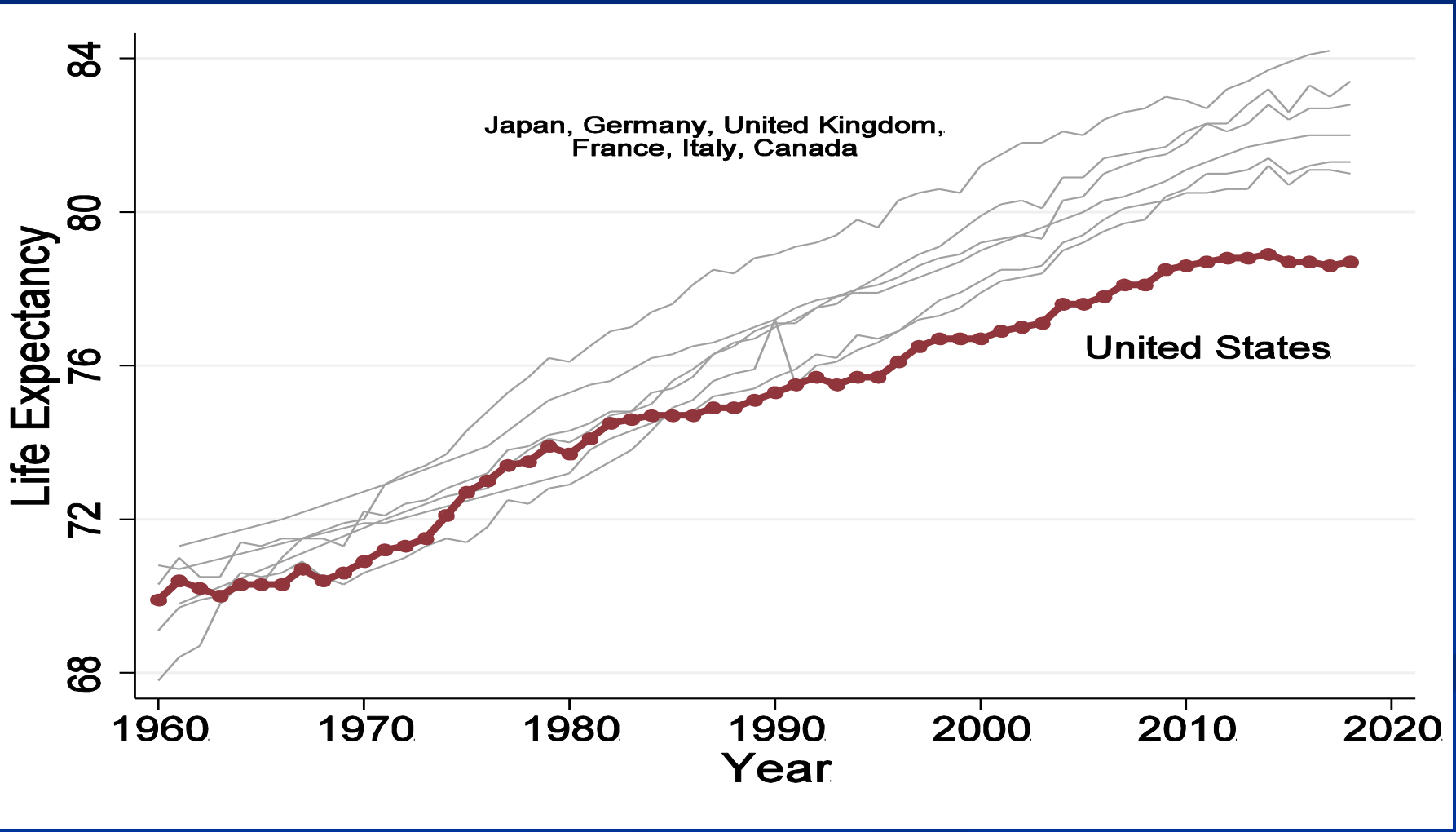
Slides prepared by Drs. Steffie Woolhandler & David Himmelstein, Faculty at the City University of New York at Hunter College and Harvard Medical School, and Research Associates, Public Citizen Health Research Group

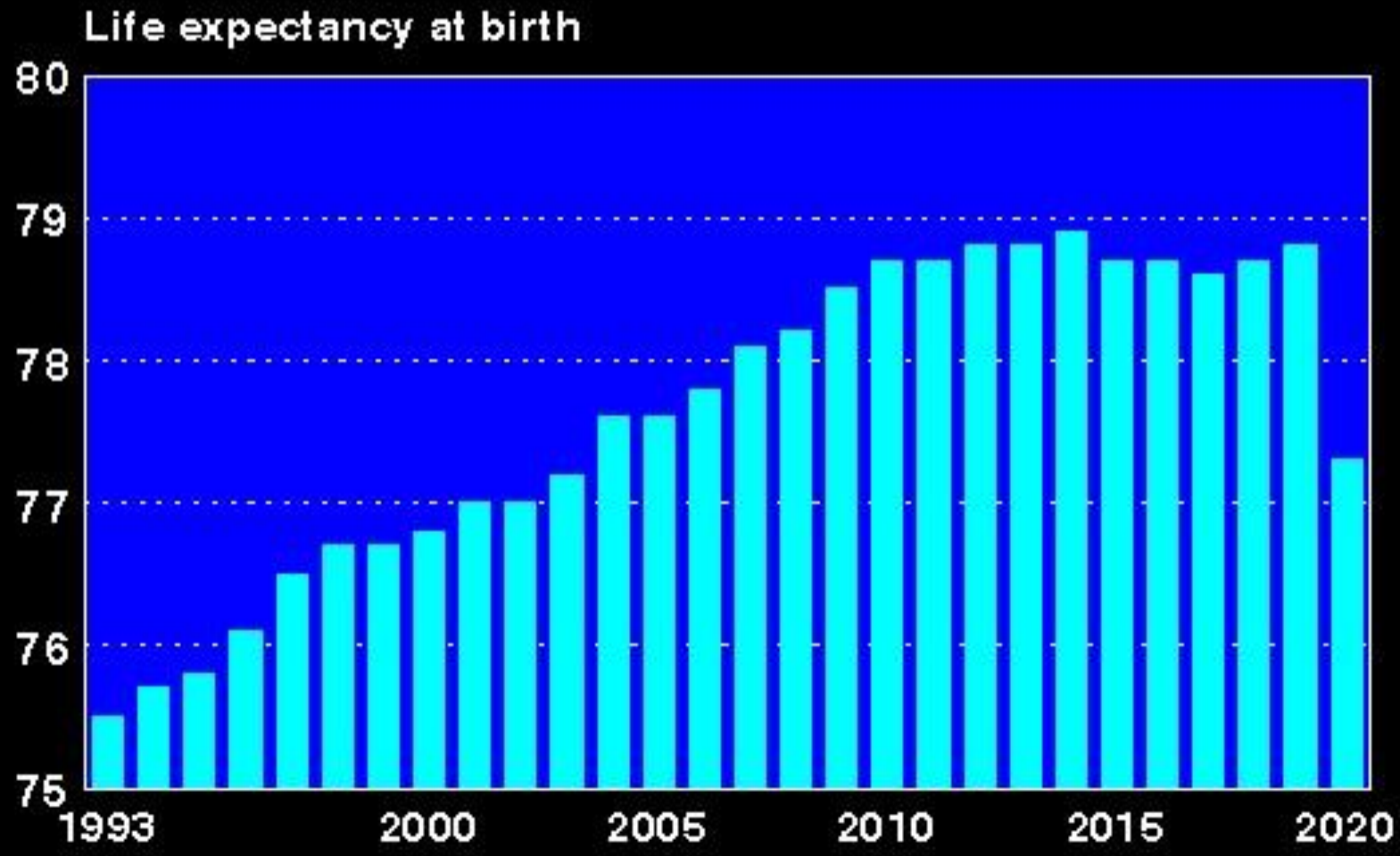
Life expectancy in the US and other G7 countries, 1960–2018



Source: J. Bor based on OECD 2020

Progress on Longevity Halted

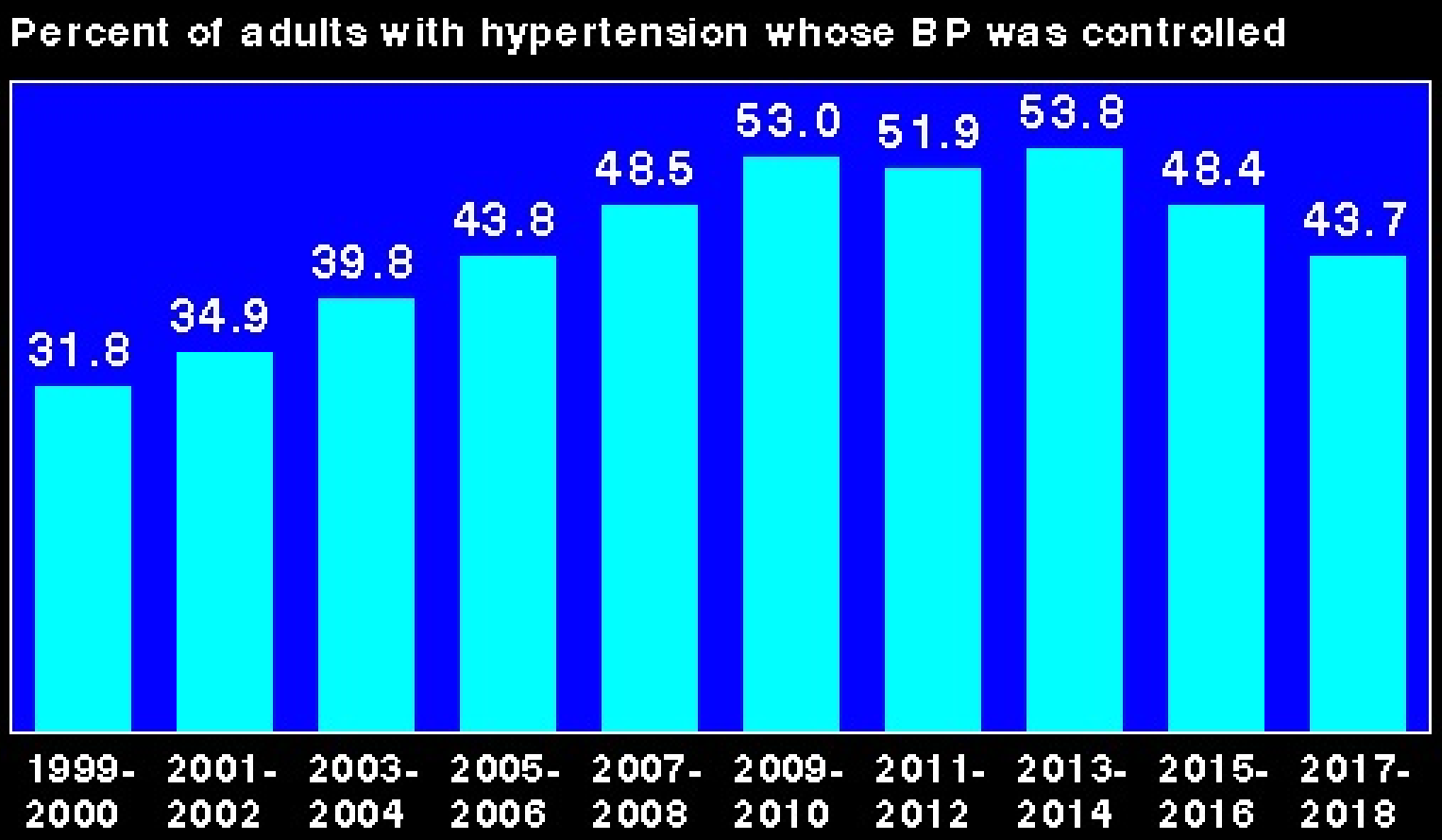
Even Before COVID-19 Pandemic



Source: NCHS

Worsening Blood Pressure Control

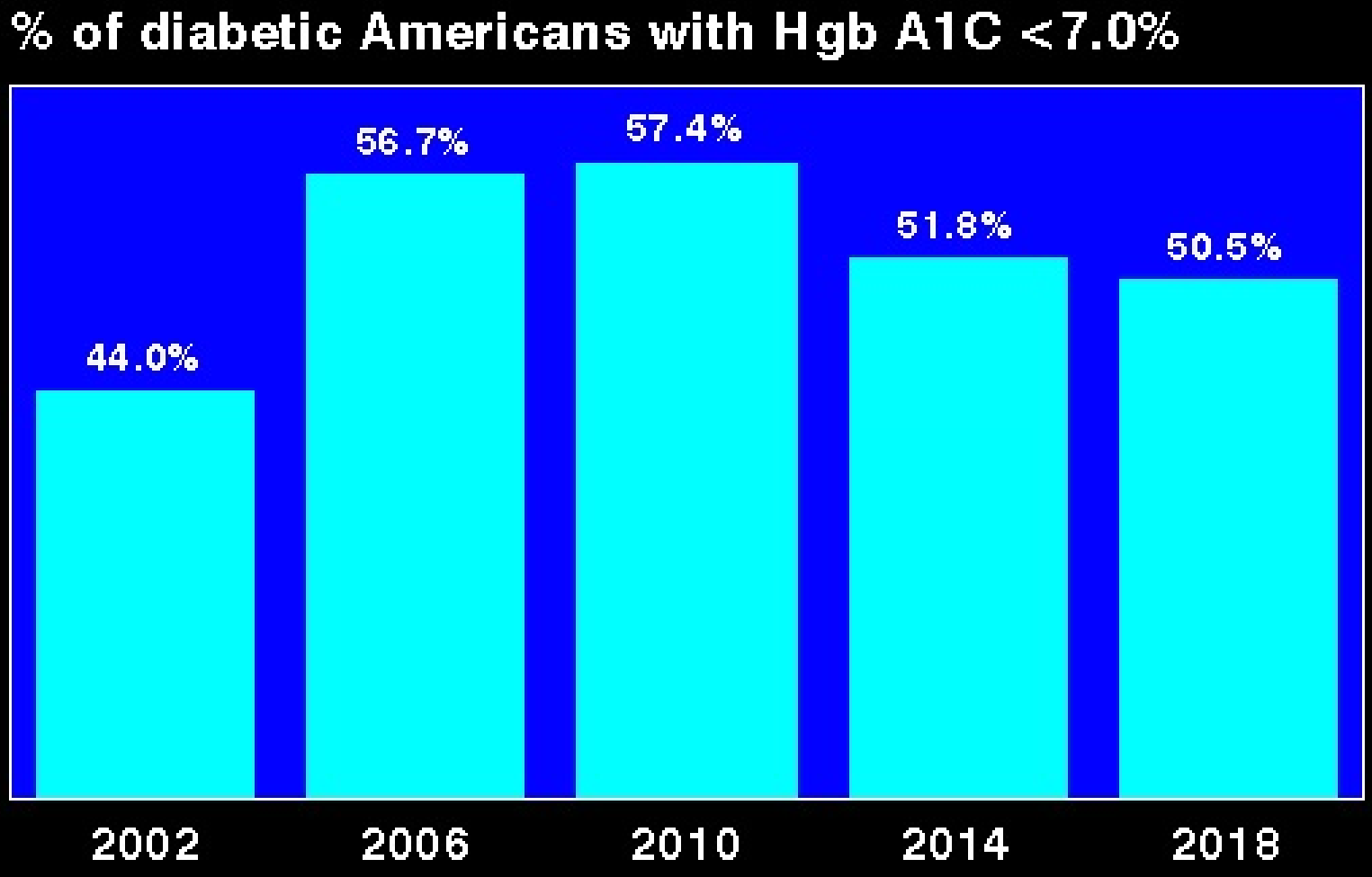
A Rising Share of US Adults Have Uncontrolled Hypertension



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

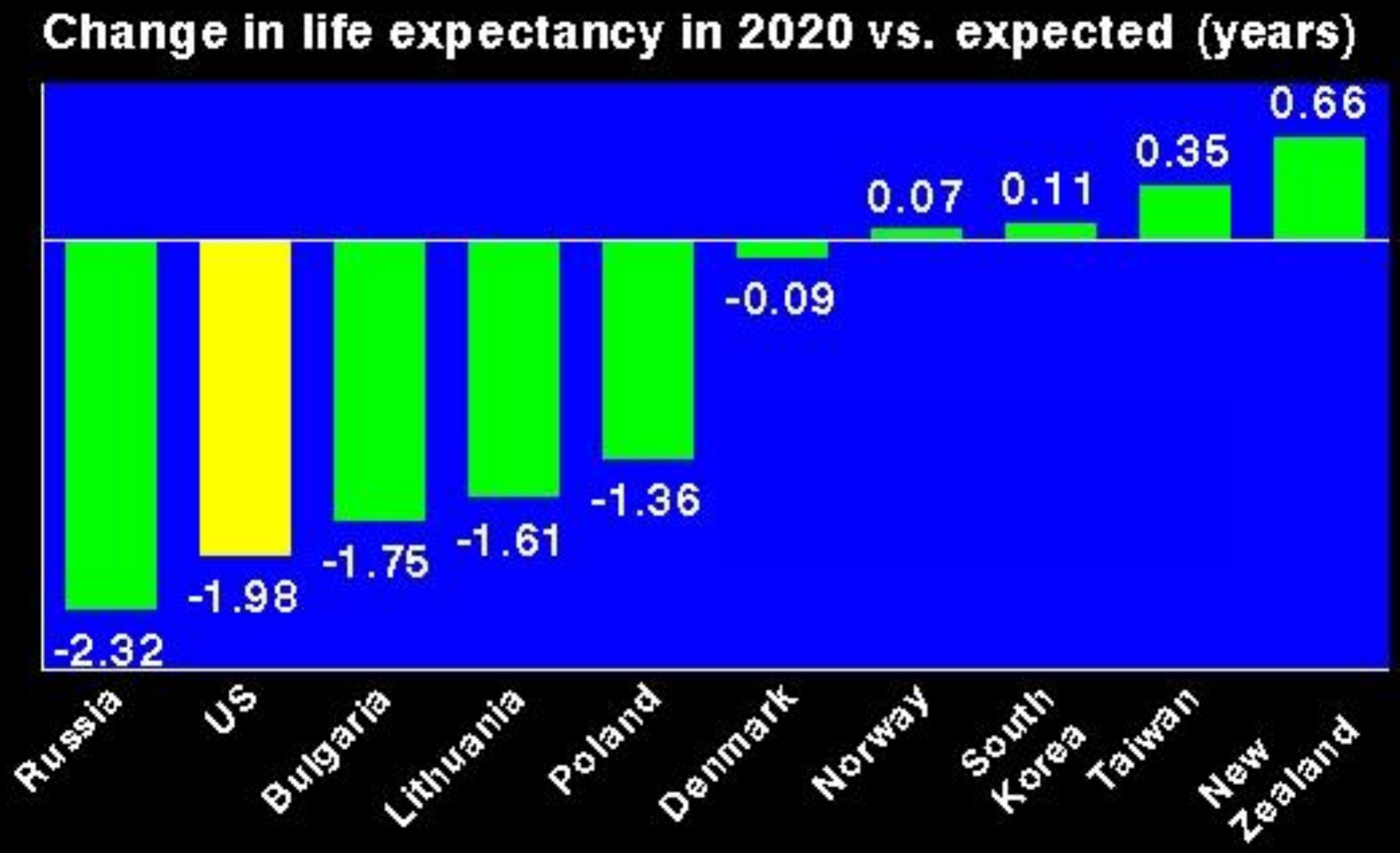
Diabetes Care is Deteriorating



Source: NEJM 2021;384:2219

Note: Data are 4 year averages ending in year shown

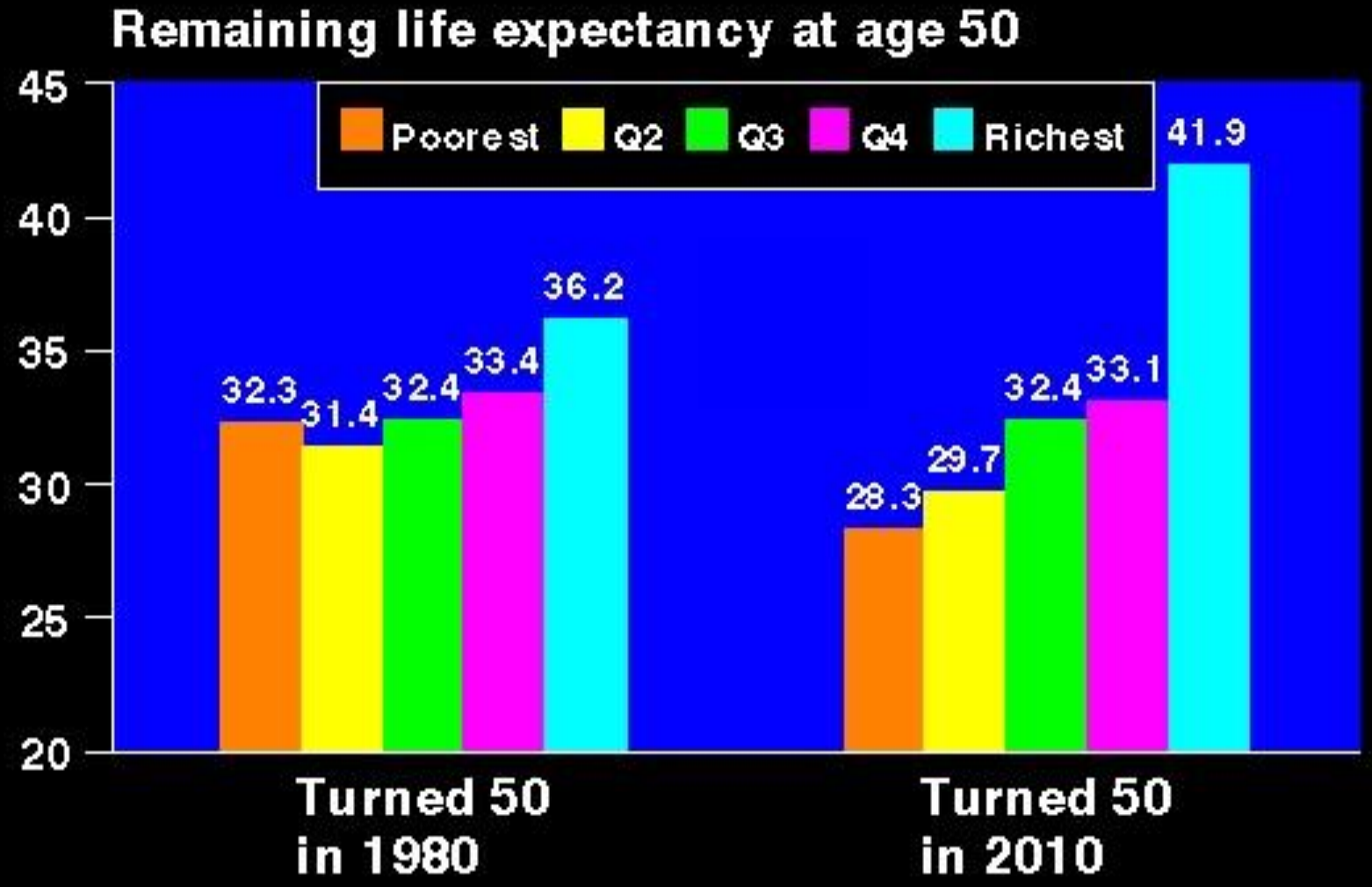
Life Expectancy Fall from COVID-19: Greater in the US Than Anyplace but Russia



Source: BMJ 2021;375:e066768

Growing Gap in Life Expectancy by Income

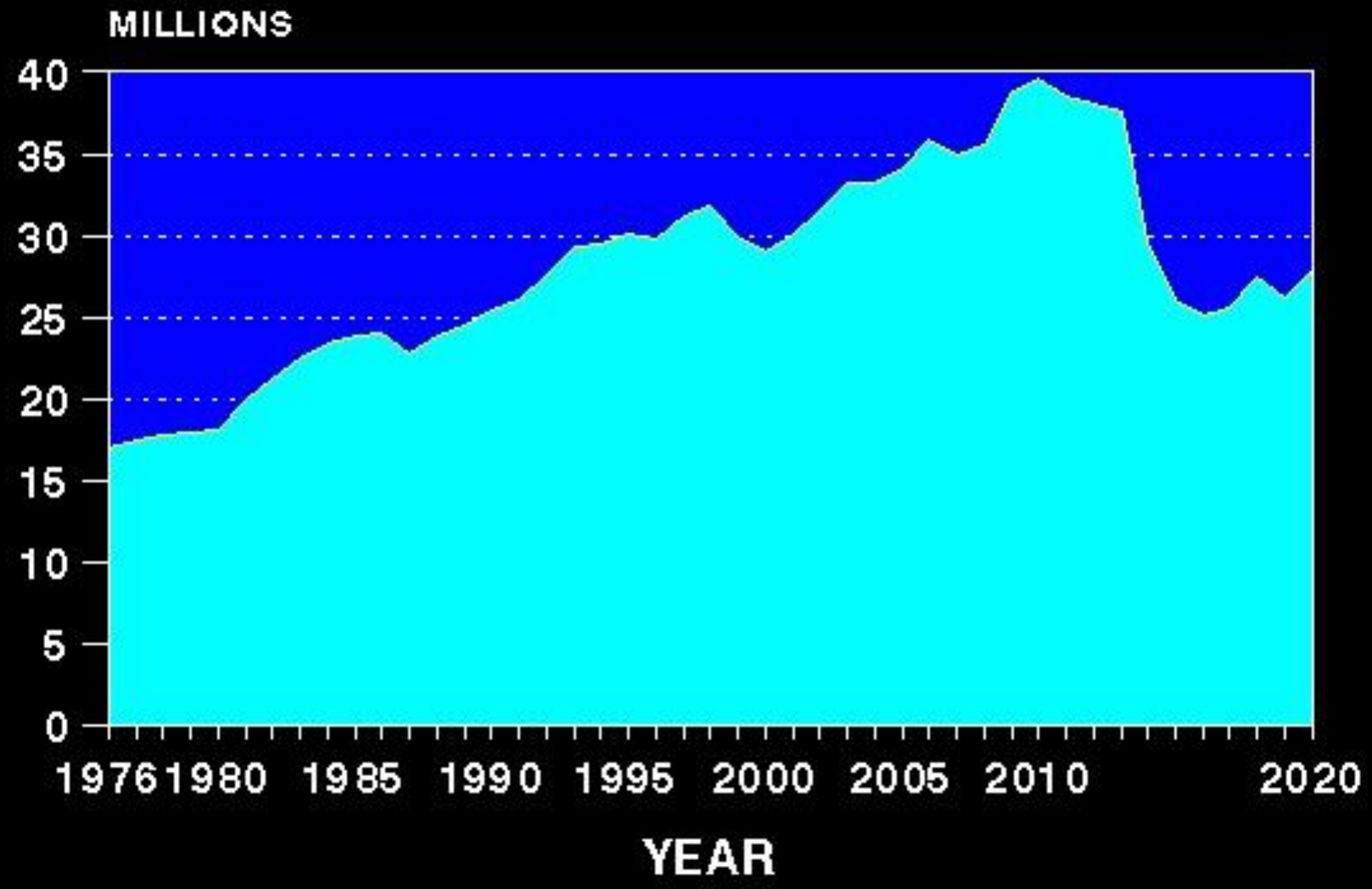
Dramatic Gains for the Wealthy, Losses for Lower Income



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

The Uninsured

Americans Uninsured All Year, 1976-2020



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

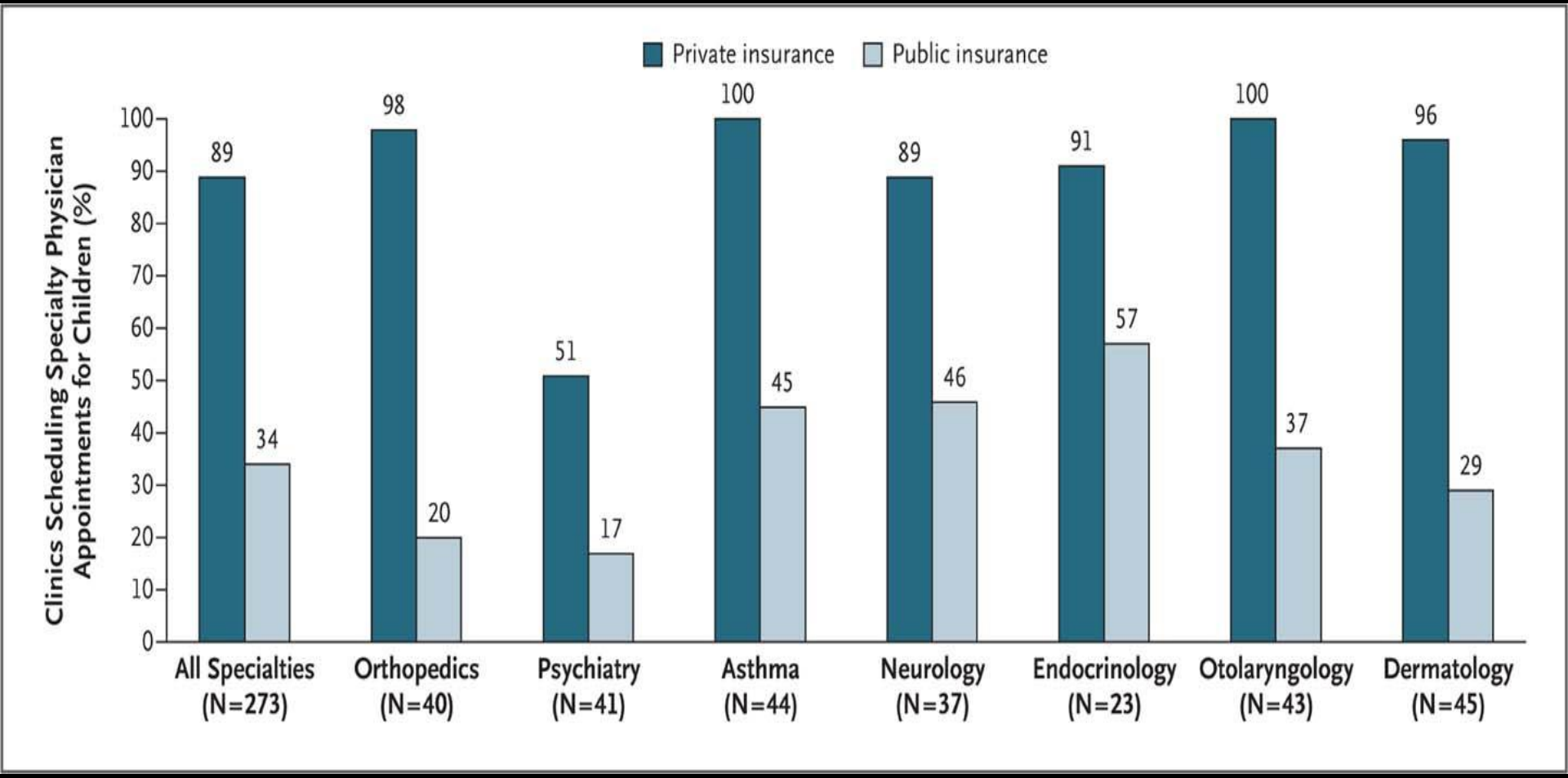
38,531 Deaths During 2019 Due to Uninsurance

