

# Proposal of the Physicians' Working Group for Single-Payer National Health Insurance

The Physicians' Working Group for Single-Payer National Health Insurance\*

**T**HE US HEALTH CARE SYSTEM IS rich in resources. Hospitals and sophisticated equipment abound, with even many rural areas boasting well-equipped facilities. Most physicians and nurses are superbly trained, and dedication to patients is the norm. Our research output is prodigious, and we fund health care far more generously than any other nation.

Yet despite medical abundance, health care is too often meager because of the irrationality of the current health care system. More than 41 million Americans have no health insurance, including 33% of all Hispanics, 19% of African Americans and Asians, and 10% of non-Hispanic whites.<sup>1</sup> Many more, perhaps most of us, are underinsured. The world's richest health care system is unable to ensure basics like prenatal care and immunizations, and we trail most of the developed world on such indicators as infant mortality and life expectancy. Even the well-insured may find care compromised when health maintenance organizations (HMOs) deny expensive medications and therapies. Fear of financial ruin often amplifies the misfortune of illness for patients.

For physicians, the gratifications of healing give way to anger and alienation in a system that treats sick people as commodities and physicians as investors' tools. In private practice we waste countless hours on billing and bu-

The United States spends more than twice as much on health care as the average of other developed nations, all of which boast universal coverage. Yet more than 41 million Americans have no health insurance. Many more are underinsured. Confronted by the rising costs and capabilities of modern medicine, other nations have chosen national health insurance (NHI). The United States alone treats health care as a commodity distributed according to the ability to pay, rather than as a social service to be distributed according to medical need. In this market-driven system, insurers and providers compete not so much by increasing quality or lowering costs, but by avoiding unprofitable patients and shifting costs back to patients or to other payers. This creates the paradox of a health care system based on avoiding the sick. It generates huge administrative costs that, along with profits, divert resources from clinical care to the demands of business. In addition, burgeoning satellite businesses, such as consulting firms and marketing companies, consume an increasing fraction of the health care dollar. We endorse a fundamental change in US health care—the creation of an NHI program. Such a program, which in essence would be an expanded and improved version of traditional Medicare, would cover every American for all necessary medical care. An NHI program would save at least \$200 billion annually (more than enough to cover all of the uninsured) by eliminating the high overhead and profits of the private, investor-owned insurance industry and reducing spending for marketing and other satellite services. Physicians and hospitals would be freed from the concomitant burdens and expenses of paperwork created by having to deal with multiple insurers with different rules, often designed to avoid payment. National health insurance would make it possible to set and enforce overall spending limits for the health care system, slowing cost growth over the long run. An NHI program is the only affordable option for universal, comprehensive coverage.

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reaucracy. For the uninsured, we avoid procedures, consultations, and costly medications. In HMOs we walk a tight-

rope between thrift and penuriousness, under the surveillance of bureaucrats who prod us to abdicate allegiance

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to patients and to avoid the sickest who may be unprofitable. In academia, we watch as the scholarly traditions of openness and collaboration give way to secrecy and assertions of private ownership of vital ideas—the search for knowledge displaced by a search for intellectual property.

For 9 decades, opponents have blocked proposals for national health insurance (NHI), touting private sector solutions. Reforms over the past quarter century have emphasized market mechanisms, endorsed the central role of private insurers, and nourished investor ownership of care. But promises of greater efficiency, cost control, and responsiveness to consumers are unfulfilled; meanwhile, the ranks of the uninsured have swelled. Health maintenance organizations, launched as health care's bright hope, have raised Medicare costs by billions<sup>2</sup> and fallen substantially in public esteem. Investor-owned hospital chains, born of the promise of efficiency, have been wracked by scandal, their costs high and their quality low.<sup>3-12</sup> Drug firms, which have secured the highest profits and lowest taxes of any industry, price drugs out of reach of many who need them most.

Many in today's political climate propose pushing on with the marketization of health care. They would shift more public money to private insurers; funnel Medicare through private managed care; and further fray the threadbare safety net of Medicaid, public hospitals, and community clinics. These steps would fortify investors' control of care, squander additional billions of dollars on useless paperwork, and raise barriers to care still higher. Instead, we propose a fundamental change in US health care—a comprehensive NHI program.

Four principles shape this vision of reform:

1. Access to comprehensive health care is a human right. It is the responsibility of society, through its government, to ensure this right. Coverage should not be tied to employment.

2. The right to choose and change one's physician is fundamental to pa-

tient autonomy. Patients should be free to seek care from any licensed health care professional.

3. Pursuit of corporate profit and personal fortune have no place in caregiving. They create enormous waste and too often warp clinical decision making.

4. In a democracy, the public should set health policies and budgets. Personal medical decisions must be made by patients with their caregivers, not by corporate or government bureaucrats.

We envision an NHI program that builds on the strengths and rectifies the deficiencies of the current Medicare system. Coverage would be extended to all age groups and expanded to include prescription medications and long-term care. Payment mechanisms would be structured to improve efficiency and ensure prompt, fair reimbursement, while reducing bureaucracy and cost shifting. Health planning would be enhanced to improve the availability of resources and minimize wasteful duplication. Finally, investor-owned facilities would be phased out. These reforms would shift resources from bureaucracy to the bedside, allowing universal coverage without increasing the total costs of health care.

Key features of the proposal [in italics] followed by the rationale for our approach are presented below.

## ELIGIBILITY AND COVERAGE

*A single public plan would cover every American for all medically necessary services, including long-term care, mental health and dental services, and prescription drugs and supplies. Unnecessary or ineffective services, as determined by boards of experts and community representatives, would be excluded from coverage. As in the Medicare program, private insurance duplicating the public coverage would be proscribed. Patient co-payments and deductibles would also be eliminated.*

Abolishing financial barriers to health care is the sine qua non of reform. Only a single comprehensive program, covering rich and poor alike, can end disparities based on race, ethnicity, so-

cial class, and geographic region that compromise the health care of the American people. A single-payer program is also key to minimizing the complexity and expense of billing and administration.

Private insurance that duplicates the NHI coverage would undermine the public system in several ways. First, the market for private coverage would disappear if the public coverage were fully adequate. Hence, private insurers would continually lobby for underfunding of the public system. Second, if the wealthy could turn to private coverage, their support for adequate funding of NHI would also wane. Why pay taxes for coverage they don't use? Third, private coverage would encourage physicians and hospitals to provide 2 classes of care. Fourth, a fractured payment system, preserving the chaos of multiple claims databases, would subvert quality improvement efforts, eg, the monitoring of surgical death rates and other patterns of care. Fifth, eliminating multiple payers is essential to cost containment. Public administration of insurance funds would save tens of billions of dollars each year.

Private health insurers and HMOs now consume 12% of premiums for overhead,<sup>13</sup> while both the Medicare program and Canadian NHI have overhead costs below 3.2%.<sup>14</sup>

Our multiplicity of insurers forces US hospitals to spend more than twice as much as Canadian hospitals on billing and administration; forces US physicians to spend vast amounts on billing; and nourishes a panoply of business consultants, coding software vendors, and other satellite businesses.<sup>14,15</sup> Only a true single-payer system would realize large administrative savings. Perpetuating multiple payers would force hospitals to maintain expensive cost-accounting systems to attribute costs and charges to individual patients and payers. In the United Kingdom, market-based reforms that fractured hospital payment have swollen administrative costs.<sup>16,17</sup>

Co-payments and deductibles discourage preventive care, decrease the

use of essential care, are expensive to administer, and especially endanger the most vulnerable patients—the poor and those with chronic illnesses.<sup>18</sup> Many nations with NHI have effectively contained costs without resorting to such charges.

