PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

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Notes for Activists

Finding your niche in activism

PNHP Leadership Training Institute
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1. The first rule of activism is to "use your talents."

If you are writer, write. If you prefer speaking (most physicians do) speak. If you like to entertain, hold a "house party." If you are a cartoonist (e.g. Rex Morgan, MD), put single payer in your cartoon.

Some things you can learn to do (e.g. fundraising and speaking), and to overcome fears, but having fun is more important than most people realize. It's difficult to get people to volunteer their time to do something they don't enjoy, find relatively easy, and meaningful.

2. "Start where you are"

We find that once a person becomes active, they find it relatively easy to keep going. Speakers get invited to speak again. Health reporters phone and ask questions. There are always new reasons to write a letter to the editor. But it can be difficult to get started as an activist. So we say, "Start where you are."

Your specialty, physician group, and local hospital are sources of potential speaking engagements and writing opportunities: Grand Rounds, informal bag lunches, specialty conferences, newsletters and journals, etc.

Any place you already go to hear speakers, and already read for your health care news, is a potential place for you to reach others.

Your community is a source of contacts with local media and potentially supportive civic groups (League of Women Voters, Rotary Clubs, unions, churches, senior centers, even book clubs). If you are new to activism, speaking to grassroots groups can help you overcome any doubts or fears because the public is, generally speaking, so eager to hear about this issue. Don't underestimate how exciting and empowering it is for a public audience to hear a physician say "health care should be a right."

Physicians can usually get a lunch meeting with the local paper's health/business reporter (small papers usually use the AP wire for health policy stories, so you may try to meet with the AP

reporters for your region) and editorial writers/Board. You can ask to meet with them yourself or invite another PNHP speaker (perhaps someone coming to town to give a Grand Rounds).

3. Use your network of friends, family, and contacts.

Physicians are more likely to know businesspeople and have influential political contacts than other activists. Use your connections! We are in particular need right now for small and large business support for single payer. Would a business owner you know be willing to talk to a reporter about why we need a single payer system? Invite you to speak at his annual business convention?

Do you know someone running for office? Offer to be their health policy advisor, or to come in and meet with them about effective health care reform. Meet with your national and state legislators to educate them and their health aides on national health insurance, but don't get hung up on them. In general, "politicians are followers, not leaders. If we create momentum for change, they will follow, but they won't lead."

Many people/physicians can contribute financially to this movement easier than they can volunteer. It is a privilege to have the resources to make a financial donation, and it makes people feel good to be able to help. Don't deprive them of the opportunity to contribute.

4. Work at a sustainable pace – for the rest of your life.

Although some activists are retired, and some are able to travel long distances to speak and meet, most people will need to fit in their activism with job, family, kids, hobbies, chores, and other volunteer activities. "This is a long-term struggle, so we don't want to ask people to work at a pace they can't sustain over many years." Thus, the closer the fit between your daily life and your single payer efforts, the easier it is to stay involved over the long-term.

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Building the Movement with Public Speaking

By Gordon Schiff, MD, revised 5/05, transcribed/revised 11/09

Know the values, needs, and issues of the audience/organization

Be sure to have a good conversation before your talk with someone from the organization (perhaps the person arranging the talk), and read up on the group's literature. One highly effective practice is to come early, listen to their issues at their (business/residency) meeting, and refer back to these issues while you talk. Every organization you speak with is a potential ally in a coalition.

Use humor and modesty to win over the audience

So many of our opponents are arrogant, uncaring, thoughtless, and non-clinical. This often makes it easy and important to distinguish them from ourselves.

If possible, go in a pair

Bring a partner. If you are more experienced, bring along someone new to help you and learn from you. If newer, go along with someone more experienced and take notes on their tricks and audience responses. Share constructive criticism and feedback when you debrief each other.

Be self-critical, and honestly introspective

Identify the weaknesses of single payer (past strategic miscalculations, Canadian weaknesses) – without being apologetic. However there is nothing worse than a speaker who begins by apologizing and persists in doing so throughout the talk. Don't apologize for any speaking weaknesses and certainly don't be apologetic for your bold ideas – put these forward distinctly and forcefully.

