

# Single-Payer 2017

An Evidence-Based Guide to the Fight for Health Equity

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# Introduction

## A. A Note from the Authors

As medical students, physicians, and members of Physicians for a National Health Program (PNHP), we believe that health care is a human right. Despite an abundance of resources—money, technology, physicians—the United States has some of the worst health disparities in the world. Throughout history, it has failed time and again to repair these gaps, adopting policies that have left us with a health care system that generates waste, rewards greed, and continuously fails those who need it most.

In a nation built on a foundation of racism, sexism, and violence, it would be impertinent to suggest that there is a simple solution for closing the wide gaps in our society's health outcomes. However, evidence shows that there is clearly a next best step. Equality starts with treating health care as a human right. It starts with adopting policy that guarantees equitable health care access to all Americans: a national single-payer health care program, or improved Medicare for all.

The idea for this book was the product of rotating on the wards of a safety net hospital as a medical student, and the curiosity that arose from observing well-intentioned physicians caring for the sickest, poorest patients as they sat back and let an unjust health care system work against them. The questions that follow are a collection of common themes that came up in conversations during this time. Many of them have since come up in conversations with activists and legislators, and will likely continue to be asked in such discussion until single-payer becomes a reality.

Often, the most difficult part of discussing health care reform with colleagues or legislators is being ready with facts to back up an argument. The intention of this pocket guide is to put the facts on single-payer health care reform at your fingertips.

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We hope you will use it for your own education, and that it empowers you to fight against the common misconceptions that have kept single-payer out of reach.

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## B. How to Use This Book

[Section I](#) addresses the failures of our current health care system. It provides the facts behind common arguments, and should help explain the ways in which the Affordable Care Act has been insufficient.

[Section II](#) explains how a single-payer system will resolve the issues of cost, quality, and access addressed in [section I](#), and outlines the single-payer plan proposed by PNHP.

In [sections III](#) and [IV](#), we address common concerns related to single-payer health care. Each of the subsections is followed by “Questions for Further Discussion”, which are designed to stimulate conversation and require introspection that could help individuals rethink their opinions.

Throughout the book, “Key Points” will be highlighted alongside the text, should you need to find critical information in a hurry. References will be included at the end of each section for your own edification, and for ease of presenting and clarifying arguments to others. And finally, definitions of the **bolded** terms can be found in the glossary.

If you have questions, concerns, or suggestions, please feel free to contact us!

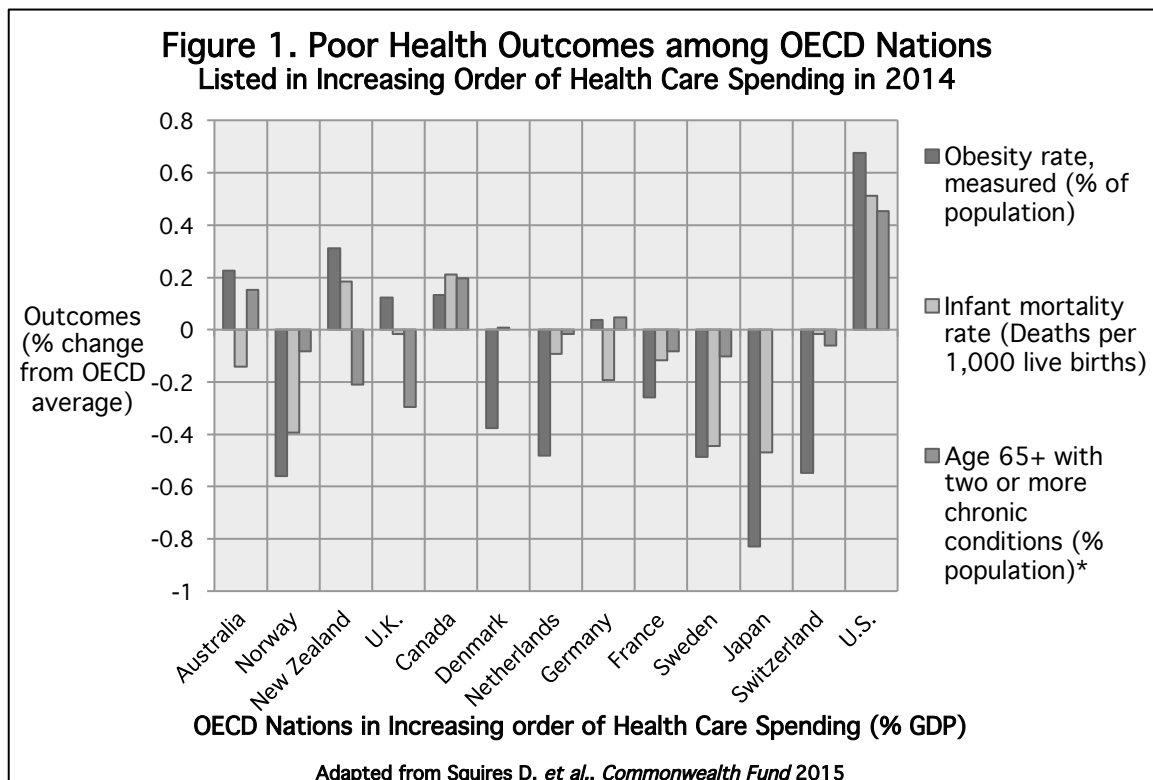
Enjoy!

# I. Shortcomings of the Current U.S. Health Care System

## A. Quality

*“Doesn’t the U.S. already have the best health care in the world?”*

The belief that the United States has “the best health care in the world” is not uncommon. Despite spending more on healthcare than any other developed nation (as discussed in [section IB](#)) the United States performs remarkably poorly in numerous health categories when compared to other wealthy nations (figure 1).<sup>1</sup> Notably, it fares worse than most nations and falls on the undesirable side of the OECD<sup>2</sup> average for life expectancy, infant mortality, and obesity rates. Of twelve OECD nations, it also has the third highest rate of diabetes-related lower extremity amputations, and the highest percentage of adults over 65 years old with at least one chronic condition.



Similarly, a 2014 Commonwealth Fund report comparing health outcomes for eleven developed nations found that the United States health care system ranked worst overall (Table 1).<sup>3</sup> In this analysis, over 80 health care system indicators were quantified and used to compare performance in the realms of quality, access, efficiency, equity, and healthy lives. Though the U.S. scored well on effective, patient-centered, and timely care, it ranked 11th of 11 for cost-related problems, efficiency, equity, and healthy lives.

Table 1. Overall Health Care System Ranking of Eleven Developed Nations											
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>Overall Ranking (2013)</b>	4	10	9	5	5	7	7	3	2	1	11
<b>Quality Care</b>	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
<b>Access</b>	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
<b>Efficiency</b>	4	10	8	9	7	3	4	2	6	1	11
<b>Equity</b>	5	9	7	4	8	10	8	1	2	2	11
<b>Healthy Lives</b>	4	8	1	7	5	9	6	2	3	10	11
<b>Health Expenditures Per Capita, 2011**</b>	<b>\$3,800</b>	<b>\$4,522</b>	<b>\$4,118</b>	<b>\$4,495</b>	<b>\$5,099</b>	<b>\$3,182</b>	<b>\$5,669</b>	<b>\$3,925</b>	<b>\$5,643</b>	<b>\$3,405</b>	<b>\$8,508</b>
Country Ranking Key: <b>Top 2*/Middle/Bottom 2*</b> Notes: *Includes ties. **Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010. Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; <i>Commonwealth Fund National Scorecard 2011</i> ; WHO; and Organization for Economic Cooperation and Development, <i>OECD Health Data, 2013</i> (Paris: OECD, Nov. 2013). Adapted from Davis <i>et al.</i> , <i>Commonwealth Fund</i> 2014.											

While it can be argued that the U.S. has some of the highest quality medical training and is home to many of the world's most advanced specialists, these are not valid indicators of the quality of the nation's health care system overall, and there is significant work to be done.



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<sup>1</sup> Squires D, Anderson C. Issues in International Health Policy U. S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries. *Commonw Fund*. 2015;15:1-12. <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>.

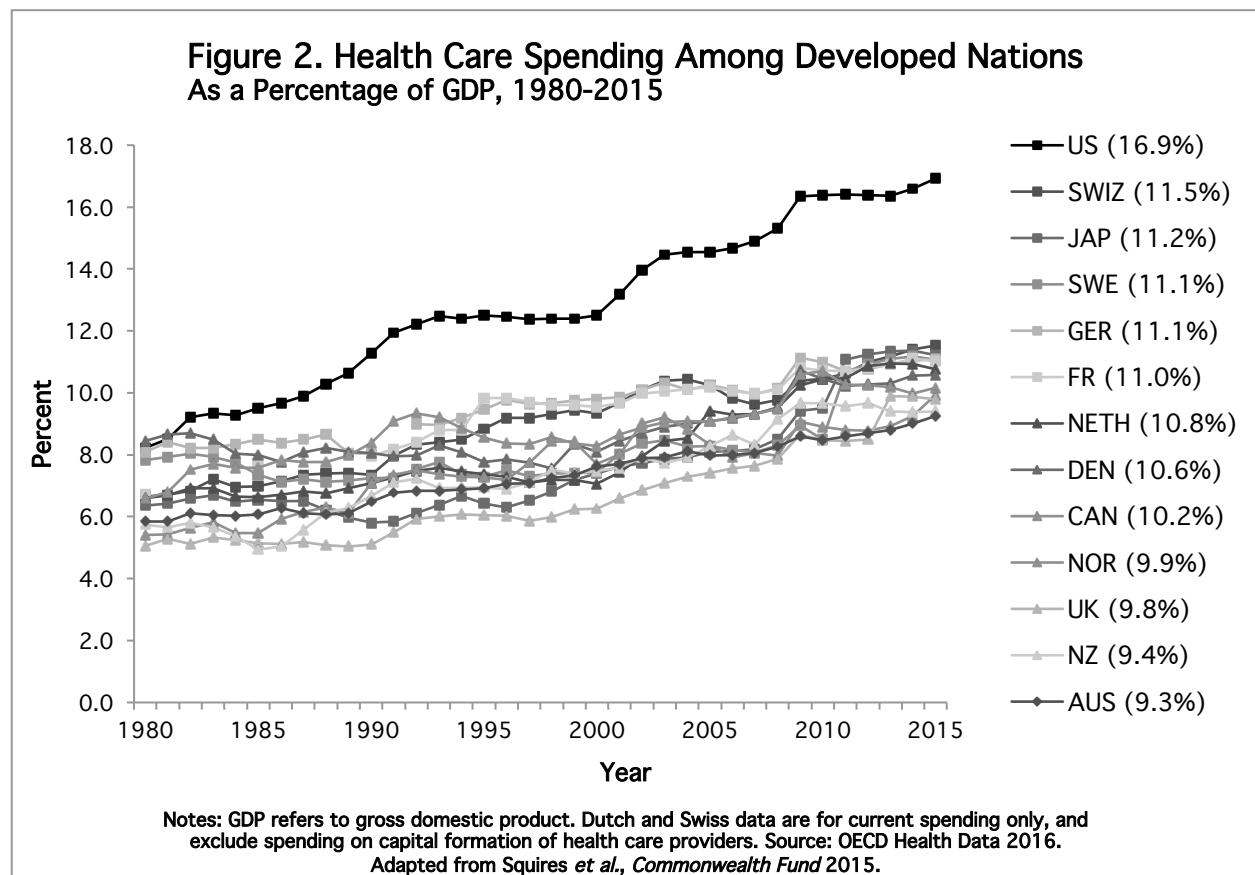
<sup>2</sup> OECD: Organisation for Economic Cooperation and Development

<sup>3</sup> Davis K, Stremikis K, Squires D, Schoen C. Mirror, mirror on the wall: How the performance of the U.S. health care system compares internationally. *Commonw Fund*. 2014;(June):1-32. doi:10.1002/uog.1825.

