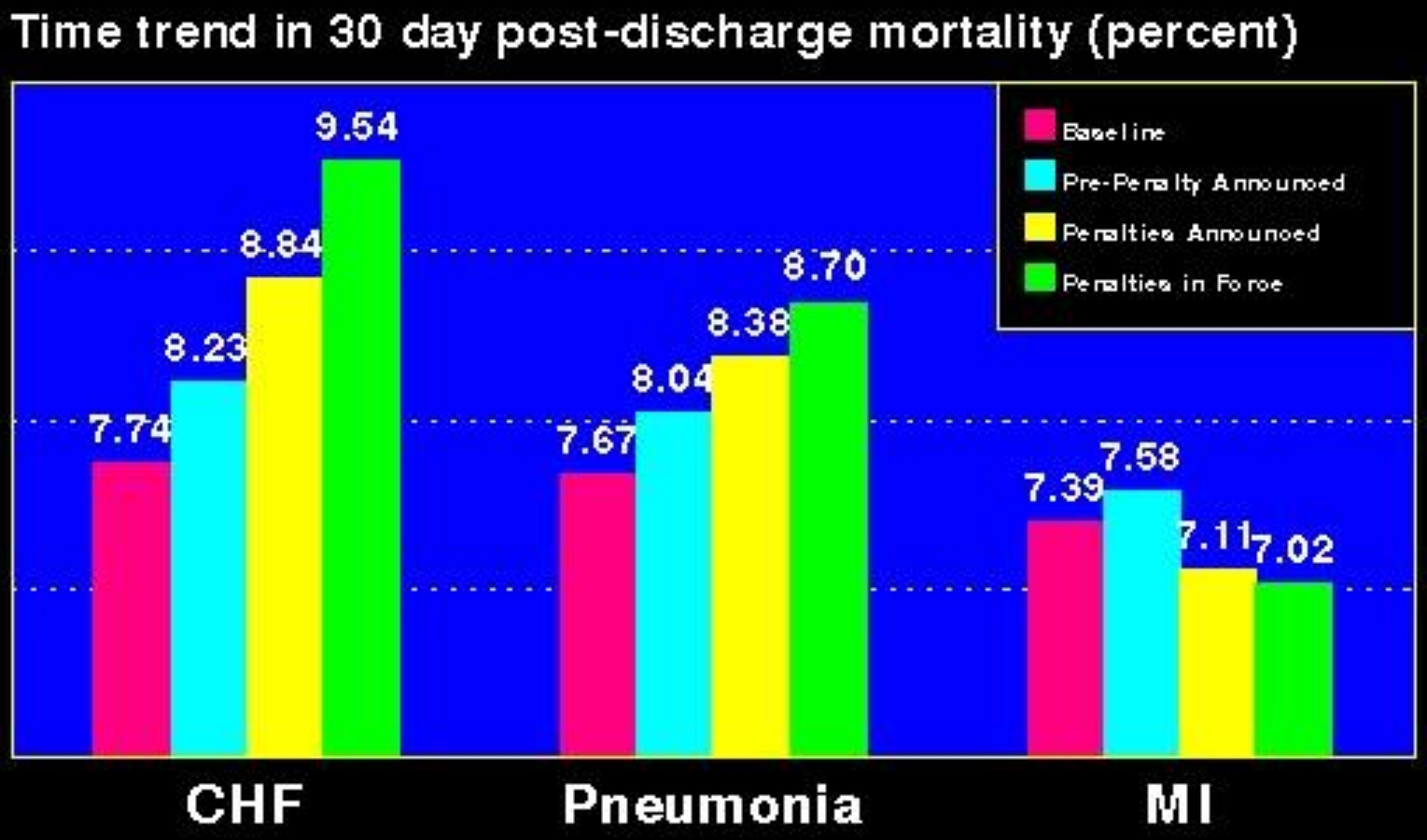


Source: JAMA Network Open 2020;3(10):e2019429 (RCT with 805 patients)

*Percent of first 180 days with pill bottle opening

CHF and Pneumonia Death Rates Rose With Readmission Penalties

Big Penalties for Readmission, Small Penalties for Mortality

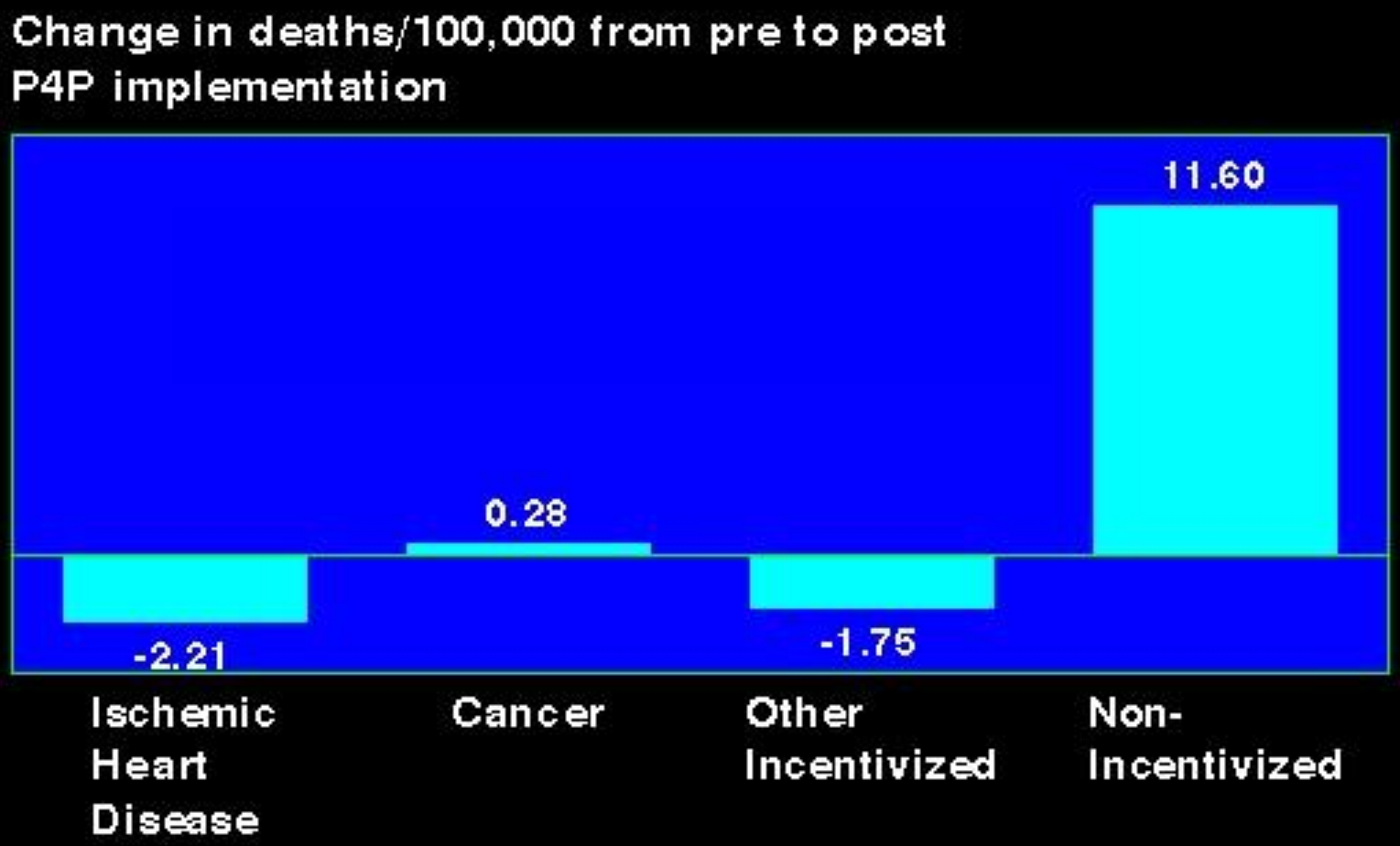


Source: JAMA 2018;320:2542

P4P Didn't Improve Mortality in England

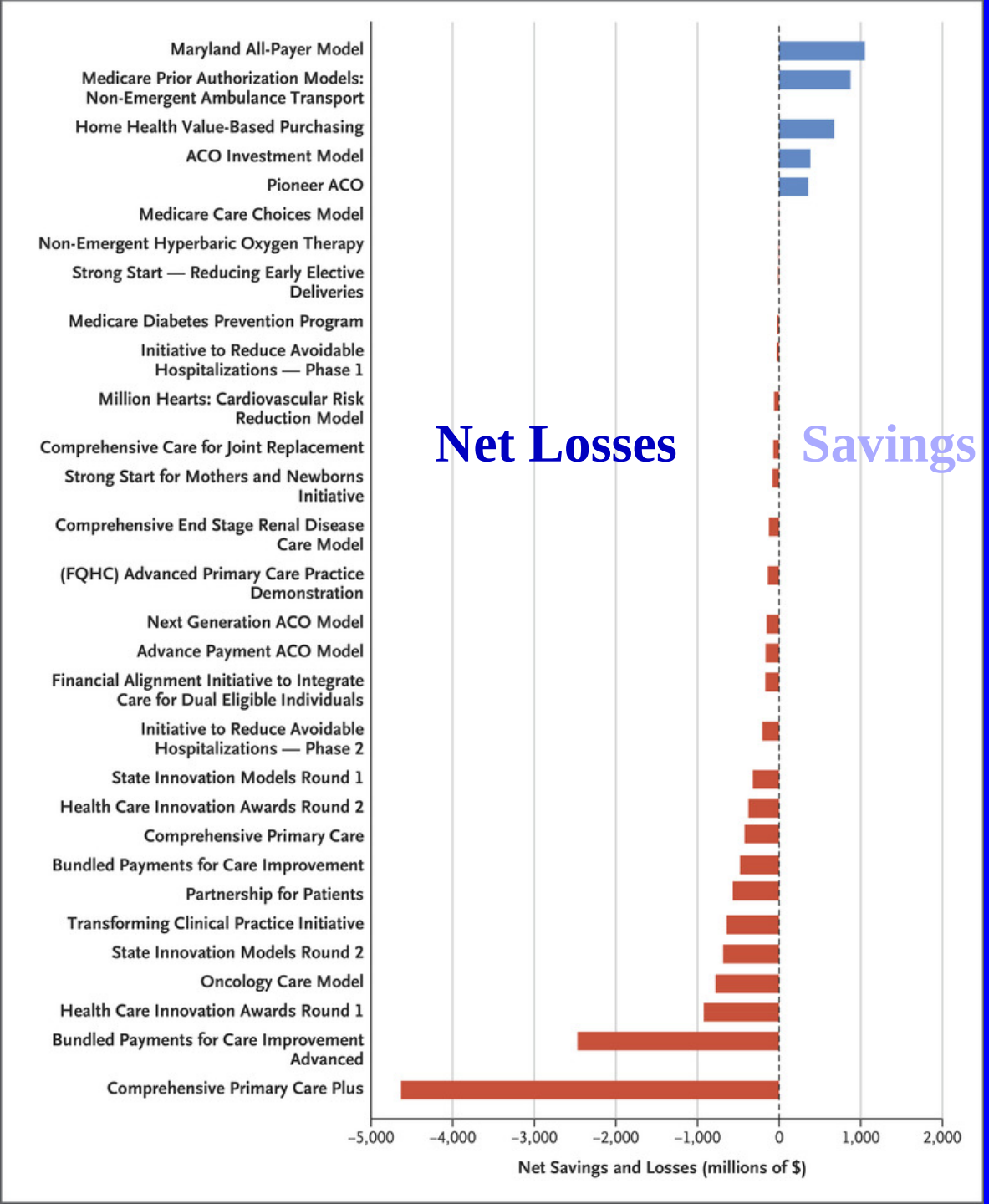
World's Largest P4P Program Tied 25% of GP Income to Quality Targets

>100 Quality Measures, >95% of Targets Were Met



Source: Lancet 2016;388:268

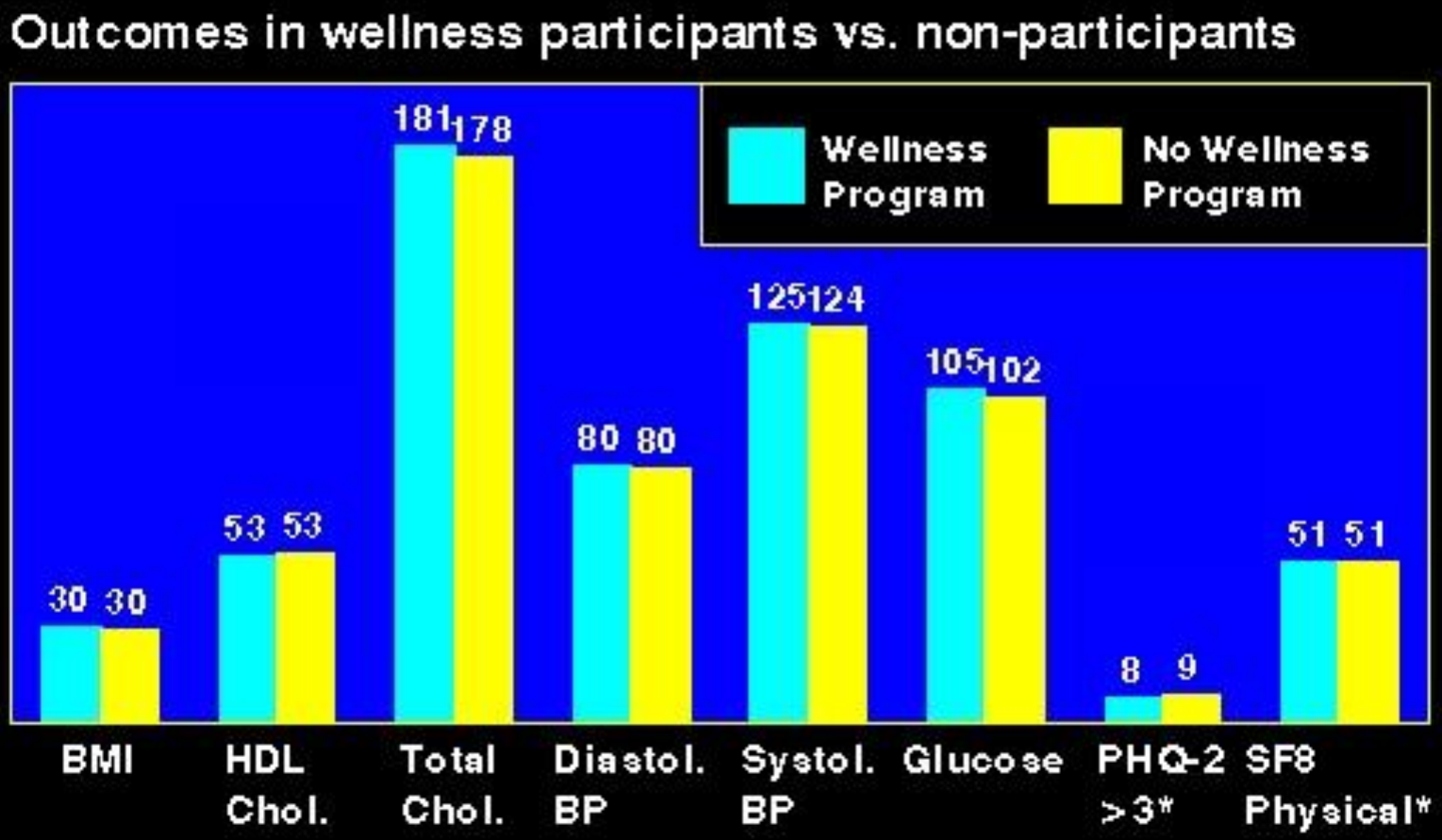
Note: Data show trends compared to developed nations without P4P



Most Value-Based Payment Programs Have Flopped:

Costs Exceed Savings

Worksite Wellness Program - an RCT
No Benefit at 6 Months or 3 Years



Source: JAMA 2019;32:1491; Health Aff 2021;40:951 - 6 month results show, 3 year almost identical
* PHQ-2>3 indicates likely depression; SF-8 Physical is a physical health score
Note: No significant differences in utilization of care or medical costs

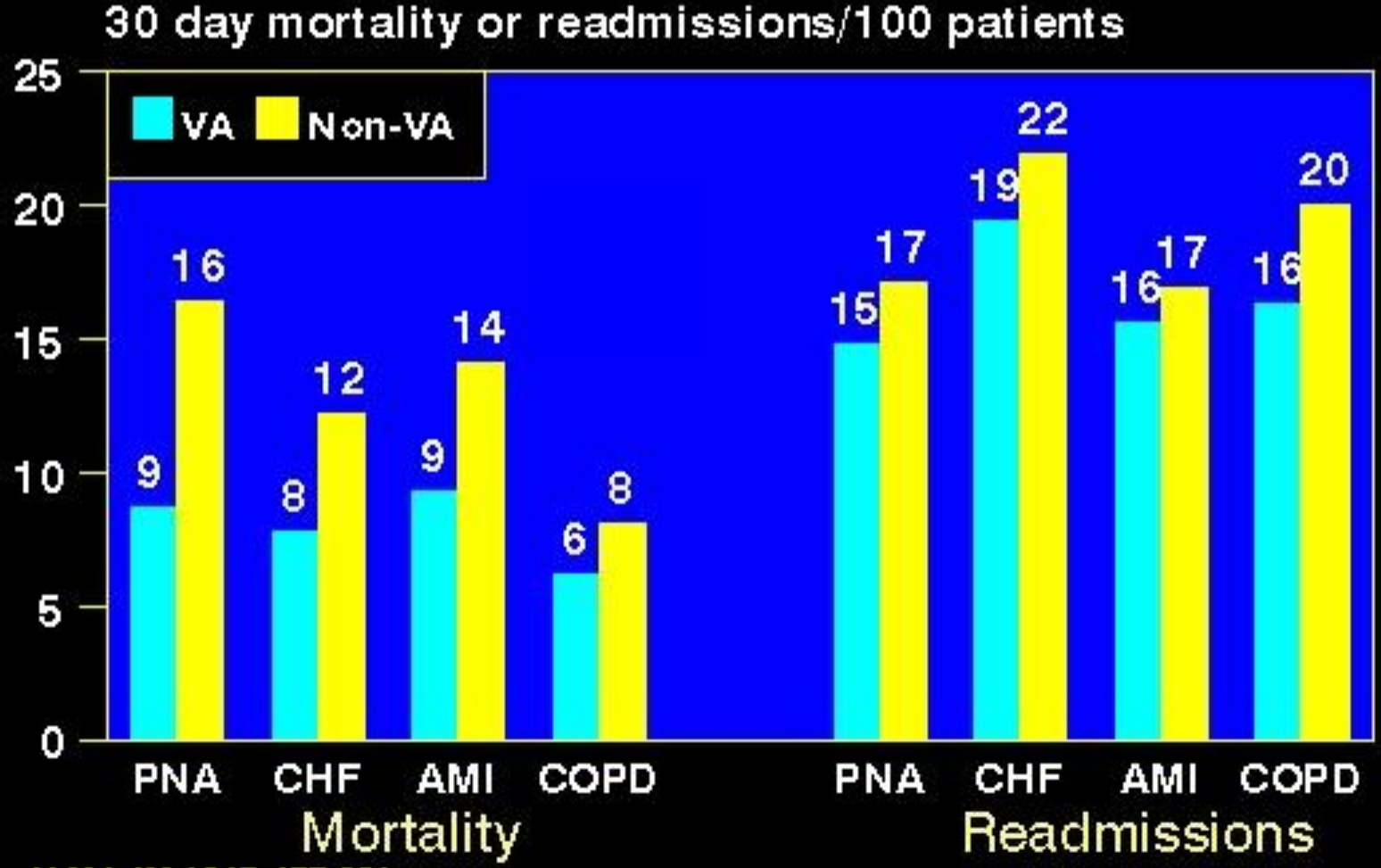
ACOs and P4P: Implementation Without Evidence

- P-4-P – Official Medicare policy, widely adopted by private payers
  - No RCTs showing improved outcomes.
  - No improvement in 3 largest programs.
  - Negative side effects likely, e.g. increased CHF deaths.
  - VA (no P4P) has better quality than hospitals paid P4P
- ACOs – Newest health policy panacea
  - No RCTs.
  - No savings once bonuses factored in.
  - Disturbing HMO experience.

Implementing everywhere interventions which have been proven nowhere risks failure on a colossal scale

Veterans Health Administration: Better and Fairer Care

VA Hospitals Have Lower Mortality and Readmissions than Other Hospitals

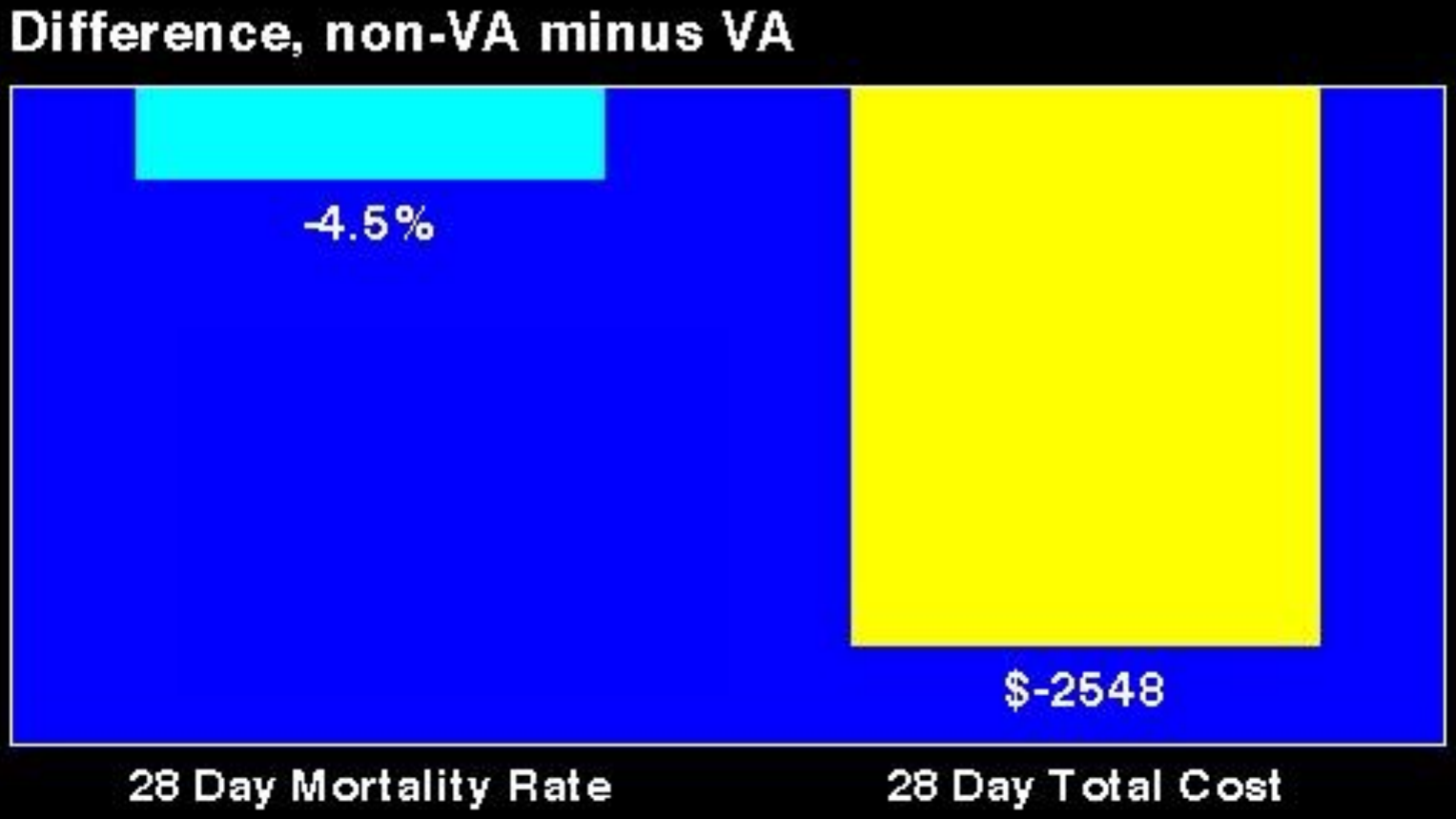


Source: JAMA IM 2017;177:882

Note: PNA=pneumonia; All rates are risk adjusted

VA vs. Non-VA Care for MI: Fewer Deaths, Lower Costs

A Quasi-Randomized Analysis

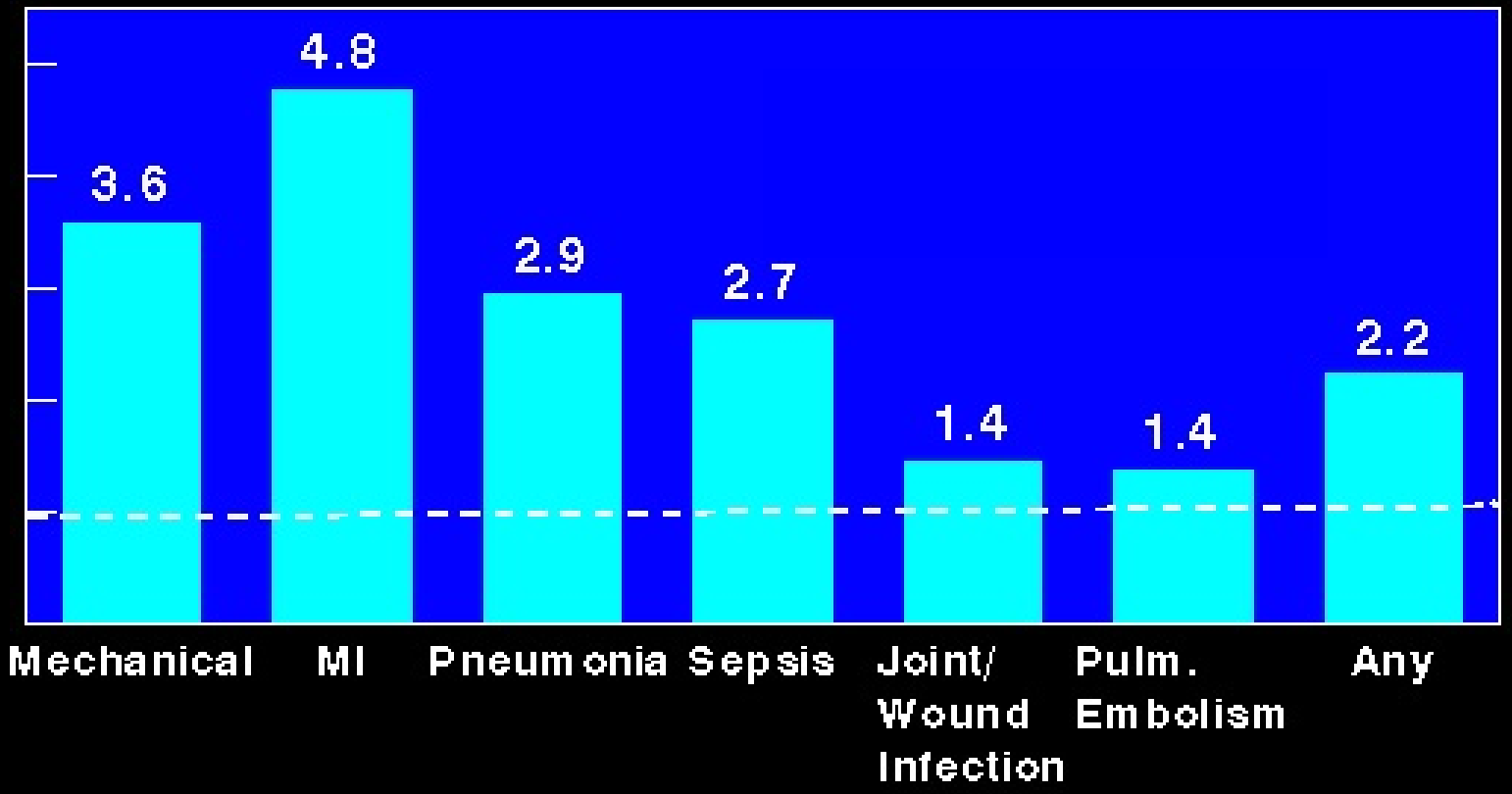


Source: "Is There a VA Advantage: Evidence From Dually Eligible Veterans." NBER November, 2020
Note: Quasi-randomized based on ambulance transport

VA-Paid Knee Replacement: Better at VA Hospital than Purchased Private Care

VA Privatization Worsens Care

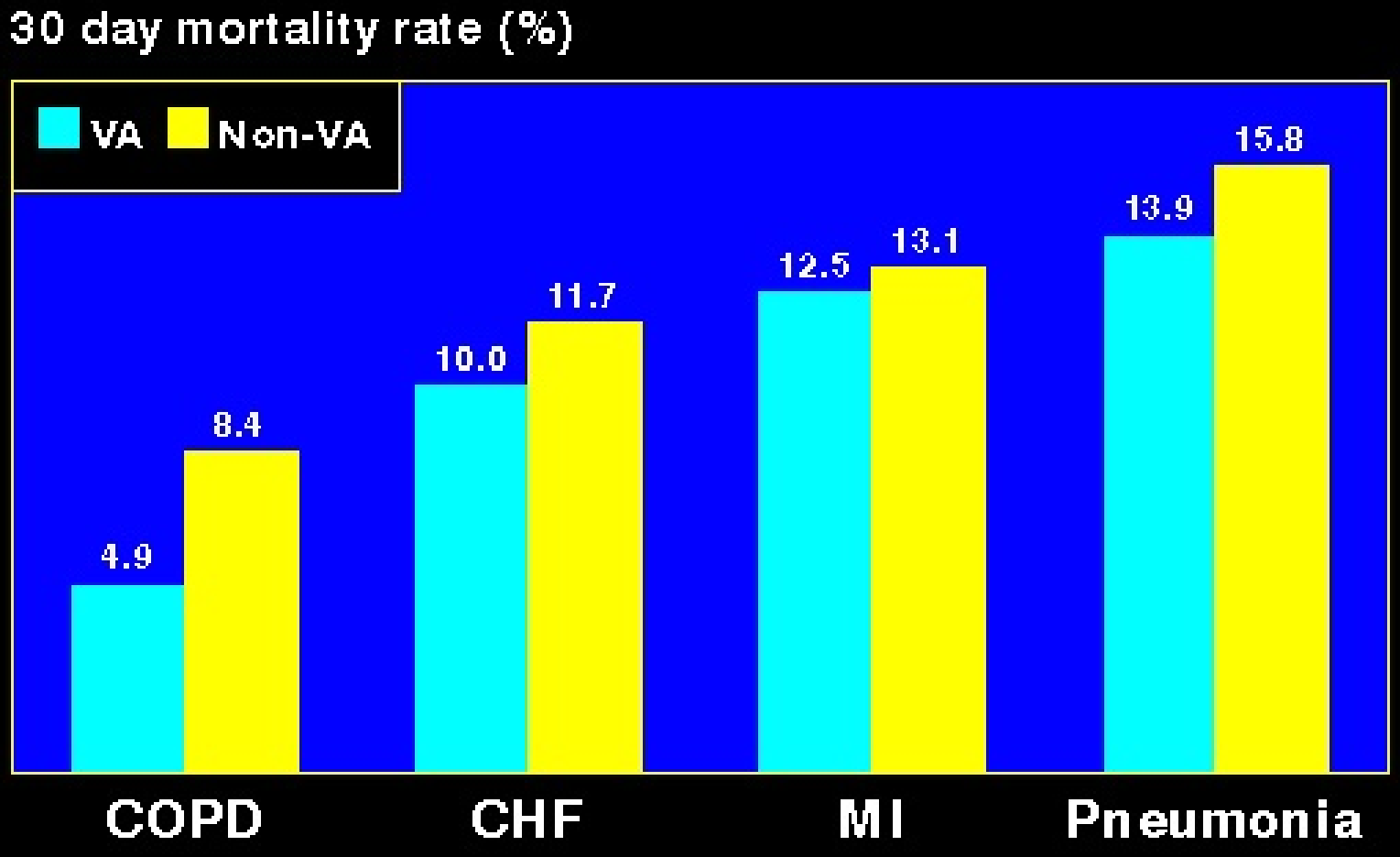
Odds ratio for complication:
VA-Purchased vs. VA-Delivered Surgery



Source: Health Affairs 2021;40:1312v- Figures are adjusted for multiple patient characteristics