State	% Uninsured	Excess Deaths
Texas	18.4	6,804
California	7.7	3,903
Florida	13.2	3,619
Georgia	13.4	1,817
Noth Carolina	13.4	1,504
New York	5.2	1,309
U.S.	9.2%	38,531

Source: Woolhandler & Himmelstein, Ann Int Med 2017;167:424 - Based on 2019 ACS
Based on best estimate from multiple studies of 1 death per 769 uninsured/year, and # uninsured at time of survey

Medicaid: Poor Access, But Better Than Nothing

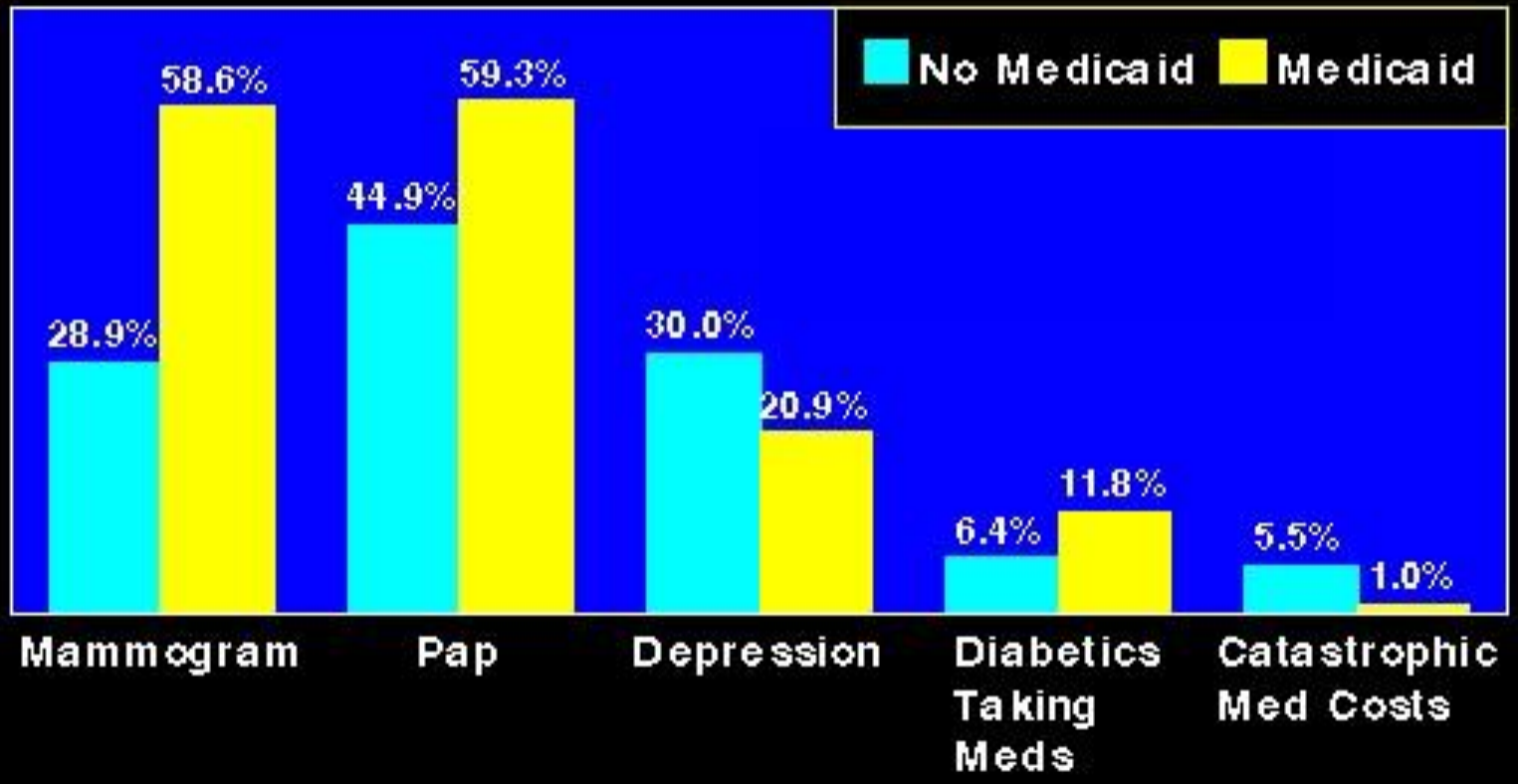
Many Specialists Won't See Kids With Medicaid



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

Medicaid Helps

An RCT in Oregon



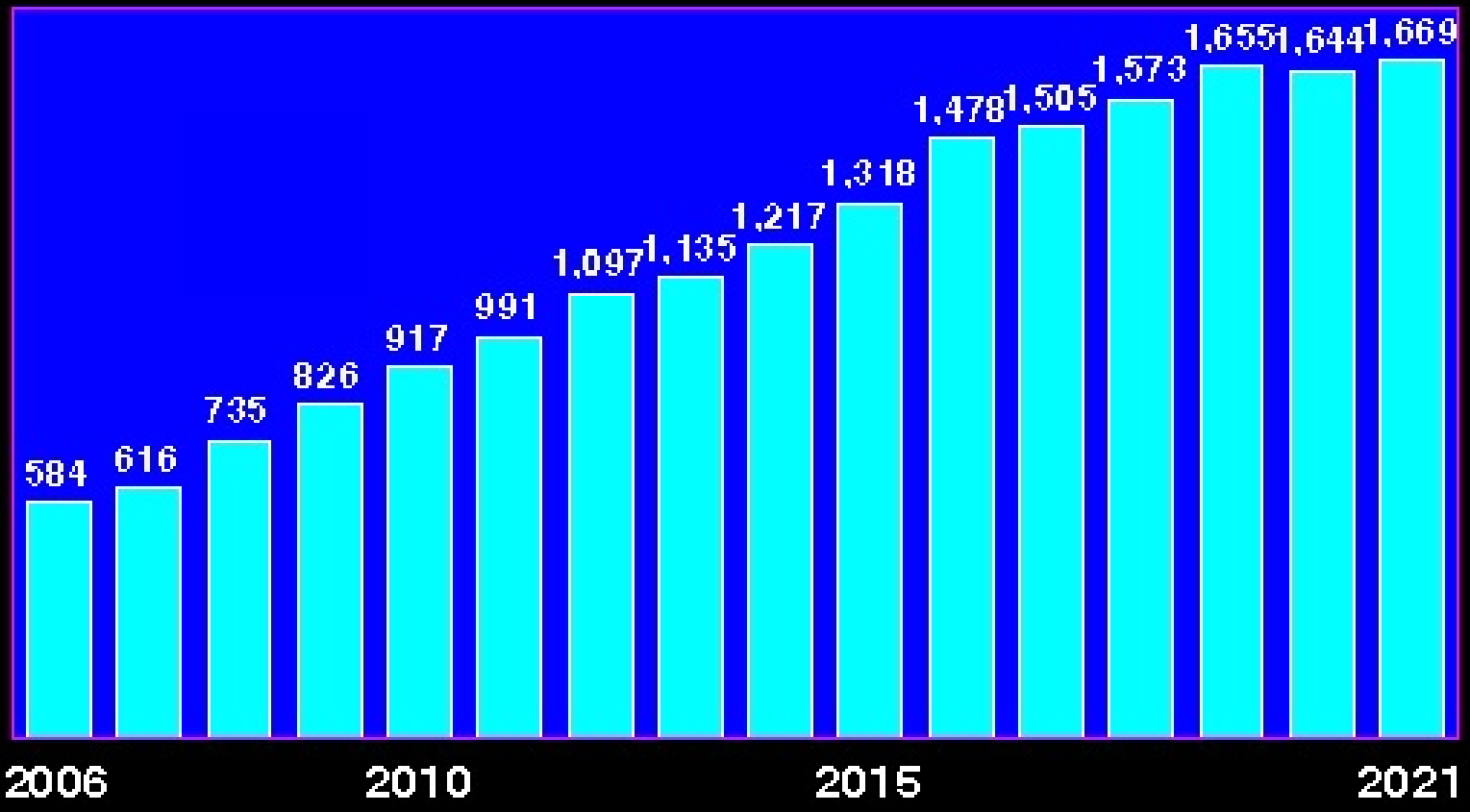
Source: NEJM May 2, 2013

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

Under-Insurance

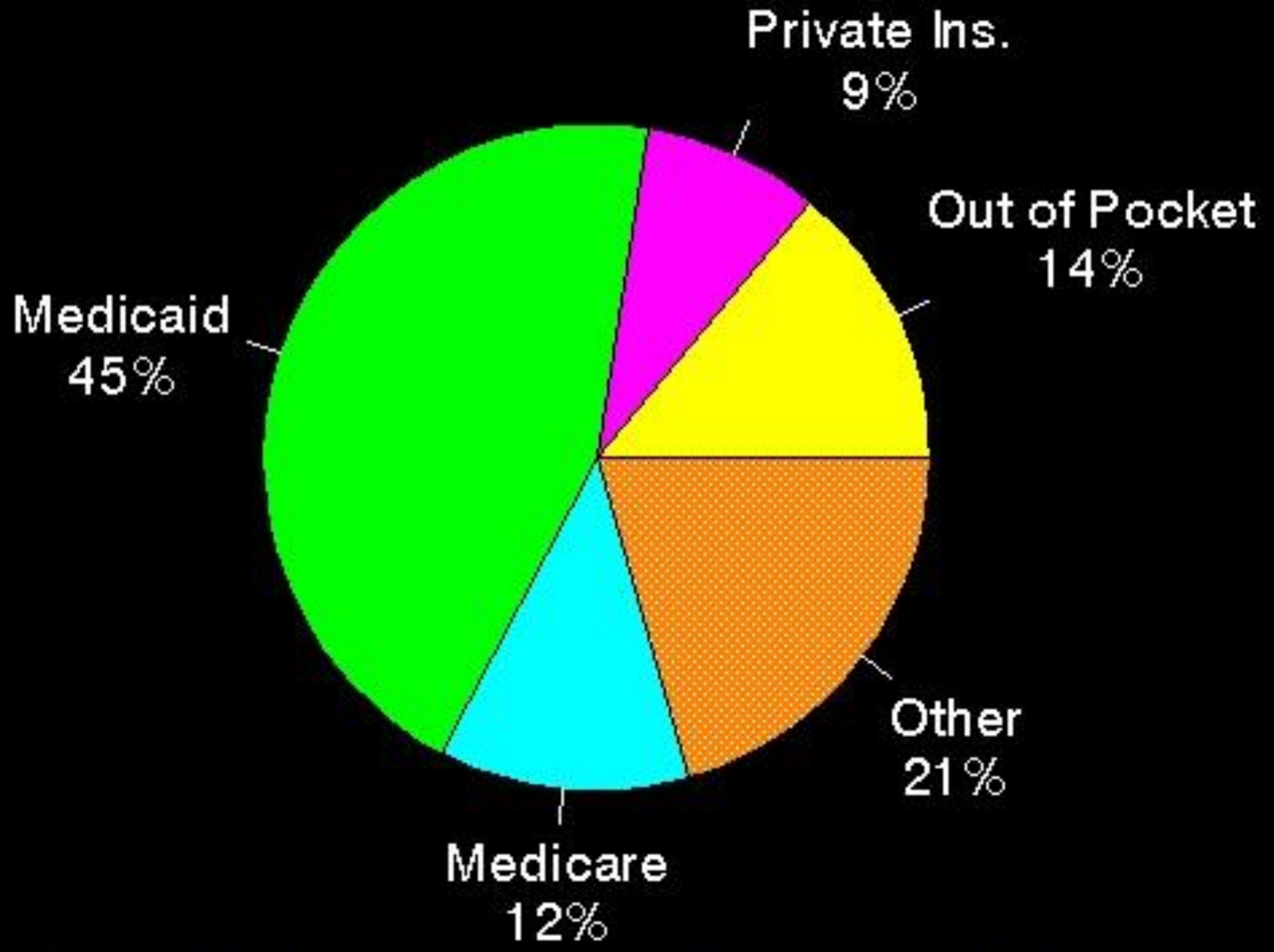
Average Deductible Rising

Average Deductible for Covered Workers, Single Coverage ($s)



Source: Kaiser/HRET Survey of Employer-Sponsored Benefits

Who Pays for Long Term Care?



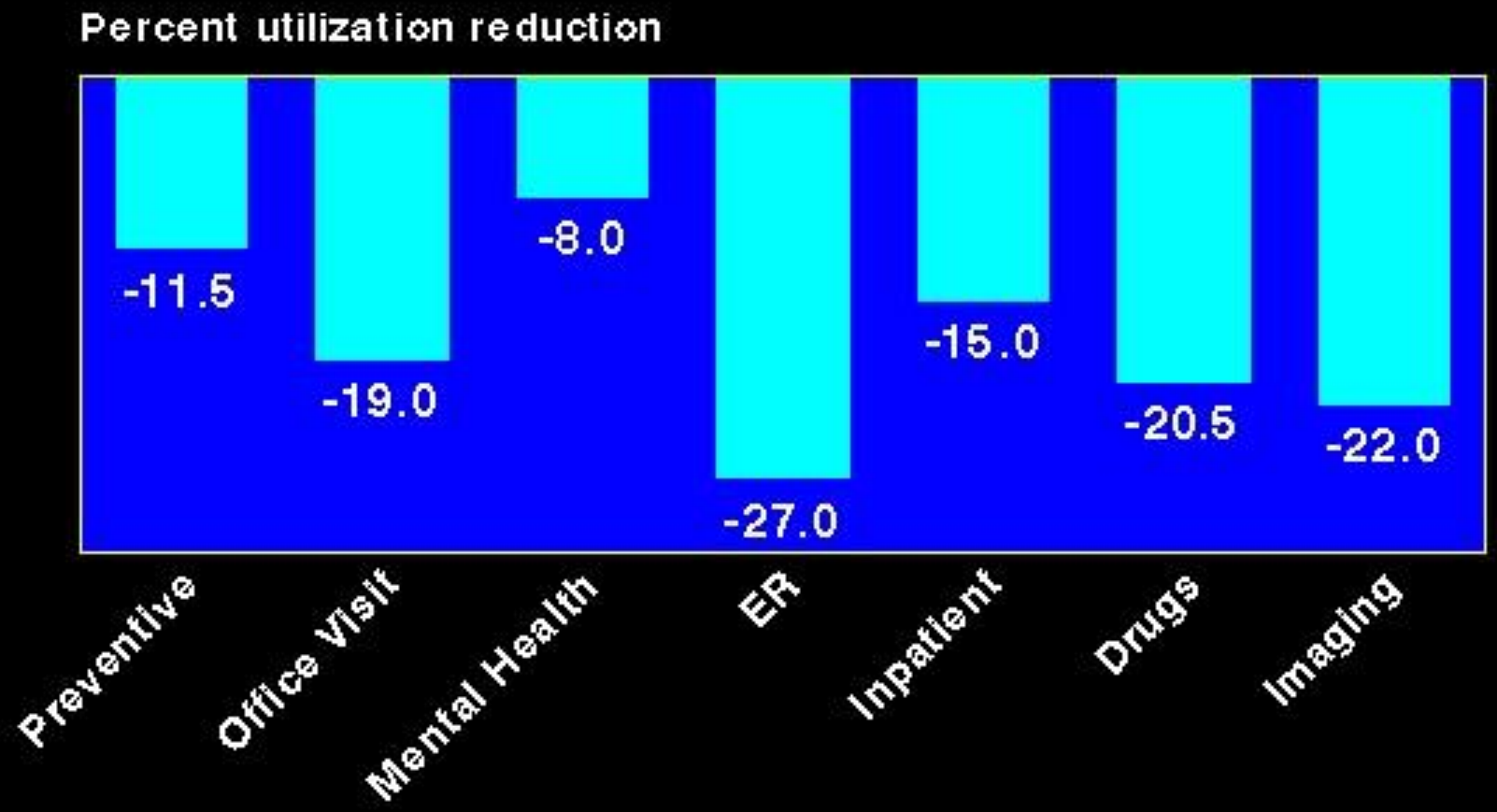
Source: NCHS - National Health Expenditure Accounts - Data are for 2021
Note - Includes spending for NHs + Home care + "other residential and personal care"

Under-Insurance Impedes Care, Worsens Health

High Deducticles Cut All Kinds of Care

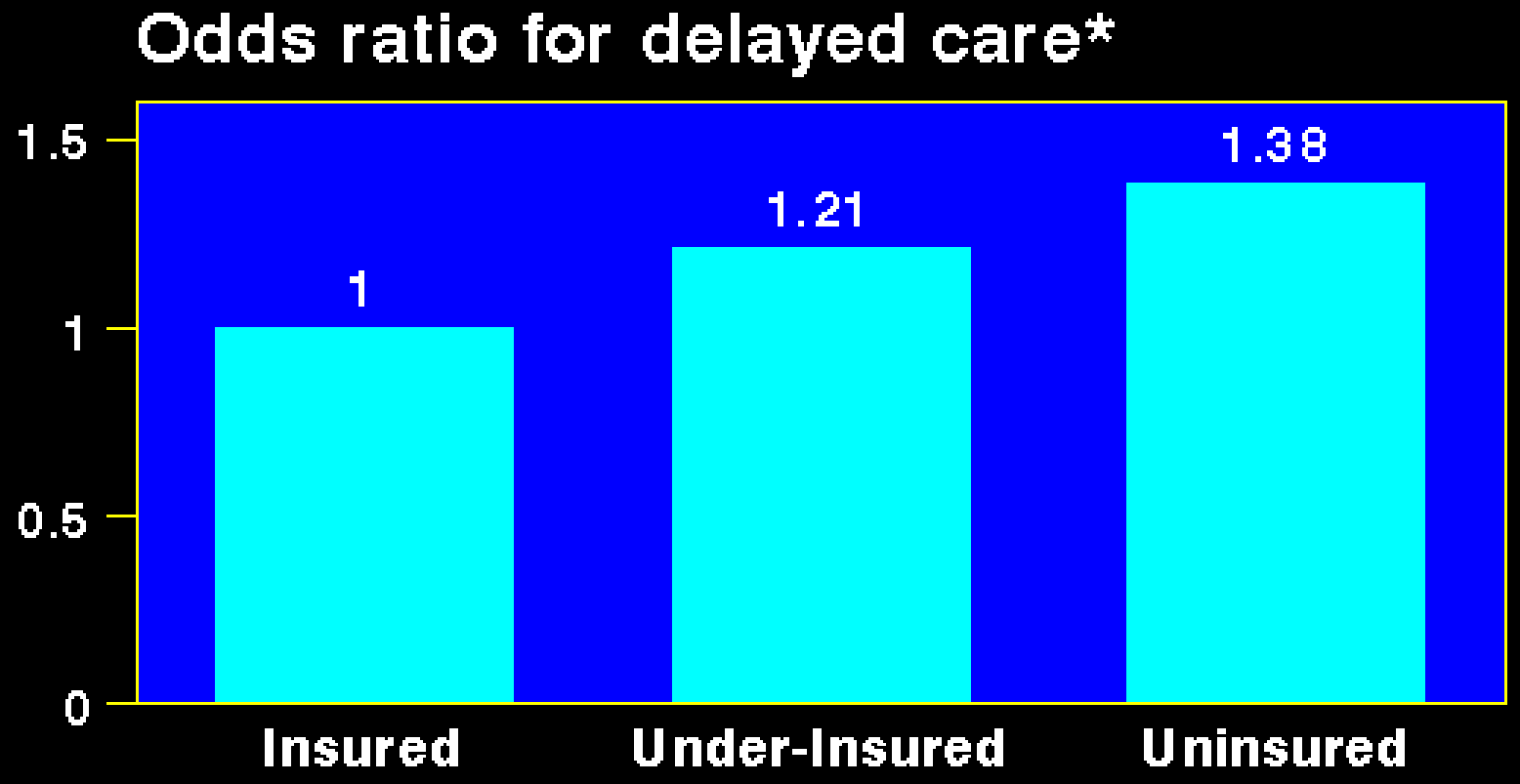
150,000 Employees Lost "Cadillac" Coverage

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

Uninsured and Under-Insured Delay Seeking Care for Heart Attacks



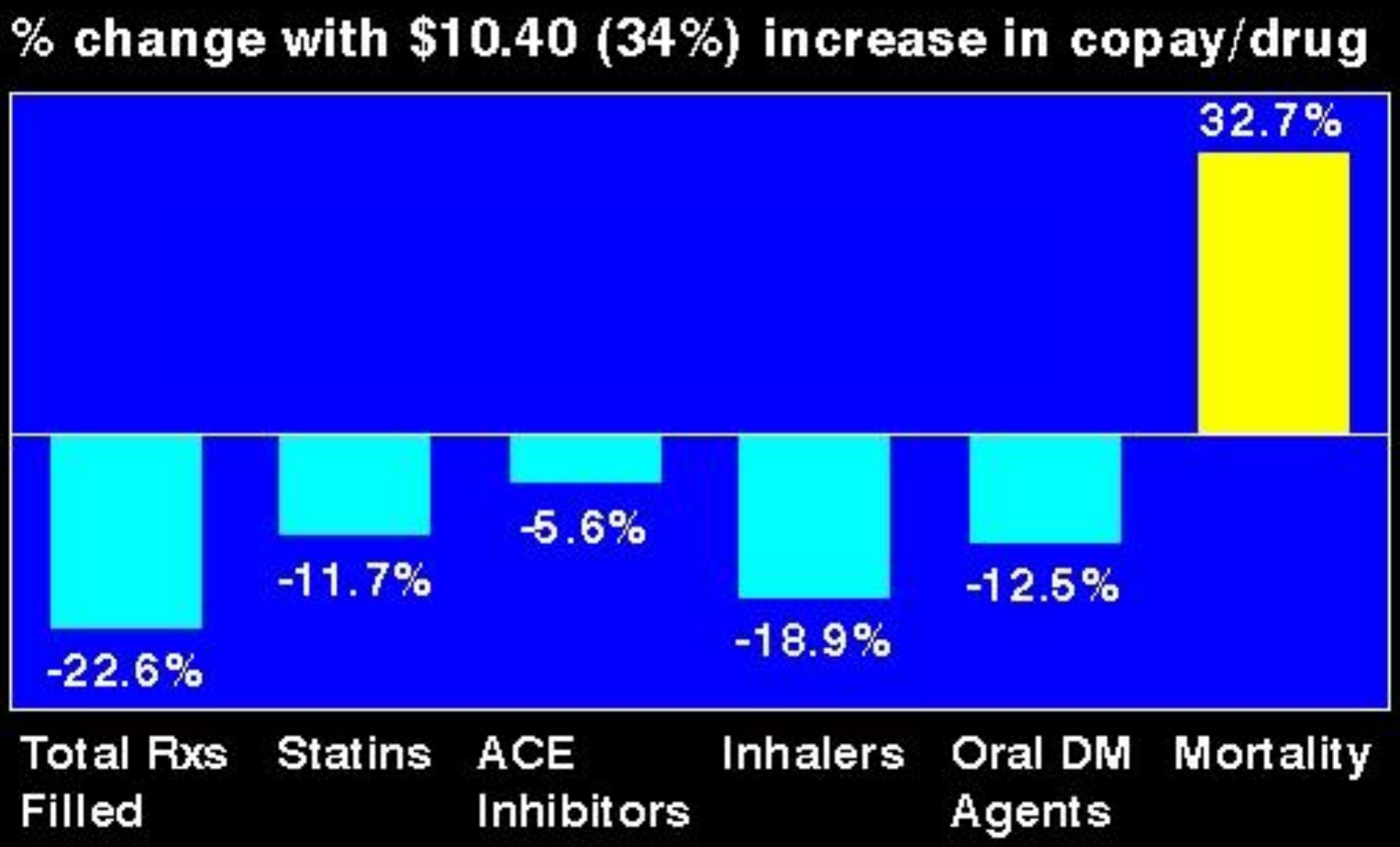
Source: JAMA April 15, 2010:303:1392

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

Under-insured = Had coverage but patient concerned about cost

Drug Copayments Kill

Quasi-Experimental Analysis of Medicare Part D Copays



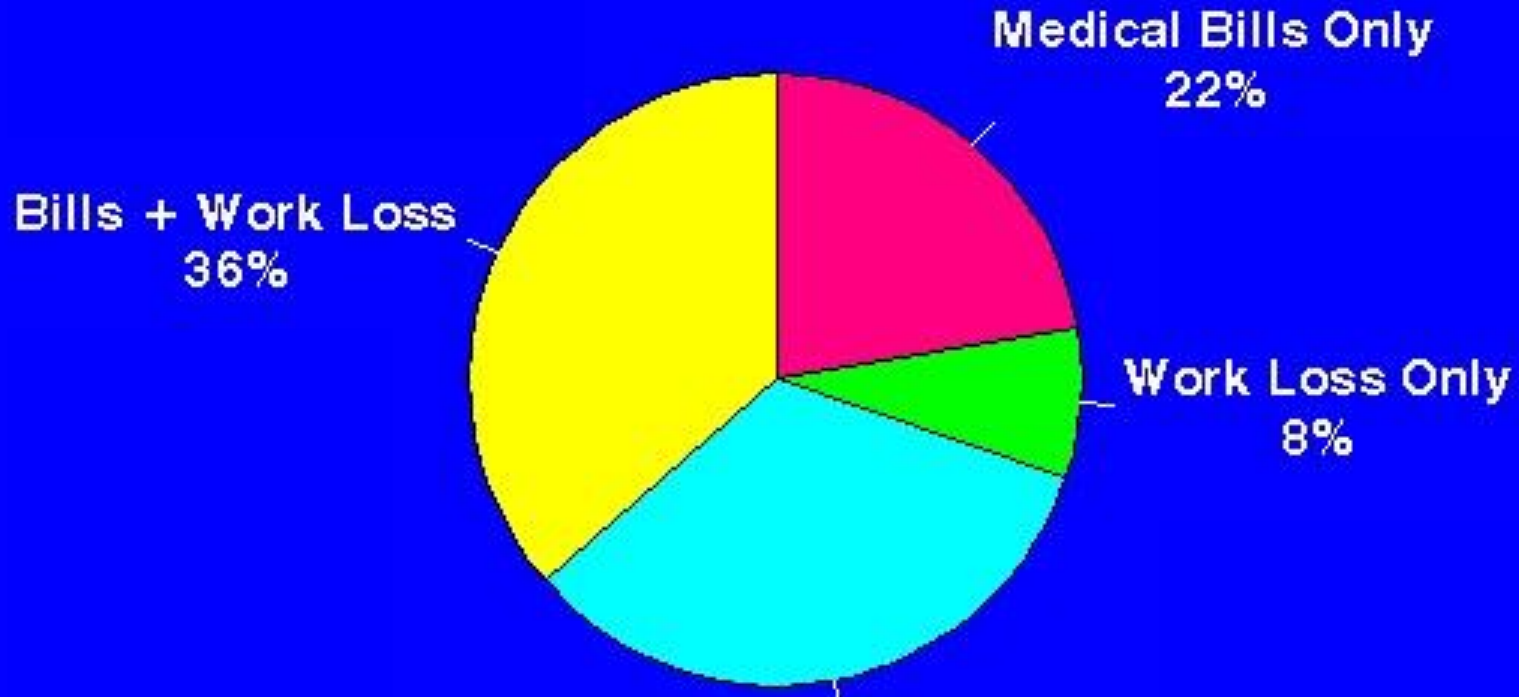
Source: "The Health Costs of Cost Sharing) NBER #28439, February, 2021

