The Politics of Policy

MYTHS AND MEMES ABOUT SINGLE-PAYER HEALTH INSURANCE IN THE UNITED STATES: A REBUTTAL TO CONSERVATIVE CLAIMS

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Recent years have seen the rapid growth of private think tanks within the neoconservative movement that conduct "policy research" biased to their own agenda. This article provides an evidence-based rebuttal to a 2002 report by one such think tank, the Dallas-based National Center for Policy Analysis (NCPA), which was intended to discredit 20 alleged myths about single-payer national health insurance as a policy option for the United States. Eleven "myths" are rebutted under eight categories: access, cost containment, quality, efficiency, single-payer as solution, control of drug prices, ability to compete abroad (the "business case"), and public support for a single-payer system. Six memes (self-replicating ideas that are promulgated without regard to their merits) are identified in the NCPA report. Myths and memes should have no place in the national debate now underway over the future of a failing health care system, and need to be recognized as such and countered by experience and unbiased evidence.

As one-seventh of the nation's economy, the U.S. health care system is enormous and complex, so that consideration of reform of its many problems is a daunting challenge at best. It is all the more difficult when ideologies without facts are used to frame the debate over reform alternatives, but that is exactly what is happening today in the fog of battle over the future of U.S. health care. Although incremental market-based strategies have failed for more than 25 years to contain costs and improve access to health care, they are still being promoted to address the increasing unaffordability of health care in a failing system. Powerful stakeholders in the medical marketplace are distorting the issues with phony "policy research"

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in an effort to protect and promote their interests, while limiting public regulation and constraints.

As Alex Carey describes in his book *Taking the Risk Out of Democracy: Corporate Propaganda versus Freedom and Liberty* (1), many private think tanks have emerged in the United States since 1970 within the neoconservative movement, including such examples as the American Economic Institute for Public Policy Research and the Heritage Foundation. They are well funded, produce studies and reports supporting their own interests, and lobby strongly for competitive open markets. Over time, these think tanks have been very influential in shaping language patterns of the media and public opinion (2).

The National Center for Policy Analysis (NCPA) describes itself on its website as a "nonprofit, nonpartisan public policy research organization, established in 1983, with the goal to develop and promote private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector" (3, accessed March 4, 2004). The NCPA is based in Dallas, Texas, and maintains an office in Washington, D.C., as well. The following statements are made on the NCPA's website (3, accessed June 28, 2004):

- "Through productive use of resources and sound management practices, the NCPA provides contributors with the highest return on investment. The NCPA continues to grow by seizing opportunities at the right time. With revenue increasing at 20 percent per year, the NCPA was one of the fastest-growing think tanks in the 1990s, increasing from a $1 million budget in 1990 to a $4.6 million budget in 2003." (IRS Form 990 was reviewed for 2002; no specific disclosure of contributors was included.)
- *Hard News Coverage*: "In the first decade of the organization's founding, over half the NCPA's studies were covered in wire service stories—the result of highly focused press releases and well-planned press conferences."
- *Television*: "In addition to regular appearances on shows such as Crossfire, C-Span and the News Hour with Jim Lehrer, the NCPA participated and co-sponsored over twenty 30-minute debates and five two-hour, prime time debates with Firing Line—shown on 238 PBS stations nationwide. NCPA scholars also appear regularly on DebatesDebates, shown on nearly 200 PBS markets."
- *Talk Shows*: "The NCPA has a well-organized outreach program regularly blast faxing [faxing to multitude of recipients] critical information on timely topics to 750 television and radio talk show hosts, producers and personalities."
- *Opinion Columns*: "The NCPA sponsors two of its own syndicated columnists: Peter du Pont (Scripps Howard) and Bruce Bartlett (Creators Syndicate)."
- *Guest Editorials*: "The NCPA's track record in placing editorials in highly visible newspapers is superior, with regular placements in the *Wall Street Journal,* the *Washington Times, Investor's Business Daily, Los Angeles Times* and other major publications."

• *Congressional Connection*: "Dozens of NCPA studies have been released by members of Congress—a rare feat for a think tank—and members of Congress frequently appear at NCPA Capitol Hill briefings for congressional aides."

• "NCPA ideas about public policy issues reached U.S. households almost 1.1 billion times through print and broadcast media in 2002—10.3 times per residence in one year. We average over 4.25 million hits on our main website per month; hits for all the sites topped 52 million and subscribers for all five newsletters totaled over 15,000."

As the health care debate again takes center stage on the nation's domestic agenda, fueled even more actively in an election year, the NCPA is promoting its interests through its extensive 2002 report, *Twenty Myths About Single-Payer Health Insurance: International Evidence on the Effects of National Health Insurance in Countries Around the World* (4). A previous report on the same subject was published in 1991 (5). The 2002 report, totaling 135 pages, is intended to counter the 20 alleged myths listed in Table 1. Due to space constraints, all 20 "myths" cannot be rebutted in this article. Instead, 11 are selected out for critique, as italicized in Table 1. The purpose of this article, then, is three-fold: (*a*) to review and critique 11 alleged myths in the NCPA report; (*b*) to identify the counter-myths, or memes,[1] that the NCPA report puts forward to advance its agenda; and (*c*) to bring more clarity to the real issues in the health care debate.

REBUTTAL OF ELEVEN "MYTHS"

For obvious reasons, an exhaustive review and rebuttal of these 11 alleged myths is not possible here. However, they will be critiqued in terms of major evidence for and against each, under eight categories: access, cost containment, quality, efficiency, single-payer as solution, control of drug prices, ability to compete abroad (the "business case"), and public support for single-payer. In three instances, two relevant "myths" will be considered under a larger heading.

Access to Care

Alleged myth no. 2: In countries with single-payer health insurance, all people have equal access to health care.

The NCPA's "debunking" of this myth focuses upon inequalities in access to care in Britain and Canada. Disparities between rich and poor in access to care are described for both countries (as are typical everywhere). Disparities in access are also noted between residents in rural areas and those in urban areas (again, as is typically the case elsewhere). With reference to only one study (7),

[1] A meme is a self-replicating idea or slogan that by constant repetition makes its way into common language and culture, regardless of its merits (6).

