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Health Care Reform, Obama Style

By Stephen Lendman
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On February 26, The New York Times headlined: "Obama Offers Broad Plan to Revamp Health Care….a (down payment $634 billion "reserve fund" for the next decade) toward his goal of covering the uninsured, and he would pay for it in part by cutting federal payments to hospitals, insurance companies and drug companies." More on that below.

Details so far are sketchy, but here's what The Times and others reported:

— $634 billion as a "down payment….additional funding will be needed;"

— increased prescription drug premiums for higher income Medicare recipients;

— $6 billion for cancer research to the National Institutes of Health (NIH), up from last year's $5.6 billion;

— faster FDA generic biotech drug approvals;

— increased access to family planning services for low-income women on Medicaid;

— no information on how the uninsured will be covered with details to be worked out later with Congress; one idea is make it mandatory, but tell that to people who can't afford it or enough of it;

— drug makers to be required to give Medicaid at least a 22.1% discount, up from the current 15.1%;

— payment cuts to insurers, hospitals, drug makers, home health agencies, and perhaps doctors;

— "rebalancing the tax code so that the wealthiest pay more," but not enough;

— the goal is reduce costs and achieve "universal coverage;" saying it is one thing, achieving it another;

— eliminating subsidies paid to insurers selling Medicare Advantage plans and opening the process to competitive bidding; and

— in introducing Kansas governor Kathleen Sebelius as HHS secretary and Nancy-Ann DeParle as White House Health Reform director, Obama proposed "affordable health care for every American" while acknowledging no "silver bullet" exists to provide it, but he'll be "flexible" to achieve it, or at least say he is while intending to do nothing to offend a powerful industry.

Sibelius and DeParle – Obama's "Health Reform" Dream Team

After defense (at over $1 trillion annually with all categories included), HHS (Health and Human Services) is the nation's largest federal agency based on its FY 2009 $737 billion budget, of which Medicare and Medicaid comprise 85% of the total. In 1995, Social Security became an independent agency and ranks third with a FY 2009 $695 billion budget.

With little Washington experience, Kathleen Sebelius will head HHS. Her official biography states:

— in 2003, she became Kansas' 44th governor, and in 2006 was reelected to a second term;

— her "commitment (is) to growing the Kansas economy and creating jobs, ensuring every Kansas child receives a quality education, (and) improving access to quality, affordable health care;"

— in 2005, Time magazine named her one of the nation's top five governors;

— she's served on the National Governors Association Executive Committee and as co-chair of the National Governors Association initiative, Securing a Clean Energy Future; and

— she's the immediate past chair of the Education Commission of the States as well as past chair of the Democratic Governors Association;

She's also a former Kansas Trial Lawyers Association director (1977 – 1987) and Kansas Insurance Commissioner (1994 – 2002) before being elected governor. Her public statement on health care states: "We are stronger as a nation when our people have access to the highest quality, most affordable health care."

Kansas Republican Party executive director Christian Morgan responded by saying:

With her appointment, Sibelius "leaves behind a long string of broken promises. Chief among these is….to provide health care reform to Kansans – but none ever occurred. Since the governor took office, the number of people covered by commercial health insurance has decreased by approximately 15% while the number covered by Medicaid (rose) 30%. At the same time, the number of uninsured….remained steady. The governor has done nothing to reduce the number of people without health insurance in this state – instead there has been a large increase in the (Medicaid population). She offered no initiatives to make health care insurance more affordable, nor has she created her own plan. (It's) a frightening indication of what is to come" when she's HHS Secretary in Washington.

Morgan left out Sibelius' pro-business agenda of supporting cuts in state corporate income and property taxes and repealing its estate and corporate franchise tax to make Kansas more attractive for investment.

The Wall Street Journal called her administration "notably bipartisan….elected to her first term with a former Republican businessman as her running mate (and to her second) with the former Republican party chairman."

Still, as state insurance commissioner in 2001, she blocked the Indianapolis-based Anthem Insurance Cos.' offer to buy Blue Cross – Blue Shield of Kansas after concluding that premiums would rise under its ownership. She prevailed when the state's high court

overturned a lower court ruling that she exceeded her authority. Ever since, she used that victory to promote herself as a staunch consumer advocate who'd stand up to powerful entrenched interests.