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

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

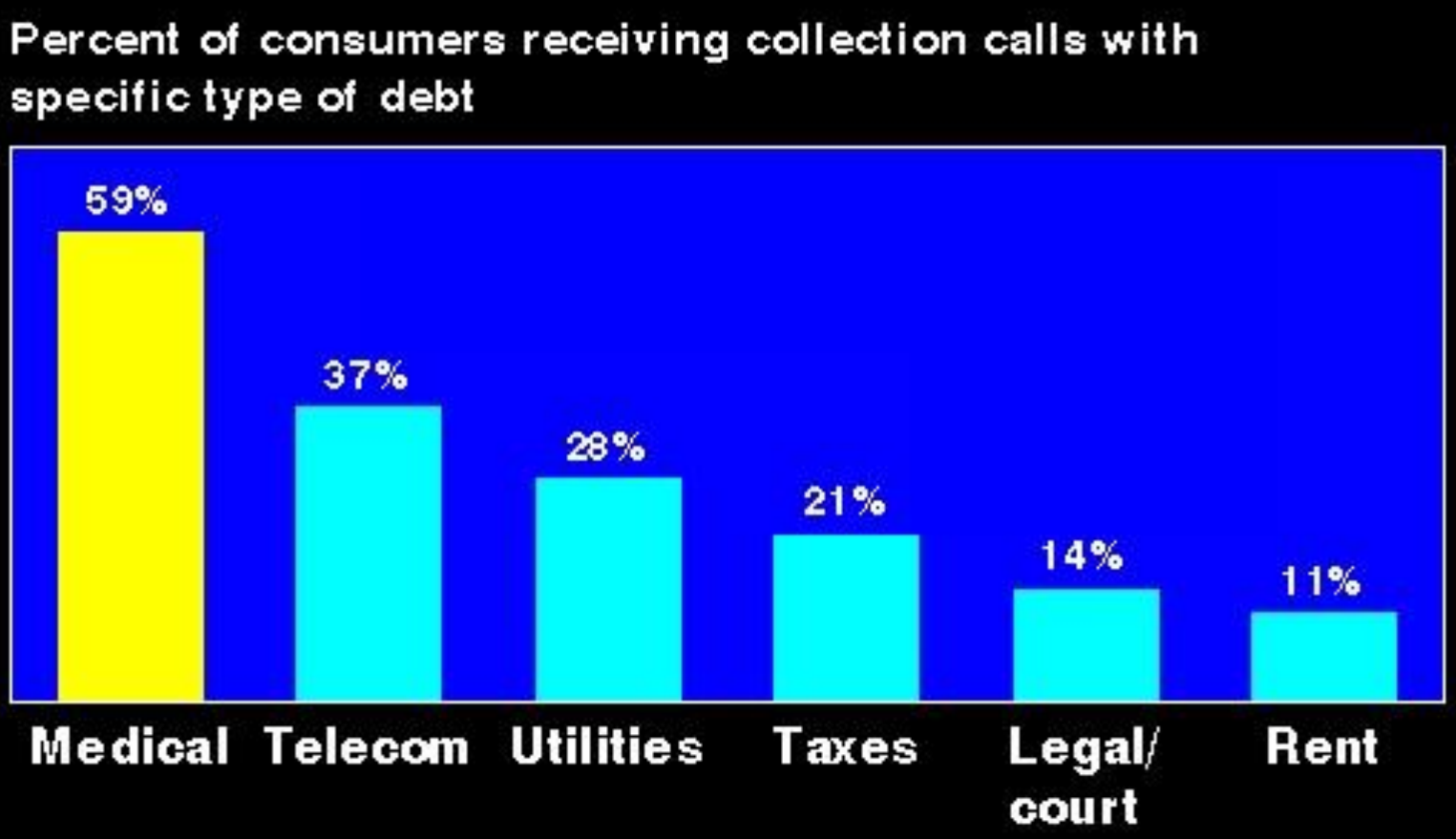
2/3 of Bankruptcy Filers Cite Medical Bills or Illness-Related Work Loss as a Cause

National Survey of Debtors, 2013-2016



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

Medical Bills are Most Common Reason for Collection Calls

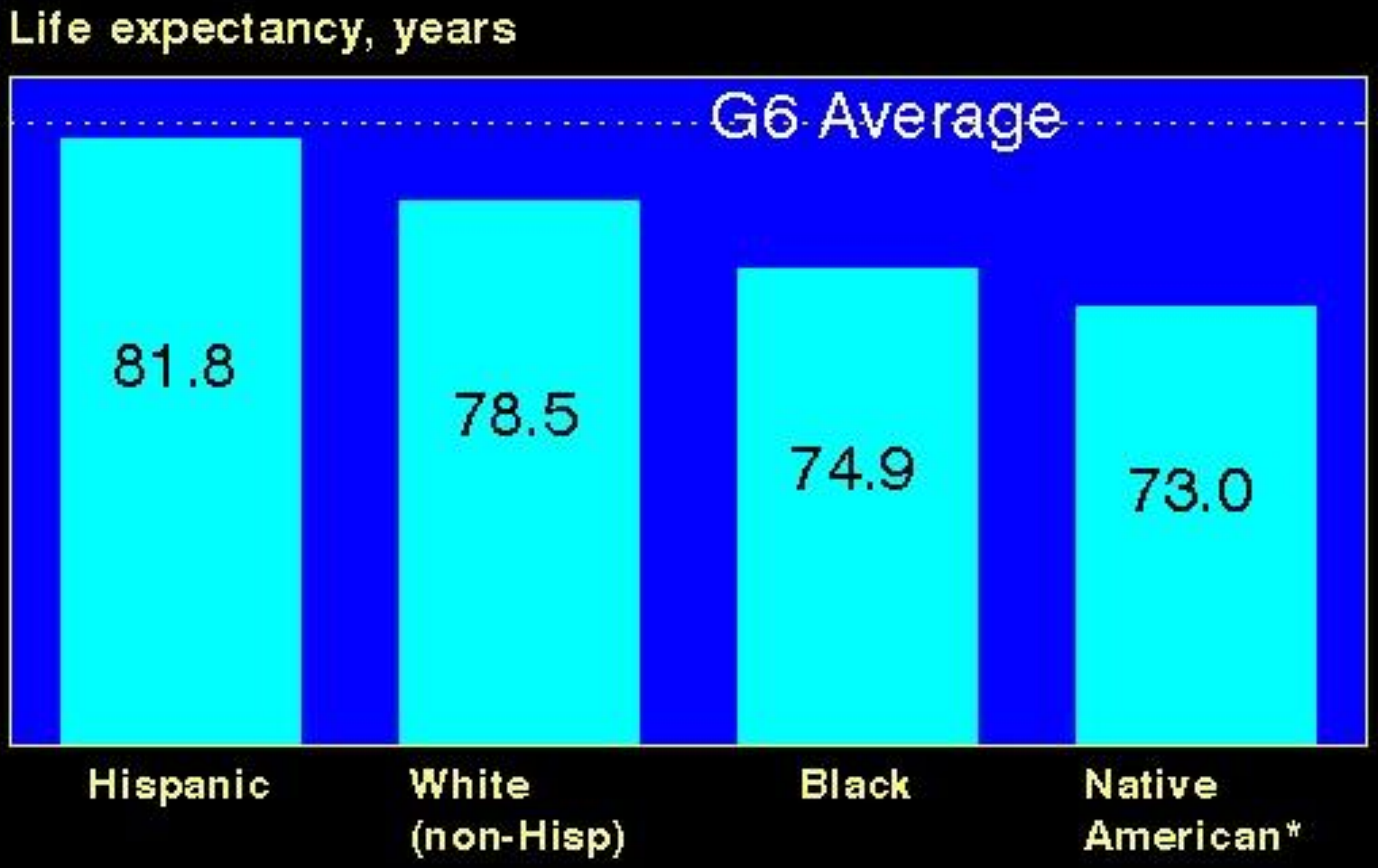


Source: Consumer FInancial Protection Bureau, January, 2017
Note: Medical collection calls were the only category which did not differ by income

Racism Harms Health

Black and Native Americans Die Younger

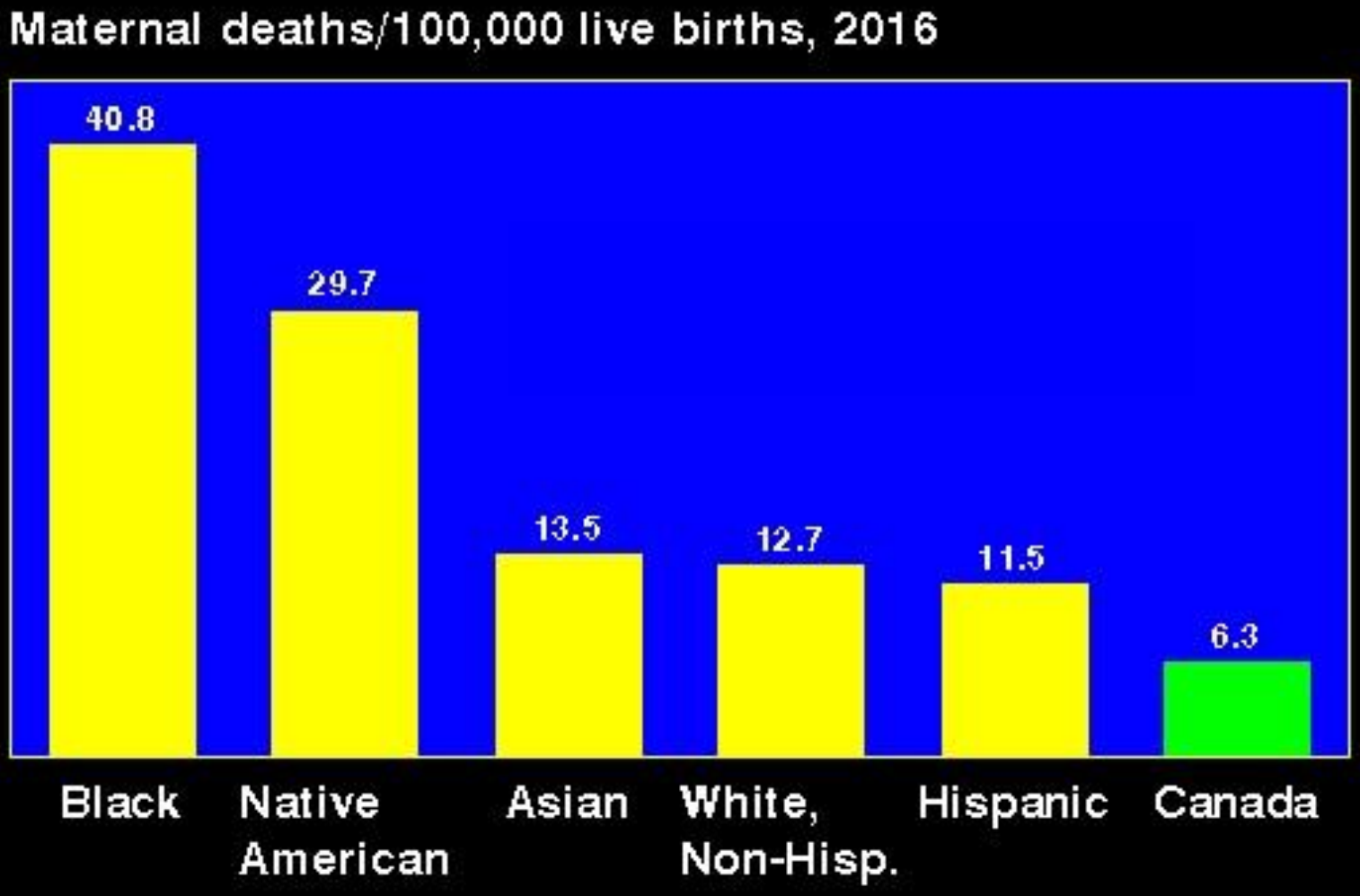
But Life Expectancy for Every Group is Shorter Than Other G7 Nations



Source: NCHS, IHS, OECD
Other G7 nations = Canada, France, Germany, Italy, Japan, UK

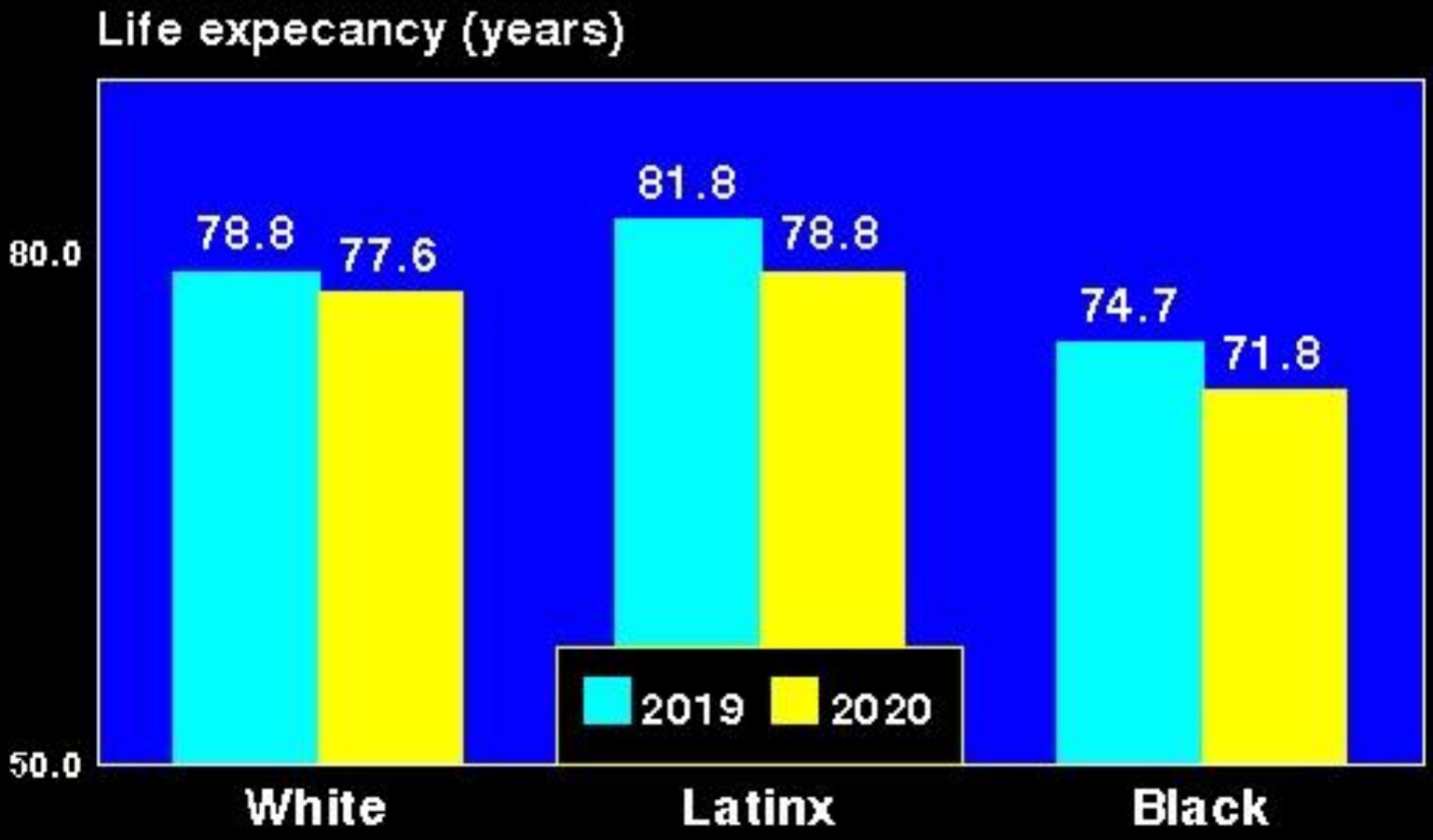
Race/Ethnicity and Maternal Mortality

Every Group in the US Does Worse than Canadians



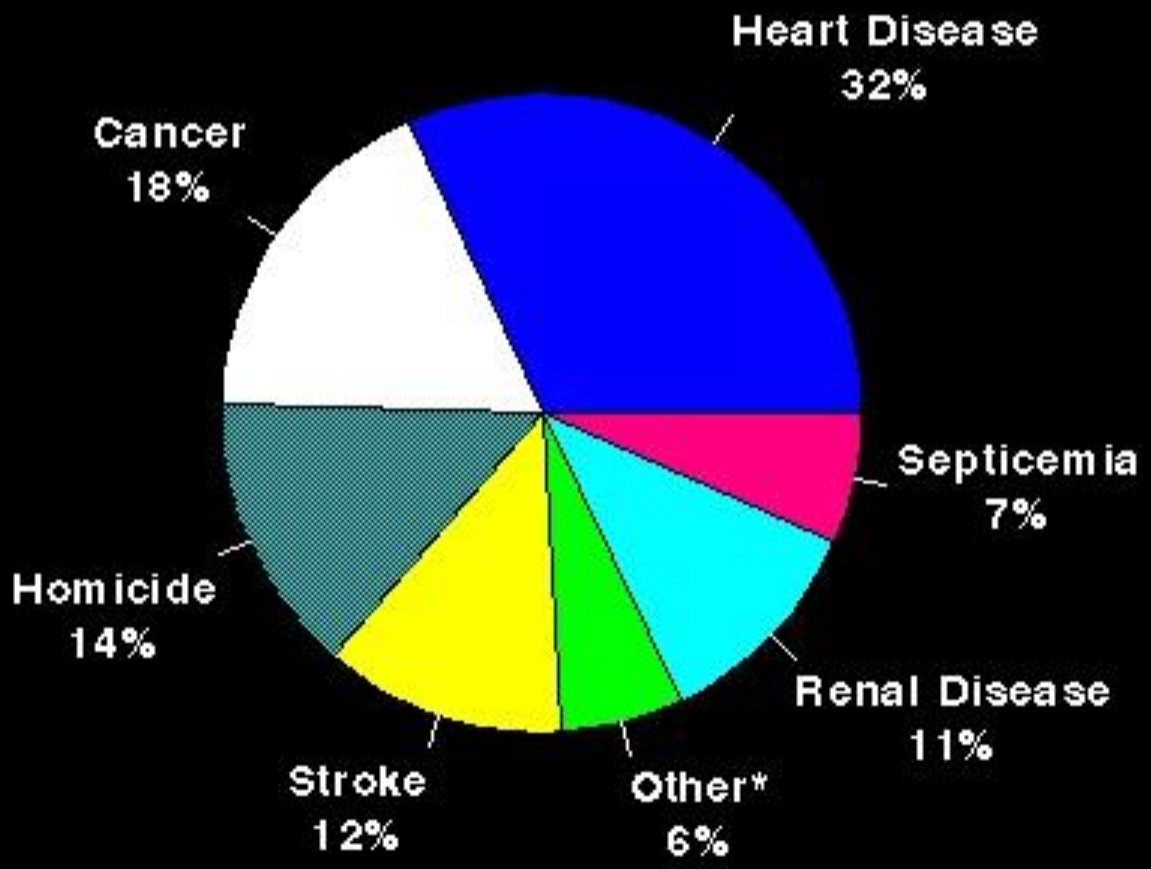
Source: MMWR September, 2019 and OECD

COVID-19 Has Sharply Reduced Black and Latinx Life Expectancy



Source: NCHS, 2021

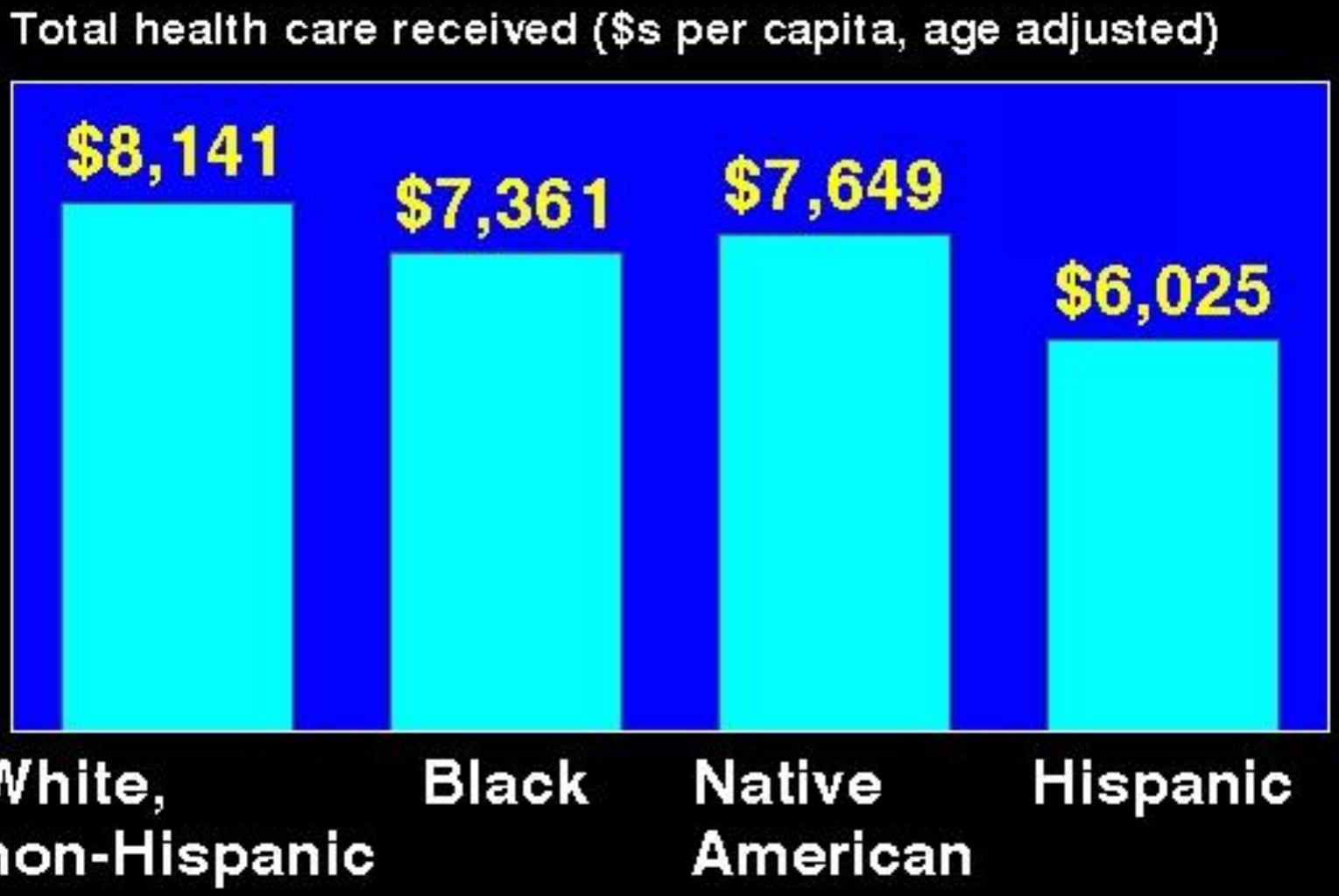
Causes of Black/White Disparity in Adult Mortality



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

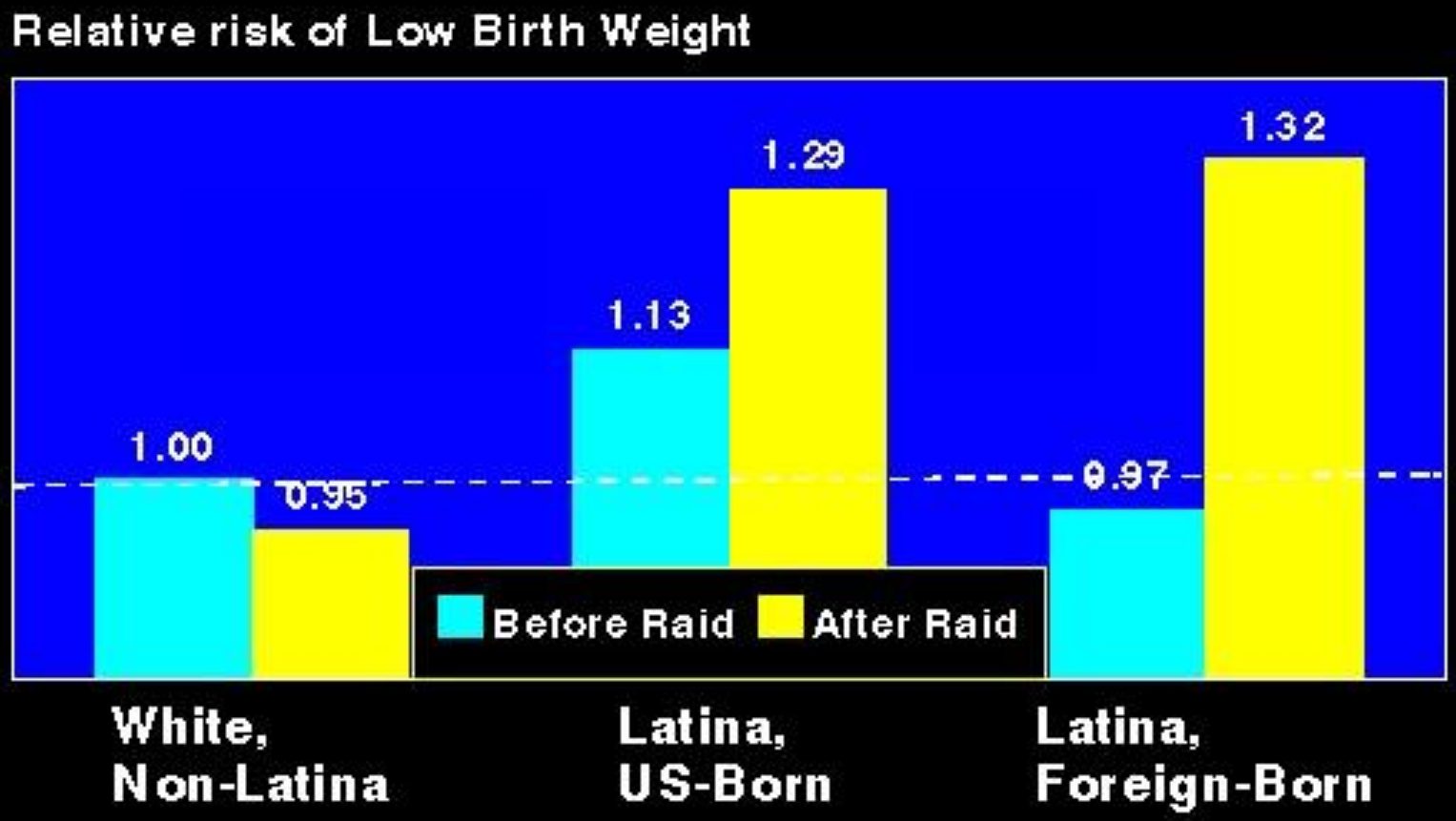
People of Color Get Less Care



Source: JAMA 2021;326:649-59

Protecting Immigrants' Right to Health Care

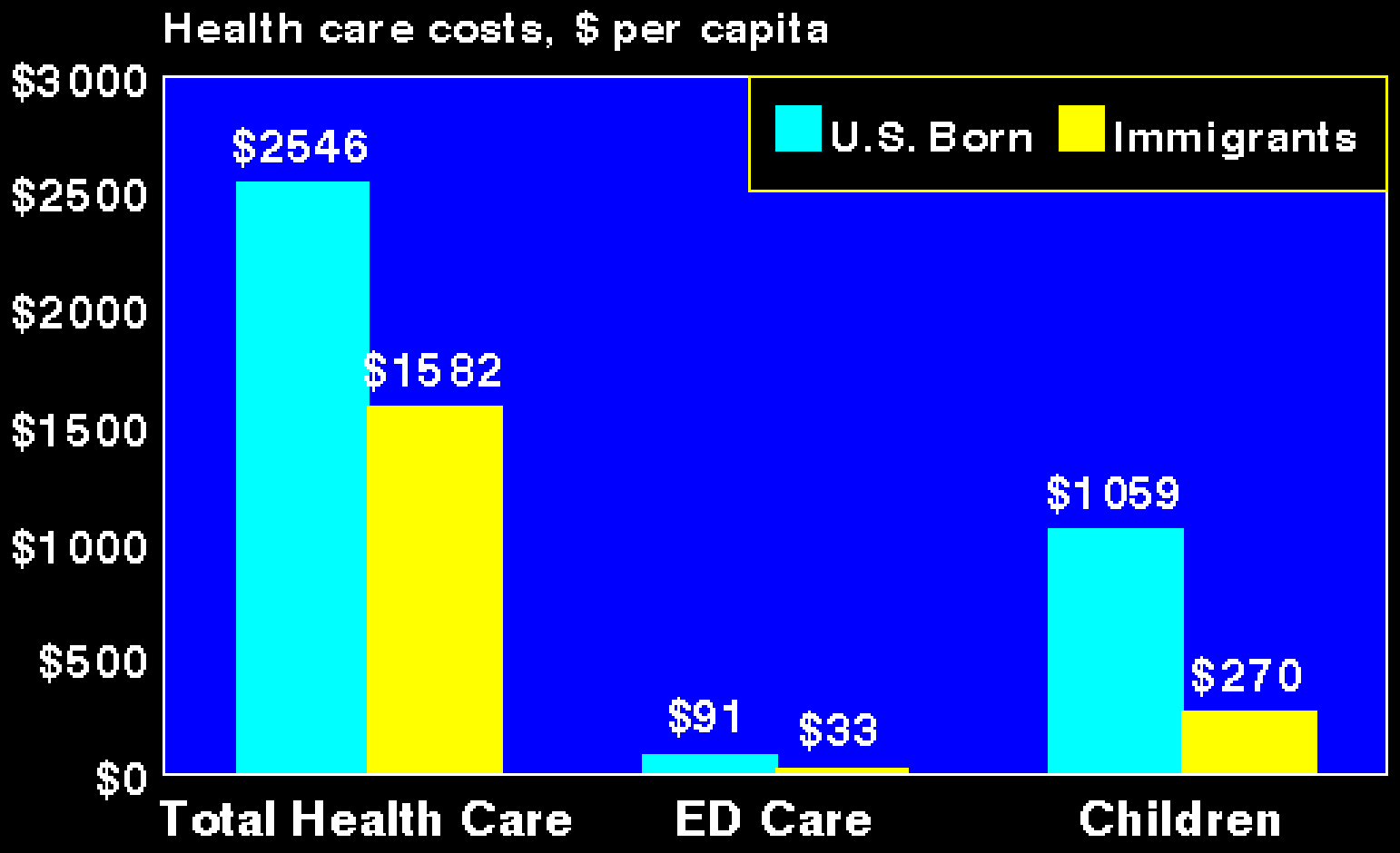
Low Birth Weight Increased In Iowa After A Massive Immigration Raid



