



## **"Single-Payer" Simply Won't Work in California**

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By David J. Gibson, MD

**An increased state tax liability for expanded California entitlements would impoverish our children and their families.**

HOW WE PAY FOR HEALTH CARE is near the top of the public's agenda once again. Democratic Presidential candidate Richard Gephardt has offered a universal healthcare plan with a \$247 billion a year price tag. Several universal health care proposals are moving in the Legislature. Blue Shield of California and the California Medical Association are putting political muscle behind the single-payer concept.

No one disputes our serious health care access and financing problem. The state now spends \$150 billion a year, a 10th of its economy, on public and private medical services. California's Medi-Cal program has grown 25 percent in two years and more than 50 percent since 1997.

Even so, the state's percentage of medically uninsured residents, about 20 percent, is the third highest of any state, and in sheer numbers, 6.6 million, far surpasses any other state. The L.A. Times<sup>1</sup> recently reported that people were dying needlessly in Southern California hospital emergency rooms during 30-hour waits for medical attention.

Rethinking the underwriting mechanism for public and privately financed health care is both timely and appropriate. The current third-party payment system is quite simply not sustainable. It has created an inflationary juggernaut that is quite literally destroying California's economy.<sup>2</sup>

As we dismantle the current system of paying for health care, a single-payer model is being examined and debated. But is single-payer a viable option? I believe the answer is, "no." I base this conclusion on the following:

### **Single-payer proposals do not go far enough to curtail inflation.**

A hybrid system that combines a competitive private service sector with public sector funding will exacerbate rather than stabilize health care's cost spiral.

The current health care financing system has distanced consumers from the cost of the services they are using. Consequently, pricing is based upon what the government and the employer can pay rather than on what the patient can afford. Such a system stifles innovation, efficiency and quality. There is no accountability.

For single-payer to be a realistic option, it must go further than any of the proposals currently before the Legislature. All of the current proposals will put more inflationary pressure, not less, on the system - inevitably leading to overt, rather than current covert, rationing.

To implement statewide overt rationing, the state would need to take over all of the health

care delivery system. Hospitals, nursing homes and pharmacies would become public institutions and physicians, nurses and pharmacists would all work for the government.

Canada's system has been around long enough to judge the merits of a state financed underwriting system. Canada's massive system has put the average family's tax burden at nearly 50 percent of its income. In return, Canadians have access to 7.3 CT scanners and 7 radiation machines per million persons - a worse ratio than the Czech Republic, which is still recovering from communism.

Canada rations health care services by using waiting lists. For example: The median waiting time for angioplasty in British Columbia is 12 weeks; radiation for breast cancer in Ontario will take 8 weeks; there is an average 12 week wait in Quebec to get prostate cancer radiation treatment. The average waiting time across Canada increased from 9.3 weeks in 1993 to 14 weeks by 1999.<sup>3</sup>

It is beyond the ability of a publicly-financed private delivery system to impose this draconian health care rationing in California.

### **Taxpayers will not support the cost for single-payer.**

Single-payer has not fared well at the polls. In 1994, Californians resoundingly defeated Proposition 186, a single-payer health-care initiative.

In November of 2002, Oregon voters defeated a universal health care proposal for state residents. It would have raised the state's income tax rate to 17 percent to pay for a \$20 billion health care system. It failed by almost a 4-to-1 margin.

Blue Shield recently proposed a universal coverage plan that it estimates would increase California's spending on health care by \$7.8 billion a year (state spending - \$4.5 billion, businesses - \$3.2 billion and individuals - \$63 million).<sup>4</sup> This is about 10 percent of the state's general fund budget.

Daniel Weintraub<sup>5</sup> points out that this plan is fundamentally flawed. "By placing on employers a \$3.2 billion-plus tax increase burden for providing insurance for their workers, it amounts to a tax on hiring at a time when creating new jobs is something we should be making more attractive, not more difficult, for employers to do."

Blue Cross' proposal not only faces resistance from voters and employers, but it also is the victim of bad timing. California has a \$35 billion plus deficit that is growing by \$21 million a day. The Legislature is dismantling large portions of the public social welfare safety-net infrastructure, not enlarging it.

Last year, the Legislature enacted a "family leave" mandate along with enriched workmen's compensation benefits. Employers across the state claim such actions are killing jobs. California's manufacturing overhead costs are now 32 percent higher than the national average. The state lost more than a quarter-million industrial jobs in the last two years - a 16 percent loss in our industrial work force.

California's voters are not California's tax payers - that is a major problem. The top 10 percent of filers pay 75 percent of personal income taxes. This means that most beneficiaries in a government-based single-payer system will not have to pay for it.

