

"Hijacked, Stolen Health Care Reform" by Dr. John Geyman

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Five part series analyzing the Obama health plan by Dr. John Geyman, Professor Emeritus of Family Medicine at the University of Washington School of Medicine in Seattle, where he served as Chairman of the Department of Family Medicine from 1976 to 1990. As a family physician with over 25 years in academic medicine, he has also practiced in rural communities for 13 years. He was the founding editor of The Journal of Family Practice (1973 to 1990) and the editor of The Journal of the American Board of Family Practice from 1990 to 2003.

Hijacked, Stolen Health Care Reform I: Why Health Care Costs Will Not Be Contained

The passage of the Patient Protection and Affordable Care Act of 2010 (PPACA), our new health care legislation, in March was hailed by its supporters as an historic event of the magnitude of Social Security and Medicare. But four months later, it remains controversial, with repeated polls showing three large groups of divisive opinion, including those who would work to repeal it and others who believe that it will make no difference. The Democrats have launched a \$125 million PR campaign to defend the new law amidst growing signs that many Democrats facing re-election are failing to get political traction on the issue. (1)

We are being advised by many to "wait and see" how this complex new bill plays out over the next five to ten years, but we can already know what its outcomes will be. More than 30 years of health policy science, including documentation of the repeated failures of incremental changes built into the new law, together with well-entrenched trends in our market-based system, allow us to project its outcomes with confidence. For this legislation has been molded and crafted by the political power and money of corporate stakeholders in the medical-industrial complex.

Five previous posts in 2009 described the uneasy "alliance" of the five biggest players -- the insurance industry, the drug industry, the hospital industry, business and organized medicine. They will do just fine with the new law at the expense of patients, families and Main Street.

Health care "reform" this time around was intended to address these four basic system problems: (1) containing health care costs, (2) making health care more affordable, (3) increasing access to care, and (4) improving the quality of care. This post introduces a series of five that will examine how well the PPACA will do on each of these four goals, followed by an overall assessment of the law. These posts will draw in part from my new book *Hijacked: The Road to Single Payer in the Aftermath of Stolen Health Care Reform*, soon to be released by Common Courage Press in both print and eBook format.

Continued Unrestrained Drivers of Health Care Costs

These are some of the many reasons that we can already conclude that health care costs will continue to run out of control at rates far exceeding the costs of living and median household incomes.

- No price controls. Wall Street has already factored in rapid expansion of markets for drugs, medical devices and other services in a system of expanded access. There is also a long line forming of providers of information technology and administrative services that will exploit the complex implementation of this law.
- No bulk purchasing. The PPACA has prohibited the government from negotiating the prices of prescription drugs and retains a ban on importation of drugs from Canada and other countries.
- Lack of control over perverse incentives that drive increased volume of services. These in turn are driven by retention of fee-for-service (FFS) reimbursement that encourages physicians and other providers to offer more services than are medically appropriate or necessary.
- No effective mechanism to rein in marginal or ineffective technologies. Coverage policies for new drugs and medical devices are still lax and not

subject to rigorous evidence-based criteria for either efficacy or cost-effectiveness.

Although the PPACA does call for a Patient-Centered Outcomes Research Institute, its role is already neutered by not having the power to mandate or even endorse coverage or reimbursement rules for any particular treatment. (2)

- The dominant business model of health care prevails, with many facilities and services remaining for-profit and investor-owned and with an ongoing trend for increasing consolidation within industries.
- The PPACA has grandfathered-in specialty hospitals, typically physician-owned facilities that focus on well-reimbursed procedures in such areas as cardiology and orthopedics, whereby physicians can "triple dip," earning high incomes as providers, owners and investors.
- More preventive services will further fuel health care inflation. While the PPACA does provide new coverage for many preventive services, this will lead to increased costs due to additional diagnostic and treatment services engendered. (3)
- Private insurers can't contain health care costs, even where they have dominant market power. A 2009 report by the Congressional Research Service, "The Market Structure of the Health Insurance Industry," concludes that:

The exercise of market power by firms in concentrated markets generally leads to higher prices and reduced output -- high premiums and limited access to health insurance -- combined with high profits. (4)

- There are no controls over premium rate increases by insurers. Despite the outcry by government officials, annual premium rates are escalating at rates up to 56 percent (5), and there is no end in sight for continued exorbitant rate increases. Insurers will continue to game the system by extracting maximal profits and offering reduced coverage with actuarial values (the amounts insurers actually pay in coverage) as low as 60 or 70 percent.