VA Hospitals Have Lower Mortality Than Nearby Hospitals

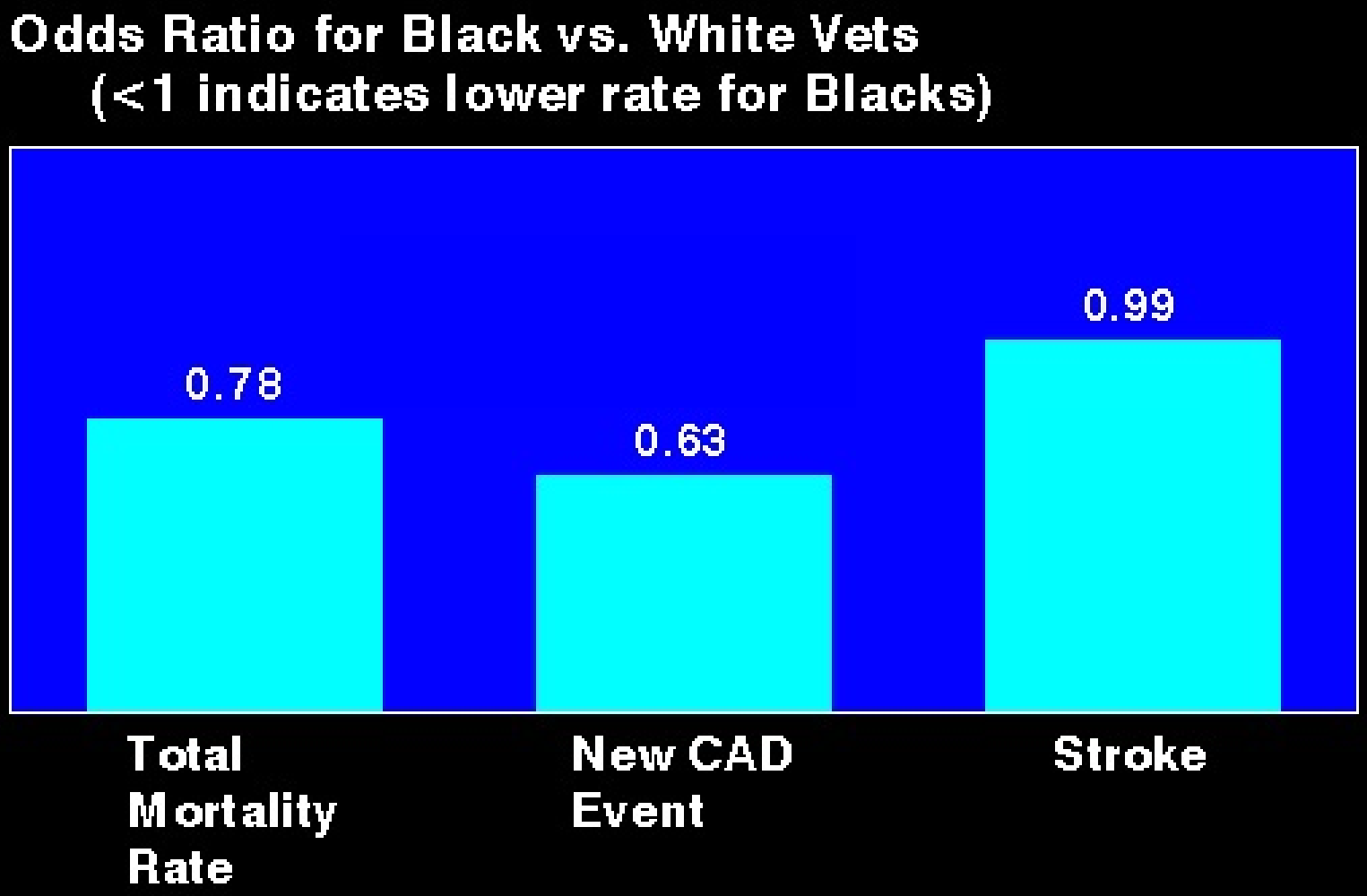
A comparison of VA and Non-VA hospitals in 121 Hospital Market Areas



Source: Ann Intern Med 2019;170:426

Blacks in VA: No Health Disadvantage

A Longitudinal Study of 3,072,966 Vets Cared for at VAs

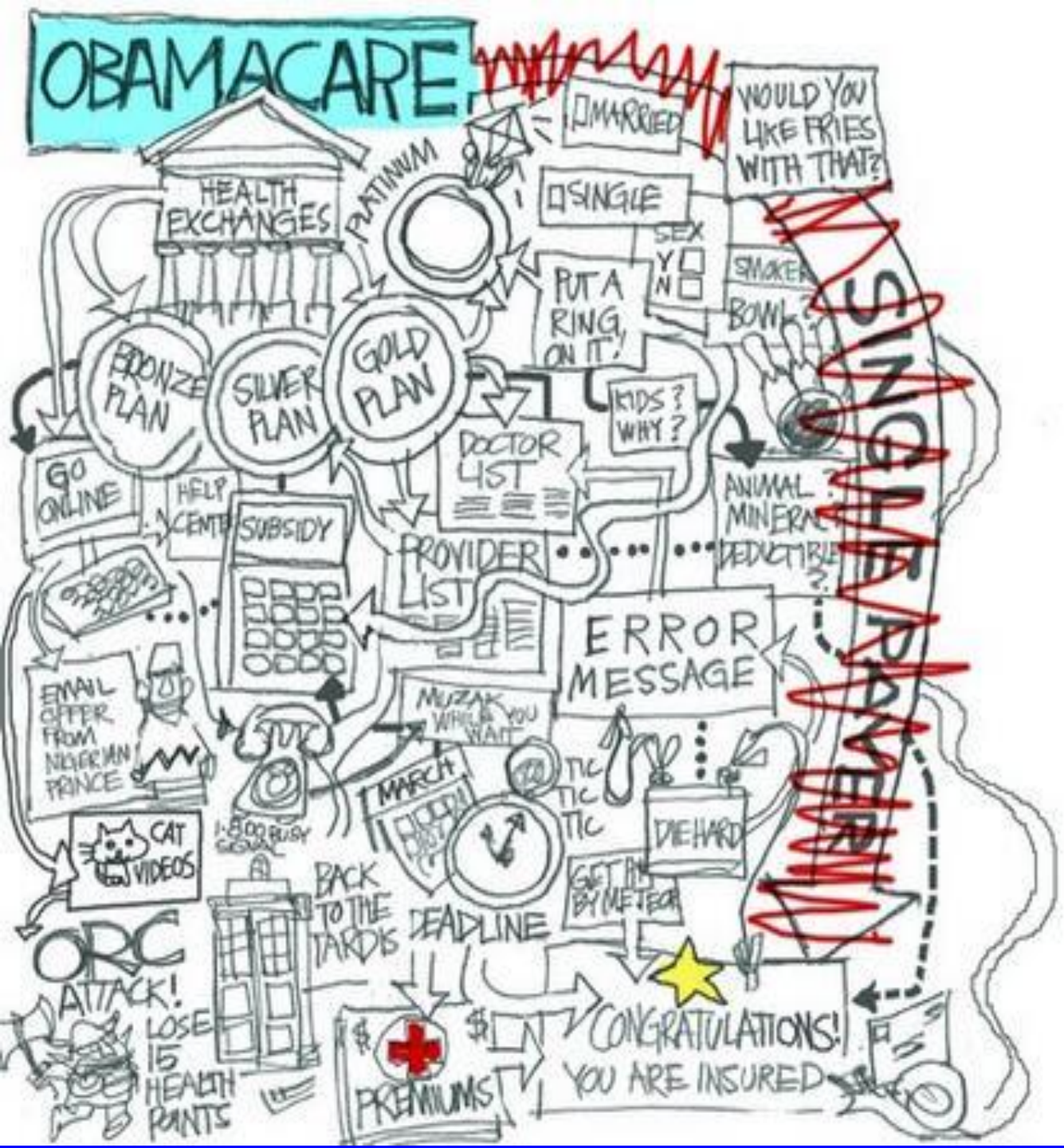


Source: Kovesdy et al. Circulation 9/18/2015

Mandate Model Reform: Keeping Private Insurers In Charge

"Mandate" Model for Reform

1. Expanded Medicaid-like program
   - Free for poor
   - Subsidies for low income
   - Buy-in without subsidy for others
2. Employer Mandate +/- Individuals
3. Insurance Exchanges



THE SALT LAKE TRIBUNE

THE SIMPLE GOP PLAN FOR THE UNINSURED

GET SICK

↓

DIE PENNILESS

Medicare's "Software"

18.9 Million Seniors Enrolled Within11 Months

DHEW — SOCIAL SECURITY ADMINISTRATION

488-40-6969-A

APPLICATION FOR ENROLLMENT
in the
Supplementary Medical Insurance Program
Under the Social Security Act

PLEASE READ THE ENCLOSED LEAFLET

Harry S Truman
Independence, Missouri

Do not write in the space above

TO GET MEDICAL INSURANCE → CHECK [X] YES

The Federal Government will pay half the cost of this insurance. Your share of the cost ($3) will be deducted from your monthly social security benefits.

IF YOU DO NOT WANT THIS MEDICAL INSURANCE → CHECK [ ] NO

SIGN HERE Harry S Truman

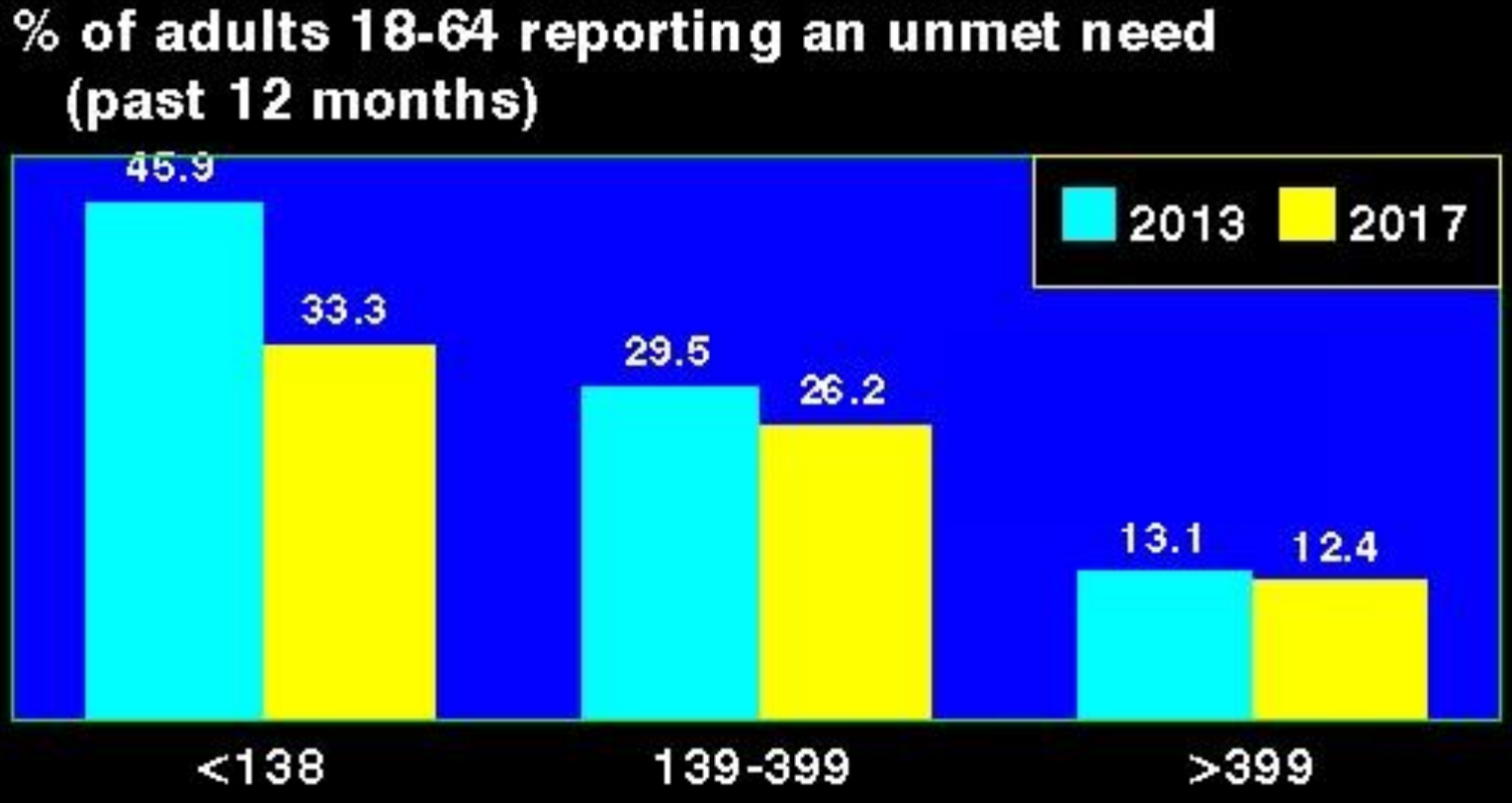
Signature by mark (X) must be witnessed below.

SIGNATURE OF WITNESS

ADDRESS OF WITNESS

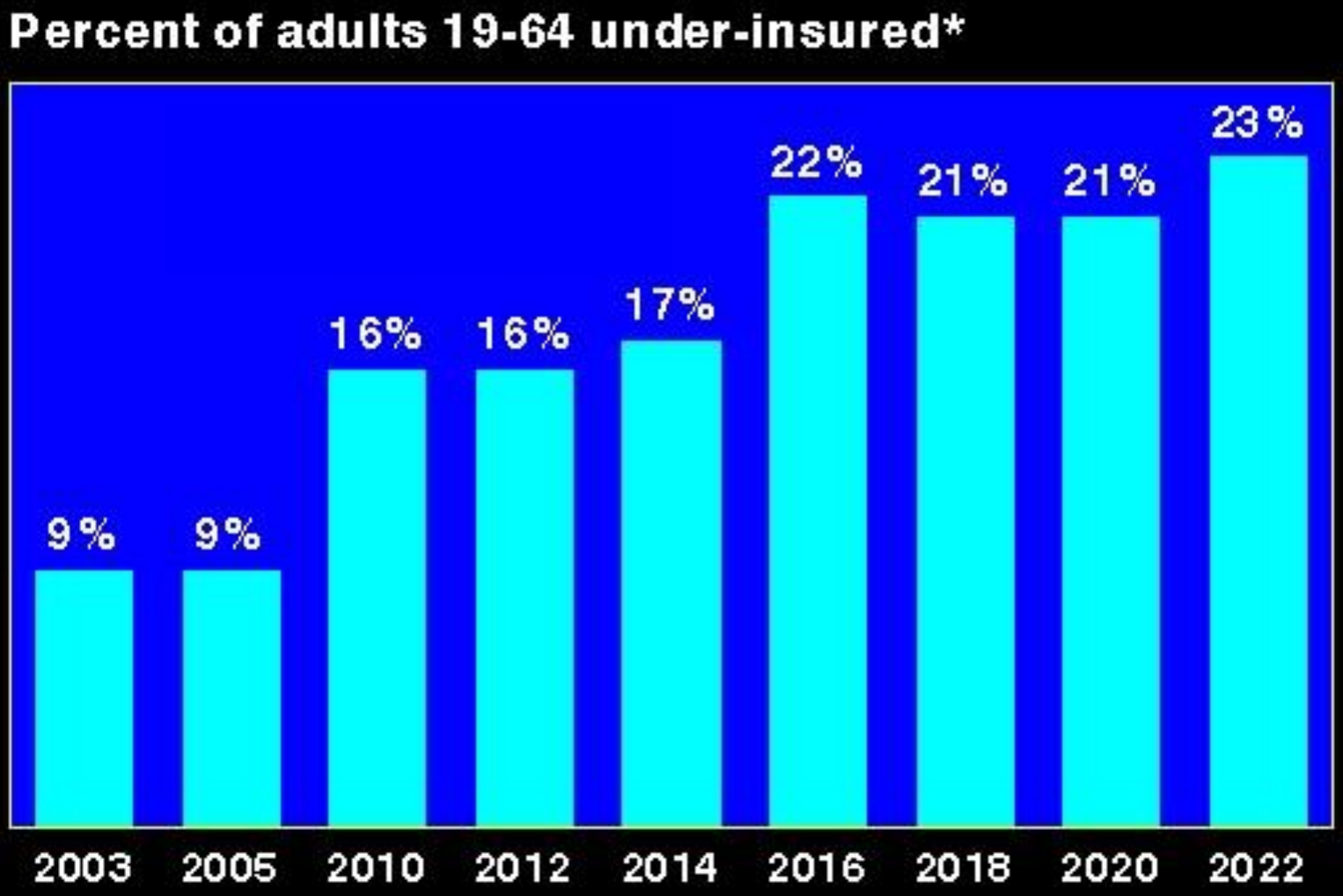
ACA Decreased Incidence of Unmet Medical Needs Due to Cost

Better, But Still Not Good



Source: Health Affairs 2017;36:1656

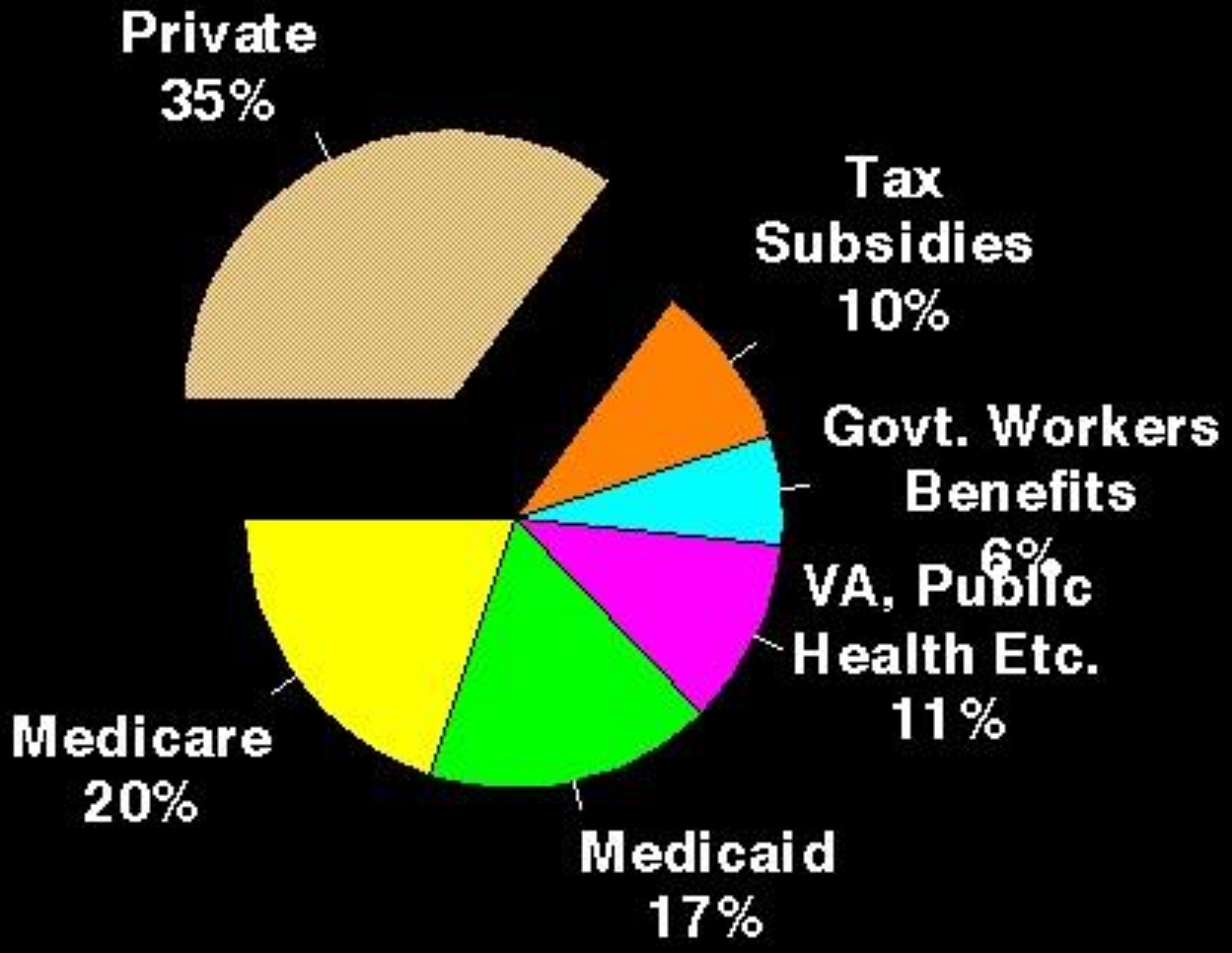
Under-Insurance Increased After ACA



Source: Commonwealth Fund Health Insurance Surveys 2003-2022
* Under-insurance: Insured all year but OOP>10% of income (>5% if low income) or deduct>5% of income

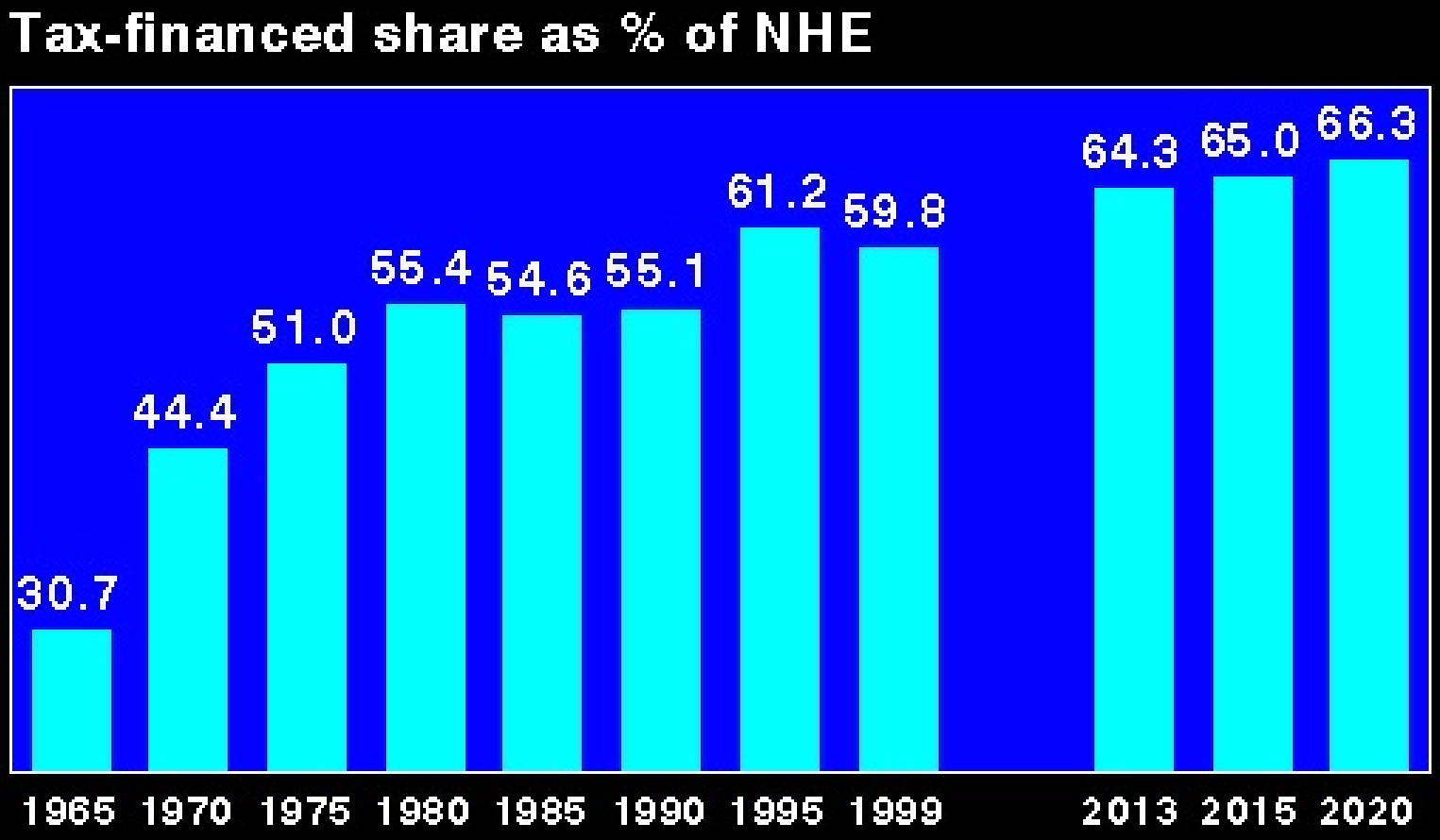
American Taxpayers Already Pay More Than People in Nations With National Health Insurance

Taxes Fund 2/3 of Health Spending



Source: Himmelstein & Woolhandler - Analysis of NCHS data

Tax-Financed Share of Total Health Spending, 1965-2020



Source: Woolhandler & Himmelstein - Health Af July/Aug. 2002 & AJPH March, 2016 - Updated
Tax-financed = govt. health programs + govt. employees' benefit costs + tax subsidy for private ins.

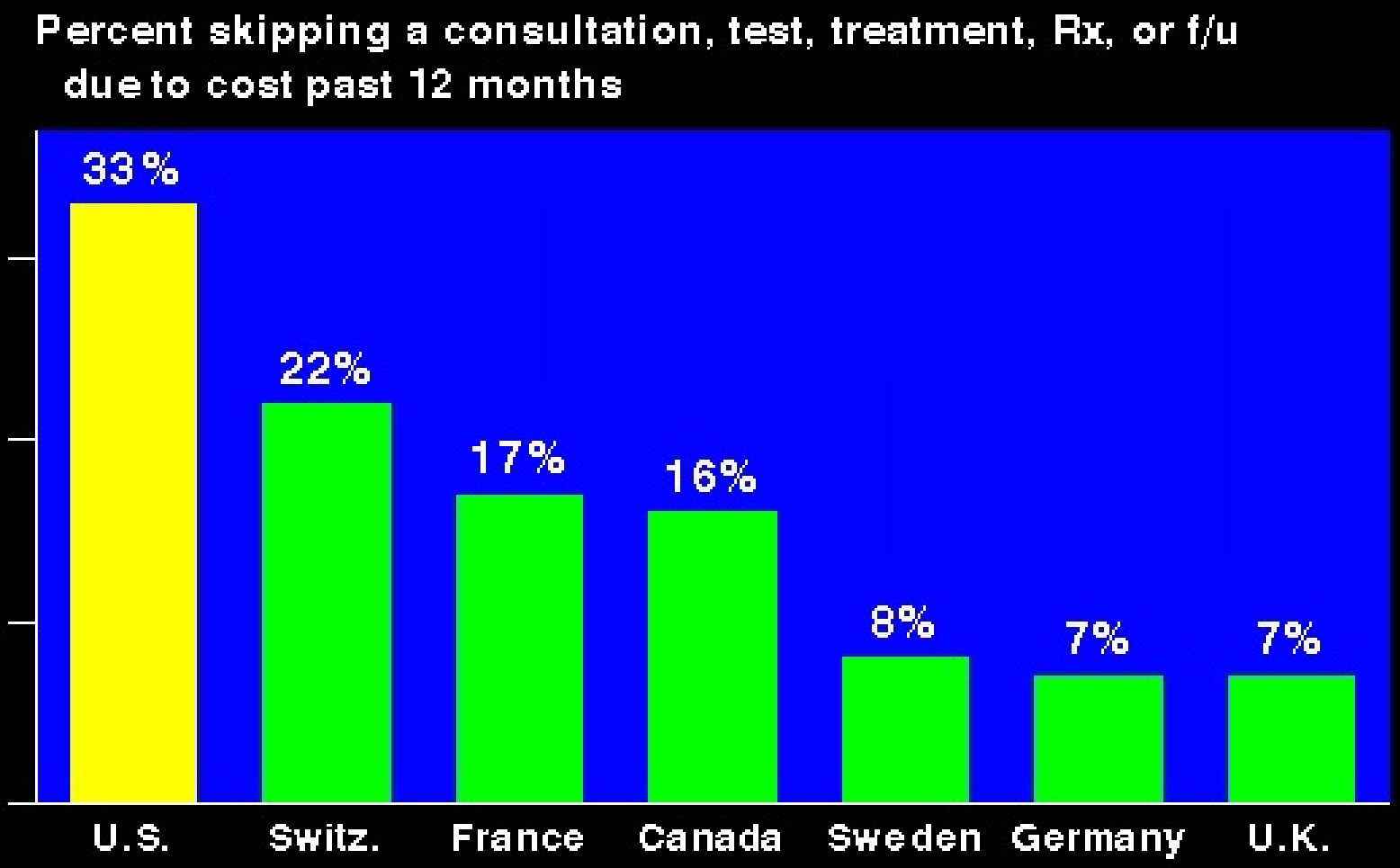
U.S. PUBLIC Spending Per Capita for Health Exceeds TOTAL Spending in Other Nations

Note: Public includes benefit costs for govt. employees & tax subsidy for private insurance

