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# What Is "Single-Payer" Health Care?

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Leading Democrats in the U.S. Senate and more than half of Democrats in the U.S. House of Representatives have voiced support for "single-payer" health care—a full government take-over of American health care.[1] Its promise of simplicity strikes a chord with Americans who are frustrated with high costs and complex payment arrangements. This sentiment is amplified by the fact that some Americans face additional trouble accessing care if they are sick or low-income. Single-payer advocates claim that full government control of health care is the answer, and they argue that such a system would deliver superior quality care for everyone at lower costs than current public and private arrangements.

Upon closer examination, however, these claims are greatly exaggerated. Government-controlled health care would substantially raise taxes for all Americans. Moreover, it would slash payments to medical providers, resulting in less access to quality care for millions of Americans. The experiences of the United Kingdom and Canada offer a cautionary lesson of government-run health care. Under these systems, the government rations care—resulting in delays and denials for its citizens.

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## Leading Single-Payer Proposals: Medicare for All

The term "single-payer" is an umbrella term for a variety of approaches to government-funded health care.[2] In its purest form, it refers to a universal system in which the government itself becomes the national health insurer. With few exceptions, it typically supplants or abolishes previously existing public and private health coverage.

The most prominent proposal for government-controlled health care is S. 1804, the Medicare for All Act of 2017, introduced by Senator Bernie Sanders (I–VT).[3] This proposal would create a national health insurance program covering all U.S. residents.[4] Coverage would include 10 benefit categories and eliminate nearly all cost sharing, making care "free" at the point of service. It would prohibit employer-sponsored coverage and all other private insurance, except for non-covered benefits or services.[5] The proposal would also eliminate nearly all existing public coverage arrangements, most notably Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP).[6]

Following a four-year transition period, the federal government would enroll all residents covered under current private and public arrangements (as well as those currently uninsured) into the new, federal insurance program.[7] Under this scenario, 164 million Americans would lose their employer-sponsored insurance; 17 million Americans would lose their individual-market insurance; and 75 million Americans would lose Medicaid or CHIP. Ironically, even though the title of the bill is "Medicare for All," over 57 million elderly and disabled Americans would lose their existing Medicare coverage and

instead be enrolled in the new program.[8] In short, almost all Americans would lose the health care coverage they have today.

The Sanders plan suggests financing the cost of the program in part through a combination of new payroll and income taxes.[9] The plan would impose a set of specialized taxes—including taxes on investments and dividends—and target tax-rate increases on Americans making over $250,000. The proposal also assumes significant savings from reductions in administrative costs and substantial cuts in payment for doctors, hospitals, and other medical professionals. Under the Sanders proposal, doctors and other medical professionals would receive Medicare-level reimbursements, and the proposal would severely restrict any private contracting between doctors and patients outside the government program.[10] Health spending in the new government program would be subject to a global health care budget and governed by an elaborate regulatory system of centralized decision making in the U.S. Department of Health and Human Services.[11]

There is a similar Medicare for All proposal in the U.S. House of Representatives, H.R. 676, the Expanded and Improved Medicare for All Act of 2017. The bill was originally introduced by Representative John Conyers (D–MI) and is currently sponsored by Representative Keith Ellison (D–MN).[12] While broadly similar, this proposal varies on some points from Senator Sanders' bill.

- The House bill does not provide a transition period between systems, while Sanders' offers a four-year transition period.[13]
- The House bill permits anyone arriving at a medical facility to receive care: They are presumed covered under the plan, though they must submit an application for coverage.[14] Sanders' bill does not include this provision.
- The House bill also includes long-term care in the list of covered Medicare-for-All services, while Sanders keeps long-term care in the Medicaid program.[15]
- The House bill does not include any cost sharing, while Sanders' bill includes small copays for prescription drugs.[16]
- The House bill bans for-profit, investor-owned medical facilities, while the Sanders plan does not.[17]
- While the House bill is silent on private contracting, the Sanders proposal specifies that providers may opt-out of Medicare for All (though private insurance is banned).[18]
- Under the House bill, individual facilities and providers would receive global (fixed) budgets, while the Sanders plan sets the budget only at the national level.[19]
- Finally, the House bill proposes a combination of revenue sources, including a payroll tax, while the Sanders bill does not specify his revenue sources in the bill itself (other than current spending).[20] Sanders does, however, provide revenue suggestions in a separate document from the bill and proposes a variety of funding sources—but primarily relies upon a combined payroll tax and income-related premium equal to 11.5 percent of income.[21]

## The High Cost of Government-Run Health Care

Health policy analysts from across the ideological spectrum have examined the potential cost of the Sanders' proposal. While the estimates vary methodologically, they all consistently show the proposal would require substantial federal tax increases and could impose major deficits, depending on actual incurred revenue. The Urban Institute, a widely respected liberal-leaning think tank, estimates that Senator Sanders' plan would cost $32 trillion in new federal spending over 10 years. Yet Urban finds that the proposed combined payroll and income tax of 11.5 percent would bring in only $15.3 trillion of the needed $32 trillion—leaving a 10-year deficit of more than $16.7 trillion.[22]

Economist Ken Thorpe of Emory University, a former adviser to President Bill Clinton, estimates the 10-year cost of Sanders' plan at $24.7 trillion.[23] Like the Urban Institute, Professor Thorpe finds that Senator Sanders' tax proposal would be insufficient to cover the full cost of the proposal. He estimates a shortfall of nearly $1.1 trillion *per year*. Professor Thorpe estimates that the tax level required to cover the true cost would need to be about *20 percent* in combined new payroll and income taxes.

