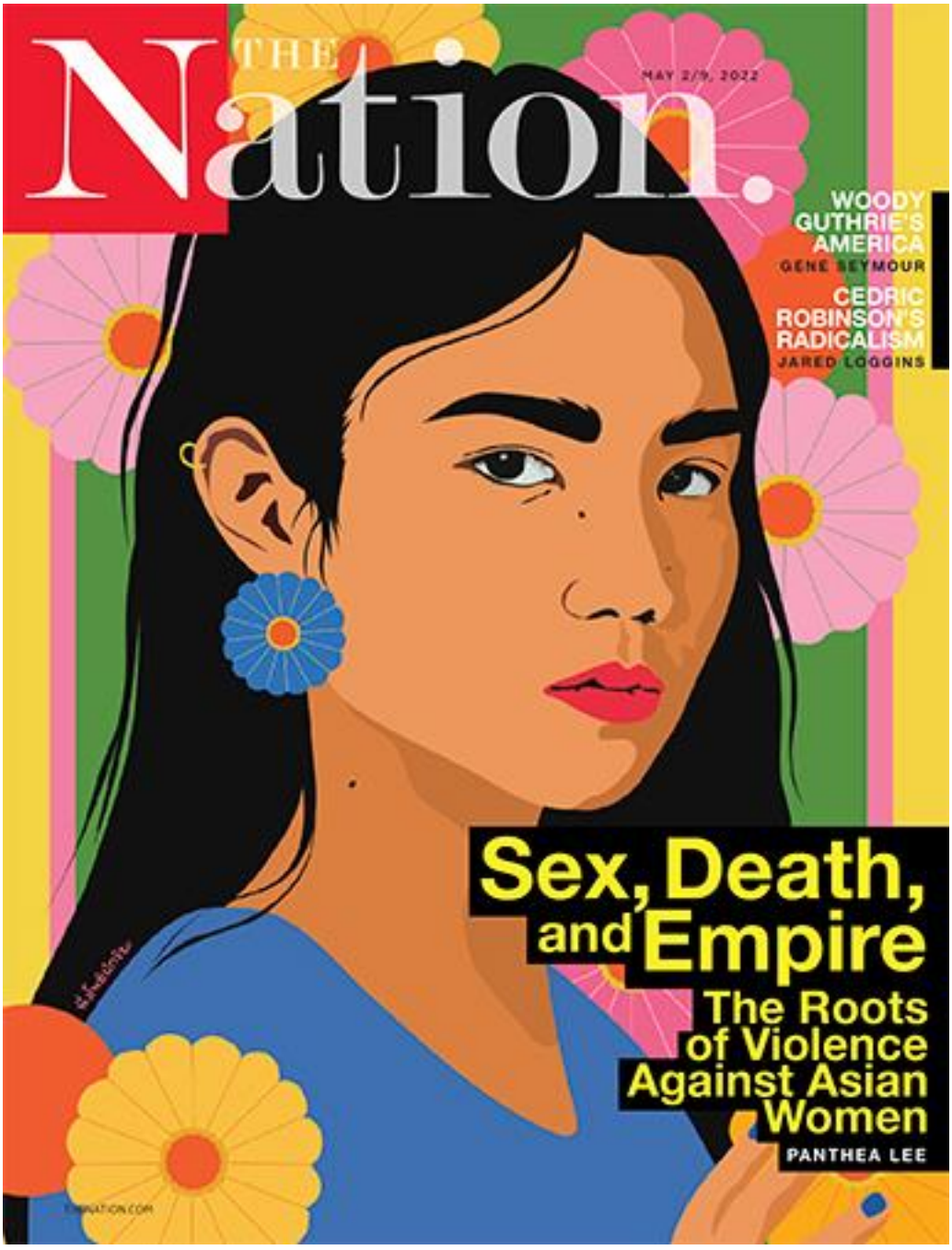
Medicare for All Is Not Enough

Communities, not corporations, should own our most vital health care assets.