- National health care spending will grow unabated despite the passage of PPACA. The Centers for Medicare and Medicaid Services (CMS) projects that overall national health expenditures (NHE) will increase from its present 17 percent of GDP to 21 percent in 2019, a total of \$4.470 trillion. (6) (Foster, RS. Office of the Actuary. Estimated financial effects of the "Patient Protection and Affordable Care Act," as Amended. Centers for Medicare and Medicaid Services, April 22, 2010)

These well-documented trends leave no room to think that health care "reform" will have any chance to contain health care costs. Instead, health care inflation will be exacerbated by all the new incentives and inefficiencies in the new "system." In our next post we will examine the impact of these trends on affordability of health care.

(1) Allen, M. Dems launch \$125 M health campaign. *Politico*, June 7, 2010(2) Kaiser Health News staff. True or false: Seven concerns about the new health law, March 31, 2010(3) Russell, L. Preventing chronic disease: An important investment, but don't count on cost savings. *Health Affairs* 28 (1): 42-5, 2009(4) Austin, DA, Hungerford, TL. The Market Structure of the Health Insurance Industry. Washington, D.C. Congressional Research Service, November 17, 2009(5) Johnson, A. Fight over health-care premiums heats up. *Wall Street Journal*, February 19, 2010: A6(6) Foster, RS. Office of the Actuary. Estimated financial effects of the "Patient Protection and Affordable Care Act," as Amended. Centers for Medicare and Medicaid Services, April 22, 2010

Hijacked—Stolen Health Care Reform II: Why will health care become much less affordable?

Posted by John Geyman MD on Friday, Jul 9, 2010

In our last post, we looked at some of the uncontrolled drivers of rapidly rising health care costs despite all the assurances of our politicians supporting the new health care law, the Patient Protection and Affordability Care Act of 2010 (PPACA).

During the long run-up to this bill, President Obama told us that it would save

the average American family \$2,500 a year on insurance premiums (a claim that the Congressional Budget Office later dispelled as untrue, instead projecting a \$2,300 increase in premium costs for the average family). (1) (Hemingway, M. Obama promised \$2,500 health care savings; CBO says plan is \$2,300 price increase. Washington Examiner on line, March 10, 2010)

The inconvenient fact is that premiums for families enrolled in employer-sponsored health plans from 2000 to 2008 increased by 97 percent, while those enrolled in individual plans increased by 90 percent; during this period, insurers' payments to providers rose by 72 percent, medical inflation increased by 39 percent, wages grew by 29 percent and overall inflation went up by 21 percent. (2) (Health Care for America Now! (HCAN). Insurance industry inflates rates while falsely blaming new health care law. June 2010)

According to a recent survey by the Council of Insurance Agents and Brokers, more than one-half of smaller employers with 50 or fewer employees will face premium hikes for group policies in the 11 percent to 20 percent range for 2011. (3) (Wojcik, J. Group health insurance rates on the rise: Survey. Business Insurance, June 3, 2010)

So how in the world can we expect the new health care "reform" legislation to actually make health care and health insurance more affordable?

The new law promised not only cost savings but also provided for \$476 billion (almost one-half of the total \$1 trillion cost of the law in its first 10 years) in new federal subsidies to help lower- and middle-income Americans to pay for health insurance. We need to ask whether the promised cost savings are likely to materialize and whether the subsidies will help that much.

For openers, cost savings are an illusion. Supporters of PPACA assure us that several approaches will contain health care costs – such as an increase in wellness and prevention programs, wider application of health information technology, and experimentation with such initiatives as "accountable care organizations" and tweaks to the fee-for-service reimbursement system. Most are delayed for years into the future and none have yet been

demonstrated to save money for patients and their families.

