PNHP Single-Payer FAQ

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Is national health insurance ‘socialized medicine’?

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

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

Won’t this result in rationing like in Canada?

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

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

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

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

Who will run the health care system?

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

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

What about medical research?

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

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

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

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

Won’t this just be another bureaucracy?

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

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

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

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

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

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

How will we keep doctors from doing too many procedures?

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

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

Another approach is to compare physicians’ use of tests and procedures to their peers with similar patients. A physician who is “off the curve” will stand out. A related approach is to set spending targets for each specialty. This encourages doctors to be prudent stewards and to make sure their colleagues are as well, because any doctor doing unnecessary procedures will be taking money away from colleagues.

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

What will happen to physician incomes?

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

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

How will we keep drug prices under control?

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

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

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

What will be covered?

All medically necessary care would be funded through the single payer, including doctor visits, hospital care, prescriptions, mental health services, nursing home care, rehab, home care, eye care and dental care. We also advocate a sharp increase in public health funding.

What about alternative care, will it be covered?

Alternative care that is proven in clinical trials to be effective will be covered. For example, spinal manipulation for some lower back conditions would be covered. Antioxidant vitamins would be covered for people with macular degeneration, but not for the general population (where they appear to be harmful). In general, coverage decisions will be made by the health care planning board or another public body. New kinds of treatments will be added to the benefits package over time as they are shown to be effective, including “alternative” treatments. Similarly, ineffective or harmful care can be removed from the benefits package, such as high dose epo for cancer.

Can a business keep private insurance if they choose?

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

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

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

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

The new system will still need some people to administer claims. Administration will shrink, however, eliminating the need for many insurance workers, as well as administrative staff in hospitals, clinics and nursing homes. More health care providers, especially in the fields of long-term care, home health care, and public health, will be needed, and many insurance clerks can be retrained to enter these fields. Many people now working in the insurance industry are, in fact, already health professionals (e.g. nurses) who will be able to find work in the health care field again. But many insurance and health administrative workers will need a job retraining and placement program. We anticipate that such a program would cost about $20 billion, a small fraction of the administrative savings from the transition to national health insurance.

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

How will we contain costs with the population aging?

Studies show that aging of the population accounts for only a small fraction of the increases in health costs. Japan and Europe are already facing the problem of an aging population head-on and are doing fine. They have a much higher percentage of elderly than we do, and still spend far less on health care.

The best way to approach this is to regard it as a societal problem, one that needs a solution with everyone in mind. Germany and Japan recently adopted single-payer long-term care systems to cover the long-term care needs of the elderly at home and in specialized housing. Germany is pioneering a program that pays family members to care for the elderly at home.

What about ERISA? Doesn’t it stand in the way of states implementing universal health care plans?

No. ERISA (the Employees Retirement Income Security Act) prevents a state from requiring that a self-insured employer provide certain benefits to their employees. However, a single-payer plan would not mandate the composition of employer benefit plans - it would replace them with a new system that would essentially be “Medicare for all.” The state would require employers to pay a payroll tax into the health care trust fund, which is clearly legal.

How will the Health Planning Board operate?

A health planning board would be a public body with representatives of patients and medical experts. The representatives would decide on what treatments, medications and services should be covered, based on community needs and medical science, and allocate capital for major new investments based on assessments of where need is greatest.

Since we could finance a fairly good system, like the Norwegian, Danish or Swedish system, with the public money we are already spending (60% of health costs), why do we need to raise the additional 40% (from employers and individuals)?

There are three reasons why the U.S. health care system costs more than other systems throughout the world. One, we spend two to three times as much as they do on administration. Two, we have much more excess capacity of expensive technology than they do (more CT scanners, MRI scanners, and surgery suites). Three, we pay higher prices for services than they do.

There is no doubt that we do not need to spend more than we currently spend to cover comprehensive care for everyone. But the initial transition to a universal system would be very disruptive if we spent less. That is because we have a tremendous medical infrastructure, some

of which would likely retain its excess capacity during the transition phase. Secondly, we would likely retain salaries for health professionals at their current levels. Thirdly, we would cover much more than most other countries do by including dental care, eye care, and prescriptions. And for these reasons we would need the extra 40% that we are already spending - but NOT more. We could cover all the uninsured and improve coverage for those who have skimpy coverage for the same amount we are currently spending!

How much of the health care dollar is publicly financed?

Over sixty percent (60.5 percent) of health spending in the U.S. is funded by government. Official figures for 2005 peg government's share of total health expenditure at 45.4 percent, but this excludes two items:

1. Tax subsidies for private insurance, which cost the federal treasury $188.6 billion in 2004. These predominantly benefit wealthy taxpayers.