Source: OECD 2021; NCHS; AJPH 2016;106:449 (updated) - Data are for 2020

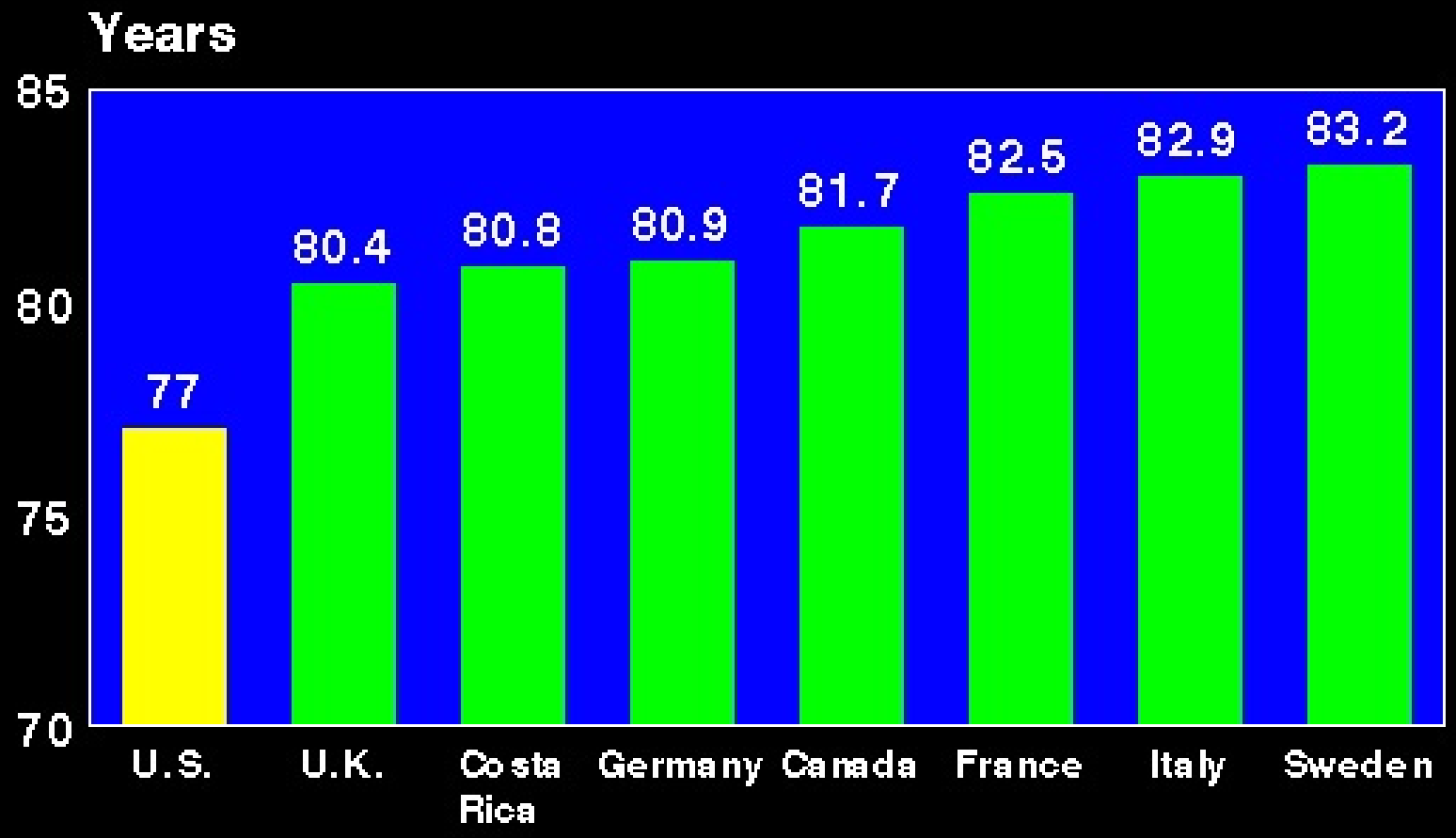
The U.S. Trails Other Nations om Health

U.S. Patients Skip Care More Often



Source: Commonwealth Fund Survey 2016

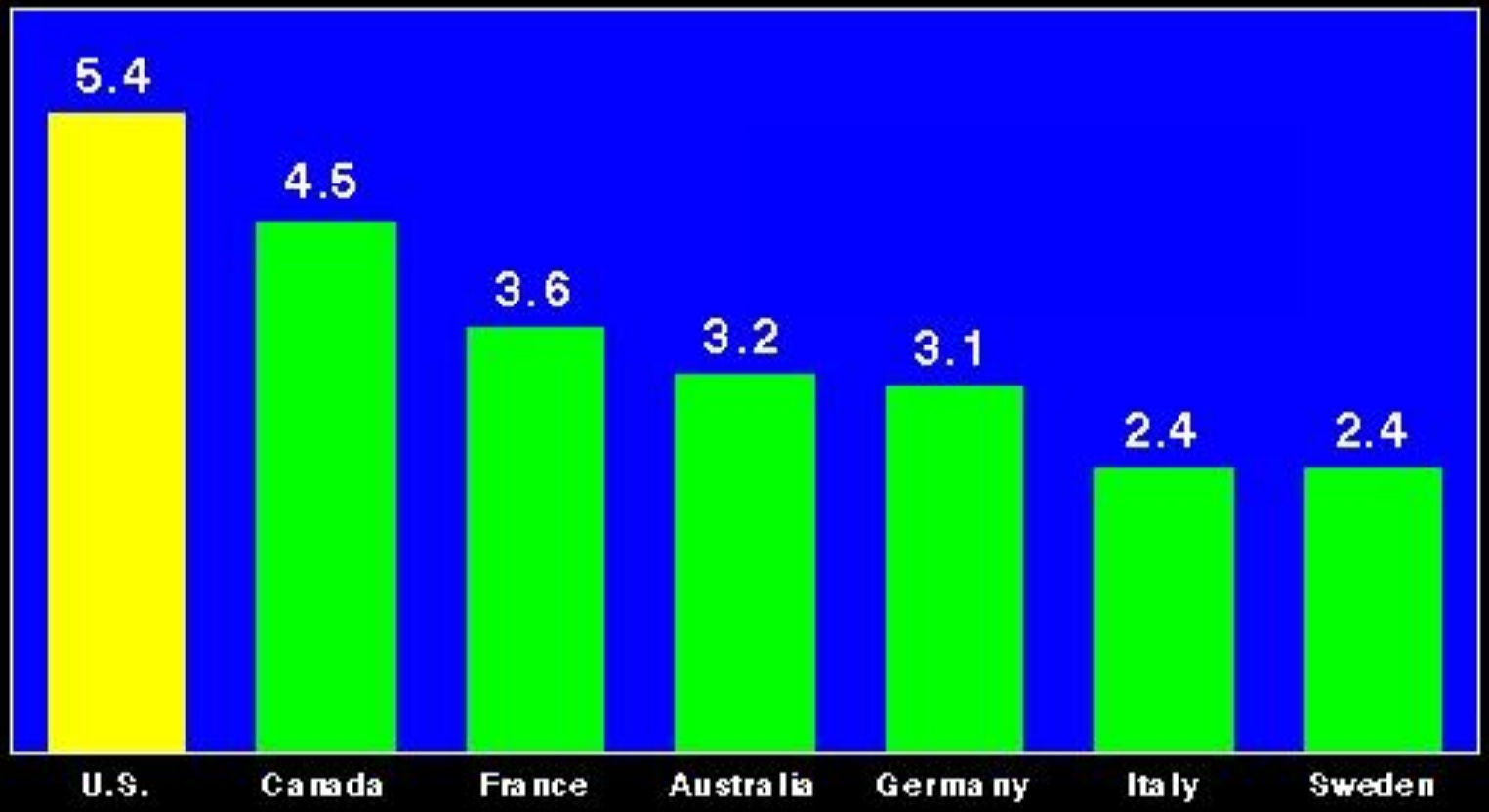
Life Expectancy



Source: OECD, 2022
Note: Data are for 2021

Infant Mortality

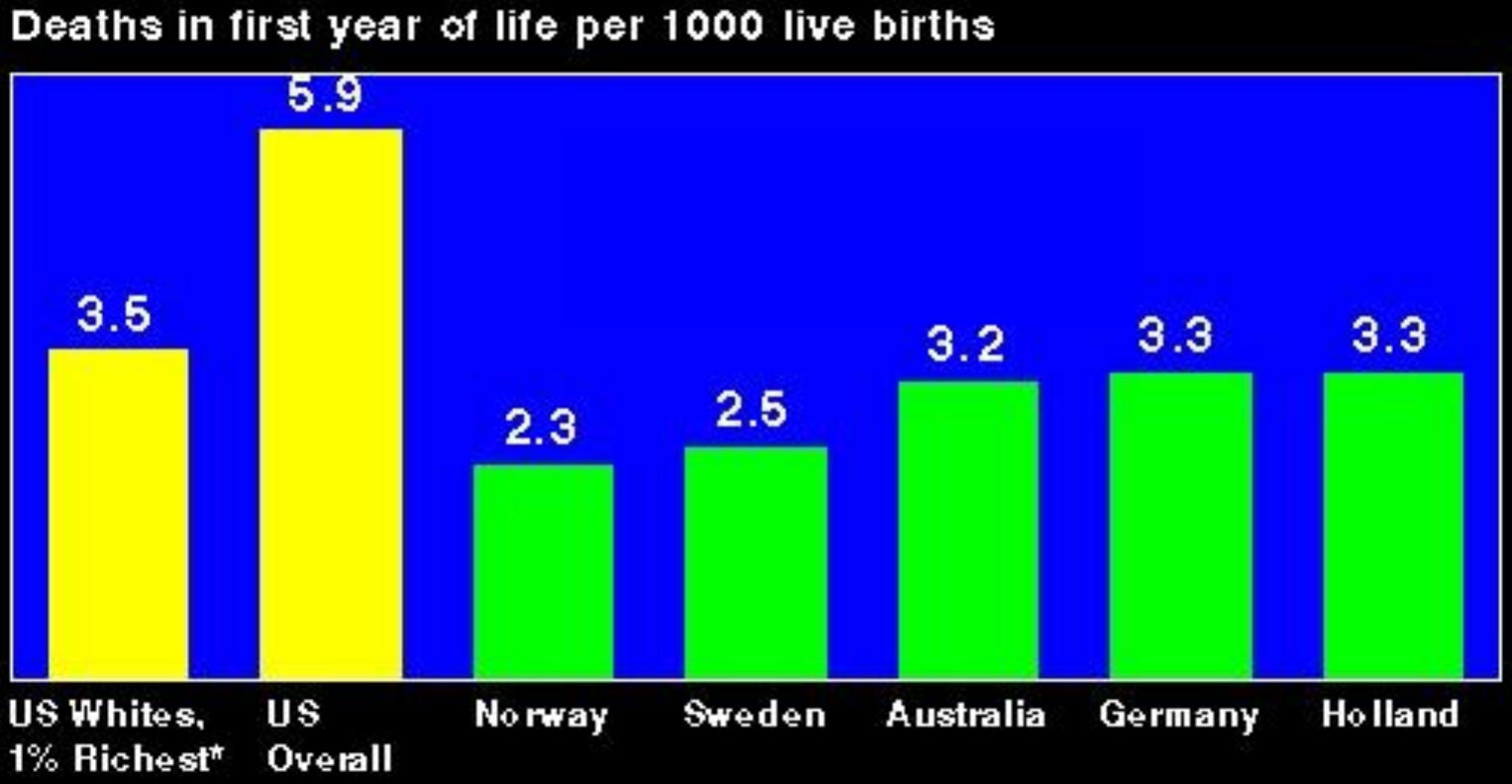
Deaths in First Year of Life/1000 Live Births



Source: OECD, 2022

Note: Data are for 2021 or most recent year available

Even Wealthy White Americans Have High Infant Mortality



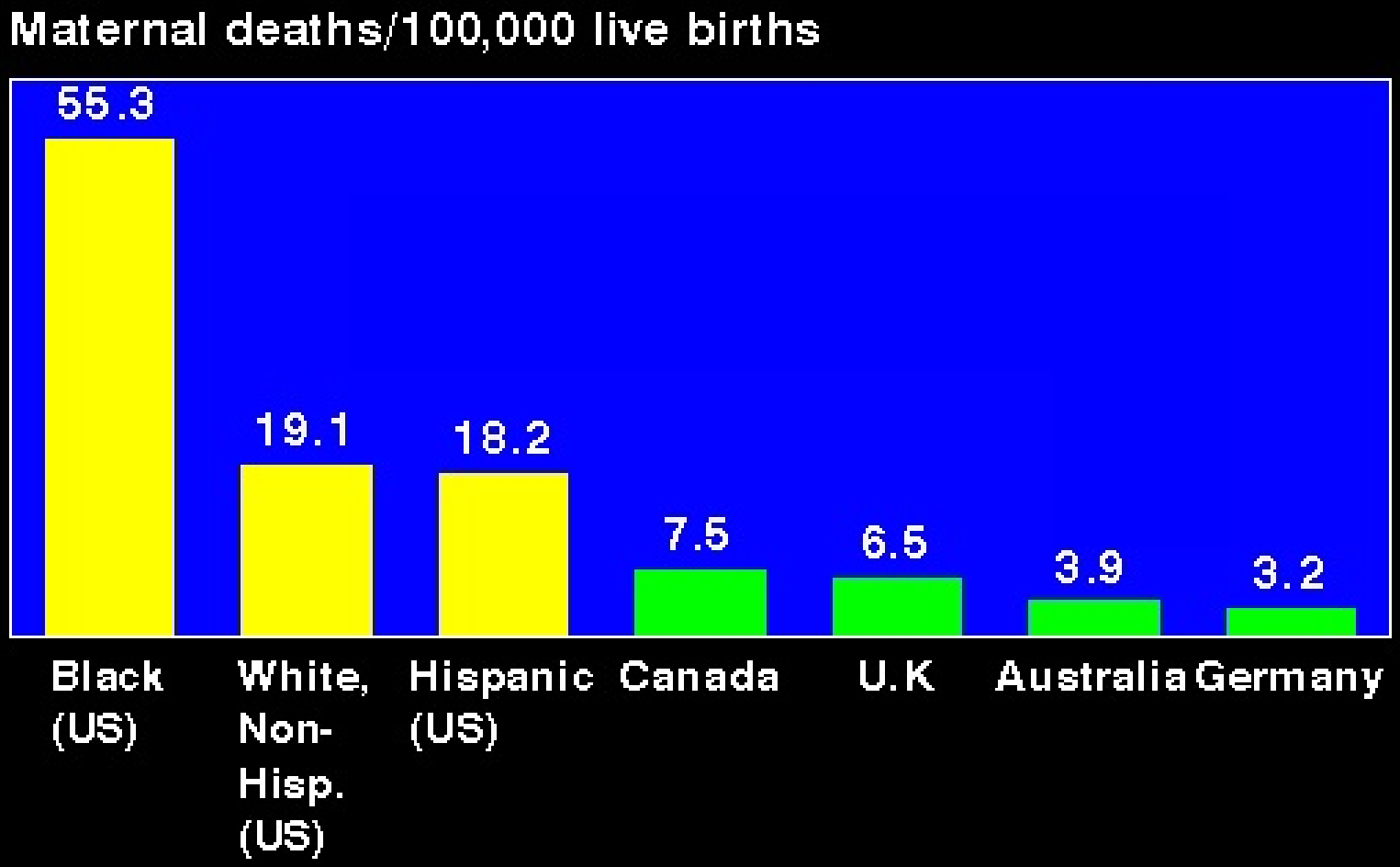
Source: JAMA IM 2021;181:339

Note: Data are for 2015

* White people living in the wealthiest 1% of US counties

U.S. Mothers at Risk

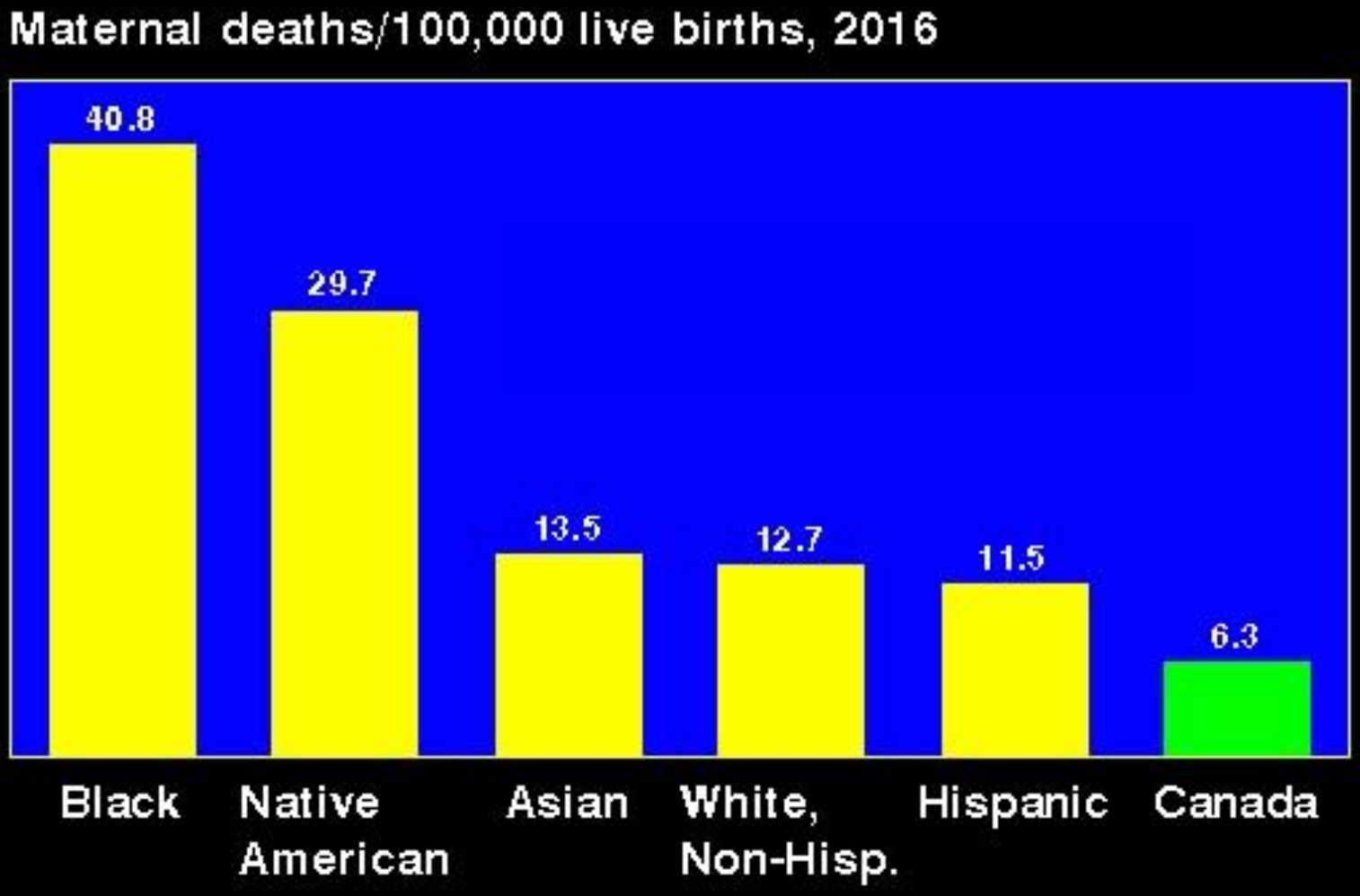
Black Women at Highest Risk, But All Fare Poorly



Source: CDC, February 25,2022 and OECD 2021

Race/Ethnicity and Maternal Mortality

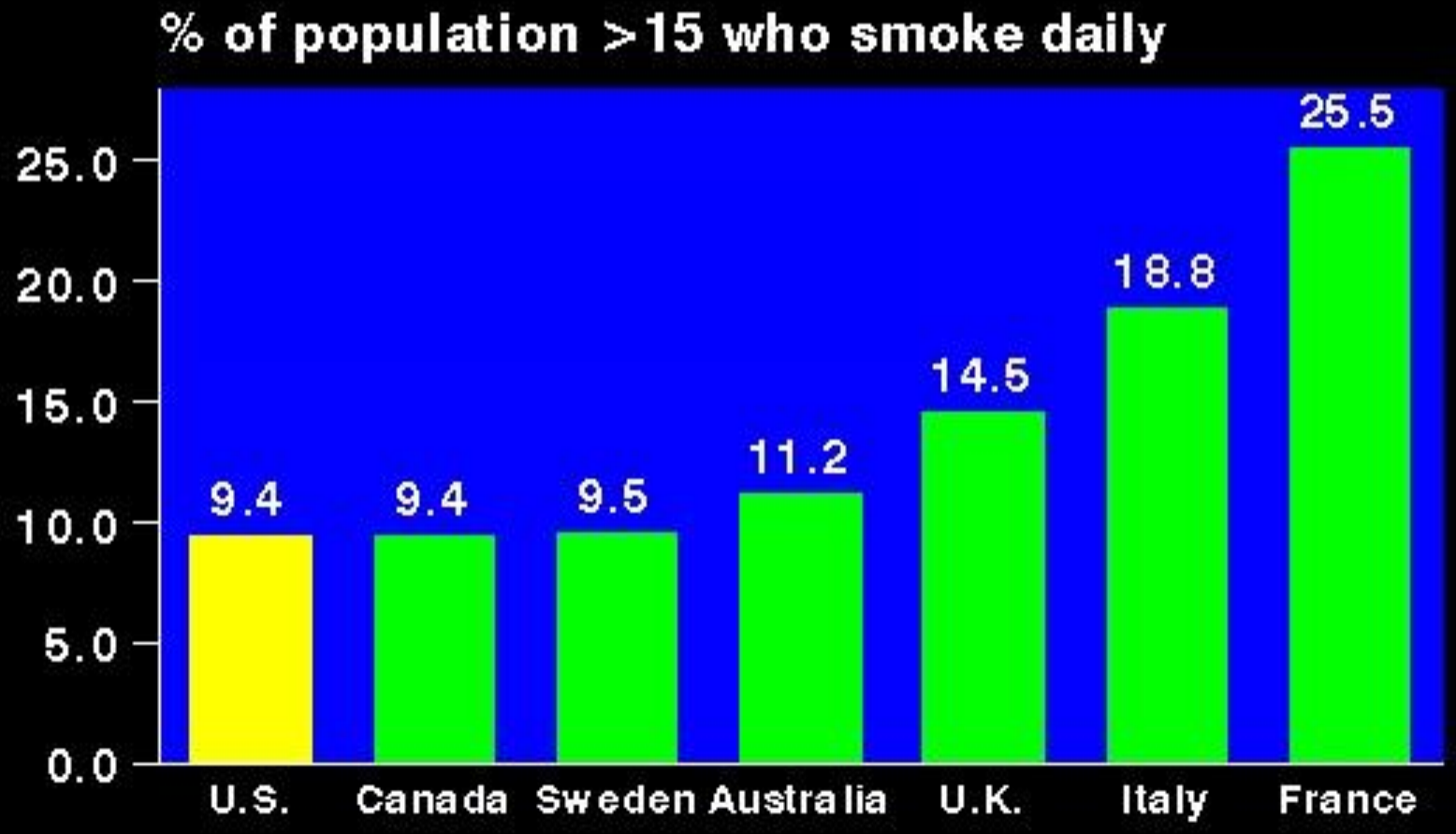
Every Group in the US Does Worse than Canadians



Source: MMWR September, 2019 and OECD

High U.S. Costs Don’t Result From Bad Health Habits, Aging or Overuse of Care

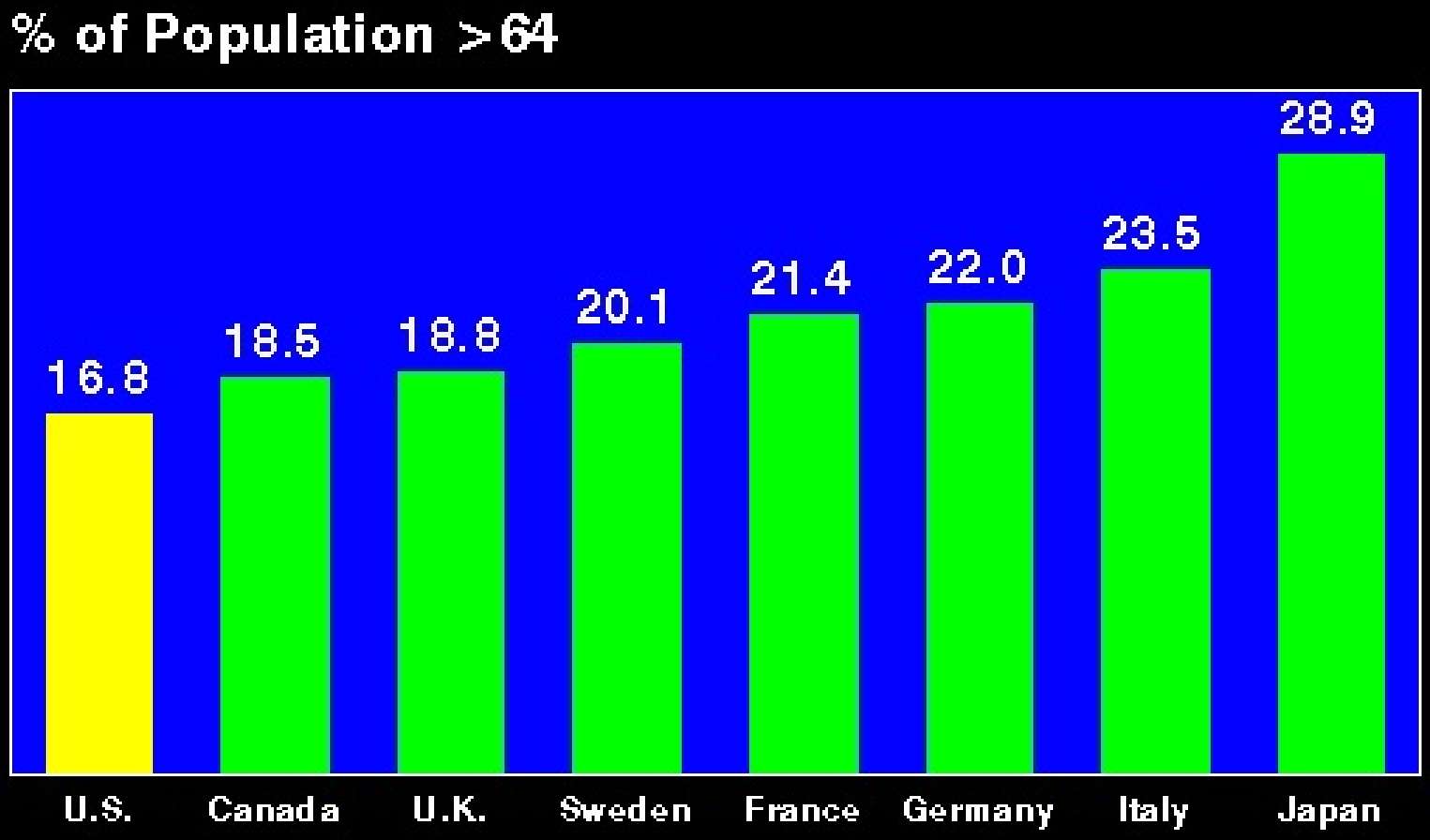
Smoking Prevalence



Source: OECD, 2022

Note: Data ae for 2021 or most recent year available

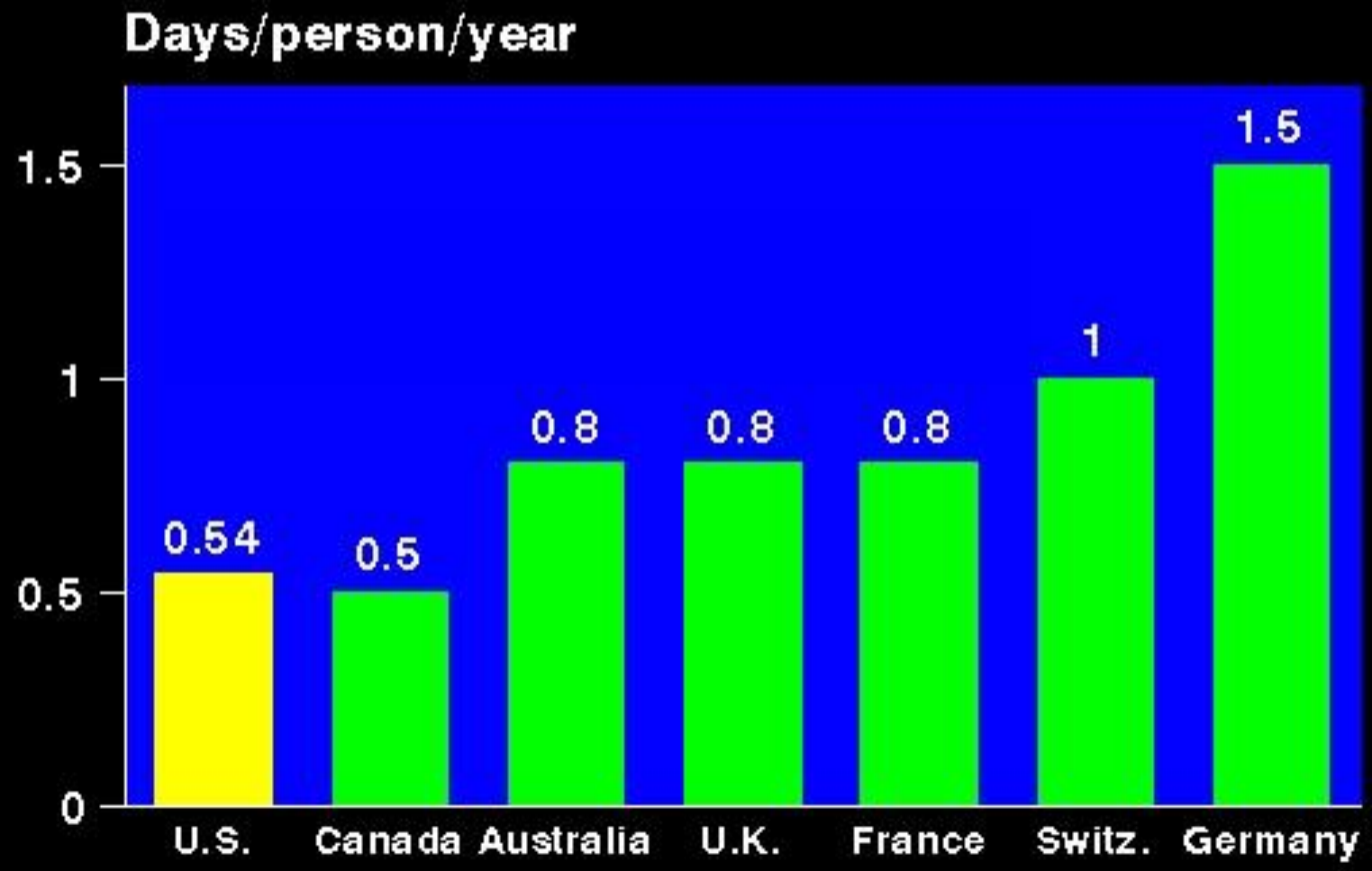
Percent Elderly



Source: OECD, 2022

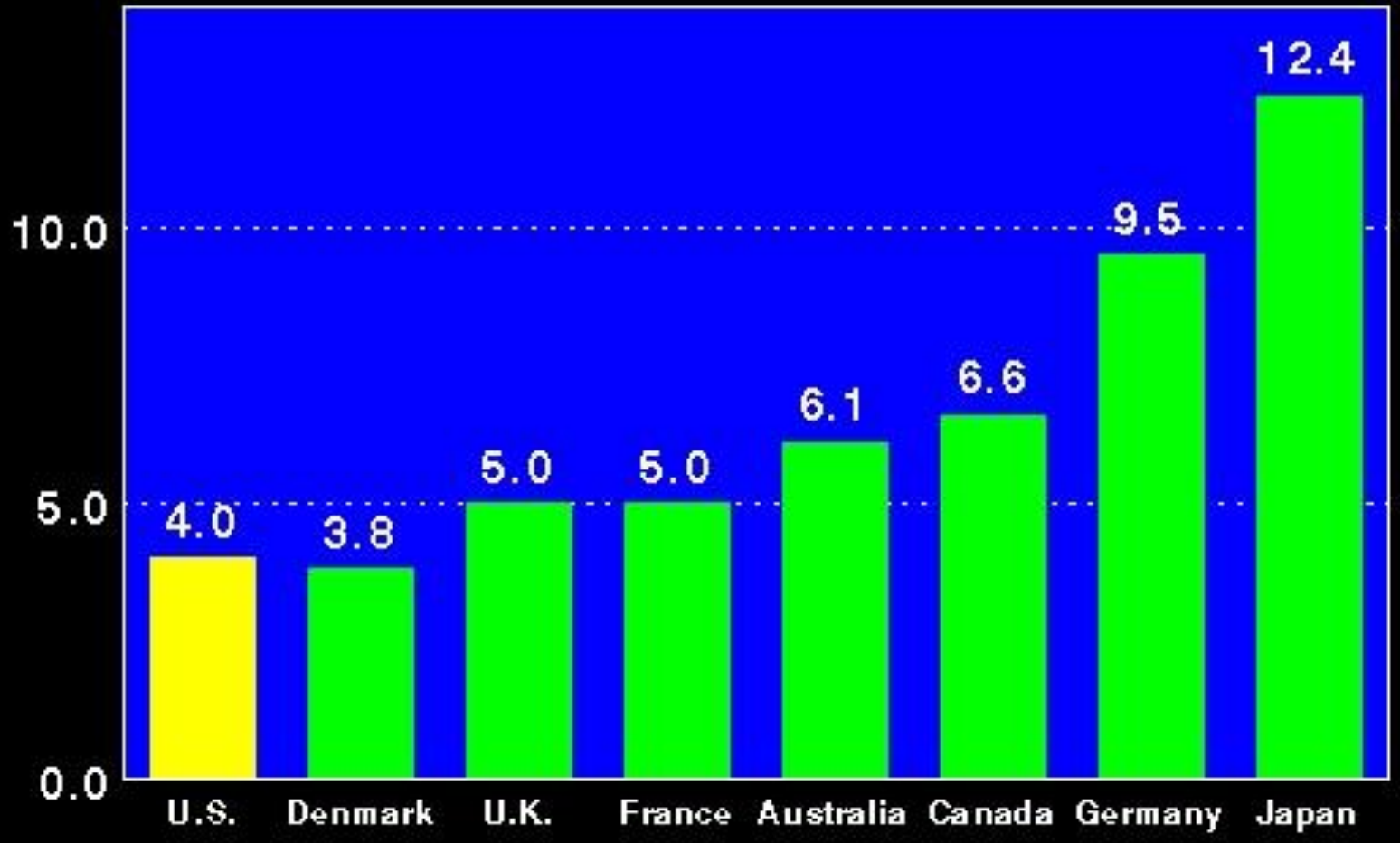
Note: Data are for 2021 or most recent year available

