

Toward Universal and Less Costly Healthcare

By Lane Kenworthy
Yankelovich Professor of Sociology

In a rich nation such as the U.S., everyone should have health insurance. We also should do better at controlling healthcare costs; while we won't go bankrupt spending 18% of our GDP on health, or even more, the fact that every other rich democratic country achieves equivalent or better health outcomes while spending far less suggests that we have considerable room for improvement. How can we achieve these two goals?

The most straightforward path would be to expand coverage through Medicare, Medicaid, and a "public option", lower the age at which Americans can get Medicare, raise the income limit for Medicaid eligibility, and add a Medicare-like program that individuals and families can purchase on health insurance exchanges and that firms can purchase for their employees. Or simply allow any employer or individual to buy into Medicaid or Medicare, with subsidies for those who need them.

Eventually, a large portion of the population would be covered by these public programs. This would achieve universal coverage, and the government, as the dominant payer, would be in a strong position to control healthcare costs.



Lane Kenworthy

Canada's experience suggests that this type of arrangement can function quite effectively. Every Canadian has health insurance, and, over the past half century life expectancy has increased more in Canada than in the U.S. despite a far smaller rise in healthcare expenditures.

Such a system wouldn't eliminate private insurers. There would be a market among the affluent for insurance plans better than the one(s) offered by the government. And employers and individuals might choose to supplement the basic health insurance plan with an additional one, as many elderly Americans who have Medicare currently do.

Over time, government has gradually increased its role in promoting access to health insurance in the United States. The Veterans Administration was created in 1865 and significantly reformed in 1930 and 1994. In the 1940s and 1950s the federal government created and expanded a tax deduction for firms that contribute to

health insurance for their employees. Medicare was created in 1965 and extended to cover prescription drugs in 2004. Medicaid too was created in 1965, and the share of the population it covers was expanded in the 1980s, in 1999 with the S-CHIP program, and in 2010 via the Affordable Care Act. Together, these two programs now cover about 40 percent of the U.S. population. The 2010 ACA also requires that medium-size and large firms offer health insurance to their employees, it provides subsidies for persons and families with modest incomes, it requires that health insurers

cont. on page 2 →

◆◆◆ Inside ◆◆◆

Toward Universal and Less Costly Healthcare	1
Remembering Elizabeth Barrett-Conner	3
"Dare to be Dull" (Part I) How UCSD-TV Came to be.....	4
Emeriti Assn. Book Club.....	6
Anecdote: Lexit, Not Brexit How to Save the European Union	7
Mark your calendar	8

Kenworthy, cont. from page one.

allow people to remain on their parents' plan through age 25, and it forbids insurers from denying insurance to persons with preexisting conditions. (Its mandate that individuals have health insurance was removed in 2017.)



Why not instead expand employer-based health insurance? America's employer-centered health insurance system was a historical accident. It originated during World War II, when wage controls made it difficult for firms to offer higher pay in order to attract and retain good employees. Some decided to offer health insurance instead. After the war, encouraged by a new tax break, this practice proliferated, and it has remained in place ever since. But in a society where people switch jobs frequently, it makes little sense for insurance against a potentially major and very costly risk to be tied to one's employer. Moreover, providing health insurance is expensive for firms, putting them at a disadvantage relative to small firms and foreign competitors. And it likely acts as a brake on wage increases.

Why does employer-based health insurance work well in some other countries, such as Germany and Japan? The reason is that if people quit or lose their job, they are automatically switched into a government ("community") health insurance plan. And the cost of health care is contained, so it's less of a burden for employers. This happens in part because

health insurance firms and funds aren't for-profit, so they aren't inserting additional costs into the system, and partly via cost controls set by centralized agreements between insurers and providers, with government stepping in if that fails.

Do Americans like government health insurance? Most say they do. About two-thirds of Americans think Medicare and Medicaid are working well for the groups they serve. In 2015, Gallup asked a representative sample of U.S. adults "Are you satisfied or dissatisfied with how the healthcare system is working for you?" Satisfaction was higher among those getting their health insurance via the military, the VA, Medicare, or Medicaid than among those getting it via an employer or purchasing it directly themselves.

Should government not only pay for health insurance and oversee it but also be the provider? That's how countries such as the UK, Sweden, Finland, and some others do it, and it tends to work well. Indeed, the UK got top ranking in a recent Commonwealth Fund assessment of healthcare quality in 11 affluent nations. But these might be isolated examples; there is no systematic evidence to support a conclusion that government provision is superior to mixed public and private provision. In any event, it's extremely unlikely that the US will replace its existing array of private for-profit and nonprofit

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medical providers with a fully government-run physician and hospital system.

