

## Why the United States Should Reject Socialized Medicine (a.k.a. “Single Payer”) and Restore Private Medicine

In August, 2003, Physicians for a National Health Program (PNHP) announced with great fanfare that some 8,000 physicians and medical students have endorsed a Proposal by the Physicians’ Working Group for Single-Payer National Health Insurance. This was published in *JAMA*, along with two favorable editorials, although the AMA is officially opposed to a “single-payer” system.<sup>1</sup>

This is the latest effort in a long march toward socialized medicine that began with President Truman more than five decades ago. Incremental steps have brought huge cost increases, burgeoning numbers of uninsured patients, a proliferation of bureaucratic rules and draconian criminal penalties, a deterioration in the quality of care, physician demoralization, patient anger, and dire predictions of impending bankruptcy of federal entitlement programs.

Small steps toward the goal having had so many adverse side effects, a “great leap forward”<sup>2</sup> is now proposed to enact the program once and for all—no going back. The current problems in American medicine are not attributed to past actions, but rather to stopping short of the goal of forcing all Americans into a single, uniform program.

Perhaps the advocates for this “giant leap” have forgotten the origin of the phrase “Great Leap Forward”: the 1958-1960 fiasco launched by Mao Zedong, which resulted in from 10 to 30 million deaths from starvation in China.<sup>3</sup>

We should certainly take the basic precaution of looking before we leap.

### What the PNHP Program Would Do

1. Cover all Americans for “comprehensive” services, including long-term care, mental health, dental services, and prescription drugs and supplies. The cost of insuring some of these risks is so high that most Americans can’t afford the premiums.
2. Set up boards of expert and community representatives to decide what services to exclude because they are “unnecessary” or “ineffective.” Their word will be law.
3. Proscribe private coverage of all items covered by the public program (as Medicare does) and forbid doctors to bill patients directly for any covered service or for costly office-based equipment such as MRI scanners, even if the public program refuses to provide the service.
4. Eliminate all copayments and deductibles and thus all barriers to overuse.
5. Prevent individuals from buying better care than is available to all (“eliminate disparities”).
6. Create a government monopsony, forbidding other sources of payment, or cost accounting systems that could attribute charges to individual patients.
7. Put all hospitals on a global budget—a fixed income that must cover everything.
8. Forbid hospitals to use any part of their operating budget to make major capital purchases.
9. Force all HMOs and group practices to convert to “non-profit” status.
10. Subject physicians paid by fee for service to price controls.
11. Impose other methods of “cost containment” on fee-for-service physicians, including: limiting the supply of physicians; monitoring for “extreme” practice patterns; limits on regional spending for physician services that force physicians to “police” themselves; and capping individual physician earnings.
12. Forbid major capital projects funded by private donations unless approved by the health planning board, if such projects would entail future operating expenses.
13. Establish a national formulary and require use of the lowest cost “therapeutically equivalent” product with exceptions for “medical necessity.”
14. Force pharmaceutical companies to lower prices.
15. Limit total health expenditures to the same proportion of the GNP as in the year prior to enactment—apparently regardless of demographic changes, epidemics, or new discoveries.
16. Fund the program through taxes, “the least cumbersome and least expensive mechanism for collecting money,” preferably a progressive income tax.

### PNHP Principles—Translated

PNHP states that four principles shape its vision of reform.

First: “Access to comprehensive health care is a human right”—that government must enforce. The corollaries are that patients have *no right* to the care of their choice, but only to that which government deems necessary and effective. Patients have *no right* to spend their own money to improve the “necessary” care that they receive, but only to buy such items as cosmetic surgery. Patients have *no right* to economize on medical services or to benefit from their own good health but must pay for the care of spendthrifts with poor health habits.

Second: “The right to choose one’s physician...is fundamental to patient autonomy.” This choice, however, must be from the “licensed health care professionals” permitted by government, with the above constraints on supply and capped expenditures.

Third: “Pursuit of corporate profit and personal fortune have no place in caregiving.” Physicians can increase their income—up to a certain limit—only by “working harder” and following the

government rules, not by investing in superior equipment or facilities, enhancing their skills, developing better methods, or satisfying patients better.

