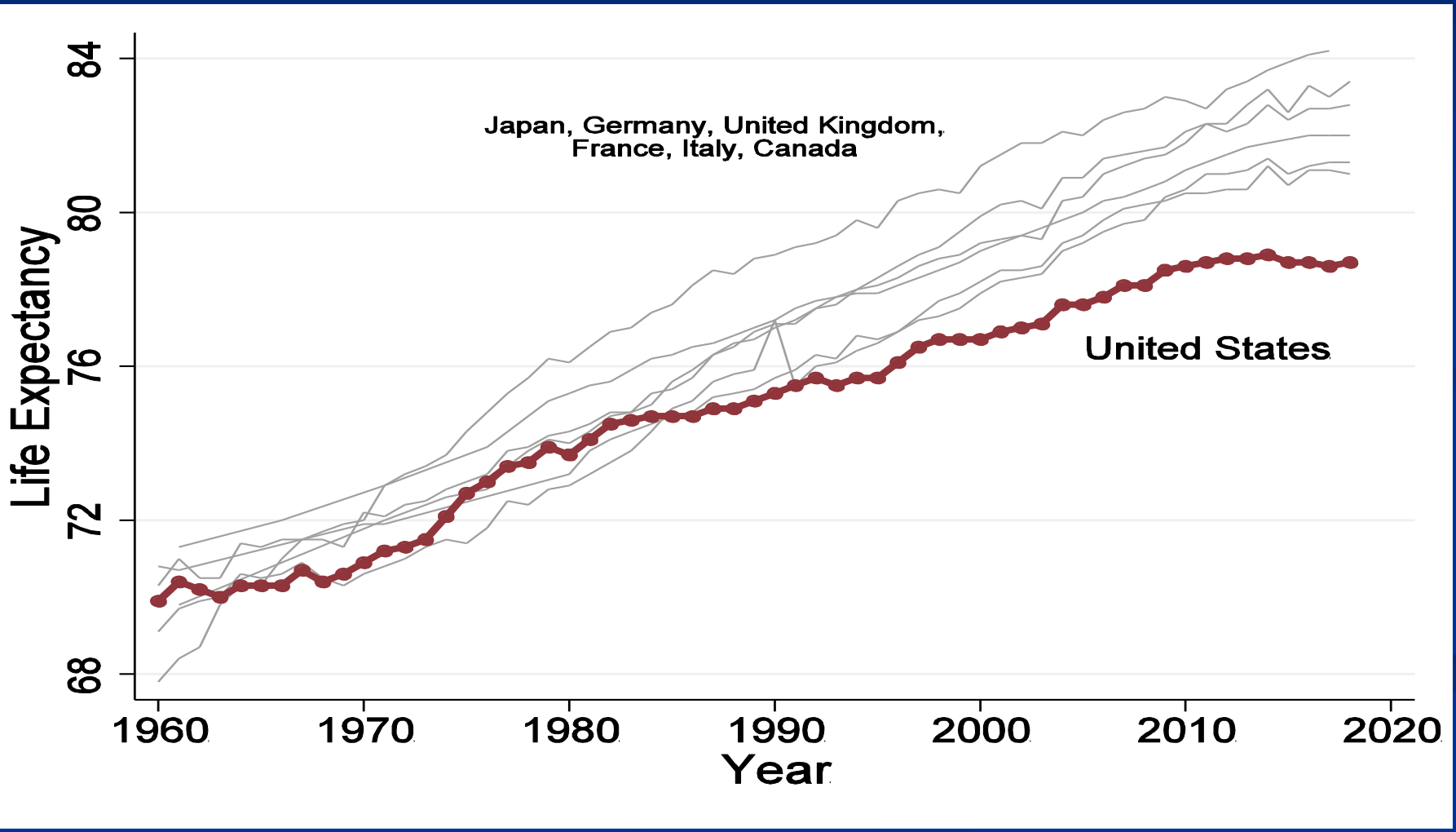
Slides prepared by Drs. Steffie Woolhandler & David Himmelstein, Faculty at the City University of New York at Hunter College and Harvard Medical School, and Research Associates, Public Citizen Health Research Group

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

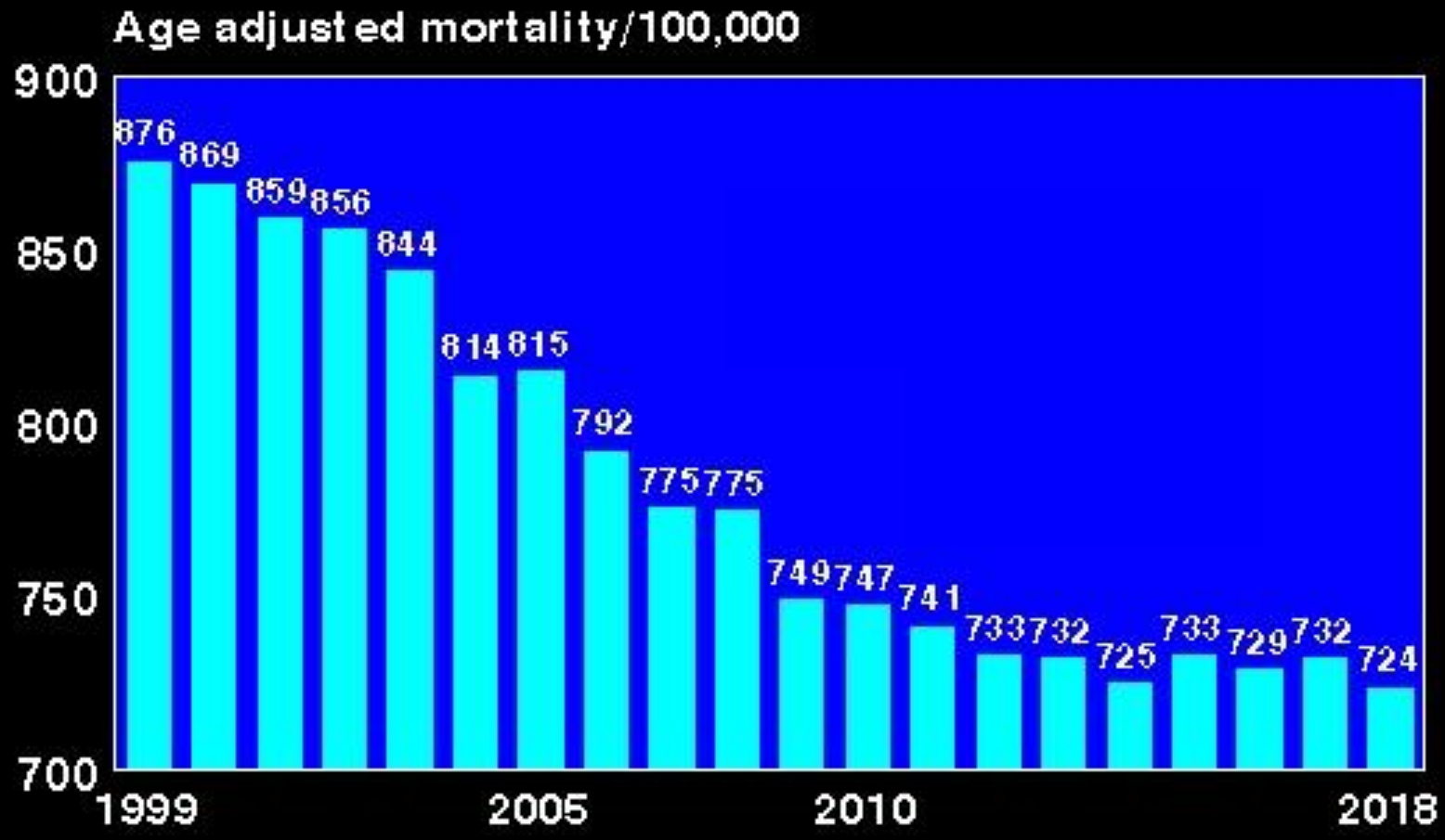
- Deteriorating health status.
- Weakened public health capacity.
- Increasing economic inequality.
- Racism that harms people of color and erodes support for safety-net programs.
- Wasteful health care system that prioritizes profitability over needs.

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



Source: J. Bor based on OECD 2020

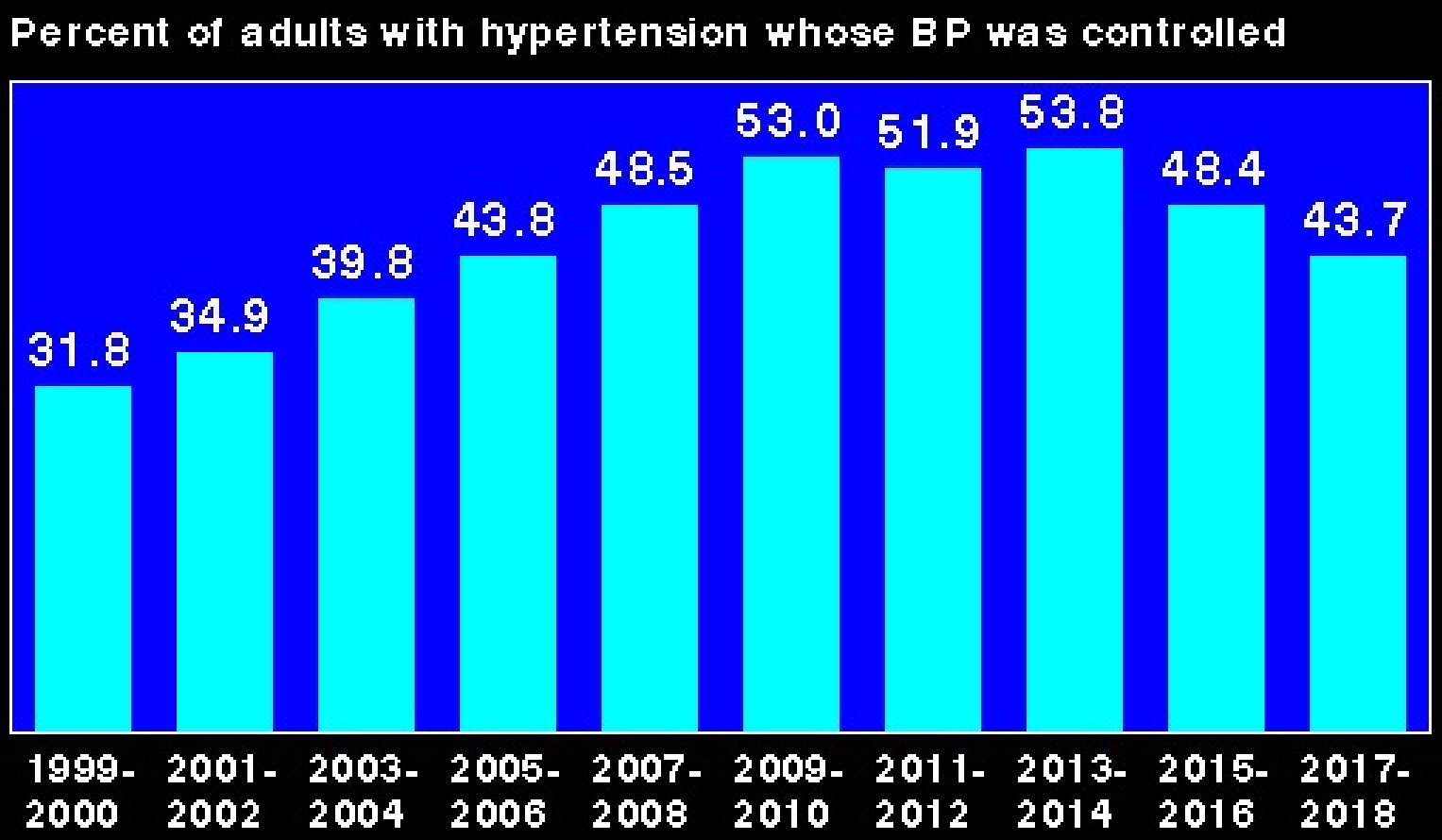
Progress on Mortality Halted



Source: NCHS
Note: Data for 2017 is preliminary

Worsening Blood Pressure Control

A Rising Share of US Adults Have Uncontrolled Hypertension

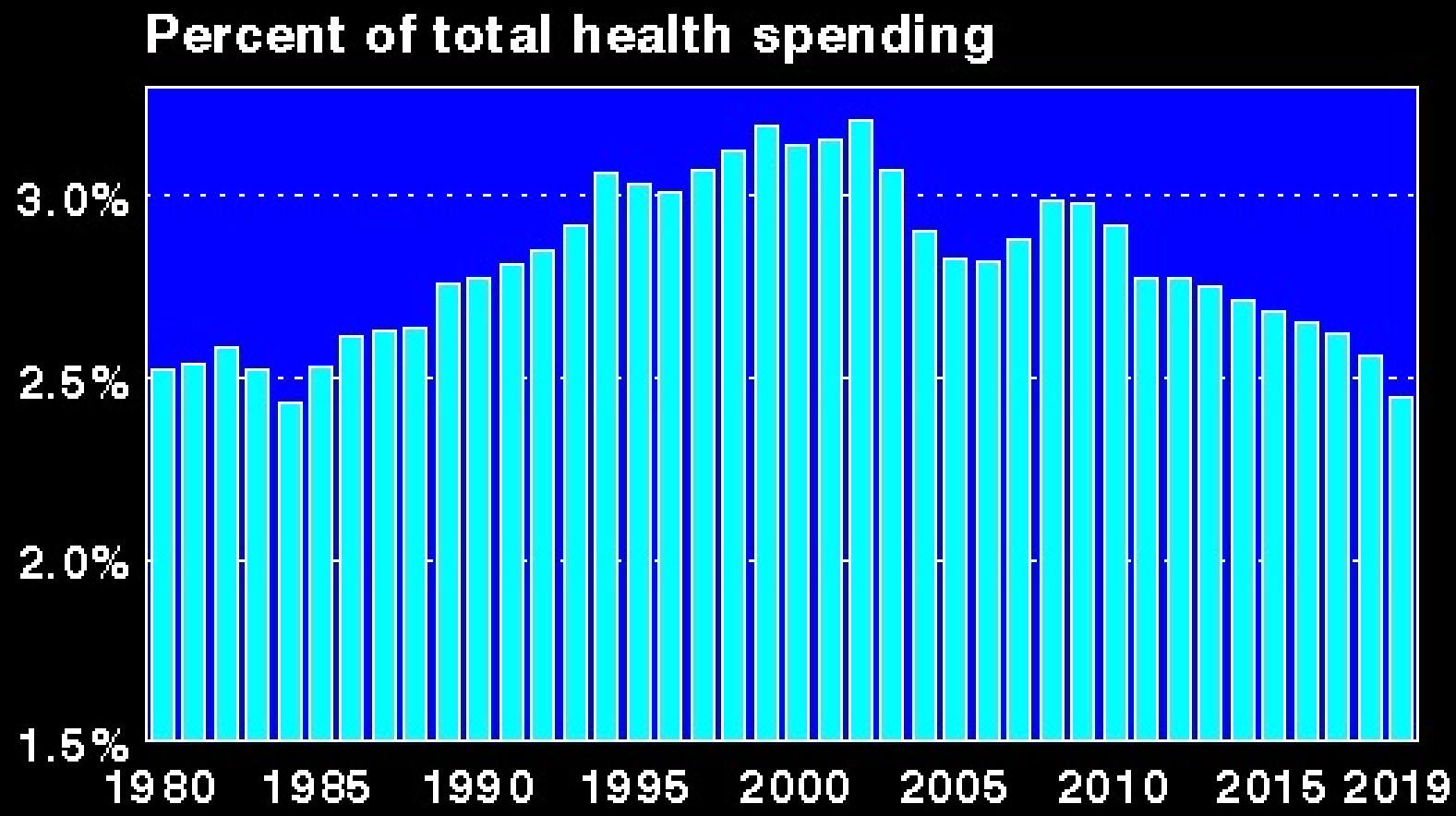


Source: JAMA 2020;324:1190 - Worsening control was seen in virtually every demographic group

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

Weakened Public Health Capacity

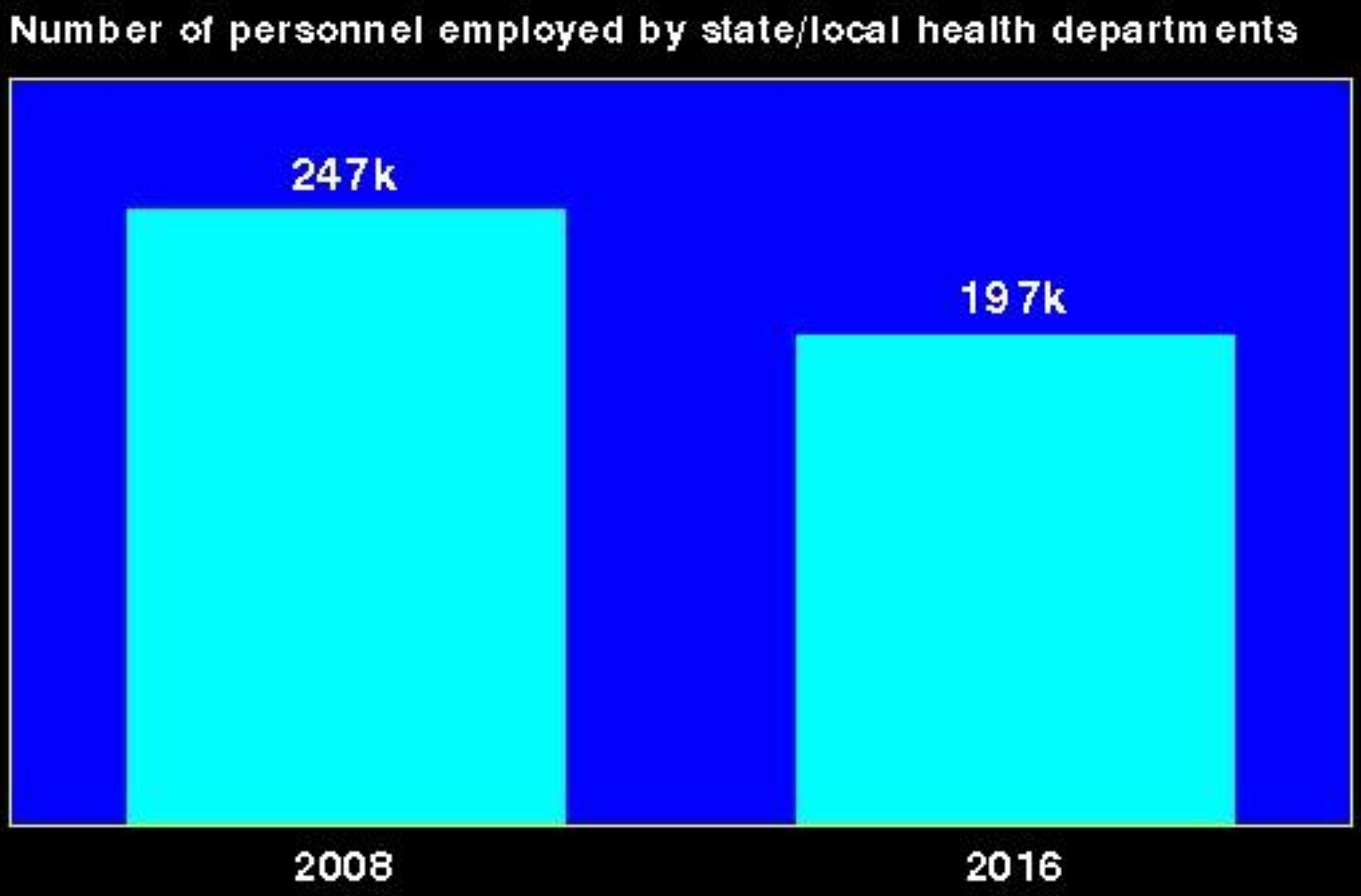
Public Health's Falling Share of Total Health Spending



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



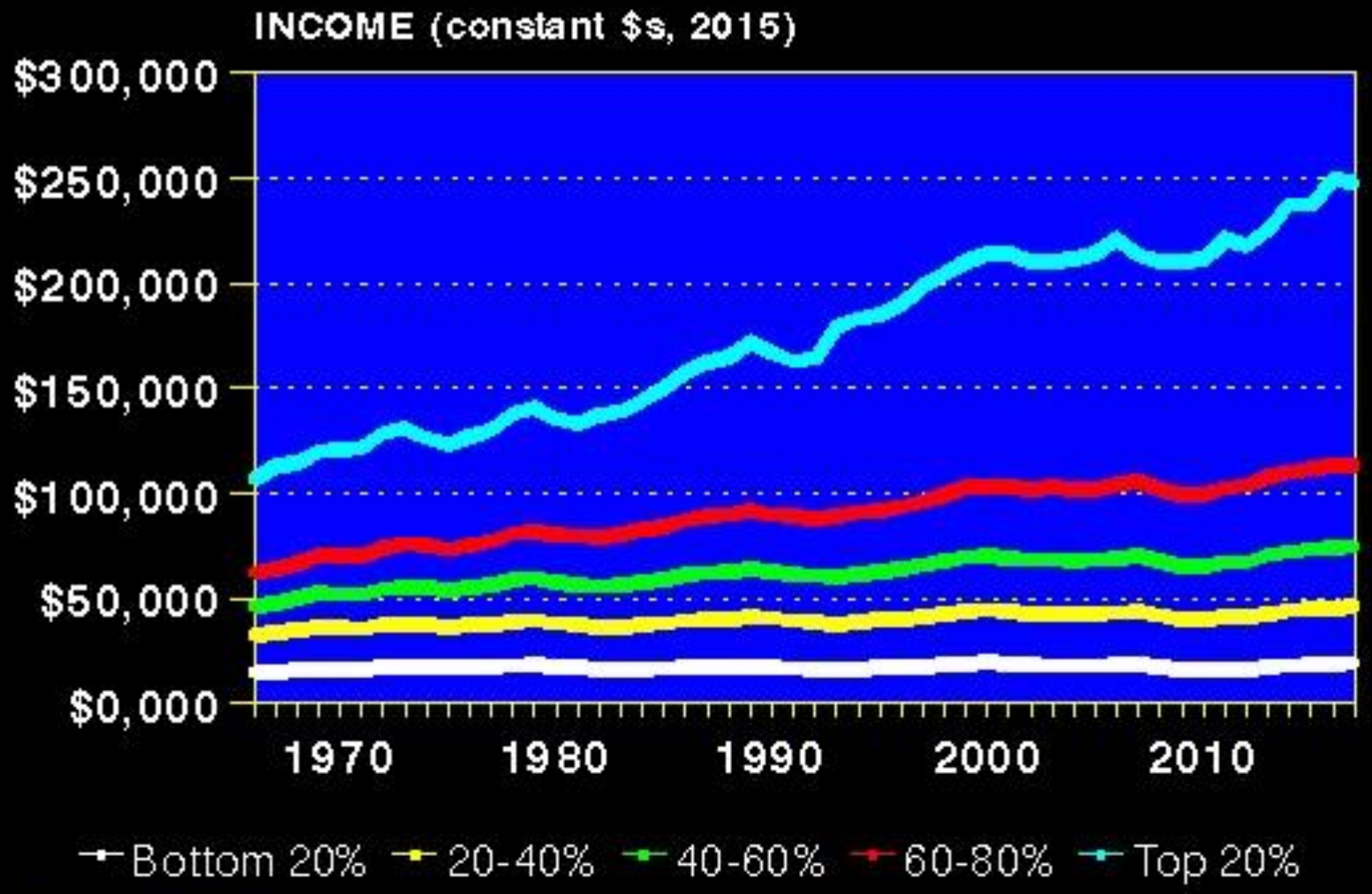
Source: Am J Preventive Med 2018;54:334

Trump Further Weakened Pandemic Response Capacity

- 2017 Hiring freeze at CDC left 700 vacant positions.
- 2018 - Abolished Global Health Security team of the National Security Council
- 1600 government scientists have left positions since January 2017.
- Many key science policy positions (e.g. OSHA Administrator) remain vacant.
- Defunding WHO in 2020 – A crime against humanity.

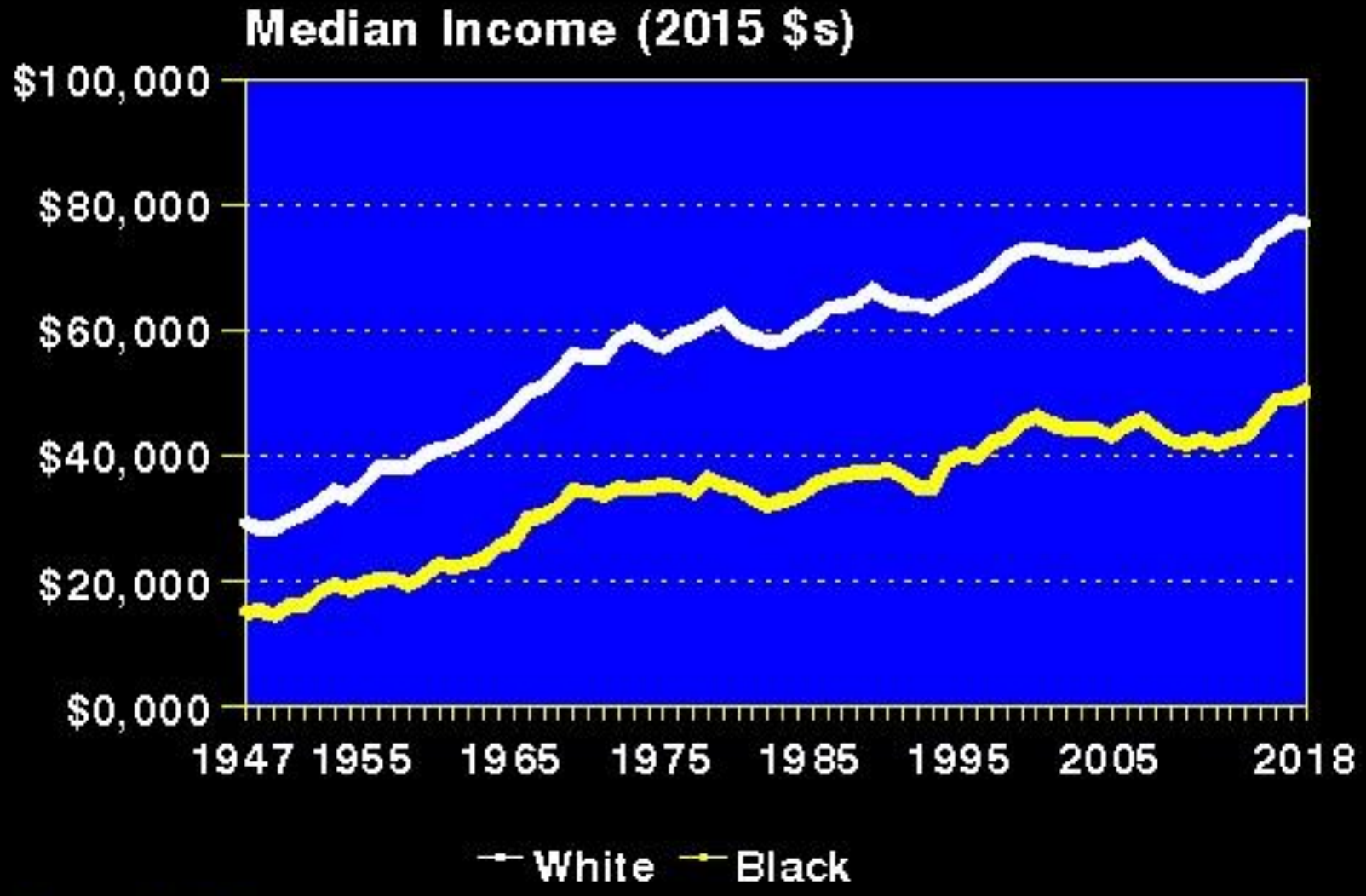
Increasing Economic Inequality

Mean Family Income for Each Fifth: 1966-2018 (Inflation Adjusted)



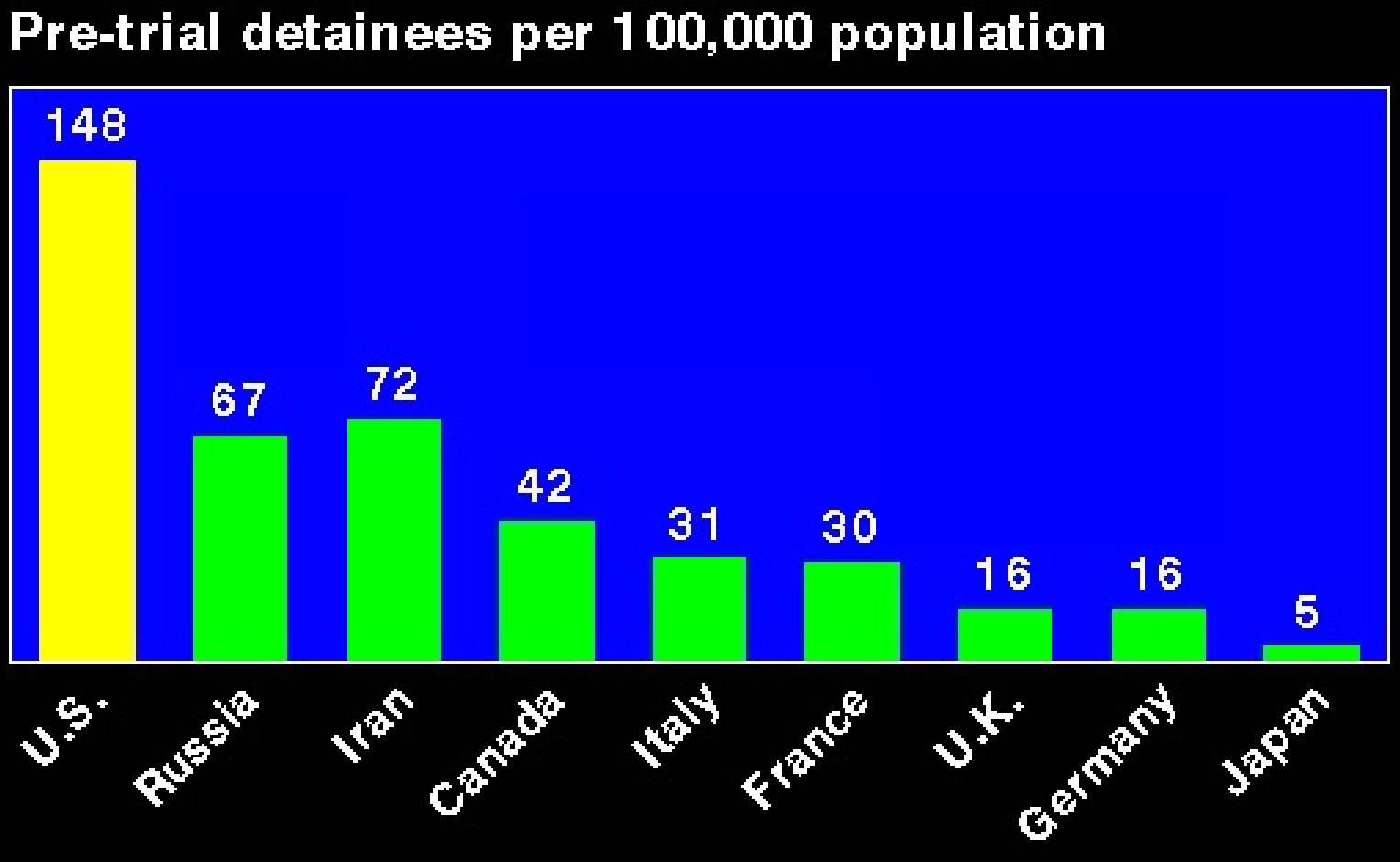
Source: Bureau of the Census

Median Family Income for Blacks and Whites: 1947-2018 (Inflation Adjusted)



Source: Bureau of the Census

Prisoners in Pre-Trial Detention

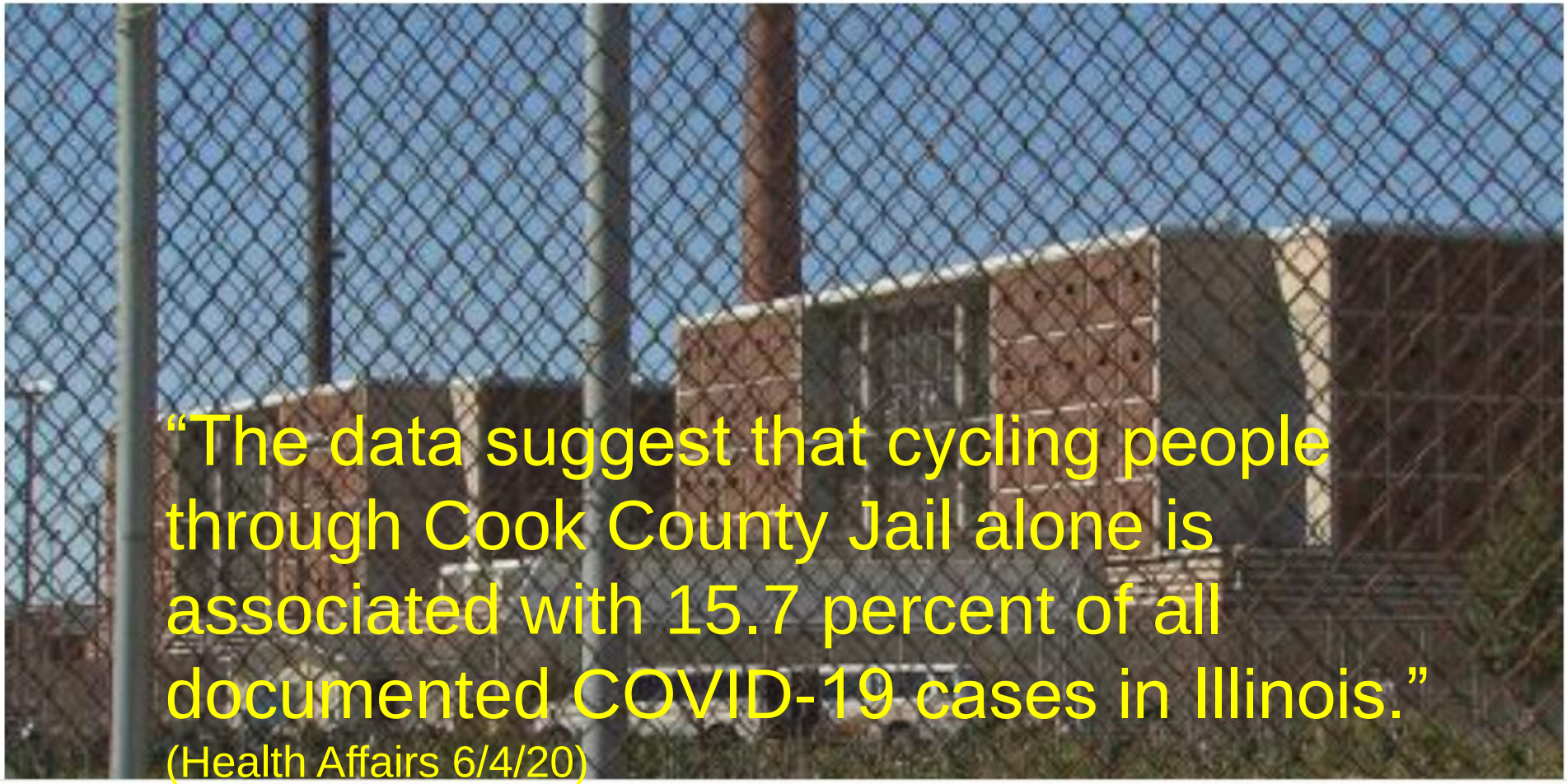


Source: Walmsley - World Pretrial Remand List, 4th Ed.

Increasing Economic Inequality Harms Health

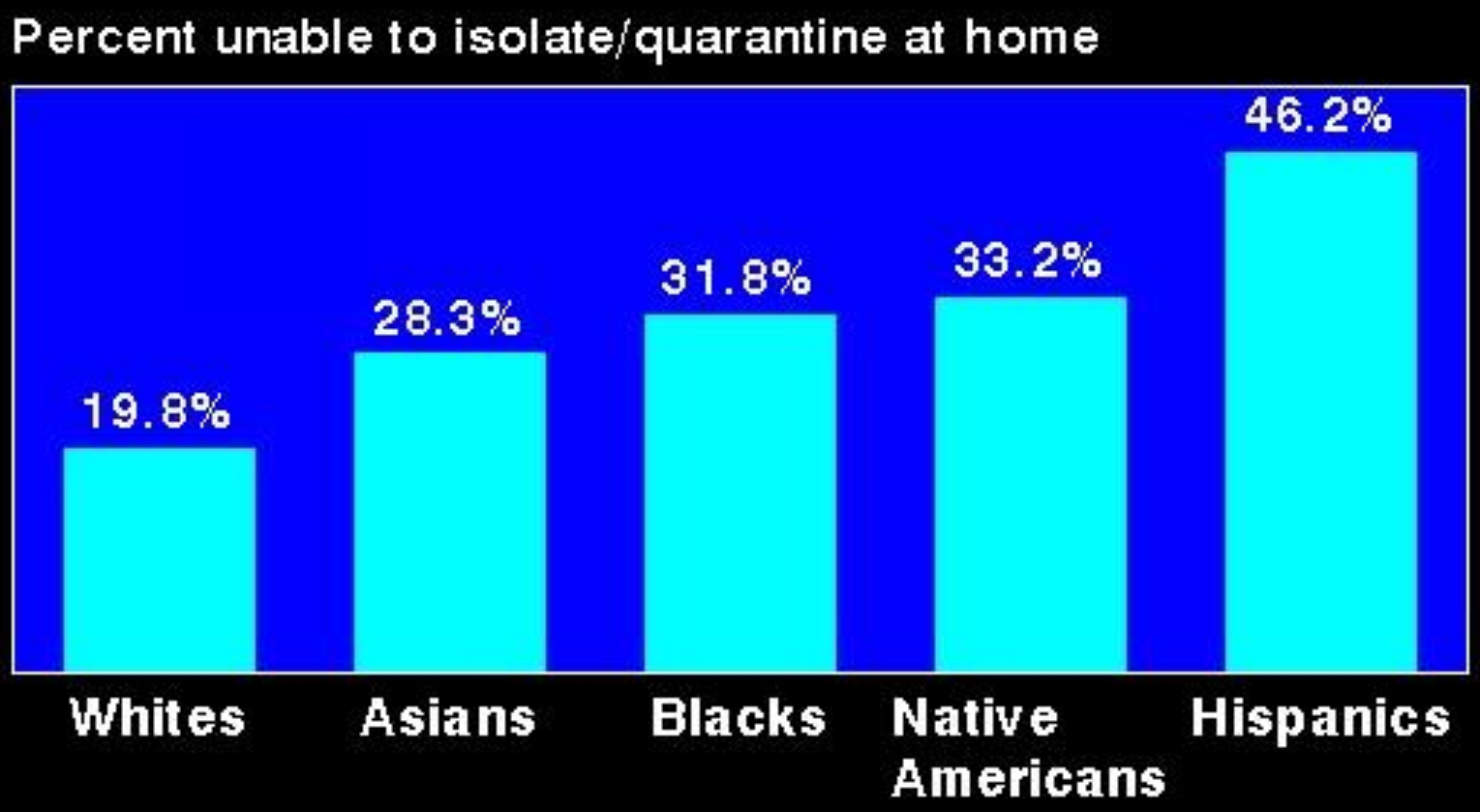
Report: 1 in 6 Chicago COVID-19 Cases Can Be Tied to Cook County Jail

Matt Masterson | June 4, 2020 6:33 pm



Many Live in Homes Unsuitable for Quarantine/Isolation

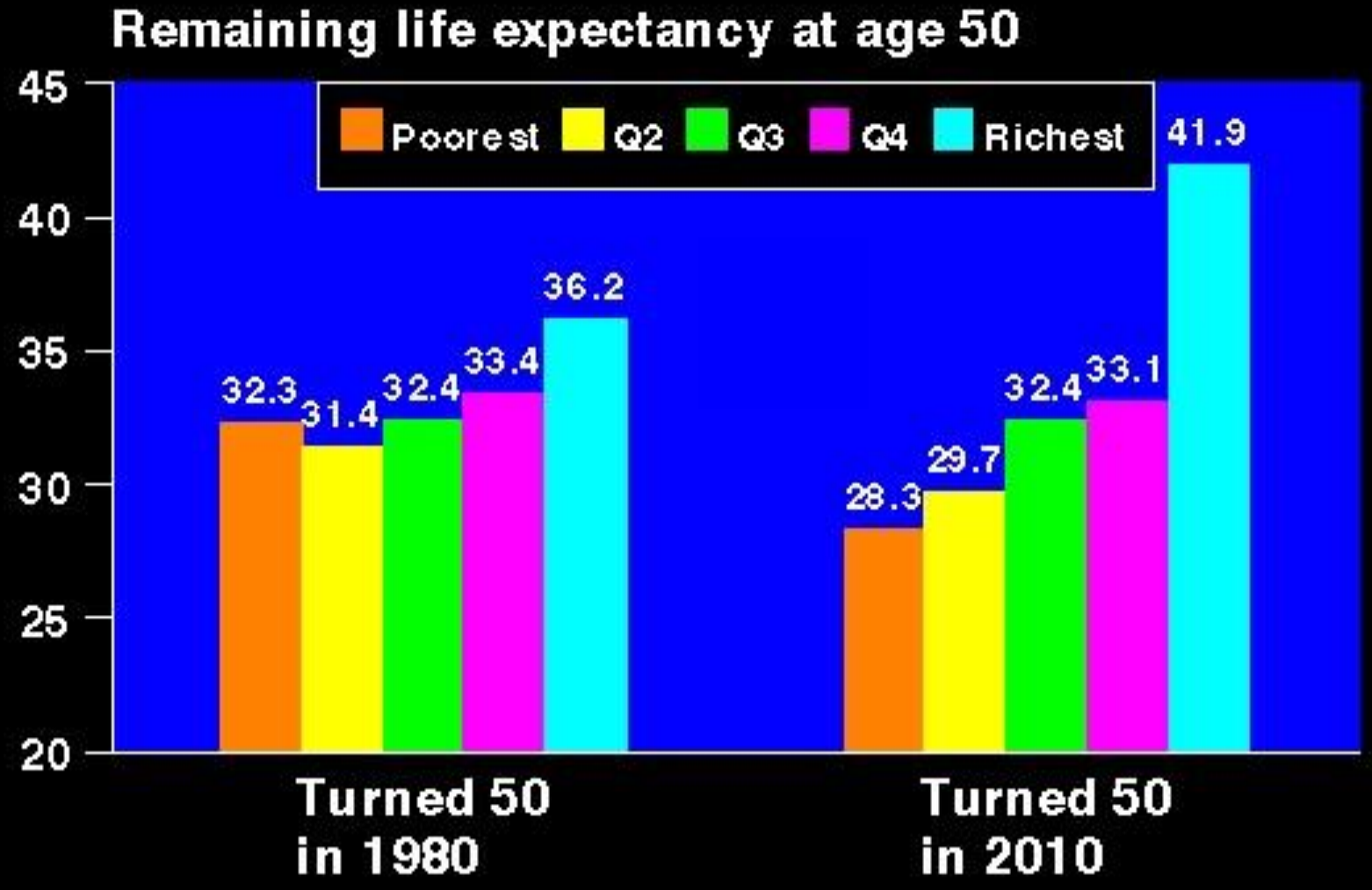
Too Many People, Too Few Bedrooms or Bathrooms



Source: Sehgal, Himmelstein & Woolhandler - Ann Intern Med - published online July 21, 2020
Data are from analysis of 2017 American Housing Survey

Growing Gap in Life Expectancy by Income

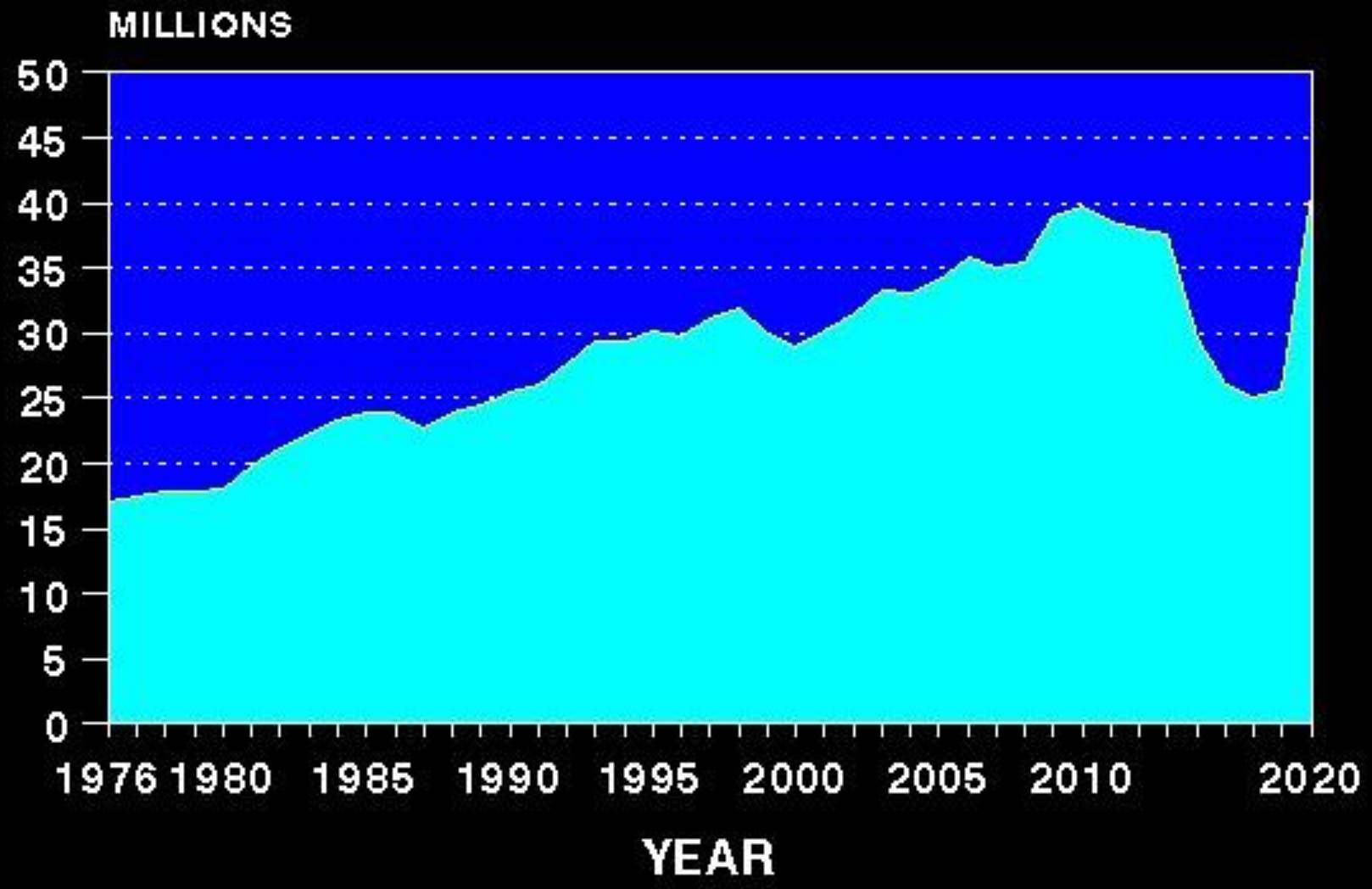
Dramatic Gains for the Wealthy, Losses for Lower Income



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

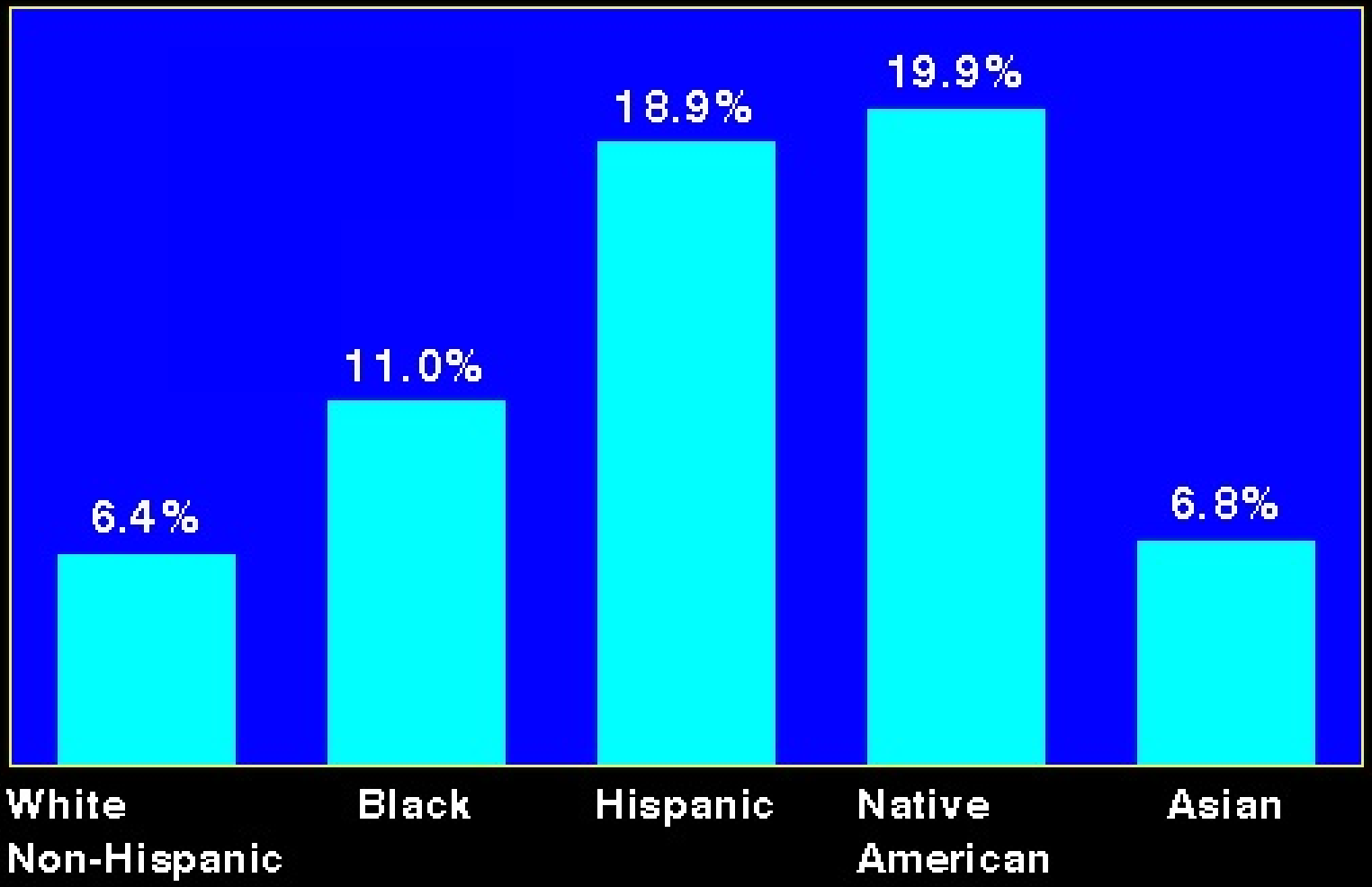
The Uninsured

Number Uninsured, 1976-June, 2020



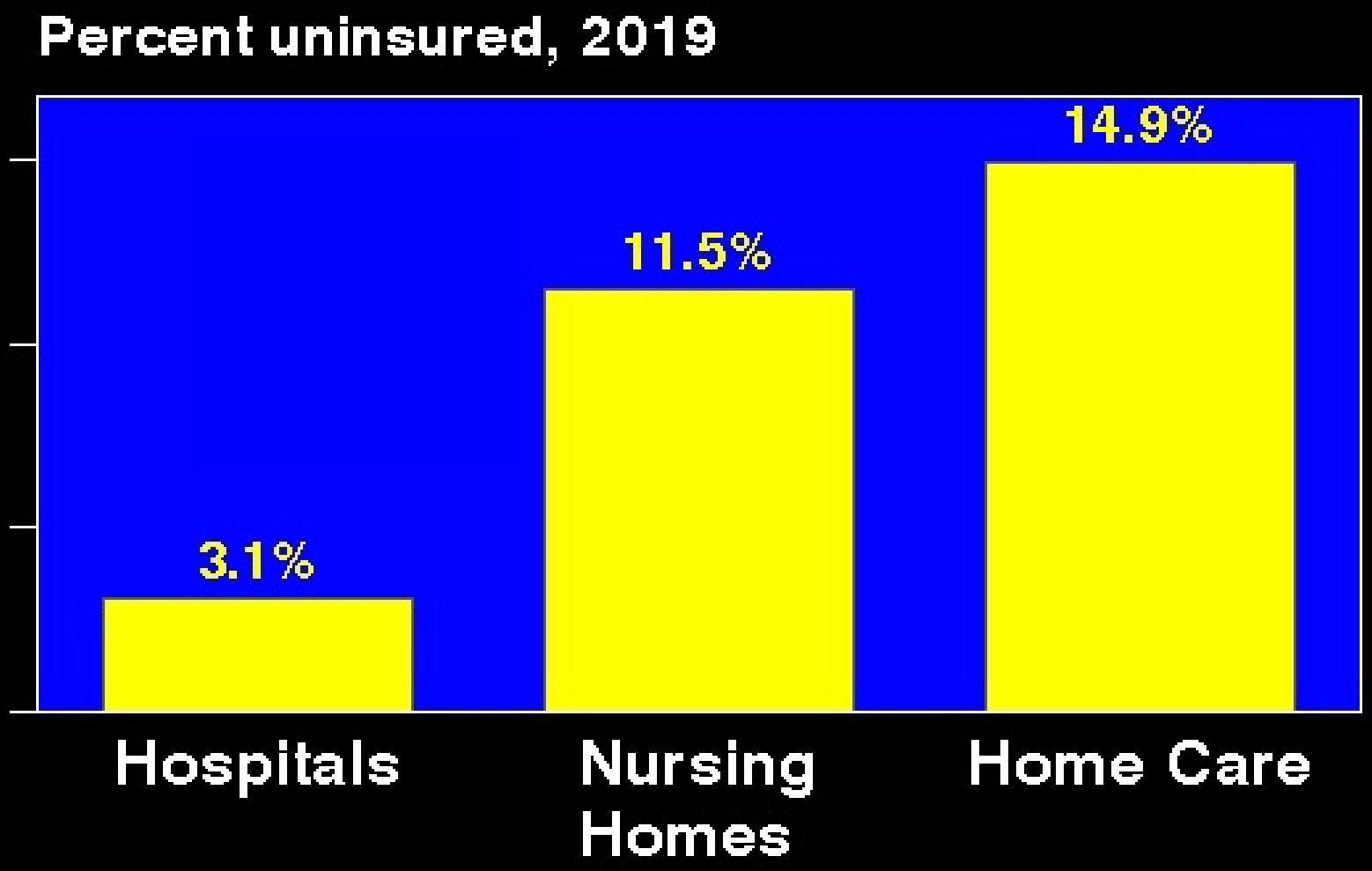
Source: Himmelstein & Woolhandler - Tabulation from CPS, ACS & NHIS Data
Figure for 2020 is estimated based on increase in unemployment

Percent Uninsured by Race/Ethnicity, 2019



Source: American Community Survey

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

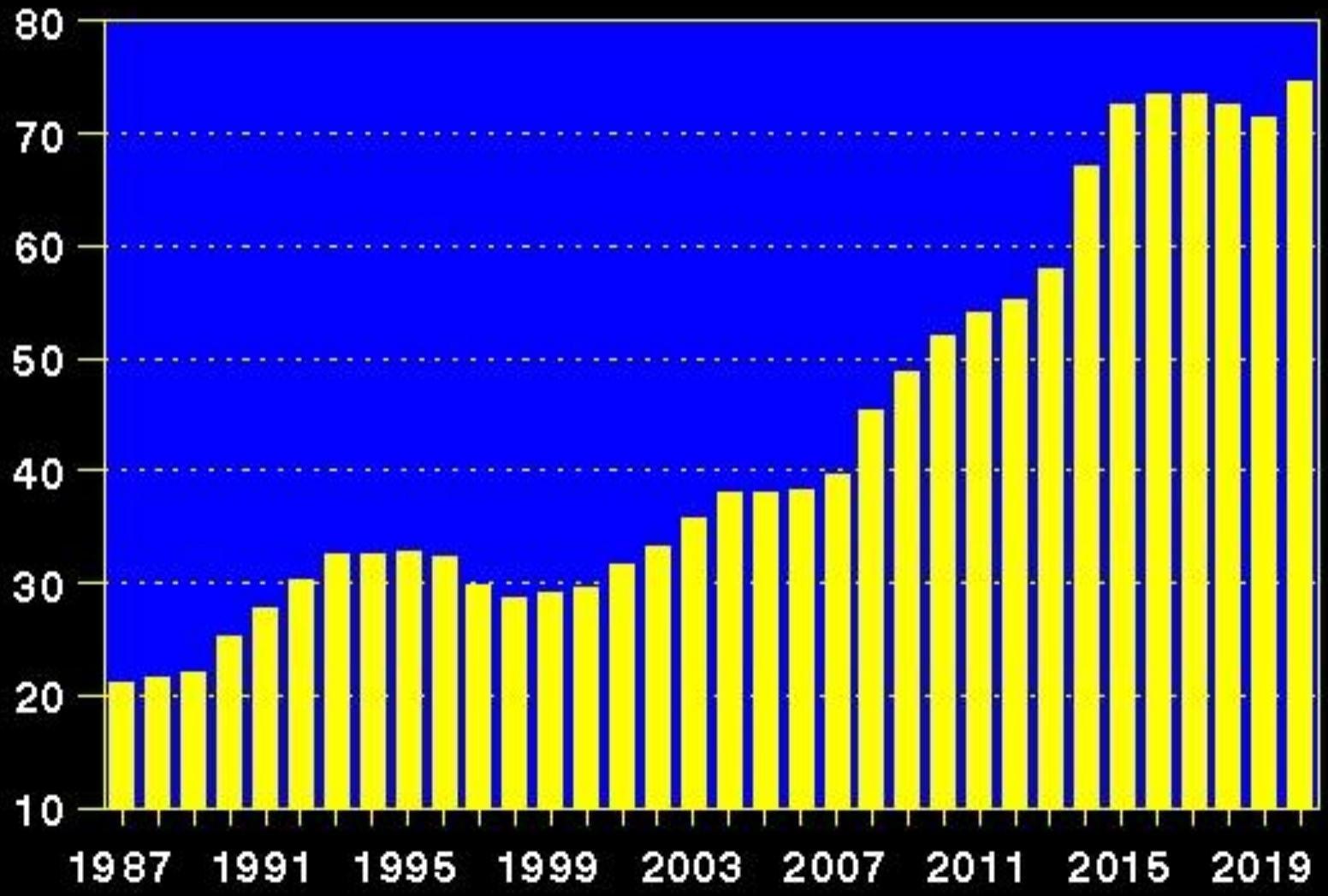
38,531 Deaths During 2019 Due to Uninsurance