Table 1

Twenty "myths" about single-payer health insurance

1. "In countries with single-payer health systems, people have a 'right to health care.'"
2. "*In countries with single-payer health insurance, all people have equal access to health care.*"
3. "*Countries with single-payer health insurance make health care available on the basis of need, rather than ability to pay.*"
4. "*Although the U.S. spends more on health care per capita than countries with single-payer health insurance, Americans do not get better care.*"
5. "*Countries with single-payer systems have access to the latest technology.*"
6. "Countries with single-payer health care systems maintain a high quality of care."
7. "*Countries with single-payer health insurance systems have been more successful than the U.S. in controlling health care costs.*"
8. "*Countries with single-payer systems of national health insurance hold down costs by operating more efficient health care systems*."
9. "Countries with single-payer systems eliminate unnecessary medical care."
10. "*Single-payer health insurance would reduce the administrative costs of the U.S. health care system.*"
11. "Under single-payer health systems, health care dollars would be allocated so that they have the greatest impact on health."
12. "A single-payer system would lower health costs because preventive services would be more widely available."
13. "*Single-payer health insurance is the solution to problems of managed care.*"
14. "*A single-payer system of health insurance would improve the United States' ability to compete in international markets and benefit American labor.*"
15. "Single-payer health insurance would benefit America's elderly."
16. "Single-payer health insurance would benefit racial minorities."
17. "Single-payer health insurance would benefit residents of rural areas."
18. "*Single-payer health insurance systems would reduce the costs of prescription drugs for Americans.*"
19. "*Single-payer health insurance would be popular in the United States.*"
20. "The defects of single-payer health insurance schemes in other countries could be remedied by a few reforms."

Source: Goodman and Herrick (4).
Note: "Myths" in italics are those discussed in the text.

the report draws this largely undocumented conclusion: "In every country, some people slip through the social safety net. But for the most part, the United States has already made considerable progress toward the goal of socialized medicine: the removal of financial barriers to health care. And, considering the rationing of medical technology in countries with national health insurance, the United States may have gone further in removing barriers to medical care than any other country in the world" (4, p. 19).

In so doing, the NCPA analysis completely ignores access problems for many millions of Americans, as illustrated by these examples:

- There are now more than 45 million Americans without health insurance, in itself an important key to adequate access to care (8).
- Almost 60 million Americans lack health insurance at some point during the year (9).
- About 20 million American families, representing 43 million people, had trouble paying medical bills in 2003; many had trouble gaining access to health care and paying for other basic necessities—rent, mortgage payments, transportation, or food (10).
- Twenty percent of the uninsured cannot afford health insurance even if offered by their employers (11).
- About two-thirds of the uninsured have no regular physician and have cost-related barriers to physician visits, prescription drugs, and necessary care (12).
- About one-half of the non-elderly U.S. population earn less than $50,000 a year, and have major problems in affording health care (13).
- In 32 states, a parent working full-time at a minimum wage of $5.15 an hour is ineligible for Medicaid and cannot afford health insurance (14).
- Americans with above-average incomes have more access problems than patients in Canada, the United Kingdom, Australia, and New Zealand (Figure 1) (15).

Alleged myth no. 3: Countries with single-payer health insurance make health care available on the basis of need, rather than ability to pay.

The NCPA report raises the specter of rationing by government-run programs, then focuses on minorities of the populations in Britain, Canada, Australia, and New Zealand who seek private care outside publicly financed services. These are mainly patients not wanting to wait for elective or non-urgent care within the system, who gain access to private care through either private insurance or out-of-pocket payments. No evidence is presented that waiting times within the system adversely affect clinical outcomes, and no distinction is made between "need" and "desire" on the part of patients who bypass waiting lists. An exaggerated impression is given of both waiting lists and the "growing number" of Canadians traveling to the United States for medical care, based on a 1996 article (16).

The NCPA analysis fails to acknowledge the benefits of universal access to medical care—even without the ability to pay—in any of these countries, while omitting mention of ongoing access problems in the United States, due especially to financial barriers to care. Without question, the more a private system is used, to the benefit of smaller numbers of affluent patients, the more the public system may be threatened, to the detriment of larger numbers of people, in terms

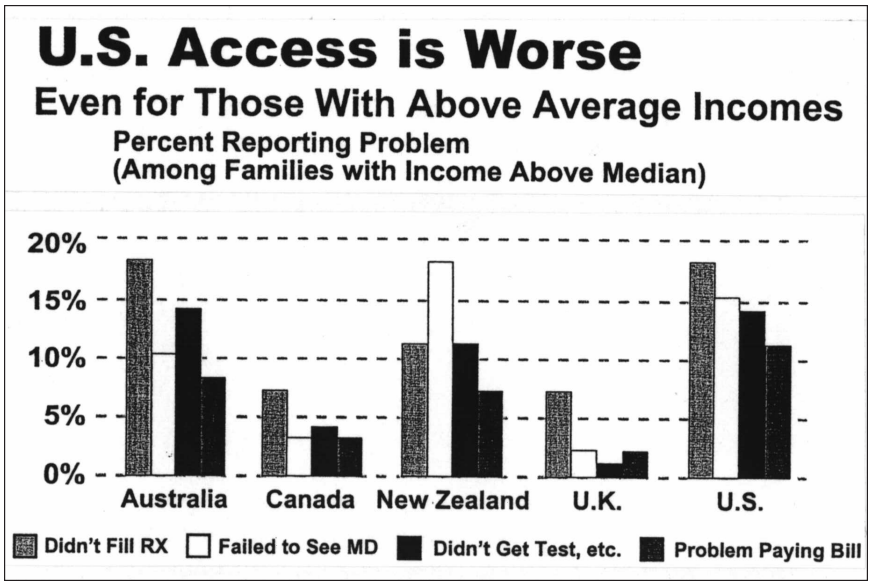

Figure 1. *Source:* Blendon et al. (15). Reprinted with permission from S. Woolhandler and D. U. Himmelstein, The National Health Program Slide-show Guide, Center for National Health Program Studies, Cambridge, Mass., 2000.

of adverse selection, limited resources, and longer waiting times. The following examples cast a different light on the NCPA report:

- Overcrowding of emergency rooms in Canada is increasingly mirrored by the same problem in the United States, though underreported in this country. Physicians at the Los Angeles County–USC Medical Center have testified that some emergency room patients can wait up to four days for a bed and that others may die before receiving care (17). Of the millions of Americans crowding U.S. emergency rooms, many have problems that could have been prevented by earlier care; they end up being charged the highest rates for emergency care, then are released with often inadequate follow-up care (18).
- Though admittedly the Canadian system is underfunded, and extended waits for some elective services may be a problem in some parts of the country, these problems are often exaggerated by its detractors based on unreliable self-reported data. In 1998, fewer than 1 percent of Canadians were on waiting lists, with fewer than 10 percent of these waiting longer than four months (19). Waiting times in the United States, even for the privately insured, are now increasing for checkups as well as for sick visits (20).