Analysts at the Center for Health and Economy estimate a 10-year cost of up to $44 trillion. This estimate assumes the Sanders proposal offered coverage equivalent to current "platinum"-level plans offered in the individual and small-group health insurance markets. The Center's analysts also find that Senator Sanders' revenue proposal would be insufficient and would result in a deficit of up to $2.11 trillion in the program's first year.[24]

More recently, Dr. Charles Blahous, Senior Fellow at the Mercatus Center at George Mason University and former public trustee of Social Security and Medicare, estimates a 10-year cost of $32.6 trillion. In his estimate of the Sanders bill, he notes that "doubling all currently projected federal individual and corporate income tax collections would be insufficient to finance the added federal costs of the plan."[25]

## Reduced Access to Care in Single-Payer Systems

With insufficient revenue, single-payer systems usually depend on government officials holding firm to the global health care budgets that restrict national spending or imposing payment regulations, reductions, or price controls on medical goods and services. The Sanders bill includes both approaches to control national health spending.

U.S. policymakers can look to international experience on how such systems work in practice. The British National Health Service (NHS) and Canadian health systems, both single-payer systems, explicitly ration health care—creating access problems for patients.

**Wait Lists.** Wait lists are a significant problem in the Canadian system. In 2017, Canadians were on waiting lists for an estimated 1,040,791 procedures.[26] Physicians reported that only about 11.5 percent of patients "were on a waiting list because they requested a delay or postponement," meaning much of the remainder was systemic failure.[27] Often, wait times are lengthy. For example, the median wait time in Canada for arthroplastic surgery (hip, knee, ankle, shoulder) ranges from 20 weeks to 52 weeks.[28]

**Cancellations.** In the British NHS, cancellations are common. In 2017, the NHS canceled 84,881 elective operations in England for non-clinical reasons on the day the patient was due to arrive.[29] The same year, the NHS canceled 3,845 urgent operations in England.[30] Episodes of frequent illness tend to aggravate this problem. During the 2018 flu season, for example, the NHS canceled 50,000 "non-urgent" surgeries.[31]

**Poor Performance.** In the United States, the Veterans Administration (VA) health program and the Indian Health Services (IHS), both government-run health care programs, have a history of poor performance.[32] A 2015 report revealed that in the VA, as many as 238,000 veterans may have died while they were waiting for care. Curiously, in spite of these shocking revelations, the Sanders' bill would preserve the VA program, along with the troubled IHS.[33]

**Professional Problems.** Not only patients, but also doctors would face a more difficult practice environment under a single-payer program. Earlier this year, the *British Medical Journal* published a study of general practitioners who have left practice or are planning to leave.[34] The most commonly cited reasons were the lack of professional autonomy, administrative challenges, and increasingly unmanageable workloads.

## Conclusion

American policymakers should reject "single-payer" proposals such as Medicare for All. Although the promise of "free" care may be attractive, in reality such a system would cost most taxpayers more than they pay today. It would take control from patients and their doctors and put it in the hands of government politicians and bureaucrats.

The international track-record on single-payer plans confirms that this consistently leads to poor access to care—and even to denial of care. In short, single-payer would have the effect of higher costs and reduced access to care for many patients. Instead, Congress should seek to reduce costs and increase access to care for Americans through proposals that empower patients and doctors.[35]