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

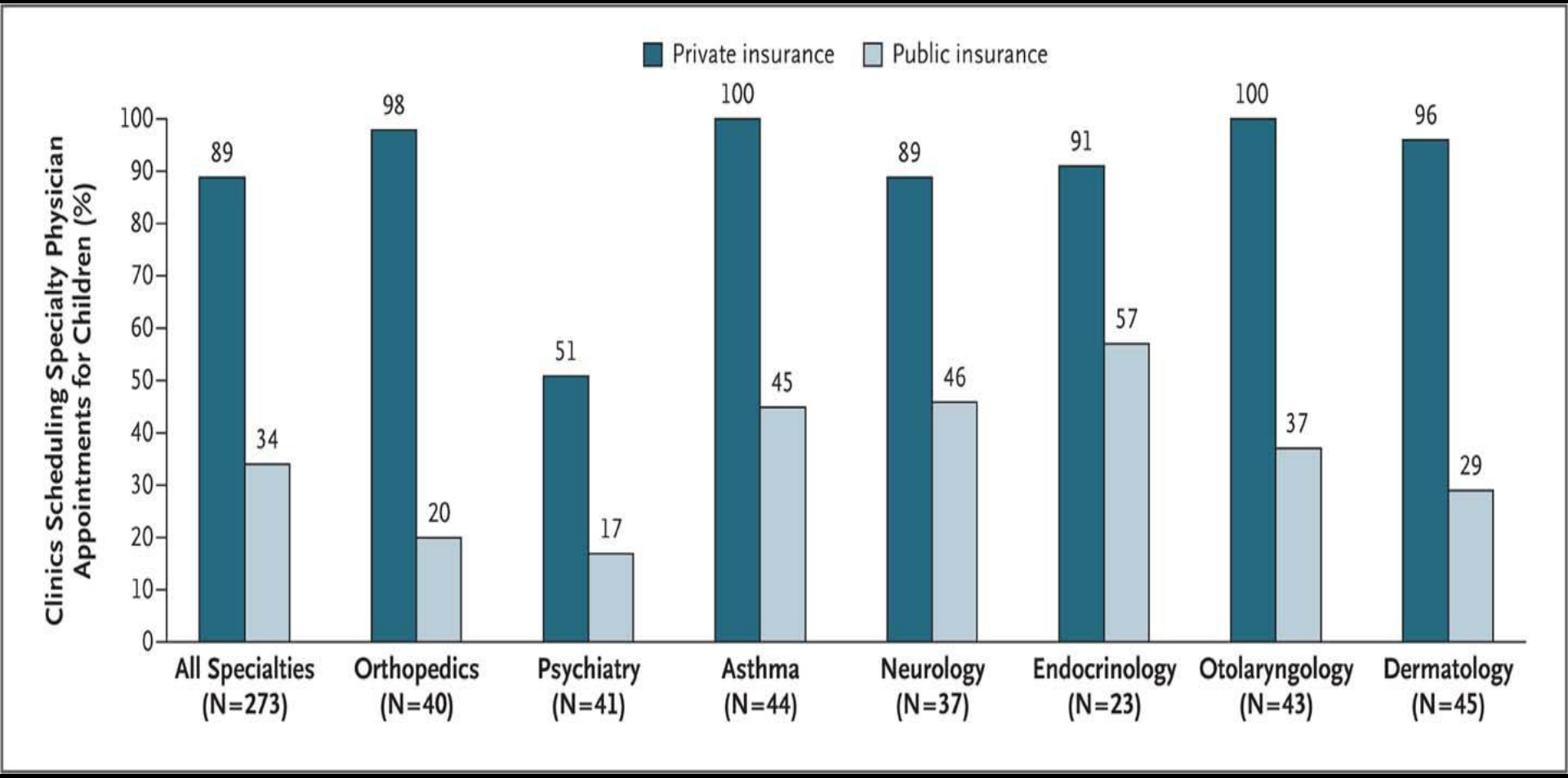
Medicaid: Poor Access, But Better Than Nothing

Medicaid Enrollment, 1987-2020



Source: Kaiser Foundation - Figures are for mid year

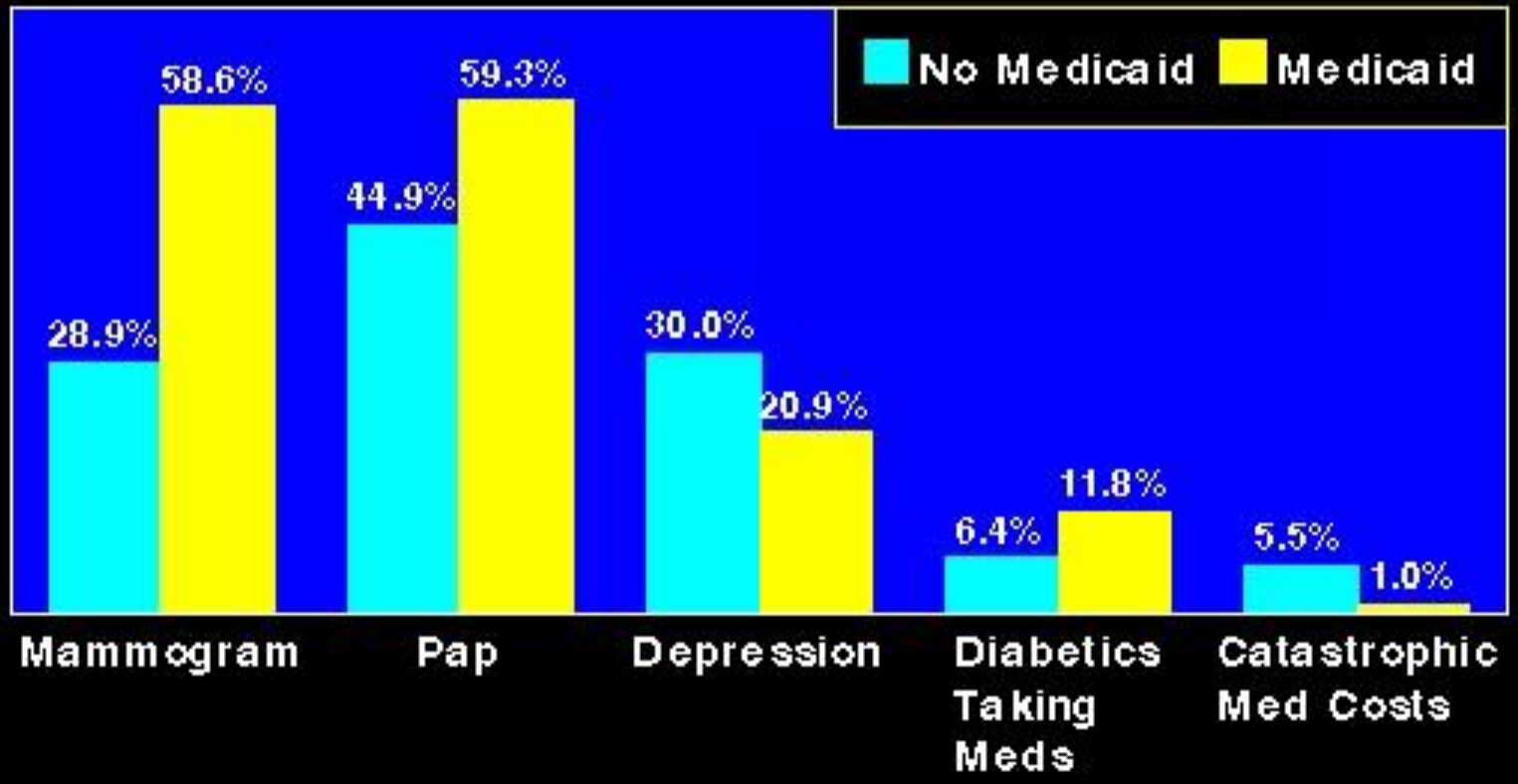
Many Specialists Won't See Kids With Medicaid



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

Medicaid Helps

An RCT in Oregon

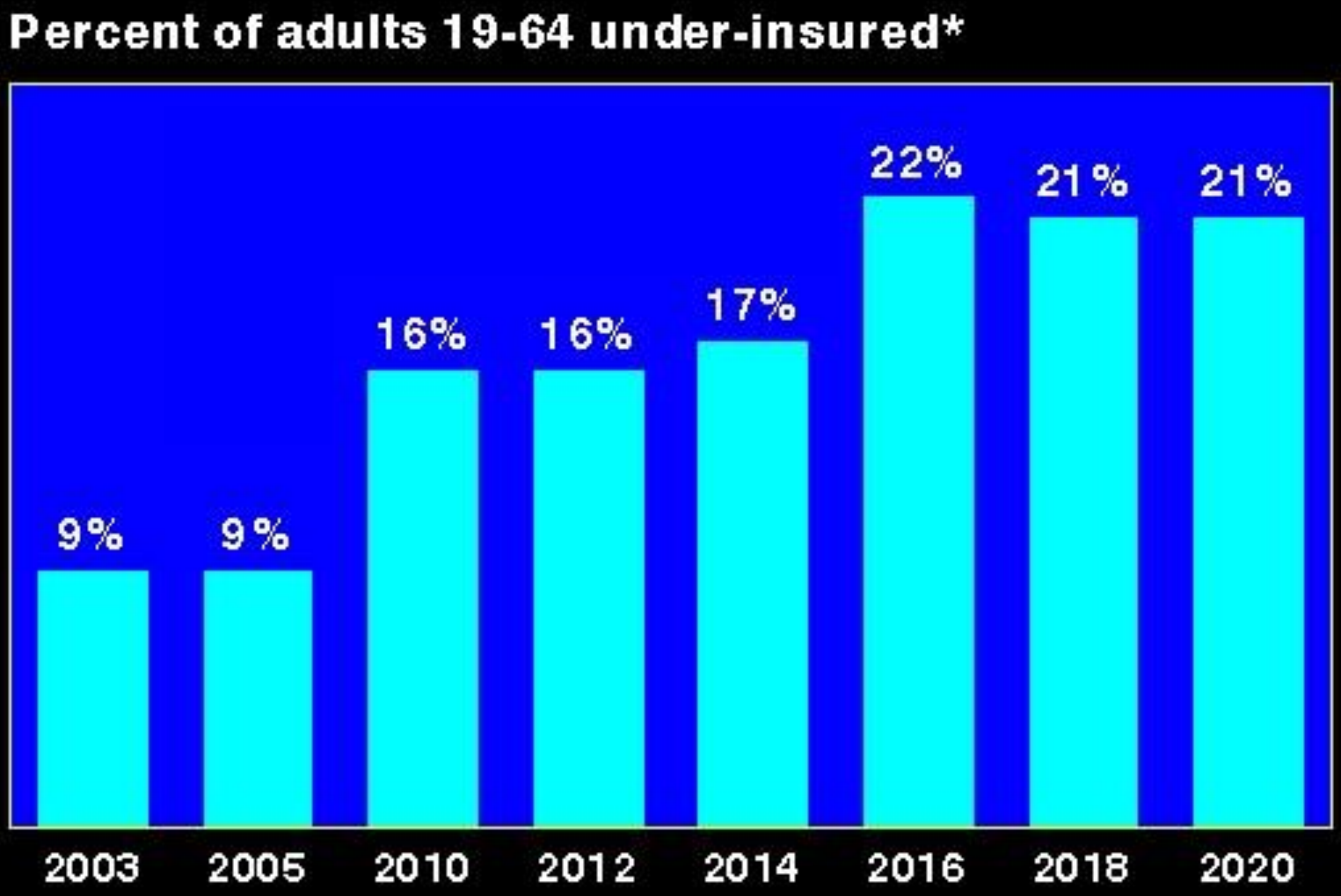


Source: NEJM May 2, 2013

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

Under-Insurance On the Rise

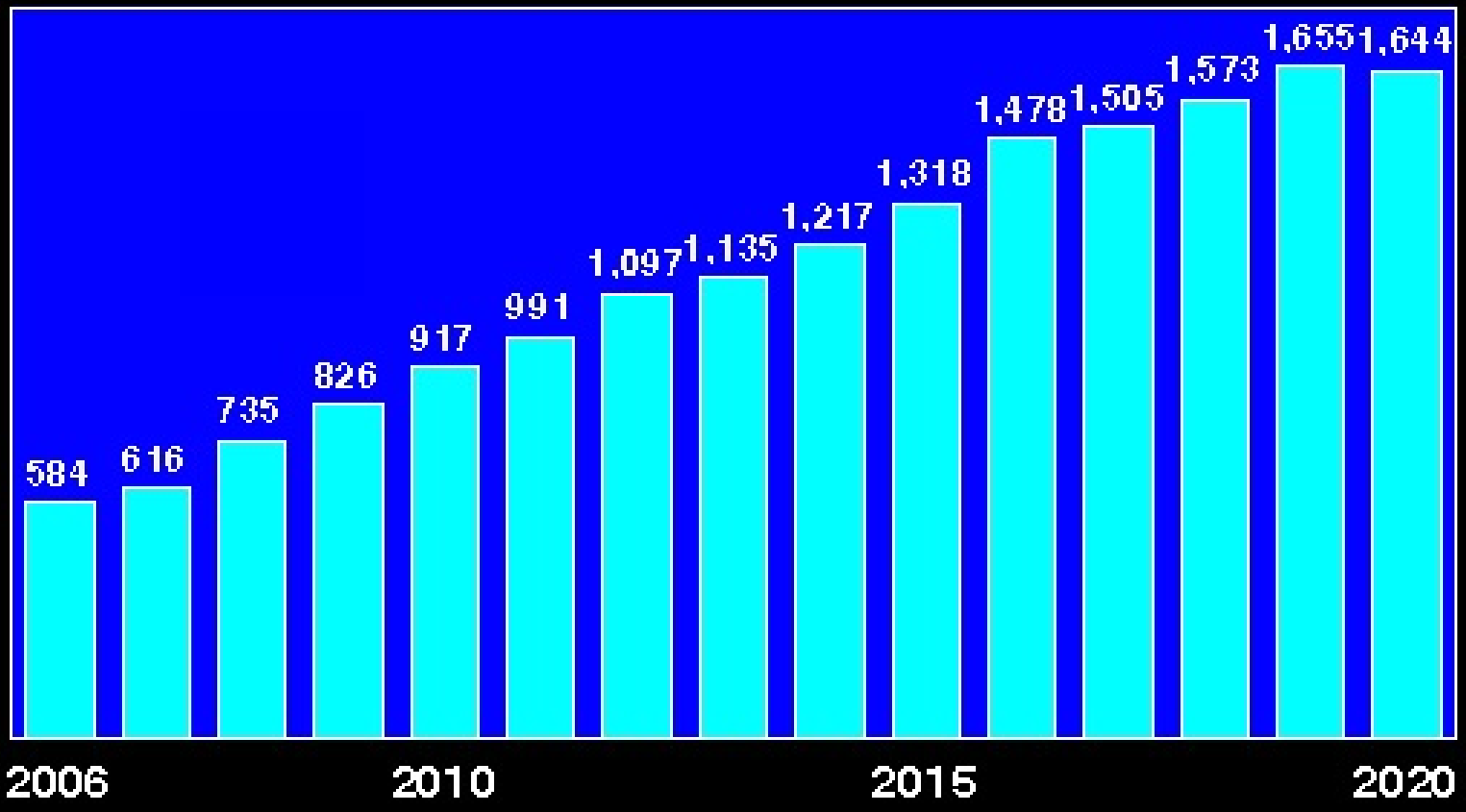
Under-Insurance Increased After ACA



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

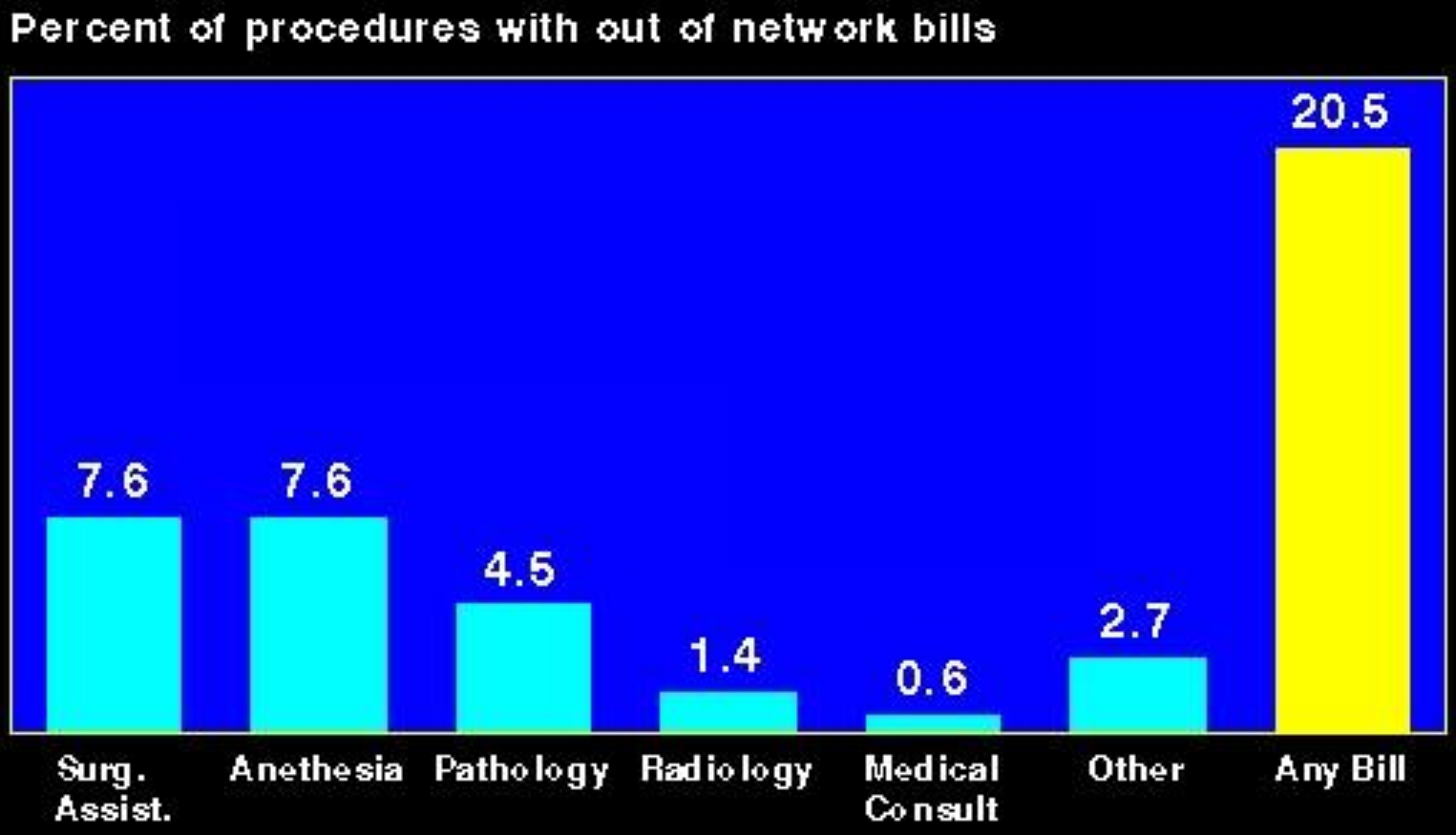
Average Deductible Rising

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



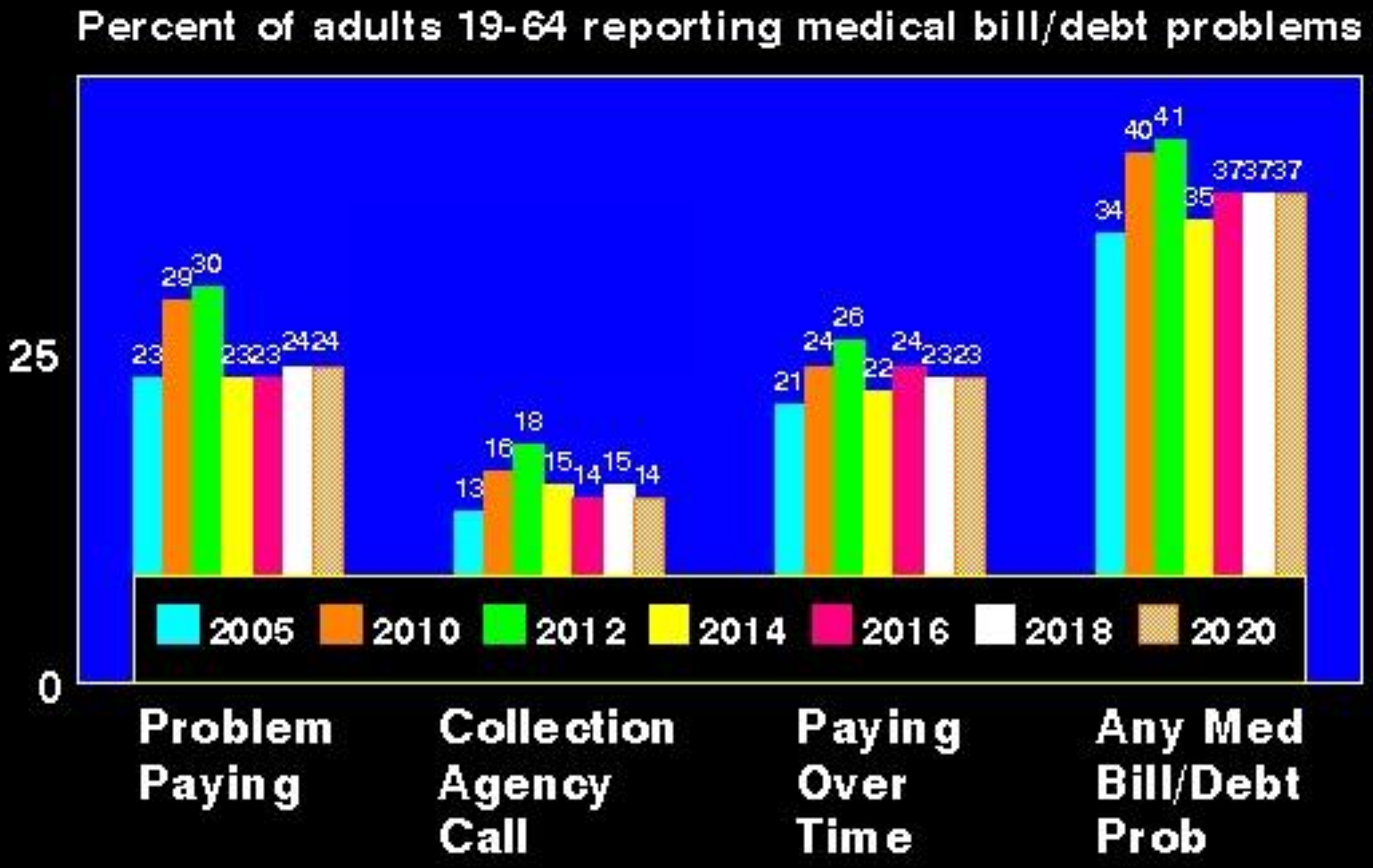
Source: Kaiser/HRET Survey of Employer-Sponsored Benefits

One Fifth of Privately Insured Surgical Patients Get a Surprise Bill



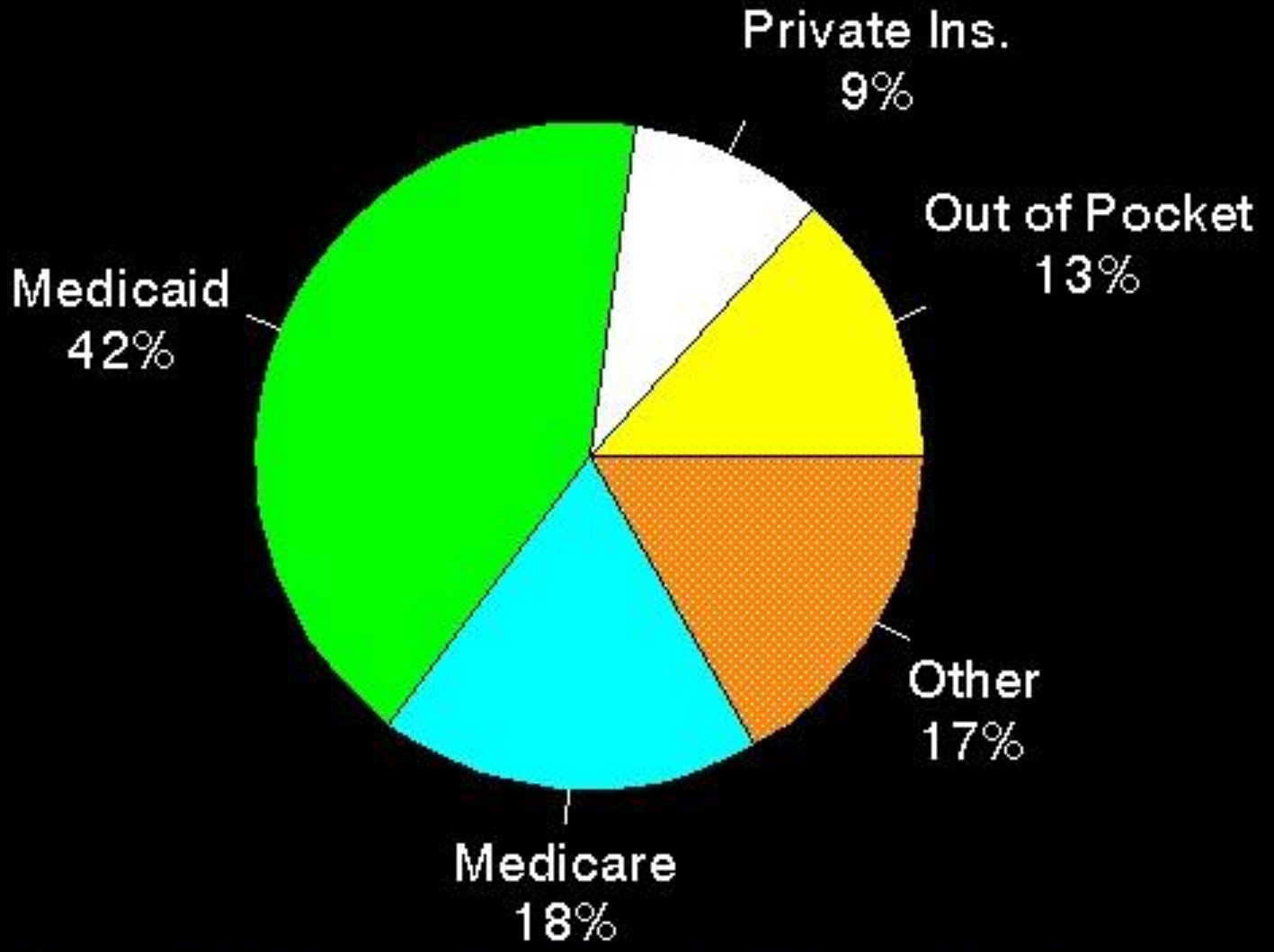
Source: JAMA 2020;323:538
Note: All patients had surgery at in-network hospital with in-network primary surgeon
Average surprise bill = $2,011

Medical Bill and Debt Problems, 2005-2020
No Better than in 2005



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

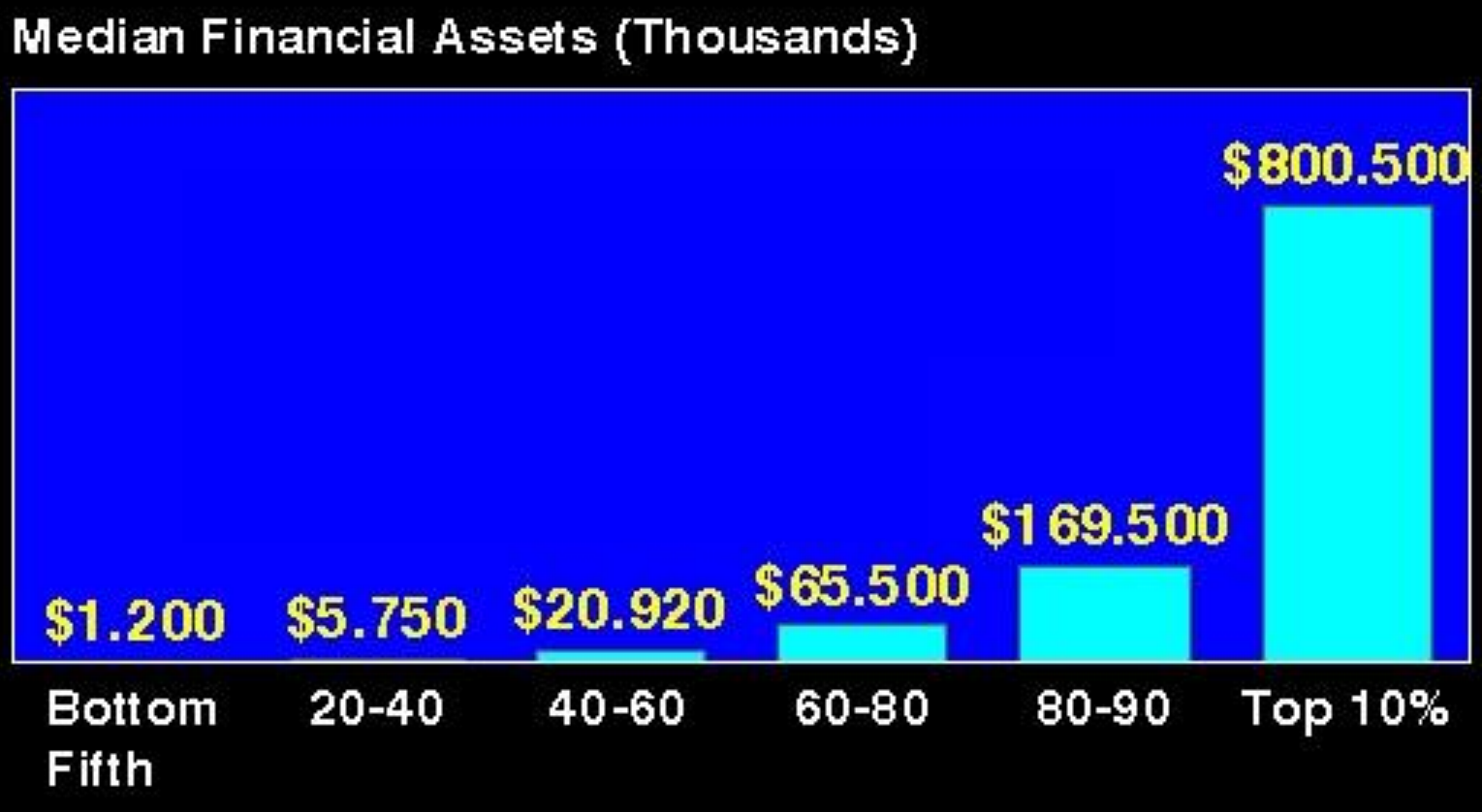
Who Pays for Long Term Care?



Source: NCHS - National Health Expenditure Accounts - Data are for 2019
Note - Includes spending for NHs + Home care + "other residential and personal care"

Under-Insurance Impedes Care, Worsens Health

Many Families Lack Assets to Pay High Deductibles

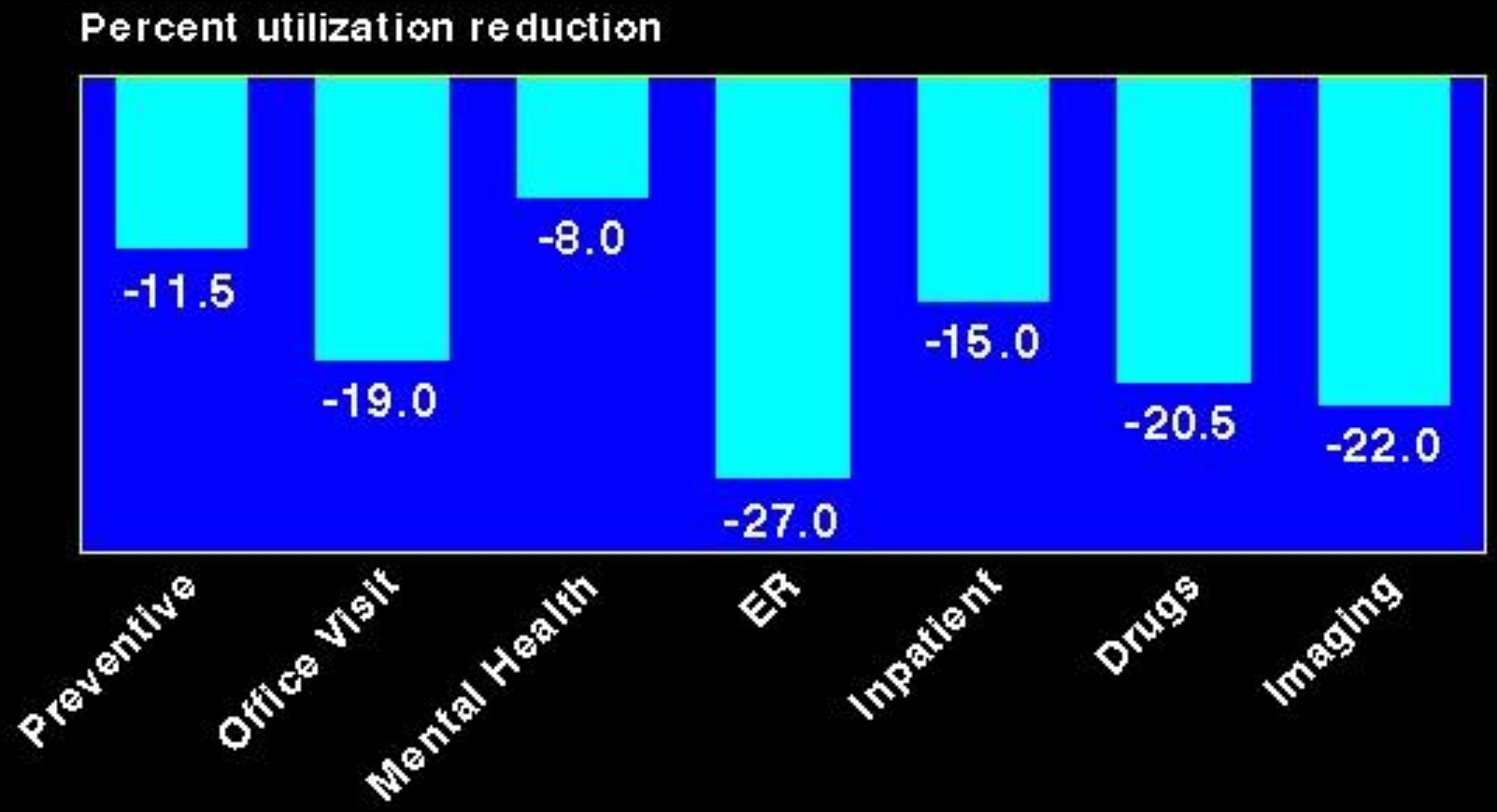


Source: Federal Reserve Survey of Consumer Finance 2019

High Deducticles Cut All Kinds of Care

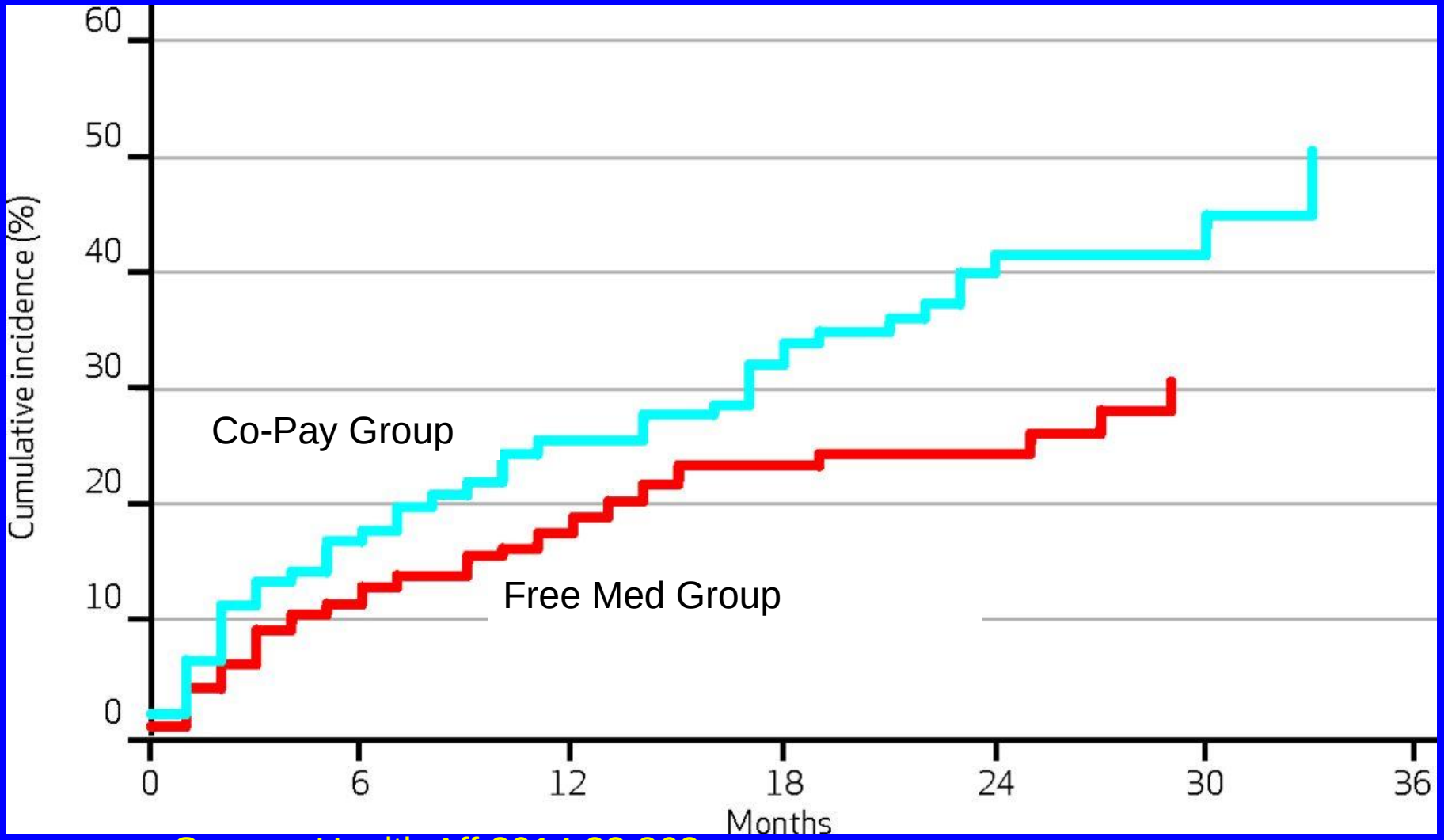
150,000 Employees Lost "Cadillac" Coverage

No Evidence that Patients Shifted to "Higher Value" Care



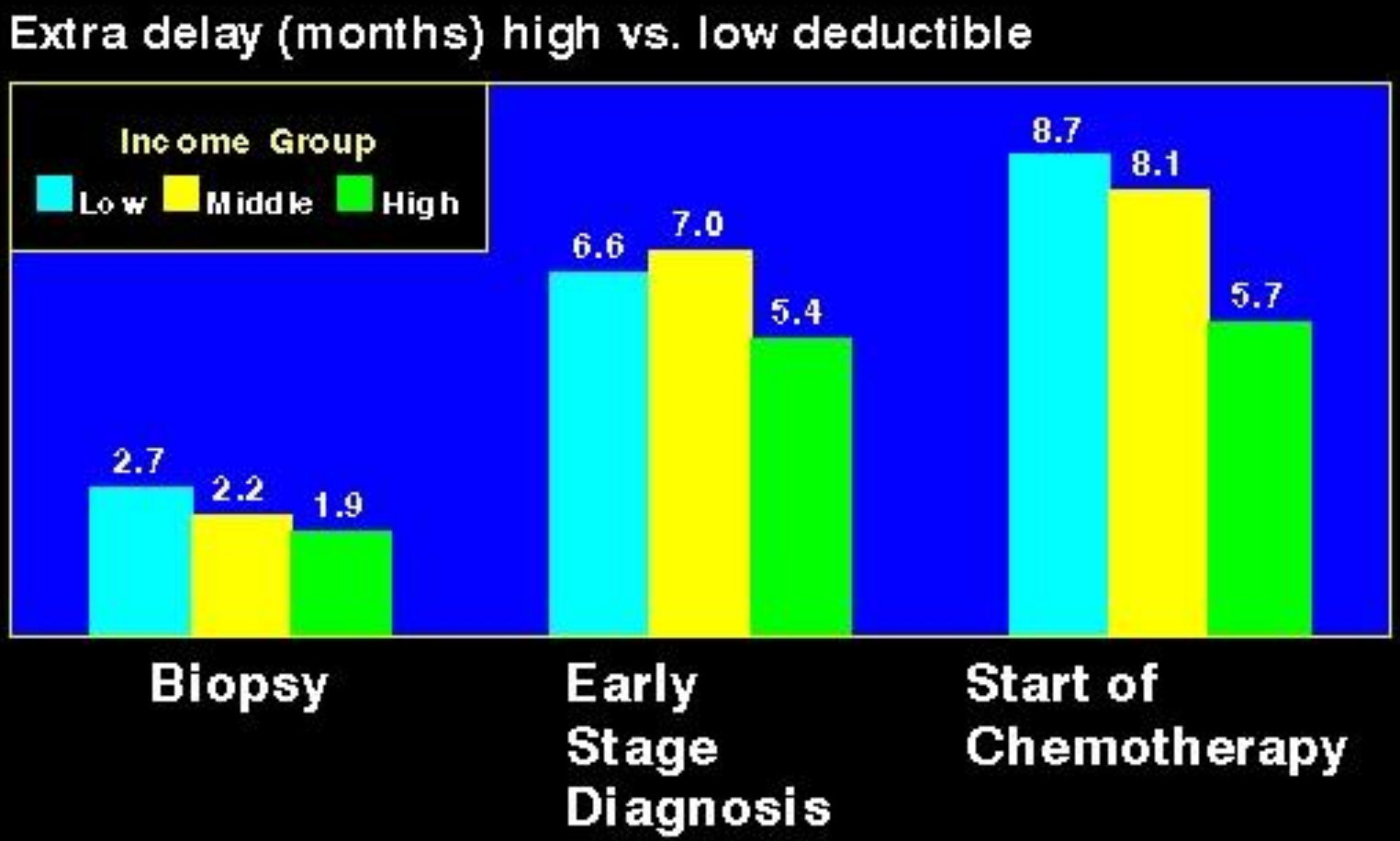
Source: Brot-Goldberg et al, 6/2015 - http://eml.berkeley.edu/~bhandel/wp/BCHK.pdf
Note: Findings closely resemble those of Rand Health Insurance Experiment
Note: Study found no evidence that patients shopped for lower prices

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



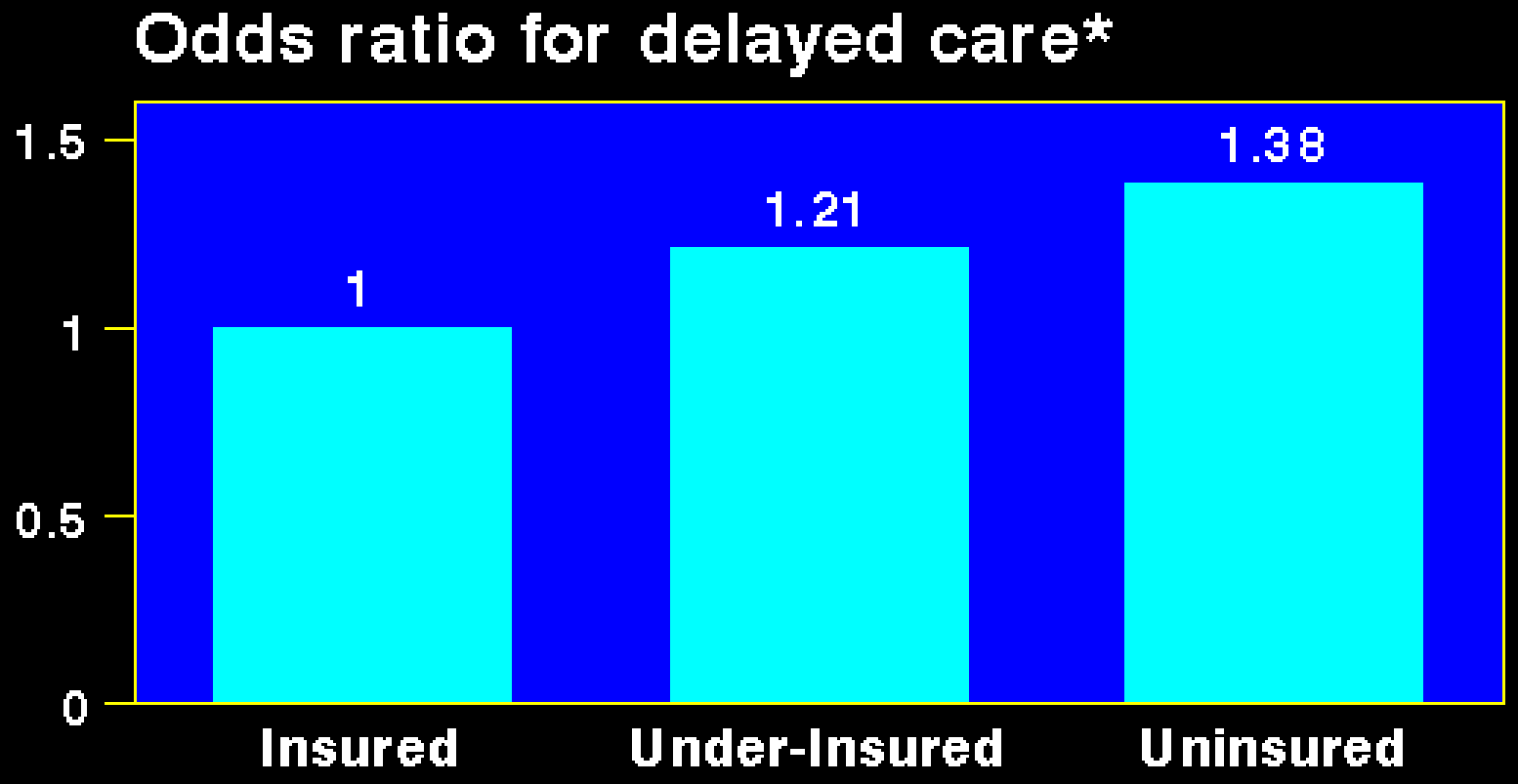
Source: Health Aff 2014:33:863

High Deductible Plans Delayed Breast Cancer Care



Source: Health Affairs 2019;38:408

Uninsured and Under-Insured Delay Seeking Care for Heart Attacks



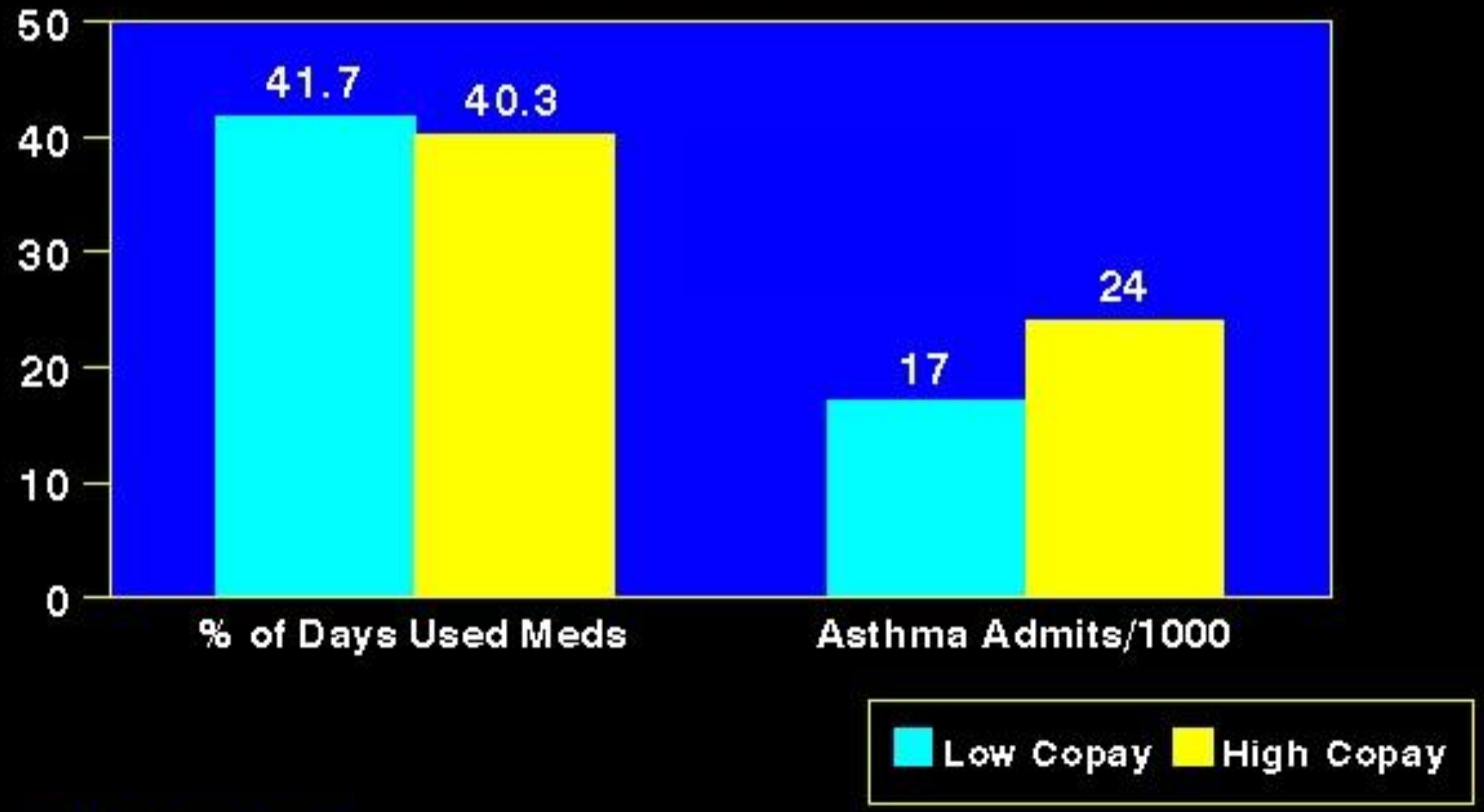
Source: JAMA April 15, 2010:303:1392

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

Under-insured = Had coverage but patient concerned about cost

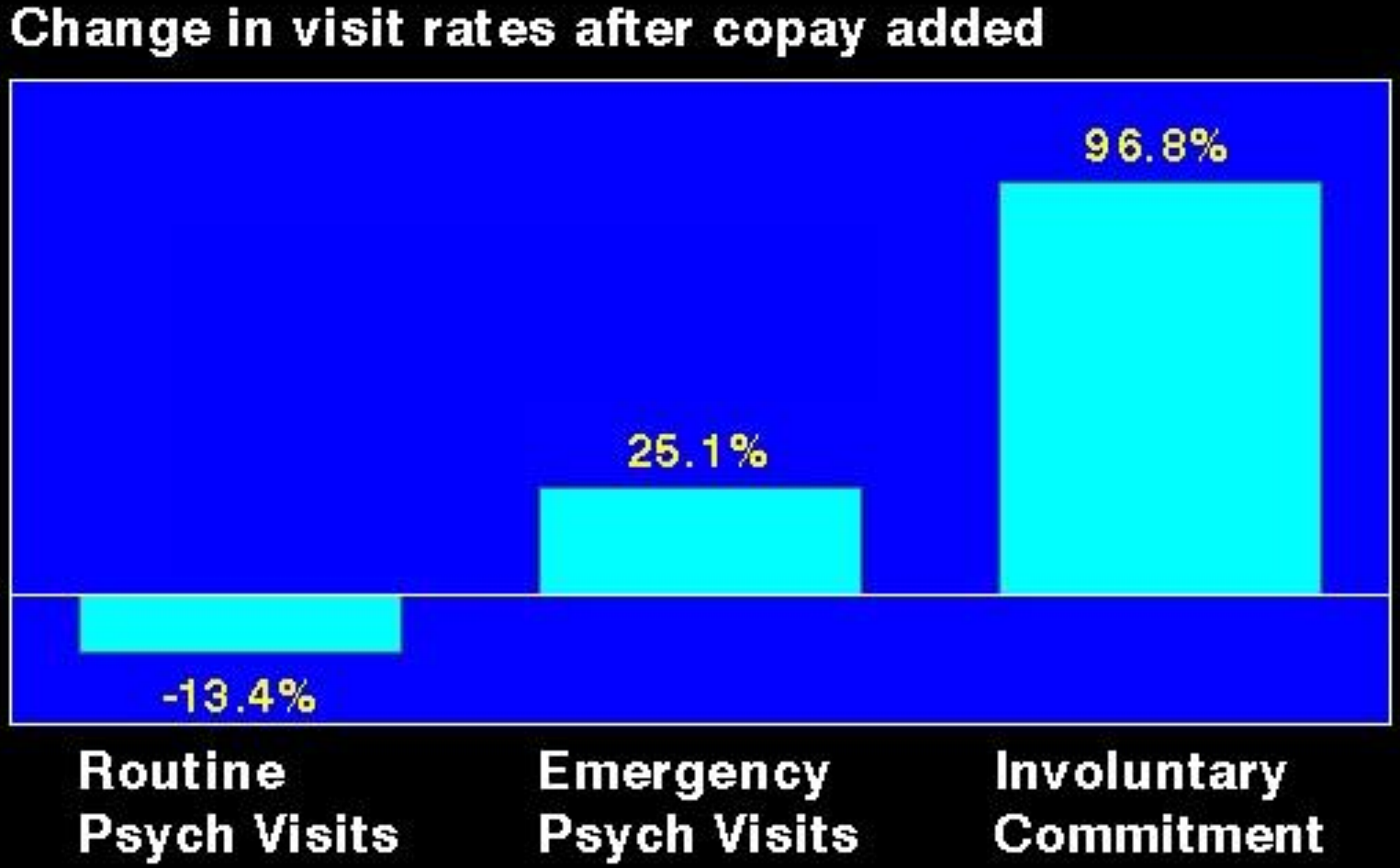
Higher Medication Co-Pays = Worse Asthma Outcomes

Children Age 5-18



Source: JAMA 2012;307:1284

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

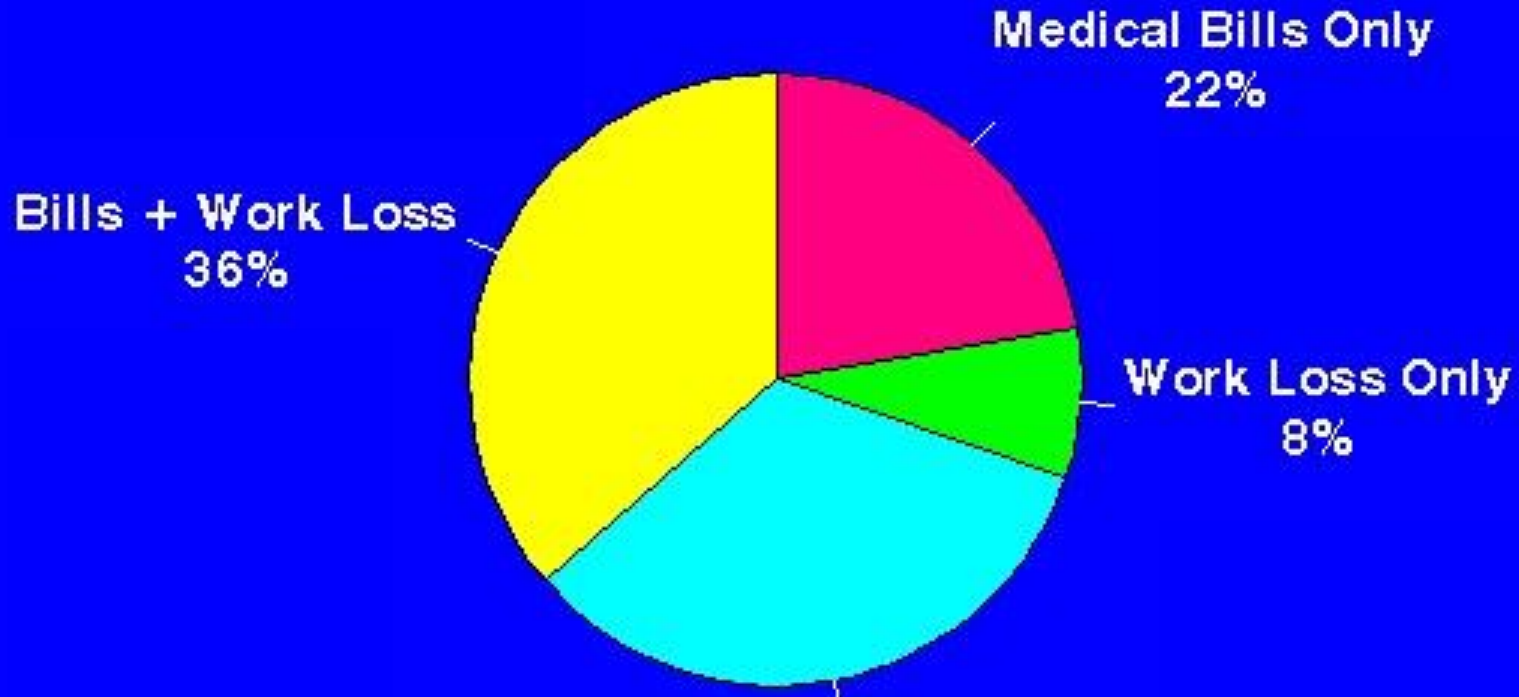


Source: JAMA Psychiatry 2017;74:932
Note: Copay was not applied to children, whose use rates remained stable

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

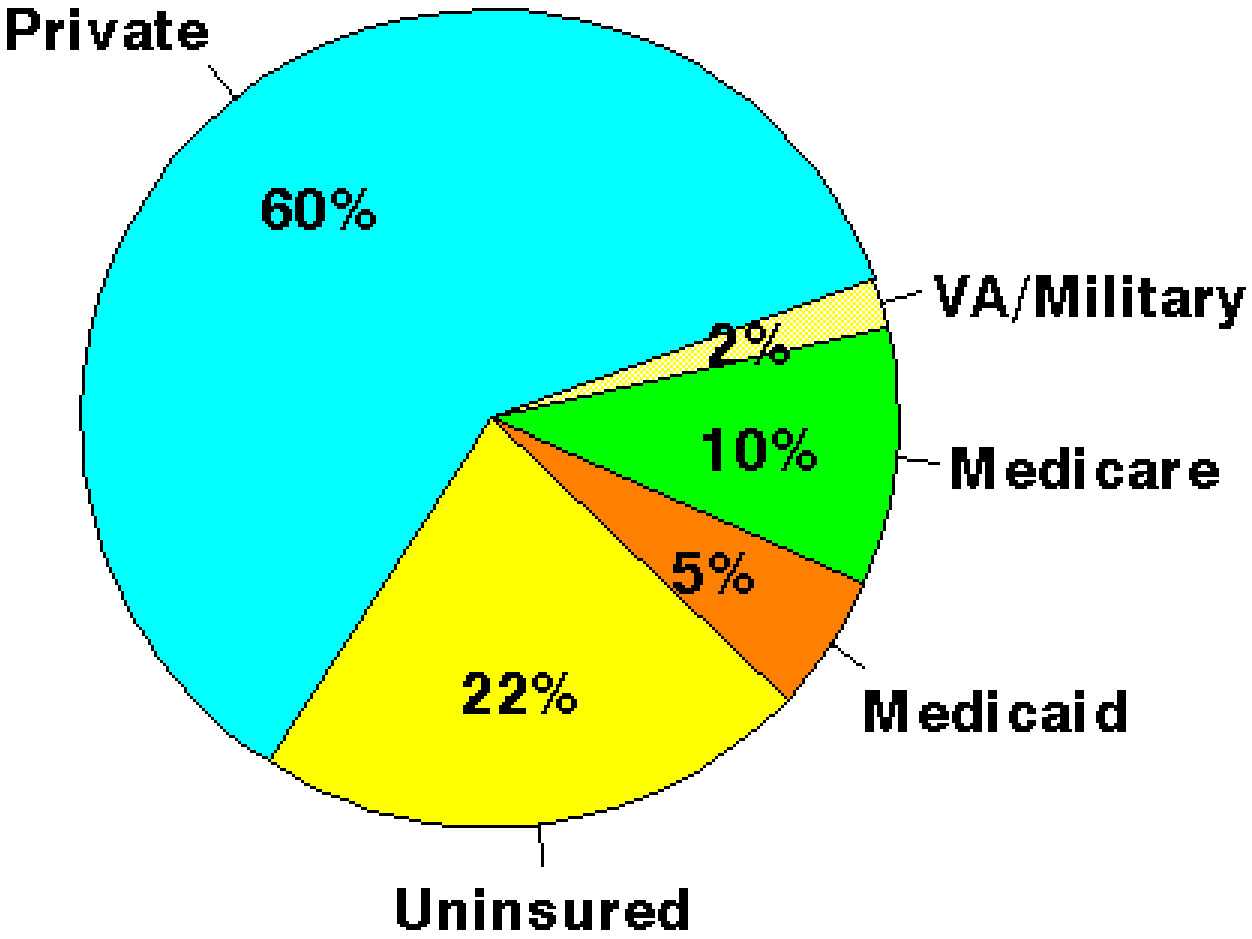
2/3 of Bankruptcy Filers Cite Medical Bills or Illness-Related Work Loss as a Cause