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

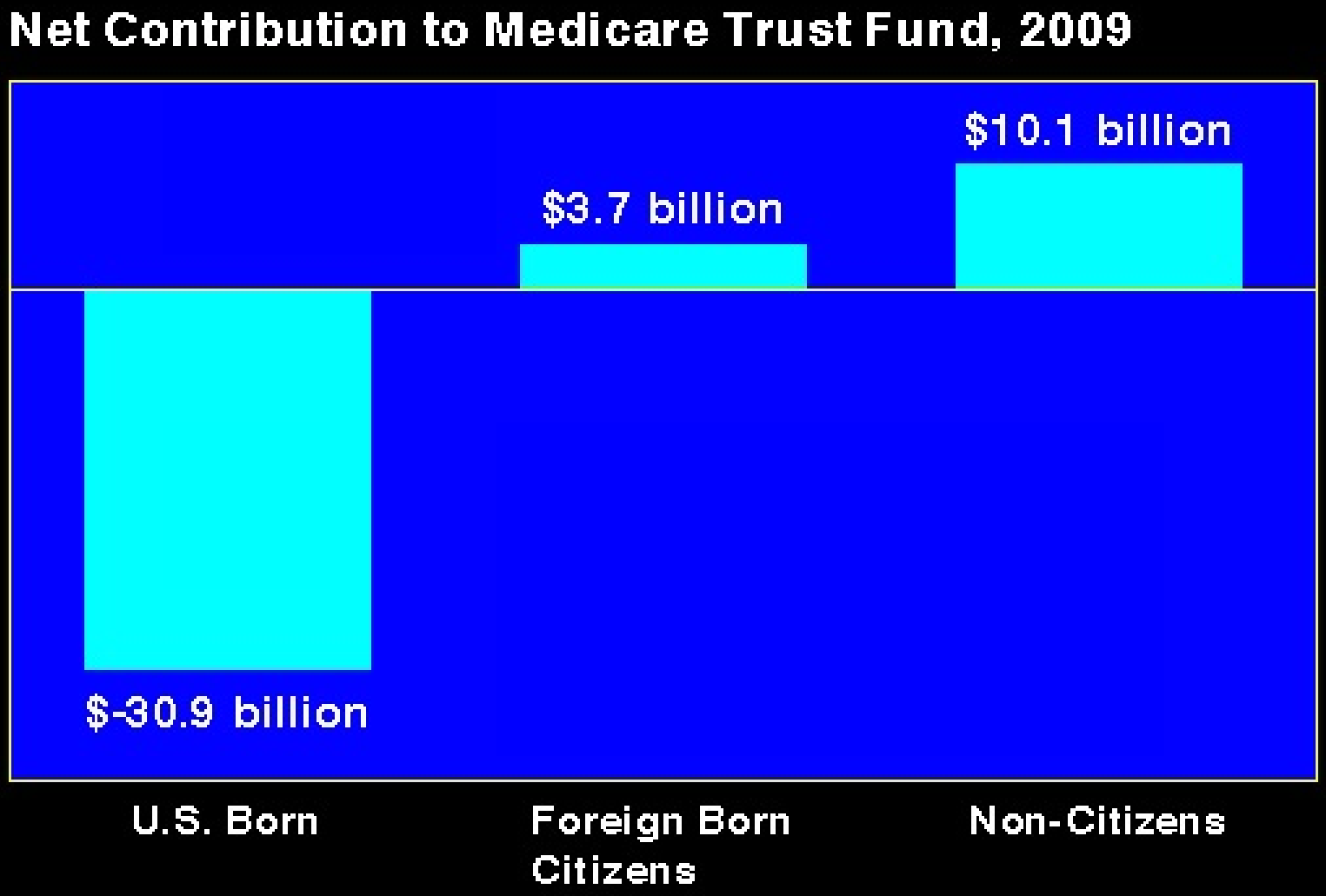
Immigrants Get Little Care



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

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

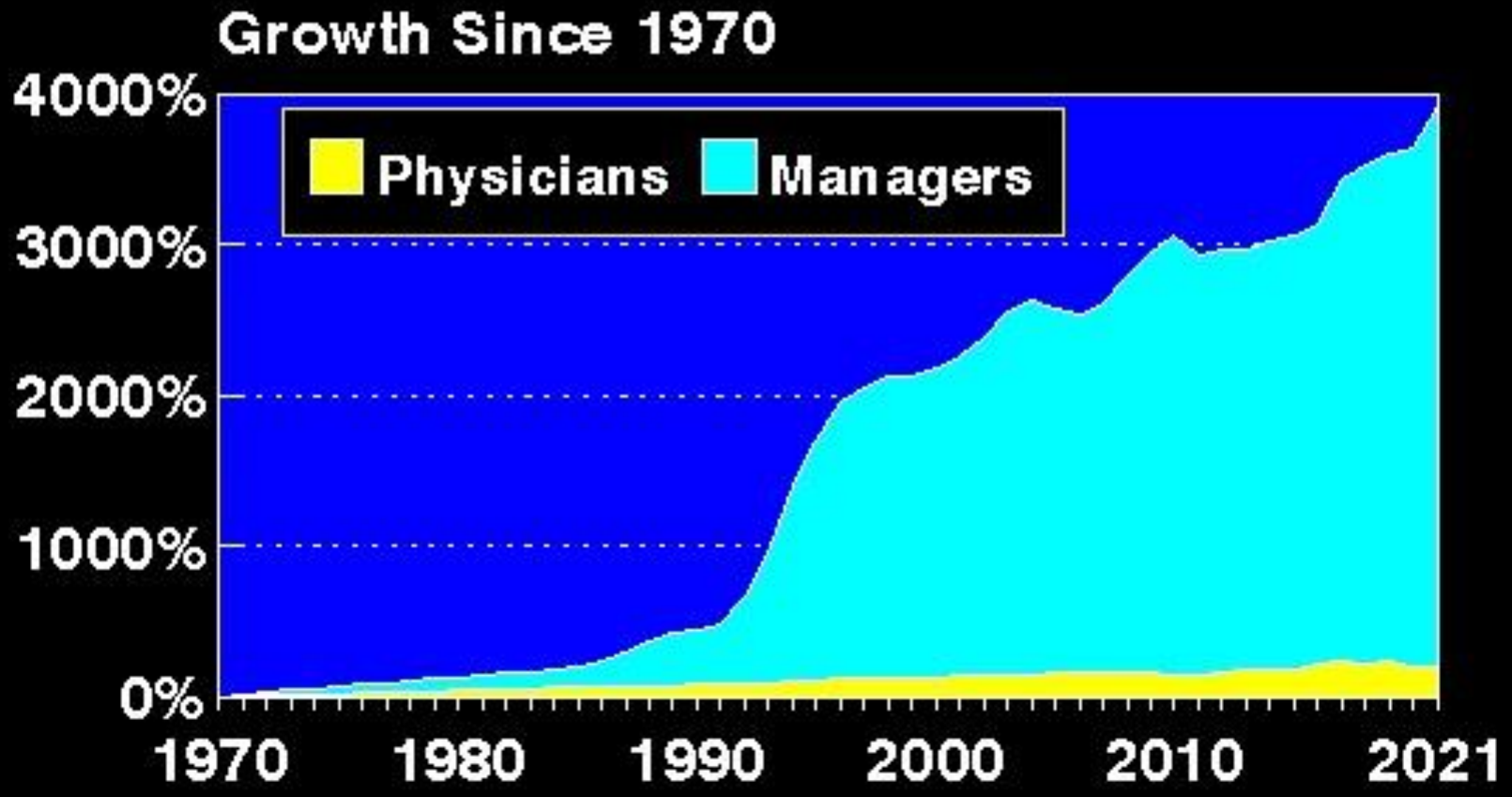
Immigrants Keep Medicare Afloat



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

Administrative Overhead Rising

Growth of Physicians and Administrators 1970-2021



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

Investor-Owned Care: Inflated Costs, Inferior Quality

Health Industry Profits, 2020

Pharmaceuticals	$52.4 bil
Insurers	$26.2 bil
Pharmacy/Lab/Benefit Mgr.	$19.7 bil
Equipment/Supplies	$11.5 bil
Providers	$6.7 bil
Distributors/Wholesalers	$6.4 bil

Source: Fortune 500, 2021

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

For-Profit Hospitals Cost 19% More

Source: CMAJ 2004;170:1817

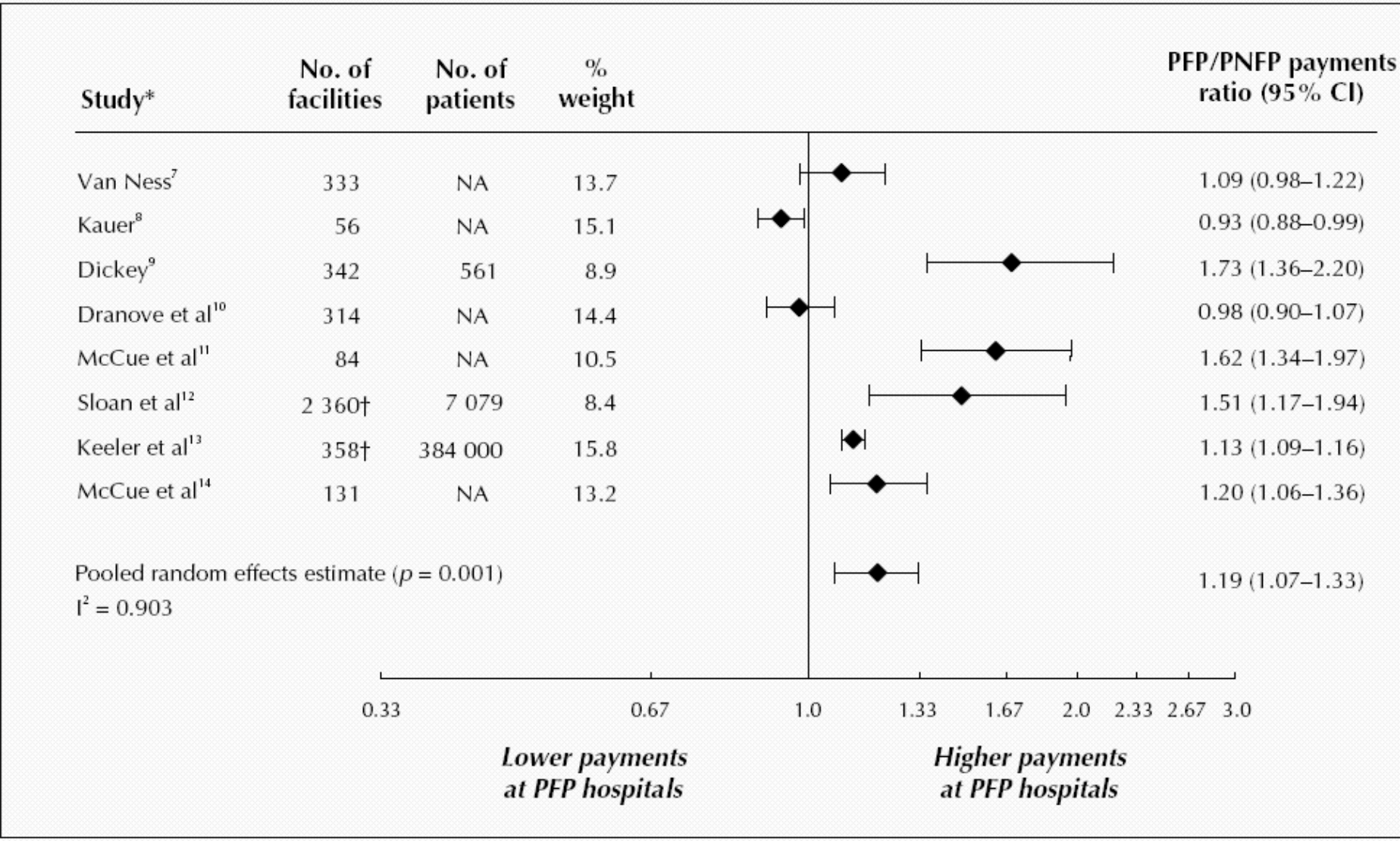
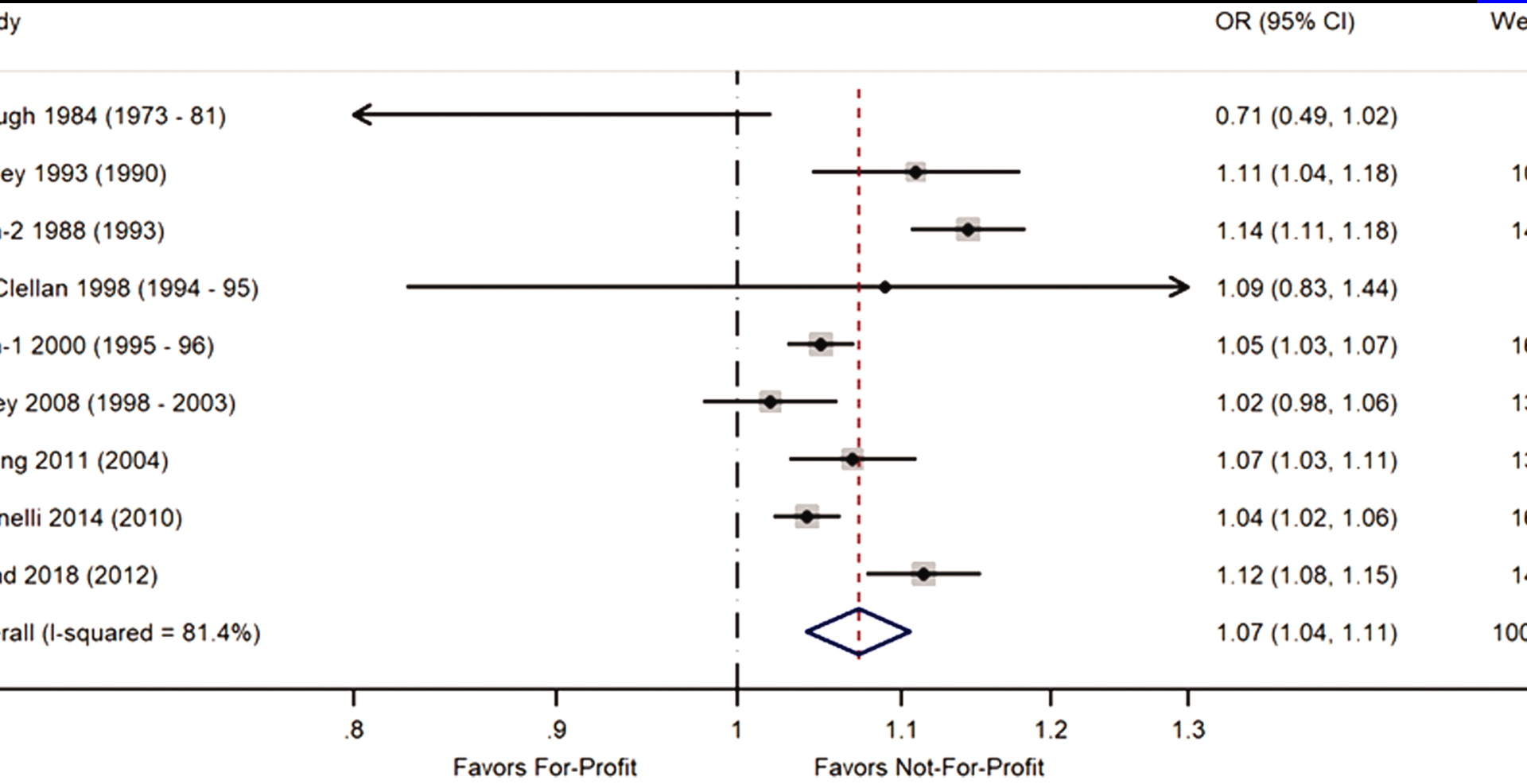


Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.
*The studies are in chronological order by midpoint of the data collection period. †Approximation from investigator.

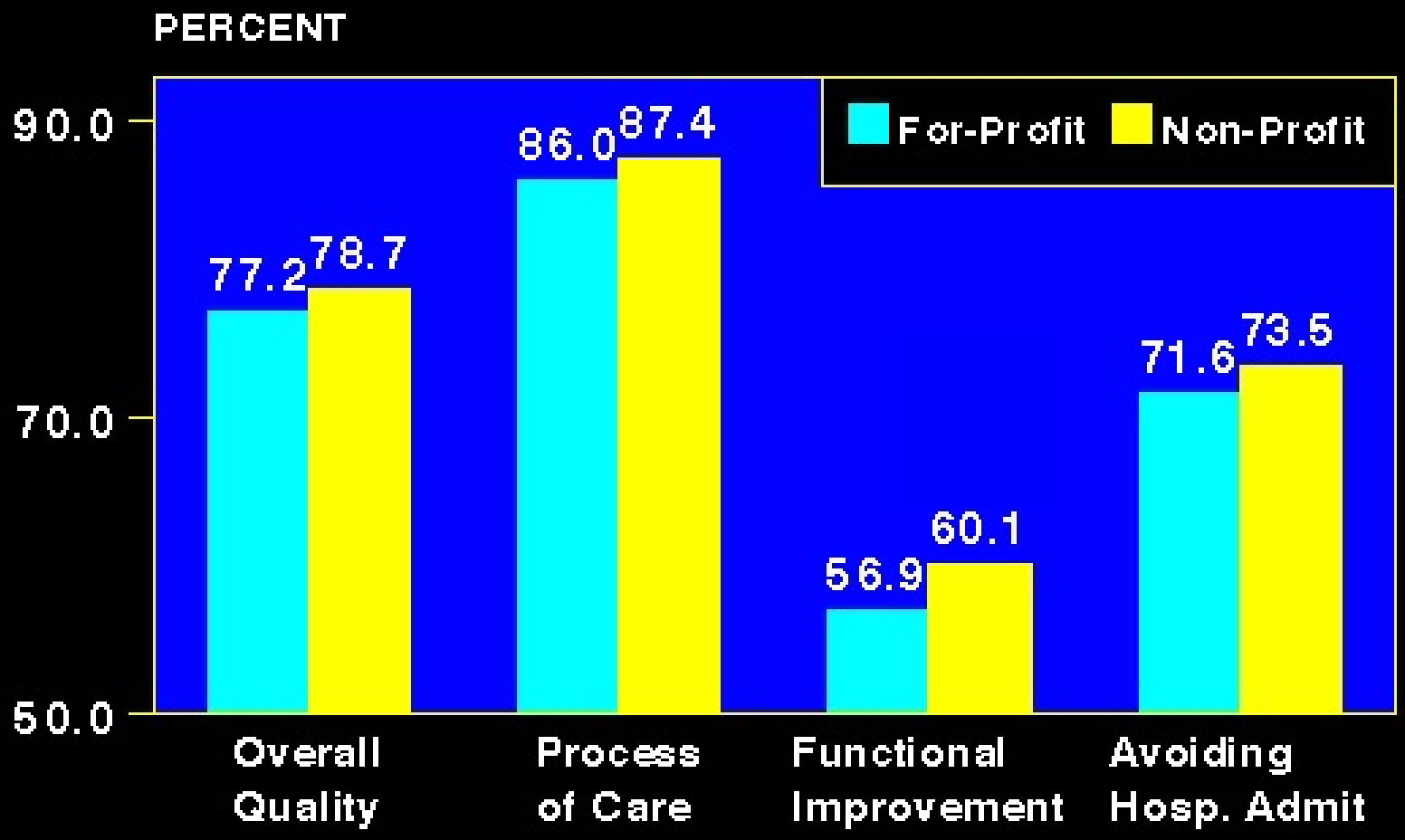
For-Profit Dialysis Clinics' Death Rates are 7% High

3800 Excess Death Annually



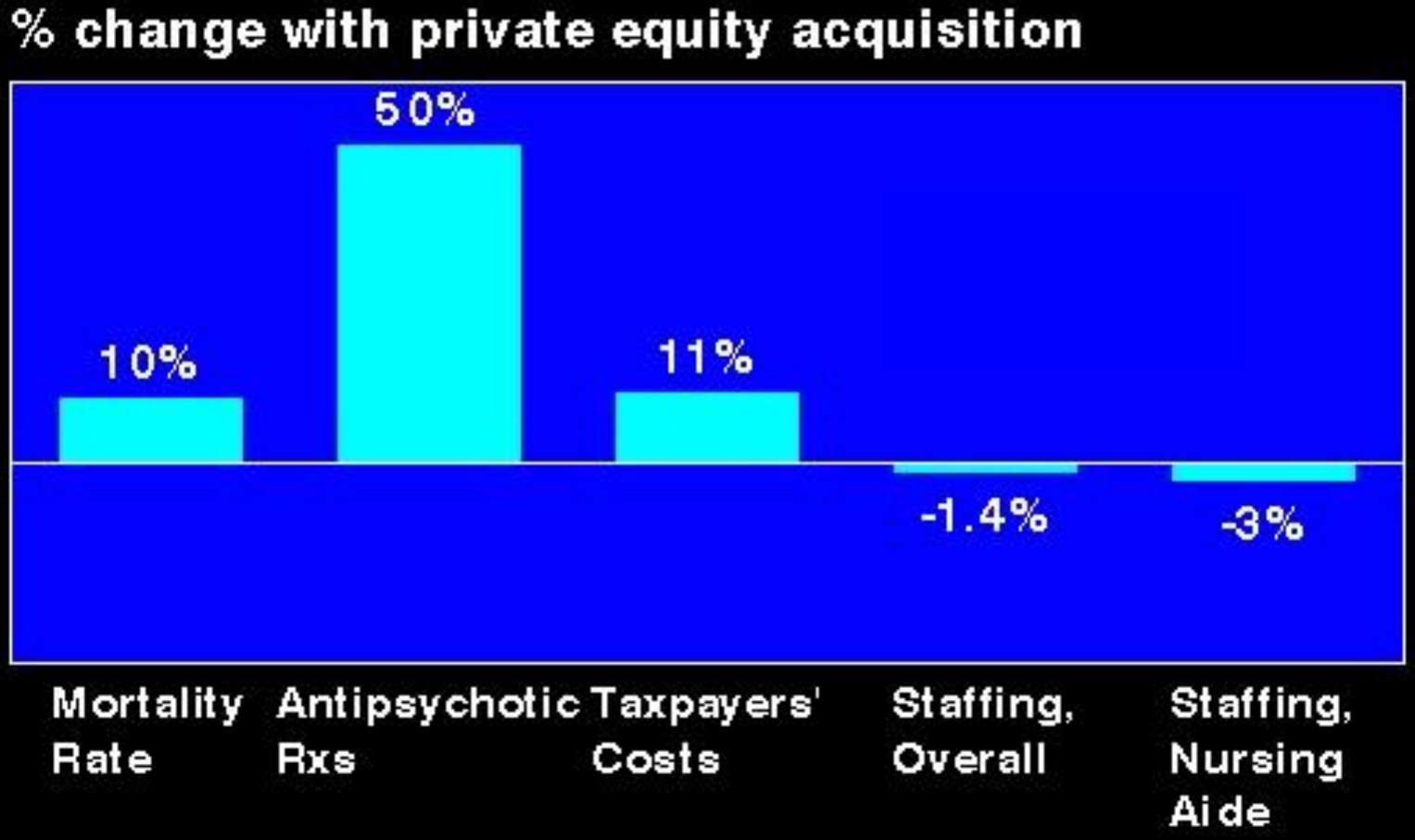
Source: Dickman, Mirza et al. Int J Health Serv 2021;51:371

For Profit Home Care: Lower Quality



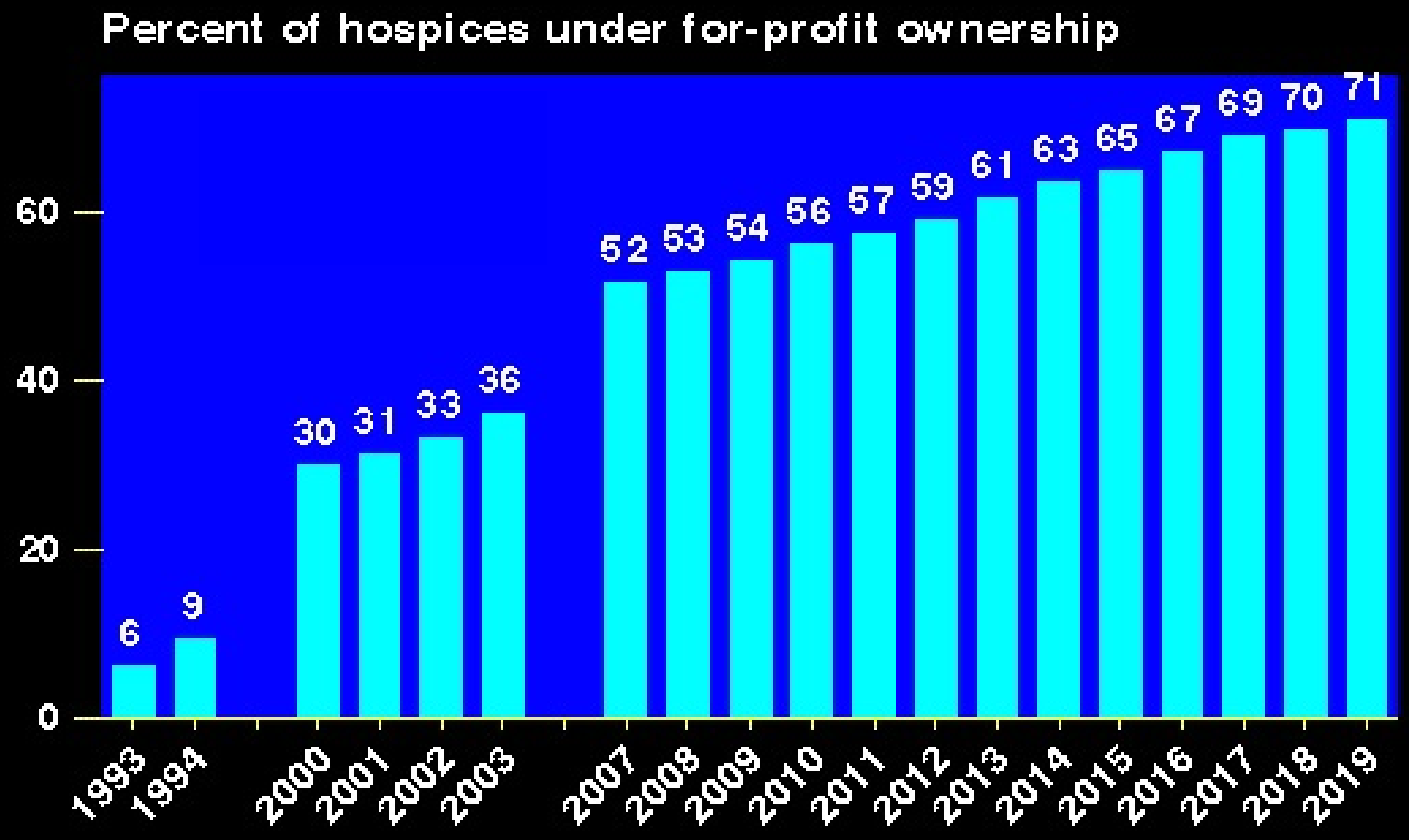
Source: Cabin, Siman, Himmelstein & Woolhandler, Health Affairs 8/2014

Private Equity Nursing Home Takeovers Harm Patients, Raise Costs



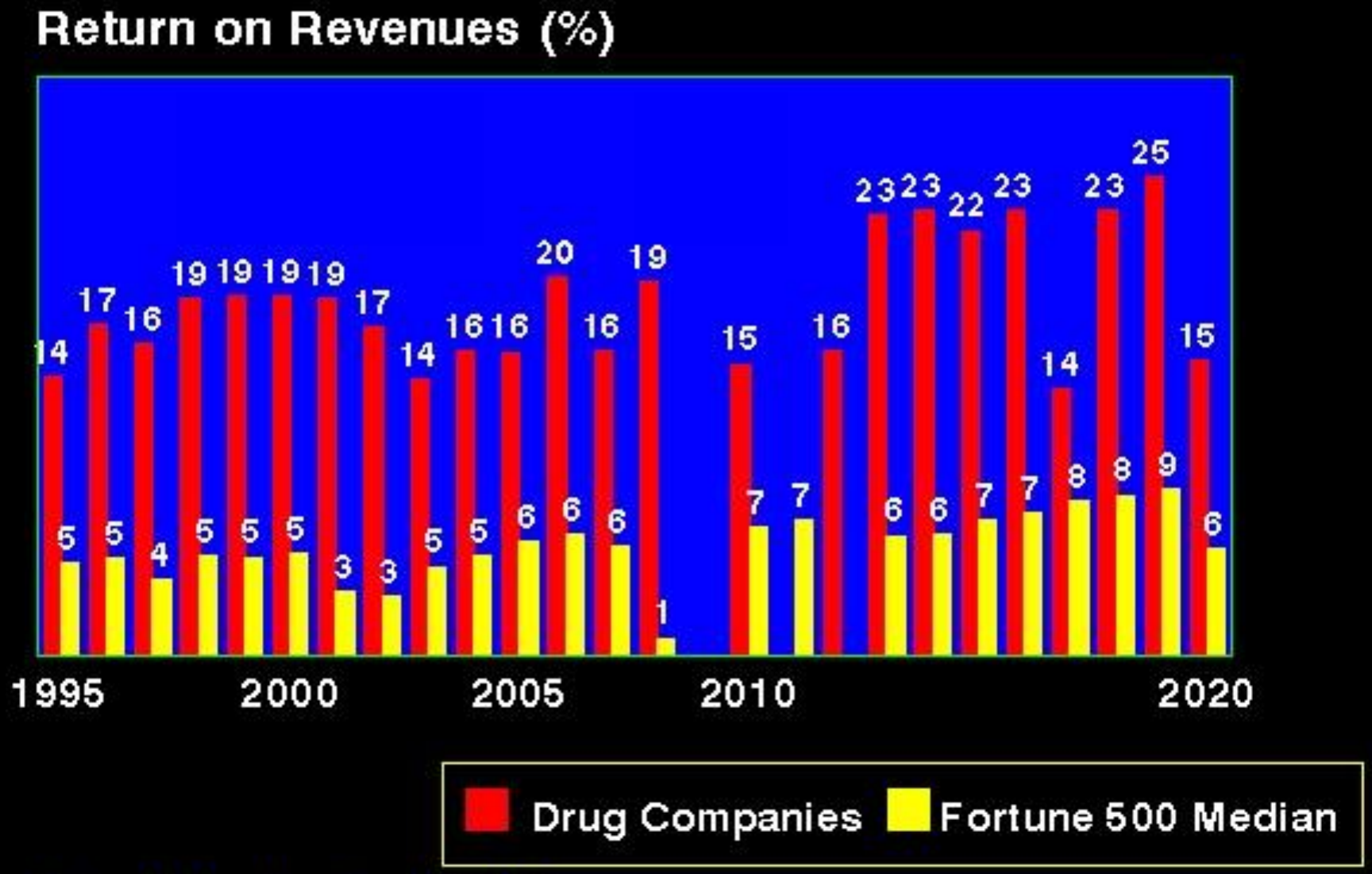
Source: "Does Private Equity Investment in Healthcare Benefit Patients" NBER #28474, February, 2021
Note: Study used a within-facility DinD analysis + instrumental variable control for pt. factors

