## Framework

#### I negate the resolution, Resolved: The United States ought to implement a single-payer universal healthcare system.

#### I will agree to my opponent’s framework, meaning that the debater who best promotes health should win the round

#### The debate, then, breaks down simply if I can prove to you that implementing single-payer healthcare would have a negative impact on the world, then you should vote for the negative in today’s debate.

### Our sole contention is the Economy

#### Single payer decimates the economy for 4 reasons:

#### Single payer healthcare would remove the private insurance industry overnight, devastating not only private insurance but also hurting the effectiveness of healthcare in all.

Caird 9/20/17 (Lawrence - worked in health care management and public affairs for the Veterans Administration for more than 28 years, “Medicare For All would likely be a huge failure,” http://registerguard.com/rg/opinion/35974386-78/medicare-for-all-would-likely-be-a-huge-failure.html.csp)

In 1987 Bernie Sanders said that if everyone had Medicaid (essentially his Medicare For All) it would bankrupt the country. It would not. But there is a video going around with him saying just that. Our total health care costs would be about the same they are now. Medicare would cost more to administer, because the government regulates things. But we would save the cost of CEO reimbursements and other large salaries of private insurance companies. And, since you cannot sue the government for malpractice, we would save the lion’s share of the $56 billion annually that it adds to our total health care costs. MFA probably would not cost us a lot more; but, it would not cost us less. You say, “What about the profits?” Profits are paid to stockholders, many of whom are people investing for their retirement. The balance is invested in the economy. Insurance companies, unlike the government, have to have assets to cover unanticipated costs. How do you think 9/11 claims were paid? Insurance companies did not have that amount of cash on hand. They liquidated investments to get the cash. The investments of health insurance companies, if they were put out of business by this law, would probably be sold and the proceeds would be paid to stockholders. But the industries and real estate they invest in would suffer the loss of capital. Beside losing the right to sue for losses, we would probably also lose the Affordable Care Act in the process. It is hard to defend one program while advocating for another. It is impossible to estimate how much the stock market would tumble. Stock prices are based on the confidence of investors. If the government can wipe out an entire industry because it does not like the way it is being run, hospital stocks, drug company stocks, medical supply stocks and medical equipment stocks would probably be affected. This could cause the stock market to crash, somewhere between what happened in 1929 and 2008. The losses to American families in retirement funds could possibly be in the trillions of dollars.

#### 2] Jobs – single payer removes private insurance jobs, which would have a huge impact on the economy.

Boughton 17 (Janice – MD from Johns Hopkins University School of Medicine, “High medical costs? Blame the insurance industry.,” 3/9/17, http://www.kevinmd.com/blog/2017/03/high-medical-costs-blame-insurance-industry.html)

Insurance includes not only private health insurance companies, like Blue Cross and Humana, but also federal and state administered insurance, Medicare and Medicaid. Public and private payers have very similar inefficiencies built into their systems. Public insurance providers, at least in theory, have another level of inefficiency built in since they not only are large bureaucracies using elaborate schemes for paying for services delivered to people who are far removed, but they also require expensive legal processes to be funded. There are other parts of the equation that add up to high medical costs, and some of them have their very own devoted blog posts. A third-party payment system, such as we have, along with fee-for-service payment for medical care are a recipe for rising costs. It would be jolly to dismantle such an inefficient system, except that it would also be economically horrific on a national and possibly global scale. Nine percent of Americans are directly employed in the health care industry. This doesn’t include all of the people employed because we have a large and growing health care industry. It doesn’t include the postal worker who delivers health related junk mail, the construction workers who build the new health insurance building, the people who polish the Mercedes-Benz of a hospital CEO, the devoted teachers who educate health care workers or the many other individuals who thrive or survive because the health care industry is booming. Reducing costs by making a major cut in the way we do business, getting rid of private insurance companies for example, would have far reaching consequences on employment and the economy.

#### 3] Taxes – Single payer would cause multitrillion dollar tax hikes, destroying the economy and stifling entrepreneurship.

