

# Single Payer Health Care

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“You might think that you don’t have to worry about paying for medical care if you have health insurance. But you would be wrong” (Are you really covered? 16). Getting cheap and quality health insurance is a real problem in America. As Consumer Reports showed in the above quote, there are skyrocketing health care, health insurance, and prescription drug costs. There are 47 million people uninsured in “the richest nation on Earth.” Worst of all, though, is that the United States has a broken health care system.

This paper will attempt to show that the experts agree that universal, single payer health care is economically sound and is the best way to fully cover the population of the United States of America. Due to time constraints, this paper will focus mainly on expert opinion and stated facts.

To start, this author will define some phrases that will be used throughout this paper. Single payer health care “is a public insurance system, a system in which governments at various levels pay for health services” (Armstrong, Armstrong, and Fegan 2). Socialized medicine, on the other hand, “means government ownership of facilities and government employment of the personnel delivering the care” (Relman 127).

The idea of universal health care in the United States started back in 1915 when the American Association of Labor Legislation introduced a bill requiring everyone to buy health insurance (Palmer 2). The American Medical Association, which is the closest thing to a doctor’s union as you can get, actually supported the bill while the American Federation of Labor was against it. Ultimately, it failed because of “Opposition from doctors, labor, insurance companies and business” (Palmer 3). The next attempt was by President Franklin Delano Roosevelt. He tried, and failed, “to include [universal health care] in the Social Security Bill of 1935” (Palmer 3). Roosevelt was persistent though, and tried and failed again in The Wagner National Health Act of 1939 (Palmer 4). After Roosevelt died in 1945, President Harry Truman tried adamantly to make “a single universal comprehensive health insurance plan” (Palmer 5). But he failed because of, as Karen Palmer stated,

interest group influence (code words for class), ideological differences, anti-communism, anti-socialism, fragmentation of public policy, the entrepreneurial character of American medicine, a tradition of American voluntarism, removing the middle class from the coalition of advocates for change through the alternative of Blue Cross private insurance plans, and the association of public programs with charity, dependence, personal failure, and the almshouses of years gone by (5).

The next attempt worked, but it only covered elderly people and poor people. In 1965, President Lyndon Baines Johnson signed Medicare, which covered the elderly, and Medicaid, which covered the poor, “into law as part of his Great Society Legislation” (Palmer 6).

The issue of universal health care lay dormant for almost 28 years when in 1993, the new president, Bill Clinton, proposed a bill called the Health Security Act of 1993. The act covered everybody by mandating that employers buy insurance for their employees. Its main points were “security, simplicity, savings, choice, quality, and responsibility” (Clinton 2). Two key phrases were “A hospital ought to be a house of healing, not a monument to paperwork and bureaucracy” (Clinton 3). Also, “This health care system of ours is badly broken and it is time to fix it” (Clinton 1). Ultimately, the bill failed to pass because of the strong Republican majority in the House of Representatives after the 1994 mid-term elections.

The economics of single payer, universal health care have been widely popularized as “socialistic,” “communistic,” and “statist.” Here is the truth about the economics of single payer, universal health care. “If we compare the United States with other countries, we find that in 2006 we were spending more than \$7,026 (Catlin, et. al.) for every person in this country, while the typical advanced country elsewhere in the world is spending just \$3,840 per person (Organization for Economic Cooperation and Development)” (O’Brien and Livingston, 15-16). The author’s question is; why do we have such high costs (almost doubling the average of the other countries)? “Is it that we provide the best care and are thus the healthiest in the world? Far from it” (O’Brien and Livingston 16). Then why do we spend so much? “...[W]e are the only country that uses private, for-profit insurance to finance health care for the majority of its population” (O’Brien and Livingston 16).

Some people believe that the only way for the United States to cut costs in the health care industry is to cut back on new technology (MRIs, CAT scans, ICU facilities, etc.), cut back on life saving medications, and/or reduce access to doctors and hospitals (O’Brien and Livingston 17). This is not correct. We can save money “by eliminating the wasteful administrative and billing costs that gobble up increasing portions of our health care dollar” (O’Brien and Livingston 17). As Mary O’Brien and Martha Livingston point out,

[insurance company balance sheets] show us that what they spend on medical care (they call this their ‘medical loss ratio’) is about 80 percent of total revenue. That is, the cost of processing claims, marketing (advertising and payments to their salespeople), ‘underwriting’ (determining whether they are actually willing to insure an individual or group, and at what price), ‘utilization reviews’ (checking on whether to approve the care that doctors want to provide and medications they want to prescribe), and profits consume 20 cents out of every dollar. All of this expense adds nothing to patient care.

