Myth Busters - Answering Difficult Questions about Single Payer

MYTH	***REALITY***
The uninsured get free health care. They can just go to the emergency room.	This is a common myth that the uninsured are already taken care of in this country. In fact, among families with at least one uninsured member, less than ¼ report getting free or discounted care in any given year. There is indeed a safety net for a minority of the uninsured, including government-sponsored clinics (FQHCs) and hospitals, as well as care provided by private physicians. However, financial pressures are reducing the ability of private physicians to provide charity care. The uninsured are much less likely than the insured to have a usual source of care. This results in delays in seeking care and worse health outcomes. Finally, emergency department care is not free (hospitals bill the uninsured at higher prices than insurance companies pay) and emergency departments don't provide many kinds of care, such as primary care for chronic illnesses like hypertension, diabetes, and depression, or preventive care, or medication refills.
Single payer is fundamentally anti-American because America is a capitalist and individualistic society.	It is anti-American to perpetuate a system that discourages entrepreneurship because health insurance is tied to employment. Making business pay for health care puts American firms at a tremendous economic disadvantage relative to other industrialized countries. In the current system there is increasingly less protection against skyrocketing health care costs. It is estimated that more than 78% of all bankruptcies are related to medical bills and most of those bankrupted had private insurance at the time they got sick. Single payer will boost our economy, reduce healthcare expenditures in the long run and help us remain strong as a country.
Single payer is socialized medicine.	A single payer or national health program is NOT socialized medicine, which is a system in which doctors and hospitals work for and draw salaries from the government. Doctors in the VA and the Armed Services are paid this way. The health systems in England 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 traditional 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. This is why our motto for single payer is “improved Medicare for all”.
We have the best health care system in the world, why change it?	The US health system does not perform well compared to other wealthy countries. We rank 19th out of 19 nations in preventing deaths from causes amenable to medical care. We rank 27th out of 34 developed countries on infant mortality. The WHO ranks our system 37th on overall performance and 24th on health level attainment. Our system is mediocre at best and the worst part is, we spend more than any other nation in the world per capita on health care! Only a select few who can afford it get some of the best care in the world.

	Americans get less of most kinds of care (doctor's visits, days in the hospital, elective surgery, etc.) than the citizens of other industrialized nations.
We already have health care reform. The ACA will cover everybody who is uninsured.	The ACA will reduce the numbers of uninsured starting in 2014 (with about half of the new coverage being Medicaid, and the other half private plans) but by 2020 it is estimated it will still leave 31 million Americans uninsured, according to the Congressional Budget Office. In addition, with ongoing cuts to employer-sponsored coverage and the proliferation of skimpy plans with high deductibles, a growing number of people are underinsured. The tens of millions of people who are underinsured face financial hardship if they get sick and need to use their insurance, so they often put off care due to cost, or don't fill prescriptions. Underinsurance will actually increase under the ACA, although the trend started before the ACA passed. The ACA will make very little difference in access to care in America.
Single payer will restrict provider choice.	A single payer system would promote increased patient autonomy and choice of providers by removing all “network” restrictions. Currently, many private insurers severely limit patients’ ability to choose their health care provider.
Quality of care will suffer under single payer.	Single payer provides the most effective financial structure for increasing the quality and efficiency of care. It will make it possible to identify "outliers" who are practicing outside community norms, and through large-scale adoption of quality improvement initiatives such as vaccination campaigns.
Doctors will never buy into single payer because it will interfere with their autonomy and decrease their salaries.	More than 60% of physicians support a single payer system, and Canada is experiencing a net influx of physicians (both Canadians returning home and Americans moving to Canada). Private insurers interfere in physicians’ ability to practice medicine. Under single payer, physicians will not need to ask for approval for tests or waste time figuring out what treatment options and pharmaceuticals are covered for each patient. Decision making will be returned to doctors and their patients. Single payer could also improve physician reimbursement, since it would allow physicians to pool together and negotiate reimbursement rates, as physicians do in the Canadian provinces. Malpractice costs will also fall dramatically by eliminating the need for malpractice awards to pay future medical costs. 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.
Single payer is politically unfeasible, look what happened in Vermont!	In the years since the bill passed in 2011, Vermont had veered away from a single payer plan and was instead aiming for a multi-payer model of universal coverage called "all payer" (where all payers, private and government, pay the same rates for the same services). Although the Governor of Vermont stated the decision to forsake reform was due to fiscal necessity, the Green Mountain Care reform would have provided universal coverage for less than what Vermont is already spending on health care. Activists there plan to continue the struggle and the main lesson is that grassroots organizing does make a