Get names

Sign-in sheets allow the local chapter to continually build its list of names and contact information. If you are speaking with physicians who would like more information or to become a member, feel free to contact the national PNHP office for assistance. If you are with another single-payer activist, they may be able to pass around a clipboard during your presentation. Be sure to follow-up on all requests in a timely manner.

Pass out information

Bring pamphlets and brochures with you to each talk. If you are speaking to physicians, PNHP can supply you with physician-targeted information. If you are speaking to community group, Healthcare Now can assist in providing materials. PNHP will donate $100 for lunches to any medical student organization that hosts a PNHP speaker.

Solicit other speaking engagements

Many people are involved in more than one organization. Feel free to let your audience know that you are available to speak with other groups on the importance of single payer. If you can't meet a request, you can always forward the request to the national office for follow-up.

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PNHP PowerPoints

The PNHP PowerPoint, along with yearly supplements and presentations on specific topics by PNHP leaders, are available for viewing and download from the PNHP website.

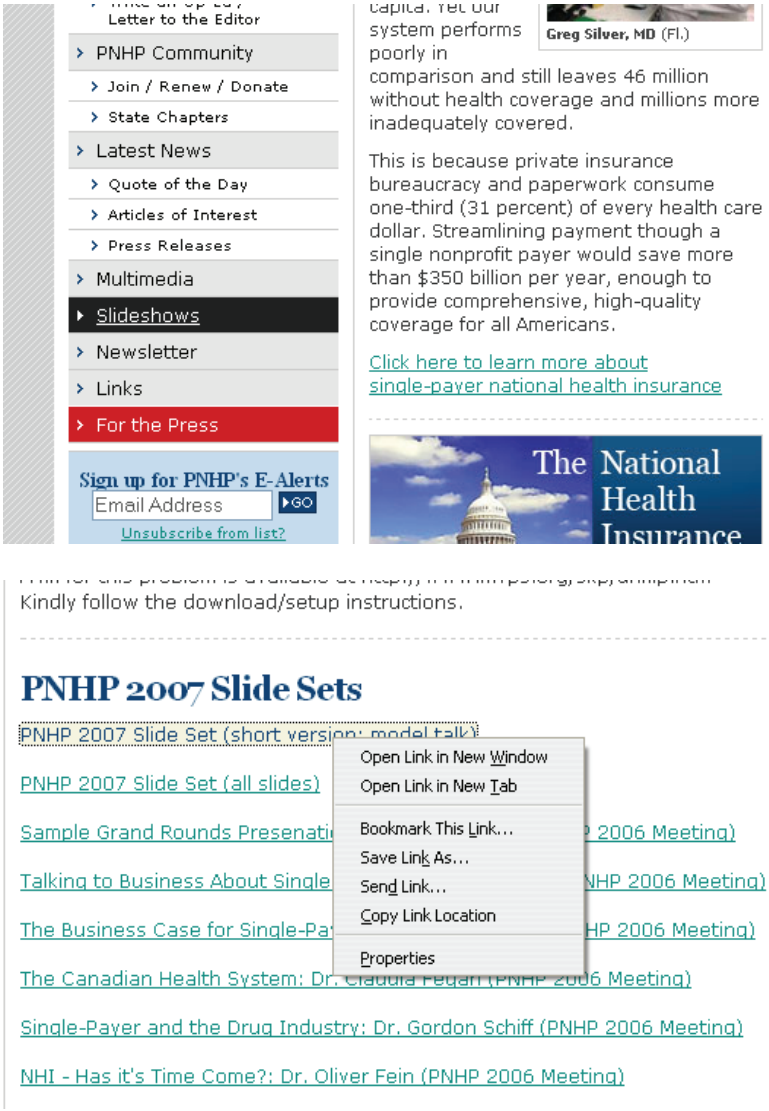
To download PowerPoints:

1. Go to www.pnhp.org/slideshows

2. Enter the password: adams

3. View a PowerPoint by clicking on the link. To save a slideshow, RIGHT-CLICK on the link of the presentation you would like and select "Save Target As" or "Save Link As." When the pop-up box appears, select where you would like to save the PowerPoint and select "save." The slides are now accessible from the directory in which you saved them.