By contrast, the federally run Medicare program...spends 97 cents of every dollar on patient care (Woolhandler, Campbell, and Himmelstein). So one way to think of our health care system is that the insurance companies are wasting 17 cents out of every dollar (18-19).

But how much would it cost to cover the uninsured? “The cost of providing full care to the uninsured...has been estimated by the Urban Institute to be between \$40 billion and

\$60 billion annually (Holahan). But any proposal that would end up covering the uninsured through private insurance... would add upwards of \$150 billion in additional spending by individuals, government, or both” (O’Brien and Livingston 17-18).

Some people say that the United States citizens will have to pay higher taxes if the United States adopts a universal, single-payer health care system. This is true, but it would be much lower than most people think. “...the current tax-financed share of health spending is far higher than most people think: 59.8 percent” (Woolhandler and Himmelstein 88). “U.S. tax-financed health spending is now the highest in the world” (Woolhandler and Himmelstein 88). The percentage of tax-financed health expenditures have, amazingly, gone up over the years, as Steffie Woolhandler and David Himmelstein discussed.

In 1965 U.S. tax-financed health expenditures per capita were well below the total spending levels in most other developed nations (Appendix 1)...By 1999 tax-financed health expenditures per capita in the United States exceeded total health spending per capita in every other nation except Switzerland (Appendix 2) and dwarfed government spending in any other nation (92-93).

Also, “While national health insurance [universal health care] wouldn’t cost Americans more, it would mean that taxes would pay a bigger share of health care costs and that private insurance and patients would pay a smaller share” (Woolhandler and Himmelstein 94). How would we get to that level of taxation? “The step from our current level of tax financing--59.8 percent--to Canada or Australia’s 70 percent is...about \$130 billion per year--the amount of recent tax cuts [the Bush Tax Cuts of 2001]--would get us from here to there” (Woolhandler and Himmelstein 94).

Probably the worst problem with the tax-financed health spending is its regressivity, which means that poorer people pay more than richer people. Woolhandler and Himmelstein asserted that

Highly visible Medicaid spending benefits the poor; obscure but burgeoning tax subsidies benefit the affluent who are most likely to have employer-paid coverage and whose higher marginal tax rates translate into greater tax savings (Enthoven)(Brandon)(Sheils and Hogan)(Budetti, et. al.). For instance, in 1998 federal tax subsidies alone averaged \$2,357 for families with incomes above \$100,000 but only \$71 for families with incomes below \$15,000 (Sheils and Hogan) (94).

So let’s get something straight. The poor pay for most of the health care that the rich get. So if the United States were to have universal, single payer health care, the rich would have to pay more in taxes and it would seem fair because the rich have been riding the coat-tails of the poor for some time now, but especially since 1980. Some people say that the government has less of a purchasing role than the private sector. This, again, is not correct. “The federal government is now the largest purchaser of private coverage in the United States, followed by the State of California (Pear)” (Woolhandler and Himmelstein 95). But what about the private sector employers? “private-sector employers contribute to

the principal coverage of only 43.1 percent of Americans (Carrasquillo). But even this figure greatly overstates private employers' role in funding care; they rarely pay the entire premium, and their contribution is tax-subsidized" (Woolhandler and Himmelstein 95).

Some people say that there is no way that the United States could get a better system of health care because the United States is the best in the world in everything. You know the chant, "USA! USA! USA!" The exact opposite is, in this case, true.