Hospice Goes For-Profit



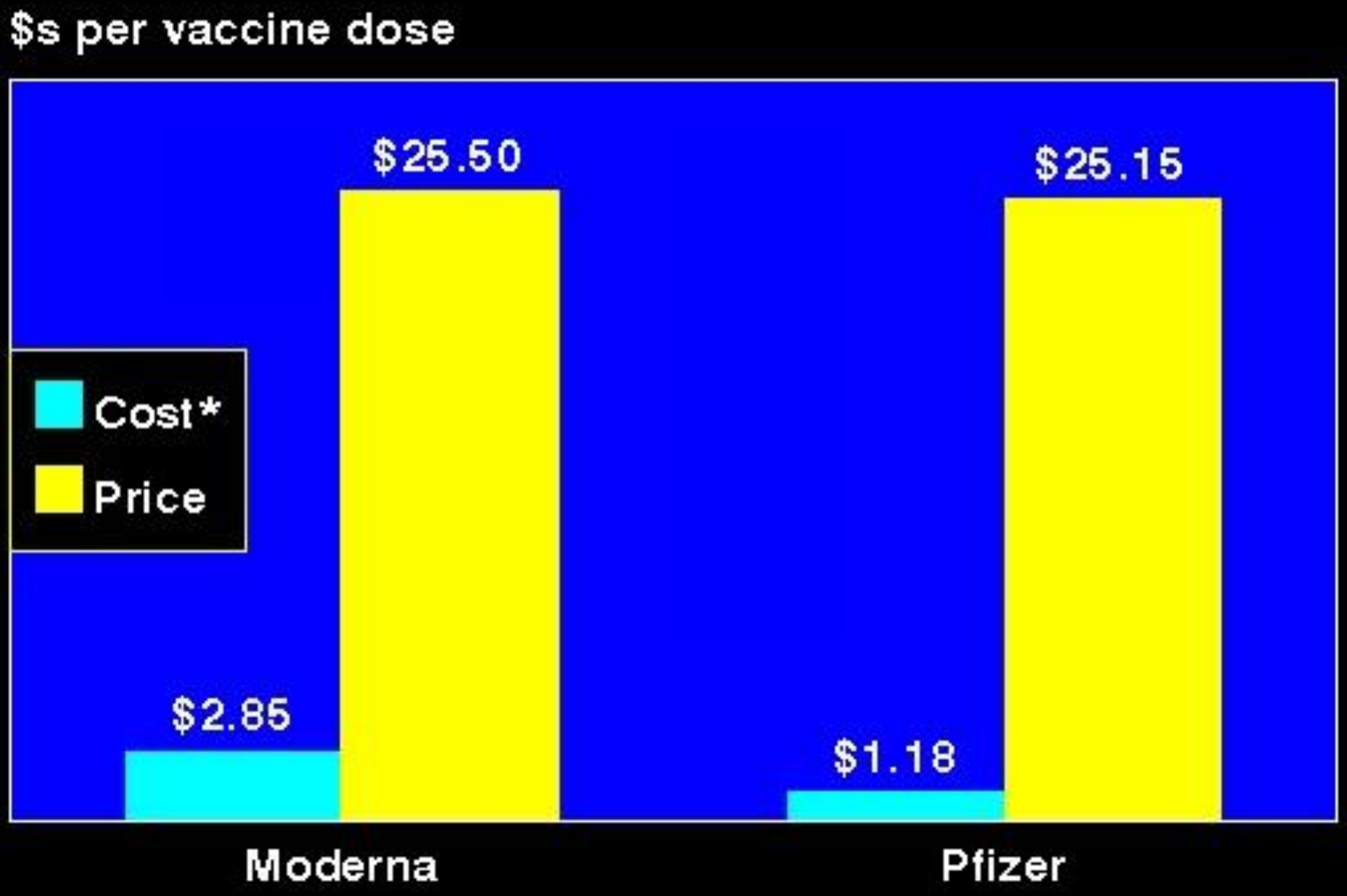
Source: MedPac Annual Report, 2021 and previous
Note: Profit rate: for-profits = 19.0%; non-profits = 3.8%
Mean LOS: for-profits = 112 days; non-profits = 71 days

Drug Company Profits, 1995-2020



Source: Fortune 500 rankings for 1995-2021

COVID-19 Vaccine Makers Jack Up the Price

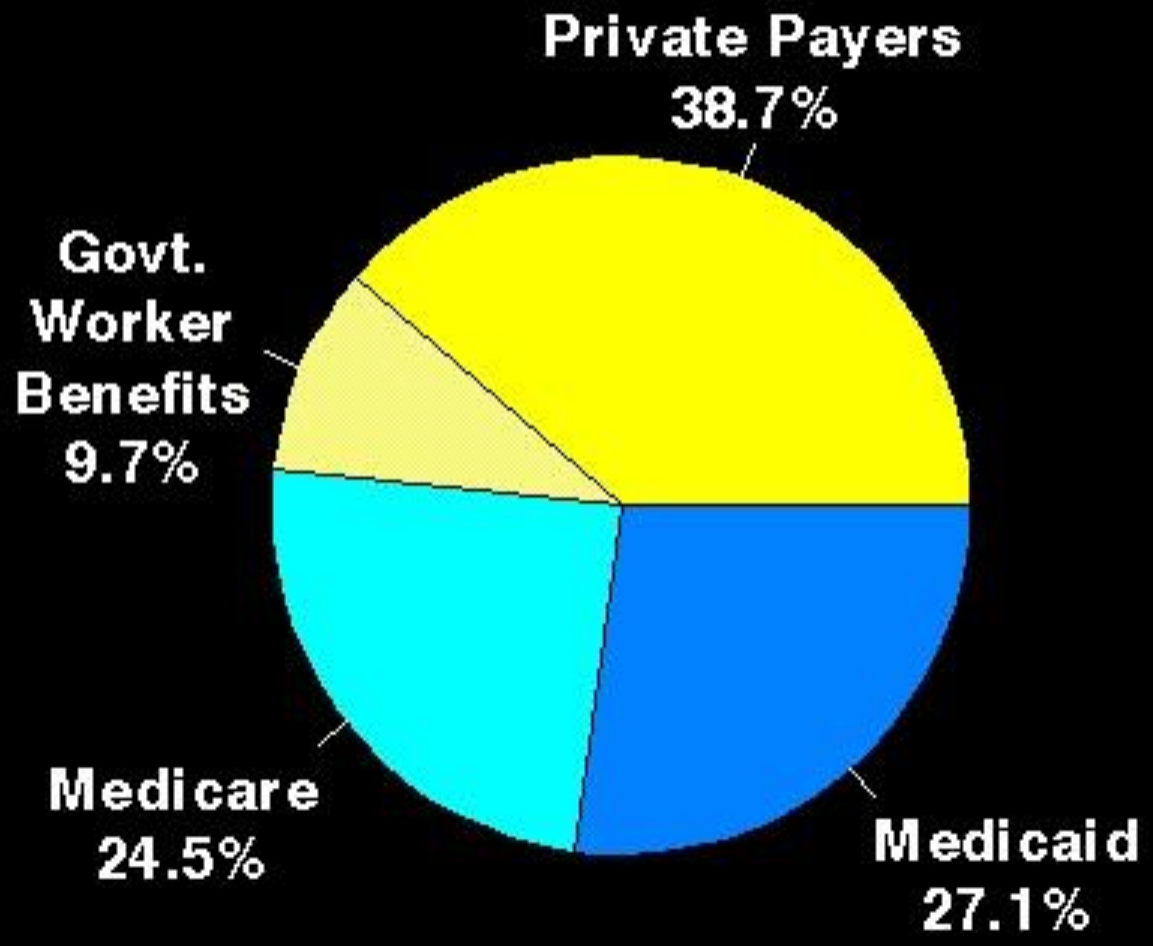


Source: Light & Lexchin. J Royal Soc Med 2021;114:502

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

Private Insurers: Middlemen Who Add Costs But Not Value

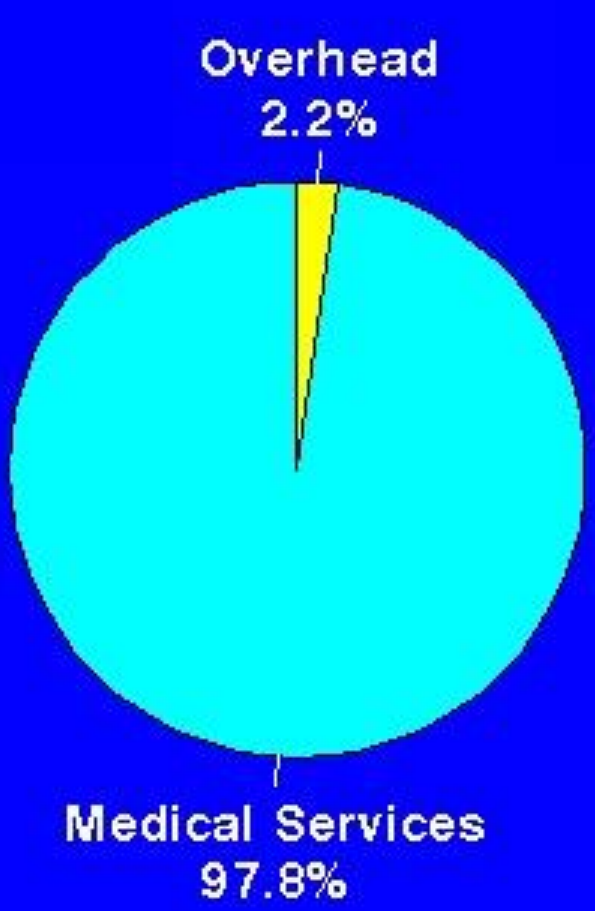
61% of Private Insurers' Revenues Come From Government Payers



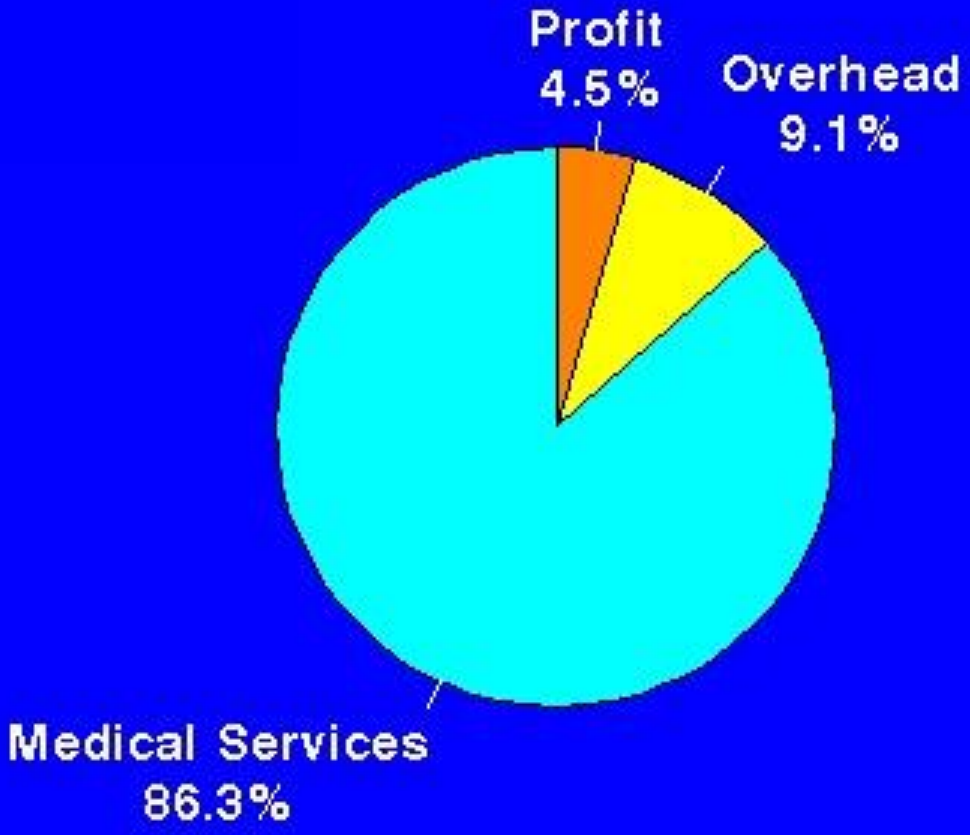
Source: AM Best 8/13/2018 - Government workers' benefit costs estimated from CMS data

Medicare Advantage: Privatizing Medicare, Raising Taxpayers' Costs and a Public Option Preview

Medicare Advantage Plans' High Overhead



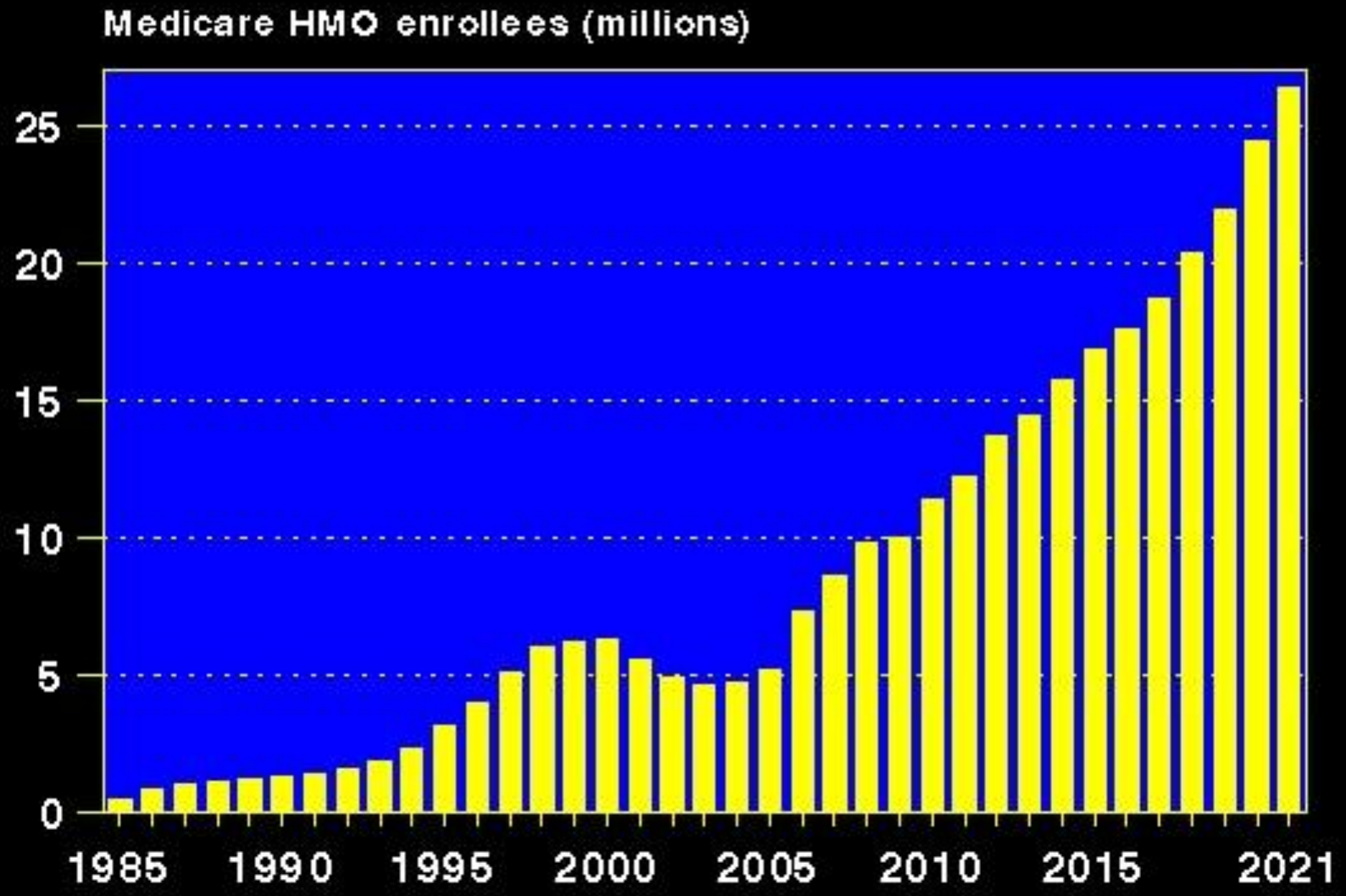
Traditional Medicare



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, 1985-2021

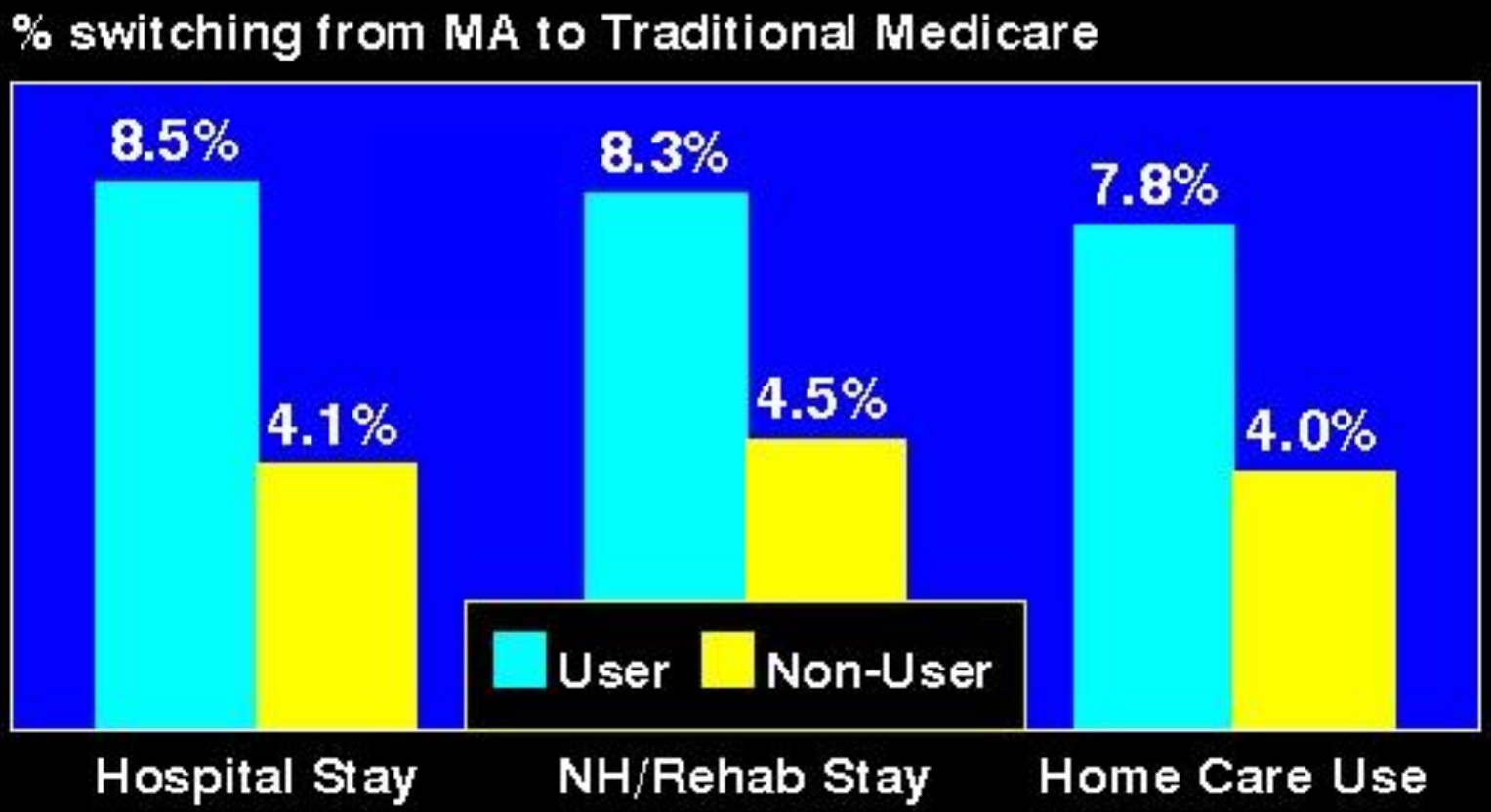


Source: CMS & Kaiser Foundation

How do Medicare Advantage Plans With High Overhead 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

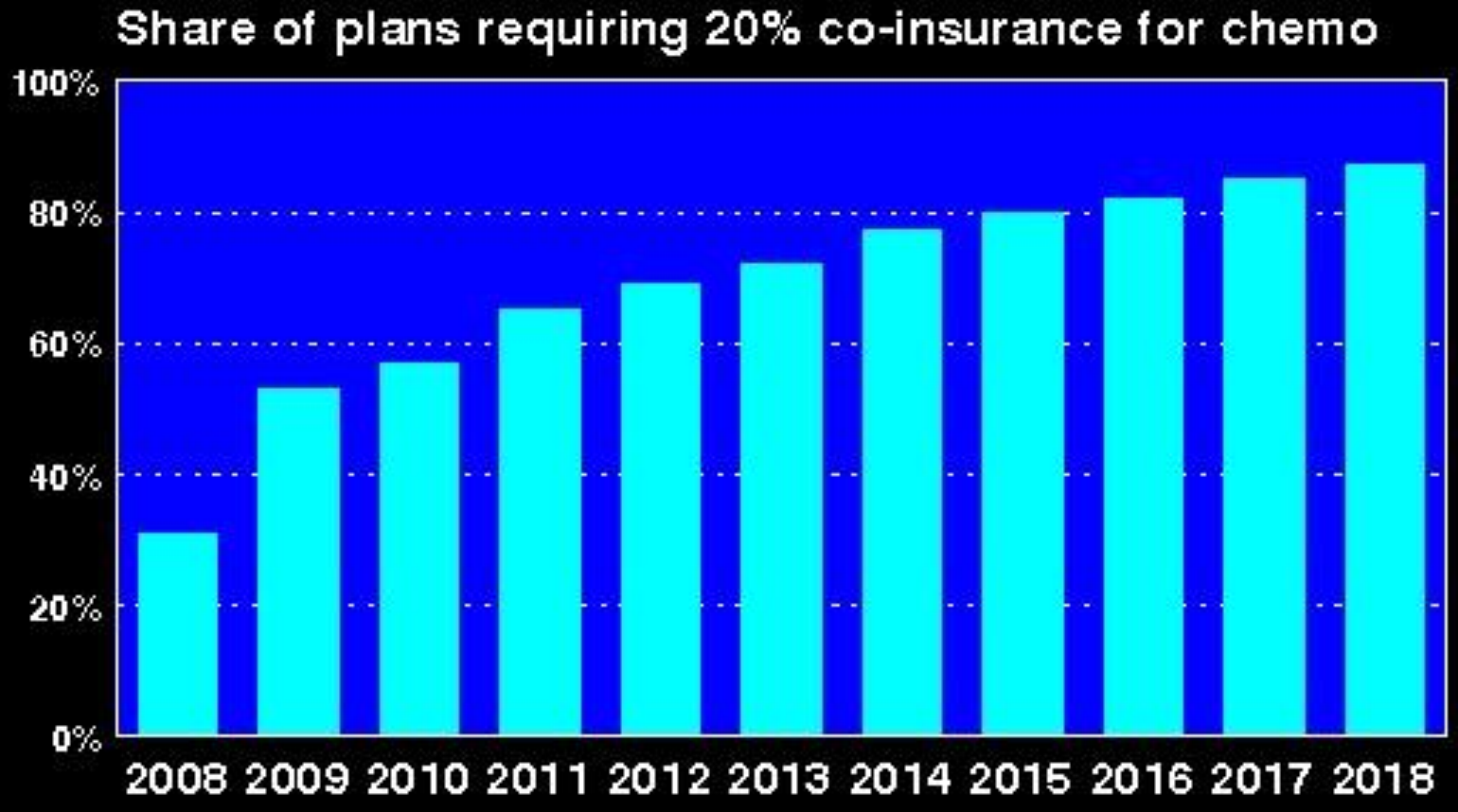
MA Plans Eject Patients Using Expensive Care



Source: Health Affairs 2021;40:469

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

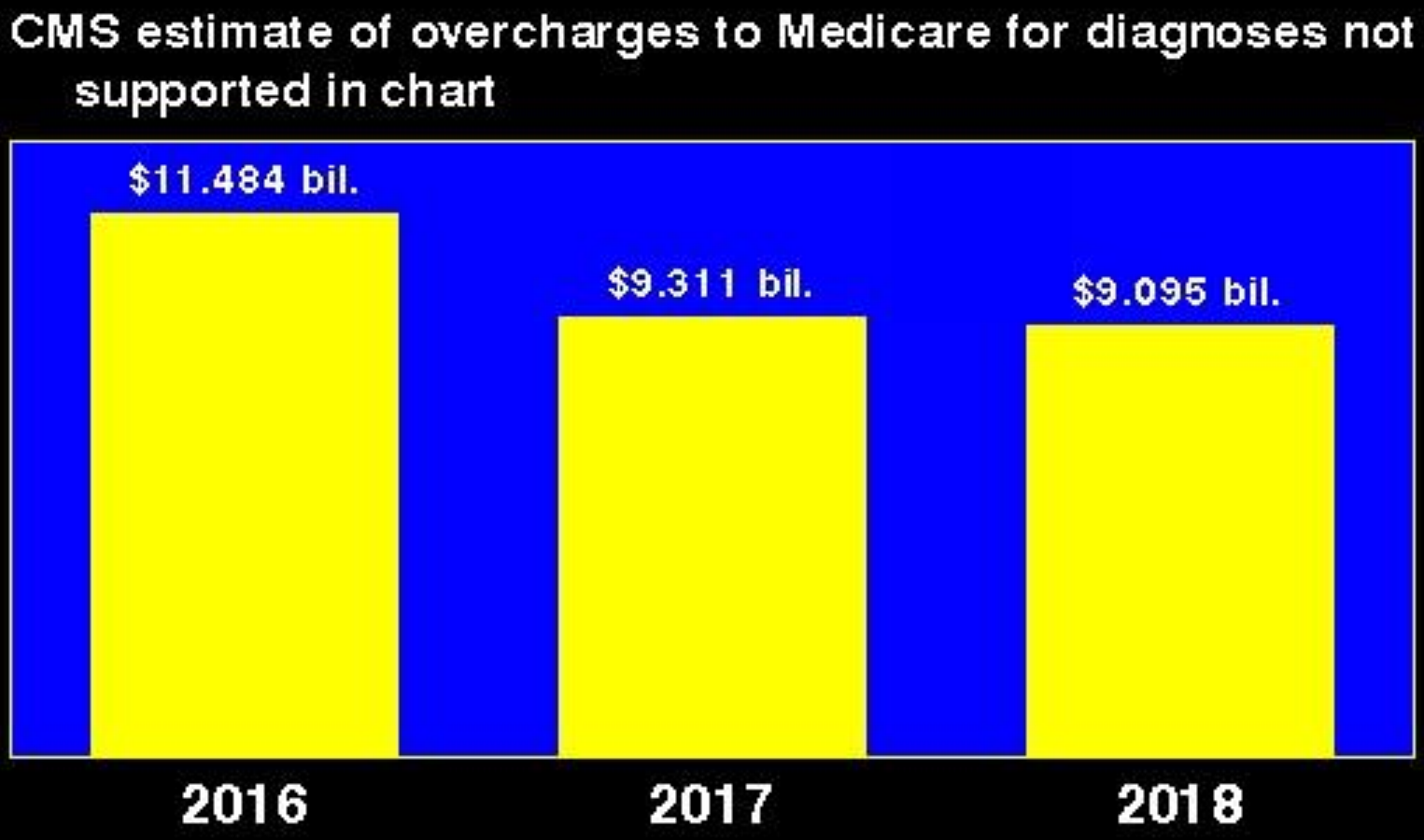
Medicare Advantage Plans Push Cancer Patients Out by Imposing 20% Co-Insurance for Chemotherapy



Source: JGIM 2019;34:1119

Medicare Advantage Plans' Claims for Unsupported Diagnoses

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



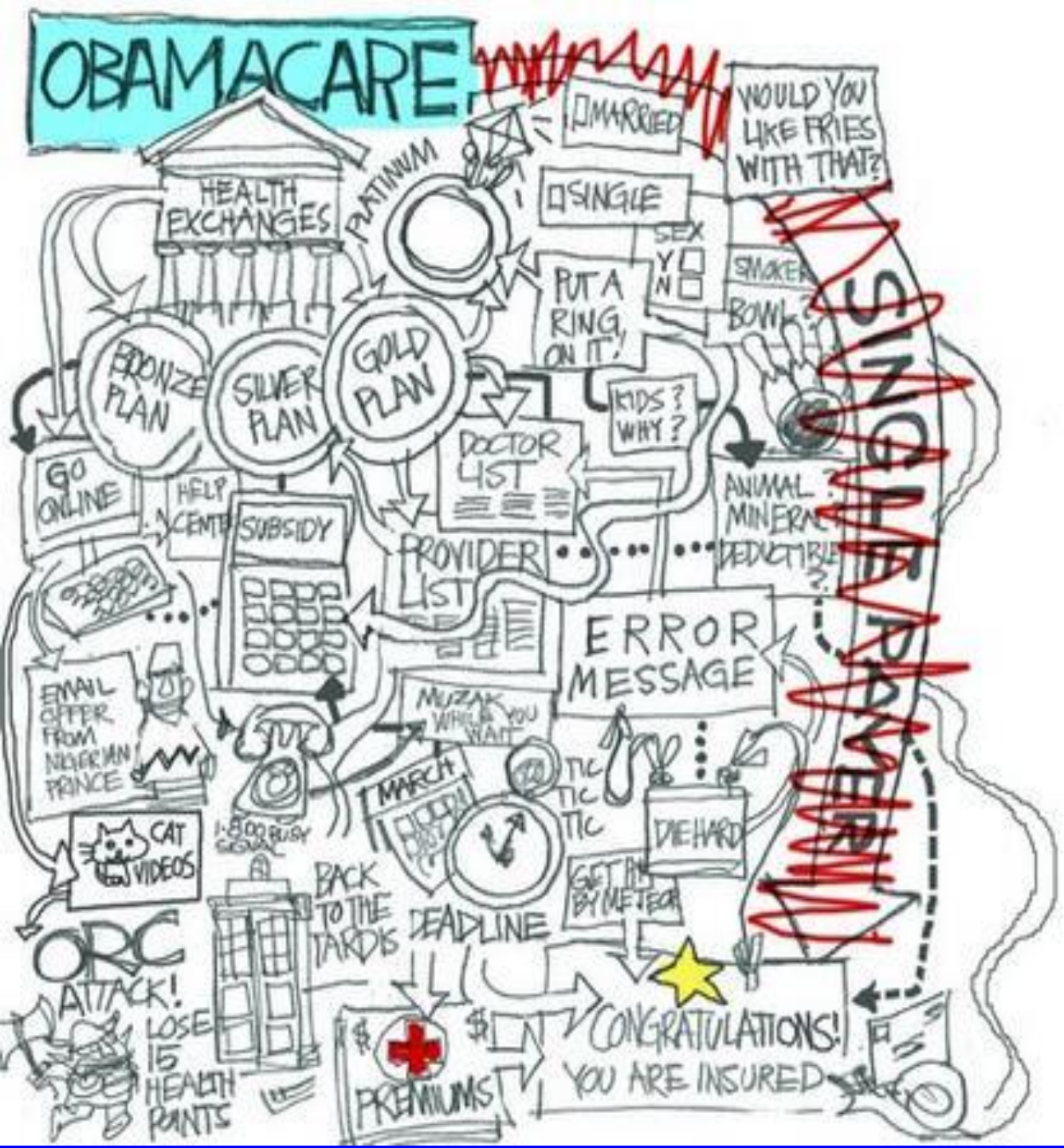
Source: Kaiser Health News 7/16/2019

"Direct Contracting Entities" (DCEs)
The Latest Medicare Privatization Scheme

- Traditional Medicare enrollees assigned to a DCE – can't opt out.
- DCEs paid capitation similar to Medicare Advantage (MA).
- Many owned by insurance giants or for-profit startups.
- As in MA, overdiagnosis/upcoding key to profitability, e.g.:
  - Routine screening carotid ultrasounds (contrary to USPSTF guidelines); + test raises capitation $2800/patients.
  - "Clover Health" offers PCPs $30/visit bonus to use its upcoding software.
- Wall Street valuing DCE startups at $87,000 per patient enrolled, anticipating windfall profits from Medicare.