The cost of health care is certain to rise exponentially as far as we can see, since the market controls prices and the volume of services in a deregulated non-system. And insurance premiums are also certain to rise rapidly at rates way above the cost of living and median household income based on various industry-friendly loopholes in the law and gaming by the industry. These examples show how easy it will be for the industry to continue to exploit the public through both private and public programs:

- Under the new law, insurers can raise premiums based on age (by a 3:1 ratio), by geographic area, by the number of family members, and by tobacco use (by a 1.5 to 1 ratio).
- Many insurers are now aggressively marketing “wellness plans” in both private and public plans. One example is the Healthways SilverSneaker’s membership fitness plan for seniors enrolled in Medicare Advantage plans. This is a clever strategy for insurers in two ways – they cherry-pick healthier seniors without infirmities that prevent their participation in such programs and then they charge 20 percent higher premiums to those seniors not enrolled in fitness programs. (4) (Blue Shield of California. Blue Shield of California to offer award-winning fitness program to Medicare beneficiaries in San Bernardino. January 18, 2010) (5) (Britt, R. Experts: Critical loophole in Senate health bill. Market Watch. January 7, 2010)
- Many healthier younger people will gamble with being uninsured until they get sick, in order to avoid paying fines for noncompliance with the individual mandate. This has already happened in Massachusetts over the four years since the “Massachusetts Miracle” was adopted in 2006. Since then, the number of short-term insurance buyers has increased by four-fold, getting insurance only after they have health care problems, then dumping coverage after they get care. This has increased the cost of insurance for other people and costs the state’s program an additional \$300 million a year. (6) (Lazar, K. Short-term insurance buyers drive up cost in Mass. The Boston Globe, June 30, 2010) (6) (Lazar, K. Short-term insurance buyers drive up cost in Mass. The Boston Globe, June 30, 2010)

People with employer-sponsored group coverage will also take hits. As

employers confront hikes in the costs of group coverage, they will pass along these costs to their employees in the form of increased co-payments and deductibles, often with other restrictions in coverage. Middle-income families will be especially hard-hit if they have so-called Cadillac plans – those with annual premiums in excess of \$8,500 for individuals and \$23,000 for families. Employers will be faced with a tax on such plans beginning in 2013, when we can expect them to avoid the tax by limiting coverage and forcing more cost-sharing on their employees. (7) (Herbert, B. Op-Ed. A less than honest policy. New York Times, December 29, 2009)

But won't the nearly half a trillion dollars in federal subsidies over 10 years make health care affordable for lower- and middle-income Americans? Here too the story is not what we are being led to believe by pundits and supporting politicians. Subsidies will not start until 2014, and then are not available to people already covered by employer-sponsored insurance, those qualifying for Medicaid (incomes less than 133 percent of the federal poverty level, or FPL) and those earning more than 400 percent of FPL. Subsidies can only be obtained by those purchasing coverage on their own on an Exchange.

The Commonwealth Fund has established useful criteria to assess affordability of health care vs. other costs of living. When put up against other basic necessities of life, such as food, housing, and one car to get to work, health care costs above 10 percent of family income become a hardship level, as are medical expenses above 5 percent of family income for lower-income adults below 200 percent of the federal poverty level and those with health plan deductibles above 5 percent of income. (8) (Schoen, C, Doty, M, Collins, SR, Holmgren, AL. Commonwealth Fund. Insured but not protected: How many adults are underinsured, the experiences of adults with inadequate coverage mirror those of their uninsured peers, especially among the chronically ill. Health Affairs Web Exclusive, June 14, 2005)

The Kaiser Family Foundation has developed a useful Health Reform Subsidy Calculator, by which people can readily determine their own health care costs. As an example, a family of four in with an income of \$60,000 in 2014 can expect to be responsible for an insurance premium of \$16,858 as well as \$6,250 in out-of-pocket costs, which together would account for 18.6 percent of their household income. And those costs may well be higher due

to restricted coverage of their own plan and changes in cost-sharing requirements. By comparison, seniors were paying an average of 15 percent of their annual income on premiums and out-of-pocket health care costs in 1965 when Medicare was enacted. (Blumenthal, D., et al. "Renewing the Promise: Medicare & its Reform." New York, Oxford University Press, 1988.)

So far we have found little evidence that health care "reform" circa 2010 will contain health care costs or make health care more affordable. In our next post we will consider how much we can believe about claims of improved access to care.

Hijacked: Stolen Health Reform III: How Much Will Access to Care Be Expanded?

The Patient Protection and Affordable Care Act of 2010 (PPACA) is being touted by its proponents as moving the country to near-universal coverage and a great step ahead in U.S. health care. But what does this really mean? Are the many barriers to care almost a thing of the past?

On the plus side, the PPACA does offer these welcome provisions:

- Extending health insurance to 32 million more people by 2019.
- Allowing parents to keep their children on their policies until age 26.
- Expansion of Medicaid to cover 16 million more lower-income Americans.
- New funding for community health centers that could allow them to double their patient volume.