## B. Cost

*“I’ve heard a lot about the rising costs of health care. Why is this happening?”*

The United States has the highest health care costs in the world; in 2013, average spending on health care was \$9,086 per capita, a total of 17.1% of GDP (Figure 2).<sup>4</sup> As discussed in [section 1A](#), though the U.S. pays more than any other nation, it has far from the best health outcomes. This high cost of health care in the U.S. can be attributed in some degree to the fact that prices for procedures (including hospital and physician fees) in the U.S. are higher than those of any other nation. For example, OECD data show that in 2007, a normal delivery cost \$2,800 in Canada compared to \$4,451 in the United States.<sup>5</sup> Similarly, Americans typically spend more on pharmaceuticals and use new medical technology at higher rates.



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A major reason for these high prices in the U.S. is its level of spending on administration, a fact recognized by the business community.<sup>6</sup> This is true of U.S. hospitals, which have been shown to spend more than those of other developed nations on paper pushing.<sup>7</sup> Additionally, the nation's current multi-payer system involves thousands of complex **private** and **public health insurance** plans, each of which is allowed to provide different coverage to a different population at a different cost. To enforce the innumerable complicated rules and regulations within such a system, and to ensure that health care providers are sufficiently reimbursed for their services, administrative support is necessary for both providers and insurance companies. In a 2012 study, administrative and billing support was estimated to cost the United States \$375 billion—about 15% of total health care spending—annually, none of which has been linked to clear health benefits.<sup>8</sup>

*“Isn’t the free market supposed to keep costs down in our capitalist society?”*

Though competition may be effective in containing costs for most goods and services in the U.S., health care is not like other commodities. Prices for procedures, doctor visits, and medications are largely hidden from health care consumers making it difficult for patients to “shop around” in the same way they would for a car or a carton of eggs.<sup>9</sup> As a result, there is no incentive health care providers to reduce their prices.

Similarly, competition among health insurance plans has been proven ineffective as a means of reducing overall health care costs. Though competitive pricing has been shown to reduce **premium** rates,<sup>10</sup> it is overwhelmingly difficult for individuals to compare the additional costs that could be incurred under each plan on the market. Additionally, it is near impossible for individuals to foresee what health-related goods or services they might need; in this sense, they cannot be fully informed health insurance consumers, and the traditional model of supply and demand simply does not work. As long as insurance plans are allowed to operate with convoluted **cost-sharing** schemes,

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and until patients can predict the future, competition between insurance companies will not substantially reduce health care costs.

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- <sup>4</sup> **Note: Disparities** in outcomes relative to this high spending will be discussed in [section IC](#); Squires D, Anderson C. Issues in International Health Policy U. S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries. *Commonw Fund*. 2015;15:1-12. <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>.
- <sup>5</sup> OECD. *Health at a Glance 2011: OECD Indicators*. Paris: OECD Publishing; 2011. doi:10.1787/888932315602.
- <sup>6</sup> Pfeffer J. The Reason Health Care Is So Expensive: Insurance Companies. *Bloomberg*. 2014. <http://www.businessweek.com/articles/2013-04-10/the-reason-health-care-is-so-expensive-insurance-companies>.
- <sup>7</sup> Himmelstein DU, Jun M, Busse R, et al. A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others By Far. *Health Aff*. 2014;33(9):1586-1594. doi:10.1377/hlthaff.2013.1327.
- <sup>8</sup> Jiwani A, Himmelstein D, Woolhandler S, Kahn JG. Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence. *BMC Health Serv Res*. 2014;14:556. doi:10.1186/s12913-014-0556-7.
- <sup>9</sup> Emanuel EJ, Tanden N, Altman S, et al. A systemic approach to containing health care spending. *N Engl J Med*. 2012;367(10):949-954. doi:10.1056/NEJMs1205901.
- <sup>10</sup> Dafny LS. Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience. *Commonw Fund*. 2015;33(November).

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## C. Access

*“Don’t we already have a universal health care system?”*

The United States took a step toward achieving universal health care *coverage* with the implementation of the Affordable Care Act (ACA) by requiring all U.S. Citizens to be enrolled in a health insurance program providing a minimal level of reimbursement for health care costs. However, the reform has fallen short of achieving universal health care *access* in a number of ways.<sup>11</sup>

Firstly, a large number of Americans are still without health insurance. Though 11 million were reported to have gained coverage under the ACA, 29 million Americans went uninsured for the entire year of 2015.<sup>12</sup> Additionally, the reform has left in place significant racial disparities in health insurance status. In 2015, while non-Hispanic Whites were uninsured at a rate of 6.7%, 11.7% of non-Hispanic Blacks, 7.5% of Asians, and 16.2% of Hispanics remained uninsured.

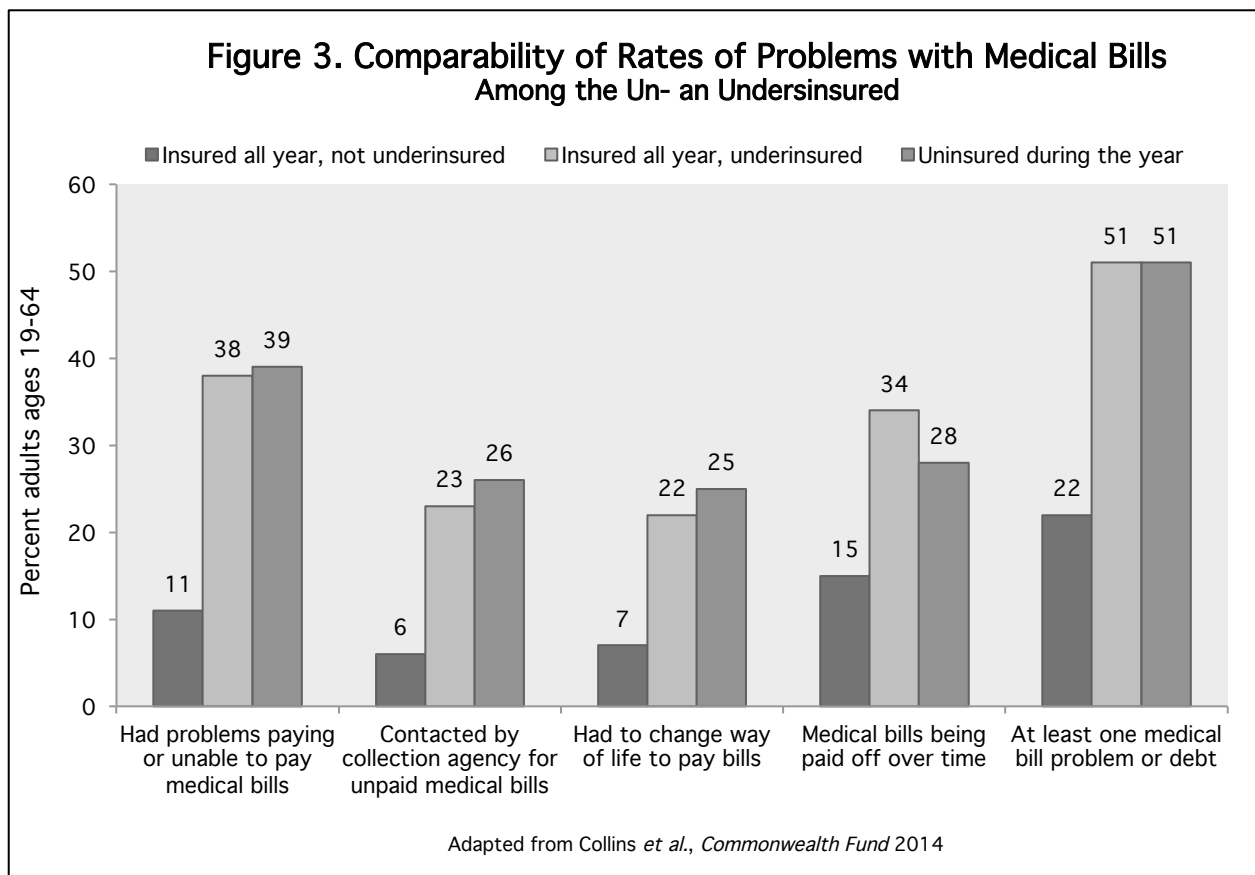
For Americans of all ethnic groups, the consequences of uninsurance are devastating. Studies have shown that the uninsured are more likely to die than those with insurance, with a hazard ratio of 1.40. This equates to approximately 44 thousand deaths per year as a result of uninsurance.<sup>13</sup> Additionally, there is wide consensus in the literature that obtaining insurance reverses the effects of having been uninsured, and decreases mortality rates approximately five to 25 percent.<sup>14</sup>

In addition to leaving so many uninsured, the ACA has failed to improve coverage for those who are insufficiently protected from the price of health care, or “underinsured”, secondary to high out-of-pocket costs for **copayments**, **coinsurance**, and **deductibles**. As of 2014, nearly 31 million people fell into this category.<sup>15</sup>

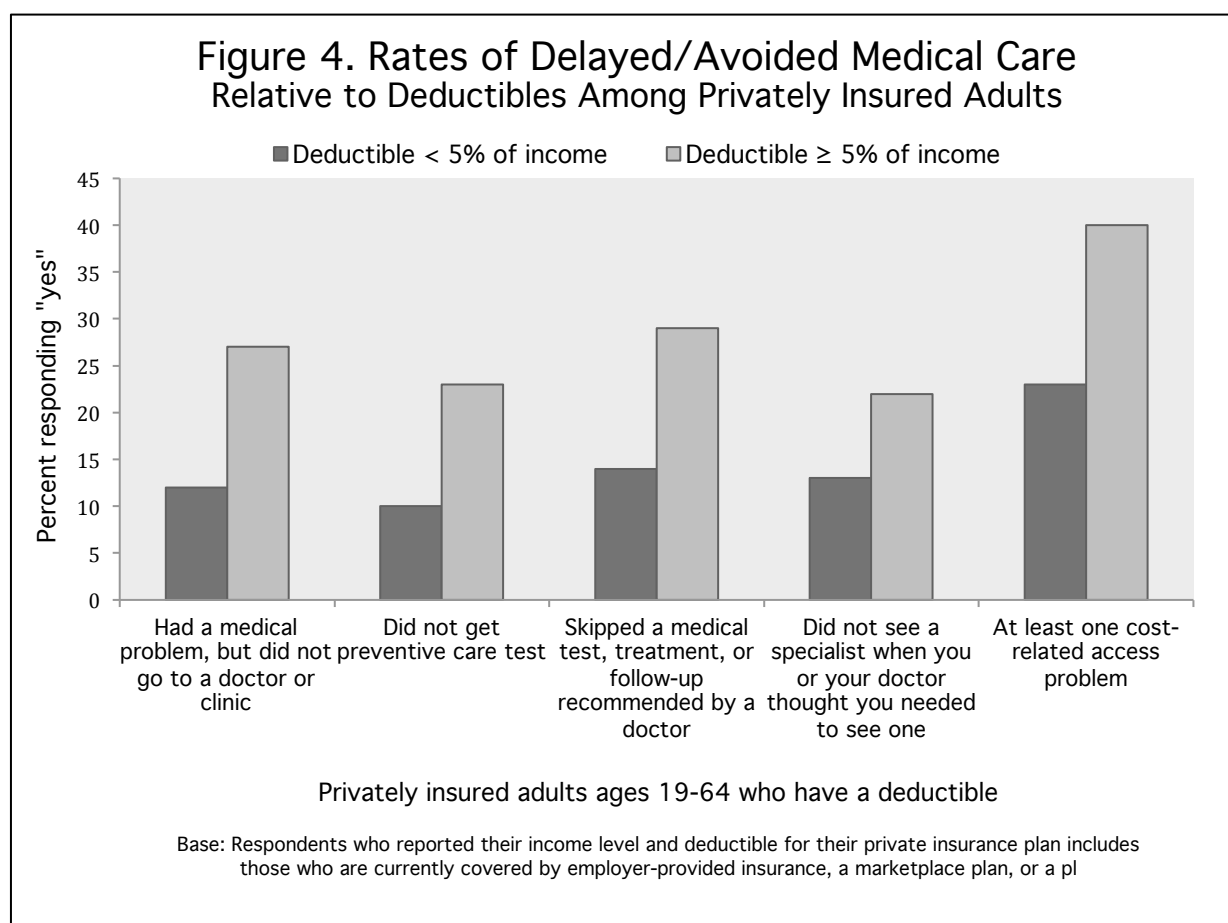
Specifically, being “underinsured” means having:

- “out-of-pocket costs, excluding premiums, over the prior 12 months [of] 10 percent or more of household income; or
- out-of-pocket costs, excluding premiums [of] 5 percent or more of household income if income is under 200 percent of the federal poverty level...; or
- [a] deductible [of] 5 percent or more of household income.”

