**SNaHP 5th Annual Summit**

**March 5, 2016**

**Answering Difficult Questions about Single Payer**

**Supplemental Reading**

**Question:** How is single-payer politically and economically feasible in the United States?

**Political Feasibility**

Over the years, single payer has growing support from health professional, labor, business, and faith-based groups. Organizing for single payer state plans and organizing for national legislation should be complementary strategies. The ultimate goal for both is a single, inclusive program for the entire nation. There have been single payer proposals in many state legislatures (NY, CA, CO, HI, IL, MA, MI, MO, OR, PA, and VT) and a national bill, HR 676. In 2015, the New York State Assembly voted overwhelmingly (89-47) in favor of the New York Health Act. This demonstrated an important turning point at least in NY state, as this bill had not gone to the floor for a vote since 1999.

The 2015 Kaiser poll found that [58% of Americans](http://pnhp.org/blog/2015/12/17/kaiser-poll-58-of-americans-support-medicare-for-all/) support single-payer, including 81% of Democrats, 60% of Independents and even 37% of Republicans. In 2009 the Democrats had the White House, a large majority in the House, and 60 Senators – all the votes needed to pass single payer. What was lacking back then was political will, which we have in the current political climate. The 2016 elections are putting single payer on the public radar once again. Senator Bernie Sanders has made a federal-level single-payer system a critical component of his health care platform. Not to mention problems with the ACA have already presented themselves. Inevitably, we also need grassroots mobilization and campaign finance reform, so that Congress can represent the people they are supposed to serve, not the insurance and drug companies. A concerted national campaign with health professional organizations, labor unions, and other public sector organizations can overcome private insurers. We are now working toward this partnership.

**Economic Feasibility**

Transitioning to single payer would be easier than for any other health reform, or dealing with annual insurance changes at work, for that matter. Americans would only need to enroll once for life, and most people could be automatically enrolled through the Social Security System. For those that aren’t enrolled automatically, it should be noted that Medicare enrolled 19 million people in 1966 with index cards, for a cost of [$867 million](http://healthaffairs.org/blog/2014/01/02/medicares-rollout-vs-obamacares-glitches-brew/) (in today’s dollars), including the cost of beneficiaries’ medical care. In contrast, the transition to the ACA was filled with “glitches” and cost $6 billion.

According to Dr. Steffie Woolhandler, our insurance companies’ overhead is seven times higher than Canada’s single-payer program. And insurers force doctors and hospitals to spend billions fighting to get paid. Overall, bureaucracy consumes 31 cents of every healthcare dollar in the U.S. vs. 16.7 cents in Canada. By eliminating the waste and bureaucracy associated with the private insurance industry, single payer saves over [$400 billio](http://www.pnhp.org/news/2015/january/375-billion-wasted-on-billing-and-health-insurance-related-paperwork-annually-stud)n a year on administrative costs that can be funneled into patient care. That’s enough money to cover all the uninsured and to eliminate co-pays and deductibles for everyone. A single-payer system could save even more money by bargaining with drug companies for discounts on drugs. Other countries get discounts of about 50%, and as the biggest customer we could have the bargaining power to get similar savings. As a result, single payer is able to cover everyone with no increase in national health spending, and is the only reform that pays for itself. A recent attack by Ken Thorpe that single payer will raise costs is refuted [here](http://www.huffingtonpost.com/david-himmelstein/kenneth-thorpe-bernie-sanders-single-payer_b_9113192.html).

Over the long term, single payer’s ability to control healthcare costs will generate even more savings compared to the status quo. At the current rate of medical inflation (5.6 percent), health care is projected to consume 20 percent of GDP in 2024 year, about double the share of GDP other wealthy nations devote to health care. Single payer controls costs with [proven effective](http://pnhp.org/blog/2012/03/20/marmor-and-oberlander-controlling-costs-through-emulation-not-innovation/) strategies such as negotiated fees with doctors, global budgets for hospitals and other institutions, bulk purchasing from drug and device companies, and real health planning for capital investment. Since Canada adopted a single-payer program, their health care costs have grown more slowly than costs in the U.S. One [study](http://www.pnhp.org/news/2012/october/canada%E2%80%99s-health-costs-for-seniors-rising-slowly-points-way-to-medicare-solvency-ar) estimated that U.S. could have saved over $2.2 trillion between 1980 and 2009 in the Medicare program alone if costs had grown at Canadian rates.

