

Background Paper 5:

Single Payer: The Healthcare System That America Needs

Unlike virtually every other industrialized country, the United States does not have a unified system of healthcare for its citizens. Instead, it has several systems for different populations – the Veterans Administration system for veterans; analogous systems for Native Americans and military personnel and their families; Medicare for those people 65 years and older (plus some other groups); Medicaid for many with extremely low incomes; employer-based health insurance for many of the employed – and essentially no system for the one-sixth of our population who are not covered by any of the other programs and who largely remain uninsured.

The Harvard health economist Dr. William Hsiao has stated, "Before you set up a health care system for any country, you have to know that country's basic ethical value. The first question is: Do people in your country have a right to basic health care? If 'Yes', then a country can design a system that means anybody who is sick can see a doctor. If, on the other hand, society considers medical care to be an economic commodity, then you set up a system that distributes health care based on ability to pay." The U.S. has a schizophrenic response to this question: our system treats health care as an economic commodity, but desperately sick people who can't pay get treated anyway (mostly in emergency rooms).

The current problems of health care in our country include the following:

- Health care costs, already at least twice those of almost all other industrialized countries, are continuing to rise.
- Our health outcomes in general lag behind those of most other developed countries.
- 50 million of our people are uninsured – in contrast to zero in other industrialized countries.

A primary cause of this situation is our heavy reliance on the private, for-profit health insurance industry.

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In 2004, the Institute of Medicine (IOM) offered a set of guiding principles with respect to evaluating strategies for health care coverage in our country:

1. Health care coverage should be universal.
2. Health care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable for society.
5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

These principles are as relevant and appropriate today as they were eight years ago.

There are several possible ways to design a unified health care system to meet the IOM principles. In our opinion, the most feasible system is embodied in HR 676 'Expanded and Improved Medicare for All' as well as HR 1200 'American Health Security Act of 2011' bills in Congress. Members of our state's Congressional delegation should be asked to co-sign and promote these bills.

Does the 2010 Patient Protection and Affordable Care Act (PPACA) have the promise of fulfilling the IOM principles? Even the most ardent proponents agree with me that the answer is: "No." There are no proven cost-controlling provisions in PPACA. The Congressional Budget Office has estimated that, under PPACA, there will still be 21-23 million people uninsured by 2019. For these reasons, we must continue to work to change the fundamentals of the health care system in our country. Any proposed changes should be evaluated on the basis of the likelihood that such changes will be steps in the direction of universal, quality, affordable health care for all.

Some are advocating that a "public option" be included in P-PACA. Will this be a step in the right direction? Not in our opinion. A "public option" creates its own problems: How will it be financed? How will premiums be set? What can be done to prevent the sickest people primarily gravitating to this option? There is no experience to suggest that a "public option" would truly add benefit.

For more information, find us at: www.healthcareforallwa.org