Single-Payer Universal Health Care

— An Idea Whose Time Has Come —

Report of the Sudbury (MA) Democratic Town Committee

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1 The big disconnect

Our country has first-rate medical schools, performs stunning medical research, and has a large number of wonderfully capable doctors. Yet in spite of this,

- Our infant mortality rate is 47^{th} among all countries in the world (Central Intelligence Agency, 2009a).
- Our life expectancy for babies born today is 50^{th} in the world (Central Intelligence Agency, 2009b).
- The wealthiest third of U.S. citizens have about the same level of health as the poorest third of British citizens (Gluckman and Thuotte, 2008).
- We spend about $7000 per person each year on health care, about twice what other developed countries spend (Brummel-Smith, 2009).

There's a real disconnect here. We're going to examine the reasons for this and what can be done about it.

2 The components of the problem

2.1 Coverage

There are two different aspects of coverage that are problematic—some people have no insurance at all, while others have inadequate insurance.

In 2007, 15.3% of the US population—45.6 million people—had no health insurance (DeNavas-Walt et al., 2008). Some of these were people who simply could not afford to lay out the money needed for even the least costly health insurance policy. Others—especially employed young people—could afford to obtain a policy, but reasoned that it would be a waste of their money because they considered themselves to be unlikely to need health care. Others work for small employers who cannot afford to provide health insurance coverage to their employees. Many of these people regularly resort to hospital emergency care if and when they do require medical assistance.

Estimating the number of people who are underinsured is more difficult, but it is undoubtedly substantial. In some cases, this inadequate coverage is due to a desire to save money by purchasing the least costly alternative. In other cases, people have inadequate coverage because they are confused by the multitude of options available, and choose a policy without fully understanding its consequences.

When one has no or inadequate health insurance, the potential consequences are enormous. A single event can wipe out years of savings. A large portion of the people who are forced into bankruptcy each year have unexpected health costs to blame. Precisely, a careful study (Himmelstein et al., 2005) showed that in 2001, about 54.5% of personal bankruptcies were caused primarily by uncovered medical expenses. (Interestingly, the same study revealed that people filing for bankruptcy because of medical expenses were less likely to have trouble managing money than other debtors.)

2.2 Employer base

Most unusually, the US health care system relies upon employers to pay a large portion of their employees' health insurance premiums.

This in itself causes problems: Often a person is forced to seek a job, or to remain in a job, based upon the availability of health insurance rather than being able to move to a better job in a better location. When a job-holder becomes unemployed, the situation is even worse, with the loss of income almost always compounded by loss of health insurance.

Even aside from these personal consequences, this system makes American business less competitive than companies in countries where health care expenses are paid from general government revenue. For example, it is estimated that cars made in America are $1,500 more costly than they would be if the automakers did not have to pay for employee and retiree health care.

Our unique employer base for health care payment and decisions concerning health insurance derived from a historical accident. After World War II, throughout Europe, unions pushed through various forms of universal government-sponsored health care. In this country, however, the unions found themselves under ferocious attack—usually in the guise of anti-communism—and it was clear that they would not be able to do this. What they were able to do was negotiate individual contracts with industrial companies for health insurance coverage for their members, and this then became the model for the American system which now is profoundly broken.

2.3 Insurance companies

Approximately 31-35% of each dollar spent in the United States for health care actually goes to pay insurance company overhead. (See for instance, Woolhandler et al. (2003).) By comparison, the basic "insurance company" for the elderly—Medicare—only takes 3-5% of each premium dollar for its administrative expenses. This difference is astounding, deriving from a combination of a highly efficient government agency, a confusing array of insurance companies and types of policies, and extraordinary and wasteful insurance company advertising costs, management compensation, and profits.

Health insurance companies have convinced our legislatures that they should have the right to pick and choose whom they will cover. Since profit is their only real objective, they prefer to insure people who do not have medical problems, and insure others only if they are willing to pay very high premiums. Thus, they are able to ignore the basic concept of insurance—of any type of insurance—that everyone pays a small premium in order to cover the few who require the service.

> In addition to the insurance companies' own overhead and profit, there is the added cost to each doctor and hospital of hiring additional administrative staff to manage the forms for these companies:
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> "Between 1969 and 1999, the share of the U.S. health care labor force accounted for by administrative workers grew from 18.2 percent to 27.3 percent. In Canada, it grew from 16.0 percent in 1971 to 19.1 percent in 1996. (Both nations' figures exclude insurance-industry personnel.)" (Woolhandler et al., 2003)

Health insurance policies tend to be extremely complex. In any policy, there is a long list of things

that will be covered, things that will not be covered, payment schedules for different procedures, rules that must be followed, forms that must be completed. Each company, each policy differs. In order to sort out this confusion, health care providers spend a lot of their own time on paperwork rather than providing health care. Alternatively, they are forced to hire administrative personnel to do this for them. In most cases, they do both—waste their own time and hire extra personnel.

This same confusion often results in patients being uncertain if—and the extent to which—they are covered for a specific procedure or situation. This enables the insurance companies to make arbitrary decisions in order to save money. Sometimes, they rely upon the "squeaky wheel" approach, refusing to pay a legitimate claim unless the patient complains vehemently. Or they may refuse to pay a legitimate claim until they are sued. In other instances, the policy may be sufficiently ambiguous that it is truly unclear whether a procedure is covered. In most such instances, the insurance company is in a much stronger financial position to press its case than is the patient.

Whenever a patient faces such refusal by an insurance company to pay for services or treatment that the patient reasonably had assumed would be covered, mental anguish is added to the physical problem, compounding the negative effects of the medical issue. In addition, such patients are often required to pay themselves for legal expenses in order to pursue remedies at a time when they often can least afford it.

2.4 Pharmaceutical companies

Over the years, American and international pharmaceutical companies have provided a wide variety of effective pharmaceuticals, both brand name and generic, that have improved health care in many areas. Most pharmaceutical companies also conduct their own research, or pay to have others conduct research for them to produce new drugs that they will be able to patent and sell. Some of this research produces useful new drugs.