How much would a single-payer healthcare system cost, and where would the money come from? In 2015, the U.S. spent \$3.2 trillion, 18 percent of the country's GDP, on health care. The government's share is a little less than half of this total. The tax benefit to employers costs about \$250 billion, Medicare \$650 billion, Medicaid \$560 billion, health care for veterans \$65 billion, and health care for current military personnel and their families \$40 billion.

Medicare and Medicaid limit the amount they will pay to healthcare providers, and they have relatively low administrative costs, even though they've been covering more and more of the population. The share of GDP spent on these two programs has been rising at about the same pace as the rest of the healthcare system. Their cost will continue to rise going forward, owing partly to population aging and expansion of Medicaid coverage and partly to the general rise in healthcare costs, but the projected increases are fairly small.

A key obstacle facing proposals for a single-payer system is that taxes would have to increase significantly in order to pay for it. But this isn't insurmountable. A single-payer system likely would reduce total spending on health care. According to one estimate, adding coverage for the roughly 9 percent of Americans who now lack it and improving coverage for the 35 percent who currently are underinsured would increase costs by about 10 percent. But single-payer would reduce overall healthcare costs by approximately 18 percent: 7 percent from reduction in administrative costs, 3 percent from lower pharmaceutical prices, 3 percent from paying Medicare rates to healthcare providers, and 5 percent

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from improved service delivery (reduction in unnecessary services, inefficiently delivered services, missed prevention opportunities, and fraud). If correct, this estimate suggests a single-payer healthcare system would cost roughly 90 percent of the current spending total, or about 16 percent of GDP. That means government expenditures on health would rise by about 8 percent of GDP.

Of current health spending, 45 percent is by government (federal, state, and local). The other 55 percent is private: 27 percent by households, 20 percent by private firms, and 8 percent by other private sources. The cost of a single-payer system would need to come from taxes that replace these private expenditures. There are many possibilities, from a payroll tax paid by employers to an income tax and/or consumption tax on households. While the dollar figure will scare some Americans, such a system won't mean additional payments for health care; it will simply mean a different form of payment — public instead of private.

So is single-payer the solution for the US? In the long run, probably yes. In the short run, it may be more sensible to focus on making health insurance universal and making sure all Americans have insurance that is minimally adequate. The most straightforward way to do this is by expanding access to Medicaid and/or Medicare, in one or more of the ways described earlier. According to one estimate, this would increase government health care expenditures by approximately 10 percent, or about 1.75 percent of GDP. The benefits would easily outweigh the costs.

Adapted from a chapter of Kenworthy's latest book, Social Democratic Capitalism (forthcoming, Oxford University Press).

Remembering Elizabeth Barrett-Conner

By Henry C. Powell, Professor Emeritus of Pathology, and Marguerite Jackson, Associate Clinical Professor Emerita

Dr. Elizabeth Barrett-Conner joined our Department of Community Medicine in 1970, at the same time as her husband, **Dr. Jim Connor**, a virologist, came to head the Division of Infectious Disease in the Department of Pediatrics. The success of the Health Sciences program and the high reputation of the School of Medicine are in no small measure the legacy of founding faculty like her, who came with a vision and leaves a cohort of colleagues, many of them her trainees. The eminent medical historian **Roy Foster** liked to quote the saying of **Hippocrates** that the art of medicine has three factors, "the patient, the doctor, and the disease." Elizabeth was a master of that triad.

After college, Elizabeth thought of becoming a nurse but decided to study medicine and entered the profession at a time when women were less than warmly welcomed. Characteristically, she turned that neglect into opportunity, becoming a forceful advocate for women's education and a dedicated student of women's health issues. Throughout her career she also invited many young PhDs, a number of them women, to join her research teams. She was also especially mindful of the role nurses play in health care and opened research opportunities to them at a time when the prevailing view was that "doctors give orders and nurses take them." In the 1970s she showed how important nurses could be in the emerging field of the epidemiology of infection prevention and control. For that purpose,



Elizabeth Barrett-Conner †

she was a key developer of the first certificate program through UCSD Extension designed to educate these new practitioners (of whom MJ was one) and in 1978 co-authored the first book on the subject, *Epidemiology for the Infection Control Nurse*.

Over more than four decades, beginning in 1972, she and her colleagues established one of the best-known longitudinal research programs in community public health, the Rancho Bernardo Heart and Chronic Disease Study. She mentored many investigators and successfully engaged public participation. At first the study focused on cholesterol and heart disease, but it was expanded to cover broader issues, such as the significance of early indicators like fasting blood sugar levels in the pathogenesis and onset of cardiac disease. Her findings on the epidemiology of heart disease and other chronic conditions have helped both doctors and patients, as have her forays into related fields such as neurovascular illness and its connections to cognitive and intel

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Barrett-Conner, cont. from page three.