However, on the other side of the ledger, there are many problems that will render restricted access to care for tens of millions of Americans, an ongoing and even increasing problem. These examples show how far short of the mark the PPACA falls on access to care:

- There will still be 23 million people without any kind of health insurance in 2019.

- Federal support for Medicaid expansion will not kick in until 2014.
- More than 32 million other Americans will be under-insured in 2019, as a result of these kinds of circumstances:

1. Many younger healthier people, the "Young Invincibles," will opt out of coverage until they have an accident or get sick.

2. Many people will not be able to afford coverage through either exchanges (which won't be operational until 2014) or high-risk pools.

3. The new federal temporary high-risk pool is already underfunded and plagued with many problems; at best, it will be available for up to 7 million uninsured people, but more likely for only about 200,000 or 3 percent of the target population. (Merlis, M. Health coverage for the high-risk uninsured: Policy options for design of the temporary high-risk pool. National Institute for Health Care Reform. May 27, 2010.)

4. The actuarial value of insurance plans for most of the newly "insured" will be as low as 60 to 70 percent (i.e. insurers leave 30 percent to 40 percent of the bill with patients and their families).

5. Even those fortunate enough to have employer-sponsored (ESI) coverage will find their plans costing more, covering less, and more difficult to afford; the Congressional Budget Office projects that the average family premium in the ESI market in 2016 will cost more than \$20,000, not including deductibles and other out-of-pocket expenses. (Congressional Budget Office. An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act. Nov. 30, 2009.)

6. Access to care will further deteriorate as a result of 36 billion in Medicare and Medicaid cuts to safety-net hospitals. We can expect closure of some of these critical facilities that provide a wide range of services that other hospitals find too unprofitable to provide, including kidney dialysis, cancer treatment and mental health care.

7. Although the PPACA does call for an increase in reimbursement for primary care physicians, that won't happen until 2013, and will then last only

two years -- just a small gesture toward the nation's growing crisis in primary care.

8. The U.S. is facing a shortage of 35,000 to 44,000 primary care physicians for adults by 2025 (Colwill, J, Cultice, JM, Kruse, RL. Will generalist physician supply meet demands of an increasing and aging population? *Health Affairs [Millwood]* 27: w232-41, 2008.) An increasing number of people with insurance coverage cannot find a primary care physician to take care of them, especially those on Medicare or Medicaid, due to low reimbursement in those programs.

9. Since the PPACA calls for phased cuts in overpayments to private Medicare Advantage plans over the next few years, enrollees will face cuts in benefits and rising premiums.

10. As they confront deficits of 127 billion over the next two fiscal years, states are making draconian cuts in Medicaid across the country that will only aggravate current barriers to care. State appeals to the federal government for relief of Medicaid costs are now caught in a political crossfire threatening further unraveling of Medicaid funding. (Solomon, D. States face new pinch as stimulus ebbs. *Wall Street Journal*, June 23, 2010: A5.)

11. A majority of states outsource their Medicaid programs to private insurers that frequently create profits by cutting services. A recent report found that 2.7 million children on Medicaid in nine states were not receiving required screenings and immunizations. In Florida, the insurer WellCare paid 40 million in restitution to the state after it acknowledged that it had set up a subsidiary to make it appear that it was spending more on health care than it actually was. (MacGillis, A. Some states say they're not receiving the Medicaid services they're paying for. *The Washington Post* on line, July 8, 2010.)

Despite the hype we hear about "near-universal" access just down the road with PPACA, the above leads us to believe that access to care will remain inadequate for much of the population. In our next post, we will look at what this year's health care "reform" legislation means for the quality of care Americans receive.

Hijacked: Stolen Health Care Reform IV: Will the Quality of Care Improve?

In our last three posts, we examined how the Patient Protection and Affordable Care Act of 2010 (PPACA) stacks up against the goals of reform for cost containment, affordability and access to care. Here we consider what its likely impact will be on the quality of care, the fourth major goal of the reform effort.