Strikingly, for these individuals, rates of difficulty with medical bills are twice those of the insured, and are comparable in many cases to those of the uninsured (Figure 3).



As a result, even those who are “covered” are often forced to make difficult choices between physical and financial well-being, and access to care is not guaranteed. In fact, many lower-income and some higher-income individuals have reported foregoing necessary medical care due to financial strain (Figure 4).<sup>16</sup>



The impact of the U.S. health care system’s failure to provide universal access to care is striking: by some estimates, over the next ten years, the combined effects of un- and underinsurance in the U.S. could result in the otherwise preventable deaths of a quarter million U.S. adults.<sup>17</sup>

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- <sup>11</sup> Gaffney A, Woolhandler S, Angell M, Himmelstein DU. Moving forward from the affordable care act to a single-payer system. *Am J Public Health*. 2016;106(6):987-988. doi:10.2105/AJPH.2015.303157.
- <sup>12</sup> Barnett JC, Vornovitsky MS, Davis KE, et al. *Health Insurance Coverage in the United States: 2015*. Washington, D.C.; 2016. <http://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>.
- <sup>13</sup> Note: This figure adjusts for age, gender, race/ethnicity, income, education, self- and physician-related health status, body mass index, leisure exercise, smoking, and regular alcohol use. Adjusting for age and gender only, the hazard ratio for mortality among the uninsured is 1.80 relative to the insured; Wilper AP, Woolhandler S, Lasser KE, McCormick D, Bor DH. Health Insurance and Mortality in U.S. Adults. 2009;99(12):2289-2295. doi:10.2105/AJPH.2008.157685.
- <sup>14</sup> Hadley J. Sicker and Poorer — The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income. *Med Care Res Rev*. 2003;60(2). doi:10.1177/1077558703254101.
- <sup>15</sup> Collins SR, Rasmussen PW, Beutel S, Doty MM. The Problem of Underinsurance and How Rising Deductibles Will Make It Worse. 2014;(May):1-10.
- <sup>16</sup> Collins S, Rasmussen P, Doty M, Beutel S. Too High a Price: Out-of-Pocket Health Care Costs in the United States. *Commonw Fund pub*. 2014;29(1784):12. [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/nov/1784\\_collins\\_too\\_high\\_a\\_price\\_out\\_of\\_pocket\\_tb\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/nov/1784_collins_too_high_a_price_out_of_pocket_tb_v2.pdf) \n[http://www.medscape.com/viewarticle/852200?src=WNL\\_exclsv\\_160506\\_MSCPEDIT&uac=12272FK&impID=1086895&faf=1](http://www.medscape.com/viewarticle/852200?src=WNL_exclsv_160506_MSCPEDIT&uac=12272FK&impID=1086895&faf=1).
- <sup>17</sup> Gaffney A, Woolhandler S, Angell M, Himmelstein DU. Moving forward from the affordable care act to a single-payer system. *Am J Public Health*. 2016;106(6):987-988. doi:10.2105/AJPH.2015.303157.



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## II. The Single-Payer Solution

### A. Quality Improvement

*“How would switching to single-payer improve the overall quality of our health care system?”*

As discussed in [section IA](#), there is marked room for improving the performance of the U.S. health care system. Recall from Table 1 that the United States health care system performs last of eleven wealthy nations, including several countries with national single-payer programs, including Canada, New Zealand, and the United Kingdom (which ranks #1).<sup>18</sup> This difference is largely attributed to the greater degree of equity these systems have achieved in eliminating financial barriers to care.

More equal access to medical care positively impacts health care systems in a number of ways. First, it improves individual health outcomes ([section IC](#)), as the adverse effects of having been un- or underinsured are known to reverse when individuals gain sufficient coverage.<sup>19</sup> Second, eliminating differential treatment “based on employment, financial status, or source of payment,” ensures that resources, including physician services and space in hospitals or clinics, are delegated according to need, as opposed to potential reimbursement. Finally, guaranteed access allows the previously disenfranchised to demand higher quality care, thereby driving up the standards of the entire system.<sup>20</sup>

A single-payer program would also improve the overall quality of the U.S. health care system by increasing continuity of primary care. Currently, patients are frequently forced to select new primary care physicians on short notice as contracts and insurance plans change. In fact, one-fourth of patients studied in three states with varying implementation of Medicaid expansion under the ACA reported having changed coverage in the prior 12 months.<sup>21</sup> As a result, many experienced “...disruptions in

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physician care and medication adherence, increased emergency department use, and worsening self-reported quality of care and health status.”

Such fragmented care is not only detrimental to patient health, but also causes physicians to practice defensive medicine, performing extra tests and more expensive procedures to avoid liability for fear of missing a key diagnosis or problem.<sup>22</sup> On the other hand, it has been shown that physicians are more likely to deliver thoughtful, conservative care when they have long-standing, trusting, relationships with their patients. Such relationships are significantly easier to maintain under a single-payer model, when patients and physicians are not limited by insurance company contracts.

By removing financial incentives for performing more expensive procedures and tests, as well as for providing too much or too little care, a single-payer system would also allow medical providers to make evidence-based decisions using their own clinical judgment. Additionally, creating a nationwide formulary provides an opportunity to guarantee that all medically necessary treatments are available to all who need them.<sup>23</sup>

Though these are just a few of many possible solutions for improving quality under single-payer, additional benefits could include:

- Enhanced preventive care
- More deliberate and efficient allocation of resources
- Creation of a single, standardized, confidential electronic medical record
- Pooled data for further quality improvement

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<sup>18</sup> Davis K, Stremikis K, Squires D, Schoen C. Mirror, mirror on the wall: How the performance of the U.S. health care system compares internationally. *Commonw Fund*. 2014;(June):1-32. doi:10.1002/uog.1825.

<sup>19</sup> Hadley J. Sicker and Poorer — The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income. *Med Care Res Rev*. 2003;60(2). doi:10.1177/1077558703254101.

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- <sup>20</sup> Schiff GD, Bindman AB, Brennan TA, et al. A Better-Quality Alternative: Single-Payer National Health System Reform. *JAMA*. 1994;272(10):803-808. doi:10.1001/jama.1994.03520100065035.
- <sup>21</sup> Sommers BD, Gourevitch R, Maylone B, Blendon RJ, Epstein AM. Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many. *Health Aff*. 2016;35(10):1816-1824. doi:10.1377/hlthaff.2016.0455.
- <sup>22</sup> Schiff GD, Bindman AB, Brennan TA, et al. A Better-Quality Alternative: Single-Payer National Health System Reform. *JAMA*. 1994;272(10):803-808. doi:10.1001/jama.1994.03520100065035.
- <sup>23</sup> Schiff GD, Bindman AB, Brennan TA, et al. A Better-Quality Alternative: Single-Payer National Health System Reform. *JAMA*. 1994;272(10):803-808. doi:10.1001/jama.1994.03520100065035.

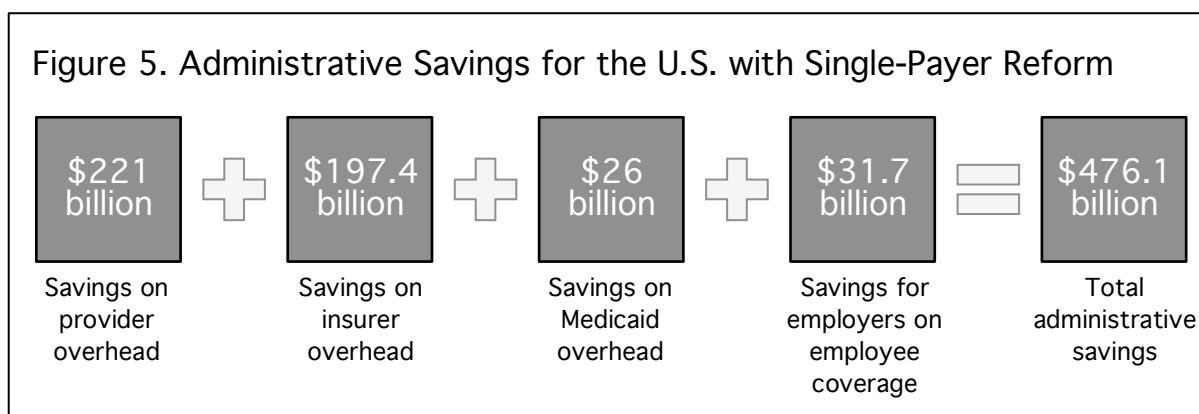
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## B. Cost Savings

*“How would switching to single-payer save us money?”*

Health care costs have risen across the globe in recent decades, due mostly to improved technologies, increased longevity, and other innovations in medical care. Though efforts to control overall health care costs would continue, as described below, the main mechanism of saving under a single-payer system would be the elimination of billions of dollars in wasteful spending on administrative activities ([section IB](#)).

It is estimated that under a streamlined, single-payer system, providers would spend 73% less and the private insurance sector would spend 93% less than they do currently on billing and insurance-related costs. Taken together, this could reduce administrative waste by 80%, resulting in savings totaling \$300 billion per year for the United States.<sup>24</sup> More recent estimates taking into account the overall rate of increase of health care expenditures have shown that by simply cutting out middlemen, the administrative savings of single-payer could be close to \$476 billion (Figure 5).<sup>25</sup>



Another large means of savings under single-payer could be through reform of pharmaceutical pricing practices, given that the U.S. is known to spend up to twice as much as its European counterparts in this arena.<sup>26</sup> This is partially related to the fact that while private providers of prescription coverage may negotiate with

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pharmaceutical companies for lower prices, Medicare is not permitted to do so. The current single-payer bill in the U.S. House of Representatives (H.R. 676) proposes permitting Medicare to negotiate drug prices. By some estimates, this reform could save the U.S. up to an additional \$116 billion annually.<sup>27</sup>

Though the majority of savings under single-payer would come from reduction of administrative waste, and another portion from regulating the pharmaceutical industry, a number of other well-established cost control strategies could be put in place for additional savings.