2. Government purchases of private health insurance for public employees such as police officers and teachers. Government paid private insurers $120.2 billion for such coverage in 2005: 24.7 percent of the total spending by U.S. employers for private insurance.

So, government's true share amounted to 9.7 percent of gross domestic product in 2005, 60.5 percent of total health spending, or $4,048 per capita (out of total expenditure of $6,697).

By contrast, government health spending in Canada and the U.K. was 6.9 percent and 7.2 percent of gross domestic product respectively (or $2,337 and $2,371 per capita). Government health spending per capita in the U.S. exceeds total (public plus private) per capita health spending in every country except Norway, Switzerland and Luxembourg.

(Source: Himmelstein and Woolhandler, "Competition in a publicly funded healthcare system" BMJ 2007; 335:1126-1129 [1 December] and Woolhandler and Himmelstein, Health Affairs, 2002, 21(4), 88, "Paying for National Health Insurance - And Not Getting It.")

Why not MSAs/HSAs?

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

Individuals with significant health care needs would rapidly deplete their accounts and then be exposed to large out-of-pocket expenses; hence they would tend to select plans with more comprehensive coverage. Since only healthy individuals would be attracted to the MSAs/HSAs, higher-cost individuals would be concentrated in the more comprehensive plans, driving up premiums and threatening affordability. By placing everyone in the same pool, the cost of high-risk individuals is diluted by the larger sector of relatively healthy individuals, keeping health insurance costs affordable for everyone.

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

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

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

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

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

What is PNHP's response to libertarian proposals for health savings accounts and deregulated insurance plans?

In response to the libertarian view: 1) We are already spending more than enough to provide all necessary health care services to everyone, and 2) The majority of Americans believe that everyone should be able to obtain necessary health care without having to face financial hardship.

The goal then is not only to have everyone covered with insurance, but also to make sure that insurance is effective in preventing the consequences of medical debt. We have a rapidly expanding epidemic of underinsurance, and the proposals of libertarians would expose the majority of us to the potential of excessive medical debt were we to develop significant medical problems. Policies with affordable premiums work for those who remain healthy, but most of health care spending is for those with major acute and chronic problems. The deregulated insurance plans and HSAs proposed by libertarians cannot ever effectively address the problem of how we are going to pay for most of the health care in this nation.

The most efficient and effective system would be to establish a single risk pool covering everyone, and fund it equitably. The libertarians do have a problem with "equitable." That would require a transfer from the healthy to those with greater health care needs. But the United States has an additional unique problem. Since we spend twice as much per capita as the average industrialized nation, each person's share (national health expenditures divided by the U.S. population) is no longer affordable. For a family of four, that would be over $30,000 when median household income is about $50,000. So an equitably financed system in the United States would also require a transfer from wealthier individuals to the majority of us. Libertarians and egalitarians will never agree on the appropriate course. All other nations tend toward an egalitarian approach.

The World Health Report 2008, published by the World Health Organization, singles out the United States for its exceptionalism - a system with "singularly high additional private expenditure" that persistently underperforms "across domains of health outcomes, quality, access, efficiency and equity." Everyone should read this report. Very brief excerpts and a link to the full report can be found at: http://www.pnhp.org/news/2008/october/the_world_health_rep.php

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

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

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

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

Why not make people who are higher risk pay higher premiums?

Experience-rated insurance requires higher risk people to pay higher premiums. This approach says that people who have had cancer in the past, or who have chronic conditions like diabetes and hypertension, or who have had dangerous exposures to substances like asbestos, must pay more because they are at higher risk of using health services. Experience rating allows insurance companies to cherry-pick the healthiest

people and either refuse to insure the sickest or, what amounts to the same thing, charge prohibitively high rates. This approach makes no sense. The whole point of insurance is to spread the risk so that everyone is covered. If you raise premiums - and thereby exclude from coverage - those people unfortunate enough to be sick, you defeat the point of both insurance and the health care system. Genetic conditions, childhood diseases, accidents, injuries and income distribution (or how much equality there is in a society) play a much bigger role in people's health than "individual lifestyle" factors. And we know that even for motivated patients, alcohol and tobacco cessation are difficult, and medical weight loss nearly impossible. We need public health, primary care and education programs to try to prevent disease, but punishing patients once they are ill is inhumane and counterproductive.

Community-rated health insurance is the socially fair approach. It spreads the risks evenly among all the insured. It removes the punitive element. It does not discriminate against the very sick, nor against those of us who are at higher risk because of our age (say, over 50) or our gender (reproductive-age females have higher health expenses than men, for obvious reasons).

Health care should be organized as a public service, like a fire department. A health system organized as a business is discriminatory and accountable to no one. At some point in our lives all of us will predictably need health care. Hence health insurance is unlike any other form of insurance; we all are involved.