Countries in order of their average ranking on the health indicators (with the first being the best) are Japan, Sweden, Canada, France, Australia, Spain, Finland, the Netherlands, the United Kingdom, Denmark, Belgium, the United States, and Germany. Rankings of the United States on the separate indicators (Starfield, Primary Care: Balancing Health Needs, Services, and Technology) are:

- 13<sup>th</sup> (last) for low-birth-weight percentages
- 13<sup>th</sup> for neonatal mortality and infant mortality overall
- 11<sup>th</sup> for postneonatal mortality
- 13<sup>th</sup> for years of potential life lost (excluding external causes)
- 11<sup>th</sup> for life expectancy at 1 year for females, 12<sup>th</sup> for males
- 10<sup>th</sup> for life expectancy at 15 years for females, 12<sup>th</sup> for males
- 10<sup>th</sup> for life expectancy at 40 years for females, 9<sup>th</sup> for males
- 7<sup>th</sup> for life expectancy at 65 years for females, 7<sup>th</sup> for males
- 3<sup>rd</sup> for life expectancy at 80 years for females, 3<sup>rd</sup> for males
- 10<sup>th</sup> for age adjusted mortality (Starfield, "Is US Health Really the Best in the World?" 483).

So as you can see, the old "USA! USA! USA!" chant does not mean that the United States has the best health care system, it just means that U.S. citizens (the author included) can chant really, really loudly.

Another problem with the health care system is the health care system itself is making people die from adverse effects.

...U.S. estimates (Leape)(Phillips, Christenfield, and Glynn)(Lazarou, Pomeranz, and Corey) of the combined effect of errors and adverse effects that occur because of iatrogenic damage not associated with recognizable error include:

- 12000 deaths/year from unnecessary surgery
- 7000 deaths/year from medication errors in hospitals
- 20000 deaths/year from other errors in hospitals
- 80000 deaths/year from nosocomial infections in hospitals
- 106000 deaths/year from nonerror, adverse effects of medications

These total to 225000 deaths per year from iatrogenic causes...225000 deaths per year constitutes the third leading cause of death in the United States, after deaths from heart disease and cancer (Starfield, "Is US Health Really the Best in the World?" 483- 484).

So would you rather have a health care system that killed more people (under the current system) or less people (under a single payer system)?

The current system the United States has is hurting the countries' businesses and their competitiveness around the world. Adopting a system of universal, single payer health care is good for the economy. The automobile industry is "being absolutely crippled by health care costs; in 2003, GM spent \$4.5 billion on health care, or \$1,200 for every car it produced (Downey E1)" (Waldman 199). The cost of health care is also putting pressure on out-of-country-companies not to invest in the U.S.. For example,

In June 2005, Toyota announced that it was spurning the millions of dollars in tax incentives offered by Southern states and would instead build a new plant in Ontario. Toyota cited two reasons: first, that Canadian workers are easier to train.... Second, the fact that Canada has a single-payer health system means Toyota would not have to pick up the cost of its employees' health coverage (Naughton 47). Yet, like so many other corporations, car companies refuse to advocate for the one solution that would slash their costs, improve the conditions for their workers, lower the price of their cars, and increase their profits. Why? The only answer anyone has been able to come up with is ideology (Waldman 199- 200).

The biggest advantages of having a single payer system go to the patients. There would be no out of pocket charges for anything, no premiums, no pre-existing conditions. You could see any doctor you want for free and not get less care, but more due to the decreased paperwork and thus more time for the doctor to focus on you getting better. There was a bill that was introduced 2003 that proposed a single payer system. Here is the funding of that bill, H.R. 676:

#### Savings

- Administrative (paperwork, etc.)=\$278 billion
  - Bulk Purchases
    - Prescription Drugs=\$87 billion
    - Non-Durable Medical Supplies=\$13 billion
    - Durable Medical Equipment=\$9 billion

#### New Sources or Revenue

- Payroll Tax (3.3% additional on employer/employee)=\$538 billion
- Stock Transfer Tax (0.25% on seller and buyer)=\$150 billion
- Reduce Corporate Welfare=\$100 billion
- Reverse 2001 and 2002 Tax Cuts=\$251 billion
- Tax Surcharge: 5% on Richest 5% of Taxpayers; 10% on Richest 1%=\$200 billion

Under this plan, we would eliminate the private insurance spending and reduce the out of pocket cost by 75% and still save \$387 billion.

In a 2007 poll, a majority of doctors believe that the United States should have a single-payer health care system. In said poll, “One respondent summed up the rationale: ‘The system is broken,... There are too many rules, too many deductibles, too many games doctors have to play. The paperwork is a nightmare for doctors and patients alike’” (Mattera 1). Other doctors have the same feelings, like this one:

A colleague who supports a single-payer system, however, looks at competition from another angle [than a person who is against single-payer]. ‘The current health care environment takes away the competitiveness of all our industries in the global arena. We need a basic universal health care system for all.’... [T]hat doctor is right about the timing of this debate, he said, “I am glad that this question on health care reform comes up now before a new president is elected.” (Mattera 2).