Hospital Inpatient Days Per Capita



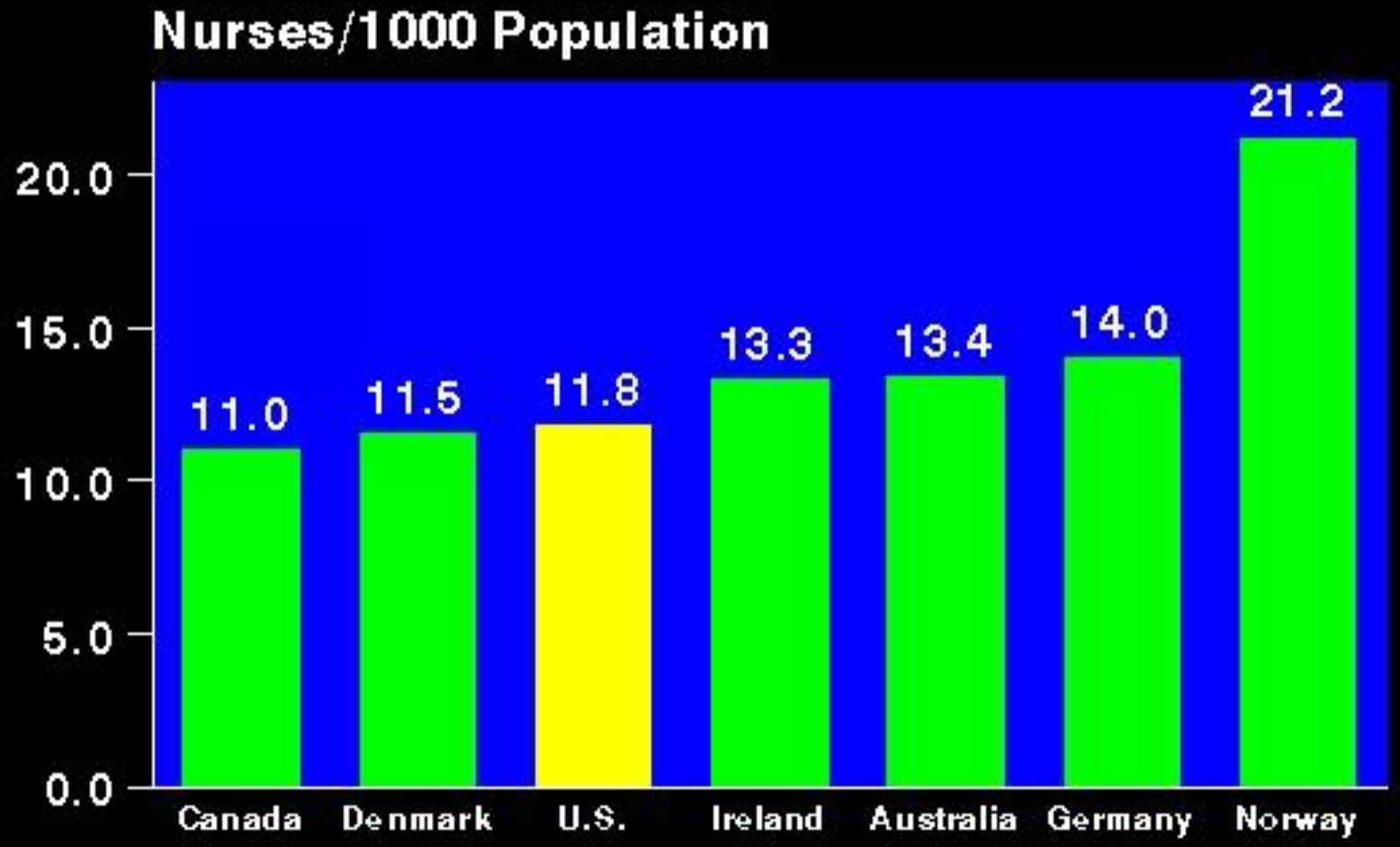
Source: OECD, 2022 & Kaiser Fdn. - Figures are for 2021 or most recent available

Physician Visits Per Capita



Source: OECD, 2022 - Data are for 2021 or most recent available year

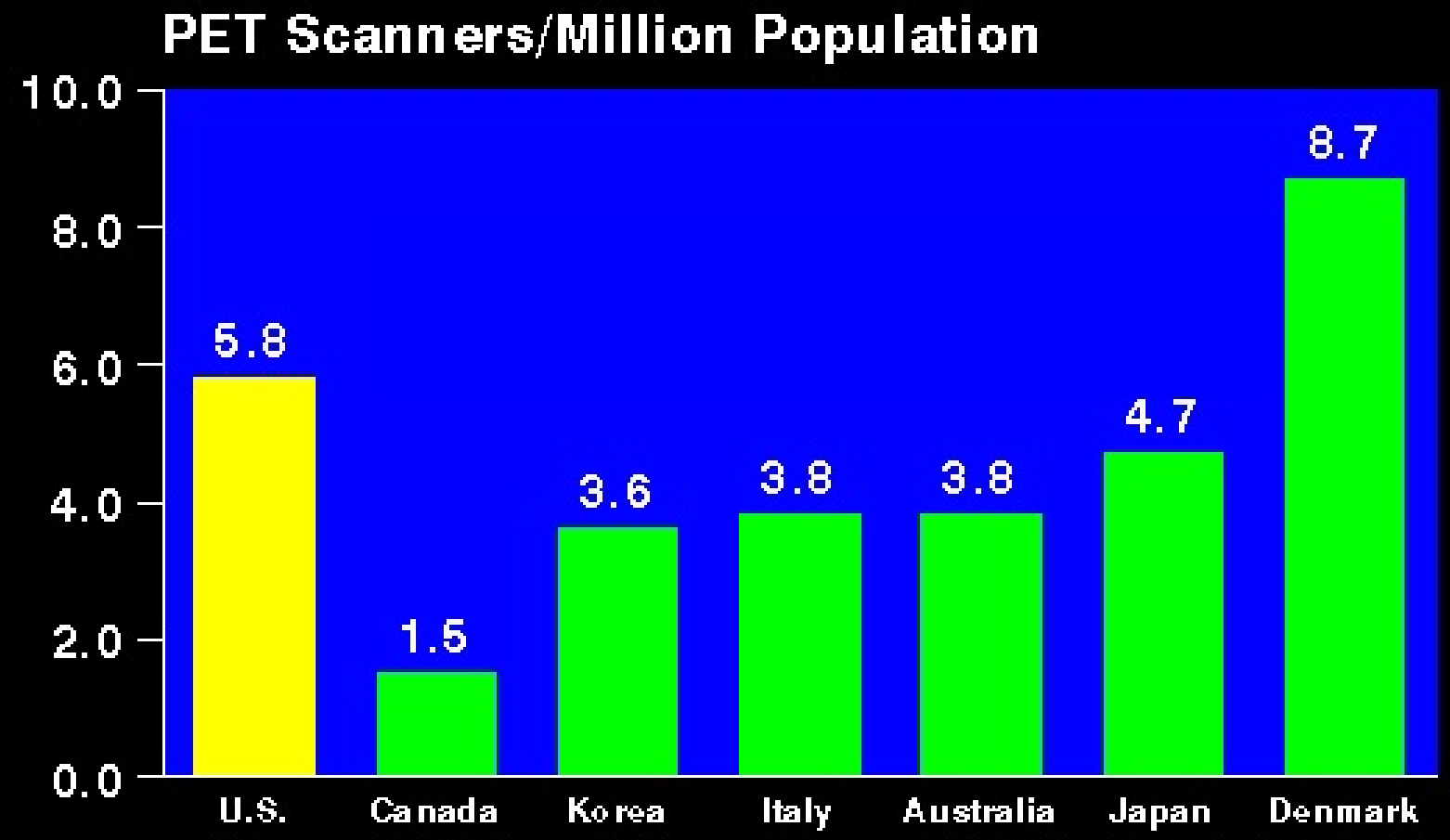
Number of Nurses Per 1000 Population



Source: OECD, 2022

Note: Data are for 2021 or most recent year available

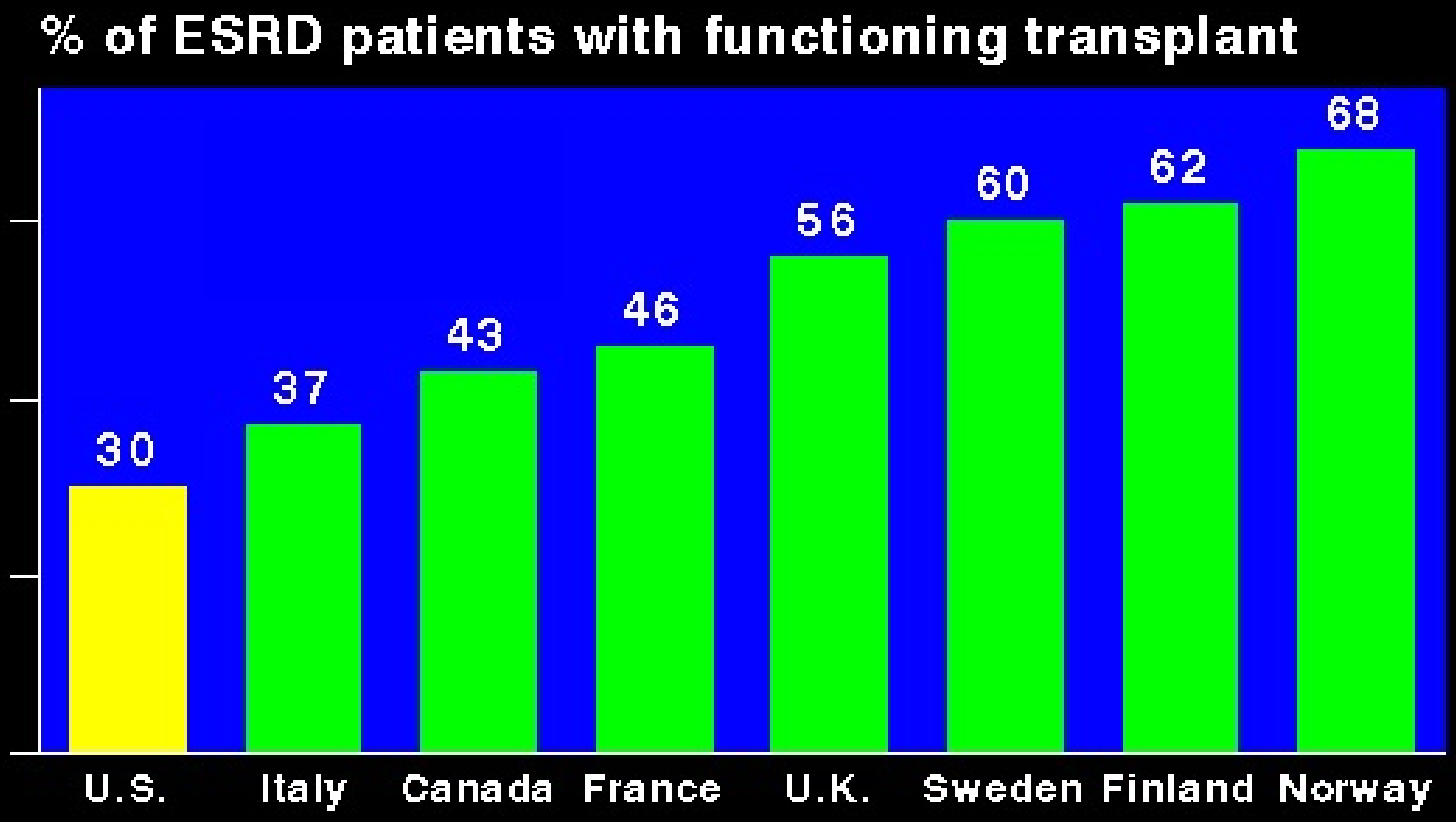
PET Scan Units/Million Population



Source: OECD, 2022

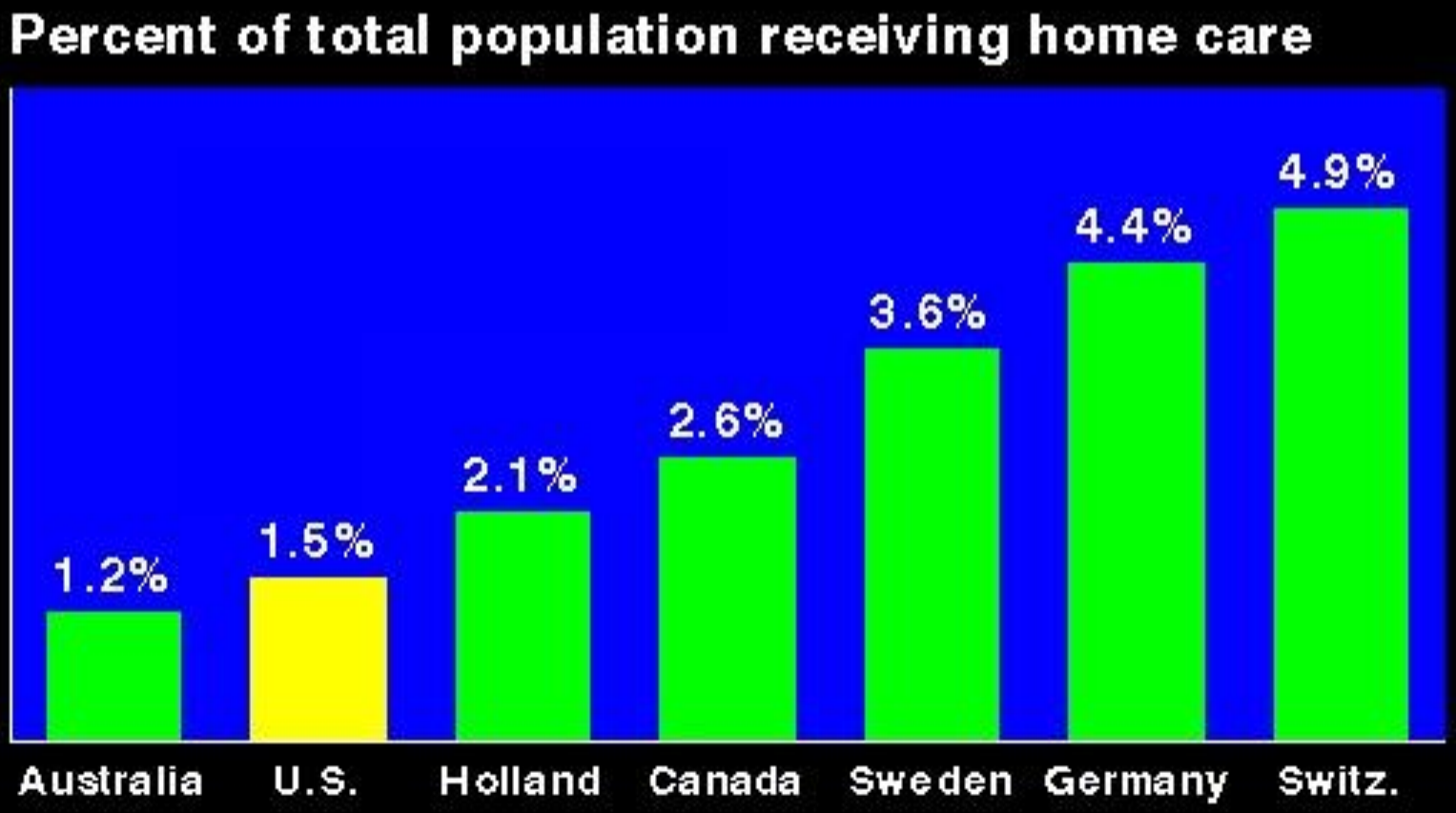
Note: Data are for 2021, or most recent year available

U.S. Renal Failure Patients: Fewer Receive Transplants



Source: U.S. Renal Data System Annual Report, 2020 & 2021 - Data are for 2019 or most recent avail.

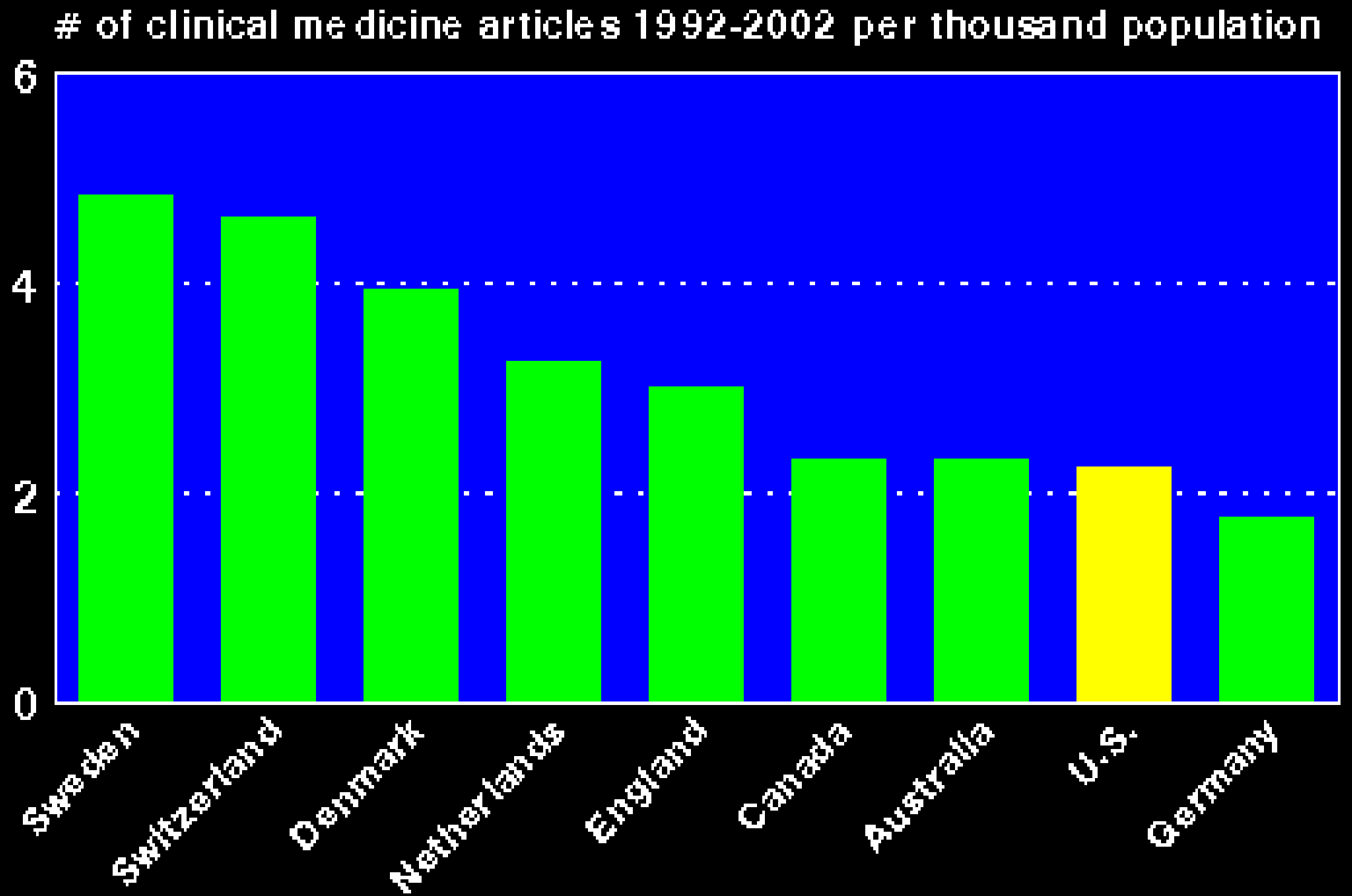
Other Countries Provide More Long Term Care at Home



Source: OECD, 2022

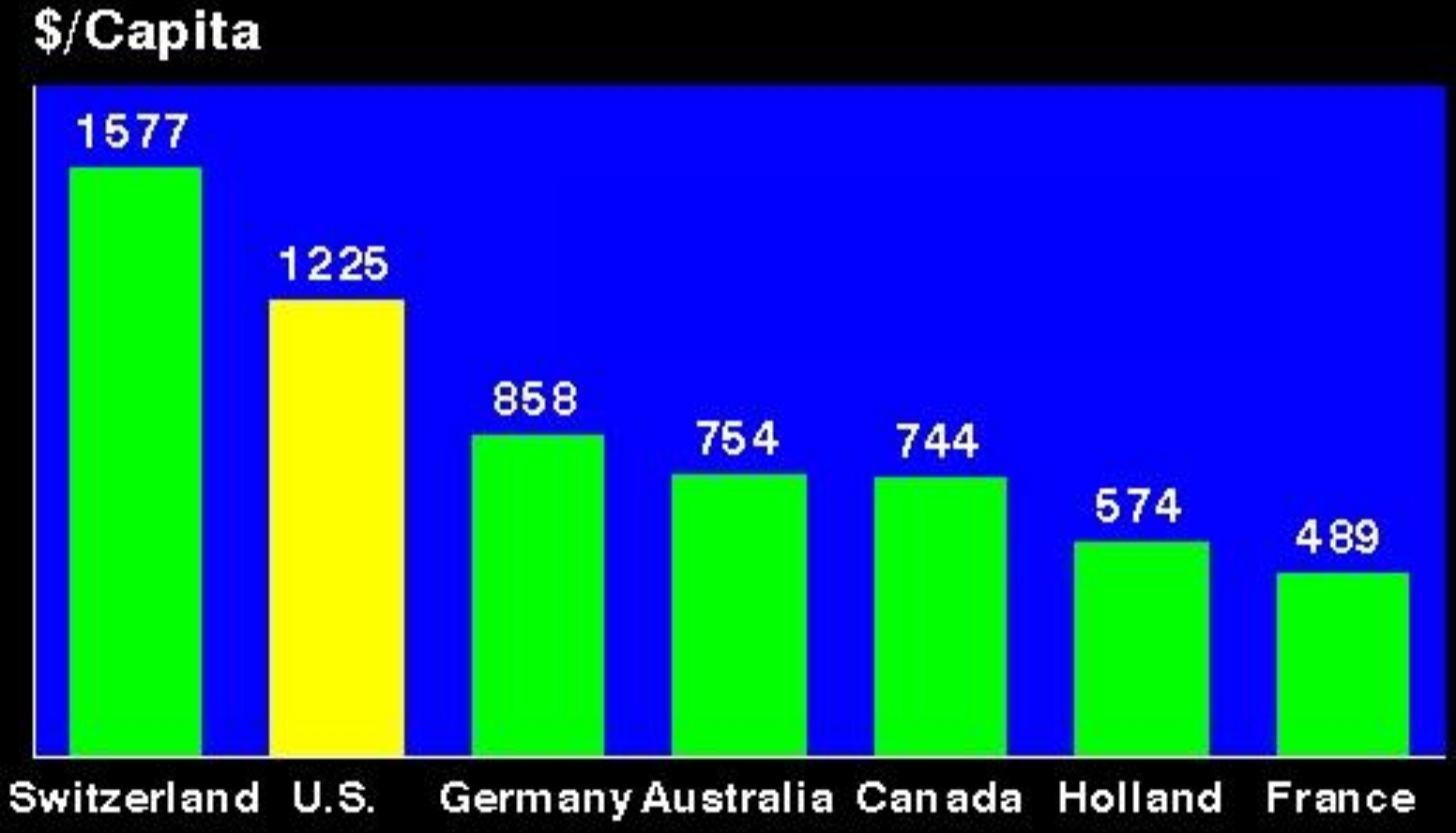
Note: Data are for 2020 or most recent year available

Medical Journals Articles Per Capita



Source: Lancet 2004; 363:250

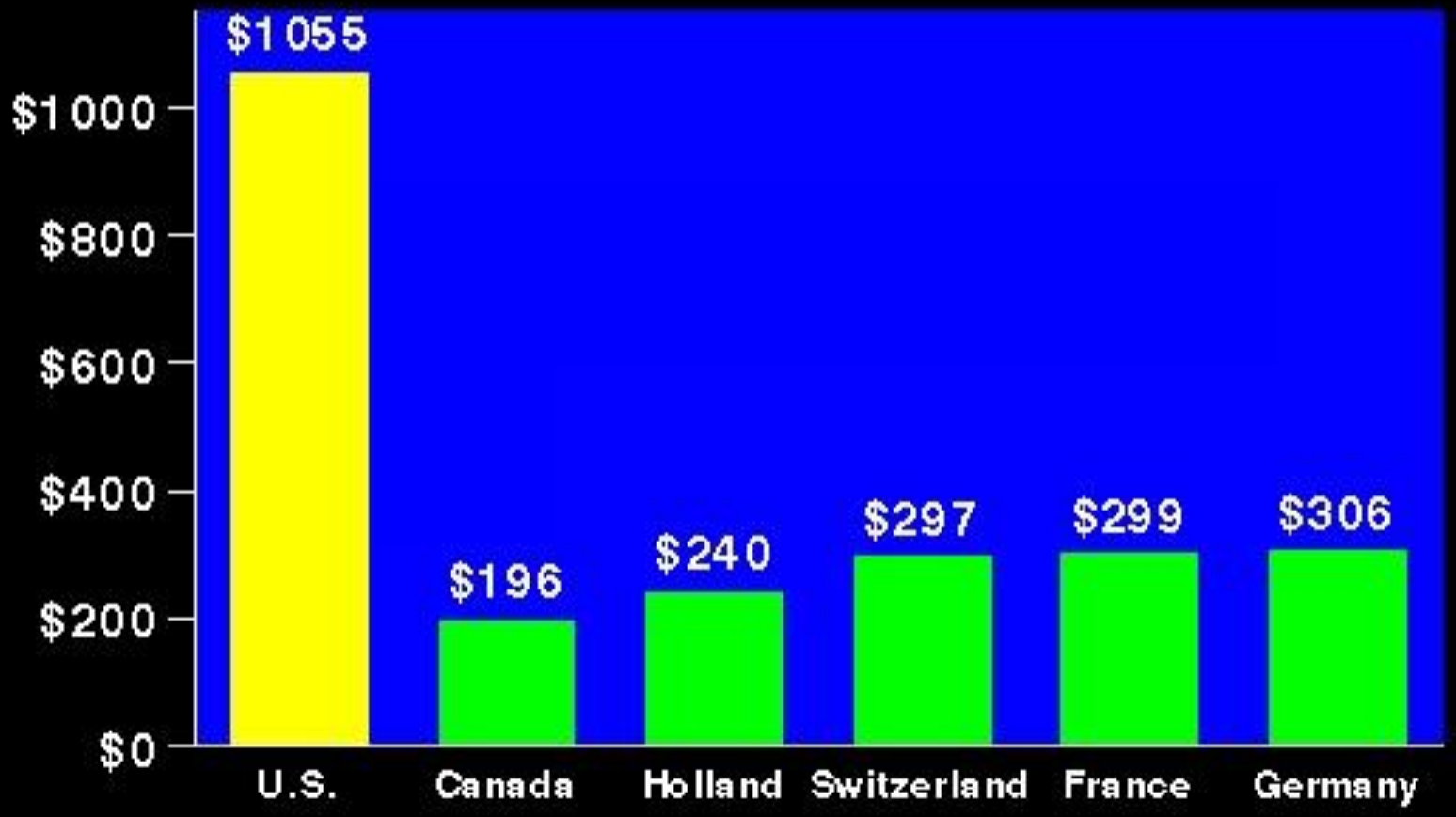
Out-Of-Pocket Payments



Source: OECD, 2022 & NCHS

Note: Data are for 2021 or most recent year available; figures adjusted for Purchasing Power Parity

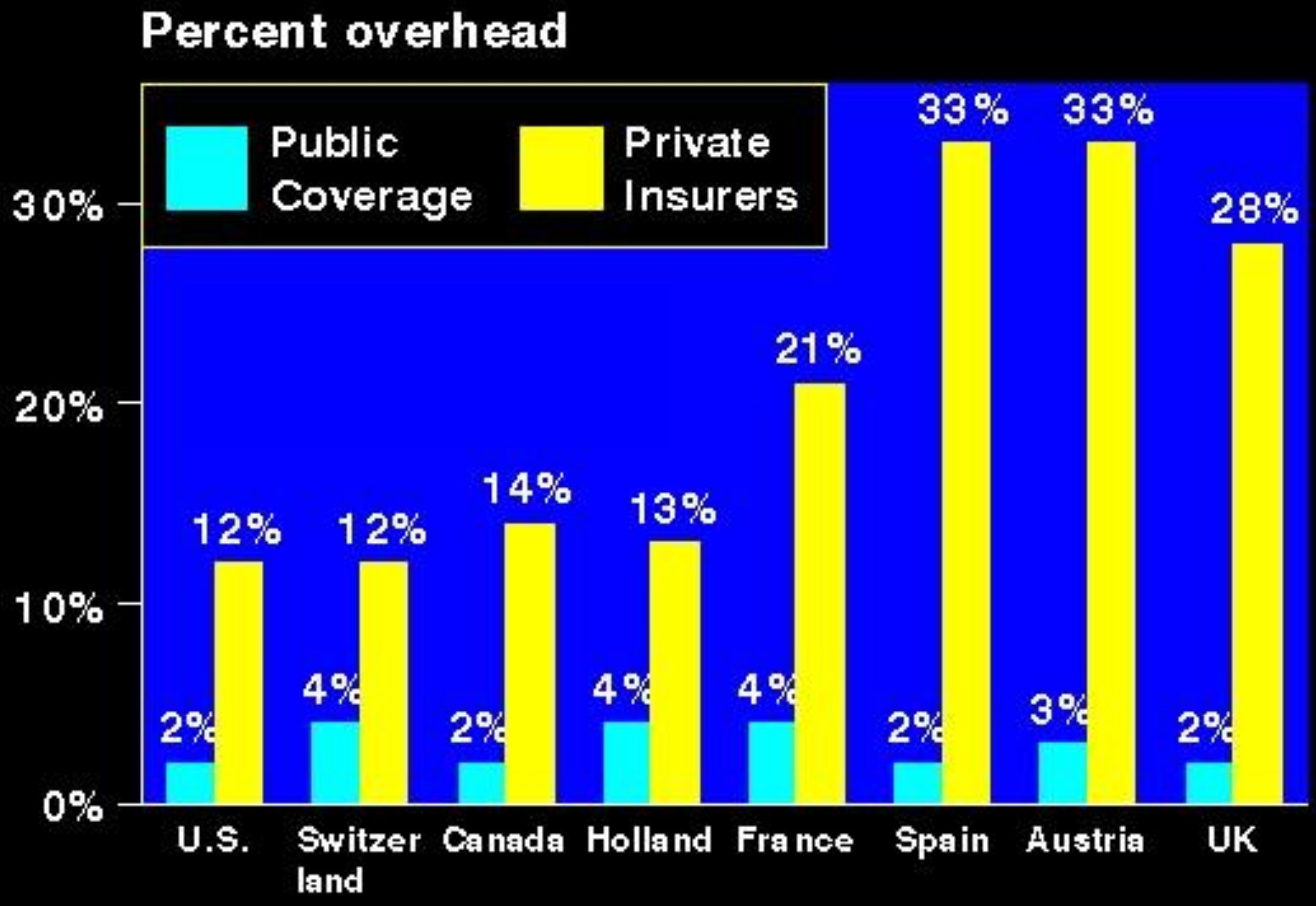
Insurance Overhead



Source: OECD, 2022 NCHS; CIHI

Note: Figures adjusted for Purchasing Power Parity; data are for 2021 or most recent available

Private Insurance: High Overhead Everywhere

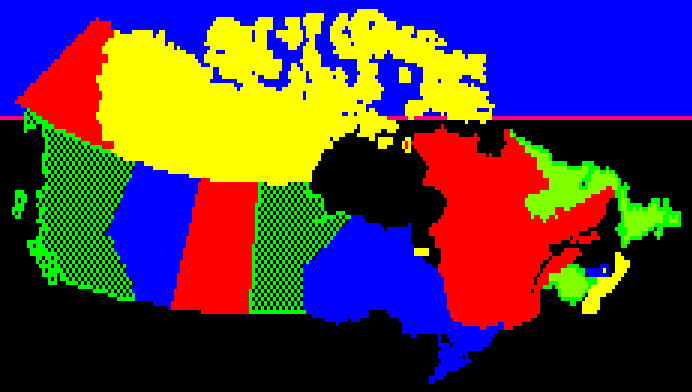


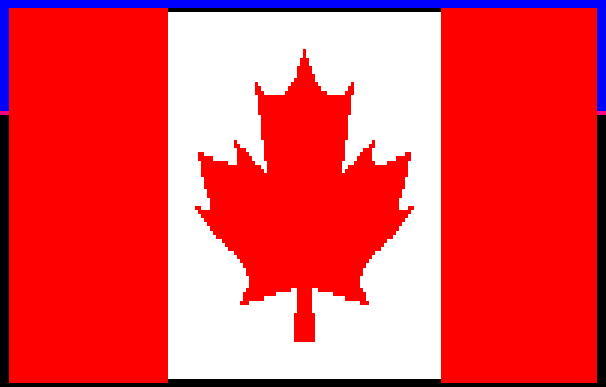
Source: Int J Health Planning and Management 2018;e:263 and NCHS