Pipes 16 (Sally C. - president and chief executive officer of the Pacific Research Institute, “The Ugly Reality of Single-Payer,” 1/21/16, https://www.usnews.com/debate-club/is-single-payer-health-care-a-good-idea/the-ugly-reality-of-single-payer)

Late Sunday night, just hours before the fourth Democratic presidential debate, Vermont Sen. Bernie Sanders unveiled what's probably the purest expression to date of his unreconstructed 1970s radicalism: a plan for "universal" single-payer health care in the United States. Proudly titled "Medicare-for-All," the Sanders scheme would eliminate the private insurance industry and establish a single, federally run insurance pool open to all. Sanders promises a healthcare utopia – a future of "no more co-pays, no more deductibles and no more fighting with insurance companies." During Sunday's debate, the candidate claimed that his health care plan would "save the average middle-class family thousands of dollars a year." This is complete nonsense. Every other single-payer system around the world delivers subpar care at astronomical cost. Worse still, the multitrillion-dollar tax hikes – that's "trillion," with a "t" – that Sanders has proposed to finance his single-payer monstrosity would decimate the American economy. Voters in need of a definitive reason to dismiss Vermont's "democratic socialist" as a legitimate candidate now have one. [SEE: Political Cartoons on Obamacare] Sanders's "Medicare-for-All" proposal would require $14 trillion in new public spending over the next decade and would expand the size of the federal government by over 50 percent. He plans to cover those costs by ratcheting up taxes on virtually everyone. He wants to hike income tax rates by 2.2 percentage points and levy a new 6.2 percent payroll tax on employers. He'd also dramatically crank up income tax rates for families making over $250,000 year. And he'd set the estate tax at 65 percent. These new taxes would slow our economy to a halt. They'd rob businesses of capital to invest in expansion and job creation. The returns on entrepreneurship would dwindle. Corporations would direct investments to friendlier environs abroad. Sanders ought to be intimately familiar with the eye-popping costs of single-payer. They just prevented leaders in his home state from implementing a single-payer scheme within their borders. Four years ago, the Vermont legislature approved a plan to create a state-level single-payer system with basically all the features of Sanders's "Medicare-for-All." But last month, Gov. Peter Shumlin announced that he'd be killing the project, specifically because the requisite tax increases on individual earners and businesses "might hurt our economy." The Sanders "Medicare-for-All" plan is specific about how much lucre it'll extract from the American public, but short on the details about how it would actually be administered. How will physicians' compensation be determined? Who will they work for? For those that refuse to leave private employment, what will the punishment be? Who will own hospitals? The list of unanswered questions goes on and on. Sanders and his ilk are pushing for single-payer in the United States in large part because they admire socialized health care systems in other countries like the United Kingdom and Canada. In their romanticized view, single-payer is more efficient, more egalitarian, more humane and less costly. [SEE: Editorial Cartoons on the 2016 Presidential Elections] But the facts don't fit that portrayal. Single-payer systems typically use price controls to control the cost of health care goods and services. Those price controls cause the purveyors of health care goods and services to limit the supply that they'll deliver. Limited supply meets unlimited patient demand – after all, health care appears "free" – and shortages result. There isn't enough equipment. There aren't enough doctors. And patients, while technically insured, have to endure long wait times before they actually receive care. Take the United Kingdom. Over 3.4 million British patients are currently stuck on waiting lists for care, the biggest total in nearly a decade. That includes 6,100 that have been forced to wait for at least a year. Those waiting lists have consequences. According to one major study, some 13,000 Brits died unnecessarily while in government hospitals between 2005 and 2012. Researchers unearthed systemic abuse and negligence. Sick patients were left to waste away in soiled beds without food or water In Canada, over 40 percent of patients have been forced to wait two months or more to see a specialist. In rural provinces, the problem is even worse. A recent report found that 90 percent of spine surgery patients in Alberta have had to wait at least six months to get treated. This is the ugly reality of single payer. And it's what Sanders would bring to America if he becomes president.

#### That creates 3 uniquely bad impacts:

#### 1] Doctor shortages – the government physically cannot pay them more than private insurance, leading them to retire

Marchand 9/25/17 (Ross - policy analyst with the Taxpayers Protection Alliance, “Single-payer promises consumers, taxpayers a world of pain,” http://thehill.com/opinion/healthcare/352252-single-payer-promises-consumers-taxpayers-a-world-of-pain)

With large required payment cuts to hospitals and physicians and tax hikes on the working class, it’s little wonder why support can’t and won’t expand beyond Bernie’s base. The problem with single-payer goes far beyond the gargantuan price tag. If the federal government were emboldened as the sole national insurer, it would likely cut medical reimbursement rates in a bid to cut costs. In other words, the government would not be able to pay doctors nearly as much as they enjoy under private insurance schemes. Faced with severe salary and revenue cuts, many practices would need to close and “insured” individuals would be left with far fewer options. And this isn’t mere armchair theorizing. As we’ve seen in the real world, low federal reimbursement rates (under Medicaid) mean low patient acceptance rates by physicians. This, along with several other unsavory features of federal insurance, leaves Medicaid patients in no better health than before obtaining insurance.