- Comprehensive and reliable provincial databases on waiting times show that in recent years, waiting times have decreased while services have increased. For example, coronary bypass surgery increased by 66 percent between 1991 and 1997 in Manitoba, while waiting times were reduced for that procedure and also shortened for five other elective procedures—carotid endarterectomy, cholecystectomy, hernia repair, tonsillectomy, and transurethral resection of the prostate (21).
- Although there is a widespread myth that many Canadians seek medical care in the United States, a three-state study reported in 2002 found that this number is very low for either outpatient or hospital care, and largely due to these Canadians needing medical care while traveling in the United States (22).
- As private interests lobby for an increased role in countries with national health insurance, their success adversely affects the public system. In Canada, for example, the waiting list for cataract surgery by surgeons who operate only in the public system is 10 weeks, compared with 26 weeks for those who operate in both the public and private systems as they preferentially care for private patients (23).

Cost Containment

Alleged myth no. 7: Countries with single-payer health insurance systems have been more successful than the United States in controlling health care costs.

While admitting that the United States spends more on health care than any other country in the world, the NCPA analysis argues that this country gets more value for these expenditures and that it rations care less, that the nation's more affluent population naturally spends more on health care, and that international comparisons of health care costs are too variable in their methodology to be reliable. It also argues that the U.S. population places more demands on the health care system than do the populations of most other Organization for Economic Cooperation and Development (OECD) countries. A 2000 report is cited that showed how the United States experienced an average annual real growth in per capita health spending of 2.6 percent (comparable to that of the United Kingdom, Australia, and New Zealand and lower than that of Japan) between 1960 and 1998 (24).

That the NCPA assessment is off the mark is shown by these points:

- The same 2000 report cited above (24), in its comparison of per capita health spending between 1990 and 1998, documented that the United States in more recent years does *not* compare favorably with countries with single-payer health insurance systems (Figure 2).
- Figure 3 shows that Canada experienced the same growth of health care costs as a percentage of gross national product (GNP) as did the United States until

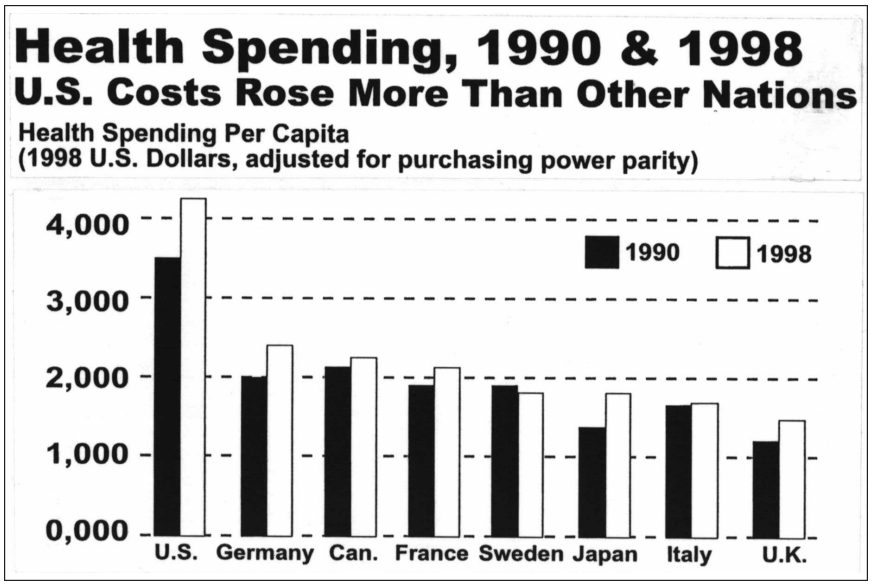

Figure 2. *Source:* Anderson et al. (24). Reprinted with permission from S. Woolhandler and D. U. Himmelstein, The National Health Program Slide-show Guide, Center for National Health Program Studies, Cambridge, Mass., 2000.

Canada fully implemented its single-payer system (NHP—national health program) and since then has better controlled health care costs (25).

- Health care expenditures in the United States are expected to total about $1.8 trillion in 2004 ($6,167 per capita, and 15.5 percent of gross domestic product (GDP), and the health care portion of GDP is expected to soar to 18.4 percent in 2013 (26).
- A new cost-containment model has failed to emerge in the United States after the failure of managed care to contain costs in the 1990s. Rapid increases in health care costs are occurring at a time of relatively high unemployment and greater need for a safety net of public programs (27).

Alleged myth no. 10: Single-payer health insurance would reduce the administrative costs of the U.S. health care system.

