the way of better quality—by blocking moral connection, altruism, and relationships that drive actual quality. As the metric mentality becomes internalized and thus becomes the compass for moral and ethical behavior, caregivers become increasingly burned out and cynical. According to Robert Wachter, “These businesslike efforts to measure and improve quality are now blocking the altruism and love that motivates people to enter the helping professions.”

Conclusion: Quality and a National Health Program

Health workers and patients care deeply about quality. For quality to flourish, certain prerequisites are needed, and these are currently lacking in the U.S. health system. All persons need access to care, and services must be organized and provided in a fair and affordable way that is based on community, continuity relationships, and primary care, supported by specialty services where needed. These simple concepts require a universal and unified health insurance system to provide access and to pool the resources required for organizing and supporting needed services. As shown in later chapters of this book, such a universal and unified system can only be achieved by a public, single-payer national health program.

Quality depends on achievement of such a basic framework to deliver quality care, as well as a recognition that liberating our collective desires for quality can help build, drive, and nurture such shared universal system. Only in such a system can the values of public service rather than those of the market be unleashed to construct a system that values quality over profitability.

4—The Political Economy of Health Reform

David Himmelstein and Steffie Woolhandler

NOTE FROM HOWARD WAITZKIN: This chapter takes the form of an interview, in which the authors respond to a series of questions I submitted to them about the political economy of health reform.

HW: What is the commodification of health care?

DH–SW: Health care was for millennia a deeply personal interaction between a patient and caregiver, a relationship between people. Of course, reality often fell short of this idealized version of the past. Doctors sometimes acted in venal, self-interested ways, and the ruling class often decreed that care for working people should encompass only the things needed to maintain their productivity. (Of course, many working people—for example, serfs and slaves—received little or no medical care.) But care was provided mostly by individual doctors and nurses who formed personal relationships with patients.

Over the past fifty years in the United States, health care has been transformed into an impersonal economic relationship between a patient, who is viewed as a buyer of care, and a large-scale corporate seller. Health care is a thing, or commodity, that is bought and sold. This transformation required a redefinition of care. Instead of a doctor who offers to “take care of you when you are sick or need help,” corporate care providers offer a defined set of services for sale. Instead of turning to a particular human being for care, patients are supposed to relate to a corporate institution, where doctors and nurses are interchangeable parts.
HW: How have health services been transformed in the current stage of capitalism? How has the social-class position of physicians and other health professionals changed?

DH-SW: Until recently, the vast majority of doctors were self-employed, worked in solo practices or small groups, and were paid either directly by their patients or (starting mostly after the Second World War) by the patients’ insurers. In these arrangements doctors had a great deal of control over their work and work environment. They also had great influence over how hospitals were run, and hospitals exercised little control of doctors.

Over the past decade it has become virtually impossible for small-scale, independent practices to survive economically. Insurers either refuse to contract with such practices or demand impossibly low fees—demands that huge corporate providers can resist because they control vital services such as hospitals providing specialized care, which insurers have to include in their networks. Moreover, many insurers now insist on paying a single annual fee, called “capitation,” to cover all of a patient’s care including hospitalizations, medications, and specialized services. The care of one severely ill patient can cost a million dollars, which would bankrupt a small practice but can be easily absorbed by a huge organization that receives capitation fees for hundreds of thousands of patients, most of whom are healthy and require little care.

As most doctors have been driven out of small-scale practices, they have become employees of large corporate health care organizations, such as hospitals, managed care organizations, or group practices with thousands of doctors. In those organizations, corporate executives and managers largely dictate where and when doctors work, how many patients they see, how much patients are charged for care, and, increasingly, the details of the care doctors are allowed to give.

Doctors who are unprofitable or uncooperative with management risk being fired and face a rapidly shrinking number of other options for practice. Hence, doctors are becoming proletarianized in terms of their relationship to management, although they remain a very highly paid group and are likely to remain so for the foreseeable future.

HW: Has Obamacare contributed to corporate control of health care?