Doing it in Kansas is one thing. Washington is another matter where all previous health care reform efforts were defeated, and no wonder as Cornell University Professor Emeritus Rosemary Stevens explained. In her analysis titled: "Health Reform in 2007: What Can We Learn from History," she stated that:

"There is nothing simple and tangible called 'health reform.' The history of American health care is as messy, disjunctive, and complex as is our present health care system. Battalions of lobbyists have argued for different reforms, together with platoons of politicians, skirmishing professionals and a battling throng of others, representing a wide variety of agendas. There is no single narrative of health care….that points to a logical way ahead" or new ways to achieve now what always before failed because reform efforts couldn't muster a congressional majority given the stranglehold business has over lawmakers.

Stevens reviewed our history of successes but overall failure to provide quality coverage for all:

— as early as 1798, every American ship arriving from a foreign port had to pay 20 cents a month for health care for each merchant seaman;

— the same 1798 legislation mandated that federally-funded Marine hospitals be set up, and by 1802 they operated in Boston, Norfolk, VA, Newport, RI, and Charleston, SC with plans for more;

— in 1916, compensation was provided for injured federal workers as in-or-outpatients at Marine hospitals, soon to be called US Public Health Service (PHS) ones;

— during and after WW I, PHS added new hospitals for veterans, transferred in 1921 to the new Veterans' Bureau; others remained in the PHS;

— since the 1950s, phasing out PHS hospitals became policy; eight remained by 1981, but the federal model remains with little teeth or funding for enforcement;

— as early as the 19th century, state and local governments were also involved; they set up mental hospitals for "dangerous and unwanted individuals" in institutions isolated from urban areas; general hospitals also, including special ones for tuberculosis, miners in Pennsylvania, and in cities for the uninsured poor; in some cases, religious or nonsectarian nonprofit organizations ran them;

— in 1903, the first (public) hospital census showed public subsidies covered 10% or more of their operating costs in 13 states, with wide variations from one to another; concern for a "proper governmental role in hospital care was largely a 20th century phenomenon," when the phrase "socialized medicine" gained it added traction;

— "cooperative public – private ventures" also played a role as early as 1751 when Benjamin Franklin got a state of Pennsylvania grant to establish the private nonprofit Pennsylvanian Hospital; many other similar examples happened later at a time when there was less of a distinction between "public" and "private;"

— in the late 1940s, cooperative rural hospitals were established with the help of federal Hill – Burton grants.

US health reform efforts go back to "the health insurance movement of 1913 – 1918" – spurred by the American Association for Labor Legislation to improve industrial workers' health and welfare, and supported at the time by the AMA and other organizations. In 1917, 15 states "introduced a standard health insurance bill (and) eight states set up commissions to study the issue" – to no avail as Colin Gordon's book explained, "Dead on Arrival." Then and later, "proposals were weak on practical details and generated considerable confusion, even among their supporters."

So much so that by 1920, the health insurance movement was dead, despite the poor response to the 1918 – 1919 influenza epidemic. After WW I, doctors settled into private practice, medical specialties expanded, community and university hospitals proliferated, and government's role "was to pick up the slack."

In the 1930 and 1940s, government-sponsored health insurance again surfaced – either in the form of federally-subsidized state programs or through Social Security. By then, the issue was contentious for reasons including medical opposition, a lack of clarity on the advantages or disadvantages for business and labor, private health insurance as an alternative, and concern about "too much government and states' rights."

By 1950, views were changing, given the "rapid growth of (employer-provided) private health insurance, complemented by new and expanding hospitals and a national commitment to (federally funded) biomedical research in cancer and other areas." But what about the retired, disabled, unemployed, or others who for various reasons were uninsured. After years of debate, Medicare and Medicaid emerged in 1965.

Medicare covers the elderly, people with disabilities, and with end-stage renal disease. Medicaid is for the uninsured whose incomes fall below state-specified levels. "In the language of the time, the elderly and poor were to be 'brought into the mainstream.' " In theory at least, they'd be "one, undifferentiated, relatively egalitarian health system in terms of patient status…."

However, fulfillment failed its promise. Medicaid and Medicare both had unexpected cost overruns, corruption and fraud charges, and in some states "a backlash against allegedly high, state-mandated income levels for (Medicaid) eligibility." Calls for "reform" resulted while at the same time employer-based insurance weakened "in the face of rising costs (and) shifts in the structure and nature of the job market." In 1993 – 1994, the Clinton administration addressed the issue but failed so today we're approaching 50 million uninsured, tens of millions more underinsured, and many uninsured at some portions of each year.

