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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 copays 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?

Doctors are increasingly fed up with the bureaucratic hassles, paperwork and meddling imposed on them by today's private-insurance-based system. National and state surveys of physician attitudes have shown a marked shift over the past few decades toward support for a single-payer plan.

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 American Medicare.

Is there any support for this approach in Congress?

Support in the House and Senate is at an all-time high. The Expanded and Improved Medicare for All Act, H.R. 676, would establish an American single-payer health insurance system, publicly financed and privately delivered, that builds on the existing Medicare program. H.R. 676 has been introduced in multiple sessions of Congress by former Rep. John Conyers Jr. of Michigan. In 2017, it had 120 co-sponsors, a majority of the House Democratic caucus.

On the Senate side, Sen. Bernie Sanders has introduced the Medicare for All Act of 2017, S. 1804, which had 16 original co-sponsors. PNHP has welcomed Sanders' bill, but notes it could be strengthened by establishing global budgets for hospitals, covering long-term care, eliminating all prescription copays, and banning investor-owned health facilities.

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 $500 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.

Even so, as of 2017, about 28 million people remain uninsured, and an estimated 31 million would still be uninsured in 2027 if the ACA remains in place. That number could rise significantly if "free market" proponents are able to push through their preferred legislative and administrative changes.

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 guaranteed access and by 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 as of 2017 at least 94 NIH-supported researchers in medicine have been sole or shared recipients of 49 Nobel Prizes.

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 with-out hurting research.

What will happen to all of the people who do billing or work for insurance companies?

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 health care 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 small fraction of the administrative savings from the transition to national health insurance.

PNHP has worked with labor unions and others to develop plans for a jobs conversion program with would protect the incomes of displaced clerical workers until they were re-trained and transitioned to other jobs. Both H.R. 676 and S. 1804 allocate funds for this purpose.

Five Things You Can Do:

1. Call the Capitol switchboard at **(202) 224-3121** and urge your congressional representatives to cosponsor single payer legislation, such at H.R. 676 and S.1804.

2. Form a chapter of PNHP, or get involved in the one nearest you. To get started, email **organizer@pnhp.org**.

3. Speak at a grand rounds or other forum at your hospital, or invite another PNHP member to do so. Contact **organizer@pnhp.org** for assistance.

4. Subscribe to "Quote of the Day" by Senior Health Policy Fellow Dr. Don McCanne to stay on top of the rapidly changing health reform landscape. Visit **pnhp.org/qotd**

5. Recruit at least one physician to join PNHP. Refer them to **pnhp.org/join** or visit **pnhp.org/store** to request our updated membership brochures.

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.