DH-SW: Obamacare strengthened health care firms in several ways. First, it mandated that most people in the United States purchase private insurance, guaranteeing insurers’ market. In addition, the new subsidies for private coverage provided a huge infusion of public money to the private insurance industry, nearly a trillion dollars over ten years. Obamacare also incorporated a deal with drug firms that omitted any restraint on drug prices. As a result, drug costs and drug company profits have soared since the passage of the Affordable Care Act (ACA) in early 2010. Finally, the law required Medicare to move to capitated payments for care. As we've described above, this is making small-scale practices non-viable and has greatly accelerated the shift to large-scale, corporate-owned practices.

HW: How have electronic medical records affected this process?

DH-SW: As long as doctor-patient interactions remained private (and hence largely opaque to management) it was difficult to implement corporate control of medical practice and to fully integrate doctors’ work into corporate structures. Computerized medical records have been the key to “managing” doctors, allowing surveillance of how long they spend with each patient, their adherence to rigid care and billing protocols, and monitoring whether they are profitable for the corporation that employs them.

This focus on using computerization to manage doctors and to make health care a business has deformed electronic medical records (EMRs). Instead of realizing the great promise of computerization, the systems that have been widely adopted are essentially billing and management tools, with some patient care elements tacked on. In the past, doctors often wrote brief, informative, but sometimes illegible notes. Today, many electronic notes are little more than legible gibberish. Medical records are larded with pages of previously collected information of dubious quality that’s auto-populated (or cut and pasted); documentation of extensive physical examinations and history-taking that justify billing for a lengthy visit and can be entered with a few keystrokes (whether or not the exams were actually done or the history taken); and myriad boxes checked to comply with orders from headquarters.
HW: As co-founders of Physicians for a National Health Program (PNHP), please describe how PNHP was founded.

DH–SW: Starting in 1982, we had worked with activists in Massachusetts advocating a single-payer reform. In 1986, those activists, led by the Massachusetts Gray Panthers, placed a resolution on the statewide ballot that would instruct the state’s congresspersons to support such reform. We feared that the Massachusetts Medical Society would be a potent opponent of the referendum (although ultimately that group opted not to take a position on it), and thought that a pro-single-payer doctors’ group could serve as a useful counterweight.

That summer, at a retreat in New Hampshire of physicians and other clinicians who cared for the poor, we proposed the formation of such a group. After considerable discussion the attendees decided to go forward with the project. That decision grew from the need to support the Massachusetts initiative and from frustration with previous efforts to defend the care of the poor, which mostly meant defending the Medicaid program—a poor program for poor people. Moreover, the health care system also poorly served many middle-class patients, and we were convinced that a movement that would upgrade coverage and care for both the poor and middle class had much more potential. A national health program could do just that, saving billions on health care bureaucracy that could be redirected to making universal, comprehensive coverage affordable.

HW: How and why was the decision made to advocate a “Canadian-style” single-payer insurance program, rather than a national health service as Representative Ron Dellums and others had proposed?

DH–SW: During the 1970s there had been a sharp division among progressive health care activists. Some, particularly in the labor movement, advocated for National Health Insurance (NHI) like Canada’s that would pay for all care but not directly employ doctors and other health workers, nor nationalize hospitals and other health facilities. Others, often associated with the New Left and younger generation, pushed for a National Health Service (NHS) like England’s, which had a publicly owned and operated system.

We decided to use the term “National Health Program” (NHP) to avoid sectarian fights between those two camps, and to express our support for a range of single-payer options, including both NHI and NHS models. Moreover, we thought that restricting the emergence of a parallel, private system—that is, mandating that everyone was in the same health care boat—was as important as the differences between NHS and NHI. In England, despite having an NHS, most wealthy people also have private insurance and can jump the queue for care. In contrast, Canada’s NHI bans private insurance that duplicates the public coverage, so by and large the wealthy can’t opt out or buy their way to better or quicker care.