"The history of health insurance proposals in the United States is….a history of failure if its goal (is to cover) the whole population." However, Medicare and Medicaid so far are successes for having "transform(ed) the lives and health of millions of individuals." Other public health services include SCGIP (the State Children's Health Insurance Program), emergency room access, EMTALA (the Emergency Medical Treatment and Active Labor Act), government-supported clinics, and the VA for veterans.

Yet all these programs "call out for reform – from relieving excess burdens on, and

inappropriate use of emergency rooms (to) getting affordable insurance to all those who can pay for it," but what about for those who can't.

Expanding access is one issue. Creating "coordinated care and service organizations" another. "Expanding access to insurance alone does not ensure more efficient or effective care. Quite the reverse in some instances." Medicare and Medicaid "led to huge changes in disconnected aspects of health care provision," including a new nursing home industry, encouraging hospitals and doctors to be more business oriented, and pushing public hospitals to close since Medicare and Medicaid covered seniors and the poor.

By the 1980s, nonprofit hospitals were almost extinct. They and private ones "competed in a single, profit-oriented" market treating health care like any other commodity. Mental health services also suffered when state hospitals for its treatment began closing. Between 1955 – 1973, California reduced its mental hospital population by three-fourths. The chronically ill ended up in nursing homes or all too often on city streets or in prisons.

Today as a result, the "uninsured or underinsured and medically needy patient who is without a family (for help) is at a particularly high risk in the United States." For decades, health reformers addressed the issue without success. So far, reform has been an impossible Gordian Knot to cut.

The 1973 HMO Act tried through federally-subsidized nonprofit health maintenance organizations. By the 1990s, they "became synonymous with managed care" and all the backlash it created by having "gatekeeper" bureaucrats make health decisions, not doctors.

Stevens stressed "the extraordinary hold rhetoric and deep fears have held in health policy debates" over the "dangers of big government" under "socialized medicine," unmindful that it works very well, if imperfectly, in all other western states – where their populations dread the idea of not having it.

In America "inegalitarianism lingers on." Despite the successes of Medicare and Medicaid, little sentiment where it matters most is for similar coverage for all under a single-payer system. The usual arguments say:

— "reform" is code language for "rationing;"

— government will end the right to choose providers; and

— "socialized medicine" will result, a "dreaded" notion in a nation championing the "free market" right to plunder at the expense of people.

In the end, debate creates controversy and produces failure, so another effort to extend quality care to all dies. Changing it will require "lay(ing) aside old doctrines, bugaboos and fears" – to achieve what's been impossible up to now, so don't hold out hope that Obama will do it, or even try, despite all his high-sounding rhetoric saying otherwise. As long as the business of America is business, profits will always trump need, and today more than ever given the nation in economic collapse and most federal revenues going for militarism and to Wall Street.

Look for Nancy-Ann DeParle, Obama's new "health czar," to assure that "health reform" efforts better industry profits, not human health, and a glance at her background shows

why. From her close ties to the industry she'll oversee, it wreaks conflict of interest and privilege, not popularism:

— in 1987, appointed Tennessee Commissioner of Human Services overseeing a 6000-employee agency responsible for cash assistance, food stamps, child welfare, and adult rehabilitation services;

— from 1993 – 1997, as Associate Director of the Clinton White House Office of Management and Budget overseeing health care policy and other budget issues; and

— in 1997, as Administrator of the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services.

Her private sector experience includes employment as managing director at CCMP Capital Advisors, senior advisor at JP Morgan Partners, the Covington & Burling law firm, the boards of Cerner Corporation, the Robert Wood Johnson Foundation, the DaVita Corporation, Medco Health Solutions, Boston Scientific, Triad Hospitals, as well as being a health care systems professor at the Wharton School, University of Pennsylvania.

Even The New York Times remarked that "Obama (chose) to overlook Ms. DeParle's business ties that have a direct stake in the health-care debate….the White House instantly faced questions about whether her appointment was skirting the spirit, if not the letter, of the president's tough conflict-of-interest policy."

On taking office, Obama laid out rules barring executive branch officials from working on issues "directly and substantially related" to their employers or former clients for at least the past two years. Appointing DeParle crosses the line, even though she's described as competent, non-ideological, honest, and pragmatic. Nonetheless, when asked, White House Press Secretary Robert Gibbs said the administration doesn't view her directorships as a conflict of interest. The president "has confidence in her and her abilities as part of the health care reform effort here."

Perhaps he'll reconsider given the fallout from several of his other appointees, forced to decline for failing to pay back taxes, another with the same problem now Treasury Secretary, one more as well who says he'll pay up, and perhaps other skeletons in all their closets yet to come out.