The NCPA report attempts to discredit this "myth" by arguing that the ability of single-payer insurance systems to lower health care costs by reducing administrative costs is based on "three mistaken assumptions: (*a*) that low administration costs and efficiency are synonymous, (*b*) that the higher administrative costs of private programs result in worse outcomes, and (*c*) that the relatively low

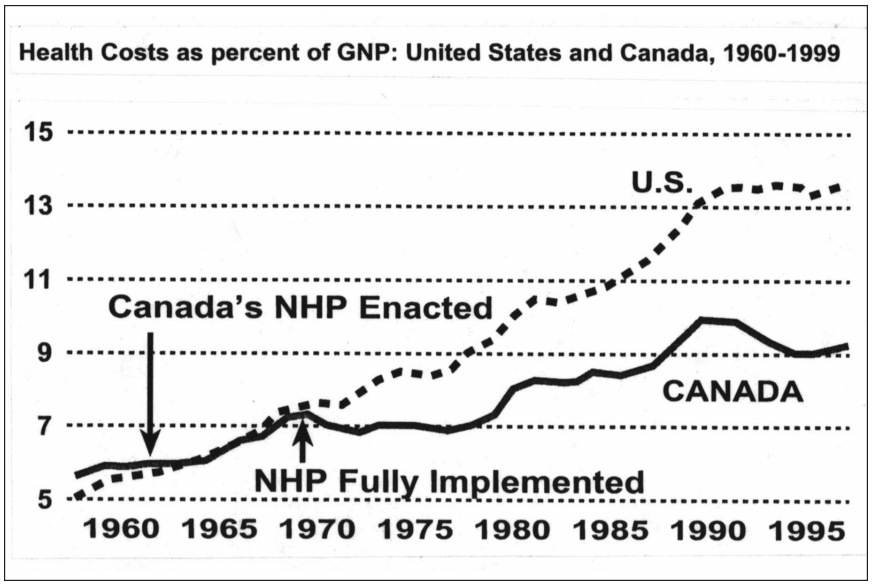

Figure 3. *Source:* Statistics Canada, Canadian Institute for Health Information and NCHS/Commerce Department. Reprinted with permission from S. Woolhandler and D. U. Himmelstein, The National Health Program Slide-show Guide, Center for National Health Program Studies, Cambridge, Mass., 2000.

administrative costs of public programs result in better outcomes" (4, p. 50). The NCPA contends that administrative costs in single-payer systems have been underestimated by not accounting for "hidden costs." Citing a 1994 study funded by private insurers and conducted by a Technical Committee of the Council for Affordable Health Insurance (an industry trade group), the claim is made that Medicare and Medicaid spend 27 percent of their budgets on administrative costs compared with 16 percent for private insurance (28). Here are some excerpts from the NCPA report that try to show the private insurance industry in a better light, largely without evidence (4):

> The argument that a single-payer system is more efficient than America's decentralized system because its administrative costs are lower assumes that administrative costs do not produce offsetting benefits (pp. 50–51).

> The presence of multiple payers in the U.S. system reflects different tastes and preferences among consumers for amenities such as varied levels of co-payment, choice of physician network, limited waiting for physician visits, etc. In fact, all private health insurance companies use a portion of

> a policyholder's premium to assure the remaining funds are spent wisely while providing quick and convenient service. In doing so, American health plans control moral hazard (e.g. the tendency to over-consume when the service is perceived as being free) rather than rely on the Canadian approach of using waiting lines as a method of rationing services (p. 51).

> The costs of rationing by waiting and the waste of resources caused by perverse incentives are real costs of administering a national health insurance system. For example, the physician fee structure found in Canada (and elsewhere) is designed to limit the volume of procedures performed in doctor's offices. As a result, patient contact is cut short and patients are often forced to make multiple visits to get the same services previously received in one visit. Roughly speaking, the administrative (overhead) costs associated with private insurers are more than offset by hidden costs of public insurers (p. 54).

No quality outcome data are presented, and the NCPA report goes on to promote the use of medical savings accounts.

Without engaging in technical details, the following points appear to fully substantiate the assertion that single-payer health insurance would reduce the administrative costs of the U.S. health care system:

- Based on 1999 data, a 2003 study revealed that administrative costs of U.S. health care now total more than $294 billion a year (31 percent of annual national health care expenditures, or $1,059 per capita—more than three times the per capita costs in Canada (Table 2). With more than 1,200 health

Table 2

Costs of health care administration in the United States and Canada, 1999

	Spending per capita, U.S.$	
Cost category	United States	Canada
Insurance overhead	259	47
Employer's cost to manage health benefits	57	8
Hospital administration	315	103
Nursing home administration	62	29
Administrative costs of practitioners	324	107
Home care administration	42	13
Total	1,059	307

Source: Woolhandler et al. (29).

insurers in the United States, administrative and clerical personnel now account for 27 percent of the entire U.S. health care workforce (29).
- A follow-up study updated these findings to 2003 spending as estimated by the Office of the Actuary, National Center for Health Statistics. Based on these estimates, $286 billion could be saved in 2003, almost $7,000 for every American without health insurances (30).

Quality

Alleged myth no. 4: Although the United States spends more on health care per capita than countries with single-payer health insurance, Americans do not get better care.

Alleged myth no. 5: Countries with single-payer systems have access to the latest technology.

These two myths are considered together, since much of the NCPA's analysis comparing quality of care between the United States and other countries is based on the advantages that the United States has in greater access and use of medical technology, with the unproven assumption that more technology necessarily leads to better quality of care. The NCPA report first describes various technical reasons that limit the validity of life expectancy and infant mortality rates as quality markers for international comparisons. The report then proceeds to ignore a rich literature of cross-national studies of quality of health care, changing the subject to how many more procedures and high-technology services Americans receive—with little attention to their clinical outcomes. Along the way, an assertion is made that such factors as race, income, education, or geography have nothing to do with the quality of (or access to) the U.S. health care system. And further, "In the United States we pay more for health care. We also get more and what we get may save lives" (4, p. 31).

Although there is no question that many Americans can receive the best health care in the world (if they can afford it and avoid the hazards of over-utilization of care), this does not mean that Americans have the best health care system. Nor does it mean that residents in many other industrialized countries around the world do not receive care equivalent to the best care available in the United States. Here are some data, selected from among many, that document the serious short-comings of the U.S. health care system compared with single-payer systems in other industrialized nations:

- Among six countries, the United States ranks worst in terms of potential years of life lost per 100,000 people, from all causes (25, p. 285) (Figure 4).
- A 2000 report by the World Health Organization ranked the United States fifteenth of 25 industrialized countries for such indicators as disability-adjusted life expectancy, child survival to five years of age, experiences in

