



## The Case for Single Payer

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by Ed Rudin, MD

HEALTH CARE MELTDOWN, by Bob LeBow, MD, MPH, JRI Press, 5398 N. Cattail Way, Boise, ID 83703-1778. Copyright 2002. 269pp. ISBN 0-9710972-1-6

*Dr. Rudin died before completing this review on a topic addressed in several recent articles.*

SINCE THE CLINTONS AND HARRY AND LOUISE, it has not been easy to find a physician like Bob LeBow who is willing to put in writing why a single-payer system is the best, or only, way to provide universal health care in this country.

LeBow, an MD and MPH, has reduced his work in a community health center to half-time so he could "counter the diversions and myths most Americans have been sucked into by the 'medical-industrial complex'" that is promoting "a variety of political and economic agendas."

His "myths" are familiar:

- Everybody has access to health care through the emergency room.
- We don't need to fix what's not broken.
- "The Market" can solve our health care system problems.
- Private solutions are always better than public solutions.
- Medicare is going broke.
- We can't afford universal coverage; it will overburden our system.
- Americans don't want "rationing" of health care.
- Americans don't want Canadian-style "socialized medicine."
- The insured have to pay more to cover the uninsured.
- Research and development raise our drug costs.
- We can get to universal coverage through incremental change.
- Americans won't accept single-payer coverage.

Much of what he calls "myths" we call frustrations with the U.S. health care "non-system." He presents a well-organized brief, laced with case examples, court decisions, statistical data and frequent summaries. It is easy to read, if a bit repetitious for many of us. He gives credit where credit is due, but identifies the shortcomings as well.

He concludes that for people with good health insurance, good connections, and good luck, the quality of health care can be excellent, but medical errors, poor access, failure to practice scientific-based medicine, the relative inattention to prevention, and a failing financial system are still major health care problems for patients and providers.

Most telling, he considers the market an "abject failure" in financing health care. The number of uninsured people rose from 37 million in 1994 to 43 million last year, with an added 50 million or so who are underinsured. These are people with chronic diseases and "preexisting conditions" who cannot afford insurance, many of whom don't even bother to

show up for care unless they are critically ill.

Competition, almost exclusively based on cost, has created oligopolies in which large corporations control the market. The short-lived flattening of health care cost inflation that managed care wrought was "mostly due to cutting back of provider reimbursements and denying care to patients."

As a result of under-priced products to gain market share, half the managed care organizations lost money in the 1990s and many continue to lose money now. Moreover, the popular backlash to managed care abuses forced the organizations to abandon many of their rationing mechanisms. He wonders whether competition might lead to better outcomes if quality were the issue, rather than cost and profit.

Increased diversion of resources to administration, marketing, and profits has left less money and less physician time for patient care. Administrative costs in the U.S. are estimated at 25-50 percent, with the highest rates in areas with the highest "penetration" of managed care.

The overhead costs for private-sector health insurance vary between 9 and 30 percent, about 15 percent on average. The 50, 000 health insurance brokers ("parasitic middlemen") collect commissions that range from 3 to 20 percent of the total cost of insurance plans, adding hundreds of billions of dollars to premium costs.

By contrast, Medicare's overhead is only between two and three percent; Medicaid's, between five and six percent. Hospital administrators argue that bureaucratic regulations make their overheads larger, but agree that bureaucratic demands from the private sector have been just as onerous.

Some allege that Medicare has a bloated bureaucracy. The opposite is true. Medicare and Medicaid far outperform their private counterparts. Moreover, government programs, unlike the private sector, cannot select out enrollees to avoid the poor, the sick, or the costly cases. Government can be ponderous and slow, but people have access to the ballot box and public pressure, and they have little or no ability to influence investor-owned companies, especially where employers are the primary purchasers.

The blame for Medicare's overpayments belongs to the (mostly private) health care providers who have systematically (often fraudulently) overbilled. Tenet, HCA/Columbia and Blue Cross of Illinois, among others, have paid huge fines for robbing Medicaid and Medicare through upcoding, providing unnecessary expensive services or just plain fraud.

Times have changed since Medicare began in 1965. Added benefits to cover more preventive measures and Alzheimer's disease, a growing elderly population and new technologies have made the program much more costly, and the demographic bubble of the aging "baby boomers" will present a new challenge in 2011.

Medicare's current major gap, outpatient pharmaceutical coverage needs resolution, but the system will adjust. Medicare is not about to go under. That is because people want to improve and expand Medicare, not dismantle or privatize it. They want a choice of provider rather than a choice of plan.

The U.S. spends about twice as much per capita as most industrialized countries. Health care spending in 1998 was 13.6 percent of GDP, compared with 10.6 percent for Germany, 9.5 percent for Canada, and 6.7 percent for the UK. All of those systems have their problems and critics, but so does ours, and they spend a lot less to cover everybody and their health indices are better than ours. We have failed to deal with the more pressing, but less profitable, aspects of health care - mental health and public health, as the anthrax scare revealed.

LeBow's case against the status quo is devastating, but I was interested in his solutions.

He calls for ending "the perverse link between employment and health insurance, a link which is ... actually hurting U.S. industry by making it less competitive in the world market."

He calls for improved cooperation among physicians and other health care providers instead of competition, citing the Kaiser model of salaried physicians and integrated care, where duplication of services is minimized. Instead of conspiring to keep prices high, drug companies should enter into "joint efforts to produce drugs that are really needed, not look-alike drugs."

He favors some form of no-fault malpractice insurance, except for egregious or malicious deviations. That would require a consensus that we are all in this society together, all at risk at some point. The malpractice phenomenon is not all bad, he says. "However, its application has been uneven and often capricious and more often than not driven by opportunism and greed."

As for liability and health plans, LeBow says, "If plans make decision affecting health care outcome, they should be legally responsible and pay for their faulty judgment."

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