Coverage decisions would doubtless be difficult and sometimes hotly contested. Even the fairest and best-informed board would confront costly choices where evidence was sparse and passions abundant. Yet we are encouraged by Medicare's generally open and reasoned approach. Moreover, in both Medicare and NHI, the inclusion of the affluent in the same program with others creates a powerful lobby for maintaining adequate coverage. For these reasons, we believe NHI provides a framework for replacing the confused and often unjust dictates of insurance companies with rational, evidence-based decision making.

### HOSPITAL PAYMENT

*The NHI program would pay each hospital a monthly lump sum to cover all operating expenses. The hospital and the regional NHI office would negotiate the amount of this payment annually based on past budgets, clinical performance, projected changes in demand for services and input costs, and proposed new programs. Hospitals would not bill for services covered by NHI.*

*Hospitals could not use any of their operating budgets for expansion, profit, excessive executives' incomes, marketing, or major capital purchases or leases. Major capital expenditures would come from the NHI fund and would be appropriated separately based on community needs. Investor-owned hospitals would be converted to not-for-profit status and their owners compensated for past investment.*

Global budgeting would simplify hospital administration by virtually eliminating billing, thus freeing up resources for enhanced clinical care. Prohibiting the transfer of operating funds to capital projects or shareholders would eliminate the main financial incentive for both excessive interven-

tions (under fee-for-service payment) and skimping on care (under capitated or diagnosis related group systems), since neither inflating revenues nor limiting care could result in institutional gain. Separate and explicit appropriation of capital funds would facilitate rational health care planning. These methods of hospital payment would shift the focus of hospital administration away from lucrative services that enhance the bottom line and toward providing optimal clinical services according to patients' needs.

### PAYMENT FOR PHYSICIANS AND OUTPATIENT CARE

*Physicians and other practitioners could choose from 3 payment options: fee-for-service, salaried practice in institutions receiving global budgets, and salaried practice in group practices or HMOs receiving capitation payments. Investor-owned HMOs and group practices would be converted to not-for-profit status. Only institutions that actually deliver care could receive NHI payments, excluding most current HMOs and some practice management firms that contract for services but don't own or operate clinical facilities.*

(1) *Fee-for-service: The NHI and organizations representing fee-for-service practitioners (eg, medical associations) would negotiate a simple, binding fee schedule. As in Canada, physicians would submit bills on a simple form or via computer and would receive interest for bills not paid within 30 days. Physicians accepting payment from the NHI program could not bill patients for covered services, but they could bill for excluded procedures such as cosmetic surgery.*

(2) *Salaries within institutions receiving global budgets: Hospitals, group practices, clinics, home care agencies, and the like could elect to be paid a global budget, which could include funding for items such as education, community prevention programs, and patient care. Regulations regarding capital payment would be similar to those for inpatient hospital services, as would the budget setting process.*

(3) *Salaries within capitated groups: Group practices and nonprofit HMOs*

*could opt to receive capitation payments to cover all physicians and other outpatient care. Regulation of payment for capital would be similar to that for hospitals. The capitation payment would not cover most inpatient services, which would be included in hospital global budgets. However, a capitated group could elect to provide and be compensated for physician services to inpatients. Enrollment would be open to any patient, and efforts to selectively enroll those at low risk would be prohibited. Patients could disenroll with appropriate notice. Health maintenance organizations would pay physicians a salary, and bonuses based on the utilization or expense of care would be prohibited.*

The proposed pluralistic approach to health care delivery would avoid unnecessary disruption of current practice arrangements. All 3 proposed options would eliminate profiteering and uncouple capital from operating costs, features essential to cost containment and health planning.

The fee-for-service option would greatly reduce physicians' office overhead by simplifying billing. Canada and several European nations have developed successful mechanisms for controlling the inflationary potential of fee-for-service practice.<sup>19</sup> These include limiting the supply of physicians, monitoring for extreme practice patterns, and setting overall limits on regional spending for physicians' services (thus requiring the profession to monitor itself). Because of the administrative advantages of single-source funding, these regulatory options have been implemented without extensive bureaucracy. Similar cost-constraint mechanisms might be needed in the United States. We also recommend capping expenditures for the regulatory and reimbursement apparatus; the Canadian experience suggests that 2% to 3% of total costs should suffice.<sup>14</sup>

Global budgets would allow institutions to virtually eliminate billing, while assuring them a predictable revenue stream. Such funding could also stimulate the development of community prevention programs whose costs cannot

be attributed (or billed) to individual patients.

### **LONG-TERM CARE**

*The NHI program would cover disabled Americans of all ages for all necessary home and nursing home care. Persons unable to perform activities of daily living would be eligible for services. A local public agency in each community would determine eligibility and coordinate care. Each agency would receive a single budgetary allotment to cover the full array of long-term care services in its district. The agency would contract with long-term care providers for the full range of needed services, eliminating the perverse incentives in the current system that often pays for expensive institutional care but not the home-based services that most patients would prefer.*

The NHI program would pay long-term care facilities and home care agencies a lump sum budget to cover all operating expenses. For-profit nursing homes and home care agencies would be converted to not-for-profit status. Physicians, nurses, therapists, and other individual long-term care providers would be paid on either a fee-for-service or salaried basis.

Since most disabled and elderly people would prefer to remain in their homes, the program would encourage home- and community-based services. The 7 million unpaid caregivers, the family and friends who currently provide 70% of all long-term care,<sup>20</sup> would be assisted through training, respite services, and in some cases, financial support. Nurses, social workers, and an expanded cadre of trained geriatric physicians would assume leadership of the system.

Few Americans have private coverage for long-term care. For the rest, only virtual bankruptcy brings entitlement to public coverage under Medicaid. Universal coverage must be combined with local flexibility to match services to needs.

Our proposal borrows features from successful long-term care programs in some Canadian provinces<sup>21</sup> and in Germany. The German program, in particular, demonstrates the fiscal and hu-

man advantages of encouraging rather than displacing family caregivers, offering them recompense, training, and other supports.<sup>22</sup>

### **CAPITAL SPENDING, HEALTH PLANNING, AND PROFIT**

*The NHI budget would fund the construction of health facilities and the purchase of expensive equipment. Regional health planning boards would allocate these capital funds. These boards would also oversee capital projects funded from private donations when they entailed any increase in future publicly supported operating costs.*

The NHI program would compensate owners of investor-owned hospitals, HMOs, nursing homes, and clinics for the loss of their clinical facilities, as well as any computers and administrative facilities needed to manage NHI. They would not be reimbursed for loss of business opportunities or for administrative capacity not used by NHI.