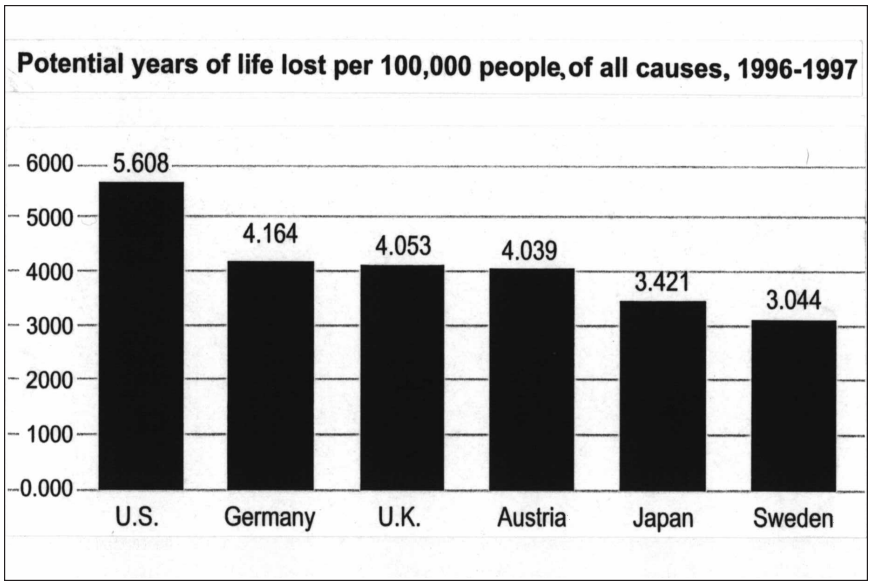

Figure 4. *Source:* OECD, 1999. Reprinted with permission from S. Woolhandler and D. U. Himmelstein, The National Health Program Slide-show Guide, Center for National Health Program Studies, Cambridge, Mass., 2000.

the health care system, social disparities of care, and family out-of-pocket expenditures for health care (31).

- The United States ranks last among 11 industrialized nations on 11 criteria for performance of its primary care base (32).
- A 1998 cross-national comparison ranked the United States second from last among 13 countries on an average for 16 health indicators (33).
- Having more specialists and high-technology services may not produce improved clinical outcomes, as illustrated by Figure 5, which compares neonatal intensive care unit (NICU) resources and infant mortality rates in the United States and three other western countries (34).
- About 1 million preventable treatment-related injuries occur to U.S. patients each year, including transfusion errors, adverse drug events, surgery on the wrong side, and mistaken identity (35, 36).
- A 1998 RAND review of all available studies on the quality of U.S. health care found that 30 percent of Americans receive *contraindicated* acute care, and 20 percent receive contraindicated chronic care (37).
- A 1998 report of the Technology Evaluation Committee of the national Blue Cross and Blue Shield Association found that 10 of 28 evaluations

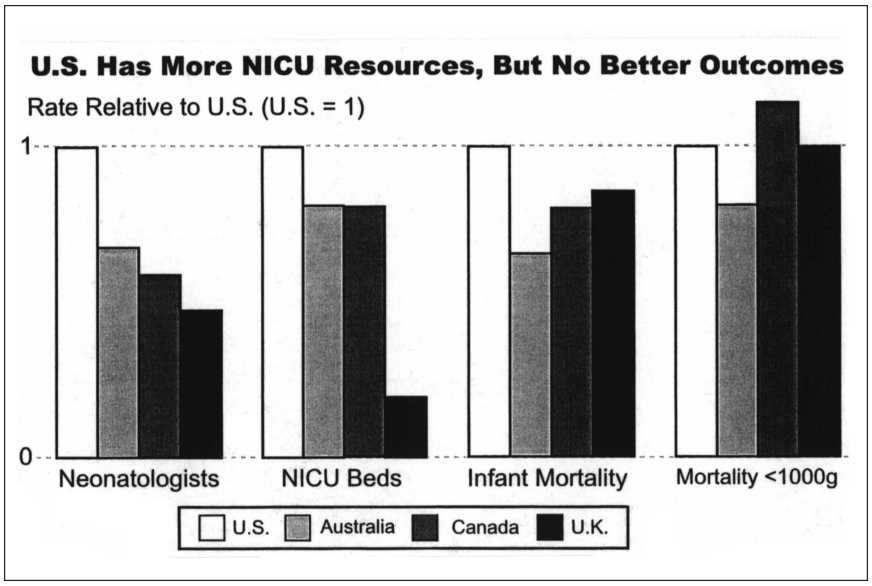

Figure 5. *Source:* Thompson et al. (34).

showed drugs, medical devices, or procedures to be either lacking or uncertain in their effectiveness (38).

- In the United States, where 85 percent of renal dialysis centers are for-profit, death rates for dialysis patients are 47 percent higher than in Canada, and more than one-half of American patients are treated with reprocessed dialysis (an unsafe practice). Twice as many patients in Canada get kidney transplants as in the United States (39).

Efficiency

Alleged myth no. 8: Countries with single-payer systems of national health insurance hold down costs by operating more efficient health care systems.

The NCPA report begins its discussion of this "myth" with this statement (4): "Advocates of single-payer health insurance often point to the low level of health care spending in countries with national health insurance as 'proof' of efficient management. But cheap is not the same as efficient. By and large, countries that have slowed the growth of health care spending have done so by *denying* services, not by using resources more efficiently" (p. 38). The report then goes on to describe shortages of hospital beds and longer lengths of stay in British and Canadian hospitals as examples of inefficiencies in single-payer systems. It asserts that "the more efficient the hospital, the more quickly it will admit and discharge

patients." The actuarial firm Milliman & Robertson is lauded as "the market leader in devising guidelines" (the Length of Stay Efficiency Index) (p. 40). Without any acknowledgment of the enormous bureaucracy and administrative waste within the private health insurance, provider, and supply industries, the report claims (without any supporting data) greater efficiency through competition in the private medical marketplace. Elsewhere in the report, the efficiency issue is summarized in this way: "Single-payer health insurance differs from many private insurance companies in one important respect—no profit motive. But, far from [stockholders] being a burden, having no stockholders removes any incentive to operate efficiently. In fact, national health insurance provides all the wrong incentives for both the health care system itself and the patients in the system" (p. 64).

The NCPA's claims to greater efficiency within the private sector do not stand up well against these lines of evidence:

- As a single-payer program serving the elderly for four decades, U.S. Medicare operates with an administrative overhead of about 3 percent, compared with overheads five to nine times higher for private insurers (Figure 6; "Blues" indicates Blue Cross–Blue Shield) (40).