Made your own PowerPoint? Share it with the PNHP office; email it to info@pnhp.org



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Media tips

By Mark Almberg, Communications Director

Build your story – 3 main points – your 'messages'

1. What: What is the problem, what are you proposing, what is PNHP?
2. Why: Why is this important, why is it a problem – especially, why is this important to the reporter's readers/listeners/audience?
3. How: How can you solve the problem, how will people benefit from your solution?

Stay on message – Your messages are more important than their questions (you have an agenda and you know what you need to get across). Think in terms of 'What questions do they have for my answers?'

1. Use transitions to direct the conversation back to your message

   "That's a good question, but what's really important here is..."

   "That's an interesting point, but what we're concerned with is..."

   "I don't know the answer to that question, but what I do know is..."

   If the other person being interviewed is giving a great deal of incorrect information about PNHP: "I can't even begin to respond to all that misinformation, but what you need to know is ..."

   If the misinformation is really outrageous, you can say, "I can't even dignify that with a response, but here is the real issue..."

2. Get your message out early and often

   No matter what they ask first, go straight to your message first – it may be your only chance.

   Repeat your messages – you can use different phrases and emphasize different things, but don't be afraid to say the same thing more than once even if they ask you the exact same question. It is human nature to want to be helpful and try to give the reporter a different answer when s/he asks the same question, but just stick to your messages.

3. Use your message as a life preserver

   If it gets confrontational or if the "opponent" (if you are debating) disputes your information, go back to your main points.

   If the interview goes off in a different direction, take control and bring it back to your main message.

Be Yourself (as corny as that may sound)

Speak the way you normally speak.

Don't try to sound smarter or dumber than you are – the more you seem like a "real person" and genuine, the more believable you will appear (for TV, radio, or print).

Don't try to speak in sound bites. Be concise and be succinct, but explain it the way you are comfortable explaining it.

Feel free to express your personality or use personal experience. Remember you are the expert on the single payer system – but, if appropriate, you also can take advantage of the fact that your profession is respected by the public and that you have real world experience (for example, "As a pediatrician nurse/teacher who sees hundreds of children every week, I know that...") OR you can insert relevant personal experience (it makes you more human) to make your point: "As a veteran/retiree/other, I can tell you that it's not just physicians who support a single-payer plan..."

Be natural and try to show the enthusiasm that you have for the subject (in most cases, it is good to smile and have a positive inflection in your voice – print, radio, or TV).

Keep in mind … these interviews are putting you in a very artificial setting, so, as strange as it sounds, you have make "more of an effort" to "be yourself."

Miscellaneous tips

1. Always practice and go over your main points before the interview!
2. What to do if you disagree in a debate or panel: Shake your head (TV) to show disagreement (and the host will usually want to know why – makes show exciting) or use the host's name to get attention (TV or radio)
3. Try not to talk over the person you disagree with or interrupt. (Use a motion or the host's name to gain attention instead.) You don't want to come across as overbearing – even if you are right!
4. Don't repeat a negative question in your answer and don't sound defensive (Avoid the "Nixon mistake"!) Thank them for the question and move on to your positive message. For example: "Isn't it true that most physicians are against a national health program?" Don't reply "No, it's not true that most physicians are against a national health program." Instead, say "Thank you for bringing that up, but actually, the majority of physicians support a sensible plan to provide affordable health care for all, etc."
5. Don't fall for a question with a false premise. For example: "Since patients will no longer be able to choose their own doctors in the plan you propose, how will patients benefit from it?" First refute the premise by saying: "I disagree with the premise of your question. Actually, with a national health program, patients continue to be able to choose their own doctors -the only thing that changes is …"
6. Learn the moderator's first name and incorporate it into a few of your responses. Be "conversational."

