| **Topic** |
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**Topic Overview**

Resolved: The United States ought to implement a single-payer universal healthcare system.

Universal healthcare and single-payer universal healthcare are similar, but different terms. Universal healthcare refers to everyone in a country having access to those resources. Universal healthcare coverage can be achieved by multiple different plans, the plan proposed in this resolution is just one of them. Single-payer healthcare describes the method by which those universal healthcare costs are paid for, which would be one (or a single) entity.

This method of care and payment is sometimes titled as Medicare for All. However, the Medicare program currently in place is not single-payer. It involves the government, enrollee premiums, some private insurance options, and beneficiary cost-sharing requirements. The current Medicare system has a few different options for individuals, each having its own out-of-pocket and premium cost requirements. Those private insurance options can be purchased by choice by enrollees.

In the majority of cases, that single-payer would be the government of the country. They would collect all of the fees and such of the care of every citizen in the United States. These methods can vary, but generally would look like an insurance plan that is government run. Most countries that have universal healthcare coverage do not use a single-payer system, rather they rely on multiple sources of payment.

Universal healthcare coverage has been something many policy-makers have pushed for over the years.

A good amount of individuals are in agreement that healthcare is a human right, and not having to pay for it is in our best interest. Most individuals are of the opinion that even if we don’t have universal healthcare, systems like Medicare and Medicaid should still be provided by the government

A single-payer system would be a huge change, resulting in political resistance from private health insurers, those who invest in health care systems, the pharmaceutical and medical device industries, and those who see no reason to change the insurance plans that they currently have. Also, Americans generally do not like a major upheaval of change, especially when they are not certain that those changes will make anything better. They also prefer policies to be slowly enacted as to give citizens time to adjust.

**Further Readings**

<https://www.thebalance.com/is-single-payer-health-insurance-a-good-deal-how-does-it-work-4175823#:~:text=A%20single%20payer%20pays%20directly,how%20healthcare%20costs%20are%20paid>.

<https://www.pewresearch.org/fact-tank/2020/09/29/increasing-share-of-americans-favor-a-single-government-program-to-provide-health-care-coverage/>

<https://www.urban.org/sites/default/files/publication/99918/pros_and_cons_of_a_single-payer_plan.pdf>

<https://www.tennessean.com/story/opinion/2021/07/16/universal-healthcare-would-be-simpler-more-affordable-for-americans/7954774002/>

<https://www.healthaffairs.org/doi/10.1377/hlthaff.9.4.149>

<https://mint.intuit.com/blog/trends/what-is-universal-health-care/>

<https://www.commonwealthfund.org/publications/newsletter-article/health-experts-discuss-ways-achieve-universal-health-coverage>

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**Definitions**

**Ought**

**Merriam-Webster Dictionary**

Merriam-Webster Dictionary, “Ought”, https://www.merriam-webster.com/dictionary/ought

Used to express obligation, advisability, natural expectation, or logical consequence; can also be an expression of duty

**Implement**

**Merriam-Webster Dictionary**

Merriam-Webster Dictionary, “Implement”, <https://www.merriam-webster.com/dictionary/implement>

carry out, accomplish; especially to give practical effect to and ensure of actual fulfillment by concrete measures or to provide instruments or means of expression for

**Single-payer Healthcare System**

**National Healthcare for the Homeless Council 22**

*Single-Payer Health Care*. National Health Care for the Homeless Council. (2022, July 10). https://nhchc.org/policy-issues/single-payer-health-care-2/#:~:text=What%20is%20Single%20Payer%3F,everyone%20in%20the%20United%20States

Single-payer—or Medicare for All—is simply a streamlined financing mechanism where one entity administers the health care funding and payments. It expands the cost-effective and administratively efficient Medicare program to cover everyone in the United States.

**Universal Healthcare**

**World Health Organization**

World Health Organization. (n.d.). *Universal Health Coverage*. World Health Organization. https://www.who.int/health-topics/universal-health-coverage#tab=tab\_1

Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

**Value-Criterion**

**For today’s value, I offer general welfare. A single-payer health care system can be established by the government to promote the general welfare of citizens.**

**The Legal Dictionary no date**

Farlex. (n.d.). *General welfare*. The Free Dictionary. https://legal-dictionary.thefreedictionary.com/General+Welfare

*Definition: The concern of the government for the health, peace, morality, and safety of its citizens.*

Providing for the welfare of the general public is a basic goal of the government. The preamble to the U.S. Constitution cites promotion of the general welfare as a primary reason for the creation of the Constitution. Promotion of the general welfare is also a stated purpose in state constitutions and statutes. The concept has sparked controversy only as a result of its inclusion in the body of the U.S. Constitution.

The first clause of Article I, Section 8, reads, "The Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States." This clause, called the General Welfare Clause or the Spending Power Clause, does not grant Congress the power to legislate for the general welfare of the country; that is a power reserved to the states through the Tenth Amendment. Rather, it merely allows Congress to spend federal money for the general welfare. The principle underlying this distinction—the limitation of federal power—eventually inspired the only important disagreement over the meaning of the clause.

According to James Madison, the clause authorized Congress to spend money, but only to carry out the powers and duties specifically enumerated in the subsequent clauses of Article I, Section 8, and elsewhere in the Constitution, not to meet the seemingly infinite needs of the general welfare. Alexander Hamilton maintained that the clause granted Congress the power to spend without limitation for the general welfare of the nation. The winner of this debate was not declared for 150 years.

In *United States v. Butler*, 56 S. Ct. 312, 297 U.S. 1, 80 L. Ed. 477 (1936), the U.S. Supreme Court invalidated a federal agricultural spending program because a specific congressional power over agricultural production appeared nowhere in the Constitution. According to the Court in *Butler*, the spending program invaded a right reserved to the states by the Tenth Amendment.

Though the Court decided that *Butler* was consistent with Madison's philosophy of limited federal government, it adopted Hamilton's interpretation of the General Welfare Clause, which gave Congress broad powers to spend federal money. It also established that determination of the general welfare would be left to the discretion of Congress. In its opinion, the Court warned that to challenge a federal expense on the ground that it did not promote the general welfare would "naturally require a showing that by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted to the Congress." The Court then obliquely confided,"[H]ow great is the extent of that range … we need hardly remark." "[D]espite the breadth of the legislative discretion," the Court continued, "our duty to hear and to render judgment remains." The Court then rendered the federal agricultural spending program at issue invalid under the Tenth Amendment.

With *Butler* as precedent, the Supreme Court's interest in determining whether congressional spending promotes general welfare has withered. In *South Dakota v. Dole*, 483 U.S. 203, 107 S. Ct. 2793, 97 L. Ed. 2d 171 (1987), the Court reviewed legislation allowing the secretary of transportation to withhold a percentage of federal highway funds from states that did not raise their legal drinking age to twenty-one. In holding that the statute was a valid use of congressional spending power, the Court in *Dole* questioned "whether 'general welfare' is a judicially enforceable restriction at all."

Congress appropriates money for a seemingly endless number of national interests, ranging from federal courts, policing, imprisonment, and national security to social programs, environmental protection, and education. No federal court has struck down a spending program on the ground that it failed to promote the general welfare. However, federal spending programs have been struck down on other constitutional grounds.

**For today’s criterion, I offer social contract theory.**

**The Ethics Centre 21**

The Ethics Centre, (2021, December 9). *Ethics Explainer: Social Contract*. THE ETHICS CENTRE. https://ethics.org.au/ethics-explainer-social-contract/

## Social contract theories see the relationship of power between state and citizen as a consensual exchange. It is legitimate only if given freely to the state by its citizens and explains why the state has duties to its citizens and vice versa.

##

## Although the idea of a social contract goes as far back as Epicurus and [Socrates](https://ethics.org.au/big-thinker-socrates/), it gained popularity during  The Enlightenment thanks to Thomas Hobbes, [John Locke](https://ethics.org.au/big-thinker-john-locke/)  and  Jean-Jacques Rousseau. Today the most popular example of social contract theory comes from [John Rawls](https://ethics.org.au/big-thinker-john-rawls/).

##

## The social contract begins with the idea of a state of nature – the way human beings would exist in the world if they weren’t part of a society. Philosopher Thomas Hobbes believed that because people are fundamentally selfish, life in the state of nature would be “nasty, brutish and short”. The powerful would impose their will on the weak and nobody could feel certain their natural rights to life and freedom would be respected.

##

## Hobbes believed no person in the state of nature was so strong they could be free from fear of another person and no person was so weak they could not present a threat. Because of this, he suggested it would make sense for everyone to submit to a common set of rules and surrender some of their rights to create an all-powerful state that could guarantee and protect every person’s right. Hobbes called it the ‘Leviathan’.

##

## It’s called a contract because it involves an exchange of services. Citizens surrender some of their personal power and liberty. In return the state provides security and the guarantee that civil liberty will be protected.

##

## Crucially, social contract theorists insist the entire legitimacy of a government is based in the reciprocal social contract. They are legitimate because they are the only ones the people willingly hand power to. Locke called this popular sovereignty.