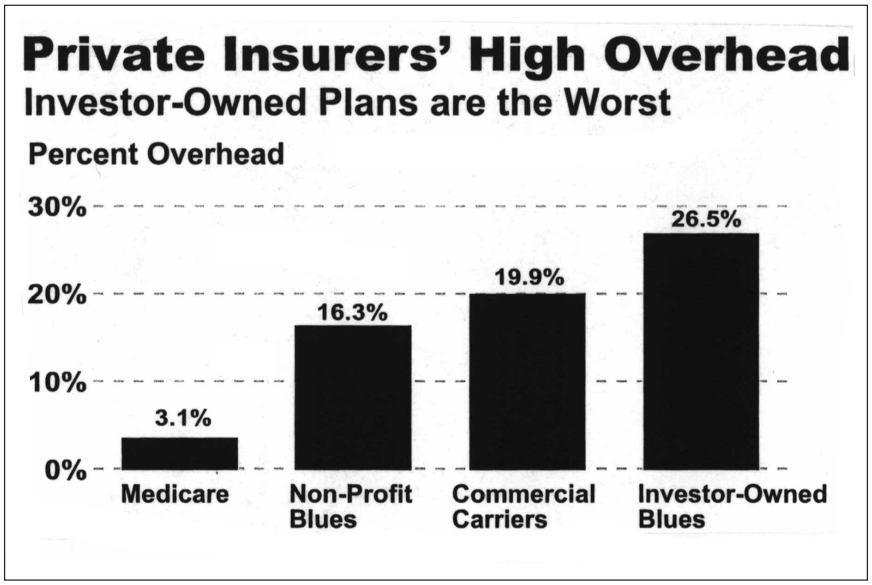

Figure 6. *Source:* Geyman (40). Reprinted with permission from S. Woolhandler and D. U. Himmelstein, The National Health Program Slide-show Guide, Center for National Health Program Studies, Cambridge, Mass., 2000.

- Major private health insurers in the United States range from 13 to 31 employees per 10,000 enrollees, compared with only 1 or 2 per 100,000 in Canadian provincial health plans (29).
- With more than 1,200 private health insurers in the United States, fragmentation, inefficiency, and duplicative bureaucracy are the rule for providers and patients alike. One study of 2,000 patients with depression in Seattle found that they were covered by 189 different plans with 755 different policies (41).
- While claiming greater efficiency and value than fee-for-service Medicare, Medicare + Choice HMOs are subsidized by government, and still exit the market if not sufficiently profitable. Between 1998 and 2000, the government paid them 13 percent more than traditional Medicare costs, and still many HMOs withdrew from the market, leaving 2.4 million seniors to find alternative coverage and often other health care providers (42).
- Medicare Advantage, the successor to Medicare + Choice plans, continues to claim greater efficiency and value than fee-for-service Medicare, but is still subsidized by federal payments well in excess of traditional Medicare's funding. The average overpayment to a Medicare Advantage plan is 107 percent of fee-for-service Medicare in 2004, with some high-cost counties receiving overpayments of 132 percent (e.g., San Francisco County) (43).
- The Milliman & Robertson guidelines, touted by the NCPA report for their "efficiency," have been considered medically unsafe by many physicians. For example, the guidelines have recommended hospital stays of only 3 days for children with *complicated* appendectomy, while a national database of 2,400 U.S. hospitals found average lengths of stay for these children to be 5.3 days (44).

Single-Payer as Solution

Alleged myth no. 13: Single-payer health insurance is the solution to problems of managed care.

After noting the failure of managed care to contain costs in the 1990s and the resulting consumer backlash to it, the NCPA report lists reasons why single-payer would not solve health system problems in the United States. It argues that a single-payer system would limit access to specialists and to diagnostic and treatment services; provide the wrong incentives to providers (no competition) and patients ("free" care); and threaten physician compensation and satisfaction. The report promotes entrepreneural providers in an unfettered marketplace over negotiated fees, and direct access to specialists and specialty services based on willingness to pay. The role of primary care is discounted, and financial barriers to care by a large part of the population are not considered.

The following points counter the premise and concerns of the NCPA:

- After a nine-year study of 12 major U.S. health care markets, a recent report of the landmark Community Tracking Study found widespread and deep skepticism that markets can improve efficiency and quality in our health care system. This study identified four major barriers to efficiency: (*a*) providers' market power; (*b*) absence of potentially efficient provider systems; (*c*) employers' inability to push the system toward efficiency and quality; and (*d*) insufficient health plan competition (45).
- Several government agencies and private sector analysts have concluded that single-payer national health insurance would *not* increase total health care costs (46–51). A leading health economist at the World Bank has concluded that universal health care results in cost containment, not explosion of costs (52).
- Increased cost sharing with patients, especially in lower-income groups, leads to decreased utilization of necessary care and worse outcomes (53, 54). Many countries with single-payer systems have effectively controlled health care costs without the use of copayments and deductibles (29).
- The extent to which the for-profit investor-owned private sector, in its drive toward "efficiency" and profits, abuses the public interest in terms of cost and quality is summarized in Table 3 (55).
- U.S. physicians face more intrusive cost reviews than physicians in countries with single-payer systems (Figure 7) (70). The average American physician spends 8 hours per week on burdensome paper work (71), and both patients and providers are dissatisfied with the increasing bureaucracy of health care (72).
- A 1999 study of more than 2,100 medical students, residents, faculty, and deans in U.S. medical schools found that 57 percent support single-payer national health insurance (73).

Controlling Drug Costs

Alleged myth no. 18: Single-payer health insurance systems would reduce the costs of prescription drugs for Americans.

Here, the NCPA report argues against price controls of drugs as ineffective, restricting research and development (R&D) of new drugs, and limiting access abroad to important new drugs through national drug formularies. It also argues that drug prices in other countries are often higher than in the United States. Unsupported claims are made: "On the whole, prescription drug prices in countries with national health insurance are comparable to U.S. prices despite stringent rationing of availability in the other countries" (4, p. 81) and "the United States produces by far the most innovative drugs" (p. 83).