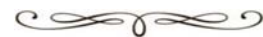
lectual decline. Studies of bone density, diabetes mellitus, and, in particular how the same disease behaves differently in women, have also benefited from her work. Her breadth was indeed extraordinary. A New York Times obituary quoted a recent tribute from former student, **Kay-Tee Khaw**, a professor at the University of Cambridge: “So much of what she pioneered is now so well established in mainstream epidemiologic research that it may be difficult to realize how groundbreaking her approach was at the time.” By focusing on the clinical presentation of cardiac disease in women, she proved that there were key sex-related differences in the symptoms and signs of heart disease. As the Times obituary also noted, “she was among the first to show that diabetes removes the usual advantage that women have in avoiding heart disease; that increasing potassium in the diet may protect against stroke; and that drinking

lots of caffeinated coffee over a lifetime can lead to low bone mineral density in women who do not also drink milk daily.” More generally, the new emphasis on “healthy aging” has arisen in large part thanks to her work. As co-author of over a thousand papers, she contributed a prodigious body of new knowledge.

Both of us had many opportunities to speak to and learn from her. One of us (HCP), remembers attending her lectures to the second-year medical students in the early ’seventies. Although my field of research was very different, talking to Elizabeth was always great fun. We usually met by bumping into each other in the parking lot where after congratulating each other on finding a place to park, we would then talk about the state of the university, the lack of introspective capacity in our leaders, and how it could all be reformed. In the early ’90s she recalled a visit to the White House where former First Lady **Hillary**

Clinton had invited a group of 50 women with nationally significant achievements to celebrate their accomplishments. Elizabeth was very impressed by HRC’s ability to remember what each individual was doing and to establish rapport with them all. No doubt Hillary was equally impressed with EBC.

Her professional example, as well as the synoptic quality of her inquiry into the place of lifestyle, socio-economic factors, education, and human physiology have significantly revised academic medicine’s approach to the most common diseases. Her influence will long endure. Following the aphorism of Hippocrates, she studied the patient and the disease and influenced the doctors, especially those whose careers are anchored in the art of clinical observation. Those of us who knew her personally and enjoyed the company of Elizabeth and Jim, will miss her greatly.



“Dare To Be Dull” (Part I): How UCSD-TV Came to Be

By **Mary Walshok**

Associate Vice Chancellor for Public Programs and Dean, University Extension

“Dare to be dull” is what **Brian Lamb**, the founder of C-SPAN told me over lunch at the Faculty Club in the fall of 1987 when the campus had just been awarded a low-power television broadcast license. At that time, new channels were popping up across the country thanks to the emergence of cable television. Lamb noted that when C-SPAN began operating out of Washington, DC, it had barely a thousand subscribers, all in the capital and its suburbs, who were drawn to its political conversations, book talks, and world affairs panels. But when it became the



Mary Walshok

only channel to offer gavel-to-gavel coverage of the explosive confirmation hearings for Supreme Court nominee **Clarence Thomas**, featuring the riveting testimony of **Anita Hill**, suddenly the subscriber base exploded nation-wide. Based on that experience, he suggested that if a research university like UCSD would focus on truth-telling, scientific

discovery, and informed civic discourse, its new television service would find an eager audience in this emerging multi-channel media world.

Today, more than three decades since that pivotal lunch meeting, UCSD-TV/UCTV has become the largest university-based television service in the US. This growth is due not so much to the proliferation of cable channels as to the reach of the worldwide web and our embrace of the web as a venue for informative, enriching, and other worthwhile if sometimes “dull” programming. Today we enjoy as many as five million monthly visitors on the web, half of them from outside the U.S. Across Cali-

fornia, six million households enjoy access to our programming via cable and we have a rapidly growing YouTube subscriber list, today numbering 500,000, also with a global reach. Who would have thought that such a small initial effort to launch a low-power TV station with a minimal early investment would grow into a media service with such reach and potential?

The notion of a UCSD TV station was the inspiration of **Charles Wood**, a World War II hero and broadcasting entrepreneur who wanted to show his gratitude for surgical care he was receiving at the School of Medicine's Division of Plastic and Reconstructive Surgery. During World War II, Wood's aircraft had crashed and burned, leaving him significantly disfigured. Nonetheless, he built a significant business empire which included television stations. Wood also had real estate investments that included San Diego's Westgate Hotel. During a visit here, he sought consultation from our plastic surgeons.