When it came time to formulate a proposal for PNHP (which was published in the New England Journal of Medicine in 1989) we opted for the Canadian route, both because it was far easier to imagine a transition to that system and because we thought banning a parallel private sector for the wealthy was a priority. Recently, the emergence of huge integrated health systems incorporating multiple hospitals and thousands of physicians (so-called Accountable Care Organizations or ACOs), which dominate the care of entire regions, is causing us again to talk about NHS models. In the latest PNHP proposals we advocate that such dominant systems should be brought under direct public ownership.

HW: Why did PNHP focus mainly on doctors as a target for organizing? In your answer, please feel free to address the social-class position of doctors and comment on their role in social change. Also feel free to comment on relationships with the labor movement and other organizations fighting for social change.

DH–SW: The need for a physician group that could counter organized medicine’s opposition to the 1986 single-payer ballot question in Massachusetts was a trigger for the formation of PNHP. It also seemed to us that in the longer term a group identified as presenting doctors’ views could play an important role in reassuring the public that physicians were not uniformly opposed to an NHP, and that medical care would not be disrupted by such reform.

We also had in mind the practical question of what would be the best strategy to organize a large number of doctors to publicly
support an NHP. We were convinced, based on surveys of doctors' opinions on NHI and our interactions with colleagues, that a substantial fraction of doctors favored such reform. In part, this reflected the threat that the incipient corporate takeover of medicine posed to doctors' privileged position. But while we thought we could gain substantial support, we also thought that relatively few colleagues would feel comfortable working closely in a political organization with non-physicians, especially working-class activists. As your question suggests, for many physicians, their social-class position and the cultural norms that arise from it present a barrier to their integration into a broader progressive movement.

Moreover, the social and professional structures of the medical community also favored organizing a specifically physicians' group. Medical journals offered a means to reach out to doctors that circumvented the virtual blackout on discussion of an NHP in the mainstream media. But while leading journals were open to progressive articles from a doctors' group, the bar was much higher for articles that came from outside the profession. In addition, doctors frequently gather for hospital grand rounds, department conferences, and meetings of regional and national specialty groups, which offer potential forums for discussion of health care reform and, again, are far more open to presentations on behalf of a physicians' group than from broader-based advocacy groups.

Finally, doctors have specific concerns and ideas about health care reform that need to be addressed if we are to gain their support. For instance, they're concerned about medical student debt, pay disparities among specialties, and medical malpractice laws. An organization of doctors facilitates engaging these issues, some of which carry little interest for non-doctors.

For all of these reasons, we thought it best to move ahead with a doctors' group, which we hoped would ally with nurses' groups, organized labor, and other elements of a progressive coalition. In fact, National Nurses United (a powerful union group) has been a key ally, and that organization's Executive Director serves as a Board Advisor for PNHP.

That said, PNHP welcomes non-physician members. Although only health professionals can vote in the organization, we virtually never actually vote on anything. We work on consensus, and several non-physicians have played important roles in the group.

HW: How has PNHP addressed the contradictions of the capitalist state? Where would the single-payer system fit into the structure and political-economic processes of the capitalist state?

DH-SW: PNHP has pushed for making health care a non-market good, one distributed based on medical need, not ability to pay. That's essentially an embodiment of the traditional slogan, "From each according to his [sic] ability, to each according to his need."

It's clear from the examples of several other capitalist countries that progress in this direction is possible, even without fundamentally restructuring the rest of the economy. But we also recognize the difficulties imposed by the context of a capitalist state. Though in our view government management of health care financing is preferable to management by private insurers, government largely reflects the interests of the corporate class. So, as in education, government is imposing damaging "pay-for-performance" incentives and computerization strategies that are part and parcel of making health care a commodity; is constantly seeking to channel public dollars to private health care investors; skews investments in new health care facilities toward the wealthy; and does little or nothing to address the most important determinants of health, namely, economic and racial inequality, global warming, toxic food environments, and public health issues like occupational hazards.

HW: How has PNHP addressed the entrenched positions of for-profit insurance, pharmaceutical, and other corporations in the so-called medical-industrial complex? How would the single-payer proposal envision changes in these corporations' roles if the proposal passed at the state or federal level?