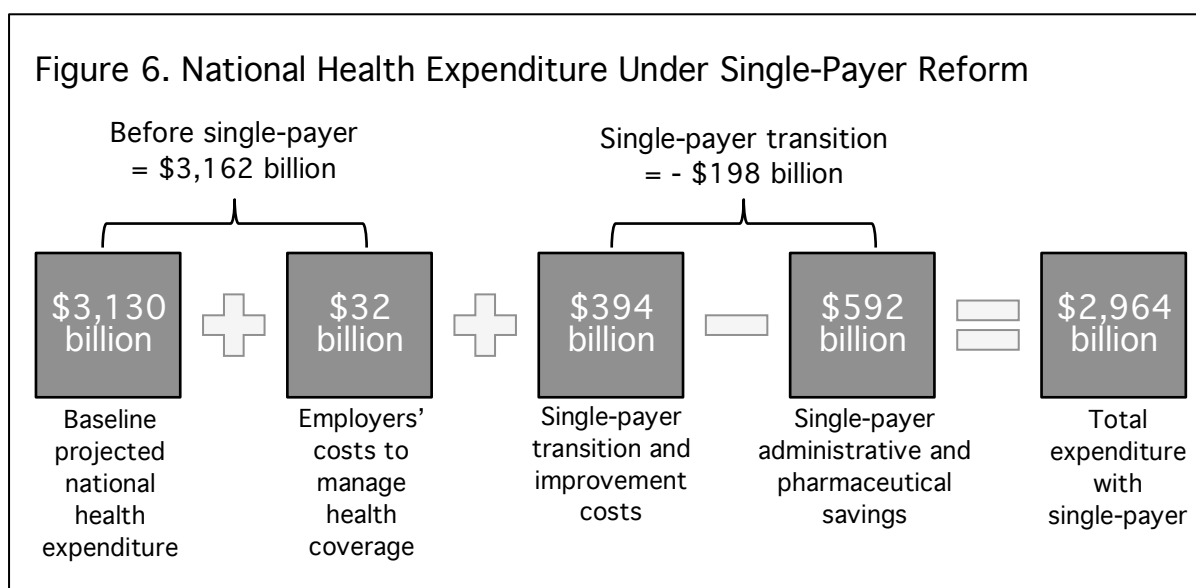
The most important cost control strategy that would be incorporated into single-payer reform is the establishment of **negotiated fees** for physicians. In this strategy, the payer would negotiate maximum fees for physician services and procedures, adjusted for the needs of different geographic areas. This would not only limit the amount charged for medical services, but could reduce incentives for consolidation of practices and formation of healthcare monopolies, which have played a large role in increasing health care prices.

Similarly, **global budgets** could limit spending by providing hospitals with set budgets for achieving certain targets. In this case, each facility would be granted an annual budget based on past operating expenses. Without the promise of more money for performing more procedures or treating more patients, such funding eliminates financial incentives for providing (or not providing) care.<sup>28</sup>

Finally, while market forces are insufficient to control prices of procedures, physician visits, and out-of-pocket costs to consumers (as discussed in [section IB](#)), competition can play an important role in some aspects of cost control. By having manufacturers bid against one another to offer the lowest possible price, Medicare is able to control costs of medical devices and supplies.<sup>29</sup> **Competitive bidding** of this

nature would continue and be encouraged in future healthcare reform given its current efficacy in maintaining reasonable pricing of health care commodities.

Under the single-payer system proposed in H.R. 676, these strategies could not only control costs in the immediate future, but would also ensure the solvency of the U.S. health care system for generations to come.<sup>30</sup> A detailed analysis of the total savings on U.S. health care with the implementation of H.R. 676 has shown that even when the costs of system improvements and the transition itself are taken into account, single-payer health care would still be less expensive for the U.S. than the current system. As an example, in 2014, savings would have been almost \$200 billion less under single-payer with all costs considered (Figure 6).<sup>31</sup>



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- <sup>24</sup> Jiwani A, Himmelstein D, Woolhandler S, Kahn JG. Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence. *BMC Health Serv Res.* 2014;14:556. doi:10.1186/s12913-014-0556-7.
- <sup>25</sup> Friedman G. *Funding HR 676: The Expanded and Improved Medicare for All Act, How We Can Afford a National Single-Payer Health Plan.*; 2013.  
[http://www.pnhp.org/sites/default/files/Funding HR 676\\_Friedman\\_7.31.13\\_proofed.pdf](http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf).
- <sup>26</sup> Farrell D, Jensen E, Kocher MD B, et al. *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More.*; 2008.  
<http://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/accounting-for-the-cost-of-us-health-care>.
- <sup>27</sup> Friedman G. *Funding HR 676: The Expanded and Improved Medicare for All Act, How We Can Afford a National Single-Payer Health Plan.*; 2013.  
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- <sup>28</sup> Gaffney A, Himmelstein DU, Woolhandler S, Angell M. Beyond the Affordable Care Act: A physicians' proposal for single-payer health care reform. 2016.  
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[http://www.pnhp.org/sites/default/files/Funding HR 676\\_Friedman\\_7.31.13\\_proofed.pdf](http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf).
- <sup>31</sup> Friedman G. *Funding HR 676: The Expanded and Improved Medicare for All Act, How We Can Afford a National Single-Payer Health Plan.*; 2013.  
[http://www.pnhp.org/sites/default/files/Funding HR 676\\_Friedman\\_7.31.13\\_proofed.pdf](http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf).

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## C. Increased Accessibility

*“How would single-payer increase access?”*

The answer to this question is simple.

First, everyone would be covered. The system would be designed to include all United States residents, regardless of employment or socioeconomic status. Immediately, the number of uninsured Americans would drop from 29 million to zero.<sup>32</sup>

Second, there would be no financial barriers to medically necessary care. Premiums, **copayments**, **coinsurance**, and other surprise charges for medically necessary care would be eliminated, relieving the underinsured from undue financial and physical suffering.<sup>33</sup>

Finally, patients would be free to see any doctor without fear of being turned away. Without the limitations imposed by contracts between insurance plans and physicians, Americans would be able to choose who provides their medical care. Similarly, physicians who participate in the national health plan would not be able to turn patients away based on coverage or ability to pay, increasing the likelihood that patients could find the physicians who are best suited to their needs.<sup>34</sup>



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<http://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>.
- <sup>33</sup> Collins SR, Rasmussen PW, Beutel S, Doty MM. The Problem of Underinsurance and How Rising Deductibles Will Make It Worse. 2014;(May):1-10.
- <sup>34</sup> Woolhandler, Steffie et al. "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance." *JAMA: the journal of the American Medical Association* 290.6 (2003): 798-805. Web.

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## D. The Physicians' Proposal for National Health Insurance

*"How would single-payer work?"*

Evidently, the U.S. healthcare system is plagued by a variety of complex problems. But there are a number of well-researched, detailed proposals to provide supporters and skeptics alike with an understanding of how a single-payer system could work in the U.S. to address issues of quality, cost, and accessibility. In conjunction with PNHP, the Working Group on Single-Payer Program Design has put forward its own single-payer plan, *A Physicians' Proposal for Single-Payer Health Care Reform*,<sup>35</sup> the main features of which are as follows:

### A. Eligibility and Coverage

- A single, public plan covering every American, regardless of legal status, for all medically necessary services (including long-term care, mental health, dental, prescription drugs, and supplies)
- Private insurance, copayments, and deductibles would be eliminated

### B. Hospital Payment

- Hospitals would receive global budgeting in monthly lump sums, which would be negotiated annually based on past budgets, clinical performance, projected changes in demand for services/input costs, and proposed new programs
- None of a hospital's operating budget could be used for profit or capital expenditures, which would be considered separately

### C. Payment for Physicians and Outpatient Care

- Physicians would have the ability to choose, so as not to interrupt practice structures, between:
  - **Fee-for-service**
  - Salaries within institutions receiving global budgeting

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■ Salaries within **capitated** groups

D. Long-Term Care

- All necessary home and nursing home care would be covered for all persons unable to perform activities of daily living
- Local public agencies would coordinate care and oversee provision of services in a given area by contracting with long-term care providers for all needed benefits (which eliminates “perverse incentives” currently plaguing the nation’s long-term care system)

E. Capital Allocation, Health Planning, and Profit

- National health insurance (NHI) would fund construction of health facilities and purchase of expensive equipment; allocation of funds and oversight of capital projects funded from private donors (when such projects increased future publicly supported operating costs) would be determined by regional health planning boards
- Owners of investor-owned hospitals, HMOs, nursing homes, and clinics would be reimbursed by the NHI for loss of facilities, computers, and administrative facilities needed to manage the new program

F. Medications and Supplies

- Everything medically necessary would be covered
- The government would be able to negotiate drug and equipment prices with manufacturers (based on manufacturing costs, excluding marketing and lobbying)

G. Funding<sup>36</sup>

- The government would disburse the vast majority of health payments
- Government contributions would represent approximately 85% of all health spending (vs. approximately 66% in 2015)
- Progressive taxes would replace other cost-sharing

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*“How would we transition?”*

Other industrialized countries have used a variety of methods to transition from multi- to single-payer health care systems. The National Health Service in Great Britain, for example, was born from a need for reconstruction in the post-World War II era, and introduced single-payer health care on a national scale in conjunction with other needed social reforms.<sup>37</sup> In Canada, on the other hand, single-payer was first adopted by a single province, Saskatchewan, in 1962; by 1972, all ten provinces had enacted plans for both hospital and medical services.<sup>38</sup>

The United States’ transition will ultimately depend on the nature of the legislation it adopts, and will hopefully take into account the lessons learned by those nations that have already implemented single-payer health care.

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- <sup>35</sup> Note: For the most up-to-date version and additional resources, see <http://www.pnhp.org/resources/physicians-proposal-intro>. Woolhandler, Steffie et al. "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance." *JAMA: the journal of the American Medical Association* 290.6 (2003): 798-805. Web.
- <sup>36</sup> For a detailed breakdown of financing under HR 676, see: Friedman G. *Funding HR 676: The Expanded and Improved Medicare for All Act, How We Can Afford a National Single-Payer Health Plan.*; 2013. [http://www.pnhp.org/sites/default/files/Funding HR 676\\_Friedman\\_7.31.13\\_proofed.pdf](http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf).
- <sup>37</sup> Light, Donald W. "Universal Health Care: Lessons From the British Experience." *American Journal of Public Health* 93.1 (2003): 25-30. Web.
- <sup>38</sup> Duffin MD PhD J. The Impact of Single-Payer Health Care on Physician Income in Canada, 1850-2005. *Am J Public Health*. 2011;101(7):1198-1208. <http://www.ncbi.nlm.nih.gov/pubmed/2118594>.

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### III. For Skeptics: National Concerns

#### A. Government Efficiency

*“How can we trust the federal government to administer a cost-effective, high quality health care system?”*

Though many government-administered programs have the reputation of being inefficient, the U.S. government has proven itself capable of operating an efficient and effective health care system since 1965. Medicare has long provided aged and disabled Americans with access to high quality medical care more efficiently than the nation’s current multi-payer system in a number of ways.

First, Medicare is better than private health insurance at controlling health care costs. From 1989 to 2014, for example, as total health care costs grew, the average annual growth rate of Medicare spending per enrollee was only 5.5%, compared to 6.3% per year for **private insurance**.<sup>39</sup> According to the Congressional Budget Office, growth rates of excess spending by private health insurers will continue to outstrip those of Medicare for decades to come.<sup>40</sup> Thus, it is only a matter of time before private insurance becomes significantly more expensive for enrollees than equivalent coverage through Medicare.

Second, Medicare operates with significantly lower administrative costs than private health insurance companies. According to a study by the Kaiser Family Foundation, overhead spending for Medicare—including involved government agencies, as well as the “cost of claims contractors and other costs incurred in the payment of benefits, collection of Medicare taxes, fraud and abuse control activities, various demonstration projects, and building costs associated with program administration”—was far less than that of private insurance companies.<sup>41</sup> The Centers for Medicare &

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Medicaid Services (CMS) reported total overhead costs of 2.1% for fee-for-service Medicare in 2014,<sup>42</sup> compared to an average of 12% for private health insurance.<sup>43</sup>

Regarding quality, Medicare is legally required to ensure that the providers with whom it contracts meet professional standards of medical care. To this end, it operates Quality Improvement Organizations (QIO), comprised of consumers, health care providers, and quality improvement experts. These organizations are charged with improving “...the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.”<sup>44</sup>

In the most recent QIO program report to Congress, significant improvements were achieved in individual health measures, including reduction of health care-associated infections both in- and outside of nursing homes, among others.<sup>45</sup> On the level of system-based improvement, the organizations were reported to have reduced overall hospital admissions and readmissions, and to have increased quality-related reporting for additional monitoring and improvement efforts. As discussed in [section IIA](#), single-payer reform would incorporate similar measures to ensure that the system delivers high quality care to all Americans.