##

## Unlike Hobbes, Locke thought the focus on consent and individual rights meant if a group of people didn’t agree with significant decisions of a ruling government then they should be allowed to join together to form a different social contract and create a different government. Not every social contract theorist agrees on this point. Philosophers have different ideas on whether the social contract is real, or if it’s a fictional way to describe the relationship between citizens and their government.

##

## If the social contract is a real contract – just like your employment contract – people could be free not to accept the terms. If a person didn’t agree they should give some of their income to the state they should be able to decline to pay tax and as a result, opt out of state-funded hospitals, education, and all the rest. Like other contracts, withdrawing comes with penalties – so citizens who decide to stop paying taxes may still be subject to punishment.

##

## Other problems arise when the social contract is looked at through a feminist perspective. Historically, social contract theories, like the ones proposed by Hobbes and Locke, say that (legitimate) state authority comes from the consent of free and equal citizens. Philosophers like Carole Pateman challenge this idea by noting that it fails to deal with the foundation of male domination that these theories rest on. For Pateman the myth of autonomous, free and equal individual citizens is just that: a myth. It obscures the reality of the systemic subordination of women and others. In Pateman’s words the social contract is first and foremost a ‘sexual contract’ that keeps women in a subordinate role. The structural subordination of women that props up the classic social contract theory is inherently unjust.

##

## The inherent injustice of social contract theory is further highlighted by those critics that believe individual citizens are forced to opt in to the social contract. Instead of being given a choice, they are just lumped together in a political system which they, as individuals, have little chance to control. Of course, the idea of individuals choosing not to opt in or out is pretty impractical – imagine trying to stop someone from using roads or footpaths because they didn’t pay tax.

##

## To address the inherent inequity in some forms of social contract theory, John Rawls proposes a hypothetical social contract based on fundamental principles of justice. The principles are designed to provide a clear rationale to guide people in choosing to willingly agree to surrender some individual freedoms in exchange for having some rights protected. Rawls’ answer to this question is a thought experiment he calls the [veil of ignorance](https://ethics.org.au/big-thinker-john-rawls/).

##

## By imagining we are behind a veil of ignorance with no knowledge of our own personal circumstances, we can better judge what is fair for all. If we do so with a principle in place that would strive for liberty for all at no one else’s expense, along with a principle of difference (the difference principle) that guarantees equal opportunity for all, as a society we would have a more just foundation for individuals to agree to a contract that in which some liberties would be willingly foregone.

## Out of Rawls’ focus on fairness within social contract theory comes more feminist approaches, like that of Jean Hampton. In addition to criticising Hobbes’ theory, Hampton offers another feminist perspective that focuses on extending the effects of the social contract to interpersonal relationships.

##

## In established states, it can be easy to forget the social contract involves the provision of protection in exchange for us surrendering some freedoms. People can grow accustomed to having their rights protected and forget about the liberty they are required to surrender in exchange. Whether you think the contract is real or just a useful metaphor, social contract theory offers many unique insights into the way citizens interact with government and each other.

**Contention 1: Efficiency**

**A more streamlined system of healthcare makes the whole process much simpler for everyone involved.**

**American Public Health Association 21**

American Public Health Association. (2021, October 26). *Adopting a Single-Payer Health System*. APHA. <https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Adopting-a-Single-Payer-Health-System>

Health care is a human right. Achieving universal health coverage for all U.S. residents requires significant system-wide changes in financing of health care. The best, most efficient, equitable health system is a public, single-payer (SP) system. The rapid growth in national health expenditures can be addressed through a system that yields net savings over projected trends by eliminating profit and waste. With universal coverage, providers can focus on optimizing triage of services rather than working within a system covered by payers who have incentives to limit costs regardless of benefit. With SP systems, people act as their own insurers through partnerships with provider organizations wherein tax dollars work for everyone. Consumer choice is then based on best care to meet needs with no out-of-pocket payments.

SP is the best option to ensure equity, fairness, and priorities aligned with medical needs. This approach benefits public health, as everyone will have universal access to needed care, with treatment plans based on what works best for the patient. Clinics and hospitals will be free to provide appropriate treatments based on need. Hospitals will accept all patients, with care reimbursed equally for all. Resolving the great discrepancy in coverage for mental health and substance use disorders relative to medical and surgical services is more likely in an SP model. Patients will partner in their care, receiving diagnosis, treatment, and prevention services without facing cost barriers. We will build a healthier nation, saving lives and reducing financial burdens while addressing inequities rooted in social, demographic, mental health, economic, and political conditions.

Efficiency in the United States relative to single-payer countries: While the United States spends more per capita on health care than any other OECD (Organization for Economic Co-operation and Development) country, the additional spending contributes little value from either an economic or a health outcomes perspective.[3,5,10] Countries with SP spend less while their populations live longer, healthier lives.[11] The average life expectancy and the burden of adverse health outcomes for almost all major chronic illnesses (apart from cancer treatments) in the United States also fall short of the OECD median.[7,10,11]

As seen during the COVID-19 pandemic, the health of the nation relies on creating a universal, efficiently coordinated system that improves access, eliminates disincentives to preventive care, and fosters access with a streamlined approach to universal coverage. Indeed, a single-payer health system is not only financially feasible but also the most fiscally viable approach for all.

Because a single-payer health system would create health care savings by creating a more efficient administrative system, as a matter of health equity, some of these savings can and should be used to address additional ways to tackle health disparities outside of insurance.

**Contention 2: Finances**

**A single-payer system reduces costs on consumers**

**Blumberg and Holahan 19**

Blumberg, L. J., & Holahan, J. (2019, March). *The Pros and Cons of Single-Payer Health Plans*. https://www.urban.org/sites/default/files/publication/99918/pros\_and\_cons\_of\_a\_single-payer\_plan.pdf

Elimination of surprise billing. Under current law, each health care provider decides independently which insurers to participate with, so it can be extremely difficult for patients to identify participating providers a priori. This is particularly problematic in emergency situations, where patients do not have sufficient time to investigate provider options; it also arises when providers working on site at a hospital (e.g., radiologists, anesthesiologists, emergency room physicians) do not participate with the same insurers as does the hospital in which they work. In these cases, patients often assume that the care they receive at a network hospital is also in network, and they can be surprised by large out-of-network bills after the fact. Eliminating provider networks and applying Medicare-like prohibitions on balance billing would end such surprise billing.

Affordability at point of service. With no premiums, no out-of-pocket costs, and a broad set of medically necessary benefits covered (including services for any preexisting conditions), the cost of care would be spread across all taxpayers. Financial burdens would no longer fall disproportionately on those with serious health problems, and segmentation of health care risks would be eliminated.

Broad-based implementation of cost-containment strategies. With all providers and health care consumers in the same system, the potential to implement effective system-wide cost containment strategies increases. For example, a government-run system can regulate provider payment methods and incentives that would affect all providers serving all insured people, a strategy that is substantially harder to implement in a fragmented insurance system.

**A single-payer system reduces costs on providers (insurance providers and medical providers)**

**Weisbart 12**

Weisbart, E. (2012, November 1). *A Single-Payer System Would Reduce U.S. Health Care Costs*. Journal of Ethics | American Medical Association. https://journalofethics.ama-assn.org/article/single-payer-system-would-reduce-us-health-care-costs/2012-11#:~:text=A%20single%2Dpayer%20model%20would,amounts%20in%20overhead%20%5B19%5D.

A single-payer model would eliminate the inefficiencies of fragmentation by converting public programs such as Medicare, Medicaid, and CHIP into a single administratively efficient financing system. Streamlined billing under single payer would save physicians vast amounts in overhead [19].

In addition to reduced billing expenses, physicians would also enjoy a meaningful drop in their malpractice premiums. Roughly half of all malpractice awards are for present and future medical costs [20], so if malpractice settlements no longer need to include them, premiums would fall dramatically.

A single-payer system enables the kind of bulk purchasing of drugs and medical devices that would give the buyer power. A model for this structure exists today in the United States: the Department of Veterans Affairs. Due to governmental authority to negotiate drug prices for the VA, it pays roughly half of the retail price of drugs [24].

Negotiations with clinicians should ensure adequate reimbursement of expenses plus fair profits, while ensuring value for taxpayers. A recent careful analysis found that this model is effective and does not lead to a loss in physician income [25].

**A single-payer system reduces costs on the government**

**Blumberg and Holahan 19**

Blumberg, L. J., & Holahan, J. (2019, March). *The Pros and Cons of Single-Payer Health Plans*. https://www.urban.org/sites/default/files/publication/99918/pros\_and\_cons\_of\_a\_single-payer\_plan.pdf

Elimination of employer and state government administrative responsibilities and possibly spending related to providing health coverage. With a single-payer approach, employers and state governments could dismantle the administrative structures associated with providing health insurance coverage, resulting in savings. They would also eliminate direct payments for providing health insurance coverage to their workers and residents. Changes in their overall spending related to health, however, would depend on the mechanisms financing the new program. For example, state maintenance of effort requirements and new payroll taxes would offset other savings in whole or part if used for funding.

