



Advantages of the Single-Payer Health Coverage



- * Comprehensive Health Coverage for everyone
- * Greater choice of provider
- * Health decisions made by patient and provider instead of HMOs
- * Improved Health Planning
- * Health coverage would be portable, not tied to employment.
- * Eliminates the high (up to 33 percent) overhead cost of multiple private, for-profit insurances by including coverage for everyone in a single-risk pool (reducing administrative costs to 1-5%).
- * Instead of hundreds of insurances with differing requirements (requiring increased office staff), providers would deal with only one form.
- * The plan would be financed with a progressive tax, at less per-capita cost.
- * Companies would avoid hassles of managing health care, and become more competitive without annual inflationary health costs.
- * Consumers would pay less for goods and services that are inflated by businesses' high health costs - e.g., currently \$1,500 is added to the cost of each U.S.-made automobile due to health costs.
- * U.S. Consumers, who now spend twice as much per capita as consumers in other developed countries (with poorer outcomes), would save as administrative health costs are reduced.
- * Single-risk-pool coverage would permit negotiation of lower, bulk rates for medications.
- * Increased U.S. life expectancy: Similar socioeconomic single-payer European countries enjoy average two-year longer life expectancies.
- * The 47 million uninsured Americans and 50 million more underinsured would have access to preventative care, without having to resort to delayed, crisis Emergency Room care, at 4 to 5 times higher cost.
- * Lessening demands on the nation's emergency rooms for primary care would stem the tide of closures of overburdened emergency rooms.
- * Retirees would not face loss of health coverage by employers.

Myths about single payer healthcare

Common Health Care Myths, summarized from HEALTH CARE MELTDOWN: Confronting the Myths and Fixing our Failing System by Robert LeBow M..D., M.P.H.

Myth #1: Everybody Has Access to Care Through the Emergency Room

ERs are the most expensive and inefficient way to deliver primary care. The uninsured have a 10-15% higher mortality rate and earn 10-30% less due to poor health.

Myth #2: We Don't Need to Fix What's Not Broken

Major problems of U.S. health care include poor access and lack of a preventive health care approach. Primarily, a failing system of health care finance drives the delivery system, which is failing the uninsured (15% of Americans), including the chronically ill and those with preexisting conditions, who seek care only when critically ill. An additional 50 million or so underinsured receive inadequate care.

Myth #3: "The Market" Is the Solution

Profit is a perverse incentive for health care. Rather than quality of care, U.S. health care competition is based on cost and profits, resulting in coverage for the healthy and wealthy, and exclusion of the sick and high-risk. Since the '90s, there has been an increase of uninsured, a decrease in choice of health care providers, and diversion of resources to administrative costs (an estimated 25 to 50 percent), marketing and profits, with less left for patient care. An increasing number of for-profit HMOs has resulted in failure to deal with less profitable aspects of health care, (e.g., mental and public health).

Myth #4: Private Is Always Better Than Public

The private sector has manipulated regulations to maximize profits, e.g., the pharmaceutical and energy (Enron) industries. Overhead costs for private health insurance average 15 percent (global administrative costs 25 percent). Medicare, with overhead costs of 2 to 3 percent, cannot avoid the poor, the sick or expensive cases, like the private sector can.

Myth #5: Medicare Is Going Broke

Those with a political agenda of privatization or dismantling Medicare, perpetuate the myth of Medicare "crisis." Despite exploitation by fraudulent claims, Medicare costs actually decreased in 1999, extending its solvency to 2030. Privatized Medicare, in the form of HMOs, have decreased choices for many.

Myth #6: We Can't Afford Universal Coverage

The U.S. spends almost twice as much per capita on health care as most industrialized countries, with worse health outcomes. Refundable tax credits, supplemental insurance for all, or medical savings accounts would add complexity and administrative wastefulness. Single risk pool coverage would permit over 50 percent administrative savings (an estimated \$200 billion in 2002), permitting coverage of every person in America. Delayed emergency room care for the uninsured is much costlier. Congressional Budget Office and General Accounting Office studies consistently show savings for single-payer coverage. The link between employment and health insurance makes U.S. industry less competitive in the world market. General Motors spends nearly \$3,000 for employee health for every car made.

Myth #7: Americans Don't Want "Rationing" of Health Care

"Rationing" is a code word, like "socialized medicine," meant to trigger negative responses. The U.S. currently has "rationing" or "waiting times," with some waiting up to 3 to 6 months to see a doctor. Some uninsured have delayed needed surgery until they are old enough for Medicare coverage.

Myth #8: We Don't Want Socialized Medicine Like in Canada

Canadians don't worry about lacking needed care, or going bankrupt because of serious illness. The Canadian delivery system is made up overwhelmingly of private health care providers and hospitals.

Myth #9: The Insured Pay More To Help Cover the Costs of the Uninsured

This used to be true, but today's practice of cost shifting means that the uninsured and people with individual insurance now substantially subsidize (paying 4 to 5 times more) the care of those with group insurance plans. The largest subsidy to the insured occurs as tax-free insurance payments by employers, made up for by taxes paid by the uninsured (a \$140 billion federal subsidy in 2001). The 2000 WHO report ranked the U.S. health care system 54th in the world in "fairness."

Myth #10: Universal Coverage Will Overburden Our System

After an initial backlog of "catchup work," people would have access to primary care, resulting in more appropriate use of emergency rooms. Primary providers freed from administrative tasks would be more efficient. Solutions include shifting some specialists to primary care; utilization of mid-level clinicians, e.g., nurse practitioners; and rewards for primary care-givers in medically under-served areas.

Myth #11: Costs of "Research and Development" Drive Our Higher Drug Prices

Drug companies have the highest profit margin of all American corporations, with profits as a percent of sales about 19 percent, compared to a median of about 5 percent for all Fortune 500 companies. Drug companies benefit from taxpayer-funded drug research, and spend almost three times as much on marketing and administrative costs as on research and development. U.S. drug prices average 60 percent higher than in Canada and the U.K. Patent laws have been manipulated to permit drug monopolies, exorbitant pricing, and to keep cheaper generic products off the market. The pharmaceutical industry operates without price controls, unprecedented among developed nations.

Myth #12: We Can Get to Universal Coverage Through Incremental Changes

Like "shoveling sand against the tide," incremental changes over the past decade resulted in increased uninsured (about 5 million). Recent years have witnessed annual double-digit health insurance inflation. Even with Children's Health Insurance Program (CHIP), the number of uninsured children remains at about nine million. Costly, complex proposals include a mix of refundable tax credits, federal subsidies, medical savings accounts, vouchers, employer-defined contributions, supplemental insurance, etc. Complexity raises administrative costs and enlarges cracks in the system, through which the working poor too often fall, with only corporate profits insured.

Myth #13: Americans Won't Accept Single-Payer Universal Coverage

Vested interests have attempted to discredit a single-payer approach, invoking "hated government" and "socialized medicine." The pharmaceutical industry has fought efforts at group negotiation of bulk rate medicines. Drug and insurance industries have spent millions to lower people's expectations, and to oppose the formation of a single risk pool national health insurance. Americans have expressed overwhelming support for universal coverage. Consumers are enticed to pay higher costs, and lulled into complacency by phrases like "consumer-directed care" and "personal health accounts."

<http://www.healthcareforallcolorado.org/> 303-277-8306

http://csaction.org/TPs/TP_healthcare.html