#### That prevents new doctors from joining the workforce.

Book 9 furthers (Robert A. - Senior Research Fellow in Health Economics. 4/3/9, “Single Payer: Why Government-Run Health Care Will Harm Both Patients and Doctors” http://www.heritage.org/health-care-reform/report/single-payer-why-government-run-health-care-will-harm-both-patients-and)

The Medicare Model If Medicare or something like it were the "single payer"-the sole purchaser of health care-no such pressure would exist. If the single payer established lower payment rates, by definition physicians could not drop out and make their living from other patients, because there wouldn't be any other patients.[3] The only alternative for a physician would be to cease the practice of medicine and either retire or find another profession. While this would certainly happen to some degree, a large percentage of physicians-who have invested many dollars and years of training in their practices-would be unable to find an alternative profession that is nearly as satisfying or as remunerative. The inevitable result would be much lower payment rates and lower income for physicians.[4] Patients would suffer as well, especially in the long run. Because fewer highly talented people would be willing to undergo the years of training (under difficult working conditions and low pay) to become physicians, patients would suffer decreased access to health care and longer wait times. Lower payments would mean that physicians would invest less in advanced medical equipment and would likely spend less time with each patient. In addition, with fewer people undergoing the training necessary to conduct medical research, new treatments and cures would be developed at a slower rate, costing many lives.

#### This shortage destroys the medical industry – a lack of medical professionals devastates hospitals and quality of care.

#### 2] Economic collapse would cause inflation, increase resource scarcity, and plummet the overall quality of life of everyone.

Kimberly Amadeo, an expert on U.S. and world economies, wrote on March 4th that [KIMBERLY AMADEO](https://www.thebalance.com/kimberly-amadeo-3305455) [Kimberly Amadeo is an expert on U.S. and world economies and investing, with over 20 years of experience in economic analysis and business strategy. She is the President of the economic website World Money Watch. As a writer for The Balance, Kimberly provides insight on the state of the present-day economy, as well as past events that have had a lasting impact.] REVIEWED BY [ERIKA RASURE](https://www.thebalance.com/erika-rasure-4800809) [Erika Rasure, is the Founder of Crypto Goddess, the first learning community curated for women to learn how to invest their money—and themselves—in crypto, blockchain, and the future of finance and digital assets. She is a financial therapist and is globally-recognized as a leading personal finance and cryptocurrency subject matter expert and educator.] FACT CHECKED BY [DANIEL RATHBURN](https://www.thebalance.com/daniel-rathburn-5218540) [Daniel Rathburn is an associate editor at The Balance. He has over three years of experience working in print and digital media as a fact-checker and editor. Daniel holds a bachelor's degree in English and political science from Michigan State University.] “US Economic Collapse: What Would Happen?” The balance. Updated March 04, 2022 <https://www.thebalance.com/u-s-economy-collapse-what-will-happen-how-to-prepare-3305690> SJMS

What Would Happen If the US Economy Were To Collapse? If the [U.S. economy were to collapse](https://www.thebalance.com/us-economy-wont-collapse-3980688), you would likely lose access to credit. Banks would close. Demand would outstrip [supply](https://www.thebalance.com/aggregate-supply-what-it-is-how-it-works-3306216) of food, gas, and other necessities. If the collapse affected local governments and utilities, then water and electricity might no longer be available. A U.S. economic collapse would create global panic. Demand for the dollar and [U.S. Treasurys](https://www.thebalance.com/what-are-treasury-bills-notes-and-bonds-3305609) would plummet. Interest rates would skyrocket. Investors would rush to other currencies, such as the yuan, euro, or even gold. It would create not just inflation, but [hyperinflation](https://www.thebalance.com/what-is-hyperinflation-definition-causes-and-examples-3306097), as the dollar would lose value to other currencies. If you want to understand what life would look like during an economic collapse, think back to the [Great Depression](https://www.thebalance.com/the-great-depression-of-1929-3306033). The stock market crashed on Black Thursday.3 By the following Tuesday, it was down 25%. Many investors lost their life savings that weekend. By 1932, one out of four Americans was unemployed.4 Wages for those who still had jobs fell precipitously—manufacturing wages dropped 32% from 1929 to 1932.5 U.S. gross domestic product was cut nearly in half. Thousands of farmers and other unemployed workers moved to California and elsewhere in search of work. Two-and-a-half million people left the Midwestern Dust Bowl states.6 The Dow Jones Industrial Average didn't rebound to its pre-Crash level until 1954.7

#### 3] Drug innovation – Universal Healthcare will shift the focus from innovation to marketing, France proves. This decreases medical innovation.

