



# Health Care for All - Washington

An Information Pipeline for Members and Friends of Health Care for All-Washington  
Formerly known as HealthCare2000

## What Should Congress Do?

by Sarah K. Weinberg, MD

Few reading this newsletter would disagree the health care system and payment mechanisms in the U.S. are broken. To summarize: we spend twice as much as the average per capita of other rich nations and we have worse health statistics, in general, than all of them. To make our system better we need to do three things:

1. **Figure out why our system performs so badly**
2. **Look at how other nations have achieved better results**
3. **Pick one system and work to implement it in the U.S.**

This report is basically a quick summary of a book recently published by T.R. Reid: "The Healing of America". He has done a beautiful job of writing what I wish I could have written.

### Why does the American health care system perform so badly?

When we discuss this fact, we tend to shake our heads dolefully... and

**"We need to pick ONE system and then work to implement it."**

then dive into minutiae of the myriad failings of our chaotic non-system. Although all these failings are intertwined, we have no overarching controls to enable changes for the better without severe unintended consequences. Mr. Reid instead focuses on the fact that of four possible types of health care coverage systems, the U.S. has all four in operation and they are incompatible. All the other rich nations have picked one system and worked to make the chosen system

function well. They're also constantly tinkering with their systems to improve them.

### How have other nations achieved better results?

The real meat of Mr. Reid's book is a presentation of the four kinds of health care systems in use in the rest of the world. Let's look at them:

1. **The Bismarck model.** Named after Otto von Bismarck, the German leader who created the system in the 1880s, this system is

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**October - December  
2009**

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**Health Care for All - Washington advocates for affordable comprehensive health care coverage for all Washington residents implemented through a unified financing system.**

### **ANNUAL MEETING**

1:00-4:00 pm  
 Sunday  
 November 15, 2009  
 In the Sky Lounge at  
 Horizon House  
 900 University St.,  
 Seattle.

# Health Care for All- Washington

October - December 2009

P.O. Box 30506  
Seattle, WA 98113-0506

Seattle phone ..... (206) 323-3393  
Toll-free ..... (877) 903-9723  
E-mail: . info@healthcareforallwa.org  
Web site: www.healthcareforallwa.org

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Vice-President ..... Sarah K. Weinberg,  
MD, FAAP  
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# Message from Our President

## Reform: Not in Our Best Interests

I read the first 200 some pages of HR 3200, America's Affordable Health Choices Act of 2009, the core of the health care reform proposal prepared by three committees in the House of Representatives in Washington, D.C. This package outlines the mechanics of the Health Insurance Exchange and the Public Option.

First, let me explain what the Health Insurance Exchange will do. Private, for-profit insurance companies will be able to bid on service areas throughout the US in the hope of winning a contract to offer individuals and small businesses a four-tiered health insurance plan. A qualifying person or business will be able to enroll into one of four plans, that is to say, the Basic, Enhanced, Premium or Premium-Plus plan, depending on how much money is at the enrollee's discretion to pay for any one plan. Since this proposal mandates purchasing insurance as well banning pre-existing conditions, you most likely will have guaranteed issue of coverage. Let's say that you subscribe to a plan and receive a quote on how much the policy will cost you. After reviewing the benefit package and the premium, you may find that the cost is more than you expected. But don't worry. Within HR 3200 there is a provision detailing how you can apply for "affordability credits" to help pay for the aggregate.

Or, you can enroll into the Public Option, if you qualify. (However, most people offered insurance by their employers will NOT qualify.) Like the Health Insurance Exchange, you will have your choice of plans within the four-tiered scheme and you will have your choice of doctor within the preferred provider structure as well.

Sounds like a pretty good deal, doesn't it?