Big Pharma (PhRMA) on Obama's Plan

The Pharmaceutical Research and Manufacturers of America (PhRMA) is the lobbying and trade group for "the country's leading pharmaceutical research and biotechnology companies" under its president and CEO, former congressman (1980 – 2005), Billy Tauzin.

In a March 4 CNBC interview, he expressed optimism over Obama's plan. Think about what it does, he stated:

"This plan talks about providing comprehensive health insurance to people who don't have it – that means to patients who can't take our medicines because they can't afford it. (About) $650 billion spent to better insure Americans for the products we make. That ought to be a very optimistic and positive message for everyone" in our industry.

"Think about this: Almost half of the prescriptions that are written today go

unfilled….because people don't have adequate insurance – they have no insurance, or their insurance doesn't cover our products the way it covers hospitalizations."

The more people insured, the more drugs sold so providing them cheaper is good business – more volume, greater profits. The same holds for insurers if universal coverage is required – more customers, greater profits even at lower per policy premiums. Depending on whatever final plan emerges, look for health care providers to get behind this one, and if so, expect people once again to be betrayed.

The White House Health Reform Forum

On March 5, the East Room of the White House was center stage for the first of a series of meetings "to enact comprehensive health reform by the end of this year," according to the president who led the discussion for a who's who of attendees, including politicians, lobbyists, industry representatives, insurers, PhRMA, physicians' groups, labor, and a handful of reform advocates. Below is a partial listing from the roughly 150 participants:

— AARP president, Bill Novelli;

— AFL-CIO assistant to the president for governmental affairs, Gerry Shea;

— America's Health Insurance Plans president and CEO, Karen Ignani;

— American Cancer Society president, Daniel Smith;

— American Heart Association president, Timothy Gardner

— American College of Physicians president, Jeff Harris;

— American Hospital Association president, Rebecca Patton;

— American Medical Association president, Nancy Nielsen;

— Blue Cross Blue Shield Association CEO, Scott Serota;

— Families USA president, Ron Pollack;

— General Mills president and CEO, Ken Powell;

— National Association of Manufacturers president and CEO, John Engler;

— National Association of Independent Businesses president, Dan Danner;

— National Association of Public Hospitals president, Larry Gage;

— Pfizer CEO, Jeffrey Kindler;

— PhRMA president and CEO, Billy Tauzin;

— Physicians for a National Health Program president, Dr. Oliver Fein;

— Planned Parenthood Federation of America president, Cecile Richards;

— Robert Wood Johnson Foundation president and CEO, Dr. Risa Lavizzo-Mourey; and

— US Chamber of Commerce president, Tom Donohue.

Meetings like these are for show, whereas deals happen behind closed doors to protect the interests of a powerful industry that the Washington Post describes as "one of the mightiest political forces in Washington, spending nearly $1 billion on lobbying and contributing $162 million to candidates of both parties over the past two years." It gave Obama $19 million for his campaign and now wants payback for its investment. It's coming and will be right in line with its wish list.

For one thing, the White House and key congressional members ruled single-payer Canadian-style coverage "off the table," according to Senate Finance Committee chairman, Max Baucus. Physicians for a National Health Program's (PNHP) co-founder and director, Dr. David Himmelstein, responded:

"The president once acknowledged that single payer reform was the best option, but now he's caving in to corporate healthcare interests and completely shutting out (chances for) single reform. The majority of Americans favor (it), and it's the most popular reform option among doctors and health economists…."

In addition, "he's appointed as his health reform czar Nancy-Ann DeParle, a woman who has made her living advising health care investors and sits on the board of many for-profit firms that have made billions from Medicare. Her appointment – and the invitation list to the healthcare summit – (are) clear signal(s) that the administration plans to propose a corporate-friendly (plan) that has no chance of actually solving our health care crisis." It likely will make it worse and shows this president serves the powerful, not the people. But based on his ties to Wall Street, we already know that.

PNHP is an independent, non-partisan, voluntary organization supported by dues, contributions, and progressive foundation grants. It accepts no funding from health care industry companies or other for-profit entities. Since 1987, its 15,000 members have advocated for universal, comprehensive, single-payer national coverage from chapters across the country. It's the only national physician organization exclusively dedicated to achieving it. It believes that "high-quality health care is a right of all people and should be provided equitably as a public service rather than bought and sold as a commodity."