One of the most often made criticisms made by critics of universal, single payer health care is: if the United States adopts a system of universal, single payer health care, there would be longer waiting times for general treatment, but this assumes that the United States has the shortest waiting times of all countries. But, alas, the United States has a very poor waiting time record.

A 2005 survey conducted by the Commonwealth Fund of sicker adults in six highly industrialized countries found that only Canada was worse than the U.S. when it came to waiting six days or longer to schedule a doctor’s appointment for a medical problem.

Of the countries surveyed, 81% of patients in New Zealand got the same or next-day appointment for a no routine visit, 71% in Britain, 69% in Germany, 66% in Australia, 47% in the U.S. and 36% in Canada (Arnst 2).

That same survey did find that “patients in the U.S. had shorter wait times than every country except Germany when it came to getting an appointment with a specialist for non emergency elective surgery” (Arnst 2). So if you want to wait less and pay less, move to Germany.

Another often made criticism of universal, single payer health care is: the U.S. would ration care if it adopted a universal, single payer health care system. The thing the critics miss is that the U.S. already rations care in the most Draconian of ways, by income. Other countries do not ration this way. “[Countries with universal health care] systems are publicly accountable and ours is not. Problems with their health care systems are aired in public, ours is not” (PNHP 2-3). “In Canada, when waits for care emerged in the 1990s... wait times for each hospital were posted on the Internet” (PNHP 2-3).

Another, and probably the most outrageous, claim made by the critics is that: if The United States adopts a system of universal, single payer health care then the quality of the care they would receive would go down. This is ridiculous. The care today is not the best by far. The United States has to have some “keys” that show that the U.S. is on the correct path. “One key... is that patients understand the medications they are to take

when they get home” (Davis, et. al 633). Another key is to have timely care. “Timely care can improve the likelihood that conditions will be caught early, and avoid the use of costly emergency room or inpatient hospital care” (Davis, et. al. 635). Another key is patient centered quality care. “Patient-centered quality care... includes easy access to care outside of regular working hours (Davis, Schoenbaum, and Audet 954). Access to care on nights, weekends, and holidays without going to the emergency room is difficult for sick adults ” (Davis et. al. 635). But, obviously, the biggest key is getting universal health care and covering everybody. Also, universal, single payer health care “would improve care for most Americans, not just the poor: solidarity is stronger than charity” (Himmelstein and Woolhandler 103).

Universal, single payer health care is the best way to reform the medical system in the United States. It is more efficient than the current system, cheaper than the current system, and fairer than the current system. Finally, here is a quote from a man who is known all around the country, if not the world, Martin Luther King, Jr. It was said in 1967, but it still rings true today. “Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”

