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The American health system is uniquely expensive and inflationary. Last year we spent about $2.5 trillion on health care, or some $8,000 per person, and costs keep growing much faster than the background inflation rate. What about comparably wealthy countries? If we look at the 30 members of the OECD, we find a startling disparity. In the most recent year for which figures are available, we spent two and a half times as much per person on health care as the median for the OECD countries. The other countries clustered fairly close together, while we stood clearly apart, and that gap is growing. Clearly, our health system is unsustainable.

As if that weren't bad enough, we don't get anywhere near our money's worth. By all the usual measures of health care – life expectancy, infant mortality, immunization rates, preventable mortality – we rank near the bottom of the OECD countries. Furthermore, contrary to conventional wisdom, we don't provide more basic services. On average, we have fewer hospital beds and fewer doctors and nurses per capita, we see our doctors less often and have shorter hospital stays. Canadians, for example, see their doctors nearly twice as often as we do. Worst of all, we're the only wealthy nation that does not provide comprehensive health care to all its citizens. Nearly 50 million Americans are uninsured – disproportionately the sick, the poor, and minorities -- and many of the rest of us are underinsured, in the sense that we're not covered for every contingency. Loss of employment often means loss of health insurance, a particularly devastating problem in the current recession.

Our health care system, then, is outrageously expensive, yet inadequate and inequitable. How can we account for the paradox of spending more and getting less? The only plausible explanation is that there's something about the system itself – about the way we finance and deliver health care – that's enormously wasteful.

The underlying problem, I believe, is that we, alone among OECD countries, rely on a market-based system for health care. In fact, it's not a *system* at all, but a hodge-podge of different commercial arrangements that exist more or less independently from one another. The other countries all have national health systems. Some are single-payer arrangements, which means that all health care funds, whatever their source, are funneled through a single public agency, which then coordinates the distribution of resources. Some have multiple payers, but the system is tightly regulated so that everyone is covered, and prices and benefits are uniform.

Most of our other problems stem from that decision to treat health care like a market commodity instead of a social service. Thus, we distribute it not according to medical need, but according to the ability to pay. But there's a great mismatch between medical need and the ability to pay. In fact, those with the greatest need are precisely those least able to pay. So while markets are good for many things, they're not a good way to distribute health care. People who are well insured may get an MRI they don't need (and overuse of tests is a major contributor to cost inflation), while people without insurance may not get an MRI they *do* need.

Furthermore, successful markets expand; they don't contract. Businesses aim to increase revenues and maximize profits. Hospitals in the U. S., for example, often advertise their services. Like all businesses, they want more, not fewer customers. So each element in the health market is working to grow, even while the country as a whole presumably wants the system to contract.

Let's look more closely at how the health care market works. Most Americans receive tax-exempt health benefits from their employers, who pay insurers a portion of the insurance premiums – these days, a smaller and smaller portion. But not all employers offer benefits – it's strictly voluntary -- and when they do, the benefits may not be comprehensive. Increasingly, employers cap their contributions, so that the burden of increasing costs falls entirely on workers. Workers, in turn, often turn down benefits, even when they're offered, because they can't afford their growing share.

The insurers with whom employers contract are mostly investor-owned, for-profit businesses. They try to keep premiums down and profits up by stinting on medical services. In fact, the best way for insurers to compete is by not insuring the sickest patients at all; by limiting the coverage of those they do insure (for example, by excluding expensive services from the benefit package); and by passing costs back to patients as deductibles and co-payments and claim denials. *We're the only nation in the world with a health care system based on dodging sick people.* These practices add enormously to overhead costs because they require a great deal of paperwork. They also require creative marketing to attract the affluent and healthy and avoid the poor and sick. Not surprisingly, the U. S. has by far the highest overhead costs in the world.

Now let's follow the health care dollar as it wends its way from employers toward the doctors and nurses and hospitals that actually provide medical services. First, private insurers regularly skim off the top a substantial fraction of the premiums – on average about 20 percent – for their administrative costs, marketing, and profits. The remainder is then passed along a veritable gauntlet of satellite businesses that have sprung up around the health care industry. These include brokers to cut deals, disease-management and utilization review companies, drug-management companies, legal services, marketing consultants, billing agencies, information management firms, and so on and so on. They, too, siphon off some of the premiums, including enough for their administrative costs, marketing, and profits. Probably no more than 70 cents of the health care

dollar actually reaches the providers – who themselves have high overhead costs to deal with the requirements of multiple insurers often bent on avoiding payment. Cutting overhead in half would save the system about 350 billion dollars -- more than enough to cover the uninsured.

In the past, there have been many attempts to reform the system incrementally. Mainly these have been efforts to counteract the harshest effects of the market by subsidizing care to people who would otherwise go without and discouraging demand by stratagems such as managed care. But all attempts to reform the system piecemeal have run into the following dilemma. If we expand coverage, then costs inevitably rise. And if costs are lowered, coverage is reduced. If the system stays essentially as it is and we tinker around the edges, coverage and costs have to move in the same direction. *The only way both to increase health coverage and reduce costs is to change the system entirely.*

With few exceptions, neither the Democrats nor the Republicans have advocated changing the system entirely. They have instead embraced different horns of the coverage/cost dilemma. Democrats generally favor increasing coverage, even though costs would rise still further, and Republicans favor controlling costs, even though coverage would surely shrink.