Edmund Haislmaier, an expert in healthcare policy, wrote in ‘93 that [Edmund Haislmaier](https://www.heritage.org/staff/edmund-haislmaier) [Senior Research Fellow, Center for Health and Welfare Policy Ed is an expert in health care policy and frequently is asked to help lawmakers design and draft reforms to the health systems.] “Why Global Budgets and Price Controls Will Not Curb Health Costs Report Health Care Reform Why Global Budgets and Price Controls Will Not Curb Health Costs” Heritage Foundation March 8, 1993 <https://www.heritage.org/health-care-reform/report/why-global-budgets-and-price-controls-will-not-curb-health-costs> SJMS

Price controls in fact encourage manufacturers to shift resources from research and development to marketing. The reason: investing money in experimental R&D is much riskier than investing money in increased marketing of existing products. Only the potential of a high payoff justifies a high-risk investment. If the potential payoff is kept low by government price controls, then only low-risk investments, like increased marketing or incremental R&D, are justifiable strategies. Of course, with or without price controls, the reason for investing more in marketing is to increase profits by increasing sales volume. Thus, if price controls induce pharmaceutical manufacuturers to shift investment from R&D to marketing, and if those marketing efforts are successful, then the results are: 1) fewer innovative new drugs; 2) increased consumption of existing drugs; and 3) a consequently higher level of individual and national spending on drugs, despite lower prices. These are, of course, exactly the opposite effects of what the price controllers intended. France is a good example of how pharmaceutical price controls can backfire in just such a fashion—simultaneously destroying innovation while boosting total costs. One analyst notes that, “In France, the calibre of pharmaceutical research is seen as having deteriorated, because severe price control has encouraged French companies to give priority to small therapeutic improvements which are useful in price negotiations. Such systems tend to stifle originality and induce risk aversion.” (Heinz Redwood, “The Price of Health,” The Adam Smith Institute, London, 1989, p. 42.) Indeed, the French drug industry produced only three of the 66 world class drugs brought to market between 1975 and 1989, while the U.S. drug industry produced thirty—or ten times as many. (Barral, op. cit.) Yet, despite lower drug prices, the French spend considerably more on pharmaceuticals than do Americans. While pharmaceuticals account for 8.3 percent of health spending in the U.S., they account for twice that level, 16.7 percent, in France (See chart on page 7). Measured another way, per-capita drug spending is almost three times greater in France ($492 per person) than in the U.S. ($182 per person) (See chart on page 8). Price controls also hamper the ability of industries, such as pharmaceuticals, to compete internationally. The U.S. International Trade Commission, in a study prepared for the Senate Finance Committee, notes that, “Several countries that have implemented such programs [price controls] have seen their pharmaceutical industries weaken or shift outside their borders.” (ITC, op. cit.) The study also notes that price variations for particular drugs resulting from the imposition of different drug price control schemes in eleven of the twelve nations of the European Community have resulted in the growth of “parallel trade” in pharmaceuticals. Parallel trade refers to the practice of “brokers” buying a drug in a country that sets the price low and reselling it in countries that set the price higher, taking their profits out of the margin. For example, Glaxo makes its popular and very effective ulcer treatment drug, Zantac, in both France and Britain. In France, the price is set low, so Zantac is imported from there by British parallel traders. A recent British study of the European parallel drug trade notes even greater distortions caused by price controls: In some cases a medicine is made in a high price country, such as Germany, and then exported to a county such as Greece where a low price has been set by the government. Parallel importers in Germany buy supplies of the medicine n Greece and re-import them to Germany. Thus the product concerned has been transported twice in order to end up being consumed in the country where it was made. The absurdity of this is clear. In a properly working market redundant activities such as double transporting would disappear. (M.L. Burstall, I.S.T. Senior, Undermining Innovation: Parallel Trade in Prescription Medicines (London: Institute of Economic Affairs, 1992), pp. 16-17.) These and other distortions induced by price controls so far have had only limited adverse effects. But there is growing concern in EC nations that maintaining such controls could severely damage European drug companies, adversely affecting trade with the rest of the world. Consequently, there is new interest in restoring free pricing policies in pharmaceuticals as part of the EC move for greater European economic integration. (Ibid., p. 76.)