**Other Cards**

**Extension: Equity**

**Healthcare costs would be distributed equitably**

**Blumberg and Holahan 19**

Blumberg, L. J., & Holahan, J. (2019, March). *The Pros and Cons of Single-Payer Health Plans*. https://www.urban.org/sites/default/files/publication/99918/pros\_and\_cons\_of\_a\_single-payer\_plan.pdf

A more equitable distribution of health care costs. Even calculating the distribution of health care costs and benefits across people of different incomes and characteristics is an immense challenge in the current patchwork health care system. A single financing entity (i.e., the federal government) can be explicit and deliberate in distributing newly raised revenues to fund the population’s health care costs.

Access to care. With broad benefits and no out-of-pocket costs at the point of service, access to care would increase, particularly for those with low or modest incomes. In addition, by including benefits such as long-term services and supports, dental, and vision, even many higher-income people should have increased access to some services. In principle, improved access would tend to improve health. See below for a caveat on potential increases in demand relative to the supply of health care providers.

Universal coverage. All members of the eligible population would be insured or would become insured when seeking to access health care services. Coverage would also be continuous: people would not lose coverage or need to change coverage when their jobs, family status, income, state of residence, or age change.

Equity. All US residents would have the same coverage. This would go a very long way toward redressing racial/ethnic and income-related disparities in coverage and access to care.

**All citizens would have equitable access to healthcare**

**Petrou et al 18**

Petrou, P., Samoutis, G., & Lionis, C. (2018, October). *Single-payer or a multipayer health system: a systematic literature review*. Science Direct. https://reader.elsevier.com/reader/sd/pii/S0033350618302312?token=57D1C7DBBC6477396DB22653DB1BB5121BB22C40C9A20B2EAF3C9C196FAF005D9FA06BFCCE264C6617A123065D4CFC9A&originRegion=us-east-1&originCreation=20220904201636

Equity is a fundamental pillar of health systems and it encompasses timely access, equivalence of care and absence of avoidable or remediable differences among groups of people, pertinent to distinct social, economic, demographical or geographical criteria.[11](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib11), [12](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib12) Persistent differences in the health status due to socio-economic status constitute a major concern across developed countries.[13](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib13) Health inequalities escalate to significant health [disparities](https://www.sciencedirect.com/topics/medicine-and-dentistry/disparity), which were primarily reported in the oncology sector. Four out of the six studies that investigated cancer patient outcomes in single-payer vs multi payer health system settings, indicated that the insurance type was interwoven with survival. Among these, one study reported that certain insurances were correlated with advanced stage colorectal cancer diagnosis, which leads to lower relative survival.[14](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib14) McDaid et al. concluded that the outlined variability of outcomes of lung, colorectal, prostate and breast cancer could be attributed to insurance type.[15](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib15) One study regarding breast cancer evinced that within a multi payer system, patients with private insurances presented with statistically significant smaller tumors, compared with public beneficiaries.[16](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib16) Robins and Niu reached the same conclusion for colorectal, breast, lung cancer and non-Hodgkin lymphoma.[17](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib17), [18](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib18), [19](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib19) Nevertheless, two studies did not find significant differences in breast, cervical and colorectal cancer.[20](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib20), [21](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib21)

Three studies reported on orthopedic care. Among these, two attested a significant association between income-related health insurance and hindered access to medical care, leading to impaired functionality after hip replacement therapy.[22](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib22), [23](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib23) It was also observed that there was a statistical difference among several types of health insurance; patients covered by non-commercial insurance be in a disadvantaged position regarding their referral to rehabilitation services. Martin et al. in 2012 also reported that the payer type was statistically significantly associated with disparate joint arthroplasty outcomes.[24](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib24)

Two more studies reported data on sepsis and lung transplantation. O'Brien et al. argued that risks of sepsis-associated death varied by insurance cover.[25](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib25) In the same vein, Allen et al. found a statistically significant correlation between survival of lung transplant recipients and insurance type.[26](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib26) Two studies reported on pediatric data indicating disparities between asthma management and insurance type among children,[27](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib27) and some payer types demonstrated diverging results contingent on the neonatal and postneonatal period.[28](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib28)

Three studies reported findings from Germany. Lungen et al. stated that for five specific specialist examinations, patients enrolled with statutory health insurance (SHI) waited 3.08 times longer for an appointment, compared with patients with private health insurance (PHI).[29](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib29) Kuchinke et al. concluded that private insurance patients in Germany have statistically significant lower waiting times in a sample of 485 hospitals.[30](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib30) Adding to this, Scwiertz et al. concluded that exacerbated discrimination in waiting times between SHI and PHI beneficiaries, is -paradoxically-related to better financial performance of the hospitals.[31](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib31)

Four studies reported data in the cardiology sector. The insurance type also proved to determine the use or not of drug-eluting stents.[32](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib32) Moreover, Laux et al. also stated that PHI patients are more likely to be prescribed newer antihypertensive agents.[33](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib33) Two of these four studies reported conflicting data with regard to the association of the payer type and outcomes of cardiac surgery.[34](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib34), [35](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib35)

Finally, Taiwan's recent shift to a single-payer design verifies that a single-payer system culminates to equal access to healthcare substantiated by high public satisfaction rate.[36](https://www.sciencedirect.com/science/article/pii/S0033350618302312#bib36)

**Extension: Finances**

**More on reducing costs for providers (both insurance and medical)**

**Blumberg and Holahan 19**

Blumberg, L. J., & Holahan, J. (2019, March). *The Pros and Cons of Single-Payer Health Plans*. https://www.urban.org/sites/default/files/publication/99918/pros\_and\_cons\_of\_a\_single-payer\_plan.pdf

Administrative savings relative to the current system of public and private insurance. Private health insurer administrative costs include commissions, claims administration, premium determination, risk and profit, and other general administration tasks. Many of these costs could be reduced or eliminated, most notably commissions and risk and profit. There would also likely be significant economies of scale in claims administration when managed by a single entity. However, administrative savings could be limited by the development of systems to effectively set provider payment rates, as well as programs to monitor and maintain care quality and efficiency. Many of the administrative “middlemen” (e.g., prescription benefit managers, agents who negotiate provider panels and health insurance rebates) would be eliminated. Some private third-party administrators might remain in the system, however, to process claims (as is done in the current Medicare program).

Administrative savings for providers. Health care providers currently hire administrative staff focused solely on filing claims, collecting cost sharing, addressing claims denials, and meeting prior authorization requirements that vary significantly across multiple public and private insurers. Limiting all patients to a single insurer would greatly reduce these administrative costs incurred by nearly every provider in the nation. These administrative savings would also make reduced provider payment rates more palatable. However, these savings could be limited by the strategies the single-payer system might implement to contain costs. For example, the traditional Medicare program requires hospitals to perform utilization review functions and appeal claims denials.

**A single-payer healthcare system is likely to save the US money**

**Kurtzman 20**

Kurtzman, L. (2020, January 15). *Single-payer systems likely to save money in US, analysis finds*. University of California News. https://www.ucsf.edu/news/2020/01/416416/single-payer-systems-likely-save-money-us-analysis-finds

A single-payer healthcare system would save money over time, likely even during the first year of operation, according to nearly two dozen analyses of national and statewide single payer proposals made over the past 30 years.

The study, published Wednesday, Jan. 15, 2020, in [*PLOS Medicine*](https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003013), comes as California Gov. Gavin Newsom has named a state commission to find ways to achieve universal coverage, possibly through a single-payer system, and as the Democratic presidential candidates are debating “Medicare for All” proposals on the national stage.

The U.S. spends more on healthcare than any other country, yet is one of only a few developed nations that does not provide universal coverage. Under proposed single payer bills, such as “Medicare for All,” a unified public financing system would replace private insurance, similar to the healthcare system in Canada and many other wealthy nations.

To estimate what would happen if the United States adopted a single-payer system, researchers from UCSF, UCLA and UC Berkeley examined 22 economic analyses by government, business and academic organizations of national and state-level single payer plans, including proposals made in Massachusetts, California, Maryland, Vermont, Minnesota, Pennsylvania, New York and Oregon.

These analyses were used by policymakers to evaluate the proposals, estimating savings the plans would create through simplified billing and lower drug costs while also taking into account increases in health spending that would arise as newly insured people sought healthcare.

The researchers found that 19 of the 22 models predicted net savings in the first year after implementation, averaging 3.5 percent of total healthcare spending.

The researchers were able to estimate longer-term savings by using cost projections made in 10 of the models, which looked as far as 11 years into the future. These studies assumed that savings would grow over time, as the increases in healthcare utilization by the newly insured leveled off, and the global budgets adopted by single-payer systems helped to constrain costs. By the 10th year, all modeled single payer systems would save money, even those that projected costs would initially increase.

“Even though they start with different single designs and modeling assumptions, the vast majority of these studies all come to the same conclusion,” said [James G. Kahn](https://profiles.ucsf.edu/james.kahn), MD, MPH, a professor in the UCSF Department of Epidemiology and Biostatistics, and a member of the [Philip R. Lee Health Policy Institute](https://healthpolicy.ucsf.edu/). “This suggests that fears that a single-payer system would increase costs are likely misplaced.”

