

Health Care Reform in the United States: Arguments for a Single Payer System

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The rationale for single-payer has become increasingly compelling right now, when US businesses are increasingly feeling the pinch of rising health care costs, the number of uninsured continues to rise, the nation is losing its comparative advantage in world markets, hospitals are eager to shed the burden of their "bad debt and charity" pool, and consumers are increasingly baffled by an array of insurers who offer confusion in the guise of 'choice.'

The arguments in favor of having a single payer are summarized below. These reasons are in addition to the most overwhelming reason, namely that such a system is the only way we can realistically afford to end the dangerous, embarrassing, and worsening situation wherein about 45 million people in this country lack health insurance and tens of millions more are seriously uninsured.

Single Payer is good for business.

Publicly financed but privately run health care for all would cost employers far less in taxes than their costs for insurance.ⁱ With universal coverage, employers would no longer have to pay for medical care as part of the compensation package offered to workers. And with health care outlays expected to increase between 14% and 18% between now and 2010, employers can expect no relief from the already unsustainable situation they are facing at present. A survey of senior-level executive in Detroit found that 75% consider employee health insurance "unaffordable," while the remaining 25% consider it "very unaffordable."

If the situation is untenable for individual employers, it is even worse for the economy as a whole. Increases in health care costs are a drag on economic growth:



they thwart job growth, suppress increases for current workers, weaken the viability of pension funds, and depress the quality of jobs. Rising health care costs are also causing budgetary problems for federal and state governments, who are currently paying over 50% of the US health care bill.

Universal health coverage would also have a salutary effect on labor-management relations. Many if not most strikes in the past five years have involved conflicts over health benefits. Universal coverage would defuse this contentious issue, provide benefits independent of employment status, and allow business greater flexibility in whom to hire.

Single Payer will enhance the comparative position of the US in the global market.

President Bush has repeatedly said that the United States is not reluctant to compete on the international market as long as there is an even playing field. At present, the lack of universal health insurance places the US at a disadvantage vis-à-vis other countries. Companies such as General Motors that have factories in both the US and other countries have learned this lesson well; for example, in 2003 the costs of manufacturing a midsize car in Canada were \$1,400 less than that of manufacturing the identical car in the US, primarily because of much higher health costs in this country.ⁱⁱ

Single Payer builds on the existing experience.

Those who fear that single

payer is new and foreign, and therefore untested, need to be reminded that Medicare is, in essence, a single-payer system. For those who are eligible, Medicare is universal and identical, not means-tested, and administered by the government, which acts as a single-payer for hospital and outpatient physician services. Because it did not have to sift and sort the population or cope with a layer of insurers, the rollout of Medicare in 1966 was amazingly smooth.ⁱⁱⁱ Practically overnight—and without computers—the program covered services provided by 6,600 hospitals, 250,000 physicians, 1,300 home health agencies, and hundred of nursing homes. By the end of its first year, Medicare had enrolled more than 90% of eligible Americans, a feat that cemented its popularity and redeemed President Johnson's faith in the efficacy of government.

In contrast, Part D of Medicare, which departed from the single-payer model and introduced private insurers, encountered the wrath of consumers who were unable to maneuver the complicated choices required to obtain prescription drug benefits.

Single Payer has significantly lower administrative costs.

Studies by both the Congressional Budget Office and the General Accounting Office have repeatedly shown that single-payer universal health care would save significant dollars in administrative costs. As early as 1991, the GAO concluded that if the universal coverage and single-payer features of the Canadian system had been applied in the United States that year, the total savings (then estimated at \$66.9 billion) "would have been more than enough to finance insurance coverage for the millions of American who are currently uninsured."^{iv} More recently, estimates published in the International Journal of Health Services conclude that "streamlining administrative overhead to Canadian levels would

save approximately \$286 billion in 2002, \$6,940 for each of the 41.2 million Americans who were insured as of 2001. This is substantially more than would be needed to provide full insurance coverage.”^v At present, the US spends 50% to 100% more on administration than countries with single-payer systems.

Single Payer facilitates quality control.