#### You should ask yourself why the UK or Canada, some of the biggest countries with single payer, did not create a COVID vaccine.

## Case

#### Framing issue: Single payer healthcare is a radical reform that completely changes the current system – they need to prove the system is so flawed that there is no room for reform in order for you to vote for them.

#### There are three main problems with their case:

#### Private healthcare lobbying means that the government would never be able to lower prices since they would lash out.

Klein 14 (Ezra – columnist for *The Washington Post* citing Uwe Reinhardt - professor of political economy at Princeton University, “Is the U.S. too corrupt for single-payer health care?,” 1/16/14, https://www.washingtonpost.com/news/wonk/wp/2014/01/16/is-the-u-s-too-corrupt-for-single-payer-health-care/?utm\_term=.87d7824ccab8)

You often hear people say that the reason the United States doesn't have a single-payer health-care system is that special interests have a hammerlock on Congress. But in the course of reporting out my article on what liberals miss about single payer, Princeton's Uwe Reinhardt, a single-payer supporter, made an interesting variant of this argument: The reason the United States shouldn't have a single-payer system, he said, is that it's too captured by special interests to manage one well. "I have not advocated the single payer model here," he said, "because our government is too corrupt. Medicare is a large insurance company whose board of directors (Ways and Means and Senate Finance) accept payments from vendors to the company. In the private market, that would get you into trouble." The key to a single-payer system is that the government sets prices. Usually, it empowers boards of independent experts who set those prices low. Reinhardt's argument is that in the United States, health industry interests have so much sway over Congress that the prices would end up being set by health-care interests. "When you go to Taiwan or Canada," Reinhardt said, "the kind of lobbying we have here is illegal there. You can’t pay money to influence the party the same way. Therefore the bureaucrats who run these systems are pretty much insulated from these pressures. Here you have basically a board of directors in the House Ways and Means Committee that gets money from lobbyists both at the regulatory writing stage and during normal operations. And they can call an administrator and demand they stop something from happening." The question in any argument like this is the counterfactual. Outside of Medicare, Medicaid and some other government-run health systems, prices are set by health-care interests now. But they're much lower in Medicare and Medicaid than they are for private insurers. So it's simultaneously possible for the U.S. government to be much worse at setting prices than, say, France's government, but still be able to negotiate much lower prices than private insurers can manage. Still, Reinhardt's argument is a reminder that the simple fact that a policy worked in another country does not mean it will work in this country. His point about the importance of independence is particularly crucial.

#### Single-payer is too big – it causes countries to ration care and creates long wait times which undermines single payer’s ability to provide quality care

Pipes 16 (Sally C. - president and chief executive officer of the Pacific Research Institute, “Single-payer collides with reality,” 2/5/16, <http://thehill.com/blogs/congress-blog/healthcare/268238-single-payer-collides-with-reality>)

If it sounds too good to be true, that's because it is. For evidence, look no further than Canada's single-payer system. To keep a lid on health costs, Canadian officials ration care. Canada ranks last among 11 industrialized nations in the ability of a patient to get a same-day or next-day appointment with a doctor. It also has the worst emergency room wait times. More than one-quarter of patients wait four or more hours to be treated. It gets worse. After being referred to a specialist by a primary car doctor, Canadian patients wait four and a half months for treatment, on average. Wait times for MRIs are more than eight weeks; for CT scans, patients wait almost four weeks. As a native-born Canadian, I've witnessed this sort of rationing firsthand. My own mother died from colon cancer after doctors delayed her colonoscopy so younger people on the waiting list could go first. These long wait times result in low-quality care. A study in the Lancet medical journal concluded that the United States had higher 5-year survival rates for breast and colon cancer than Canada. When Canadians do need treatment, many come to the United States and pay for it out-of-pocket. According to the Fraser Institute, 52,000 Canadians sought care abroad in 2014. There's also a domestic example of the failures of single-payer -- the U.S. Veterans Health Administration. The VA operates like Canada's system, with the government paying all doctors, nurses, and hospitals. Despite ever-increasing budgets, the VA has been plagued by chronic delays for treatment, some of them deadly.