National Survey of Debtors, 2013-2016



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

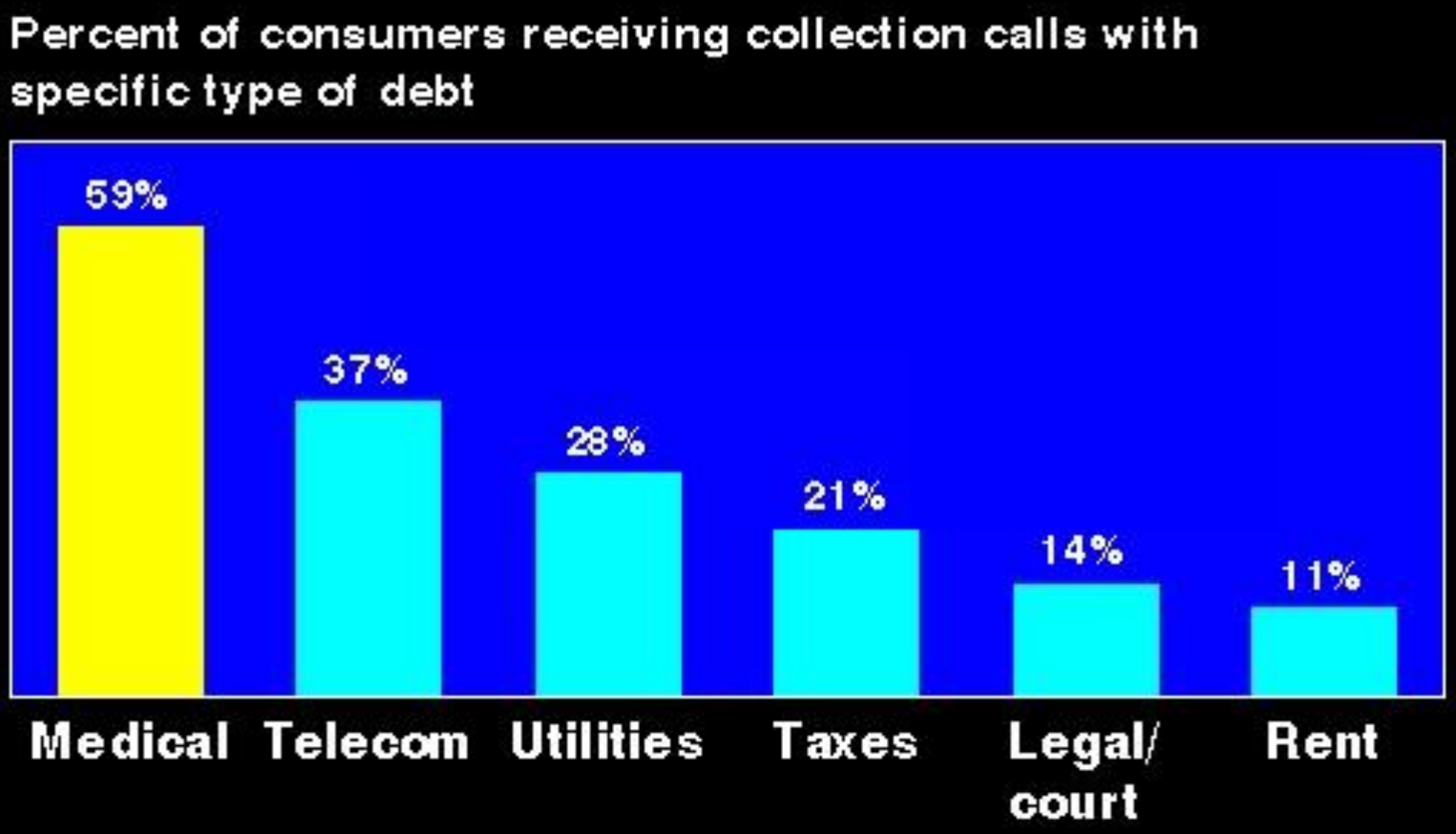
Most of the Medically Bankrupt Had Coverage



Insurance at Illness Onset

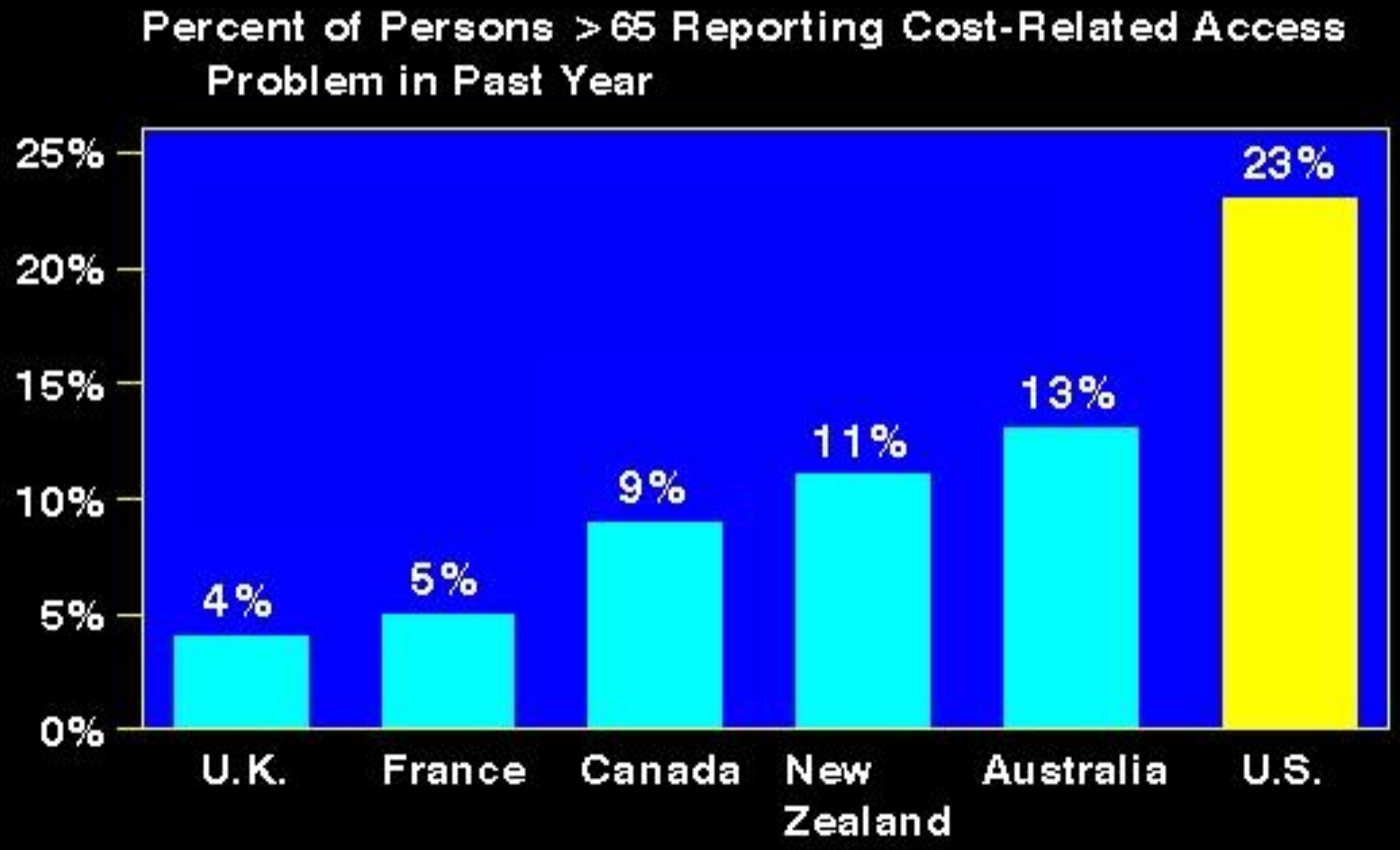
Source: Himmelstein et al. Am J Med; August, 2009

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

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

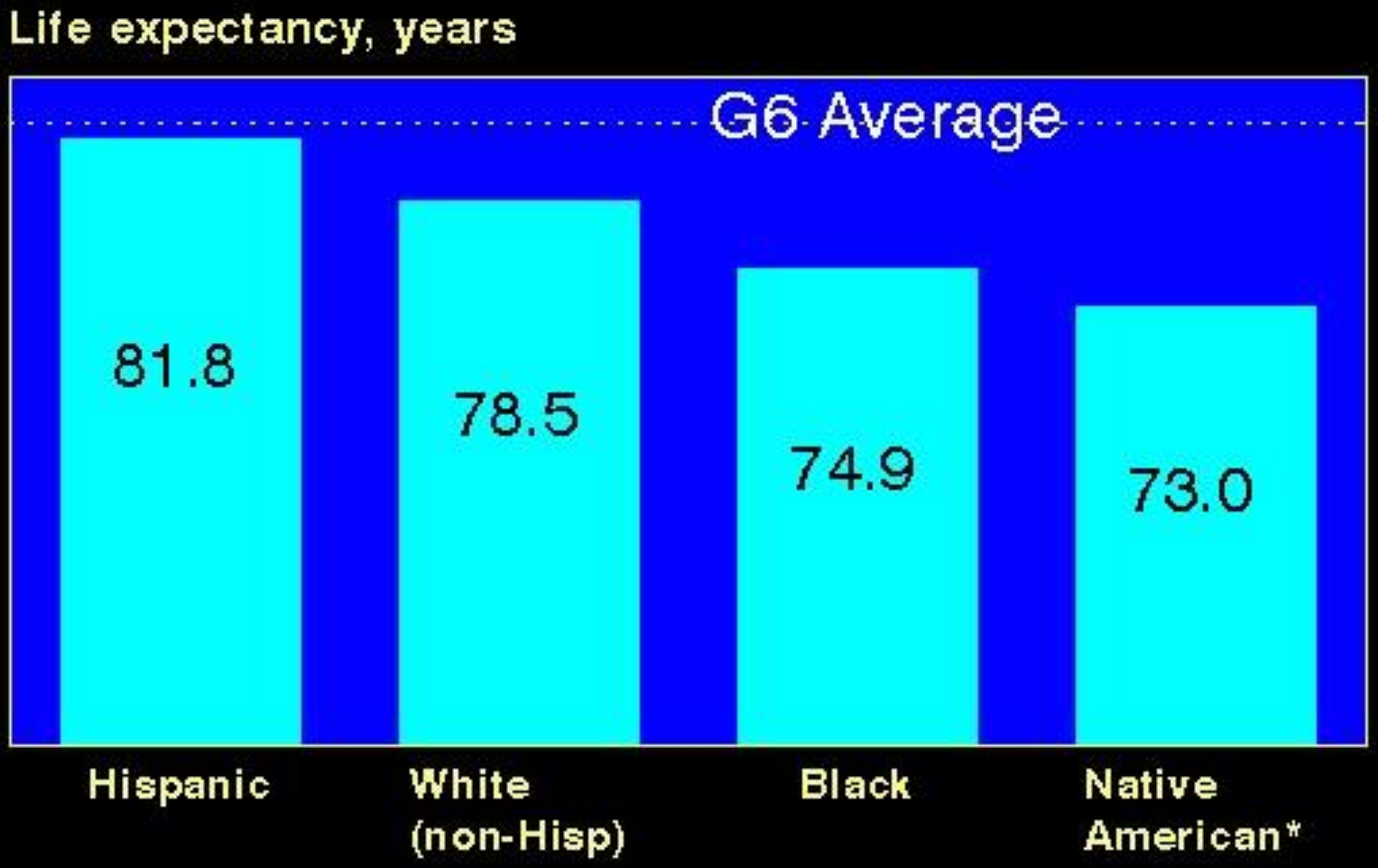


Source: Health Affairs 2017; 36:2123

Racism Harms Health

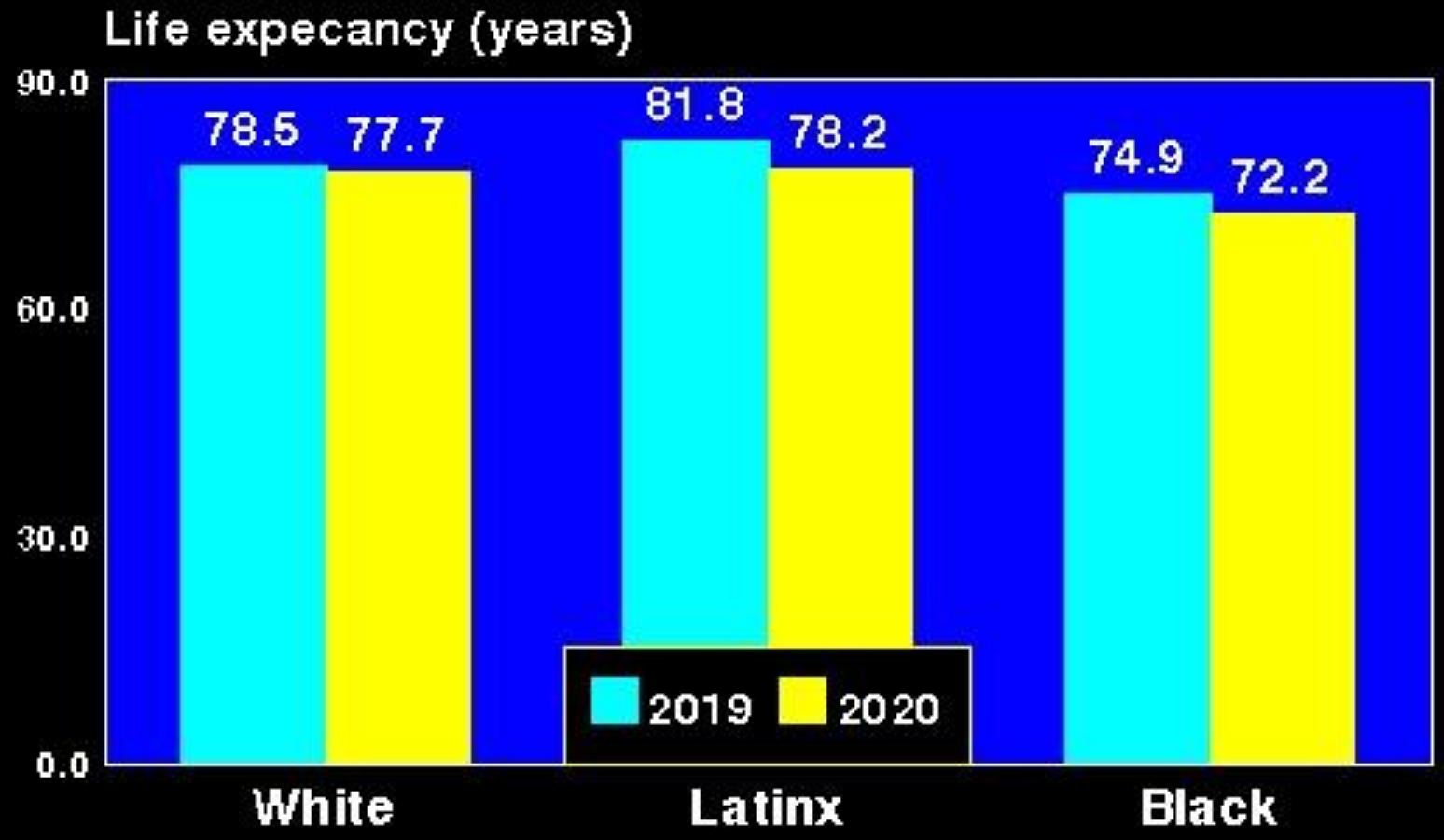
Black and Native Americans Die Younger

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



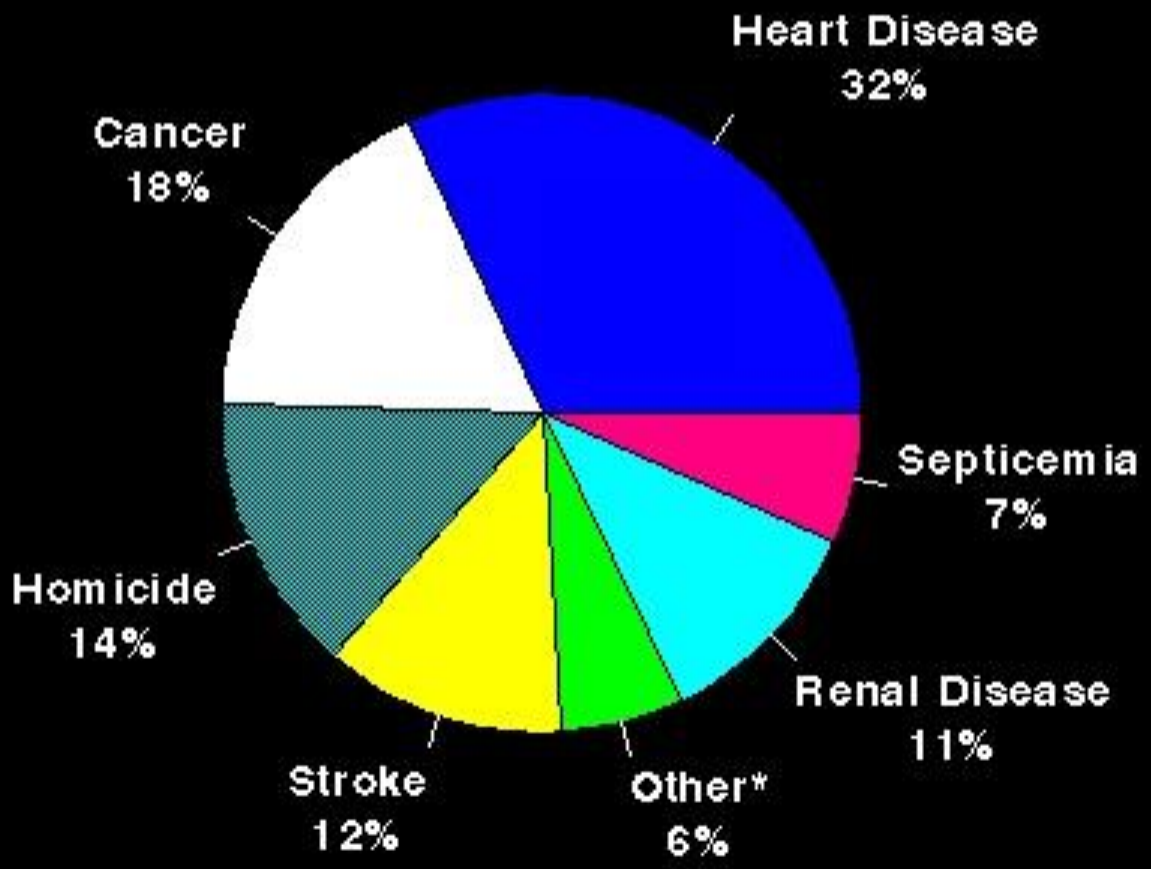
Source: NCHS, IHS, OECD
Other G7 nations = Canada, France, Germany, Italy, Japan, UK

COVID-19 Has Sharply Reduced Black and Latinx Life Expectancy



Source: Andrasfay and Goldman MedRxiv preprint 9/15/2020

Causes of Black/White Disparity in Adult Mortality



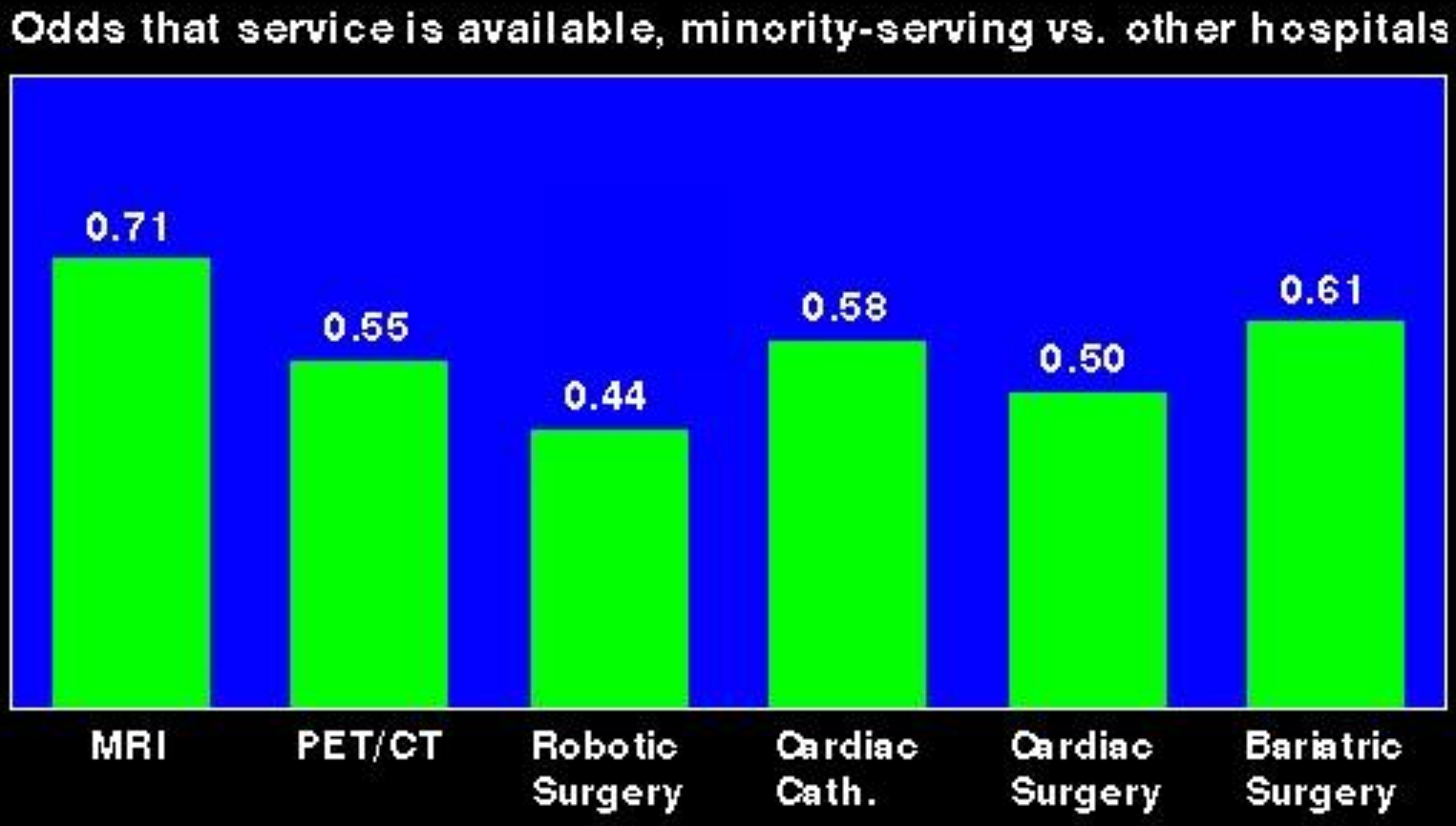
Source: MMWR May 2, 2017

* 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

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

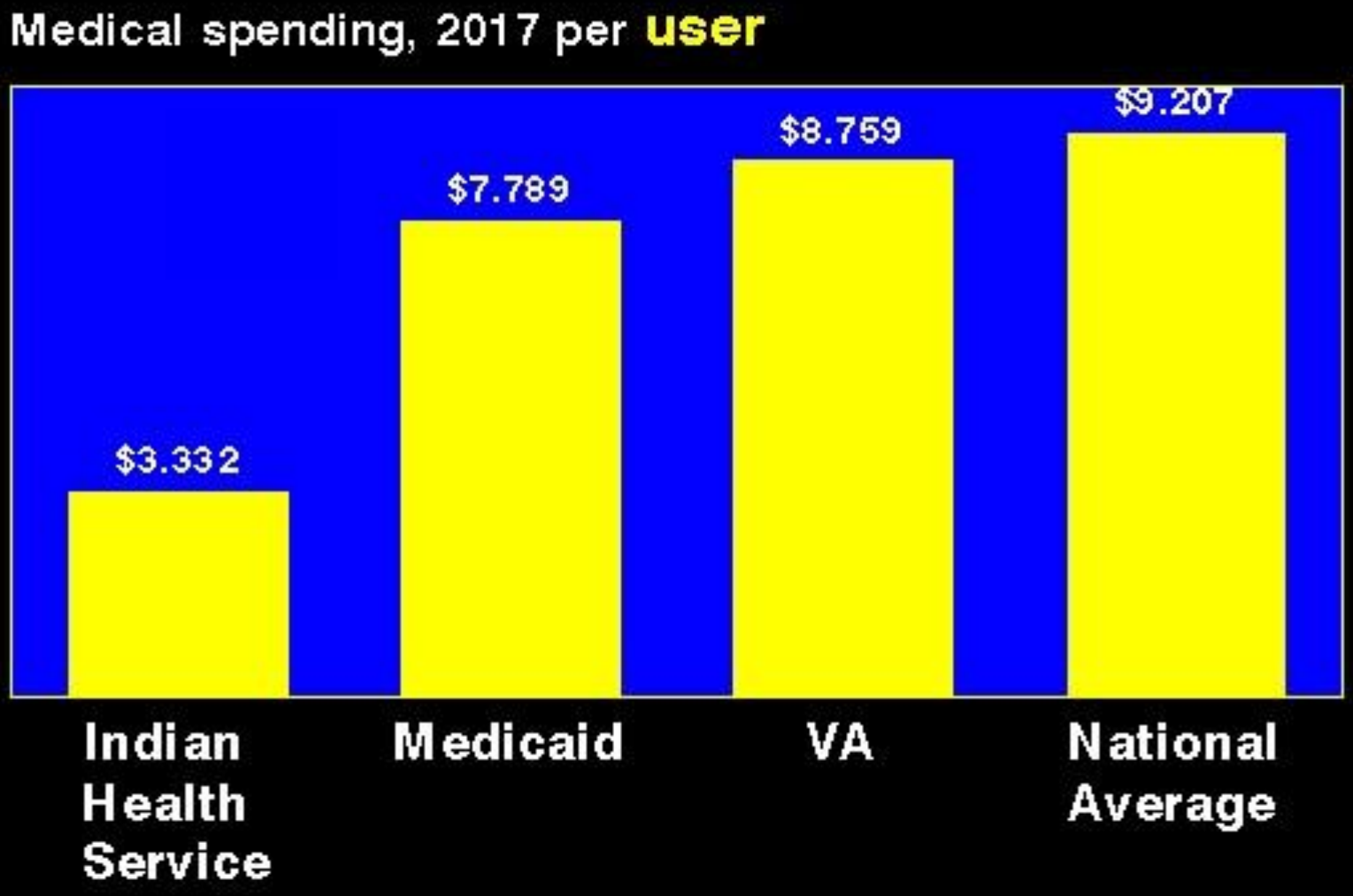
Source: Gracie and Kathryn Himmelstein, Int J Health Services 2020
Black- and Latinx-serving = 10% of US hospitals with highest percent of Black/Latinx pts.

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



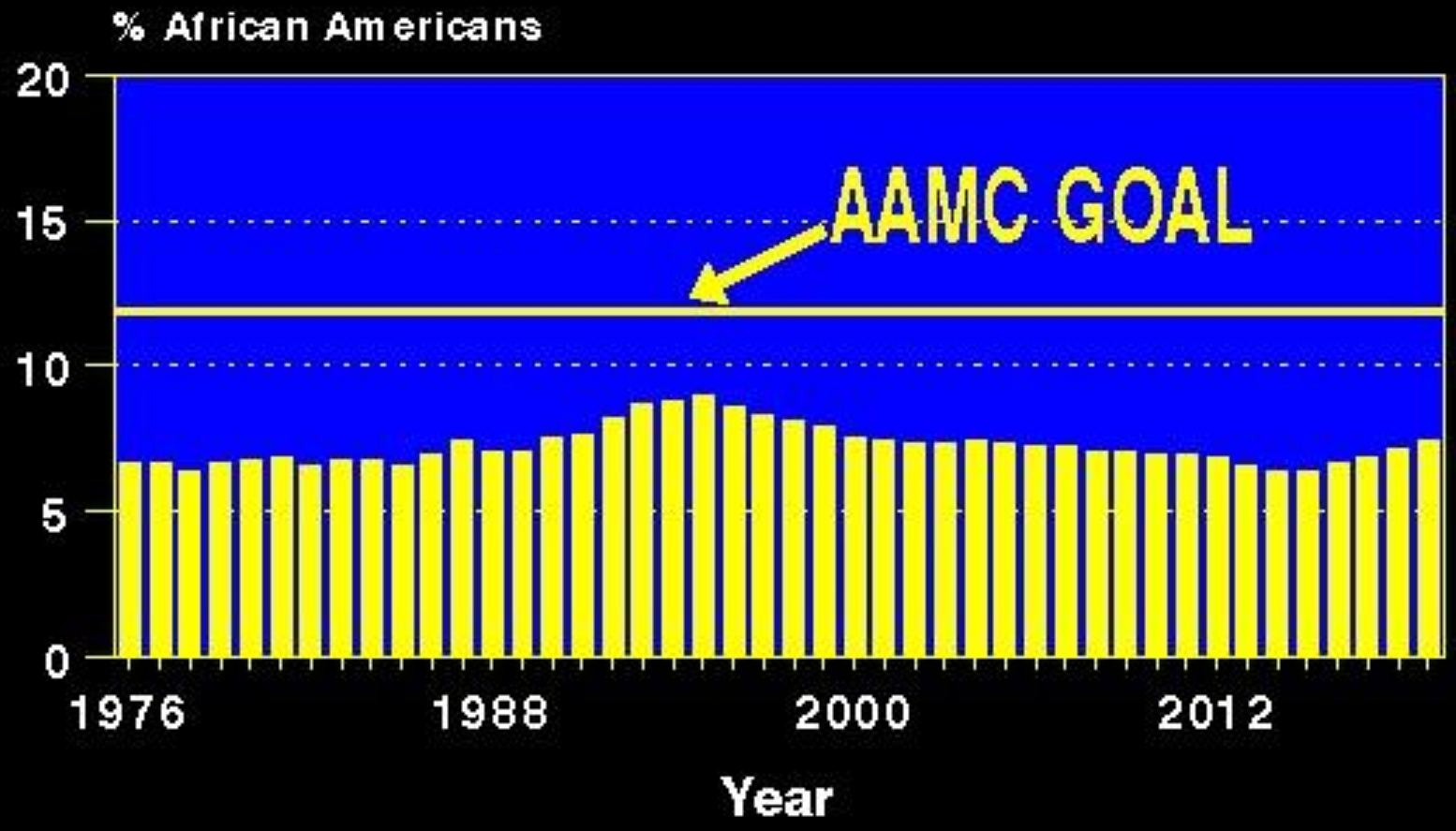
Source: Gracie and Kathryn Himmelstein, Int J Health Services 2020
Black- and Latinx-serving = 10% of US hospitals with highest percent of Black/Latinx pts.
Odds ratios are adjusted for size, location, teaching status and ownership

Indian Health Service, Grossly Underfunded



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

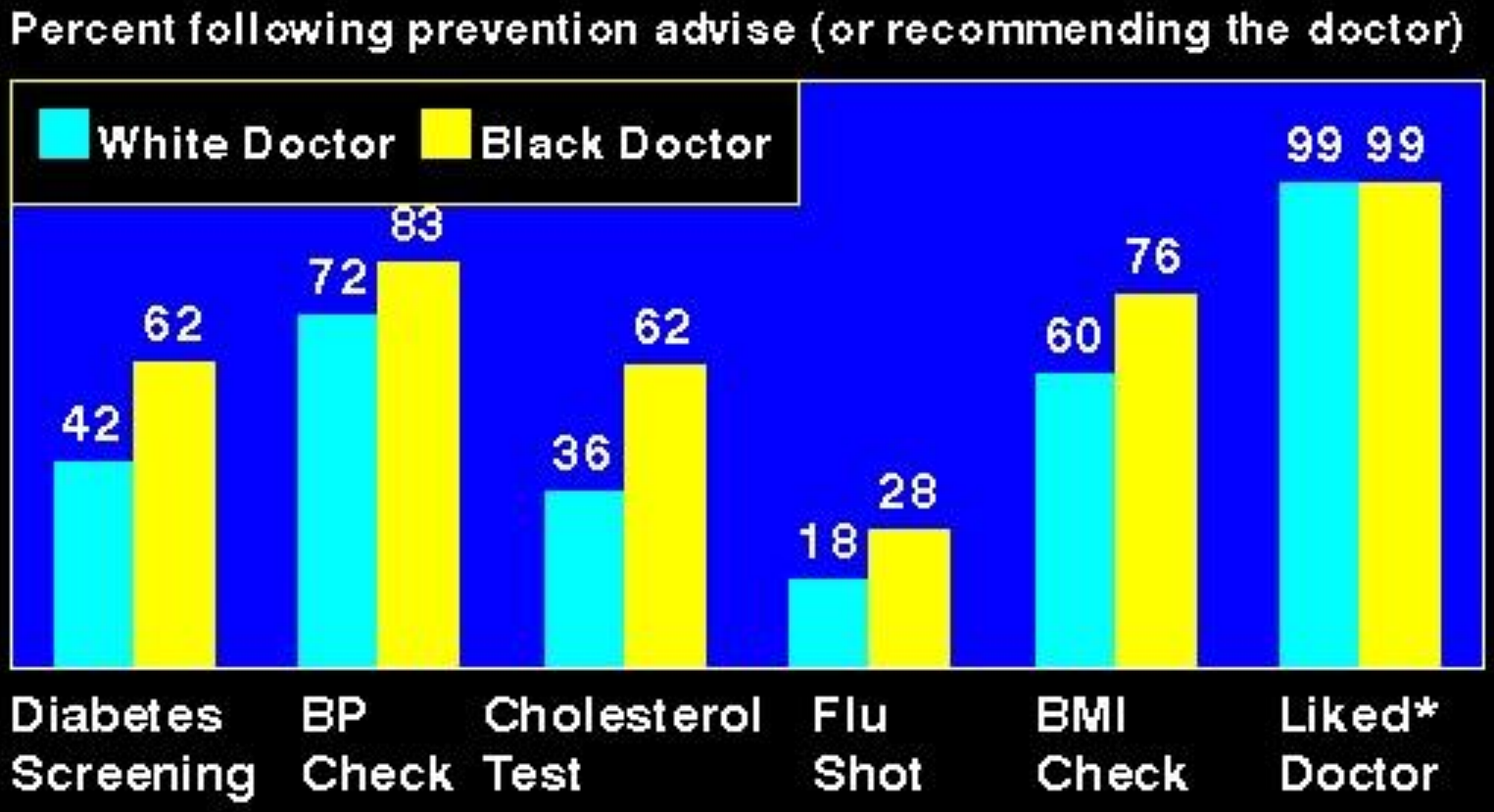
Black Enrollment in U.S. Medical Schools, 1976-2019/20



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



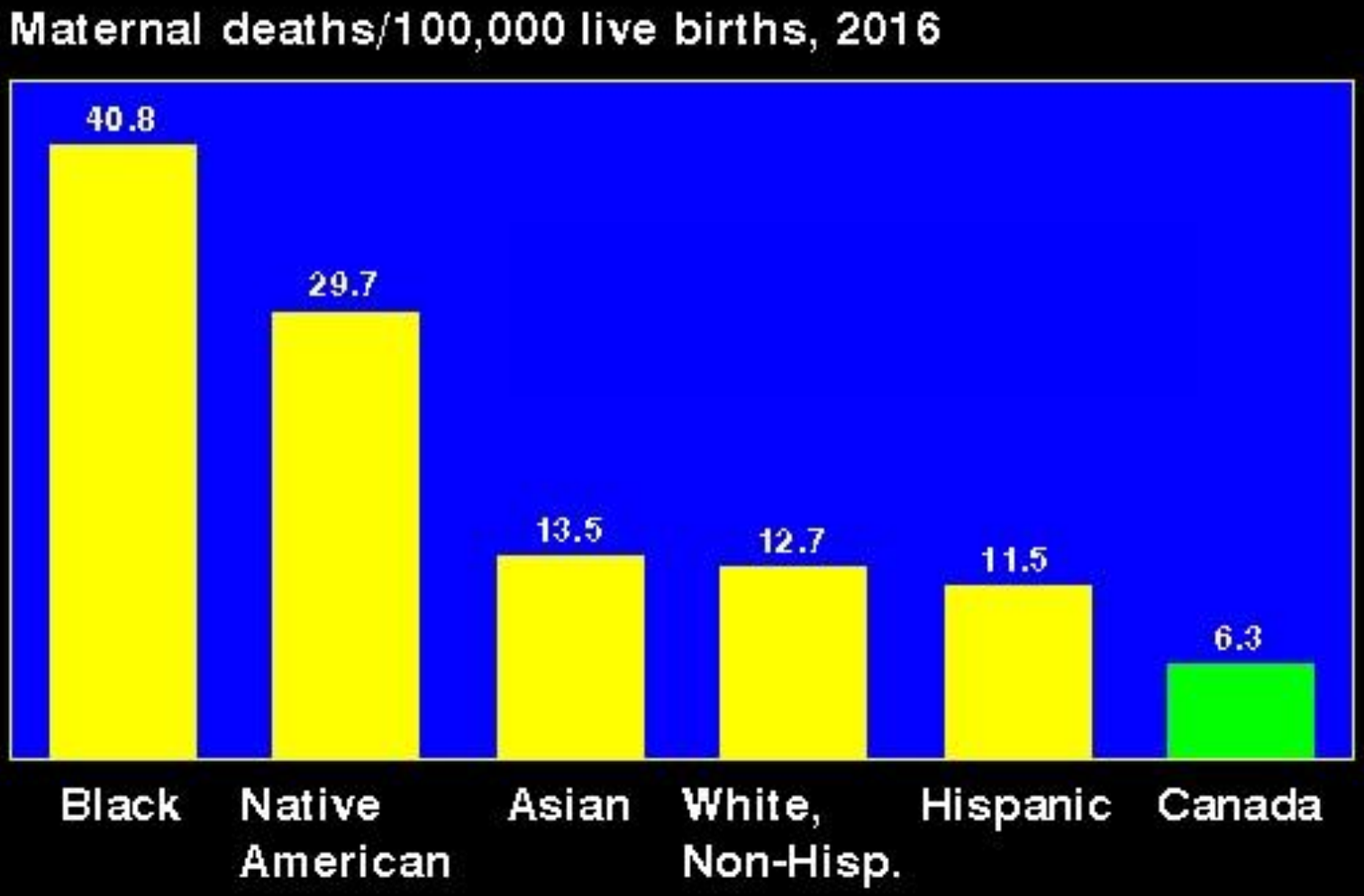
Source: American Economic Rev 2019;109:4071

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

* Liked = would recommend doctor to others

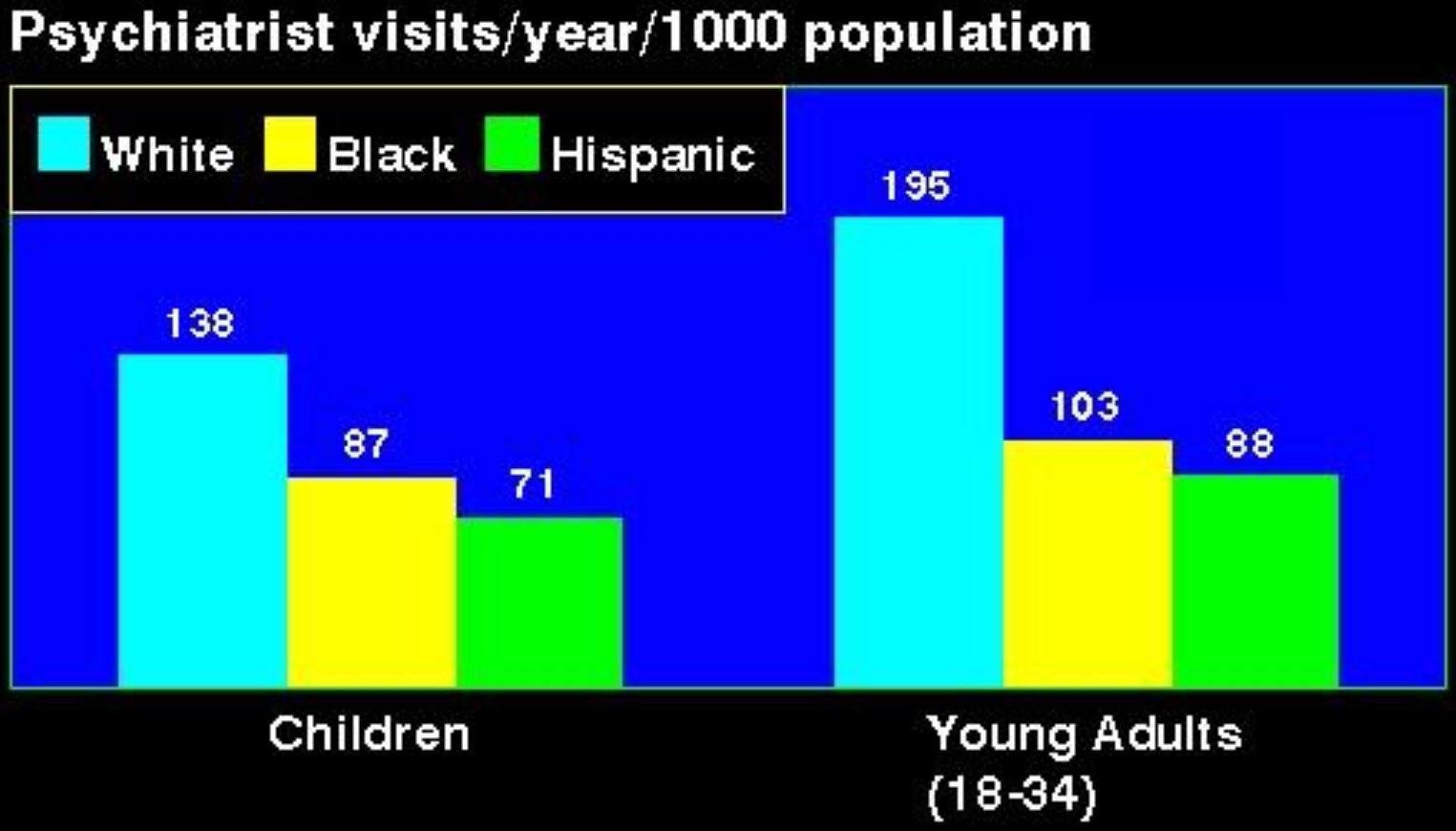
Race/Ethnicity and Maternal Mortality

Every Group in the US Does Worse than Canadians



Source: MMWR September, 2019 and OECD

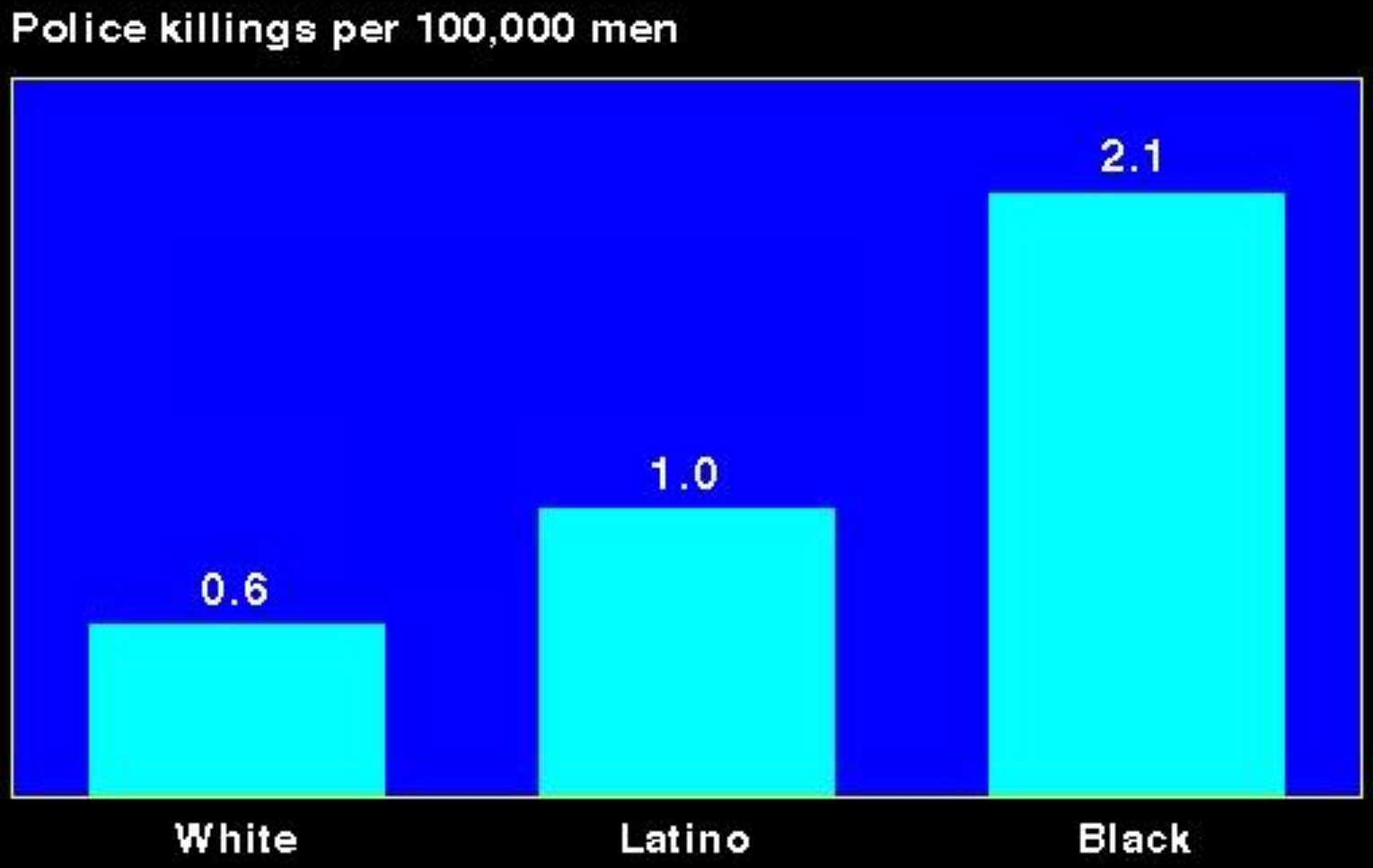
Minority Children & Youth Get Few Psychiatrist Visits



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

Police More Likely to Kill Minority Men

2.8 Police Killings/Day in U.S.

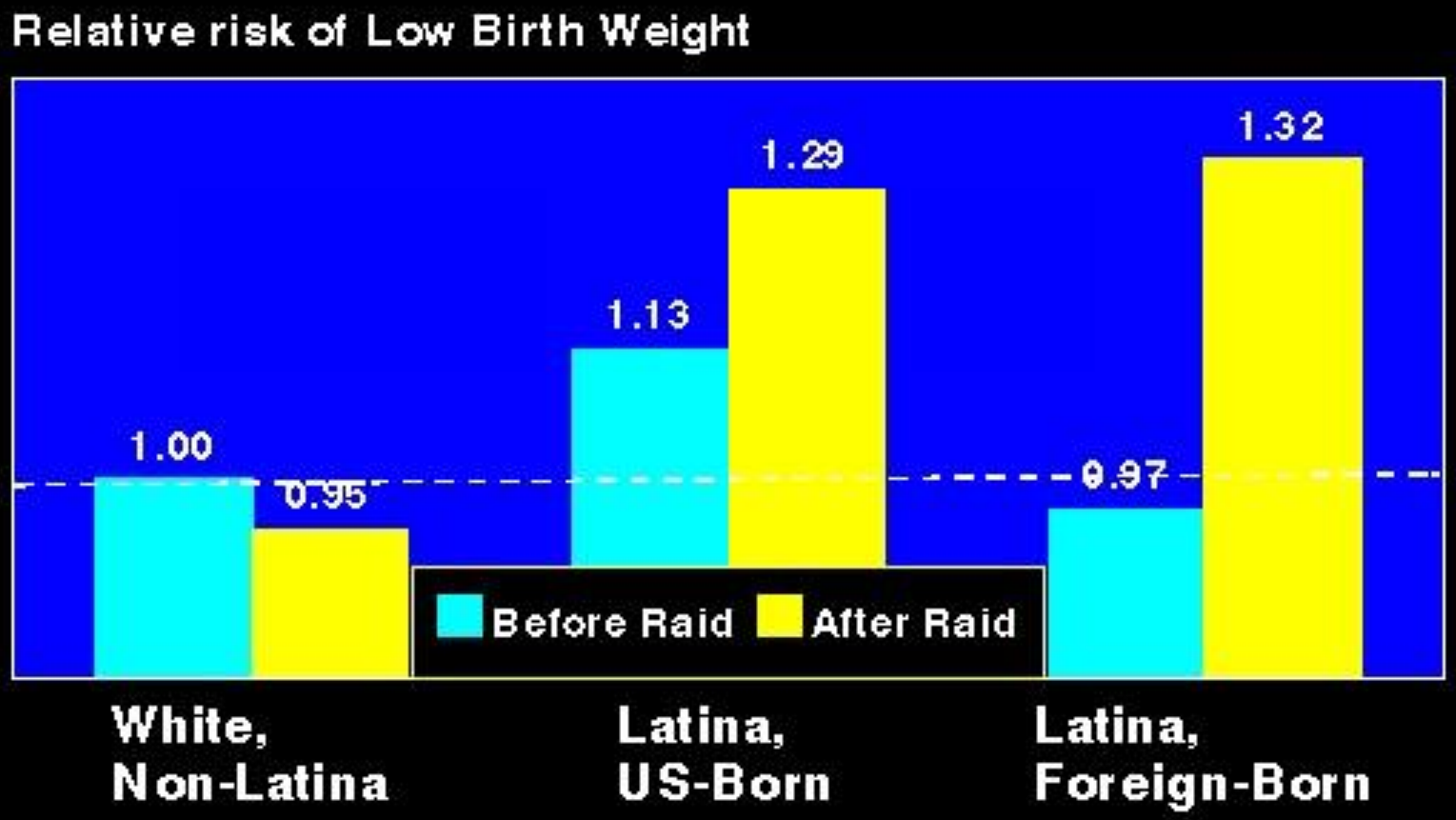


Source: AJPH 2018;108:1241

Police killings account for 8% of all homicides

Protecting Immigrants' Right to Health Care

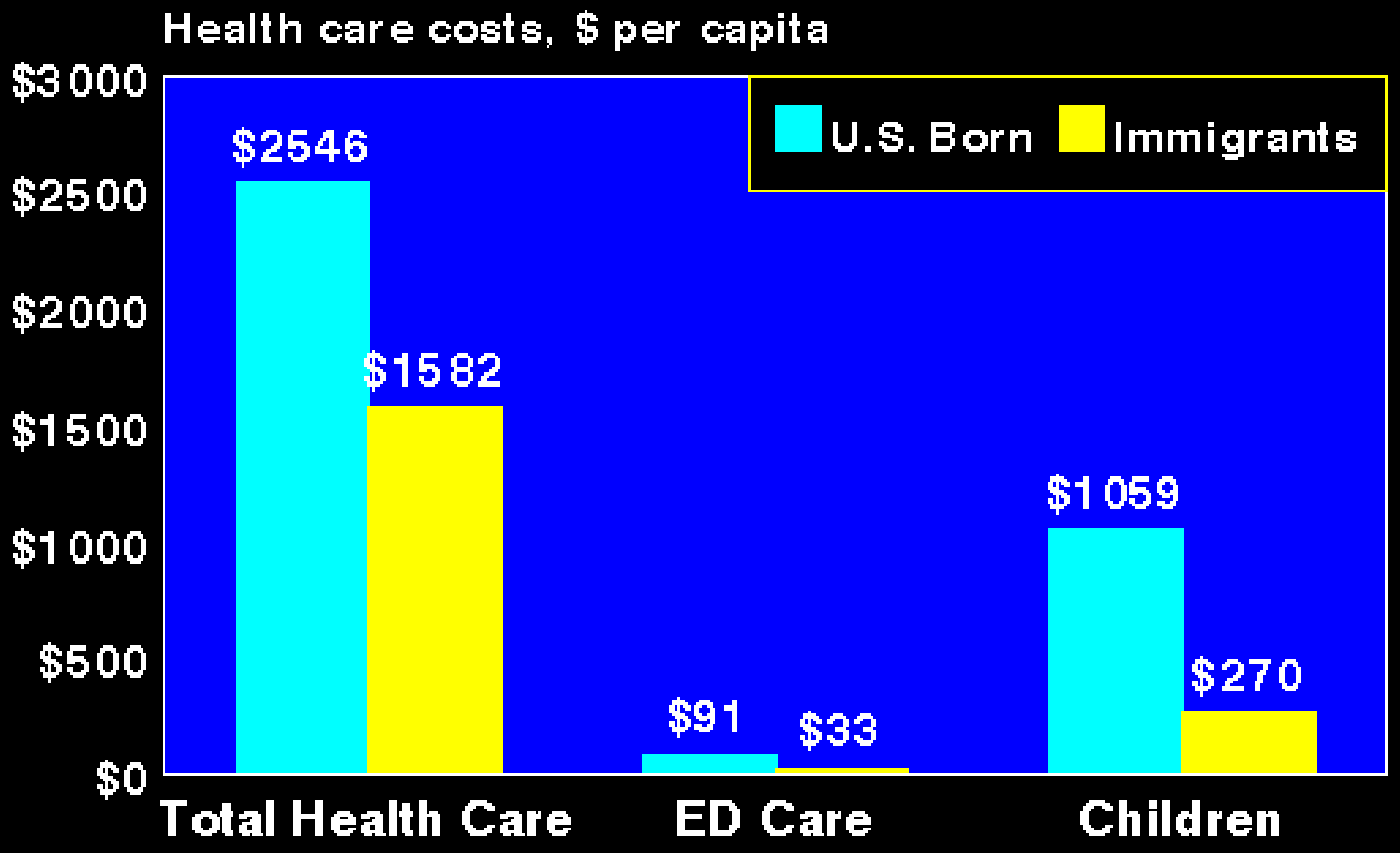
Low Birth Weight Increased In Iowa After A Massive Immigration Raid



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

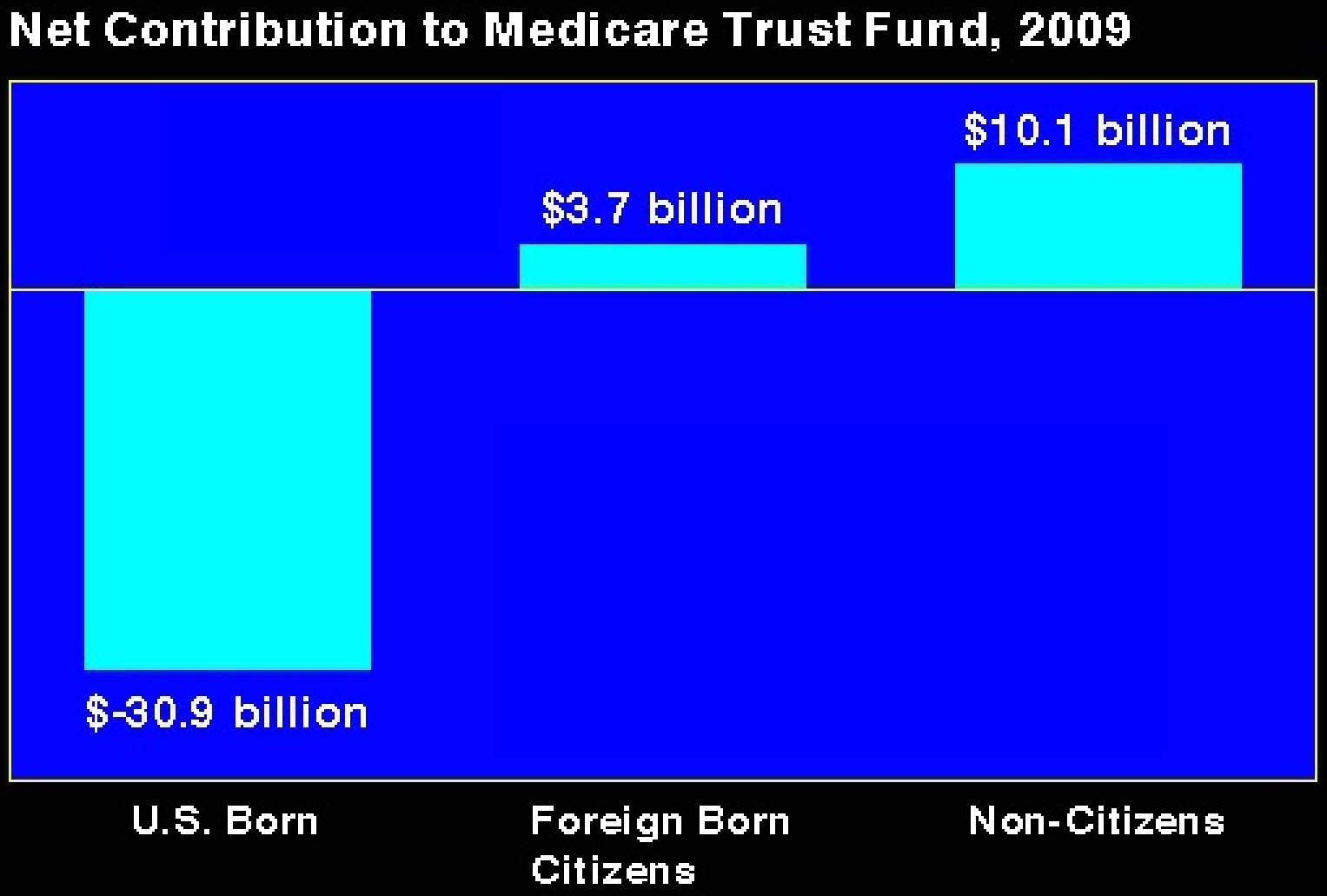
Immigrants Get Little Care



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

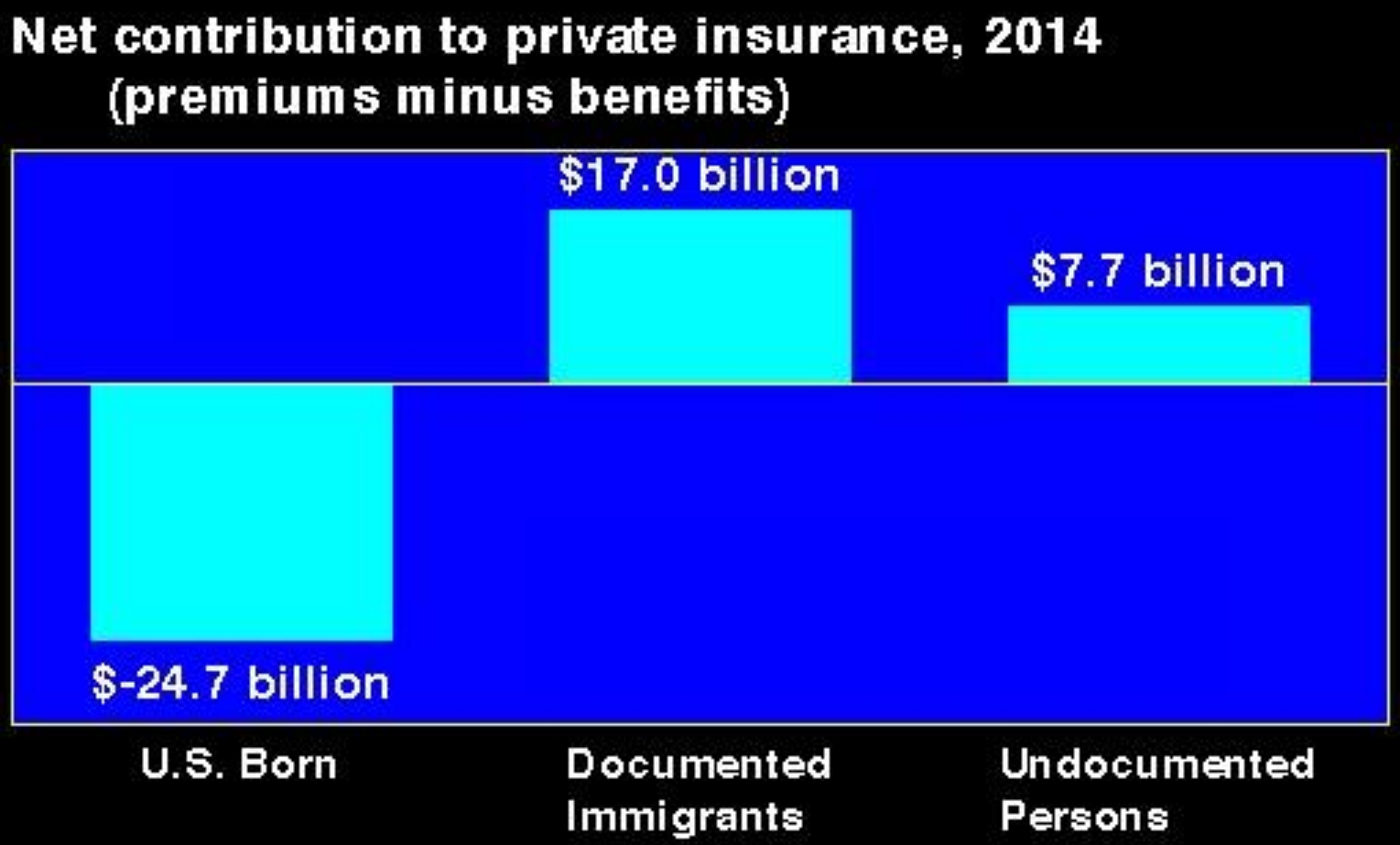
* Adjusted for ethnicity, poverty, age, insurance status, patient/parent-reported health status