Having a single-payer system would create for the United States a comprehensive, accurate, and timely national data base on health service utilization and health outcomes. This would provide information on gaps and disparities or duplication of care, thereby serving as valuable intelligence for decision-making and resource allocation. At present, the closest analogy to this is the Veterans Health Administration (VHA), which has been highly successful in containing costs while providing excellent care. The key to its success is that it is a universal, integrated system: “Because it covers all veterans, the system doesn’t need to employ legions of administrative staff to check patients’ coverage and demand payment from their insurance companies. Because it’s integrated, providing all forms of medical care, it has been able to take the lead in electronic record-keeping and other innovations that reduce costs, ensure effective treatment and help prevent medical errors.”^{vi}

Single Payer gives the government greater leverage to control costs. A single payer would be able to take advantage of economies of scale and exert greater leverage in bargaining with providers, thereby controlling costs. Recent experiences with both the VHA system and that of Medicare Part D indicate the difference exerting such leverage can make. The Department of Veterans Affairs⁴ uses its power as a major purchaser to negotiate prices with pharmaceutical makers. But when the legislation leading to the drug prescription plan (better known as Medicare Part D) was passed, Congress explicitly barred negotiating prices with drug makers. The results of this are now becoming evident: at present, the VA is

paying 46% less for the most popular brand-name drugs than the average prices posted by the Medicare plans for the same drugs.^{vii} Because Part D increased the effective demand for drugs without controlling costs, prescription drug prices have risen sharply: during the first quarter of 2006, prices for brand-name pharmaceuticals “jumped 3.9%, four times the general inflation rate ...and the largest quarterly price increase in six years.”^{viii}

If this trend is allowed to continue unchecked, it could jeopardize the fiscal viability of the Medicare drug program and seriously undermine whatever political and public support it now has. In addition, this could have significant repercussions on the program as a whole. In the words of economist Stephen W. Schondelmeyer, who specializes in drug industry issues, “Higher drug prices may lead to higher premiums next year, which may discourage enrollees from joining or staying in the program, and fewer enrollees could drive premiums even higher.”^{ix}

Single Payer promotes greater accountability to the public.

One of the key features of the US health care system is its fragmentation. When every player is responsible for only part of the care of part of the population part of the time, there is no overall accountability for how the system functions as whole. Consumers are therefore left wondering who is in charge, and whom they can appeal to when their knowledge is incomplete or their care is inadequate. The most recent report to Congress of the Medicare Advisory Commission recognizes this: “...perverse payment system incentives, lack of information, and fragmented delivery systems are barriers to full accountability.”^x

The creation of a single payer would provide an opportunity for creating a system run by a public trust. Benefits and payments would be decided by the insurer which would be under the control of a diverse board representing consumers, providers, business and government.

Single Payer fosters transparency in coverage decisions. Single-payer plans

have been criticized for “making all sorts of unbearable trade-offs explicit government policy, rather than obscuring them in complexities.” Given finite resources, it may not be possible to cover every single treatment, device or pharmaceutical a patient may require or desire. Priorities must be set, and the criteria for these should be transparent and consistently applied.

The practice of “obscuring trade-offs” is irresponsible and demeaning to the American public. Medical care decisions are too important and affect everyone to be made surreptitiously. Moreover, forcing policy-makers to make decisions concerning what to cover will ensure their confronting issues of safety, efficacy, and value-for-money that are often circumvented or overlooked. Tradeoffs that are transparent to health care consumers will therefore be in the public’s interest.

In sum, the reasons for supporting single payer are practical as well as principled, based on values of openness, equity, and social responsibility. We therefore urge the Citizens Health Care Working Group to adopt the creation of a single payer as an essential pillar without which the guiding values underpinning the Interim Recommendations will not be fulfilled.

Published July 18, 2006

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 - iv. Quoted in Mintz, Op cit.
 - v. Himmelstein DU, Woolhandler S, and Wolfe SM. “Administrative Waste in the US Health Care System in 2003: The Cost to the Nation, The States, and the District of Columbia, with State-Specific Estimates of Potential Savings. *International Journal of Health Services*. Vol. 34, No. 1, 2004: 79-86.
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