Capital spending drives operating costs and determines the geographic distribution of resources. Capital funds must go to excellent and efficient projects in areas of greatest need. When operating and capital payments are combined, as they are currently, prosperous hospitals can expand and modernize while impoverished ones cannot, regardless of need or quality. National health insurance would replace implicit mechanisms of capital allocation with explicit ones. Insulating these crucial decisions from lobbying and other distorting influences would be difficult and require rigorous evaluation, needs assessment, and active participation by providers and the public. The consistently poor performance of investor-owned facilities precludes their participation in NHI.

Investor ownership has been shown to compromise quality of care in hospitals,<sup>3-5</sup> nursing homes,<sup>23</sup> dialysis facilities,<sup>24</sup> and HMOs<sup>25</sup>; for-profit hospitals are particularly costly.<sup>6-12</sup> A wide array of investor-owned firms have defrauded Medicare and been implicated in other illegal activities.<sup>26</sup> Investor-owned providers would be converted to nonprofit status. The NHI

program would issue long-term bonds to amortize the one-time costs of compensating investors for the appraised value of their facilities. These conversion costs would be offset by reductions in payments for capital that are currently folded into Medicare and other reimbursements.

### **MEDICATIONS AND SUPPLIES**

*The NHI program would pay for all medically necessary prescription drugs and medical supplies, based on a national formulary. An expert panel would establish and regularly update the formulary. The NHI program would negotiate drug and equipment prices with manufacturers based on their costs, excluding marketing or lobbying. Where therapeutically equivalent drugs are available, the formulary would specify use of the lowest-cost medication, with exceptions available in specific cases. Outpatient suppliers would bill the NHI program directly for the negotiated wholesale price, plus a reasonable dispensing fee, for any item in the formulary that is prescribed by a licensed practitioner.*

National health insurance could simultaneously address 2 pressing needs: providing all Americans with full drug coverage and containing drug costs. As a single purchaser with a disproportionate influence on the market, the NHI program could exert substantial pressure on pharmaceutical companies to lower prices. Similar programs in the United States and other nations have resulted in substantial drug price reductions.<sup>27-29</sup>

Additional reforms are needed to improve prescribing practices, minimize medication errors, upgrade monitoring of drug safety, curtail pharmaceutical marketing, ensure that the fruits of publicly funded drug research are not appropriated for private profit, and stimulate real innovation while ameliorating current incentives to develop “me-too” drugs that add little to the therapeutic armamentarium.<sup>30</sup>

### **FUNDING**

*The NHI program would pay for virtually all medically necessary health ser-*

vices, with total expenditures set at approximately the same proportion of the gross domestic product as in the year preceding the establishment of NHI.

While it is critical that the vast majority of funds flow out to providers from a single payer in each region, the mix of taxes used to raise these funds is a matter of tax policy, largely separate from the organization of health care per se.

Single-source payment is the sine qua non of administrative simplification and the cornerstone of cost containment and health planning. Government expenditures, including payments for public employees' private health coverage and tax subsidies to private insurance, already account for about 60% of total health spending in the United States.<sup>31</sup> This would increase under NHI, to perhaps 80% of health costs with the remainder used for such items as non-prescription drugs, cosmetic surgery, and other excluded services. The public money now routed through private insurers would be used to fund public coverage. The additional funds could be raised in a number of ways, including earmarked income taxes, payroll taxes, or required employer contributions. During a transition period, it seems reasonable to require that employers transfer money earmarked for health benefits under existing labor pacts to the NHI program. In the long run, we believe that funding based on income or other progressive taxes is fairest. Federal funding would attenuate inequalities among the states in financial and medical resources. The increase in government funding would be offset by reductions in premiums and out-of-pocket costs. The total costs of the NHI program would be no greater (and eventually less) than those of the current fragmented system.

## COMMENT

Under an NHI program, the financial threat of illness to patients would be eliminated, as would current restrictions on choice of physicians and hospitals. Taxes would increase, but except for the very wealthy, would be fully offset by the elimination of insurance

premiums and out-of-pocket costs. Most important, NHI would establish a right to health care.

Clinical decisions would be driven by science and compassion, not the patient's insurance status or bureaucratic dictum. National health insurance would offer physicians a choice of payment options and practice settings. Nurses and other personnel would also benefit from the reduction in paperwork and a more humane clinical milieu.

National health insurance would curtail the entrepreneurial aspects of medicine, including both the problems and the possibilities. All patients would be insured, with a uniform fee schedule. Physicians who work harder would make more. Billing would be simplified, saving each practitioner thousands of dollars annually in office expense. Based on experience in Canada, NHI would have little impact on physicians' average incomes, although differences among specialties might be attenuated.

National health insurance would contain costs by enforcing overall budgets and eliminating profit incentives and not by detailed administrative oversight of utilization. Since hospitals and HMOs could not transfer monies for patient care to shareholders or divert them to institutional expansion, pressure to skimp on care would be minimized.

National health insurance would eliminate many administrative and insurance worker positions, necessitating a major effort at job placement and retraining. Many of these displaced workers might be deployed as support personnel to free up nurses for clinical tasks; others might be retrained to staff expanded programs in public health, home care, and the like.

Clinical departments would see only modest changes, eg, the elimination of billing-related work. However, hospitals' and nursing homes' administrative departments would shrink, and their financial incentives would change. Responsiveness to community needs, quality of care, and efficiency would replace financial performance as the bottom line.

Operating revenues would become stable and predictable; capital requests would be weighed against other priorities for health care investment. Facilities would not grow or shrink based on their financial performance, although rational health planning would mandate that some expand and others close. Investor-owned providers would be converted to not-for-profit status.

The insurance/HMO industry's role would be virtually eliminated. Most of the funds to expand care under NHI would come from eliminating insurance company overhead and profits, as well as the administrative expense they impose on health professionals and hospitals.

Private employers now fund 19% of health spending.<sup>31</sup> Even if new NHI taxes on employers fully replaced this spending, firms would achieve savings on their employee benefits departments, which currently cost billions of dollars to administer. Hence, for the average business, reform would likely yield at least modest short-term savings. Over the longer term, enhanced cost containment under NHI would spare firms from rapid and erratic health care cost growth. Many firms would undoubtedly choose to continue current wellness programs and workplace safety initiatives.

Covering the uninsured would save thousands of lives annually.<sup>32</sup> Upgrading coverage for those who are currently insured (eg, by adding full prescription drug benefits) would yield additional health benefits.

Independent estimates by several government agencies and private sector experts indicate that NHI would not increase total health care costs.<sup>33-37</sup> Savings on administration and billing, which would drop from the current 30% of total health spending to perhaps 15%, would approximately offset the costs of expanded services. Over the long run, improvements in health planning and cost containment made possible by single-source payment would slow health care cost escalation.

This article presents a framework for the urgently needed reform of our health

care payment system. We do not pretend to address the full range of health care problems or even to provide the detailed transition plan that will be needed to minimize dislocations during reform of the financing system. The need for quality improvement would remain urgent. National health insurance would not, in itself, encourage healthy lifestyles or upgrade environmental and public health services. Non-financial barriers to care—racial, linguistic, and geographic—would persist. Many issues in medical education would remain, including medical students' debt burden that skews specialty choices and discourages low-income applicants, the underrepresentation of minorities, and the appropriate role for commercial firms in supporting research and education. Some patients would still seek unnecessary services, and some physicians would still yield to financial temptation to provide them. The malpractice crisis would be partially ameliorated—the 25% of jury awards designated as compensation for future medical costs would be eliminated. However, our society would probably remain litigious, and legal and insurance fees would still consume about three fifths of malpractice premiums.<sup>38</sup> The aging of our population and the development of costly new technologies would present a continuing challenge to affordability.