By David U. Himmelstein, Steffie Woolhandler, Adam Gaffney, Don McCanne and John Geyman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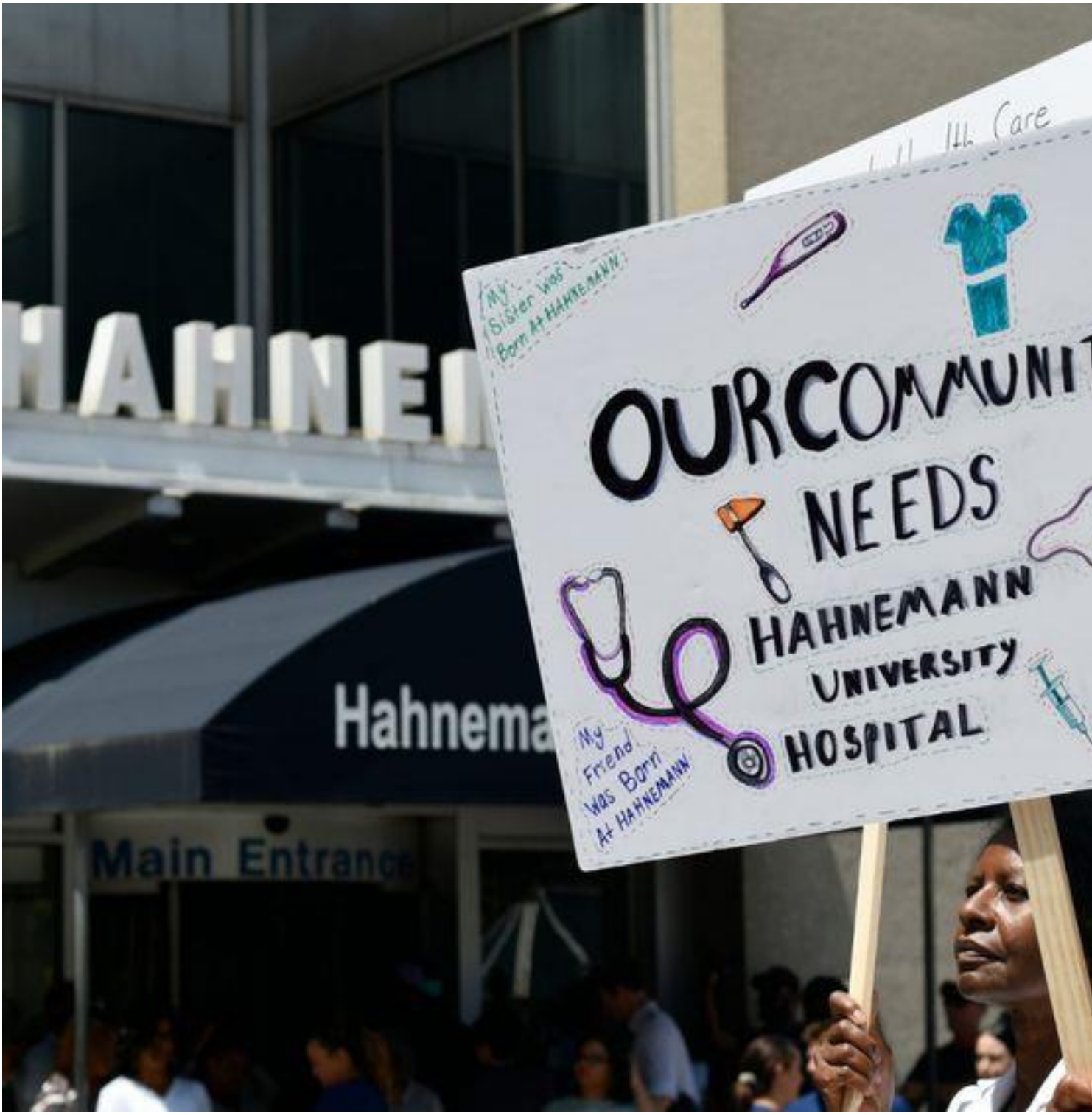

Hospital workers, union members, and local politicians protested the imminent closure of Hahnemann University Hospital at a rally in Philadelphia on July 15, 2019. *(Bastiaan Slabbers / NurPhoto via Getty Images)*

We have long advocated for single-payer national health insurance. By eliminating private insurers and simplifying how providers are paid, single-payer would free up hundreds of billions of dollars now squandered annually on insurance-related bureaucracy. The savings would make it feasible to cover the uninsured and to eliminate the cost barriers that keep even insured patients from getting the care they need. And it would free patients and doctors from the narrow provider networks and other bureaucratic constraints imposed by insurance middlemen. We still urgently need this reform.

