becoming evident that these factions increasingly support a single-payer system: 65% of the United States population and 59% of American physicians voiced this opinion in recent polls (7, 8). Finally, while there are major cost concerns regarding the proposed increased role for the private insurance industry in covering just some of the uninsured, a single payer system would cover *all* comprehensively (something no other proposed system can claim) at a cost no higher than we are currently spending, and potentially significantly less, if the experience of other industrialized nations is any guide. The time for true universal health coverage is now, and the best path to universal coverage is through single-payer health insurance.

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Con: Single-Payer Health Care
Why It's Not the Best Answer

In the United States, medical costs have been increasing inexorably for many years, as have the numbers of the uninsured; the latter is currently estimated to be as high as 47 million persons. A single-payer system has long been suggested by some as the most logical solution to the current crisis in health care access and affordability (1). Under a single-payer health system, the federal government would ultimately be responsible for reimbursement of most medical services provided by clinicians and hospitals. The hope is that a single-payer system will both improve access to health care and reduce health care costs. By definition, under a single-payer system no one would be without health insurance, and cost savings might be achieved through a reduction in administrative expenses coupled with an emphasis on preventive medicine and the universal adoption of electronic medical records. However, I have substantial concerns over whether these potential benefits can actually be accomplished. It is the history of government bureaus to become large and complex rather than lean and efficient. Furthermore, access to preventive care does not equate to individual adherence to the precepts of such care. Finally, I fear that the ultimate toll of a single-payer system will be a reduction in the quality of health care that Americans may be unwilling to bear.

Proponents of a single-payer system argue that government-sponsored insurance would save money by reducing wasteful administrative costs. Yet comparisons of administrative expenditures between private and government-run insurance programs are misleading (2). For instance, the cost of administering a private insurance plan includes the expense of collecting premium dollars, which also applies to government insurance programs such as Medicare. However, this expense does not register on Medicare's budget insofar as a separate government agency (the Internal Revenue Service) performs this function. Furthermore, many states tax premiums paid to private insurers, and also tax their profits; government programs are not so encumbered. Finally, Medicare spends approximately twice as much on claims than most private insurers (older patients consume more services), and administrative expense is expressed as a percent of claims paid. Thus, Medicare looks more thrifty than it really is (2). Estimates of the bureaucratic cost savings under a single-payer system do not account for the expense of administering a greatly expanded Medicare-like program or the price of collecting new employer and individual taxes.

Additionally, administrative costs are only a small portion of health care costs in this country. The main problem is overuse of health care, particularly that involving expensive new technologies and drugs (3). Even within Medicare, which functions as a single-payer health system for elderly Americans, there are wide variations in health care spending across regions, with little or no gains in quality in regions with greater expenditures (4). Overattention to administrative costs distracts us from the real problem of wasteful spending due to the overuse of health care services.

A single-payer system will subject physicians to unwanted and unnecessary oversight by government in health care decisions. With the newfound power to benchmark physicians and regulate payments, the government will inevitably restrict the use of potentially beneficial therapies and pay differentially for perceived differences in quality, with potential unintended consequences such as increased health care disparities (5). Without price competition from private insurers, the government will be free to pay whatever it wants for health services. Physicians are already inadequately reimbursed for services provided under Medicaid (6), and reductions in Medicare reimbursement over the years have demonstrably affected access and quality of care in a variety of health care venues (7–10). Even lower physician payments under single payer will drive many physicians out of business, further restricting access to care. Decreased reimbursement will also prevent hospitals from investing in new health care technologies or trying innovative new therapies (11). Allowing government, rather than the free market, to set health care prices is a dangerous proposition.

Despite the general perception, health insurance alone will not overcome the problem of access to health care in this country. Many patients with adequate insurance do not come to their appointments or do not adhere to recommended therapies. Part of what we perceive to be medical problems can actually be traced to societal conditions. How can we ensure, for example, that all pregnant women receive prenatal care? How can we force patients with asthma to use their prescribed inhalers

regularly? How can we stop patients from smoking and eating an unhealthy diet? Health coverage and medical advice would yield little or nothing unless patients do their part.

Single-payer health insurance would also lead to rationing and long waiting times for medical services. The adverse consequences of waiting for health services in countries with single-payer insurance are well documented (12, 13). Access to a waiting list for health care does not equate with access to health care, which is one reason why patients from abroad often prefer to come to the U.S. for treatment. It is unlikely that Americans would welcome these changes.

The strongest argument against a single-payer system may well be the outcomes in states that have attempted to expand health care access through the use of government programs and mandates. TennCare was a widely touted managed-care Medicaid program adopted by Tennessee in 1994 that was characterized as the solution to providing health insurance to most uncovered residents while simultaneously controlling costs (14). TennCare's subsequent collapse has been attributed to mismanagement and unrealistic fiscal planning, a perhaps predictable consequence of government administration of health care (15). Massachusetts enacted legislation in 2006 that was intended to move that state to near-universal health care coverage. Indeed, by 2008 some 165,000 more residents were insured through a combination of employer mandates and government subsidized insurance, and overall, almost 93% of nonelderly adults had coverage by late 2007 (16). However, because inadequate (or no) provision was made to expand the provider workforce, many of these patients had no access to care (16), and costs have escalated so far beyond estimates that additional financial support is required (17).

Instead of adopting universal coverage through single-payer health care, a better approach to the health insurance problem in this country would be to control costs. There are several ways to do this. First, we need tort reform, with limits on allowable law suits and malpractice awards. The practice of defensive medicine has been estimated to add up to $50 billion annually to health costs (18). Using an example from our own field, does every patient with an abnormal chest radiograph require computed tomography and then positron emission tomography? How many of us feel comfortable not ordering these tests when they are recommended by the radiologist, who is also practicing defensive medicine? Second, we need to increase the use of medical savings accounts (MSAs). MSAs are a type of insurance plan that allows patients to spend tax-free income on health care before meeting their insurance deductible, and they are allowed to keep the money they do not spend. When consumers spend their own money, they look for a better price (19), and value becomes an important consideration. Third, all money spent on medical care, including drugs, should be tax-deductible. This will level the playing field for people who do not receive insurance as a medical benefit from an employer. Fourth, physicians should be permitted to charge lower fees for patients paying cash, without financial penalties from private insurers. Finally, retired physicians should be permitted to work at free health care clinics with immunity from malpractice threats.

Personally, I would welcome a system that can provide health care for all, and the current health reform movement appears to be headed toward the desirable goal of universal coverage. Yet a government-controlled system is not the answer insofar as recent history tells us the government is not best equipped to do that job. Once the government wrests control and dictates the practice of medicine, it would mean the death knell for the medical profession as we know it and the end of what many consider to be the best medical care in the world.

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