Finally, while we propose a central role for government in financing care, we hold no illusions about government's shortcomings. Many of us disagree with government policies and priorities and are concerned by the influence of powerful special interests. Yet only a public NHI program can streamline our system and garner the savings needed to make universal coverage affordable. Ultimately, we prefer the democratic process, however flawed, to the boardroom decision making of private insurance firms.

## ALTERNATIVES TO NHI

The mounting crisis in health care has called forth a variety of incremental reform proposals discussed below. All

share one critical liability: because they would retain the role of private insurers, they would perpetuate administrative waste, making universal coverage unaffordable. Most would augment bureaucracy. Proponents' assertions that private insurers would achieve large savings through computerized bill processing are not credible; most claims processing is already automated.

### "Defined Contribution Schemes" and Other Mechanisms to Increase Patients' Price Sensitivity

These plans cap employers' premium contributions at a fixed amount, pressuring employees to choose lower-cost insurance options. Many cite the Federal Employees Health Benefit Program as a model for such reform, even though premiums in this program are rising faster than in Medicare or for private employers.<sup>39</sup> Hence, such programs are more likely to shift costs from firms to employees than to slow overall cost growth. Moreover, defined contribution schemes ensure a multi-tiered insurance system, with lower-income workers forced into skimpy plans, and the uninsured remaining uncovered.

### Tax Subsidies and Vouchers for Coverage for the Uninsured

These proposals would offer tax credits to low-income families who purchase private coverage. While promises of new government funding to expand coverage are attractive, the proposed subsidies (eg, \$3000 per family under President Bush's proposal) fall far short of the cost of adequate insurance, requiring low-income families to pay thousands of dollars out of their own pockets. Hence, few of the uninsured would actually purchase coverage, even with the subsidy. Instead, most of the tax credits would subsidize premiums for low-income people who already have coverage. As a result, large outlays for tax subsidies would buy little new coverage. For instance, outlays of \$13 billion annually would cover only 4 million of the uninsured.<sup>40</sup>

### Expansion of Medicaid, State Children's Health Insurance Program (SCHIP), and Other Public Programs

Some proposals would expand Medicaid eligibility. Others would allow states to buy stripped-down HMO coverage for Medicaid recipients, with the savings ostensibly used to enroll more beneficiaries. Several problems bedevil these strategies. First, Medicaid already offers second-class coverage. Such programs that segregate the poor virtually ensure poor care and are more vulnerable to funding cuts than public programs that also serve affluent constituencies. In most states, Medicaid payment rates are so low that many physicians resist caring for Medicaid patients. As a result, access to care for Medicaid enrollees is often little better than for the uninsured.<sup>41,42</sup> Further cuts to benefits, as envisioned in some Medicaid HMO schemes, would leave Medicaid recipients with coverage in name only. Moreover, the disempowered Medicaid population is particularly vulnerable to exploitation by profit-seeking HMOs, as evidenced by past scandals in California, Florida, Tennessee, and other states.<sup>43-45</sup> Promises (eg, in Oregon<sup>46,47</sup> and Tennessee<sup>48</sup>) that savings from Medicaid coverage cuts would lead to universal coverage have proven empty.

Second, even large Medicaid expansions in the past have failed to keep pace with the erosion of private coverage.<sup>49</sup> Moreover, Medicaid funding is most endangered when it is most needed; any economic downturn depletes states' tax revenues, reducing funds for Medicaid just as rising unemployment rates deprive many of private coverage.

While few can argue with proposals to cover more of the poor and near-poor, Medicaid expansion without systemwide reform is a stopgap measure unlikely to stem future increases in the number of uninsured. It does not lead to universal coverage.

### Employer Mandates

This approach would require most employers to offer private coverage for

their workers, with employees paying part of the premiums. The proposed mandates are usually coupled with a plan to expand Medicaid-like public programs. Some versions would offer employers the option of paying into a public program rather than providing the coverage themselves. Such programs can only add coverage by adding cost, leaving premiums unaffordable to many. In states where such plans have been passed, they have achieved neither universal coverage nor cost control.<sup>1,50-53</sup> Hawaii's program has left many uncovered because of loopholes in the law, and costs in that state have continued to spiral upward. A 1988 Massachusetts employer mandate law was passed but later abandoned when costs soared.<sup>51</sup>

### The Medicare HMO Program and Medicare Voucher Schemes

Under Medicare's HMO program, private HMOs have already enrolled millions of senior citizens. Prominent proposals would expand Medicare's use of private insurers by offering seniors a voucher to purchase private coverage in lieu of traditional Medicare. These strategies assume that private plans are more efficient than Medicare, that seniors can make informed choices among health plan options, and that private insurers' risk avoidance can be thwarted. All 3 assumptions are ill-founded. Traditional Medicare is more efficient than commercial insurers; costs per beneficiary have risen more slowly and overhead is far lower.

An American Association of Retired Persons survey of seniors found that few had adequate knowledge to make informed choices among plans.<sup>54</sup> Despite regulations prohibiting risk selection in the current Medicare HMO program, plans have successfully recruited healthier than average seniors. Hence HMOs have collected high premiums for patients who would have cost Medicare little had they remained in fee-for-service Medicare. Moreover, HMOs have evicted millions of seniors in counties where profits are low, while continuing to enroll Medicare patients in prof-

itable areas.<sup>55</sup> As a result, HMOs have increased Medicare costs by \$2 billion to \$3 billion each year<sup>2</sup> and disrupted the continuity of care for many patients.

A voucher program for Medicare would also push low-income seniors into skimpy plans similar to the defined contribution approach to employee coverage discussed above. Moreover, Congress is unlikely to increase the value of the voucher to keep pace with the rising costs of private plans. Over time, seniors' out-of-pocket costs for coverage would likely rise.

### CONCLUSION

Health care reform is again near the top of the political agenda. Health care costs have turned sharply upward. The number of Americans without insurance or with inadequate coverage rose even in the boom years of the 1990s. Medicare and Medicaid are threatened by ill-conceived reform schemes, and middle-class voters are very concerned about the abuses of managed care. Other wealthy countries manage to provide universal health care at half the cost we pay. Their problems stem mainly from inadequate funding, not the structure of their systems. In contrast, the problems in the United States are systemic. Incremental changes cannot solve them; further reliance on market-based strategies will exacerbate them. What needs to be changed is the system itself.

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Thoughts give birth to a creative force that is neither elemental nor sidereal. . . . Thoughts create a new heaven, a new firmament, a new source of energy, from which new arts flow.  
—Philippus Aureolus Paracelsus (c 1493-1541)





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## Frequently Asked Questions

### What is single payer?

Single-payer national health insurance is a system in which a single public or quasi-public agency organizes health financing, but delivery of care remains largely private. Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs. Patients would regain free choice of doctor and hospital, and doctors would regain autonomy over patient care.