And some does not. Some of the research is more related to improving profit than to improving health care, such as research that produces new drugs (the so-called "me-too" drugs) that are really only an extremely minor improvement on an old drug, or frequently no improvement at all (and in some cases, even *less* effective), but enable the company to obtain a new patent.

And in any case, much of the really basic research is performed in universities, and is funded directly by our government.

Many Americans have discovered that they can obtain the drugs they need from sources outside the US at much lower cost. In most instances, they are able to get precisely the same item, only with different packaging. This is due to the fact that US pharmaceutical companies charge more in the US than they do in other countries. The main reason they are able to do so is that the US does not have a single agency negotiating these prices.

Whenever we sit down in front of a TV set we see that pharmaceutical companies spend a lot of money on advertising—something that used to be considered wrong both medically and ethically. The purpose of touting the benefits of a specific drug to the general public is to encourage patients to demand this drug—skewing the prescribing decisions of the physician or other health care provider away from whatever is best for the patient.

These advertising expenses add considerably and unnecessarily to the cost of our basic health care. They make no one any healthier.

In addition, pharmaceutical companies (as well as insurance companies) spend a significant amount

of money cultivating influence. Just as one example: Tom Daschle—President Obama's original choice for Secretary of Health and Human Services, and former Democratic leader in the Senate—received since he left the Senate and started lobbying over $200,000 in speaking fees alone from the health industry. (He actually received about $5.2 million from various industry groups, which shows the amount of money that gets thrown around for these purposes.) This kind of influence peddling skews the political debate and drives up health care costs for all of us.

2.5 Other problems

There are many other problems with the way health care is provided and paid for in our country. The lack of computerized medical and financial records has received the most attention. There are other problems as well, such as the over-abundance of specialists and inadequate numbers of primary care physicians; the lack of transparency of physician-industry relationships; fraud and abuse in the billing for Medicare and Medicaid; unnecessary testing of patients; the high cost of physicians' liability insurance. We applaud efforts to address these types of issues, but do not consider them in this report. Our focus here is solely upon the *system* for delivering health care.

3 What are some possible alternative health care systems?

3.1 Health care in other countries

Most modern industrialized countries provide universal health care of one sort or another that covers all citizens comprehensively throughout their lives. In considering the health care systems of a variety of countries, a number of common features emerge. These commonalities are closely connected with their ability to deliver highly effective health care, control costs, and provide for sustainable funding. In the following discussion, we first describe specific features of several health care systems and, at the end, develop a list of commonalities that in large part assure their success and popularity. These commonalities are important to keep in mind as the US begins to move toward a national health plan for all citizens.

England England has a single-payer system in which the national government is the insurer. It supports national health care as an entitlement program through general taxation and distributes money to the suppliers of health care (doctors, hospitals, etc.) for services rendered. The government owns most hospitals and clinical facilities and most physicians are salaried government employees. In addition, the government each year negotiates with the care providers and sets the payment schedule for all medical procedures, tests, and drugs covered. Individual doctors and hospitals are paid on the basis of the number of patients seen, the procedures carried out, and the medical success of actions taken. Patients can choose their internist (primary care provider) or hospital, and in that sense, doctors compete with other doctors and hospitals with other hospitals. Patients receive no bills and make no co-payments for office or hospital visits, and necessary forms are standardized. Coverage is never terminated due to unemployment, disability, or prior medical condition. Total overhead costs are accordingly low, perhaps 5-6%. Because of a decision made years ago to emphasize preventative medicine, England has a relatively large number of internists and a relatively small number of specialists. Internists also serve as "gate keepers" to allow patients to visit specialists or receive hospital care only when it is medically important for such steps to be taken. One of the undesirable

consequences of this situation is that, whereas there is virtually no waiting time for a patient to see an internist, the wait to see a specialist or be admitted to hospital tends to be long. On the other hand, people in England, of all income levels, are significantly healthier than their counterparts in the United States.

In England, the health care system is truly universal, and no one is permitted to opt out of the system. Notwithstanding this, there does exist a small parallel, for-profit, private health care system that can be used for procedures, such as elective cosmetic surgeries, that are not covered by the national roster of procedures. This private system, supported by for-profit insurance companies, is limited to these non-covered procedures and may not duplicate any of the covered procedures.

The cost of the English system is 7-8% of GDP or about half of that of the current American system. Not only is it less expensive and covers everyone, its medical outcomes are on average better than in the US. For example, life span is greater and infant mortality is lower.

Canada The Canadian system is somewhat similar to the English system but differs significantly in certain respects. Money to support the system comes primarily from provincial taxes and fees and to a lesser extent from national taxes. For this reason, health care is not equally financed in the several provinces and so varies from province to province. In addition, a few hospitals and clinics are privately-owned, non-profit institutions; and the practices of physicians are considered to be private in the sense that they receive fees-for-service and are not government employees. Each province negotiates a fee schedule with its physicians, paying them on a fee-for-service basis that is adjusted as necessary to control the total cost of reimbursed services. Coverage exclusions are also decided at the provincial level. Services that are not covered consist mainly of home care and long-term care, private nurses in hospital care, outpatient drugs, dental care, eyeglasses and other medical devices, and elective cosmetic surgery. Private insurance companies are allowed to sell insurance for those services, but not services covered by the public system. Although persons cannot opt out of the national system, they can seek medical care through for-profit private insurance companies from physicians who have opted out of the national system. So far, not many have availed themselves of this private system of care; few can afford it. The Canadian system consumes 8-10% of GDP, but its rather extensive list of excluded services limits the public health care services to 70-75% of total health care expenditures. The Canadian system is therefore not quite as comprehensive as is the case with most other national health care plans. Basically, it is under-funded and in need of more support from the central government.