This argument breaks down under overwhelming evidence to the contrary:

Table 3

Investor-owned care: Comparative examples versus not-for-profit care

Hospitals	Costs 3 to 13 percent higher, with higher overhead, fewer nurses, and death rates 6 to 7 percent higher (56–61)
HMOs	Higher overhead (25 to 33 percent for some of the largest HMOs); worse scores on 14 of 14 quality indicators reported to National Committee for Quality Assurance (62–64)
Dialysis centers	Death rates 30 percent higher, with 26 percent less use of transplants (65, 66)
Nursing homes	Lower staffing levels and worse quality of care (30 percent committed violations that caused death or life-threatening harm to patients) (67)
Mental health centers	Medicare expelled 80 programs after investigations found that 91 percent of claims were fraudulent (68); for-profit behavioral health companies impose restrictive barriers and limits to care (e.g., premature discharge from hospitals without adequate outpatient care) (69)

Source: Geyman (55); adapted with permission from the American Board of Family Practice, Lexington, Kentucky.

- According to studies by the AARP Public Policy Institute, drug manufacturers' drug prices are 69 percent higher in the United States than in Canada, wholesale prices are 72 percent higher, and retail prices up to 72 percent higher (71).
- According to IMS Health, a pharmaceutical industry research firm, in 2003 Americans spent $695 million on drugs bought from Canada (75).
- The average price for prescription drugs around the world is just one-quarter of the U.S. price (76).
- Even though R&D costs of many drugs developed in the United States are funded in large part by federal tax monies through basic research by the National Institutes of Health, drug manufacturers exaggerate their own R&D expenditures, claiming that about $800 million are expended to bring a new drug to market (77). Studies by Public Citizen's Health Research Group put that figure closer to $110 million (78).
- Most new drugs are not innovative and are merely "me-too" drugs with minimal structural change but maximal marketing hype as "breakthroughs," launching another 17-year period of patent protection (79). The nonprofit

Figure 7. *Source:* Blendon et al. (70). Reprinted with permission from S. Woolhandler and D. U. Himmelstein, The National Health Program Slide-show Guide, Center for National Health Program Studies, Cambridge, Mass., 2000.

National Institute of Health Care Management estimates that 85 percent of drugs approved by the FDA between 1989 and 2000 were modifications of existing drugs (80).

- Fifty-seven percent of the more important new drugs are discovered by R&D in other countries and later marketed in the United States (81). The European Federation of Pharmaceutical Industries, despite the presence of price controls in their countries, spent $47 billion on R&D in 2002, about 50 percent more than R&D spending by U.S. drug manufacturers (82, 83).
- The price of Lanoxin (digoxin), the most common drug used by the elderly, rose seven times the inflation rate in 1998 (84). Tamoxifen (Nolvadex), a long-term drug used by patients with breast cancer, costs $360 in the United States for a 30-day supply, compared with $60 at the pharmacy at the Munich International Airport in Germany (85).

Competing Abroad

Alleged myth no. 14: A single-payer system of health insurance would improve the United States' ability to compete in international markets and benefit American labor.

Citing its own 1991 report on myths about national health insurance, the 2002 NCPA report asserts that "there is no evidence that the cost of private health insurance adds anything to the price of a good" (4, p. 68). It further claims that a single-payer system would render U.S. business *less* competitive in the international marketplace, because employers would have to shoulder an increased tax burden.

Both of these assertions are patently false, for reasons such as the following:

- A 2003 random survey of U.S. employers found that the typical employer spends $6,619 a year per family for health insurance premiums (to which the typical employee adds another $2,419). Despite increasing cost shifting from employers to employees, employers' premiums have climbed 38 percent in the last three years (86).
- Escalating health care costs are now being blamed as a major factor in the nation's jobless recovery, as many employers rely on existing employees and temporary workers not requiring health benefits (86).
- Big U.S. employers are quite sure that their burden of health care costs puts them at a competitive disadvantage abroad. General Motors, the largest provider of health care benefits in the country, spends about $1,400 on health care for each car sold in the United States—more than the cost of the steel. GM's future obligation to retirees' health care has risen to more than $63 billion (87). Ford's vice chairman recently had this to say on the subject: high health care costs have "created a competitive gap that's driving investment decisions away from the U.S. . . . Right now the country is on an unsustainable track and it won't get any better until we begin—business, labor and government in partnership—to make a pact for reform. A lot of people think a single-payer system is better" (88).
- The National Association of Manufacturers, a trade group in Washington, D.C., representing hundreds of small employers across the country, estimates that health care costs now account for a much larger part of labor costs in the United States than in most other countries, putting U.S. companies at a competitive disadvantage (89).
- The lack of health insurance for more than 45 million Americans adversely affects the nation's workforce; the Institute of Medicine recently estimated that the annualized cost of the diminished health and productivity and the shorter life spans of the uninsured totals $65 to $130 billion for each year of health insurance foregone (90).
- There is already plenty of money in the present health care system, if it were reallocated under single-payer insurance, to cover all Americans. Simplification and elimination of administrative waste would generate savings well over $200 billion a year, fully offsetting the costs of universal coverage (30, 91).

Public Support

Alleged myth no. 19: Single-payer health insurance would be popular in the United States.

With only cursory and limited reference to a considerable body of literature on public opinion about health care, the NCPA report asserts that most Americans support the present health care system with only minor changes needed. These unsupported statements are made: "Americans are accustomed to a level of health care that socialized medical systems cannot provide. . . . Only a small percentage of Americans are dissatisfied with their family's care. . . . We also have a legal system that protects the rights of those without political power or money, and a strong devotion to basic rights of due process. Single-payer systems of national health insurance, as it operates in other countries, simply would not survive in the U.S. cultural and legal system" (4, pp. 83–84).