### Is national health insurance ‘socialized medicine’?

No; socialized medicine is a system in which doctors and hospitals work for and draw salaries from the government. Doctors in the Veterans Administration and the Armed Services are paid this way. The health systems in Great Britain and Spain are other examples. But in most European countries, Canada, Australia and Japan they have socialized health insurance, not socialized medicine. The government pays for care that is delivered in the private (mostly not-for-profit) sector. This is similar to how Medicare works in this country. Doctors are in private practice and are paid on a fee-for-service basis from government funds. The government does not own or manage medical practices or hospitals.

The term socialized medicine is often used to conjure up images of government bureaucratic interference in medical care. That does not describe what happens in countries with national health insurance where doctors and patients often have more clinical freedom than in the U.S., where private insurance bureaucrats attempt to direct care.

### Who will run the health care system?

There is a myth that with national health insurance the government will make the medical decisions. But in a publicly financed, universal health care system, medical decisions are left to the patient and doctor – as they should be. This is true even in the countries like the U.K. and Spain (or in U.S. systems like the VA) that have socialized medicine.

In a public system, the public has a say in how it’s run. Cost containment measures are publicly managed at the state level by elected and appointed agencies that represent the public. This agency decides on the benefit package and negotiates doctor fees and hospital budgets. It also is responsible for health planning and the distribution of expensive technology. Thus, the total budget for health care is set through a public, democratic process, but clinical decisions remain a private matter between doctor and patient.

### Won’t this just be another bureaucracy?

The United States has the most bureaucratic health care system in the world. Over 31% of every health care dollar goes to paperwork, overhead, CEO salaries, profits, etc. Because the U.S. does not have a unified system that serves everyone, and instead has thousands of different insurance plans, each with its own marketing, paperwork, enrollment, premiums, and rules and regulations, our insurance system is both extremely complex and fragmented.

In contrast, the Medicare program operates with just 3% overhead, compared to 15% to 25% overhead at a typical HMO. Provincial single-payer plans in Canada have an overhead of about 1%.

It is not necessary to have a huge bureaucracy to decide who gets care and who doesn’t when everyone is covered and has the same comprehensive benefits. With a universal health care system we would be able to cut our bureaucratic burden in half and save over \$300 billion annually.

## **Won't this raise my taxes? How will the system be financed?**

Currently, about 60% of our health care system is financed by public money: federal and state taxes, property taxes and tax subsidies. These funds pay for Medicare, Medicaid, the VA, coverage for public employees (including police and teachers), elected officials, military personnel, etc. There are also hefty tax subsidies to employers to help pay for their employees' health insurance. About 20% of health care is financed by all of us individually through out-of-pocket payments, such as co-pays, deductibles, the uninsured paying directly for care, people paying privately for premiums, etc. Private employers only pay 21% of health care costs. In all, it is a very "regressive" way to finance health care, in that the poor pay a much higher percentage of their income for health care than higher income individuals do.

A universal public system would be financed in the following way: The public funds already funneled to Medicare and Medicaid would be retained. The difference, or the gap between current public funding and what we would need for a universal health care system, would be financed by a payroll tax on employers (about 7%) and an income tax on individuals (about 2%). The payroll tax would replace all other employer expenses for employees' health care, which would be eliminated. The income tax would take the place of all current insurance premiums, co-pays, deductibles, and other out-of-pocket payments. For the vast majority of people, a 2% income tax is less than what they now pay for insurance premiums and out-of-pocket payments such as co-pays and deductibles, particularly if a family member has a serious illness. It is also a fair and sustainable contribution.

Currently, 47 million people have no insurance and hundreds of thousands of people with insurance are bankrupted when they have an accident or illness. Employers who currently offer no health insurance would pay more, but those who currently offer coverage would, on average, pay less. For most large employers, a payroll tax in the 7% range would mean they would pay slightly less than they currently do (about 8.5%). No employer, moreover, would gain a competitive advantage because he had scrimped on employee health benefits. And health insurance would disappear from the bargaining table between employers and employees.

Of course, the biggest change would be that everyone would have the same comprehensive health coverage, including all medical, hospital, eye care, dental care, long-term care, and mental health services. Currently, many people and businesses are paying huge premiums for insurance so full of gaps like co-payments, deductibles and uncovered services that it would be almost worthless if they were to have a serious illness.

## **How much do private insurance companies spend on overhead and profit?**

Private insurance overhead and profit, on average, fluctuates between 12% and 14% nationally. This figure is somewhat lower than the 16-20% at many of the big insurers because it includes self-insured plans of many big employers that have overhead of about 6-7%. On the other hand, overhead in the individual market is often substantially higher than 20%, and in some cases above 30%.

The estimate that total administrative costs consume 31% of U.S. health spending is from research by Drs. David Himmelstein and Steffie Woolhandler and published in the *New England Journal of Medicine* in 2003. Insurance overhead accounts for a minority of the overhead. Much more occurs in physicians' offices, hospitals, and nursing homes - driven by our current fragmented payment system. The fact that insurance overhead per se accounts for a minority of the bureaucratic waste in the system explains why implementing a public option plan would not achieve most of the potential bureaucratic savings that can be realized through single payer. Even with a public option, hospitals, physicians and nursing homes would still have to maintain virtually all of their internal billing and cost tracking apparatus in order to fight with private insurers.

## **Why are health care costs rising and how can single payer "bend the cost curve"?**

High administrative costs and excessive - and even ridiculous - prices under the current system are themselves symptoms of the increasing commercialization of health care and the growing dominance of private firms in health care delivery and financing. Cutting administrative costs and mandating reasonable pricing would result in very large one-time savings and allow an affordable transition to comprehensive

coverage of the un- and under-insured, but without other cost control mechanisms these savings would soon be eaten up by continued health care inflation.

Over the longer term, the keys to savings lie in improved health planning implemented through control of capital spending, as well as limitations on market incentives and limitations on for-profit involvement in health care delivery.

- Health planning to assure that investments in expensive new technology meet needs, but do not exceed them, is the only proven means to limit the excessive and dangerous interventions that drive up costs and lower quality. It is the salutary alternative to the current strategies of case-by-case review by HMOs, or the potentially disastrous incentives offered under capitation arrangements.

- Limits on for-profit ownership and excessive compensation of health care executives are needed to dull the incentives for institutional gain at the expense of system-wide performance. For-profit hospitals and dialysis facilities paid by Medicare have higher costs and lower quality than non-profits. Eliminating them is key to “bending the cost curve.”

### **How will we keep costs down if everyone has access to comprehensive health care?**

People will seek care earlier when chronic diseases such as hypertension and diabetes are more treatable. We know that both the uninsured and many of those with skimpy private coverage delay care because they are afraid of health care bills. This will be eliminated under such a system. Undoubtedly the costs of taking care of the medical needs of people who are currently skimping on care will cost more money in the short run. However, all of these new costs to cover the uninsured and improve coverage for the insured will be fully offset by administrative savings.

In the long run, the best way to control costs is to improve health planning to assure appropriate investments in expensive, high-tech care, to negotiate fees and budgets with doctors, hospital and drug companies, and to set and enforce a generous but finite overall budget.

### **Won't competition be impeded by a universal health care system?**

Advocates of the “free market” approach to health care claim that competition will streamline the costs of health care and make it more efficient. What is overlooked is that past competitive activities in health care under a free market system have been wasteful and expensive, and are the major cause of rising costs.