Especially grateful for the additional correction of a post-burn eyelid deformity, he offered generous support to Interface UCSD, an international program that brought corrective surgery to underserved children born with birth defects. While recovering from another surgery, he asked whether an educational television license might be appreciated by university officials. If so, he offered to help the campus attain one. Surgeon **Jack Fisher**, who became one of Wood's closest allies, broached the question to **Pat Ledden** in the Chancellor's office. Ledden relayed it to Chancellor **Dick Atkinson**, who reacted warmly. The campus agreed to pursue a bid for a low-power TV channel with the help of Wood's attorneys in Washington.

On the advice of professionals like Brian Lamb in public broadcasting, we decided to take part in the channel lottery by proposing one



with a broad public service mission, rather than an exclusively instructional charter. The Chancellor appointed a broad campus committee chaired by me as Dean of Extension, to come up with a recommendation on whether to go forward were we to win the lottery, and a set of goals for it.

To the delight of all involved, in the fall of 1987 UCSD was awarded LPTV Channel 35. In March of 1988, the campus committee strongly recommended moving forward to create a new kind of television station that would be intellectually connected to the work of a research university and on topics of interest for and about the region. The committee's report emphasized the need for this station to differentiate itself from PBS, which provided nationally produced cultural and public affairs programming intended for a general audience on the one hand and highly specific educational purposes (like "Sesame Street") for narrowly defined audiences on the other. At the outset of the committee deliberations, the goal of UCSD-TV was envisioned as to serve as the C-SPAN of the research university. In many ways, that is what it has become over the subsequent decades of growth and diversification.

The committee put a strong emphasis on broadcasting campus lectures, colloquia, and performances. It also recommended outreach programs to communities not typically served by UCSD or local broadcasters: new immigrants, the large Latino community in the region, and constituencies not served or underserved by

the healthcare establishment. Finally, the committee recommended, as an alternative to the "sound bites" on local commercial stations and the then exclusively national news from the local PBS station, that the station produce public affairs programs that dealt in depth with regional issues as well as conversations and debates on topics of civic interest.

It took five years from the spring of 1988 report to the Chancellor for the station to go on the air. The small implementation committee made up of me, **Sherman George**, Director of the University Media Center, and **Jerry Shannon**, Director of Campus Telecommunications Services, prepared a two-year timeline, which had to be extended an additional two-and-a-half years due to: 1) the complexities of securing approval from the Regents to launch the UC system's first broadcast station; 2) settling the licensing issues with the FCC, which were delayed by the need to gain approvals from both Washington, D.C. and Mexico City because of UCSD's location near the border with Mexico; 3) the problems mounting a broadcast antenna on a hillside contiguous to an affluent neighborhood; 4) the challenges of putting together a financing package for a completely new broadcast entity; 5) the process of building a core staff; and 6) the need to develop a model program schedule consistent with the highly consultative faculty governance structure of the UCSD campus.

Had it not been for the continuous moral support of Chancellor Atkinson and **Harold Ticho**, then the Senior Vice Chancellor for Academic Affairs

cont. on page 6 →

Walshok, cont. from page one.

as well as the extraordinary generosity and technical problem-solving skills of Sherman George, combined with the broad network of community and funding resources of the Extension Division, the station would never have made it off the launch pad.

Additionally, early on, two talented people emerged from the documentary and public affairs television world who were willing to be the nucleus of UCSD-TV's start-up team. **Rhyena Halpern** became Director of Programming and Operations and **Shannon Bradley**, who had worked on the PBS

McNeill-Lehrer Report, became full-time producer. The station's start-up momentum was inextricably tied to a group of community advisers who, between the fall of 1988 and going on the air in the winter of 1993, shared ideas, experiences, and connections, provided ongoing management advice and television know-how. The team included **Ann Burr**,



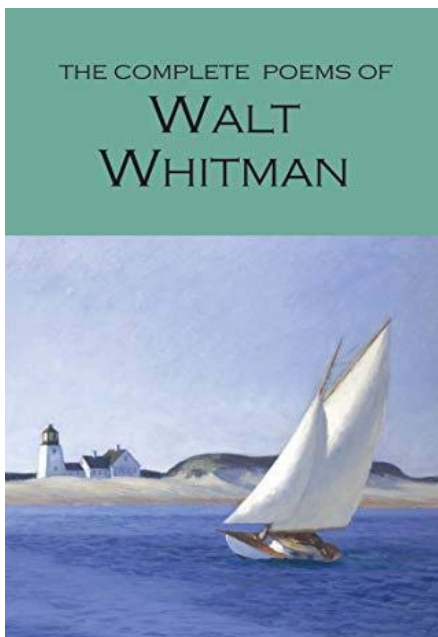
the regional Time Warner Cable general manager, **Jerry Warren**, editor of the San Diego Union Tribune, **Neil Derrough**, general manager of the local NBC-TV affiliate, **Viviane Warren**, a member of the PBS national board, **Jeff Kirsch**, director of the Fleet Science Museum and a documentary film maker, and a variety of academics knowledgeable about film and media from several disciplines. An *esprit de corps* animated the entire effort much like the "Hey kids, let's put on a show" spirit of **Mickey Rooney** and **Judy Garland** in the Andy Hardy movies of the 1940s. There was never a doubt that UCSD-TV would come into being; it just took twice as long as originally expected.



