Setting the Record Straight on US Health Care, Single-Payer Systems, and Medicare-For-All[1]

Scott W. Atlas, MD
David and Joan Traitel Senior Fellow
Hoover Institution
Stanford University
Email: swatlas@stanford.edu

Introduction

The overall goal of US health care reform is to broaden access for all Americans to high quality medical care. Over decades, the improper expectation has developed that health insurance will subsidize the entire gamut of medical services, including routine care, with little out-of-pocket payment. Through a series of regulations, including coverage mandates, copayment limits, and restrictions on medical savings accounts, the Affordable Care Act (ACA) counterproductively doubled down on that longstanding misapplication of health insurance and pushed health care reform in the wrong direction. Fundamentally, insurance is about reducing risk, and in health care, the risk is incurring large and unanticipated medical expenses. Instead, the ACA's broad coverage requirements and misguided subsidies encouraged more widespread adoption of bloated insurance and furthered the inappropriate construct that insurance should minimize out-of-pocket payment for all medical care. Patients in such plans do not perceive themselves as paying for these services, and neither do physicians and other providers. With patients having little incentive to consider value, prices and doctor qualifications remain invisible, and providers don't need to compete on price. The natural results are overuse of health care services and unrestrained costs.

In response to the acknowledged failures of the ACA superimposed on decades of misguided incentives in the system and the considerable health care challenges facing the country, US voters at the time of this writing are being presented with two fundamentally different visions of US health care reform: 1) a single-payer, government-centralized system, including "Medicare-for-All", based on increasing government regulation and authority over health care and health insurance. This model is intended to broaden health care availability to everyone while minimizing concern for price; or 2) a competition-based, consumer-driven system, based on increasing competition among providers, removal of regulations that shield patients from considering price, and empowering patients with control of the money. This model is intended to reduce the costs of medical care and enhance its value, thereby providing broader availability of higher quality care for everyone.

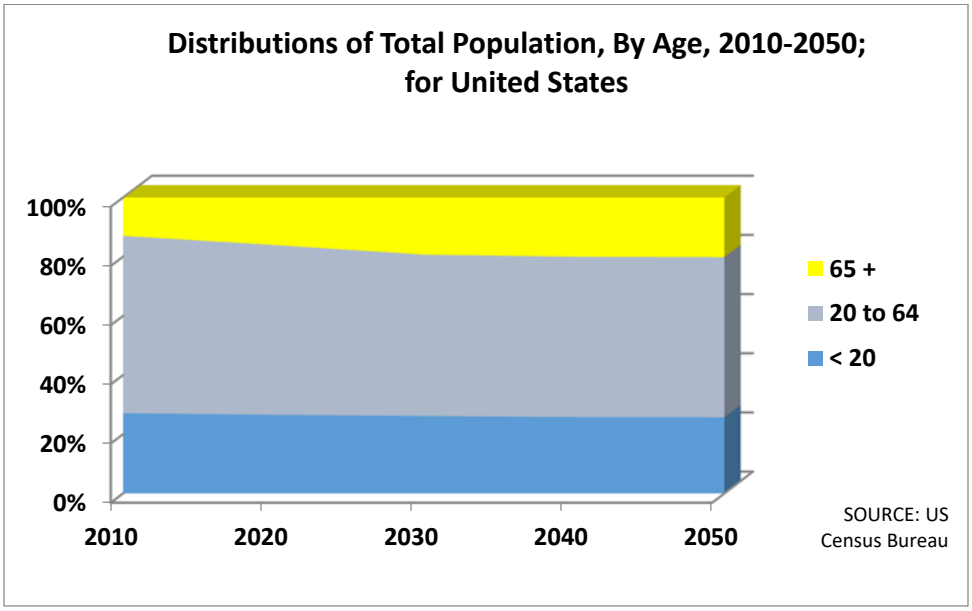
Policy proposals must be informed by evidence and data. One undeniable fact is that the US already

spends significantly more on health care than any other nation by OECD health spending data[2], whether calculated on a per capita basis or as a percent of GDP. That was true in 2008, prior to the ACA, and it remains true today. This fact appropriately prompts questions about what Americans get in return for that expenditure. It also prompts a separate and legitimate concern of whether that spending is sustainable, regardless of relative comparisons of access and quality of care.

Before we consider how to reform the US system to reach the extraordinary promise of twenty-first-century health care, we need to understand the facts about the state of US health care, both before and after implementing the Affordable Care Act. We also need to examine the data about single-payer nationalized systems.

Background: The Urgency of Reforming America's Health Care System

Health care reform cannot wait, despite the excellence of American medical care. America is facing its greatest health care challenges in history. Unprecedented demand for costly medical care is a certainty. According to the Department of Health and Human Services' Administration on Aging and US Census Bureau statistics[3], the number of Americans sixty-five and older has increased by a full six million in the past decade alone, to more than 13 percent of the overall population, while those age eighty-five and older have increased by a factor of ten from the 1950s to today's six million (*Figure 1*). Achieving this goal of health care and development - longer life spans - paradoxically also implies additional health care expenditures. Older people tend to have the most disabling diseases, including heart disease, cancer, stroke, and dementia—the diseases that depend most on specialists, complex technology, and innovative drugs for diagnosis and treatment.



[2] Health Spending, 2018 OECD Data, https://data.oecd.org/healthres/health-spending.htm

[3] Source: US Census Bureau, ™The Next Four Decades: The Older Population in the United States: 2010 to 2050 (based on 2008 data), https://www.census.gov/prod/2010pubs/p25-1138.pdf

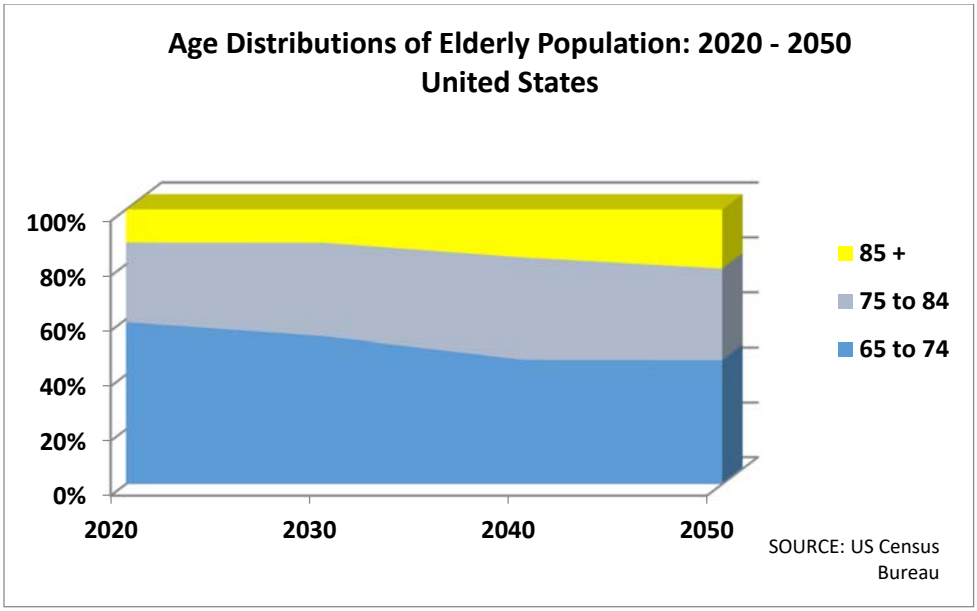


FIGURE 1. (*top*) Relative Age Distribution of Total US Population, 2010-2050; (*bottom*) Relative Age Distribution of Senior US Population, 2020-2050. The population of seniors is rapidly growing. For those over sixty-five years of age, the proportions of seniors over seventy-five and over eighty-five are rapidly growing.

In addition to an aging population, the US harbors an enormous future disease burden from lifestyle choices, most notably obesity, smoking, and alcohol abuse. For cancer alone, the most recent US data[4] estimates that 42 percent of all cancers and 45 percent of cancer deaths are attributable to cigarette smoking, excess body weight, and alcohol. Obesity, America's most serious health problem, has increased to crisis levels, already affecting more adults and children in the United States than in any other nation[5] (*Figure 2*). Given the known lag time for such risk factors to impact health, these modifiable lifestyle behaviors promise to impose unprecedented cumulative health and economic harms over the next several decades.

[4] Proportion and number of cancer cases and deaths attributable to potentially modifiable risk factors in the United States. F Islami et al, CA: A Journal for Clinicians 2017; 10.3322/caac.21440

[5] Organisation for Economic Co-operation and Development, OECD Fact Book 2018 (Paris, France: OECD, 2018)

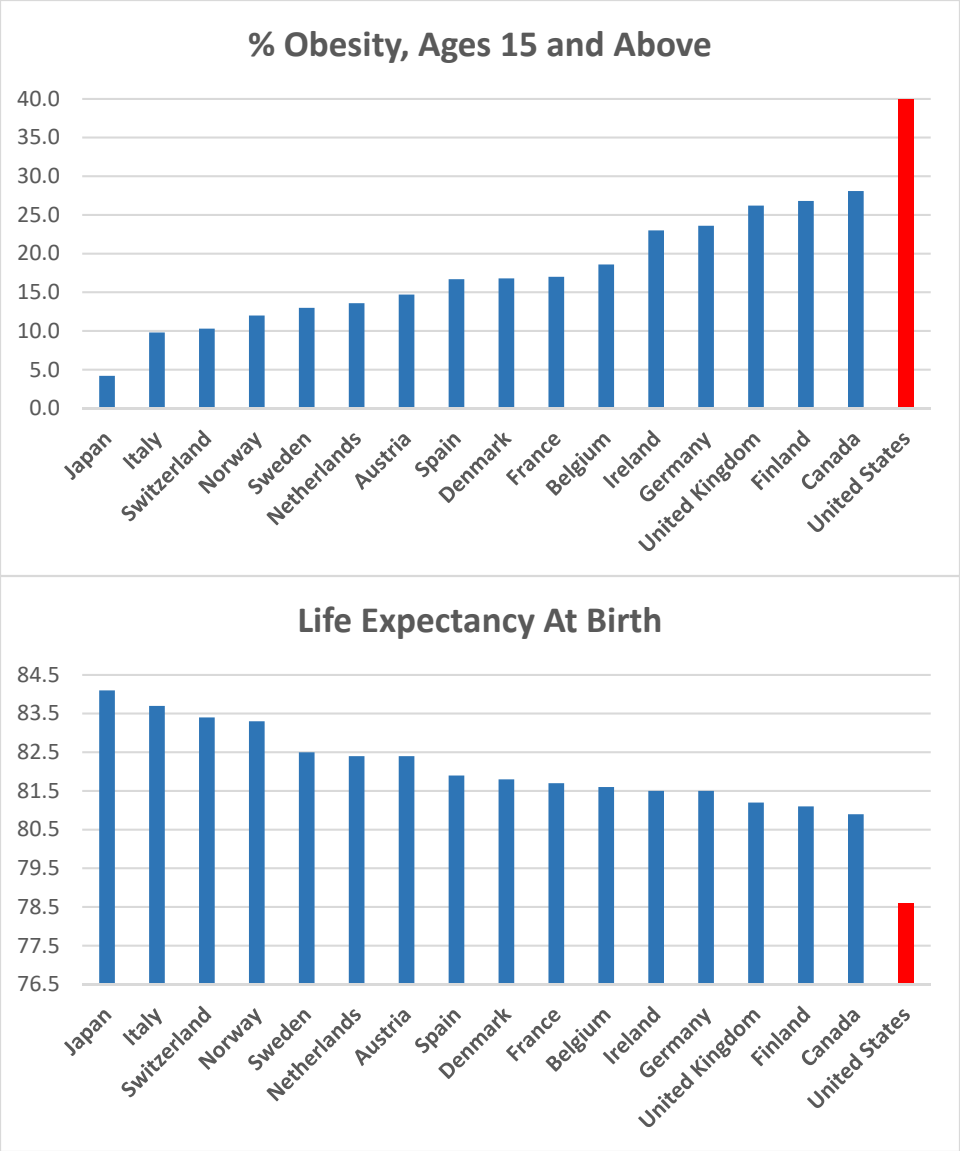


FIGURE 2. Prevalence of Obesity (percent BMI > 30) compared to Life Expectancy; United States and selected OECD Nations.
Note the almost direct inverse relationship between life expectancy and prevalence of obesity.
Source: Organisation for Economic Co-operation and Development, *OECD Fact Book 2018* (Paris, France: OECD, 2018)