There are two main areas where competition exists in health care: among the providers and among the payers. When, for example, hospitals compete they often duplicate expensive equipment in order to corner more of the market for lucrative procedure-oriented care. This drives up overall medical costs to pay for the equipment and encourages overtreatment. They also waste money on advertising and marketing. The preferred scenario has hospitals coordinating services and cooperating to meet the needs of their communities.

Competition among insurers (the payers) is not effective in containing costs either. Rather, it results in competitive practices such as avoiding the sick, cherry-picking, denial of payment for expensive procedures, etc. An insurance firm that engages in these practices may reduce its own outlays, but at the expense of other payers and patients.

### **How will we keep doctors from doing too many procedures?**

This is a problem in any system that reimburses physicians on a fee-for-service basis. In today's health system, another problem is physicians doing too little for patients. So the real question is, “How do we discourage both overcare and undercare?”

One approach is to carefully control new capital expenditures. Once a hospital or imaging center purchases a multimillion-dollar CT scanner, it will try to generate enough scans to pay off the fixed cost. Explicit health planning should be done to assure that expensive machines and facilities are sited where they are needed and not where they are redundant and likely to generate overuse.

Another approach is to compare physicians' use of tests and procedures to their peers with similar patients. A physician who is “off the curve” will stand out. A related approach is to set spending targets for

each specialty. This encourages doctors to be prudent stewards and to make sure their colleagues are as well, because any doctor doing unnecessary procedures will be taking money away from colleagues.

In addition, expert guidelines by groups like the American College of Physicians, etc., can help shape professional standards - which will certainly change over time as treatments change. This really gets to the heart of “how do you improve the quality of health care,” which is a longer topic. Suffice it to say that single-payer, universal coverage provides a framework for achieving thoughtful quality improvement.

### **How will we keep drug prices under control?**

When all patients are under one system, the payer wields a lot of clout. The VA gets a 40% discount on drugs because of its buying power. This “monopsony” buying power is the main reason why other countries’ drug prices are lower than ours. This also explains the drug industry’s staunch opposition to single-payer national health insurance.

### **Won’t this result in rationing like in Canada?**

The U.S. already rations care. Rationing in U.S. health care is based on income: if you can afford care, you get it; if you can’t, you don’t. A recent study by the prestigious Institute of Medicine found that 18,000 Americans die every year because they don’t have health insurance. Many more skip treatments that their insurance company refuses to cover. That’s rationing. Other countries do not ration in this way.

If there is this much rationing, why don’t we hear about it? And if other countries ration less, why do we hear about them? The answer is that their systems are publicly accountable, and ours is not. Problems with their health care systems are aired in public; ours are not. For example, in Canada, when waits for care emerged in the 1990s, Parliament hotly debated the causes and solutions. Most provinces have also established formal reporting systems on waiting lists, with wait times for each hospital posted online. This public attention has led to recent falls in waits there.

In U.S. health care, no one is ultimately accountable for how the system works. No one takes full responsibility. Rationing in our system is carried out covertly through financial pressure, forcing millions of individuals to forego care or to be shunted away by caregivers from services they can’t pay for.

The rationing that takes place in U.S. health care is unnecessary. A number of studies (notably a General Accounting Office report in 1991 and a Congressional Budget Office report in 1993) show that there is more than enough money in our health care system to serve everyone if it were spent wisely. Administrative costs are at 31% of U.S. health spending, far higher than in other countries’ systems. These inflated costs are due to our failure to have a publicly financed, universal health care system. We spend about twice as much per person as Canada or most European nations, and still deny health care to many in need. A national health program could save enough on administration to assure access to care for all Americans, without rationing.

### **Will medical research suffer?**

Much current medical research is publicly financed through the National Institutes of Health. Under a universal health care system this would continue. For example, a great deal of basic drug research, for example, is funded by the government. Drug companies are invited in for the later stages of “product development,” the formulation and marketing of new drugs. AZT for HIV patients is one example. The early, expensive research was conducted with government money. After the drug was found to be effective, marketing rights went to the drug company.

Medical research does not disappear under universal health care system. Many famous discoveries have been made in countries with national health care systems. Laparoscopic gallbladder removal was pioneered in Canada. The CT scan was invented in England. The treatment for juvenile diabetes by transplanting pancreatic cells was developed in Canada.

It is also important to note that studies show that, in the U.S., the number of clinical research grants declines in areas of high HMO penetration. This suggests that managed care increasingly threatens clinical research. Another study surveyed medical school faculty and found that it was more difficult to do research in areas where high HMO penetration has enforced a more business-oriented approach to health care.

Finally, it appears that the increasing commercialization of research is beginning to slow innovation. Drug firms' increasing reliance on contract research organizations (and for-profit ethical-review boards) has coincided with a sharp drop in innovative new drugs and a spate of "me-too" drugs - minor variations on old drugs that offer little benefit other than extended patent life.

### **What will happen to physician incomes?**

On the basis of the Canadian experience under national health insurance, we expect that average physician incomes should change little. However, the income disparity between specialties is likely to shrink.

The increase in patient visits when financial barriers fall under a single-payer system will be offset by resources freed up by a drastic reduction in administrative overhead and physicians' paperwork. Billing would involve imprinting the patient's national health program card on a charge slip, checking a box to indicate the complexity of the procedure or service, and sending the slip (or a computer record) to the physician-payment board.

### **Can a business keep private insurance if they choose?**

Yes and no. Everyone has to be included in the new system for it to be able to control costs, reduce bureaucracy, and cover everyone. In Canada, businesses can purchase additional private insurance that covers things not covered by the national plan (e.g. private rooms, orthodontia, etc.). However, we support a comprehensive benefit package for the single-payer program that would eliminate the need (and most demand) for supplemental coverage.

Insurance companies would not be allowed to offer the same benefits as the universal health care system, a restriction contained in the traditional Medicare program. Allowing such duplication of coverage weakens and eventually destabilizes the health care system. It undermines the principle of pooling the risk. Health care systems act as universal insurers. At any one time the healthy help pay for those who are ill. If private insurers are allowed to cherry-pick the healthy, leaving the public health care system with the very sick, the system will fail.

This, in fact, is what we see happening to Medicare through the Medicare Advantage program. The government pays Medicare HMOs 13% more than it pays traditional Medicare, yet the HMOs care for a healthier mix of seniors. This is leading to privatization of Medicare and funding shortfalls for the traditional Medicare program.

### **What will happen to all of the people who work for insurance companies?**

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 health care 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 small fraction of the administrative savings from the transition to national health insurance.

PNHP has worked with labor unions and others to develop plans for a jobs conversion program with would protect the incomes of displaced clerical workers until they were retrained and transitioned to other jobs.

### **What will happen to malpractice costs under national health insurance?**

They will fall dramatically, for several reasons. First, about half of all malpractice awards go to pay present and future medical costs (e.g. for infants born with serious disabilities). Single payer national health insurance will eliminate the need for these awards. Second, many claims arise from a lack of communication between doctor and patient (e.g. in the Emergency Department). Miscommunication/mistakes are heightened under the present system because physicians don't have continuity with their patients (to know their prior medical history, establish therapeutic trust, etc) and patients aren't allowed to choose and keep the doctors

and other caregivers they know and trust (due to insurance arrangements). Single payer improves quality in many ways, but in particular by facilitating long-term, continuous relationships with caregivers. For details on how single payer can improve the quality of health care, see “A Better Quality Alternative: Single Payer National Health Insurance.” For these and other reasons, malpractice costs in three nations with single payer are much lower than in the United States, and we would expect them to fall dramatically here.

