Life expectancy in the US and other G7 countries, 1960–2018

Source: J. Bor based on OECD 2020
Public Health's Falling Share of Total Health Spending

Note: Public health's share in Canada = 6.2%
Growing Gap in Life Expectancy by Income
Dramatic Gains for the Wealthy, Losses for Lower Income

Remaining life expectancy at age 50

Source: Growing Gap in Life Expectancy by Income, National Academy of Sciences, 2015
The Uninsured
Number Uninsured, 1976-June, 2020

Source: Himmelstein & Woolhandler - Tabulation from CPS, ACS & NHIS Data
Figure for 2020 is estimated based on increase in unemployment
38,531 Deaths During 2019 Due to Uninsurance

<table>
<thead>
<tr>
<th>State</th>
<th>% Uninsured</th>
<th>Excess Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>18.4</td>
<td>6,804</td>
</tr>
<tr>
<td>California</td>
<td>7.7</td>
<td>3,903</td>
</tr>
<tr>
<td>Florida</td>
<td>13.2</td>
<td>3,619</td>
</tr>
<tr>
<td>Georgia</td>
<td>13.4</td>
<td>1,817</td>
</tr>
<tr>
<td>North Carolina</td>
<td>13.4</td>
<td>1,504</td>
</tr>
<tr>
<td>New York</td>
<td>5.2</td>
<td>1,309</td>
</tr>
<tr>
<td>U.S.</td>
<td>9.2%</td>
<td>38,531</td>
</tr>
</tbody>
</table>

Based on best estimate from multiple studies of 1 death per 769 uninsured/year, and # uninsured at time of survey.
Medicaid: Poor Access, But Better Than Nothing
Many Specialists Won’t See Kids With Medicaid

Medicaid Helps
An RCT in Oregon

Source: NEJM May 2, 2013
Note: Catastrophic medical costs = out-of-pocket spending >30% of income
Depression = screened positive for depression using PHQ8
Under-Insurance On the Rise
Average Deductible Rising

Average Deductible for Covered Workers, Single Coverage ($\$s$)

Source: Kaiser/HRET Survey of Employer-Sponsored Benefits
Who Pays for Long Term Care?

- Medicaid: 42%
- Medicare: 18%
- Out of Pocket: 13%
- Other: 17%
- Private Ins.: 9%

Source: NCHS - National Health Expenditure Accounts - Data are for 2019
Note: Includes spending for NHs + Home care + "other residential and personal care"
Under-Insurance Impedes Care, Worsens Health
High Deductibles Cut All Kinds of Care

150,000 Employees Lost "Cadillac" Coverage
No Evidence that Patients Shifted to "Higher Value" Care

Percent utilization reduction

Preventive: -11.5%
Office Visit: -19.0%
Mental Health: -8.0%
ER: -27.0%
Inpatient: -15.0%
Drugs: -20.5%
Imaging: -22.0%

Note: Findings closely resemble those of Rand Health Insurance Experiment
Note: Study found no evidence that patients shopped for lower prices
Uninsured and Under-Insured Delay Seeking Care for Heart Attacks

Odds ratio for delayed care*

Source: JAMA April 15, 2010:303:1392
*Adjusted for age, sex, race, clin. characteristics, hlth status, social/psych factors, urban/rural
Under-insured = Had coverage but patient concerned about cost
Under-Insurance: A Leading Cause of Financial Distress and Ruin
2/3 of Bankruptcy Filers Cite Medical Bills or Illness-Related Work Loss as a Cause

National Survey of Debtors, 2013-2016

- Medical Bills Only: 22%
- Work Loss Only: 8%
- No Medical Cause: 33%
- Bills + Work Loss: 36%


Work loss = "work loss due to illness"
Medical Bills are Most Common Reason for Collection Calls

Percent of consumers receiving collection calls with specific type of debt

- Medical: 59%
- Telecom: 37%
- Utilities: 28%
- Taxes: 21%
- Legal/court: 14%
- Rent: 11%

Source: Consumer Financial Protection Bureau, January, 2017
Note: Medical collection calls were the only category which did not differ by income
Racism Harms Health
Black and Native Americans Die Younger
But Life Expectancy for Every Group is Shorter Than Other G7 Nations

Life expectancy, years

<table>
<thead>
<tr>
<th>Group</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>81.8</td>
</tr>
<tr>
<td>White (non-Hisp)</td>
<td>78.5</td>
</tr>
<tr>
<td>Black</td>
<td>74.9</td>
</tr>
<tr>
<td>Native American*</td>
<td>73.0</td>
</tr>
</tbody>
</table>