> Compared with Canadians, US residents are one third less likely to have a regular medical doctor, one fourth more likely to have unmet health care needs, and are more than twice as likely to forgo needed medicines. (Lasser et al., 2006)

France The French system is one of the most costly—in 2007, it amounted to about $3,500 per person, still far less than the 2007 figure of $6,100 in the United States.

In return, the French have a system that is the envy of other nations. Unlike England, all practitioners are private and autonomous. And while they make considerably less than their counterparts in this country, they start off with no medical school debt—medical school is free in France. They also pay much lower malpractice insurance premiums, because such lawsuits are discouraged by the legal system.

> In 2000, health care experts for the World Health Organization tried to do a statistical ranking of the world's health care systems. They studied 191 countries and ranked them on things like the number of years people lived in good health and whether everyone had access to good health care. France came in first. The United States ranked 37th.
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> Some researchers, however, said that study was flawed, arguing that there might be things other than a country's health care system that determined factors like longevity. So this year, two researchers at the London School of Hygiene and Tropical Medicine measured something called the "amenable mortality." Basically, it's a measure of deaths that could have been prevented with good health care. The researchers looked at health care in 19 industrialized nations. Again, France came in first. The United States was last. (NPR (Joseph Shapiro), 11 Jul 2008)

As in Canada, French patients have their choice of doctors. There are also no waiting lists for elective procedures, in contrast with the situation in England and Canada. In France, private insurance companies have been allowed to administer the system, but overhead costs have been kept low, and insurance companies are not allowed to compete by lowering their premiums. As in Canada and England, insurance companies may sell insurance for items not covered by the national insurance plan, and most people in fact have such insurance (Rodwin, 2003).

The French system is not without its challenges: Doctors may choose to practice outside the system, and some are starting to do that. And in the last few years costs have started to increase, although they are still nowhere near what they are in the United States. France may ultimately have to move more in the direction of a system basically run by the government. Still, France has an incredibly high standard of universal health care, and the French are very proud of this. Expatriate Americans living in France laud the system.

Japan The system in Japan uses non-profit private insurance companies to collect and disburse funds to support the system. All but the poor must buy a social insurance policy, generally through their place of employment, at premiums set by the government and scaled to income. The government provides free insurance to the poor. Insurers cannot refuse insurance to any person or increase premiums on the basis of age or prior medical conditions. They compete on the basis of efficiency and service.

About 80% of hospitals are privately owned and doctors are private in the sense that they can, if they wish, expand their office or clinical facilities to expand their incomes. On the other hand, hospitals and doctors are reimbursed for services according to a strict schedule generated by the government. In Japan, there are no gate keepers, and patients can see any specialist they wish, usually with very little delay. Paperwork, such as there is, is standardized and most records are kept and financial transfers are made electronically. Like in England and to a large degree in Canada, the government controls the price of every procedure and drug.

One of the most interesting and counterintuitive features of the Japanese system is that increasing use of high-technology tests (e.g., MRI scans, CT scans, etc.) by a hospital or physician leads to a decrease in the unit reimbursement for the test. This has driven the development of inexpensive high-technology machines, such as scanning machines, which then enjoy even greater use (and are important in the export market).

Taiwan Taiwan has a rather new national health insurance program that features a national insurance premium or tax scaled to income, and the provision that any deficit be made up from general tax revenues. No one can opt out; all have free choice of physician or hospital; there are no gate keepers; and there is no waiting time for an appointment, even for specialists. Perhaps the most notable feature is that individual access to the system is by way of a smart card that contains one's medical record. Records and payment transfers are entirely electronic, and overhead is kept to less than 2%, with a total cost for the entire program of about 6% of GDP, perhaps the lowest in the world.

Commonalities From an examination of the above and similar heath care systems in modern, industrial nations, one can find features common to all successful national health care plans. These commonalities are:

1. The insurer is either the government or non-profit private insurers. If the latter, competition among insurers is based upon quality of services, supplementary private policies covering medical procedures not covered under the national program, and upgrades in hospital accommodations. Basic medical care is always on a non-profit basis.

2. Physicians are either salaried employees of the government or reimbursed for services according to strict guidelines set by the government. These guidelines take into account the number of patient visits, the nature of the procedures and tests carried out, the quality of medical outcomes, or all of these factors.

3. The insurer or insurers must accept everyone without regard to age or medical history.

4. The national health care program is treated as an entitlement program with a mandate that everyone pays into the system through taxation or insurance premiums, except for the poor, who are insured directly by the government. These payments are scaled to income, and benefits are the same for everyone.

5. The government negotiates with drug suppliers, hospitals, clinics, and groups of physicians to set global or regional budgets, costs for individual procedures and drugs, and the basis for salaries or reimbursements. Medical providers accept these negotiated schedules.

6. Continuing efforts are made to minimize overhead and costs. Overhead is held to 6% or less of costs, and total costs are less than 10% of GDP.

7. Great emphasis is placed on preventative medicine.

These commonalities can be summarized as follows:

- *Successful national health care programs are ones in which the government assures funding, sets prices, and controls costs; the profit motive is removed from medical care; the well support the sick; and coverage is universal.*

- *Successful national health care programs recognize that sickness and health are not classical commodities and therefore are not properly dealt with by a market-based solution.*

For example, while the sale and purchase of commodities can be deferred to await better market conditions, the treatment of sickness can not be deferred. Furthermore, while it is certainly true

that healthy people are more productive, it is difficult, (and perhaps even immoral) to reduce the value of good national health to a number. It is sensible to view health care as a birthright or social good, as we do education, social justice, and access to opportunity. None of these goods are truly quantifiable.

3.2 The Massachusetts Plan

In 2006, Massachusetts passed a law designed to significantly increase the number of people covered by health insurance. Its basic components were for the state to purchase health insurance for those whose income was below 1.5 times the poverty level, subsidize insurance for those up to three times the poverty level, and mandate that everyone else buy an insurance policy or pay a fine. All employers were required to purchase health insurance for their employees or pay a fine. This plan (referred to as "Chapter 58") is administered by an entity referred to as the "Connector," connecting people with insurance policies; its tasks include ensuring that each policy is adequate and affordable, and matching individuals to a private health insurance policy.