Won't this raise my taxes?

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

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

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

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

Isn't a payroll tax unfair to small businesses?

The payroll tax means a cost increase for businesses that are not currently insuring their workers. However, it is much less than they would pay at present for adequate coverage for themselves and their workers. For most small (and large) businesses already providing coverage, the payroll tax will mean substantial savings.

Walter Reed Army Medical Center has been in the news lately for poor care and treatment of returning soldiers from Iraq. Won't national health insurance have similar problems?

As we consider what we can learn from the Walter Reed Army Medical Center debacle with regard to government-run efforts, some clarifications should be made:

1. Walter Reed Army Medical Center is an Army hospital and is run by the Department of Defense. The VA hospitals are run by the Veterans Administration (Veterans Health Administration), a separate organization. The news media has clouded this fact and has led the public to presume that all government-run health efforts fail. The VA health system continues to receive the best quality scores of any segment of the U.S. health system, with the most satisfied patients. It beats the best HMOs in quality ratings, has a model information system, and focuses on primary care. It has led in addressing medical errors and in its application of AHRQ quality guidelines to both inpatients and outpatients. In 2004 it won the Baldridge Prize for quality and patient-safety improvements.

2. There is a lot we can learn from the Walter Reed disgrace. Its operation was outsourced to a Halliburton-connected company in 2002, over the objections of some Army medical personnel and leadership, with a subsequent drastic reduction in staff and loss of government employees with institutional experience. There was also some hanky-panky with the contracting process; when the government employees' bid for the operations contract came in lower than the Halliburton company's bid, the bids were "recalculated" to make the private company the lowest bidder.
(This section was contributed by Dr. Anne Carroll.)

What about incremental reform of the health system?

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

What happens to investor-owned hospitals under national health insurance (NHI)?

"The NHI program would compensate owners of investor-owned hospitals, group/staff model HMOs, nursing homes and clinics for the loss of their clinical facilities, as well as any computers and administrative facilities needed to manage NHI. They would not be reimbursed for loss of business opportunities or for administrative capacity not used by NHI. Investor-owned providers would be converted to nonprofit status. The NHI would issue long-term bonds to amortize the one-time costs of compensating investors for the appraised value of their facilities. These conversion costs would be offset by reductions in payments for capital that are currently folded into Medicare and other reimbursements."
(Physicians' Proposal, JAMA, August 13, 2003.)

What proportion of health spending is for undocumented immigrants?

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

The insurance industry says that PNHP's figures on administrative costs are outdated. Is this true?

PNHP has published a series of peer-reviewed studies over the past 20 years showing a steady increase in health administrative costs. While some aspects of administrative cost estimation (e.g. physicians' billing costs) require special studies, others, such as insurance overhead, can be easily tracked from publicly available data. These figures show no evidence of a fall in administrative costs since our most recent (2003) comprehensive estimate that administration consumes at least 31% of U.S. health care spending.

Recently, right-wing "think tanks" have released studies claiming that Medicare's administrative costs are far higher than the official 3% estimate. These estimates add to Medicare's costs a share of the salaries of the President and members of Congress, the cost of running the Internal Revenue Service, etc. But none of these added costs would go away if Medicare were abolished, or up if Medicare were expanded to cover everyone. Most economists agree that such expenses should not be included in calculating Medicare's overhead.

How much could the states save on administrative waste by adopting a statewide single-payer program?

Data on total health expenditures by state (excluding administrative spending) is available at:
http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccountsResidence.asp#TopOfPage

Estimates of state administrative costs (a few years old, but the best available) are in an article by Drs. David Himmelstein and Steffie Woolhandler from 2003.

What will happen to malpractice costs under national health insurance?

They will fall dramatically, for several reasons. First, about half of all malpractice awards go to pay present and future medical costs (e.g. for infants born with serious disabilities). Single payer national health insurance will eliminate the need for these awards. Second, many claims arise from a lack of communication between doctor and patient (e.g. in the Emergency Department). Miscommunication/mistakes are heightened under the present system because physicians don't have continuity with their patients (to know their prior medical history, establish therapeutic trust, etc) and patients aren't allowed to choose and keep the doctors and other caregivers they know and trust (due to insurance arrangements). Single payer improves quality in many ways, but in particular by facilitating long-term, continuous relationships with caregivers. For details on how single payer can improve the quality of health care, see "A Better Quality Alternative: Single Payer National Health Insurance." For these and other reasons, malpractice costs in three nations with single payer are much lower than in the United States, and we would expect them to fall dramatically here. For details, see "Medical Liability in Three Single-Payer Countries" paper by Clara Felice and Litsa Lambkros.

Should PNHP support a public Medicare-like option in a market of private plans?