However, the accelerating corporate transformation of US health care delivery complicates this vision. In the past, most doctors were self-employed, free-standing hospitals were the norm, and for-profit ownership of facilities was the exception. Single-payer proposals hence envisioned payment flowing from a universal, tax-funded insurer (like traditional Medicare) to independent clinicians, individual hospitals, and other locally controlled, nonprofit providers. This was usually the state of play when national health insurance (NHI) was achieved in other nations, such as Canada in the 1960s and ’70s—the model for single-payer reform in the United States.

But insurers are now being joined by a new set of corporate middlemen asserting control over American

care. Amazon plans to expand Amazon Care from Seattle to 20 other cities this year, and then to all 50 states. Wall Street is buying up doctors, hospitals, and other health care institutions, distorting care to generate profit. Today, most doctors are employees of large organizations, and most hospitals have become subsidiaries of corporate enterprises encompassing many facilities and firms with tenuous ties to the communities they serve. Meanwhile, for-profit control of health care providers—including by private equity firms—has burgeoned, despite strong evidence that profit-seeking siphons off resources and undermines quality.

These sweeping changes require an expansion of the traditional single-payer vision. Reform needs to go beyond changing the *way* we pay for care: It also needs to change *whom* we pay for care. Communities, not corporations, should own our nation's vital health care assets.

The rise of corporate ownership of American health care has been stunning. For-profits now own the vast majority of hospices, nursing homes, urgent care and dialysis clinics, imaging facilities, ambulance companies, and home care agencies. They garner nearly one-third of the total revenue of psychiatric and substance-use treatment hospitals, and control a growing share of

general hospitals. Meanwhile, insurers are buying up clinics and doctors, eliminating any semblance of clinical independence. Optum—a subsidiary of UnitedHealth, the nation's largest insurer—controls more than 1,500 clinics with 60,000 doctors, and CVS/Aetna already runs 1,200 Minute Clinics, with plans to expand its offerings in primary and behavioral care. Increasingly, Americans' insurer is also their doctor.

Even more malevolent actors have now entered the fray. Private equity firms' health care acquisitions totaled about $750 billion over the last decade, more than $119 billion in 2019 alone. KKR and Blackstone now employ or control more than 40,000 doctors, physician assistants, and nurse practitioners, and provide staffing for about one-third of US emergency rooms. Those companies were largely responsible for the epidemic of surprise bills. And private equity has been gobbling up primary care practices and mental health, orthopedics, and vision care providers; they already employ nearly 10 percent of dermatologists.

At least UnitedHealth and CVS plan to stay in business for the foreseeable future, and may be constrained by the worry that substandard care will damage their reputation. Private equity companies face no such constraints. They promise investors quick profits, and often sell off the businesses they've bought within five years, often after stripping their assets and loading them with debts that hobble future operations.

Philadelphia's Hahnemann Hospital epitomized the danger of private equity takeovers. Its billionaire owner shuttered the vital safety net hospital, whose downtown real estate was worth more for condos than for caregiving. Moreover, private equity owners are exempt from SEC (and most other) reporting requirements, allowing them to hide their actions (and the identity of the investors). patients and staff don't have the right to know whom to blame for misbehavior.

A raft of evidence warns that for-profit ownership undermines quality. Two giant for-profit chains (one based in Germany) have gained dominance in dialysis, even as research has documented for-profit dialysis centers' high death rates—driven in part by their over-prescribing of sometimes dangerous medications that boost dialysis firms' profits. For-profit hospices shun (even insured) patients whose extensive care needs make them unprofitable, provide a narrower range of services, use less-skilled clinical staff, and have high rates of substantiated complaints of substandard care. And the for-profits that have long dominated the nursing home industry skimp on nursing care are more often cited for quality deficiencies, and have a higher death rate.