These daunting demographic realities add to today's already serious fiscal challenges in US health care that promise to worsen over the near future and overwhelm the system. America's national health expenditures now total more than $3.8 trillion per year, or 17.8 percent of gross domestic product (GDP), and they are projected to reach 19.4 percent of GDP by 2027[6]. Medicaid, originally covering 250,000 beneficiaries, has expanded to cover more than seventy million people[7] at a cost of over $550 billion per year[8]. Medicare spent less than $1 billion in its first year, but today it spends more than

[6] National Health Expenditure Projections, 2018-27: Economic and Demographic Trends Drive Spending and Enrollment Growth. AM Sisko et al, Health Affairs 2019;38:491
[7] August 2019 Estimated Medicaid and CHIP Enrollment, Medicaid.gov
[8] Medicaid Enrollment & Spending Growth: FY 2018 & 2019, Kaiser Family Foundation

$300 billion annually on hospital benefits alone and $740 billion in total[9]. In 1965, at the start of Medicare, workers paying taxes for the program numbered 4.6 per beneficiary, whereas that number will decline to 2.3 in 2030 (*Figure 3*) with the aging of the baby boomer generation. By 2034, people 65 years and older will outnumber children for the first time in US history (77.0 million elderly vs. 76.5 million under 18), according to the US Census Bureau National Population Projections. That demographic shift has serious implications.

Outside a discussion of the role of private vs public health insurance is the undeniable reality that America's main government insurance programs, Medicare and Medicaid, are already unsustainable without reforms. The 2019 Medicare Trustees Report projects that the Hospitalization Insurance trust fund will face depletion in 2026. Regardless of trust fund depletion, Medicare and Medicaid must compete with other spending in the federal budget. Without reforming the current system, federal expenditures for health care and social security are projected to consume all federal revenues by 2049, eliminating the capacity for national defense, interest on the debt, or any other domestic program[10].

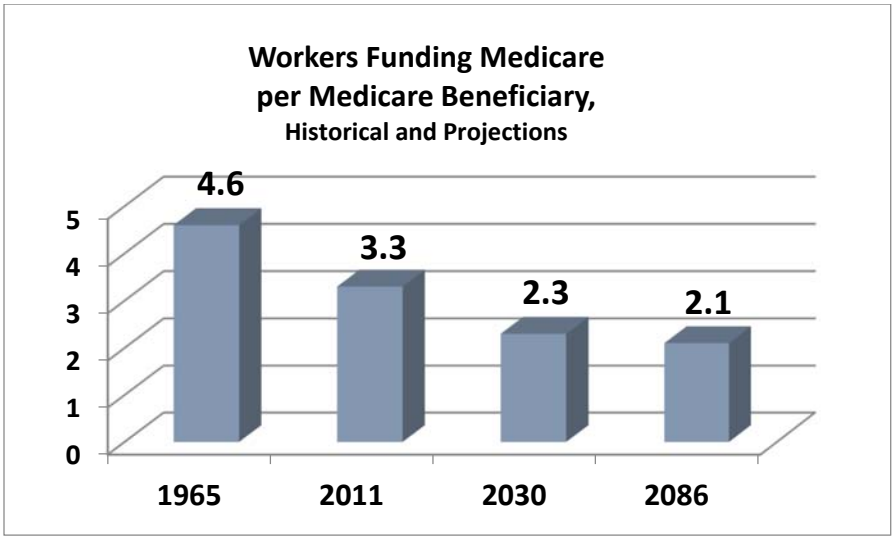


FIGURE 3. Workers Funding Medicare per Medicare Beneficiary, Historical and Projections. The number of workers per beneficiary supporting Medicare is far less than at the beginning of the program and is rapidly declining.
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, 2014 Annual ™Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, ∫July 2014, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2014.pdf.

Assessing The US Health Care System: A Critical Appraisal

The WHO Report

A decade prior to passage of the ACA, the ambitious *World Health Report 2000* [11] by the World Health Organization (WHO) ranked health care systems of 191 nations. Its most notorious finding – the relatively low US ranking as 37th in "overall performance" as defined by the WHO - has been repeatedly asserted

[9] 2019 Annual Medicare Trustees Report
[10] National Research Council and National Academy of Public Administration, Choosing The Nation's Fiscal Future (Washington DC); National Academy of Sciences, 2011
[11] *The World Health Report 2000*: health systems: improving performance. World Health Organization, Geneva, 2000

as objective evidence of the overall failure of America's health care by many policymakers and advocacy groups, especially in light of the higher expenditures for health care in the US. Contrary to naïvely drawn inferences from that study, the WHO study methods and conclusions were heavily criticized in a body of peer-reviewed literature by academic international experts who examined the report in detail.

Why would the WHO rankings have been deemed severely flawed by health policy experts? First, almost two-third of the WHO rankings were based on *equality*, rather than *quality* (*Figure 4*). For instance, a system with C-quality but equal performance for everyone would be ranked higher than a system with A-quality excellence for some and C-quality performance for others.

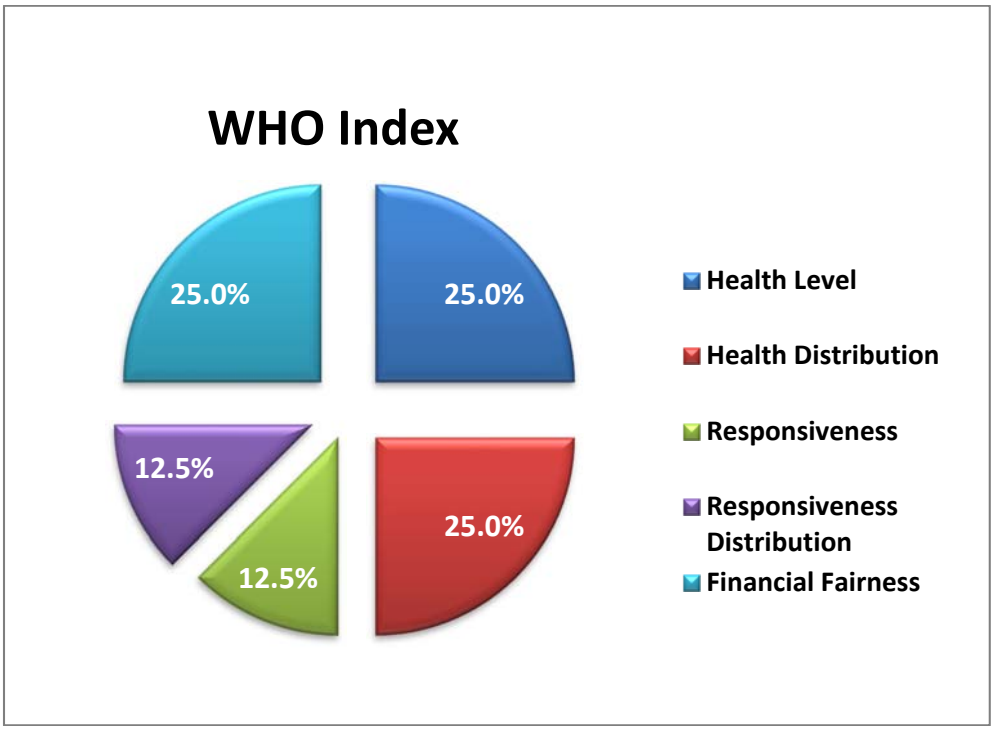


FIGURE 4. WHO Index components. Almost two-thirds (62.5%) of a system's overall ranking was based on measures of *equality*, rather than quality.

Other fundamental flaws in the WHO methodology have also been detailed throughout the published literature[12]. Serious problems have undermined legitimacy of the comparative rankings in the

[12] Almeida C, Braveman P, et al. Methodological concerns and recommendations on policy consequences of the World Health Report 2000; *Lancet* 2001;357:1692; Asada Y and Hedemann T. A problem with the individual approach in the WHO inequality measurement; *Int J Equity Hlth* 2002;1:2; Musgrove P. Judging health systems: reflections on WHO's methods. *Lancet* 2003;361:1817; Navarro V. Assessment of the World Health Report 2000. *Lancet* 2000;356:1598; Ollila E and Koivusalo M. The World Health Report 2000: World Health Organization health policy steering off course – change values, evidence, and lack of accountability. *Int J Health Serv* 2002;32:503; Murray CJL et al. Overall health system achievement for 191 countries. *Global Program on Evidence for Health Policy Discussion* Paper Series No. 28, p. 8, fig. 1, Geneva, WHO

[12] "Ill-Conceived Ranking Makes for Unhealthy Debate", *Wall Street Journal*, October 21, 2009

[12] Long-term trends in fetal mortality: implications for developing countries. R Woods, *Bulletin of the World Health Organization* 2008;86:417

report, including: 1) highly subjective inputs, many of which do not closely reflect health care access or quality; 2) arbitrary assumptions about relative importance of inputs based on ideological bias; 3) when data was missing from dozens of countries, it was filled in simply based on assumptions of the study authors; and 4) substantial measurement errors with comparisons lacking statistical significance were ignored and misleading rankings were still put forth. Even the 37th place overall ranking had already been adjusted downward due to the high expenditures in the US, rather than based on quality per se. Ultimately, *World Health Report 2000* can be considered at best deceptive - a document that was essentially a rank of countries in accordance with their alignment to a specific political and economic ideology, socialized medicine, rather than an objective measurement of health system quality. Indeed, Mark Pearson, head of health for the Organization for Economic Cooperation and Development, the Paris-based organization of the world's largest economies, was quoted[13] to say that "Health analysts don't like to talk about it in polite company. It's one of those things that we wish would go away."

Infant Mortality and Life Expectancy as Indicators of Health Care Quality

Beyond the widely discredited WHO Report, single-payer advocates often point to America's consistently low ranking in two statistics: *life expectancy* and *infant mortality rate*. But expert studies have proven these two statistics to be grossly flawed in ways that do not reflect health care system quality and also misleadingly rank the US lower than peer nations.