For starters, quality of care in the U.S. is highly variable, and is unsatisfactory for many millions of Americans, as these cross-national comparisons against other nations with one or another form of universal access clearly show:

- The U.S. ranks last among 19 industrialized countries in "amenable mortality rates," deaths that could have been prevented by timely and effective health care; that translates to about 101,000 excessive deaths per year in this country. (U.S. has most preventable deaths among 19 nations. Health Affairs 27 (1):58-71, 2008)
- The U.S. ranks last among 23 industrialized nations on infant mortality, with rates double those of Iceland, Japan and France. (U.S. health system performance: A national scorecard. Health Affairs Web Exclusive, W457-475, 2006)
- Lower-income people in this country receive worse care than their higher-income counterparts on 21 of 30 primary care quality measures, four to five times higher rates of disparity compared to Australia and Canada. (The U.S. health care divide. Commonwealth Fund, April 2006)

On the plus side, the PPACA does make some attempts to improve the quality of care through such provisions as these: expanded access to care; elimination of cost-sharing for preventive services; establishing a comparative effectiveness research initiative; expansion of health information technology (HIT); and modification of payment mechanisms (e.g. accountable care organizations, or ACOs and "value modifiers" for physician reimbursement).

But these are important ways that will largely cancel out the impact of these efforts to improve the quality of care:

- We can expect an increase in cost-sharing (with reduced affordability) as employers downgrade the actuarial value of their coverage and as insurers market their underinsurance products in the individual market and through exchanges. A recent study of Medicare Advantage plans found that increased co-payments resulted in fewer outpatient visits, more hospital admissions and longer hospital stays for patients with hypertension, diabetes and a history of acute myocardial infarction. (Increased ambulatory care copayments and hospitalizations among the elderly. N Engl J Med 363 (4):320-8, 2010)
- The critical shortage of primary care physicians and an underfunded primary care infrastructure persist as our specialist-dominated workforce continues to provide more care than is appropriate or necessary, with less coordination and worse outcomes. For optimal quality of care, patients need both primary care and appropriate specialist care. (Closing the divide: How medical homes promote equality in health care: results from the Commonwealth Fund 2006 Health Care Quality Survey)
- The new Patient-Centered Outcomes Research Institute lacks the authority to mandate or even endorse coverage and reimbursement rules for any particular test or treatment. (True or false: Seven concerns about the new health care law. March 31, 2010)
- Perverse incentives will still permeate the system because of largely unchanged reimbursement policies (mostly fee-for-service) and coverage decisions influenced more by politics and lobbying by industry than hard scientific evidence of efficacy and cost-effectiveness. Procedures will continue to be over-reimbursed, primary and cognitive care services will remain under-reimbursed, and there will be little restraint over excess volume of services in most practice settings. These are examples of how big this problem is:
- One-third of U.S. births today are by Caesarian section (compared to a national average of just 5 percent in the 1960s). (Overtreated: More medical care isn't always better. Associated Press, June 7, 2010)

- About one-third of tests and treatments are inappropriate or unnecessary and often harmful. (Geography and the debate over Medicare reform. Health Affairs Web Exclusive W-103, February 13, 2001)

- Investor-owned hospitals, HMOs, nursing homes and mental health centers provide more expensive care of lower quality than not-for-profit facilities. (The Corrosion of Medicine: Can the Profession Reclaim its Moral Legacy? Monroe, ME. Common Courage Press, 2008, p 37)

- Well-reimbursed imaging procedures are greatly overused, thereby increasing risk of cancer; as an example, a recent report found that Illinois hospitals are using twice as many double CT scans (one with dye, the other without) than the national average, believed by many experts to be unwarranted. (New government report raised questions about CT scans at Illinois hospitals. Chicago Tribune, July 12, 2010)

- Wider adoption of health information technology has not been demonstrated to improve outcomes of care in most non-integrated parts of our health care "system"; most of the increase in medical computing has been driven by financial and billing reasons, not quality of care. And most quality improvement efforts have been based on process measures, such as use of beta blockers after a heart attack or use of hemoglobin A1C in diabetes, without good correlation with actual outcomes. (Hospital computing and the costs and quality of care: A national study.)

- The long-delayed experiments with accountable care organizations and bundled payments are likely to be ineffective in improving quality of care in non-integrated practice settings which involve non-salaried physicians. So despite what we are being asked to believe by supporters of PPACA, we cannot really expect much, if any, improvement in the quality of care for the U.S. population as a result of this legislation.

Hijacked: Stolen Health Care Reform V

Our last four posts have examined the PPACA from the perspectives of the four main goals of health care reform -- cost containment, affordability, improved access and quality of care. Here we draw these goals together in

asking whether this legislation delivers enough to be worth the \$1 trillion investment over the next 10 years and whether it will really work.