Response by Drs. David Himmelstein and Steffie Woolhandler:

The "public plan option" won't work to fix the health care system for 2 reasons.

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

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

Would a “public plan option” at least be a step in the right direction?

Answers contributed by PNHP Board members Dr. Andy Coates and Dr. Don McCanne

Answer by Dr. Andy Coates

I am not convinced that it is fair to call the “public plan option” (aka Jacob Hacker’s proposal) “a move in the right direction.”

In the best case scenario this proposal would, I believe, accelerate the trend toward two-tiered care in our country. But we should recognize first that MoveOn and its friends are suggesting scenarios, not backing a specific proposal. The “public plan option,” as yet, amounts to no more than talking points, with some therefore ungrounded assertions along the lines of the quotes by Dr. Dean. (Single payer advocates in contrast have been winning support for legislation — H.R. 676 in the house and now a bill in the Senate, introduced by Senator Sanders.)

If these “public plan option” talking points are intended as a wedge for single payer against private insurance, we should see that they are also a wedge for private health insurance against single payer, the program of national health insurance that the large majority have been shown to want in poll after poll. Single payer has been dismissed by Dr. Dean and many other leading Democrats as “not politically feasible.” Indeed, the “public option” notion grew out of this very idea — the assumption that the insurance industry is too powerful, that we will always have private health insurance.

When Dean and others insist on the “choice” of insurer, they insist upon the “choice” of “keeping the insurance you have” — let’s keep the insurance business and its market, they assert. But the purpose of private health insurance and its market are the opposite of social responsibility — and individual responsibility too.

Choice of insurance companies only matters because it restricts choice in care. What matters for our health is choice among caregivers, choice in location of care. The very purpose of the insurance market is to restrict these choices and by doing so extract money from the health care system. “Adverse selection,” the name of the game of health insurance business success is a reason why we should abolish health insurance as a business. Keeping that market offers the industry plenty of what Jessica calls “protection.”

The insurance companies know all about how to keep the healthy and wealthy while showing the sick and the poor the “choice” of another plan. That is why the insurance industry lately has offered to move to community rating — if only the government will criminalize the uninsured and mandate the purchase of health insurance.

Getting back to one of the scenarios — the “choice” of buying Medicare, the “option” of paying health insurance premiums to a government entity (1) will not guarantee health care to all (as Dr. Dean asserts) and (2) will not be sustainable due to cost. Hundreds of billions of additional dollars annually will not be sustainable — on top of 2.5 trillion dollars, on top of spending that is twice what any nation spends per person. That is why Mr. Obama called $600 billion over ten years a “down payment.”

In another scenario, Senator Baucus, leader of the bipartisan “board of directors” who are working this out behind closed doors has suggested that the “public option” will be the chance to buy insurance through Federal Employee Health Benefit Program, something candidates Clinton and Obama discussed. These are (1) administered by the insurance industry and (2) way out of reach for the uninsured and underinsured, thus would at least require colossal government subsidy, way beyond the $600 billion “down payment.” Baucus also supports a “mandate” that criminalizes the uninsured.

The “public plan option” will not expand our choice of caregivers, will not be universal, cannot offer comprehensive care (and thus can not lessen disparities in care or improve quality) — and above all there will be no way to pay for it, especially as the economy continues to tank. We should conclude that it is not reform!

We should also recognize, with confidence in people to decide and act for themselves, that the single payer cause is growing into a mass movement for civil rights. We may not be likely to win single payer this spring, but as the only proposal for health reform that will save hundreds of billions of dollars annually, that is comprehensive and just and practical, our prospects will continue to brighten, no matter what inside-the-beltway compromise people like Dr. Dean ultimately recommend we make with the insurance industry.

Answer by Dr. Don McCanne

The option to purchase a public plan within a market of private health insurance plans would merely provide one more player in our inefficient, dysfunctional, fragmented, multi-payer system of financing health care, that is if the public option even survives the political process. It would leave in place the deficiencies that have resulted in very high costs with the poorest health care value of all nations (i.e., overpriced mediocrity in health care).

Those who believe that the people of this nation would have the wisdom to drop their private plans and join the government program are ignoring history. When Congress authorized private plans to compete with our existing public program, Medicare, many enrollees did just the opposite. One-fifth have left the traditional Medicare program and joined the private plans.

So why should we care? Why shouldn't they have the right to choose private plans if they want them? We know that those private plans are wasting money, both in their own costs and the administrative burden they place on the delivery system, but what all too many don't realize is that we are all paying for that waste because of the inherent structural deficiencies in our financing system. Plus we are being deprived of the reforms needed in our health care delivery system that our own single payer monopsony would bring us.