**Question:** Will single payer be an expensive “tax hike on the middle class”?

A new study shows that taxes already fund [64.3 percent](http://www.pnhp.org/news/2016/january/government-funds-nearly-two-thirds-of-us-health-care-costs-american-journal-of-pub) of U.S. health spending. As a result, the tax increase necessary to fund a national health program is relatively low. Americans spend more public dollars per capita ($5,960 per capita in 2013) on health care than the citizens of other nations pay – including those with universal health systems – except Switzerland. In that sense, Americans are paying for national health insurance, but not getting it.

Two possible financing schemes have been proposed for single payer, [one](http://pnhp.org/blog/2013/07/31/friedman-analysis-of-hr-676-medicare-for-all-would-save-billions/) for H.R. 676, single-payer legislation in the House, and [another](https://berniesanders.com/wp-content/uploads/2016/01/Medicare-for-All.pdf) by Sen. Bernie Sanders. Both plans would raise household incomes for the vast majority of families. An attack on the Sanders financing plan is [refuted here](http://www.huffingtonpost.com/david-himmelstein/kenneth-thorpe-bernie-sanders-single-payer_b_9113192.html).

The Sanders plan would institute a small payroll tax or “income-based health premium” that would replace current health care spending by middle-class families on insurance premiums, co-pays, and deductibles for medically necessary care. In his financing [plan](https://berniesanders.com/wp-content/uploads/2016/01/Medicare-for-All.pdf), this tax is 2.2 percent of income. As a result, net household incomes for the vast majority of families would rise under single payer. Employers would also pay a payroll tax of 6.2 percent for health care for their workers that would replace what they are currently spending on health benefits (private employers pay [7.7 percent](http://www.bls.gov/news.release/ecec.nr0.htm) of total compensation towards health benefits, while state and local government pays 11.6 percent). Under his proposal, the typical middle class family would save over $5,000. Last year, the average working family paid $4,955 in premiums and $1,318 in deductibles to private health insurance companies. Under this plan, a family of four earning $50,000 would pay just $466 per year to the single-payer program, amounting to a savings of over $5,800 for that family each year. The average middle-class household would pay less in taxes than they are already paying for care.

The Sanders plan redistributes the burden of health care costs from low- and middle-income households to the wealthy by raising marginal tax rates on incomes above $250,000, taxing capital gains, dividends, and estates, and closing some tax loopholes. The top one-tenth of 1 percent of households (average incomes of $2 million - $10 million) and in particular, the 1,300 wealthiest households (average incomes over $10 million) would pay the highest marginal tax rates (48 percent and 52 percent, respectively). He also proposes taxing capital gains and dividends as the same as income from work, limit tax deductions for the rich, and the responsible estate tax.

**Question:** What will happen to all the administrators who currently work for health insurance companies?

The payment and provider structures already exist within the Medicare program to permit a relatively smooth transition to a single payer. The new system will still need some people to administer claims. Administration will shrink, however, eliminating the need for many insurance workers, as well as administrative staff in hospitals, clinics and nursing homes. More health care providers, especially in the fields of long-term care, home health care, and public health, will be needed, and many insurance clerks can be retrained to enter these fields. Many people now working in the insurance industry are, in fact, already health professionals (e.g. nurses) who will be able to find work in the healthcare field again. But many insurance and health administrative workers will need a job retraining and placement program. We anticipate that such a program would cost about $20 billion a year during a transition period, a small fraction of the administrative savings from the transition to national health insurance.

When money leaves one part of the economy (the waste currently spent due to the private insurance system), it flows to another part. Employers in particular spend outsized amounts on insurance benefits for their employees; as health care costs have risen precipitously, this has suppressed growth in wages, kept companies from hiring more staff, and made our domestic industries less competitive in terms of pricing compared to those in countries with lower cost public insurance systems. The savings in health care spending realized under single-payer would bolster many other areas of the economy, creating growth that would manifest as training and employment opportunities that could accommodate many individuals previously employed by the private insurance industry.