Consider America's rate of ***infant mortality***—death within the first year after birth—calculated to be 5.9 per 1,000 live births in the latest statistics, 32nd among 35 developed countries, according to the OECD. First, basic terminology and definitions vary country-to-country, generating false comparisons. The US strictly adheres to the World Health Organization (WHO) definition of live birth ("irrespective of the duration of the pregnancy. . . breathes or shows any other evidence of life"), counting all births, even extremely premature infants who have the least chance of survival. This isn't necessarily true for European nations. The WHO noted "(it is) common practice in several countries (e.g. Belgium, France, Spain) to register as live births only those infants who survived for a specified period beyond birth", and infants who did not survive were completely ignored for registration purposes[14]. A British study[15] of Belgium, Denmark, Finland, France, Germany, Greece, Netherlands, Norway, Portugal, Spain, Sweden, and UK found that terminology alone caused up to 40% variation and 17% false reductions in infant mortality. Consider this - American physicians consistently make heroic efforts to save extremely premature infants, unlike their counterparts in other countries, who often don't even count such babies when they die. Official data from the U.S. National Center for Health Statistics and the European Perinatal Health Report show that when it comes to newborns who need medical care and

[12] Comparability of published perinatal mortality rates in Western Europe: the quantitative impact of differences in gestational age and birthweight criteria. Graafmans WC et al, *Brit J Obst Gyn* 2001;108:1237poor evidence, and lack of accountability. *Int J Health Serv* 2002;32:503; Murray CJL et al. Overall health system achievement for 191 countries. *Global Program on Evidence for Health Policy Discussion* Paper Series No. 28, p. 8, fig. 1, Geneva, WHO

[13] "Ill-Conceived Ranking Makes for Unhealthy Debate", *Wall Street Journal*, October 21, 2009

[14] Long-term trends in fetal mortality: implications for developing countries. R Woods, *Bulletin of the World Health Organization* 2008;86:417

[15] Comparability of published perinatal mortality rates in Western Europe: the quantitative impact of differences in gestational age and birthweight criteria. Graafmans WC et al, *Brit J Obst Gyn* 2001;108:1237

have the highest risk of dying, the US has the world's third-best infant-mortality rate—trailing only Sweden and Norway.

Second, premature birth, the main risk factor for infant death, is far more frequent in the US than any developed country[16] - 65% higher than in Britain, more than double that of Ireland and Finland. A Centers for Disease Control (CDC) study found that standardizing for gestational age alone eliminated 68% of the difference in infant mortality between Sweden and the US. Whether from harmful behaviors during pregnancy or other causes, the CDC's National Center for Health Statistics concluded "the primary reason for the United States' higher infant mortality rate when compared with Europe is the United States' much higher percentage of preterm births."

Third, three-fourths of the world's neonatal deaths are counted by highly unreliable household surveys up to five years after pregnancy, instead of being recorded by health care professionals. These surveys frequently misclassify what were really live births as "stillbirths," thereby excluding most neonatal deaths. Perhaps the most glaring example is the widely cited ranking of perinatal and neonatal mortality, the WHO 2006 report "Neonatal and perinatal mortality: country, regional and global estimates", in which up to 47% of the 192 ranked countries provided unreliable data[17]. The WHO warned that differing mortality rates between countries "may be due to diverging definitions and reporting systems, sources of data, or levels of accuracy and completeness."

America's ***life expectancy*** ranking is also often cited as an indicator of poor quality health care in the US. In 2017, life expectancy was 76.1 years for men and 81.1 years for women, 26th and 29th respectively among the 35 developed nations. Yet, life expectancy is a coarse statistic that reflects many factors, several of which are wholly unrelated to health care quality (*see Figure 5 below*)**.**

[16] Behind International Rankings of Infant Mortality: How the United States Compares with Europe. MF MacDorman, TJ Mathews, *Int J Health Serv* 2010;40:577

[17] World Health Organization, 2006. Neonatal and perinatal mortality: country, regional and global estimates. World Health Organization. https://apps.who.int/iris/handle/10665/43444

Some Additional Factors Influencing Life Expectancy Calculations	
Lifestyle choices	• Nutritional decisions • Obesity • Exercise or sedentary behavior • Safe sex practices • Drug abuse • Cigarette smoking • Marriage rates
Population heterogeneity	• Range of genetic predisposition to disease and response to treatment • Range of socioeconomic classes • Range of behaviors acceptable in population subgroups • Income inequality • Education
Societal and environmental conditions	• Homicide rate • Suicide rate • High speed, fatal motor vehicle collisions • Urbanization
Cultural differences	• Response to behavior recommendations reducing risk for disease • Acceptance of medical advice • Reliability of patients on maintaining doctor-recommended therapies • Willingness to miss work for illness recovery
Differences in decision-based standards of medical care	• Inclusion of all births as recorded live births • Rates of higher risk multiple births from infertility treatments • Prioritization to preserving high risk, premature births • Willingness to extend end-of-life care in elderly patients

FIGURE 5. Many factors influencing the calculation of life expectancy are not related to health care system quality (from: *In Excellent Health*, SW Atlas, Hoover Press, 2011).

For instance, life expectancy does not separate illness-related death from immediately fatal gunshot wounds or fatal car accidents, deaths that clearly do not reflect health care quality. For those 1 to 25 years of age, two-thirds of US deaths are not from illness; for those 25 to 44, more than 40 percent are not from illness[18]. For men ages 20-24 years, accidents and homicides account for 84% of the gap in mortality rates between Canada and the US[19], with those death rates about 6 times of Sweden's and Canada's, and about 10 times those of the UK and Japan. Just like the disadvantageous effect of including US neonatal infant deaths using different criteria from other nations, deaths in younger adults

[18] Heron M. Deaths: Leading causes for 2016. National Vital Statistics Reports; vol 67 no 6. Hyattsville, MD: National Center for Health Statistics. 2018

[19] Health Status, Health Care and Inequality: Canada vs. the U.S., June E. O'Neill, Dave M. O'Neill. in *Frontiers in Health Policy Research*, Volume 10, Cutler, Garber, and Goldman. 2007

have a particularly significant impact on overall life expectancy calculated from birth, yet they often do not reflect health care quality.

Secondly, personal lifestyle choices, especially obesity and smoking, but also exercise patterns, high risk sex practices, marriage rates, and numerous others all have significant impact on life expectancy[20]. Obesity, defined by the OECD as a "non-medical determinant of health", along with tobacco and alcohol consumption, is proven to shorten life expectancy, regardless of country or health care system[21]. Obesity rates are substantially higher in the US than in any other developed nation. According to the OECD's *Health Statistics 2018*, 40% of Americans are obese, compared to 17% in France, 13% in Sweden, 10.3% in Switzerland, 9.8% in Italy, and 4.2% in Japan, where people have the longest life expectancy. Based on the estimated 6.5 years of lost life expectancy, obesity differences *alone* accounts for approximately *40% or more* of the life expectancy differences between the US and almost every other country (*Figure 3*).

Despite declining smoking rates, the US had the highest level of cigarette consumption per capita compared to all other developed nations over a 50-year period ending in the mid-1980s[22]. Smoking generally causes death after 30-to-60-year lag times, sometimes long after cessation. Life expectancy for smokers is at least 10 years shorter than for nonsmokers, according to the CDC. According to the Surgeon General, smoking causes 480,000 premature deaths and $300 billion in direct health care expenditures and productivity losses each year in the US. Life expectancy numbers in the US are lower, in part, due to a higher historical burden of smoking, a separate issue from today's smoking incidence.

Fundamentally, infant mortality and life expectancy calculations are both filled with inconsistencies and inputs unrelated to health care quality. The CDC itself explicitly warned at the bottom of its life expectancy table "Because calculation of life expectancy (LE) estimates varies among countries, ranks are not presented. Therefore, comparisons among countries and their interpretation should be made with caution". Life expectancy and infant mortality rankings reflect significant deviations in terminology, reporting, populations, and lifestyle choices – almost all of which deceptively skew the US ranking negatively.

The Affordable Care Act and Its Impact on the US Health Care System

Partly based on a goal of reducing the uninsured population and partly based on now-discredited studies alleging the poor quality of America's relatively expensive health care, the ACA was enacted. Its two core elements, a significant Medicaid expansion and subsidies for exchange-based private insurance, were projected to each cost about $850 billion to $1 trillion over the next decade per CBO analysis[23].

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[20] Predicting life expectancy: a cross-country empirical analysis. A Baer and PE Graves, University of Colorado, 2002 https://spot.colorado.edu/~gravesp/WPLifeExpectancy6-6-02.htm

[21] Body-mass index and all-cause mortality: individual-participant-data meta-analysis of 239 prospective studies in four continents. Global BMI Mortality Collaboration, *Lancet* 2016;388:776

[22] *International Smoking Statistics: A collection of historical data from 30 economically developed countries*. B Forey, J Hamling, P Lee, and N Wald, Oxford Publishing, 2002

[23] Congressional Budget Office, "Federal Subsidies for Health Insurance (Includes Effects of the Affordable Care Act)", January 2017, www.cbo.gov/publication/51298

The ACA aimed first and foremost to reduce the percentage of Americans without health insurance. It did so by expanding government insurance programs and government regulatory authority over US health care via new mandates, regulations, and taxes. Indeed, since the law's passage, the uninsured population has decreased significantly, declining from over 17% nationally to about 11% in recent Gallup polling. The bulk of the new coverage came from Medicaid expansion; overall, between 60 and 85 percent of all newly insured were able-bodied adults enrolled into Medicaid by various estimates. During the first three quarters of 2014, 89 percent of the newly insured under Obamacare were enrollees into Medicaid, not private insurance[24]. A full 27% of Californians were enrolled in Medi-Cal (California's Medicaid program) as of 2016, a 50% increase since 2008, according to Kaiser Family Foundation[25].

Why is that a problem? First, we already know that categorizing someone as "insured" is not the same as enabling timely, quality health care for them (see, for example, the single-payer health VA system for America's veterans). The fact is that regardless of expanding Medicaid insurance, most doctors do not accept new Medicaid patients[26]. Less well known to the public is that about half of doctors who signed contracts to accept Medicaid patients in truth do not, according to the government's own Department of Health and Human Services (HHS) data[27]. That refusal of providers to accept Medicaid is not difficult to understand, given that Medicaid pays below cost of administering the care – doctors and hospitals will not provide care broadly when they lose money per patient served. The second problem with adding more patients to Medicaid is that Medicaid's insurance delivers worse outcomes[28], including more in-hospital deaths and adverse events, more complications from surgery, shorter survival after treatment, and longer hospital stays, than private insurance covering medically similar patients. Medicaid's worse health outcomes are likely due to Medicaid's stricter limits on covered diagnostics, drugs, and treatments. It seems unconscionable to celebrate funneling millions of poor Americans into a program that affords very limited access to doctors and that has poor outcomes. Third, there is a massive cost to taxpayers for expanding Medicaid, even though it is substandard in every meaningful way. Medicaid is thought of as a state-based program, yet about 60 percent of costs come from federal taxpayers and 40 percent from state budgets, totaling $574.2 billion in FY 2016[29]. In

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[24] EF Haislmaier and D Gonshorowski, "Q3 2014 Health Insurance Enrollment: Employer Coverage Continues to Decline, Medicaid Keeps Growing"; Heritage Foundation Backgrounder 2988, January 29, 2015

[25] Kaiser Family Foundation, State Health Facts, California: Health Coverage and Uninsured; https://www.kff.org/state-category/health-coverage-uninsured/?state=CA; accessed 9/24/2018; and Kaiser Family Foundation, "Facts on Health Reform", October, 2009

[26] Merritt Hawkins, "Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates, 2014 Annual Survey"

[27] Department of Health and Human Services, "Access to Care: Provider Availability in Medicaid Managed Care," Report OEI-02-13-00670 (December 2014), http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf

[28] See, for example: Michael A. Gaglia, "Effect of Insurance Type on Adverse Cardiac Events after Percutaneous Coronary Intervention," *American Journal of Cardiology* 107 (2011): 675–80; D. J. LaPar et al., "Primary Payer Status Affects Mortality for Major Surgical Operations," *Annals of Surgery* 252 (2010): 544–51; J. Kwok et al., "The Impact of Health Insurance Status on the Survival of Patients with Head and Neck Cancer," *Cancer* 116 (2010): 476–85; R. R. Kelz et al., "Morbidity and Mortality of Colorectal Carcinoma Differs by Insurance Status," *Cancer* 101 (2004): 2187–94; J. G. Allen et al., "Insurance Status Is an Independent Predictor of Long-Term Survival after Lung Transplantation in the United States," *Journal of Heart and Lung Transplantation* 30 (2011): 45–53

[29] Kaiser Family Foundation, State Health Facts. "Total Medicaid Spending" https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

California, Medicaid spending growth has more than doubled since ACA passage, so that a full 38 percent of California taxes are used to fund Medi-Cal[30].