Emeriti Association Book Club

Monday, September 23, 2019
Selected Poems from "The Complete Poems of WALT WHITMAN"

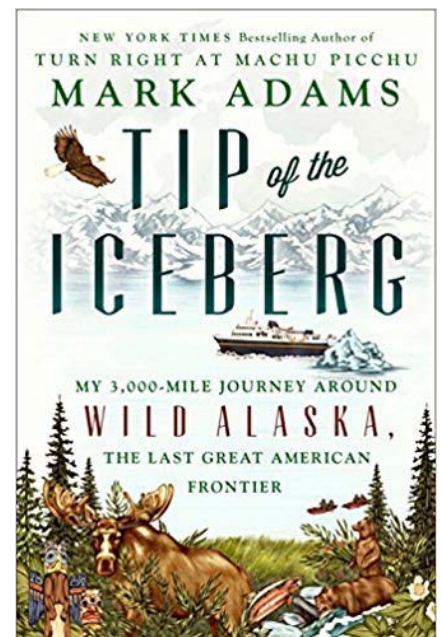
Monday, October 28, 2019
"Tip of the Iceberg" by Mark Adams



Meeting time:
11:30 AM - 1:00 PM

**at the Ida & Cecil Green
 Faculty Club
 Small Conference Room**

Please register at
<https://hrweb.ucsd.edu/ea/>
 or call (858) 534-4724,
 if you have no online access.



Anecdotalage

Lexit, Not Brexit! How to Save the European Union

(From our Brussels correspondent, thanks to Jacob Goldberg)

Anonymous sources have revealed that in an effort to keep Britain from leaving the European Union, the European Commission has reached a still secret agreement to make English the official language of the Union rather than German, which was the other possibility.

During the negotiations, however, Prime Minister **Boris Johnson** conceded that English spelling had some room for improvement and has accepted a five-year phase-in plan for a lexical reform to be known as "Euro-English".

In the first year, "s" will replace the soft "c". Certainly, this will make the sivil servants all exsited – not to mention



the tourists visiting Nise and Florense.

The hard "c" will be dropped in favour of "k". This should klear up konfusion, and keyboards kan have one less letter, causing less konsternation in korrespondense.

There will be growing publik selebration in the sekond year when the troublesome "ph" will be replaced with "f." This will make words like fotograf 20% shorter. In the 3rd year, publik akseptanse of the new orthografy kan be ekspekted to reach the stage where more komplikatated changes are possible.



Governments will encourage the removal of double letters which have always ben a detertent to akurate speling.

Also, al wil agre that the horibl mes of the silent "e" in the languag is disgrasful and it should be don with.

By the 4th yer peopl wil be reseptiv to steps such as replasing "th" with "z" and "w" with "v".

During ze fifz yer, ze unesesary "o" kan be dropd from vords kontaining "ou" and after ziz fifz yer, ve vil hav a reil sensibl riten styl. Zer vil be no mor trubl or difikultis and evrivun vil find it ezi tu understand ech oza. Ze drem of a united Europ vil finali kum tru. Und efter ze fifz yer, ve vil al be speking German like zey vunted in ze forst plas.





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Chronicles

Newsletter of the UCSD Emeriti Association



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Mark your calendar for Fall 2019 events!



Fall Emeriti Association Meeting

Wednesday, October 16*, 2019
3:30 - 5:00 PM

Ida & Cecil Green Faculty Club

**“Venomous Sea Creatures: The
Deadliest Animals in the Ocean”**
presented by
Dr. Karen Van Hoesen

*** Meeting moved to the third Wed. of
October in observance of Yom Kippur**

UCSD Emeriti and Retirement Associations Festive Holiday Party

Saturday, December 7
12:30 - 3:30 PM
**Ida & Cecil Green
Faculty Club**

**Fabulous Holiday Buffet
& No-Host Bar**

**\$10 per member
(non-members: \$50)**

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