7. You are in charge of the interview – they can't print or broadcast anything you didn't say.
8. Before the interview, ask the reporter about possible questions and who the other participants will be. Be helpful to the reporter.
9. Look the part. If the interview is at your facility, stay in the normal attire for your profession. For TV studios, dress appropriately for the camera (generally avoid bright white clothing, not too many patterns, be well-groomed because the camera exaggerates stubble, etc.)
10. You are talking about a system that will greatly benefit society (a "feel good" message), so your media interviews will go well.

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Congressional visit 'How to' kit

Setting up the meeting

Call the District Office. When you call your legislator's office, ask to speak with the person who handles the legislator's schedule. Tell the scheduler the date and time you would like to meet with your legislator (be flexible) and the general topics you wish to discuss.

For visits to the local office, seek appointments during congressional recess periods when your Member of Congress returns to your district (check the House schedule at www.house.gov/house/House_Calendar.shtml). Legislators are also frequently home in the district Friday through Monday when Congress is in session.

Let the scheduler know that the meeting should take no longer than one hour. If there is more than one person attending the meeting, let the scheduler know their names and affiliations. (A good delegation is between five to eight persons.) If someone in your group knows the legislator personally or professionally, make sure that the scheduler is aware of the relationship.

Congressional visits in Washington, D.C. Please coordinate your visit with members of our D.C. chapter; let them know you're planning a visit and ask them for suggestions and useful tips. Remember that most legislative business occurs Tuesday through Thursday and that the closing days of a session are extra busy. When you arrive in Washington, call the Member's office to confirm your appointment.

Be persistent. The objective of this initial contact is to secure a time and date to meet with your representative. Be persistent yet polite, and make it clear that YOU, the Member's constituent, are the most important person (s)he will ever listen to. Lots of times it can be hard to get a meeting, but persistence will generally be rewarded with a meeting with your representative.

Meet with *somebody*. If your Member of Congress can't meet with your group, don't feel snubbed. Meet with the staff member who works on the issue that most concerns you. For most issues relating to health care reform, you will want to meet with the domestic policy staffer. Usually that person will be based in Washington, but there will also be an aide in the local office who can meet with you. Try to meet with the highest ranking aide possible in the local office, i.e. the Senior Aide.

Confirm your appointment. After you schedule a meeting, send a confirmation letter that includes a list of those who will attend the meeting.

Preparing for the Meeting

Research your representative. You can use the Congressional Directory: www.congress.org, www.house.gov, www.senate.gov.

Just punch in your ZIP Code and the site provides you with contact information and a web page for your Member of Congress. You will be able to find biographical information, committee and subcommittee assignments, and key issues of concern for your Member. Review your legislator's voting record and any publicly stated views or opinions. If you are uncertain whether he or she has endorsed the U.S. National Health Insurance Act, H.R. 676, sponsored by Rep. John Conyers Jr. (D-Mich.), visit http://tinyurl.com/3prleu. Check the legislative status of the bill.

Determine your agenda and goals for the meeting. Your group's members should meet beforehand in order to determine the agenda and to delegate who will raise which agenda items. Have different people cover different issues, but have one person act as a facilitator for the discussion and deliver the bulk of your message. Your main objective is to get your Member to commit to endorsing single-payer legislation (if he or she hasn't already done so) and to attempt to enlist other legislators to do so.

Bring it all back home. All legislators supposedly want to improve the economy and quality of life in their district/state. It is your job to convince them that single-payer national health insurance will have a beneficial impact on people living in their own congressional district.

Make sure everyone in your group is prepared. Be certain everyone agrees on the central message and what will be asked of the legislator. This way you will avoid a possible internal debate in front of your legislator. Don't feel that you have to be an expert. Most representatives of Congress are generalists. Be open to counter-arguments, but don't get stuck on them. If you don't know the answer to a question, say so. Nothing is worse than being caught in a lie or inaccuracy. Offer to look into the question and get back to the Member (this is also an excellent opportunity to stay in touch).

Prepare an information packet to leave with your legislator. This should include information on your organization including the group's contact information, as well as a description of your objectives. You should also leave a business card with the receptionist.