Its current president, Dr. Oliver Fein, calls the need for an "expanded Medicare-for-All….more urgently needed (than ever given the severity of the) economic recession….As long as we rely on private health insurers, universal coverage will be unaffordable," and growing millions will lose out.

"Mandates to buy private insurance are not the answer. Experience" shows they don't work, either to achieve universal coverage or contain costs. They also "cherry-pick healthier patients and insist on more than their share of payment."

Medicare-for-All is the only solution, and cost savings will be impressive – around $400 billion annually from reduced administrative overhead. With single-payer national coverage, lifelong, high quality, comprehensive and affordable coverage can be assured for everyone at much less than is spent today.

An Annals of Internal Medicine study shows 59% of US physicians support it, and in a recent

AP poll, 65% of respondents backed universal government-run coverage financed by taxes. In the 110th Congress (January 2007 – January 2009), Rep. John Conyers and 93 co-sponsors endorsed HR 676, the US National Health Care Act, the most of any health reform legislation so far but far short of a majority in the House, let alone the Senate where 60 votes are needed to assure passage.

Dr. Fein is a practicing internist and Professor of Clinical Medicine and Clinical Public Health at Weill Medical College, Cornell University, where he also serves as Associate Dean responsible for the Office of Affiliations and the Office of Global Health Education.

He's a longtime advocate for Medicare-for-All. It works. Private for-profit ones don't, except for the dwindling few who can pay the increasingly unaffordable costs – for insurance and all forms of care. The rest are out of luck, on their own, and not included in Obama's proposed "change" – for the usual empowered interests the way it always works in America. So at the other end of the health "reform" debate, the title of Jill Quadagno's 2005 book aptly explains that we'll remain "One Nation Uninsured" without the single-payer kind that matters.

Automatic Savings Under Medicare-for-All

Private insurers add about 15% to health care costs. Under Medicare/Medicaid, it's 2% for a major saving over insurer payments that cost more and provide less. They game the system to crowd out the sick, cherry-pick the healthy, and find ways to choose cheaper treatments over expensive ones, usually to the detriment of patients paying high premiums but losing benefits when they need them most.

Medicare-for-All solves all problems except one – the influence of a powerful industry throwing its weight into the fight to assure in the end it wins. So far, Obama backs it – big insurers, PhRMA, hospitals, the AMA, and other health care providers with enough clout to matter. With those kind of odds, consumers are outgunned, outmatched, and have little hope that this time will be different.

Media Blackout of Single-Payer Healthcare

More evidence is from a new Fairness & Accuracy in Reporting (FAIR) study showing that "in the week leading up to (the White House forum, there was a) media blackout on single-payer healthcare." The major print and electronic media hardly mentioned it, and when they did, it was in hostile op-eds and disparaging on-air comments. Not one single-payer advocate appeared on television, not even on PBS' News Hour With Jim Lehrer that gave plenty of time to the opposition.

Comments from CNN's medical correspondent, Elizabeth Cohen, were typical. On February 26, she said:

"If in time, Americans start to think what president Obama is proposing is some kind of government-run health system – a la Canada, a la England – he will get resistance in the same way that Hillary Clinton (was treated) when she tried to do this in the '90s."

Instead of explaining both sides fully and accurately, the major media ignore public opinion, filter news, suppress truths, marginalize dissent, and support business as usual for the powerful. As a result, Medicare-for-All advocates are shut out and at times ridiculed for suggesting what all other western nations know works best, costs less, and delivers the highest quality health care to everyone – something millions of Americans never had nor will

get from an Obama administration, committed to the rich at the expense of the rest.

Stephen Lendman is a Research Associate of the Centre for Research on Globalization. He lives in Chicago and can be reached at lendmanstephen@sbcglobal.net.

Also visit his blog site at sjlendman.blogspot.com and listen to The Global Research News Hour on RepublicBroadcasting.org Monday through Friday at 10AM US Central time for cutting-edge discussions with distinguished guests on world and national issues. All programs are archived for easy listening.

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About the author:

Stephen Lendman lives in Chicago. He can be reached at lendmanstephen@sbcglobal.net. His new book as editor and contributor is titled "Flashpoint in Ukraine: US Drive for Hegemony Risks WW III." http://www.claritypress.com/LendmanIII.html Visit his blog site at sjlendman.blogspot.com. Listen to cutting-edge discussions with distinguished guests on the Progressive Radio News Hour on the Progressive Radio Network. It airs three times weekly: live on Sundays at 1PM Central time plus two prerecorded archived programs.