Savings from simplified payment administration and reductions in drug prices and other efficiencies ranged from 3 to 27 percent, with the largest savings found in plans that lowered drug costs. Higher initial costs were associated with plans that had low co-pays or none at all, offered rich benefits, or that did not expect savings from lower drug and medical equipment costs.

The models were created by analysts from different political perspectives, and they provided a range of cost estimates in the first year of operation, from 7 percent higher to 15 percent lower. The researchers found that the economic models that were supported by left-leaning funders or that were done by academics found slightly larger net savings. But analyses supported by more conservative funders or performed outside of academia still predicted single-payer systems would yield savings.

“This means that across the political spectrum, there is near consensus among these economists that a single-payer system would save money,” said Christopher Cai, a third-year medical student at UCSF and the study’s first author. “Replacing private insurance with a public system is essential to achieving these savings.”

**Miscellaneous**

**Philosophically, a single-payer system makes the most sense**

**Chau and Casoy 15**

Chua, K.-P., & Casoy, F. (2015). *Single payer 101*. American Medical Student Association. Retrieved from https://www.amsa.org/wp-content/uploads/2015/03/SinglePayer101.pdf

The U.S. healthcare system is driven largely by market forces, which are predicated on the profit motive. The theory behind the U.S. system is that private health insurance companies seeking to maximize profit will compete with each other, thus driving down costs. How well does this theory work in practice? From 2000-2004, profits for the top 17 U.S. health insurance companies rose 114%; in contrast, the profits of companies in the S&P 500 (an index of 500 commonly owned stocks) rose 5% during the same period.3

Simultaneously, the number of uninsured individuals grew by six million people, and health insurance premiums rose 60%.3,4 Contrary to popular belief, the newly uninsured were overwhelmingly native citizens, not immigrants.5 This situation – private insurance companies making record profits while health insurance premiums and the number of uninsured skyrocket – suggests that insurance companies have an incentive to price people out of health care to maximize profit. The methods by which private health insurance companies achieve this include denial of insurance to people with pre-existing conditions, heavy utilization review, and “cherry picking” (selectively insuring the healthy and charging higher premiums for the less healthy).2 Whether this is an acceptable situation depends foremost on how valuable society believes it is to have equitable, universal health care access. The free market in health care may deliver a good health insurance product to those who can afford it, but it is not designed to distribute health insurance equally or universally. Private health insurance companies seeking to maximize profit have no incentive to insure everyone, as this would require them to insure patients with high healthcare costs. If society believes that equality and universality are important features of a health care system, then the current system is necessarily unacceptable. A single payer system would be a far better alternative.

**Providing for the health of everyone is a social good**

**Markowitz and McLeod-Sordjan 21**

Markowitz, W., & McLeod-Sordjan, R. (2021, April 28). *Values-based foundation for a U.S. Single Payer Health System Model*. Frontiers. https://www.frontiersin.org/articles/10.3389/fsoc.2021.627560/full

Immanuel Kant’s categorical imperative includes two types of duties within his ethical and moral philosophy. There are positive duties, which include actions we are commanded to take and there are negative actions which are prohibited. Kant assumes that people are rational and have choices, which are selected based on rationality and duty (Yudanin, 2015). “The primacy of duty is affirmed in Kantian ethics. In true sense the moral worth of a person is revealed only when he acts from duty. Actions qualify as moral when they are worthy and enacted upon for the sake of duty (Mulia et al., 2016). Actions should be taken because they are inherently good unto themselves and not a mean to achieve something else (Foot, 1972). Promoting access and health equality can be viewed as a positive duty, a moral action, a good unto itself within Kant’s categorical imperative.

According to a deontological philosophy actions are morally acceptable when consistent with relevant moral norms. In the case of universal healthcare in America, strategically adopting the norms of health systems with equitable health outcomes should be the duty of legislators. What should serve as the moral norms; what is right and what is wrong; what is a duty and obligation? Ross’ duties for pluralistic deontology assists in answering these questions. Consider their connectivity to foundational values:

1. Dues deriving from our own previous acts or actions: a) keeping promises, be they explicit or implicit
2. Duties of justice … they guarantee that people can get what they deserve
3. Duties of beneficence, which rest on the mere fact that there are other beings in the world whose condition we can make better in respect of virtue, or of intelligence, or of pleasure …
4. Non-maleficence, ensuring that no harm occurs to the ill, the infirmed the disenfranchised (Craig, 2014)

Craig (King, 2006) considered health care to be a social good, based on the tenets of religion, American ideals, morality and ethics for the foundations for the health system. The author challenges Americans to get away from looking in the mirror as the wicked witch did in *Snow White*. Americans are really not the “fairest of them all.” In looking in the mirror Americans must evaluate who we really are as a society and what we should be, using our values to provide directionality as we struggle to provide a more rational, a more just health system. Dr. Martin Luther King Jr reminded the nation, soon after the 1964 Civil Rights Law and the passage of Medicare and Medicaid, there was more to be done when he proclaimed: “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” (Meadowcroft, 2015) The provision of healthcare as the means of providing life, liberty and access to should not be determined by market forces.

**We are duty-bound to help others in need**

**Markowitz and McLeod-Sordjan 21**

Markowitz, W., & McLeod-Sordjan, R. (2021, April 28). *Values-based foundation for a U.S. Single Payer Health System Model*. Frontiers. <https://www.frontiersin.org/articles/10.3389/fsoc.2021.627560/full>

Friedberg (Friedberg, 2013) points to the Jewish philosopher Maimonides who wrote about the mitzvot aseh, representing an absolute obligation. The term mitzvah refers to such an obligation or commandment in Hebrew writings. While we are commanded or are obliged to perform mitzvot, when done we are blessed. Performing mitzvot provides the performer with recompense which should not be viewed as monetary reward. Biblical references to the blessings that will accrue if mitzvot are performed can be found for example in Leviticus 26: 3-12; Deuteronomy 7: 12-24; Deuteronomy 11: 22-25; and Matthew 7: 24.

Tzedakah, is the related Hebrew term for the commandment associated with charity, which has the literal meaning of righteousness or justice. Consider the following capturing the essence of the mitzvah of tzedakah from Rabbenu Bachya Ben Asher, a 13th century Torah commentator:

“Justice shall be pursued whether to one’s profit or loss, whether in words or an action, whether to Jews or non-Jews. Hence we are not to wait for the right opportunity, the right time, and the right place to come along, but instead we are to actively seek the opportunity to practice justice. As a matter of simple justice, we are duty bound to help others in need”. (Taitz, 2007).

**The United States would be a healthier country**

**Troy 18**

Troy, A. (2018, August 27). *There are many advantages to single-payer health care*. PNHP. https://pnhp.org/news/there-are-many-advantages-to-single-payer-health-care/

Under a single-payer system we would be healthier. It is well known that people without insurance or with high deductibles wait longer to seek medical care; thus, their illnesses and problems become more deep-rooted and more difficult to treat. They suffer more from injuries, disabilities and ill-health, resulting in decreased productivity and poorer quality of life. Sometimes they die because they put off getting care.

Under a single-payer system, people would have a wider choice of doctors and would not have to change their doctors every time they change jobs or their employer finds a cheaper health plan. Continuity of care would improve and problems would be treated earlier (when easier and less expensive to treat). More people would receive vaccines and preventive care. Public health would improve and social problems associated with untreated mental illness and addiction would decrease.

The U.S. ranks at or near the bottom of the developed world on every measure of health. According to the World Health Organization, we are No. 37 on overall measures of health. Shameful for such a rich country that spends so much on health care!

**It is politically feasible**

**Day Jr. 09**

Day, J. A. (2009). *Pro: Single-Payer Health Care; Simple, Fair, Affordable*. ATS Journals. https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0881ED

Given the social, clinical, and economic benefits of single-payer health care, the only barrier would seem to be that of political feasibility. Indeed, adoption of a single-payer health care system will be challenging in today's economic climate and in a country seemingly dedicated to a free-market ideology. Yet many current social programs faced similar political obstacles at the time of adoption, including Social Security and Medicare. Ironically, today it is the disbanding of these programs that would be considered not politically feasible. Although some major stakeholders (mainly the insurance and pharmaceutical industries) may be unalterably opposed to single-payer health care, the most important and relevant stakeholders are the American people and their health care providers. It is 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0881ED), [8](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0881ED)). 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.

**There would be less waste and costs would stabilize**

**Health Care for All - California no date**

*Why We Need Single Payer*. Health Care for All - California. (n.d.). Retrieved from https://healthcareforall.org/single-payer/why/

The insurance-hospital industry now spends more than 30% of each health care dollar on administration, marketing, and paperwork. When single payer eliminates this costly 30%, your doctor will not have to spend oodles of time on the phone to get permission from your insurance for your ruptured appendix surgery.

Billions of dollars spent on insurance now go toward administering multiple plans, packaging and marketing the plans, excessive profits and executive compensation, lobbying for policies that detract from health care, and for campaign donations.

Single payer streamlines administration by having one agency handle all financing and by giving everyone the same benefits. With “everyone in and nobody out”, money will no longer be wasted on marketing, underwriting, and administration of multiple health insurance plans. Health care professionals will no longer incur the cost of dealing with so many different plans, rules, and forms.