### **What proportion of health spending is for undocumented immigrants?**

Very little. All foreign-born people, including immigrant workers who have legal status and who have lived in the U.S. for years, account for somewhat less than one-quarter of the uninsured, according to the Census Bureau. We do know that foreign-born people in the U.S. are, on average, healthier and utilize little health care - about half of the health care (per capita) of U.S.-born persons. Surprisingly this is true whether or not they have insurance. Immigrant children receive very little care, 74 percent less overall than other children. So, if the foreign born are less than one-quarter of the uninsured, only one-eighth of health spending on the uninsured is going to the foreign born, which translates into a tiny fraction of all U.S. health spending. In fact, most immigrants have health insurance coverage, and 30% of immigrants use no health care at all in the course of a year. Undocumented immigrants are politically unpopular and hence a convenient target, but they are not the cause of rising health care costs.

### **Why shouldn't we let people buy better health care if they can afford it?**

Whenever we allow the wealthy to buy better care or jump the queue, health care for the rest of us suffers. If the wealthy are forced to rely on the same health system as the poor, they will use their political power to assure that the health system is well funded. Conversely, programs for the poor become poor programs. For instance, because Medicaid doesn't serve the wealthy, the payment rates are low and many physicians refuse to see Medicaid patients. Calls to improve Medicaid fall on deaf ears because the beneficiaries are not considered politically important. Moreover, when the wealthy jump the queue, it results in longer waits for others. Studies in New Zealand and Canada show that the growth of private care in parallel to the public system results in lengthening waits. Additionally, allowing the development of a parallel, private system for the wealthy means the creation of a permanent lobby for underfunding public care. Such underfunding increases the demand for private care.

### **Universal healthcare is okay for a small country or organization like Switzerland, Canada, or the Veterans Administration, but it wouldn't work when scaled up to meet the needs of a large country like the US.**

Medicare is a national program that works reasonably well. There is no reason whatsoever that would make it hard to scale up. Indeed, Medicare was initiated (and administered for tens of millions of enrollees) before computers became available - scaling it up 7 or 8 fold should not prove difficult.

In Canada, health care is administered at the provincial level. The Ontario Health Insurance Program, which includes the city of Toronto as well as rural areas, is a good example. Since much of the program we envision would be regionalized, with regions similar in size to Ontario, that program seems a sound indication that scale should not be problematic.

### **What about incremental reform of the health system?**

As a matter of policy, PNHP expressly opposes many so-called gradual steps towards single-payer. Many well-meaning supporters often push these bills as “feasible steps” to move us towards single-payer, but the history of these kinds of health reform efforts - Hawaii in 1974, Massachusetts in 1988, Oregon in 1989, Tennessee in 1992, Minnesota in 1992, Maine in 2003, etc. - shows that despite their claims of pragmatism, incremental reforms have consistently failed for more than three decades. Incremental reforms cannot garner administrative savings and redirect them to care. Hence they always founder on the shoals of cost. In addition, these reforms distract attention from the economically realistic, if politically challenging, option of single-payer reform.

## **Should PNHP support a public Medicare-like “public option” in a market of private plans?**

The “public plan option” won’t work to fix the health care system for 2 reasons.

1 - It foregoes at least 84% of the administrative savings available through single payer. The public plan option would do nothing to streamline the administrative tasks (and costs) of hospitals, physicians offices, and nursing homes, which would still contend with multiple payers, and hence still need the complex cost tracking and billing apparatus that drives administrative costs. These unnecessary provider administrative costs account for the vast majority of bureaucratic waste. Hence, even 95% of Americans who are currently privately insured were to join the public plan (and it had overhead costs at current Medicare levels), the savings on insurance overhead would amount to only 16% of the roughly \$400 billion annually achievable through single payer - not enough to make reform affordable.

2 - A quarter century of experience with public/private competition in the Medicare program demonstrates that the private plans will not allow a level playing field. Despite strict regulation, private insurers have successfully cherry picked healthier seniors, and have exploited regional health spending differences to their advantage. They have progressively undermined the public plan - which started as the single payer for seniors and has now become a funding mechanism for HMOs - and a place to dump the unprofitably ill. A public plan option does not lead toward single payer, but toward the segregation of patients; with profitable ones in private plans and unprofitable ones in the public plan.

## **What about the proposal to lower the eligibility age for Medicare to 55?**

Lowering the eligibility age for Medicare to 55 only works if it is mandatory. Otherwise it becomes the place where all the sickest patients get dumped. That might be okay for the sick people since Medicare is often better and more secure than private coverage, but it would drive total health care costs (and premiums) up, not down.

## **Won’t the Affordable Care Act cover the nearly 50 million uninsured Americans?**

The Patient Protection and Affordable Care Act (PPACA) will reduce the numbers of uninsured starting in 2014 (with about half of the new coverage being Medicaid, and the other half private plans) but by 2019 it is estimated it will still leave 23 million of the 49.9 million Americans identified as being uninsured without coverage.

However, it is important to note that the CBO estimate of 23 million uninsured does not include a whole additional category of people who face barriers to accessing care: People who are underinsured, who will face financial hardship should medical needs arise. Underinsurance will actually increase under PPACA.

Here’s why PPACA is an underinsurance program: Employers will see little relief and will expand their present trend of shifting more insurance and health care costs onto their employees. Individuals buying plans in the new insurance exchanges will select underinsurance products with low actuarial values (30 to 40 percent of costs must be paid by the patient) with subsidies that are inadequate to avoid financial hardship. Many will move into the Medicaid program which has more expansive coverage, but which reimburses providers at such a low rate that far too many will not be willing to accept patients under this program. With Medicaid chasing away providers, it too has become another form of underinsurance.

Thus the touted increase in insurance enrollment under PPACA will be more than offset by the explosion in underinsurance - affecting the majority of Americans.

## **What is PNHP view of ACO's?**

While the term ACO remains at best vaguely defined, the concept is hauntingly similar to the capitated managed care experiment that proved disastrous in the 1990s. In both instances, providers receive a set annual payment to cover the costs of all care, and get to keep whatever they don't spend on patients. The obvious winning strategy - from a business point of view - is to recruit relatively healthy patients, offering luxurious care for the healthy and minimally ill, and subtle queues that those with expensive illness would be better off elsewhere. Neither risk adjustment nor quality-monitoring schemes are up to the task of blunting these incentives.

An ACO can game risk adjustments by ferreting out additional diagnoses that may be clinically unimportant but would up its capitation payment, and make its outcomes look better as well. The Dartmouth group has already shown that more expensive providers label their patients with more diagnoses in this way. Quality monitoring efforts measure only a tiny slice of what's important in medicine. Overarching measures of quality like death rates and family/community well being are either too rare to measure in a statistically reliable manner, too subtle to capture with current or foreseeable measurement strategies, or too biased by differences in the baseline health of enrollees. Evidence from the UK shows that providers will improve on the aspects of care that are measured, but neglect those that are not, and it's far from clear that monitoring of quality measures has actually improved quality or can prevent abuses.