Conducting the Meeting

Be on time, listen well, and don't stay too long. Be on time! Arrive five minutes early. When the meeting begins, introduce yourselves and say what issues and legislation you want to discuss. Stress that you are constituents. However, make sure that all introductions are kept brief, allowing more time for conversation with the representative.

Listen well! You will hear occasional indications of your representative's actual views, and you should take those opportunities to provide good information.

Don't stay too long! Try to get closure on the issues you discuss but leave room to continue the discussion at another time.

Build the relationship. If your representative has supported single payer in the past, be sure to thank him/her; if the opposite is true, consider that your visit may prevent more active opposition in the future, and perhaps even result in a positive vote at a later time.

Remember: This meeting shouldn't be an end in itself. Think of it as the beginning of a relationship with your representative that will allow you to voice your opinion on topics in the future. With this in mind, make sure the relationship you build is a positive one, based on respect. Try not to be hostile: agree to disagree, if necessary. They may not share your viewpoint, but your information does have an impact on how they vote.

Take notes. Make sure someone in your group takes notes on what is said during the meeting. However, don't use any recording devices. These notes should be circulated to the entire group after the meeting, as well as shared with others.

Ask for specific action. Avoid asking open-ended questions that may result in ceding control of the meeting to the legislator or his/her aide, who may spend a large part of the meeting talking about an unrelated issue. Always ask for specific actions; always get a specific commitment and then follow up. No matter how supportive or unsupportive your legislator is, there is always a next step. Visit the PNHP web site to find out what specific action should be sought at the time of your meeting.

Ask his or her position. Zero in on the basics: How will s/he vote? Do party leaders have positions on the issue? What is their influence likely to be? Is the office hearing from opponents? If so, what are their arguments and what groups are involved? Does the Member know any other key House Members or Senators who should be contacted to get favorable action on the bill? Is s/he willing to facilitate contact and to write a "Dear colleague" letter?

The Member likely won't give you an answer on the spot. Tell them you will follow up with an aide in two weeks, and be sure to do so. Offer to answer their questions or to provide additional information.

If the Member says no, be sure to find out why. Ask them what, specifically, they oppose in the bill.

Provide affirmation where possible. Look for areas of agreement and affirm them. Convey your appreciation for positive steps, no matter how small. Try to end the meeting on a positive note.

Debrief/Follow up. After the meeting, find a place where you can relax with your delegation and compare notes on the meeting. This is important because different people might have different interpretations of what happened. Agree as a group on who will do which follow-up tasks. Send a thank-you note after the meeting to the representative via the person who scheduled the meeting, and, if commitments were made during the meeting, repeat your understanding of them. Don't forget to give a phone number and address where you can be reached. Finally, let PNHP know how the meeting went.

Above compiled and adapted from multiple lobbying guides by nonprofits.

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Key Features of Single Payer

- **Universal, Comprehensive Coverage**
  Only such coverage ensures access, avoids a two-class system, and minimizes expense

- **No out-of-pocket payments**
  Co-payments and deductibles are barriers to access, administratively unwieldy, and unnecessary for cost containment

- **A single insurance plan in each region, administered by a public or quasi-public agency**
  A fragmentary payment system that entrusts private firms with administration ensures the waste of billions of dollars on useless paper pushing and profits. Private insurance duplicating public coverage fosters two-class care and drives up costs; such duplication should be prohibited

- **Global operating budgets for hospitals, nursing homes, allowed group and staff model HMOs and other providers with separate allocation of capital funds**
  Billing on a per-patient basis creates unnecessary administrative complexity and expense. A budget separate from operating expenses will be allowed for capital improvements

- **Free Choice of Providers**
  Patients should be free to seek care from any licensed health care provider, without financial incentives or penalties

- **Public Accountability, Not Corporate Dictates**
  The public has an absolute right to democratically set overall health policies and priorities, but medical decisions must be made by patients and providers rather than dictated from afar. Market mechanisms principally empower employers and insurance bureaucrats pursuing narrow financial interests

- **Ban on For-Profit Health Care Providers**
  Profit seeking inevitably distorts care and diverts resources from patients to investors

- **Protection of the rights of health care and insurance workers**
  A single-payer national health program would eliminate the jobs of hundreds of thousands of people who currently perform billing, advertising, eligibility determination, and other superfluous tasks. These workers must be guaranteed retraining and placement in meaningful jobs.