	difference. It got real healthcare reform on the political radar screen in Vermont, and can get it back on the radar there and elsewhere. There are single payer bills in many other state legislatures and a national bill, HR 676. Over the years, single payer has growing support from health professional, labor, business, and faith-based groups. Organizing for single payer state plans and organizing for national legislation are not competing strategies, but complementary ones. The ultimate goal for both is a single, inclusive program for the entire nation.
Health care is not a right.	Different people have different ideas about what constitutes a right, and these ideas are often firmly-held and difficult to change. However, it is important to recognize that even if healthcare is not a right, single payer might still be the wisest public policy because of its moral and economic benefits. ● **Moral benefits -** Though America is the richest country in the world on a per-capita-GDP basis, tens of thousands of Americans die each year because they do not have adequate access to healthcare. This is a burden that no civilized nation should tolerate, least of all the nation most able to afford to ameliorate it. ● **Economic benefits -** The United States spends 50% more as a percentage of its GDP than most other developed countries, but we insure a lower percentage of our population and get worse outcomes by almost every measure. Also, the dependence of workers on their employers for healthcare makes them more risk-averse in seeking better opportunities, reducing the efficiency of the labor market. And finally, because real wages for lower and middle-class wage earners are stagnating, rising out-of-pocket costs are squeezing the pocketbooks of many Americans, rendering them less able to consume goods and services, which slows economic growth.
Single payer will create waiting lists. Single payer would result in rationing of care.	Defenders of the status quo often warn that single-payer health would lead to the "rationing" of care. For many people, this evokes images of Depression-era bread lines and WWII food rationing. In fact, **we are already rationing health care in the United States**. It is a fundamental principle of economics that wherever there is a limited quantity of something, the economy must have some mechanism to allocate (or ration) the resource to consumers. In single-payer systems, healthcare services are delivered on the basis of medical need. In the United States, healthcare is rationed based on the ability to pay. That means that affluent patients have easy access to health care, even to the point of receiving unnecessary care, while on the other hand, poor and middle-class patients have a hard time accessing even medically necessary procedures. **This is an inefficient allocation of healthcare resources.** In European-style single-payer systems, some elective procedures have waiting lists, but there are rarely, if ever waiting lists for medically necessary or

	emergent procedures.
How can we possibly transition from our current system to single payer?	The payment and provider structures already exist within the Medicare program to permit a relatively smooth transition to a single payer health care system in this country. 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 healthcare 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 year during a transition period, a small fraction of the administrative savings from the transition to national health insurance.

Sources:

1. AMSA. “Arguments and Counterarguments about Health Care Reform”. http://www.amsa.org/AMSA/Libraries/Committee_Docs/HealthCareReformArguments.sflb.ashx
2. PNHP. “Single-Payer FAQ”. http://www.pnhp.org/facts/single-payer-faq
3. PNHP. “Effect of Single Payer on Physicians”. http://pnhpcalifornia.org/physicians
4. Dr. Steffie Woolhander and Dr. David U. Himmelstein. “What happened in Vermont: Implications of the Pullback from Single Payer”. http://www.pnhp.org/news/2015/january/what-happened-in-vermont-implications-of-the-pullback-from-single-payer
5. Wilper et al, 2009. “Health Insurance and Morality in US Adults.” American Journal of Public Health http://www.pnhp.org/excessdeaths/health-insurance-and-mortality-in-US-adults.pdf
6. Sen. Bernie Sanders, “A Single Payer System Makes Economic Sense” http://www.pnhp.org/news/2013/september/a-single-payer-system-makes-economic-sense