PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

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Frequently Asked Questions about single-payer national health insurance

Won't national health insurance result in rationing and long waiting lines?

No. It will eliminate the rationing going on today. The U.S. already rations care based on ability to pay: if you can afford care, you get it; if you can't, you don't. At least 18,000 Americans die every year because they don't have health insurance. Many more people skip treatments that their insurance company refuses to cover. That's rationing.

Excessive waiting times are often cited by opponents of reform as an inevitable consequence of universal, publicly financed health systems. They are not.

Wait times are a function of a health system's capacity and its ability to monitor and manage patient flow. With a single-payer system - one that uses effective management techniques and which is not burdened with the huge administrative costs associated with the private insurance industry - everyone could obtain comprehensive, affordable care in a timely way.

Do U.S. doctors support this concept?

Yes. A recent survey showed that 59 percent of U.S. physicians support national health insurance, an increase of 10 percentage points from five years before. The survey appeared in the April 2008 edition of Annals of Internal Medicine.

Along the same lines, in December 2007, the nation's largest specialty group, the 124,000-member American College of Physicians, endorsed single payer as a pathway to U.S. health reform.

Physicians for a National Health Program, a single-payer advocacy group, has 15,000 members. For more than two decades, PNHP has been educating doctors and the general public about the advantages of single-payer national health insurance.

Is there any support for this approach in Congress?

Yes. The U.S. National Health Insurance Act, H.R. 676 (also known as "The Expanded and Improved Medicare for All Act"), is currently in Congress. The bill would establish an American single-payer health insurance system.

This legislation would create a publicly financed, privately delivered health care system that builds on the existing Medicare program. Patients would go to the doctors and hospitals of their choice, and there would be no co-pays or deductibles.

H.R. 676 was introduced by Rep. John Conyers Jr. of Michigan. It currently has over 90 co-sponsors, more than any other health care reform legislation.

Won't we be letting politicians run the health system?

No. Right now, many health decisions are made by corporate executives behind closed doors. Their interest is in profit, not providing care. The result is a dysfunctional health system where over 45 million have no insurance, millions more go without needed care, and most are in danger of financial disaster

Four Steps You Can Take To Help Win National Health Insurance

1). Join Up with the campaign for HR 676 and national health insurance at www.PNHP.org. Use the resources on the site to **educate yourself**, your family, and your friends about single-payer.

2). Contact Your Members of Congress to tell them that you support HR 676, and they should too.

3). Write a Letter to the Editor or an Op-Ed for your local paper. You can find tips, templates and examples at www.PNHP.org.

4). Bring Materials and Talk to your church, labor, community or other group about the single-payer solution. The PNHP website includes sample resolutions that your group can endorse and a **downloadable slideshow** you can use for a presentation.

should they become seriously ill.

In a single-payer system, medical decisions are made by doctors and patients together, without insurance company interference – the way they should be.

Is this 'socialized medicine'?

No. In socialized medicine systems, hospitals are owned by the government and doctors are salaried public employees. Although socialized medicine works well for our Veterans Administration, as well as for some countries like England, this is not the same as national health insurance.

A single-payer national health program, by contrast, is social insurance like our Social Security program. While the financing is public, the delivery of health care is through private doctors and hospitals, similar to how Medicare works today.

Can we afford universal coverage?

We already pay enough for health care for all – we just don't get it. Americans already have the highest health spending in the world, but we get less care (doctor, hospital, etc.) than people in many other industrialized countries. Because we pay for health care through a patchwork of private insurance companies, one-third (31 percent) of our health spending goes to administration.

Replacing private insurers with a national health program would recover money currently squandered on billing, marketing, underwriting and other activities that sustain insurers' profits but divert resources from care. Potential savings from eliminating this waste have been estimated at $350 billion per year. Combined with what we're already spending, this is more than enough to provide comprehensive coverage for everyone.

Lots of people have good coverage, so shouldn't we build on the existing system?

Our existing system is structurally flawed; patching it up is not a real solution. The insurance industry sells defective products. So like a car with faulty brakes, lots of people who think they have good insurance find that their "coverage" fails when they get sick: three-quarters of the 1 million American families experiencing medical bankruptcy in 2001 had coverage when they got sick. And all insured Americans continually face premium hikes, rising out-of-pocket costs, and cutbacks in covered services as costs rise. Even those who used to have very good coverage are being forced to give up benefits because of costs. Until we fix the system, things are only going to get worse.

Won't our aging population bankrupt the system?

European nations and Japan have higher percentages of elderly citizens than the U.S. does, yet their health systems remain stable with much lower health spending. The lesson is that national health insurance is a critical component of long-term cost control. In addition to freeing up resources by eliminating private insurance waste, single-payer encourages prevention through universal access and supporting less costly home-based long-term care rather than institutionalization. It also saves money by bulk purchasing of pharmaceutical drugs and global budgeting for hospital systems.

Won't a publicly financed system stifle medical research?

Most breakthrough research is already publicly financed through the National Institutes of Health (NIH). In fact, according to the NIH web site, of the last 30 Americans to win the Nobel Prize in medicine, 28 were funded directly by the NIH.

Many of the most important advances in medicine have come from single-payer nations. Often, private firms enter the picture only after the public has paid for the development and clinical trials of new treatments. The HIV drug AZT is one example. On average, drug companies spend more than half of their revenue on marketing, administration and profits, compared with 13 percent on research and development. Negotiating lower prices will allow Americans to afford drugs without hurting research.

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