Costs are rising at rates far beyond inflation. Charges for health insurance premiums and care vary dramatically and are difficult to justify. Reimbursement for services and supplies is unpredictable. People who cannot afford regular care misuse expensive hospital emergency rooms when problems arise and require more expensive treatment when conditions worsen. In a single-payer system, the single-payer agency negotiates fair prices for services, supplies, and pharmaceuticals, using the purchasing power of the entire populace to make care more affordable for all. Single payer allows negotiations for medicines and medical devices. You’ve heard of the flagrant increased costs for insulin and EpiPen. Single payer gives the government the power to negotiate pricing for medications. Preventive care and timely intervention has the potential for keeping health problems from developing or worsening, making the need for expensive treatment less likely. Access to regular care reduces costly use of emergency rooms.

Single payer means no co-payments, deductibles, or premiums. For most of us, the total bottom line for single payer, which will likely be paid for through progressive taxes, will be significantly less than the total bottom line we now pay. This is how we pay for other public goods and services: schools, roads, fire, and libraries.

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**Definitions**

**Ought**

**Merriam-Webster Dictionary**

Merriam-Webster Dictionary, “Ought”, https://www.merriam-webster.com/dictionary/ought

Used to express obligation, advisability, natural expectation, or logical consequence; can also be an expression of duty

**Implement**

**Merriam-Webster Dictionary**

Merriam-Webster Dictionary, “Implement”, <https://www.merriam-webster.com/dictionary/implement>

carry out, accomplish; especially to give practical effect to and ensure of actual fulfillment by concrete measures or to provide instruments or means of expression for

**Single-payer Healthcare System**

**National Healthcare for the Homeless Council 22**

*Single-Payer Health Care*. National Health Care for the Homeless Council. (2022, July 10). https://nhchc.org/policy-issues/single-payer-health-care-2/#:~:text=What%20is%20Single%20Payer%3F,everyone%20in%20the%20United%20States

Single-payer—or Medicare for All—is simply a streamlined financing mechanism where one entity administers the health care funding and payments. It expands the cost-effective and administratively efficient Medicare program to cover everyone in the United States.

**Universal Healthcare**

**World Health Organization**

World Health Organization. (n.d.). *Universal Health Coverage*. World Health Organization. https://www.who.int/health-topics/universal-health-coverage#tab=tab\_1

Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

**Value-Criterion**

**For today’s value, I accept the value of general welfare. However, a single-payer health care system is not the best solution to promote the general welfare of citizens.**

**The Legal Dictionary no date**

Farlex. (n.d.). *General welfare*. The Free Dictionary. https://legal-dictionary.thefreedictionary.com/General+Welfare

*Definition: The concern of the government for the health, peace, morality, and safety of its citizens.*

Providing for the welfare of the general public is a basic goal of the government. The preamble to the U.S. Constitution cites promotion of the general welfare as a primary reason for the creation of the Constitution. Promotion of the general welfare is also a stated purpose in state constitutions and statutes. The concept has sparked controversy only as a result of its inclusion in the body of the U.S. Constitution.

The first clause of Article I, Section 8, reads, "The Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States." This clause, called the General Welfare Clause or the Spending Power Clause, does not grant Congress the power to legislate for the general welfare of the country; that is a power reserved to the states through the Tenth Amendment. Rather, it merely allows Congress to spend federal money for the general welfare. The principle underlying this distinction—the limitation of federal power—eventually inspired the only important disagreement over the meaning of the clause.

According to James Madison, the clause authorized Congress to spend money, but only to carry out the powers and duties specifically enumerated in the subsequent clauses of Article I, Section 8, and elsewhere in the Constitution, not to meet the seemingly infinite needs of the general welfare. Alexander Hamilton maintained that the clause granted Congress the power to spend without limitation for the general welfare of the nation. The winner of this debate was not declared for 150 years.

In *United States v. Butler*, 56 S. Ct. 312, 297 U.S. 1, 80 L. Ed. 477 (1936), the U.S. Supreme Court invalidated a federal agricultural spending program because a specific congressional power over agricultural production appeared nowhere in the Constitution. According to the Court in *Butler*, the spending program invaded a right reserved to the states by the Tenth Amendment.

Though the Court decided that *Butler* was consistent with Madison's philosophy of limited federal government, it adopted Hamilton's interpretation of the General Welfare Clause, which gave Congress broad powers to spend federal money. It also established that determination of the general welfare would be left to the discretion of Congress. In its opinion, the Court warned that to challenge a federal expense on the ground that it did not promote the general welfare would "naturally require a showing that by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted to the Congress." The Court then obliquely confided,"[H]ow great is the extent of that range … we need hardly remark." "[D]espite the breadth of the legislative discretion," the Court continued, "our duty to hear and to render judgment remains." The Court then rendered the federal agricultural spending program at issue invalid under the Tenth Amendment.

With *Butler* as precedent, the Supreme Court's interest in determining whether congressional spending promotes general welfare has withered. In *South Dakota v. Dole*, 483 U.S. 203, 107 S. Ct. 2793, 97 L. Ed. 2d 171 (1987), the Court reviewed legislation allowing the secretary of transportation to withhold a percentage of federal highway funds from states that did not raise their legal drinking age to twenty-one. In holding that the statute was a valid use of congressional spending power, the Court in *Dole* questioned "whether 'general welfare' is a judicially enforceable restriction at all."

Congress appropriates money for a seemingly endless number of national interests, ranging from federal courts, policing, imprisonment, and national security to social programs, environmental protection, and education. No federal court has struck down a spending program on the ground that it failed to promote the general welfare. However, federal spending programs have been struck down on other constitutional grounds.

**For today’s criterion, I offer [classical] liberalism.**

**Longley 20**

Longley, R. (2020, June 29). *What is Classical Liberalism? Definition and Examples*. ThoughtCo. Retrieved from https://www.thoughtco.com/classical-liberalism-definition-4774941

Classical liberalism is a political and economic ideology that advocates the protection of [civil liberties](https://www.thoughtco.com/civil-liberties-definition-amp-examples-721642) and [laissez-faire economic freedom](https://www.thoughtco.com/laissez-faire-vs-government-intervention-1147510) by limiting the power of the central government. Developed in the early 19th century, the term is often used in contrast to the philosophy of modern social liberalism.

Emphasizing individual economic freedom and the protection of civil liberties under the rule of law, classical liberalism developed in the late 18th and early 19th centuries as a response to the social, economic, and political changes brought on by the [Industrial Revolution](https://www.thoughtco.com/guide-to-the-industrial-revolution-1221914) and urbanization in Europe and the United States.

Based on a belief that social progress was best achieved through adherence to [natural law](https://www.allaboutphilosophy.org/natural-law.htm) and individualism, classical liberals drew on the economic ideas of [Adam Smith](https://www.thoughtco.com/the-life-and-works-of-adam-smith-1147406) in his classic 1776 book “The Wealth of Nations.” Classical liberals also agreed with Thomas Hobbes’ belief that governments were created by the people for the purpose of minimizing conflict between individuals and that financial incentive was the best way to motivate workers. They feared a welfare state as a danger to a free market economy.

In essence, classical liberalism favors economic freedom, limited government, and protection of basic human rights, such as those in the U.S. Constitution’s [Bill of Rights](https://www.thoughtco.com/the-bill-of-rights-721651). These core tenets of classical liberalism can be seen in the areas of economics, government, politics, and sociology.

On an equal footing with social and political freedom, classical liberals advocate a level of economic freedom that leaves individuals free to invent and produce new products and processes, create and maintain wealth, and trade freely with others. To the classical liberal, the essential goal of government is to facilitate an economy in which any person is allowed the greatest possible chance to achieve his or her life goals. Indeed, classical liberals view economic freedom as the best, if not the only way to ensure a thriving and prosperous society.

Critics argue that classical liberalism’s brand of economics is inherently evil, overemphasizing monetary profit through unchecked capitalism and simple greed. However, one of the key beliefs of classical liberalism is that the goals, activities, and behaviors of a healthy economy are ethically praiseworthy. Classical liberals believe that a healthy economy is one that allows a maximum degree of free exchange of goods and services between individuals. In such exchanges, they argue, both parties end up better off—clearly a virtuous rather than evil outcome.

The last economic tenant of classical liberalism is that individuals should be allowed to decide how to dispose of the profits realized by their own effort free from government or political intervention.

Based on the ideas of Adam Smith, classical liberals believe that individuals should be free to pursue and protect their own economic self-interest free from undue interference by the central government. To accomplish that, classical liberals advocated a minimal government, limited to only six functions:

1. Protect individual rights and to provide services that cannot be provided in a free market.
2. Defend the nation against foreign invasion.
3. Enact laws to protect citizens from harms committed against them by other citizens, including protection of private property and enforcement of contracts.
4. Create and maintain public institutions, such as government agencies.
5. Provide a stable currency and a standard of weights and measures.
6. Build and maintain public roads, canals, harbors, railways, communications systems, and postal services.