Fourth: “In a democracy, the public should set overall health policies and budgets. Personal medical decisions must be made by patients with their caregivers, not by corporate or government bureaucrats.” The only possible operational meaning of “the public” is government bureaucrats and boards, which rigidly restrict the range of personal medical decisions. Patients are disenfranchised and dependent when they cannot use the power that consumers have in every other sphere of life: the choice of how (and whether) to spend their own money.

## **PNHP Assumptions Contrary to Evidence**

Underlying the PNHP argument are a number of unstated assumptions, which are unproved or demonstrably false.

### **The ban on patient payment will assure quality by sealing the escape hatches.**

The affluent, in PNHP’s view, can be relied upon to lobby for increasing their own high taxes to fund care for people who pay little or nothing in taxes—if and only if they are stuck in the same public system as the poor. Equal misery is mandated to avoid a “multi-tiered system.”

So far, this theory hasn’t worked. Instead of lobbying, sick Canadians travel south to buy care in the United States—including Prime Minister Jean Chrétien, who threatened to cut off federal funding to Alberta if clinics there dared to bill privately.<sup>4</sup> A one-world socialist regime would be required to prevent an off-shore exodus, but the Soviet solution of special stores and hospitals for the Nomenklatura could develop in that circumstance.

### **A savings of \$200 billion, enough to cover all the uninsured, will result from abolishing private insurance with its profits and administrative overhead.**

It is asserted that administration by the public sector is much more efficient, with Medicare spending only 2 to 3 percent for this purpose.

This estimate is highly misleading, for it disregards many costs such as tax collection and compliance, lobbying, and the administrative burdens shifted onto physicians, hospitals, and others. A 1994 study for the Council for Affordable Health Insurance showed that when hidden costs are considered, the administrative overhead of public programs is \$0.27 per dollar of benefits, compared to \$0.16 for private insurance—69 percent more.<sup>5</sup> Moreover, government accounting is even more dishonest than Enron’s. Internal controls are so poor that the Government Accounting Office has been unable to render an opinion on consolidated government financial statements.<sup>6</sup> But whatever the overhead percentage is, it will apply to *all* medical expenditures. If most small medical bills were paid directly by patients, there would be *zero* third-party overhead for most expenditures.

PNHP’s estimates of the cost savings from importing Canadian-style administration,<sup>7</sup> published in *The New England Journal of Medicine*, were criticized in the same issue. A more realistic method, which PNHP spokesmen had used in the past, reduced the hypothetical savings by \$50 billion.<sup>8</sup> An analysis by Patricia Danzon calculated that, with all costs included, the

overhead of the Canadian system is 45 percent of claims.<sup>9</sup>

However, even if \$200 billion in savings were realized, it would be immediately used up by eliminating out-of-pocket costs for Medicare beneficiaries. Today’s seniors pay 50 percent of their medical costs out of pocket.<sup>10</sup>

### **Incentives for skimping on care and avoiding sick patients will be removed.**

Capitation will still exist; however, there will be no prodding from profit-minded managed-care bureaucrats—only policing by central planners and by others who must share the single global budget. The magic will supposedly be worked by eliminating the profit motive, or at least the ability to earn a profit or to keep any savings from the global budget.

Throughout human history, private profits have been the only incentive that has brought progress and prosperity.<sup>11</sup> PNHP would repeat past disastrous experiments by trying to substitute peer pressure and government compulsion. Self interest has always emerged—in buying influence and exploiting the system rather than in productive activity.

In the absence of the engine of the profit motive, and of voluntary transactions in which both buyer and seller benefit, an enterprise becomes a zero-sum game. A gain for one is always a loss to another: a prescription for the war of all against all.<sup>12</sup>

Such a system cannot work for the advantage of the weak or the sick. The Canadian system is notorious for skimping on patient care,<sup>13</sup> with possibly 150,000 patients waiting for needed care.<sup>14</sup> The primary focus is on budget, not patients, who are a very small proportion of an official’s constituency.<sup>15</sup>