### Questions for Further Discussion:

1. Consider a fire station and a furniture store. One of these is guaranteed by the government, providing services that protect lives, while the other makes goods available only to those who can afford them.
  - a. Where do you think health care should fall on this spectrum?
  - b. What do you think about the fact that for-profit fire stations only protect those who pay? Does this change your opinion?
2. How can we trust a *profit-driven market* to administer a cost-effective and high quality health care system?

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- <sup>39</sup> Cubanski J, Neuman T. The Facts on Medicare Spending and Financing. 2016;(March):1-7.
- <sup>40</sup> Congressional Budget Office T. The 2016 Long-Term Budget. 2016;(July):32.  
<https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51580-LTBO-One-Col-2.pdf>.
- <sup>41</sup> Potetz L, Cubanski J, Neuman T. Medicare Spending and Financing: A Primer. *Kaiser Fam Found*. 2011. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7731-03.pdf>.
- <sup>42</sup> The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, D.C.; 2014. Table II.B1 <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2014.pdf>.
- <sup>43</sup> Centers for Medicare & Medicaid Services. Table 19 National Health Expenditures by Type of Expenditure and Program. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>
- <sup>44</sup> Centers for Medicare & Medicaid Services. Quality Improvement Organizations. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html>. Published 2016.
- <sup>45</sup> Centers for Medicare & Medicaid Services. Report to Congress: The administration, cost, and impact of the quality improvement organization (QIO) program for Medicare beneficiaries for fiscal year 2013. 2014.



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## B. Health Care Utilization

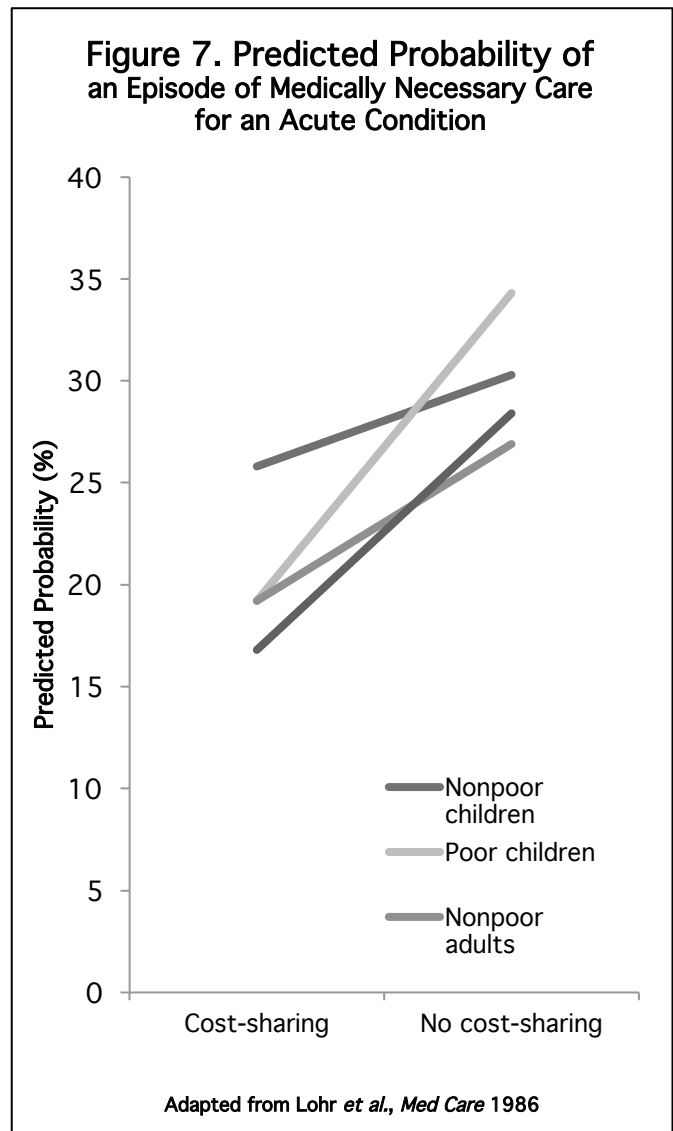
*“Wouldn’t people just use more health care?”*

Some have argued that a single-payer system designed to eliminate **cost-sharing**, making health care “free” for everyone, would encourage wasteful use of health care resources. However, there is no evidence to suggest that rates of unnecessary care would skyrocket as predicted. In fact, studies have shown that cost-sharing has no bearing on rates of unnecessary hospitalizations in the U.S.<sup>46</sup>

As discussed in [section IC](#), instead of simply preventing patients from seeking *unnecessary care*, high deductibles and copayments also cause people to forego *necessary* medical care. In fact, in 2015, “[t]wo of five (40%) of adults with deductibles of 5 percent or more of income reported that because of their deductible, they had not gone to the doctor when sick, did not get a preventive care test, skipped a recommended follow-up test, or did not get needed specialist care.”<sup>47</sup>

The question of whether decreased cost-sharing leads to higher rates of wasteful health care utilization has also been tested in Canada. A study of Winnipeg in 1999, for example, showed that while health care costs in the city were higher for low-income neighborhoods, “expenditures were strongly related to health status.”<sup>48</sup> Ultimately, 74% of health care dollars in the province were spent on the sickest 10% of the population from neighborhoods of all socioeconomic statuses. This implied that the highest utilizers of health care—even with single-payer reform in place—were the sickest members of the population, not simply those who had recently gained access to the system.

Ultimately, if the 30 million Americans who are currently un- or underinsured were to gain full access to medical care, it would be fair to expect utilization of necessary care—especially for conditions for which medical care is considered highly effective (Figure 7)<sup>49</sup>—among this population to increase. This outcome is precisely what a single-payer system would aim to achieve, given the association—time and again—of improved health outcomes with access to and utilization of medically necessary care.<sup>50</sup>



#### Questions for further discussion:

1. What are the overall goals of a health care system?
2. As physicians, shouldn't we be trying to provide as many people as possible with high quality care?

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- <sup>46</sup> Siu A et al. Inappropriate use of hospitals in a randomized trial of health insurance plans. *NEJM*. 1986;315:1259–66.
- <sup>47</sup> Collins S, Rasmussen P, Doty M, Beutel S. Too High a Price: Out-of-Pocket Health Care Costs in the United States. *Commonw Fund pub*. 2014;29(1784):12.  
[http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/nov/1784\\_collins\\_too\\_high\\_a\\_price\\_out\\_of\\_pocket\\_tb\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/nov/1784_collins_too_high_a_price_out_of_pocket_tb_v2.pdf)  
[http://www.medscape.com/viewarticle/852200?src=WNL\\_exclsv\\_160506\\_MSCPEDIT&uac=12272FK&impID=1086895&faf=1](http://www.medscape.com/viewarticle/852200?src=WNL_exclsv_160506_MSCPEDIT&uac=12272FK&impID=1086895&faf=1).
- <sup>48</sup> Roos NP, Forget E, Walld R, MacWilliam L. Does universal comprehensive insurance encourage unnecessary use? Evidence from Manitoba says “no”. *CMAJ*. 2004;170(2):209-214.  
<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=315526&tool=pmcentrez&rendertype=abstract>.
- <sup>49</sup> Lohr KN, Brook RH, Kamberg CJ, et al. Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial. *Med Care*. 1986;24(9):S1-S87. doi:10.2307/3764706.
- <sup>50</sup> Data to support this statement is everywhere, given that most modern medical practice is “evidence based.” For a review of the impact of insurance status and medical care on specific health outcomes, and ultimately on work and income, see: Hadley J. Sicker and Poorer — The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income. *Med Care Res Rev*. 2003;60(2). doi:10.1177/1077558703254101.

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## C. Rationing of Care

*“Why should the government decide who gets what care? Isn’t this rationing?”*

Under the current U.S. health care system, most medical services are theoretically available to those with health insurance. However, these services are often limited to those considered “medically necessary”, a determination not made by any physician, but by an insurance company. Thus, the United States already rations care in the sense that physicians are forced to treat based on what an insurance company will or will not pay for instead of based on their clinical judgment.

Without insurance, individuals can pay out-of-pocket for physician visits, procedures, and hospital stays to the extent that their financial situations allow. But with the high cost of health care in the U.S., for most people, this is not realistic. In this case, a “ration”, or guarantee of some basic level of health care, would be a good thing. This is one aim of single-payer health care reform.

As previously described, under the single-payer system proposed in H.R. 676, all U.S. residents would be guaranteed a

### Figure 8. Benefits and Portability of Single-Payer Health Care Under H.R. 676

#### SEC. 102. BENEFITS AND PORTABILITY.

(a) IN GENERAL.—The health care benefits under this Act cover all medically necessary services, including at least the following:

- (1) Primary care and prevention.
- (2) Approved dietary and nutritional therapies.
- (3) Inpatient care.
- (4) Outpatient care.
- (5) Emergency care.
- (6) Prescription drugs.
- (7) Durable medical equipment.
- (8) Long-term care.
- (9) Palliative care.
- (10) Mental health services.
- (11) The full scope of dental services, services, including periodontics, oral surgery, and endodontics, but not including cosmetic dentistry.
- (12) Substance abuse treatment services.
- (13) Chiropractic services, not including electrical stimulation.
- (14) Basic vision care and vision correction (other than laser vision correction for cosmetic purposes).
- hearing aids.
- (16) Podiatric care.

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minimum level of medically necessary care (Figure 8).

Though restrictions could exist, they would be determined by a National Board of Universal Quality and Access, the goals of which would be to “ensure quality, access, and affordability” of the system. This board would appointed by the president, and would include at least one of each of the following: health care professional; representative of institutional providers of health care; representative of health care advocacy groups; representative of labor unions; and citizen patient advocate.<sup>51</sup> These stipulations would ensure that care is not “rationed”, but rather guaranteed.

**Questions for Further Discussion:**

1. As a provider, have you ever felt that you have been forced to give less care than you feel is medically necessary under our current health care system?
2. As a patient, have your options for providers or treatments ever been limited by your health insurance plan?

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<sup>51</sup> Conyers J. *Expanded & Improved Medicare for All Act, H.R. 676*. 114th Congress; 2015.  
<https://www.congress.gov/114/bills/hr676/BILLS-114hr676ih.pdf>.

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## D. Innovation

*“Wouldn’t single-payer reduce the incentive for pharmaceutical companies to develop helpful, innovative drugs?”*

Pharmaceutical companies are driven by profit, not the well-being of patients. Though it can be argued that financial incentives are important for promoting innovation in pharmaceutical development, such incentives ultimately encourage companies to prioritize developing drugs that earn substantial sums of money as opposed to helping substantial numbers of patients.<sup>52</sup>

Many also argue that innovation in the pharmaceutical industry is dependent on investment in research and development (R&D). While some R&D spending may be necessary, the high R&D costs cited by pharmaceutical corporations are frequently exaggerated for the sole purpose of justifying the high prices of their products. Their estimates of R&D costs are often developed by industry-paid economists, and the methods of obtaining these data are often convoluted.<sup>53</sup>

Whether high prescription prices can be attributed to R&D or unfair price gouging, they must be better controlled for the sake of patients’ health. In 2013, according to Consumer Reports, 19% of those with and 37% of those without prescription drug benefits skipped filling at least one prescription because of cost. Similarly, many patients take medications less often than prescribed to save money.<sup>54</sup>

One must also be cautious in the use of the term “innovation,” as it is itself misleading. Throughout history, this word has come to connote that everything novel is inherently good. In discussions of pharmaceutical development, however, this is not always the case. Though some novel agents will significantly benefit a given population, many “new” drugs are simply slightly tweaked iterations of medications that are already widely available and in use. Studies have shown that as few as 10% of new drugs

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approved between 2002 and 2011, for example, truly represented clinical advances, while others were duplicates of existing products or offered patients little to no benefit.<sup>55</sup>

Finally, studies have shown that government contributions account for 40-80% of funding for pharmaceutical development in the United States.<sup>56,57</sup> A single-payer system would not preclude such investment in innovation, and in fact, could serve as a basis for more transparent communication regarding the sources and allocation of funding for pharmaceutical development.