Canada's Single Payer National Health Insurance Program

MINIMUM STANDARDS FOR CANADA'S PROVINCIAL PROGRAMS

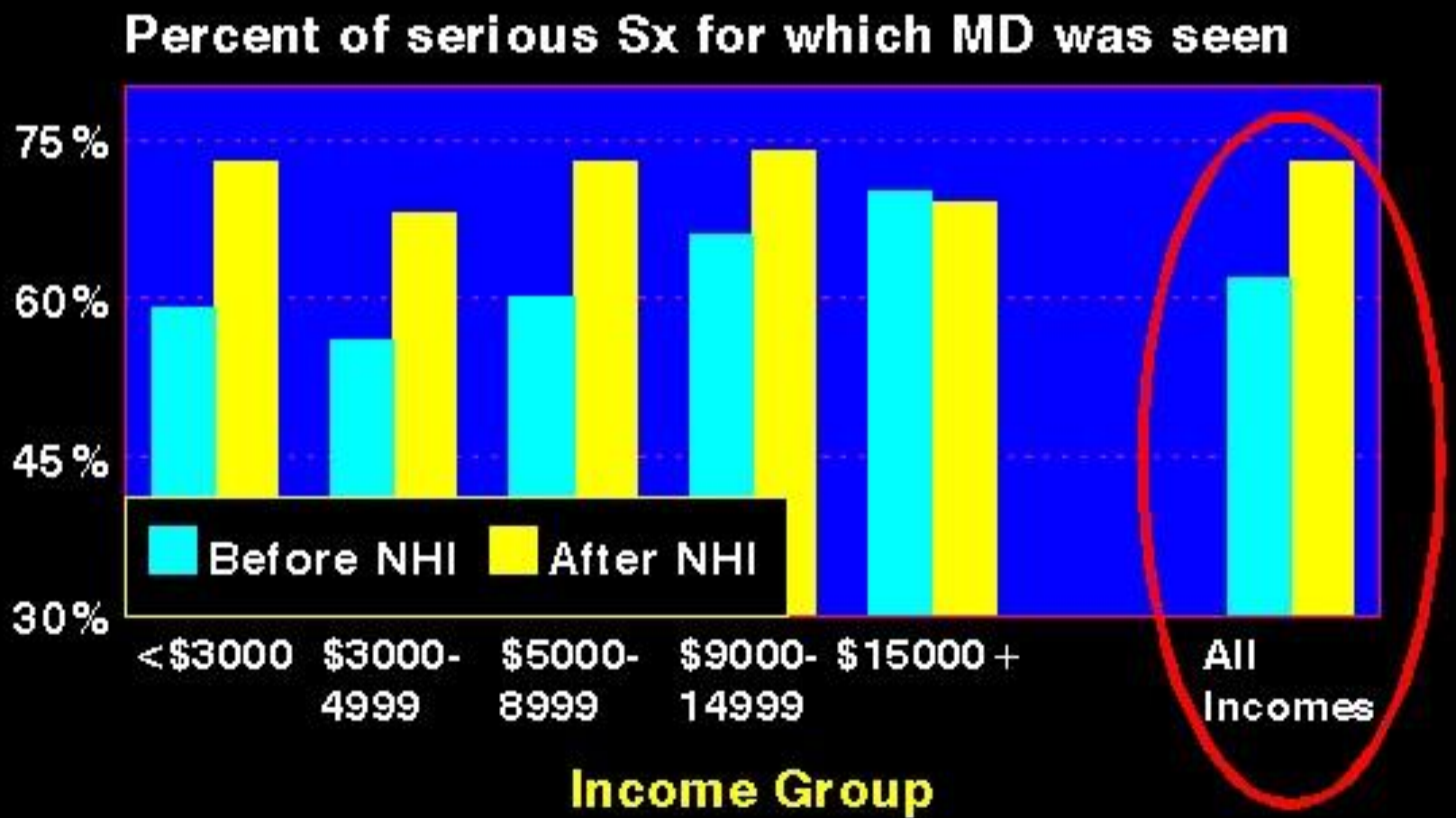
1. UNIVERSAL COVERAGE THAT DOES NOT IMPEDE, EITHER DIRECTLY OR INDIRECTLY, WHETHER BY CHARGES OR OTHERWISE, REASONABLE ACCESS.
2. PORTABILITY OF BENEFITS FROM PROVINCE TO PROVINCE
3. COVERAGE FOR ALL MEDICALLY NECESSARY SERVICES
4. PUBLICLY ADMINISTERED, NON-PROFIT PROGRAM





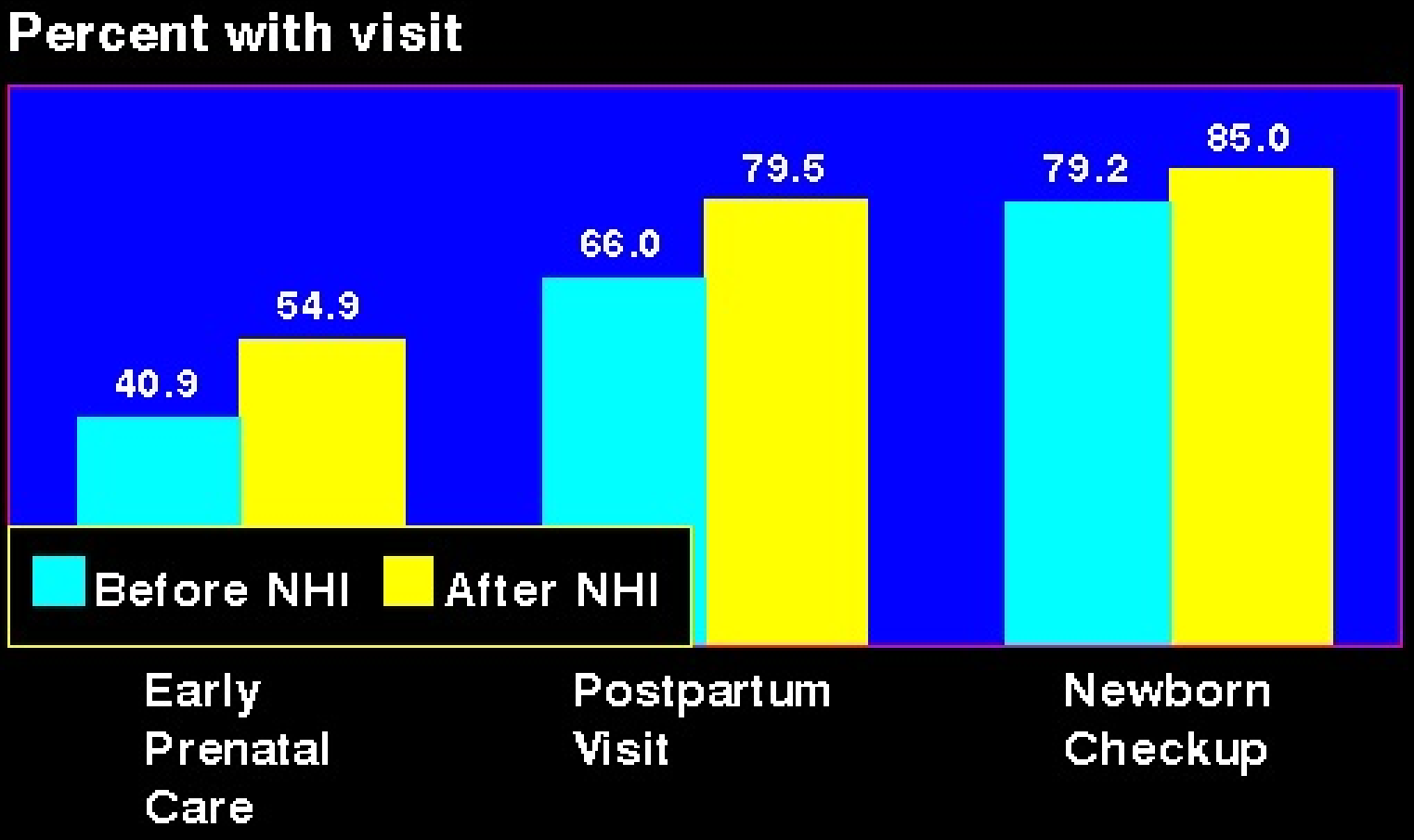
Free Care in Quebec Increased Physician Care for Serious Symptoms

Biggest Impact on Poor and Middle Class



Source: NEJM 1973;289:1174

Free Care in Quebec Improved Maternal/Infant Care



Source: NEJM 1974;291:649

Quality of Care Slightly Better in Canada Than U.S.

A Meta-Analysis of Patients Treated for Same Illnesses

(U.S. Studies Included Mostly Insured Patients)

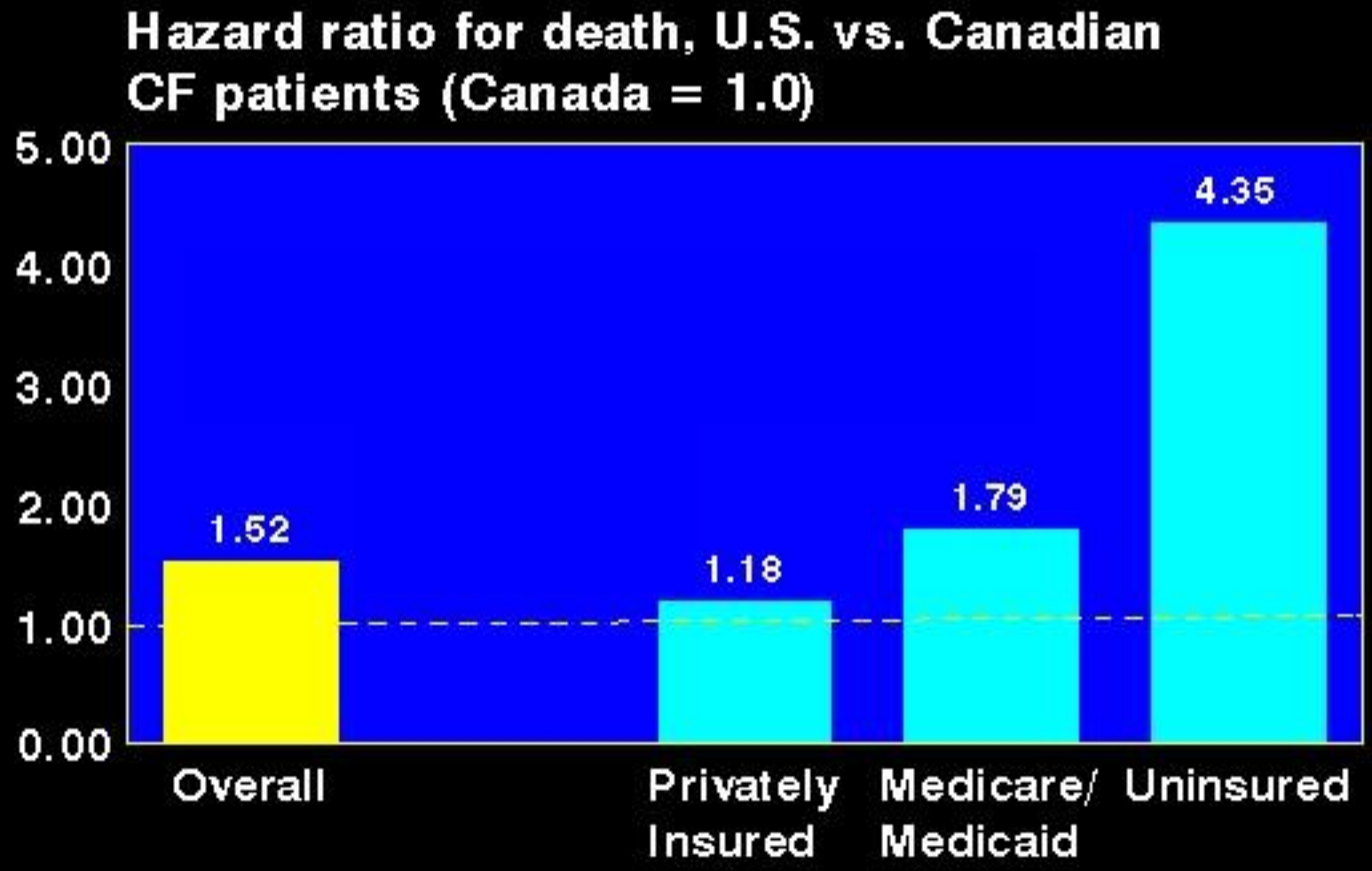
Table 1: Summary of findings

	High-quality studies	Low-quality studies
Results favoured United States	2	3
Results favoured Canada	5	9
Mixed or equivocal results	3	16

Source: Guyatt et al, Open Medicine, April 19, 2007

Cystic Fibrosis Patients Live Longer in Canada

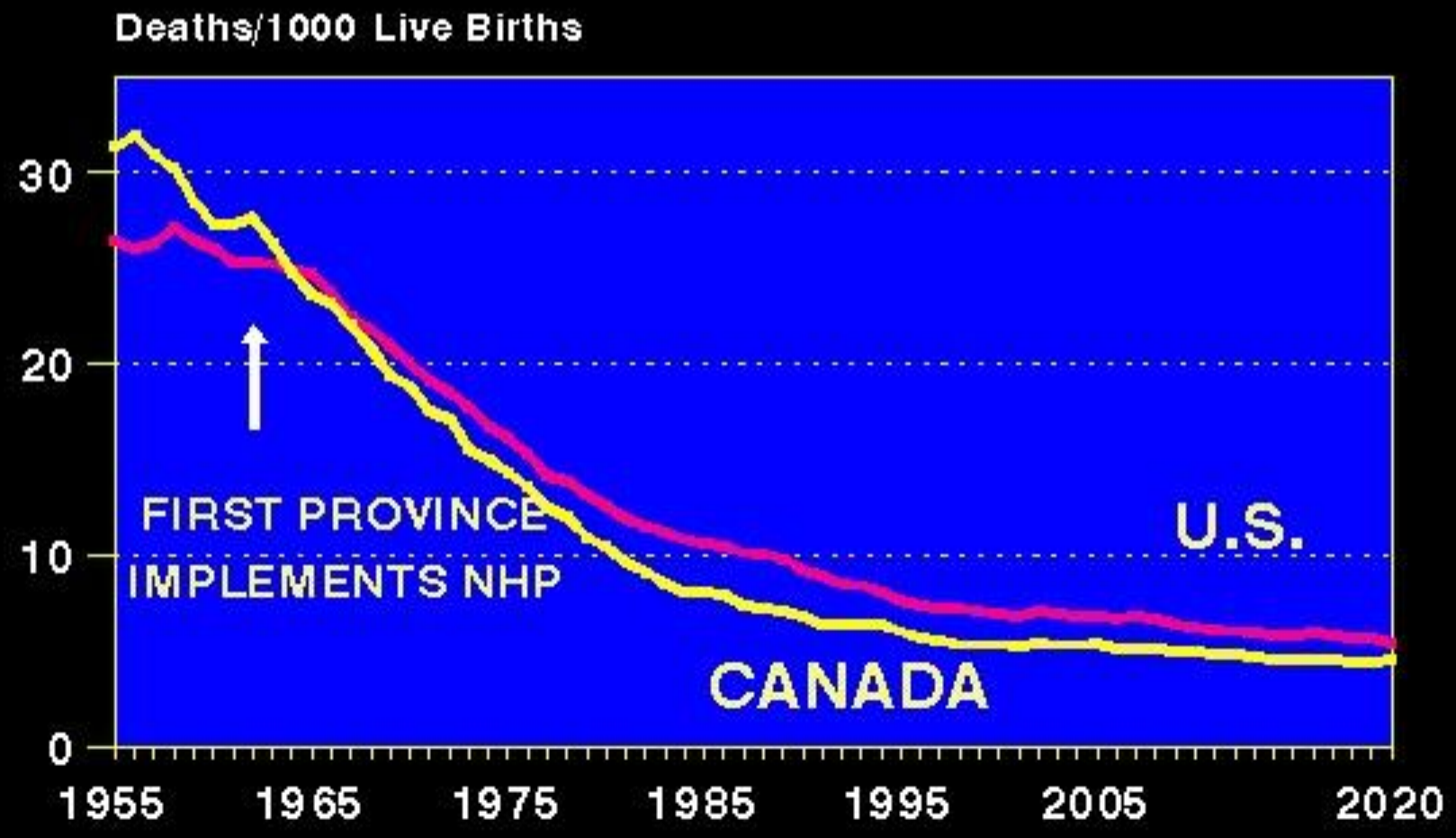
Uninsured in U.S. Have Highest Risk of Death



Source: Ann Int Med 2017;166:537

Note: Hazard ratios are adjusted for multiple genetic and clinical characteristics

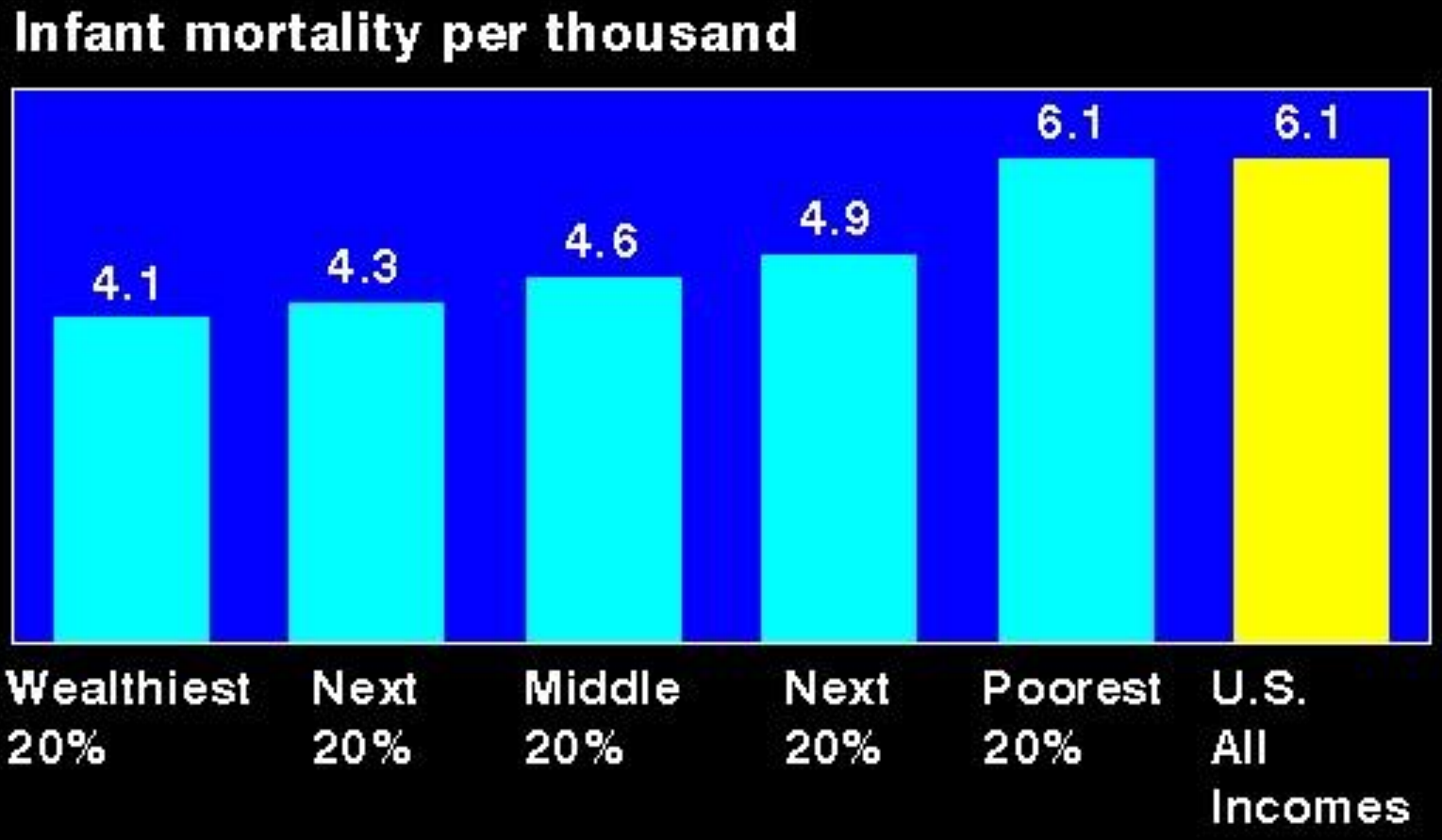
Infant Mortality
U.S. & Canada, 1955-2020



Source: Statistics Canada, Canadian Institute for Health Information, Natl Ctr for Health Statistics

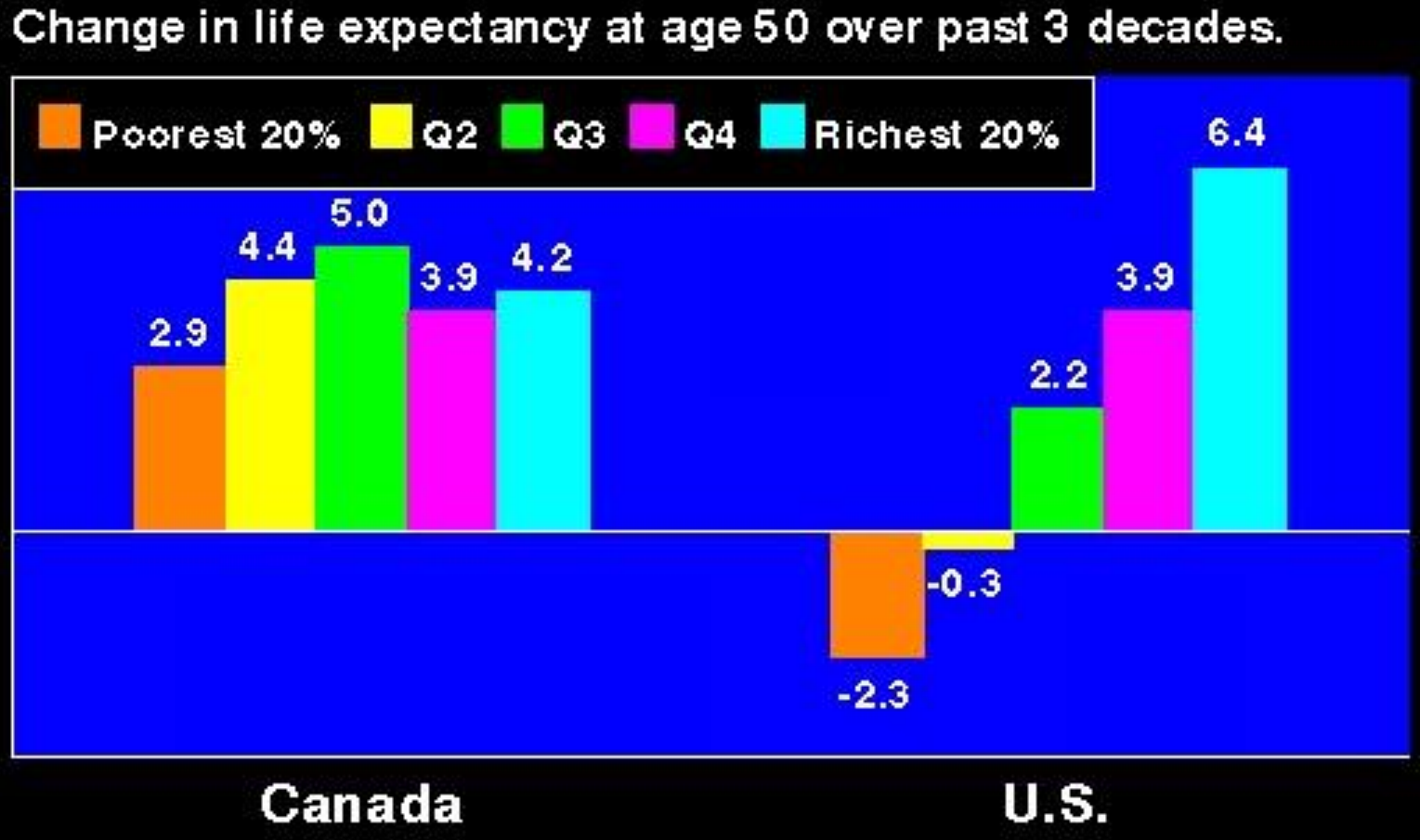
Infant Deaths by Income, Canada 2011

Even the Poor Do as Well as the U.S. Average



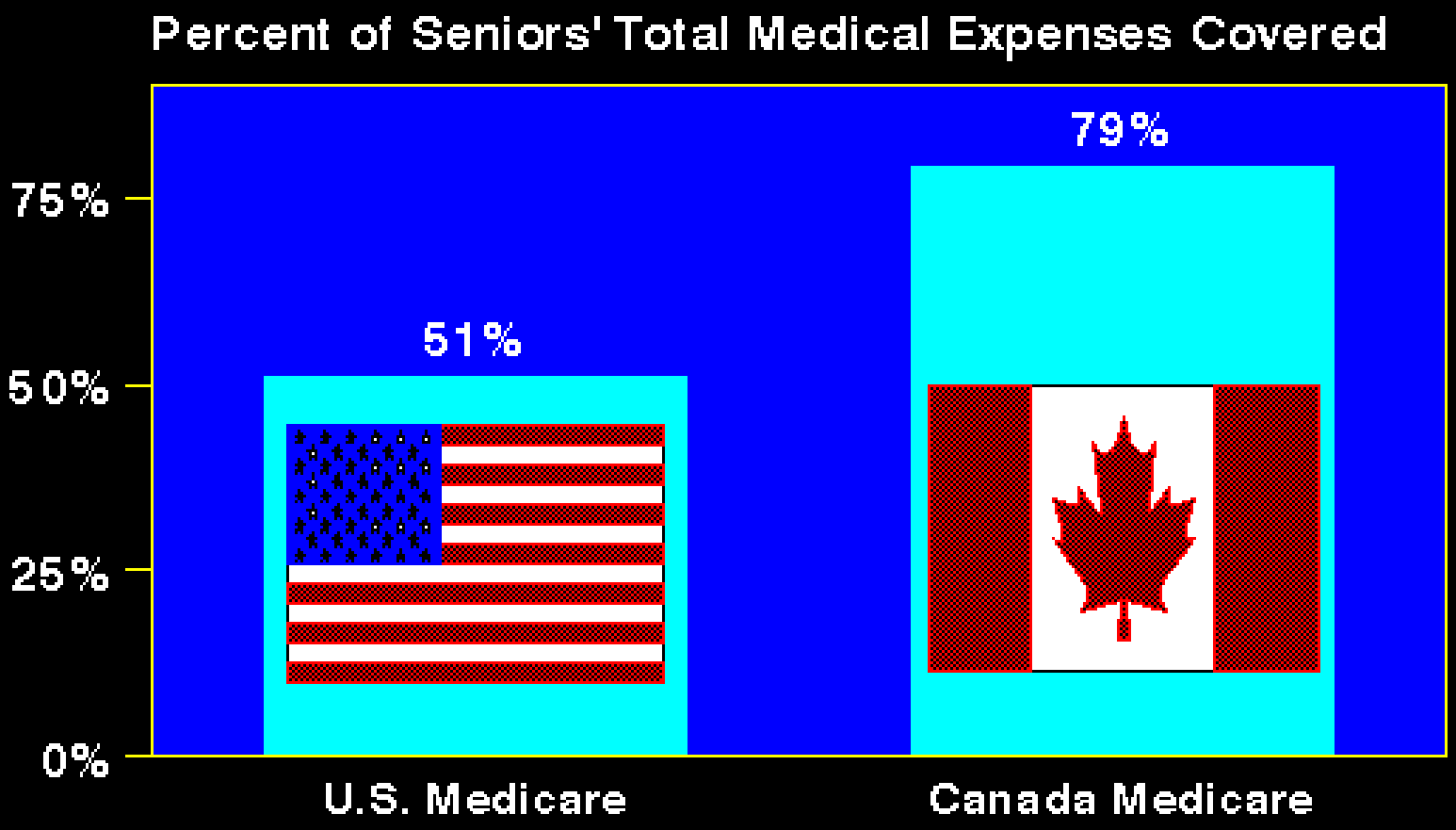
Source: CDC and StatCan

Life Expectancy Falling for Lower-Income Americans, Rising for All Canadians



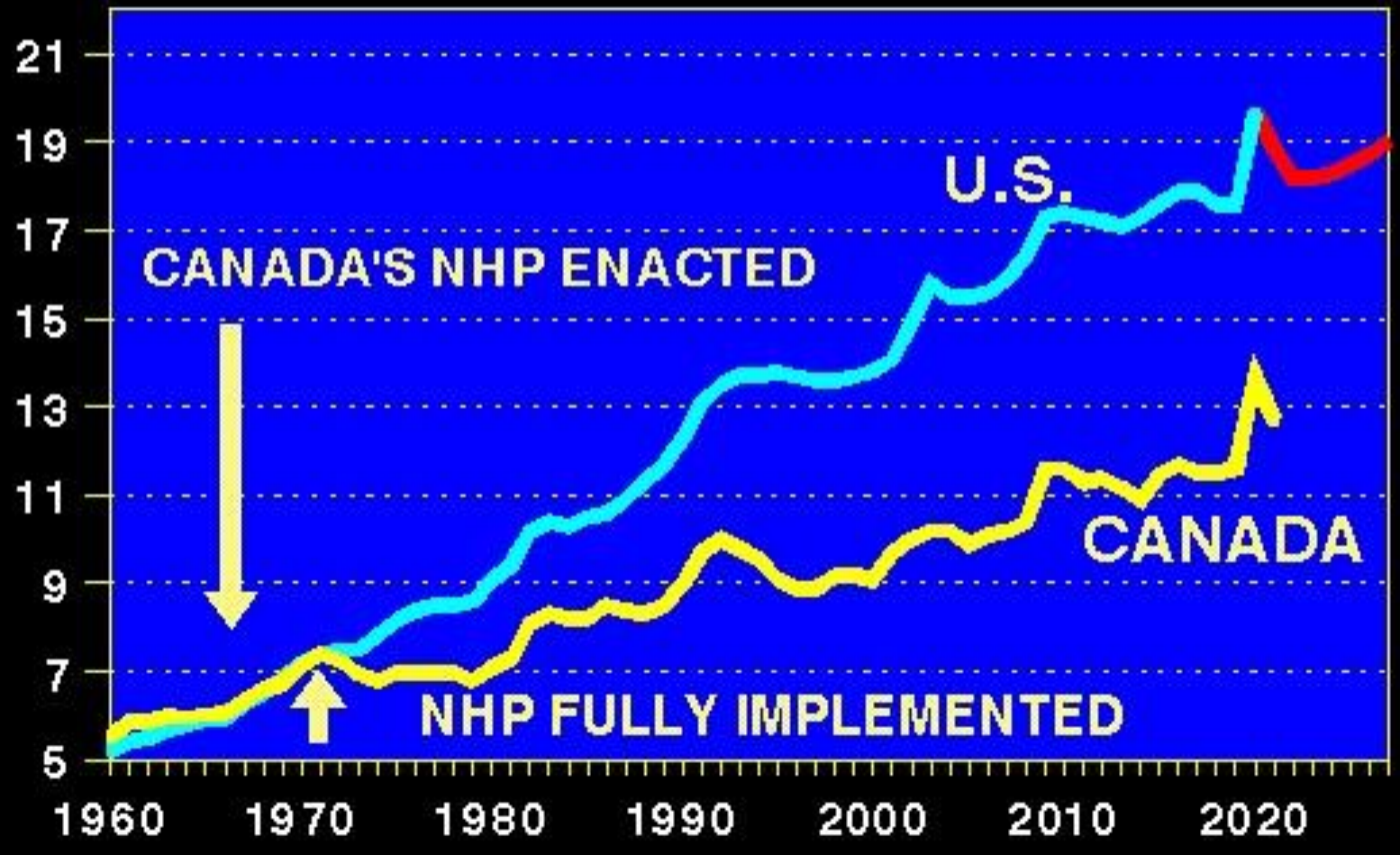
Source: Growing Gap in Life Expectancy by Income, NAS; Rich Man Poor Man, CD Howe Institute
Data is non-weighted average of male and female figures.
Data are for Canadians turning 50 in 2000 vs. 1970 and for Americans turning 50 in 2010 vs. 1980

U.S. Medicare Coverage, Much Worse Than Canada's



Source: EBRI and Himmelstein/Woolhandler analysis of Health Canada data
Note - Not comparable to figures for employer coverage because of high LTC needs in elderly