G6 Average

Source: NCHS, IHS, OECD
Other G7 nations = Canada, France, Germany, Italy, Japan, UK
Race/Ethnicity and Maternal Mortality
Every Group in the US Does Worse than Canadians

Maternal deaths/100,000 live births, 2016

- Black: 40.8
- Native American: 29.7
- Asian: 13.5
- White, Non-Hisp.: 12.7
- Hispanic: 11.5
- Canada: 6.3

Source: MMWR September, 2019 and OECD
COVID-19 Has Sharply Reduced Black and Latinx Life Expectancy

Source: Andrasfay and Goldman MedRxiv preprint 9/15/2020
Causes of Black/White Disparity in Adult Mortality

- Heart Disease: 32%
- Cancer: 18%
- Septicemia: 7%
- Homicide: 14%
- Renal Disease: 11%
- Stroke: 12%
- Other*: 6%
- Other**: 1%

Source: MMWR May 2, 2017

* Includes conditions (e.g., diabetes) for which Black death rates are higher and some (e.g., COPD, cirrhosis) for which Black death rates are lower.
Indian Health Service, Grossly Underfunded

Medical spending, 2017 per user

- Indian Health Service: $3.332
- Medicaid: $7.789
- VA: $8.759
- National Average: $9.207

Source: National Tribal Budget Formulation Workgroup, April, 2018
Note: Estimated spending shortfall, including facility upgrades = $36.83 billion
Protecting Immigrants’ Right to Health Care
Low Birth Weight Increased In Iowa After A Massive Immigration Raid

Relative risk of Low Birth Weight

Source: Int J Epidemiol 2017;839
Note: 2008 Postville, Iowa raid was largest single-site immigration raid in history. 900 agents handcuffed and chained all Latinos at meatpacking plant.
Immigrants Get Little Care

Health care costs, $ per capita

- Total Health Care: $2546 (U.S. Born) vs. $1582 (Immigrants)
- ED Care: $91 (U.S. Born) vs. $33 (Immigrants)
- Children: $1059 (U.S. Born) vs. $270 (Immigrants)

* Adjusted for ethnicity, poverty, age, insurance status, patient/parent-reported health status
Immigrants Keep Medicare Afloat

Net Contribution to Medicare Trust Fund, 2009

- U.S. Born: $-30.9 billion
- Foreign Born Citizens: $3.7 billion
- Non-Citizens: $10.1 billion

Source: Zallman et al, Health Affairs 2013; 32:1153
Administrative Overhead Rising
Growth of Physicians and Administrators 1970-2020

Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS
Note - Managers shown 3 year moving average - 2020 figure distorted by data collection difficulties
Investor-Owned Care: Inflated Costs, Inferior Quality
# Health Industry Profits, 2019

<table>
<thead>
<tr>
<th>Category</th>
<th>Profits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceuticals</td>
<td>$83.6 bil</td>
</tr>
<tr>
<td>Insurers</td>
<td>$23.5 bil</td>
</tr>
<tr>
<td>Equipment/Supplies</td>
<td>$16.9 bil</td>
</tr>
<tr>
<td>Pharmacy/Lab/Benefit Mgr.</td>
<td>$14.1 bil</td>
</tr>
<tr>
<td>Providers</td>
<td>$4.2 bil</td>
</tr>
<tr>
<td>Distributors/Wholesalers</td>
<td>$2.9 bil</td>
</tr>
</tbody>
</table>

Source: Fortune 500, 2020  
Note: Excludes firms not in Fortune 500 which account for substantial pharma profits
## For-Profit Hospitals Cost 19% More