**Questions for further discussion:**

1. Can we encourage the development of drugs that will significantly help specific populations without high R&D costs?
2. Who should decide what research gets funded?



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- <sup>52</sup> Light, Donald W, and Joel R Lexchin. "Pharmaceutical Research and Development: What Do We Get for All That Money?" *BMJ (Clinical research ed.)* 345.7869 (2012): e4348. Web.
- <sup>53</sup> Light, Donald W, and Rebecca Warburton. "Demythologizing the High Costs of Pharmaceutical Research." *BioSocieties* 6.1 (2011): 34–50. Web.
- <sup>54</sup> Some Americans take risks with needed drugs due to high costs, But they remain leery of low-cost generics, Consumer Reports poll finds. *Consumer Reports*. <http://www.consumerreports.org/cro/2014/09/some-americans-take-risks-with-needed-drugs-due-to-high-costs/index.htm#>. Published September 2014.
- <sup>55</sup> Note: Though this study comes from France, the French drug market is similar to that of the U.S. in the types of products available and its consumer-oriented nature.; "New Drugs and Indications in 2011. France Is Better Focused on Patients' Interests after the Mediator Scandal, but Stagnation Elsewhere." *Prescrire International* 21.126 (2012): 106–110. Print.
- <sup>56</sup> Light, Donald W. "Basic Research Funds to Discover Important New Drugs: Who Contributes How Much?" *Monitoring Financial Flows for Health Research*. Ed. Mary Anne Burke and Andrés de Francisco. Council on Health Research for Development (COHRED), Geneva, Switzerland, 2005. 27–45. Web.
- <sup>57</sup> Moses, Hamilton et al. "The Anatomy of Medical Research." *Jama* 313.2 (2015): 174. Web.

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## E. Coverage of Immigrants

*“Would unauthorized immigrants get free health care under single-payer? Why should citizens pay for them?”*

Based on past health care legislation, it could be difficult to win enough support to gain coverage of unauthorized immigrants under future health care reform; they are not officially covered by the Affordable Care Act (ACA), Medicare, or non-emergency Medicaid.<sup>58</sup> However, more progressive states such as California have started to adopt policies of allowing unauthorized immigrants to gain coverage through the exchanges established under the ACA.<sup>59</sup>

Additionally, in areas with large unauthorized immigrant populations, local governments already subsidize health care for these individuals. Given that hospitals are “required by law to screen and stabilize any patient, regardless of his or her ability to pay,” even the uninsured must be given necessary treatment in emergency situations.<sup>60</sup> To reduce emergency room visits and thereby decrease overall costs, some regions have found it practical to provide free or low-cost access to at least some basic care. In other words, though this comes at a substantial cost to local taxpayers, it is less expensive overall to provide this population with basic coverage and preventive care than to continue subsidizing emergency room visits and care for more advanced disease.

Recently proposed single-payer legislation does not exclude unauthorized immigrants, but their inclusion will likely be a point of contention in the future. Given that legislators will ultimately decide who is covered by a single-payer system, concerned physicians should engage with their representatives on this issue.

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**Questions for further discussion:**

1. Ethically, should U.S. physicians treat unauthorized immigrants?
2. How would U.S. health care change if unauthorized immigrants were given a path to citizenship? How would the health of our country change?
3. Consider an undocumented immigrant with active pulmonary tuberculosis. What are the public health consequences of leaving this individual out of coverage?

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- <sup>58</sup> "Immigrants and the Affordable Care Act (ACA)." *Affordable Care Act*. National Immigration Law Center, Jan. 2014. Web. 07 Feb. 2016.
- <sup>59</sup> Reuters. California Senate Approves Bill Allowing Undocumented Immigrants To Buy Health Insurance. *Huffington Post*. 2015:1.  
[http://www.huffingtonpost.com/2015/06/02/california-undocumented-immigrants-health-insurance\\_n\\_7496354.html](http://www.huffingtonpost.com/2015/06/02/california-undocumented-immigrants-health-insurance_n_7496354.html).
- <sup>60</sup> Radnofsky L. Illegal Immigrants Get Public Health Care, Despite Federal Policy. *Wall Str J*. March 2016. <http://www.wsj.com/articles/illegal-immigrants-get-public-health-care-despite-federal-policy-1458850082>.

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## F. Public Opinion

*“Do Americans want single-payer?”*

Historically, the U.S. has been roughly split on single-payer. But public opinion has been increasingly favorable in recent years. Though it may not be possible to eliminate bias from this type of survey, some of the more reputable polls have found significant support for single-payer among Americans:

<i>2008 Annals of Internal Medicine Survey</i> <sup>61</sup>	→	<b>59%</b> of U.S. physicians support “legislation to establish national health insurance”
<i>2010 Gallup Healthcare System Poll</i> <sup>62</sup>	→	<b>52%</b> of Americans believe the ACA should include a public, government-run insurance plan
<i>2015 Gallup Healthcare System Poll</i> <sup>63</sup>	→	<b>78%</b> of Americans are dissatisfied with the total cost of health care in the U.S.
<i>2015 Kaiser Health Tracking Poll</i> <sup>64</sup>	→	<b>58%</b> of Americans favor Medicare-for-all (a 19% increase from 2009 <sup>65</sup> )
<i>2016 Gallup Poll: The Future of the ACA</i> <sup>66</sup>	→	<b>58%</b> of Americans favor replacing the ACA with a federally funded healthcare program providing insurance for all Americans

In addition to increasing support in polls, recent political events suggest that interest in single-payer is rising. In the last several years multiple states—Colorado,<sup>67</sup> Illinois,<sup>68</sup> Maine,<sup>69</sup> New York,<sup>70</sup> Pennsylvania,<sup>71</sup> South Carolina,<sup>72</sup> Vermont,<sup>73</sup> Washington<sup>74</sup>— have made serious efforts toward passing single-payer legislation with significant support. Similarly, multiple candidates have run for office on single-payer platforms, including Peter Shumlin (governor, VT), Don Berwick (governor, MA) and Bernie Sanders (president, U.S.A), earning significant proportions of the vote in their respective races. Evidently, the nation is dissatisfied with the U.S. health care system as it stands, and a majority of Americans now favor single-payer reform.

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**Questions for further discussion:**

1. Are you surprised at the amount of public and physician support for single-payer?
2. Does this change your opinion on single-payer reform?
3. How do these polling data compare to support for single-payer in the U.S. Congress? What does that say about our political system, and how might we address it?

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- <sup>61</sup> Carroll AE, Ackerman RT. Support for national health insurance among U.S. physicians: 5 years later. *Ann Intern Med.* 2008;148(7):566-567. doi:10.7326/0003-4819-148-7-200804010-00026.
- <sup>62</sup> "Healthcare System." *In Depth: Topics A to Z.* Gallup, Inc., 2010. Web. 07 Feb. 2016. <<http://www.gallup.com/poll/4708/health-care-system.aspx>>.
- <sup>63</sup> "Healthcare System." *In Depth: Topics A to Z.* Gallup, Inc., 2015. Web. 07 Feb. 2016. <<http://www.gallup.com/poll/4708/health-care-system.aspx>>.
- <sup>64</sup> DiJulio, Bianca, Jamie Firth, and Mollyann Brodie. "Kaiser Health Tracking Poll: December 2015." The Henry J. Kaiser Family Foundation, 17 Dec. 2015. Web. 07 Feb. 2016. <<http://kff.org/uninsured/poll-finding/kaiser-health-tracking-poll-december-2015/>>.
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- <sup>66</sup> Newport F. *Majority in U.S. Support Idea of Fed-Funded Healthcare System*; 2016. <http://www.gallup.com/poll/191504/majority-support-idea-fed-funded-healthcare-system.aspx>.
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- <sup>74</sup> Appleton S. *Washington Health Security Trust, H.B. 1025.* Legislature of the State of Washington; 2015.
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## G. Politics

*“Single-payer is impossible in this political climate!”*

Perhaps, but the political winds are changing. Even if it is not possible to pass national single-payer legislation today, it may be possible in the near future. Many ideas in U.S. history that initially seemed impossibly radical are now taken for granted as facts of life. See, for example, the emancipation of U.S. slaves, women’s suffrage, the Vietnam war, and the Civil Rights Act of 1964. Physicians have the power to influence the national conversation about health care legislation. It is simply a matter of speaking up.

### Questions for further discussion:

1. How much political sway do individual physicians have in U.S. politics?  
What about physician groups?
2. If single-payer is a good idea for the country, should physicians wait until the idea becomes even more popular, or should they speak up about it now?



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## H. Failed State-Based Solutions

*“If single-payer is so great, why did it fail in Vermont?”*

This is a complicated question, with a complicated answer. There are several arguments for why “Green Mountain Care”, Vermont’s single-payer bill, passed in 2011, but was ultimately abandoned.

Firstly, several laws make it near impossible for Vermont’s “single-payer” legislation to establish a true single-payer system.<sup>75</sup> Under the ACA, states are unable to opt out of the law without a waiver—and are therefore stuck with private health insurance—which will only become available by application in 2017. Similarly, a waiver is required in order to incorporate Medicaid into a state single-payer system. And with respect to incorporating Medicare, the issue is more complicated, as no such waiver exists. To have one, single payer, these systems, along with other federal health programs, would need to be incorporated or eliminated, and the barriers would have been difficult for Vermont to overcome. As discussed in [sections I and IIB](#), the existence of multiple payers contributes to costly administrative complexity; without eliminating overhead costs, Vermont’s new plan could never achieve the savings of a true single-payer system.

Secondly, the design of the Vermont bill made it impossible for the state’s system to save money on pharmaceutical spending, as Medicare would remain unable to negotiate drug prices.<sup>76</sup> Given that allowing Medicare to negotiate down the cost of drugs has been another large stipulation of and means of savings under proposed national single-payer legislation, the system would again fall short of its savings goals.

Finally, political will appears to have played a role in the failure to enact Green Mountain Care. Despite evidence that the plan could ultimately have saved money and increased revenues for the state overall—at the cost of private insurance companies

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and high-wage businesses not offering health insurance at the time—a number of forces were likely to have played a role in Governor Shumlin’s decision to drop the legislation.<sup>77</sup> It is speculated that conservative groups, large corporations, and other stakeholders who might have been financially hurt by the new system were highly influential in the plan’s ultimate downfall.

It is likely that all of these arguments, and others, contain some truth about why Green Mountain Care failed. But one important lesson that can be drawn from the entire process is that state-level reform is difficult for a number of reasons. Most likely, national efforts at single-payer reform will be the ones to succeed.

**Questions for further discussion:**

1. What do you think about the possibility of state-based single-payer reform?
2. What external forces would you expect to encounter both for and against state single-payer?

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[http://www.pnhp.org/sites/default/files/Funding HR 676\\_Friedman\\_7.31.13\\_proofed.pdf](http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf).
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## IV. For Skeptics: Individual Concerns

### A. Physician Income

*“Wouldn’t doctors make less money under a single-payer system?”*

Physicians often argue against adopting a single-payer health care system for fear that income would decrease substantially for all members of the profession. While it is true that the average physician income in the U.S. is currently higher than that of most other nations,<sup>78</sup> there are few data to support the claim that this would necessarily change under single-payer reform. In fact, some physicians could earn more.