Even if voters support increasing the scope and cost of state entitlements, the next generation of taxpayers cannot sustain the federal commitments that have already been made. By 2050, Social Security and Medicare will require more than half of federal income tax revenue - 54.2 percent - in addition to payroll taxes. An increased state tax liability for expanded California entitlements would impoverish our children and their families.

### **Voters are skeptical of the competence of policy makers.**

As its deficit approaches \$40 billion, California must borrow \$30 billion over the next year in short-term loans to cover operating expenses, long-term general obligation bonds approved by voters and other borrowing. Wall Street is sending clear warnings that the state must quickly craft a budget plan that addresses the structural imbalance between spending and revenues or access to the loan market may not be available in the future.<sup>6</sup>

The state's economy generates \$1.3 trillion in annual output and is the fifth or sixth largest economy in the world. The Tax Foundation ranks California's overall tax burden as the seventh highest among the 50 states. Sacramento took in \$69 billion in revenue this year, 18 percent more than four years ago. Yet the Governor and Legislature have created a deficit of such magnitude that even if the state fired every single person on the payroll it would still be more than \$6 billion short. Now THAT is incompetence.

Politically expedient overspending has produced a budget debacle dictating significant health funding cutbacks. The state is planning cuts in benefits, in eligibility and payments to health care providers. It is also considering proposals to eliminate dental and vision coverage for adults. In all, the governor has called for eliminating health coverage for 300,000 low-income patients with even more significant cuts a likely probability.

Few in California have confidence that our policy making class is competent to control a vital service like health care. Statewide polling<sup>7</sup> found that just 9 percent of voters have "a great deal of confidence" in Governor Gray Davis "to do what is right" on the budget. The Legislature scores even lower at 7 percent.

Davis, with a 24 percent overall approval rating, is the most distrusted governor since the 1960s, when nonpartisan statewide polling began surveying public support for California governors.

With these historically low levels of confidence in political leadership, this is not a conducive environment for expanding the scope of state based entitlements.

### **Voters will not support a Scandinavian-style social welfare state.**

As Dan Walters recently pointed out<sup>8</sup> in his Sacramento Bee column, there is a political agenda within which the single-payer concept resides. The overall goal is stated in a resolution carried by Sen. Richard Alarcón. The measure would declare the state's ambition to "end poverty in California" by "closing the income gap between haves and have-nots" through income redistribution programs such as single-payer.

In short, the ascendant Democratic activists within the Legislature would like to create an ever-expanding government somewhat akin to the Scandinavian-style social welfare state, with universal access to income support, health care, higher education and other benefits.

Scandinavian-level services here would expand government, and the taxes to pay for it, by quantum amounts. Governmental spending in Scandinavia typically runs about 50 percent of gross national product. Norway, for example, with a population only 12 percent of California's and an economy less than 10 percent as large, has a national budget that rivals California's.

As it happens, liberals achieved dominance in the Legislature just as the state was sliding into a fiscal abyss. And that probably means dismantling portions of the public social welfare infrastructure, not enlarging it.

Experience shows that government programs, once launched, tend to grow irrespective of how inefficient, counterproductive or corrupt they may become. Furthermore, such programs are practically impossible to eliminate.

The most effective way to broaden access to health care is to control its cost. The way America controls costs in all other segments of its economy is by putting individuals in charge of their own spending decisions. That approach works.

Political reallocation, the taking of something from someone and giving it to someone else, and myriad pricing schemes, testing programs and qualification rules will not fix the health care system. Creating ever more aggressive plans for underwriting healthcare's unsustainable cost spiral is a mistake. Working harder at a failed strategy will never produce success.

Advocates of the single-payer concept need to level with the public. Single-payer will not work unless California converts its economy from a meritocracy into a utopian, Scandinavian-like, egalitarian colony; unless it substantially raises taxes on the middle class; and unless the state takes over the entire health care system, not just its underwriting, to implement the inevitable rationing that will result.

It is time for both the employer and the government to get out of health care and let the market control the cost spiral and broaden access to health care.

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3. How Good is Canadian Health Care?: An International Comparison of Health Care Systems; Fraser Forum; August 2002.
4. Report commissioned by Blue Shield and prepared by Emory University professor Kenneth Thorpe; 2003.
5. Daniel Weintraub; Sacramento Bee; April 29, 2003.
6. Goldman Sachs memorandum; April 18, 2003; Sac Bee; Thursday, May 8, 2003.
7. Field Poll, April 2003.
8. Dan Walters; Sacramento Bee; April 27, 2003.

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