Single payer activists, don't give up. As President Obama said in his press conference this week, "persistence!?

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

Medicare is a national program that works reasonably well. There isno reason whatsoever that would make it hard to scale up. Indeed, Medicare was initiated (and administered for tens of millions of enrollees) before computers became available - scaling it up 7 or 8 fold should not prove difficult.

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

Recent Attacks on Single Payer Health Reform: Ideology Masquerading as Scholarship

By David U. Himmelstein, M.D. and Steffie Woolhandler, M.D., M.P.H.

Some conservative opponents of single payer health reform have been claiming that new research proves that Canada's single payer national health insurance program has performed poorly, and that projected savings on administration are illusory. In the commentaries below we analyze the two most prominent examples of this new research a paper by June and Dave O'Neill ("Health Status, Health Care and Inequality: Canada Vs. the U.S.") and a report by Bejamin Zycher ("Comparing Public and Private Health Insurance: Would a Single Payer System Save Enough to Cover the Uninsured?").

The O'Neill's "Health Status, Health Care and Inequality: Canada vs. the U.S."

A recent paper by June and Dave O'Neill contests previous research findings that health outcomes are better in Canada than in the U.S. The O'Neills also claim that income-based health disparities are larger in Canada than in the U.S., that access to care is better in the U.S. and that cancer screening and survival are worse in Canada.

The O'Neills collected no new data. Their analysis rests on idiosyncratic, highly selective and overtly biased reinterpretations of previously published data — mostly from the Joint Canada/U.S. Survey of Health (JCUSH), a population-based survey conducted jointly by the U.S. and Canadian government statistical agencies. While they extensively cite the few pieces of published data that supports their grim view of Canada's health system, they ignore a large body of research and statistics that conflicts with their portrayal.

We will briefly discuss the main assertions in the O'Neill paper.

1-Canada's lower mortality rates are not a result of better health care

The O'Neills assert that Canada's longer life expectancy (2 years longer) and lower infant mortality rate (5.3 deaths/1000 live births vs. 6.8 in the U.S.) have nothing to do with health care. Rather, they claim that non-medical factors such as substance abuse, obesity, low education and "cultural factors" explain the U.S.' poor performance.

They argue that high infant mortality in the U.S. simply reflects the high frequency of preterm births and low birth weight, and especially the very poor outcomes among African-Americans. American's short life expectancy, they say, comes from high rates of obesity, as well as homicides and accidents.

But the U.S.' high rate of prematurity and low birth weight is, largely, a result of poor care — inadequately treated infections and chronic illnesses among pregnant women, and the shockingly frequent failure to deliver adequate prenatal care. 16% of pregnant women in the U.S. receive no care at all in the first trimester of pregnancy, far higher than in Canada.

While the O'Neill's dwell on the high obesity rates in the U.S. as an important non-medical cause of mortality differences, they ignore Canada's significantly higher smoking rate — a graver threat to health than obesity. Moreover, they cite data from the OECD that exaggerates the obesity differences, ignoring the more reliable JCUSH data that they use for most of their other comparisons (presumably because the JCUSH found more modest differences in obesity rates).

They emphasize that accidents and homicides account for a large fraction of the U.S./Canada mortality difference among young adults, age 20-24. But deaths are rare in this age group, and accident/homicides account for virtually none of the difference in older age groups, where almost all of the deaths occur. In fact, differences in heart disease cause most of the Canadian advantage — a difference that almost certainly reflects, at least in part, better access to care in Canada.

The O'Neills also ignore the fact that the U.S. had a lower infant mortality rate than Canada's until the passage of national health insurance (NHI) in Canada, after which Canada's rate fell sharply. Similarly, they never mention that most of Canada's advantage in life expectancy emerged shortly after NHI was implemented.

In many of their data tables on mortality and other health measures, the O'Neills' separate out white from minority Americans, and indicate that Canadians' health outcomes are similar to those of white Americans. Of course, excluding minorities in the U.S. means excluding one third of the entire population, and more than three quarters of the poor. In essence, they want to exclude the 100 million poorest and sickest Americans, and compare the remainder to a cross section of Canadians, including the sick and poor.

2-Other measures besides mortality rates are better indicators of the quality of health care in the two nations, and the U.S. comes out well on these.

The O'Neill's simply assert that self-reported health status (the answer to the question "How would you rate your health? Excellent, good, fair or poor?") is a better measure of the impact of the health care system than are mortality rates. Yet this measure has never been validated for cross national comparisons of the type they make, and it seems very likely to be greatly affected by cultural norms. And, as with death rate comparisons, only by eliminating minority Americans from the comparison can they conclude that the U.S. looks slightly better than Canada.