Immigrants Keep Medicare Afloat



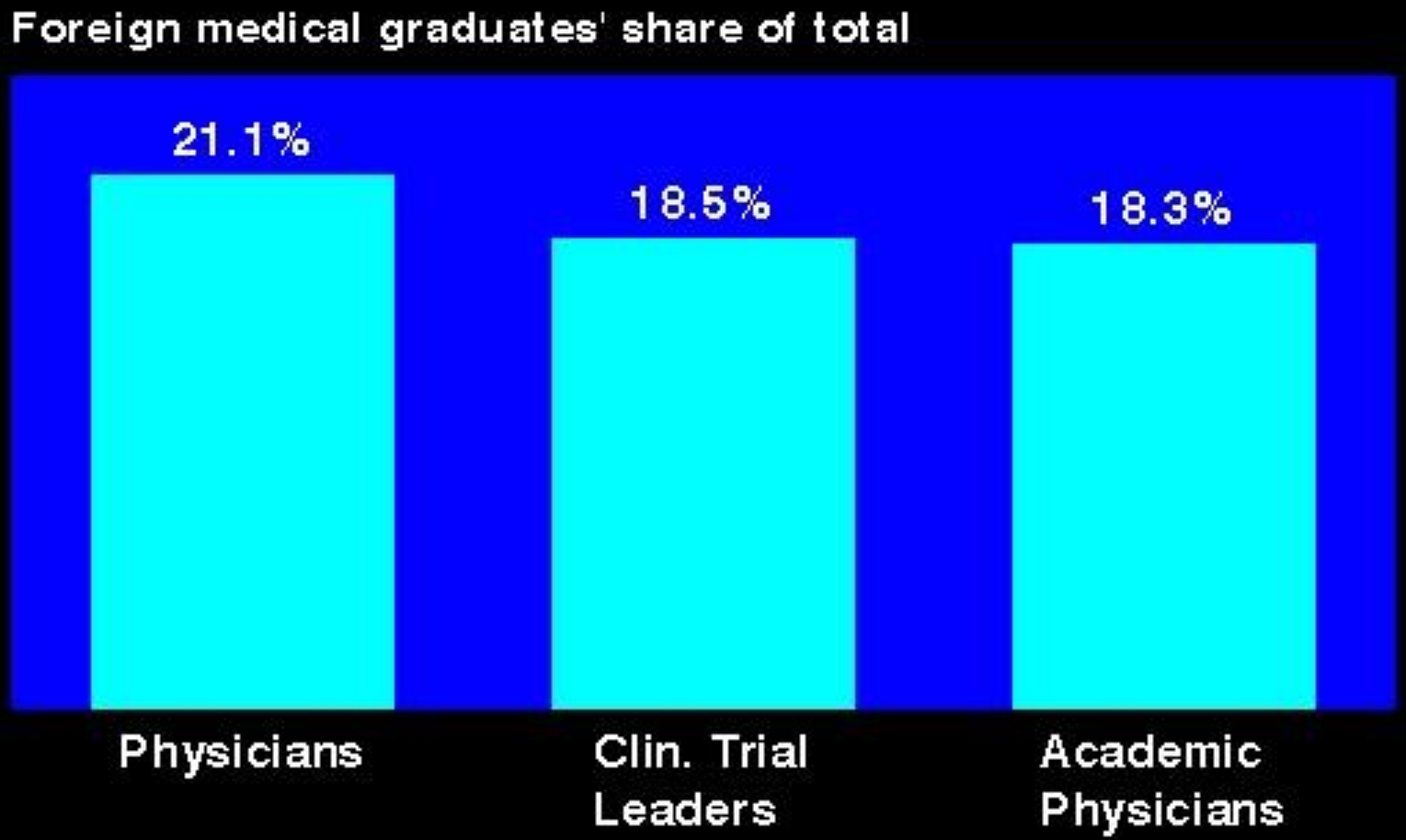
Source: Zallman et al, Health Affairs 2013; 32:1153

Immigrants Subsidize Native-Born in Private Insurance



Source: Zallman et al, Health Affairs October, 2018

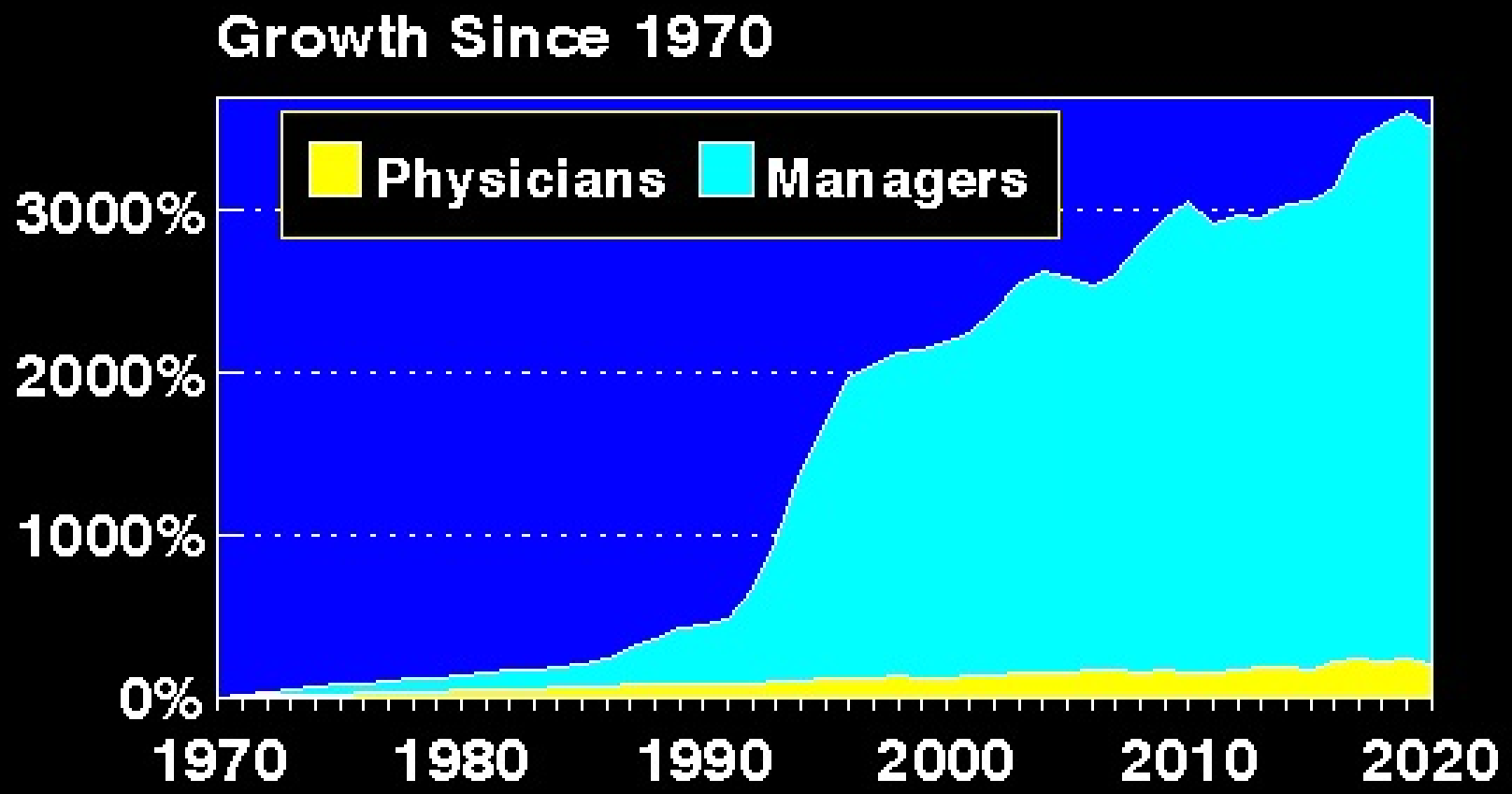
Immigrants Play Vital Roles in U.S. Care, Science and Education



Source: Ann Int Med 2017;157:584

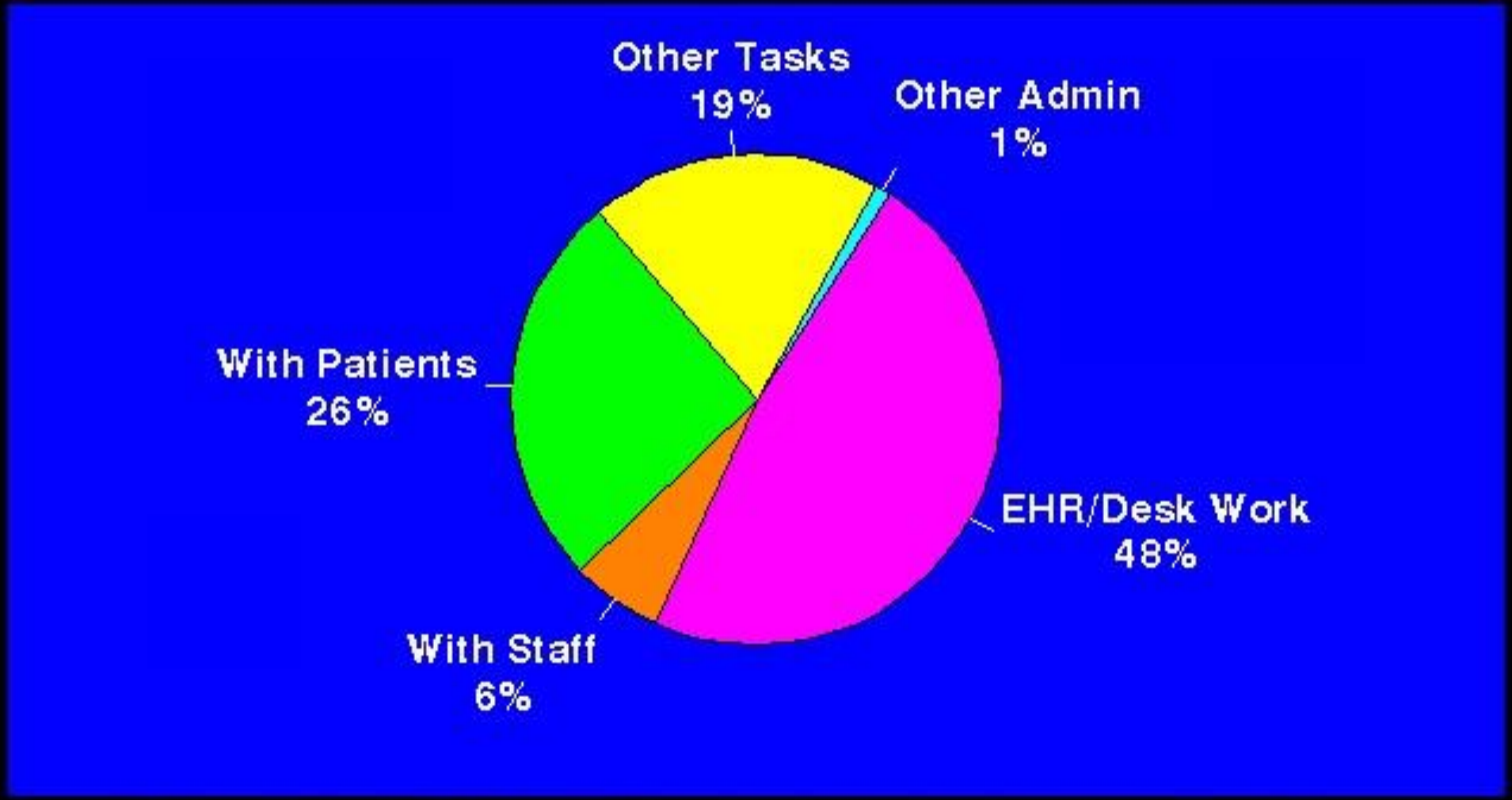
Administrative Overhead Rising

Growth of Physicians and Administrators 1970-2020



Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS
Note - Managers shown 3 year moving average - 2020 figure distorted by data collection difficulties

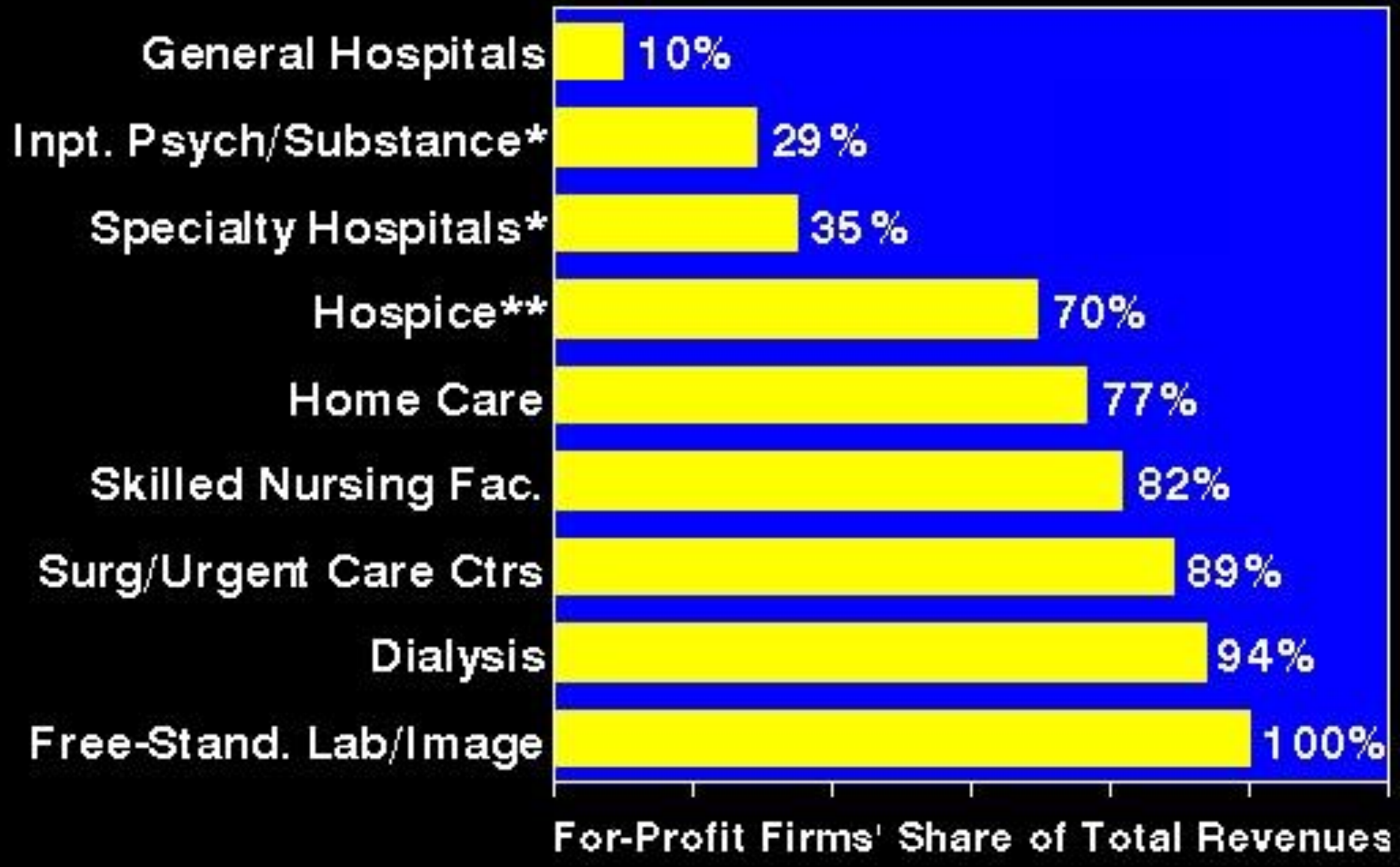
Doctors Spend Twice as Much Time on EHR/Desk Work as With Patients



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

Investor-Owned Care: Inflated Costs, Inferior Quality

Extent of For-Profit Ownership



Source: Commerce Dept. Service Annual Surveys & MedPac. Data are Q1, 2019 or most recent available

* Data are for non-government-owned hospitals

** Data are for share of establishments

Health Industry Profits, 2019

Pharmaceuticals	$83.6 bil
Insurers	$23.5 bil
Equipment/Supplies	$16.9 bil
Pharmacy/Lab/Benefit Mgr.	$14.1 bil
Providers	$4.2 bil
Distributors/Wholesalers	$2.9 bil

Source: Fortune 500, 2020

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

Health Care CEO's Pay, 2019

CEO	Firm	Total Pay
Martine Rothblatt	United Therapeutics	$45.6 mil
Larry Merlo	CVS/Aetna	$36.5 mil
Miles White	Abbott	$27.8 mil
Kenneth Frazier	Merck	$27.6 mil
Samuel Hazen	HCA	$26.8 mil
Michael Neidorff	Centene	$26.4 mil
Alex Gorsky	J&J	$25.4 mil
Alan Miller	Universal Hlth. Serv.	$24.5 mil
Ronald Rittenmeyer	Tenet	$24.3 mil

Source: AFL-CIO

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

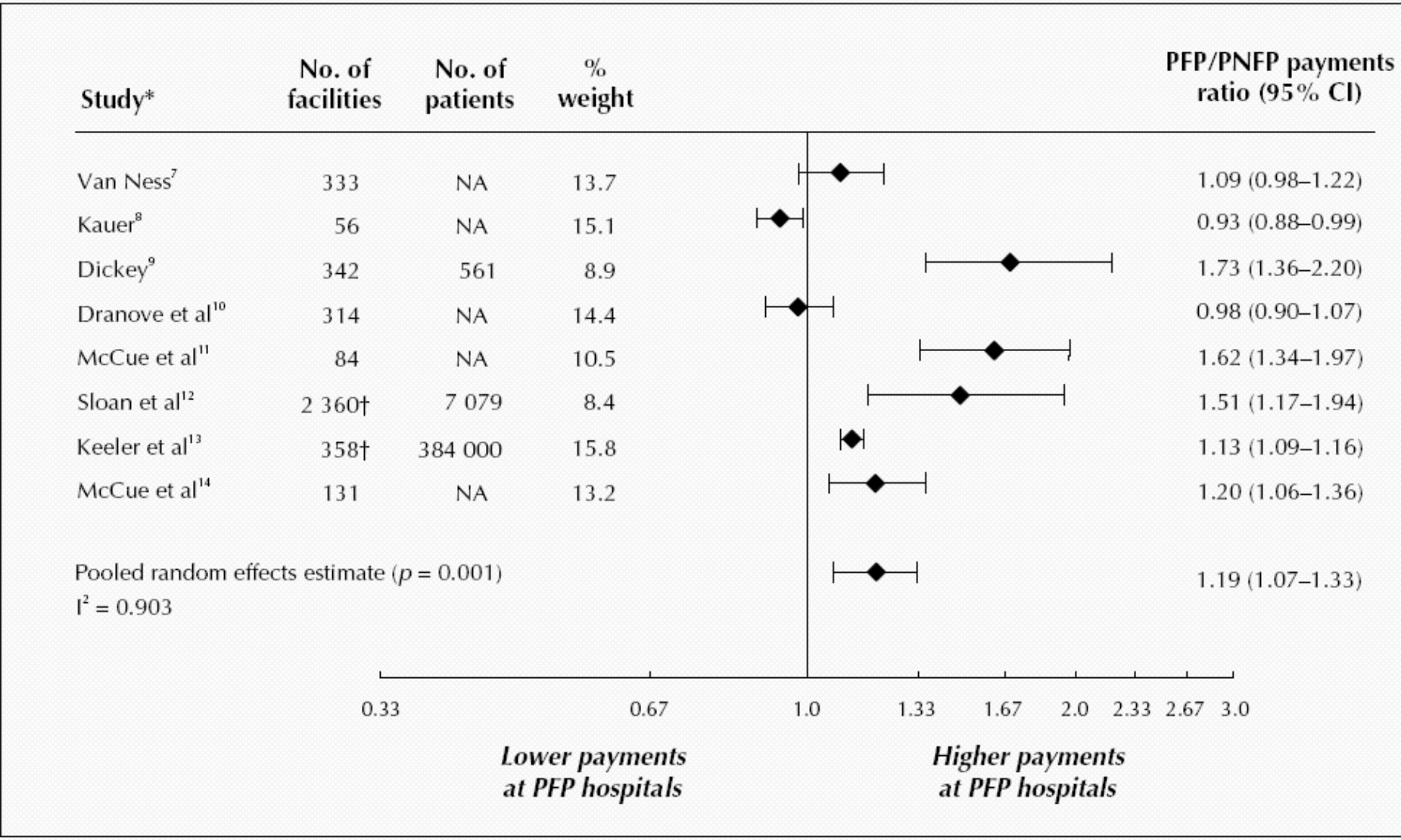
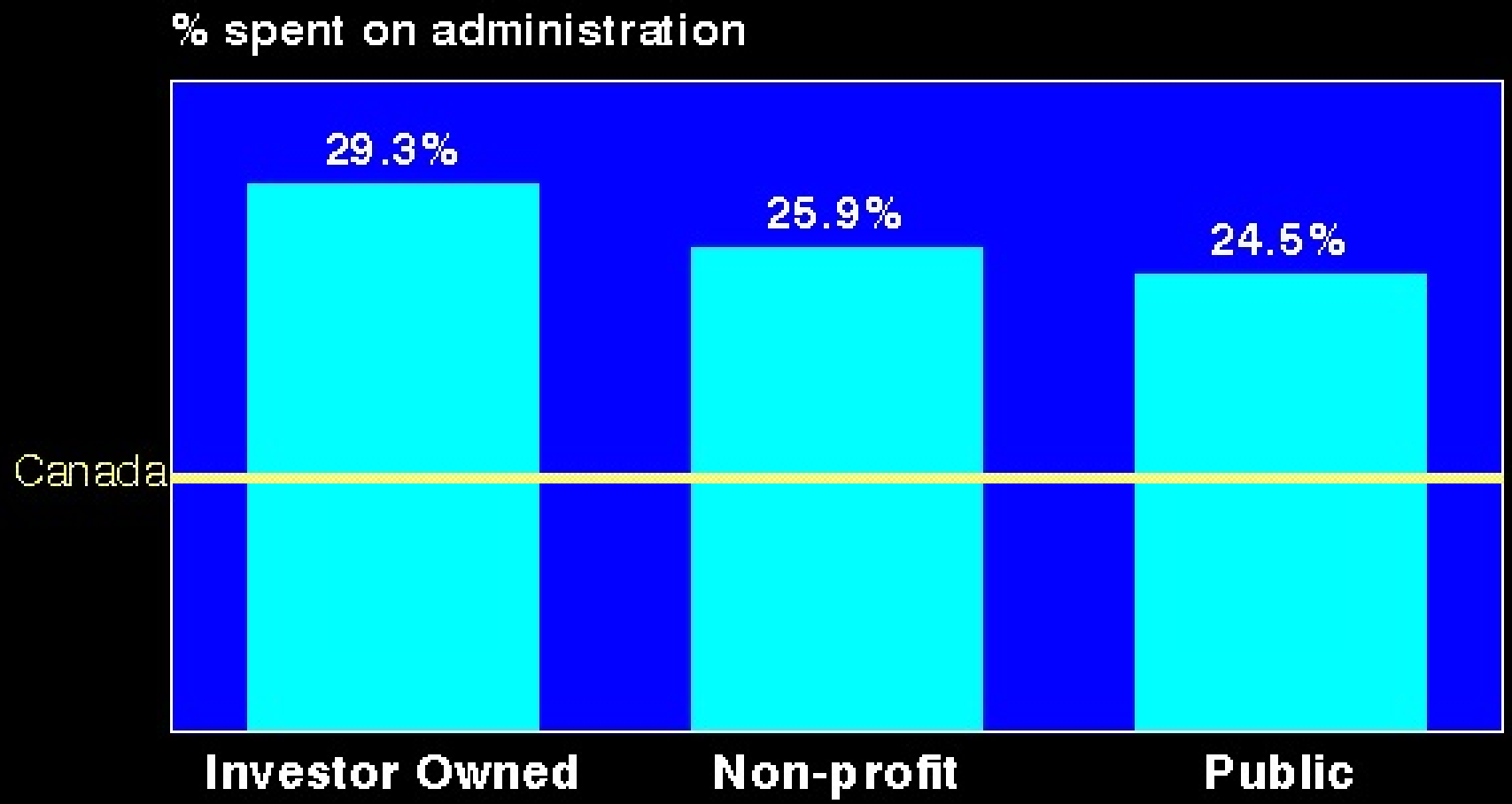


Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.
*The studies are in chronological order by midpoint of the data collection period. †Approximation from investigator.

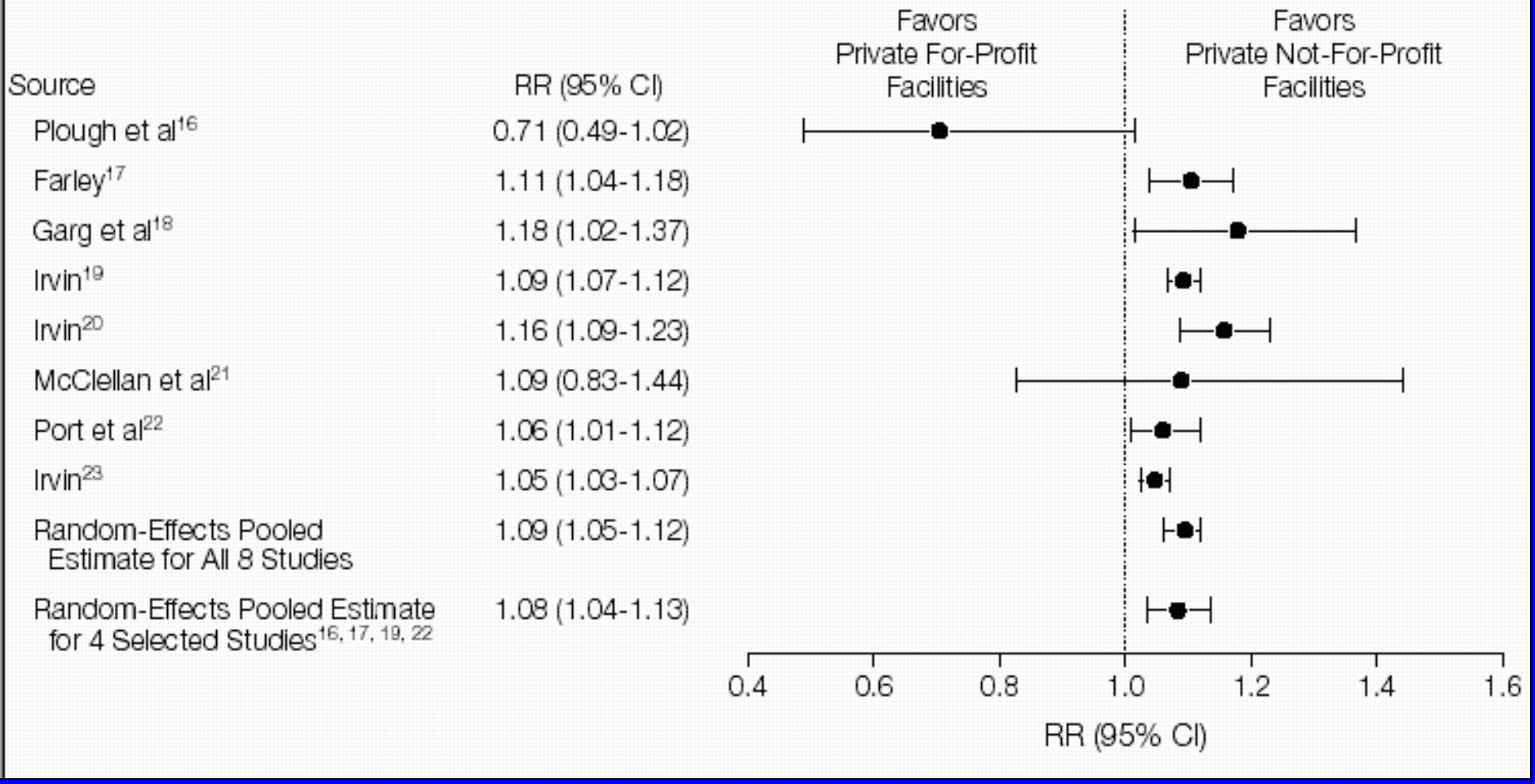
For-Profit Hospitals' Administrative Costs are Higher



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

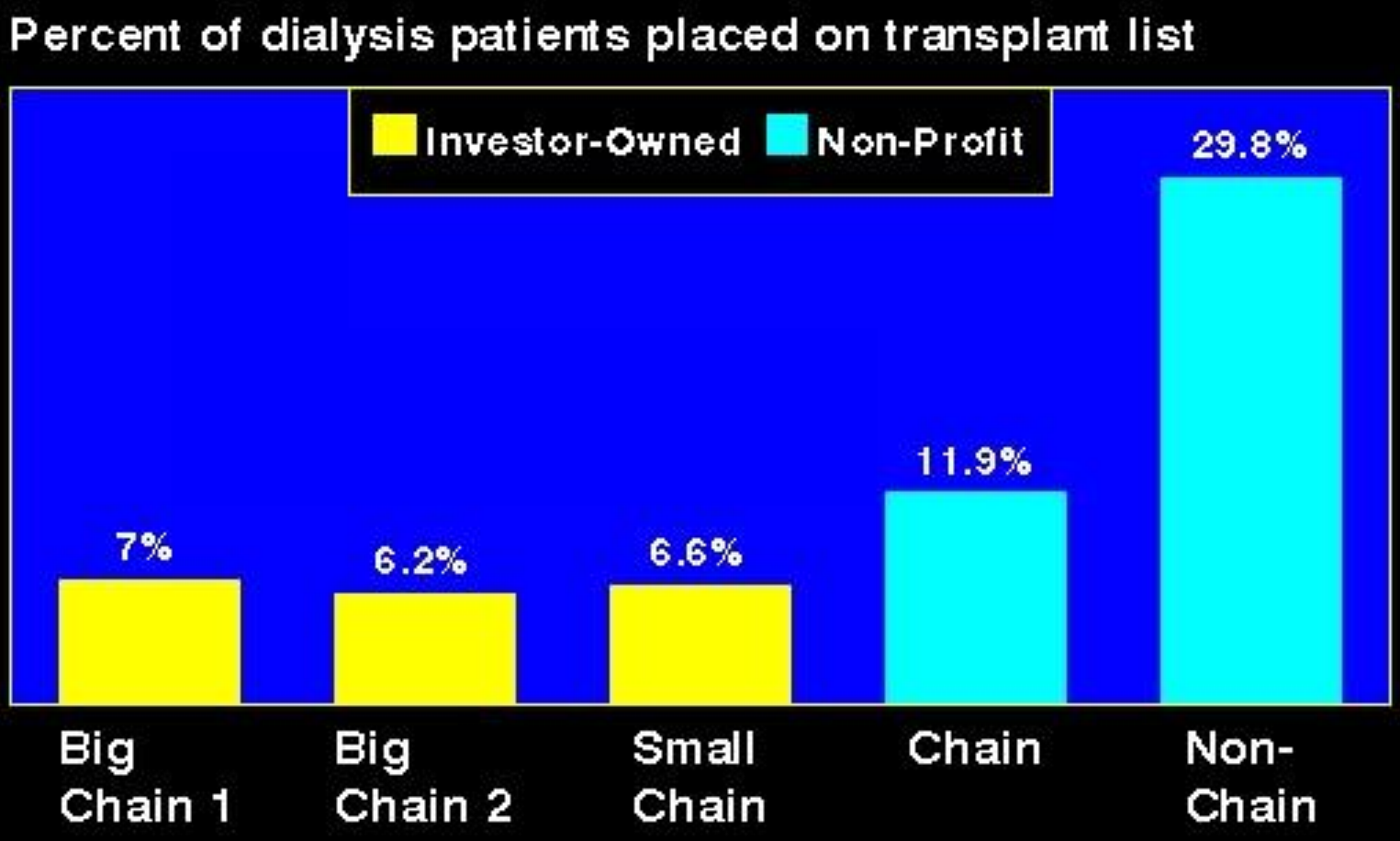
For-Profit Dialysis Clinics' Death Rates are 9% Higher

Figure 2. Relative Risk (RR) of Mortality in Hemodialysis Patients



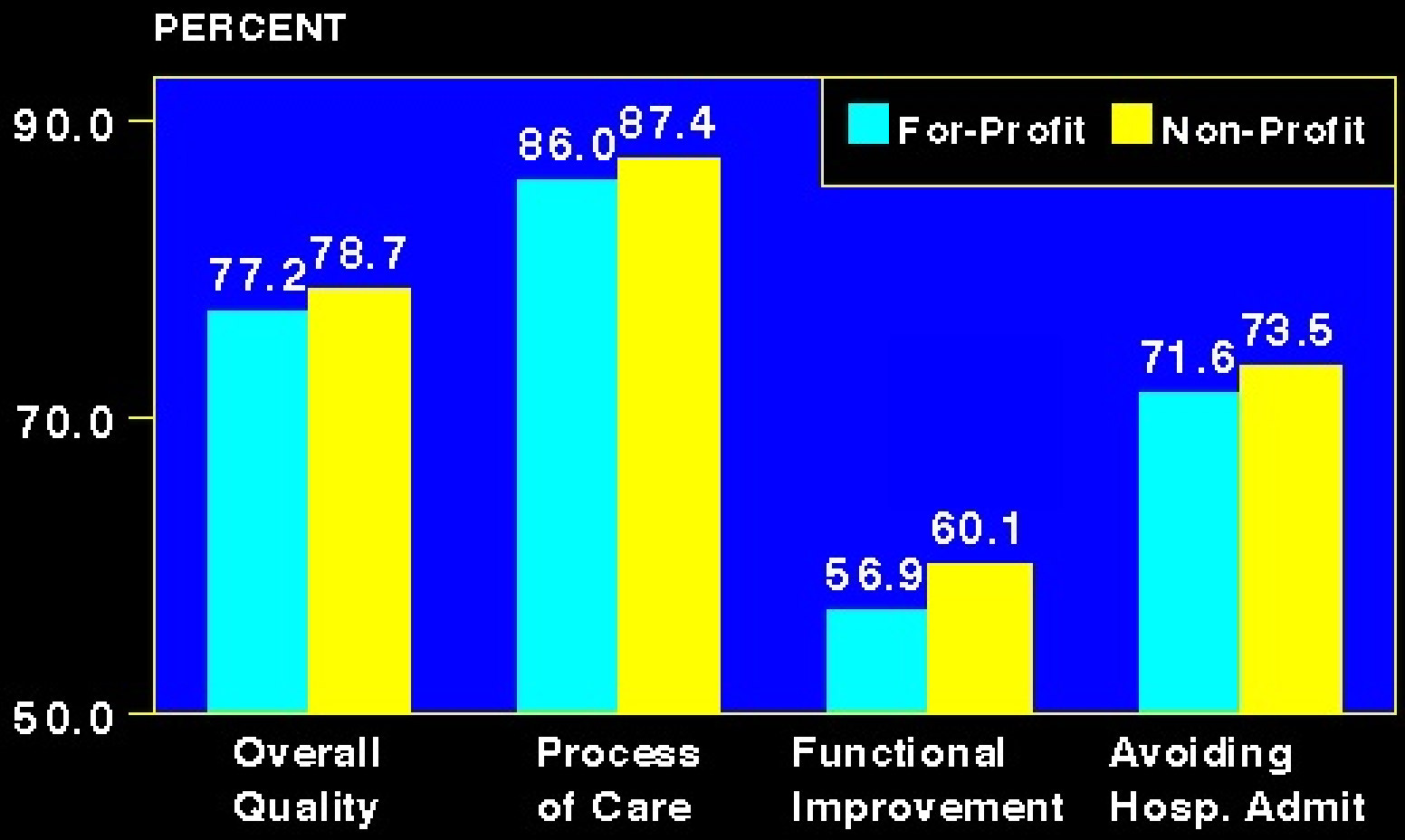
Source: JAMA 2002;288:2449

Investor-Owned Dialysis Clinics Discourage Transplants



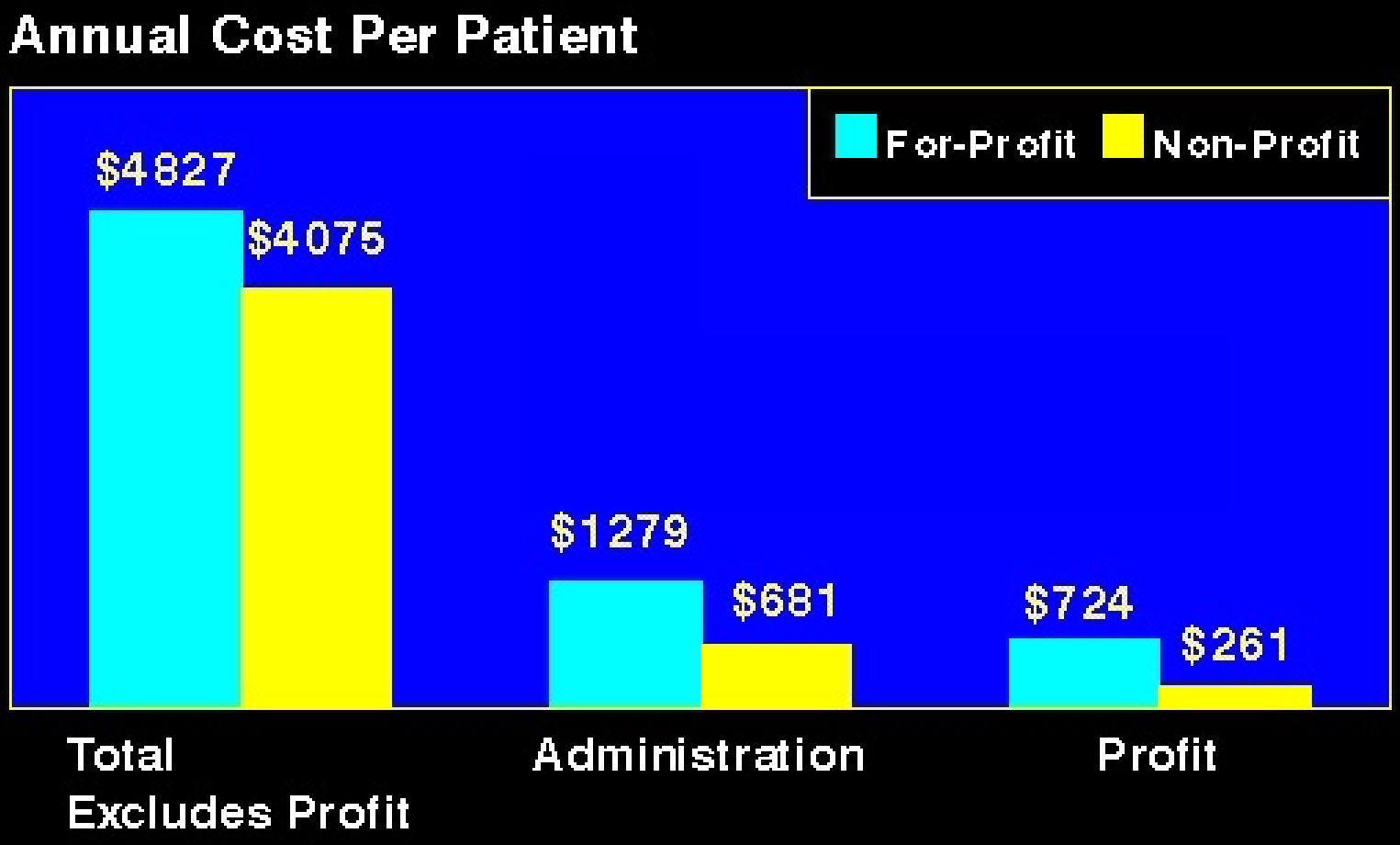
So urce: JAMA 2019;322:957

For Profit Home Care: Lower Quality



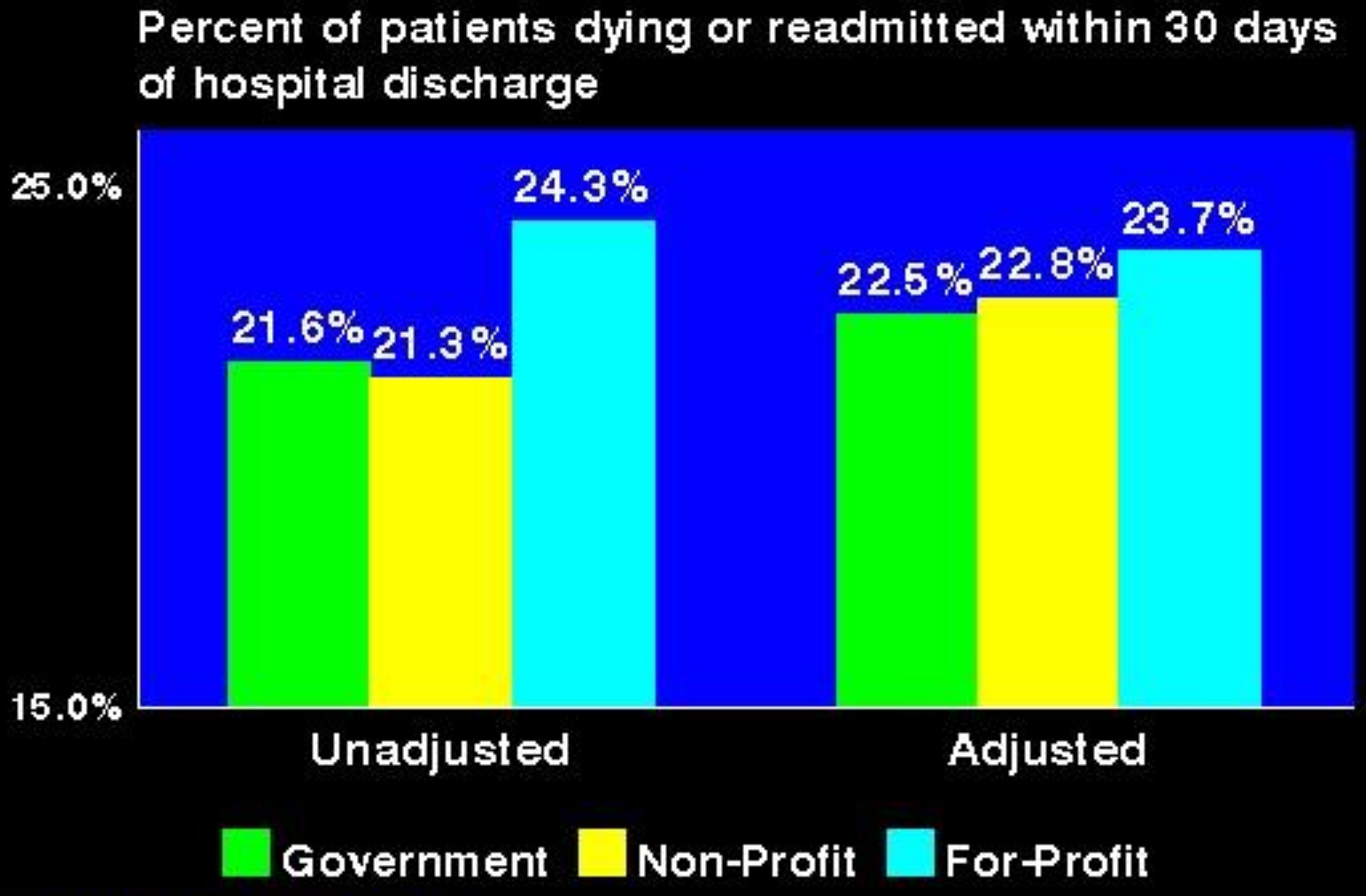
Source: Cabin, Siman, Himmelstein & Woolhandler, Health Affairs 8/2014

For Profit Home Care: Higher Cost



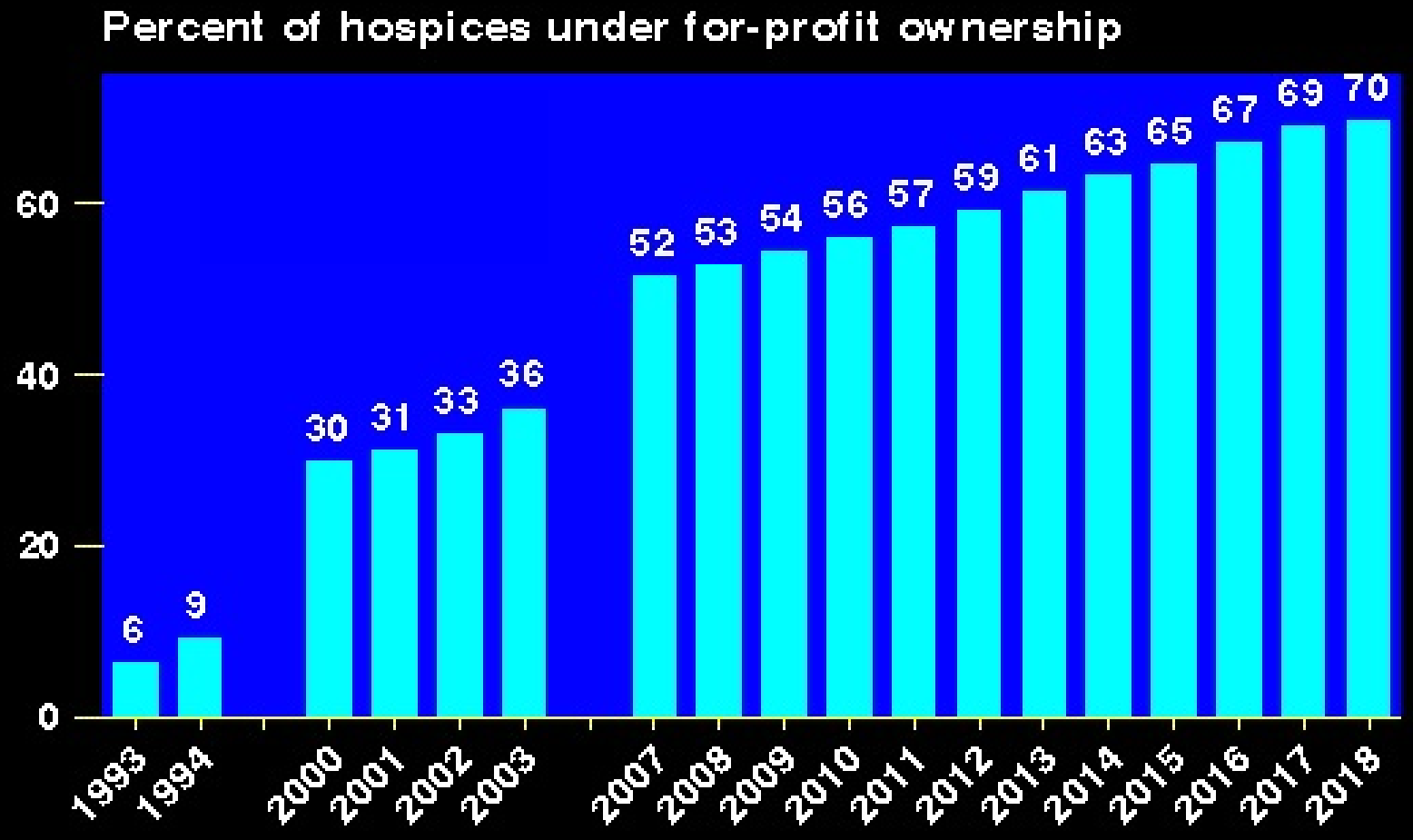
Source: Cabin, Siman, Himmelstein & Woolhandler, Health Affairs 8/2014

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



Source: JAMA 2014;312:1552

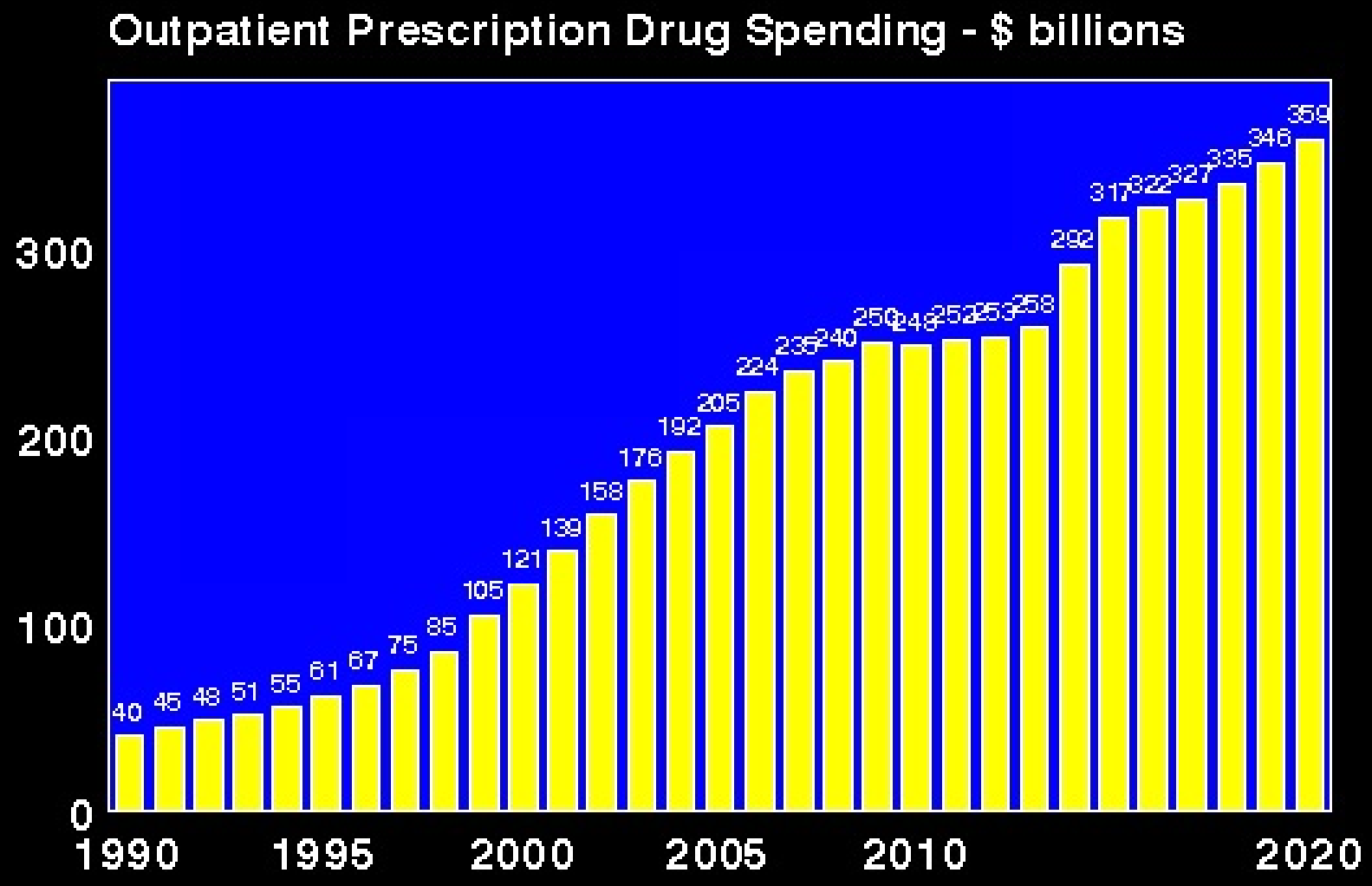
Hospice Goes For-Profit



Source: MedPac Annual Report, 2020 and previous
Note: Profit rate: for-profits = 20.2%; non-profits = 2.5%
Mean LOS: for-profits = 110 days; non-profits = 68 days

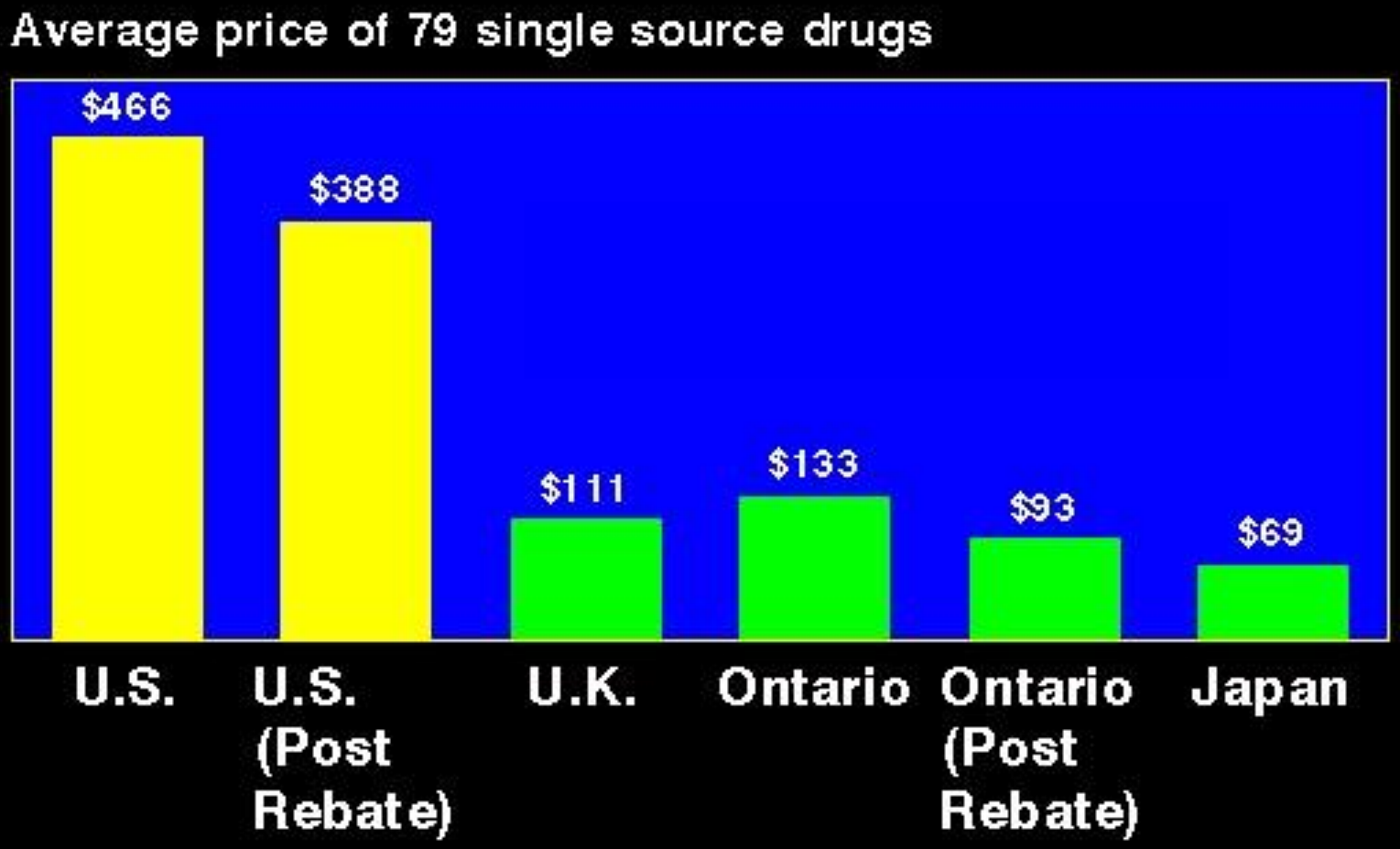
Drug and Device Firms' Inflated Prices

U.S. Drug Spending, 1990-2020



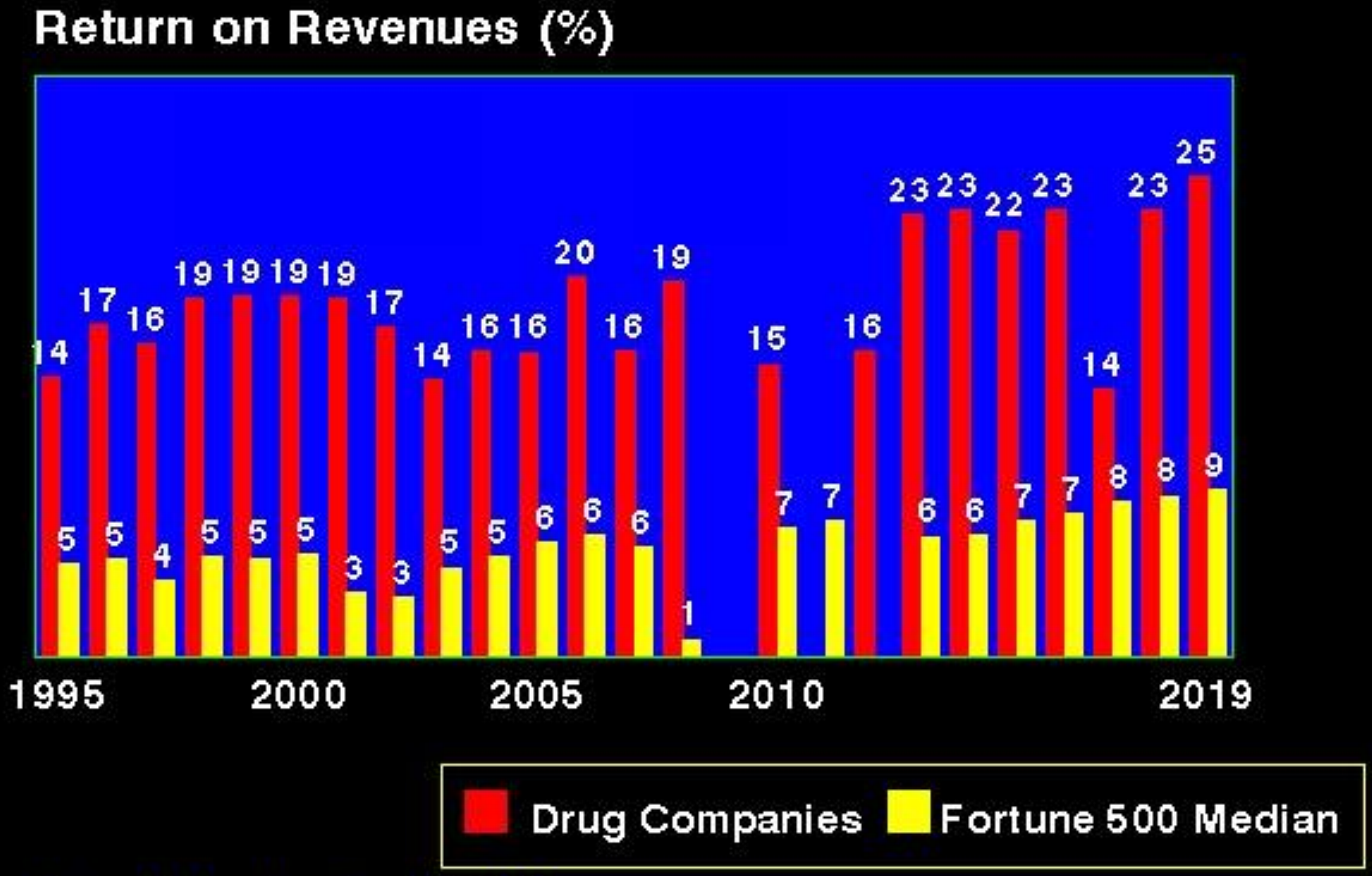
Source: CMS, Office of the Actuary - Note: 2019 & 2020 estimated

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

Drug Company Profits, 1995-2019



Source: Fortune 500 rankings for 1995-2020

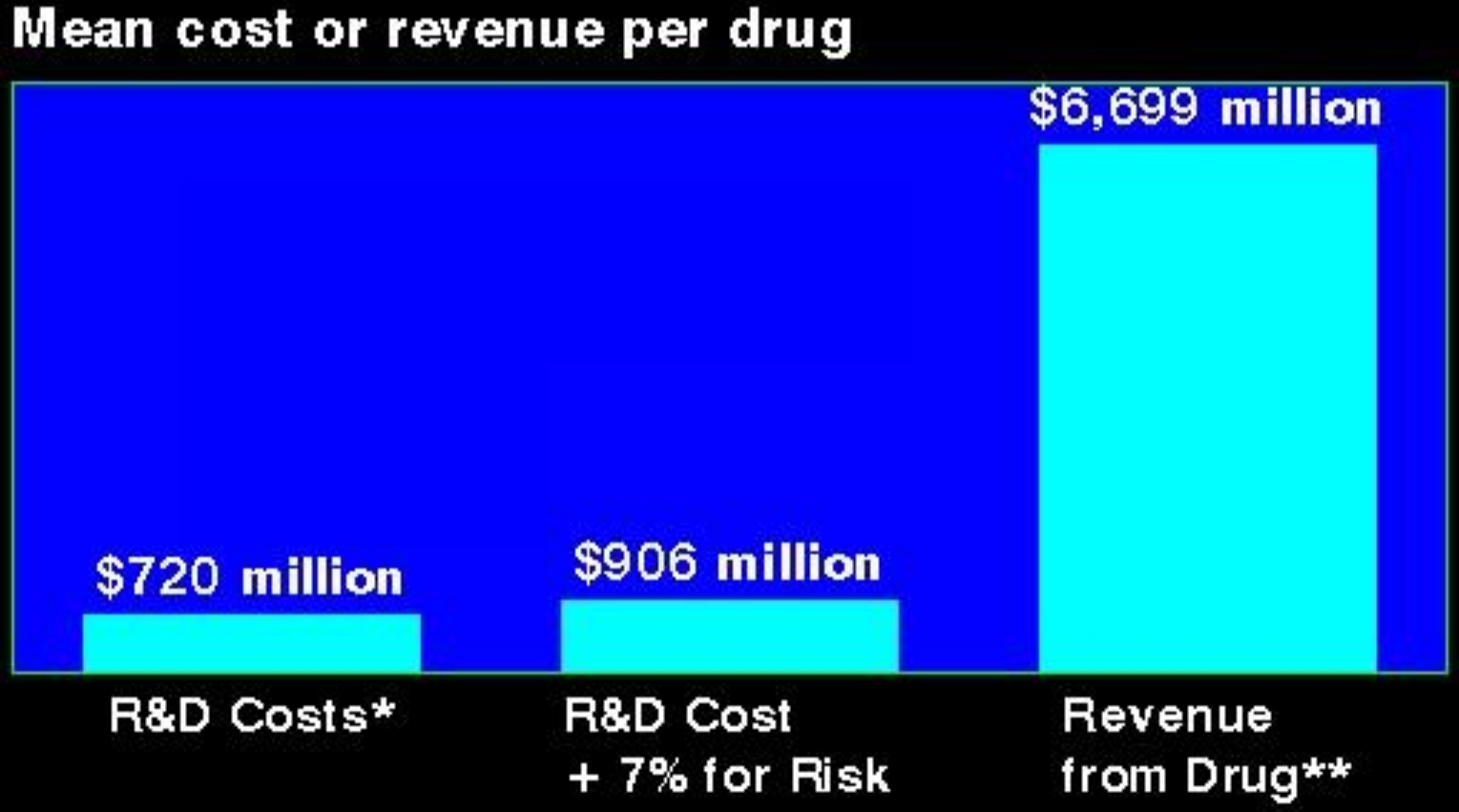
Drug Firms' Strategy: Pay the Ticket, Keep on Speeding

- 85% of drug firms paid fines for illegal activities, 2003-2016.
- Most common violations: kickbacks, illegal marketing, overcharging.
- Fines over 14 years = $33 billion (< ½ of single year profits).
- 21/26 firms engaged in illegal activities for at least 4 years.