### **Single Payer = Insurance = Healthcare.**

As PNHP admits, certain types of “insurance” such as HMOs often serve as barriers to medical care. Global budgets, price controls, and other bureaucratic impediments will be an even more effective barrier. Add to this the overutilization that inevitably occurs with the removal of any payment obligation of patients, and the result is certain: long waiting lists, constantly overstressed facilities and personnel, and patients spending days on gurneys in emergency rooms. Apparently admitting that waiting lists are permanent, Canada is establishing a new bureaucracy for better “management” of the waits. The Western Canada Waiting List Project ([www.wcwl.org](http://www.wcwl.org)) seeks to define terms<sup>16</sup> and develop objective priorities.<sup>17</sup>

PNHP does not admit that “single-payer” is *not insurance*. It is a collectivized government payment system on the socialist principle of “from each according to his means, and to each according to his need.” In contrast, true insurance reimburses subscribers for a catastrophic financial loss, with premiums determined by risk. Not all medical needs can be “covered” by insurance; attempts to do so simply destroy the insurance mechanism. Charity and social welfare are ways to meet those needs. Neither should be called “insurance.”

### **The U.S. has plenty of money to finance the system.**

PNHP expects to have the same amount of money spent on medical care as under the present system; it simply wants the government to control and redistribute the money. The model of efficiency, economy, and integrity is Medicare<sup>1</sup>—even though Medicare expenditures in the tenth year of the program exceeded initial estimates by a factor of more than six.<sup>18</sup> PNHP does not

acknowledge or account for the cost shifting to the private sector that results from Medicare price controls.

The PNHP Proposal also fails to acknowledge the unfunded liabilities of existing entitlement programs that realistically can never be paid. Before adding on a prescription drug benefit, promised Medicare benefits already exceed projected revenues by \$8.9 trillion over the next 75 years,<sup>19</sup> or \$35 trillion if current tax and spending policies are projected over all future years.<sup>20</sup>

The Canadian per capita debt is already double that of the United States.<sup>13</sup>

Advocates of socialism tend to assume that increases in the public sector have no effect on the economy as a whole. In fact, as incentives to growth are taxed away, the economy stagnates. Government outlays as a percentage of GDP have a strong inverse correlation with real GDP growth. Some examples:<sup>21</sup>

	Govt outlays as % of GDP	Real GDP Growth
Ireland	34.4	3.2
U.S.	35.6	2.5
U.K.	40.9	2.1
Germany	48.6	0.3
France	54.0	1.2

**The health of Americans would improve under a socialized system.**

Prepayment for services (third-party payment) does increase utilization—of both beneficial and inappropriate services. The only randomized study of the benefits of health insurance ever performed in the U.S., by the RAND Corporation in the 1970s, showed a negligible effect on health outcomes, even though those who paid nothing at the time of service used 40 percent more services than those who had to pay up to \$1,000 out of pocket.<sup>22</sup>

It is frequently asserted that nations with socialized medicine have better health indicators, particularly infant mortality. Such comparisons are misleading. The populations being compared may be very different; a homogeneous Scandinavian population may be compared to a population with a high proportion of ethnic minorities and members of a drug-abusing underclass, who have a much greater risk of delivering low birth-weight babies. Moreover, the criteria for how long a baby has to live to be counted as a live birth may be different.<sup>23</sup> In some countries, babies weighing less than 2 pounds are not counted as live births. This explains why U.S. babies have a better chance of survival despite a higher reported infant mortality rate.<sup>24</sup>

There are socioeconomic differences in health outcomes under socialized medicine also. In England, infant mortality in the lowest socioeconomic class is double the rate in the highest class, just as it was before the introduction of the NHS in the late 1940s.<sup>25</sup>

At best, medical care has a marginal impact on average life expectancy. In all but the least developed countries, life span is primarily a function of lifestyle, environment, education, and other genetic and social factors.<sup>26</sup>

**Insuring the uninsured would save money.**

It is claimed that each uninsured person loses, on average, between \$1,645 and \$3,280 per year in lost wages and benefits, poorer quality of life, and shortened life expectancy. The free or

discounted medical care that the uninsured receive costs about \$830 to \$3,200 per person.<sup>27</sup> According to a Kaiser Family Foundation study, the average annual insurance premium is \$3,383 for individual and \$9,068 for family coverage.<sup>28</sup> Columnist Ellen Goodman may assume that one can just transfer the money spent subsidizing the care of the uninsured into an insurance policy.<sup>29</sup> But even if one could, it wouldn't be enough. Adding the hypothetical benefits in wages and life enhancement might still not be enough to pay for the insurance.