Well, actually no. The Congressional Budget Office concluded that of the \$1 trillion that it would take to roll out this reform package, \$700 billion of it would go to subsidies. Remember the affordability credits I mentioned a few seconds ago? The subsidies don't go to the enrollees, but rather to the insurance company the enrollee has chosen. In other words, pre-existing conditions won't disqualify you from getting insurance, but your age will be used to calculate the amount of premium that you have to pay for your desired policy. Keep in mind, too, that you are now required to buy insurance that you may not be able to afford, which puts a little twist on the title of the proposal just a bit. Or you may be granted "permission" to remain uninsured – tens of millions of Americans and all illegal aliens will be in this category. This is



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## Legislative Action Committee

By Mary Margaret and Paul Pruitt, Co-Chairs

### California, Vermont, and... Washington?

Almost fifty years ago, with strong leadership from then-Premier Tommy Douglas, Canada's Saskatchewan Province launched its Medicare – universal health care coverage. Recently Mr. Douglas won a contest run by the Canadian Broadcast Company to name “The Greatest Canadian”. Canadians still revere the man who brought them their national health insurance.

Is an American legislator in California, Vermont, or even Washington destined for equal distinction? Monumental corporate influence on our national leaders makes individual state initiatives the more possible and logical means for achieving health care coverage for all. California and Vermont have already passed bills to establish single payer systems to provide all residents with quality health care. The governors of both states vetoed the bills, but neither will be running for another term. Michael Corcoran wrote in *The Christian Science Monitor*: “... Vermont may be the state best suited to tackle single payer. According to a study commissioned by the Vermont legislature in 2006, Vermont would save \$5.1 million a year if it switched to single payer.”

Two measures have been introduced in Congress that would allow states to succeed in achieving universal health care without a national plan. Here in Washington State, we must consistently face the need to communicate again and again and again to our state legislators the moral demand that health care is a right, and the indisputable fact that a government funded, privately delivered system is the health care system that is most affordable and inclusive.

Working at the state level may seem like the “long way around”, but it may, in the end, be the best way to achieve the goal to which we are committed.

## Outreach Committee

By Ruth Knagenhjelm &  
Chuck Richards

Thanks to health care reform being in the forefront of the national scene this summer, there have been plenty of opportunities for outreach to the general public as well as to our legislators. New Action Teams have been established and more people brought in as a result. Other groups that also advocate for real health reform and/or single payer have collaborated with us.

After the May 30 Concerned Mothers for Health Reform march, a coalition entitled United for Single Payer was formed. HCFA-WA has been a major player in this new coalition.

HCFA-WA now has ten Chapters, Action Teams and other groups in various stages of organization and membership size. These groups are scattered across the state, and give our organization a foundation that will be needed in state action on health care reform in the future. (Whatever comes out of Congress will not be the last word, that's for sure.) Most of these groups have sent in reports of their activities over the summer, summarized below.

**Eastside:** The major event was a booth at the Mercer Island Summer Celebration! Weekend July 11-12. We collected 280 signatures in favor of single payer or a Medicare-like public option open to anyone. Copies of these signatures were given to both Senators and Rep. Reichert. We cooperated with Organizing for America (OFA) on a rally on Mercer Island late in August with a turnout of about 50 people.

**North Seattle:** Four members met with staff in both Senators' offices early in September. Mary Conway (Sen. Murray's staff) alerted us that we need to explain the importance of continued viability of Medicare. She said today's students think it will be gone by the time they need it. She pointed out that Medicare lacks lobbying support. Nate Caminos

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based on highly regulated non-profit private insurance funds. Most people join a fund through their employer, paying some kind of payroll tax, enrollment fee, or premium. The unemployed have their enrollment paid for by the government in some fashion, but essentially everyone is enrolled and covered. The benefits to enrollees and payment of providers are strictly regulated so the funds have no incentive to get rid of the sick. The funds are more successful if they have large numbers of enrollees, so in most nations with this kind of system there is strong competition, based on quality of service to the enrollees, to attract a large population. Germany, Switzerland, the Netherlands, France, and Japan all have variations of this kind of system.