Health Costs as % of GDP:
U.S. & Canada, 1960-2027



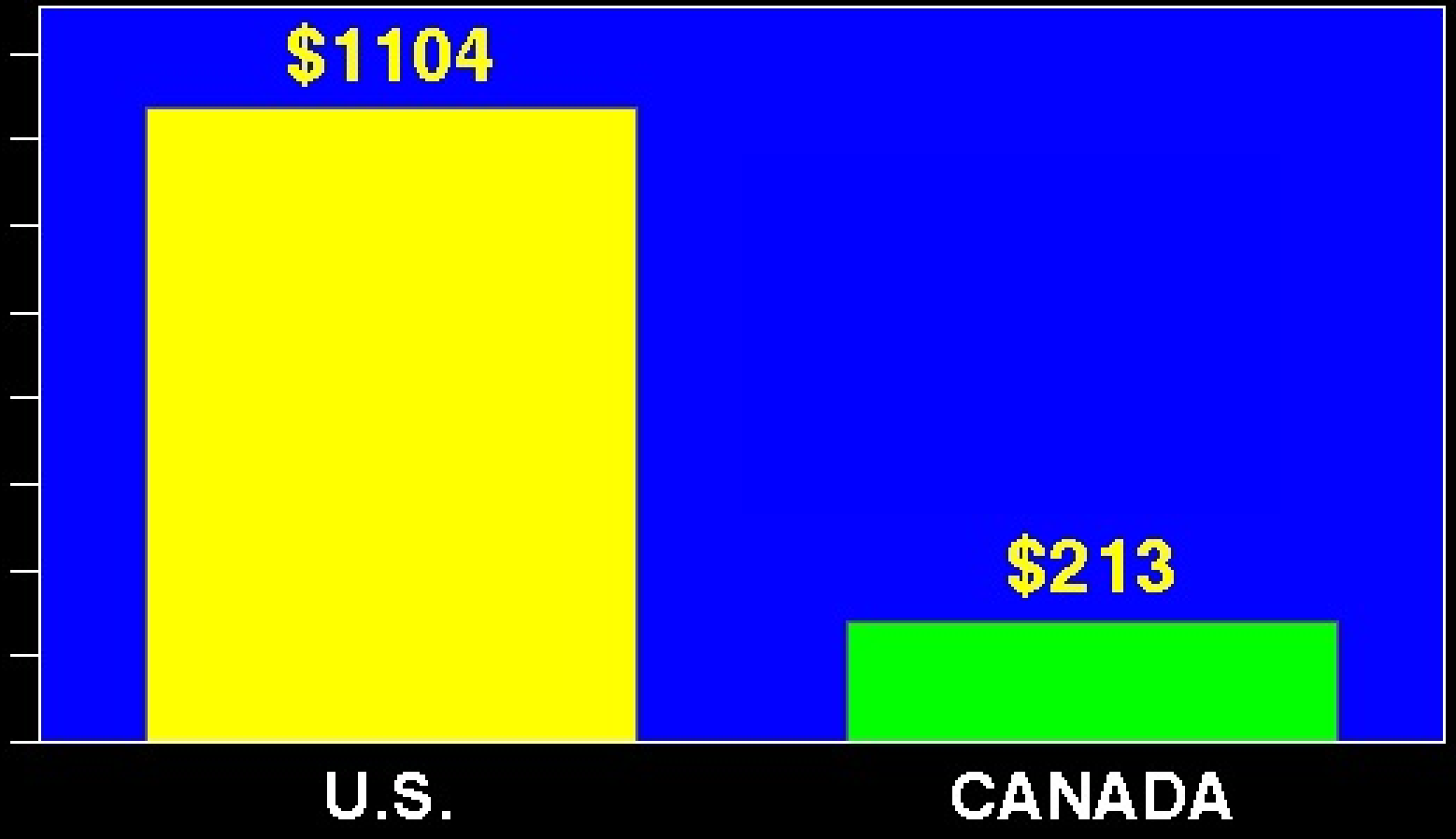
Source: Statistics Canada, Canadian Inst. for Health Info., & NCHS/Commerce Dept

How Canada Controls Costs

- Low administrative costs - 16.7% of health spending vs. 31.0% in U.S.
- Lump-sum, global budgets for hospitals
- Stringent controls on capital spending for new buildings and equipment
- Single buyer purchasing reins in drug/device prices
- Low litigation and malpractice costs
- Emphasis on primary care
- Exclusion of private insurers

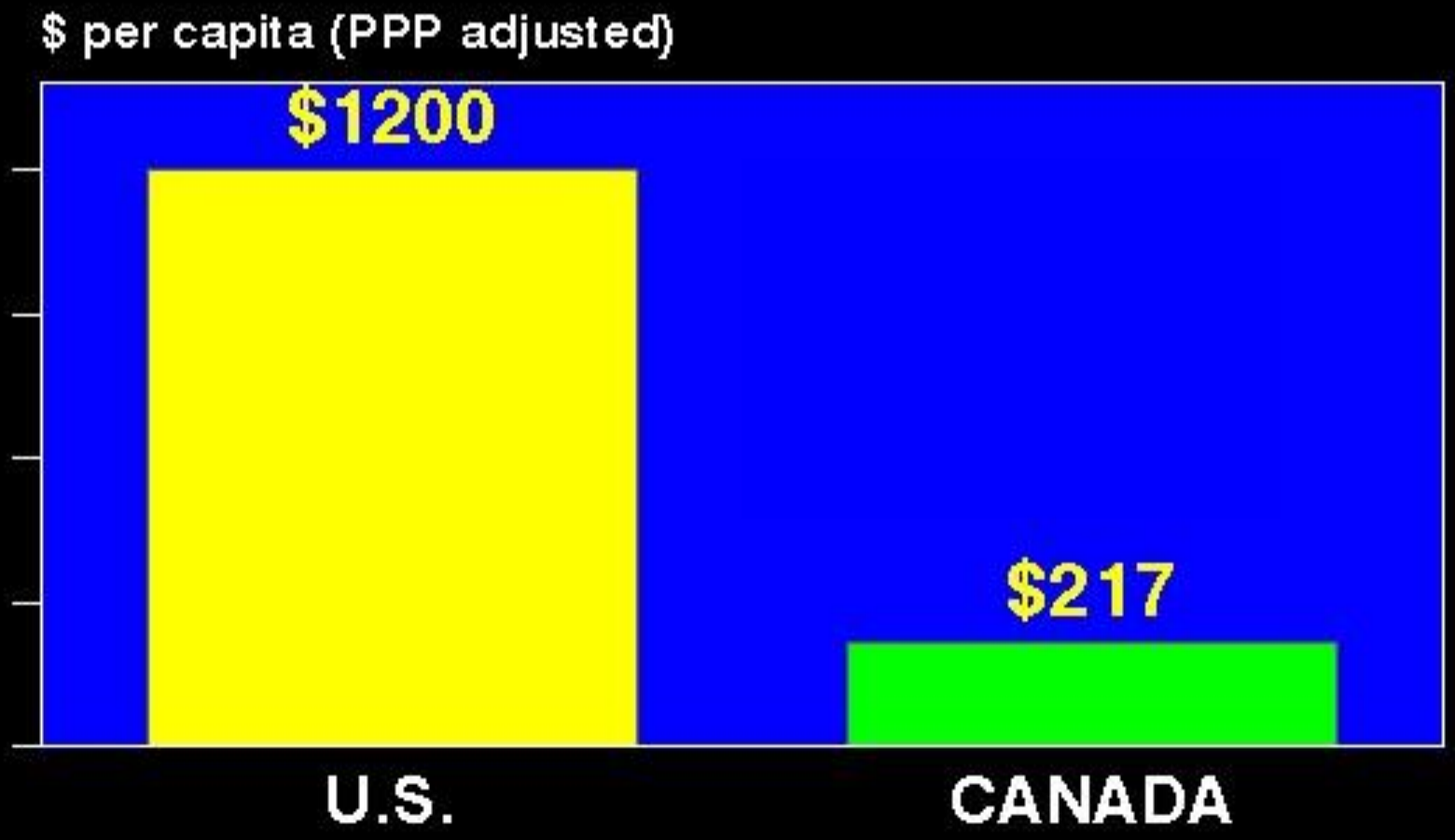
Source: Himmelstein & Woolhandler, Arch Intern Med, December, 2012

Insurance Overhead
United States & Canada, 2022



Source: NCHS and CIHI

Hospital Billing & Administration United States & Canada, 2022



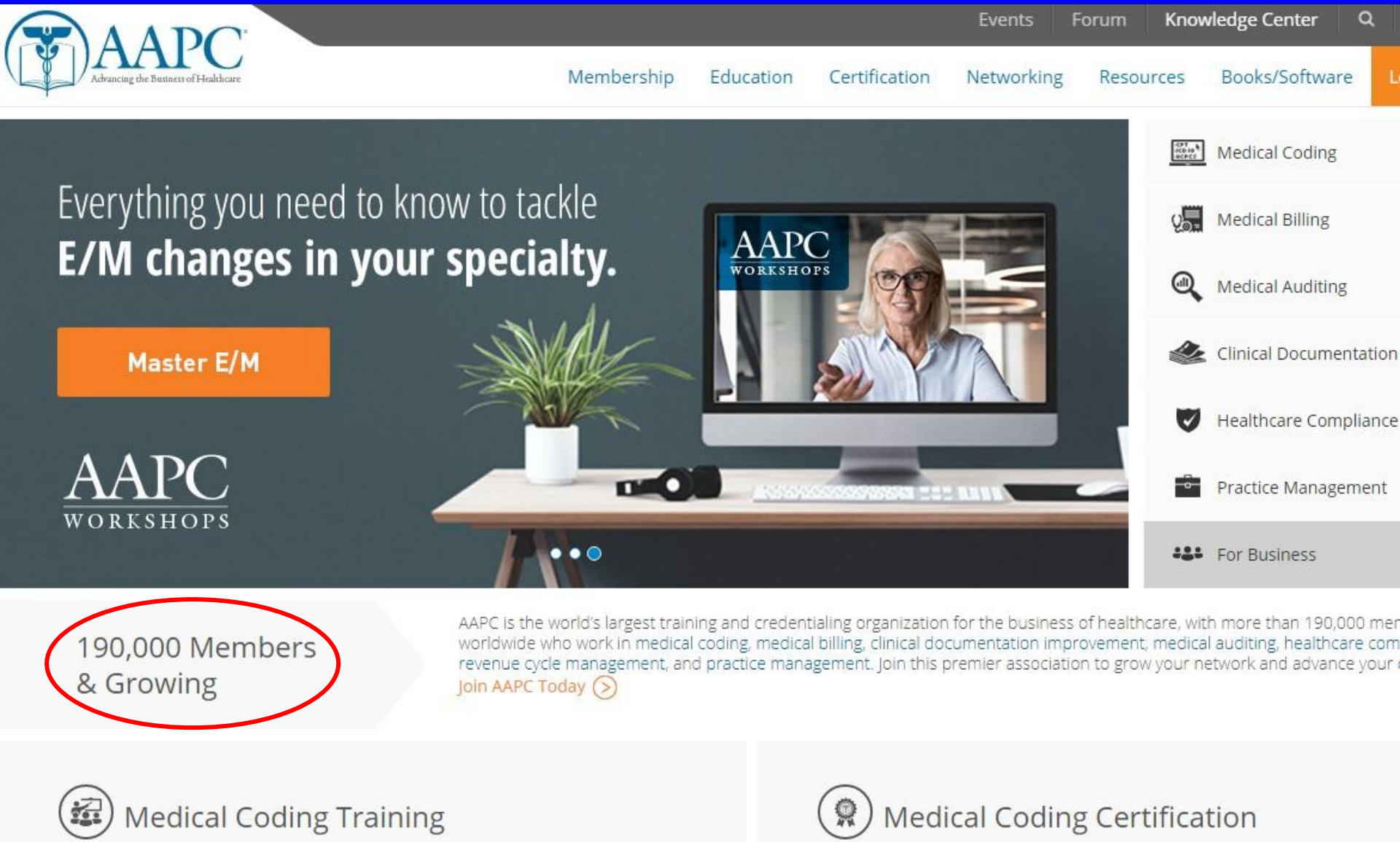
Source: Himmelstein, Campbell & Woolhandler - Ann Int Med 2020 (Updated)

Hospital Financing: Medicare vs. Medicare

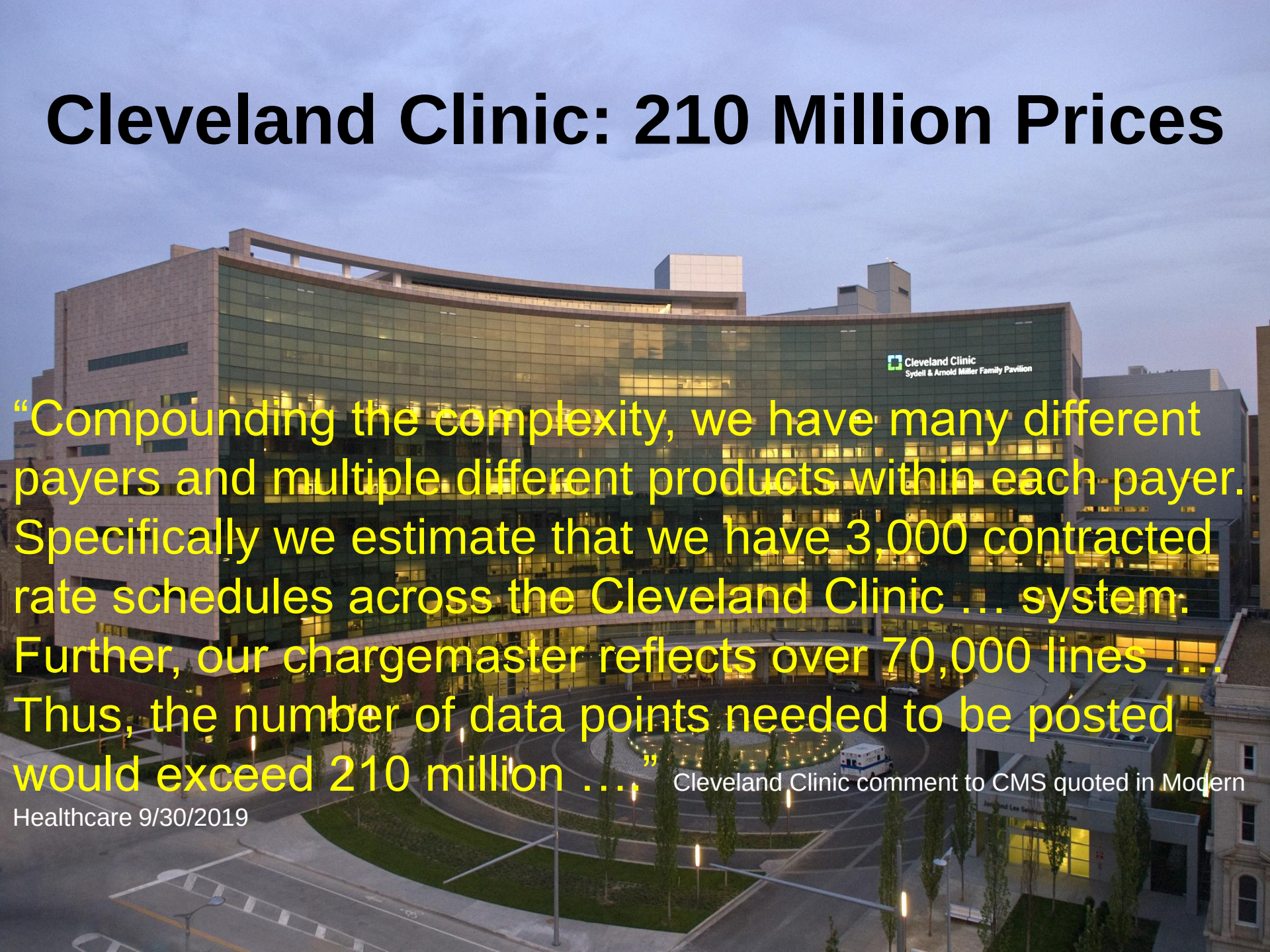
- Per-patient payments
- Capital and operating payments intermixed
- New investments funded from surplus/profit
- For-profits thrive

- Global budget
- Separate payment for capital
- New investments funded by government grants
- Eliminates opportunity for profitmaking

American Association of Professional Coders: 190,000 Members and Growing



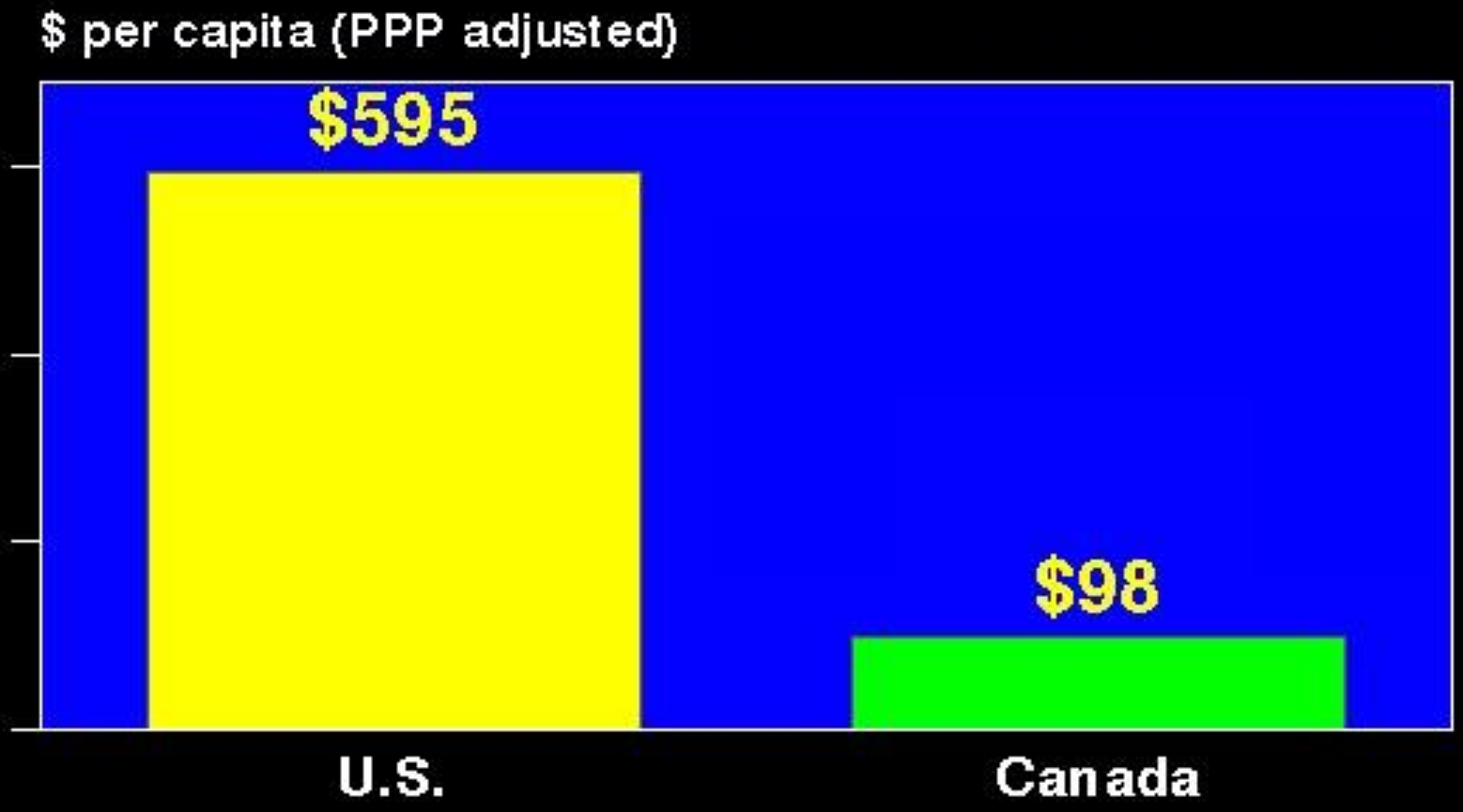
Cleveland Clinic: 210 Million Prices



"Compounding the complexity, we have many different payers and multiple different products within each payer. Specifically we estimate that we have 3,000 contracted rate schedules across the Cleveland Clinic … system. Further, our chargemaster reflects over 70,000 lines …. Thus, the number of data points needed to be posted would exceed 210 million …." Cleveland Clinic comment to CMS quoted in Modern Healthcare 9/30/2019


Duke Medical Center: 957 beds, 1600 billing clerks
Source: JAMA 2018;319:691

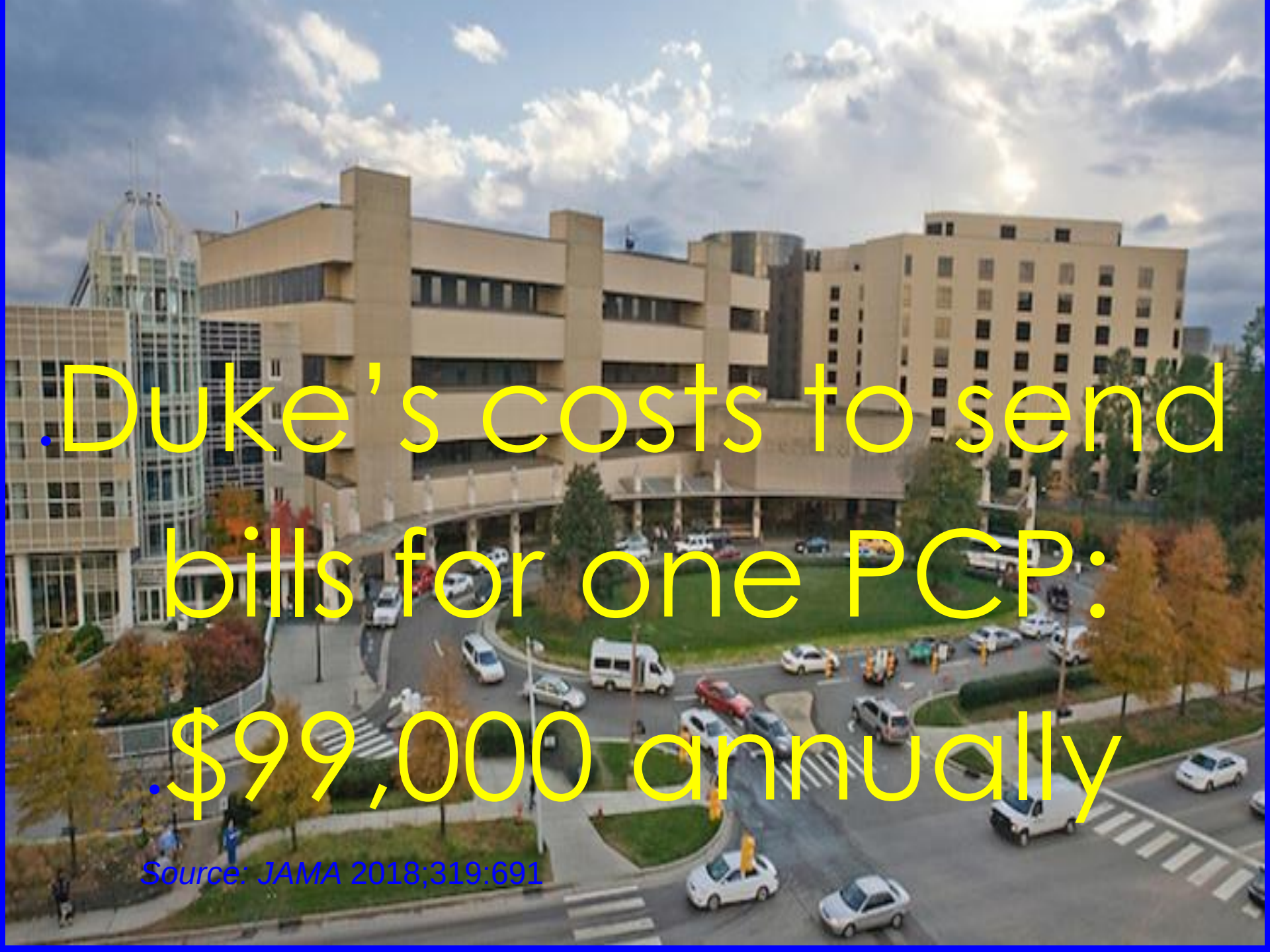
Physicians' Billing-Related Expenses United States & Canada, 2022



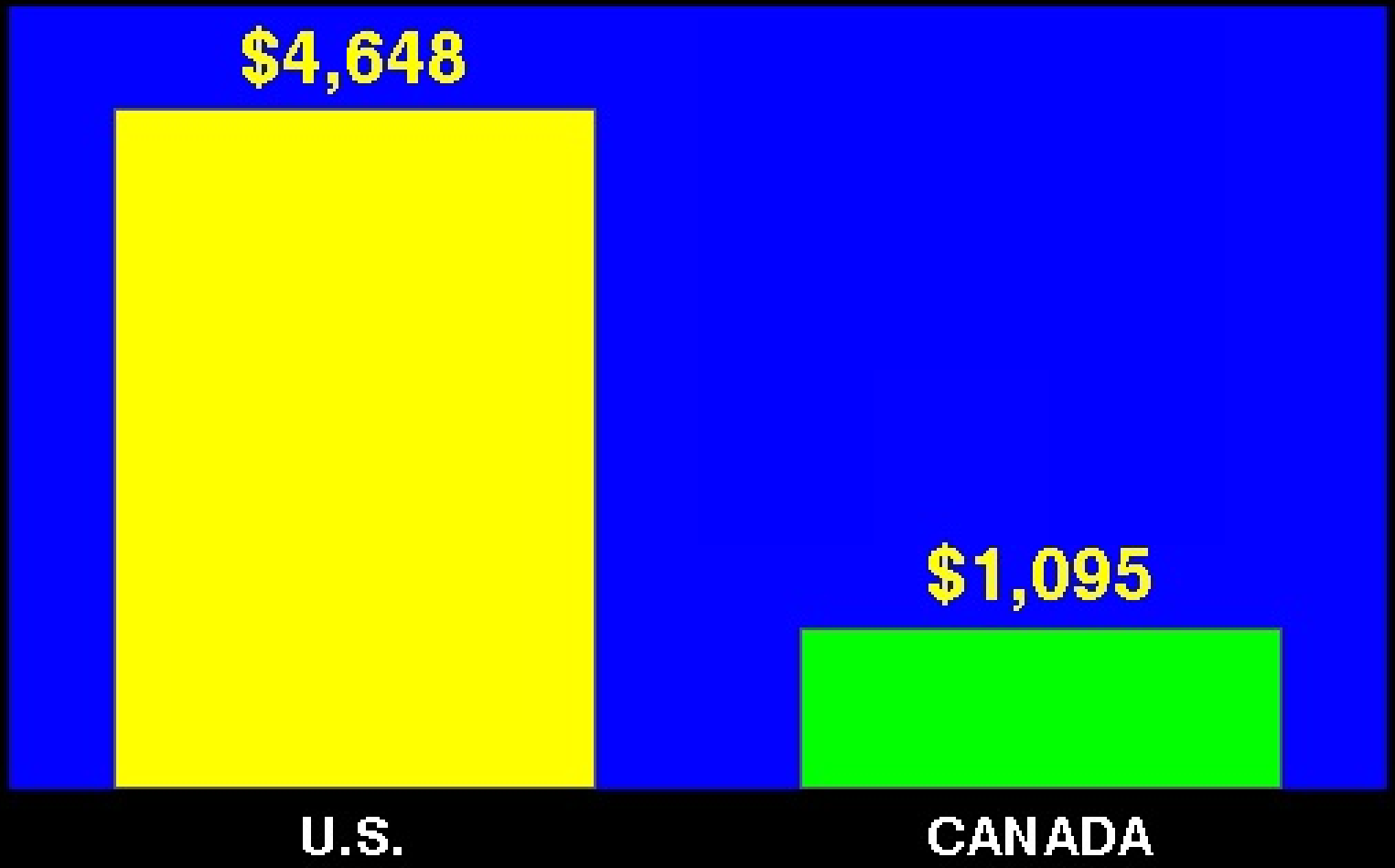
Source: Woolhandler/Campbell/Himmelstein Ann Int Med 2020 (Updated)

Note: Excludes dentists and other non-physician, office-based practitioners

Note: Excludes non-billing-related costs for documentation compliance etc.

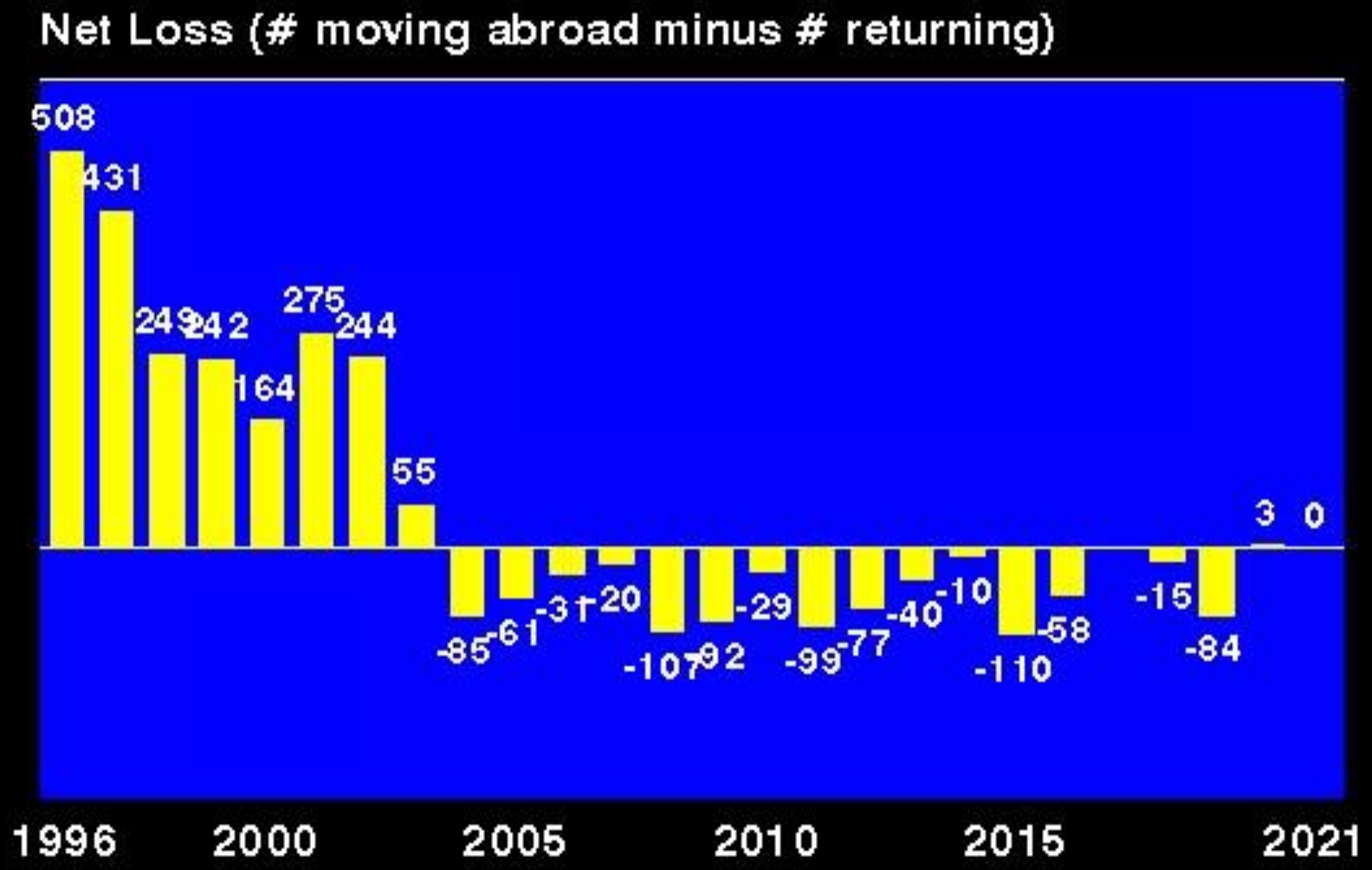

Duke's costs to send bills for one PCP:
$99,000 annually
Source: JAMA 2018;319:691

Overall Administrative Costs Per Capita United States & Canada, 2022



Source: Himmelstein/Campbell/Woolhandler - Ann Int Med 2020 (Updated)

Few Canadian Physicians Emigrate



Source: Canadian Institute for Health Information
Note - A negative number indicates that more physicians returned from abroad than moved abroad