Source: JAMA IM 2020;3324:1995

Profits Dwarf Cancer Drug R&D Costs

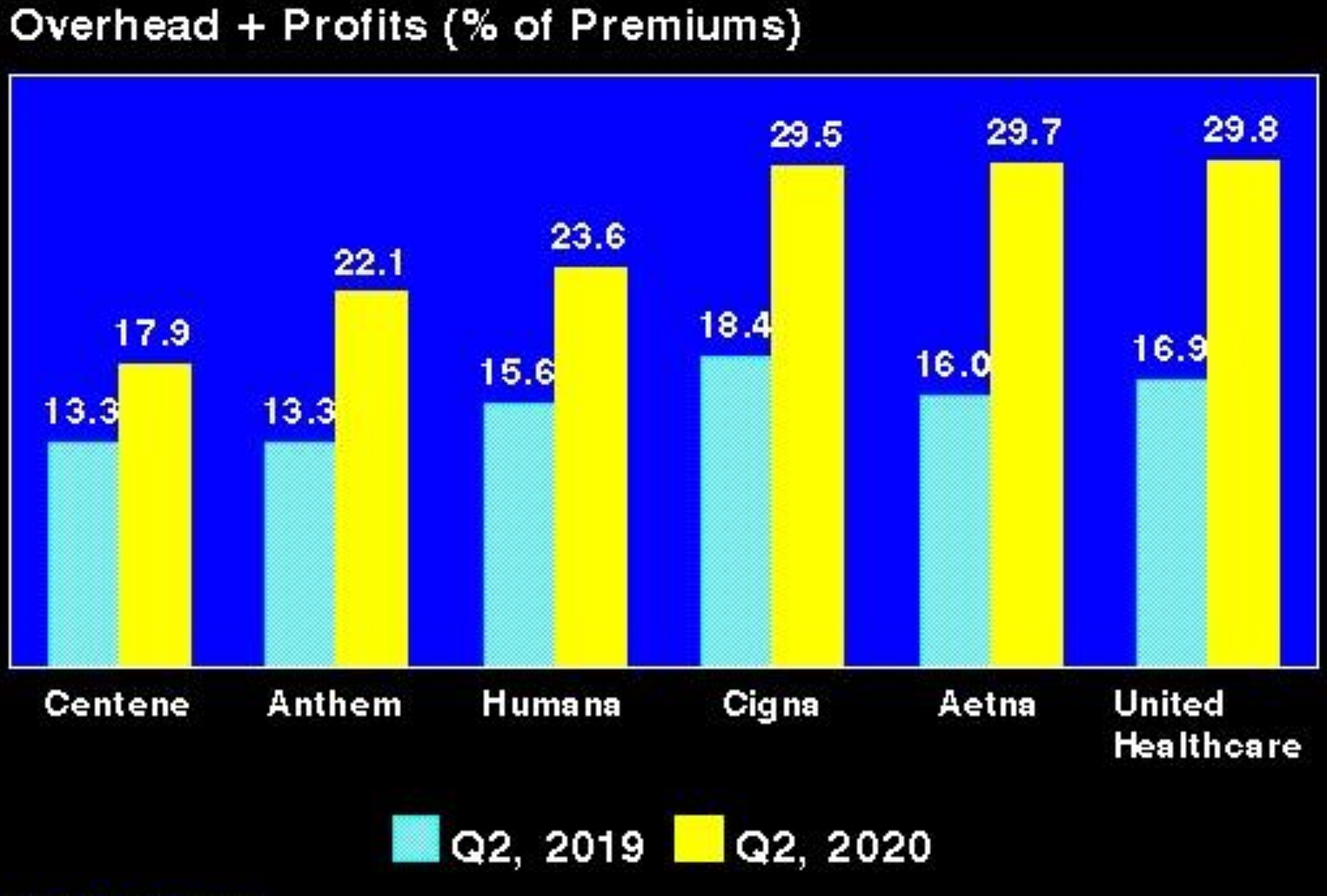
Analysis of All Drugs Approved 2006-2015
From Firms With Only 1 Approved Drug



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

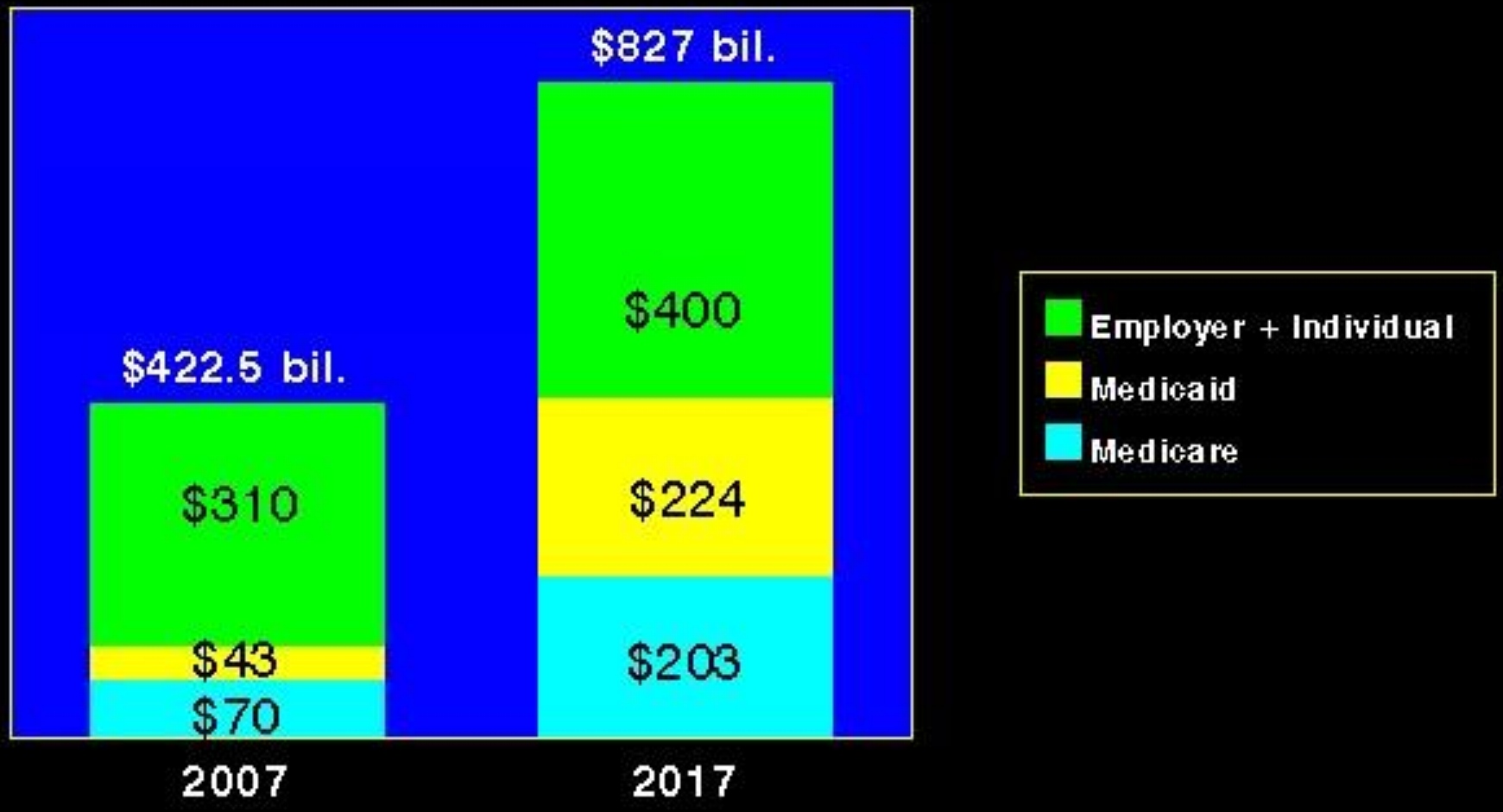
Private Insurers: Middlemen Who Add Costs But Not Value

COVID-19 Boosted Insurers' Profits



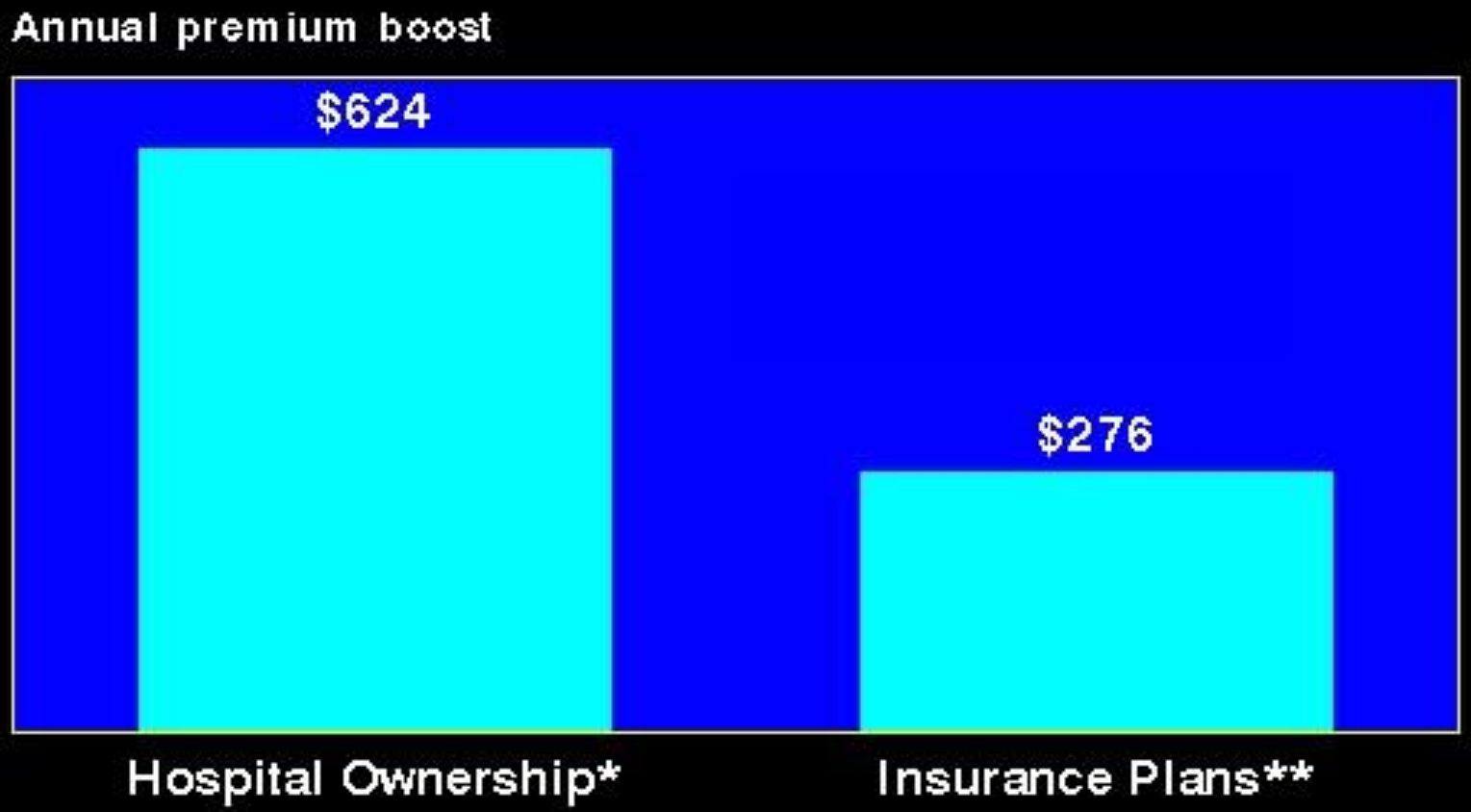
Source: SEC Filings

52% of Private Insurers' Revenues Come From Medicare and Medicaid



Source: AM Best 8/13/2018

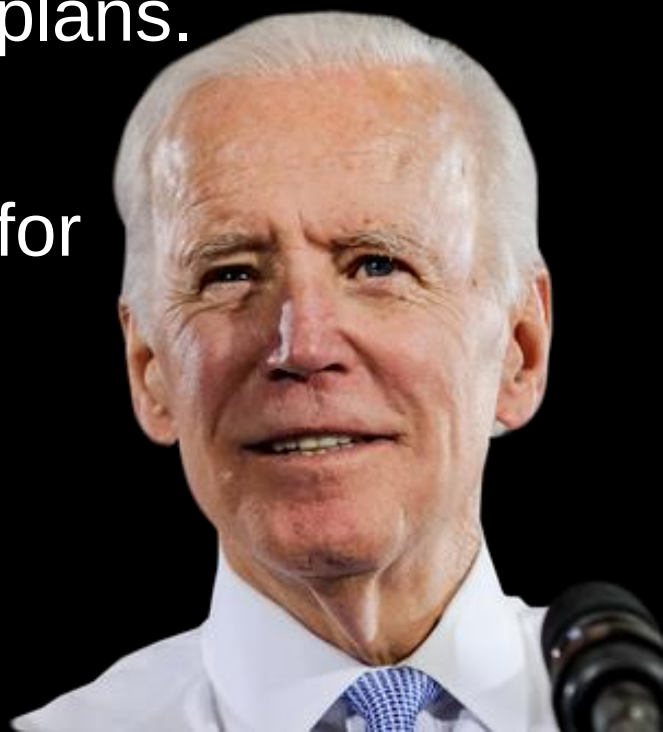
Both Hospital and Insurer Consolidation Raise Premiums



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

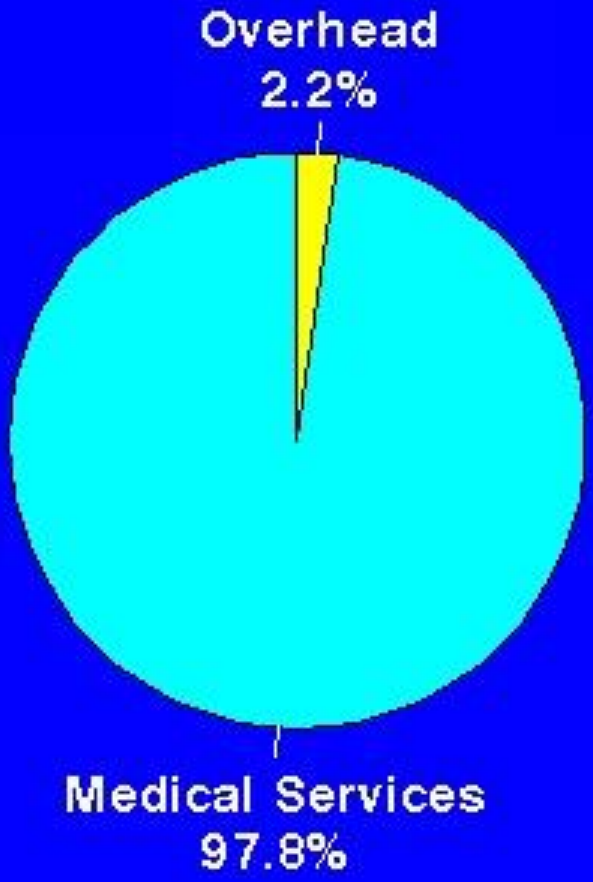
Biden's Health Reform Proposals

- **New "Medicare-like" Public Option.**
- Increase exchange subsidies to cap premiums at 8.5% of income.
- Subsidy amount based on Gold plans.
- Lower Medicare age to 60.
- Free enrollment in public option for persons <138% of FPL in non-expansion state.

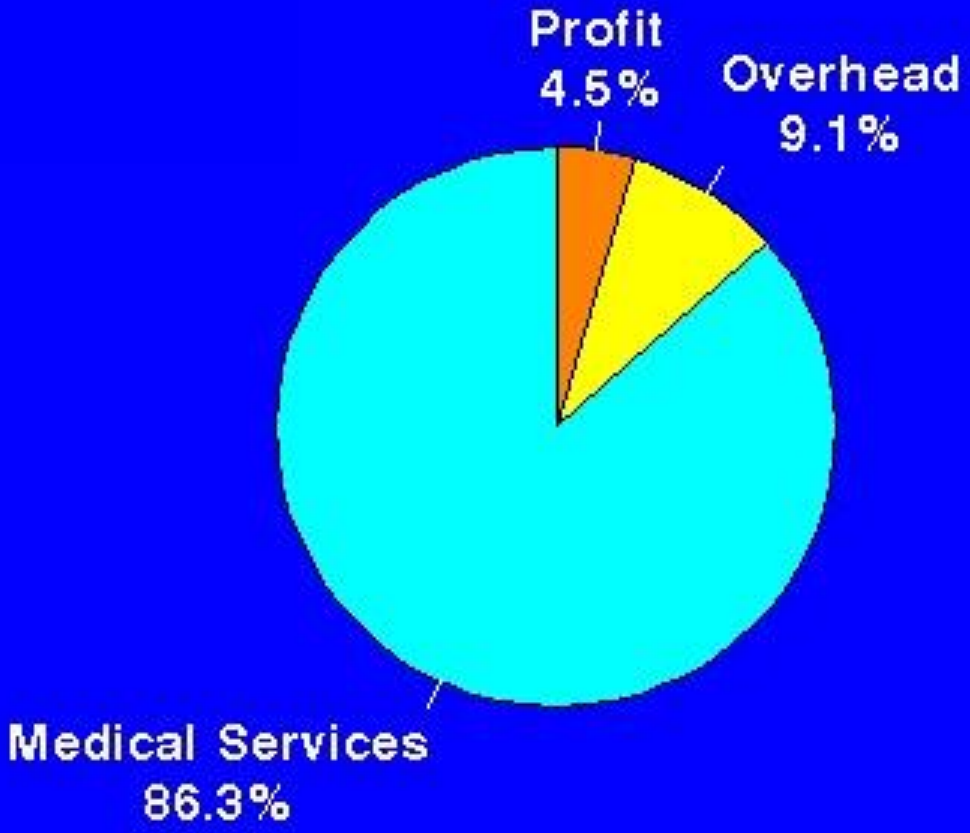


Medicare Advantage: The Only Working Model of a Public Option (Traditional Medicare) Competing With Private Plans

Medicare Advantage Plans' High Overhead



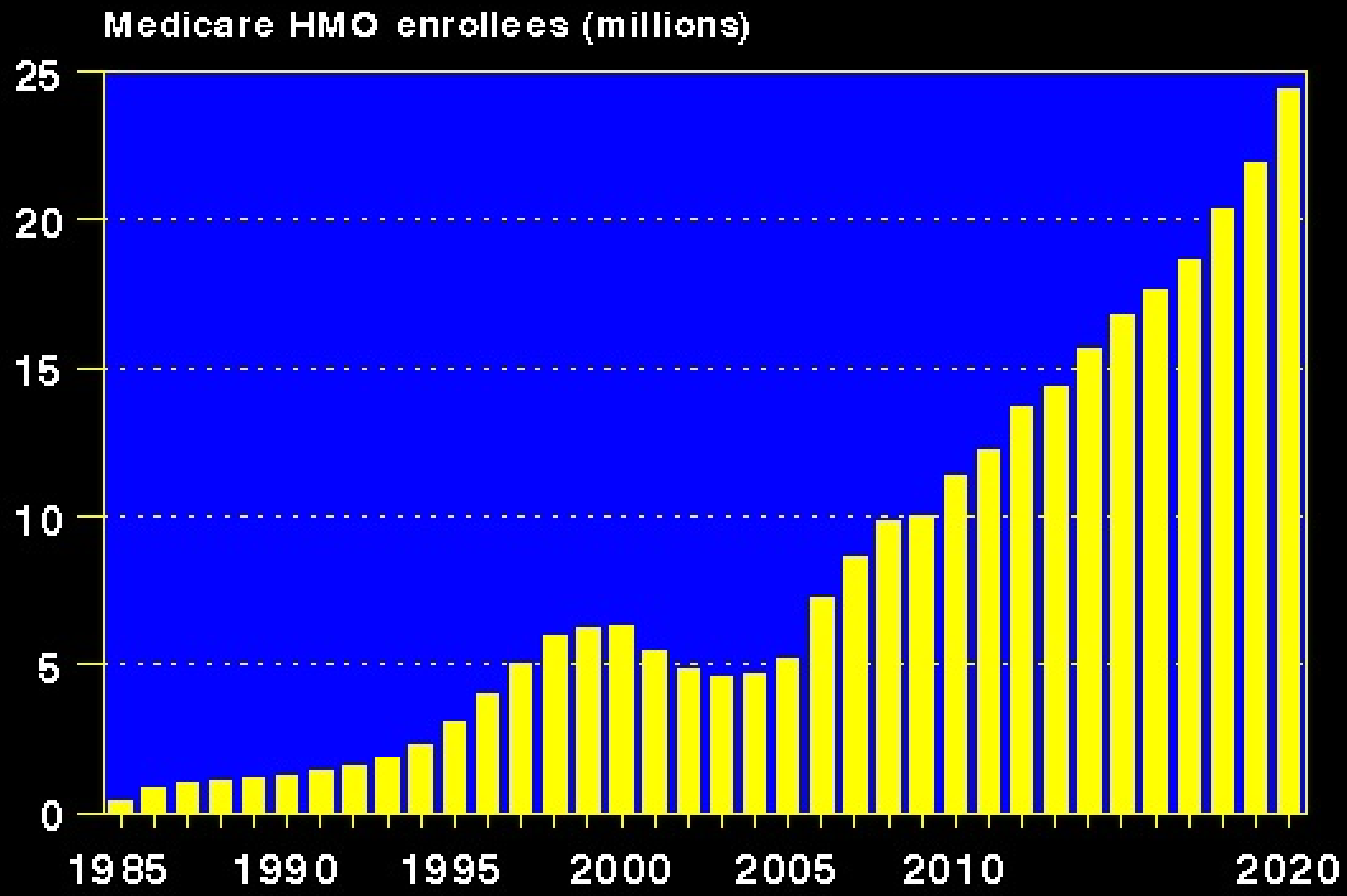
Traditional Medicare



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, 1985-2020



Source: CMS & Kaiser Foundation

How do Medicare Advantage Plans Outcompete Traditional Medicare?

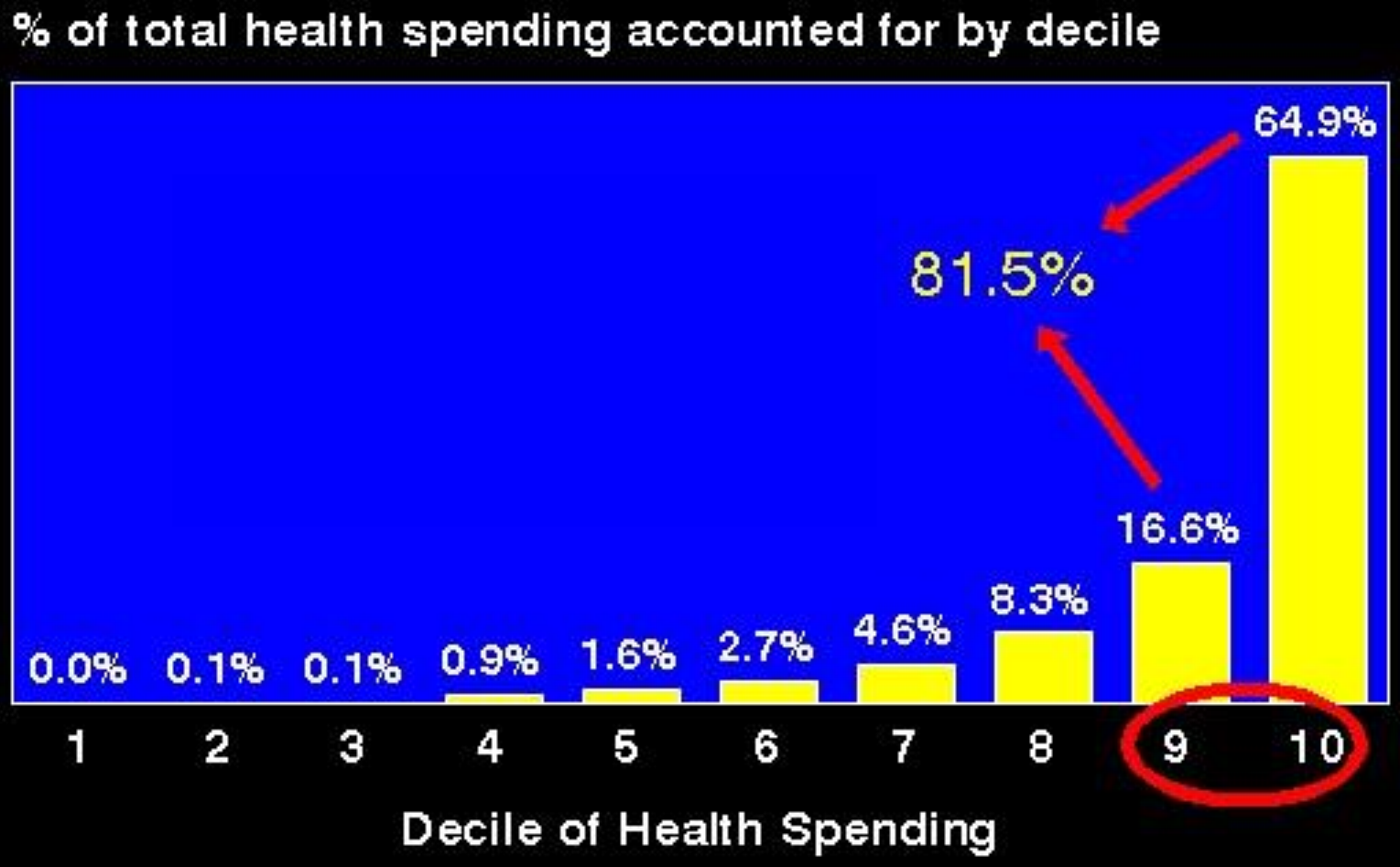
- Cherry-picking + Lemon-dropping
  - Exclude hospitals/doctors attractive to high-cost patients
  - Benefit/formulary design
  - Hassle factor
- Upcode + over-diagnose to game risk adjustment
- Outright cheating

Medicare Advantage Plans' Strategies: 1- Cherry Picking

Marketing, network manipulation, benefit design

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 Enrollees Cost $1,253/year Less Before Enrolling

MA plans selectively recruit low-cost enrollees within each diagnosis

Source: Kaiser Foundtion May, 2019

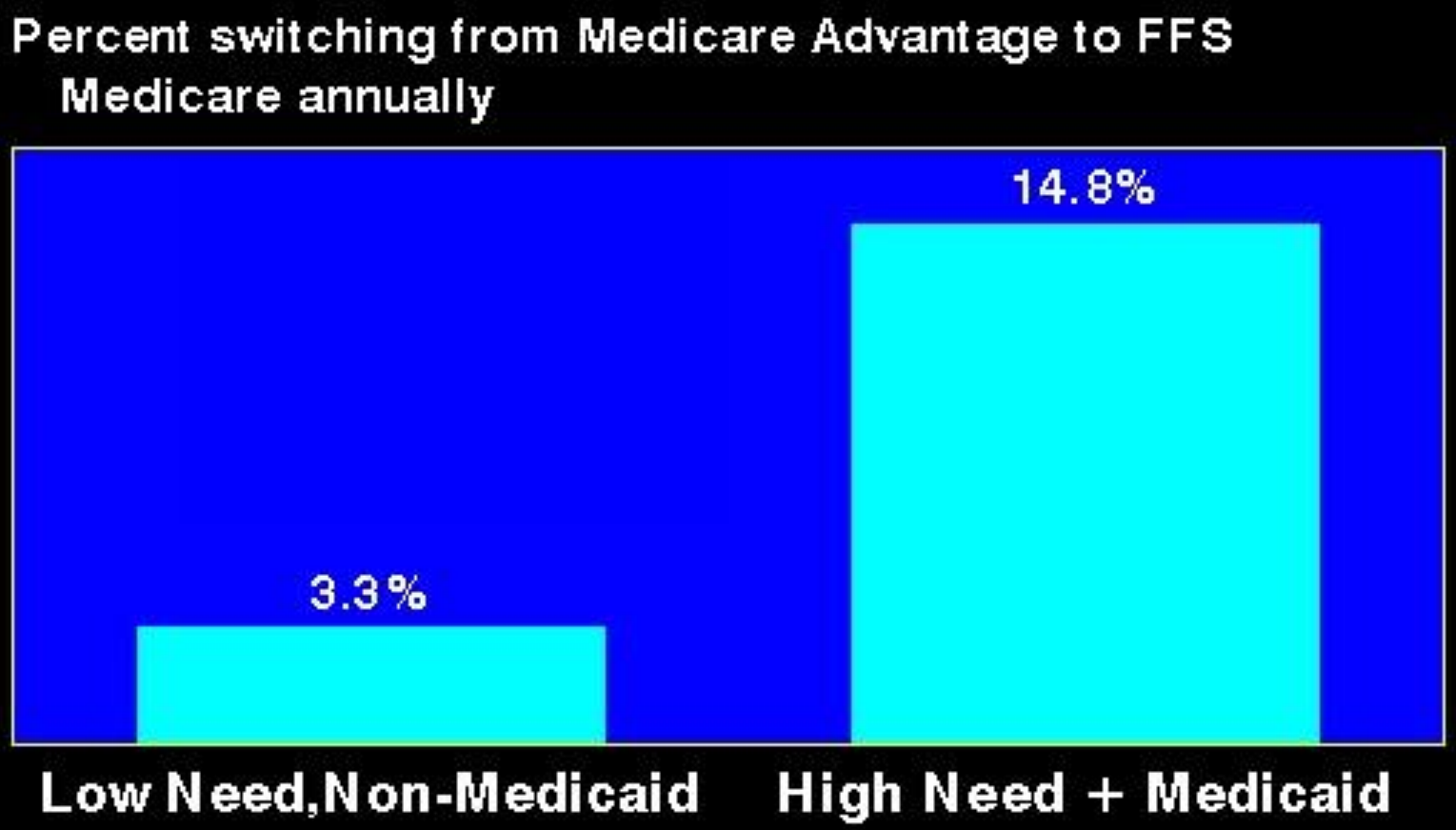
Note: For example, difference for pts. with asthma = $1410; depression = $1198; arthritis = $1371

Medicare Advantage Plans' Strategies: 2 - Lemon Dropping

Network manipulation, benefit design, hassle factor

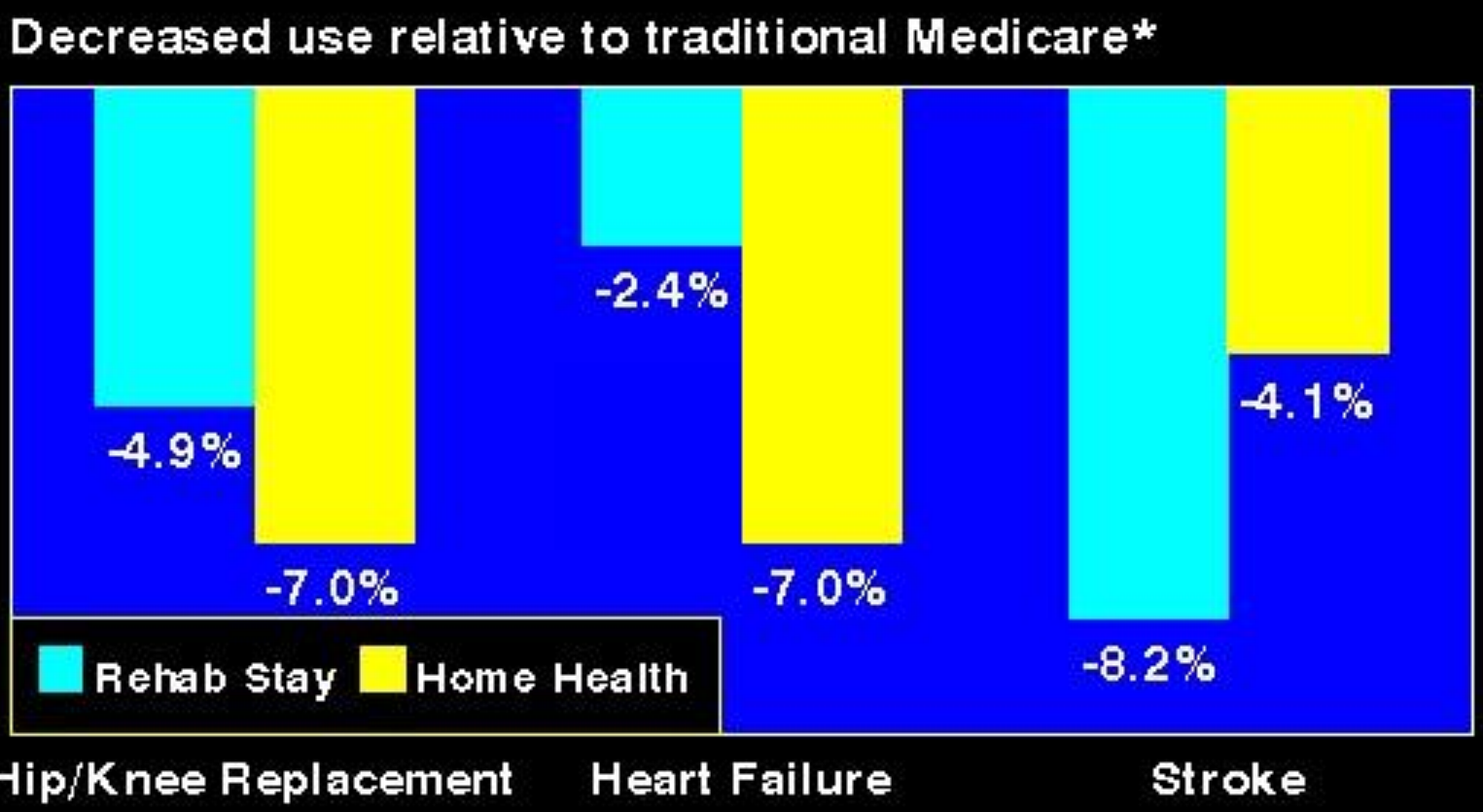
High Needs Patients Frequently Disenroll From Medicare Advantage Plans

Another Example of "Lemon Dropping"



Source: JAMA IM 2019;179:524
Note: High need = 2 or more chronic conditions; Medicaid = Medicare + Medicaid "dual eligible"

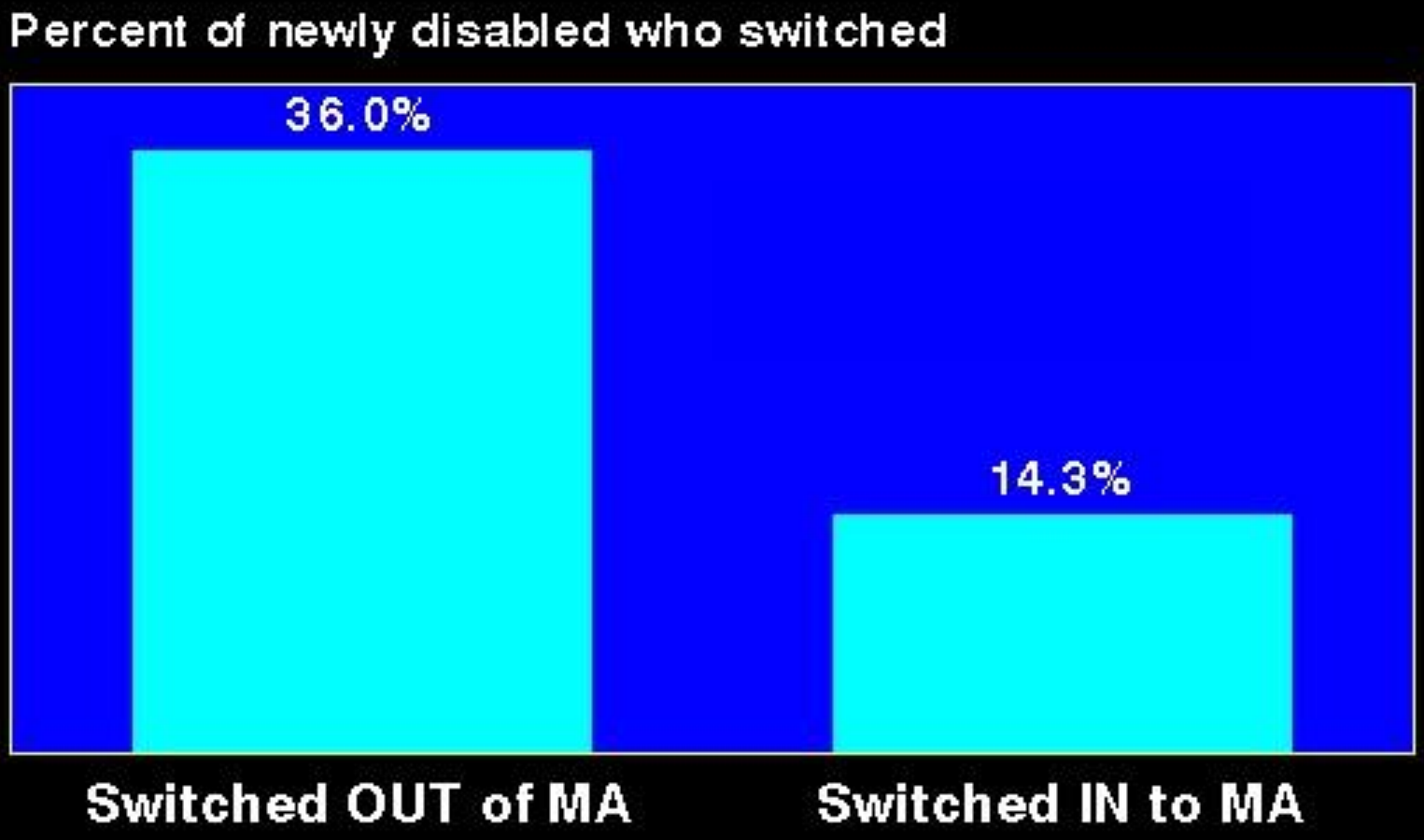
Medicare Advantage Plans Skimp on Rehabilitation and Home Care



Source: Health Aff 2020;39:837

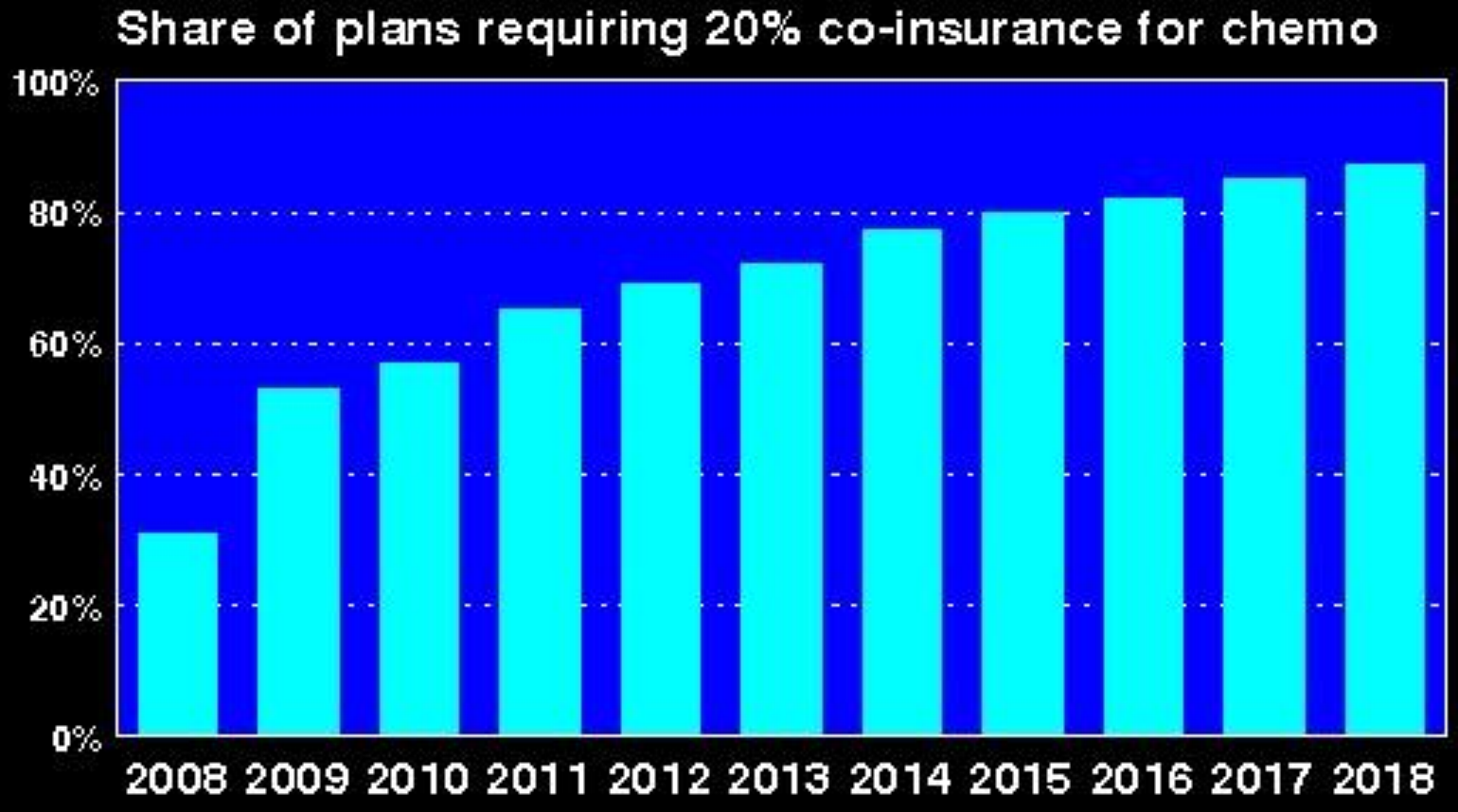
* Difference in share of patients receiving service in 90 days after discharge, adjusted for demographic, clinical and hospital characteristics

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

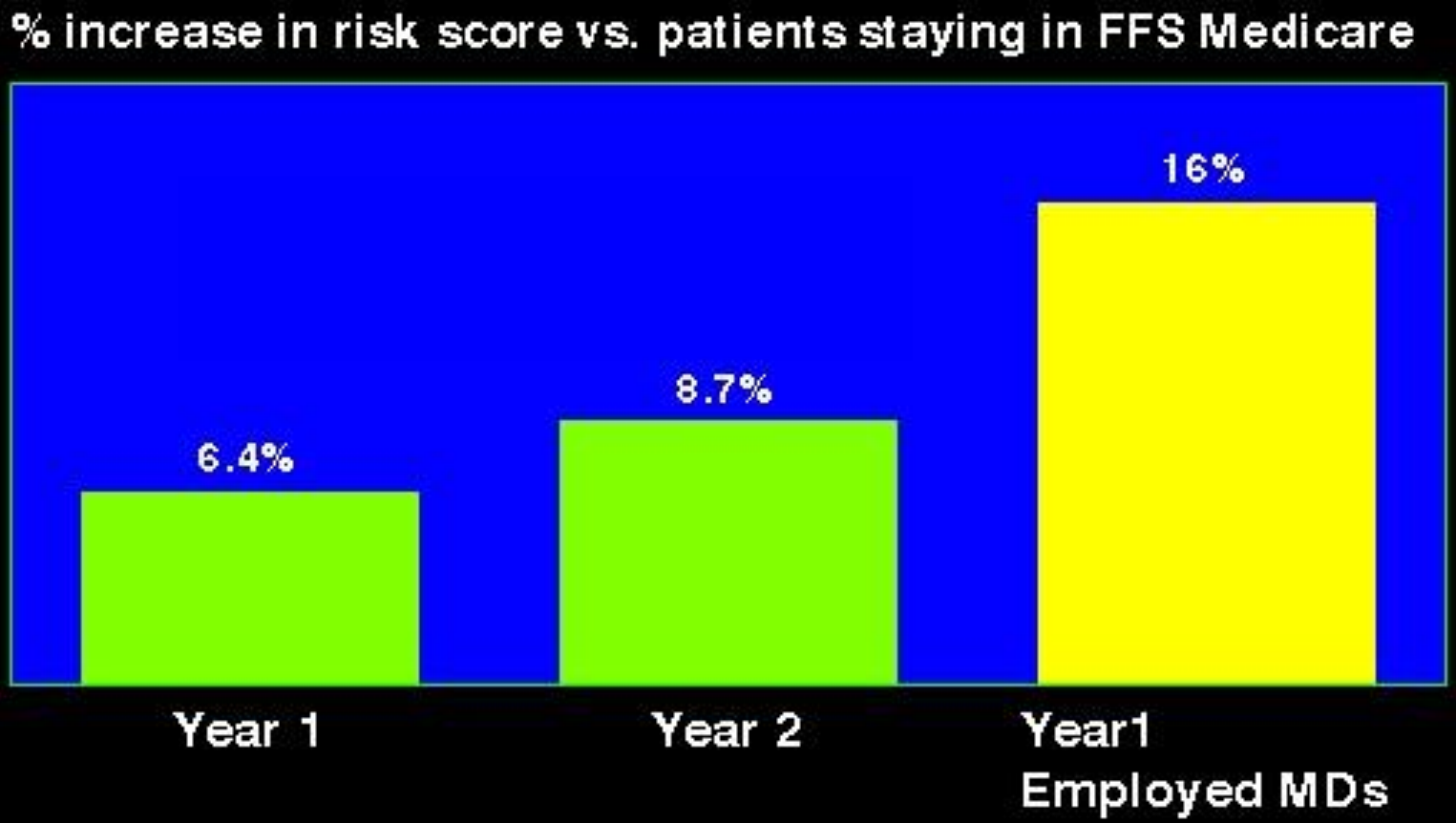


Source: JGIM 2019;34:1119

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.

Upcoding Boosts Advantage Plans' CMS-Paid Premiums

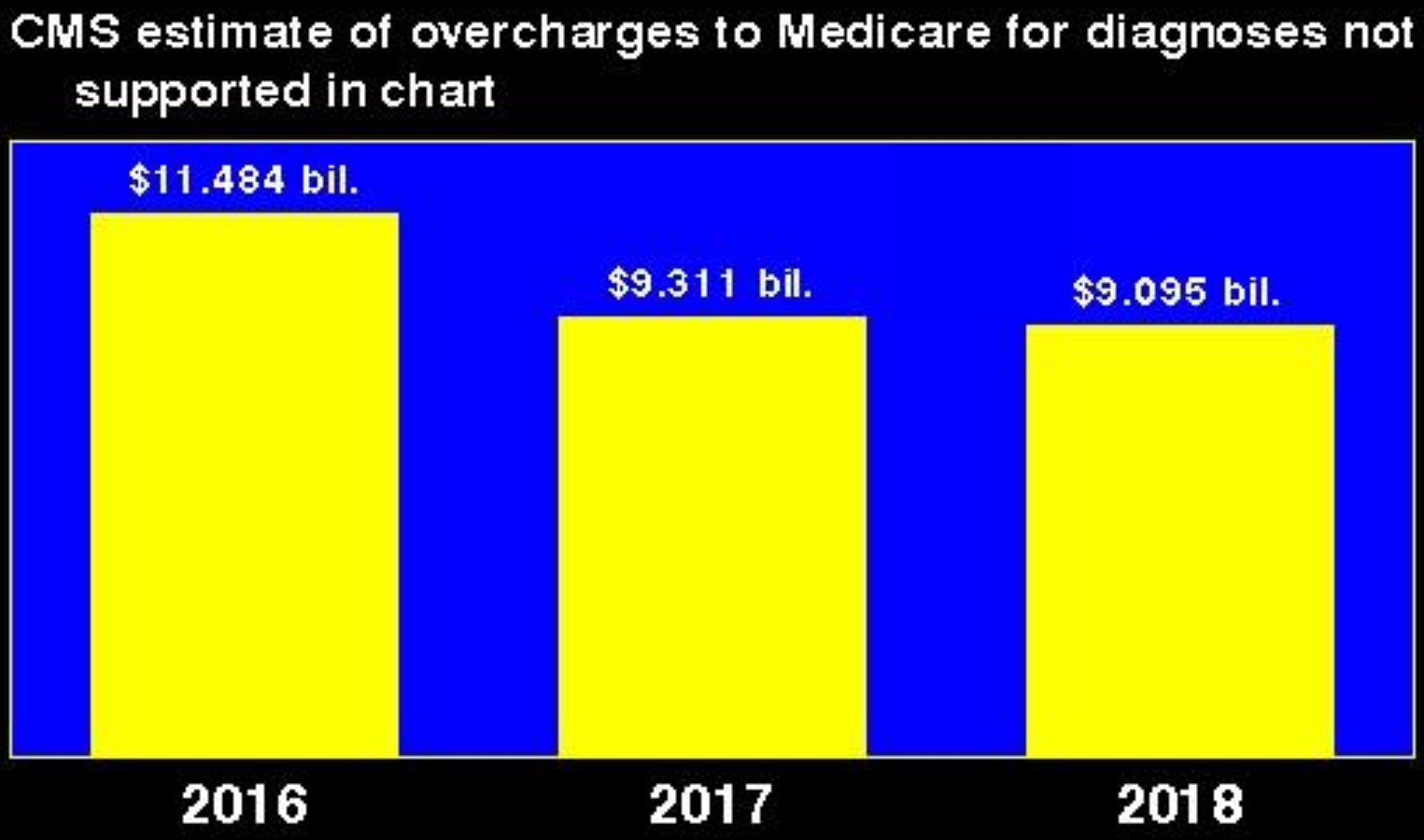
Same Patient, Different Coding

• Base rate	$3950	• Base rate	$3950
• Uncompl. DM	$1040	• DM II with diab. CKD	$3180
• CKD	$0	• CKD stage 4	$2370
• Obesity	$0	• Morbid Obesity	$2730
• Depression	$0	• Major depression	$3950
• Chronic CAD	$0	• CAD with angina	$1400
• Total	**$4990**	**• Total**	**$17580**

SOURCE: SGIM FORUM, 2017

Medicare Advantage Plans' Claims for Unsupported Diagnoses

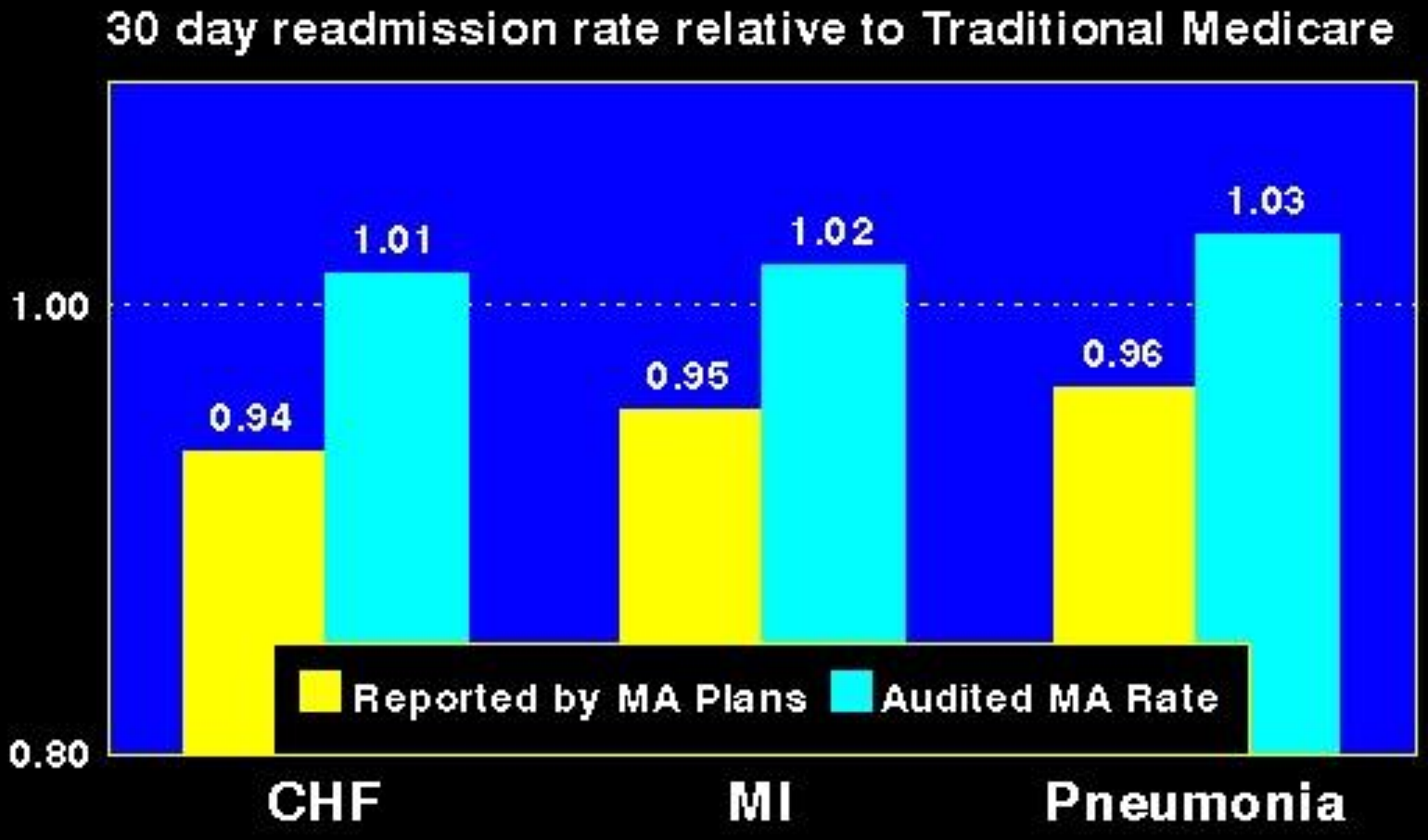
CMS Chart Audit (But CMS Only Pursued Recovery for 0.2% of Projected Overcharges)