The ACA also had a harmful impact on private health insurance. Following the implementation of its new regulations, mandates, and taxes, Americans saw dramatic increases in private insurance premiums and a disappearance of insurance options across the country. In its first four years, ACA insurance premiums for individuals doubled and for families increased by 140%; this occurred even though insurance deductibles for individuals increased by over 30% for individuals and by over 97% for families[31]. As time passed, insurance options and prices on ACA Exchanges continued to worsen, according to the HHS[32]. For 2018, only one Exchange insurer offered coverage in approximately one-half of US counties. Many Exchange enrollees continued to face large year-on-year premium increases in 2018, according to Kaiser Foundation analysis[33], even in the face of markedly higher deductibles. And the spectrum of doctors and specialists accepting that insurance continues to sharply narrow, with far fewer hospitals, primary care doctors, and specialists[34] than outside ACA Exchanges; now, almost 75 percent of plans are highly restrictive[35].

The ACA regulatory environment has also encouraged a record pace[36] of consolidation across the health care sector, including mergers of doctor practices and hospitals to create quasi-monopolies. . In the five years leading up to the ACA passage, hospital mergers averaged about 56 per year; over the five years since ACA implementation, that number nearly doubled, with 2015's pace the highest in 15 years. This is bad for patients, because research has generally shown that prices are lower when there are more competing hospitals for insurers to contract with[37]. The last period of hospital mergers increased medical care prices substantially, at times over 20 percent[38], according to a Robert Wood Johnson Foundation report. Robinson and Miller reported that when hospitals owned doctor groups, per patient expenditures were 10-20% higher, or an extra $1,200-$1,700 per patient per year[39]. Capps found that physician prices increased on average by 14% for medical groups acquired by hospitals; specialist prices

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[30] See https://www.healthinsurance.org/california-medicaid

[31] eHealth press release, January 3, 2017; https://news.ehealthinsurance.com/news/average-individual-health-insurance-premiums-increased-99-since-2013-the-year-before-obamacare-family-premiums-increased-140-according-to-ehealth-com-shopping-data

[32] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-10-20-Issuer-County-Map.pdf

[33] A Semanskee, G Claxton, and L Levitt, How Premiums Are Changing In 2018, Updated: Nov 29, 2017, Kaiser Family Foundation; https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/

[34] C Sloan, E Carpenter, Exchange Plans Include 34 Percent Fewer Providers than the Average for Commercial Plans, Jul 15, 2015; http://avalere.com/expertise/managed-care/insights/exchange-plans-include-34-percent-fewer-providers-than-the-average-for-comm

[35] CF Pearson , E Carpenter, Plans with More Restrictive Networks Comprise 73% of Exchange Market, Nov 30, 2017; http://avalere.com/expertise/managed-care/insights/plans-with-more-restrictive-networks-comprise-73-of-exchange-market

[36] L Dafny. Hospital Industry Consolidation — Still More to Come? N Engl J Med 2014; 370:198-199; DOI: 10.1056/NEJMp1313948

[37] Gaynor M, Mostashari F, Ginsburg PB. Making Health Care Markets Work: Competition Policy for Health Care, JAMA 2017;317:3131

[38] Gaynor M, Town R. The Impact of Hospital Consolidation; Robert Wood Johnson Foundation Publication: The Synthesis Project, June 1, 2012; https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html

[39] Robinson JC, Miller K. Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California. JAMA. 2014;312(16):1663–1669. doi:10.1001/jama.2014.14072

increased by 34% after joining a health system[40]. In the wake of the ACA, overall health care expenditures continued to increase while choices narrowed - for individuals, for employers, as well as for taxpayer-funded government programs.

Single-Payer and Medicare-for-All: The Facts

The notion that single-payer health care represents a goal for health system reform is mainly driven by the intuitive attractiveness of a simple concept: the government explicitly "guarantees" medical care. Indeed, many nations claim to "guarantee" health care; many further insist that such health care is provided "free of charge". For instance, the USSR Constitution, the Constitution of Venezuela, and many other failed nations with substandard health care under strictly regulated nationalized medical services have had explicit "guarantees" for "free" health care. Today, England's NHS Constitution explicitly states "You have the right to receive NHS services free of charge" … despite taxing citizens about £125 billion per year, roughly equivalent to $160 billion dollars per year. Canada's "free" health care costs the average family about $13,311 per year for government health insurance; families among the top 10% of income earners in Canada will pay $39,486[41]. Note that Canada's "free" health care actually costs billions of dollars in 2019 to individuals in foregone wages and to the overall economy[42].

Costs and funding of single-payer health care are often cited as the main objection to its implementation. And there is no question that a nationalized, single-payer system would require massive new taxes on working Americans to fund it. California's State Senate Appropriations Committee 2017 analysis estimated that the single-payer health care proposed for California alone, SB 562, The Healthy California Act, would cost about $400 billion per year, more than double the state's entire annual budget. The current Senate bill to establish single-payer health insurance in the US by Senator Bernie Sanders, "Medicare for All Act, or M4A", has been estimated to cost over $32 trillion in its first decade. Doubling all currently projected federal individual and corporate income tax collections would be insufficient to finance the added federal costs of the plan[43].

On the other hand, nationalized single-payer systems spend less on health care than the US. But disregarded by those advocating single-payer care is the fact that governments regulate costs in single-payer systems by overtly restricting its use. Single-payer systems universally hold down health care costs by limiting availability of doctors, treatments, medications, and technology, through its power over patients and doctors as the only direct payer.

The opposition to single-payer care should not focus only on the requirement for massive new taxes, but instead on the well-documented half-century of its failure to provide timely, quality medical care. Single-payer systems in countries with decades of experience have proven to be inferior to the US system in virtually every important objective measure of access to care and quality.

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[40] Capps C, Dranove D, Ody C. The effect of hospital acquisitions of physician practices on prices and spending. Institute for Policy Research, Northwestern University, Working Paper Series WP-15-02, February 2015.

[41] The Price of Public Health Care Insurance, 2019. M Palacios and B Barua, *Fraser Research Bulletin*, Fraser Institute, August 2019

[42] Barua B, Hasan S. The Private Cost of Public Queues for Medically Necessary Care, 2018. Fraser Institute. https://www.fraserinstitute.org/studies/private-cost-of-public-queues-for-medically-necessary-care-2018

[43] The Costs of a National Single-Payer Healthcare System. C Blahous, Mercatus Center, George Mason University, Government Spending Working Papers, July 30, 2018

Delays in Diagnosis and Treatment:

The truth is that single-payer systems, including in the UK, Canada, Sweden, and other European and Nordic countries, impose shockingly long waiting times for doctor appointments, diagnostic procedures, drugs and surgery that are virtually never found in the US, specifically as a means of rationing care[44]. And that failure to deliver timely medical care has serious consequences, including pain, suffering, and death; worse medical outcomes; permanent disability; lack of patient choices about their own health care; and tremendous costs. Indeed, the Supreme Court of Canada in the 2005 Chaoulli v Quebec decision was famously quoted to state "access to a waiting list is not access to health care", as it noted that patients in Canada die as a result of waiting lists for their single-payer health care.

The consistent failures of single-payer health care to deliver timely care are well documented and include the following:

- ***In those countries with the longest experience of single-payer health care, published data demonstrates massive waiting lists and delays that are unheard of in the United States.*** In England alone, according to government statistics, a record-setting 4.2 million patients are on NHS waiting lists as of 2018; 95,252 have been waiting more than six months for treatment; and more than 3,400 patients are waiting more than one full year as of July, 2018 … all *after* already receiving initial diagnosis and referral. As of late 2016, the NHS average waiting time exceeded 100 days for hip or knee replacements, hernia repair, and tonsillectomies. In Canada's single-payer system, the 2017 median wait[45] from GP appointment to the specialist appointment was 10.2 weeks; when added to the median wait of 10.9 weeks from specialist to first treatment, the median wait after seeing a doctor to start treatment was 21 weeks, or about 5 months. An average wait for a Canadian cardiology patient was 6.4 weeks for the cardiologist appointment after seeing the GP, and another 5.3 weeks to start treatment; that means 11.7 weeks after GP appointment to first treatment. The average Canadian woman waits 13.2 weeks after seeing the GP to see the gynecologist and another 9.3 weeks to first treatment, or 22.5 weeks total from GP visit to treatment. For simply the appointment with the qualified specialist after already waiting and seeing the GP, a Canadian waits another 13.4 weeks (3 months) for an ophthalmologist; a Canadian waits another 22.1 weeks (5 months) to see a neurosurgeon; and a Canadian will endure their bone and joint pain for 17.9 weeks (4 months) while waiting to see an orthopedist for further evaluation before another 23.8 weeks to treatment (*Figure 6 below*).