**2. The Beveridge model.** Named after William Beveridge, the British social reformer who inspired the National Health Service in Great Britain during the latter half of World War II, this system is a government owned and run system. The entire system is paid for from general taxes, and there is no cost to the individual when seeking health care. In general, nearly all health care is provided through the system by providers on salary. However, there is a gray market of private care privately paid for on the side (but it only amounts to about 3% of total health spending in Britain). Benefits are decided by the national governing board, advised by a panel of experts. Italy, Spain, much of Scandinavia, and Hong Kong all have variations of this kind of system.

**3. The Douglas model.** Mr. Reid did not name this model after Tommy Douglas, but he should have. Tommy Douglas was the Premier of Saskatchewan in the 1940s. He led Saskatchewan to the first province-wide health coverage system based on tax-funded government payments for health care delivered by private providers. This system first covered all hospital care in Saskatchewan in 1947, and then was expanded to cover outpatient care in 1961. The program, called Medicare, was such a success that all the other provinces joined in the 1960s. This national health insurance model is used in Canada, Taiwan, and South Korea.

**4. The “You’re On Your Own, Baby!” (YOYO) model.** This is the model in the third world, where any kind of health coverage is either rare or geographically very limited. People get only that health care they can find and pay for out-of-pocket (OOP). To quote from Mr. Reid: “In rural regions of Africa, India, China, and South America, hundreds of millions of people go their whole lives without ever seeing a doctor.” OOP payments make up 91% of total health spending in Cambodia, 85% in India, and 73% in Egypt. In the United States, 17% of total health care costs are OOP (and these numbers pre-date 2000 – they’re probably higher now).

### **The four models in the United States**

All four models exist in the United States, and part of our extra high health care costs relate to the bureaucracy of dividing our population among not only these 4, but multiple variations within each kind of system. Examples:

1. Employer-provided health insurance. This is an example of the Bismarck model, but we have no overall regulation of the various insurers to make them more uniform, and we have allowed for-profit companies to get into the mix. The insurers have all figured out that they can make more money and/or avoid adverse selection by denying coverage to anyone who is sick or who is likely to become sick. This gaming of the system completely distorts the original intent, namely, to cover medical costs for those who need care.
2. Military health care, the VA system, and the Indian Health Service. These three programs are based on the Beveridge model, and they work quite well. Costs are low, and implementation of electronic medical records has been accomplished. Being able to get full medical information to the spot where the patient currently has need of it is vital considering the traveling nature of the military and veterans. Medical care throughout the system is much more uniform, and studies show the results in terms of better health are

(Congress, from previous page)

improved over the general public.

3. Medicare. The U.S. Medicare program, enacted in 1965 and given the same name as Canada's national health insurance program, is also modeled after Canada. Medicare has brought security to American seniors, who know that if they can just get to age 65 they will have health coverage that can't be taken away from them. Medicare Part A (hospital care) is funded by payroll taxes on employers and employees. Medicare Part B (outpatient care) is funded by a monthly premium deducted (in most cases) from the patient's social security pension. Medicaid is also a variation on this model, involving both state and federal funding and rule-making.

4. The uninsured and the underinsured. These people have the YOYO plan, and there are more than 50 million of them – more than 1/6<sup>th</sup> of the population. These are the people who line up in the rain in Virginia or Los Angeles for charity care by organizations that usually put on clinics for impoverished masses in the third world. These are also the people who crowd America's emergency rooms with problems large and small because they can't be turned away until someone has determined that they are medically stable. These are also the thousands of people who file for bankruptcy due to medical bills they can't pay.

### **We need to pick ONE system and then work to implement it**

If Americans want a better health care system that costs less than what we're paying now, we need to pick ONE of these systems, obviously not the YOYO model. How might this work?