Source: Gilfillan & Berwick, Health Affairs Blog 9/29/21

The ACA:
A Complex and Expensive Way to Expand Coverage



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

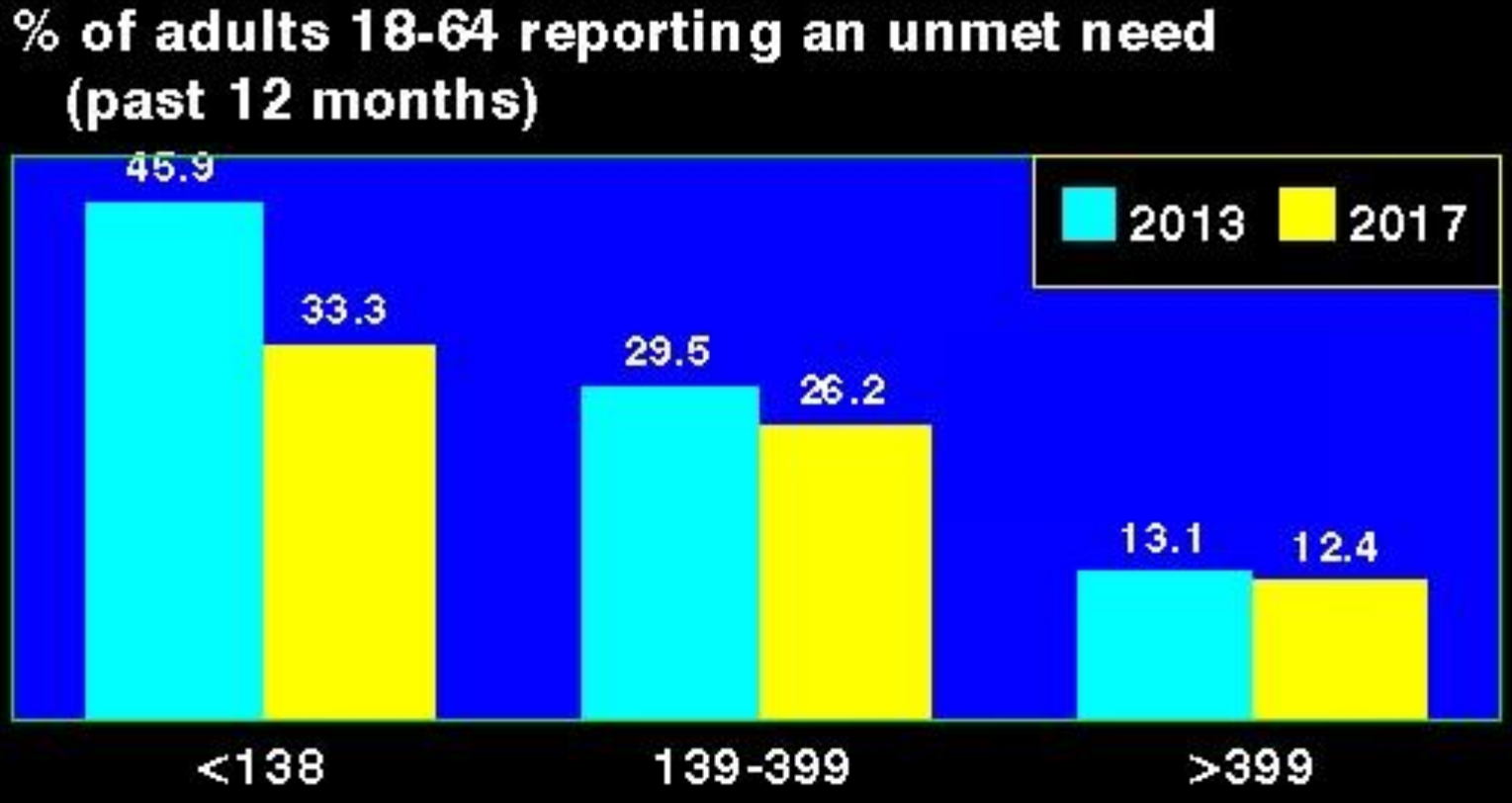
Signature by mark (X) must be witnessed below.

SIGNATURE OF WITNESS

ADDRESS OF WITNESS

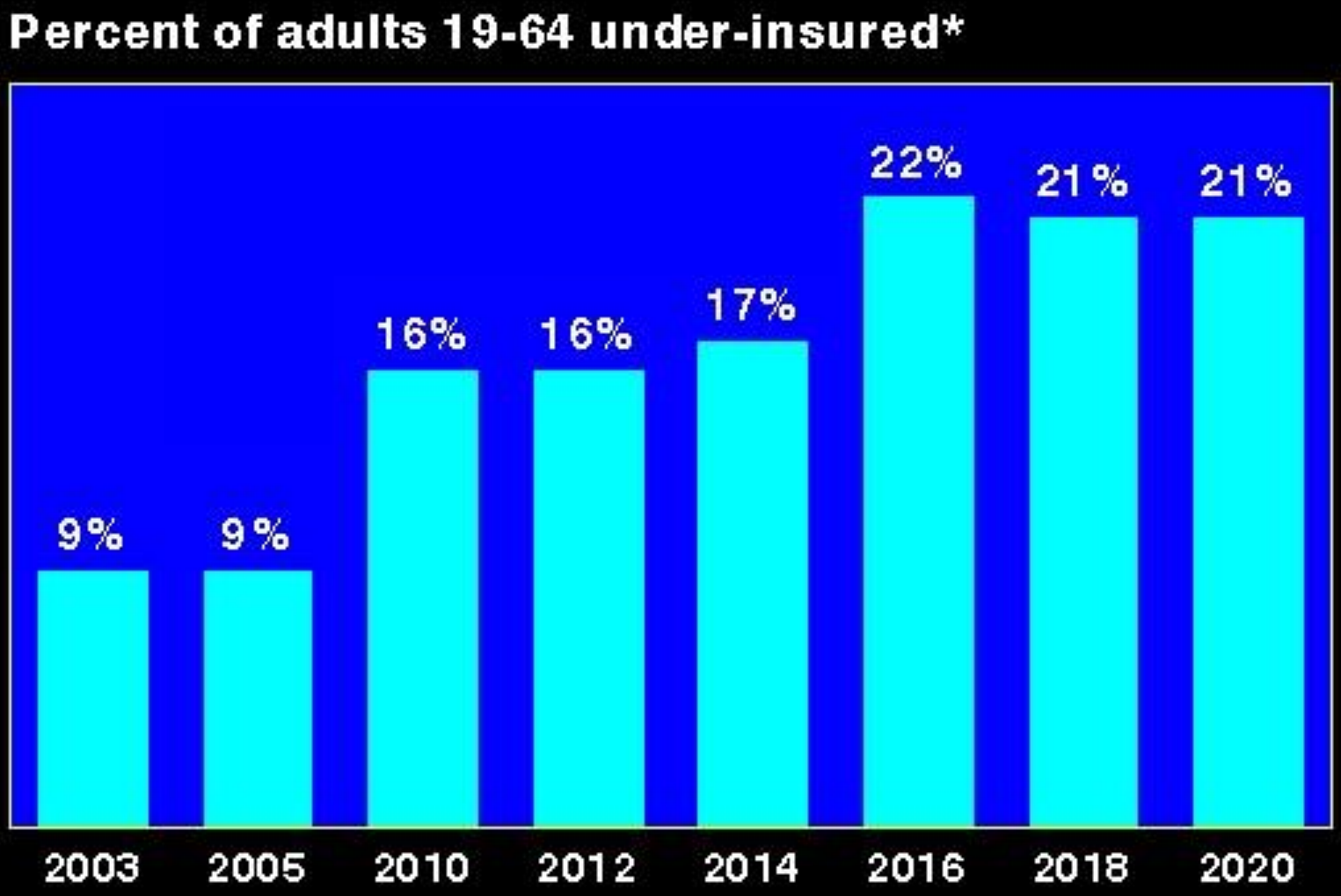
ACA Decreased Incidence of Unmet Medical Needs Due to Cost

Better, But Still Not Good



Source: Health Affairs 2017;36:1656

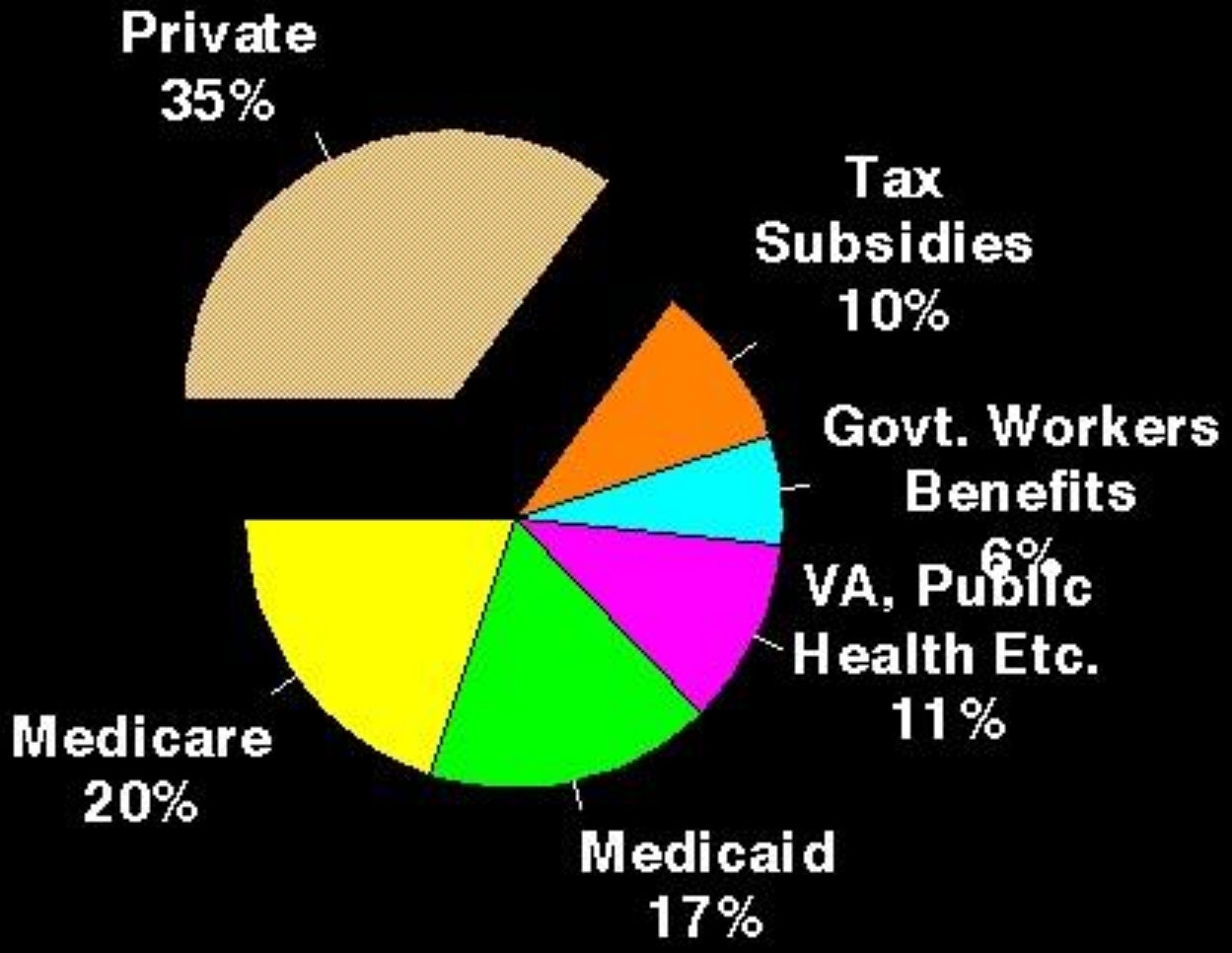
Under-Insurance Increased After ACA



Source: Commonwealth Fund Health Insurance Surveys 2003-2020
* 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

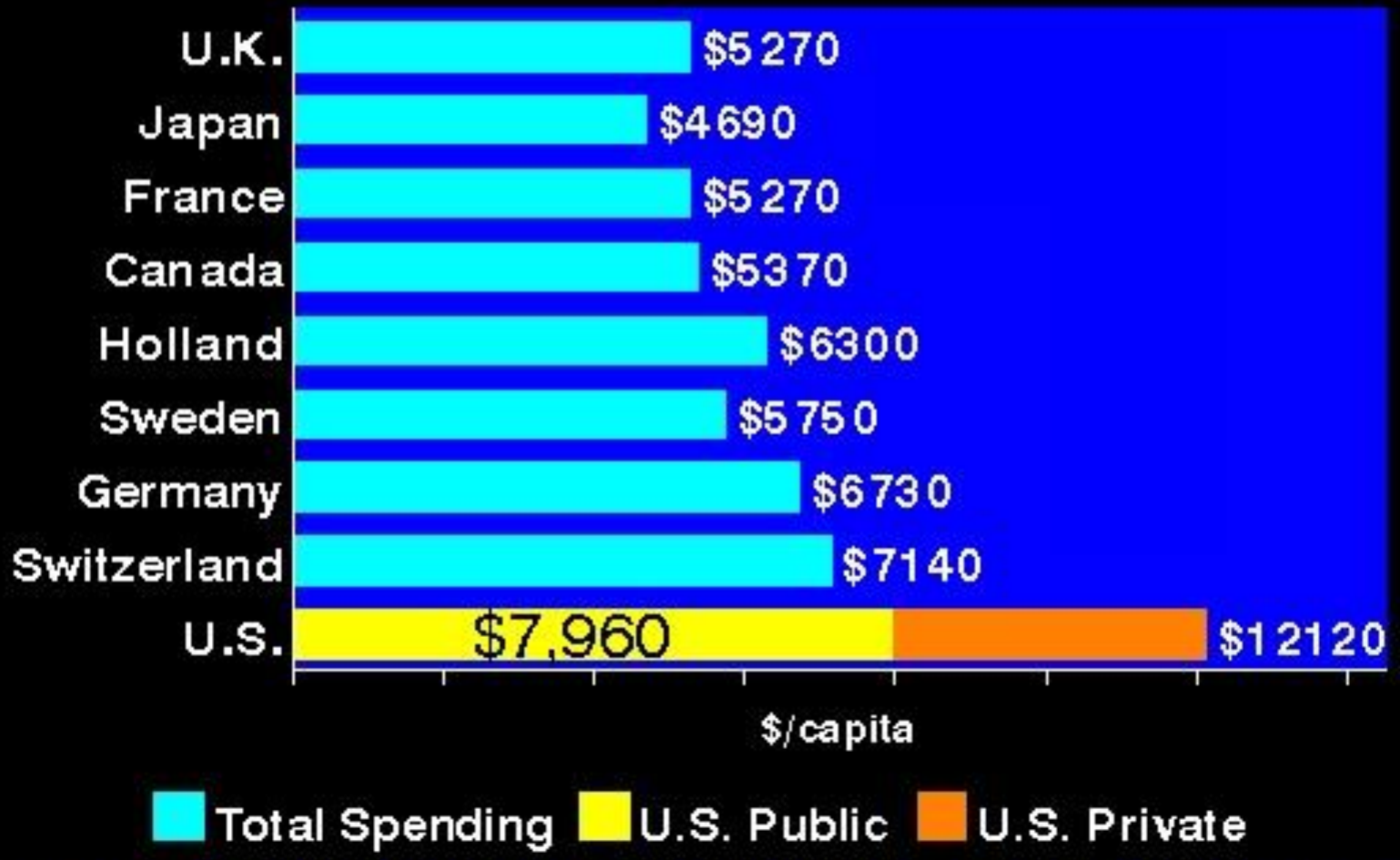
Taxes Fund 2/3 of Health Spending



Source: Himmelstein & Woolhandler - Analysis of NCHS data

U.S. Health Care: Higher Costs, Worse Outcomes, Less Care

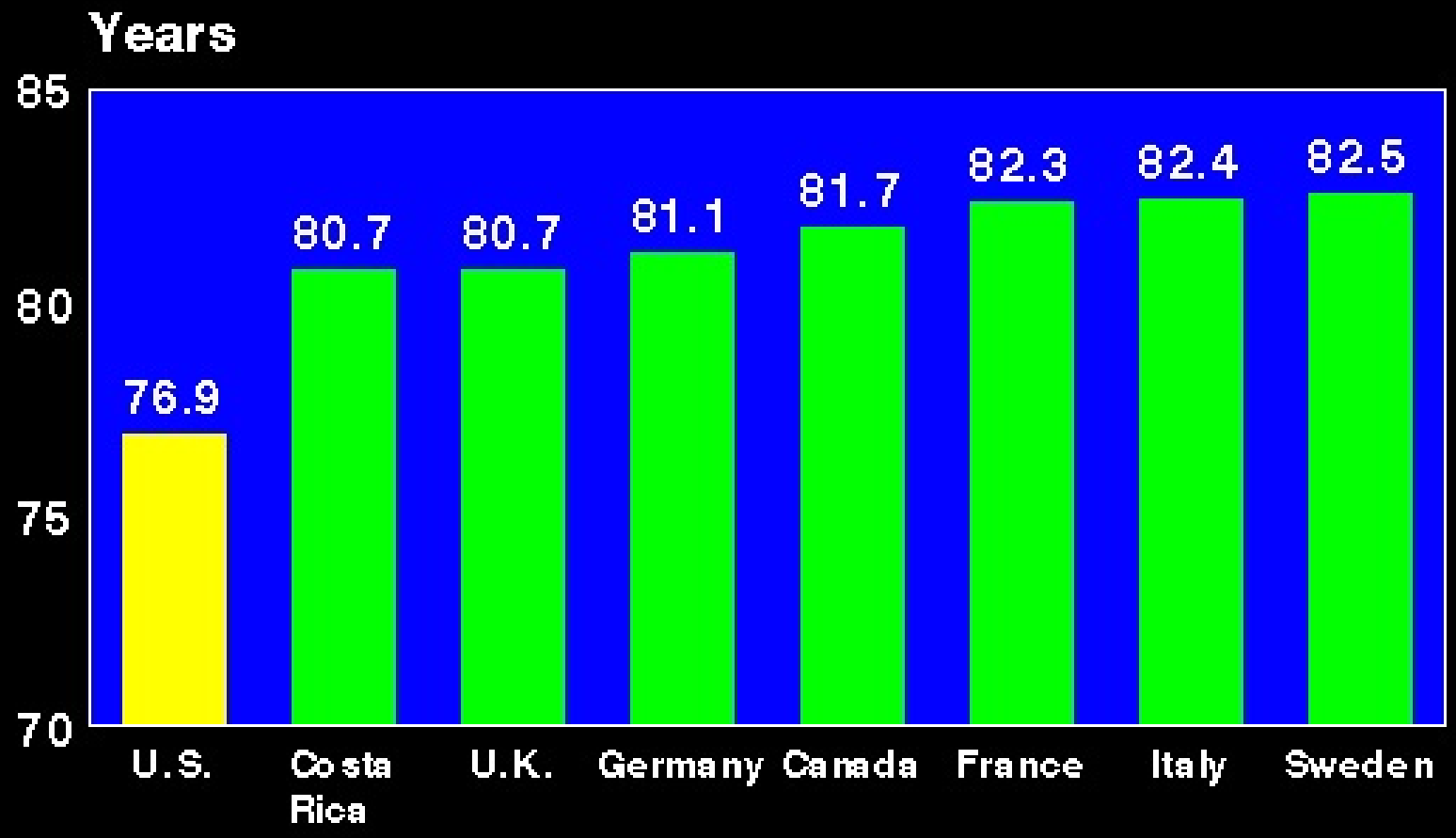
U.S. PUBLIC Spending Per Capita for Health Exceeds TOTAL Spending in Other Nations



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

Life Expectancy

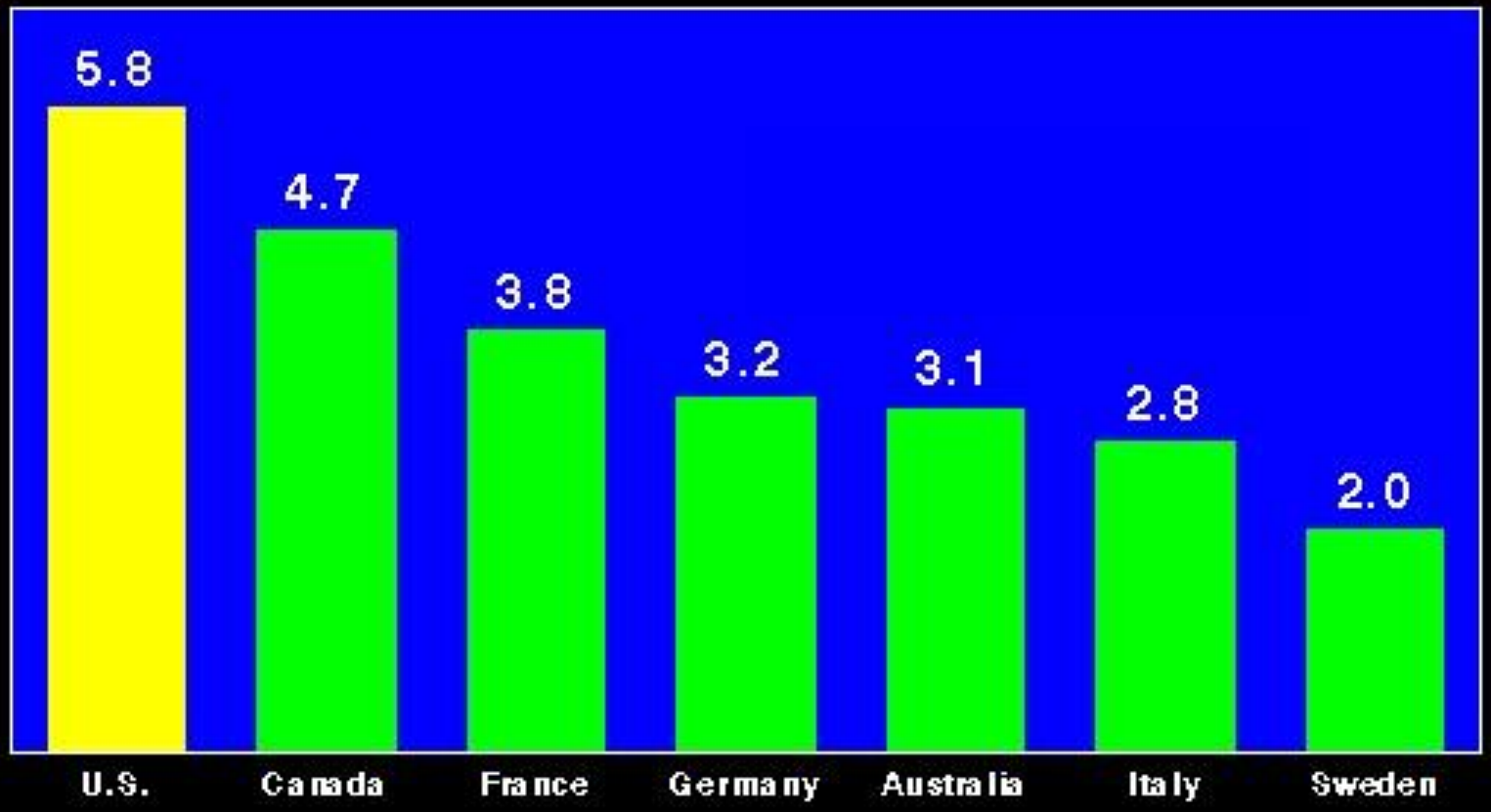


Source: OECD, 2021 and S. Woolf (BMJ 2021)

Note: Data are for 2020

Infant Mortality

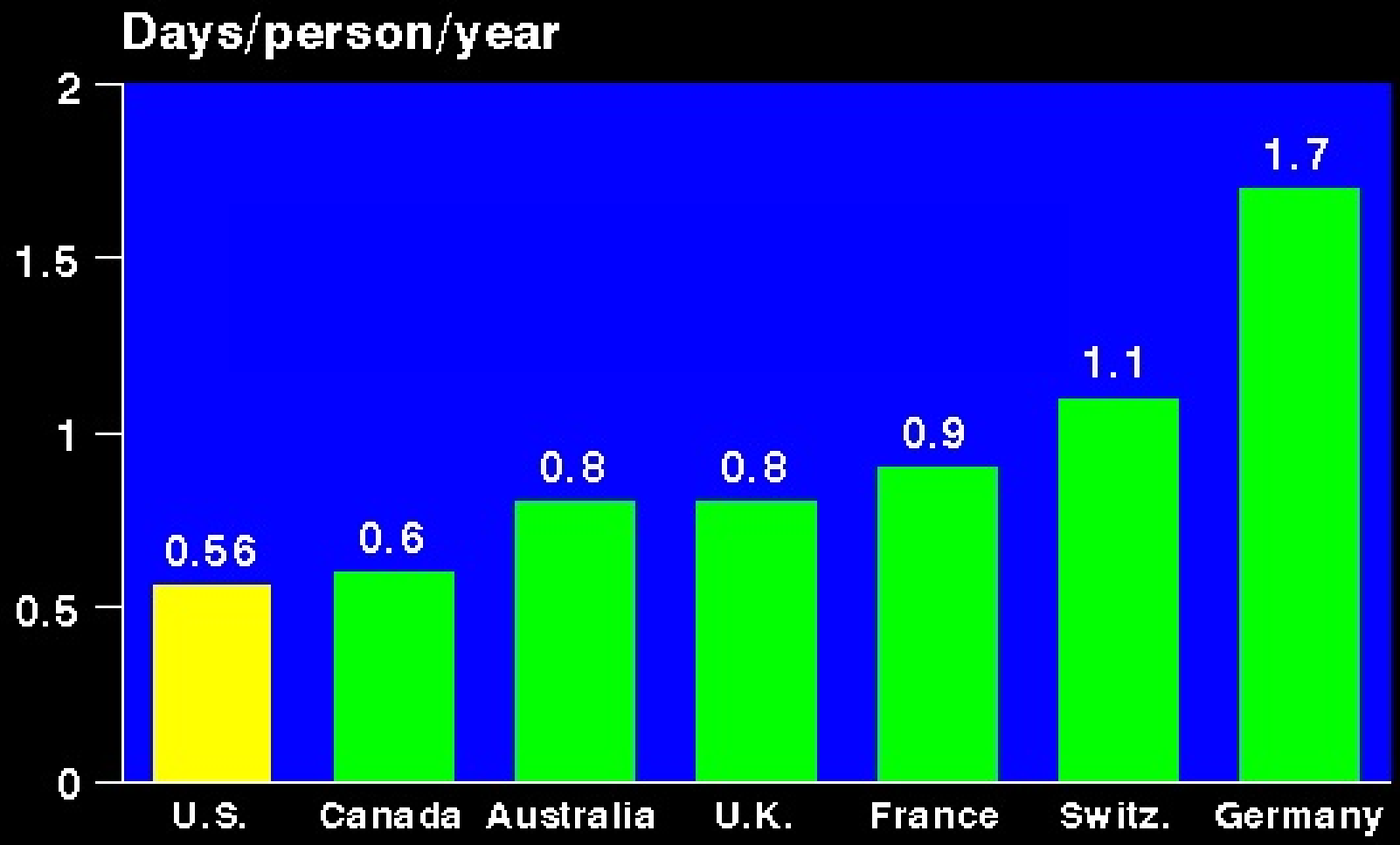
Deaths in First Year of Life/1000 Live Births