Source: Kaiser Health News 7/16/2019

M.A. Plans Lie About Quality

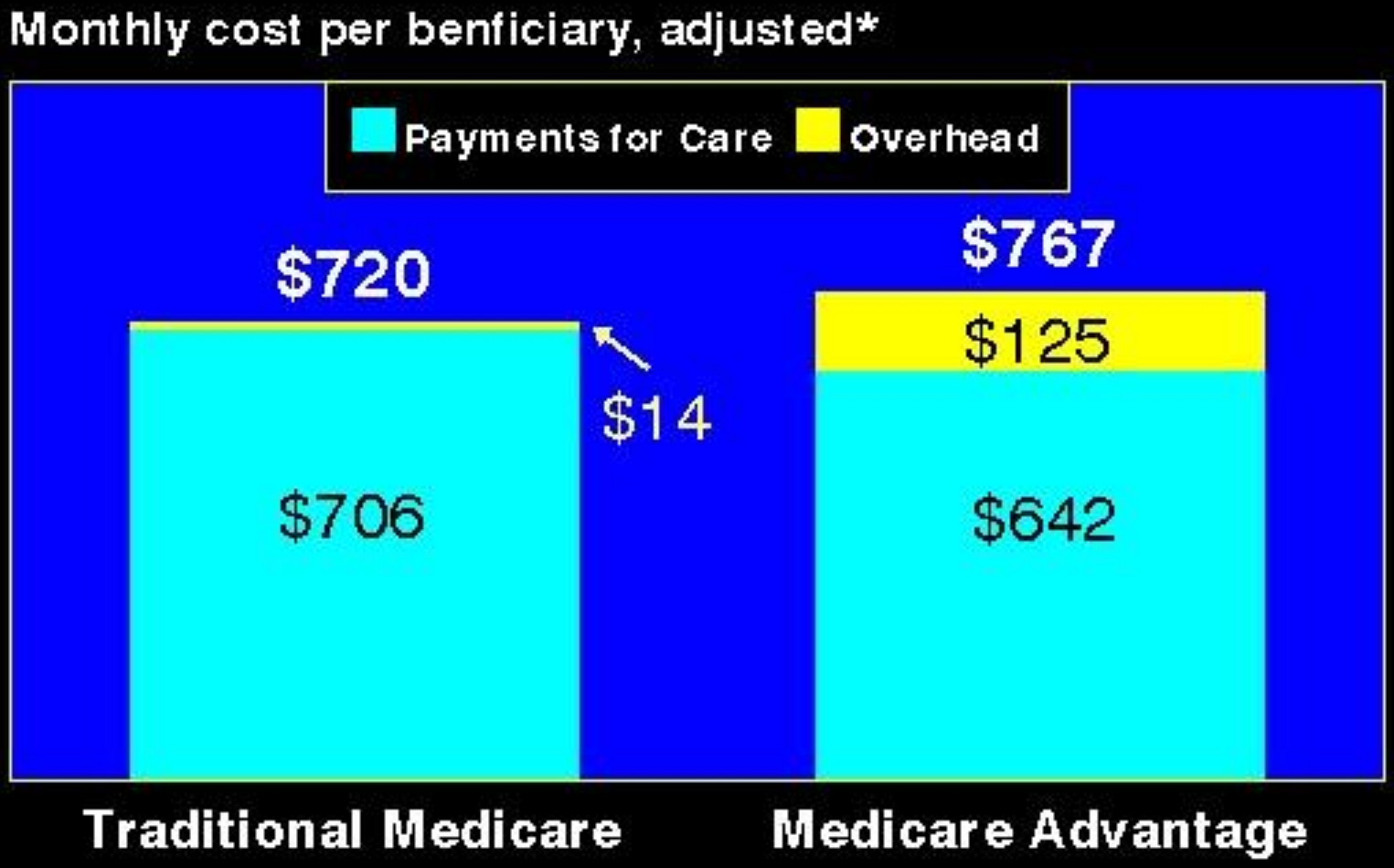
Advantage Plans Report few Readmits
But Audit Shows Rates Higher Than FFS Medicare



Source: Annals of Internal Medicine 2019; 171:99

Medicare Advantage Plans Raise Costs

Less Spending on Care, More on Overhead

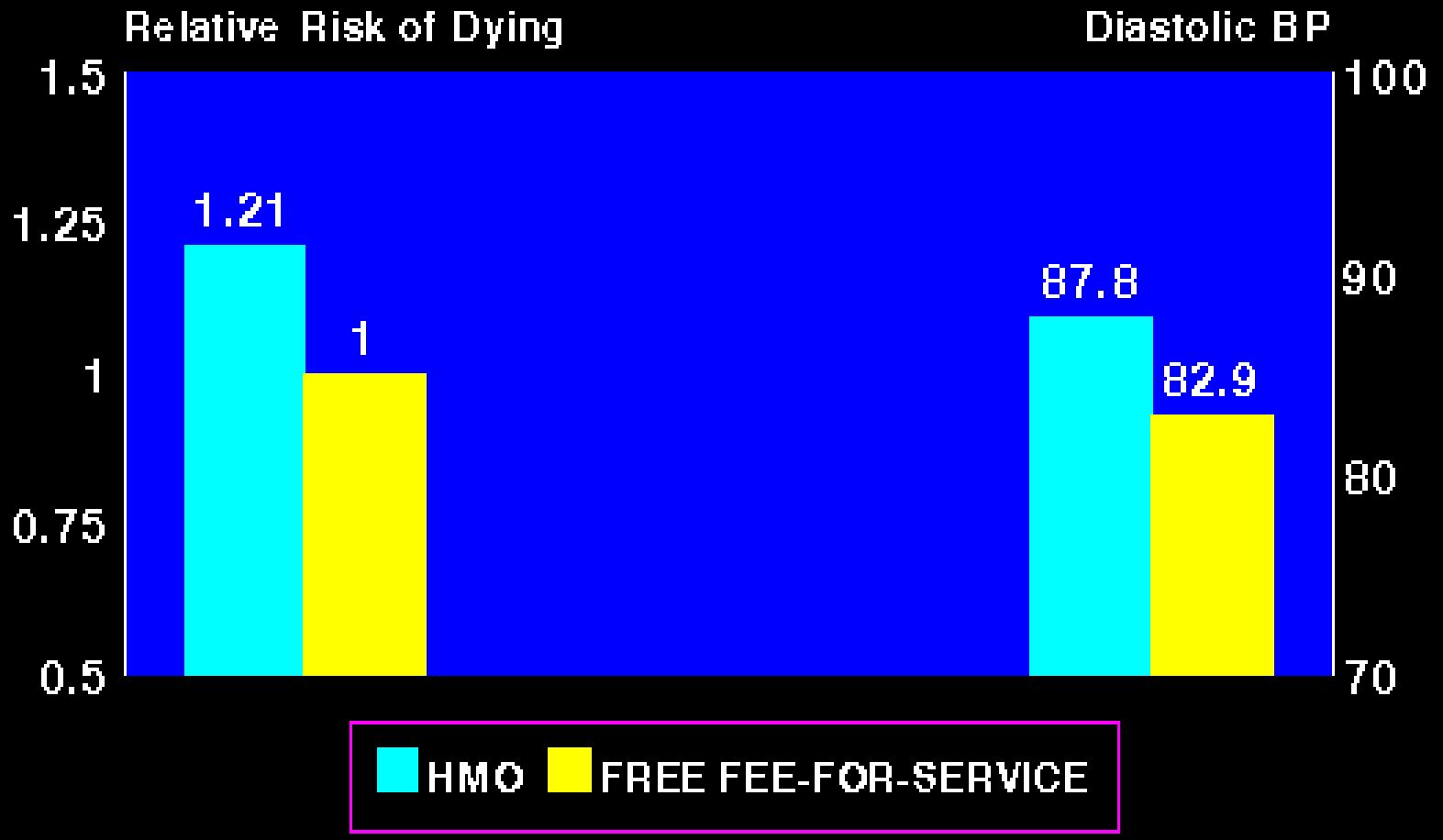


Source: Am. Econ. J. Applied Econ 2019;11:302 - Data are for 2010

* Health status adjustment based on diagnoses + mortality risk

ACOs
Warmed Over Managed Care

High Risk HMO Patients Fared Poorly in the Rand Experiment

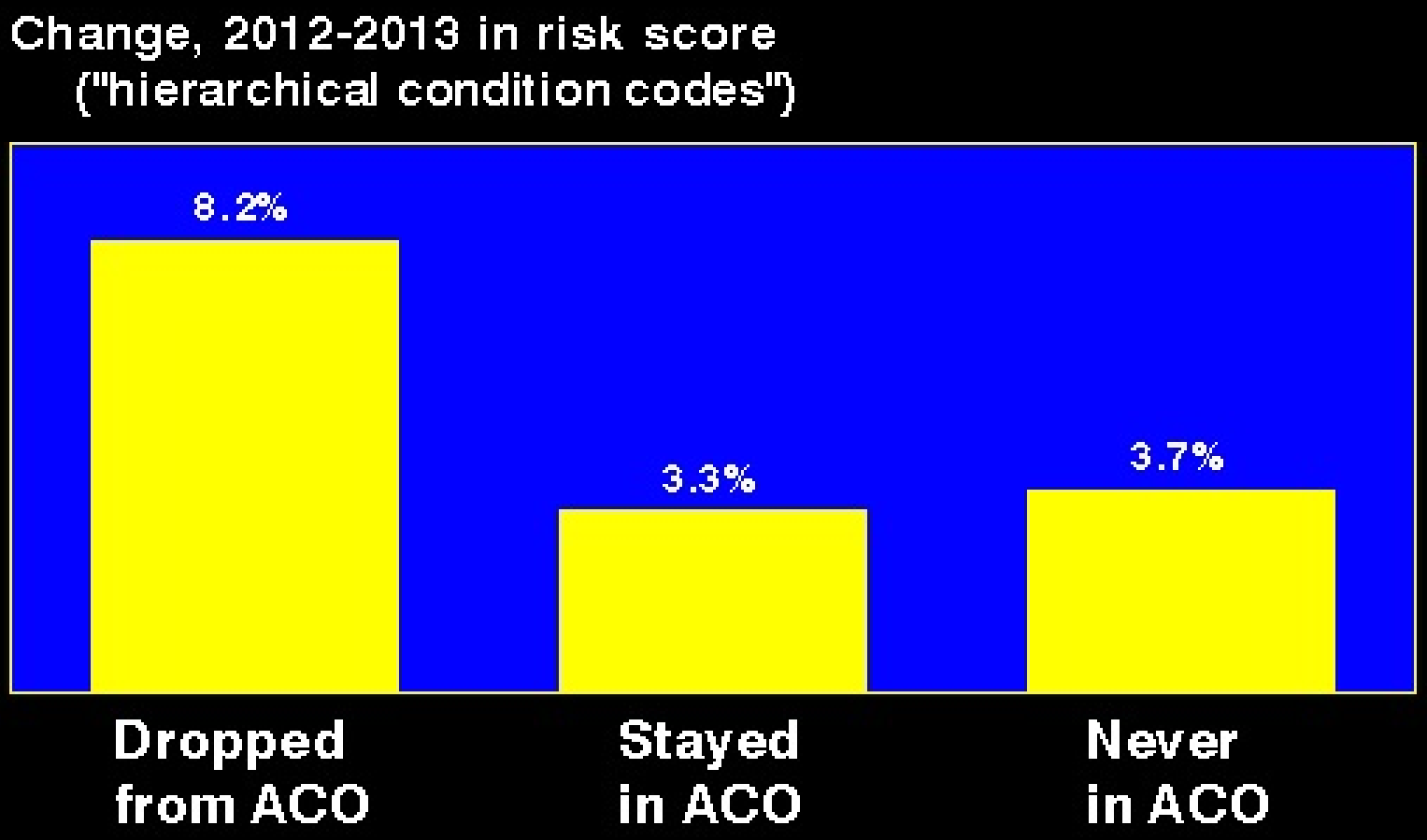


Source: Rand Health Insurance Experiment, Lancet 1986; i:1017

Note: High Risk = 20% of population with lowest income + highest medical risk

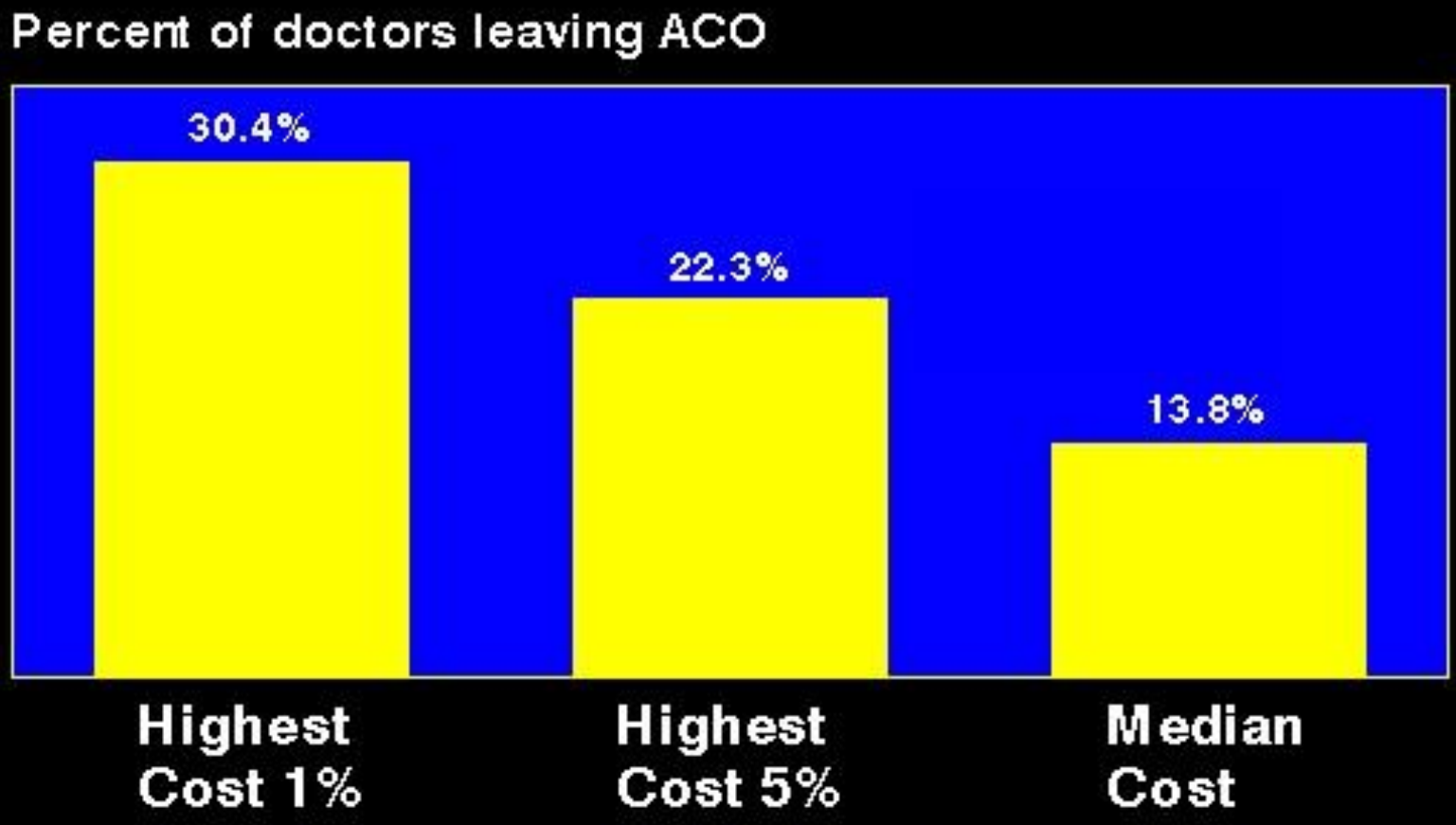
ACOs Got Rid of Patients in Deteriorating Health

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

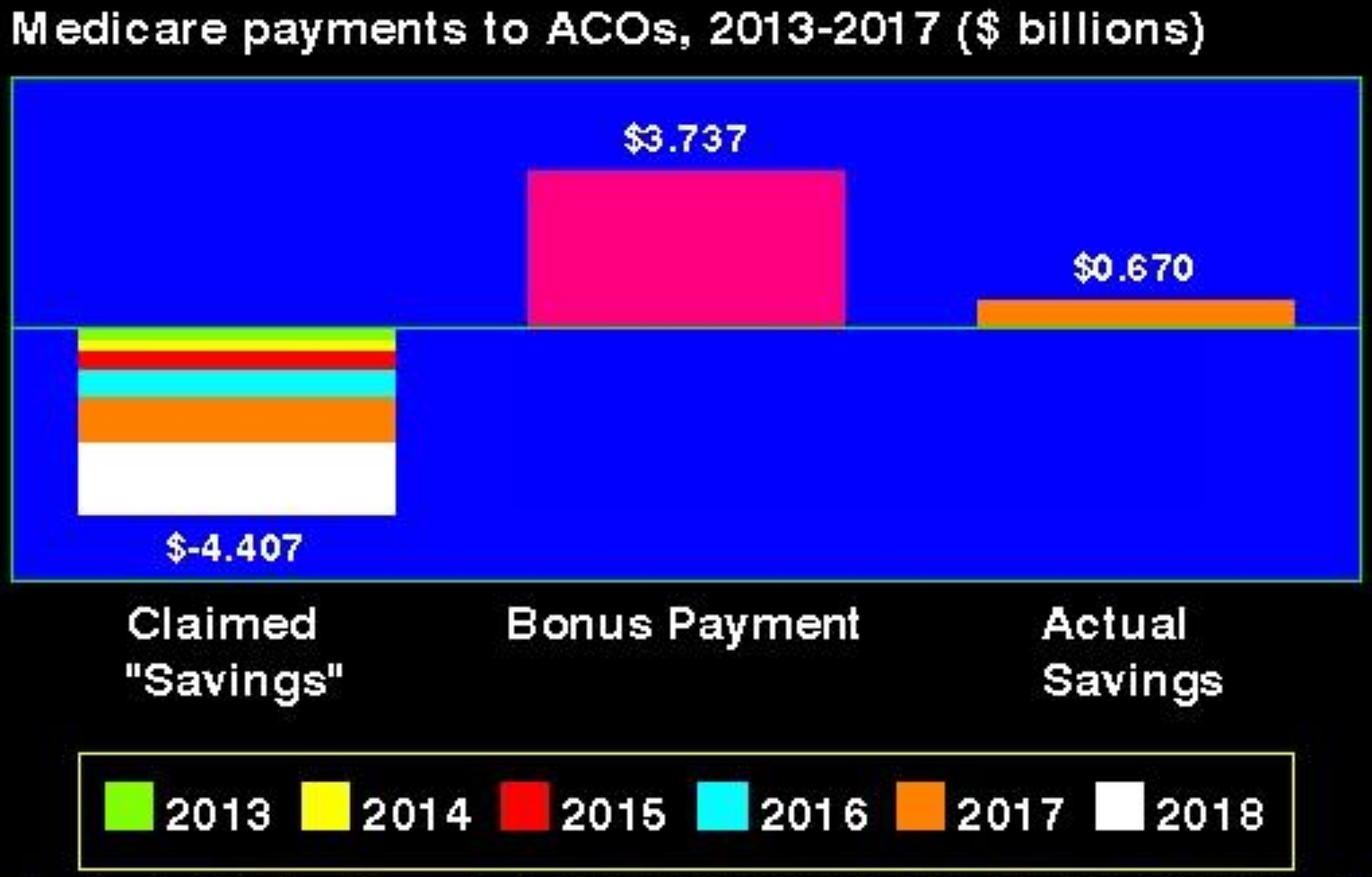
ACOs Get Rid of High Cost Patients By Ejecting Their Doctors



Source: Ann Intern Med 2019;171:27

ACO Savings = $0.67 bil. Over 6 Years =0.15% of Spending

MEDPAC Estimate: ACOs Increased Administrative Costs by $8.52 bil.



Source: Himmelstein & Woolhandler analysis of CMS ACO Public Use Files, 8/2020 + MEDPAC staff est.

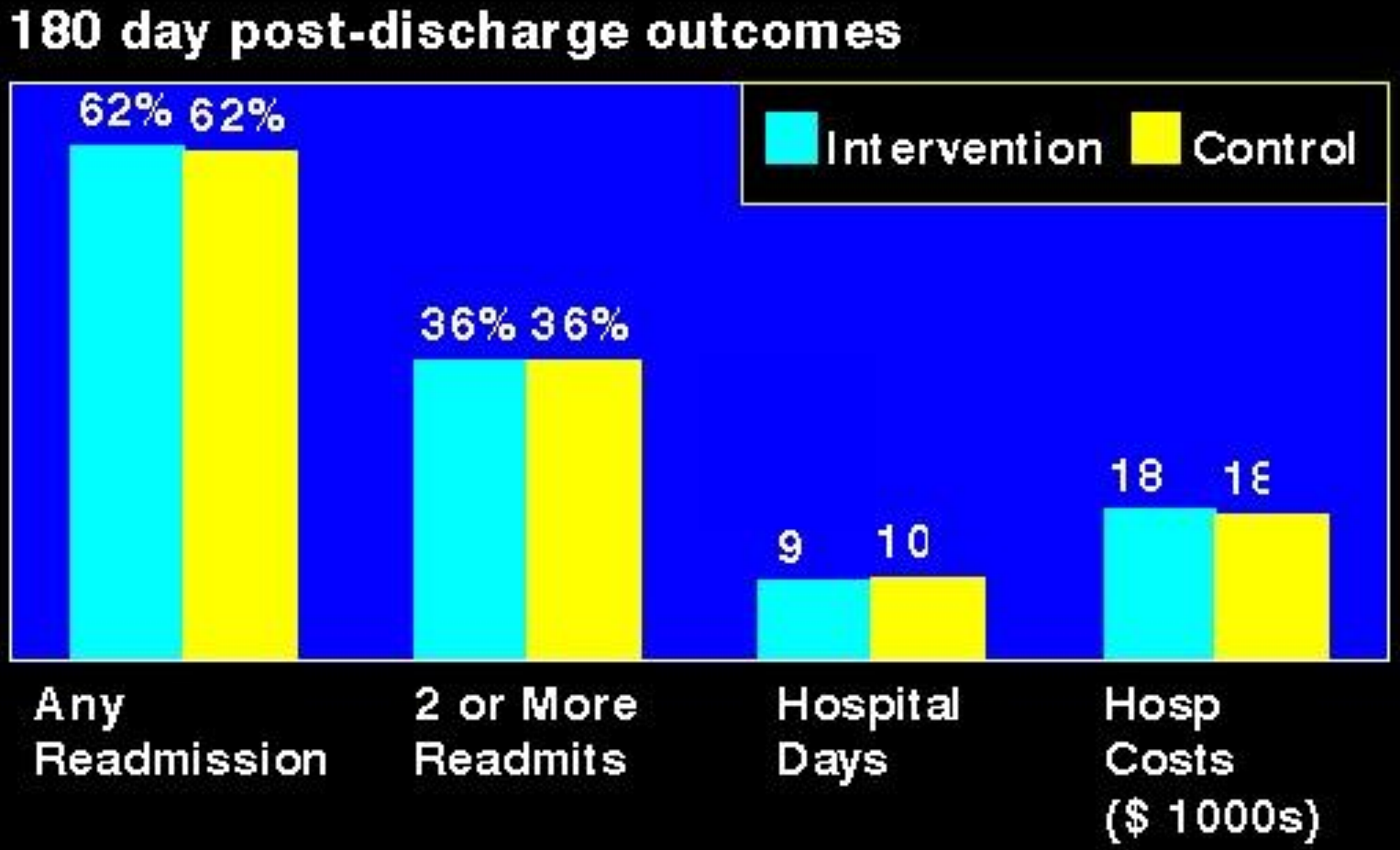
McKinsey: "The Math of ACOs"

- ~$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

The Toxicity of Pay for Performance (P4P)

Medicare Quality Scores Penalize Doctors Caring for Poor Seniors

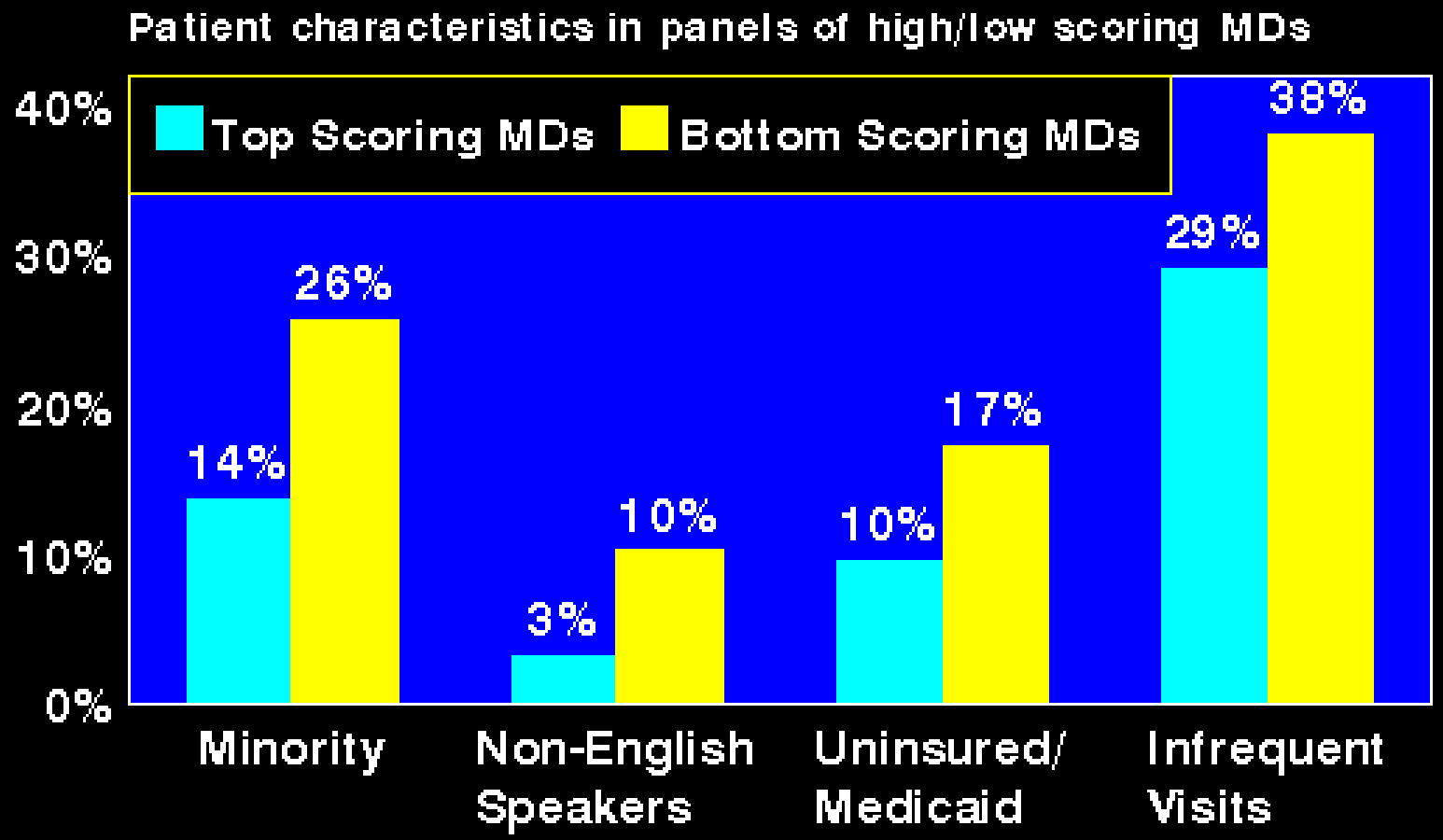
Score Difference = $15,000 Lower Medicare Payments

Source: JAMA 2020;324:975

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

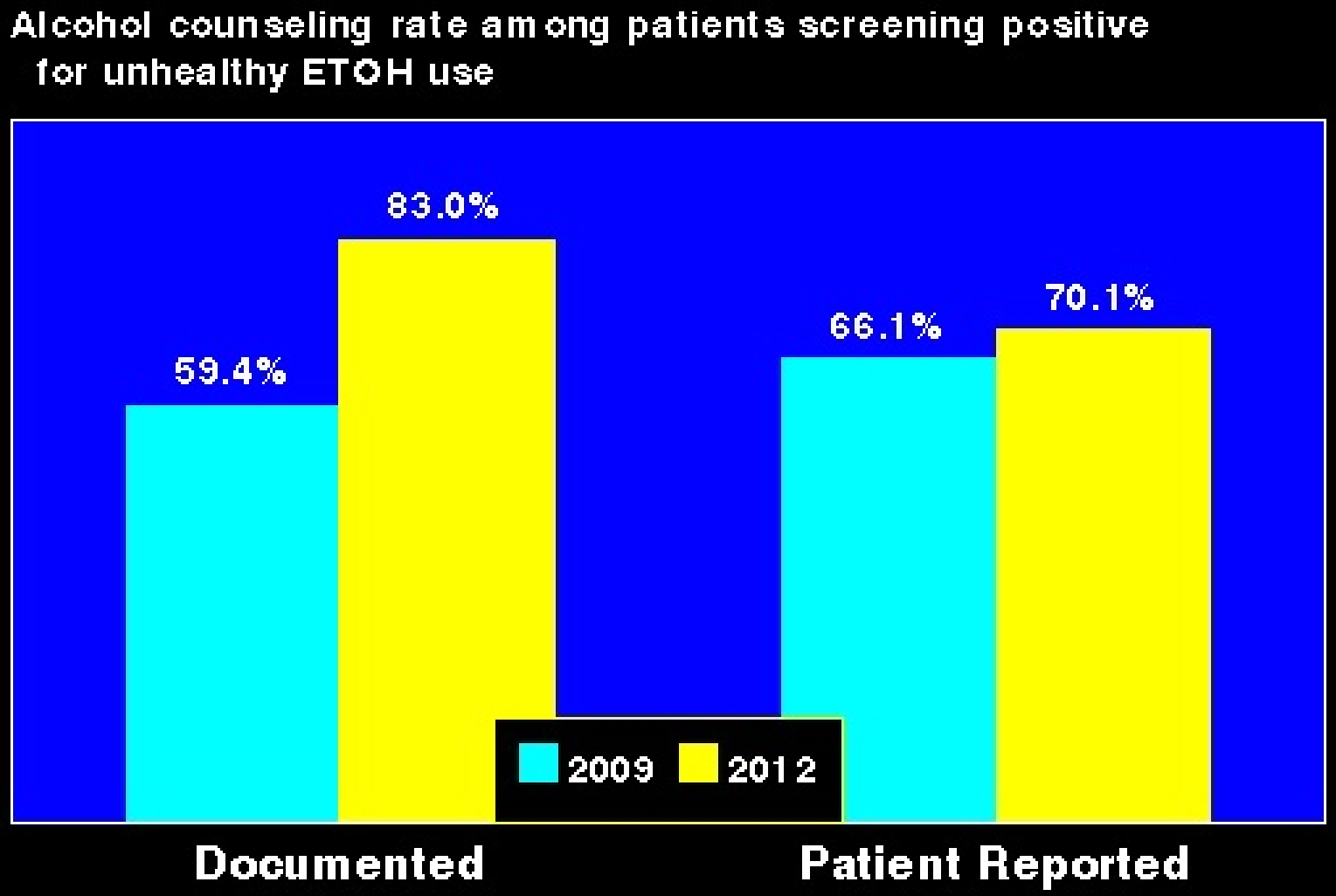
Quality Scores Tell More About Patients Than Doctors

Harvard Docs with Poorer/Minority Patients Score Low



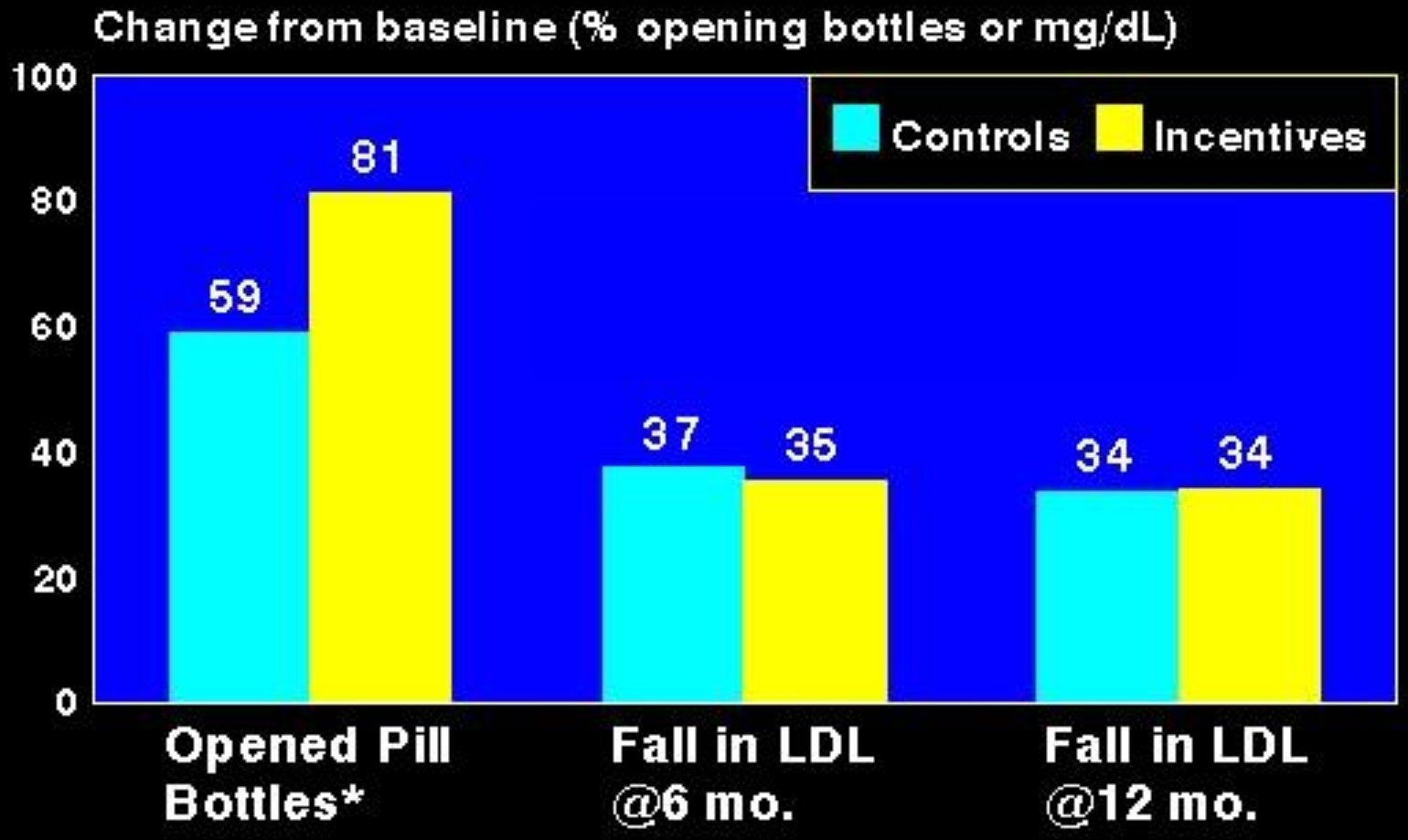
Source: JAMA 9/8/2010:1107

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

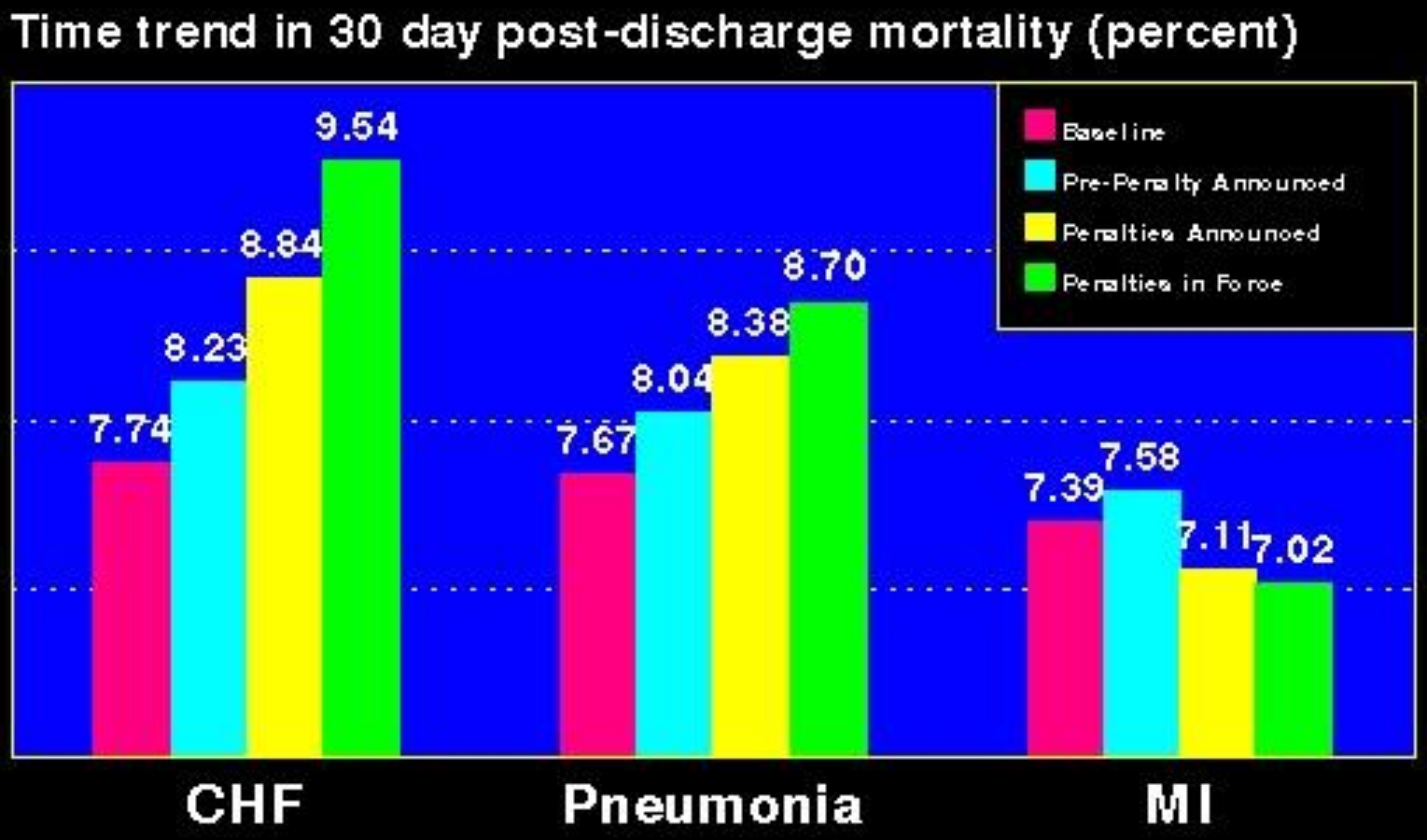


Source: JAMA Network Open 2020;3(10):e2019429 (RCT with 805 patients)

*Percent of first 180 days with pill bottle opening

CHF and Pneumonia Death Rates Rose With Readmission Penalties

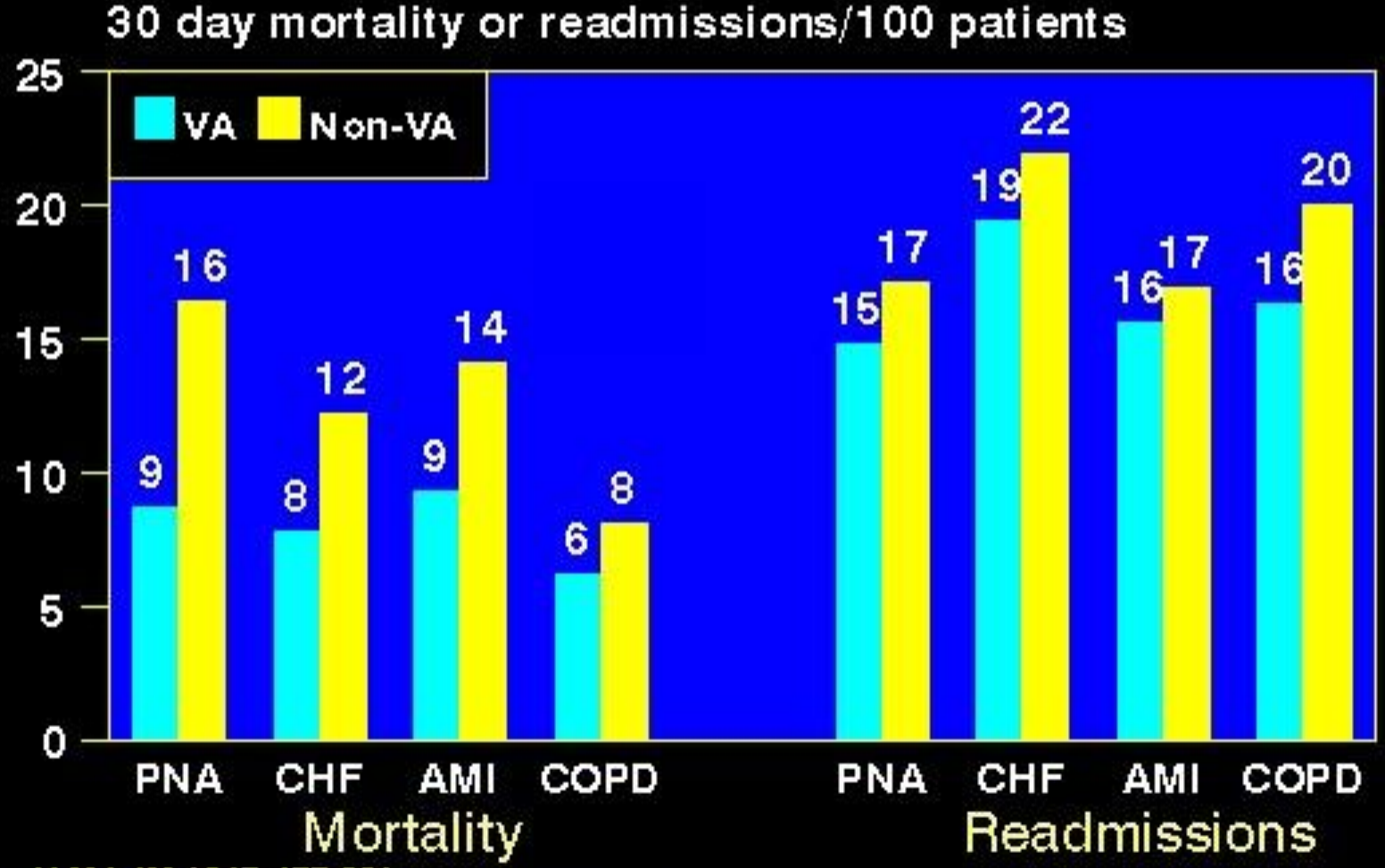
Big Penalties for Readmission, Small Penalties for Mortality



Source: JAMA 2018;320:2542

Veterans Health Administration: Better and Fairer Care

VA Hospitals Have Lower Mortality and Readmissions than Other Hospitals



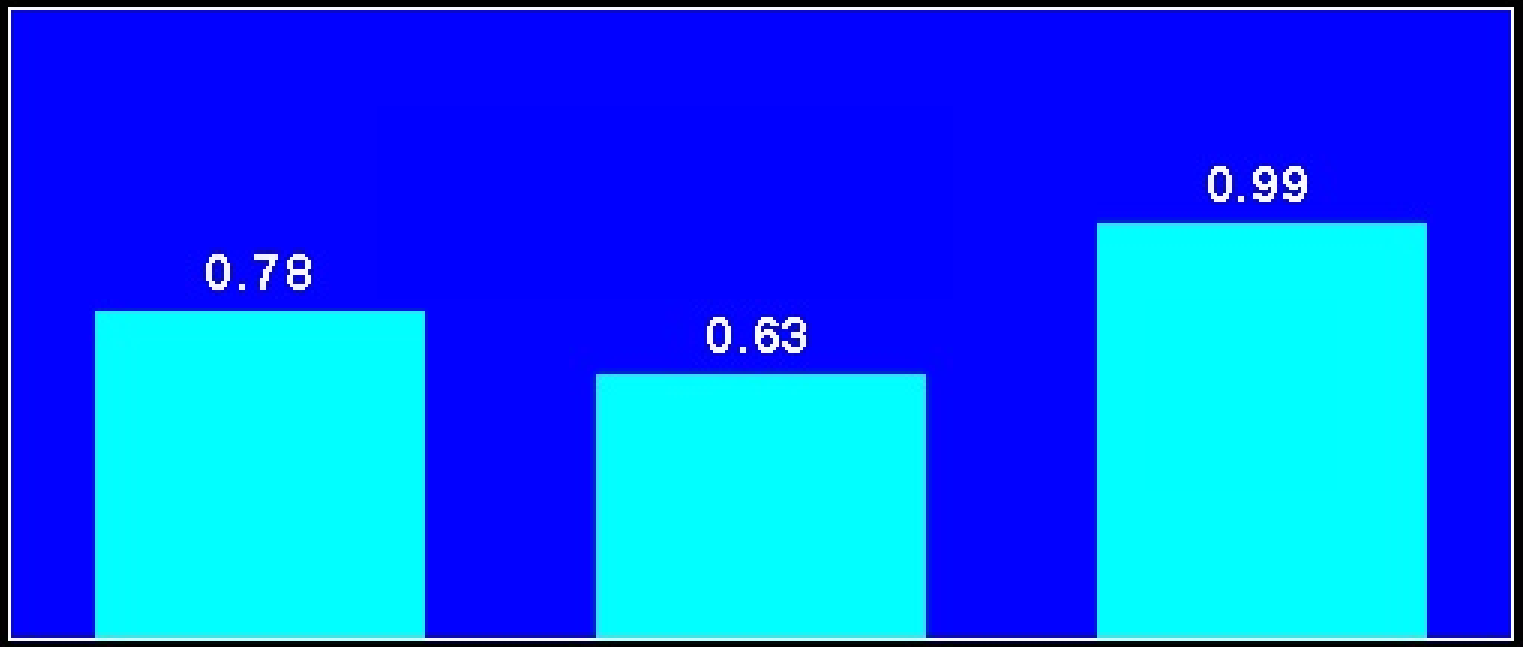
Source: JAMA IM 2017;177:882

Note: PNA=pneumonia; All rates are risk adjusted

Blacks in VA: No Health Disadvantage

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

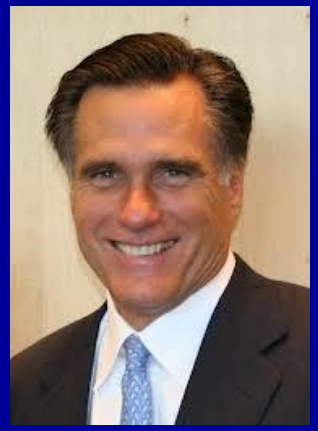
Odds Ratio for Black vs. White Vets
(<1 indicates lower rate for Blacks)



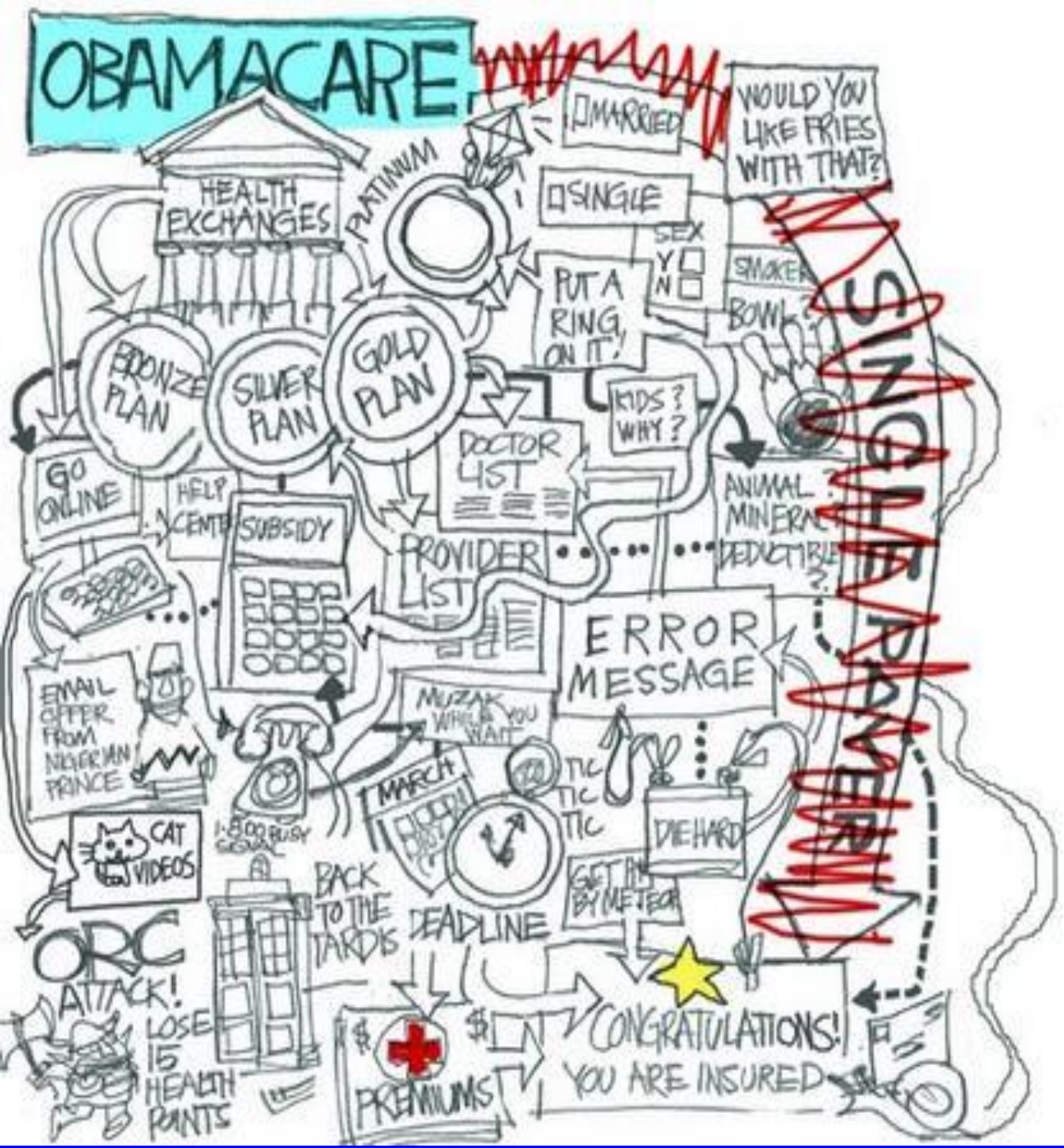
Source: Kovesdy et al. Circulation 9/18/2015

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

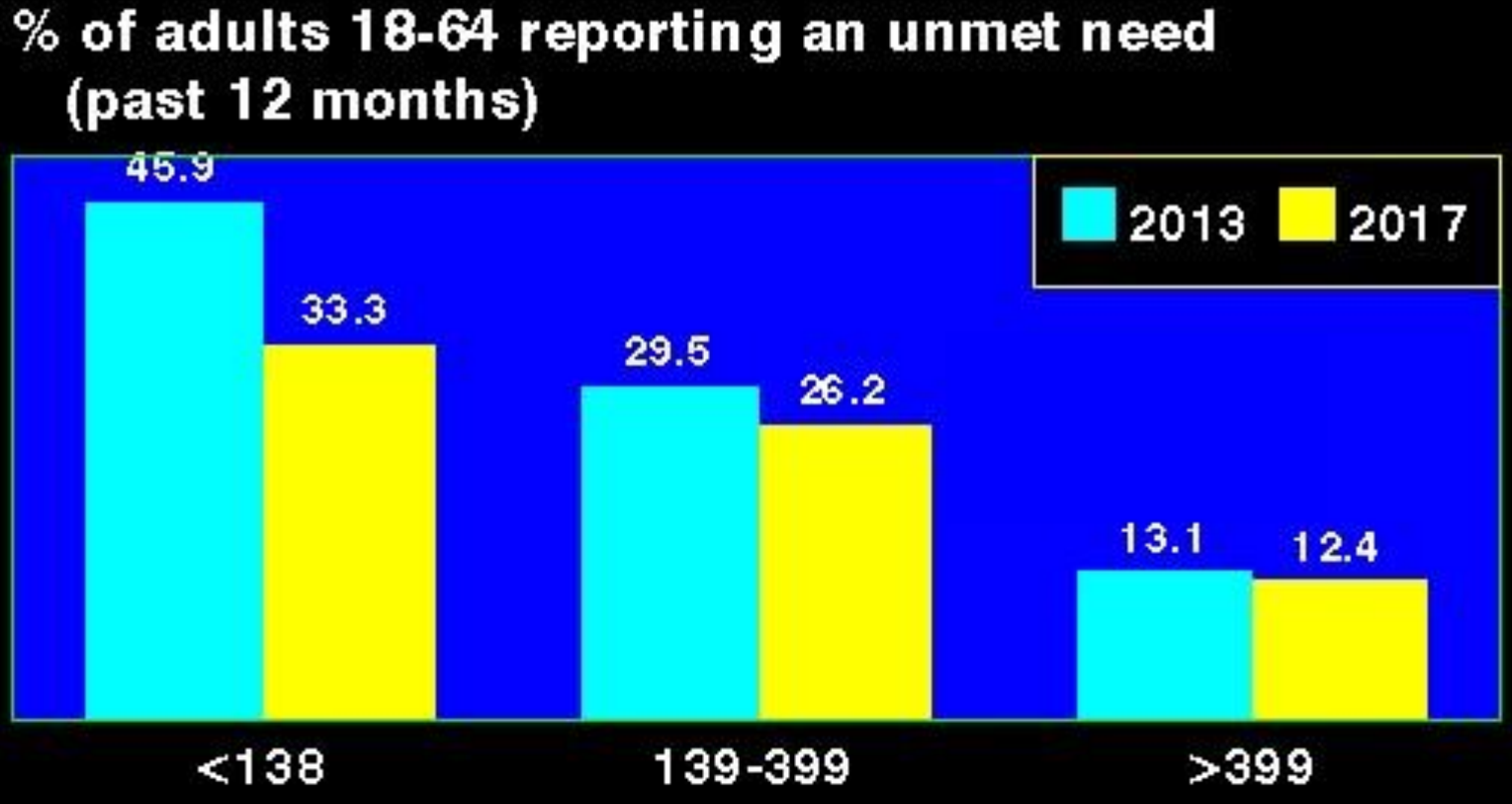
Signature by mark (X) must be witnessed below.