Many policymakers look to the Massachusetts plan, enacted in 2006, as a model. Through an individual mandate and subsidies for the poor, it has resulted in nearly universal insurance coverage. But it leaves the present profit-driven and highly inflationary system essentially unchanged, and simply pours more money into it. Already the plan is in deep trouble for that reason. The only way to control costs in such a system is to shrink the benefit package or increase deductibles and co-payments or both, and that's what Massachusetts is doing. The result is that people may have insurance that is inadequate or too expensive to actually use, because of high co-payments. Health insurance is not the same thing as health care – not by a long shot. People can have insurance that's of little use to them when

they're sick. *And there is no sense in enacting health reform if it will quickly become unaffordable.*

I believe the only answer is a nonprofit single-payer system, as called for in HR 676. In some ways, this would be tantamount to extending Medicare to the entire population. Medicare is, after all, a government-financed single-payer program embedded within our private, market-based system. It's by far the most efficient part of our system, with overhead costs of less than 3 percent, and it covers virtually everyone over the age of 65, not just some of them. It also covers everyone for the full package of benefits, so it can't be tailored to avoid high-risk patients. But Medicare is not perfect, and was weakened by the Bush administration, which was hostile to it. Out-of-pocket costs are substantial and growing. Doctors' fees are skewed to reward highly paid specialists for doing as many expensive procedures as possible. Furthermore, because Medicare pays for care in a market-based entrepreneurial system, it experiences many of the same inflationary forces as the private insurance system. If Medicare were extended to everyone, it would have to be in the context of a nonprofit delivery system. Otherwise, we would not realize the advantages of a single-payer, coordinated financing system.

The main opposition to a single-payer system comes from two powerful industries – the private health insurance industry and the pharmaceutical industry. They in turn have inordinate influence over lawmakers and many economists and health policy experts, as well. These special interests propagate a number of myths.

Myth #1 is that we can't afford a single-payer system. The truth is that we can't afford *not* to have a national health care system. Our costs are exorbitant, premiums are rising rapidly, and the number of uninsured will undoubtedly swell as more employers drop health benefits or cap their contributions, and fewer workers find they can make up the difference. A single-payer system would be far more cost-effective, since it would eliminate excess overhead, profits, cost-shifting and unnecessary

duplication. Furthermore, it would permit the establishment of an overall budget and the fair and rational distribution of resources. We should remember that we now pay for health care in multiple ways – through our paychecks, the prices of goods and services, taxes at all levels of government, and increasingly out-of-pocket. It makes more sense to pay only once. The most progressive way is through an earmarked health care tax on income.

According to Myth #2, innovative technologies would be scarce under a single-payer system, we would have long waiting lists, and maybe rationing. This misconception is based on the fact that there are indeed waits for elective procedures in some countries with national health systems, such as the U. K. and Canada. But that's because they spend far less on health care than we do. (The U. K. spends about a third of what we do per person.) If they were to put the same amount of money as we spend into their systems, there would be no waits and all their citizens would have immediate access to all the care they need. *For them, the problem is not the system; it's the money. For us, it's not the money; it's the system.* There's plenty of money in it.

Myth #3 is that a single-payer system would subject doctors and nurses and other providers to onerous, bureaucratic regulations. But nothing could be more onerous both to patients and providers than the multiple, intrusive regulations imposed on them by the private insurance industry. In fact, recent polls show that about 60 percent of doctors would prefer a national system to what we have now.

Myth #4 says that the government can't do anything right. Some Americans like to say that, without thinking of all the ways in which government functions fairly well, and without considering the alternatives. I had a very conservative uncle who once asked me (rhetorically) to name three things the government does well. I said the NIH, the National Park Service, and the IRS. I might also have added Medicare, which as I've said is far better at funding health care than the private sector. We should remember that the

government is elected by the public and is accountable to the public. In contrast, an investor-owned insurance company reports to its owners, not to the public.

According to myth #5, a single-payer system is a good idea, but unrealistic. I don't underestimate the special interests that would be arrayed against establishing such a system – they would be formidable, and it would take concerted pressure from the public and the medical profession to defeat them – but the fact remains that a national system is the only way to provide universal, comprehensive care, while providing a mechanism to contain costs. *What is truly unrealistic is anything else.*

I want to mention one final and very important reason for enacting a nonprofit single-payer health program. We live in a country that tolerates enormous and growing disparities in income, material possessions, and social privilege. That may be an inevitable consequence of a free market economy. But those disparities should not extend to denying some of our citizens certain essential services because of their income or social status. One of those services is health care. Others are education, clean water and air, equal justice, and protection from crime, all of which we already acknowledge are public responsibilities. We need to acknowledge the same thing for health care. Providing these essential services to all Americans, regardless of who they are, marks a decent and cohesive society. It says that when it comes to vital needs, we are one nation, not 300 million individuals competing with one another.