With the implementation of Medicare in Canada in 1961, for example, physician incomes rose overall, and have since grown faster than those of any other profession.<sup>79</sup> Whereas Canadian physicians earned approximately twice as much as other professionals prior to the adoption of Medicare, they now earn four times more on average than other Canadian professionals.\* This is due, in part, to the fact that physician reimbursement is significantly more reliable when it comes from a single payer, as opposed to the many private companies, public programs, and individuals the U.S. depends on now.<sup>80</sup>

The current multi-payer system also puts U.S. physicians at an economic disadvantage by forcing them to spend up to 16% of their total budgets, and an even greater proportion of their time, on billing and accounting. Medicare-for-All would free up these resources, allowing physicians to see more patients and potentially increase total revenue.<sup>81</sup>

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\* Note: it has become more difficult to track physician income in Canada in recent years due to changes in Canadian income tax law, so conflicting data exist. Similarly, while average physician income remains higher in the U.S. than in Canada, direct comparisons are difficult due to a lack of reliable data and differences in overhead, malpractice, and tax expenses

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Of note, there is less variability of income between physicians of different specialties in Canada than in the U.S. For example, among six developed nations, American primary care physicians were found to earn the least relative to orthopedic surgeons (42%), compared to 60% in Canada.<sup>82</sup> This suggests that if the U.S. were to follow a single-payer model, some of the highest earning American specialists might earn less, while lower-paid generalists could be reimbursed at higher rates for their services.

Another common misconception about single-payer health care as it relates to physician income is that the cost-savings associated with such a system would come directly from pay cuts to health care providers. However, provider reimbursement is only a small proportion of the nation's health care spending.<sup>83</sup> Savings under a single-payer system would come from significantly more expensive and wasteful areas, such as administrative and pharmaceutical costs ([section IIB](#)).

Ultimately, the fate of physician income depends on involvement of the profession in the health care reform process. Physicians who are concerned about their future earning potential should engage with other physician activists and legislators to ensure that their needs are addressed.

#### **Questions for further discussion:**

1. How large a role did potential income play in your decision to become a physician?
2. If medical education were less expensive, do you think theoretical decreases in physician income would be a problem?

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- <sup>78</sup> Farrell D, Jensen E, Kocher MD B, et al. *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More.*; 2008.  
<http://www.mckinsey.com/industries/health-care-systems-and-services/our-insights/accounting-for-the-cost-of-us-health-care>.
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- <sup>82</sup> Laugesen MJ, Glied SA. Higher fees paid To U.S. physicians drive higher spending For physician services compared to other countries. *Health Affairs* 2011;30(9):1647-1656
- <sup>83</sup> Farrell D, Jensen E, Kocher MD B, et al. *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More.*; 2008.  
<http://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/accounting-for-the-cost-of-us-health-care>.

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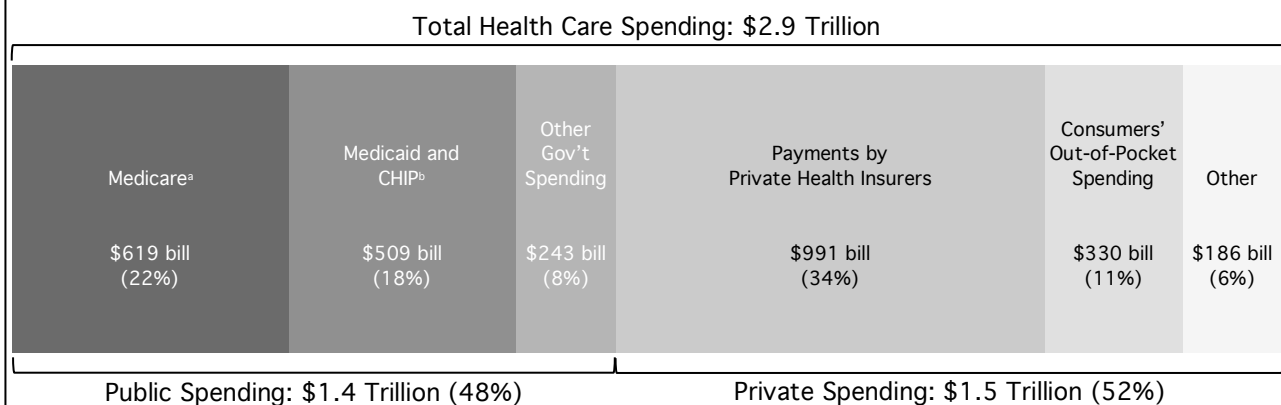
## B. Personal Spending

*“Don’t they pay higher taxes in countries with single-payer? I don’t want to spend more on my health care.”*

Though a U.S. single-payer health care system would be largely funded through taxation, most Americans are unaware that taxes already fund almost 60% of the nation’s health care spending (Figure 8).<sup>84</sup> In fact, a 2002 study showed that Americans paid “higher taxes per capita for financing health care than [did] any other nation’s citizens,” *without* single-payer.<sup>85</sup>

Figure 8. National Spending on Health Care, 2014

Total health care spending amounted to \$2.9 trillion in calendar year 2014, about half of which was private spending. **The federal government subsidizes a substantial part of that private spending, primarily through the tax exclusion for employment-based health insurance.**



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

CHIP = Children’s Health Insurance Program.

a. Refers to gross spending for Medicare, which does not account for offsetting receipts that are credited to the program. Those offsetting receipts are mostly premium payments made by beneficiaries to the government.

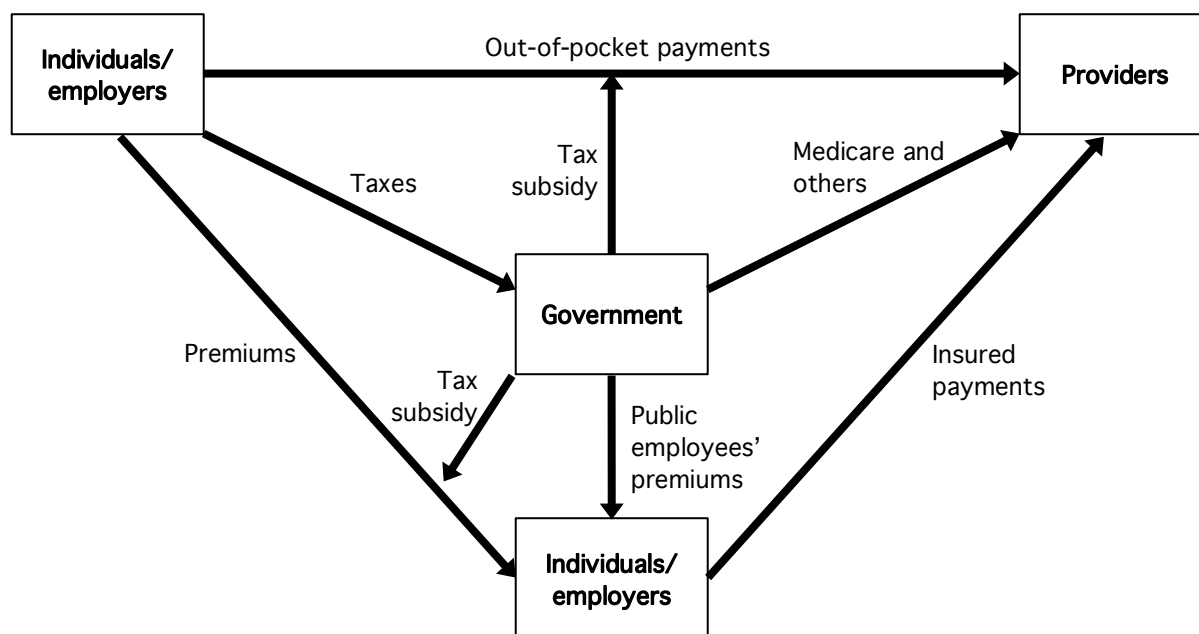
b. Includes federal and state spending.

Modified from Congressional Budget Office, 2016.

While the financing may seem complex, tax-based health spending in the U.S. can be broken down into a) direct government spending on health care; b) the cost of **private insurance** for public employees; and c) taxes (Figure 9).<sup>86</sup> Together, these

components have been shown to exceed the total public *and* private health budgets of almost every other nation—including those with single-payer health care systems.

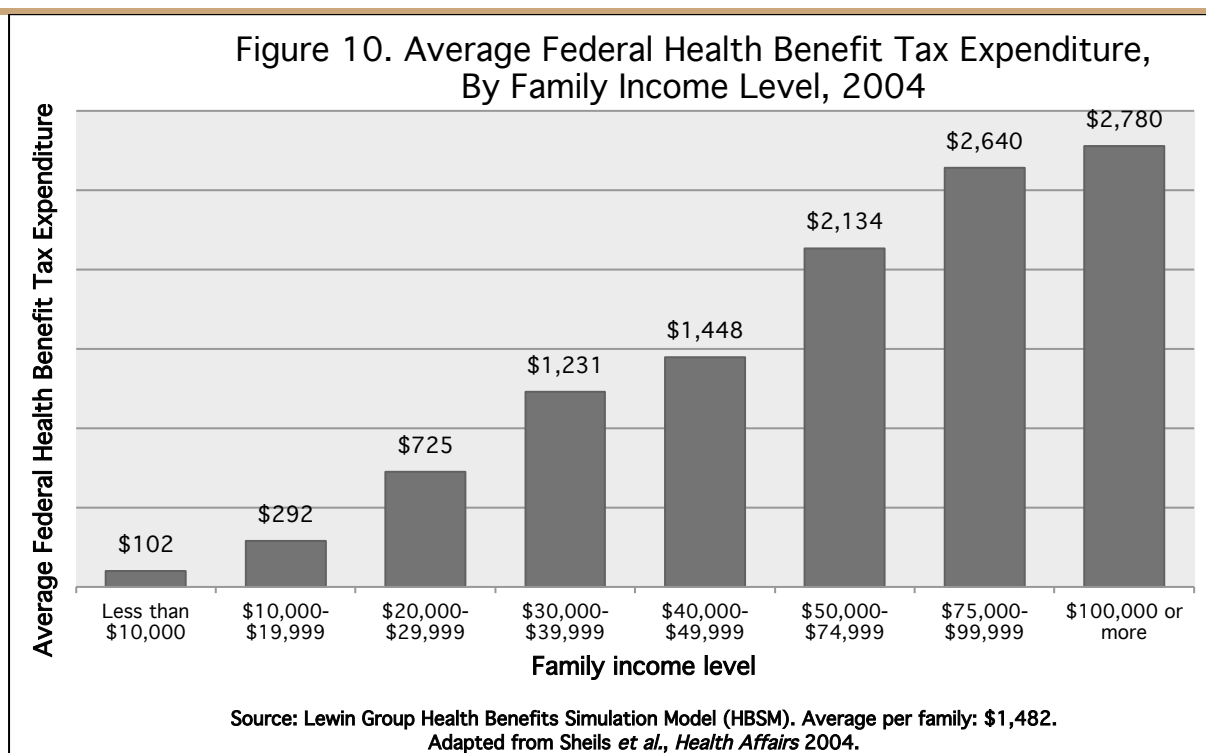
Figure 9. Flow of Health Care Financing Funds Among Individuals/Employers, Providers, Government, and Private Insurers