Classical liberalism holds that rather than granting the fundamental rights of the people, governments are formed by the people for the express purpose of protecting those rights. In asserting this, they point to the U.S. [Declaration of Independence](https://www.thoughtco.com/declaration-of-independence-104612), which states that people are “endowed by their Creator with certain [unalienable Rights](https://www.thoughtco.com/what-are-natural-rights-4108952)…” and that “to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed…”

Spawned by [18th-century thinkers](https://www.thoughtco.com/key-thinkers-of-the-enlightenment-1221868) like Adam Smith and John Locke, the politics of classical liberalism diverged drastically from older political systems that placed rule over the people in the hands of churches, [monarchs](https://www.thoughtco.com/what-is-a-monarchy-1221597), or [totalitarian](https://www.thoughtco.com/totalitarianism-authoritarianism-fascism-4147699) government. In this manner, the politics of classical liberalism values the freedom of individuals over that of central government officials.

Classical liberals rejected the idea of [direct democracy](https://www.thoughtco.com/what-is-direct-democracy-3322038)—a government shaped solely by a majority vote of citizens—because majorities might not always respect personal property rights or economic freedom. As expressed by James Madison in [Federalist 21](https://www.congress.gov/resources/display/content/The%2BFederalist%2BPapers#TheFederalistPapers-21), classical liberalism favored a constitutional republic, reasoning that in a pure democracy a “common passion or interest will, in almost every case, be felt by a majority of the whole [...] and there is nothing to check the inducements to sacrifice the weaker party.”

Classical liberalism embraces a society in which the course of events is determined by the decisions of individuals rather than by the actions of an autonomous, aristocratically-controlled government structure.

Key to the classical liberal’s approach to sociology is the principle of spontaneous order—the theory that stable social order evolves and is maintained not by human design or government power, but by random events and processes seemingly beyond the control or understanding of humans. Adam Smith, in The Wealth of Nations, referred to this concept as the power of the “[invisible hand](https://www.thoughtco.com/invisible-hand-definition-4147674).”

For example, classical liberalism argues that the long-term trends of market-based economies are the result of the “invisible hand” of spontaneous order due to the volume and complexity of the information required to accurately predict and respond to market fluctuations.

Classical liberals view spontaneous order as the result of allowing entrepreneurs, rather than governments, to recognize and provide for the needs of the society.

**Contention 1: Effectiveness**

**A single-payer healthcare system does not achieve what it claims to achieve**

**Diamond 09**

Diamond, M. A. (2009). *Con: Single-Payer Health Care; Why It's Not The Best Answer*. American Journal of Respiratory and Critical Care Medicine. https://www.atsjournals.org/doi/full/0.64/rccm.2906-0882ED

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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). Over-attention 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)), and reductions in Medicare reimbursement over the years have demonstrably affected access and quality of care in a variety of health care venues ([7](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)–[10](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED), [13](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). TennCare's subsequent collapse has been attributed to mismanagement and unrealistic fiscal planning, a perhaps predictable consequence of government administration of health care ([15](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). 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](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)). However, because inadequate (or no) provision was made to expand the provider workforce, many of these patients had no access to care ([16](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)), and costs have escalated so far beyond estimates that additional financial support is required ([17](https://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED)).

**There is no focus on patients themselves**

**McFarlane 22**

Mcfarlane, G. (2022, July 13). *The Drawbacks of Single-Payer Healthcare*. Investopedia. https://www.investopedia.com/articles/personal-finance/112713/drawbacks-singlepayer-healthcare.asp

A euphemism for “government-run,” “single-payer” means that instead of every person in the marketplace paying for their own healthcare, there’s just one payer. A monopsony. In some parts of the world, such a system has been entrenched for so long that it’s difficult to conceive of any other way. In others, in particular, the United States, there’s still plenty of debate on the issue. It’s easy to talk about a fundamental “right to healthcare,” but the issue gets complicated when one realizes that entitling a person to certain time and resources means putting an obligation on someone else to provide the same.

Advocacy for a single-payer system in the U.S. is nothing new. In the fall of 1945, just after the end of World War II, recently inaugurated President Harry Truman addressed Congress with a plea for a national healthcare system. The American Medical Association opposed the idea, and it eventually faded away.

Incremental steps did continue throughout the decades. Medicare and Medicaid were established in 1965, essentially becoming a *de facto* single-payer system for certain groups of the population – senior citizens, and young children and the poor, respectively.

In modern times, the strongest push to nationalize healthcare in the world’s largest economy happened in 1993. When her husband’s administration was months old, then-First Lady Hillary Clinton spearheaded the Health Security Act. Thus known commonly as “Hillarycare,” the bill required all citizens to enroll in a government-approved health plan and forbade them from ever exiting that plan.

Hillarycare also called for the creation of a National Health Board, a seven-member panel whose duties would include determining what constitutes “an item or service that is not medically necessary or appropriate.” The bill was a bureaucrat’s dream, as it set criteria for everything from a new tax on cigarette rolling papers, to payment limits on certain drugs. When prominent members of the President’s own party began to question the bill’s feasibility, support continued to weaken. The bill officially died a few weeks before 1994’s midterm congressional elections, which was seen as something of a referendum on Hillarycare.

One fact often used to defend the concept of a single-payer plan is that the U.S. spends more of its gross domestic product (GDP) on healthcare than do other nations.

Mexico and Turkey each spend barely a third as much on healthcare, relative to GDP, as does the United States. Among countries that aren’t part of the Organization for Economic Cooperation and Development, the numbers can go even lower. For instance, Equatorial Guinea spends less than a quarter as much of its GDP on healthcare as the United States does. But Equatorial Guinea's savings of 13.89 percentage points over the US on healthcare also nets the country 20 fewer years in life expectancy and 10 times the infant mortality rate of the US.

But it’s probably most instructive to compare U.S. healthcare expenditures to those in the nation’s “peer group” – other developed nations. Canada, for example, has a life expectancy of 82 years while the US sits at 79 years. And Canada's infant mortality rate per 1,000 live births is 4.2, as opposed to 5.6 in the US. Yet in 2018 Canada spent $5,612 less per capita on healthcare than did the U.S.

Just ask citizens of Canada or the United Kingdom, two nations famous for their universal healthcare systems. Many Canadians love to talk of their “free” healthcare system, forgetting that if a free lunch doesn’t exist, then a free colonoscopy can’t either. Neither doctor salaries nor cardiopulmonary bypass pumps are cheap, and the money to pay for them has to come from somewhere.

Canadian health care expenditures worked out to $5,370 per capita in 2018, compared to the top-ranked U.S. with $10,948. In Canada, nearly all of the $5,370 is funded via taxes. The bulk of the costs (65%) come from taxes collected by provincial and territorial governments.

Increases in per capita healthcare spending in Canada have kept pace with those in the U.S., expenditures in the former more than tripled since the mid-70s, going from $39.7 billion in 1975 (in constant 1997 dollars) to $155.1 billion in 2017. The Canadian government not only acknowledges that many of its citizens have to wait a long time for care, but recently spent an additional billion dollars to examine the issue. In the meantime, watching the months pass is an unavoidable component of Canadian healthcare. If you want a new hip or knee, prepare to live with your old one for at least half a year.

Wait times are a fact of life under socialized medicine in the United Kingdom, too. The U.K.’s National Health Service claims that you shouldn’t have to wait longer than 18 weeks for your approved service yet recent reports say patients can wait as long as five months for cataract surgery.

Wait times in Canada are increasing, too and are up by 124% since 1993, according to one measure. At least one Canadian doctor has pointed out the absurdity of dogs being able to see specialists faster than humans can. In the U.S., such wait times aren’t even an issue.

It wasn’t all that long ago that healthcare was a market no different than that for furniture or electronics: you paid as you went, usually out-of-pocket. Then rising costs led to the notion of a single-payer. When a party other than a patient or a provider starts making healthcare decisions, it’s easy to lose sight of whose interests should be paramount in a healthcare transaction. Governments and private insurers often have conflicting agendas regarding treatment, but a sick person never does. The patient simply wants to get better.

**Contention 2: Other Options**

**The private health coverage system would better promote the general welfare**

**Pollitz et. al. 19**

 Pollitz, K. F., Neuman, T., Tolbert, J., Rudowitz, R., Cox, C., Claxton, G., & Levitt, L. (2019, July 29). *What's The Role of Private Health Insurance Today and Under Medicare-for-all and Other Public Option Proposals?* KFF. https://www.kff.org/health-reform/issue-brief/whats-the-role-of-private-health-insurance-today-and-under-medicare-for-all-and-other-public-option-proposals/

Today, the majority of the U.S. population have some form of coverage delivered by a private health insurer. This includes: non-elderly people with employer-sponsored coverage or individually purchased health insurance plans; low-income Medicaid enrollees covered by managed care organizations; people age 65 and older and younger adults with disabilities in Medicare Advantage plans; and people in traditional Medicare who also have private insurance, such as Medicare part D stand-alone prescription drug plans, supplemental (Medigap) policies, or employer-sponsored retiree health coverage.

The following coverage estimates are the most current data available for each category of private insurance. These data points cannot be summed because they derive from different sources, from different years, and because some people have private insurance from multiple sources.