They then compare the two nations using a "health utility index" and the percent of people with pain that limits their activities. For both of these, Canadians do better than Americans, until minorities are subtracted from the population.

Finally, they compare the prevalence of chronic condition like diabetes, emphysema and arthritis in the two nations, and the proportion of people with each condition who are getting treatment. They conclude that while slightly more Americans are chronically ill, more of them are getting treatment. But millions of uninsured Americans with chronic illnesses like diabetes or high blood pressure are unaware of their diagnoses because they can't afford the doctors visit or lab test needed to make the diagnosis. Surveys will not identify undiagnosed persons as having chronic disease. Hence, the proportion getting treatment is falsely inflated in the U.S. Moreover, even the differences they cite to favor the U.S. are not statistically significant. Hence, a more accurate depiction of the data would state that among people who know of their diagnoses, rates of care are similar in the two nations.

3-More Americans get cancer screening and the U.S. has more high tech health resources than Canada

The O'Neills cite higher screening rates in the U.S. for cervical cancer (PAP smears), breast cancer (mammography), colon cancer (colonoscopy or sigmoidoscopy) and prostate cancer (PSA testing). Only the small PAP smear difference is real.

For mammography, they include all women 40-69 in their calculation of screening rates. But neither the American College of Physicians nor the Canadian Task Force on Preventive Health Care recommend mammograms for all women 40-50. Mammograms for women in this age group leads to more breast surgery and other cancer treatments, but has not been shown to lower overall mortality. It is likely that most of the difference in breast cancer screening is due to higher screening rates among young women in the U.S., who may even be harmed by excessive mammograms.

There's a similar problem with their analysis of colon cancer screening. They include people age 40-69. Yet standard guidelines do not recommend colon cancer screening in normal risk individuals before age 50. They've fudged the data to get a result they want.

Neither the U.S. Preventive Services Task Force nor its Canadian counterpart recommend routine PSA testing because its not at all clear that such testing does more good than harm — it turns up lots of false positives, including many small tumors that would never cause serious problems if left untreated. Routine screening may well lead to many unnecessary operations that leave men incontinent and impotent. Yet the O'Neill's interpret Canada's lower PSA screening rate as an indicator of poor quality care.

We may ultimately find that PSA screening or early mammography saves lives — or causes more harm than good. But at present, we just don't know whether the lower use of these technologies in Canada is a good thing or a bad one.

Their analysis also trumpets the greater number of CT scanners and MRI machines in the U.S. as an indicator of better quality. Yet recent estimates suggest that in the coming years radiation from CT scans may cause as many of 2% of all cancer deaths in the U.S. — about 30,000 excess deaths annually. It is far from clear that the greater use of CT scanners in the U.S. (relative to Canada) causes more good than harm.

4-Waits for care compromise access in Canada, and these access problems are worse than those in the U.S.

The O'Neill analysis admits that fewer Canadians than Americans report an unmet health need (11.3% vs. 14.4%). In the U.S., cost is the big problem, while waits for care are more prominent in Canada. They try to obfuscate the Canadian advantage on access measures by presenting a complex sub-group analysis of pain suffered by those unable to get care. But when you cut through their obfuscation, even this measure favors Canada; about 12% more Americans who say they're unable to get care report being in pain.

5-Cancer mortality rates are higher in Canada, indicating worse cancer care

The O'Neills claim that mortality rates for lung, breast, colon and prostate cancers are lower in the U.S. than in Canada. They calculate mortality rates by dividing cancer deaths by the number of cases of cancer.

When cancer death rates are calculated in a more standard fashion, i.e. the number of deaths per thousand people in the population, age adjusted cancer mortality is actually lower in Canada than in the U.S. for all of these cancers except colorectal cancer. But there are more cancers diagnosed in the U.S. Hence, the death rate among those who are diagnosed — the figure the O'Neills choose as the most important - is lower in the U.S.

This higher incidence of cancers diagnosed in the U.S. probably reflects more intensive screening programs, which diagnose more people with cancer. But, as stated above, its far from clear that diagnosing small prostate cancers based on PSA screening causes more good than harm. Most elderly men with prostate cancer do not die of that disease, but of heart disease or some other illness. (It is likely that some breast and lung cancers that are diagnosed through screening would also never come to light without screening.) In the U.S., these men with small, non-lethal cancers appear in the denominator of the O'Neill's calculation of cancer mortality rates, but not the numerator. In Canada, they appear in neither the numerator nor denominator. Thus, their estimate of cancer mortality rates is biased against Canada because of the higher screening rate in the U.S.

6-Income-based health disparities are, if anything, steeper in Canada than in the U.S.

The O'Neills admit that health differences between those above and below the median income are sharper in the U.S. than in Canada. In fact, the differences between the top and bottom 10% are also bigger in the U.S., as are those between the top and bottom 25% etc.