[44] for a detailed review of the literature, "Evaluating Access to America's Medical Care", pp 159-209, in: *In Excellent Health*, SW Atlas, Hoover Press, 2011

[45] Barua B, Fraser Institute. Waiting Your Turn: Wait times for health care in Canada, 2017 report; https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2017

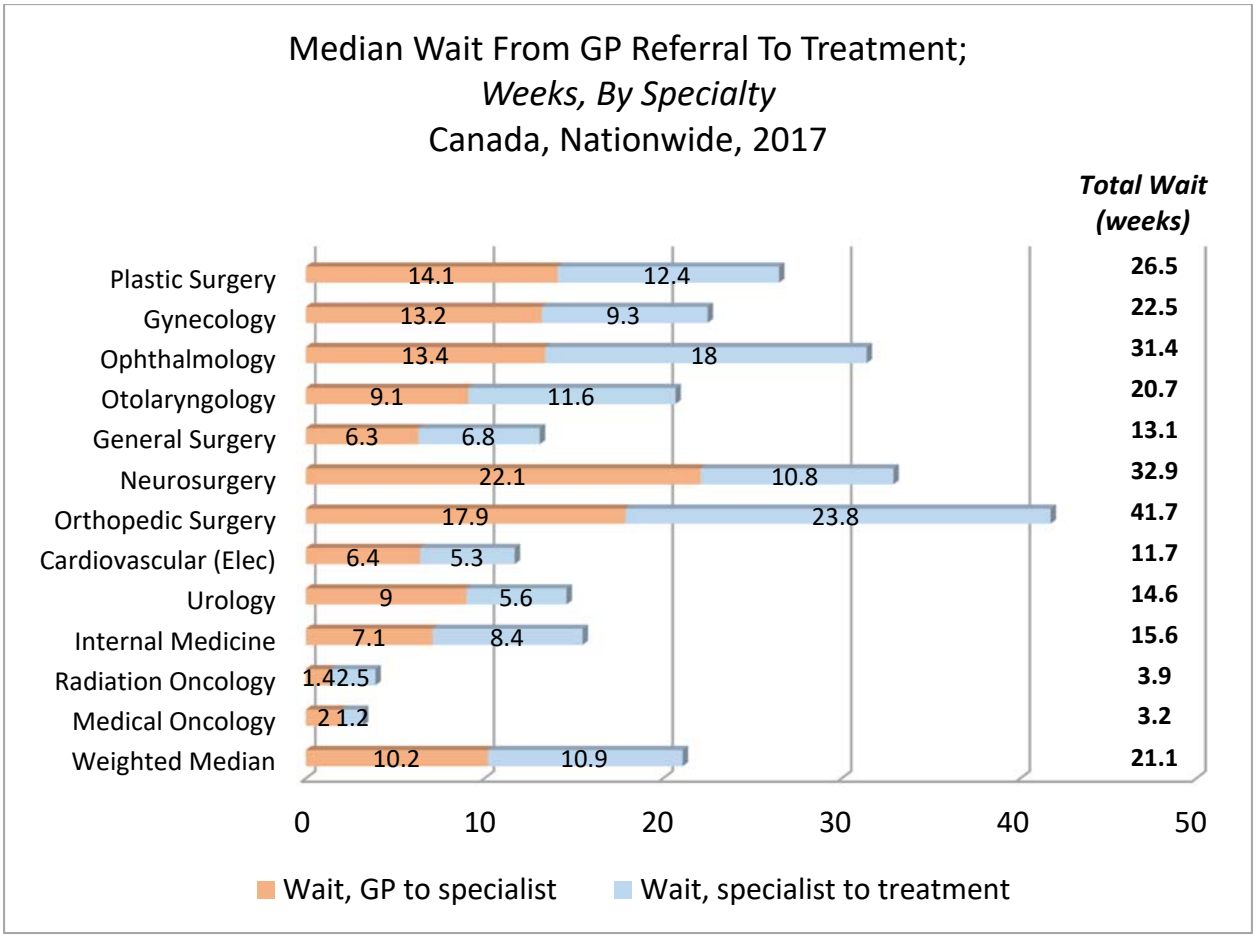

FIGURE 6. Adapted from: The Fraser Institute, National Waiting List Survey, 2017

These long waits are common for single-payer systems, but they stand in stark contrast to US health care. Aside from organ transplants, "waiting lists are not a feature in the United States," as stated by the OECD and verified by numerous studies[46]. For instance, Ayanian and Quinn noted that "in contrast to England, most United States patients face little or no wait for elective cardiac care"[47]. Low-risk patients "sometimes have to wait all day or even be rescheduled for another day", according to the Agency for Healthcare Research and Quality's "Technology Assessment: Cardiac Catheterization in Freestanding Clinics" – that is, a wait for even one single day is considered notable. Ironically, US media outrage was widespread and cited as a wake-up call for whole-system reform when 2009 data[48] showed that time-to-appointment for Americans averaged 20.5 *days* for five common specialties (note that after the implementation of the ACA, wait times in 2017

[46] Confronting Competing Demands To Improve Quality: A Five-Country Hospital Survey Amid common concerns about quality, hospital leaders endorse investing in information technology. RJ Blendon et al, Health Affairs 2004;23:119; DOI 10.1377/hlthaff.23.3.119

[47] Quality Of Care For Coronary Heart Disease In Two Countries. JZ Ayanian and TJ Quinn, Health Affairs 2001;20:55

[48] Merritt-Hawkins 2009 Survey of Physician Appointment Wait Times

increased by 30% since 2014[49]. That selective reporting failed to note that those US waits were for healthy check-ups in almost all cases, by definition the lowest medical priority. *Even for low priority check-ups and purely elective, routine appointments, US wait times are far shorter than for seriously ill patients in countries with single-payer health care.*

- ***In single-payer systems, patients are dying or left unable to perform important daily living tasks while waiting months, even after their doctors recommended urgent treatment.*** Long waiting lists for care of Canadian women between 1993 and 2009 resulted in between 25,456 and 63,090 additional deaths[50], underscoring the point of Canada's Supreme Court statement in 2005. In the UK's NHS, this would include those referred for "urgent treatment" for cancer, more than 19 percent of whom currently wait more than *two months* for their first urgent treatment in single-payer NHS England (NHS wait time statistics in Q1 2019) – a number that is increasing despite government efforts, and a number that exceeds even its own arbitrarily set "standard" that declared it would be acceptable for 15 percent of cancer patients to wait two full months for first treatment (*Figure 7*).

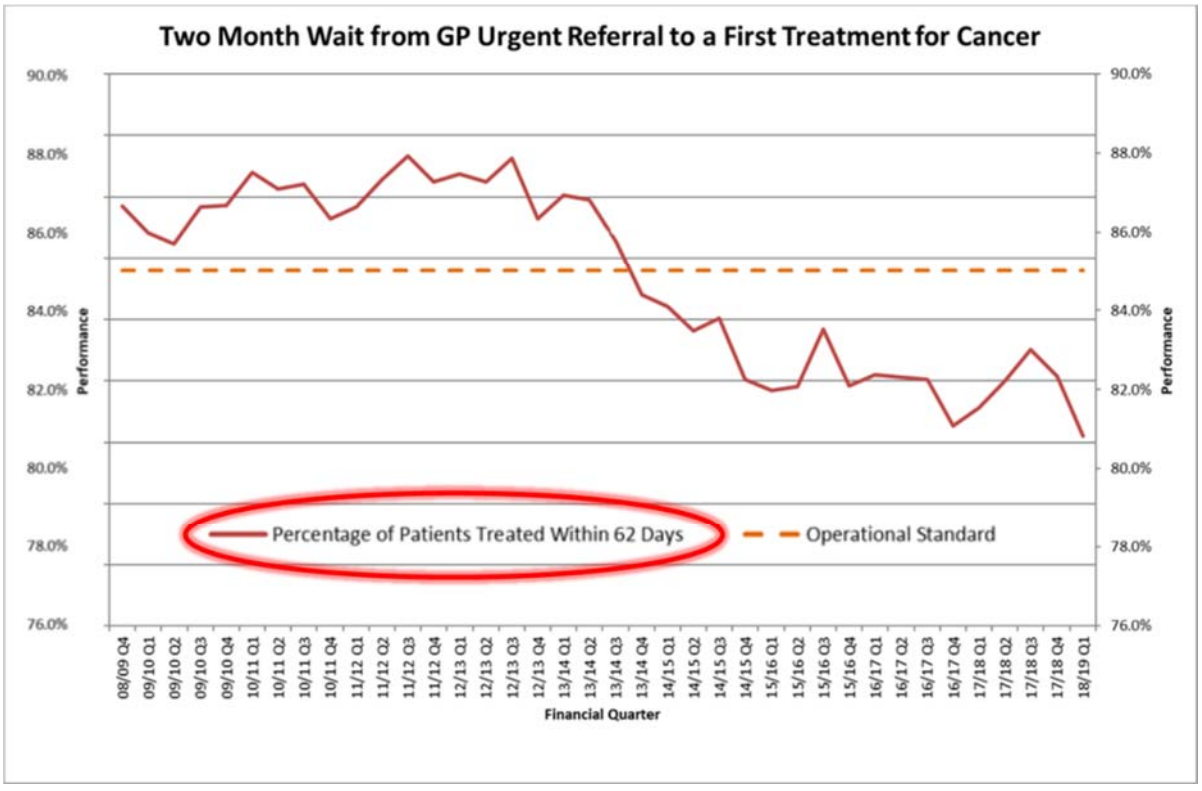

FIGURE 7. NHS statistics on patient waits for treatment after GP referral for "urgent referral for cancer"; past decade through Q1 2019

[49] Merritt-Hawkins 2017 Survey of Physician Appointment Wait Times
[50] B Barua, N Esmail, and T Jackson (2014). *The Effect of Wait Times on Mortality in Canada*. Fraser Institute

Similarly, 17 percent of brain surgery patients in England wait more than *four months after diagnosis*. In Canada's single-payer system, the most recent data revealed a median wait for neurosurgery after already seeing the doctor of 32.9 weeks – about 8 months. For their vision-restoring surgery, Canadians with cataracts waited a median time of 20.2 weeks. And in Canada, if you needed orthopedic surgery for severe pain and limited mobility, like hip or knee replacement, you would wait a startling 27.5 weeks.

- ***Single-payer systems delay the access to the newest drugs for cancer and serious diseases, sometimes for years, while Americans consistently enjoy the world's earliest access to them.*** The US has been by far the most frequent country where new cancer drugs were first launched - by a factor of at least four - compared to any country studied in the previous decade[51], including Germany, Japan, Switzerland, France, Canada, Italy, or the UK, according to the *Annals of Oncology*. In a 2011 *Health Affairs* study[52], the US Food and Drug Administration (FDA) had approved 32 of 35 new cancer drugs submitted from 2000-2011, while the European Medicines Agency (EMA) approved only 26. Median time to approval in the US was about half that in Europe. All 23 drugs approved by both were available to US patients first. Two-thirds of the novel drugs approved in 2015 (29 of 45, 64%) were approved in the US before any other country[53]. Compared to American women who had access to 26 new hormonal contraceptive drugs over a 15-year period, women in single-payer Canada and in the UK had far less choices[54], (62% and 54% respectively), as reported in the Canadian medical literature in 2016.

Of all new, approved cancer drugs from 2009 to 2014, single-payer systems of the UK, Australia, France, and Canada had only approved 30 to 60% of those already approved in the US[55] by June 30, 2014. The latest data[56] shows that of the world's 54 new cancer drugs launched from 2013-2017 and available within two years (*Figure 8*), 51 (94%) were available within two years in the US. For Brits with cancer, only 38/54 (70%) were available; for Canada's cancer patients, only 29/54 (53%) were available; cancer patients in France had access to only 23/54 (43%); and Australian cancer patients had access to 15/54 (28%).

And yet, in 2017, single-payer NHS England introduced a new "Budget Impact Test"[57] to cap drug prices specifically based on expenditures rather than medical efficacy. This will further restrict drug access, even though cancer patients could be forced to wait years for life-saving drugs, some dying as they wait for drugs already available in the US. As just one important projection under that single-payer NHS rule, a dementia drug for Alzheimer's Disease would have to cost only £29.60/year, less

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[51] Jönsson B, Wilking N. Market uptake of new oncology drugs, Annals of Oncology 2007;18, suppl 3:iii31–iii48

[52] Roberts SA, Allen JD, Sigal EV. Despite Criticism of The FDA Review Process, New Cancer Drugs Reach Patients Sooner in The United States Than in Europe. Health Affairs 2011;30; https://doi.org/10.1377/hlthaff.2011.0231

[53] US FDA Center of Drug Evaluation and Research, Novel Drugs 2015 Summary, January 2016

[54] Regulatory approval time for hormonal contraception in Canada, the United States and the United Kingdom, 2000–2015: a retrospective data analysis. C Troskie et al, CMAJ Open 2016.