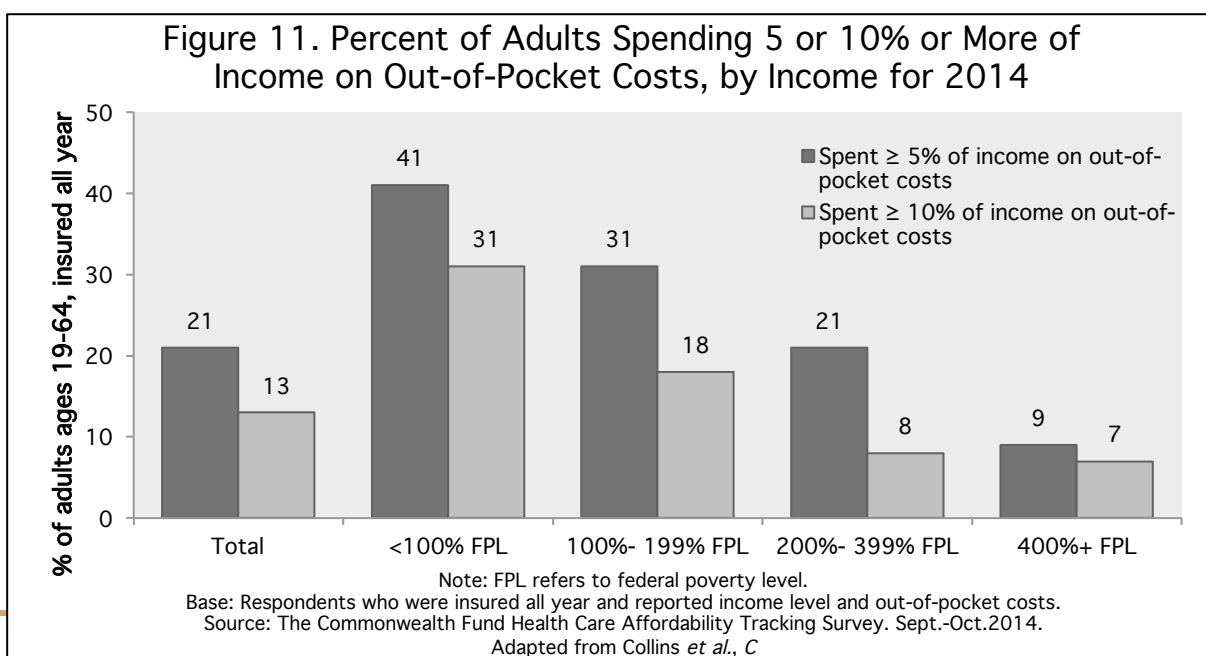
Adapted from Woolhandler *et al.*, *Health Affairs*, 2002

Notably, poorer Americans are unfairly burdened by this taxation system, paying a larger proportion of their earnings into a system that fails to provide them with sufficient coverage, and benefitting the least from tax breaks. By subsidizing taxes of employers who provide health insurance to employees, the self-employed, and those using flexible spending plans, as well as making some health expenses tax deductible, the federal government foregoes an immense amount of revenue. Ultimately, the burden of making up for these lost revenues falls on workers, as most money remains in the pockets of the wealthiest individuals. Prior to the implementation of the ACA, the resulting benefits of this regressive system were demonstrated to fall in the distribution shown in Figure 10.<sup>87</sup>





In addition to being unduly burdened by a regressive tax system, poorer adults with health insurance spend greater percentages of household income on out-of-pocket health care costs. In 2014, approximately 40% of adults with incomes below the federal poverty level were reported to have spent at least five percent of income on out-of-pocket costs for medical care (Figure 11).<sup>88</sup>



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If the United States were to adopt the single-payer system laid out in H.R. 676, 95% of families—including those with household incomes significantly over \$200,000—would pay less for health care than they do today. This would be accomplished through a system of progressive taxation as well as the elimination of cost-sharing. With progressive taxes (including payroll, property, income surtaxes, and a **Tobin tax** on financial transactions), the burden of health care costs would be shifted off of the poorest members of society. And for most high earners, the cost of these new taxes would be less than the current price of health care.<sup>89</sup>

**Questions for further discussion:**

1. Were you aware of the degree to which taxes already fund the U.S. health care system?
2. How do you feel about paying taxes to support a single-payer system with the knowledge that 95% of Americans would pay less for health care overall?

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- <sup>84</sup> Congressional Budget Office. The 2016 Long-Term Budget. 2016;(July).
- <sup>85</sup> Woolhandler S, Himmelstein DU. Paying for national health insurance—and not getting it. *Health Aff (Millwood)*. 2002;21(4):88-98. doi:10.1377/hlthaff.21.4.88.
- <sup>86</sup> Woolhandler S, Himmelstein DU. Paying for national health insurance—and not getting it. *Health Aff (Millwood)*. 2002;21(4):88-98. doi:10.1377/hlthaff.21.4.88.
- <sup>87</sup> Sheils J, Haught R. The Cost Of Tax-Exempt Health Benefits In 2004. *Health Aff*. 2004;W4. doi:10.1377/hlthaff.w4.106.
- <sup>88</sup> Collins S, Rasmussen P, Doty M, Beutel S. Too High a Price: Out-of-Pocket Health Care Costs in the United States. *Commonw Fund pub*. 2014;29(1784):12.  
[http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/nov/1784\\_collins\\_too\\_high\\_a\\_price\\_out\\_of\\_pocket\\_tb\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/nov/1784_collins_too_high_a_price_out_of_pocket_tb_v2.pdf) \n[http://www.medscape.com/viewarticle/852200?src=WNL\\_exclsv\\_160506\\_MSCPEDIT&uac=12272FK&implID=1086895&faf=1](http://www.medscape.com/viewarticle/852200?src=WNL_exclsv_160506_MSCPEDIT&uac=12272FK&implID=1086895&faf=1).
- <sup>89</sup> Note: For a breakdown of financing, see Appendix 1 of Friedman G. *Funding HR 676: The Expanded and Improved Medicare for All Act, How We Can Afford a National Single-Payer Health Plan.*; 2013. [http://www.pnhp.org/sites/default/files/Funding HR 676\\_Friedman\\_7.31.13\\_proofed.pdf](http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf).

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## C. Wait Times

*“Aren’t the wait times longer in countries with single-payer?”*

In Canada, it is undeniable that patients often face long waiting periods for specialized medical services. However, this problem cannot be solely attributed to Canada’s single-payer health care system. According to a report by the Canadian Wait Time Alliance, wait times can largely be attributed to:

- “Inability to keep up with increased demand for services;
- Shortages in health human resources;
- Inadequate operating room time and resources (e.g., nursing support);
- Suboptimum use of available operating room capacity within institutions and little coordination of surgical resources among institutions within a community or region;
- System bottlenecks (e.g. waits for residential placement);
- Inappropriate care (e.g. inappropriate requests for diagnostic tests);
- Lack of access to primary care; and
- Lack of system coordination across the continuum of care.”<sup>90</sup>

Some have argued that these issues are a result of under-funding, and that increasing the budget of Canada’s health care system could be an effective solution for reducing wait times. However, this debate is ongoing.

Notably, many other nations have proven that universal access does not inevitably lead to long wait times. In the Netherlands, U.K., and Germany, for example, patients are able to obtain specialty care in a timely fashion at little to no cost.<sup>91</sup>

Yet another misconception is that wait times for medical care are not a problem in the United States. However, studies have shown that while high-income Americans report that they are able to get care when they need it, low-income Americans “are

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more likely to report that they had to wait 6 or more days for an appointment the last time they needed medical attention and that it was somewhat or very difficult to get care in the evenings, on weekends, or on holidays.” On top of this, lower-income patients face longer wait times in emergency departments, and are less satisfied with their care overall.<sup>92</sup>

**Questions for further discussion:**

3. Have you or your patients ever waited for necessary or elective medical care for financial reasons?
4. Has the complexity of your insurance coverage ever delayed you or your patients from seeking medical care?

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- <sup>90</sup> WTA (Wait Time Alliance). Position paper on the occasion of the 10th Anniversary of the 2004 10-Year Plan to Strengthen Health Care in Canada Timely access to care for all Canadians: The role of the federal government. 2014:13.
- <sup>91</sup> Davis K, Stremikis K, Squires D, Schoen C. Mirror, mirror on the wall: How the performance of the U.S. health care system compares internationally. *Commonw Fund*. 2014;(June):1-32. doi:10.1002/uog.1825.
- <sup>92</sup> Davis K, Ballreich J. Equitable Access to Care — How the United States Ranks. *N Engl J Med*. 2014;371(17):1567-1570.

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## Conclusion

In just a few pages, we have covered a wide array of topics related to single-payer healthcare. We have addressed the shortfalls of the current U.S. health care system, including its poor rankings in overall quality compared to peer countries despite higher health care spending than any other nation, and its ongoing failure to provide access to all Americans despite major efforts at national reform. We have discussed the ways in which a single-payer system might address problems related to health care quality, cost, and access, and dispelled common misconceptions about single-payer reform.

Most importantly, we hope we have encouraged ongoing discussion about an important concern for all physicians: Healthcare as a human right.

No matter where you or your peers stand on single-payer reform, as clinicians we can all agree that patients deserve to be treated. As the authors of this book, we feel that in addition to the promise of care should come a guarantee that illness will not lead patients to financial ruin. And we believe that a single-payer national health program is the best possible means to achieve this end. We hope that you and your colleagues have had meaningful conversations surrounding each of the topics we have covered and have discovered your own stances on what the best answers might be for the United States health care system. We urge you to engage in the process of health care reform in the future to ensure that your needs and the needs of your patients will be met.

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## Appendix 1: Glossary of Terms

### Capitation

A payment system in which providers earn more money for treating more people.

### Coinsurance

Out-of-pocket payment for medical care as a percent of the total cost of a service.

For example, a \$150 procedure with 20% coinsurance would cost a patient \$30.

### Competitive bidding

A process in which manufacturers bid against one another in competition to offer the lowest price on their products. Medicare uses this system to control costs of medical supplies and devices by covering products offered by the lowest bidder.

### Copayment

Out-of-pocket payment for medical care at a flat rate, regardless of the total cost of a service. For example, a \$20 copay on a certain procedure would mean that the patient is responsible for paying \$20, regardless of the provider's charge.

### Cost-sharing

The out-of-pocket costs of medical care for which patients are responsible, including coinsurance, copayments, and deductibles.

### Deductible

The amount of money a patient must spend on his or her health care before an insurance plan provides coverage. Certain costs, such as preventive and emergency care, will be covered before the deductible is met. However, an individual with a \$1,000 deductible will be responsible for paying for all elective procedures and services up to a total of \$1,000 before his or her insurance will pay.

### Fee-for-service



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A system of payment in which providers earn more money for doing an increased number of or more expensive activities. For example, a provider might be paid more for seeing 30 patients in one day versus 20, or for using the newest MRI machine versus an old X-ray.

### **Global budget**

A payment system in which medical facilities are paid an annual lump sum based on prior years' budgets and achievement of specific outcome targets. By allowing hospitals to keep any remaining money at the end of the fiscal year, global budgeting encourages them to treat patients as efficiently as possible, avoid readmissions, and keep people healthy in the community.

### **Negotiated fees**

A cost-control strategy in which physician fees are negotiated and agreed upon for all providers in a geographic area. This prevents prices from rising at rates above that of inflation, and ensures acceptable rates of reimbursement for physicians.

### **Premium**

The monthly payment an individual is responsible for making to his or her insurance company in order to maintain coverage.

### **Private health insurance**

Health insurance obtained through a private company, including employer-sponsored coverage, health insurance exchanges, some Medicare plans, and others.

### **Public health insurance**

Government-sponsored health insurance, including fee-for-service Medicare and Medicaid.

### **Tobin tax**

A tax on financial transactions, including stocks and bonds. In H.R. 676, the proposed Tobin tax is 0.5% on stock trades and 0.01% per year to maturity on

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bond, swap, and trade transactions, amounting to an estimated \$442 billion in new revenue for the U.S. annually.