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FAQ Supplemental: Coverage & Choice

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 and complementary care?

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.

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.

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.

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. 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!

What about pushing to make health care a "human right?" Is that a good strategy?

PNHP fully endorses advocacy for health care as a human right as part of a single payer campaign. But some have adopted the "health care as a human right" slogan as a cover for inadequate reforms and retreat from confrontation with the powerful forces that ruin our health care system. PNHP has embraced not just a laudable moral stance, but a rigorous approach to health policy evidence and a clear vision of how morality can be achieved - with single-payer national health insurance.

Physicians for a National Health Program is a nonprofit educational and research organization of more than 22,000 members who advocate for single-payer national health insurance. For more information, or more detailed versions of this FAQ, visit **www.pnhp.org**.

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