**1. The Bismarck model.** If we were to choose this model, we would need to change the nature of the private insurers currently operating in the U.S. All would need to become non-profit, to remove the incentive to avoid the sick and all the distortions that causes in the system. They would have to be highly regulated and required to adhere to national standards of enrollment, premiums, benefits, payments to providers, and administrative paperwork. This process has been quite successful in Europe, and has NOT required moving away from fee-for-service payment of providers in order to keep costs down. (Note that the proposed complex diagnosis-related payment systems for outpatient visits would generate a whole new load of administrative paperwork.)

**2. The Beveridge model.** This is the least likely system for the U.S. to adopt, because it would require a complete government takeover of the health care delivery system. I can't even imagine how we could get there.

**3. The Douglas model.** It's a shame that when President Johnson managed to get Medicare passed in 1965 he didn't insist on covering everyone. It's a testament to the ideological blindness of businesses and the medical establishment at the time. This model could be implemented in the U.S. now essentially by passing HR 676, which would fix some of Medicare's problems and extend it to cover the entire population. It only took one year to implement Medicare in 1965, because it is a simple concept. Also, few seniors past working age had any health coverage at all at that time, so there was relatively little protest on the part of private insurers who weren't anxious to get a bunch of unhealthy new enrollees. To make such a change less drastic, Medicare for All could be implemented more gradually by lowering the age of eligibility in stages over a few years, allowing for adjustments to payroll taxes and/or other taxes to fund the program for a larger and larger chunk of the population. Children and Medicaid enrollees could be added at the start.

### **Summary**

Americans CAN learn from other rich nations, all of which have implemented health care systems that cover essentially everyone at reasonable cost with good health statistics and great satisfaction on the part of the population. What we need to do is to pick ONE system and then work to implement it over a relatively short time span.

Sadly, that isn't the direction in which the folks in the other Washington are going.

(Outreach, from page 3)

(Sen. Cantwell's staff) has never seen so much public interest focused on one issue. He thinks the focus now should be on getting a public option in the final bill, and he thinks single payer needs to be looked at.

**Olympic Peninsula:** We had a busy summer. 700 people attended the opening event of the Mad As Hell Doctors tour on August 22 in Sequim! We ran a full page ad in our local paper on August 27 advocating real health care reform. The ad had over 600 names signed on, and we're running a second ad with still more names. A meeting we sponsored at the Olympic Medical Center attracted a standing room only crowd. We provided over 50 copies of the "Health, Money and Fear" DVD which has been shown all over Clallam and Jefferson Counties.

**Pierce County Chapter:** Our summer was also busy. We coordinated a Tacoma rally on May 30 as part of the larger rally in Seattle that day. About 400 enthusiastic people turned out. On June 23 we collaborated with Washington Public Campaigns to present a panel discussing the need for campaign funding reform that would help Congress to be serious about real health care reform. At the end of July we were part of the Anne Feeney for Single Payer Concert, which raised \$500 to be used in local efforts to promote single payer health care reform. During August many members participated in congressional Town Hall meetings in the South Sound area. We joined the Mad As Hell Doctors caravan to Seattle on Sept. 8. We are planning to be at the Tacoma Film Festival Oct. 3, where "Health Money and Fear" will be shown. We will have an information table there. And on top of all this, we continue to work with the Tacoma City Council to encourage them to take action as a result of the overwhelming approval (70%) of the Health Care Access Resolution in 2007.

**South King County:** We have been meeting regularly. We have been involved in rallies and in informing the public during the summer: Strawberry Festival, Burien 4<sup>th</sup> of July parade, Cornucopia in Kent, farmers market in Des Moines, Auburn's Good Old Days.... Several of us also participated in

OFA's presentation of "Sick Around the World", the Mad As Hell Doctors event in Seattle, and Bite of Seattle. Ruth even got her HCFA-WA single payer sign clearly in view on TV at the OFA Rally at Westlake Mall on Sept. 13! And more....