But the O'Neills want to measure health inequities on a new scale. They observe that the rich in the U.S. are much richer than the rich in Canada, and the poor are much poorer. Rather than comparing high and low income persons, they decide to analyze how much worse health gets for each dollar decrease in income. Since the U.S. income gradient is much steeper, this analysis automatically makes the health per dollar gradient less steep. Notice that this method would find that a nation with almost no income inequality would automatically have very steep health inequalities.

Here's an example. In Country A, the top 1% has an average income of $60,000 and a mortality rate of 100 per 1000. The bottom 1% has an average income of $30,000 and a mortality rate of 130 per 1000. Then, according to the O'Neills' method for each $1000 increase in income, the mortality rate rises 1 per 1000.

In Country B, the top 1% has an average income of $603,000 and a mortality rate of 100 per 1000. The bottom 1% has an average income of $3,000 and a mortality rate of 300 per 1000. Then, according to the O'Neills' method for each $1000 increase in income, the mortality rate rises only 1 per 3000.

So the O'Neills' calculus would judge the income/health gradient less steep in Country B (where the poor have a death rate 300% higher than the wealthy) than in Country A (where the poor have a death rate 10% higher than the wealthy).

7-What's left out?

The O'Neill's paper cites dozens of references. But they fail to mention any of the numerous previous studies that directly address the questions they seek to answer. These include:

1-Previous analyses of the JCUSH data by the National Center for Health Statistics (http://www.cdc.gov/nchs/pressroom/04news/firstjointsurvey.htm) and by our group at Harvard (http://www.ajph.org/cgi/content/abstract/96/7/1300), which found a far different result.

2-The many published studies directly comparing the quality of medical care in the two nations for cancer patients, renal dialysis patients etc. 38 of these studies were included in a systematic review which concluded that, on average, mortality rates are 5% lower in Canada (http://www.openmedicine.ca/article/view/8/1).

3-The large body of literature showing that Canada's health care system is far more efficient, with administrative overhead that is a small fraction of the U.S. level (http://content.nejm.org/cgi/content/short/349/8/768)

4-A recent analysis of deaths that could be prevented by good medical care ranked the U.S. worst among the 19 nations studied, well behind Canada which ranked 6th. Moreover, while Canada's ranking improved between 1997 and 2003, the U.S. fell further behind. (http://content.healthaffairs.org/cgi/content/abstract/27/1/58)

There is much to criticize in Canada's health care system. But the O'Neill's analysis strays far from legitimate scientific discourse, mixing selective citation and creative accounting that is intellectually dishonest.

Bejamin Zycher's "Comparing Public and Private Health Insurance: Would a Single Payer System Save Enough to Cover the Uninsured?"

Benjamin Zycher, an economist at the right wing Manhattan Institute, has recently issued a report disputing claims that a single payer health care reform would realize large administrative and overhead savings. We will briefly respond to the main arguments in Zycher's paper.

1-Medicare's administrative costs are far higher than the figure given in the National Health Accounts.

The National Health Accounts indicate that administrative costs account for only 3% of total Medicare spending (vs. 14% in private insurers). But Zycher wants to add to this a proportional share of all government spending. That is, he claims that 14% of the President's salary, the cost of Congress, the FBI, the federal courts etc, should be attributed to Medicare, since Medicare accounts for 14% of federal spending. Based on this, he estimates "true" Medicare administrative costs at 6% of total outlays, and concludes that potential savings on insurance overhead is only 8% of premiums, not 11%.

Zycher's argument assumes that expanding Medicare to cover all Americans would drive up the costs of all government agencies, Congress etc. — an absurd assumption. Would we really raise the president's salary, or a senator's pay as part of implementing a single payer system? In fact, there is no reason to posit increases in any such costs, and the Canadian experience suggests that Medicare's overhead could actually be reduced to about 1% by simplifying hospital and physician payment.

2-The higher taxes needed to fund national health insurance would cause massive economic losses that more than offset any administrative savings.

Zycher argues that every dollar collected in taxes by the government actually costs the economy about $1.76 because of foregone private investment. He wants to add a large portion of this cost to Medicare's overhead, arriving at an estimate that overhead consumes 52% of total Medicare spending.

First, his estimate of the economic consequences of taxation is questionable at best. His assumption that the taxes raised for NHI would come from investment, not from existing health care expenditures, is unfounded. Its simply crazy to posit that money flowing to health care through private insurers provides strikingly more stimulus to the economy than the exact same amount flowing through a government insurance plan.

3-Private insurers' overhead is not really wasteful.