SIGNATURE OF WITNESS

ADDRESS OF WITNESS

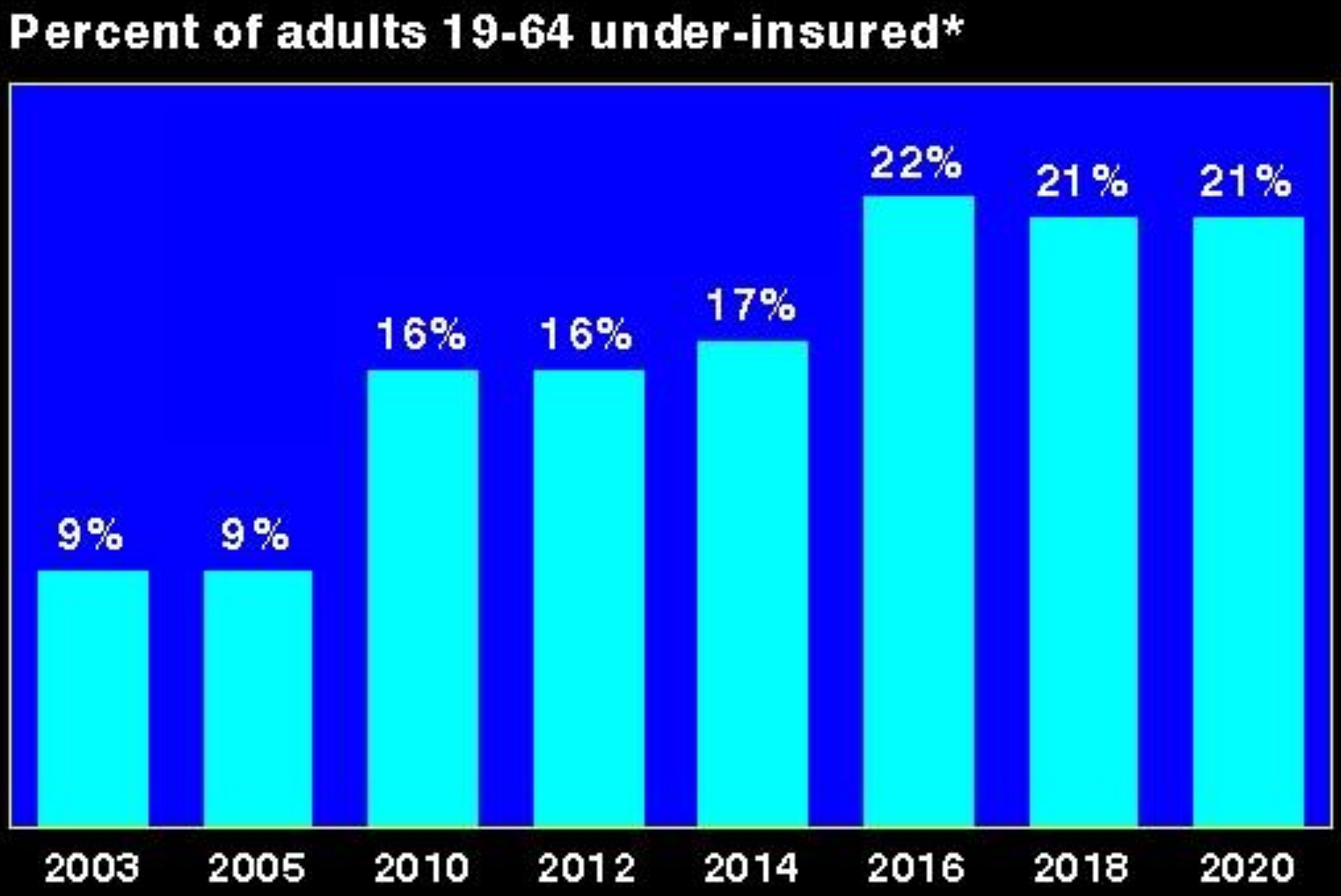
ACA Decreased Incidence of Unmet Medical Needs Due to Cost

Better, But Still Not Good



Source: Health Affairs 2017;36:1656

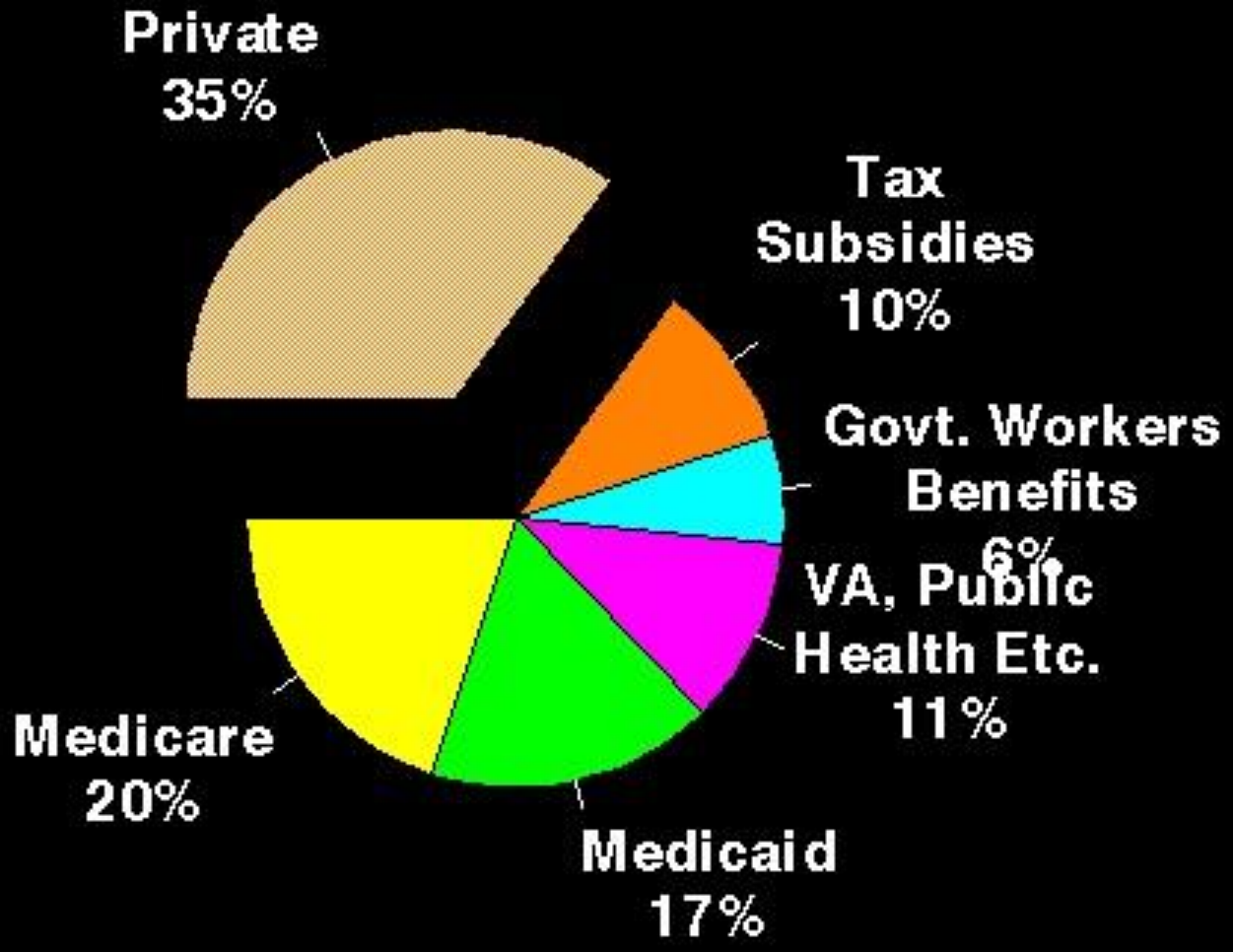
Under-Insurance Increased After ACA



Source: Commonwealth Fund Health Insurance Surveys 2003-2020
* 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

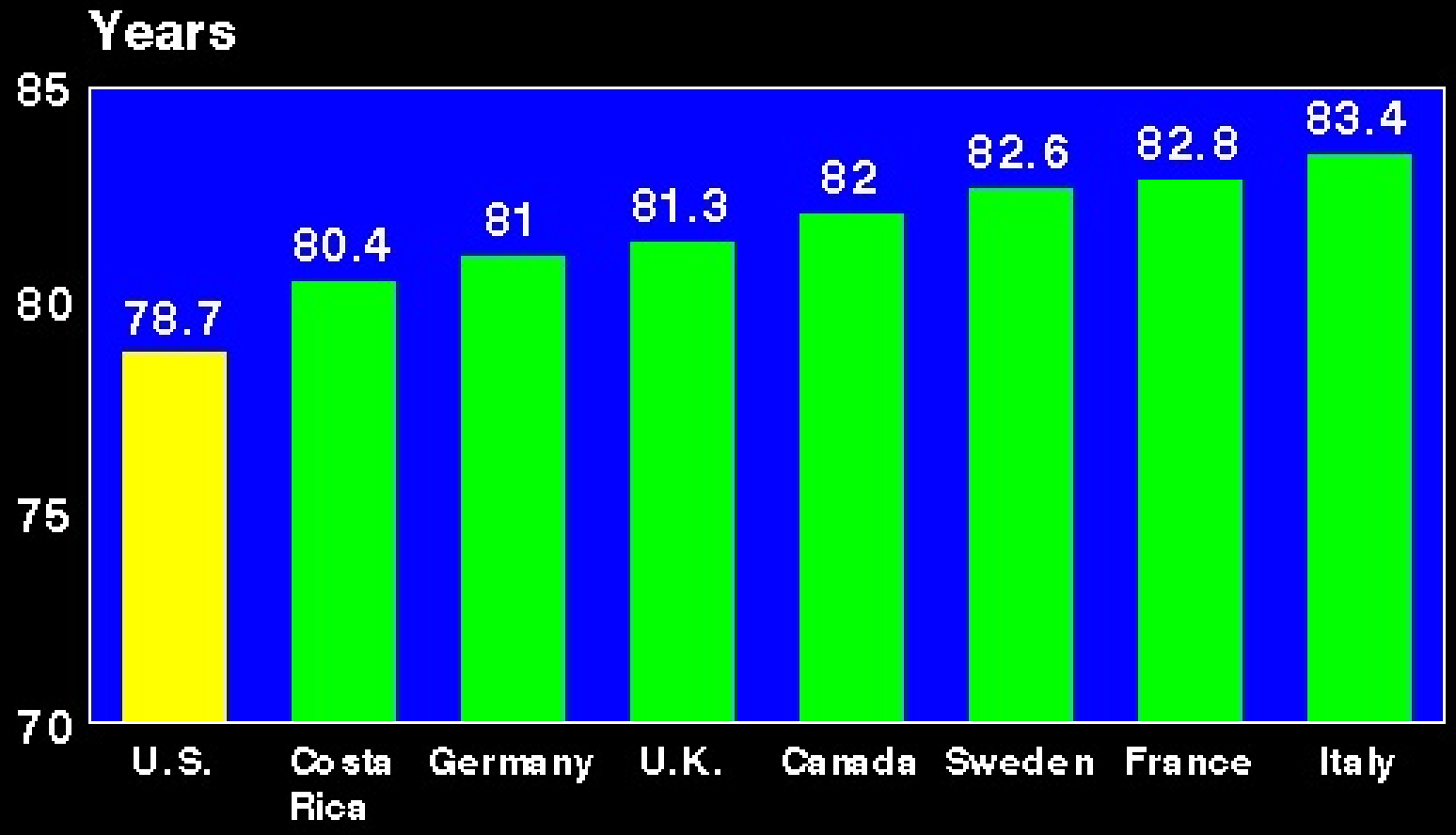
U.S. PUBLIC Spending Per Capita for Health Exceeds TOTAL Spending in Other Nations

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

Source: OECD 2020; NCHS; AJPH 2016;106:449 (updated) - Data are for 2019

The U.S. Trails Other Nations on Health

Life Expectancy

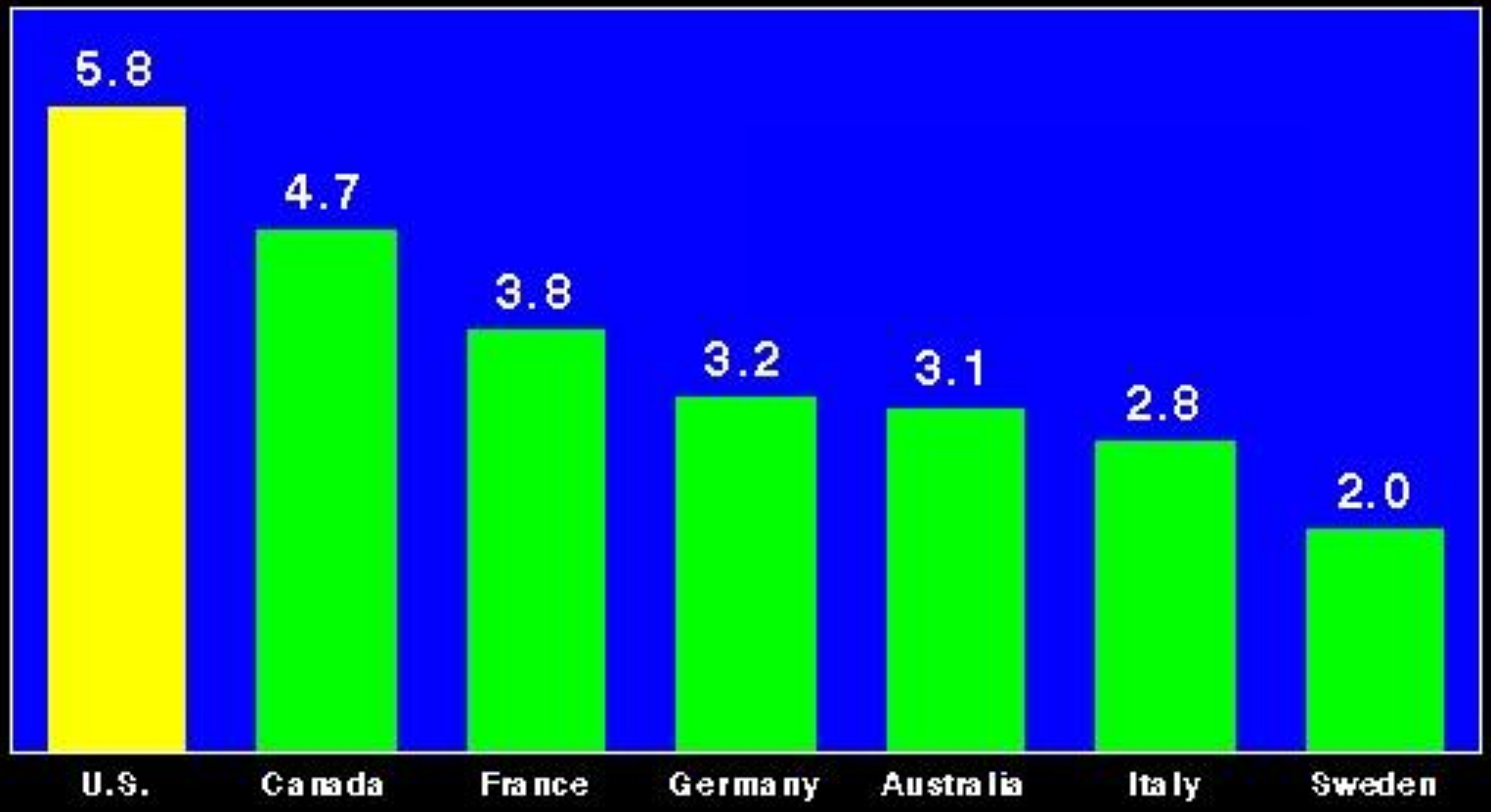


Source: OECD, 2020

Note: Data are for 2019 or most recent year available

Infant Mortality

Deaths in First Year of Life/1000 Live Births

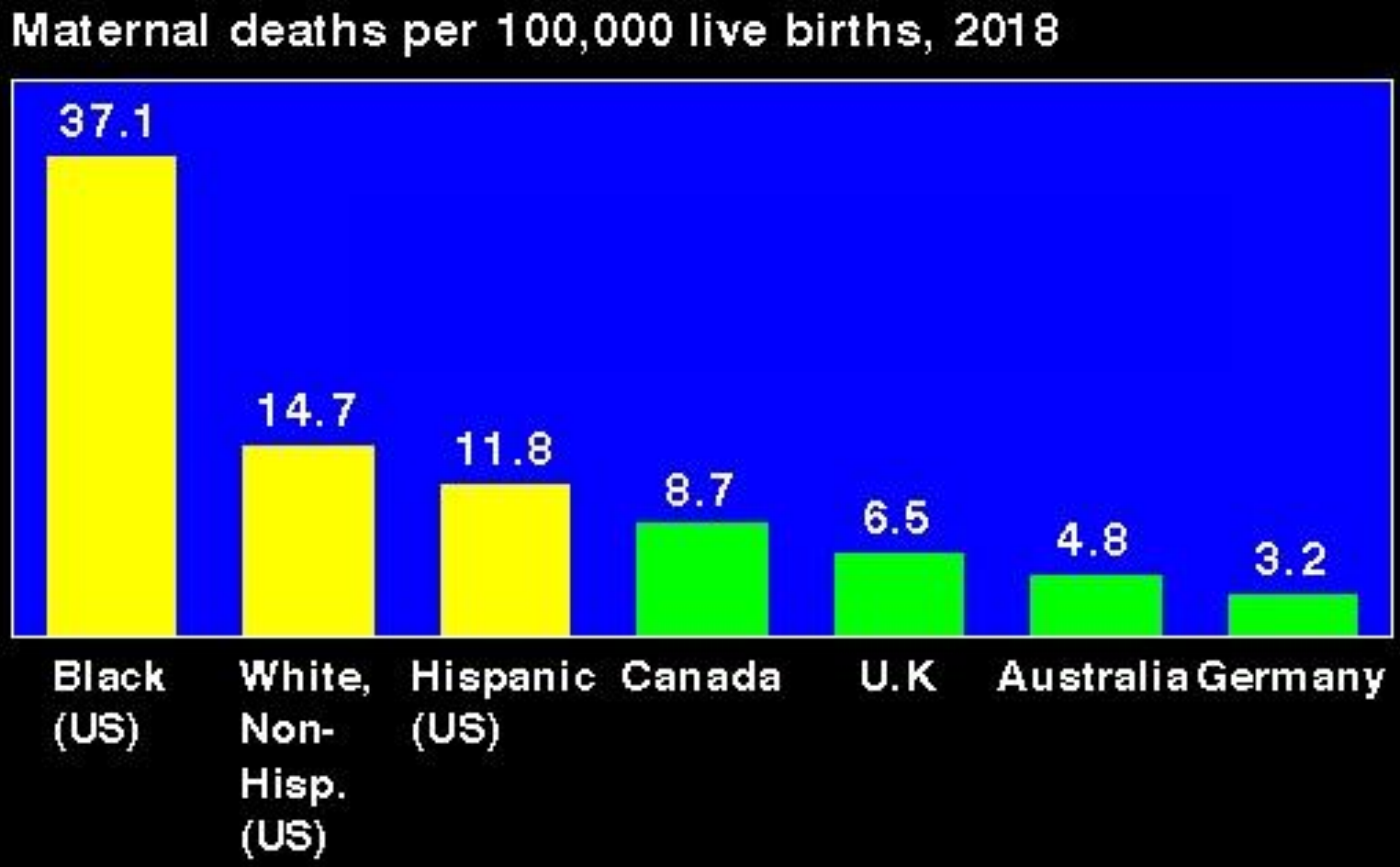


Source: OECD, 2020

Note: Data are for 2019 or most recent year available

U.S. Mothers at Risk

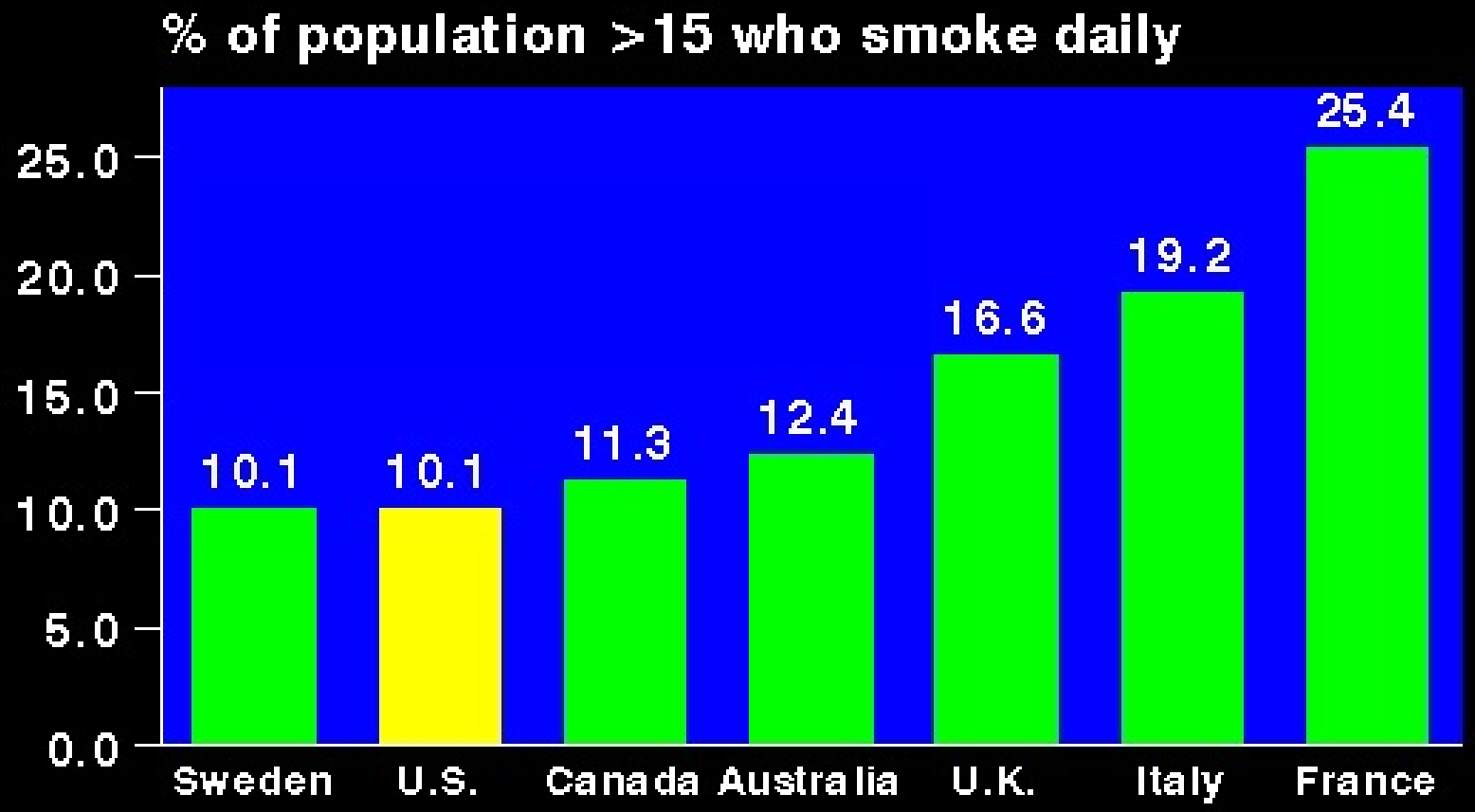
Black Women at Highest Risk, But All Fare Poorly



Source: CDC, January 30, 2020 and OECD 2020

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

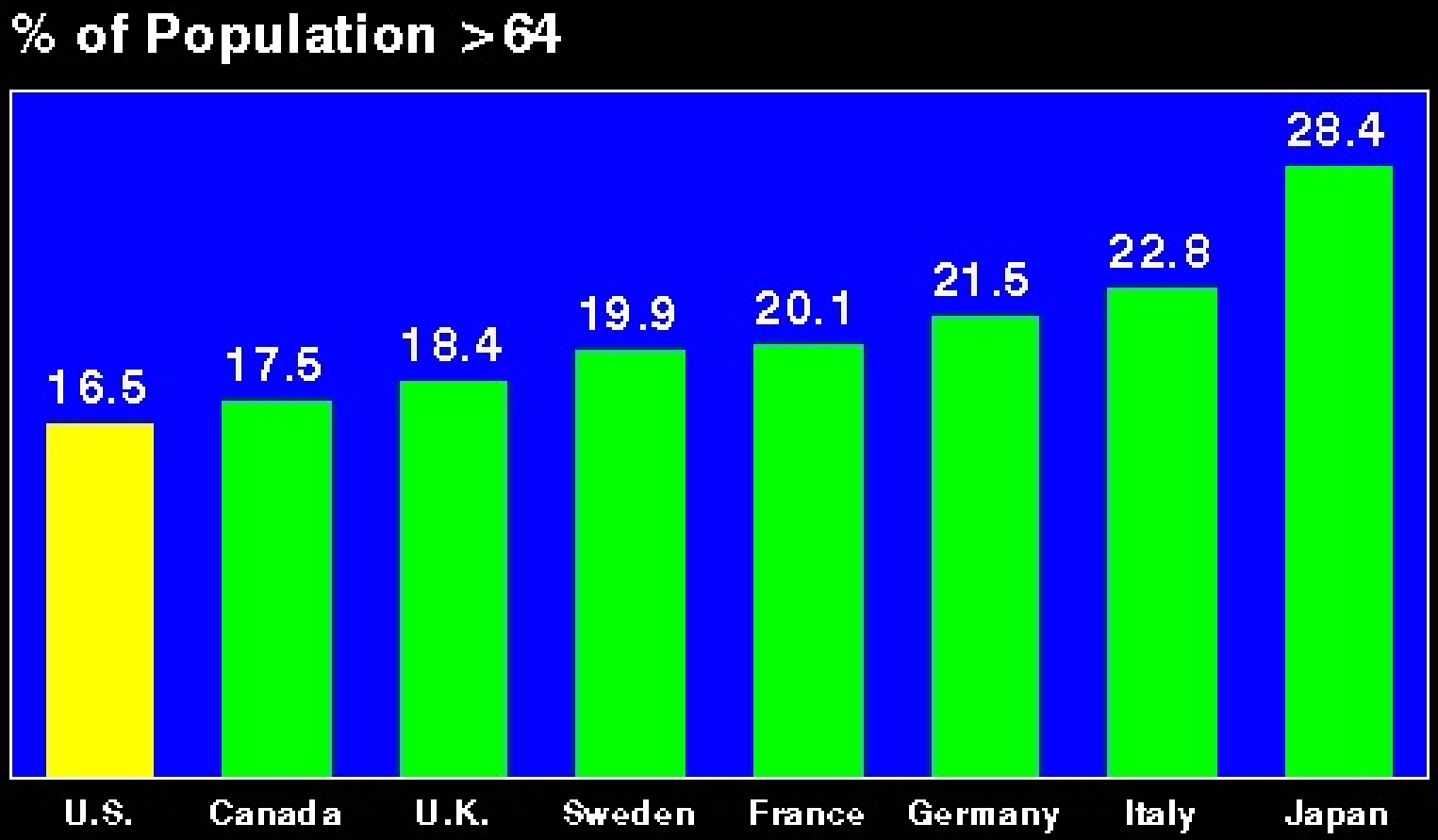
Smoking Prevalence



Source: OECD, 2020

Note: Data are for 2019, or most recent year available

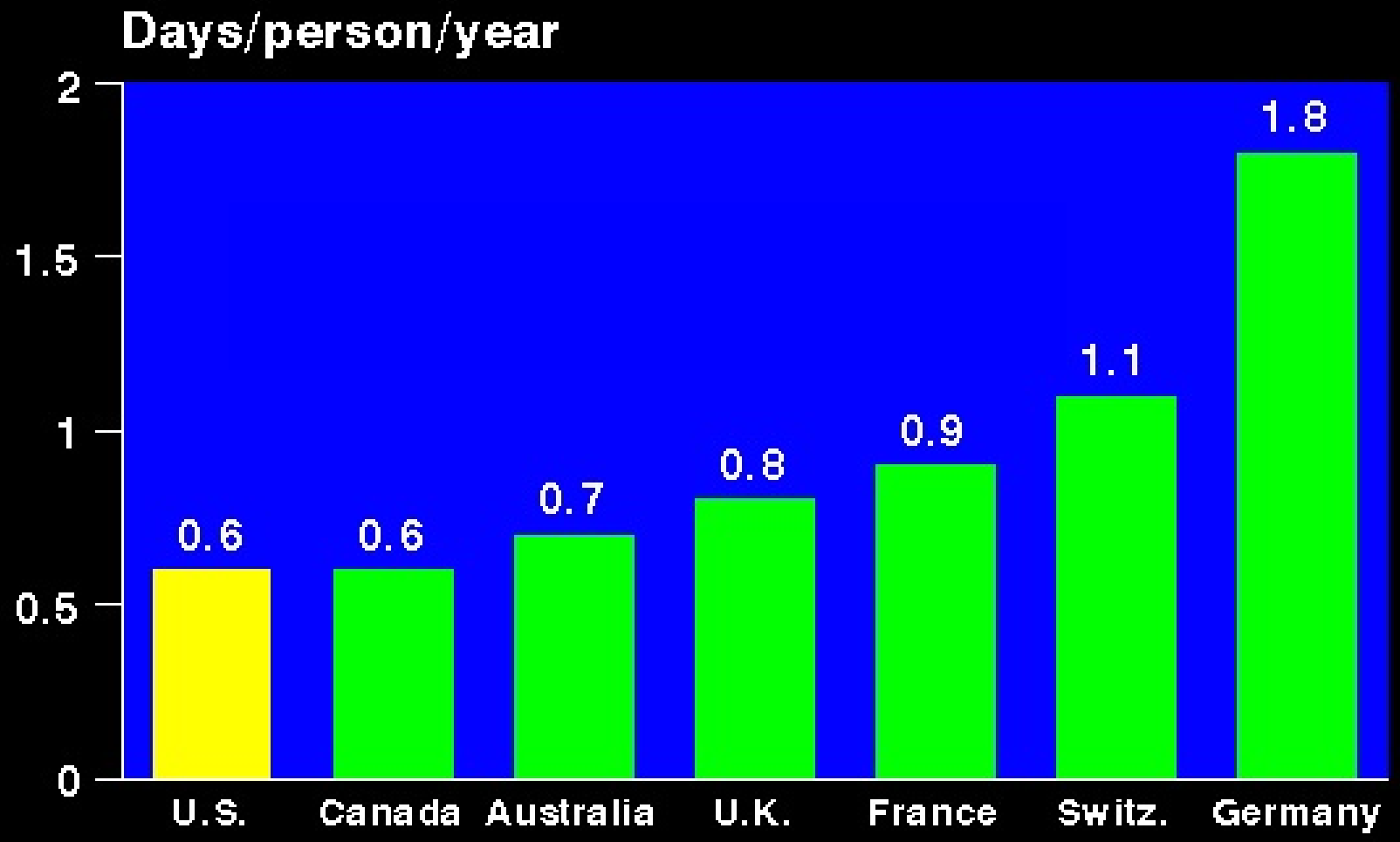
Percent Elderly



Source: OECD, 2020

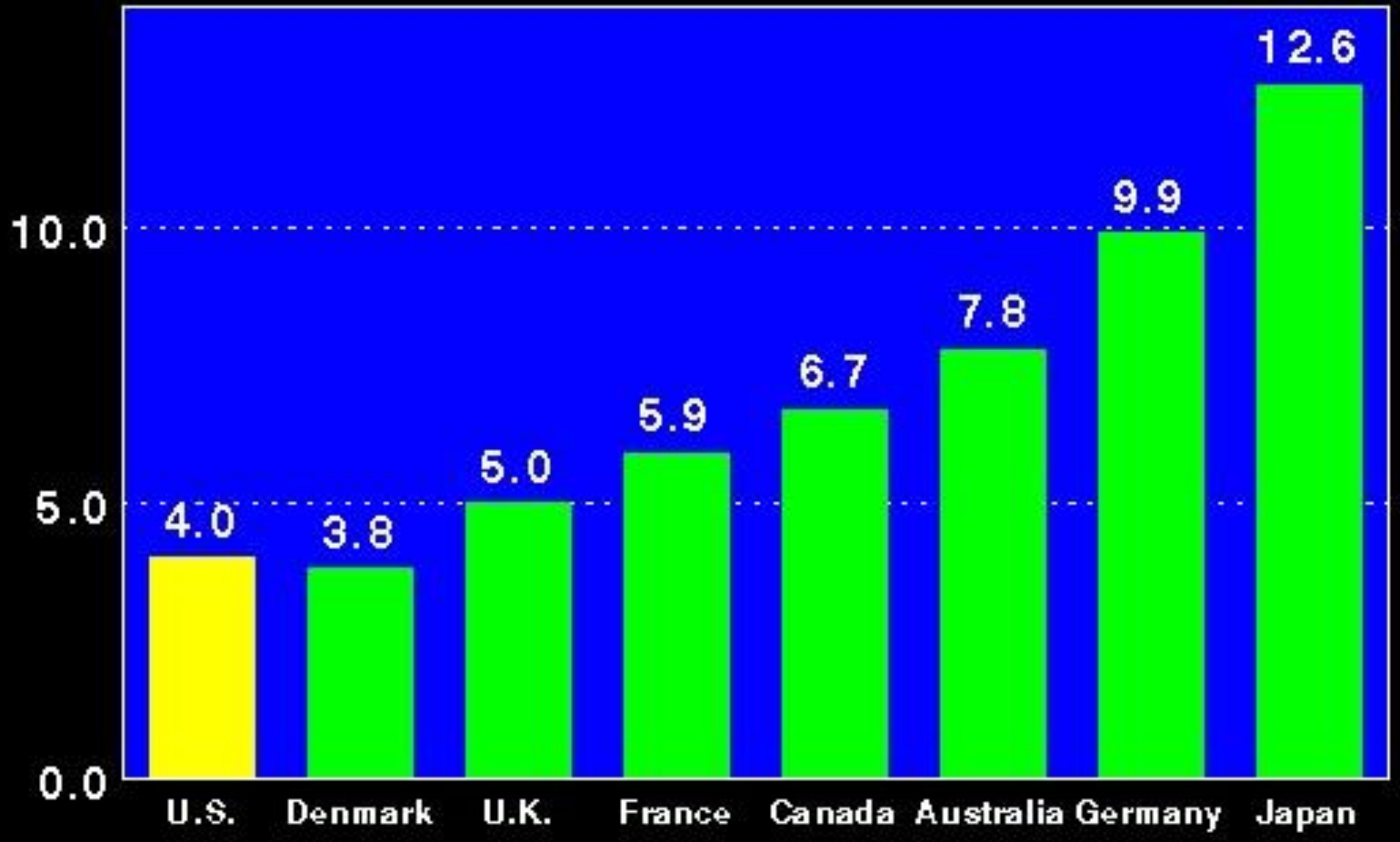
Note: Data are for 2019 or most recent year available

Hospital Inpatient Days Per Capita



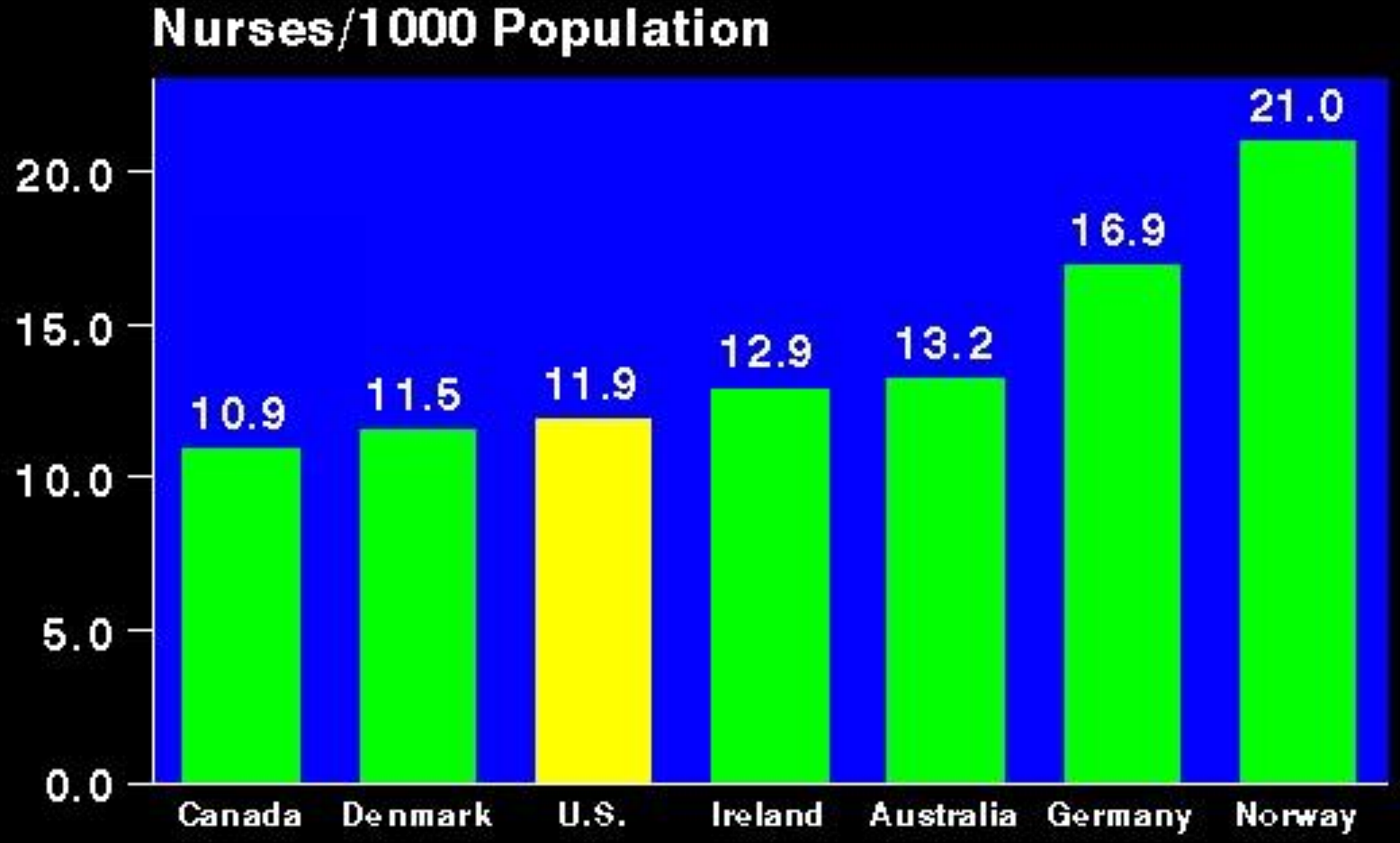
Source: OECD, 2020 & Kaiser Fdn. - Figures are for 2019 or most recent available

Physician Visits Per Capita



Source: OECD, 2020 - Data are for 2019 or most recent available year

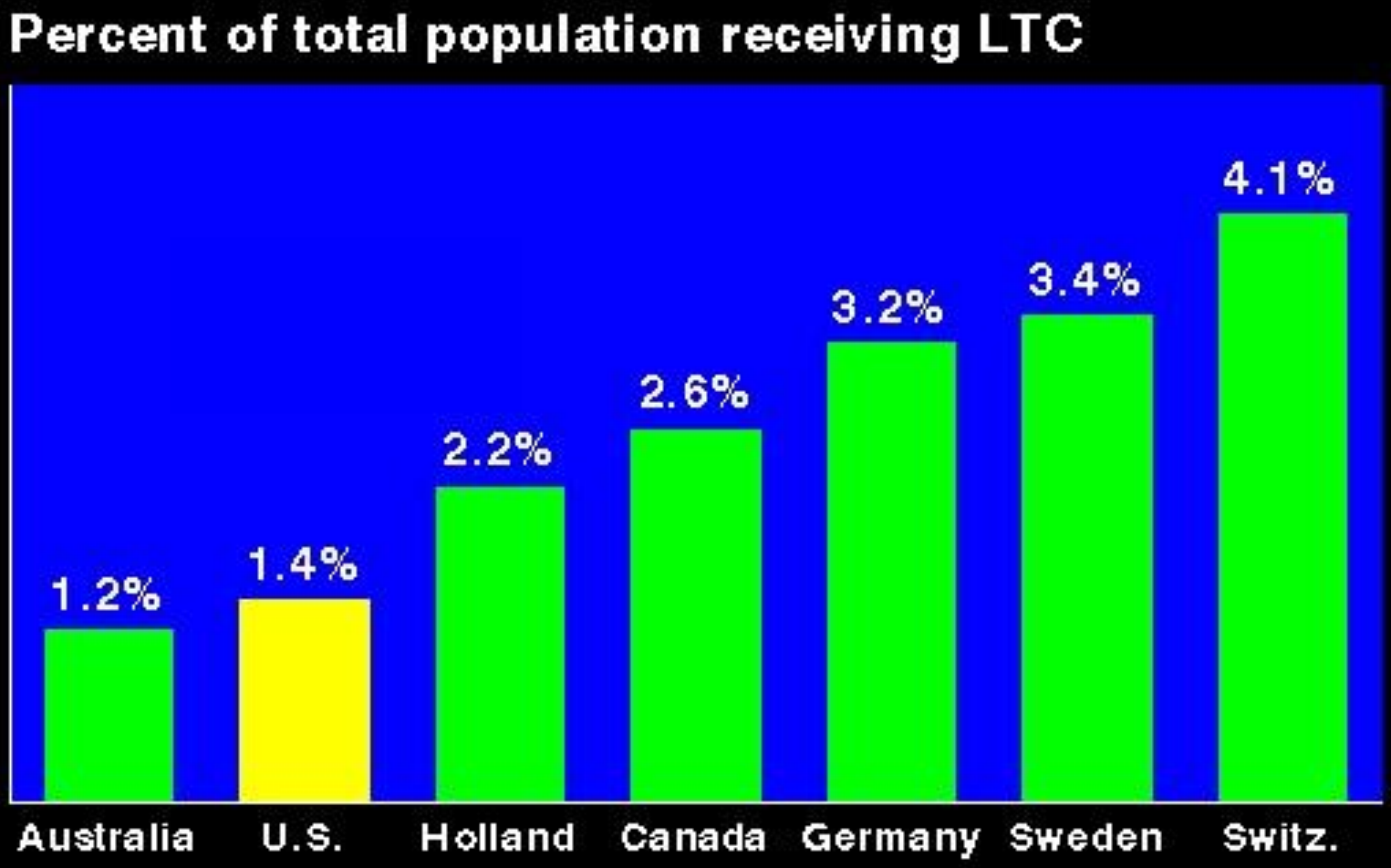
Number of Nurses Per 1000 Population



Source: OECD, 2020

Note: Data are for 2019 or most recent year available

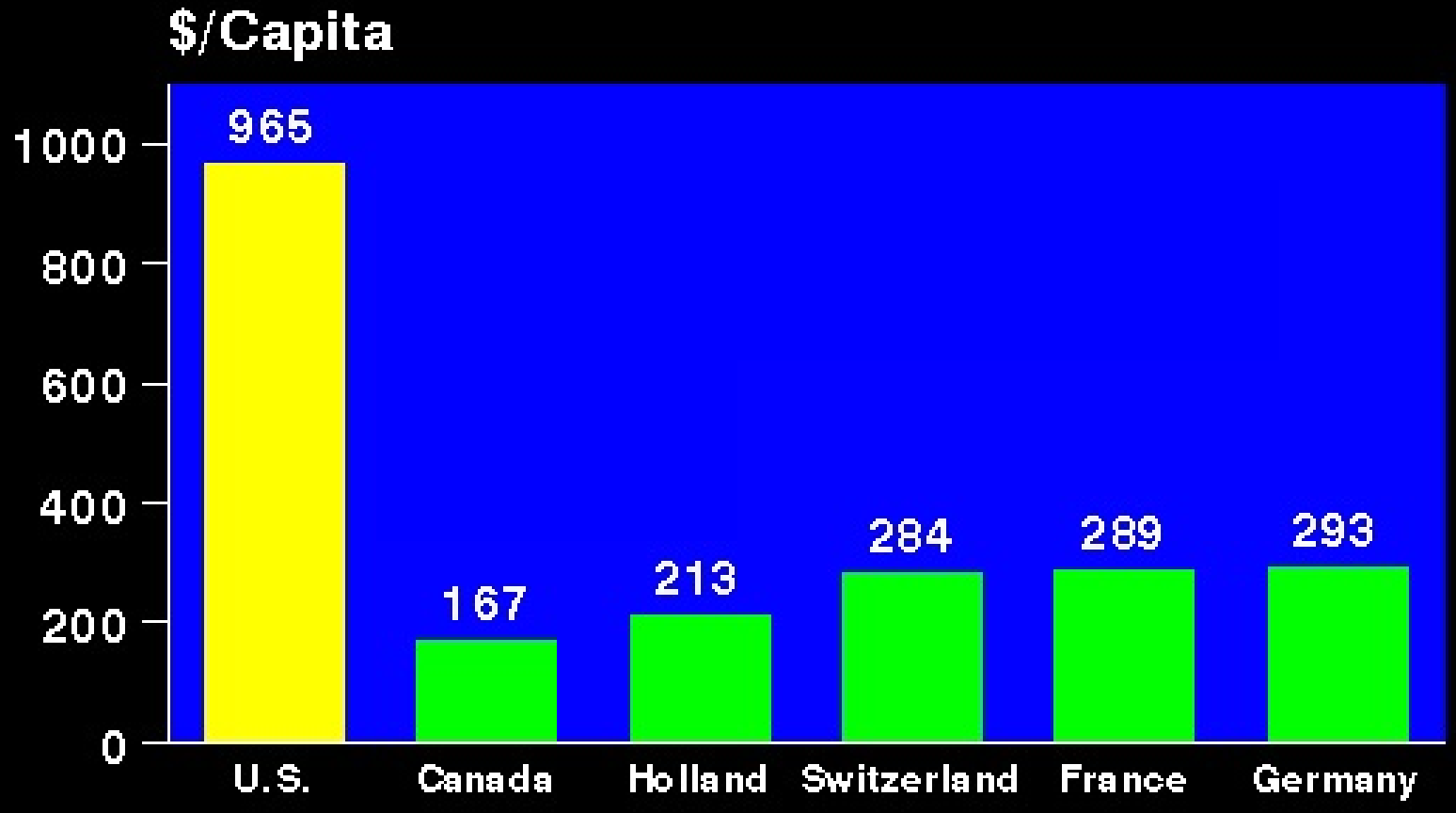
Other Countries Provide More Long Term Care



Source: OECD, 2019

Note: Data are for 2017 or most recent year available

Insurance Overhead



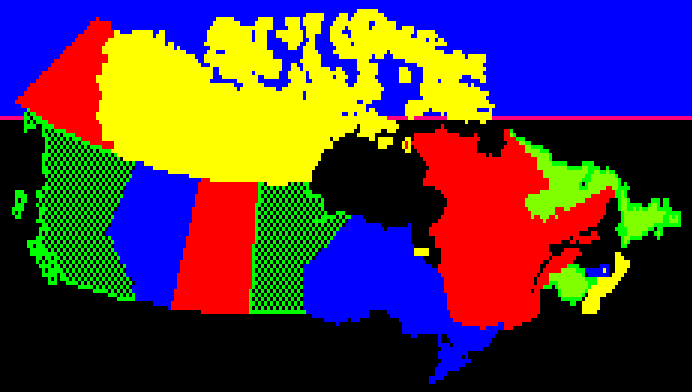
Source: OECD, 2020; NCHS; CIHI

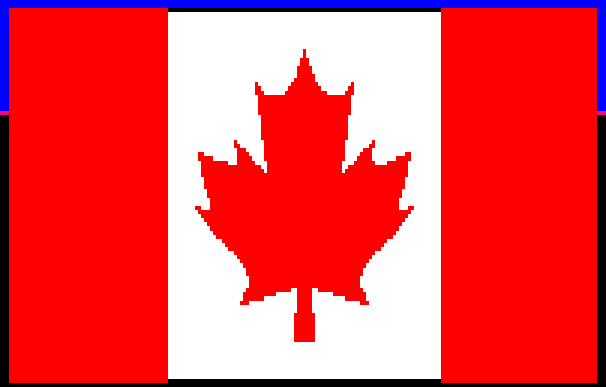
Note: Figures adjusted for Purchasing Power Parity; data are for 2019 or most recent available

Canada's Single Payer National Health Insurance Program

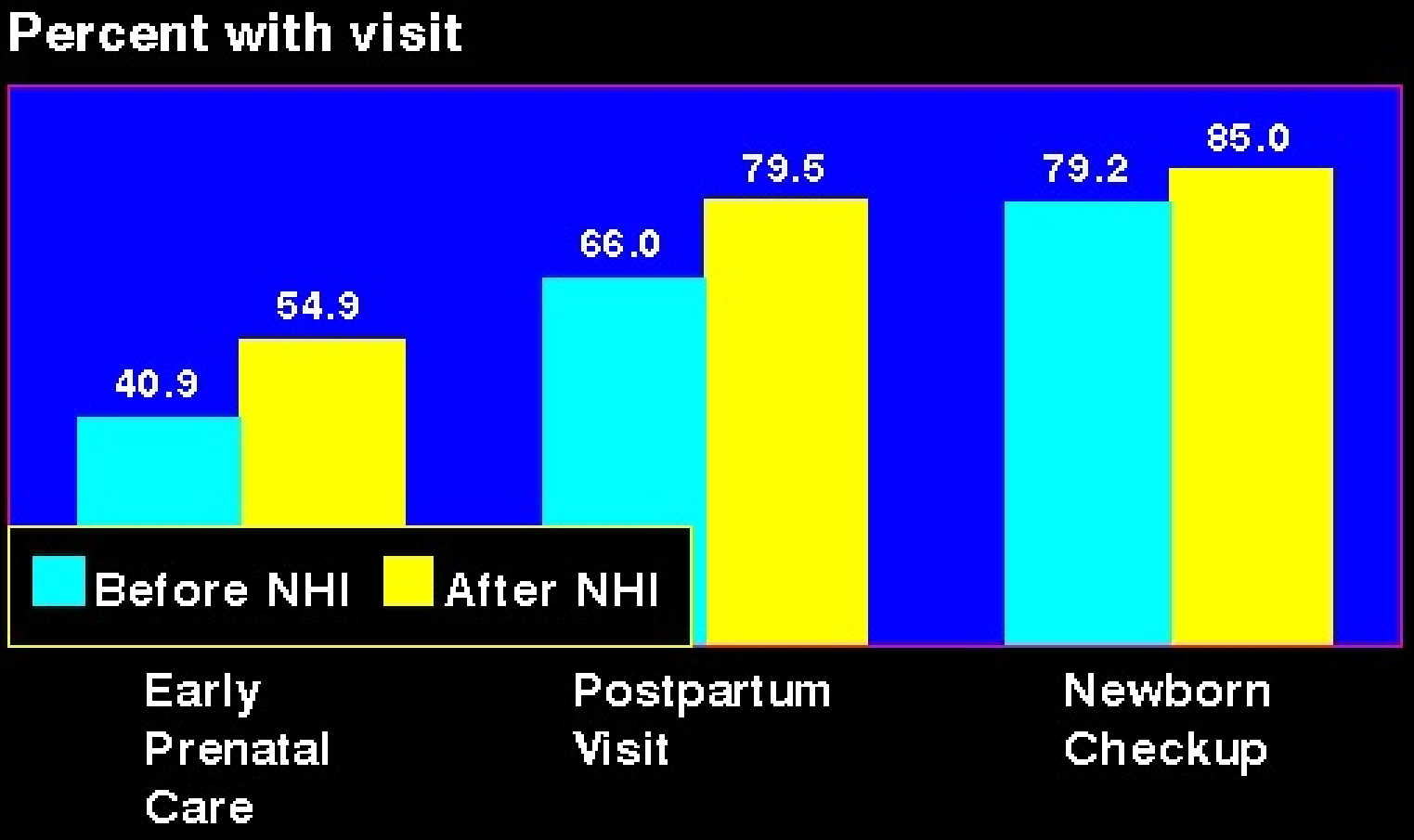
MINIMUM STANDARDS FOR CANADA'S PROVINCIAL PROGRAMS

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



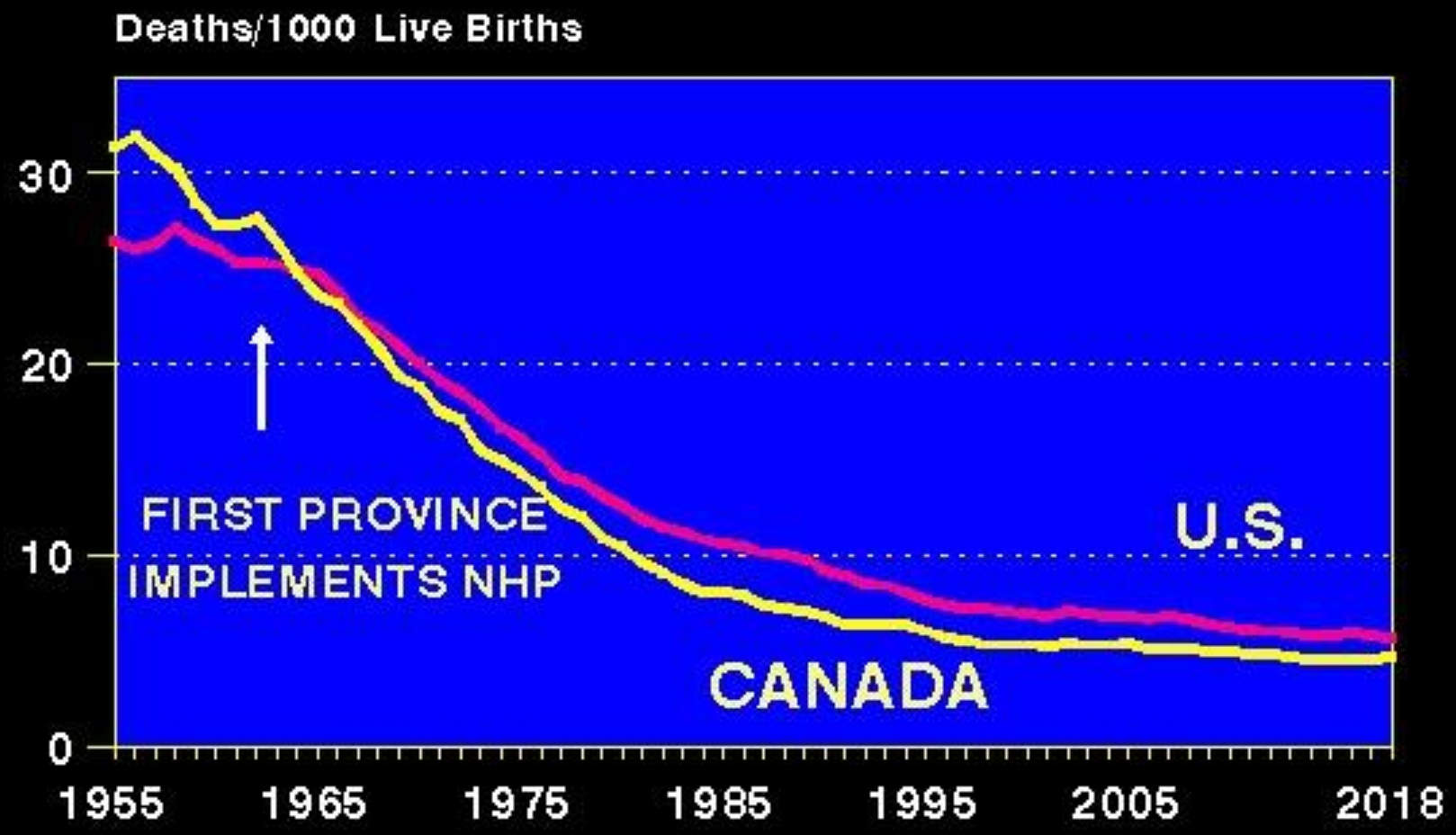


Free Care in Quebec Improved Maternal/Infant Care



Source: NEJM 1974;291:649

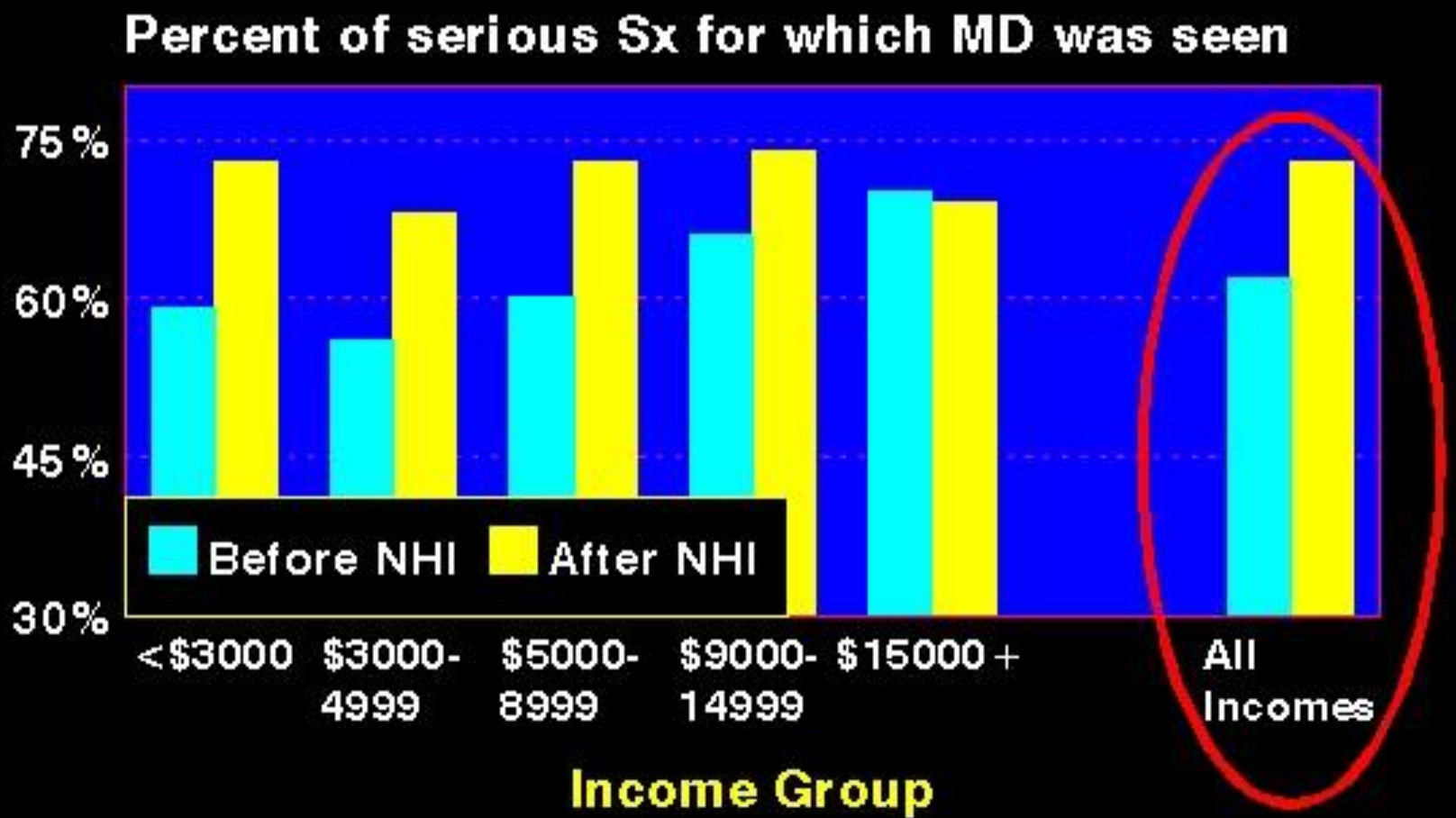
Infant Mortality
U.S. & Canada, 1955-2018



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

Free Care in Quebec Increased Physician Care for Serious Symptoms

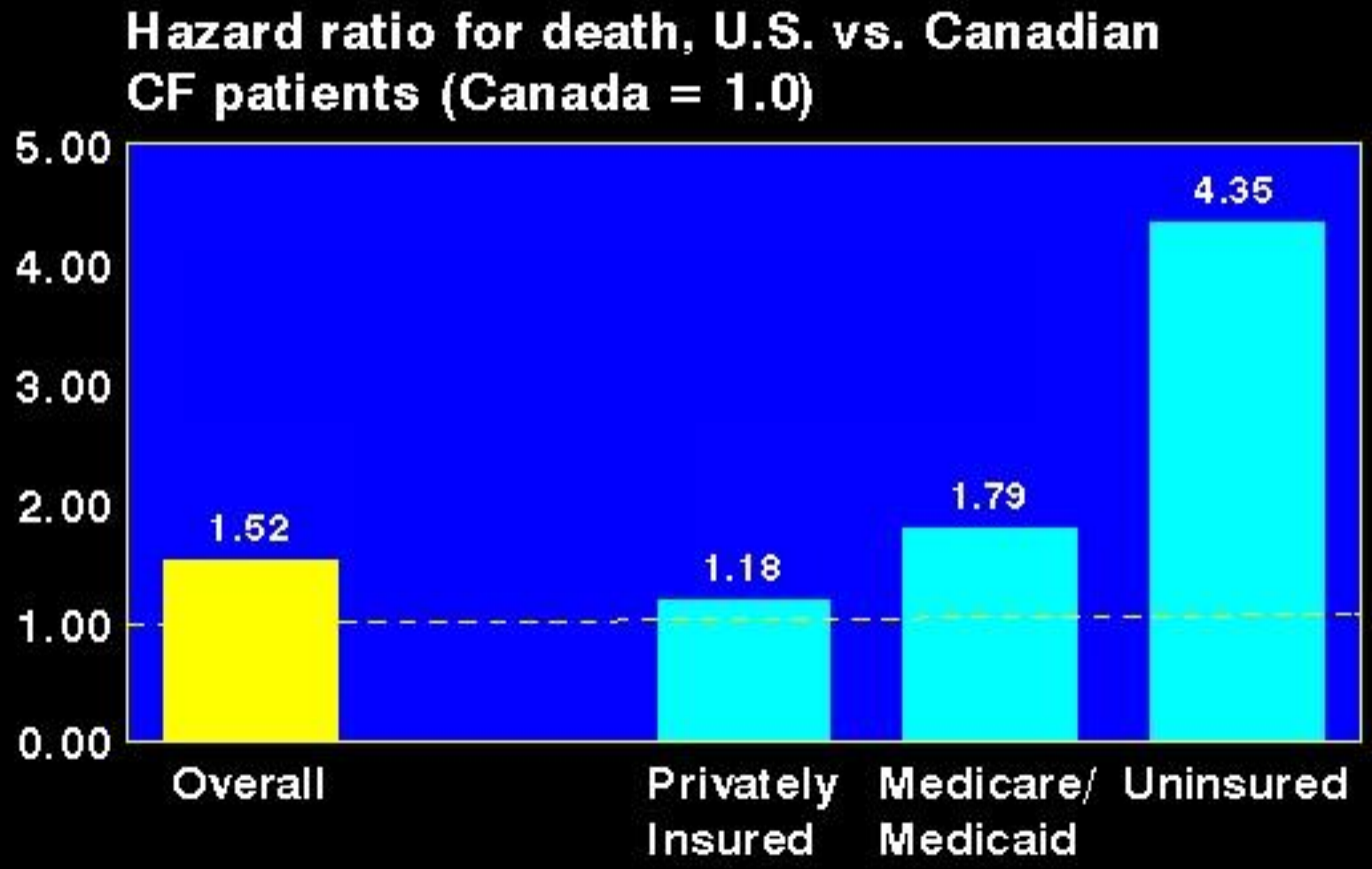
Biggest Impact on Poor and Middle Class



Source: NEJM 1973;289:1174

Cystic Fibrosis Patients Live Longer in Canada

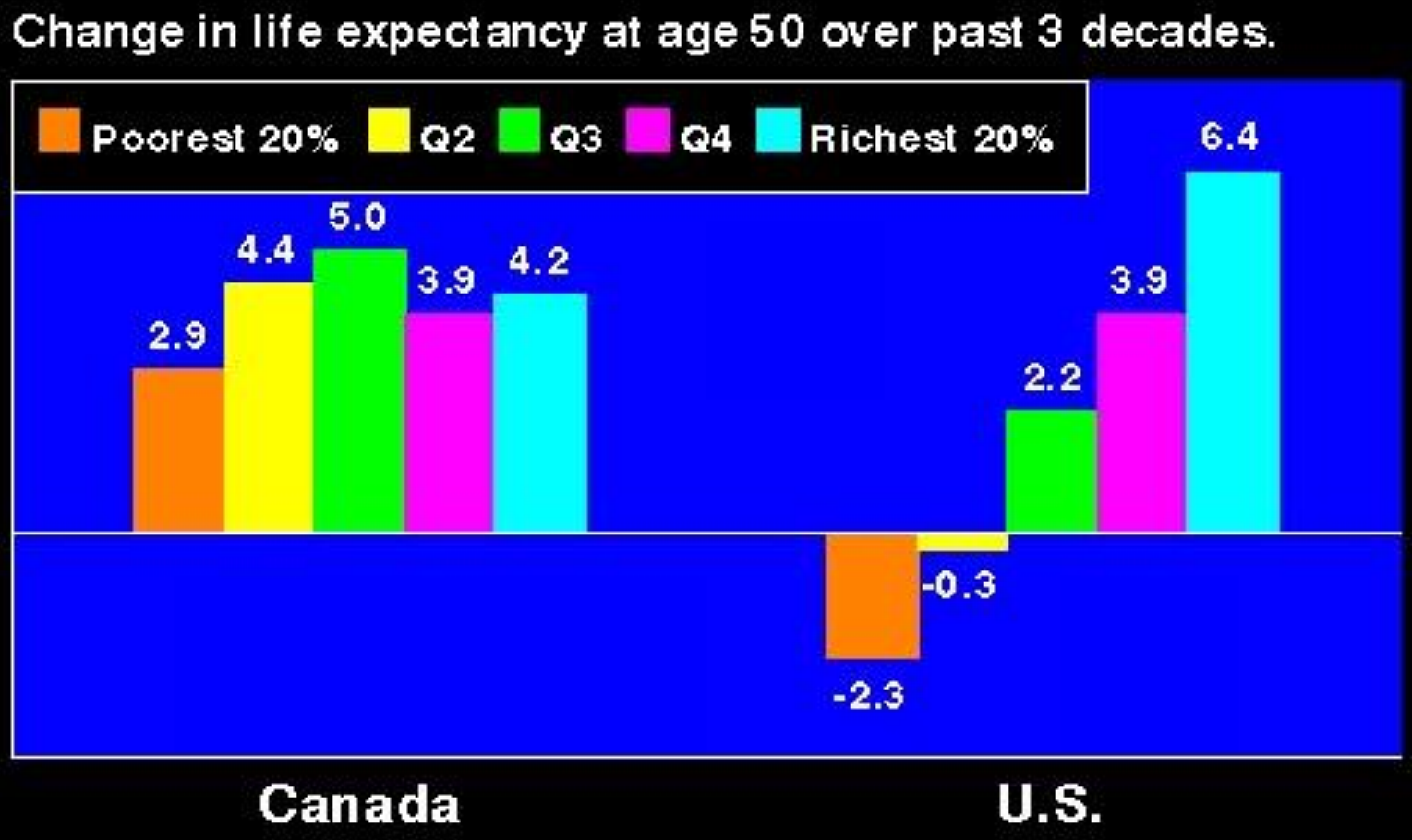
Uninsured in U.S. Have Highest Risk of Death