Source: CMAJ 2004;170:1817

<table>
<thead>
<tr>
<th>Study*</th>
<th>No. of facilities</th>
<th>No. of patients</th>
<th>% weight</th>
<th>PFP/PNFP payments ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Ness⁷</td>
<td>333</td>
<td>NA</td>
<td>13.7</td>
<td>1.09 (0.98–1.22)</td>
</tr>
<tr>
<td>Kauer⁸</td>
<td>56</td>
<td>NA</td>
<td>15.1</td>
<td>0.93 (0.88–0.99)</td>
</tr>
<tr>
<td>Dickey⁹</td>
<td>342</td>
<td>561</td>
<td>8.9</td>
<td>1.73 (1.36–2.20)</td>
</tr>
<tr>
<td>Dranove et al¹⁰</td>
<td>314</td>
<td>NA</td>
<td>14.4</td>
<td>0.98 (0.90–1.07)</td>
</tr>
<tr>
<td>McCue et al¹¹</td>
<td>84</td>
<td>NA</td>
<td>10.5</td>
<td>1.62 (1.34–1.97)</td>
</tr>
<tr>
<td>Sloan et al¹²</td>
<td>2 360†</td>
<td>7 079</td>
<td>8.4</td>
<td>1.51 (1.17–1.94)</td>
</tr>
<tr>
<td>Keeler et al¹³</td>
<td>358†</td>
<td>384 000</td>
<td>15.8</td>
<td>1.13 (1.09–1.16)</td>
</tr>
<tr>
<td>McCue et al¹⁴</td>
<td>131</td>
<td>NA</td>
<td>13.2</td>
<td>1.20 (1.06–1.36)</td>
</tr>
</tbody>
</table>

Pooled random effects estimate (p = 0.001)

I² = 0.903

---

Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.

*The studies are in chronological order by midpoint of the data collection period. †Approximation from investigator.
For-Profit Dialysis Clinics’ Death Rates are 9% Higher

Source: JAMA 2002;288:2449

Figure 2. Relative Risk (RR) of Mortality in Hemodialysis Patients

<table>
<thead>
<tr>
<th>Source</th>
<th>RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plough et al(^{16})</td>
<td>0.71 (0.49-1.02)</td>
</tr>
<tr>
<td>Farley(^{17})</td>
<td>1.11 (1.04-1.18)</td>
</tr>
<tr>
<td>Garg et al(^{18})</td>
<td>1.18 (1.02-1.37)</td>
</tr>
<tr>
<td>Irvin(^{19})</td>
<td>1.09 (1.07-1.12)</td>
</tr>
<tr>
<td>Irvin(^{20})</td>
<td>1.16 (1.09-1.23)</td>
</tr>
<tr>
<td>McClellan et al(^{21})</td>
<td>1.09 (0.83-1.44)</td>
</tr>
<tr>
<td>Port et al(^{22})</td>
<td>1.06 (1.01-1.12)</td>
</tr>
<tr>
<td>Irvin(^{23})</td>
<td>1.05 (1.03-1.07)</td>
</tr>
<tr>
<td>Random-Effects Pooled Estimate for All 8 Studies</td>
<td>1.09 (1.05-1.12)</td>
</tr>
<tr>
<td>Random-Effects Pooled Estimate for 4 Selected Studies(^{16,17,19,22})</td>
<td>1.08 (1.04-1.13)</td>
</tr>
</tbody>
</table>

Source: JAMA 2002;288:2449
For Profit Home Care: Lower Quality

Source: Cabin, Siman, Himmelstein & Woolhandler, Health Affairs 8/2014
For-Profit Nursing Homes (SNFs): More Deaths and Hospital Readmissions

Percent of patients dying or readmitted within 30 days of hospital discharge

Unadjusted
- Government: 21.6%
- Non-Profit: 21.3%
- For-Profit: 24.3%

Adjusted
- Government: 22.5%
- Non-Profit: 22.8%
- For-Profit: 23.7%

Source: JAMA 2014;312:1552
Hospice Goes For-Profit

Percent of hospices under for-profit ownership

Source: MedPac Annual Report, 2020 and previous
Note: Profit rate: for-profits = 20.2%; non-profits = 2.5%
Mean LOS: for-profits = 110 days; non-profits = 68 days
Drug Company Profits, 1995-2019

Return on Revenues (%)

Source: Fortune 500 rankings for 1995-2020
Private Insurers: Middlemen Who Add Costs But Not Value
52% of Private Insurers' Revenues Come From Medicare and Medicaid

Source: AM Best 8/13/2018
Biden’s Health Reform Proposals

- New “Medicare-like” Public Option.
- Increase exchange subsidies to cap premiums at 8.5% of income.
- Increase ACA subsidies.
- Lower Medicare age to 60.
- Free enrollment in public option for persons <138% of FPL in non-expansion state.
Medicare Advantage: The Only Working Model of a Public Option (Traditional Medicare) Competing With Private Plans
Medicare Advantage Plans' High Overhead

Traditional Medicare
- Medical Services: 97.8%
- Overhead: 2.2%

Medicare Advantage Plans
- Medical Services: 86.3%
- Profit: 4.5%
- Overhead: 9.1%

Source: GAO 12/2013 and Medicare Trustees report 2012 - Figures are for 2011
Note: MA overhead = $905/enrollee; profit = $447/enrollee; total profit = $3.3 billion
Medicare HMO Enrollment, 1985-2020

Source: CMS & Kaiser Foundation
How do Medicare Advantage Plans With High Overhead Outcompete Traditional Medicare?