[55] Zhang Y, Hueser H, Hernandez I. Comparing the Approval and Coverage Decisions of New Oncology Drugs in the United States and Other Selected Countries"; J Manag Care Spec Pharm 2017;23(2):247-54

[56] *Global Oncology Trends 2019: Therapeutics, Clinical Development and Health System Implications*; IQVIA Institute, 2019; data via *Statista* https://www.statista.com/statistics/696020/availability-of-new-oncology-drugs-by-country/

[57] National Institute for Health and Care Excellence (NICE), NHS England, Changes to NICE drug appraisals: what you need to know, April 4, 2017; https://www.nice.org.uk/news/feature/changes-to-nice-drug-appraisals-what-you-need-to-know

than US$4 per month, or it would be unavailable to patients (as calculated by the Alzheimer's Society), ironically restricted by cost because so many patients need it.

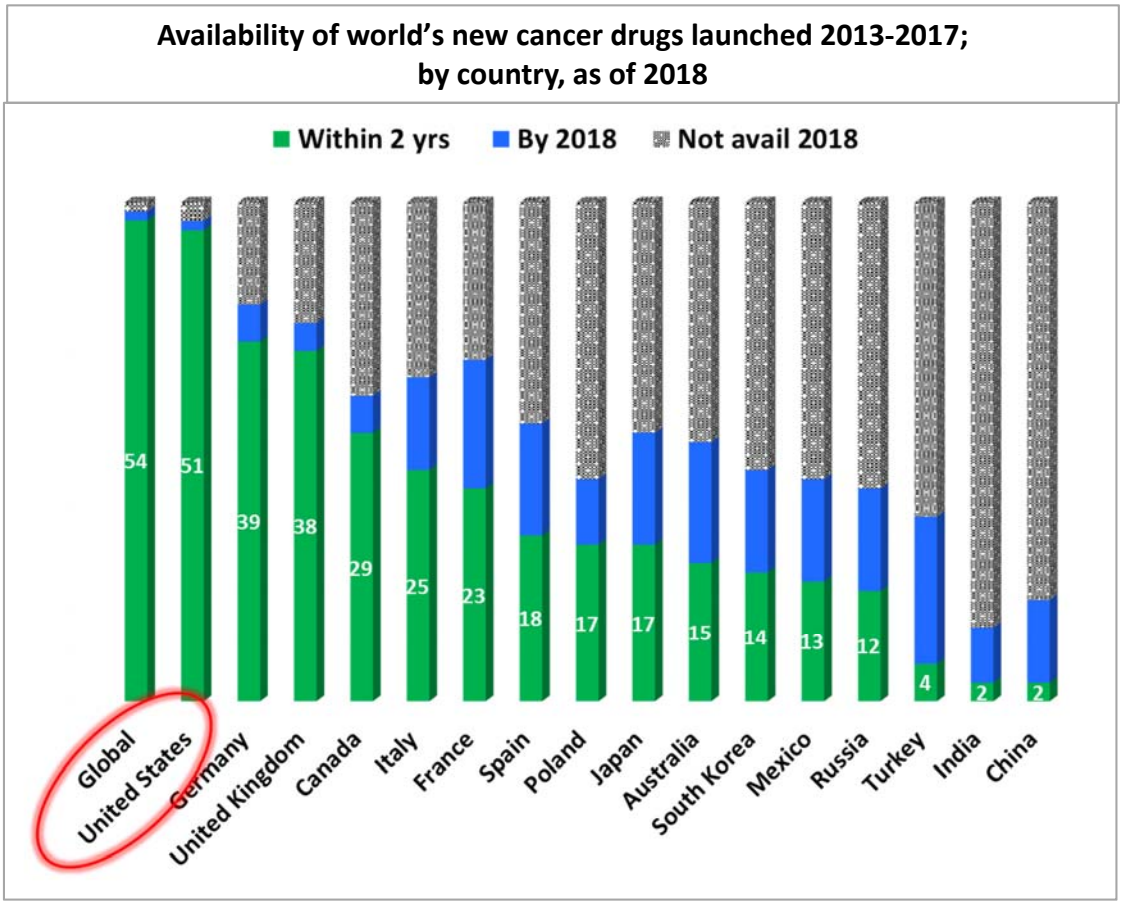


FIGURE 8. Availability of world's new cancer drugs by country, within two years after 2013-2017 launch (as of 12/18).

- ***Delays in Access to Screening Tests for Cancer:***

Single-payer systems cannot even outperform the US system in something as scheduled and routine as cancer screening tests. Confirming numerous prior OECD studies, Howard reported in 2009, before ACA requirements, that the US had superior screening rates[58] to all 10 European countries with nationalized systems (Austria, Denmark, France, Germany, Greece, Italy, the Netherlands, Spain, Sweden, and Switzerland) for all cancers. Likewise, the single payer system of Canada[59] fails to deliver screening tests for the most common cancers as widely as in the US system, including PAP smears, colonoscopy, and PSA tests. And Americans are more likely to be screened younger for cancer than in Europe, when the expected benefit is greatest. Not surprisingly, US patients have less advanced disease at diagnosis than in Europe for almost all cancers.

[58] Howard DH, Richardson DH, Thorpe KE. Cancer Screening And Age In The United States And Europe, *Health Affairs* 2009;28. https://doi.org/10.1377/hlthaff.28.6.1838

[59] O'Neill JE, O'Neill DM. Health Status, Health Care and Inequality: Canada vs. the US. *Frontiers in Health Policy Research* 2007;10, Cutler, Garber, and Goldman

- ***Outcomes From Serious Diseases:***

Long waits in single-payer systems for diagnosis, treatments, drugs, and technology have major consequences to patients. The ultimate consequence is documented throughout the peer-reviewed medical journals using data, not anecdotes – worse health outcomes than the US system from nearly all of the most serious diseases - the illnesses that cause the most deaths and the most important chronic diseases that lead to the most disability and death[60]. Those results include superior survival from cancer[61]; better outcomes from heart disease[62], and stroke[63]; and more successful treatment of the most important chronic diseases, including hypertension[64] and diabetes[65] than in those countries with centralized health systems heavily controlled by governments.

The inescapable conclusion on the basis of the evidence in the peer-reviewed medical literature is that both quality of medical care and the access to it have been superior in the United States as compared with those nationalized systems heralded as models for change by single-payer supporters (*Figures 9-11*). *Why should Americans voluntarily move toward a system proven worse than current US health care?*

[60] for a detailed review of the literature, "Measuring Medical Care Quality in the United States, pp 97-157, in: *In Excellent Health*, SW Atlas, Hoover Press, 2011

[61] A. Verdecchia et al., Recent Cancer Survival in Europe: A 2000-02 Period Analysis of EUROCARE-4 Data, Lancet Oncology 2007;8:784-96; Concord Working Group, Cancer Survival in Five Continent: A Worldwide Population-Based Study, *Lancet Oncology* 2008;9:730-56

[62] Long-term mortality of patients with acute myocardial infarction in the United States and Canada: comparison of patients enrolled in Global Utilization of Streptokinase and t-PA for Occluded Coronary Arteries (GUSTO)-I. Kaul P et al, *Circulation* 2004;110:1754-60

[63] See, for example, F. Levi et al., "Trends in Mortality from Cardiovascular and Cerebrovascular Diseases in Europe and Other Areas of the World, *Heart* 88 (2002): 119–24; P. Kaul et al., Long-Term Mortality of Patients with Acute Myocardial Infarction in the United States and Canada, *Circulation* 110 (2004): 1754–60; Melissa L. Martinson et al., "Health across the Life Span in the United States and England," *American Journal of Epidemiology*, March 9, 2011, doi: 10.1093/aje/kwq325; J. Z. Ayanian and T. J. Quinn, "Quality of Care for Coronary Heart Disease in Two Countries," *Health Affairs* 20 (2001): 55–67; H. C. Wijeysundera et al., "Association of Temporal Trends in Risk Factors and Treatment Uptake with Coronary Heart Disease Mortality, 1994–2005," *Journal of the American Medical Association* 303 (2010): 1841–47; Thorpe et al., "Differences in Disease Prevalence."

[64] Outpatient hypertension treatment, treatment intensification, and control in Western Europe and the United States. Wang YR, Alexander GC, Stafford RS *Arch Intern Med* 2007;167:141-7

[65] See, for example, Wolf-Maier et al., "Hypertension Treatment and Control"; Y. R. Wang et al., "Outpatient Hypertension Treatment, Treatment Intensification, and Control in Western Europe and the United States," *Archives of Internal Medicine* 167 (2007): 141–47; E. Gakidou et al., "Management of Diabetes and Associated Cardiovascular Risk Factors in Seven Countries: A Comparison of Data from National Health Examination Surveys," *Bulletin of the World Health Organization* 89 (2011): 172–83.

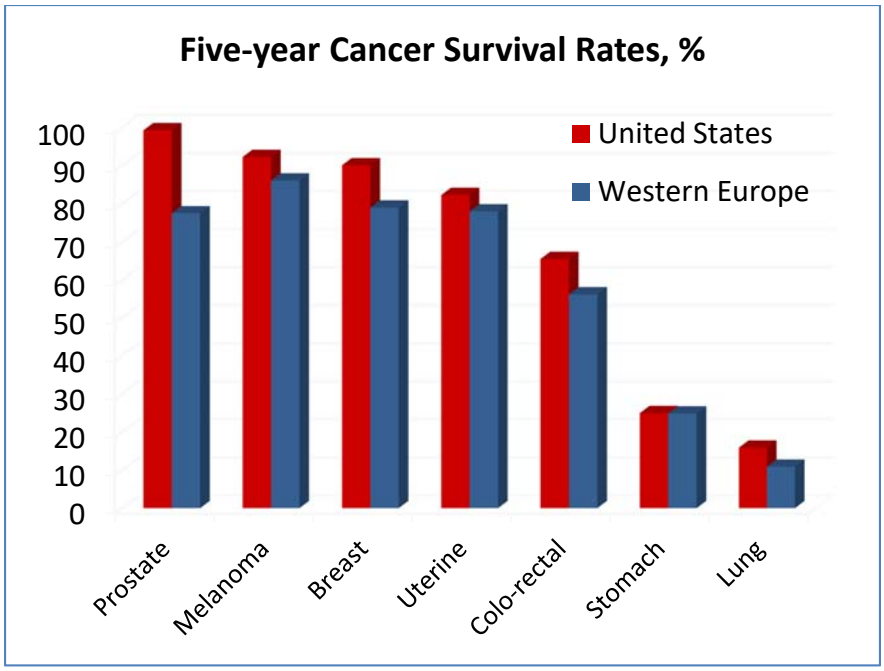


FIGURE 9. Comparison of 5-year survival rate, US versus Western Europe, 2000-2002, seven common cancers (from Verdecchio, 2007). The US has superior survival from all common cancers compared to Western European nations.