Even against the background of for-profit abuses, a transition to private equity ownership signals further deterioration of care. In the wake of PE nursing home

takeovers, nurse staffing has declined and fatality rates have risen, resulting in 20,150 excess deaths. Meanwhile, the owners shield their assets from lawsuits by injured patients (or their survivors) by transferring ownership of the nursing home's real estate to a separate subsidiary. Private equity firms that buy up dermatology practices intensify a focus on selling cosmeceuticals and elective procedures, and some gin up profits by performing unneeded surgeries on frail nursing home residents with Alzheimer's disease. Their tendency to overdiagnose melanoma appears partly responsible for a growing epidemic of unnecessary, but lucrative, skin cancer operations.

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hile the conflict between financial ambition and clinical mission is most acute in for-profit organizations, even in esteemed nonprofits finances now often drive priorities.

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Johns Hopkins Hospital sued thousands of its patients for medical debt, including many who worked for it, often garnishing their wages. The University of Virginia

health care system filed more than 36,000 lawsuits against patients for unpaid medical bills over a six-year period, emptying their bank accounts, putting liens on their homes, and sending some spiraling into bankruptcy, as a *Kaiser Health News* investigation found. Meanwhile, the nonprofit (Catholic) Ascension health system, which owns 140 hospitals, partnered in a billion-dollar private equity fund, whose first investment was in a debt collection business accused of illegally demanding money from patients, even while they were still in the emergency room.

Yet bad behavior goes beyond debt collection. A memo from nonprofit Mayo Clinic's CEO, who also oversees the clinic's network of hospitals outside Minnesota (sited in locales chosen for their business opportunities rather than clinical needs), prodded the staff to prioritize care for patients with the best-paying insurance—a rare explicit statement of a ubiquitous management strategy that's usually left unsaid.

The parent corporation of Boston's Massachusetts General and Brigham and Women's hospitals, which reaped a profit (technically, a surplus) of $3.2 billion last year and is now headquartered in the Prudential Tower, devoted $100 million to "rebranding" when the firm changed its name, and touted its new chief marketing officer for his expertise at selling Oreos and Ritz Crackers during his stint at Nabisco.

In both the for-profit and nonprofit sectors, in other words, the corporate takeover of care has been driven

by market rules and incentives rigged to favor the biggest—and most avaricious—fish. Corporate control has driven up costs and bureaucracy, and failed to deliver the improved clinical coordination, efficiency, or quality promised by advocates of market-based health policies.

In the context of this galloping corporate takeover of health care delivery, replacing current insurers with a single NHI plan is necessary but not sufficient; it would funnel payments to corporate owners rather than to the people and facilities who care for patients. That would continue to delegate control of care to profit-seeking middlemen with little involvement in providing care. In the past, such corporate providers have proven impervious to regulators' efforts to restrain profit-driven abuses, including the efforts of public payers who already provide the lion's share of health providers' revenues (e.g., almost all payment for dialysis and hospice care). Health firms' growing financial power and the entry of behemoths like Amazon amplify the ability of corporations to evade regulation.

Responding to the evidence of for-profits' misconduct, most Medicare for All bills and proposals have prudently called for either the exclusion or public buy-out of for-profit providers. However, the first option, excluding them, is not a viable solution, because their facilities—like the the 5,300 dialysis clinics owned by Fresenius

and Davita, the two dialysis giants—are needed for patient care. And while a public buy-out is economically feasible, who would then own and operate such providers? And what of the nonprofits whose boards often run them as private fiefdoms and increasingly behave like for-profit wannabes?

In both instances, a transition to public, community-based ownership—a reform model generally labeled National Health Service (NHS), in contrast to NHI—seems the most appropriate solution, especially since taxpayers have directly or indirectly bankrolled the construction of most hospitals and other health facilities. Such an NHS should have federal funding and oversight, similar to the Veterans Health Administration—a publicly owned and operated health system that delivers higher quality of care at lower cost than the private sector. However, as Democratic Representative Ron Dellums proposed in the 1970s, the NHS should delegate day-to-day governance to local communities. The system should direct new investments to currently underserved communities, develop the primary care infrastructure that is the bedrock of effective and efficient care, and build the linkages between public health and medical care whose lack has hobbled the US's pandemic response—and in so doing, turn the tide of faltering health in America.

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