DH-SW: We've been clear from the outset that private insurers should have no role in health care. There's no way to make a health care system that's reasonably fair and efficient if you allow them to persist. Of course, this means that insurers will wield their substantial financial and political power to oppose single-payer reform. Hillary Clinton once asked us
how reformers could overcome this opposition. We suggested that the president should help lead a mass movement for change, a suggestion she dismissed out of hand. But it's clear that most Americans disdain insurance firms and favor single payer. Our challenge is to mobilize that sentiment. Some potential divisions with the corporate class also offer opportunities. For much of corporate America, health care represents a cost of production, one that shifts part of their profits to insurance firms. An NHP would lessen this drain.

We've also been clear that for-profit health care institutions like hospitals and nursing homes must be converted to nonprofit status. That's based on convincing evidence that for-profits provide inferior care at inflated prices and skew investments to gaining profit rather than meeting medical needs. Like insurers, such firms are powerful but not insurmountable foes. Some capitalist nations (for example, the Netherlands) ban them.

However, PNHP has not pushed to have pharmaceutical firms, which are much larger and more powerful than private insurance corporations, taken over by government or converted to nonprofits. The question for us is where to draw the line on our demands. Banning for-profits in every industry that supplies health care is tantamount to a demand for socialism. Though some members would favor that, there's not a consensus for it in PNHP. Hence, like the national health programs in other countries, PNHP would use the monopsony (one buyer) purchasing power of an NHP, along with much stricter regulation on drug pricing, to rein in profiteering by pharmaceutical corporations. Since the NHP would pay for virtually all prescription medications, it could use its market clout to force drug companies to accept lower prices.

**HW: What have been PNHP's strengths and weaknesses?**

**DH-SW:** PNHP has provided an important rallying point for progressives in medicine and has helped provide a focus for opposition to the corporate takeover of health care, as well as support for improving care of the oppressed.

We've been most successful in appealing to the generation of physicians who came of age during the 1960s and '70s. In recent years PNHP has also done very useful organizing among medical students; we now have active chapters in nearly half of the schools in the country. But we've been less effective at involving the middle group, doctors who are now between thirty and forty-five. We've also not had sufficient outreach to African-American and Hispanic colleagues.

We think it's important that PNHP has remained an activist-led, rather than paid staff-led, organization for three decades. In many cases, progressive doctors' groups have become essentially a fundraising base that supports paid staff who do most of the organization's work. Though in the short term that sometimes facilitates getting the work done, since most doctors are busy with their day jobs, in the longer term it demobilizes and alienates the membership base. Moreover, the staff may be tempted to compromise a group's politics in order to raise the funds needed to keep getting paid. In PNHP's case, on several occasions we've been offered grants contingent on "softening" our "hard line" stance on reform, but we have been able to resist those temptations.

Of course, relying on busy members to do most of the group's work and serve as its public spokespeople also sometimes causes problems. Some things can't get done.

**HW: What have been the strengths and weaknesses of the single-payer movement in general?**

**DH-SW:** The narrow focus on reform of the health care system has been both a strength and a weakness. PNHP is a single-issue organization, as are many of the other groups working on health care reform. That's allowed the movement to reach out to many who are concerned about health care and prepared to support quite radical reforms, but not yet ready to engage a broader radical agenda. Yet realizing reform of the health care system will require a broad and powerful progressive movement that is able to challenge corporate power on many fronts. We think organizing for health care reform can be an important component of building such a broad movement, both because it builds in-depth understanding of an important sector of the economy and because it offers a concrete and obvious example of how the drive for profit interferes with rational solutions to major social problems.
Yet it remains unclear how single-payer efforts can be integrated effectively into the mass movement needed to address a multifaceted transformation of society. In other nations, national health insurance has almost always been implemented by a party with a clear socialist platform, or one that at least has close ties to a powerful labor movement. So a key question for our movement is how we can participate most effectively in building a broad and powerful progressive force.

**HW:** If you could replay history, what would you have done differently?  
**DH-SW:** Too many things to enumerate. One that seems obvious is that we'd have learned more about how to use social media and other modern organizing techniques.