A national group, Physicians for a National Health Program, has analyzed the results of the initial implementation of this program. They concluded that—although 60% of those previously not covered now have some form of health insurance—it is basically not working. The types of insurance these people have purchased require them to pay substantial premiums that they often cannot afford. And the policies offer minimal coverage; as a result, if a person does require medical care, the co-pays and/or deductibles are often beyond their reach. In addition, the state is paying an unsustainable, very high cost to the insurance companies, and just by itself has actually increased administrative costs (Nardin et al., 2009). A study of the people directly affected by this program concludes that even they—the supposed beneficiaries—believe that it has hurt rather than helped them (Blendon et al., 2008).

> Kathryn Hunt is a young diabetic who needs twelve prescriptions a month to stay healthy. Like 450,000 other uninsured people in Massachusetts, she used to be enrolled in the State's Free Care Pool. "Under free care," she says, "I used to see doctors at Mass General and Brigham and Women's Hospital, I had no co-payments for medication, appointments, lab tests or hospitalization. The care I received gave me a light at the end of the health care nightmare tunnel."
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> Under Chapter 58, Kathryn spends almost one-quarter of her take-home pay for physicians' visits and medications to treat her diabetes, and is unable to afford treatment for the stress fracture she has in her foot. She earns $11 per hour as a certified pharmacy technician. (Austad et al., 2008; Nardin, 2009)

Somewhat similar plans have been tried in Tennessee, Washington, Oregon, Minnesota, Vermont, and Maine. These plans have all failed to reduce the number of uninsured or to contain costs, or to improve access to health care for poor people.

Despite its considerable problems, the Massachusetts plan has been lauded by many as a potential national solution that would please enough of the opposition to be approved by Congress. "The consensus emerging from the two Senate committees [that are investigating health care proposals]... echoes key elements of the reforms adopted by Massachusetts." (Iglehart, 2009) As Mas-

sachusetts residents, it is our responsibility to let the rest of the country know that they are looking at a severely flawed model.

3.3 The Republican approach

The Republican party seems to be more or less satisfied with the way health care is currently delivered and paid for. Their suggestions for change have been minimal and marginal In 2003, President Bush included Health Savings Accounts in the bill that added a prescription drug benefit to Medicare. These accounts are a kind of self-insurance, where one may save tax-favored dollars in a special account whose proceeds may then be used for health care expenses. The GAO has indicated that these accounts tend to be used by healthier and wealthier people, and have the negative effect of removing these people from the pool that pays for ordinary health insurance, thus increasing the cost to those who are less healthy and well-off (Dicken, 2006).

The recent debate over various health care reforms has largely bypassed the Republicans. Their contributions have tended to be limited to rejection of any idea that increases the role of the federal government, or reduces the power of health insurance or pharmaceutical companies. President Obama has nearly pleaded with them to suggest an alternative instead of simply objecting to Democrats' ideas, but this has led nowhere. In short, although they may favor marginal change, the Republican party is opposed to any substantive improvement in the American way of delivering and paying for health care.

3.4 The Obama plan

When he was an Illinois State Senator, Barack Obama favored a single-payer health care system. However, that view dissipated when he reached the national stage. During his campaign for the presidency, Senator Obama promoted the idea of insurance options for all—a plan that would offer the same, or similar policies offered to federal employees, including himself.

Since his election, President Obama has suggested a private-public option in which people could keep their own private policies or buy new ones, or sign up for a public, improved-Medicare plan.

Insurance companies have organized a massive campaign against such a public option. contending that a public option, since it would not need to make a profit, would compete unfairly against the insurance companies.

On the other hand, single-payer supporters contend that the Obama plan is fatally flawed—the private insurance companies would get the more affluent, and thus healthier consumers, while the poorer and thus more prone-to-illness consumers would flock to the less expensive improved-Medicare for all option.

They maintain that in a single-payer plan on the other hand, the healthiest and the sickest, as well as those in-between, would be combined in one risk pool, allowing the health care each needs to be provided at a cost that the nation could afford.

Any system that mixes public and private insurance approaches will not be able to realize any savings on administrative costs. Health care providers will still need to devote a major portion of their time to paperwork, and they will still need to retain employees whose sole task is to sort out the confusion of competing policies.

The Administration believes that comprehensive health reform should:

- Reduce long-term growth of health care costs for businesses and government
- Protect families from bankruptcy or debt because of health care costs
- Guarantee choice of doctors and health plans
- Invest in prevention and wellness
- Improve patient safety and quality of care
- Assure affordable quality health care for all Americans
- Maintain coverage when you change or lose your job

(Obama, 2009)

4 The health care system we recommend

4.1 A single-payer plan

The term "single-payer" describes any system in which the government becomes the single insurance company that pays for all health care. It says nothing about how health care is provided—it just specifies how health care is paid for.

A single-payer system would cover everyone at a lower cost than we are currently paying. This is because it would

- totally eliminate the administrative costs and profit of health insurance companies,
- considerably reduce the administrative burden on health care providers by reducing the confusing multitude of payers (each with different rules, forms, payment amounts, etc.) to a single payer, and
- reduce the payer's administrative cost to the same level as Medicare (3-5 percent of total premiums).

The current annual cost of our health care system, provided by government, employers, and individuals, comes to about $2.3 trillion (U.S. Department of Health and Human Services, 2009)—and many have inadequate coverage or no coverage at all. With the savings derived from a single-payer system, everyone would be covered, and reasonable estimates for the total cost come to about $2 trillion—a savings nationally of $300 billion (PNHP, 2009).

The Sudbury Democratic Town Committee recommends that the United States adopt a single-payer system.