Zycher admits that Medicare and NHI achieve large savings on underwriting, advertising etc. But he argues that these activities are good things because they "align premiums with costs", stop the healthy from cross-subsidizing the sick, and make everybody pay the true costs of their own care. He assumes that a market-based health insurance system — which minimizes risk pooling and cross-subsidies - must be most efficient. Therefore, the costs of administering such a market are, by definition, not waste but a necessary part of efficiency.

Of course, he does not and cannot adduce any evidence that a market-based health insurance system is actually efficient. In fact, the overwhelming evidence indicates that it is far less efficient than NHI.

4-What Zycher leaves out.

Zycher's arguments completely ignore the massive administrative waste that private insurers inflict on hospitals, doctors, nursing homes etc. In fact, insurance overhead accounts for only one-quarter of total health care administrative costs in the U.S. The complexity of our current reimbursement schemes requires providers to fight with insurers for payment for every aspirin and bandaid. This requires a huge administrative staff, billing computers etc.

In contrast, a single payer system could greatly streamline providers' paperwork. Paying hospitals on a lump sum budget basis — e.g. as a fire department is currently paid — could cut hospital administration costs in half. Similar savings could be realized by simplifying doctors' billing.

In sum, Zycher's analysis falsely inflates Medicare's overhead costs, makes outlandish assumptions about the economic costs of taxes vs. premiums, attributes unsubstantiated social benefits to advertising and insurance underwriting, and ignores the massive administrative burden borne by providers.

When Canada adopted single payer, did she allow labor unions to opt-out and "keep what they have."

No. Neither the provinces nor the federal government ever allowed labor unions to opt-out of the plan. Confusion on this point seems to arise from two places. 1) The province of Alberta did not join the single payer system until 1968, and 2) from the beginning, for non-covered benefits only, unions and individuals could "keep what they had" and could bargain for supplementary health benefits with private insurance companies.

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

Countries with strong health care systems have at least half of their physicians in generalist primare care practice 50 percent in Canada, 70 percent in the United Kingdom (Starfield, B, Is primary care essential? Lancet 344: 1129, 1994)

In 2008, less than 8 percent of U. S. seniors chose family medicine, a 50 percent decline since 1997; only 199 U. S, seniors matched into primary care internal medicine, 248 into IM/Peds, and 53 into primary Peds. The percentage of international medical graduates (IMG's) in our 3 primary care specialties is now 73 percent for IM, 68 percent for Peds, and 55 percent for Fam. Med. (Pugno, P , et al Fam Med 40 (8): 563, 2008) I don't believe that we have more than about 30 percent of our physicians in primary care. Only 20 percent of internal medicine graduates become general internists, and most pediatric graduates go into sub-specialties. (Bodenheimer, T. Primary care—Will it survive? N Engl J Med 355 (9):861, 2006).

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

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

Answer contributed by Dr. John Geyman, PNHP Past President

What is a Voucher Plan? What's Wrong With It?

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

Answer contributed by Len Rodberg, Ph.D.

What about the claim (in videos circulating on the internet) that a patient in Canada would have died of a brain tumor if he hadn't come to the U.S. for an MRI?

The video of Lindsay McCreith is by Stuart Browning who is infamous for not allowing objectivity to interfere with his anti-government messages. Also, two interests intervened during the management of McCreith's care. One is a firm that arranges medical tourism to the United States, using queues as a business stimulus. The other is a law firm that specializes in cases that would promote privatization of the Canadian medicare system. Thus it began as a setup for the libertarian/conservative camp.

The claim that he would have died had he waited the four months for an MRI scan is an outrageous lie. A C-T scan was done immediately. The tumor was identified, and it was of a nature that did not require emergency management. An emergency MRI would have been done if it were indicated, but it wasn't.

We do not have all of the details that would come forth during discovery, but we do have a copy of the lawsuit. When you read it, it is clear that the claim is based on ideology rather than government mismanagement. Queues are a problem, but they are being addressed, with considerable success.

If Canadians are to continue to improve queues it is very important that non-emergency patients should never be allowed to purchase a place at the front of the queue. If that were allowed, queues for individuals who could not afford to pay for private care would become intolerable, creating a two-tiered system with boutique care for the wealthy and mediocrity in a neglected system for the non-wealthy.

Here is the lawsuit. (Keep in mind that the lawsuits are filed with inflammatory language, whereas the actual facts then must be confirmed during the discovery process.)
http://www.law.utoronto.ca/healthlaw/docs/case_McCreith.pdf

This is an article on low grade astrocytoma, confirming that this was not an emergency.
http://emedicine.medscape.com/article/1156429-overview

All health care systems can be improved, but the McCreith case should not serve as a basis for Canada to trade in their egalitarian system for the U.S. model with its profound health care injustices that cause so much financial hardship, physical suffering and death.

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