- Cherry-picking + Lemon-dropping
  - Exclude hospitals/doctors attractive to high-cost patients
  - Benefit/formulary design
  - Hassle factor
- Upcode + over-diagnose to game risk adjustment
- Outright cheating
Patients Acquiring New Disabilities Switch Out of Medicare Advantage

Percent of newly disabled who switched

- Switched OUT of MA: 36.0%
- Switched IN to MA: 14.3%

Source: Health Aff 2020;39:809
Note: New functional disability = needs assistance with >1 ADL
Medicare Advantage Plans Push Cancer Patients Out by Imposing 20% Co-Insurance for Chemotherapy

Source: JGIM 2019;34:1119
Medicare Advantage Plans' Claims for Unsupported Diagnoses

CMS Chart Audit (But CMS Only Pursued Recovery for 0.2% of Projected Overcharges)

CMS estimate of overcharges to Medicare for diagnoses not supported in chart

- 2016: $11.484 bil.

Source: Kaiser Health News 7/16/2019
The ACA:
A Complex and Expensive Way to Expand Coverage
The Simple GOP Plan for the Uninsured

Go Online
- Help Center
- Subsidy
- Provider List
- Doctor List
- Doctor on It

Email Offer
- From Magnolian Prince

Muzak
- While You Wait

Error Message
- Single
- Kids?

Get Sick
- Die Penniless

ORC Attack!
- Lose 15 Health Points

Back to the Tardis
- Deadline
- Get by Meteor

Congratulations!
- You are Insured

Premiums
- $15,000

The Tardis
- Doctor Who

Whos a Good Boy
- Mork and Mindy

Would You Like Fries with That?
- Single
- Smoker
- Bowl

Marry Me
- Married
- Sex

Health Exchanges
- Platinum
- Gold Plan
- Silver Plan
- Bronze Plan

Does Anyone Have a Calculator?
Medicare’s “Software”
18.9 Million Seniors Enrolled Within 11 Months
ACA Decreased Incidence of Unmet Medical Needs Due to Cost
Better, But Still Not Good

% of adults 18-64 reporting an unmet need (past 12 months)

Income as % of Poverty Level

Source: Health Affairs 2017;36:1656
Under-Insurance Increased After ACA

Percent of adults 19-64 under-insured*

Source: Commonwealth Fund Health Insurance Surveys 2003-2020
* Under-insurance: Insured all year but OOP >10% of income (>5% if low income) or deduct >5% of income
American Taxpayers Already Pay More Than People in Nations With National Health Insurance
Taxes Fund 2/3 of Health Spending

- Private: 35%
- Medicare: 20%
- Medicaid: 17%
- Tax Subsidies: 10%
- Govt. Workers Benefits: 6%
- VA, Public Health Etc.: 11%

Source: Himmelstein & Woolhandler - Analysis of NCHS data
U.S. Health Care: Higher Costs, Worse Outcomes, Less Care
U.S. PUBLIC Spending Per Capita for Health Exceeds TOTAL Spending in Other Nations

- U.K.: $4650
- Japan: $4820
- France: $5380
- Canada: $5420
- Holland: $5770
- Sweden: $5780
- Germany: $6650
- Switzerland: $7730
- U.S.: $7,619

Note: Public includes benefit costs for govt. employees & tax subsidy for private insurance
Source: OECD 2020; NCHS; AJPH 2016;106:449 (updated) - Data are for 2019
Life Expectancy

Source: OECD, 2020
Note: Data are for 2019 or most recent year available.
Infant Mortality
Deaths in First Year of Life/1000 Live Births

Source: OECD, 2020
Note: Data are for 2019 or most recent year available
Hospital Inpatient Days Per Capita

Source: OECD, 2020 & Kaiser Fdn. - Figures are for 2019 or most recent available
Physician Visits Per Capita

Source: OECD, 2020 - Data are for 2019 or most recent available year
Canada’s Single Payer National Health Insurance Program
MINIMUM STANDARDS FOR CANADA'S PROVINCIAL PROGRAMS

1. Universal coverage that does not impede, either directly or indirectly, whether by charges or otherwise, reasonable access.