"[I]f the nation adopted . . . [a] single-payer system that paid providers at Medicare's rates, the population that is currently uninsured could be covered without dramatically increasing national spending on health. In fact, all US residents might be covered by health insurance for roughly the current level of spending or even somewhat less, because of savings in administrative costs and lower payment rates for services used by the privately insured. The prospects for controlling health care expenditures in future years would also be improved. . . " (Congressional Budget Office, 1991)

The CBO published similar results two years later (Congressional Budget Office, 1993). Unfortunately, the CBO has not given any estimates since 1993—it may well have been dissuaded from this by political pressures.

4.2 Health care is a right, not a privilege

As societies evolve, changes are made in the activities that are considered reasonable for the public sector to perform. For example, almost all of us take for granted that our basic protection—from national defense to local police and firefighters—should be performed by government, not by the private sector. Yet it was not that long ago in our towns and cities that private fire fighting companies competed with each other for contracts to fight fires.

Public education is also historically recent. Initially, some communities paid for their children's schooling; others did not and those who could afford it had to find private alternatives. But around the middle of the 1800's a movement for universal public education formed, and by around 1900 free universal public education was an accepted fact throughout the country. As a result, K-12 schooling is now recognized by all Americans as a right, not a privilege.

We believe that health care is in the same position today: it is a right and—just like education—should be free, universal, and public:

Health care must be free By free, of course, we mean free just as public education is free. It is paid for by broad-based general revenue sources, but is available without deductibles, co-payments, or any other additional cost to everyone on an equal basis.

Health care must be universal Everyone is covered. Whether or not you are employed, or who your employer is, makes no difference. And the quality of health care, and the kinds of care that are provided, should be relatively uniform throughout the United States.

Health care must be public It must be provided as a public good without interference from profit-driven entities. To ensure this, it must provide diagnosis, prevention, and treatment of illness and injury; laboratory tests; prescription drugs, medical equipment and supplies; prenatal, perinatal, and post-natal maternal care; family planning, fertility and reproductive care; appropriate screening and counseling; mental health care; full dental services other than cosmetic dentistry; hearing evaluation and treatment, including hearing aids; vision care and correction; home and long term care; hospice care; emergency and medically-needed transportation; and health education.

And since health care is a public good, the government must be able to negotiate with drug companies (or any other companies, for that matter) to reduce costs as much as possible.

In addition, we believe that this system should have no direct impact on people's choice of doctor, hospital, or other health care provider.

4.3 Supportive mechanisms to ensure the viability of a single-payer system

Funds to pay for this system derived from a single dedicated tax. This system can only succeed if it has sufficient funds. The safest way to ensure that this occurs is to establish a single tax, whose proceeds are dedicated to this purpose only. The rates established for this tax should take into consideration the fact that our society is aging and, therefore, there will be greater health care needs in the future than at present.

Once this tax is established, it should be a permanent tax, and the funds accrued should not be available for any other purpose. There should be no need for periodic legislative action to address budgetary issues. The simplest way to establish the payment mechanism for health care is to add it to the existing social security or medicare payroll tax. Alternatively, one could imagine a tax on wealth rather than income. The essential point is that the program be funded by a single dedicated tax whose proceeds cannot be raided.

All health-care providers part of non-profit entities. All immediate providers of health care—MDs, NPs, hospitals, etc.—should be not-for-profit. This can of course be phased in over time.

Health care providers required to be part of the system. Opting out of this system should not be allowed any licensed health care provider, except for provision of "unnecessary" services. If there is a parallel private, for-profit health care system, covering the same benefits as the public system, its practitioners and advocates would undoubtedly apply political pressure to undermine the basic national system.

Administration of this system to evolve from Medicare. The existing Medicare program is extremely cost effective, spending roughly one-tenth the amount that health insurance companies spend beyond the cost of reimbursements for health care. The administration of the single payer system should use Medicare as its start and build upon this highly successful program.

Reimbursement levels for all health care providers set fairly. It is essential for health care providers to be supporters of any health care system. Right now, most are dissatisfied with the paperwork and bureaucracy that is the hallmark of the multitude of private health insurance policies. Many are also dissatisfied with the payments they receive from Medicare and other government programs. A single payer system will easily alleviate the first problem, but mechanisms must also be put in place to ensure fair reimbursement levels.

Any continuing involvement of insurance companies limited to "unnecessary" services. Insurance companies may provide policies for things such as cosmetic surgery or private hospital rooms, which would not be included in the basic system. They should not be allowed to provide insurance for the benefits that are covered under the single-payer system.

4.4 Temporary measures for the transition to a single-payer system

Making the transition from the current system to a single-payer system will involve a myriad of technical and political details. We can't possibly enumerate them all there, and we certainly can't

give definitive answers to them—they will have to be thought through as legislation is written and regulations are framed. Some obvious issues that need to be dealt with are

- Making sure that everyone—the general public as well as doctors, hospitals, drug companies, and so on—understands the road plan of the transition as well as the reasons for it, and what they can expect.
- retraining and other assistance for employees who are replaced by this system, just as with workers in the steel, auto, and textile industries,
- phasing in of new clients,
- phasing out of insurance companies from their primary role,
- phasing out of employer insurance contributions, and
- establishment of the regulatory structure that will have responsibility to establish reimbursement levels.

The basic idea of a single-payer system—or "Medicare for all"—seems to be very popular. In 2008 59% of physicians(Carroll and Ackerman, 2008) preferred it. A Business Week survey in 2005 concluded that 67% of Americans preferred it as well. Numerous government and non-government groups have expressed their preference for a single-payer system.

And yet, this consensus does not seem to have convinced Washington.

5 Opposition to single-payer universal health care

5.1 Who opposes single-payer universal health care and why?

There is considerable support for s single-payer system, but there is also strong, well-funded opposition to it, based largely upon self-interest.

Opposition by insurance companies There are tremendous profits being made by health insurance companies—profits that degrade the quality of health care of all of us. A single-payer universal health care system would put an end to this disfunctionality, and so these companies have a real economic interest in stopping this from happening.