#### Their administrative costs argument is bogus – Administrative work does not suddenly disappear, and its pushed to the hospitals, the IRS, Social Security, and Health and Human Services

Galles 6/15/17 (Gary - professor of economics at Pepperdine University and a research fellow at the non-profit Independent Institute, “Single-payer healthcare is far more expensive than advocates claim,” <http://thehill.com/blogs/pundits-blog/healthcare/337826-single-payer-healthcare-is-far-more-expensive-than-advocates>)

The usual measurement of efficiency–administrative costs as a percentage of total costs–is highly misleading. Medicare patients are far older and less healthy than the rest of the population, making health care costs far higher per person. But nonmedical administrative costs largely depend on the number of persons insured, not on medical expenditures. So the usual measure grossly exaggerates Medicare’s administrative efficiency and distorts the comparison with private insurance. Before ObamaCare, medical expenditures per Medicare recipient were more than double that per younger insured person, making Medicare look less than half as expensive as it would look if costs were computed per person. In fact, Medicare’s reported administrative cost per beneficiary has been consistently higher than for private health insurance. Another bias, as several studies have found, is that many of Medicare's administrative costs do not show up in its budget. For example, the IRS collects the taxes; Social Security helps collect Medicare premiums: and Health and Human Services helps with accounting and related concerns, as well as paying for building and marketing costs. Including those costs roughly doubles Medicare’s administrative costs. Simply computing costs in per-person terms and including administrative costs that appear in other agencies’ budgets, Medicare’s reported four-to-one administrative cost advantage over private insurers disappears, taking the promise of a treasure trove of single-payer “found money” with it. But these are not the only biases. Typically, private insurance administrative costs have been defined as premiums paid in minus claims paid out, implying that everything but claims paid is administrative. However, many states impose a premium tax (averaging about 2 percent) on health insurers (but not on Medicare), and those tax payments are counted–erroneously–as administrative costs. Also, many insurers offer disease-management and on-call nurse consultation services, which do not result in claims, so the costs of those services are counted as administrative. Ironically, by limiting private insurers’ administrative costs, ObamaCare requires more precision in defining nonmedical costs, markedly improving the estimates. Other private administrative costs are misrepresented as waste or inefficiency. Consider fraud, a major issue for Medicare. If Medicare spends less to combat fraud, it looks more efficient since its administrative costs will be lower and its other costs will be counted as medical expenses rather than waste. But $1 of fraud prevention has been estimated to reduce fraud costs by $15. So when insurance companies invest more in fraud prevention, they benefit their customers, but their administrative cost percentage appears worse than Medicare’s. In addition, the taxpayer-funded parts of Medicare (which are the vast majority since premiums cover only a small proportion) impose another substantial but unrecorded cost, which economists call “excess burden.” Taxes impose wedges between what buyers pay and what sellers receive, destroying opportunities for gains from trade as money is diverted to the government. One study found that even the “lowest plausible assumption about the excess burden engendered by the tax system raises the true costs of delivering Medicare benefits to about 20-25 percent of its Medicare outlays,” far higher than private insurance administrative costs. Thus what everyone “knows” about the lower administrative costs of single-payer systems is false.

#### Single payer doesn’t save money

Robert Moffit, a senior research fellow with a Ph.D., and Meridian Baldacci, a former research assistant, wrote in 2019 that [Robert E. Moffit, Ph.D.](https://www.heritage.org/staff/robert-e-moffit-phd) [Senior Research Fellow, Center for Health and Welfare Policy] Baldacci, Meridian. [Former Research Assistant, Domestic Policy Studies] “Why Single-Payer Would Make Health Care Worse for Americans.” The Heritage Foundation, 2019, [www.heritage.org/health-care-reform/commentary/why-single-payer-would-make-health-care-worse-americans](http://www.heritage.org/health-care-reform/commentary/why-single-payer-would-make-health-care-worse-americans). SJMS