Source: OECD, 2020

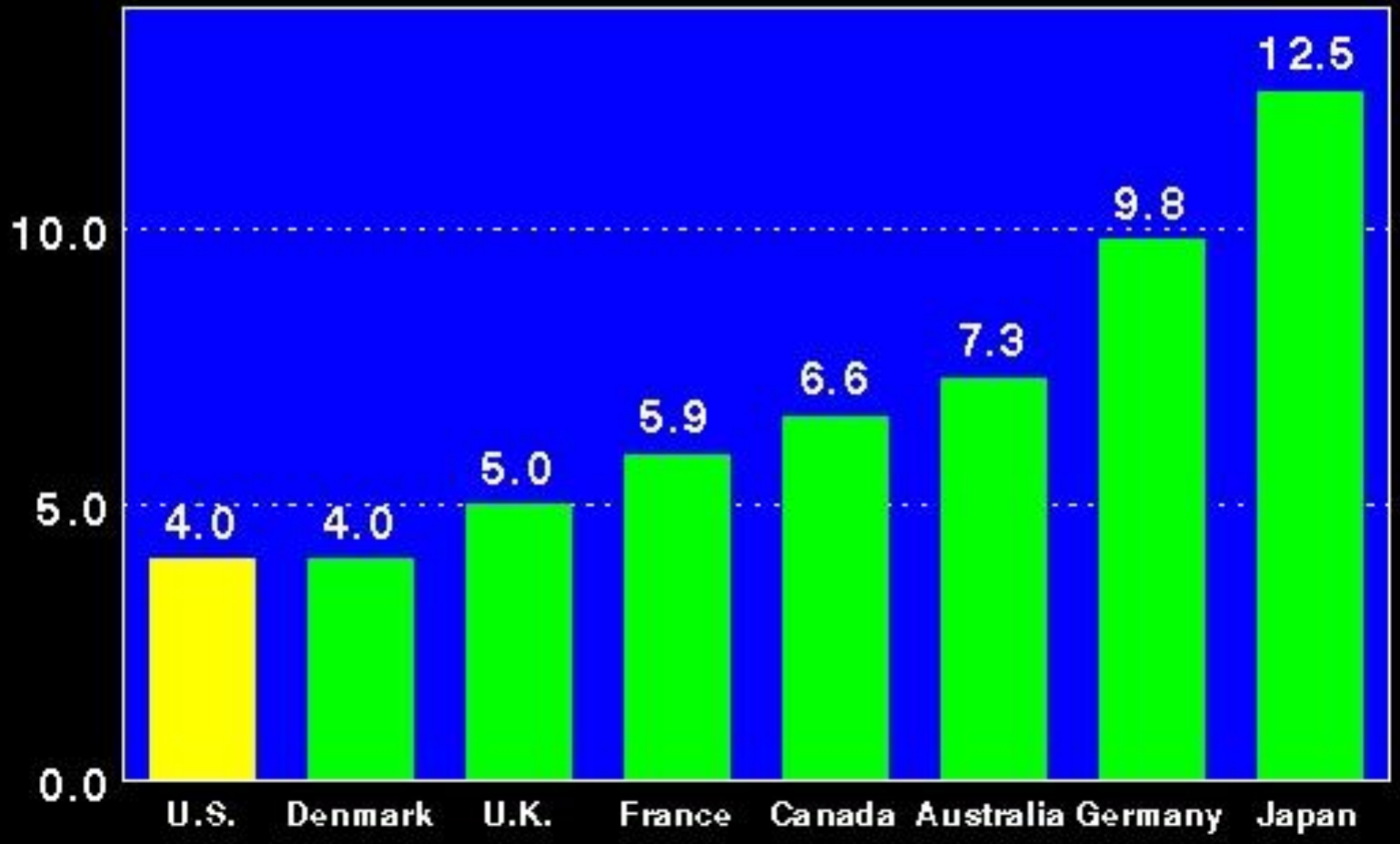
Note: Data are for 2019 or most recent year available

Hospital Inpatient Days Per Capita



Source: OECD, 2021 & Kaiser Fdn. - Figures are for 2020 or most recent available

Physician Visits Per Capita

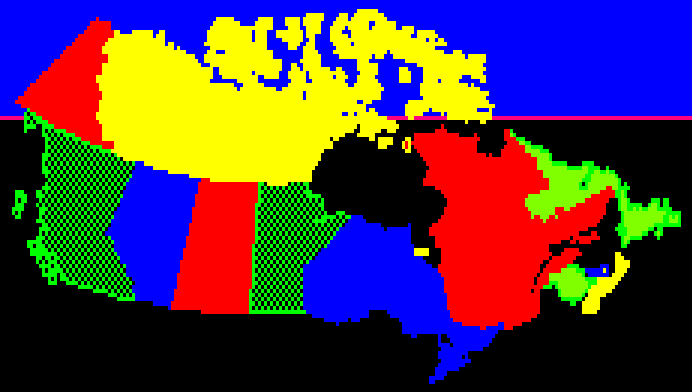


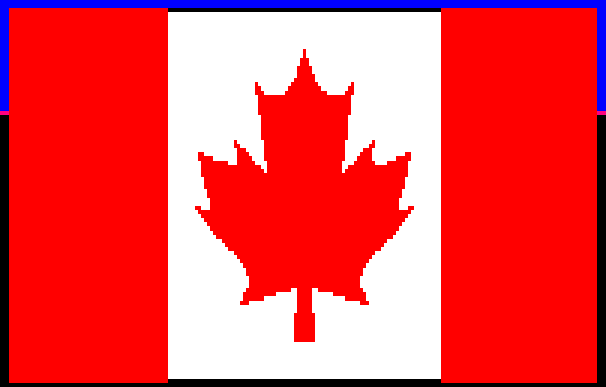
Source: OECD, 2021 - Data are for 2020 or most recent available year

Canada's Single Payer National Health Insurance Program

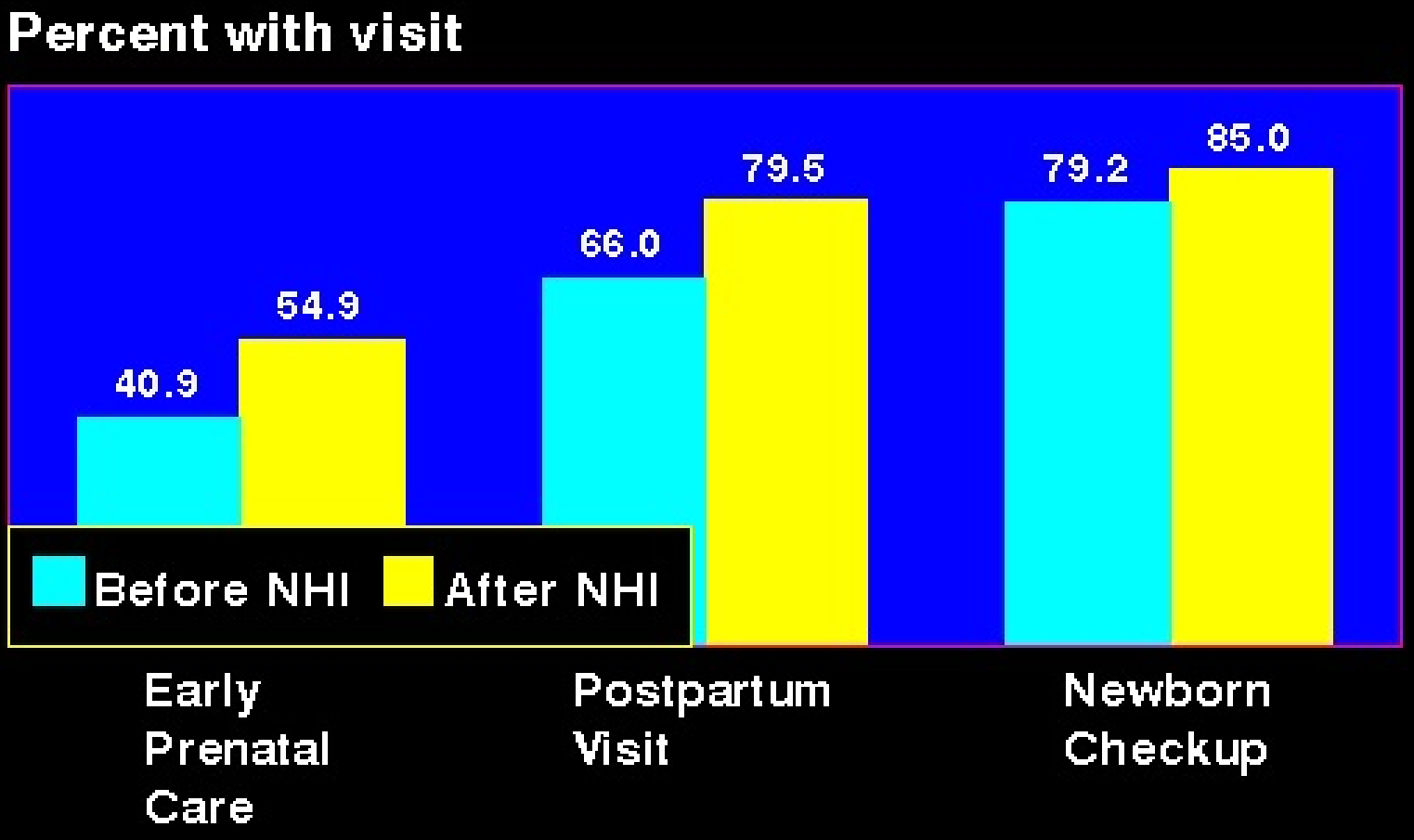
MINIMUM STANDARDS FOR CANADA'S PROVINCIAL PROGRAMS

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



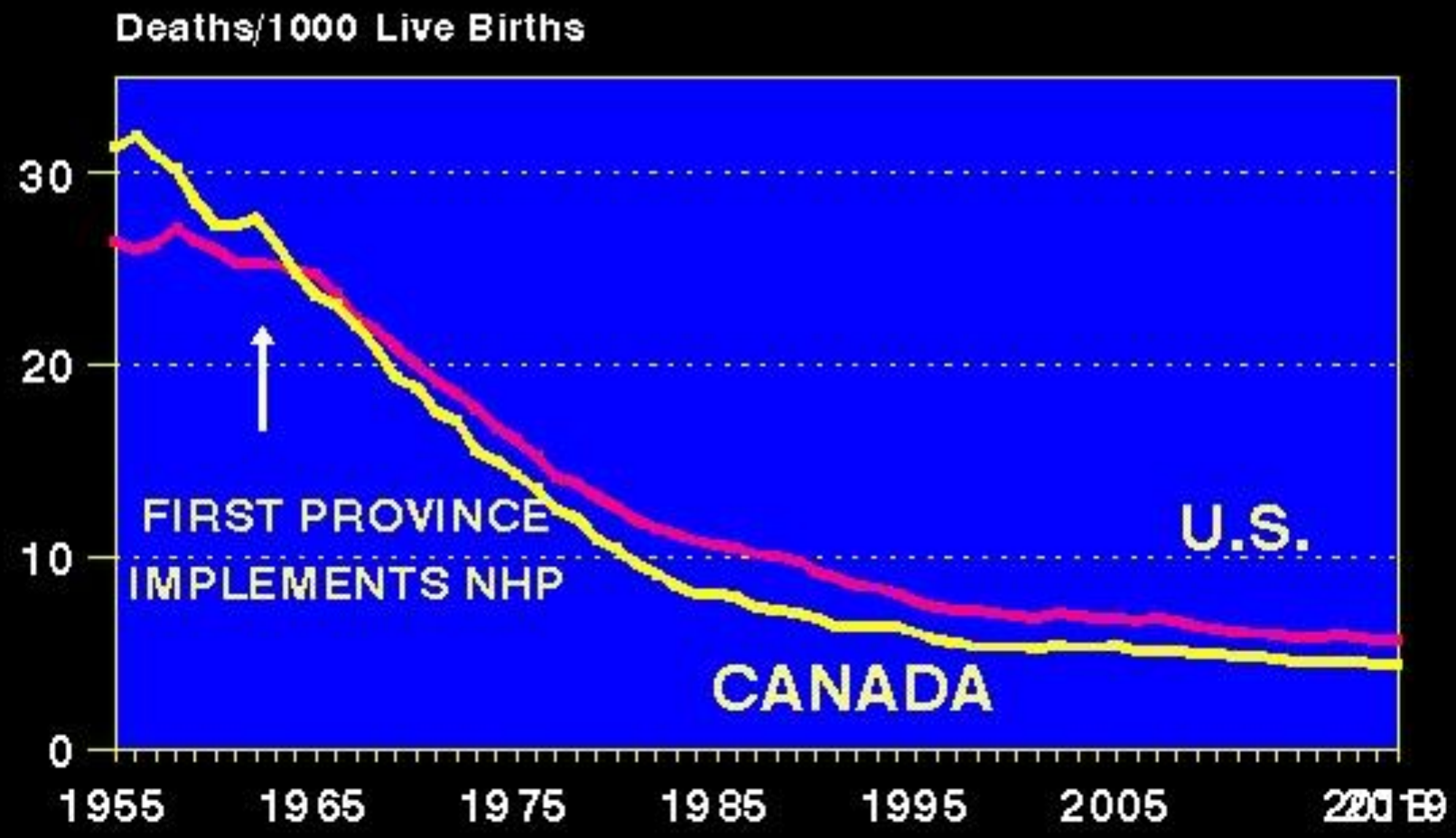


Free Care in Quebec Improved Maternal/Infant Care



Source: NEJM 1974;291:649

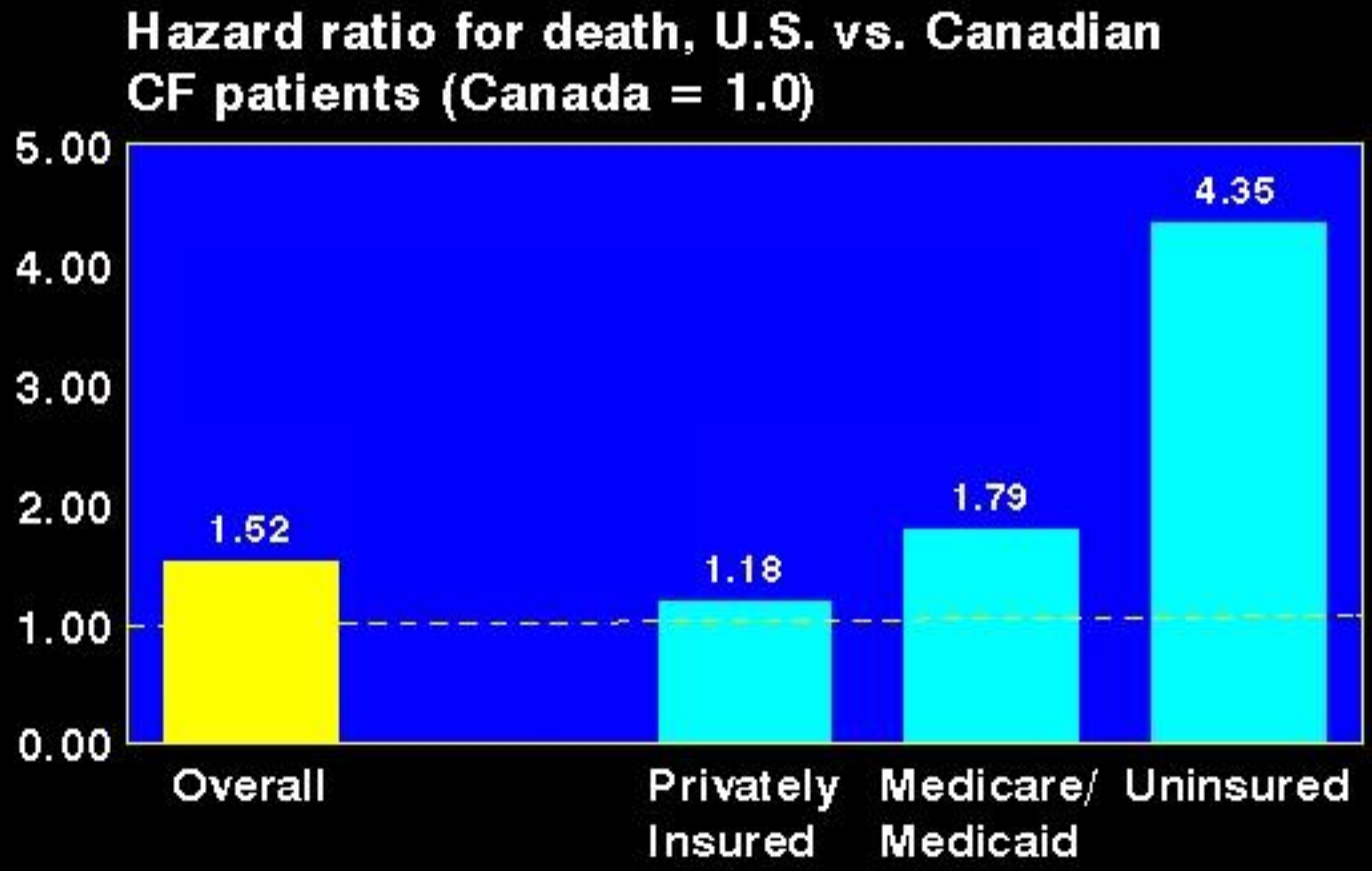
Infant Mortality
U.S. & Canada, 1955-2019



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

Cystic Fibrosis Patients Live Longer in Canada

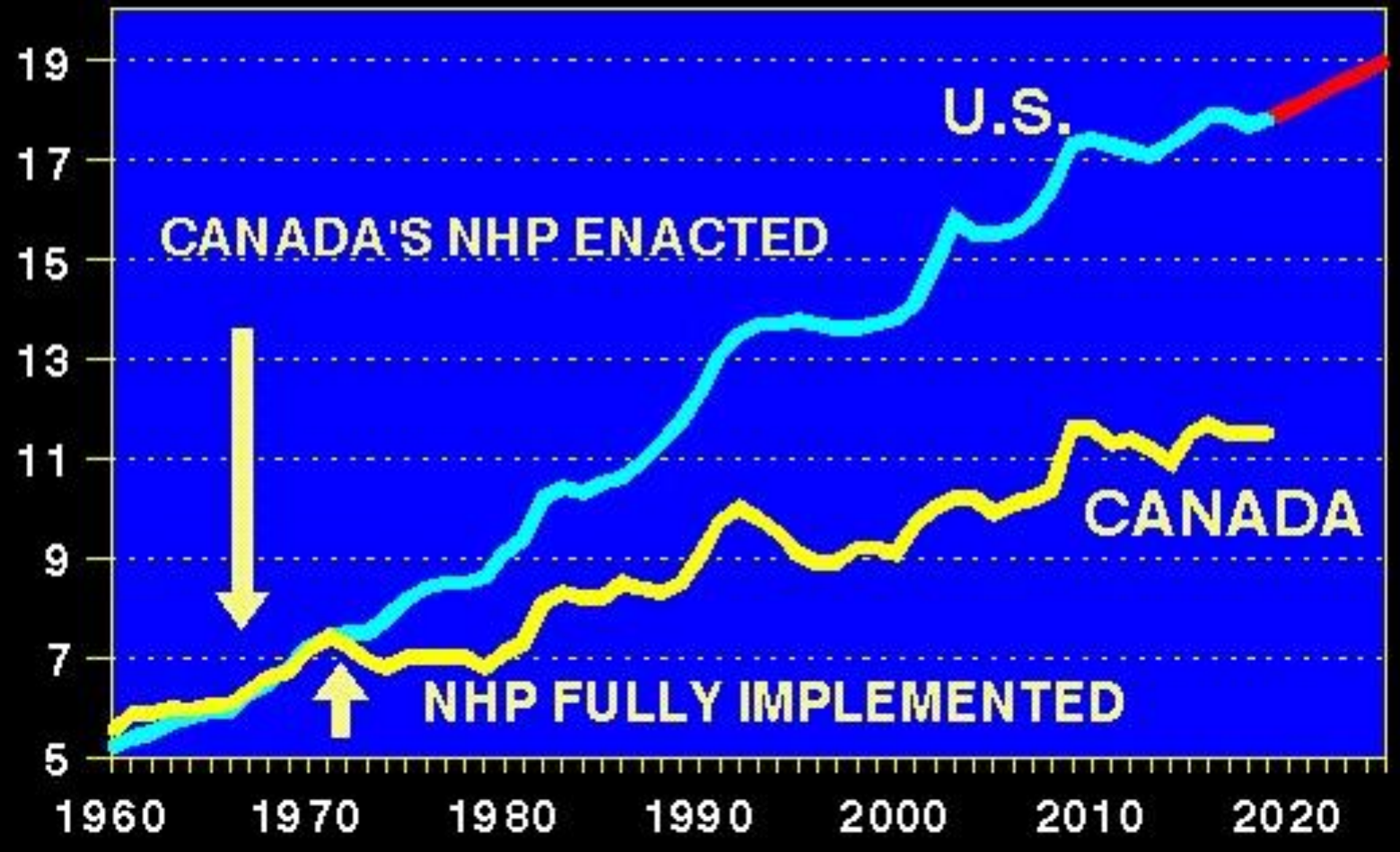
Uninsured in U.S. Have Highest Risk of Death



Source: Ann Int Med 2017;166:537

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

Health Costs as % of GDP:
U.S. & Canada, 1960-2025



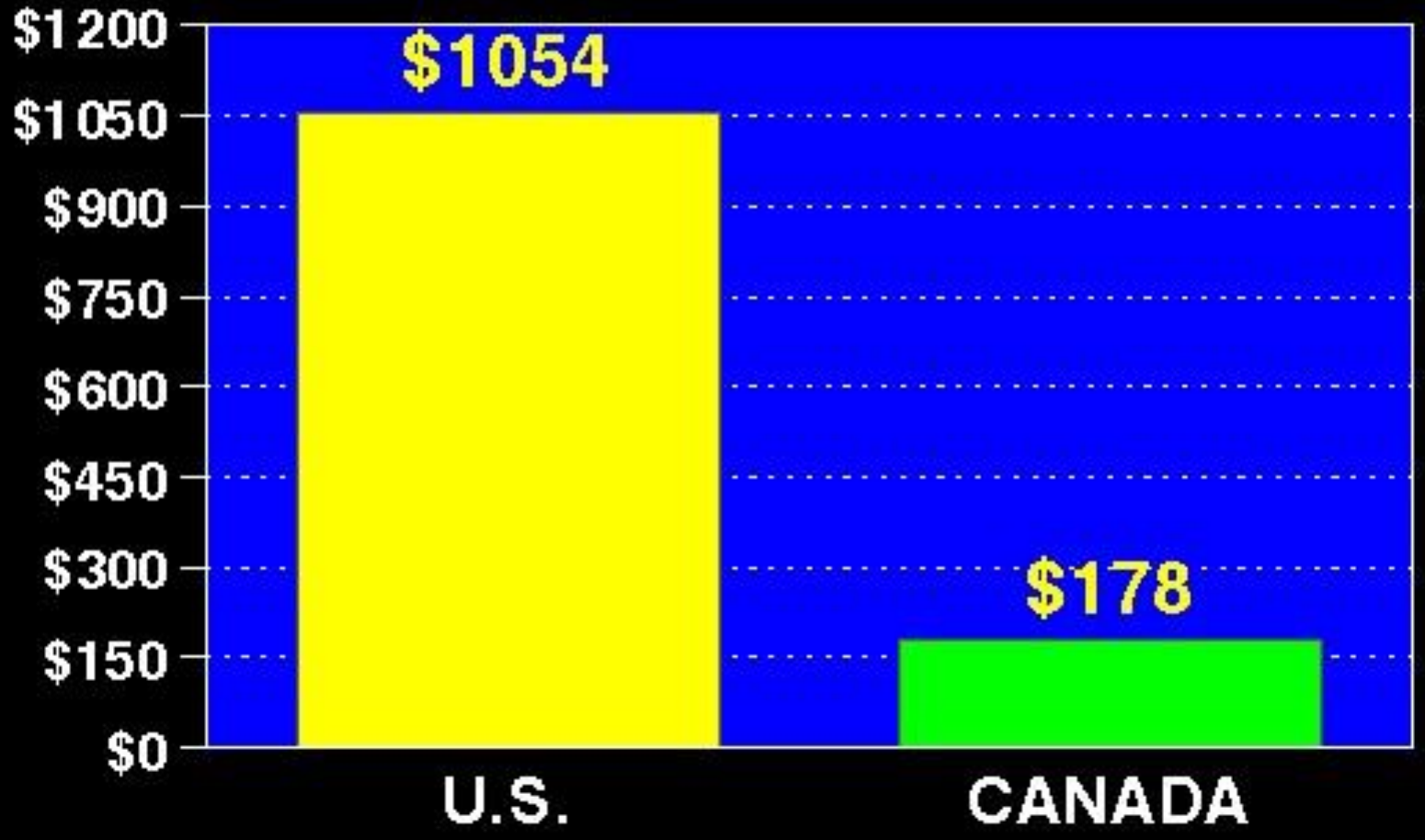
Source: Statistics Canada, Canadian Inst. for Health Info., & NCHS/Commerce Dept

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

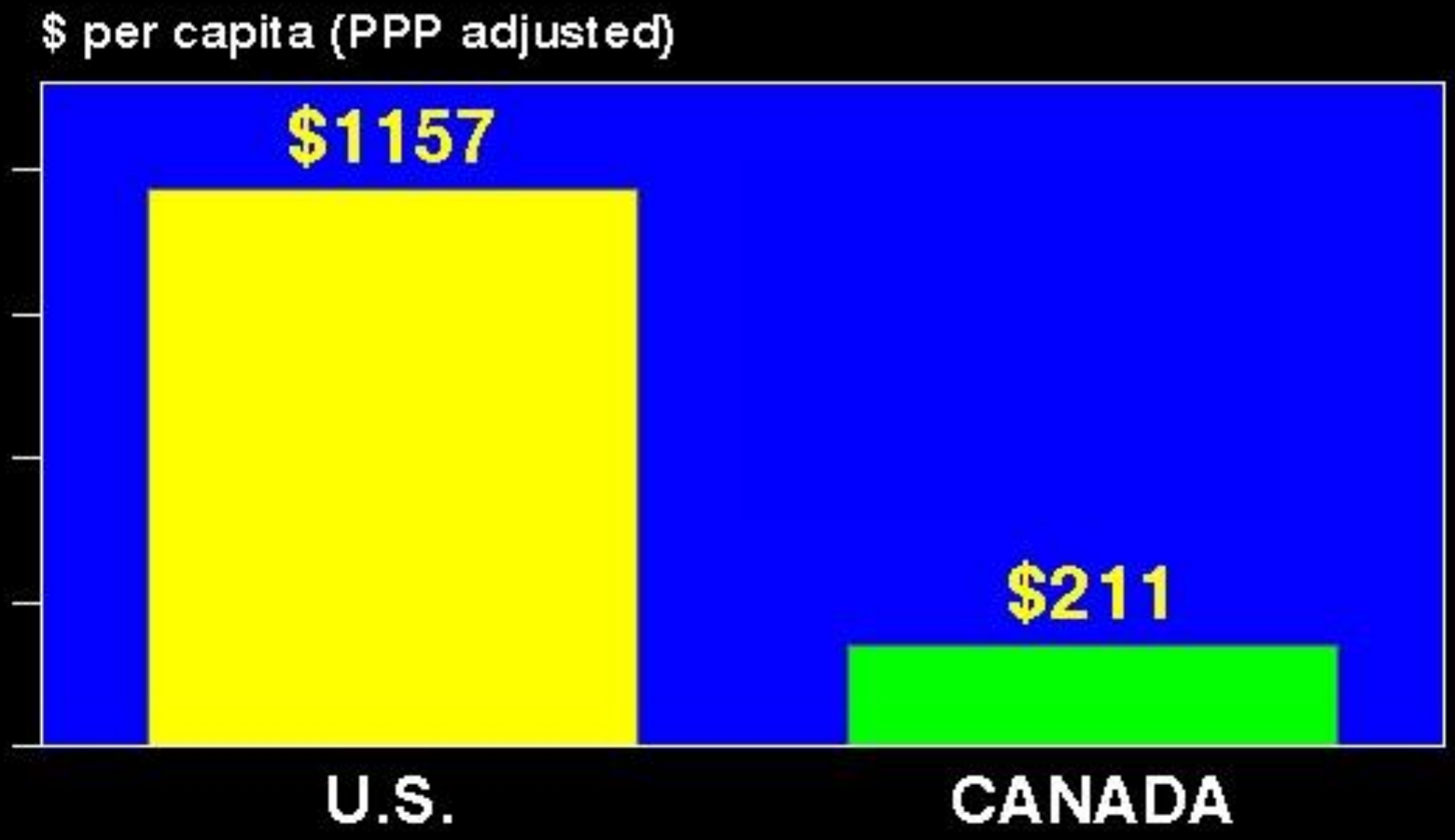
Source: Himmelstein & Woolhandler, Arch Intern Med, December, 2012