They could still continue to insure "unnecessary" aspects of health care, and they could obtain contracts from the single-payer administrative entity for some of the administrative tasks, but these would be minimal compared with the profits they garner from the current system.

As noted above, during his campaign, candidate Obama advocated for his own health insurance policy—i.e., that of the US Senate—to be available for all Americans. Insurance companies recognize that this could simply be a stealthy way of introducing a single-payer system: with much lower costs, the government could offer an insurance policy that is far cheaper and offers greater benefits than any private policy. They are trying very hard to defeat this "public option."

Huge amounts of money are involved. These companies spent more than a half billion dollars on lobbying during 2008 alone (Moyers, 2009). They will do everything in their power to ensure that their privileged position remains.

The California Democratic Party, at its 2009 convention, passed the following resolution:

WHEREAS, access to quality health care is essential for the good health and productivity of every American citizen and qualifies as a human right, not a privilege; and

WHEREAS, the steadily increasing cost of accessing health care is causing business to be uncompetitive in the world market and making it difficult to decrease the national deficit; and while the US spends more than any other industrialized country for health care, the US has demonstrably inferior outcomes, even for the insured; and

WHEREAS, the current commercial market model mediated by private health insurance corporations must function to create profits for the companies, their administrators and shareholders creating an unavoidable conflict-of-interest between promoting quality health care and maximizing their profits and currently diverts up to 25% of the insurance premium dollar from medical services and leaves 46 million people uninsured;

THEREFORE BE IT RESOLVED, that the California Democratic Party supports the establishment of a universal, single-payer, national health care system, in the United States; and

BE IT FURTHER RESOLVED, that such a system be publicly financed and privately delivered with automatic enrollment of all residents (regardless of age, status of employment, pre-existing condition, or income level) allowing people to choose from any licensed health care provider, providing all appropriate medical services including preventive education, dental care, mental health care, long-term in-home care, and affordable prescription medications.

(California Democratic Party, 2009)

Opposition by pharmaceutical companies Pharmaceutical companies should have less of an objection to a single-payer system, as their products will continue to be required. They must recognize that regardless of what happens to the health care system, it is extremely unlikely that they will be able to retain the gift that the Republican Party gave them of non-negotiated drug prices for Medicare. Presumably, they are hoping that any change will retain a diffusion of purchasing decisions, as this makes it more likely that they will be able to continue high prices for their products.

Opposition by the media An overview of the traditional media's coverage of the health care debate would, for the most part, lead one to conclude that there is no such thing as single-payer. It is hardly ever mentioned. When it is mentioned, it is usually painted as an extreme, politically juvenile proposal (e.g., "taking the dialogue around health reform 'past the kumbaya phase'. . . "(Rubenstein, 2009)). Rarely, if ever, do the mainstream media address a single-payer health care system as a plausible replacement for our current system.

We think there are at least three reasons for this:

- self-censorship on the part of writers and editors who have been convinced that single-payer just is beyond the bounds of political acceptability,
- conservative ownership of much of the mainstream media, and
- reluctance to antagonize valued advertisers.

The mainstream media is not doing its job of providing a fair exploration of the advantages and disadvantages of a single-payer system or of investigating financial interests behind opposition to it.

Opposition based on lack of trust in government to implement its promises over the long run In some other places that have instituted a single-payer system—such as England and certain Canadian provinces—politicians who opposed such a system regained power (usually for reasons unrelated to health care). They discovered that the single-payer system was too popular to destroy outright, but instead used a "stealth" approach to weaken it. By cutting its funding, they reasoned, the quality of the system would be reduced, its political popularity would be reduced, and a later conservative administration could eliminate it.

It turned out that the single-payer health care systems had too much popular support to be eliminated, but damage was certainly done. There are many Americans who fear this same problem if we were to institute a single-payer system. The Republican Party could regain power and cut the health care system's budget drastically. Therefore, there is opposition to single-payer based solely upon this expectation.

Another aspect of this same type of opposition concerns health care providers. Some of them do not trust the government to reimburse them fairly. They point to Medicaid and Medicare reimbursements—which often are lower than insurance company reimbursements for the same procedures—as proof that they will not get a fair shake.

Opposition by people who favor single-payer A seemingly odd, yet substantial, opposition to single-payer comes from people who actually believe that it would be the best health care system. Some of these people fought for years to introduce a single-payer system, only to see their efforts come to naught. Eventually, they concluded that they would support an inferior model that they felt had a better chance of being accepted. This, in essence, explains the existence of the Massachusetts model, which was proposed and passed by legislators and others, many of whom had previously supported the establishment of a single-payer system. Governor Patrick describes this as preferring the good to the perfect—a "good" that could be achieved versus a "perfect" that would never be passed.

Opposition by politicians For several years, there has been a bill in Congress, HR676, to establish a single payer system. This bill has been supported by a wide variety of government and non-government groups[1]. And yet, in the House of Representatives, only 21% of the members have signed on as co-sponsors—not nearly enough to ensure its passage.

In March, President Obama began a process of trying to determine the most appropriate health care system by convening a series of health care forums. At the first of these, in Washington, there were

[1]For an extremely long list of the government, Democratic Party, labor, medical, faith, and civic/community organizations that support single payer, see `http://www.pnhp.org/action/organizations_and_government_bodies_endorsing_hr676_single_payer.php`.

hardly any supporters of single payer invited to attend; many other valuable ideas were exchanged, but none addressed the core systemic problems of our current health care structure. In the forum in our region (co-chaired by Governor Patrick), there was only one person who spoke in favor of a single payer system—although she seemed to receive from the audience more applause than most other speakers.

During the hearings conducted by the Senate Finance Committee, single payer advocates, incensed by the fact that the Democratic Party is ignoring this approach to health care, tried to demonstrate and were promptly arrested. The Chairman of the Committee, Senator Max Baucus, has frequently stressed that he is not interested in listening to single payer advocates (Baucus: "It's not on the table because it cannot pass.") (Moyers, 2009).