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# Endnotes

1. For a list of Senate supporters, see "Cosponsors: S.1804; 115th Congress (2017–2018)," https://www.congress.gov/bill/115th-congress/senate-bill/1804/cosponsors (accessed November 5, 2018). For a list of House supporters, see "Cosponsors: H.R. 676; 115th Congress (2017–2018)," https://www.congress.gov/bill/115th-congress/house-bill/676/cosponsors (accessed November 5, 2018).
2. Signe Peterson Flieger, "What We Talk About When We Talk About Single Payer," *Health Affairs*, September 19, 2017, https://www.healthaffairs.org/do/10.1377/hblog20170919.062040/full/ (accessed November 15, 2018).
3. Medicare for All Act, S. 1804, 115th Congress, 1st Sess. For more information, see Robert E. Moffit, "Government Monopoly: Senator Sanders' 'Single-Payer' Health Care Prescription," Heritage Foundation *Backgrounder* No. 3261, July 27, 2018, https://www.heritage.org/health-care-reform/report/government-monopoly-senator-sanders-single-payer-health-care-prescription.
4. S. 1804, § 102.
5. Ibid., § 801.
6. The plan would retain the Veterans Administration Health Program and the Indian Health Service.
7. S. 1804, § 1002.
8. "Employer-sponsored" and "individual market" categories from National Association of Insurance Commissioners data, accessed through Mark Farrah Associates, http://www.markfarrah.com (accessed August 16, 2018). For Medicaid and CHIP information, see Centers for Medicare and Medicaid Services, "Updated February 2017: Medicaid & CHIP December 2016 Application, Eligibility, and Enrollment Data," https://www.medicaid.gov/medicaid/program-information/downloads/updated-december-2016-enrollment-data.pdf (accessed August 20, 2018). For Medicare information, see Centers for Medicare and Medicaid Services, "Medicare Enrollment: Medicare Advantage & Other Health Plans," 2016, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html (accessed August 20, 2018).
9. Bernie Sanders, "Options to Finance Medicare for All," https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all (accessed August 20, 2018). See also Expanded and Improved Medicare for All Act, H.R. 676, 115th Congress, 1st Sess., § 211.
10. S. 1804, §§ 202 and 303, respectively.
11. S. 1804, § 401.
12. H.R. 676. The bill will soon be sponsored by Representative Pramila Jayapal (D–WA). See Kimberly Leonard, "Pelosi Faces Conflict with Her Caucus Over 'Medicare for All,'" *The Washington Examiner*, November 10, 2018, https://www.washingtonexaminer.com/policy/healthcare/pelosi-faces-conflict-with-her-caucus-over-medicare-for-all (accessed November 26, 2018).
13. H.R. 676, § 101, and S. 1804, § 1002.
14. H.R. 676, § 101(c).
15. H.R. 676, § 102, and S. 1804, § 204.
16. H.R. 676, § 102, and S. 1804, § 202.
17. H.R. 676, § 103(a).
18. S. 1804, § 303.
19. H.R. 676, § 201, and S. 1804, § 601.
20. H.R. 676, §211, and S. 1804, § 701.
21. Sanders, "Options to Finance Medicare for All."
22. John Holahan, Lisa Clemans-Cope, Matthew Buettgens, et al., "The Sanders Single-Payer Health Care Plan," The Urban Institute, May 2016, https://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000785-The-Sanders-Single-Payer-Health-Care-Plan.pdf (accessed August 20, 2018).
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24. The Center for Health and Economy, "Medicare for All: Leaving No One Behind," May 1, 2016, http://healthandeconomy.org/medicare-for-all-leaving-no-one-behind/ (accessed August 19, 2018).
25. Charles Blahous, "The Costs of a National Single-Payer Healthcare System," Mercatus Center, July 2018, https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf (accessed August 20, 2018).
26. Bacchus Barua, "Waiting Your Turn: Wait Times for Health Care in Canada," The Fraser Institute, 2017, https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2017.pdf (accessed August 19, 2018).
27. Ibid.
28. Ibid.

29. Carl Baker, "NHS Key Statistics: England, October 2018," House of Commons Library, May 21, 2018, http://researchbriefings.files.parliament.uk/documents/CBP-7281/CBP-7281.pdf (accessed November 19, 2018)
30. Ibid.
31. Laura Donnelly, and Henry Bodkin, "NHS Hospitals Ordered to Cancel All Routine Operations in January as Flu Spike and Bed Shortages Lead to A&E Crisis," *The Telegraph*, January 3, 2018, https://www.telegraph.co.uk/news/2018/01/02/nhs-hospitals-ordered-cancel-routine-operations-january/ (accessed August 20, 2018).
32. John O'Shea, "Reforming Veterans Health Care: Now and for the Future," Heritage Foundation *Issue Brief* No. 4585, June 24, 2016, https://www.heritage.org/health-care-reform/report/reforming-veterans-health-care-now-and-the-future.
33. For a discussion of problems in the Indian Health Service, see the U.S. Government Accountability Office, *Indian Health Service: Actions Needed to Improve Oversight of Quality of Care*, Report to Congress, GAO–17–181, January 9, 2017, https://www.gao.gov/products/GAO-17-181 (accessed October 24, 2017).
34. Anna Sansom, Rohini Terry, Emily Fletcher, Chris Salisbury, Linda Long et al., "Why Do GPs Leave Direct Patient Care and What Might Help to Retain Them? A Qualitative Study of GPs in South West England," *British Medical Journal*, Vol. 8, No. 1, https://bmjopen.bmj.com/content/8/1/e019849 (accessed September 18, 2018).
35. The Health Care Choices proposal offers Congress a starting place toward such a goal. Its intent is to reduce costs, increase access, and provide patients—not the government—with more control over their health care. For more details see Health Policy Consensus Group, "The Health Care Choices Proposal: Policy Recommendations to Congress," June 19, 2018, https://www.healthcarereform2018.org/wp-content/uploads/2018/06/Proposal-06-19-18.pdf (accessed September 18, 2018).