Employment-based coverage accounts for the largest share of people in the U.S. with private insurance. In 2017, 153 million non-elderly people had [private, employer-sponsored health coverage](https://www.kff.org/other/state-indicator/nonelderly-0-64/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D). Typically, [employers pay most of the premium](https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-6-worker-and-employer-contributions-for-premiums/) on behalf of employees and their dependents – on average 82% of the premium for single coverage and 71% for family coverage. Employees and their families are typically responsible for deductibles and other cost-sharing requirements. The Affordable Care Act (ACA) requires large employers to provide full-time workers and their dependents health coverage that meets minimum standards for affordability and coverage value or pay a penalty. Although not mandated by law, a majority of small firms [offer health benefits](https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-2-health-benefits-offer-rates/).

Non-group, individually purchased coverage is another source of private health insurance. An [estimated 14 million](https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/?utm_campaign=KFF-2018-July-Health-Reform-Individual-Insurance-Market-Enrollment%20-%20clone&utm_source=hs_email&utm_medium=email&utm_content=2&_hsenc=p2ANqtz-_KVZesGa14vLV_ORYDI_kiFxoHkTbafw1j_o6Y9jvEuF00UOvKTDODBFTEgpCBNoCB9IO5Al3WkGu7wofa9cDEwRLRbw&_hsmi=2) people had private insurance coverage in the non-group market (also known as the individual market) in the first quarter of 2018. Of this total, roughly three-quarters purchased coverage through the ACA Marketplaces, where subsidies are available to eligible individuals with incomes between 100% and 400% of the federal poverty level (FPL). Most non-group plans are ACA compliant, meaning they must cover essential health benefits and cannot discriminate based on a person’s pre-existing condition; however, recent regulatory changes have made health plans that [do not comply with the ACA consumer protections](https://www.kff.org/health-reform/issue-brief/why-do-short-term-health-insurance-plans-have-lower-premiums-than-plans-that-comply-with-the-aca/) increasingly available in the individual market outside the Marketplaces.

The majority of Medicaid enrollees have coverage provided by managed care plans under contract with each state’s Medicaid program. Two thirds of all Medicaid enrollees (54 million) were enrolled in Medicaid managed care organizations (MCOs) as of July 2017 in the 38 states and DC that contract with Medicaid managed care organizations to deliver services to at least some beneficiary populations (e.g. children, parents, ACA expansion adults). MCOs generally provide all covered services to enrollees, but states may carve out specific services from MCO contracts (e.g. long-term care, dental, or behavioral health) and deliver these through fee-for service systems or limited benefit health plans. Medicaid MCOs are subject to broad federal and state standards and beneficiary protections. Federal standards prohibit premiums for most Medicaid enrollees, unless permitted under a demonstration waiver. Federal rules also prohibit deductibles and allow nominal cost-sharing for non-exempt enrollees. [Payments to Medicaid MCOs totaled nearly $264 billion](https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) in FY 2017, accounting for about 46% of total Medicaid spending. While states contract with private plans, not all enrollment and spending is for private managed care plans. For example, California has a number of public county-operated health plans.

A growing share of Medicare beneficiaries are enrolled in Medicare Advantage plans, such as HMOs and PPOs, which are sponsored by private insurers and paid by the federal government to provide Medicare-covered services. Among the more than 60 million people now covered by Medicare, about one-third ([22 million](https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/) in 2019) are in a Medicare Advantage plan. Medicare Advantage plans are required to provide all Medicare-covered services, and are subject to federal standards with respect to benefits and cost-sharing requirements, and network adequacy. [Many also provide additional benefits, such as dental, vision and gym memberships](https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/). Medicare Advantage plans receive capitated, risk adjusted payments from the federal government to provide Medicare-covered services, exceeding $250 billion in 2019, sometimes supplemented by beneficiary premiums. The Congressional Budget Office (CBO) projects [nearly half of all Medicare beneficiaries (47 percent)](https://www.cbo.gov/system/files?file=2019-05/51302-2019-05-medicare.pdf) will be in a Medicare Advantage plan by 2029.

The majority of people in traditional Medicare have additional coverage provided by one or more private plan sponsors. For example, 25 million Medicare beneficiaries in traditional Medicare are enrolled in private stand-alone Part D prescription drug plans. Enrollees typically pay an additional premium for this coverage, unless they qualify for low-income subsidies, and have cost-sharing requirements that vary across plans. In addition, nearly 20 million beneficiaries in traditional Medicare had private supplemental coverage in 2016, including [9.5 million traditional Medicare beneficiaries](https://www.kff.org/medicare/issue-brief/sources-of-supplemental-coverage-among-medicare-beneficiaries-in-2016/) who purchased Medicare supplemental insurance (Medigap) policies in 2016, and another [9.6 million Medicare beneficiaries](https://www.kff.org/medicare/issue-brief/sources-of-supplemental-coverage-among-medicare-beneficiaries-in-2016/) with private, employer or union-sponsored retiree health benefits that year.

**Community-Based health insurance would also be a good way to promote general welfare.**

**World Health Organization 20**

World Health Organization. (2020, March 7). *Community Based Health Insurance*. <https://www.who.int/news-room/fact-sheets/detail/community-based-health-insurance-2020>

 Community-based health insurance (CBHI) schemes are usually voluntary and characterized by community members pooling funds to offset the cost of healthcare. Despite much hope in these systems, evidence suggests the impact of CBHI on financial protection and access to needed health care are moderate for those enrolled. Most CBHI schemes have low participation levels and the poorest people usually remain excluded. Theory and practice show that CBHIs play only a limited role in helping countries move towards universal health care (UHC). They can have other positive impacts however, such as community development and local accountability of health care providers.

CBHI is a form of micro health insurance, which is an overarching term for health insurance targeted to low-income people. The specific feature of CBHIs is the community involvement in driving its setup and in its management.

Small, voluntary CBHI schemes are generally characterized by the following institutional design features.

* Pooling of health risks and of funds occurs within a community or a group of people who share common characteristics, such as geographical location or occupation.
* Membership premiums are often a flat rate and independent of individual health risks.
* Entitlements to benefits are linked to contributions in most cases.
* Affiliation is voluntary.
* The scheme operates on a non-profit basis.

Although CBHIs in the traditional model are one way to organize community initiatives, they cannot be expected to provide a major source of funding or coverage. Financial protection arrangements based on mandatory or automatic coverage funded from general government revenue that subsidizes those unable to pay have shown more potential to reach UHC goals than voluntary, contribution-financed schemes. Some countries with CBHI schemes have taken action and transformed their CBHI model towards a national scheme.

For countries with established small-scale voluntary CBHI schemes, the government could capitalize on the positive results of improved local governance capacity and public acceptance of prepaid insurance contributions. Here, an option is to integrate or merge existing schemes into a single national pool with decentralized arms or closely interconnected pools beyond the community level. These can provide similar benefit packages and act – with national support – as strategic purchasers of health services, while maintaining local accountability. This could also promote quality gains and efficiency while guaranteeing higher levels of re-distributive capacity and financial protection.

In countries where there is no government engagement in CBHI development, governments may focus from the start on developing a national system geared towards universality and envisage to cover the whole population rather than diverting resources and efforts to establishing CBHIs as an interim solution with limited impact on progressing towards UHC.

**Other Cards**

**Extension: Even More Options**

**Social Health Insurance**

**World Health Organization**

*Social Health Insurance*. World Health Organization. (2003, March). https://apps.who.int/iris/bitstream/handle/10665/206364/B3457.pdf?sequence=1

Social Health Insurance (SHI) is a form of financing and managing health care based on risk pooling. SHI pools both the health risks of the people on one hand, and the contributions of individuals, households, enterprises, and the government on the other. Thus, it protects people against financial and health burden and is a relatively fair method of financing health care. Desirable though it is, not many least-developed and low-middle-income countries have succeeded in adequately expanding coverage of SHI. Most countries rely primarily on tax-funded finance, which is also relatively fair.

Japan and the Republic of Korea are amongst the countries in Asia and the Pacific, which have universal coverage of SHI, while lower middle income countries like Thailand and Philippines have a high proportion of SHI coverage. Developing countries with stronger economies like China, Indonesia, and India have lower population coverage through SHI schemes. SHI implementation depends on the level of socio-economic development, financial sector development (mainly banking) and employment conditions, especially the existence of a larger proportion of formal sector organized establishments.

Countries with higher socio-economic status and a high employment ratio tend to have large SHI coverage. Countries which have reached almost universal coverage are grappling with cost containment, quality of care, equity issues, regulation, and policy re-definition. Countries without universal coverage of SHI are trying to attain substantial population coverage, through mutual health insurance and community- based schemes. Many of these efforts are frequently hampered by lack of national consensus on policy framework, poor regulation and inadequate administrative capacity.

**Compulsory Insurance**

**Kagan 19**

Kagan, J. (2021, May 19). *Compulsory Insurance*. Investopedia. https://www.investopedia.com/terms/c/compulsory-insurance.asp#:~:text=Compulsory%20insurance%20is%20insurance%20that,compensation%20and%20professional%20liability%20insurance.