Even in Massachusetts, the draft platform presented to the 2009 State Democratic Convention omitted any reference to a single-payer system, even though 32 out of 34 comments received on health care by the platform committee supported it.

Opposition by the President On June 30, 2003, Illinois State Senator Barack Obama said that he favored a single-payer health care system, but "we may not get there immediately because first we have to take over the White House..." (Moyers, 2009). This view changed when he became Senator. As candidate for President, he advocated that the government insurance plan that he as a Senator enjoyed be available for everyone. Now he seems to be wavering even on this position. Ever since becoming President, Obama has stressed that he wants to be bipartisan, to incorporate everyone's views on any issue into the decisions that he as President must make.

He tries, but he does not succeed. His primary potential partner, the Congressional Republican Party, does not appear to be at all interested in a meaningful dialogue on any issue. Unfortunately, the President's approach is to compromise anyway, even if the compromise does not produce any votes. He thereby reduces the quality of the product without achieving the bipartisanship that he wants. Inclusiveness does not work with people who have no wish to be included.

Given the extreme negativism of most current Republican Senators and Representatives, it seems reasonable to ignore them. But that is not Obama's way. In his search for solutions to health care problems, the President wants to include all of the people and institutions that created those problems. As a result, inclusiveness has become a higher priority than the needs of the American people.

5.2 How is the opposition to single-payer universal health care framed?

Insurance companies and Big Pharma can't just say, "You can't have single-payer universal health care—we'd lose money." Instead, they appeal to a certain ideology—that of extreme individualism—and they lean very heavily on cynicism as a tool in doing this.

5.2.1 The ideology of extreme individualism

By ideology we simply mean a coherent way of looking at the political world. The particular ideology we're concerned with here can be expressed like this:

> *What individuals do is efficient, forward-looking, and by encouraging people to be independent, makes the world a better place. What people do together on the other hand*

is wasteful and encourages sloth and dependence. In particular, private companies are models of the way things should be run. The trouble with government is that it's not "run like a business."

As with any ideology, there is some truth to this. There is an important place in our lives for individual responsibility. But what we are talking about here goes far beyond that. It was summed up most neatly by former British Prime Minister Margaret Thatcher, when she said, "There is no such thing as society. There are only individuals and their families."

Most people don't completely believe this. But everyone is familiar with it; it is widely expressed by radio talk show hosts and political commentators, and it is seldom challenged. In fact, it is such a deeply entrenched idea that in its own terms it is almost impervious to challenge.

For example, a big argument against single-payer universal health care is that it would put hundreds of thousands of employees of HMOs and insurance companies out of work.

Now if someone argued that a government program should not be shut down because it would put a large number of government employees out of work, they would be laughed at. In fact, Governor Patrick reports that when he had to lay hundreds of state workers off in the current budget crisis, many people felt that was a good thing. So there is a value judgment here that really colors how many people—and certainly many politicians—see this: employees of insurance companies are real people who need to keep their jobs. Employees of the government are taking our "hard-earned tax dollars" from us, and it's no great loss if they lose *their* jobs.

If efficiency were really being taken seriously, then the fact that that Social Security and Medicare have much lower administrative costs than any private insurance programs would be a conclusive argument for single-payer universal health care. The fact that it is never mentioned shows how the whole discussion is framed in terms of the needs of the private sector rather than the needs of the general public.

There is nothing efficient or worth maintaining about private health care.

This ideological world-view insinuates itself into every proposal. So if for instance, one were to try to set up a mixed system of public and private health insurance, it would have to be structured so that the private companies could make a profit. This could only happen by artificially restricting the ability of the government program to provide high-quality care. We have already seen things like this happen—the fact that Medicare was forbidden to negotiate drug prices with large pharmaceutical companies was explicitly enacted so that the private companies would have a competitive edge. Once you allow that private companies have a legitimate role to play, then the laws and regulations will be written to accomodate them, at the expense of truly efficient government programs.

5.2.2 Cynicism as a political tool

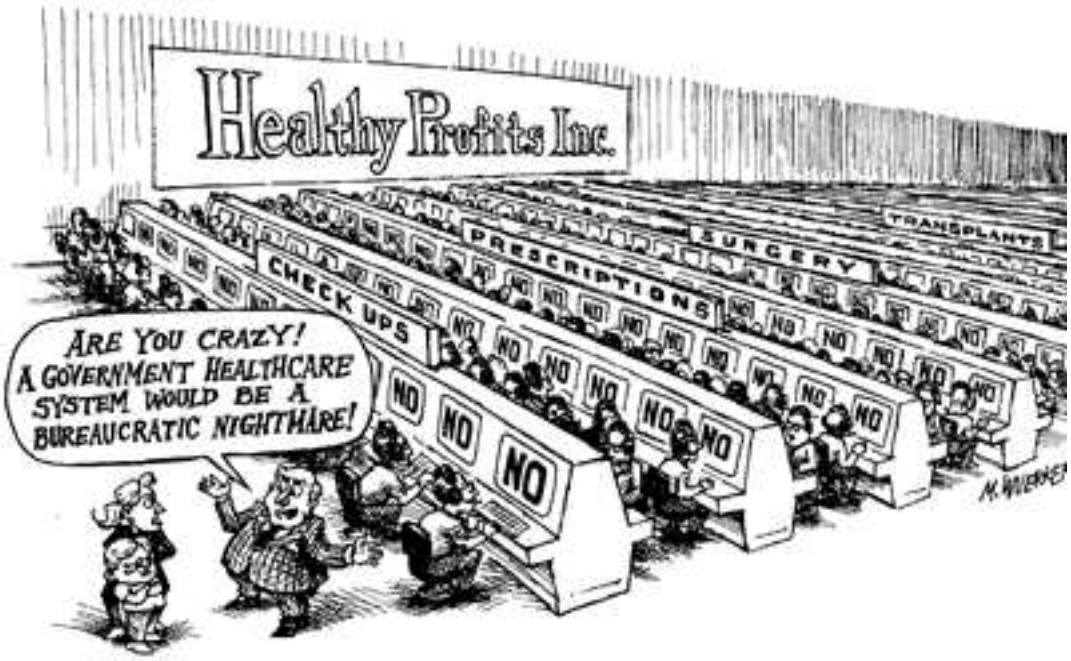
Cynicism—in its standard meaning of "disbelief in human sincerity or goodness; sneering"—is used in particular by Republicans to cast aspersions on the positive role of government. Republicans have been doing this with considerable success for decades now, and for the most part, they have not been challenged. Typical cynical notions promoted by Republicans are:

- The government always wants to raise your taxes to stuff the pockets of politicans and their cronies.