2. Portability of benefits from province to province

3. Coverage for all medically necessary services

4. Publicly administered, non-profit program
Free Care in Quebec
Improved Maternal/Infant Care

Percent with visit

<table>
<thead>
<tr>
<th></th>
<th>Before NHI</th>
<th>After NHI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Prenatal Care</td>
<td>40.9</td>
<td>54.9</td>
</tr>
<tr>
<td>Postpartum Visit</td>
<td>66.0</td>
<td>79.5</td>
</tr>
<tr>
<td>Newborn Checkup</td>
<td>79.2</td>
<td>85.0</td>
</tr>
</tbody>
</table>

Source: NEJM 1974;291:649
Infant Mortality
U.S. & Canada, 1955-2018

Deaths/1000 Live Births


Source: Statistics Canada, Canadian Institute for Health Information, Natl Ctr for Health Statistics
Cystic Fibrosis Patients Live Longer in Canada
Uninsured in U.S. Have Highest Risk of Death

Hazard ratio for death, U.S. vs. Canadian CF patients (Canada = 1.0)

Source: Ann Int Med 2017;166:537
Note: Hazard ratios are adjusted for multiple genetic and clinical characteristics
Health Costs as % of GDP:
U.S. & Canada, 1960-2024

CANADA'S NHP ENACTED
NHP FULLY IMPLEMENTED
How Canada Controls Costs

- Low administrative costs - 16.7% of health spending vs. 31.0% in U.S.
- Lump-sum, global budgets for hospitals
- Stringent controls on capital spending for new buildings and equipment
- Single buyer purchasing reins in drug/device prices
- Low litigation and malpractice costs
- Emphasis on primary care
- Exclusion of private insurers

Source: Himmelstein & Woolhandler, Arch Intern Med, December, 2012
Insurance Overhead
United States & Canada, 2019

Source: NCHS and CIHI (projected)
Hospital Billing & Administration
United States & Canada, 2019

$ per capita (PPP adjusted)

U.S. $1015
Canada $206

Source: Himmelstein, Campbell & Woolhandler - Ann Int Med 2020 (Updated)
Physicians' Billing-Related Expenses
United States & Canada, 2019

$ per capita (PPP adjusted)

U.S.: $502
Canada: $96

Source: Woolhandler/Campbell/Himmelstein Ann Int Med 2020 (Updated)
Note: Excludes dentists and other non-physician, office-based practitioners
Note: Excludes non-billing-related costs for documentation compliance etc.
Overall Administrative Costs Per Capita
United States & Canada, 2019

$3,966

U.S.

$1,196

CANADA

Source: Himmelstein/Campbell/Woolhandler - Ann Int Med 2020 (Updated)
Few Canadian Physicians Emigrate

Net Loss (# moving abroad minus # returning)

Source: Canadian Institute for Health Information
Note: A negative number indicates that more physicians returned from abroad than moved abroad.
## Canadian Physicians' Incomes, 2017/2018

**Average Clinical Payments Per Physician**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Average Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>$280,763</td>
</tr>
<tr>
<td>Int. Medicine</td>
<td>$403,942</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$298,814</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$278,069</td>
</tr>
<tr>
<td>Dermatology</td>
<td>$384,786</td>
</tr>
<tr>
<td>Ob/GYN</td>
<td>$391,743</td>
</tr>
<tr>
<td>General Surg.</td>
<td>$452,283</td>
</tr>
<tr>
<td>Thoracic Surg.</td>
<td>$599,910</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>$768,958</td>
</tr>
<tr>
<td><strong>All Physicians</strong></td>
<td><strong>$344,978</strong></td>
</tr>
</tbody>
</table>

*Source: Canadian Institute for Health Information - figures are in Canadian $s*
What's OK in Canada?
Compared to the U.S.

- Life expectancy 2 years longer
- Infant deaths 25% lower
- Universal comprehensive coverage
- More MD visits, hospital care; less bureaucracy
- Quality of care equivalent to insured Americans'
- Free choice of doctor/hospital
- Health spending half U.S. level
What's the Matter in Canada?

- The wealthy lobby for private funding and tax cuts; they resent subsidizing care for others.
- Result: government funding cuts (e.g. 30% of hospital beds closed during 90s) causing dissatisfaction and waits for care.
- U.S. and Canadian firms seek profit opportunities in health care privatization.
- Conservative foes of public services own many Canadian newspapers.
- Misleading waiting list surveys by right wing Fraser Institute.
Medicare for All Enjoys Wide Support
Most Favor Phasing Out Private Plans if They Can Keep Their Doctor/Hospital

Percent supporting Medicare for All with . . .