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Frequently Asked Questions about single-payer national health insurance

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.

Do U.S. doctors support this concept?

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

Physicians for a National Health Program, a single-payer advocacy group, has 17,000 members. For more than two decades, PNHP has been educating doctors and the general public about the advantages of single-payer national health insurance.

Is there any support for this approach in Congress?

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

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

H.R. 676 was introduced by Rep. John Conyers Jr. of Michigan. It currently has over 86 co-sponsors, more than any other health care reform legislation.

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

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

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

Is this 'socialized medicine'?

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

A single-payer national health program, by contrast, is social insurance like our Medicare program. While the financing is public, the delivery of health care is through

Four Steps You Can Take To Help Win National Health Insurance

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

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

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

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

private doctors and hospitals, similar to how Medicare works today.

Can we afford universal coverage?

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

Replacing private insurers with a national health program would recover money currently squandered on billing, marketing, underwriting and other activities that sustain insurers' profits but divert resources from care. Potential savings from eliminating this waste have been estimated at $400 billion per year. Combined with what we're already spending, this is more than enough to provide comprehensive coverage for everyone.

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

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

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

No. It will eliminate the rationing going on today. The U.S. already rations care based on ability to pay: if you can afford care, you get it; if you can't, you don't. At least 45,000 Americans die every year because they don't have health insurance. Many more people skip treatments that their insurance company refuses to cover. That's rationing.

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

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

Won't our aging population bankrupt the system?

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

Won't a publicly financed system stifle medical research?

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

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

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The case for an improved Medicare for All

The Problem: The health care crisis in the United States is worsening

- Over 60 million people were uninsured at least part of 2010 (National Center for Health Statistics), and about 23 million will likely remain uninsured in 2019 (Congressional Budget Office).
- At least 9 million working-age Americans became uninsured between 2008 and 2010, and one-third of working-age adults, 49 million people, spent 10 percent or more of their income on health care and premiums (meeting the definition of "underinsured") (Commonwealth Fund).
- About 45,000 deaths annually are associated with lack of health insurance (American Journal of Public Health).That's roughly one unnecessary death every 12 minutes.
- Sixty-two percent of all personal bankruptcies in the U.S. are linked to medical bills or illness, and three-quarters of those bankrupted had health insurance when they got sick. (American Journal of Medicine). That's about one medical bankruptcy every 15 seconds.
- Fifty-four percent of Americans report delaying needed care in 2010, while 25 percent report having trouble paying medical bills. (Kaiser Family Foundation). Many people have to choose between paying for medicine and paying for food and housing.
- Even though U.S. health spending is the highest in the world, at an estimated $8,649 per person (or 17.7 percent of GDP) in 2011 (Centers for Medicare and Medicaid Services), the U.S. ranked sixth of seven countries in terms of quality in a 2010 cross-national study by the Commonwealth Fund. We're not getting our dollars' worth.
- Private health insurance companies have high overhead expenses, including advertising, underwriting costs, and lavish payouts to executives and shareholders. They siphon off 12 percent to 25 percent of premiums – billions of dollars every year – that should be spent on health care. The U.S. has notoriously high administrative costs, about 31 cents of every health care dollar, most of which is unnecessary (New England Journal of Medicine). By comparison, Medicare's overhead is about 1.4 percent (Centers for Medicare and Medicaid Services).
- The nation's five top for-profit health insurers netted $11.7 billion in profits in 2010, up 51 percent from 2008, with UnitedHealthcare leading the pack with over $4.6 billion in profits (Health Care for America Now). The CEOs at those five firms garnered at least $54.4 million in compensation in 2010 (Executive PayWatch, AFL-CIO).