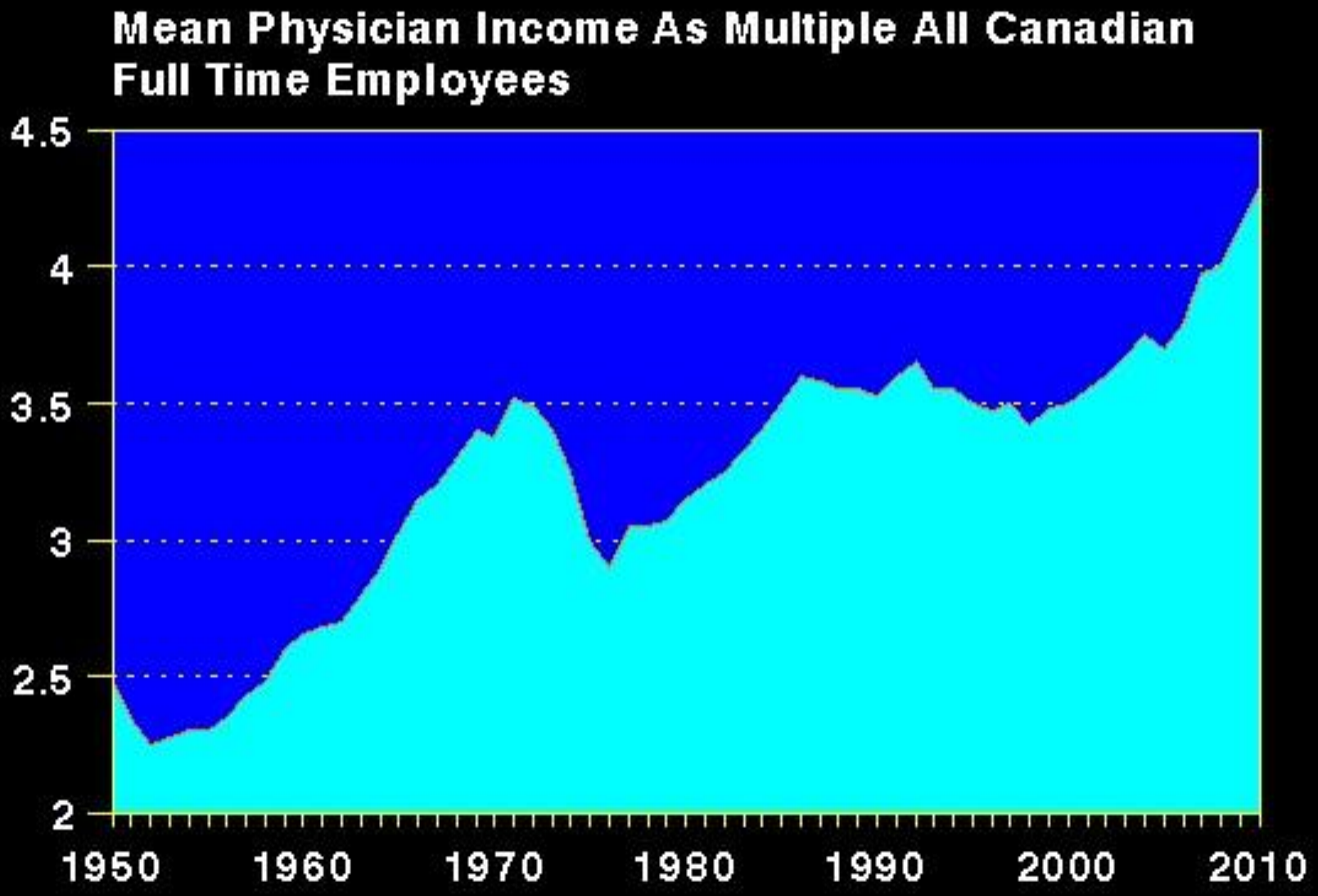
Canadian Physicians' Incomes, 2019/2020

Average Clinical Payments Per Physician

Family Medicine	$287,326
Int. Medicine	$414,126
Pediatrics	$316,265
Psychiatry	$280,078
Dermatology	$398,522
Ob/GYN	$394,684
General Surg.	$472,415
Thoracic Surg.	$594,141
Opthalmology	$804,945
All Physicians	$354,487

Source: Canadian Institute for Health Information - figures are in Candian $s

Trend In Canadian Physicians' Incomes, 1950-2010



Source: Grant and Hurley, U Calgary School of Public Pol. Research Papers - 7/2013, Vol 6, Issue 22

Malpractice Insurance Costs in Canada, 2022

All Figures in Canadian $s

Specialty	Ontario*	Quebec	BC & Alberta
Family Med	$3,540	$445	$2,568
Psychiatry	$3,540	$445	$2,568
Cardiology	$5,904	$549	$3,552
Anesthesia	$8,472	$667	$5,304
Neurosurgery	$17,304	$903	$27,000
Obstetrics	$50,532	$2,354	$31,416

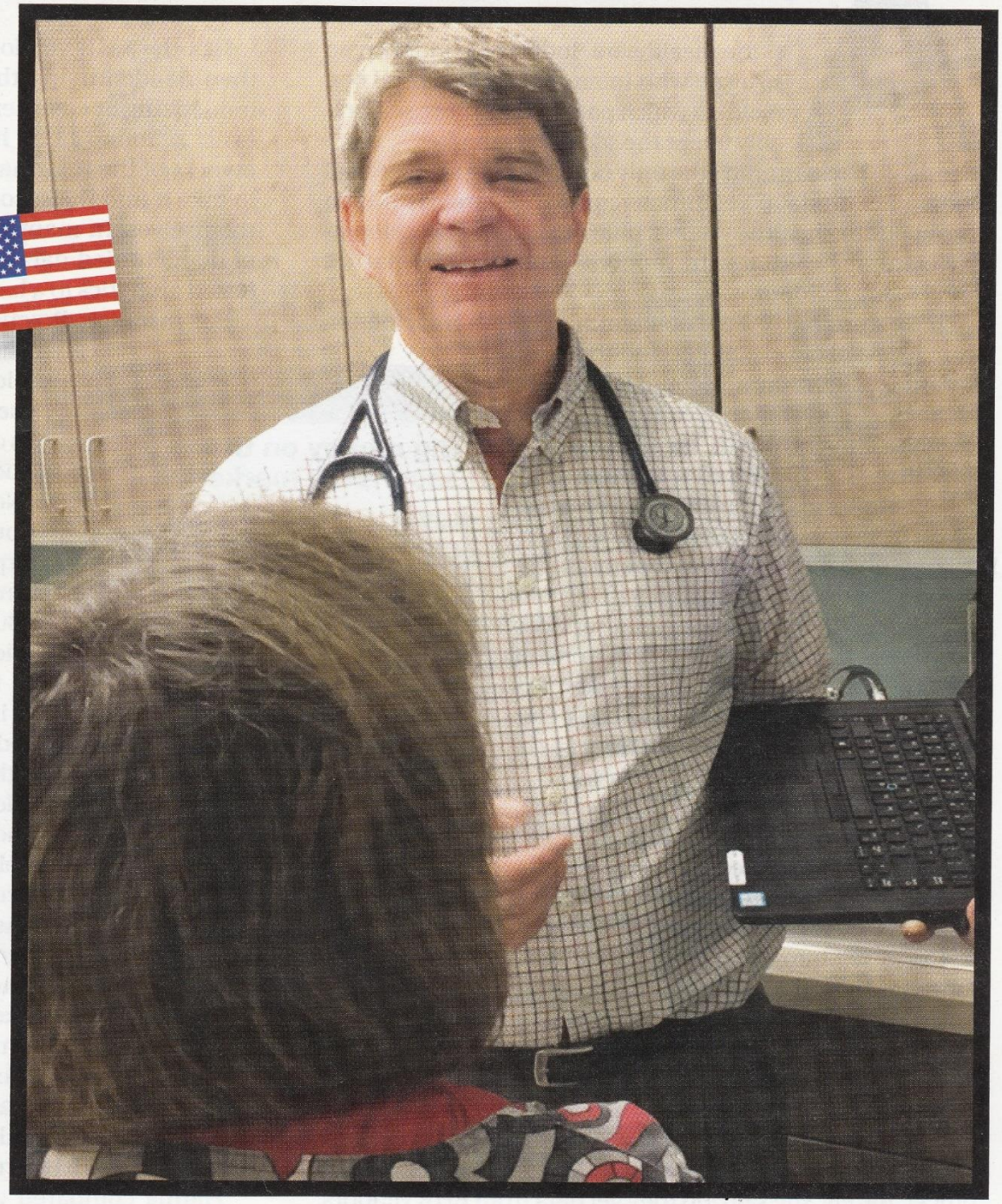
Source: Canadian Medical Protective Association - www.cmpa-acpm.ca

* Government reimburses MDs for premiums above 1986 level

"It's not a big hassle. I can focus on patient issues, not administrative issues."

Dr. Trina Larsen Soles, president of Doctors of BC, which represents physicians in British Columbia

Source: Modern Healthcare 4/ 7/ 2018



"It's an incredible bureaucratic mess to get anything done for patients."

Dr. John Cullen, president-elect of the American Academy of Family Physicians

Source: Modern Healthcare 4/ 7/ 2018

What's OK in Canada?

Compared to the U.S.

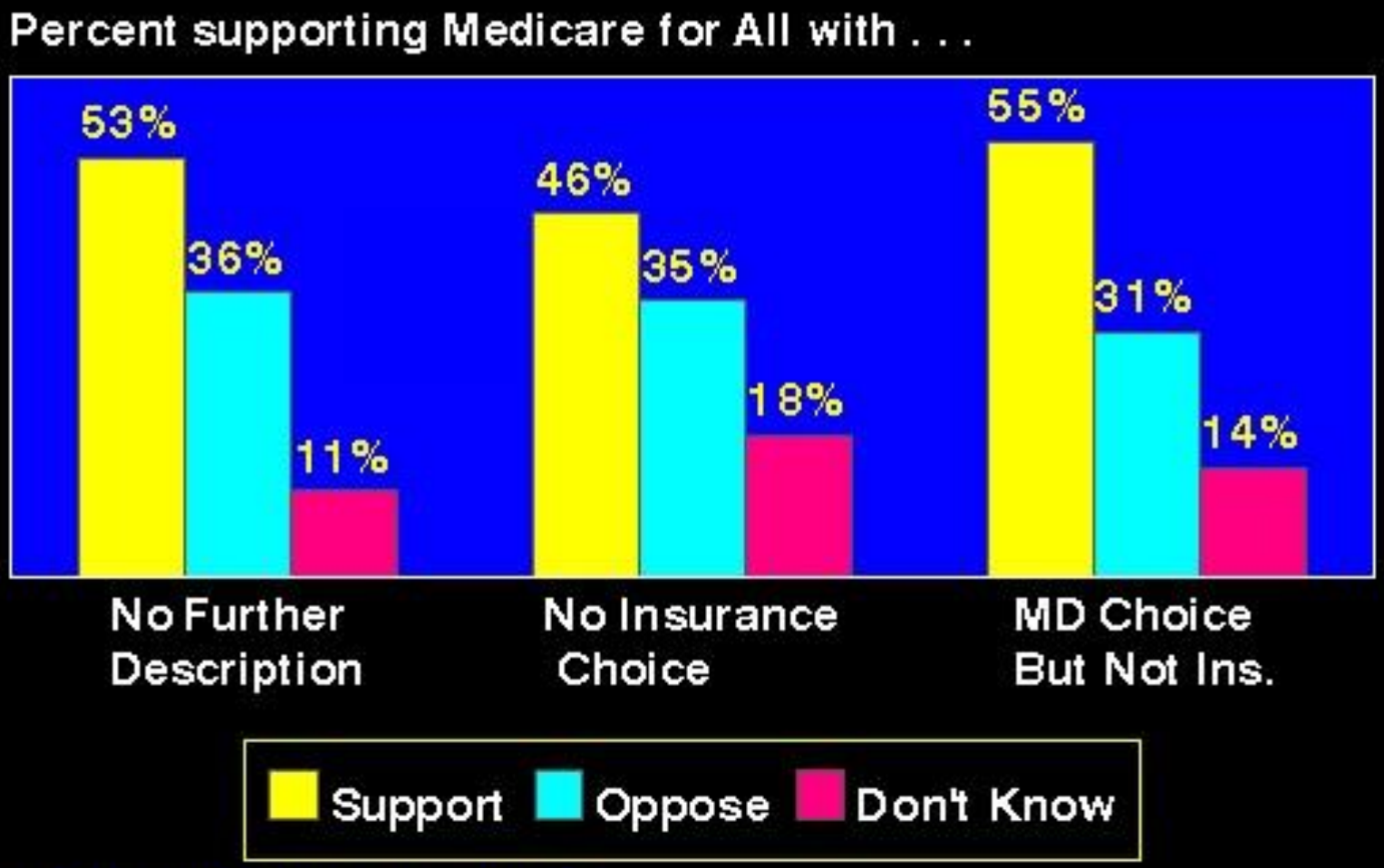
- Life expectancy 2 years longer
- Infant deaths 25% lower
- Universal comprehensive coverage
- More MD visits, hospital care; less bureaucracy
- Quality of care equivalent to insured Americans'
- Free choice of doctor/hospital
- Health spending half U.S. level

What's the Matter in Canada?

- The wealthy lobby for private funding and tax cuts; they resent subsidizing care for others
- Result: government funding cuts (e.g. 30% of hospital beds closed during 90s) causing dissatisfaction and waits for care
- U.S. and Canadian firms seek profit opportunities in health care privatization
- Conservative foes of public services own many Canadian newspapers
- Misleading waiting list surveys by right wing Fraser Institute

Medicare for All Enjoys Wide Support

Most Favor Phasing Out Private Plans if They Can Keep Their Doctor/Hospital

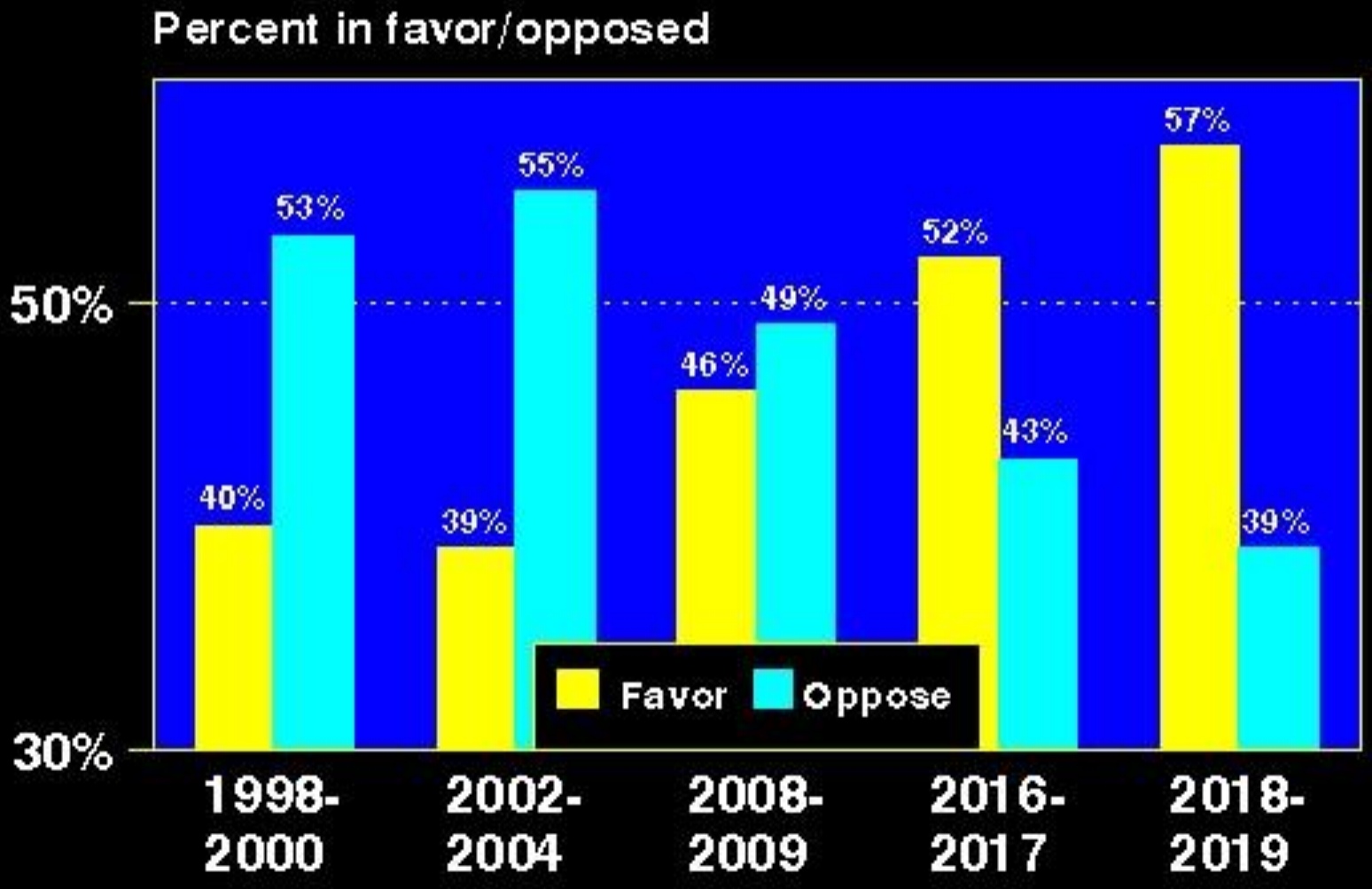


Source: Morning Consult July, 2019

Note: Question asked about choice of doctor AND hospital

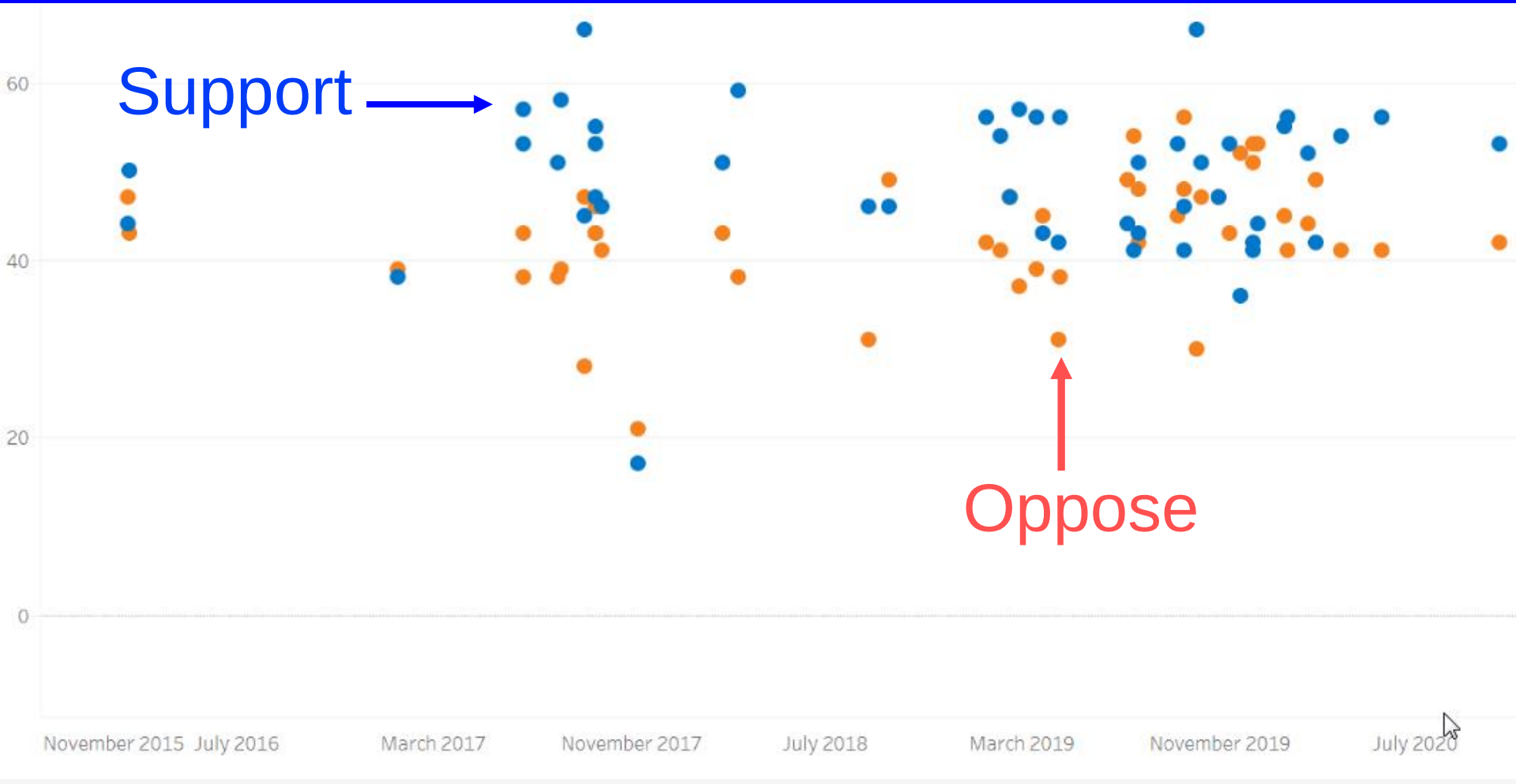
Increasing Support for Single Payer

"All Americans Would Get Their Insurance from a Single Government Plan"



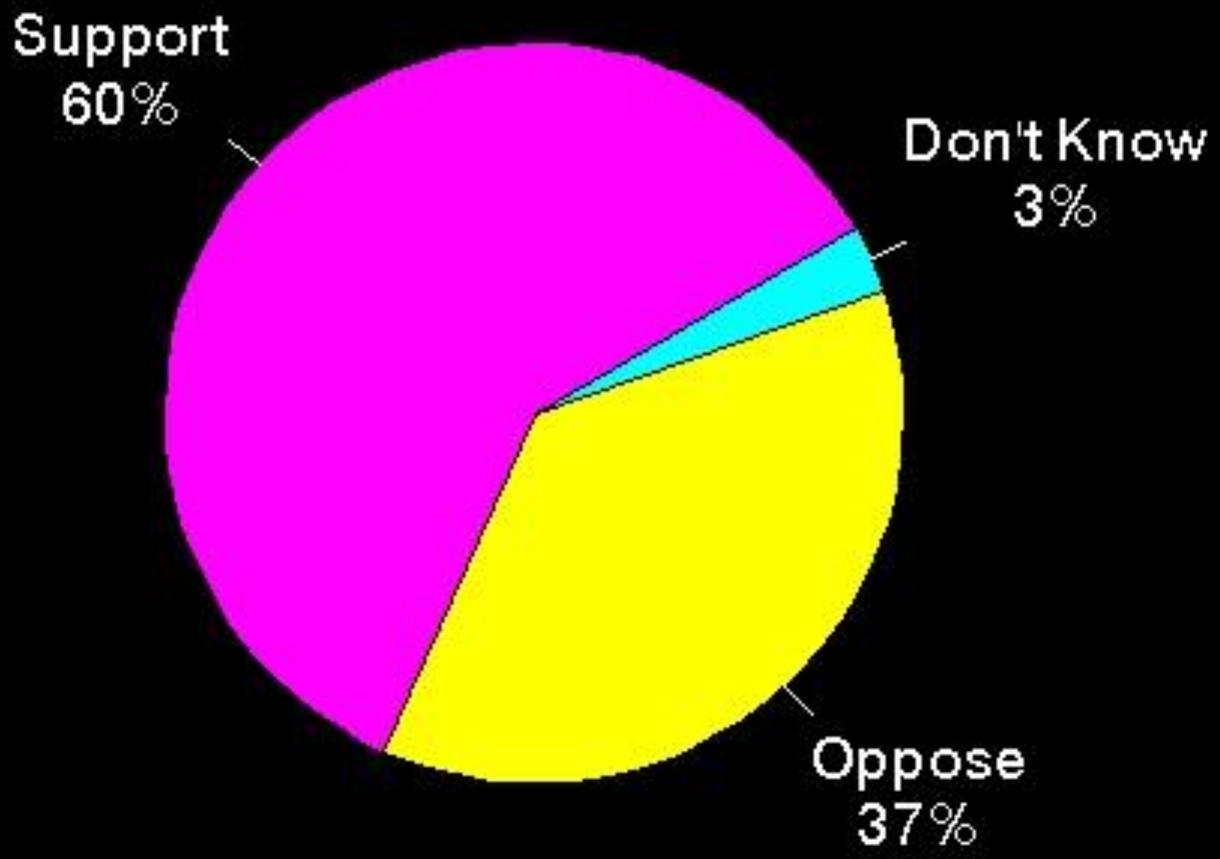
Source: Kaiser Family Foundation Polls

Polls: Consistent Support For M4A, Nov. 2015 – July 2020



Source: Kaiser Family Foundation, October, 2020

2021 Poll: 60% Want Medicare for All

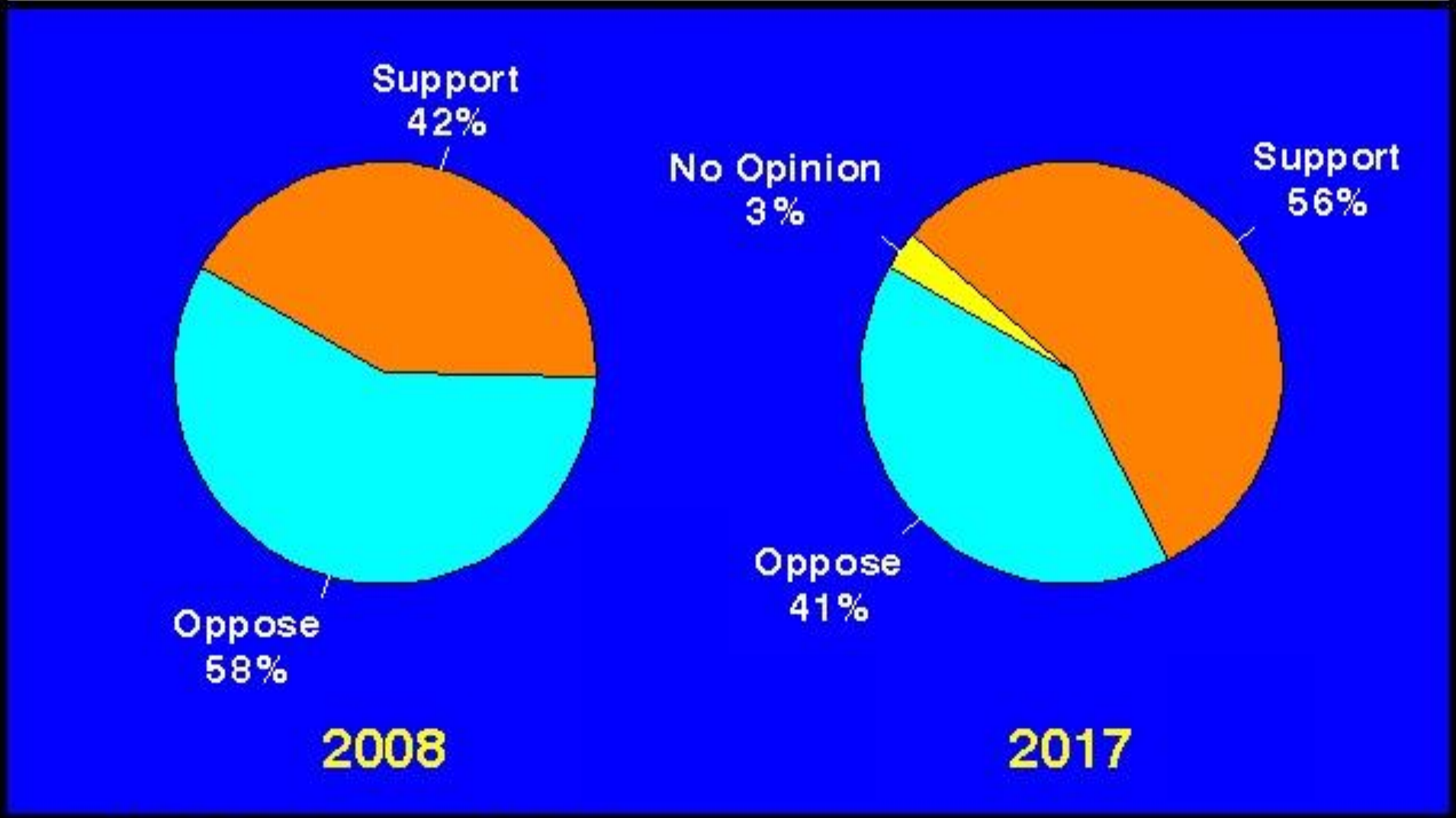


Source: Commonwealth Fund/Harvard Public Health School Survey January, 2021

"Do you support/oppose changing our health care system so that all Americans would get health insurance from Medicare ... paid for by taxpayers ... often called Medicare for all"

Most Doctors Favor Single Payer

Support Has Sharply Increased



Source: Merritt Hawkins surveys of physicians

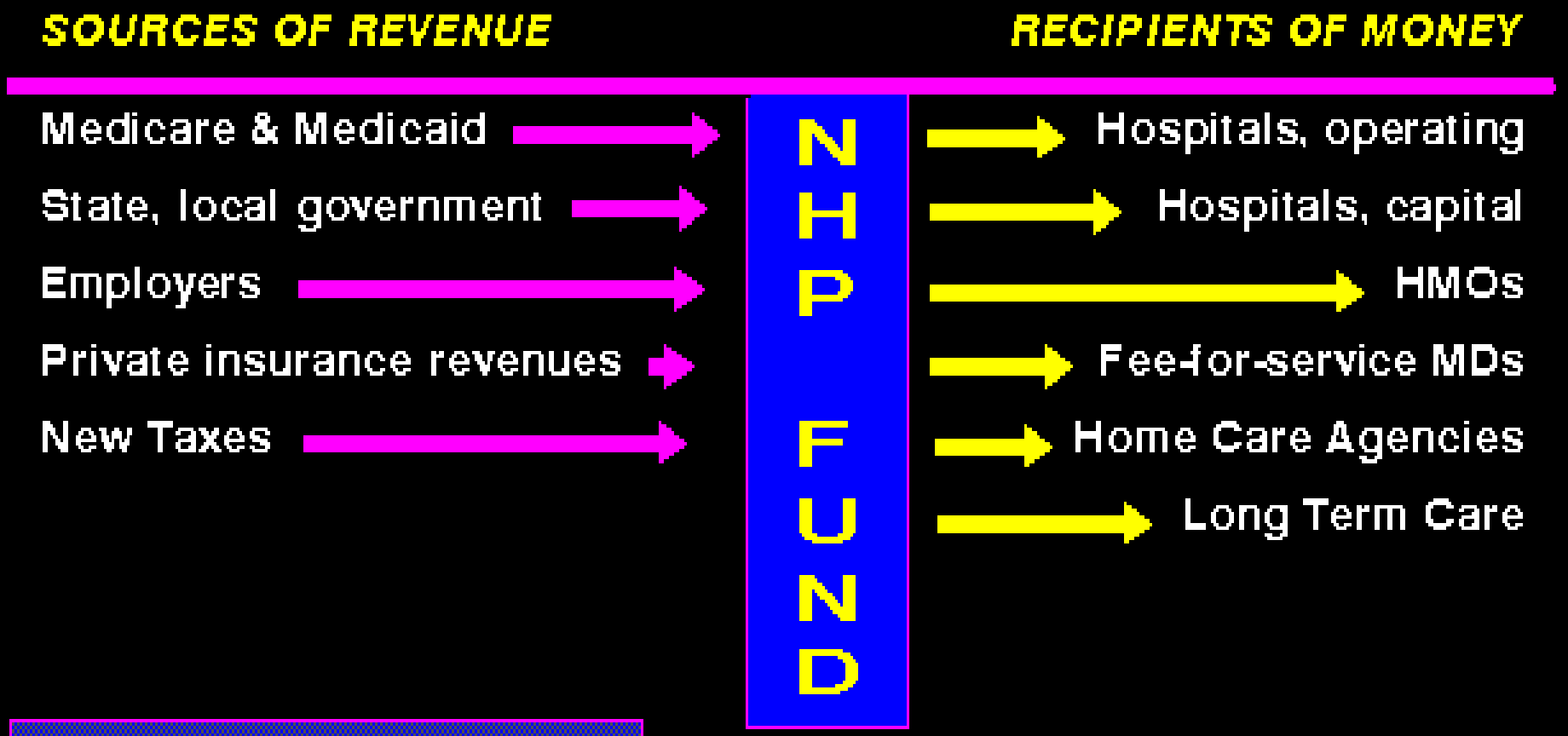
A National Health Program for the U.S.

National Health Insurance

- Universal - covers everyone
- Comprehensive - all needed care, no co-pays
- Single, public payer - simplified reimbursement
- No investor-owned HMOs, hospitals, etc.
- Improved health planning
- Public accountability for quality and cost, but minimal bureaucracy

Source: Proposal of the Physicians Working Group for Single Payer NHI. JAMA 2003;290:798

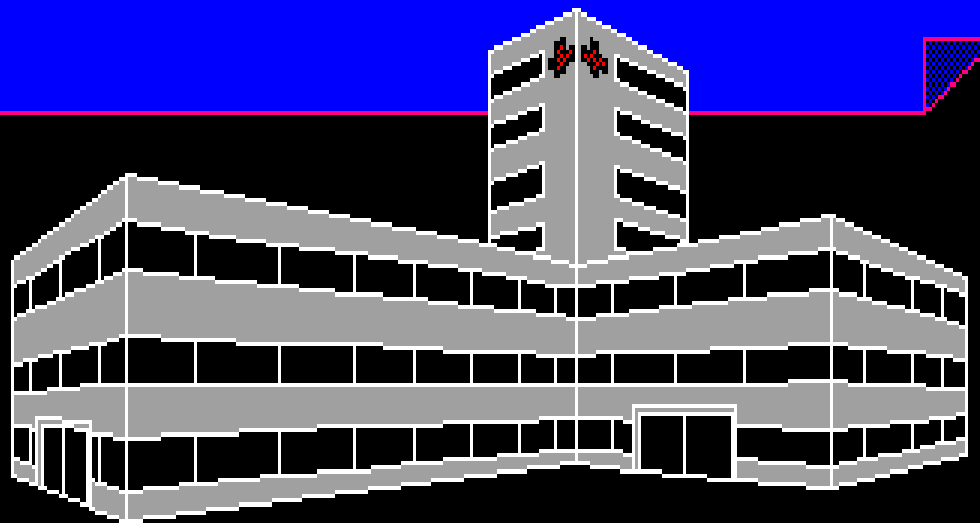
FUNDING FOR THE NHP



SOURCE: NEJM 1989; 320:102

HOSPITAL PAYMENT UNDER AN NHP

- Hospitals remain privately owned and run
- Negotiated global budget for all operating costs. Operating funds cannot be diverted to capital.
- Capital purchases/expansion budgeted separately based on health planning goals



SOURCE: Himmelstein, Woolhandler
NEJM 1989 320:102

Global Operating Budgets: Key to Single Payer Savings

- Cuts hospital administrative costs.
- Eliminates disparities in profitability of patients.
- Banning hospitals from keeping surplus minimizes entrepreneurial incentives.
- Funding capital through explicit grants minimizes unneeded duplication of expensive services.

