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Frequently Asked Questions about single-payer national health insurance

What is single payer?

Single-payer national health insurance is a system in which a single public or quasi-public agency organizes health care financing, but the delivery of care remains largely in private hands. Under a single-payer system, all residents of the U.S. would be covered for all medically necessary services, including doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs.

The program would be funded by the savings obtained from replacing today's inefficient, profit-oriented, multiple insurance payers with a single streamlined, nonprofit, public payer, and by modest new taxes based on ability to pay. Premiums would disappear; 95 percent of all households would save money. Patients would no longer face financial barriers to care such as co-pays and deductibles, and would regain free choice of doctor and hospital. Doctors would regain autonomy over patient care.

Do U.S. doctors support this concept?

Yes. A national survey showed that 59 percent of U.S. physicians support national health insurance, an increase of 10 percentage points from five years before. The survey appeared in the April 2008 edition of *Annals of Internal Medicine*.

Is this 'socialized medicine'?

No. In socialized medicine systems, hospitals are owned by the government and doctors are salaried public employees. Although socialized medicine works well for our Veterans Administration, and has worked well for some countries like England, this is not the same as national health insurance. A single-payer national health program, by contrast, is social insurance like our Medicare.

Is there any support for this approach in Congress?

Yes. The Expanded and Improved Medicare for All Act, H.R. 676, is currently in Congress. The bill would establish an American single-payer health insurance system, publicly financed and privately delivered, that builds on the existing Medicare program. Polls over the past two decades show that about two-thirds of the U.S. population

supports this approach.

H.R. 676 was introduced by Rep. John Conyers Jr. of Michigan. It had over 90 co-sponsors in 2010. You can make sure your representative supports H.R. 676 by connecting with them through the Capitol switchboard at (202) 224-3121.

Won't we be letting politicians run the health system?

No. Right now, many health decisions are made by corporate executives behind closed doors. Their interest is in profit, not providing care. The result is a dysfunctional health system where 32 million have no insurance, tens of millions more are underinsured, and most are at risk of financial disaster should they become seriously ill. In a single-payer system, medical decisions are made by doctors and patients together, without insurance company interference – the way they should be. No one will go without care.

Can we afford universal coverage?

We already pay enough for health care for all – we just don't get it. Americans already have the highest health spending in the world, but we get less care (doctor, hospital, etc.) than people in many other industrialized countries. Because we pay for health care through a patchwork of private insurance companies, about one-third (31 percent) of our health spending goes to administration.

Replacing private insurers with a national health program would recover money currently squandered on billing, marketing, underwriting and other activities that sustain insurers' profits but divert resources from care. Potential savings from eliminating this waste have been estimated at \$400 billion per year. Combined with what we're already spending, this is more than enough to provide comprehensive coverage for everyone.

What about Obamacare?

The Affordable Care Act expanded coverage to about 20 million Americans by requiring people to buy private insurance policies (partially subsidizing those policies with government payments to private insurers) and by expanding Medicaid.

About 28 million people will still be uninsured in 2026, and tens of millions will remain underinsured.

Insurers will continue to strip down policies, maintain restrictive networks, limit and deny care, and increase patients' co-pays, deductibles and other out-of-pocket costs.

The law preserves our fragmented financing system, making it impossible to control costs.

Adding a "public option" to the ACA marketplaces won't reduce costs or improve access. It just adds another payer to our already fragmented system. And most of the "co-ops" failed due to adverse selection.

Lots of people have good coverage, so shouldn't we build on the existing system?

Our existing system is structurally flawed; patching it up is not a real solution. The insurance industry sells defective products. So like a car with faulty brakes, lots of people who think they have good insurance find that their "coverage" fails when they get sick: three-quarters of the 1 million American families experiencing medical bankruptcy annually have coverage when they fall sick. And all insured Americans continually face premium hikes, rising out-of-pocket costs, and cutbacks in covered services as costs rise. Even those who used to have very good coverage are being forced to give up benefits because of costs. Until we fix the system, things are only going to get worse.

Won't national health insurance result in rationing and long waiting lines?

No. It will eliminate the rationing going on today. The U.S. already rations care based on ability to pay: if you can afford care, you get it; if you can't, you don't.

At least 30,000 Americans die every year because they don't have health insurance. Many more people skip treatments that their insurance company refuses to cover. That's rationing.

Excessive waiting times are often cited by opponents of reform as an inevitable consequence of universal, publicly financed health systems. They are not. Wait times are a function of a health system's capacity and its ability to monitor and manage patient flow. With a single-payer system - one that uses effective management techniques and which is not burdened with the huge administrative costs associated with the private insurance industry - everyone could obtain comprehensive, affordable care in a timely way.

Won't our aging population bankrupt the system?

European nations and Japan have higher percentages of elderly citizens than the U.S. does, yet their health systems remain stable with much lower health spending. The lesson is that national health insurance is a critical component of long-term cost control. In addition to freeing up resources by eliminating private insurance waste, single-payer encourages prevention through universal access and supporting less costly home-based long-term care rather than institutionalization. It also saves money by bulk purchasing of pharmaceutical drugs and global budgeting for hospital systems.

Won't a publicly financed system stifle medical research?

Most breakthrough research is already publicly financed through the National Institutes of Health (NIH). In fact, according to the NIH web site, of the last 30 Americans to win the Nobel Prize in medicine, 28 were funded directly by the NIH.

Many of the most important advances in medicine have come from single-payer nations. Often, private firms enter the picture only after the public has paid for the development and clinical trials of new treatments. The HIV drug AZT is one example. On average, drug companies spend more than half of their revenue on marketing, administration and profits, compared with 13 percent on research and development. Negotiating lower prices will allow Americans to afford drugs without hurting research.

What can I do now?

- 1. Join PNHP at www.pnhp.org/join**
- 2. Endorse the Physicians' Proposal for Single Payer at www.pnhp.org/nhi**
- 3. Recruit your friends and colleagues to join PNHP and endorse the Physicians' Proposal**
- 4. Make sure your representative supports H.R. 676: call the Capitol switchboard at (202) 224-3121**