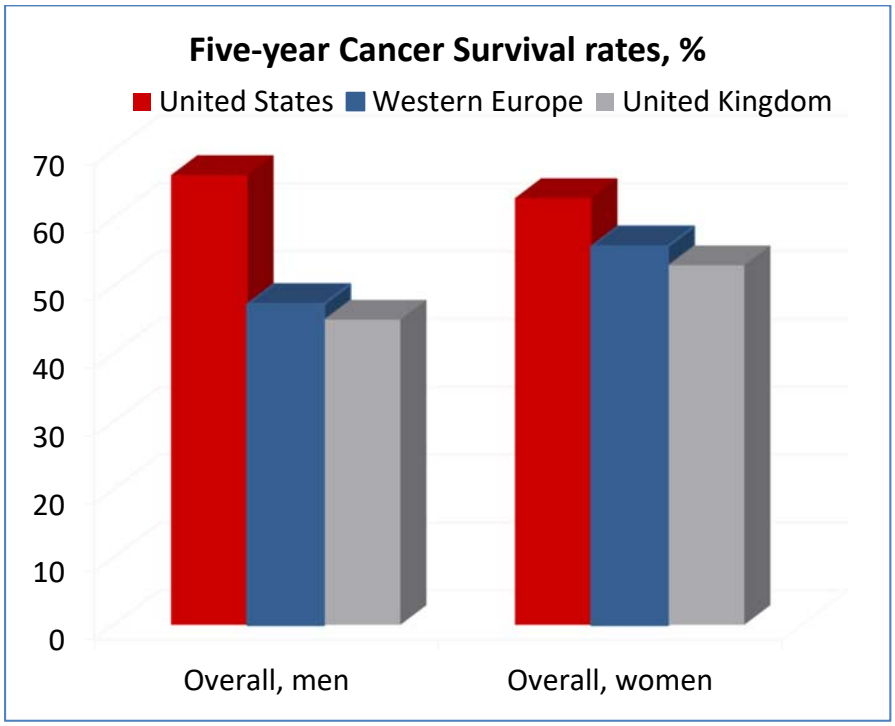
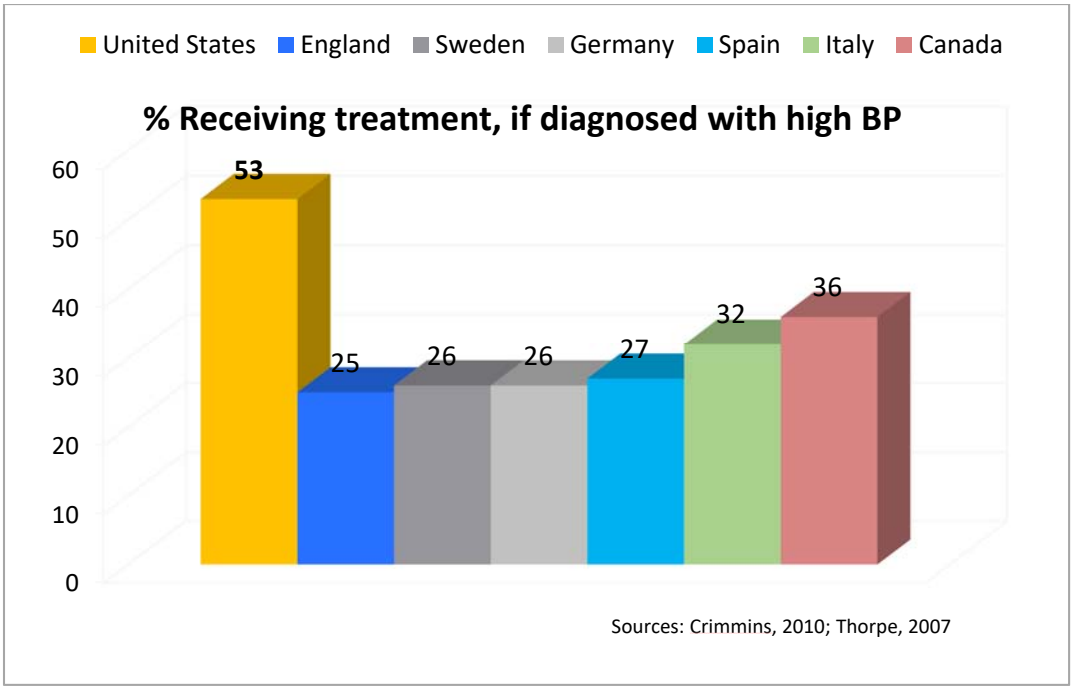


FIGURE 10. Comparison of 5-year survival rates for men and women, US versus western European nations. Note a statistically significant increased survival for American men and women (data source: Verdecchio, 2007) compared to the average western European and even more advantage over the UK.

Source: A. Verdecchia et al., ™Recent Cancer Survival in Europe: A 2000-02 Period Analysis of EUROCARE-4 Data, *Lancet Oncology* 8 (2007): 784-96.



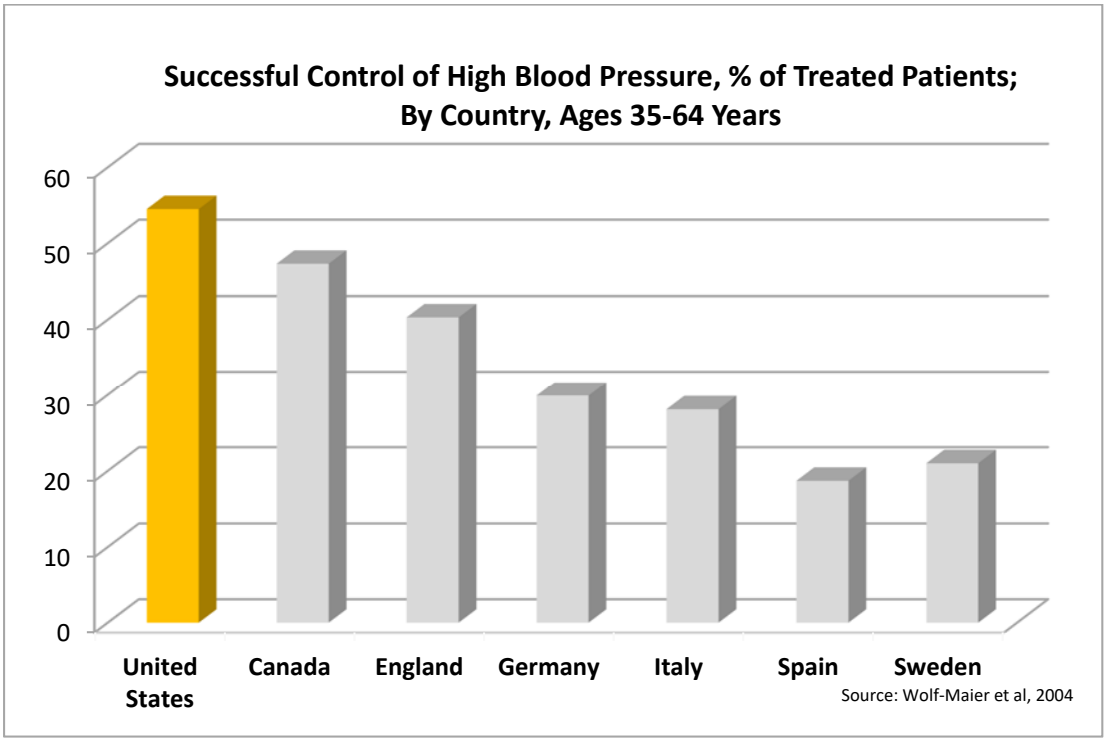


FIGURE 11. Access to Treatment (Top) and Successful Control[66] of High Blood Pressure (Bottom), Percentage of Treated Patients by Country, Ages Thirty-Five to Sixty-Four Years. The United States has more effective medical care for high blood pressure compared to other developed countries, including those held as models for single-payer care.

[66] Wolf-Maier et al, Hypertension Treatment and Control in Five European Countries, Canada, and the United States. *Hypertension* 2004;43:10-17

What Should We Learn From Countries With Longstanding Single-Payer Systems?

Americans should also ask why the US would move toward single-payer care, when countries all over the world with decades of single-payer experience now turn toward private health care to solve their failures. Even though England's NHS is projected to hit a £30B funding shortfall in 2020-2021, one of the very few areas where funding is increasing is to non-NHS providers. In one year alone, £901 million targeted for medical services by the UK government (half of the total increase) was used to buy care from private and other non-NHS providers, as reported by the Financial Times in March, 2017[67]. In 2016, the UK government spent more than half of its total budgetary increase from taxpayers on private and other non-NHS providers. Even Sweden, often heralded as the paradigm of a successful welfare state, has failed its citizens in healthcare access. To fix their system, Swedish municipal governments have increased spending on private care contracts by 50% in the past decade. Primary care clinics and nursing facilities are now run by the private sector or receive substantial public funding. Private sector competition has also been introduced into Sweden's pharmacies to tear down the previous government monopoly over all prescription and non-prescription drugs. Since 2007, Denmark's patients using taxpayer-funded single-payer health care could choose a private hospital in or outside the country if the waiting time for the treatment exceeded one month[68]. *Governments of Finland, Ireland, Italy, the UK, the Netherlands, Norway, Spain, Sweden, and Denmark, all with single-payer care, now spend taxpayer money on private care, sometimes even outside their own country, to solve their unconscionable failures to deliver adequate care.*

What Should We Learn From The Actions of Citizens In Countries With Single-Payer Systems?

Americans should wonder why those with financial means would need to spend even more money than their already high taxes for something that is "guaranteed and free". Who wouldn't want "guaranteed, free health care"? The answer is found in existing single-payer systems all over the world, in countries with decades of experience, who offer those same "guarantees". People with the financial means increasingly choose to circumvent single-payer systems for private health care. Even though they already pay £125 billion per year, equivalent to $160 billion dollars, for their single-payer NHS, half of all Brits who earn more than £50,000 buy or plan to buy private health insurance, according to *Statista 2017*. In Sweden, about 650,000 who can afford it buy private insurance despite already paying $20,000 per family per year through taxes for their nationalized system, according to Insurance in Sweden 2015. And over 250,000 Brits spend out-of-pocket cash for private care, despite paying over US$4,200 per person per year in taxes for their NHS. According to the European insurance and reinsurance federation (CEA), private insurance in the EU bought by those who can afford it grew by more than 50% over a decade to 2010, specifically to fill the "ever growing gaps in coverage" in public health systems. *Here is the reality - only the poor and the middle class are stuck with nationalized, single-payer health care, because only they cannot afford to circumvent that system*.

[67] S. Neville. "NHS funds diverted to private sector"; Financial Times, March 26, 2017

[68] Socha, Karolina and Mickael Bech. "Extended free choice of hospital - waiting time"; *Health Policy Monitor*, October 2007. Available at http://www.hpm.org/survey/dk/a10/1

Medicare-For-All: Creating Our Own Single-Payer Program?

Those who advocate a conversion to "Medicare-For-All" fail to acknowledge the widely published historical evidence in the world's top medical journals on existing single-payer systems in countries with decades of experience. Single-payer systems all over the world have proven to be inferior to the current US system in virtually every important objective measure of care, including less access to care and inferior quality of care, resulting in worse outcomes from virtually all serious diseases. And that should not be a surprise. Single-payer systems hold down health care costs by limiting availability of doctors, treatments, medications, and technology. And they are able to do so with their dominant power over patients, most of whom do not have the financial means to circumvent the system.

Our own government's Medicaid and Medicare programs employ similar methods to hold down costs. Data on payments to health care providers shows a significant underpayment from both Medicare and Medicaid for health care services (*Figure 12*). That underpayment – payment for services *below the cost* of administering those services - has increased significantly since the implementation of the ACA. This underpayment has consequences beyond shifting costs to those with private insurance.