Source: Ann Int Med 2017;166:537

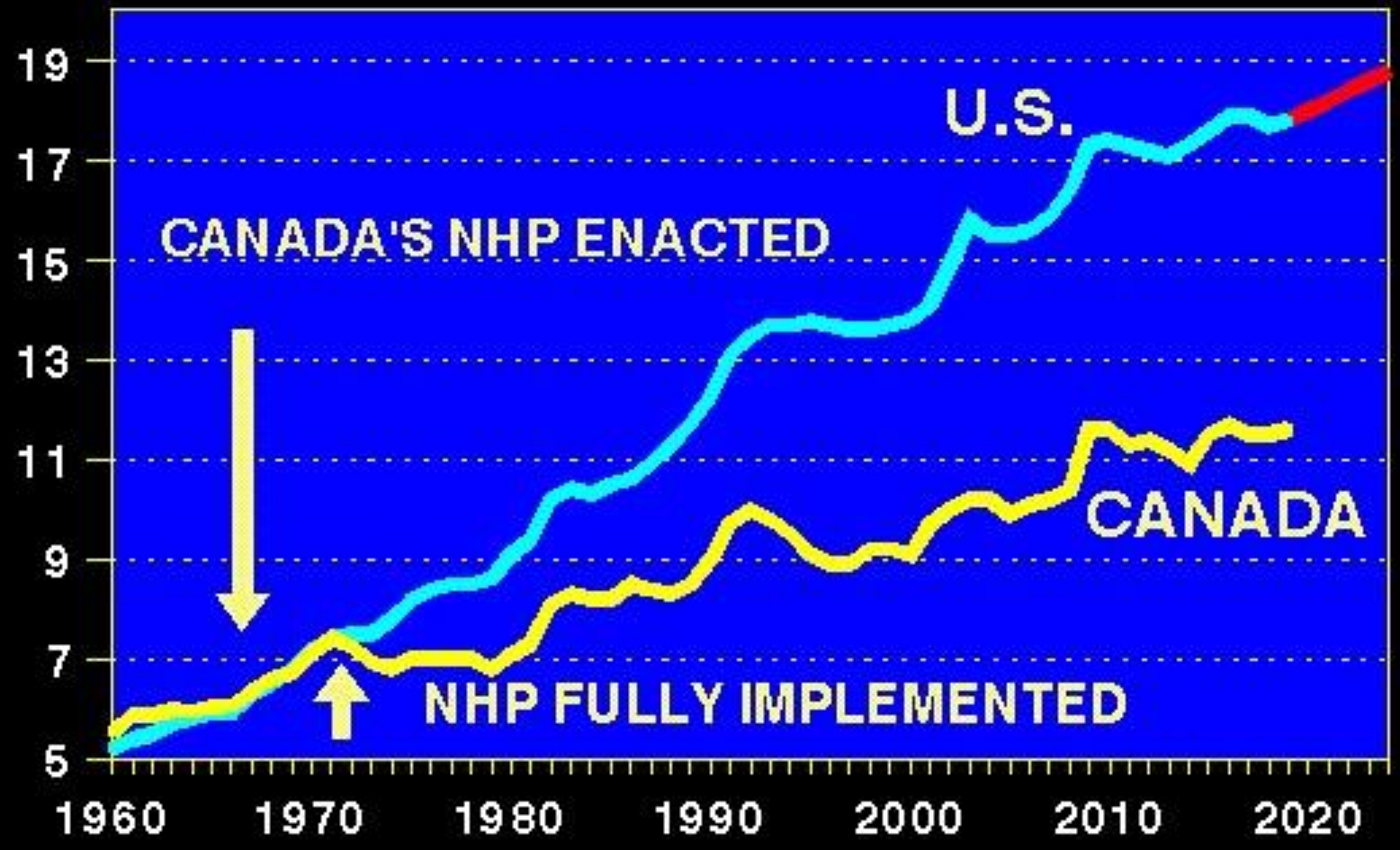
Note: Hazard ratios are adjusted for multiple genetic and clinical characteristics

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

Health Costs as % of GDP:
U.S. & Canada, 1960-2024



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

How Canada Controls Costs

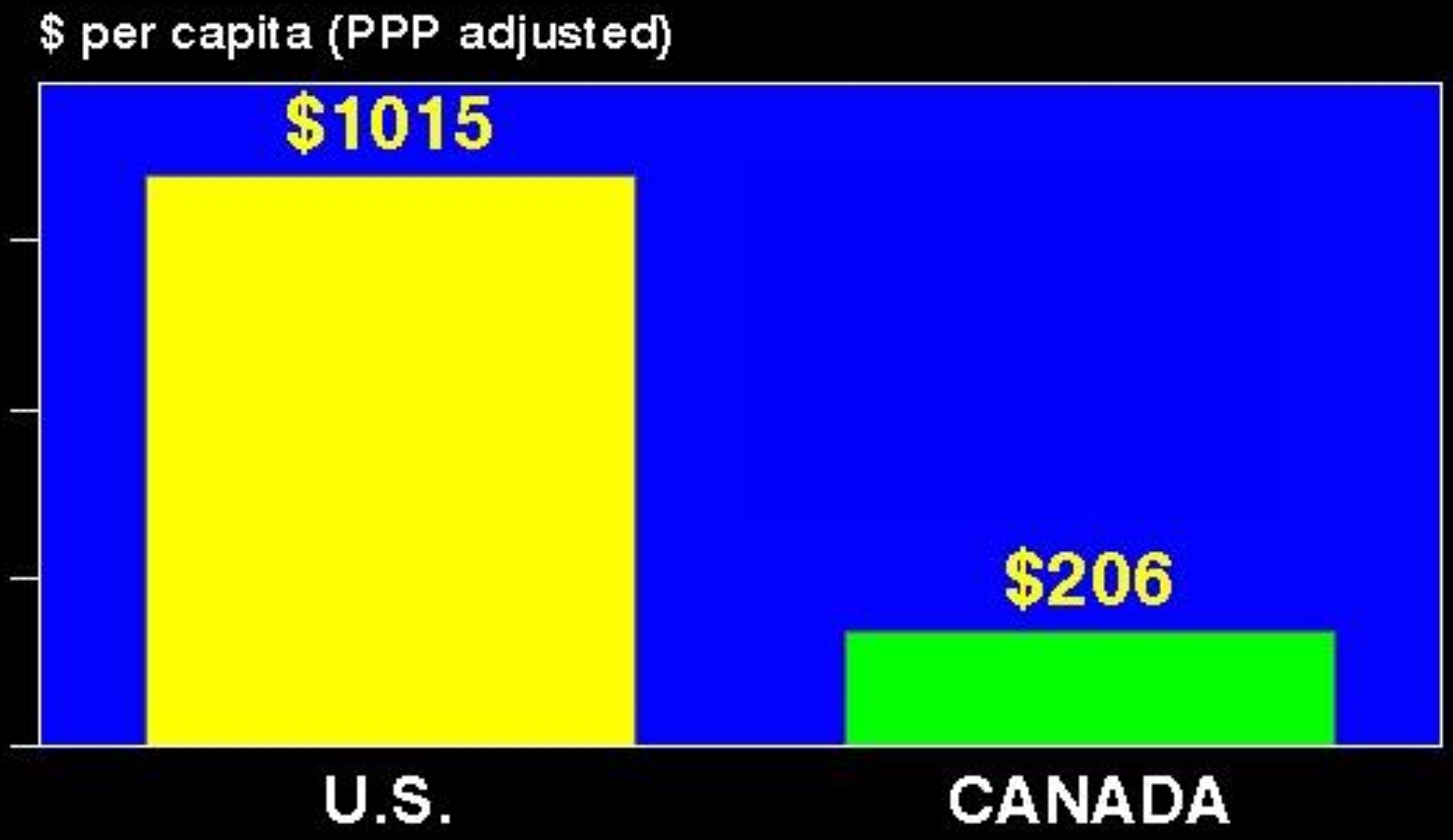
- Low administrative costs - 16.7% of health spending vs. 31.0% in U.S.
- Lump-sum, global budgets for hospitals
- Stringent controls on capital spending for new buildings and equipment
- Single buyer purchasing reins in drug/device prices
- Low litigation and malpractice costs
- Emphasis on primary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

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

Insurance Overhead
United States & Canada, 2019

Source: NCHS and CIHI (projected)

Hospital Billing & Administration United States & Canada, 2019



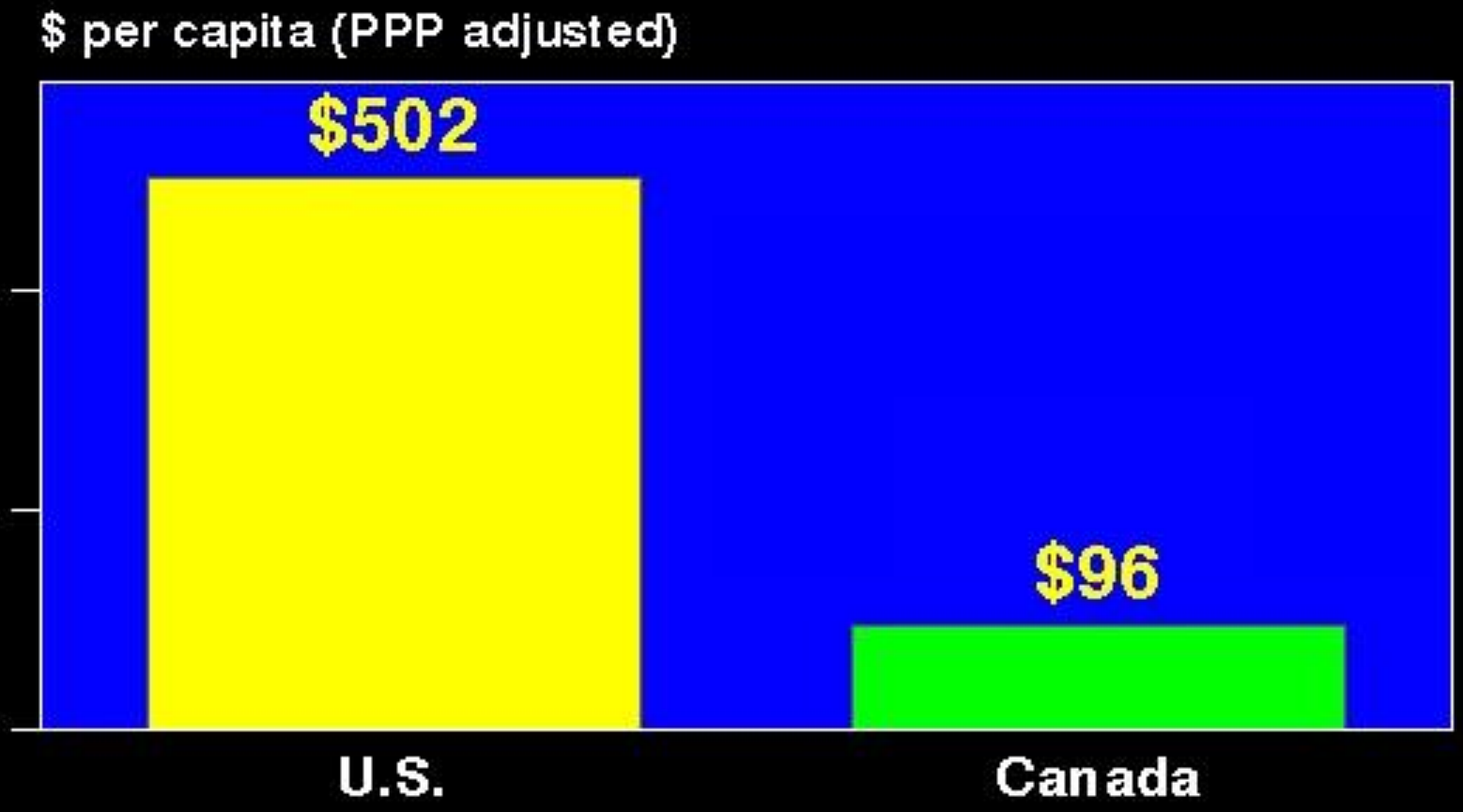
Source: Himmelstein, Campbell & Woolhandler - Ann Int Med 2020 (Updated)

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

Physicians' Billing-Related Expenses United States & Canada, 2019

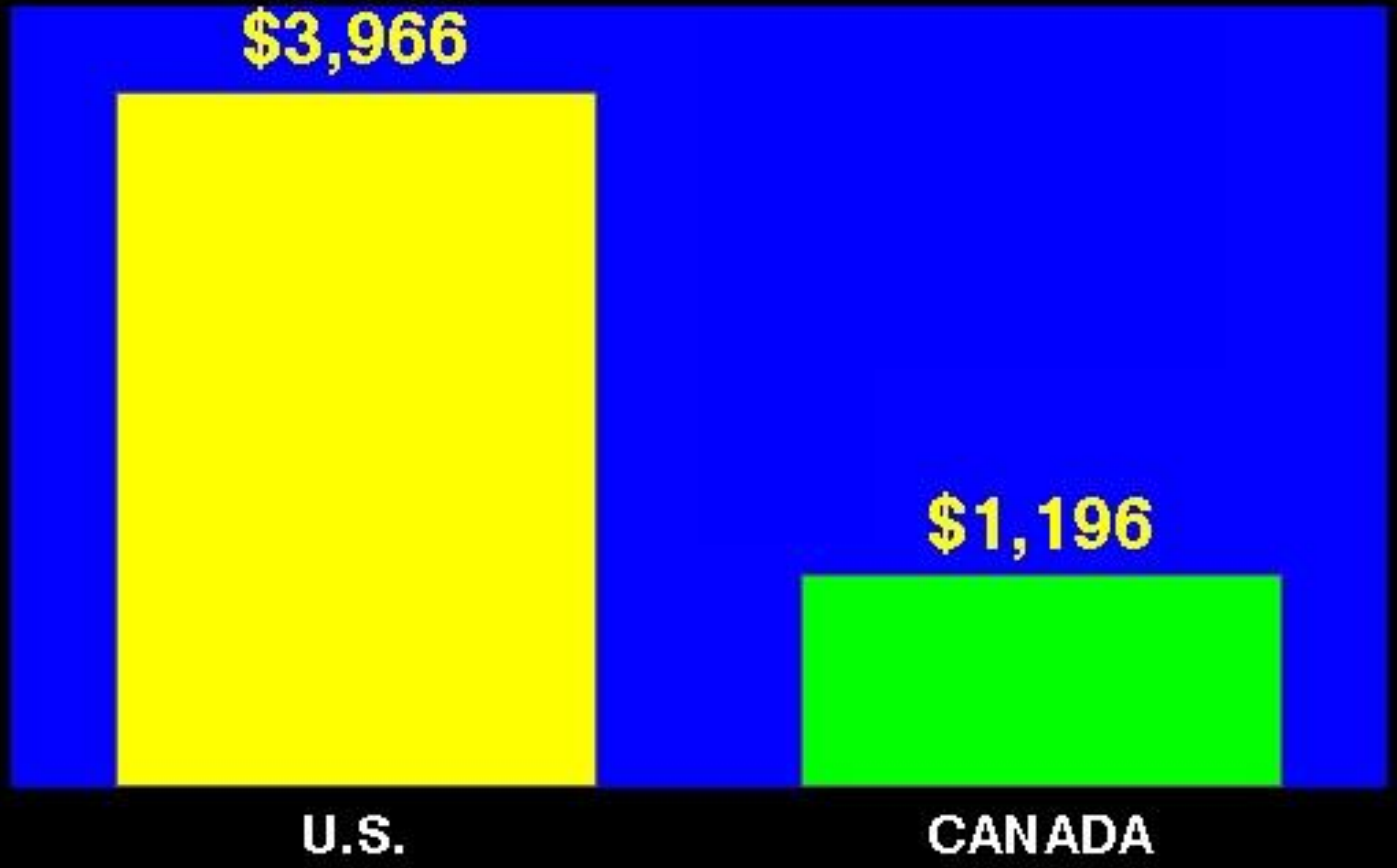


Source: Woolhandler/Campbell/Himmelstein Ann Int Med 2020 (Updated)

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

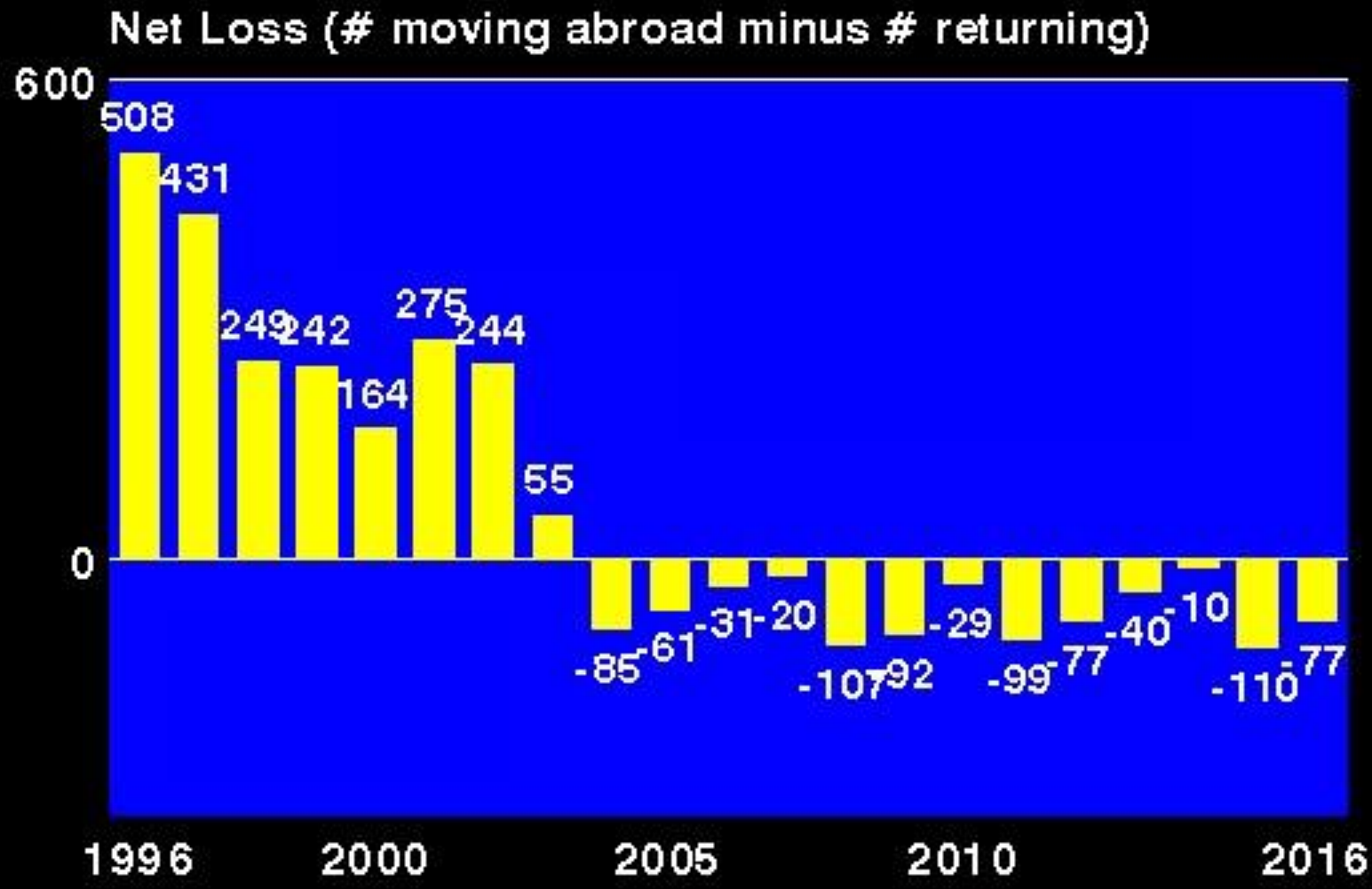
Note: Excludes non-billing-related costs for documentation compliance etc.

Overall Administrative Costs Per Capita
United States & Canada, 2019



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, 2017/2018

Average Clinical Payments Per Physician

Family Medicine	$280,763
Int. Medicine	$403,942
Pediatrics	$298,814
Psychiatry	$278,069
Dermatology	$384,786
Ob/GYN	$391,743
General Surg.	$452,283
Thoracic Surg.	$599,910
Ophthalmology	$768,958
All Physicians	$344,978

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

What's OK in Canada?

Compared to the U.S.

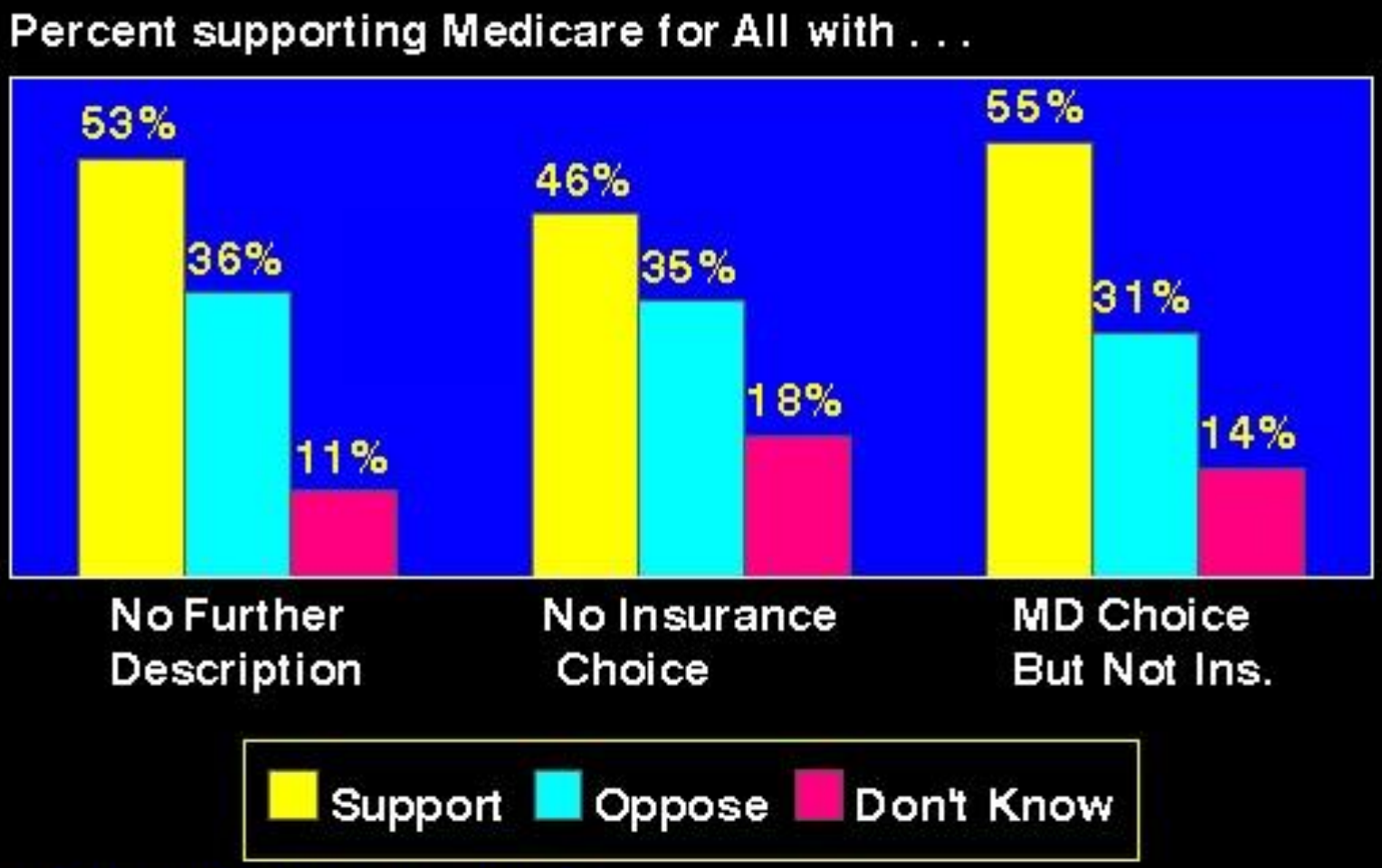
- Life expectancy 2 years longer
- Infant deaths 25% lower
- Universal comprehensive coverage
- More MD visits, hospital care; less bureaucracy
- Quality of care equivalent to insured Americans'
- Free choice of doctor/hospital
- Health spending half U.S. level

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

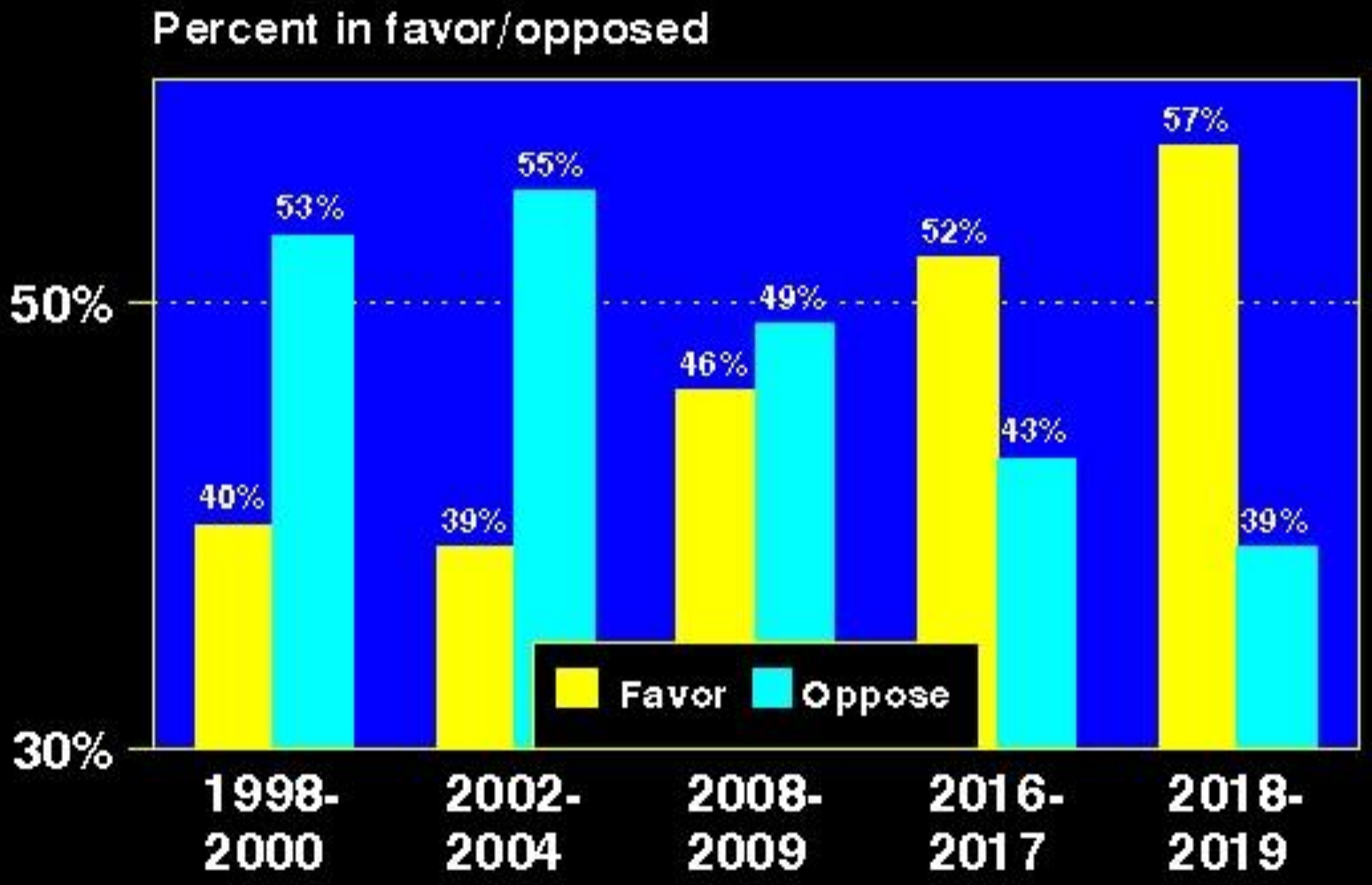


Source: Morning Consult July, 2019

Note: Question asked about choice of doctor AND hospital

Increasing Support for Single Payer

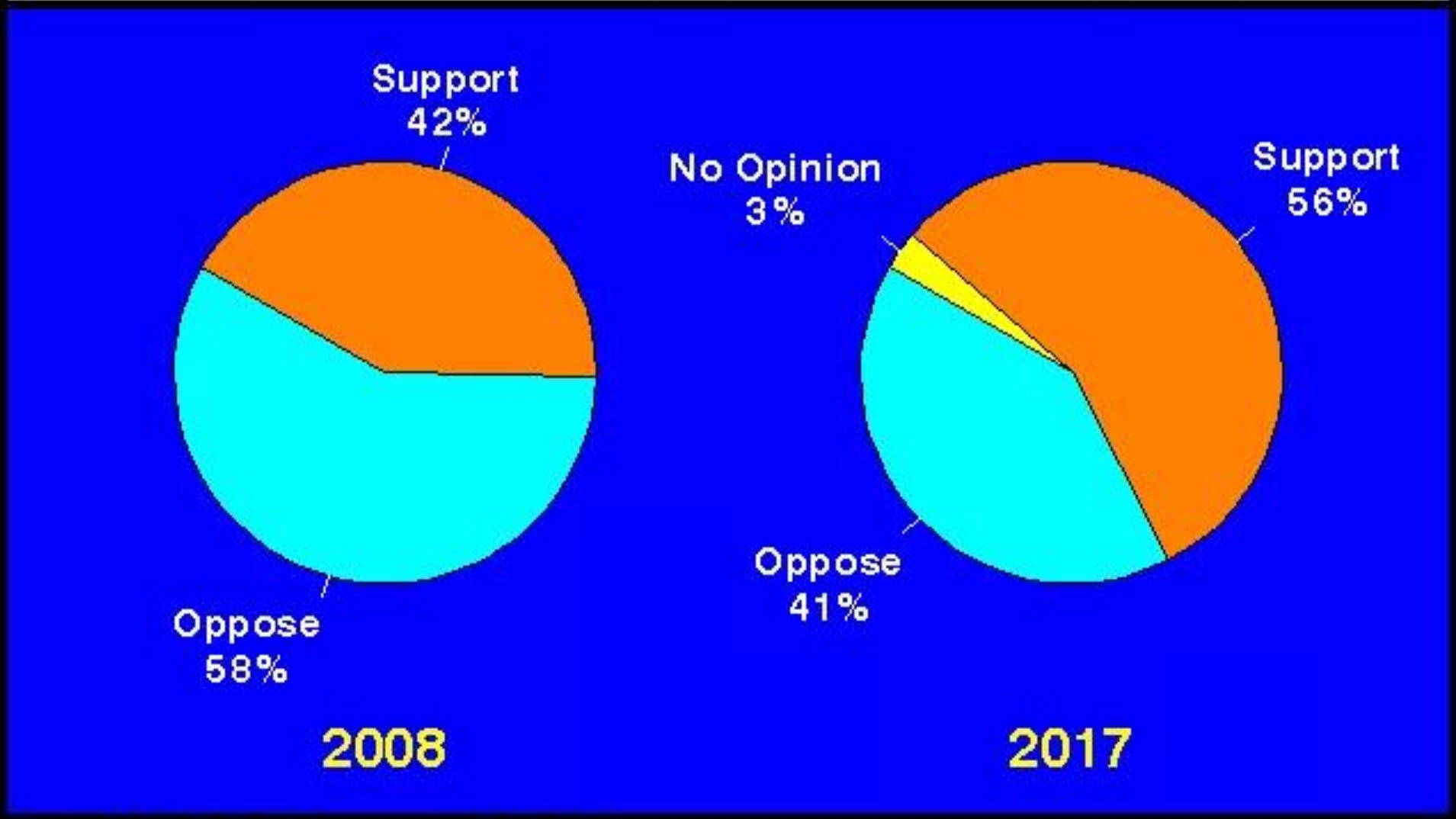
"All Americans Would Get Their Insurance from a Single Government Plan"



Source: Kaiser Family Foundation Polls

Most Doctors Favor Single Payer

Support Has Sharply Increased



Source: Merritt Hawkins surveys of physicians

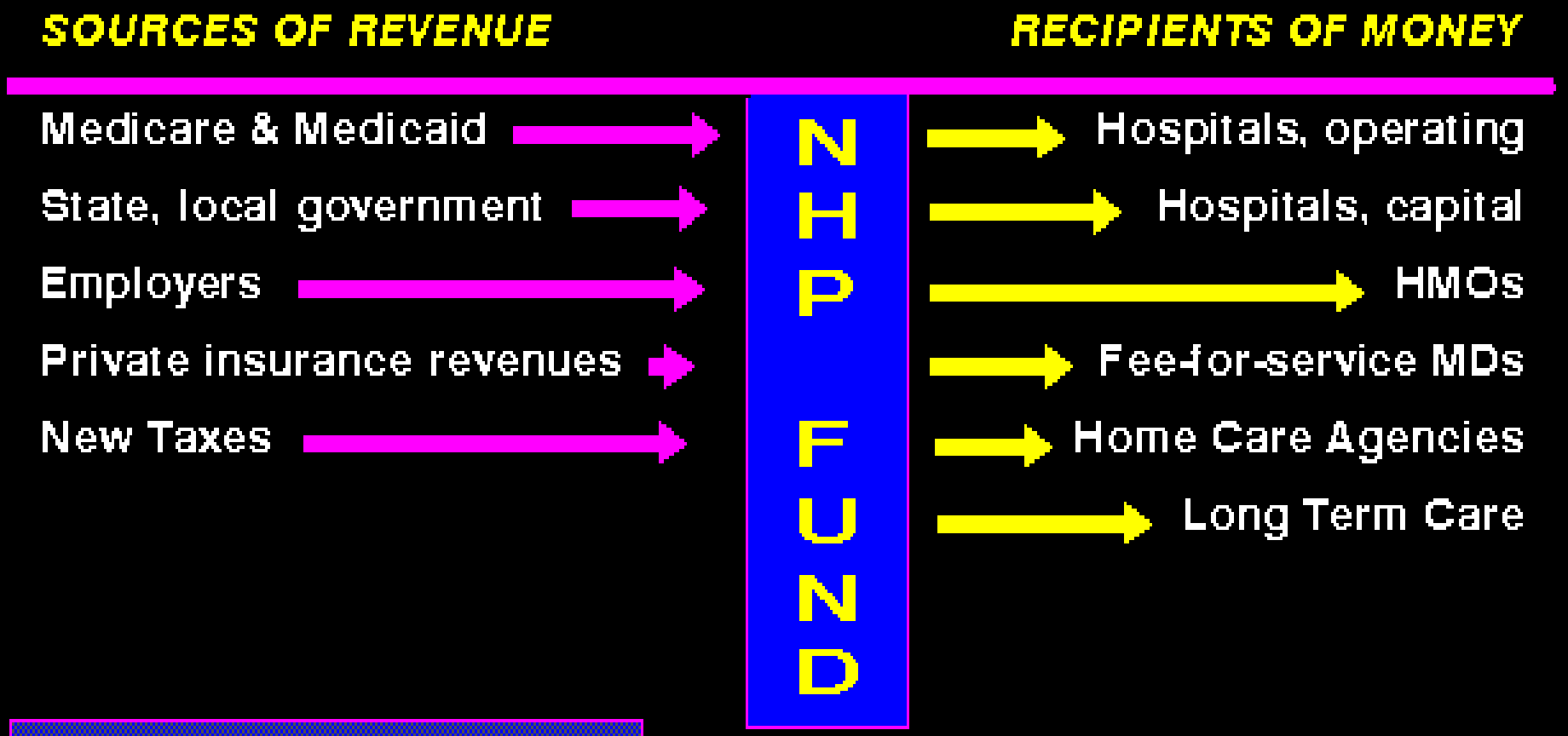
A National Health Program for the U.S.

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

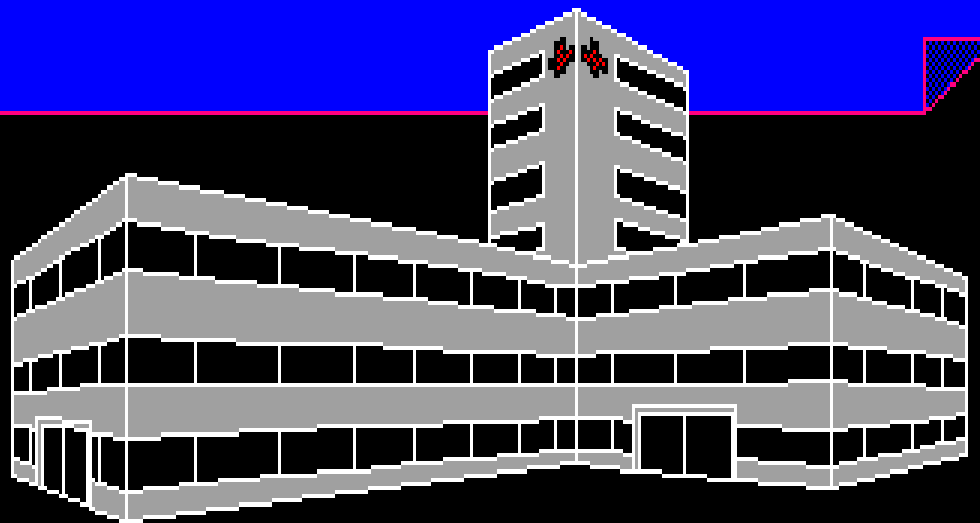
FUNDING FOR THE NHP



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 some 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.

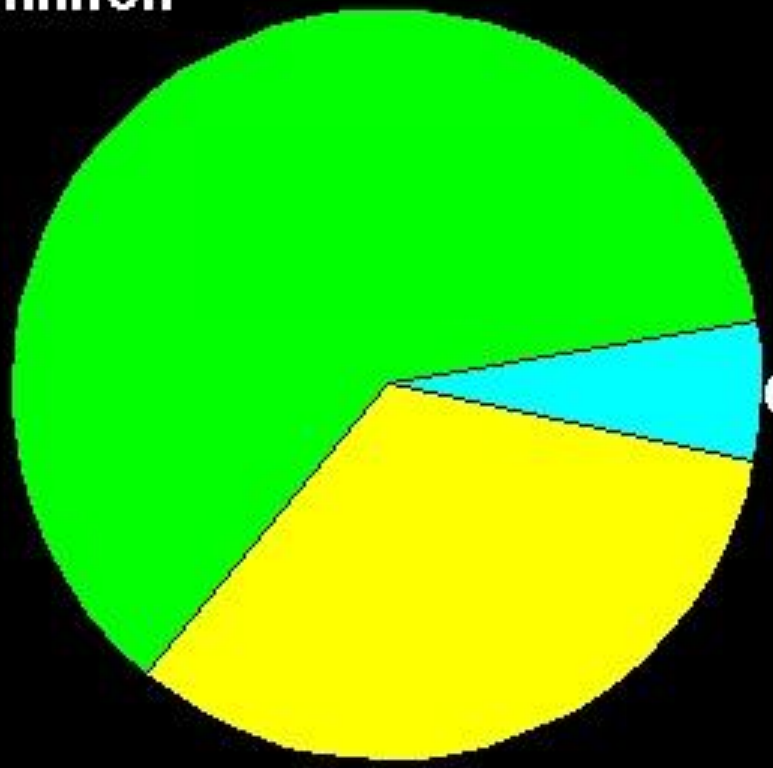
Single Payer Transition:

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.

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

Single Payer and Private Coverage

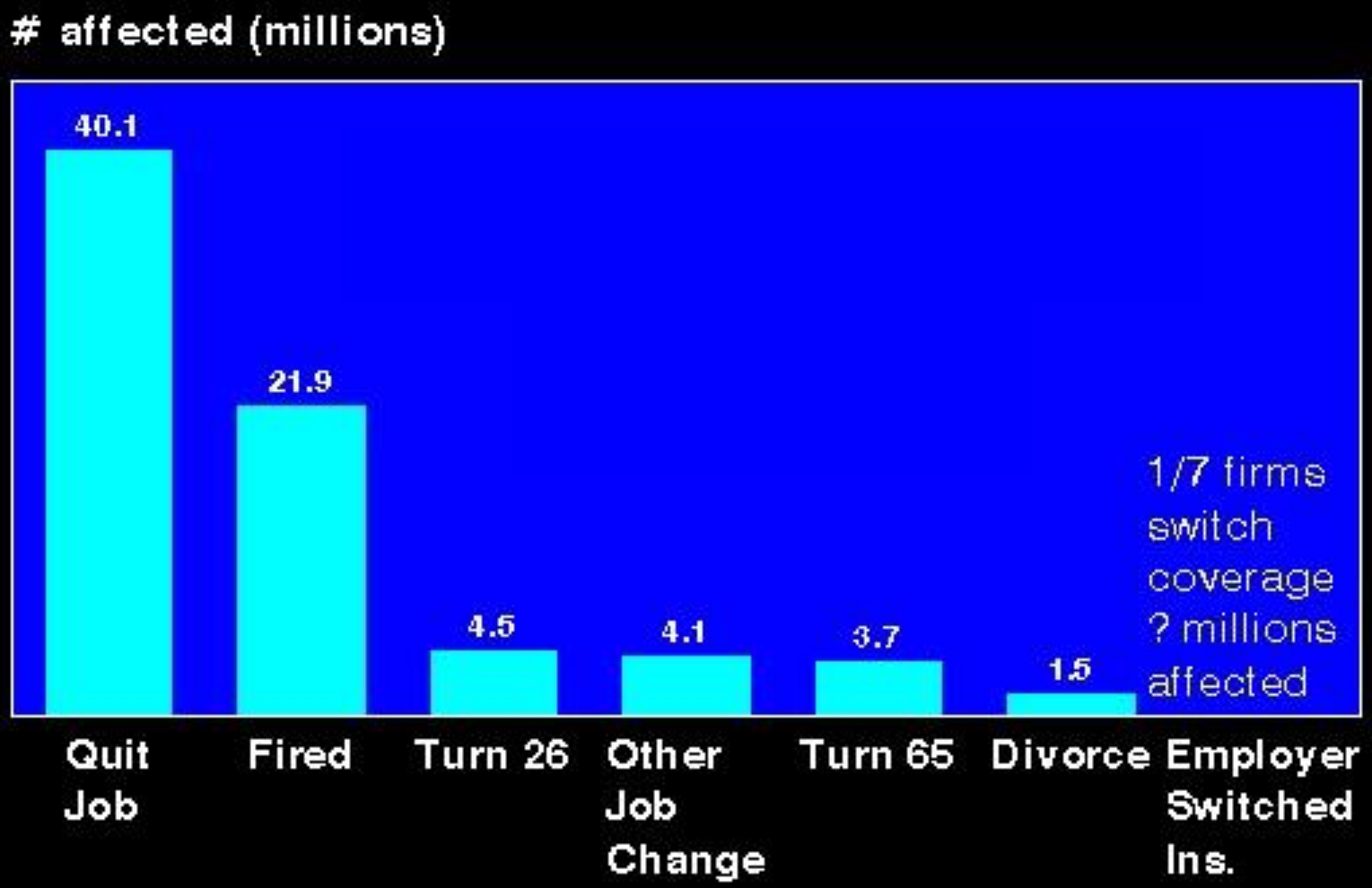
- Allowed: Supplemental non-competing – but can only cover benefits NOT covered by the public plan.

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

Public Option 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



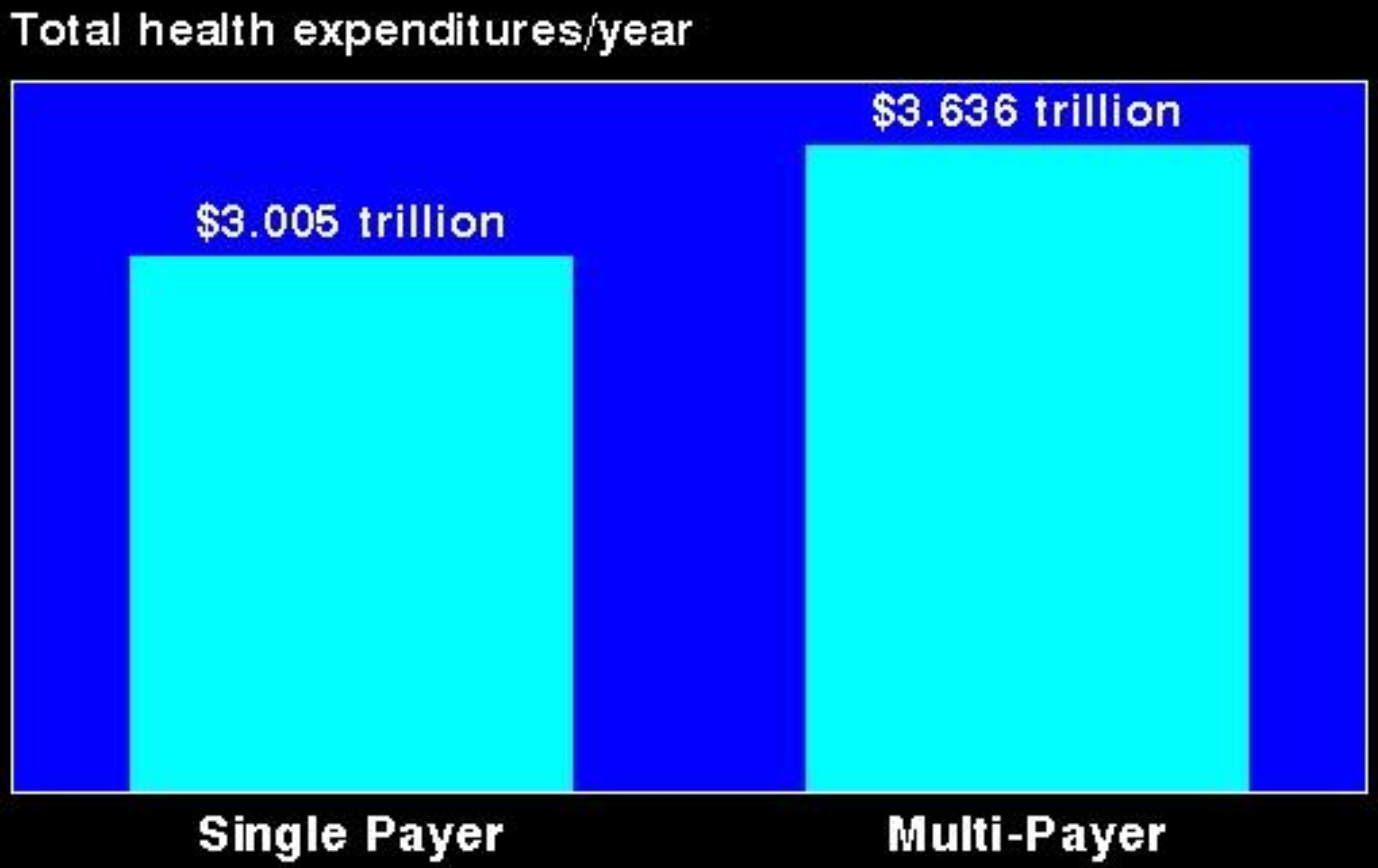
Source: Bruenig - Jacobin Blog Post July, 2019

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

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.

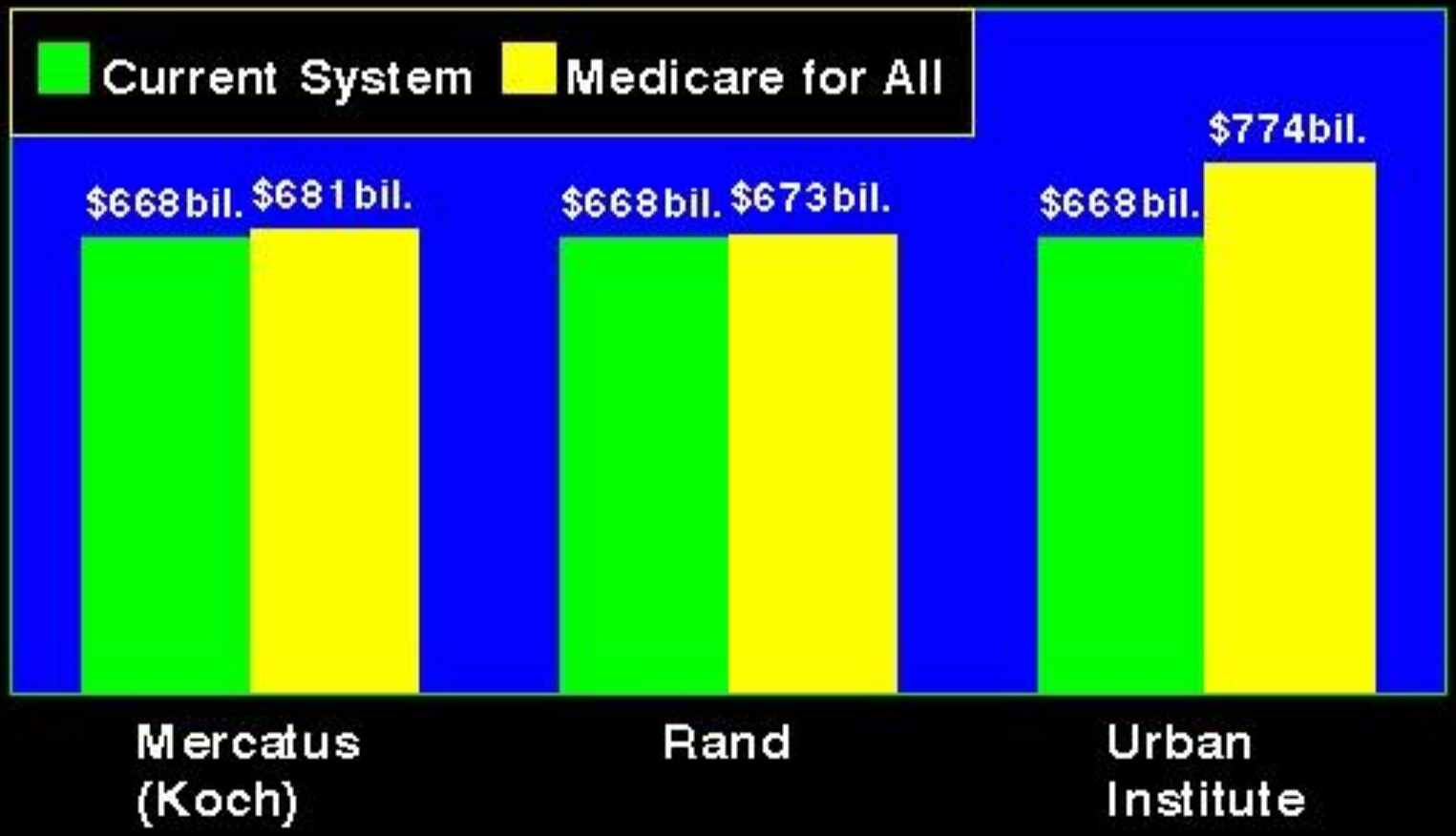
Single Payer Would Cost $631 Billion Less Than a Universal Multi-Payer Reform



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

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

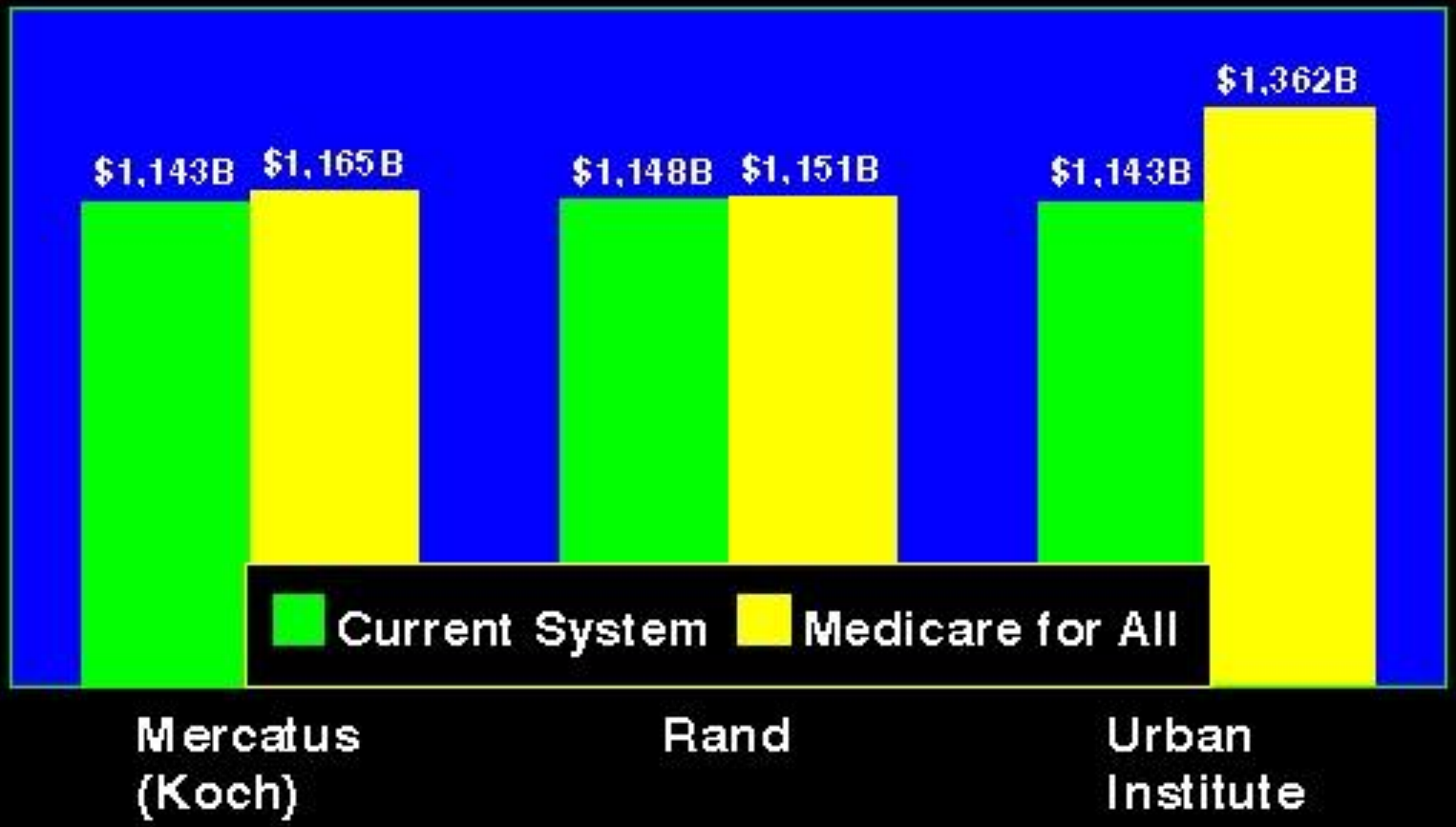
Three Recent Estimates by Single Payer Skeptics



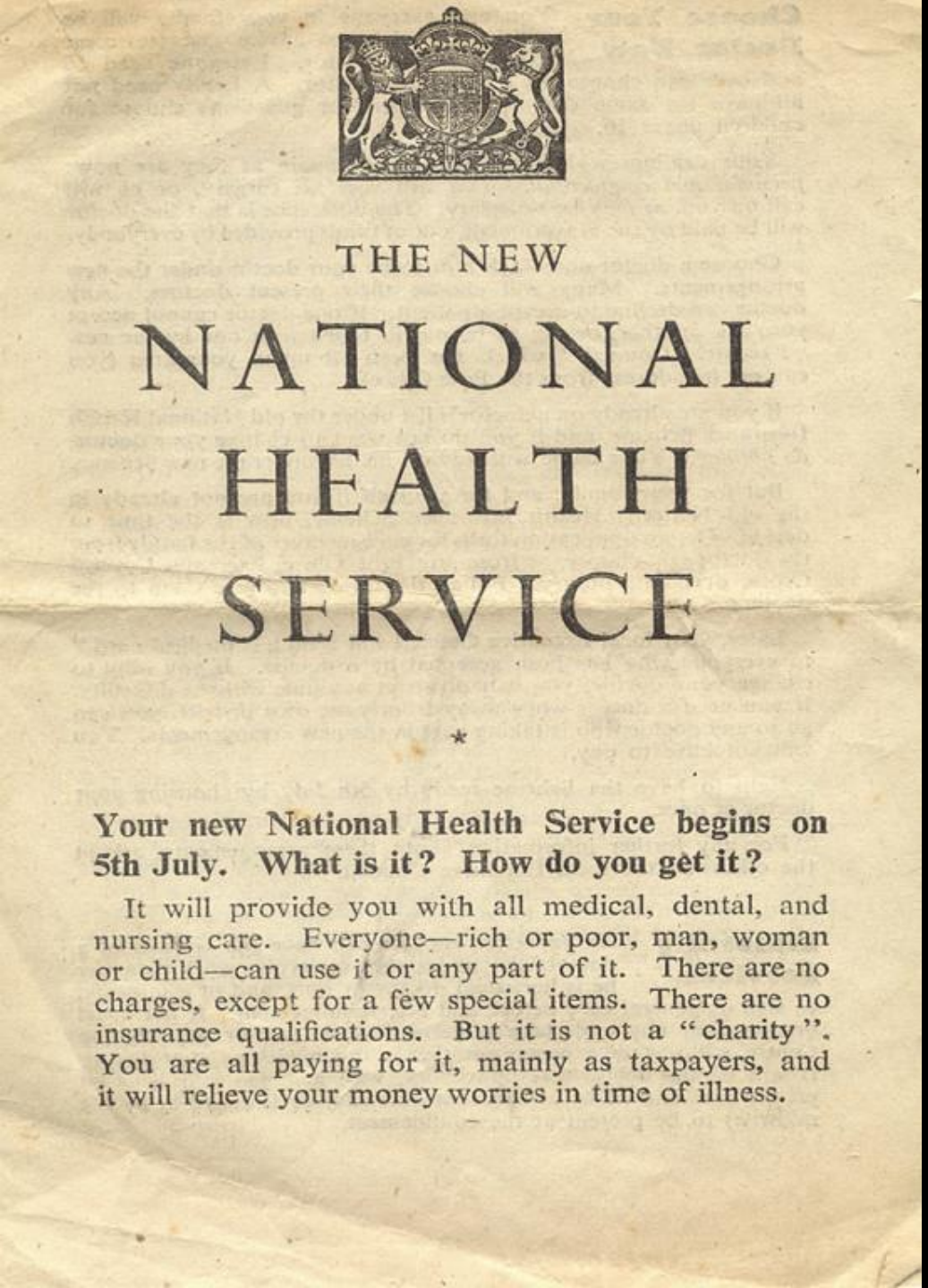
Sources: Rand Corporation (2019), Urban Institute (2016), Mercatus Center (2018)
Note: Percentage estimates from original studies, applied to 2019 total physician expenditures
Note: Urban argued that "physician incomes would be squeezed" even as payments rose by >$100 bil.

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.



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

Source: http://museum.hackney.gov.uk/object9232