Prescription Drugs and Single Payer

- Full coverage, no deductibles/copays.
- Prices reduced by negotiations, national formulary, threat of patent revocation.
- Funding for public drug development, testing, and (when necessary) manufacture.
- Raise standards and FDA funding for drug approval, marketing and post-approval surveillance.
- Eliminate tax deductions for advertising; prohibit pharma-funded CME and guideline development.

Source: Gaffney, Lexchin, Angell, Carome et al. BMJ 2018;361:K1039

Current Senate and House Bills

Strengths

- Universal coverage, single public plan
- Comprehensive acute care benefits
- No copays for covered services
- Bans duplicative private coverage
- Exemption from Hyde Amendment
- Drug formulary and price negotiations

Current Senate and House Bills Concerns

- Both allow for-profit providers, with constraints
- Senate bill: Adopts Medicare's needlessly complex payment strategies, raising administrative burdens/costs and perpetuating incentives for upcoding etc., focusing on profitable services, etc.

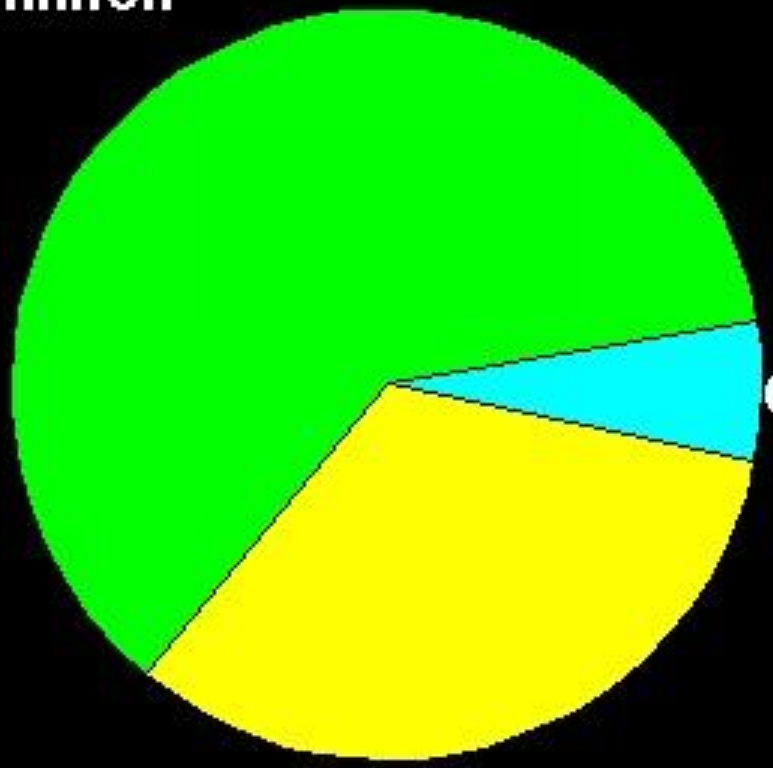
Single Payer Transition:

For Displaced Clerical and Administrative Workers

- All 400,000 health insurance workers and about ½ of the 2.6 mil. clerical/administrative employees in healthcare providers likely to be displaced – total 1.7 million.
- Many likely to be redeployed in expanded clinical workforce.
- Funding for income support and job retraining modeled on WWII GI Bill.
- Job displacement is common in the US – 60 million/year, including 20 million who are fired: 1.7 million = number who are fired every 31 days. (source: People's Policy Report)

66.1 Million U.S. Workers Separated from Jobs in 2018

Putting Job Displacement Due to Single Payer Into Perspective



Source: Bureau of Labor Statistics - Job Opening and Labor Turnover Survey, January, 2019

* Other includes deaths, retirements, transfers, disability

Single Payer Transition: For Patients

- Every U.S. resident receives an insurance card.
- Full coverage for all medically necessary care, no copayments, deductibles or coinsurance.
- Prescription drug formulary, with alternatives covered when medically indicated
- Free choice of any participating provider or hospital.

Medicare for All
or
Medicare for More?

Single Payer and Private Coverage

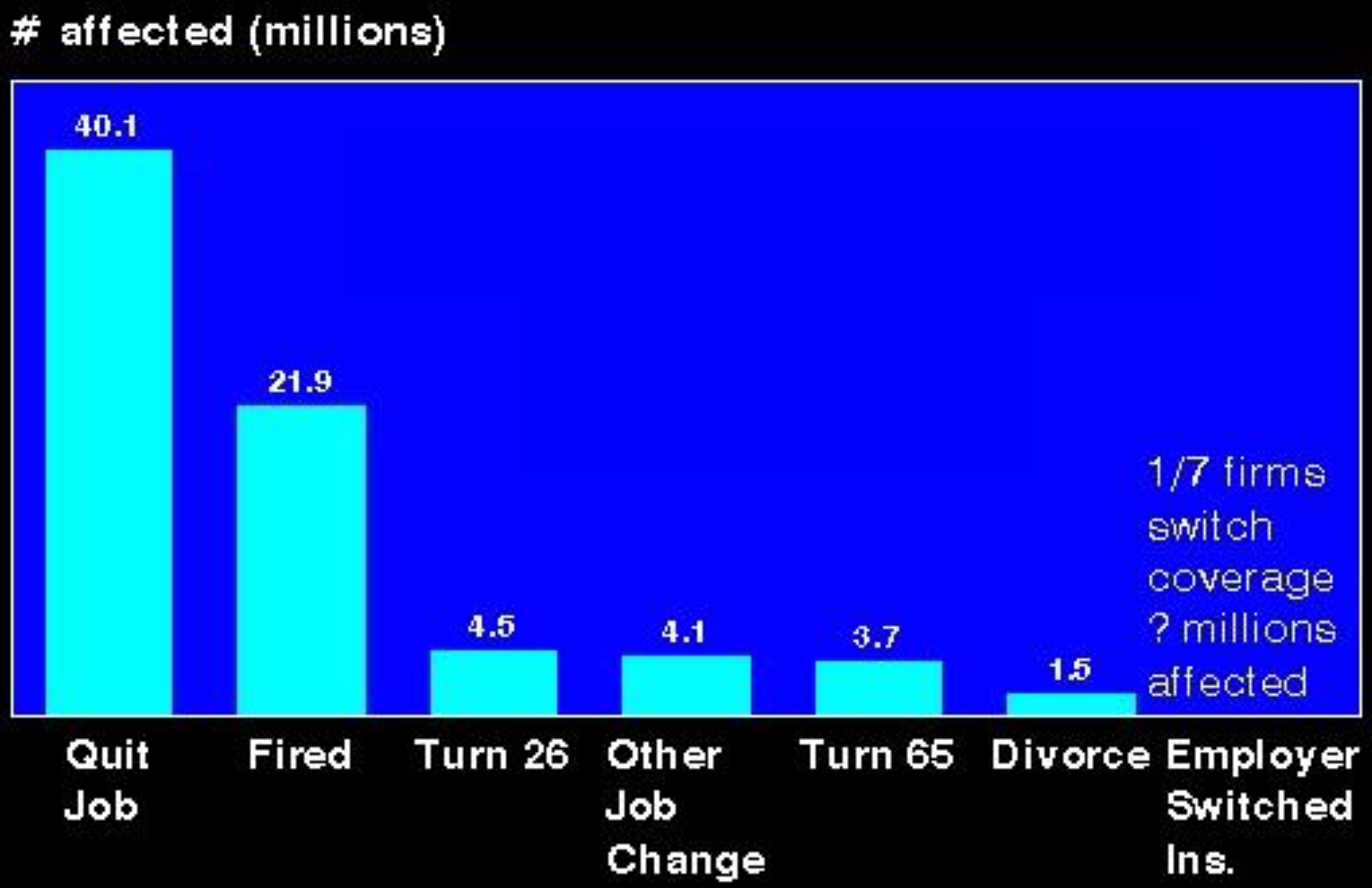
- Allowed: Supplemental non-competing – but can only cover benefits NOT covered by the public plan.

- Banned:: Private insurance (including Medicare Advantage) duplicating public plan benefits – Key to administrative savings.

Public Option Rhetoric

- “Don’t strip 150 million Americans of their private insurance; let them choose”
- “M4A means a giant tax increase”
- “If public is better, it will outcompete private insurance”
- “There’s lots of ways to get to universal care”

Millions Lose Private Insurance Every Year



Source: Bruenig - Jacobin Blog Post July, 2019

Other reasons for involuntary switch: Employer stopped offering coverage; coverage too expensive; policy holder died; hours dropped

Transitioning to Germany

- Non-profit sickness funds: boards ½ union, ½ employer.
- All insurers pay same rates and include every doctor, every hospital.
- States fund most hospital capital investment.
- Single payer for long term care.

Transitioning to Switzerland

- Mandatory coverage sold ONLY by non-profit insurers.
- All insurers pay same rates and include every doctor, every hospital.
- Cantons fund most hospital capital investment.
- Only US has higher health costs.

Transitioning to Netherlands

- Developed as German-style universal coverage.
- Private insurers introduced 2006.
- Doctors now complain of unbearable administrative burdens, and rupture of cooperation.
- Hospital administrative costs 2nd only to US.
- Single payer for long term care.

65% of Dutch GPs Sign Manifesto: "Everything Must Change"

- "Insurers have too much power"
- "Bureaucracy is growing"
- Remove doctors from Competition Act* and make "cohesion through cooperation" the guiding principle in primary care

*Act forces each GPs to negotiate individual contract with insurers

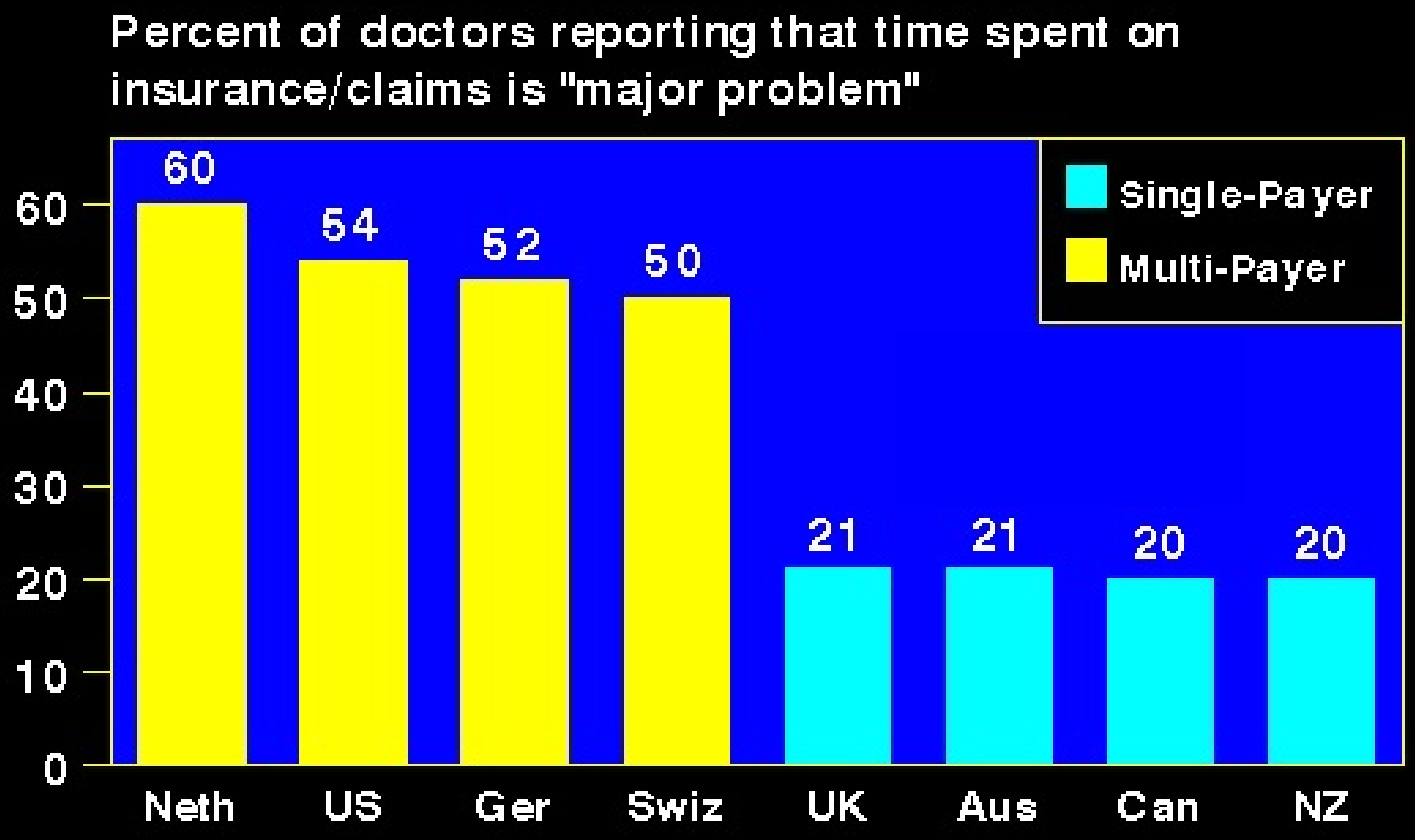
Source: "Competition Hurts Healthcare: Doctors" NL Times 4/17/15

“Insurers in the Netherlands and Switzerland are not as a matter of public policy conceived of as private businesses and in important respects they are not allowed to function as private businesses. The Dutch and Swiss models--built on a uniform mandated benefit package, a limited menu of cost sharing, and provider rate regulation-- are not the models that private insurers in the United States are in fact advocating, but rather represent a quite different tradition based on social solidarity and not on market competition.”

“They have not, moreover, been successful in holding down costs or expanding access to insurance. Finally, their experience demonstrates again the tendency of insurers—even nonprofit insurers--to compete based on risk selection rather than cost, and the difficulty posed by trying to control this tendency through legal regulation.”

The Experience of Switzerland and the Netherlands with Individual Health Insurance Mandates: A Model for the United States? Timothy Stoltzfus Jost

Doctors in Multi-Payer Systems Have More Insurance Hassles



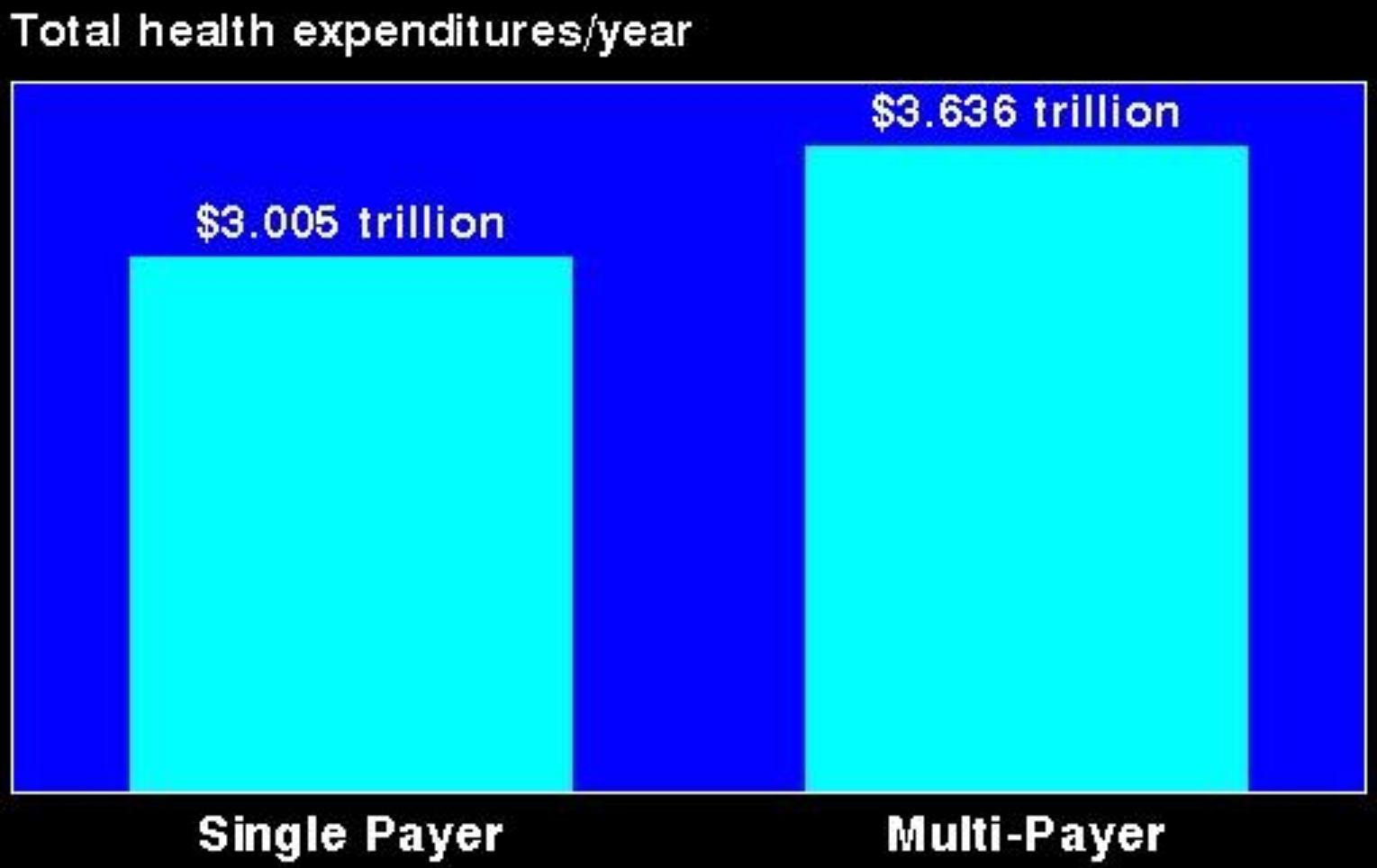
Source: Commonwealth Fund Physician Survey, 2015

Public Option = High Costs

- Less savings than single payer on insurers' overhead
- Multiple payers = no savings on doctor/hospital billing and administration.
- Private insurers will tilt the playing field (as under Medicare Advantage) raising system-wide costs and perpetuating network restrictions, cherry-picking, lemon dropping etc.
- Higher system-wide costs (compared to single payer) assure political pressure for benefit cuts.

For Any Level of Spending, Single Payer Would Purchase More Care and Less Administration Than Public Option

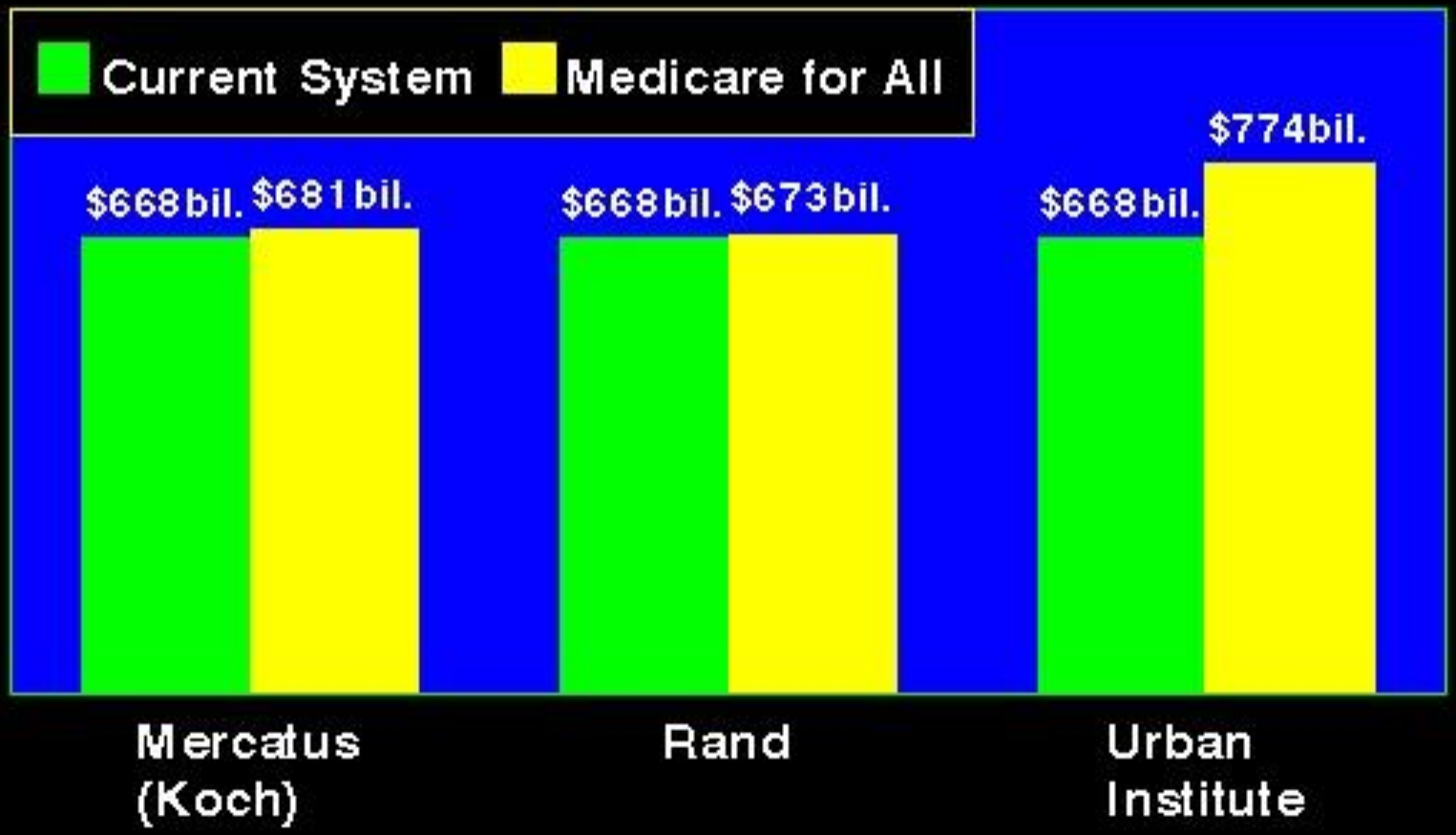
Single Payer Would Cost $631 Billion Less Than a Universal Multi-Payer Reform



Source: Galvani & Fitzpatrick, Lancet 2020;395:1692

Total Payments to America's ~1 Million Physicians With and Without Medicare for All

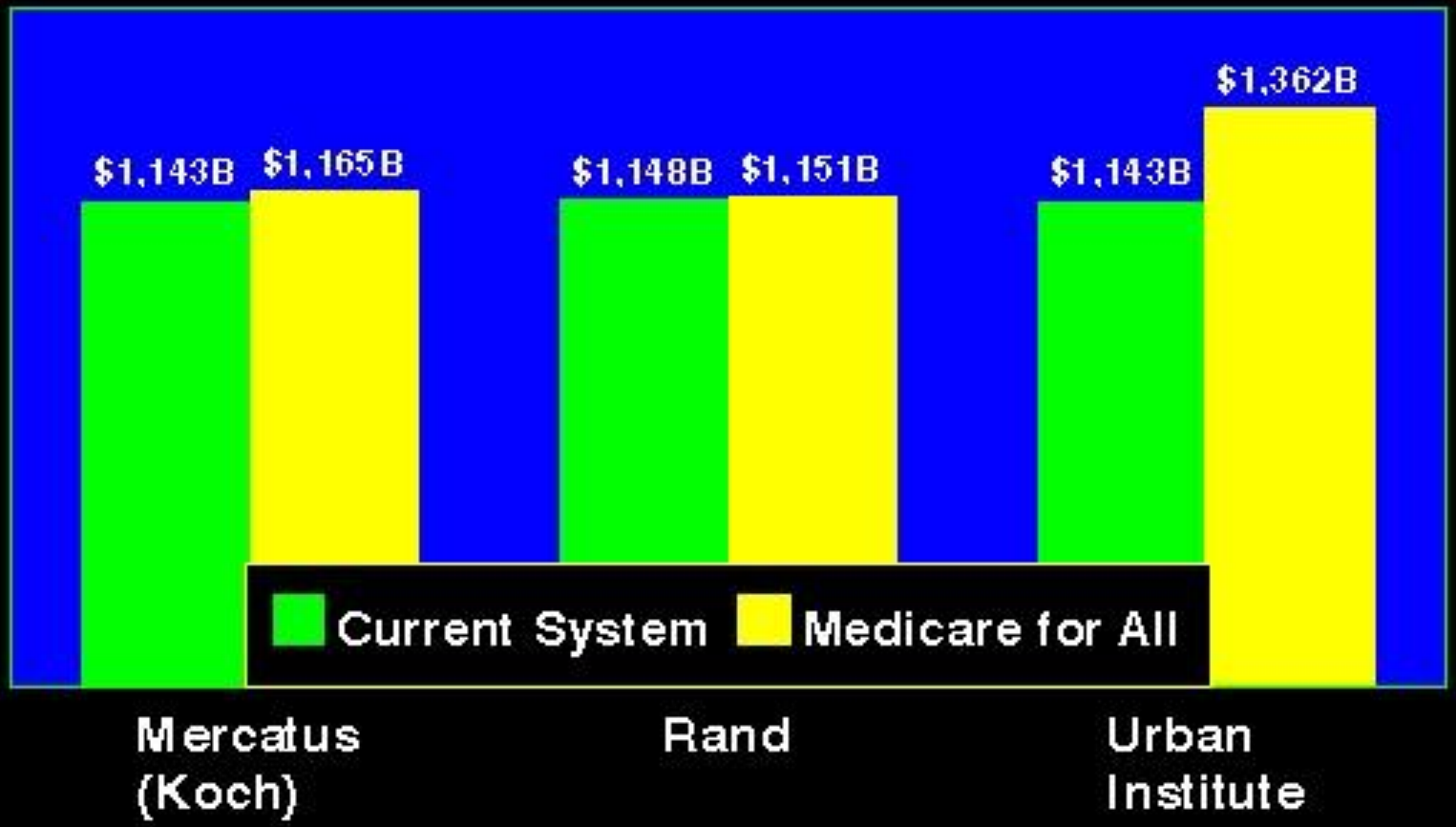
Three Recent Estimates by Single Payer Skeptics



Sources: Rand Corporation (2019), Urban Institute (2016), Mercatus Center (2018)
Note: Percentage estimates from original studies, applied to 2019 total physician expenditures
Note: Urban argued that "physician incomes would be squeezed" even as payments rose by >$100 bil.

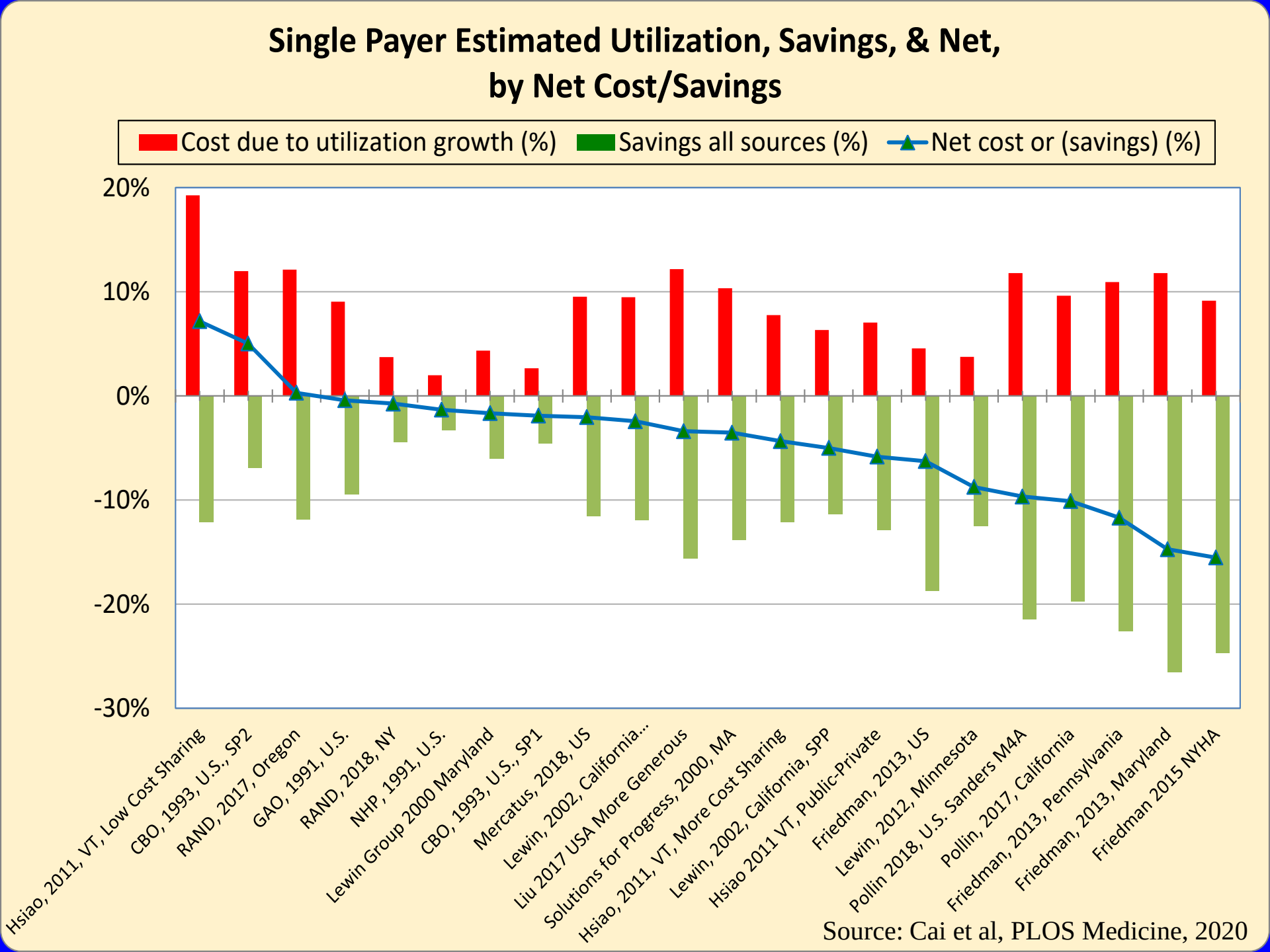
Total Payments to America's ~5,500 Hospitals With and Without Medicare for All

Three Recent Estimates by Single Payer Skeptics



Sources: Rand Corporation (2019), Urban Institute (2016), Mercatus Center (2018)
Note: Percentage estimates from original studies, applied to 2017 total hospital payments
Note: Urban's 2019 estimate is similar to 2016 estimate overall, but lacks detail.

Single Payer Estimated Utilization, Savings, & Net, by Net Cost/Savings



Source: Cai et al, PLOS Medicine, 2020

THE Nation.

HEALTH CARE CORPORATIONS SINGLE-PAYER HEALTH CARE

Medicare for All Is Not Enough

Communities, not corporations, should own our most vital health care assets.

By David U. Himmelstein, Steffie Woolhandler, Adam Gaffney, Don McCanne and John Geyman

MARCH 31, 2022

Hospital workers, union members, and local politicians protested the imminent closure of Hahnemann University Hospital at a rally in Philadelphia on July 15, 2019. *(Bastiaan Slabbers / NurPhoto via Getty Images)*

THE NEW

NATIONAL HEALTH SERVICE

*

Your new National Health Service begins on 5th July. What is it? How do you get it?

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

"…There are no charges, except for a few special items"

"…no insurance qualifications"

An equal right to healthcare

gov.uk/object9232