Despite the NCPA's claims, there is abundant evidence that a majority of Americans believe that their health care system needs to be completely rebuilt, and that government needs to play a larger role in that process:

- National polls have shown high levels of support for national health insurance at many times over the last 60 years—74 percent during the 1940s (92); 61 percent for the single-payer Medicare program in 1965; and 50 to 66 percent over the last 25 years in response to polls asking about "national health insurance financed by tax money, and paying for most forms of health care" (93).
- A 1997 national survey by the National Coalition on Healthcare found that four of five respondents agreed that "medical care has become big business that puts profits ahead of people," and three of four believed that the federal government should be more active in assuring access to care (94).
- A 2002 national poll by Harris Interactive surveyed five different groups—public citizens, physicians, employers, hospital managers, and health plan managers. One-half of all these groups favored *radical* health care reform, with less than 19 percent of any of the five groups feeling that only incremental change is needed (72).
- A 2003 national poll by ABC News and the *Washington Post* found that 62 percent of Americans preferred "a universal health insurance program, in which everyone is covered under a program like Medicare that's run by the government and financed by taxpayers" (95). If respondents had been told that a publicly financed national insurance program like Medicare would assure greater choice of physicians and hospitals than in private plans, their support for universal coverage guaranteed by the government undoubtedly would have been even higher.
- In 1993, the last time that the Gallup poll asked Canadians whether they preferred the U.S. health care system to the Canadian system, only 2 percent

did, with 96 percent preferring their own system. A 1998 Zogby poll found that 51 percent of Americans favored a "government-run health care plan like Canada's" (despite the negative connotation of "government-run," only 38 percent were against such a plan) (96).

MEMES CONCERNING NATIONAL HEALTH INSURANCE

In view of the National Center for Policy Analysis's consistent conservative and promarket approach to public policy issues, it comes as no surprise that these conclusions are drawn at the end of its 135-page 2002 report on single-payer health insurance (4, p. 95):

> Our survey of national health insurance in countries around the world provides convincing evidence that government control of health care usually makes citizens worse off. When health care is made free at the point of consumption, rationing by waiting is inevitable. Government control of the health care system makes the rationing problem worse as governments attempt to slow the use of services by limiting access to modern medical technology. Under government management, both efficiency and quality of patient care steadily deteriorates.
>
> The lesson from other countries is that America would not be served by an expansion of government bureaucracy or by greater governmental control over the U.S. health care system. Instead, what is needed is a limitation of the role of government and an expansion of the role played by the private sector and the individual in solving our health care problems.

The NCPA report, in its biased attempt to discredit 20 "myths" about single-payer national health insurance, perpetuates a number of misperceptions as memes on the subject.. These clearly serve the interests of conservative groups and stakeholders in the nation's market-based health care system. Here are just six memes that are promoted without supporting evidence.

Meme no. 1: The competitive private health care marketplace is more efficient and provides greater value than government-financed health care.

This view is touted as the "American way," despite its failure to resolve access, cost, or quality problems in health care and despite incontrovertible evidence that health care markets do not function in a freely competitive way (97).

Meme no. 2: Health care costs can be contained if overuse is managed by giving consumers more choice and responsibility for their own health care decisions.

This has become established as the theoretical underpinning of the consumer-choice model of incremental health care "reform." It disregards the greater role in rising health care costs of the market power of insurance, drug and medical

device manufacturers, hospitals, and other suppliers of services (98). More importantly, it ignores the widespread *underuse* of needed health care services by many millions of uninsured and underinsured Americans (99). Further, there is evidence that Canada's national health insurance encourages *appropriate* use of medical care, with better outcomes of care for poor women with cancer compared with poor women in Detroit with the same cancers, even after accounting for race and standards of measuring poverty (100, 101).

Meme no. 3: The more technology, the better the health care.

This notion is put forward by conservative critics of single-payer health care systems in other countries, with the false assumption that access to more medical technology correlates well with improved quality or outcomes of care. There are many examples in the United States to refute this assumption (e.g., the lack of improved outcomes in the United States with larger numbers of neonatologists and NICU facilities) (34), as well as many other examples that document the risks and harms of more technological services (102).

Meme no. 4: We don't ration care as much as do countries with national health insurance.

In this country, we cruelly ration care by income and class by maintaining barriers to care, especially financial ones, that limit essential health care services for those who cannot afford care. Then we look away and deny the problem. On the other side of the coin, many medically unnecessary high-technology services are provided to affluent patients to the economic benefit of providers and suppliers (e.g., CT body scans are a rapidly growing part of a diagnostic screening industry, without any evidence to date that they will be cost-effective or medically useful) (103). Whether one admits it or not, some kind of rationing, preferably based on medical necessity and egalitarian access, is vital to the long-term viability of any health care system.

Meme no. 5: National health insurance is socialized medicine.

Conservative critics consistently raise the fear words "socialized medicine" whenever the subject of single-payer health insurance is raised. This term appears throughout the NCPA report. Instead, however, national health insurance in Canada and in most other western industrialized countries is socialized insurance with a predominantly private delivery system. Universal access to medically necessary care is assured, with public financing of a mostly private system, and cost savings allowing long-term sustainability (104).

Meme no. 6: The American public is too individualistic to want national health insurance.

We have already touched on this in countering alleged myth no. 19. What needs emphasis here is the continuing drumbeat in the major media, fueled by

corporate stakeholder interests and funding, to suppress coverage of single-payer reform and discredit such systems elsewhere. The cultural meme of American individualism has been effective for many years in fragmenting social solidarity. Despite the findings of many public opinion polls over the years, together with growing support for national health insurance among health professionals and the provider community, the media usually give little attention to fundamental health care reform. Examples include the coverage of Canada's overcrowded emergency rooms, without mentioning that this is a major problem in the United States as well (96); and *NBC Nightly News* in its 2002 coverage of Measure 23, a single-payer proposal in Oregon, repeating private health insurers warnings about higher costs and taxes (untrue) and not disclosing NBC's conflict of interest (it is owned by General Electric, which is heavily invested in the insurance and medical industries) (105).

CONCLUSION

The NCPA case against single-payer national health insurance, based as it is on myths and memes of its own without supporting evidence, ends up as disinformation. The NCPA premise—that the unfettered private health care marketplace can resolve the United States' continuing problems of access, cost, quality, and equity in its health care system—is deeply flawed. However, powerful stakeholders in the present system are waging an ongoing self-serving battle to preserve the status quo without major reform.

Incremental attempts to resolve system problems in U.S. health care have failed for more than 25 years. The advantages of single-payer national health insurance in addressing these problems are becoming more evident all the time, including within the large and small business community. The national debate over structural health care reform needs to account for past experience and needs to be based on evidence, not outworn myths and memes.

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