Advocates of single-payer health care—like Sen. Bernie Sanders, I-Vt., with his “Medicare for All” legislation—suggest Americans would enjoy a health care utopia if only the government took over. But claims of lower costs and better, more efficient care are widely overblown. Here are the facts. What Is Single-Payer? A “single-payer” health system is a government-controlled health care system. Government is the “single-payer.” In most versions of single-payer, most private health insurance is either outlawed or restricted, and most public health programs are absorbed into the single, national health insurance program. While there are a variety of “single-payer” proposals—including several state proposals—Sanders’ “Medicare for All” bill is the most prominent. His [plan](https://www.heritage.org/health-care-reform/report/government-monopoly-senator-sanders-single-payer-health-care-prescription)would finance the national insurance program through a combination of payroll and income taxes, and it would replace private and employer-sponsored health insurance and existing government health programs—including Medicare itself. Under the Sanders plan, only the Veterans Administration and the Indian Health Service would remain largely as they are today. How Much Would It Cost? The cost of a single-payer system would depend upon its design, benefit levels, and scope of coverage. In the case of Sanders’ proposal, estimates consistently show that the plan would impose dramatic obligations on the federal taxpayer, and that the proposal would incur substantial annual deficits. For example: The Urban Institute [estimates](https://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000785-The-Sanders-Single-Payer-Health-Care-Plan.pdf) 10-year spending of $32 trillion, only about half of which would be covered under Sanders’ funding options Mercatus Center’s Charles Blahous [estimates](https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf) a 10-year $32.6 trillion increase in federal spending. Even “doubling all currently projected federal individual and corporate income tax collections would be insufficient to finance the added federal costs of the plan.” Economist Kenneth Thorpe of Emory University [estimates](https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-ofBernie-Sanders-s-single-payer-proposal) $24.7 trillion in additional federal spending, and also estimates an average deficit of $1.1 trillion per year. The Center for Health and Economy [estimates](http://healthandeconomy.org/medicare-for-all-leaving-no-one-behind/) a 10-year net cost of up to $44 trillion, and an annual deficit of $2.1 trillion. Would Single-Payer Reduce Administrative Costs? Advocates argue that single-payer would save the nation money by reducing administrative costs, eliminating the administrative expenses of marketing and advertising private health insurance, managing private benefits and utilization, and securing profits. Advocates [claim](https://www.washingtonpost.com/news/fact-checker/wp/2017/09/19/medicare-private-insurance-and-administrative-costs-a-democratic-talking-point/?utm_term=.2c1fc1f66069) that administrative costs would be much lower in a Medicare-like system than under a system dominated by private insurance. Payment would be based on the Medicare model, where annual administrative costs are about [2 percent](https://www.healthaffairs.org/do/10.1377/hblog20110920.013390/full/) of total costs. But pointing to Medicare’s low percentage of administrative costs is over-simplistic and misleading. Per capita administrative costs may be higher in Medicare. For instance, in [2009](http://s3.amazonaws.com/thf_media/2009/pdf/wm2505.pdf) they were $509 in Medicare and $453 in private insurance. Medicare costs are lower as a percentage of the total only because total claims costs tend to be much higher in Medicare than in private insurance. This is because Medicare’s older and less healthy population file the claims costs. Medicare shifts administrative costs to doctors, hospitals, nursing homes, home health agencies, and other medical professionals who must comply with Medicare’s huge and complex regulatory requirements. Compliance with tens of thousands of pages of Medicare rules, regulations, guidelines, billing, and other paperwork requirements consumes vast amounts of time, energy, and effort on the part of the private-sector professionals who participate in the Medicare program. Medicare fails to effectively control waste, fraud, and abuse in the program. This failure of administration [results](https://www.heritage.org/health-care-reform/report/medicares-next-50-years-preserving-the-program-future-retirees) in the staggering loss of tens of billions of taxpayer dollars each and every year. Private-sector health plans, policing their billing, have no comparable record in accumulating such enormous losses. How Would Single-Payer Control Health Costs? Single-payer would control costs by capping the amount spent on health care through a global budget, imposing a system or price controls or payment reductions on doctors and other medical professionals, or some combination of both. In a normal market, cost control is a function of supply and demand. Where there is no market, there are no such market forces, and the control of costs must be ultimately