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The Solution: an Improved Medicare for All, single-payer national health insurance

- We have an American system that works: Medicare. It's not perfect, but Americans with Medicare are far happier than those with private insurance. Medicare has been a leader in keeping costs down. And keep in mind that Medicare insures people with the greatest health care needs: people over 65 and the disabled. We should improve and expand Medicare to cover everyone.
- Single-payer legislation like "The Expanded and Improved Medicare for All Act," H.R. 676, sponsored by Rep. John Conyers Jr., would (1) automatically enroll everyone in the plan, (2) provide comprehensive services covering all medically necessary care and drugs, (3) allow free choice of doctor and hospital, (4) eliminate all co-pays and deductibles, (5) create a public, nonprofit agency to pay all the bills, simplifying administration, paperwork and bureaucracy, (6) finance care through progressive taxation, with people paying less than what they are paying now for premiums and out-of-pocket expenses, (7) boost job growth and the entire U.S. economy by reducing the burden of health costs on businesses, (8) provide everyone with first-dollar coverage without spending any more than we are now, thanks to the administrative savings, estimated at $400 billion annually, (9) provide powerful cost control tools like bulk purchasing and global budgeting (JAMA) for long-term, sustainable savings.
- A single-payer Medicare-for-all system would not be "socialized medicine," since many physicians and other providers would remain in private practice. Only the financing would change. It would not introduce "government rationing" (as opposed to the rationing we have now based on ability to pay), but would restore the doctor-patient relationship by removing meddlesome private insurer bureaucrats. It would be transparent and publicly accountable, fair and efficient. It would be humane.
- Polls, surveys and "citizen juries" show such an approach enjoys the support of two-thirds of the U.S. population. Endorsements by labor, faith-based and civic organizations and legislative bodies provide further evidence of strong support for this solution.
- Dr. Martin Luther King Jr. once said, "Of all the forms of inequality, injustice in health care is the most shocking and inhuman."
- We need to create a single-payer system, an improved Medicare for All.

Note: Detailed citations for each of the points made above are available at the online version of this fact sheet, which you'll find here: www.pnhp.org/Improved-Medicare-for-All-Fact-Sheet

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Physicians for a National Health Program, a single-payer advocacy group, has 18,000 members. For more than two decades, PNHP has been educating doctors and the general public about the advantages of single-payer national health insurance. For more information, visit www.pnhp.org.

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Research by Physicians for a National Health Program

Over the past two decades, PNHP research has influenced health policy and focused debate on the need for fundamental health care reform.

- Administrative costs consume 31 percent of US health spending, most of it unnecessary. The US could save enough on administrative expenses (nearly $400 billion annually) with a single payer to cover all the uninsured.

- Medical bills contribute to more than 60 percent of all bankruptcies. Three-fourths of those bankrupted had health insurance at the time they got sick.

- Nearly 45,000 Americans die each year for lack of health insurance. The uninsured do not receive all the medical care they need – they live sicker and die younger. Those most in need of preventive services are least likely to receive them.

- Taxes already pay for over 60 percent of US health spending. Americans pay the highest health care taxes in the world. We pay for national health insurance, but don't get it.

- Despite spending far less per capita for health care, Canadians are healthier and have better measures of access to health care than Americans.

- Business pays less than 20 percent of our nation's health bill. It is a misnomer that our health system is "privately financed" (60 percent is paid by taxes and the remaining 20 percent is out-of-pocket payments).

- For-profit, investor-owned hospitals, HMOs and nursing homes have higher costs and score lower on most measures of quality than their non-profit counterparts.

- Immigrants and emergency department visits by the uninsured are not the cause of high and rising health care costs.

- Computerized medical records and chronic disease management do not save money. The only way to slash administrative overhead and improve quality is with a single payer system.

- Alternative proposals for "universal coverage" do not work. State health reform efforts over the past two decades have failed to reduce the number of uninsured.

- The US could save enough on administrative costs (nearly $400 billion annually) with a single payer to cover all the uninsured.

Full text and citations for each finding are available on our web site at www.pnhp.org/research.