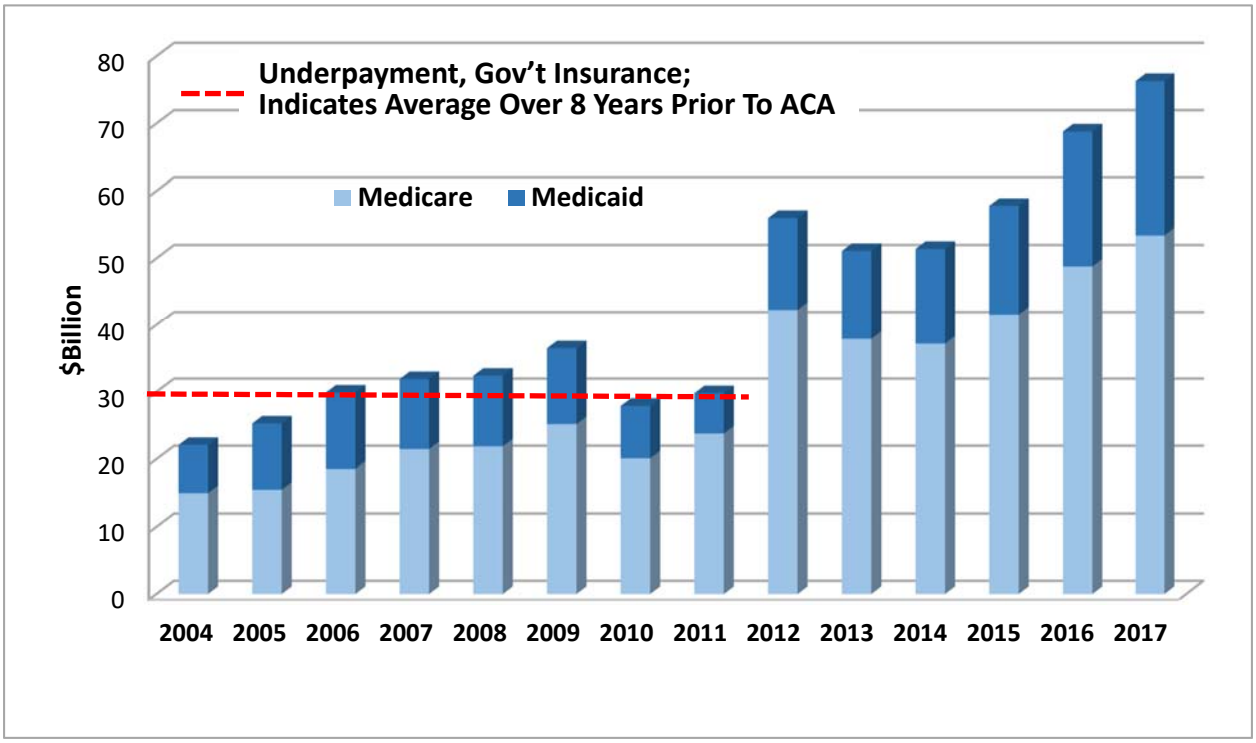


FIGURE 12. Underpayment to hospitals for delivered care, Medicare and Medicaid, 2004-2017.

Studies throughout the medical literature demonstrate that outcomes under Medicaid, where most patients are limited to purely government insurance with its restrictive coverage, are worse than those for medically similar patients under private coverage (*Figure 13*).

Medical Disorder	***Comparisons to Private Insurance (or No Insurance)***
Major surgery	Need longer hospital care (42% longer), incur more hospital costs (26% more), and almost two times more likely to die in the hospital than those with private insurance; 13% more likely to die, stayed in the hospital 50% longer, and care cost 20% more than those with NO insurance (*Ann Surgery* 2010; 893,658 major surgeries)
Cancer of the mouth and throat	50% more likely to die than patients with private health insurance (*Cancer* 2010; 1,231 patients)
Colon cancer	57% more likely to die postoperatively compared with patients with private insurance, a death rate not significantly different from the uninsured (*Cancer* 2004; 13,415 adults)
Heart procedures	More likely to have strokes and heart attacks and die than patients with private insurance and suffered the same outcome as those who lacked insurance altogether— more than twice the risk of death, heart attack or other serious cardiac event within one year of cardiac surgery compared to privately- insured patients (*Am J Cardiology* 2011; 13,573 patients)
Lung transplants	Die sooner than patients with private insurance undergoing lung transplants for end- stage pulmonary diseases; 8.1% less likely to survive ten years after surgery than privately-insured and uninsured patients (*J Heart Lung Transpl* 2011; 11,385 patients)

FIGURE 13. Even after standardizing for medical differences among patients, Medicaid patients fare worse than those under private insurance, sometimes even worse than no insurance at all (references cited within table).

Continued access to care is already at risk under today's Medicare due to below-cost payment for care. Even under the unlikely scenario of maintaining today's levels of payments for services (given the known future added costs from aging and risk factors of future beneficiaries), the Office of the Actuary of CMS in 2018 already warned of serious limitations of availability of care for Medicare beneficiaries. CMS calculated that most hospitals, skilled nursing facilities, and in-home health care providers already lose money per patient. Specifically, ~80% of hospitals will lose money treating Medicare patients by 2019; "by 2040, approximately half of hospitals, two-thirds of skilled nursing facilities, and over 80% of home health agencies would have negative total facility margins, raising the possibility of access and quality-of-care issues for Medicare beneficiaries; and absent a change in the delivery system or level of update (of reimbursements) by subsequent legislation, we expect access to Medicare-participating physicians to become a significant issue in the long term under current law". Asserting that the access and quality

Americans enjoy today, with their private insurance or private coverage supplements to Medicare, would be maintained if everyone used Medicare and private insurance were abolished, is fantasy, at best. *Ironically, Medicare is already unsustainable, even without expanding it.*

We also know that our own single-payer systems, even in their current limited form, are already fraught with problems, including errors, fraud, and waste. Our own VA single-payer system needed to turn to private care to solve its inadequacies, through the extended and broadened Veterans Choice Program in 2017. Medicare throws away $60 billion of taxpayer's money per year, by Government Accountability Office estimates[69]. The Office of the Inspector General reported[70] in 2018 that "California made Medicaid payments of $738.2 million ($628.8 million Federal share) on behalf of 366,078 ineligible beneficiaries and $416.5 million ($402.4 million Federal share) on behalf of 79,055 potentially ineligible beneficiaries."

And despite today's vilification of private insurers, Medicare ranks at or near the top for the highest rates of claim refusals—*more than nearly all comparison private insurers every year* on the AMA Insurer Report Card. The truth is that more than 70 percent of seniors choose to rely on private insurance to supplement or replace traditional Medicare coverage[71]. *Why would beneficiaries need do that if purely government insurance was already so satisfactory?*

The Public Option As A Pathway To Single-Payer

What's wrong with offering government insurance as an "option" without a requirement to switch? Government insurance expansions mainly erode, or "crowd out", private insurance, rather than provide coverage to the uninsured. MIT Professor and Obamacare advisor Jonathan Gruber showed that when government insurance expands, the number of privately insured falls by about 60% as much as the number of publicly insured rises[72].

Consider the experience in Hawaii. Only seven months after offering *Keiki Care* in 2008, the country's only state-wide universal child health insurance, the program was ended. In fact, over 80 percent of those taking up the program already had private insurance. And with that shift, massive new costs were shifted onto other taxpayers from those who were previously paying for their own private insurance.

Premiums for private insurance will further skyrocket because of underpayment by government insurance compared with costs of services. According to the American Hospital Association, the nearly $60 billion underpayment by Medicare and Medicaid surged to an all-time high, nearly doubling once Obamacare's regulations came into play. Even before the ACA, it was calculated[73] that a family of four with private insurance paid an extra $1,512 per year in private premiums, and an extra $1,788 per year

[69] GAO Highlights 15-448, MEDICARE PROGRAM: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers, June 2015
[70] Report No. A-09-16-02023, OIG, February 2018
[71] Kaiser Family Foundation and CMS Medicare data
[72] Gruber, J., and K. Simon. "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" *Journal of Health Economics* 27, 2 (2008): 201– 217
[73] W Fox and J Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," Milliman Client Report, December 2008

for all health expenses (insurance, co-pays, deductibles). This adds a significant burden on families paying private premiums, and expanding that will make private insurance even more expensive.

Why would people switch from private insurance to public insurance? Public insurance is typically cheaper, because public insurance restricts coverage for care, and public insurance pays less to providers – in fact, even below the costs of delivering the care – which results in even less access to medical care and even less choice of providers for patients. This is already proven worldwide.

The public option is not a moderate or compromise proposal – it is simply a slower, more insidious pathway to single-payer health care for nearly everyone. The death of affordable private insurance is the inevitable consequence of a single-payer option. Indeed, even those Democrat candidates calling for "a public option" openly admitted in the presidential debates that such an option will inevitably lead to single-payer for all. By introducing the public option, private insurance would disappear for all but the affluent, the only people who could afford that choice. And America's health care would become even more divided, as in the UK, Sweden, and elsewhere, where only the lower and middle classes suffer the full brunt of inferior single-payer care.

Conclusion

US health care demands reform. Health care costs are unsustainable and increasing, and that high cost already leaves some people, particularly the poor, isolated from the proven excellence of US medical care. Contrary to their false guarantees, government-centralized single-payer systems hold down health care costs mainly by strictly limiting the use of important medical care, drugs, and technology, through its power over patients and doctors as the payer. By the data in the medical literature, single-payer health care has been proven, worldwide, to be far inferior to the US system, with severe costs far beyond massive tax increases. And make no mistake about it - America's most vulnerable, the poor and the middle class, will undoubtedly suffer the most if the system turns to single-payer health care, because only they will be unable to circumvent that system.

We know there is an alternative approach[74], but it is not easily encapsulated into a marketing slogan. The critical concept is that *reducing the cost of medical care itself* is the most effective pathway to broader access to quality care, lower insurance premiums, and ultimately better health. Instead, most post-ACA ideas continue to stress making *insurance* more affordable, either through cash to consumers in refundable tax credits or other subsidies, or now by instituting government-run single-payer care. Insurance premiums are secondary, though, and historically chiefly reflect two factors: 1) the cost of medical care, accounting for about 80 percent of insurance premiums; and 2) the regulatory environment, accounting for most of the rest.

Rather than compelling Americans to accept an inferior government-run system that universally restricts access to important drugs, technology, and medical care to regulate costs, let's focus on creating conditions long proven to bring down prices while simultaneously improving quality in virtually every other good or service in America. History shows that the best way to control prices and improve quality for all goods and services is through competition for empowered, value-seeking consumers.

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[74] *Restoring Quality Health Care: A Six-Point Plan for Comprehensive Reform at Lower Cost*, by Scott W. Atlas, Hoover Institution Press, Stanford, 2016; https://www.hoover.org/research/restoring-quality-health-care

Positioning patients, including seniors, as direct payers while financially rewarding them to seek value with their money would stimulate competition among doctors and hospitals. Reducing the price of health care by competition, instead of more regulation, will lower insurance premiums, reduce outlays from government programs, and broaden access to quality care for everyone. Broadly available options for cheaper, high deductible coverage less burdened by regulations; markedly expanded health savings accounts; and tax reforms to unleash consumer power are keys to injecting price sensitivity for health care. Coupling those with strategic increases in the supply of medical care by breaking down anti-consumer barriers to competition and transparency of price and quality among doctors and hospitals would generate competition and reduce the price of health care. These reforms would permit all Americans, rich or poor, to access the same excellence of medical care that the affluent all use for their own health care, including the most strident advocates of single-payer care for the rest of us.