an administrative or legislative function. Government officials cannot control demand—they can only control supply. So, in effect, cost control in the single-payer system is inevitably supply control. Control over the supply of medical services is secured through a global budget, price controls, or regulations on payment and price. Under the Sanders proposal, for example, cost control is secured by a global budget and by imposing Medicare payment rates. Blahous, a former Medicare trustee, estimates that under the Sanders proposal, provider payments would be cut by an estimated 40 percent by [using](https://www.congress.gov/bill/115th-congress/senate-bill/1804/text) Medicare payment rates. Using Medicare payment rates throughout the entire American health care economy would hurt patients. Already, the Centers for Medicare and Medicaid Services [projects](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ACAmarginsimulations2018.pdf) that “nearly half of hospitals, approximately two-thirds of skilled nursing facilities (SNFs), and over 8 percent of home health agencies (HHAs) would have negative total facility margins.” Would Taxes Go Up Under Single-Payer? The tax burden would be enormous, roughly doubling the current tax obligations for today’s taxpayers. One funding option Sanders [proposes](https://www.congress.gov/bill/115th-congress/senate-bill/1804/text) is a 7.5 percent payroll tax, plus a 4 percent income tax on all Americans, as well as a wide variety of specialized taxes on investments and taxes targeted to higher-income Americans. (He outlines these tax proposals as [options](https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?id=8E063228-2387-4805-BFD2-82EA218861DA&download=1&inline=file), but they are not included in the latest version of his [bill](https://www.congress.gov/bill/115th-congress/senate-bill/1804/text).) The problem is that even the proposed set of new federal taxes are insufficient to fully fund the Sanders program. One estimate suggests the proposal would [require](https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-ofBernie-Sanders-s-single-payer-proposal) combined payroll and income taxes of 20 percent. In a fully-funded Sanders program, a vast [majority](https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-ofBernie-Sanders-s-single-payer-proposal) of working Americans would pay more for health care than they do today: 71 percent of all working families. 85 percent of taxpaying Medicaid recipients. 66 percent of taxpaying Medicare recipients. 65 percent of young adult workers. 57 percent of workers in firms under 50 employees. The bottom line: Compared to what most Americans pay for health care today, a fully funded program—as envisioned by Sanders—would cost more for 71 percent of the nation’s working families, including low-income families, according to [Thorpe](https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-ofBernie-Sanders-s-single-payer-proposal). Would Everyone Get Equal Access to Health Care Under Single-Payer? No. The British and Canadian experiences with single-payer demonstrate that universal government coverage is not the same thing as universal access to quality care. Moreover, social inequalities in accessing care, based on wealth or political influence, are often exacerbated. In 2017, Canadians were on waiting lists for an [estimated](https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2017.pdf) 1,040,791 total procedures. Often, wait times are lengthy. For example, the median wait time for arthroplastic surgery (hip, knee, ankle, shoulder) ranges from 20 weeks to 52 weeks. In the British National Health Service, cancelations are common. Last year, the National Health Service [canceled](http://researchbriefings.files.parliament.uk/documents/CBP-7281/CBP-7281.pdf) 84,827 elective operations in England for nonclinical reasons on the day the patient was due to arrive. The same year, it canceled 4,076 urgent operations in England, including 154 urgent operations canceled two or more times. Times of high illness are a key driver in this problem. For instance, in flu season, the National Health Service [canceled](https://www.dailysignal.com/2018/08/13/britains-inability-to-handle-last-years-flu-season-shows-perils-of-socialized-medicine/?mkt_tok=eyJpIjoiTTJNeFpEZGpZbVl6WVdReCIsInQiOiJybnBXY3ROTXo3a0pnbUNacWFFVEVrVm1PblJBWEM1YVlrRU5LaVlON2sxc25sM3FJaExKaEl6OFhpenRmM2VEMVQrV3NFeHJOZUFBcEhkOXZCOUJkRlNsWFwvbGFqSkJSVGV0QUZvTkYzTVZ4WHorT2JmWUxVSXNiZ2s2RmFOOHQifQ%3D%3D) 50,000 “non-urgent” surgeries. In Canada, private insurance is outlawed (as it would be under Sanders’ proposal). In 2017, “an [estimated](https://www.fraserinstitute.org/studies/leaving-canada-for-medical-care-2017) 63,459 Canadians received non-emergency medical treatment outside Canada.” In Britain, private insurance is permitted—but it is an additional cost to the taxes that British citizens pay for the National Health Service. Escaping the system is an option for the wealthy, or for those who are willing to forego other expenditures to get the care they want or need. Government-run health care cannot deliver on its promises. It would impose unprecedented taxes on Americans, deliver subpar care to patients, and put government in charge of personal health care decisions. Americans deserve better.