The ACO strategy remains an untested theory for health reform. Considerable experience with similar reforms in the past suggests that this ACO strategy will lead to yet another health policy dead end.

### **What is a Voucher Plan? What's wrong with it?**

A Voucher Plan is a version of health reform that seeks to provide a simplified means for individuals to purchase health insurance, while retaining the private insurance system intact. The principal advocates of this plan are Ezekiel Emanuel, a bioethicist now serving as one of President Obama's principal advisors on health care reform, and Victor Fuchs, a retired economist from Stanford University. Under this plan, individuals would be given a health care certificate, an insurance "voucher," which would entitle them to enroll in a private health plan of their choice. Employer-based insurance would be eliminated. The vouchers would, under the Emanuel-Fuchs plan, be paid for through a value-added tax (VAT), essentially a sales tax on all manufactured goods and services. This is a highly regressive way of financing such a plan, since low-income people spend a much larger percentage of their income on purchases of goods and services than do higher-income people. However, the main problem with such a plan is that it leaves the wasteful, inefficient, and inequitable private insurance system in place, with no change at all in its operation. It simply makes it easier for us to purchase their defective product.

### **Why not use tax subsidies to help the uninsured buy health insurance?**

The major flaw of tax subsidies is that they would be used to help purchase plans in our current fragmented system. The administrative inefficiencies and inequities that characterize our system would be left in place, and we would continue to waste valuable resources that should be going to patient care instead. Moreover, even with tax subsidies, moderate- and lower-income individuals would be unable to afford good coverage, leaving them with modest benefits and high cost-sharing that would often make health care unaffordable. Instead of perpetuating our current inequities, tax policies should be used to create equity in contributions to a system in which everyone is assured access to comprehensive beneficial services.

If the tax subsidies are granted to individuals, employers would be motivated to drop their coverage, and most individuals covered would have merely rotated from employer coverage to individual coverage. The net reduction in the numbers of uninsured would be small. If the tax subsidies are granted to employers, a major shift in funding passes from employers to taxpayers without significant improvements efficiency or fairness. We can use the tax system to create equity in the way we fund health care, but we should also expect equity and efficiency in allocation of our health care resources. Distributing health resources according to human needs is possible only if we eliminate the private health plans and establish a publicly administered system.

### **What's wrong with MSA/HSA plans?**

Medical savings accounts (MSAs) and similar options such as health savings accounts (HSAs) are individual accounts from which medical expenses are paid. Once the account is depleted and a deductible is met, medical expenses are covered by a catastrophic plan.

Individuals with significant health care needs would rapidly deplete their accounts and then be exposed to large out-of-pocket expenses; hence they would tend to select plans with more comprehensive coverage. Since only healthy individuals would be attracted to the MSAs/HSAs, higher-cost individuals would be concentrated in the more comprehensive plans, driving up premiums and threatening affordability. By placing



everyone in the same pool, the cost of high-risk individuals is diluted by the larger sector of relatively healthy individuals, keeping health insurance costs affordable for everyone.

Currently, HSAs offer substantial tax savings to people in high-income brackets, but little to families with average incomes, and thus serve as a covert tax cut for the wealthy.

Moreover, MSA/HSA plans discourage preventive care, which generally would be paid out-of-pocket, and do nothing to restrain spending for catastrophic care, which accounts for most health costs. Finally, HSAs/MSAs discriminate against women, whose care costs, on average, \$1,000 more than men's annually. Hence, on the MSA/HAS plan, the average woman pays \$1,000 more out-of-pocket than her male counterpart.

### **What about report cards on physicians? Won't they reduce costs and improve quality?**

The best study of the impact of report cards on providers (a study of heart surgeons in New York) found they actually increased costs, worsened care, and inevitably gave physicians incentives to avoid the sickest patients. Several papers have documented the destructive effect of the New York Department of Health's heart surgery report cards. The best is by David Dranove, et al:

"[O]ur results show that report cards [on heart surgeons] led to increased expenditures for both healthy and sick patients, marginal health benefits for healthy patients, and major adverse health consequences for sicker patients. Thus, we conclude that report cards reduced our measure of welfare over the time period of our study" (p. 577). "[M]andatory reporting mechanisms inevitably give providers the incentive to decline to treat more difficult and complicated patients" (p. 581).

– David Dranove et al., *"Is more information better? The effects of 'report cards' on health care providers,"* Journal of Political Economy 2003;111:555-588

### **What does PNHP have to say about the primary care workforce shortage?**

Countries with strong health care systems have at least half of their physicians in generalist primary care practice 50 percent in Canada, 70 percent in the United Kingdom.

In 2008, less than 8 percent of U. S. seniors chose family medicine, a 50 percent decline since 1997; only 199 U. S. seniors matched into primary care internal medicine, 248 into IM/Peds, and 53 into primary Peds. The percentage of international medical graduates in our 3 primary care specialties is now 73 percent for IM, 68 percent for Peds, and 55 percent for Fam. Med. I don't believe that we have more than about 30 percent of our physicians in primary care. Only 20 percent of U.S. internal medicine graduates become general internists, and most pediatric graduates go into sub-specialties.

Primary care has been declining in this country for many years, as a result of multiple factors, including more attractive lifestyles and reimbursement on the non-primary care fields; student perceptions of the demands, rewards, and prestige of generalist practice; and uncertainty of the health care environment. The American College of Physicians in 2007 declared that: "Our primary care infrastructure is at grave risk of collapse."

Single-payer national health insurance will provide an opportunity to restructure the U.S. physician workforce, strengthen and rebuild primary care. We should have at least 50 percent of our physicians in primary care fields. Useful approaches include reimbursement reform, loan forgiveness programs for graduating medical students entering primary care residencies, increased funding for graduate medical education teaching programs in primary care, and reallocation of GME training slots by specialty.

### **What is PNHP's perspective on the Medicare crisis?**

Medicare can only be saved by incorporating it in a single-payer program that would be very different than the current Medicare program.

1) Medicare benefits need to be greatly upgraded. At present, Medicare covers less than half of the total medical expenses incurred by its beneficiaries.

2) Medicare's payment policies for physicians, hospitals, home care, rehab, nursing homes and HMOs are all deeply flawed.

- Its physician fee schedule is wildly skewed toward specialist care and needlessly complex; it discourages salaried practice.

- Its hospital payment system uses per-patient payments rather than global budgeting, and lumps together capital and operating payments – negating any real health planning possibilities.

- Its rehab and nursing home payment methods are similarly complex, discourage health planning, and reward institutions willing and able to engage in financial scheming.

-The home care payment system burdens nurses with extreme amounts of paperwork, rather than paying home care agencies lump sum budgets.

3) As long as Medicare is one among many payers it cannot achieve substantial administrative savings (in doctors' offices, hospitals, and other facilities) and it cannot enforce the health planning changes needed to "bend the cost curve" over the long term.

In short, the only way to preserve Medicare is to replace it with a single payer program with comprehensive benefits and effective cost controls (negotiated fees, global budgets, and bulk purchasing) – not just incrementally expand it to the whole population.