On the positive side of the ledger, the PPACA brings some welcome changes:

- Will extend health insurance to 32 million more people by 2019.
- Provides subsidies to help many lower-income Americans afford health insurance.
- Starting in 2014, expands Medicaid to cover 16 million more lower-income people.
- Provides new funding for community health centers that could enable them to double their current capacity.
- Eliminates cost-sharing for many preventive services.
- Phases out the "doughnut hole" coverage gap for the Medicare prescription drug benefit.
- Will create a new national insurance plan for long-term services: Community Living Assistance Services and Supports (CLASS) program.
- Will establish a nonprofit Patient-Centered Outcomes Research Institute to assess the relative outcomes, effectiveness and appropriateness of different treatments.
- Initiates some limited reforms of the insurance industry, such as prohibiting exclusions based on pre-existing conditions and banning of annual and lifetime limits.
- Contains some provisions to improve reimbursement for primary care physicians and expand the primary care workforce.

On the negative side of the ledger, however, these are some of the reasons that the PPACA will fall so far short of needed health care reform that it is not much better than nothing:

- Surging health care costs will not be contained as cost-sharing increases for patients and their families.
- Uncontrolled costs of health care and insurance will make them unaffordable for a large and growing part of the population.
- At least 23 million Americans will still be uninsured in 2019, with tens of millions more underinsured.
- Quality of care for the U. S. population is not likely to improve.
- Insurance "reforms" are so incomplete that the industry can easily continue to game the system.
- New layers of waste and bureaucracy, without added value, will further fragment the system.
- With its lack of price controls, the PPACA will prove to be a bonanza for corporate stakeholders in the medical-industrial complex.
- Perverse incentives within a minimally-regulated market-based system will still lead to overtreatment with inappropriate and unnecessary care even as millions of Americans forego

necessary care because of cost. • The "reformed" system is not sustainable and will require more fundamental reform sooner than later to rein in the excesses of the market.

How did this latest reform effort get so far off track? Here are three of the major reasons:

- The issues and policy options were framed as the political process was hijacked by the very interests that are largely responsible for today's cost, access and quality problems in health care. As examples, the drug industry lobbied successfully to avoid any price controls of drugs, as the VA does so well; the insurance industry avoided real rate controls over their premiums and ended up with other loopholes to game the new system; and all of the corporate stakeholders will gain subsidized new markets without significant regulation of the market.
- The quest for bipartisanship was futile as reform got run over in the middle of the road. The big questions cannot be answered in the political center, such as whether health care should be a right or a privilege, or whether health care resources should be allocated based on ability to pay or medical need.
- Market failure was not recognized as the wellspring of our system problems. When it was agreed to "build on the strengths of the present system" instead of more fundamental reform, corporate stakeholders and their lobbyists found willing legislators to craft centrist "remedies" which could be sold to the public as reform. But the various incremental tweaks of our existing system, such as employer and individual mandates, have failed over the last 20 or 30 years to remedy cost, access and quality problems. In the absence of real health care reform, we can now expect these kinds of unfavorable outcomes in coming years:
 - Soaring costs without effective price controls throughout the system.
 - Managed care fails to control costs or improve quality.
 - Persistent financial and other access barriers for many millions of Americans.
 - Growing backlash by physicians and consumers.
 - Gaming of private plans and adverse selection in public plans.
 - Consolidation among hospitals sustaining high prices.
 - Increased cost-sharing for employees as employers cut back

benefits. • Continued high levels of inappropriate and unnecessary care. • Added bureaucracy and waste in an even more fragmented and dysfunctional system.

We have yet to learn that an unfettered health care marketplace can only perpetuate our problems, not fix them. Most industrialized nations have learned this many years ago, and are able to achieve better quality of care with improved outcomes for their populations even as they spend much less on health care than we do. We have to conclude that a larger role of government will be required to assure real and sustainable health care reform.

There is a fix in plain sight for our problems -- single-payer financing coupled with a private delivery system. The private insurance industry has outlived its usefulness, and is only being kept alive by government subsidies, whether by overpayments of private Medicare plans or this latest provision in the PPACA to pay out nearly half of a trillion dollars in subsidized premiums for their inadequate coverage.

When will we have the political will to face up to our real problems in health care and show that the democratic process can still work?

Extracts from Dr. Geyman's new book

Hijacked

The Road to Single Payer in the Aftermath of Stolen Health Care Reform

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