- The government just wastes our money.
- Government is not the solution—it is the problem.
- When the government runs anything you just have to spend all your time filling out forms for bureaucrats.
- If you put the government in charge of anything, they will just whittle it down and take it away.

Every one of these statements is largely false but slightly true. By harping on them, over and over again, stressing the "everyone knows that" they are true—even though they're not—the Republican party twists the truth to suit the interests of the wealthy and powerful.

In reality, it is corporations that have been whittling down and taking away health insurance from their employees, and whittling down and taking away pensions for decades now. And they have been pressing the government to do the same with Social Security. But Social Security has basically been kept intact – it is the most successful social program in history, and it is a real model of what single-payer universal health care could become. (And privately funded health care is what leads to a plethora of forms to fill out and get approved. Medicare is no more complex, and a single-payer plan would be much simpler.)



Many people feel fearful—no matter how insufficient their current health insurance is—that a change might be for the worse. ("At least now we have something. A government program might be really nothing.")

Related to this is the notion that private health care gives people a choice. This is the notion that the "free market" provides a competitive environment in which a consumer can choose what is best

for him or herself. In some abstract sense, perhaps this is true. But in practice, it's never true. First, what health insurance company you have is generally decided by your employer, not by you, and there is little or no choice there at all. But even if you could pick one out of several insurers, it is almost impossible to make a rational decision. The plans are hard to compare, and are always changing, and no one knows what their health will be like in a couple of years. There is no real way for a person to make the proverbial educated choice that economists love to pretend exists.

Another version of this fear is the notion that, as many people say, "I don't want the government telling me what health care I can get." Well, isn't that exactly what your insurance company does now? And while it is not the easiest thing to influence government policy, it's a lot easier than influencing an insurance company.

One curious thing about these cynical notions is that in the guise of justifying private solutions to public problems, they often accuse government employees of the sorts of abuses that are endemic in private enterprise. So for instance, there have been a handful of examples of high-level government managers making sweet retirement and pension deals for themselves. And there's no excuse for this. But really, this pales in comparison with the way high-level managers of large corporations have used golden parachutes to feather their own nests. And beyond that, look at the way Polaroid's management looted the pensions of its employees and retirees and made off with all the money, perfectly legally. Or look at Enron, WorldCom, AIG, Merrill Lynch, or dozens of other outrageous examples. Even more significantly—if this is possible—the magnitude of the looting of the public wealth over the past few decades by large corporations dwarfs any abuses of government officials. This is a real case of the pot calling the kettle black, except that the pot in this case is a lot grimier than the kettle.

The most successful attack on an increased government role in health care was the "Harry and Louise" television ad series. These ads were notable for not containing any real reasons why single-payer universal health care might be a bad idea. Rather, they were composed purely of cynicism. They played upon fear and upon the notion that the government was on someone else's side—not yours. The most powerful opposition to single-payer universal health care—while it is motivated and bankrolled by powerful interests who profit from a disfunctional private health insurance industry—is and will be couched almost entirely in cynical terms.

5.3 Why politicians are spooked, and what we must do

In spite of the widespread support for single-payer universal health care, there are relatively few politicians who actively support it. Why is this?

There are probably several reasons:

- Some politicians, to be sure, are actual proponents of what we have called the ideology of extreme individualism. This probably includes most Republican members of Congress and some Democrats as well.

- There are other politicians who really don't fall into that category, but who have for their entire lives associated with business leaders, and are actively cultivated by such business leaders. While these political leaders may hold progressive views on any number of issues, they find it hard to imagine any national program that is not dominated by a for-profit business perspective.

- Finally, there is a significant—probably a very significant—number of political leaders who really would approve of a single-payer universal solution, and understand that it is the only one that can work, but who nevertheless will not actively push for it. We think there is fundamentally one reason why they act this way:

  They don't believe that the support for single-payer universal health care is "hard". They are really fearful of an appeal to cynicism. They saw what happened with the "Harry and Louise" ads at the beginning of the Clinton administration, and they are afraid that it will happen again. No politician wants to be hung out to dry by a well-funded advertising campaign in his or her district that paints him or her as out of touch with "ordinary people". No politician wants to be the target of a well-funded opposition candidate who appeals to cynicism in an environment in which that cynicism is not being challenged.

The task for us who believe in single-payer universal health care is to confront that cynicism, to engage it head-on, and to weaken it as something that can be appealed to politically.

It was not so long ago that it was regarded as political suicide to support gay marriage. We are seeing this change before our eyes. This didn't happen by magic. A lot of private discussions, a lot of patient organizing, a lot of public debate went into this.

We need to do the same for health care.

6 Conclusion

Our health care system, based on the profit motive, has as a consequence widespread and completely unnecessary deaths and human suffering and desperation. No company's profit can possibly justify this. Countries with far fewer resources than ours manage to provide a quality of health care far better than this, and they do it democratically.

We can do the same. And really, we must. If we truly have as our goal the establishment of the rights of life, liberty, and the pursuit of happiness, there is no other choice.

Single-payer universal health care is an idea whose time has come.

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