**HW:** At this current critical moment of history, what strategies do you favor in moving forward? For instance, should doctors continue as a focus for political organizing as opposed to other groups?  
**DH-SW:** We don't view this as an either-or proposition. In the push for health care reform doctors have an important role to play, and substantial and vocal advocacy by physicians is important for mobilizing and supporting others. On the other hand, it's silly to think that doctors will be the main force for transforming health care, or society more generally.

We need activists from many walks of life, including doctors. Some of us can be most effective in rallying colleagues. A few might play leading roles in organizing the broader community, although we doubt that many physicians can or should assume such broad leadership.

**HW:** Given the corporate transformation of medicine, the dominant role of finance capital, and the changing social-class position of physicians, is a single-payer strategy still what you favor? If not, what would you support?  
**DH-SW:** We continue to believe that a nonprofit, single-payer reform is both needed and possible, and remains an effective rallying point for organizing. For many years, we and others in PNHP have included an anti-corporate focus as a central aspect of our work. That's more important than ever. But ultimately, health care reform is about the lives of our patients and the needless suffering they endure. And keeping that in the forefront is absolutely essential.

**HW:** Please comment on examples and collaborations with activists in other countries.  
**DH-SW:** The corporate takeover of care in the United States is a model that the ruling class in many other nations aspires to achieve. Moreover, U.S. academics have served as the main purveyors of pro-market health policies that lead to privatization and exacerbate inequality. Hence, we have a special responsibility to help contain this spreading plague. For us personally that's mostly meant sounding the warning to colleagues in other countries by telling the truth about ours in international journals, meetings, and, occasionally, in speaking tours and media appearances. PNHP has collaborated with sister organizations in Canada and a few other nations, but such work has been logistically difficult and has not become a major focus.

**HW:** Would you add anything else that you see as important to emphasize as the struggle continues?  
**DH-SW:** We've been heartened by the striking response to Bernie Sanders's candidacy, including the strong positive reaction to his proposal for single-payer reform. A recent Gallup poll found that 58 percent of Americans favor (and only 38 percent oppose) single payer, including 41 percent of Republicans. Although most politicians and much of the media have continued to insist that such reform, and the other measures that Sanders has championed, is impossible, his campaign has exposed the potential for mobilizing widespread support for radical change. It's demonstrated that there's fertile ground for organizing.

**HW:** What if anything has changed in the era of Trump?  
**DH-SW:** The Trump regime is, of course, a major setback in the short term. But the mobilization of opposition to his policies promises better things ahead.

The Democrats created the opening for Trump by offering little for working families, and much for the wealthy, in health care as in other domains. Even though the ACA expanded coverage to
about 20 million, it offered little or nothing to the other 300 million Americans, and in many respects it reinforced the corporate dominance of health care.

But when the Republicans tried to move back from the ACA, they generated a wave of opposition, and a surge of support for the single-payer reforms that would fix the ACA's defects. Tens of thousands have turned out for single-payer rallies. Dozens of congressional members have newly signed on to the single-payer bills. State-based efforts are burgeoning. And polls show strong and rising popular support for such reform—even among voters who label themselves "conservative."

So the period ahead holds undoubted dangers, but also real opportunity.

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The concept of U.S. health care as a medical-industrial complex was the product of Health/PAC (the Health Policy Advisory Center), an activist community that emerged in New York City in the late 1960s. The spark to form Health/PAC was an "exposé-analysis" written by Robb Burlage 1967. Titled *New York City's Municipal Hospitals: A Policy Review*, this report documented how, beginning in the early 1960s, powerful New York City teaching hospitals had been granted lucrative affiliation contracts by the municipal government to provide teaching and funding for the city's beleaguered public hospitals. It offered a detailed critique about how academic centers were being lavishly subsidized by the municipal government to affiliate/manage the then twenty-one New York City public hospitals. Despite receiving this public largesse and regional institutional control, these centers were ignoring the public health of surrounding communities, particularly working-class communities and communities of color. Instead, the centers viewed these "populations" as research and teaching guinea pigs. Most institutions were also resisting staff unionization.

This was a period of intense community activism in New York City, much of it centered on health care institutions such as Lincoln