**Question:** Will single-payer cause long wait-times for care?

When asked this question make sure you point out a basic conceit hidden in the questioner’s assumptions. There is in fact no good way to compare wait times in the US system and those with single-payer, like Canada or the UK. That is because, if you are one of the over 30 million Americans who remain uninsured, your wait time for care is **infinity!** You can’t factor infinity into an average. Any wait times quoted as representing a single-payer system are a product of that society’s decision to cover everyone, to make sure access to care is distributed equitably, and to ration care rationally, i.e. according to medical need rather than ability to pay. Wait times in the US are widely disparate depending on the type of coverage one has; they’re longer for those insured by public social programs that reimburse poorly because the people invested in them are disadvantaged in society and their ability to advocate for adequate coverage. They’re shorter if you have an expensive health plan with an open network as a result of good employment or other advantages. They can still be quite long for the privately insured requiring specialized care on a plan with a closed network of limited providers and no affordable choice to go somewhere that would provide a procedure or evaluation sooner. Think of the times you’ve needed to set up a doctor’s appointment for yourself or a loved one: chances are you can think of a wait time that was surprisingly or unacceptably long.

Polls show that wait times are often comparable between the US and single-payer countries, and that in some cases single-payer systems have distinct advantages. The Commonwealth fund found that in 2010 45% of Canadians and 57% of those in the US were able to get a same or next-day appointment when sick, while in the UK that proportion was 70%. Similarly, 65% of Canadians and 63% of those in the US reported difficulty getting care after hours; in the UK that figure was 38%. The US did have distinctly fewer people waiting two months or more for a specialist appointment (9%, compared to 41% in Canada and 19% in the UK), and fewer people waiting more than 4 months for elective surgery (7% compared to 25% in Canada and 21% in the UK), but at the same time had an outsized proportion of people saying they experienced a barrier to care because of cost (33% in the US, compared to 15% in Canada and 5% in the UK).

Each financing system makes choices about where to focus resources; ours is heavily biased towards reimbursing specialists and proceduralists, and so the wait for an orthopedic surgery appointment in the US is 10 days (if you’re insured, that is), while in Canada it can be over four months (varying significantly by province). When we enact single payer, however, reimbursement rates for different types of care are unlikely to change suddenly, and our significant supply of specialists won’t disappear overnight. Wait times for highly technical and elective, non-emergent procedures may eventually rise somewhat, but single-payer would allow that to happen with a complimentary redirection of resources to areas where our performance is currently lacking - access to primary care, preventive services, and more holistic management of patient health. Our system would be built around our population’s needs and preferences, and the way single-payer is administered in other countries should be a model of which we can adopt the best aspects.

**Question:** How can healthcare be effectively financed by our government?

The answer to this question is straightforward: political accountability. The questioner is likely either a patient worried about government dysfunction encroaching into their healthcare (a la the scandals with unfilled claims and poor service at the VA), or a physician worried about declining reimbursements under a government plan (many physicians consider Medicare reimbursements inadequate to cover costs, with Medicaid being even worse, despite the fact that neither of these are designed to cover all the excess costs associated with the fragmented private insurance system.). To understand why current government run insurance and health care programs have failings, you have to consider who is politically invested in them.

Medicare covers the elderly and the disabled. Medicaid covers the poorest of the poor. The VA serves armed forces veterans and their families, many of whom do not utilize its services until they age and develop increased rates of illness needing medical care. Each of these groups is a subset of greater society, and in many ways each of them lack sufficient political capital and influence to hold the government accountable for adequate funding and organization of these public insurance programs. The poor and disabled are marginalized by lacking the socioeconomic means to reliably participate in the political conversation, and they face animosity from a larger individualistic American society that is reluctant to pay them benefits without receiving something in kind. The elderly also frequently lack income and become increasingly dependent on support from younger, productive generations who are paying taxes into social programs from which they see only delayed benefits. It is difficulty for them to advocate for expansion of Medicare or VA benefits when they, as beneficiaries, are looked at purely as a cost on the balance sheet; indeed, Medicare is frequently targeted for cuts and exploitation via private, for-profit insurance schemes and increased cost sharing, rather than expansion of benefits.

A single-payer would make the entire population invested in the adequate funding and effective administration of the public insurance plan. The democratic process would allow the entire voting populace, who would all have a substantial degree of personal investment in the plan, to elect representatives with the strongest approaches to managing the single-payer and the best track records in terms of running social programs. Political careers would rest on reimbursement rates being high enough to attract enough clinicians to serve the population, and if wait times or access issues crept into the public consciousness they would be fixed either through pressure on those in administering the payer, or the installation of new representatives with fresh ideas to make the system work. Indeed; while current political engagement is often disappointing with low voter turnout and distrust of elected officials, a single-payer benefiting the entire population could serve as a strong motivator to pull more people into the political process, and engage them in closer scrutiny of elected officials’ performance.

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