PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

29 East Madison Suite 602
Chicago, IL 60602
(312) 782-6006
(312) 782-6007 fax
www.pnhp.org
pnhp@aol.com

# National Health Insurance (Single Payer) Fact Sheet

*Access and Benefits*
All residents would receive comprehensive medical and dental benefits under single payer. Coverage would include all medically necessary services, including rehabilitative, long-term, and home care; mental health care, prescription drugs, and medical supplies; and preventive and public health measures.
**Care would be based on need, not on ability to pay.**

*Payment*
Individual hospital bills would be eliminated. Instead, hospitals would receive an annual sum from the government to cover operating expenses,a "global budget." A separate budget would cover such expenses as hospital expansion, the purchase of technology, marketing, etc.

Doctors, nurse practitioners, and other licensed providers would have three options for payment: locally based, not-for-profit fee-for-service; salaried positions in hospitals; and salaried positions within group practices or not-for-profit HMOs. Fees would be negotiated between a representative of the fee-for-service practitioners (such as the state medical association), and a state payment board. In most cases, government would serve as administrator, not employer.

*Financing*
The program would be federally financed and administered by a single public insurer at the state or regional level. Premiums, copayments, and deductibles would be eliminated. Employers would pay a 7.0 percent payroll tax and employees would pay 2.0 percent, essentially converting current premium payments to a health care payroll tax, but covering everybody. For over 60 percent of households, a 2 percent income tax increase would add less than $1,000 to their annual tax bill; for another 20 percent of households the increase would average $1,600. However, many households would experience an overall decrease in their health spending as the modest increase in taxes would be offset by a substantial reduction in out-of-pocket spending on health care since the items such as medications, medical treatment, copayments, deductibles, etc. are now fully financed. In addition, households no longer carry the financial risk of an expensive illness in parent, senior or child.

*Administrative Savings*
The General Accounting Office projects an administrative savings of 10 percent through the elimination of private insurance bills and administrative waste, or over $100 billion in 1998. This savings pays for providing medical care to those currently underserved, and improving coverage for everyone else.

*Cost Containment*
The Congressional Budget Office projects that single payer would reduce overall health costs by $225 billion by 2004 despite the expansion of comprehensive care to all Americans. No other plan projects this kind of savings. Health costs are rising today, and coverage is falling under managed care.

## National Health Insurance from Different Perspectives

*Patients*
Each person, regardless of ability to pay, would receive high-quality, comprehensive medical care, and the free choice of doctors and hospitals. Individuals would receive no bills, and copayment and deductibles would be eliminated. Most people would pay less overall for health care than they pay now.

*Doctors*
Doctors' incomes would change little, though the disparity in income between specialties would shrink. The need for a "wallet biopsy" before treatment would be eliminated; time currently wasted on administrative duties could be channeled into providing care; and clinical decisions would no longer be dictated by insurance company policy.

National medical and allied health professional endorsements include the American Medical Women's Association (13,500), the National Medical Association (6,500), American Medical Student's Association (30,000), the Gay and Lesbian Medical Association, American Association of Community Psychiatrists, American Nurses Association (2.3 million), American Public Health Association (30,000), National Association of Social Workers (155,000), and the Nurses' Network for a National Health Program.

State and local medical endorsements include the D.C. chapter of the American Medical Association, the Illinois chapter of the American College of Physicians, the Massachusetts chapter of the American Academy of Family Practice, the Alameda-Contra Costa Medical Society, and the Long Island Dermatological Society.

*Hospitals*
The massive numbers of administrative personnel needed to handle itemized billing to over 1,500 private insurance plans would no longer be needed (see below). A negotiated "global budget" would cover operating expenses. Budgets for capital would be allocated separately based on health care priorities. Hospitals would no longer close because of unpaid bills and large volumes of poor patients, though hospitals in areas where there is still excess capacity may.

*Insurance Industry*
The need for private insurance would be eliminated, except for extras like cosmetic surgery and private hospital rooms. One single payer bill currently in the House (H.R. 1200) introduced by Dr. Jim McDermott, Congressman and child psychiatrist from Washington State, would provide one percent of funding for retraining displaced insurance workers during its first few years of implementation.

*Business*
In general, businesses would see single payer reduce and stabilize their health costs and remove the burden of administering health insurance for their employees.

*Congress*
Single payer would be the simplest, most efficient, and most conservative health care plan that Congress could implement. It is uniquely tailored to Americans' desire to be able to choose their physicians and improve the quality of health care for all.