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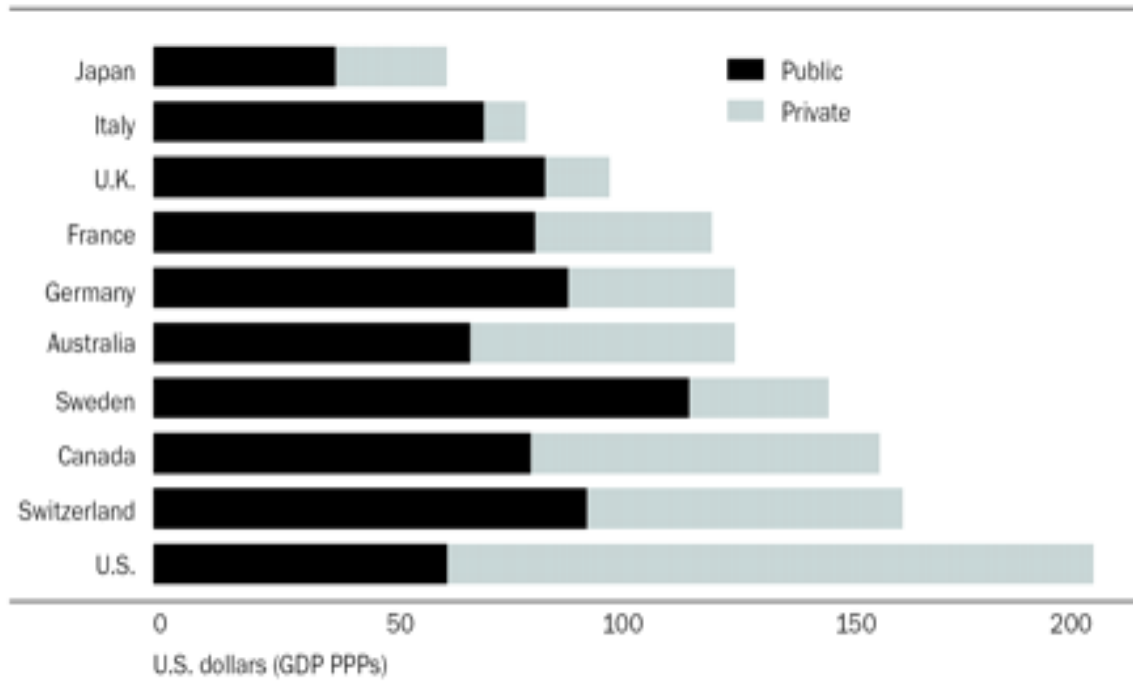
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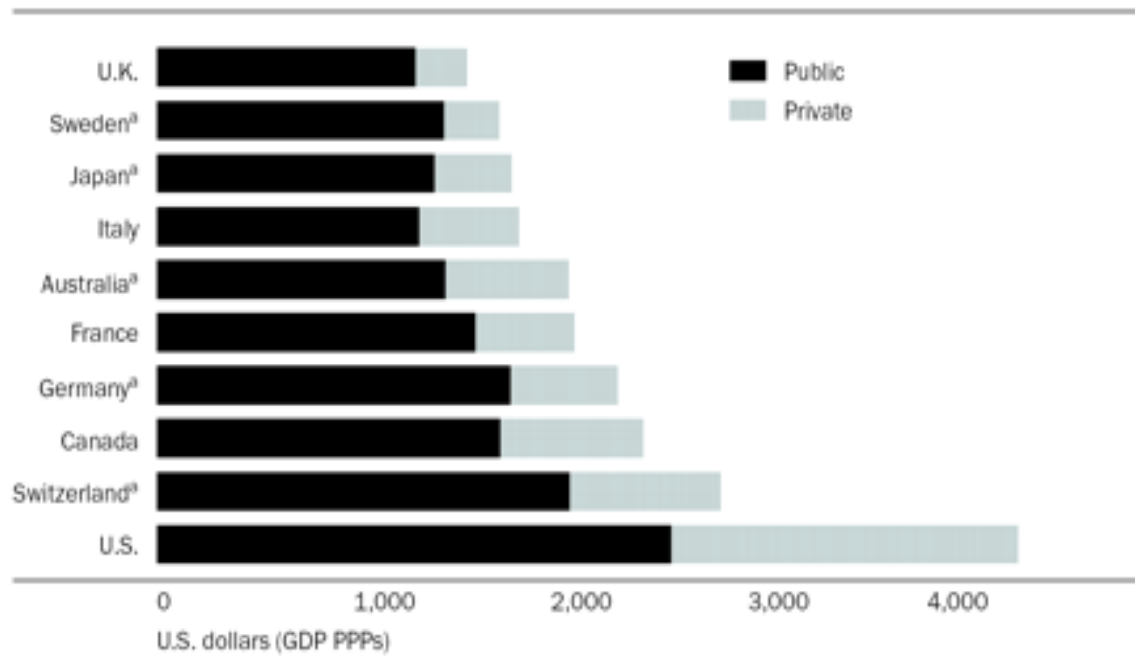
## Appendix 1:



**SOURCE:** For U.S. figure, authors' calculations. For all other countries, Organization for Economic Cooperation and Development, *OECD Health Data 2000* and *OECD Health Data 2001* (Paris: OECD, 2001 and 2002).

**NOTE:** All figures have been converted to U.S. dollars using gross domestic product (GDP) purchasing power parities (PPPs).

## Appendix 2:



**SOURCE:** For U.S. figure, authors' calculations. For all other countries, Organization for Economic Cooperation and Development, *OECD Health Data 2001* (Paris: OECD, 2002).

**NOTE:** All figures have been converted to U.S. dollars using gross domestic product (GDP) purchasing power parities (PPPs).

<sup>a</sup> 1998.