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Background Fact Sheet – Single-Payer National Health Insurance

- **49.9 million Americans were uninsured in 2010.** (US Census Bureau)

- **Nearly 45,000 Americans die from lack of coverage annually.** (American Journal of Public Health, October 2009)

- **Tens of millions more are under-insured,** lacking adequate coverage for drugs, long term care or mental health services.

- **After a lull in the mid 1990s, health care costs are again rising steeply.** The National Center for Health Statistics estimates that, absent major reform, health spending will reach 17.7% of GDP by 2012.

- **Every other developed nation has some form of national health insurance,** yet U.S. health spending is far higher — 42% higher than in Switzerland, which has world's the second most expensive health care system, and 83% higher than in Canada (Organization for Economic Cooperation and Development Health Database, 2002).

- **At present, *government* spending on health care in the U.S. is higher than *total* spending on health care in Canada.** (Health Affairs, July/August 2002)

- **Single payer national health insurance would save at least $380 billion annually** on paperwork and administration, enough to cover all of the uninsured and to upgrade coverage for Medicare enrollees and others who are under-insured. Studies by the Congressional Budget Office, the General Accounting Office and several private consulting firms all agree that NHI could assure universal, comprehensive coverage without increasing total health spending.

- **No other reform can slash administrative costs.** Assertions that computerization or patchwork reforms will cut bureaucratic costs are not credible. Most health insurance claims are already computerized. Private insurers keep a big share of their premiums as overhead in every nation. Allowing them to continue playing a big role in health care guarantees high administrative costs.

- **Surveys show surprisingly strong support for single payer NHI, even among groups that have long opposed it.** 59% of physicians now endorse single payer NHI, as do 40% of small business owners. Polls have long shown that a majority of Americans favor some form of NHI. (Annals of Internal Medicine, 2008)

- **The current economic downturn strengthens the case for NHI.** States facing budget crises are cutting Medicaid and other social programs. They should instead use the vast administrative savings from a single payer program to implement universal coverage; NHI could pay for itself. NHI would also relieve the crisis for workers, unions and corporations grappling with skyrocketing premiums

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Financing single-payer national health insurance: Myths and facts

Myth: Employers fund the majority of health care in the U.S.
Fact: *Private* business funds less than 20 percent of total health spending. (Government employees have *taxpayer-funded* coverage through the FEHBP program and employer payments for private insurance receive a substantial tax subsidy).

Myth: The U.S. has a *privately* financed health care system.
Fact: 60 percent of health spending is financed by taxpayers. (Estimates that are lower exclude two large sources of taxpayer-funded care: health insurance for government employees and tax subsidies to employers to provide coverage.)

Myth: Covering the uninsured is unaffordable.
Fact: 31 percent of current health spending is squandered on administrative tasks related to our fragmented payment system with hundreds of different health plans rather than invested in patient care. Over $350 billion – about half of the money currently wasted on overhead and bureaucracy – could be saved with simplified single-payer administration, enough to cover all the 46 million uninsured. Covering the uninsured is affordable; keeping the current private insurance system intact *is not.*

Myth: National health insurance would require large new taxes.
Fact: No increase in total health spending is needed to finance single payer. The increase in taxes required to finance national health insurance would be *fully offset by a reduction* in out-of-pocket costs and premiums.

Myth: Making people more "cost conscious" is the best way to control health costs.
Fact: The U.S. has the highest health care costs even though Americans pay the highest out-of-pocket costs of any nation.

Myth: Rising numbers of elderly Americans will bankrupt the single payer.
Fact: Europe and Japan already have a larger proportion of elderly people than America faces with the aging of the baby boomers. Germany and Japan have adopted single-payer programs for long-term care coverage precisely because of single payer's greater potential for efficiency and cost containment.

Myth: Rising numbers of obese Americans will bankrupt the single payer.
Fact: The proportion of health spending dedicated to caring for the obese is *not* rising faster than their share of the population. The best way to address the issues of obesity, smoking and other public health epidemics is through public health measures.

Myth: U.S. health spending is higher than other nations because we get more and higher quality care.

Fact: Americans get less of most kinds of care (doctor, hospital, surgery, etc.) than the citizens of other industrialized nations, and our care is lower quality by several measures.