Insurance Overhead
United States & Canada, 2021



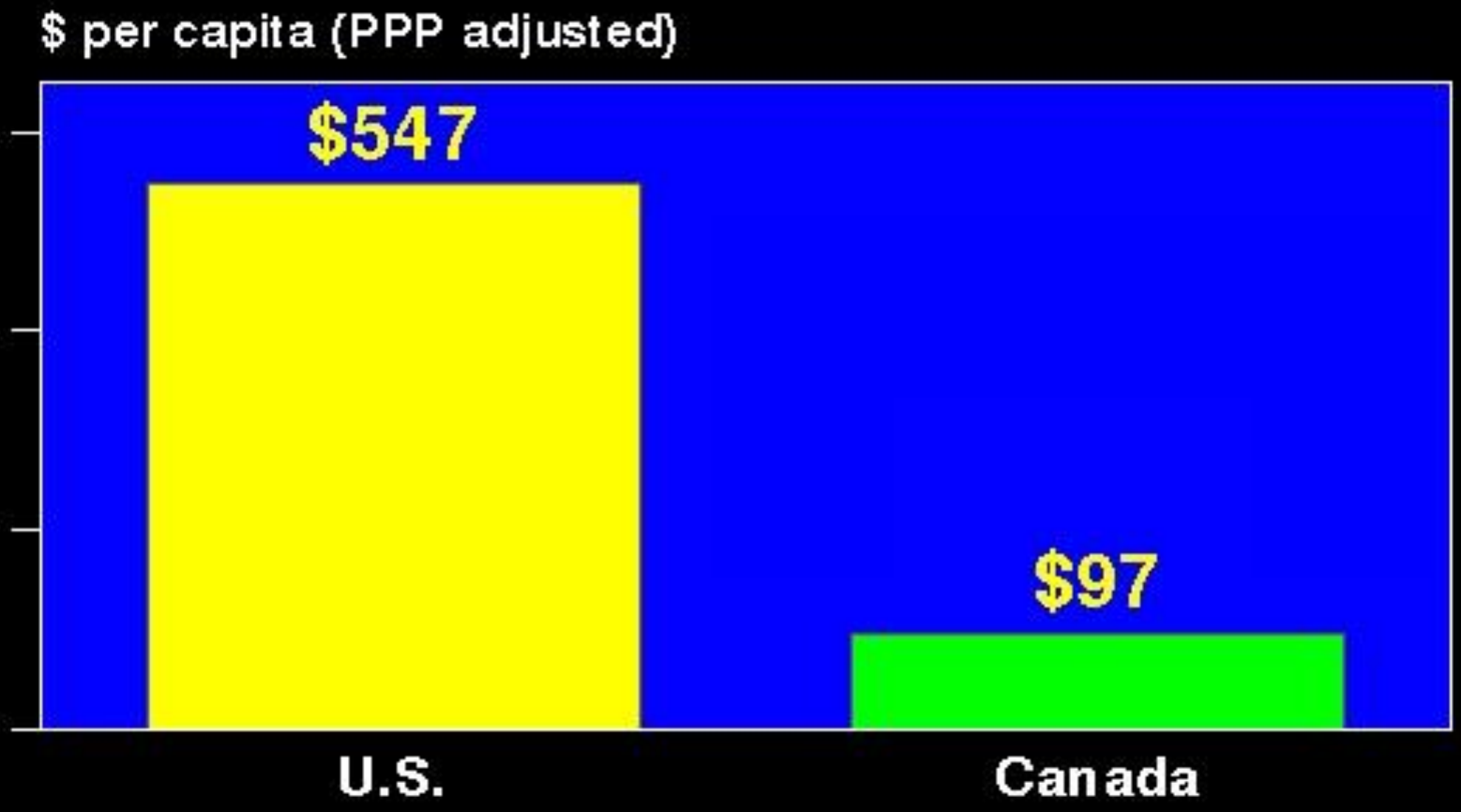
Source: NCHS and CIHI

Hospital Billing & Administration United States & Canada, 2021



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

Physicians' Billing-Related Expenses United States & Canada, 2021

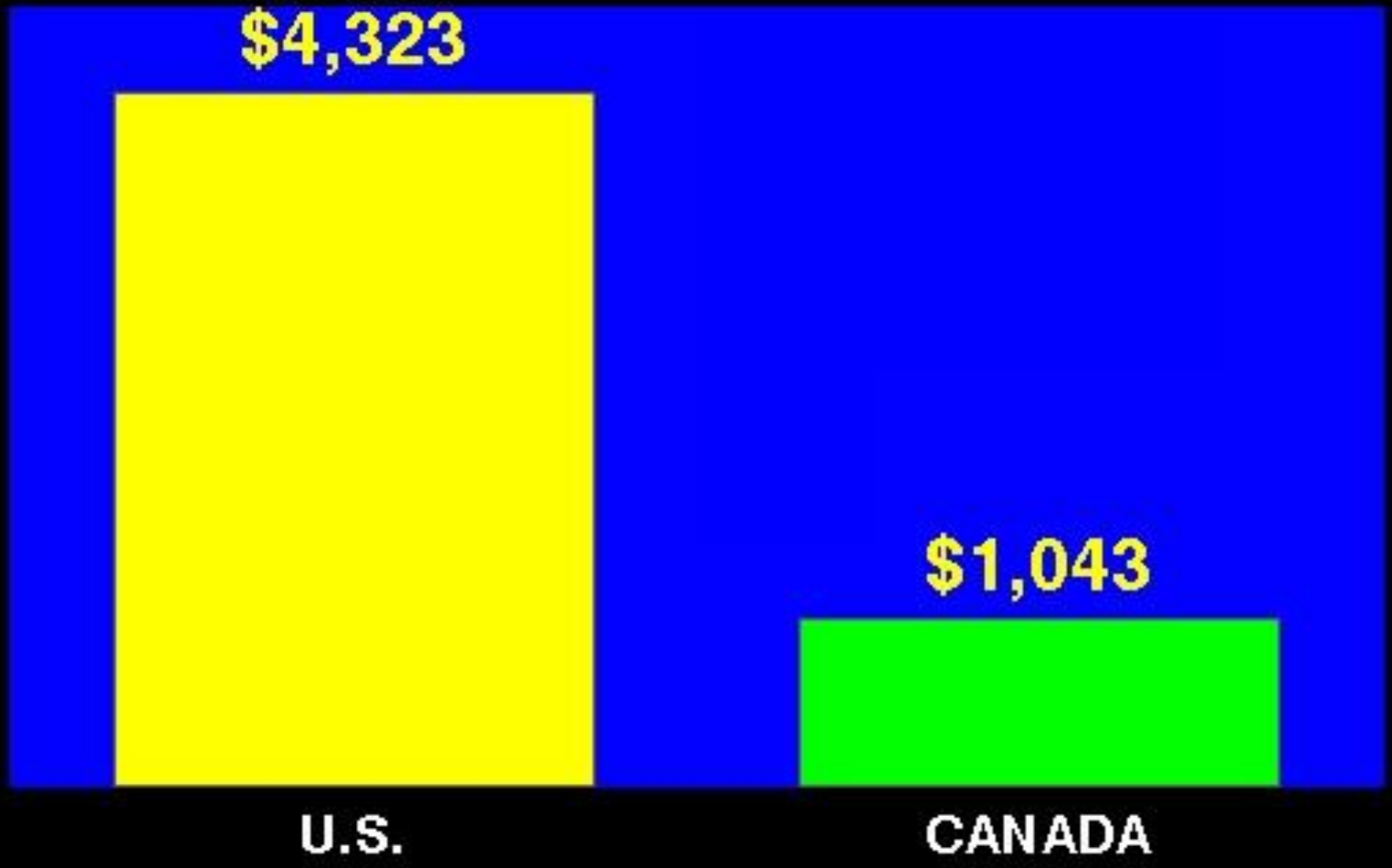


Source: Woolhandler/Campbell/Himmelstein Ann Int Med 2020 (Updated)

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

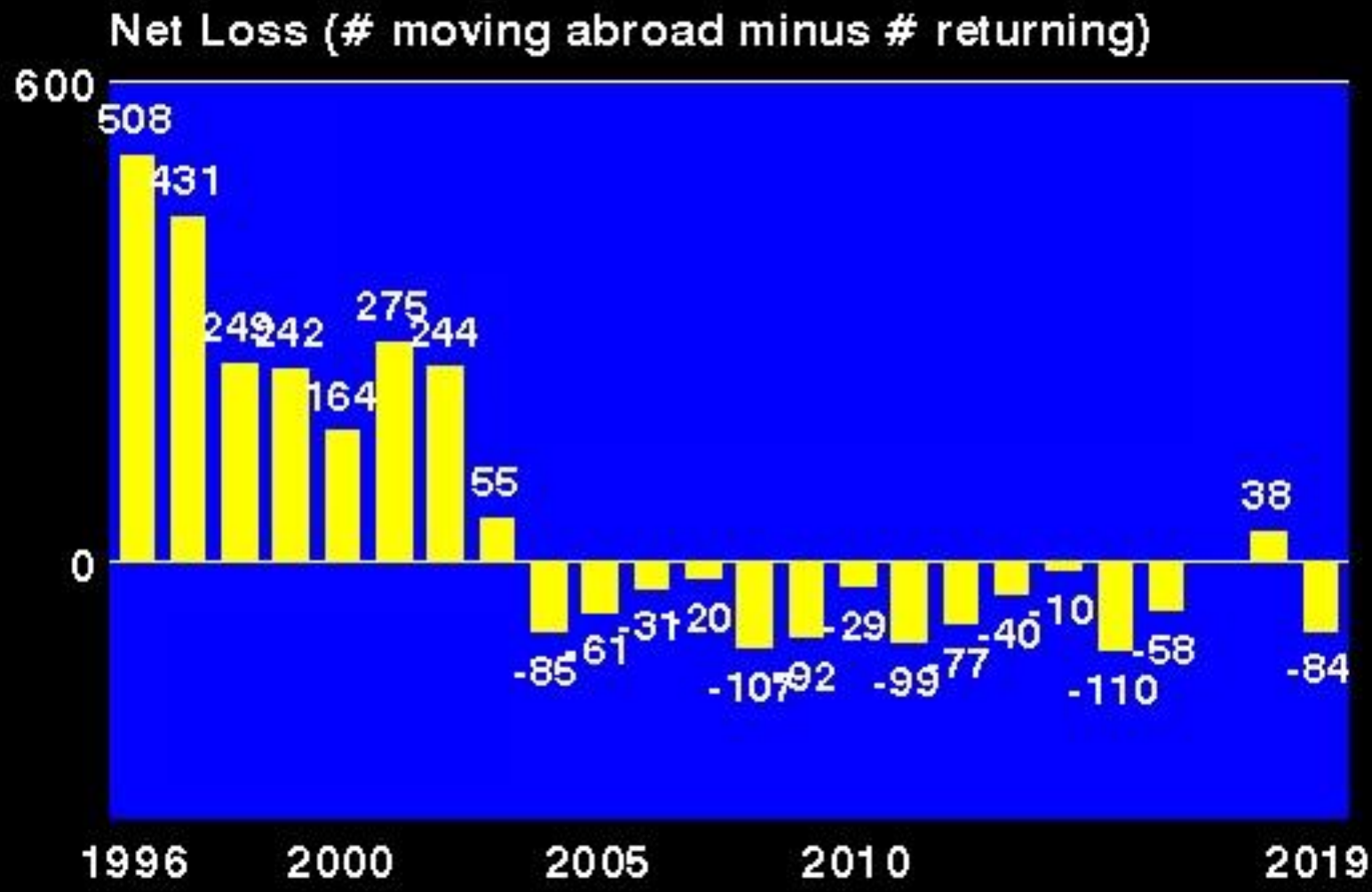
Note: Excludes non-billing-related costs for documentation compliance etc.

Overall Administrative Costs Per Capita United States & Canada, 2021



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, 2018/2019

Average Clinical Payments Per Physician

Family Medicine	$279,929
Int. Medicine	$407,171
Pediatrics	$296,010
Psychiatry	$281,614
Dermatology	$384,815
Ob/GYN	$392,115
General Surg.	$465,707
Thoracic Surg.	$587,585
Cardiology	$610,793
Opthalmology	$791,406
All Physicians	$347,464

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

What's OK in Canada?

Compared to the U.S.

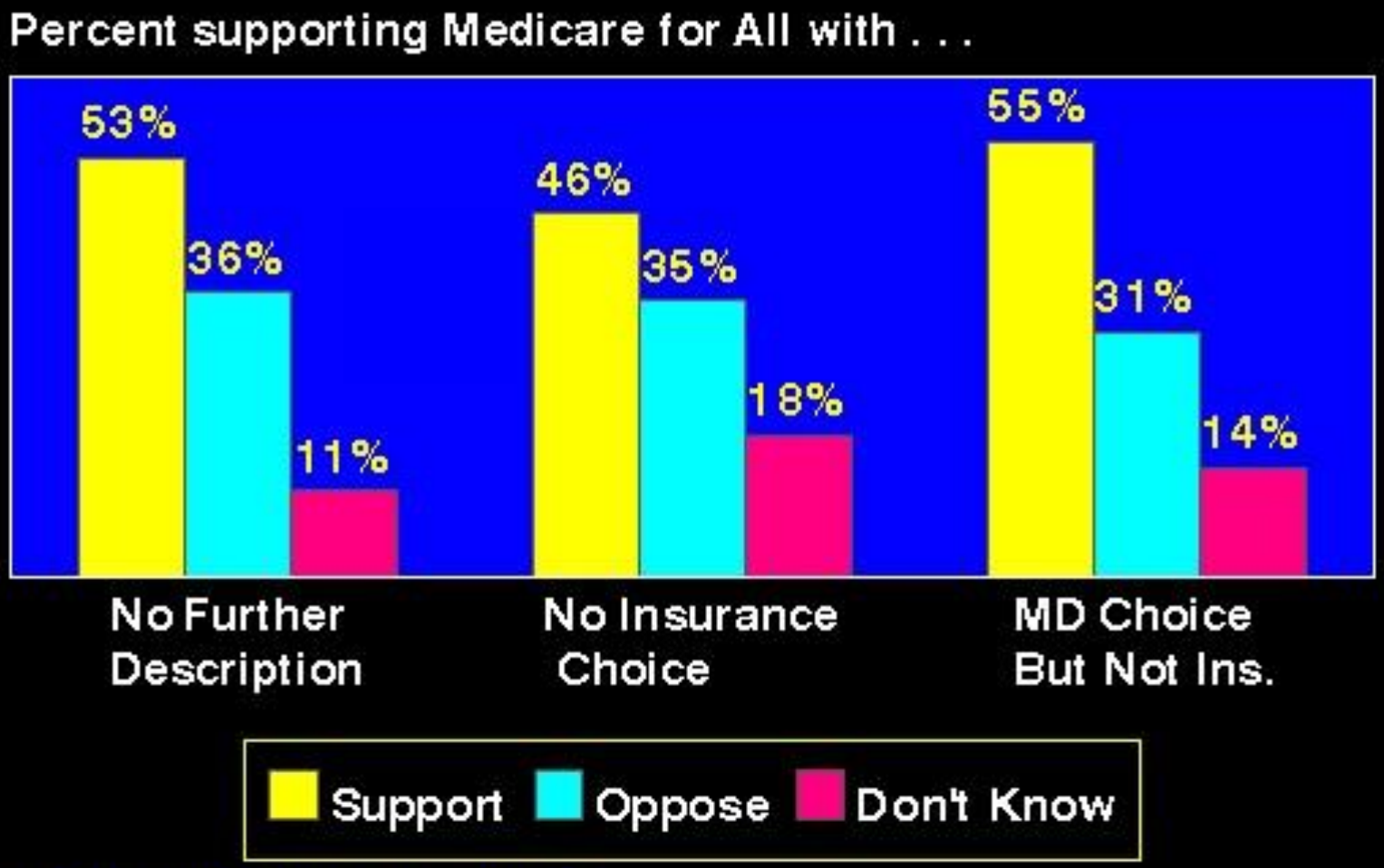
- Life expectancy 2 years longer
- Infant deaths 25% lower
- Universal comprehensive coverage
- More MD visits, hospital care; less bureaucracy
- Quality of care equivalent to insured Americans'
- Free choice of doctor/hospital
- Health spending half U.S. level

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

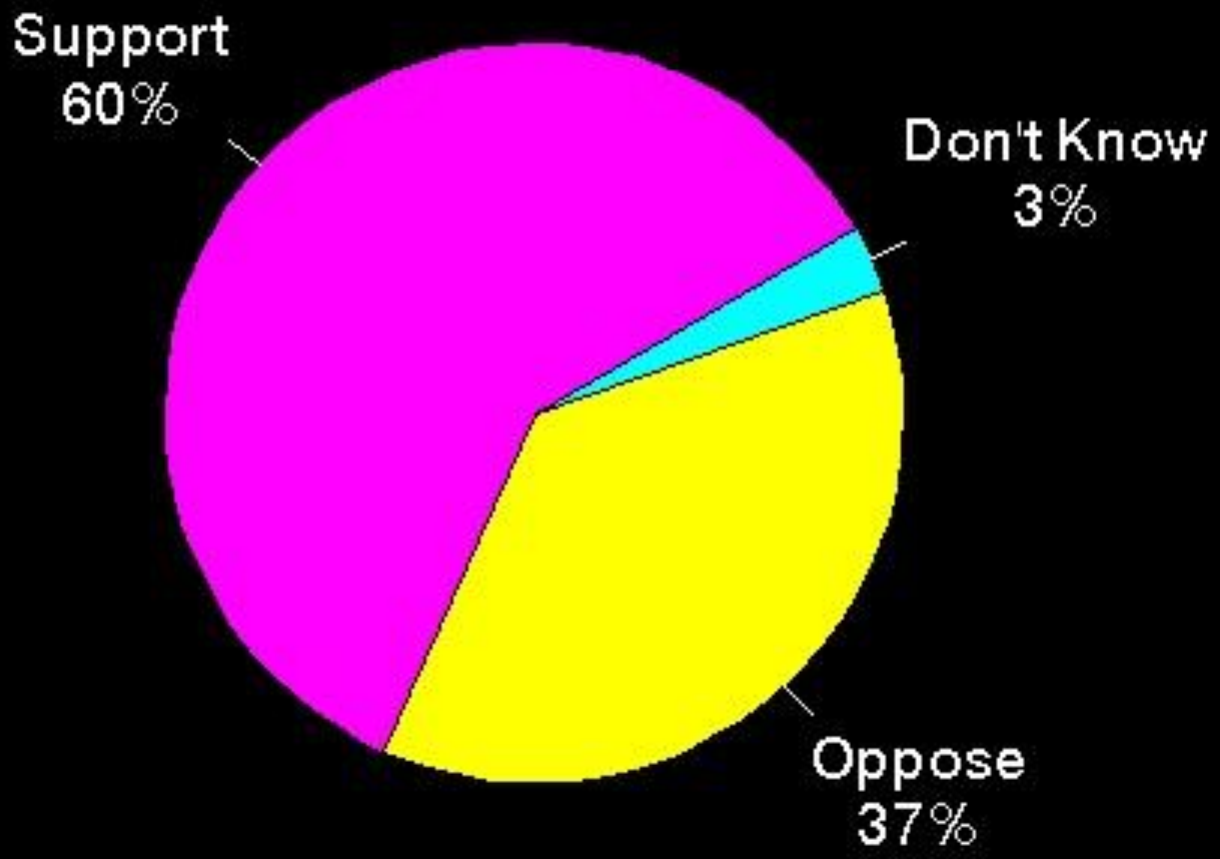
Most Favor Phasing Out Private Plans if They Can Keep Their Doctor/Hospital



Source: Morning Consult July, 2019

Note: Question asked about choice of doctor AND hospital

2021 Poll: 60% Want Medicare for All

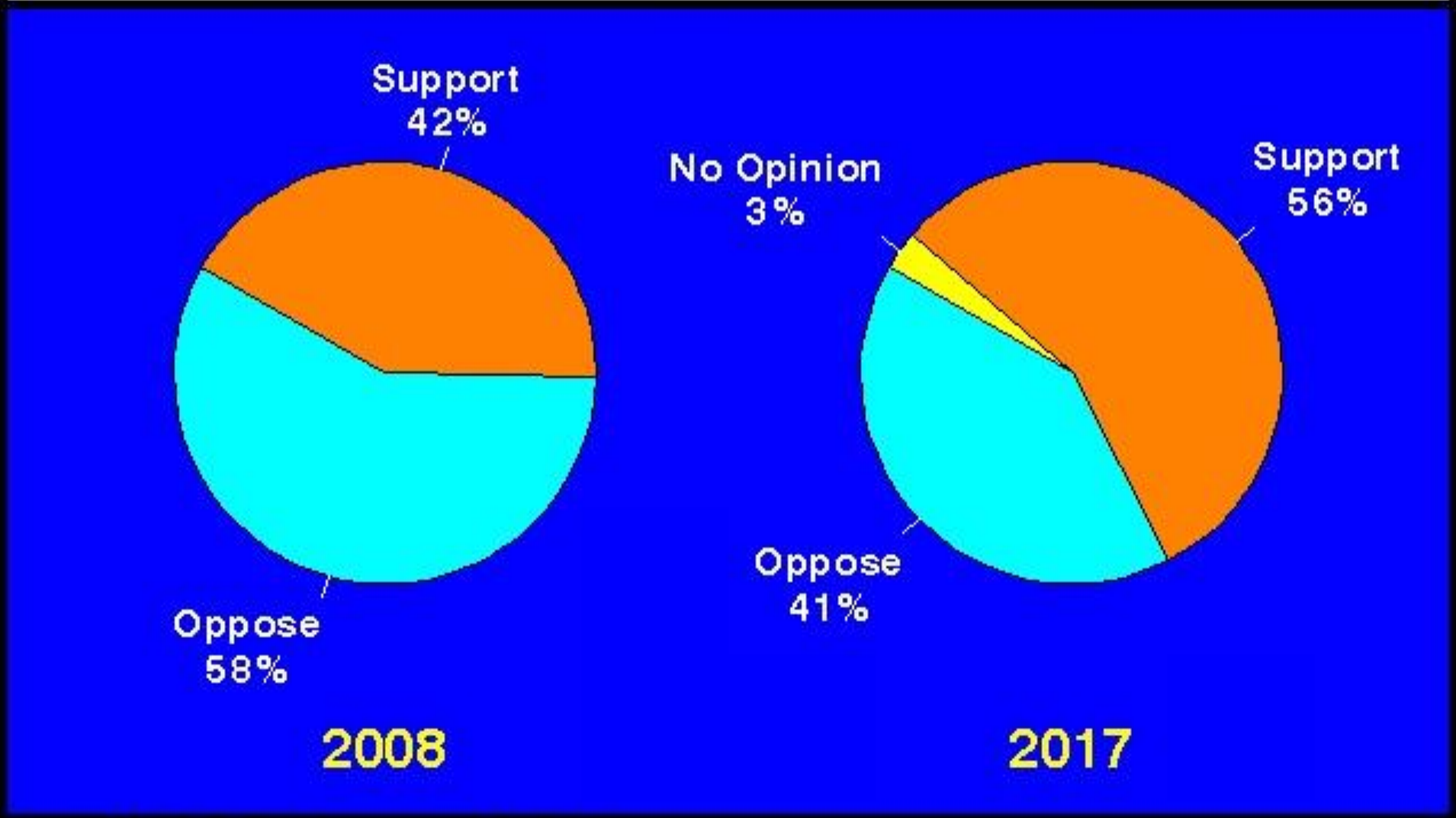


Source: Commonwealth Fund/Harvard Public Health School Survey January, 2021

"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

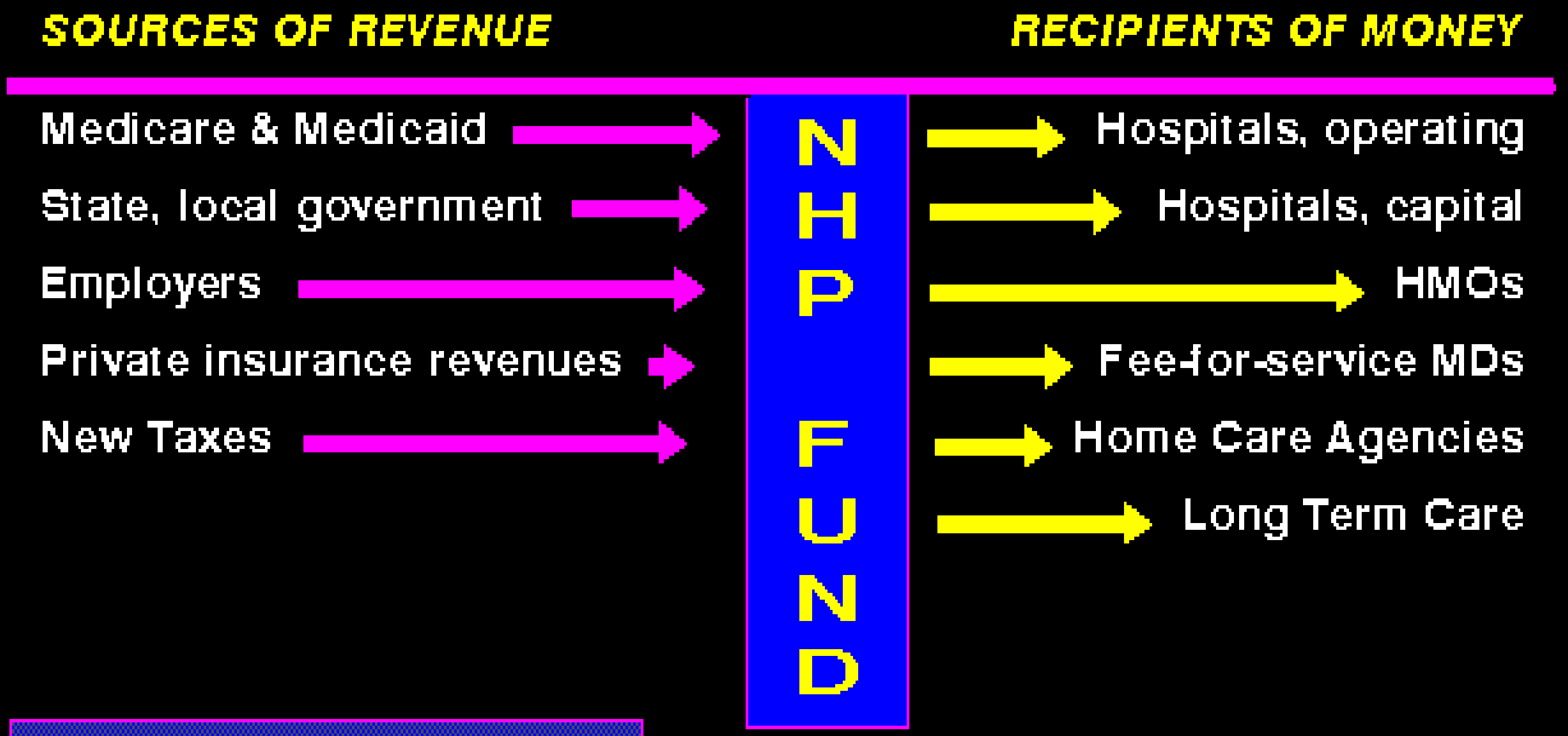
A National Health Program for the U.S.

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

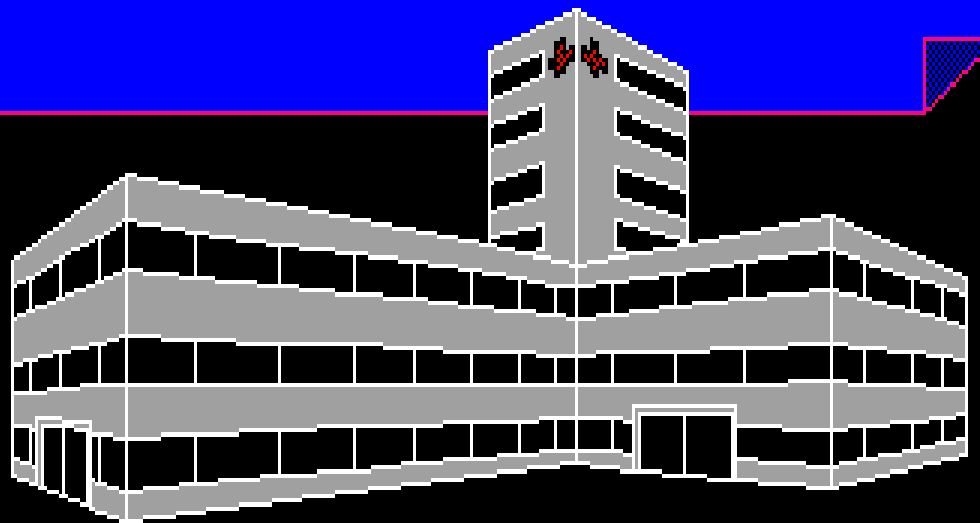
FUNDING FOR THE NHP



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

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.

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
vs.
Medicare for More
(e.g. Public Option)

Single Payer and Private Coverage

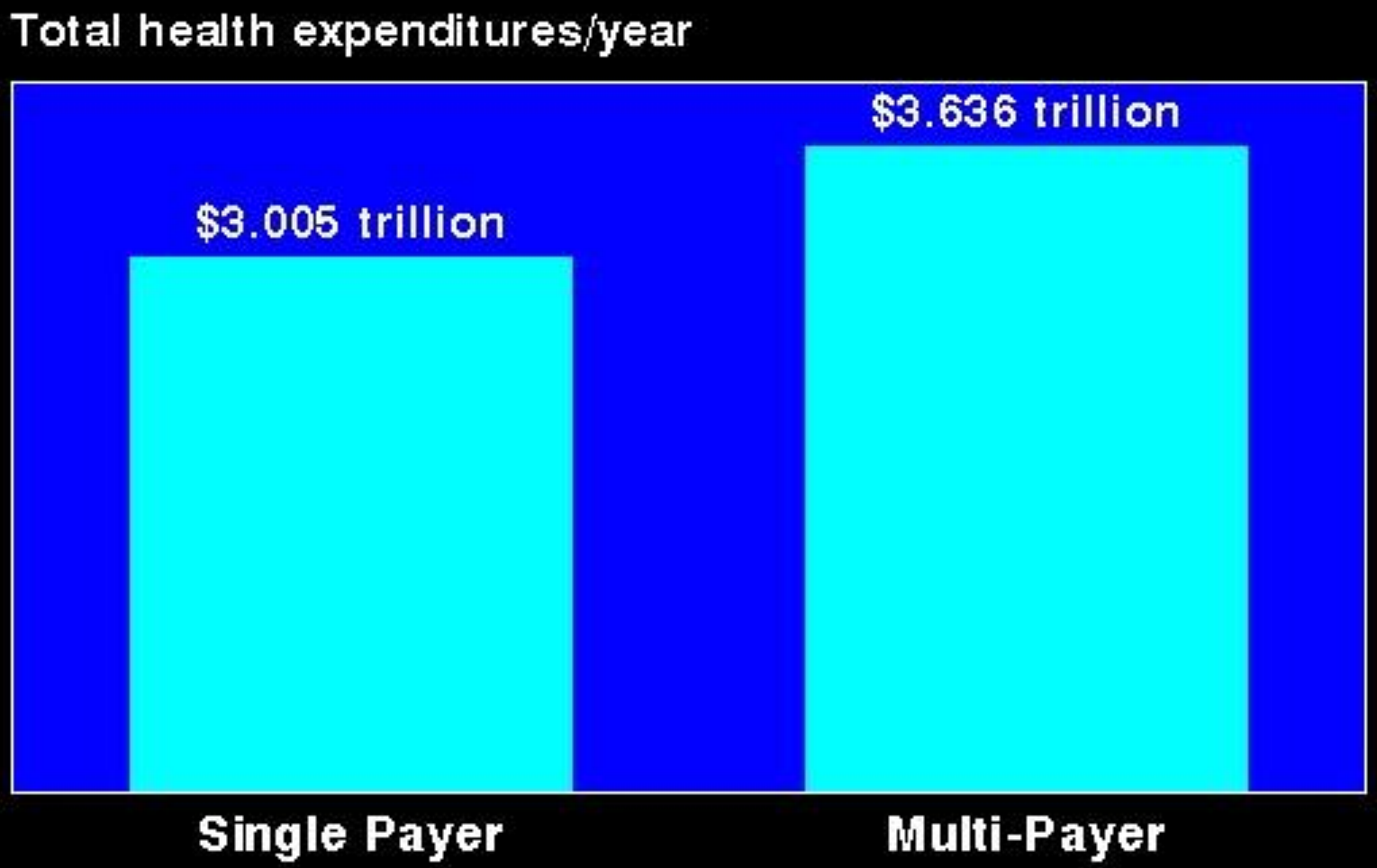
- Allowed: Supplemental non-competing – but can only cover benefits NOT covered by the public plan.

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

Public Option = 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, upcoding, cheating.
- Higher system-wide costs (compared to single payer) assure political pressure for benefit cuts.

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



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