**Preventive medicine saves money.**

The rationale for eliminating copayments and deductibles is to keep people from forgoing preventive care, on the assumption that such intervention saves money in the long run. However, with few exceptions, preventive medicine, whatever its other virtues, raises overall medical costs.<sup>26</sup>

Even more importantly, “preventive” measures are not necessarily beneficial to everyone, with hormone replacement therapy as the most prominent current example. David Sackett writes: “The *presumption* that justifies the *aggressive assertiveness* with which we go after the unsuspecting healthy must be based on the highest level of randomized evidence that our preventive manoeuvre will, in fact, do more good than harm.”<sup>30</sup>

**Medicare is nearly ideal.**

The Physicians’ Working Group declares that “we are encouraged by Medicare’s generally open and reasoned approach.”<sup>31</sup> While conceding that Medicare could “use some fixing at the margins,” Marcia Angell states that “because it is a nonprofit, single-payer system, Medicare is fairly efficient, with low overhead costs.”<sup>31</sup>

Whatever the administrative overhead costs, there is an enormous loss to the program from fraud—real fraud, not physician billing errors—inherent in the program’s nature. It is virtually a license to steal.<sup>32</sup> Malcolm Sparrow of the John F. Kennedy School of Government at Harvard University estimated fraud to constitute between 20 and 30 percent of Medicare payments.<sup>33</sup>

Several of the most egregious fraud cases have involved the watchdogs themselves, the companies contracted with the government to examine and pay claims. Most are members of Blue Cross Blue Shield Association,<sup>33</sup> of which only six of 44 were for-profits in 2002.<sup>34</sup> Conflicts of interest are pervasive. Whistleblowers are indispensable. However, the threshold of error for carriers is more than \$200 million, and the system seems designed to obstruct whistleblowing and protect the carrier, with the collusion of the Office of Inspector General and the courts.<sup>35</sup>

**What’s the Alternative?**

The Physicians’ Working Group can think of only six alternatives to national health insurance, all of which are criticized as “incremental reforms” that would retain the role of private insurers, perpetuating administrative waste and making universal coverage unaffordable. These proposals are: “defined contribution” schemes; tax subsidies and vouchers for covering the uninsured; expansion of Medicaid, State Children’s Health Insurance Programs (SCHIP), and other public programs; employer mandates; and the Medicare HMO program and Medicare voucher schemes.<sup>1</sup> Medical Savings Accounts are notably absent.

“The problems in the United States are systemic,” the Physicians’ Working Group writes. “Incremental changes cannot solve them; further reliance on market-based strategies will exacerbate them. What needs to change is the system itself.”<sup>1</sup>

The rest of the world, in contrast, has a mere funding problem.

The gauntlet has been laid down for those who do not like socialized medicine to “develop and propose something better, more effective, and with fewer adverse side effects.”<sup>36</sup>

The system does indeed need to be improved, but it is critical to diagnose correctly what the system is: Nearly half of all medical expenses are now paid for by the “single payer”: government.<sup>37</sup> Only about 20 percent of medical expenses are paid directly by patients.<sup>38</sup> There has not been a free market in medicine in the U.S. for 50 years. Any incremental steps or leaps need to be in the right direction toward (1) getting the government out of medicine (see AAPS Medicare Reform Plan<sup>39</sup> and White Paper<sup>40</sup>); (2) restoring insurance to its proper function of reimbursing subscribers for catastrophic financial losses; (3) removing impediments, especially in the tax code and discriminatory hospital pricing, to direct payment by patients; (4) putting patients in charge of their medical dollars.

The answer, in a word, is freedom. Freedom is incompatible with any top-down, single, uniform, rigid Central Plan.<sup>23</sup>

French economist Frederick Bastiat had the answer in 1850: “Now that the legislators and do-gooders have so futilely inflicted so many systems upon society, may they finally end where they should have begun: May they reject all systems and try liberty.”<sup>12</sup>

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