Beyond the Affordable Care Act

A Physicians' Proposal for Single-Payer Health Care Reform

Summary

The Physicians' Proposal for Single-Payer Health Reform was drafted by a working group of 39 physicians and has been endorsed by more than 2,231 other physicians and 149 medical students. The most important feature of the Physicians' Proposal is the removal of all financial barriers to medical care.

The plan would save enough on administrative overhead to provide comprehensive coverage to the uninsured and to upgrade coverage for everyone else, thus requiring no increase in total health spending. In addition, it would put in place effective mechanisms to control costs, lowering the rate of medical inflation and making the health system sustainable for future generations. Significantly, it would restore free choice of clinician and hospital to all Americans.

Access

Every resident of the U.S., including all immigrants, would be covered for all necessary medical care. Patients would receive a National Health Program (NHP) card entitling them to care at any hospital or doctor's office. Medical bills for covered services would generally be eliminated, although the NHP might seek reimbursement from other national health insurance systems for care provided to tourists who fall ill while visiting the U.S.

Benefits

Coverage would include outpatient and inpatient medical care as well as rehabilitation, mental health care, long-term care, dental services, and prescription drugs. In effect, the plan improves on traditional Medicare's benefits and expands coverage to all Americans. It would eliminate premiums, co-pays, deductibles, and co-insurance.

Administration / Administrative Savings

The program would be federally financed (like Medicare) and administered by federal, state and regional boards. Private insurance which duplicates NHP coverage would be prohibited. Replacing the complex and redundant private insurance bureaucracy with a streamlined single-payer program would greatly simplify administration for doctors and hospitals. Overall, cutting administrative spending to Canadian levels would save about 15 percent of national health expenditures, freeing up nearly $500 billion annually for expanded and improved coverage.

Effective Cost-Controls

The initial increase in government costs would be fully offset by savings in premiums and out-of-pocket costs. According to estimates from the Government Accountability Office, the Congressional Budget Office, and several private consulting firms, the administrative savings possible with a single payer are enough to cover all of the uninsured and to upgrade coverage for the under-insured without any increase in total health spending.

Future costs increases would be contained by the NHP's ability to set and enforce overall spending limits, negotiate prices, and improve health planning (see below).

Hospitals and other health facilities would be on a budget. Most hospitals, clinics and nursing homes would remain privately owned and operated, receiving an annual "global" lump sum budget from the NHP to cover all operating costs. Capital funds would be distributed separately on the basis of health planning goals.

Physicians would be paid based on a simple fee schedule covering all patients or by salary. Physicians in private practice would continue to practice on a fee-for-service basis with fee levels set in negotiations with the NHP. Physicians working in nonprofit hospitals, clinics, capitated group practices, HMO's, and integrated health systems would be salaried.

Medications would be purchased wholesale. The NHP would negotiate prices with pharmaceutical companies as other countries around the world do today. The NHP would pay pharmacists wholesale costs plus a reasonable dispensing fee for prescription drugs on the NHP formulary.

Investor ownership would be proscribed. Investor ownership of the health care delivery system (hospitals, clinics, etc.) would not be allowed because it raises costs and reduces quality. Regionally dominant health systems and Accountable Care Organizations would be publicly controlled to prevent them from exploiting oligopoly market power.

Financing

The program would be paid for by combining current sources of government health spending into a single fund with modest new taxes that would be fully offset by reductions in premiums and out-of-pocket spending.

*Further details of the Physicians' Proposal are offered in an editorial in the June 2016 American Journal of Public Health, "Moving Forward from the Affordable Care Act to a Single-Payer System" by Drs. Adam Gaffney, Steffie Woolhandler, Marcia Angell, and David Himmelstein. The full proposal is online at **www.pnhp.org/nhi** (starting May 5 at 1:00 p.m. Eastern time).*