- No Further Description: 53% Support, 36% Oppose, 11% Don't Know
- No Insurance Choice: 46% Support, 35% Oppose, 18% Don't Know
- MD Choice But Not Ins.: 55% Support, 31% Oppose, 14% Don't Know

Source: Morning Consult July, 2019
Note: Question asked about choice of doctor AND hospital
Increasing Support for Single Payer

"All Americans Would Get Their Insurance from a Single Government Plan"

Percent in favor/opposed

Source: Kaiser Family Foundation Polls
Most Doctors Favor Single Payer Support Has Sharply Increased

2008
- Support: 42%
- Oppose: 58%

2017
- Support: 56%
- Oppose: 41%
- No Opinion: 3%

Source: Merritt Hawkins surveys of physicians
A National Health Program for the U.S.
National Health Insurance

- Universal - covers everyone
- Comprehensive - all needed care, no co-pays
- Single, public payer - simplified reimbursement
- No investor-owned HMOs, hospitals, etc.
- Improved health planning
- Public accountability for quality and cost, but minimal bureaucracy

Source: Proposal of the Physicians Working Group for Single Payer NHI. JAMA 2003;290:798
FUNDING FOR THE NHP

SOURCES OF REVENUE
- Medicare & Medicaid
- State, local government
- Employers
- Private insurance revenues
- New Taxes

RECIPIENTS OF MONEY
- Hospitals, operating
- Hospitals, capital
- HMOs
- Fee-for-service MDs
- Home Care Agencies
- Long Term Care

SOURCE: NEJM 1989; 320:102
HOSPITAL PAYMENT UNDER AN NHP

- Hospitals remain privately owned and run
- Negotiated global budget for all operating costs. Operating funds cannot be diverted to capital.
- Capital purchases/expansion budgeted separately based on health planning goals

SOURCE: Himmelstein, Woolhandler
NEJM 1989 S20:102
Global Operating Budgets: Key to Single Payer Savings

• Cuts hospital administrative costs.
• Eliminates disparities in profitability of patients.
• Banning hospitals from keeping surplus minimizes entrepreneurial incentives.
• Funding capital through explicit grants minimizes unneeded duplication of expensive services.
Prescription Drugs and Single Payer

- Full coverage, no deductibles/copays.
- Prices reduced by negotiations, national formulary, threat of patent revocation.
- Funding for public drug development, testing, and (when necessary) manufacture.
- Raise standards and FDA funding for drug approval, marketing and post-approval surveillance.
- Eliminate tax deductions for advertising; prohibit pharma-funded CME and guideline development.

Source: Gaffney, Lexchin, Angell, Carome et al. BMJ 2018;361:k1039
Single Payer Transition: For Displaced Clerical and Administrative Workers

- All 400,000 health insurance workers and about $\frac{1}{2}$ of the 2.6 mil. clerical/administrative employees in healthcare providers likely to be displaced – total 1.7 million.

- Many likely to be redeployed in expanded clinical workforce.

- Funding for income support and job retraining modeled on WWII GI Bill.
Single Payer Transition: For Patients

- Every U.S. resident receives an insurance card.
- Full coverage for all medically necessary care, no copayments, deductibles or coinsurance.
- Prescription drug formulary, with alternatives covered when medically indicated.
- Free choice of any participating provider or hospital.
Medicare for All
vs.
Medicare for More
(e.g. Public Option)
Allowed: Supplemental non-competing – but can only cover benefits NOT covered by the public plan.

Banned: Private insurance (including Medicare Advantage) duplicating public plan benefits – Key to administrative savings.
Public Option = High Costs

- Less savings than single payer on insurers’ overhead
- Multiple payers = no savings on doctor/hospital billing and administration.
- Private insurers will tilt the playing field (as under Medicare Advantage) raising system-wide costs and perpetuating network restrictions, cherry-picking, lemon dropping, upcoding, cheating.
- Higher system-wide costs (compared to single payer) assure political pressure for benefit cuts.
Single Payer Would Cost $631 Billion Less Than a Universal Multi-Payer Reform

Total health expenditures/year

- Single Payer: $3.005 trillion
- Multi-Payer: $3.636 trillion

Source: Galvani & Fitzpatrick, Lancet 2020;395:1692