**South Seattle/Renton:** We have done some outreach at farmers' markets, but we have decided that it would be more productive to contact organizations and ask them to contact our representatives as such. These contacts can also be asked if they would like health care presentations at their meetings. We have started an Excel database to monitor contacts that we have made in order to keep them updated on health care issues.

**Eastern Washington Chapter-in-Formation:** On June 30, three of us visited the Spokane offices of both Senators and of rep. McMorris-Rodgers. We promoted HR 676. On July 29 we collaborated with several progressive organizations to celebrate Medicare's 44<sup>th</sup> birthday at the Spokane County Courthouse. Sheriff Ozzie Knezovich visited briefly with us, as one of us dressed in a shorty hospital gown with plastic buns to demonstrate inadequate health care coverage and to promote HR 676. We got good radio and TV coverage. We had a great rally and evening forum on Sept. 9 as the Mad As Hell Doctors came to town. Emeritus member Dr. George Schneider's expertise with public relations resulted in great TV coverage!

**Single Payer Vashon:** We had a good meeting with Mary Conway (Sen. Murray's staff) on August 26. We had prepared carefully for the meeting, and felt that Ms Conway was quite attentive and engaged in our dialogue.



reform?

But here is the other factor that most people are only just now beginning to learn – there is no cost containment in the either of the main proposals coming from the House or the Senate. Take into consideration that we have a large segment of the population who are getting older, some of whom are experiencing more aches and pains related to age, illness and accidents. Without cost containment, premiums will continue to rise faster than inflation and subsidies will eat up an ever growing portion of the health care dollar. The trade-off will be a diminished quality of life not only for the enrollee, but also for governments that won't be able to generate enough sales tax revenue because folks can't afford to buy goods and services while honoring personal responsibility to their health. Last year Massachusetts experienced a 10% increase in health care inflation. And the Massachusetts model is supposed to be the model for the entire US? So, every year these subsidies will get more expensive.

America's Affordable Health Choices Act of 2009 sounds like a pretty expensive gift to the insurance industry.

Another thing to remember: the Public Option is just a provision in HR 3200; it is not a stand-alone bill. The Public Option is encased in a proposal promising the private, for-profit health insurance industry handsome financial gains. A retired UW public health policy professor friend of mine confirmed my suspicion the other day. I said that this reform package is nothing but a trap to get more business and money for the insurance companies. He said that is all it is intended to be.

Larry Kalb, President, HCFA-WA

## We Need Your Help!

**Health Care for All—Washington**, despite being an all-volunteer organization, relies on membership dues and donations to promote the cause effectively. Please join in helping to make our movement even stronger.

Membership donation \_\_\_ \$35 \_\_\_ \$50 \_\_\_ \$100 \_\_\_ other. Organization level \_\_\_ \$250 \_\_\_ \$500

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## Announcements

### **Republican Representatives in the Washington State Legislature to Hold Town Hall Meetings on Health Care Solutions**

There are four of these, one of which (Bellevue) will predate this newsletter, unfortunately. The other three are:

**Burlington** Monday, October 5, 6:00-8:00 pm, Burlington-Edison High School PAC, 301 N. Burlington Blvd.

**Spokane** Wednesday, October 7, 5:30-7:30 pm, Mead High School, 302 W. Hastings Road.

**Spokane** Saturday, October 17, 2:00-5:00 pm, Museum of Arts & Culture, 2316 W. First Avenue.

### **Bus Trips from Spokane to Nelson, BC for shopping and visits to Canadian Doctors and Pharmacies**

Inland Empire Tours provides these trips. Their next one-day trip is October 21, leaving Spokane at 7:30 am. Reservations and payment (\$69) should be made by October 9. Details about medical services are available at: 1-888-654-8367. Inland Empire Tours website: [www.ietours.net](http://www.ietours.net).

### **South King County Action Team Meeting Date**

October 17, 2009, 2:30-4:30 pm, Burien Library. Send in agenda items to Ruth Knagenhjelm.