Compulsory insurance is any type of insurance an individual or business is legally required to buy. Compulsory insurance is mandatory for individuals and businesses that want to engage in certain financially risky activities, such as operating an automobile or operating a business with employees. Compulsory insurance is supposed to protect accident victims against the costs of recovering from an accident that someone else, such as another driver or an employer, has caused.

Insurance is regulated at the state level, so each state decides what types of insurance will be compulsory and how much coverage policyholders must purchase. Policyholders may purchase higher limits of coverage if they think the compulsory minimums are insufficient.

Perhaps the most well-known type of compulsory insurance is automobile liability insurance, which drivers are required to carry. In the past, physical insurance cards were required. Now, many states allow the use of electronic proofs of car insurance. That is, a mobile application on your smartphone can be used as proof. Automobile liability insurance is not compulsory in New Hampshire and Virginia. Similarly, motorcycle drivers face compulsory insurance in every state except Florida.

State governments try to enforce compulsory auto and motorcycle insurance laws by electronically matching vehicle registration records with insurance policy records. However, compulsory insurance requirements are not always easy to enforce. Despite compulsory auto insurance laws, many drivers are not insured. Some drivers refuse to purchase insurance even though it is compulsory, either because they can’t afford one or simply don’t want to pay the premiums, which can be especially high for drivers with a history of moving violations.

Another common type of compulsory insurance is workers' compensation. If an employee gets hurt on the job, compulsory workers' compensation insurance ensures that the employer has a way to pay for the injured employee’s medical care. It also provides lost wages and, in a worst-case scenario, death benefits to a deceased worker’s spouse and children.

Several states require physicians to secure a minimum level of professional liability insurance, according to the American Medical Association. The minimum requirements vary greatly, ranging from $100,000 to $1 million per claim and from $300,000 to $3 million in coverage per year.

Although its future may be in doubt, some view the Affordable Care Act (ACA) as a compulsory insurance law—not a law that provides for universal healthcare—because it requires everyone to buy insurance that is subsidized by employers or possibly the government.

**Advanced Primary Care Alternative Payment Model**

**American Academy of Family Physicians 19**

*Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States*. American Academy of Family Physicians. (2019, December 12). https://www.aafp.org/about/policies/all/health-care-for-all.html

The health care system in the United States is uncoordinated and fragmented and emphasizes intervention rather than prevention and comprehensive health management. Health care costs continue to increase at an unsustainable rate and quality is far from ideal.i,ii

Over the past two decades, policies implemented through the Children’s Health Insurance Program (CHIP) and the Patient Protection and Affordable Care Act (ACA) have extended access to affordable health care coverage to millions of previously uninsured, non-Medicare eligible adults and children. The uninsured population reached a historic low of 8.8% under the implementation of these policies.iii The greatest gains in coverage have occurred among our most vulnerable populations and young adults. However, the rollback of some provisions of these policies has increased the percentage of those uninsured to 15.5%,iv close to what it was one decade ago when our uninsured rate was nearing 17%, with nearly 50 million people uninsured.v

Ensuring that all people in the United States have affordable health care coverage that provides a defined set of essential health benefits (EHB) is necessary in order to move toward a healthier and more productive society. Additionally, our health care system must begin to account for and address social determinants that have a profound impact on individual and population health outcomes and costs, such as socioeconomic status, housing and occupational conditions, food security, and the environment. As noted by the Commonwealth Fund, the design of a system to provide health care coverage to all people “will have a deep impact on its ability to make sustainable and systematic improvements in access to care, equity, quality of care, efficiency, and cost control.”vi

Any successful health system reform designed to achieve health care coverage for all must re-emphasize the centrality of primary care, reinvigorate the primary care infrastructure in the United States, and redesign the manner of primary care delivery and payment. Compelling research demonstrates that the ever-increasing focus of resources on specialty care has created fragmentation, decreased quality, and increased cost. Studies confirm that if primary care practices redesign how they operate so that they are more accessible, promote prevention, proactively support patients who have chronic illnesses, and engage patients in self-management and decision-making, health care quality improves along with the cost efficiency of care.vii

Family medicine and primary care are the only entities charged with longitudinal continuity of care for the whole patient. The patient and primary care physician relationship and its comprehensiveness have the greatest effect on health care outcomes and costs over the long term. However, the current United States healthcare system fails to deliver comprehensive primary care because of the way primary care has been, and is currently, financed.

According to the Center for Evaluative Clinical Sciences at Dartmouth (now called the Dartmouth Institute for Health Policy and Clinical Practice), U.S. states that rely more on primary care have lower Medicare spending (inpatient reimbursements and Part B payments); lower resource inputs (hospital beds, intensive care unit [ICU] beds, total physician labor, primary care labor, and medical specialist labor); lower utilization rates (physician visits, days in the ICU, days in the hospital, and patients seeing 10 or more physicians); and better quality of care (fewer ICU deaths and a higher composite quality score).viii

The patient-centered medical home (PCMH) is one approach to providing comprehensive advanced primary care (APC) for children, youth, adults, and the elderly. It is a model of health care that facilitates a partnership between an individual patient, the patient’s personal physician, and, when appropriate, the patient’s family or caregiver. Each patient has an ongoing relationship with a personal primary care physician trained to provide first-contact, coordinated, continuous, and comprehensive care. The personal physician leads a team of individuals at the practice level and beyond who collectively take responsibility for the ongoing care of patients.ix

Fundamental change is required to shift the direction of the U.S. health system toward one that covers all people and emphasizes comprehensive and coordinated primary care. Current resources must be allocated differently, and new resources must be deployed to achieve these desired results. Payment policies by all payers must change to reflect a greater investment in primary care to fully support and sustain primary care transformation and delivery. Workforce policies must be addressed to ensure a strong cadre of the family physicians and other primary care physicians who are so integral to a high-functioning health care team. Congress and/or state legislatures must enact comprehensive legislation to achieve this change. If such legislation only addresses the uninsured and fails to fundamentally restructure the system to promote and pay differently and better for family medicine and primary care, any solution will not reach its full potential to achieve the Quadruple Aim of better care, better health, smarter spending, and a more efficient and satisfied physician workforce.

For any health care system to achieve its goals, there will be a need for greater investment in primary care. The AAFP strongly supports increased investment in primary care as part of any U.S. health care system.

Family physicians, other primary care physicians, and primary care teams provide comprehensive primary care through two distinct functions: direct patient care and non-face-to-face care, which we label as “population-based care.” The AAFP has concluded that traditional FFS payment is largely incongruent with these core functions. The APC-APM, which is outlined in *Figure 1*, is better designed to recognize the value of these complementary, yet distinct, functions.

The APC-APM establishes a payment model built on the realization that high-quality primary care is delivered through both direct patient care and the population-based services that are provided by the primary care team. Additionally, we believe the revenue cycle for primary care must move to a prospective payment model with a retrospective evaluation for performance and quality. Therefore, our model establishes prospective payments for a direct patient care global payment, a population-based global payment, and a performance-based incentive payment.

Building on our belief that primary care should remain comprehensive, the APC-APM maintains an FFS component as a means of driving comprehensive care at the primary care level. The presence of this FFS component recognizes that a comprehensive primary care practice will provide episodes of care that are beyond the scope of the direct patient care global payment.

We believe the APC-APM will support a greater investment in primary care and will allow primary care practices of all sizes and in any location to achieve and sustain success through its simplified payment structure and dramatic reduction in administrative burden. More importantly, we believe patients will achieve better outcomes and have a more favorable experience through this model.

**Miscellaneous**

**Aggregate revenue becomes a problem.**

**Hussey and Anderson 03**

Hussey, P., & Anderson, G. F. (2003, April 26). *A comparison of single- and multi-payer health insurance systems and options for Reform*. Science Direct. https://www.sciencedirect.com/science/article/pii/S0168851003000502?casa\_token=VgiUhMk8C5kAAAAA%3AE6CvVZjGOqBHx082fWCLJfBqDrPO9u5RlA-DZjX9us0XMmgsI7embky3MW9kktHkol5y9C\_Cx6g

In many countries, however, the government's ability to collect taxes is limited due to the number of workers who earn income in the “informal economy”, widespread tax evasion, and other related factors leading to a limited tax base. In these countries, government revenues may not be sufficient to fund a universal single-payer insurance system. Multi-payer systems may allow governments to enlarge the health care resource pool from other sources, when the government's own ability to collect taxes is limited. This issue is particularly relevant to low- and middle-income countries.

The aggregate level of health care funding is still a dominant issue in countries with well-functioning taxation systems, however. The rapid growth in health expenditure in most countries has often led to governments seeking to control this growth, while in other countries such as the UK there is an explicit policy to increase government spending [[4]](https://www.sciencedirect.com/science/article/pii/S0168851003000502?casa_token=VgiUhMk8C5kAAAAA:E6CvVZjGOqBHx082fWCLJfBqDrPO9u5RlA-DZjX9us0XMmgsI7embky3MW9kktHkol5y9C_Cx6g#BIB4). The governments of these countries, with single-payer health insurance systems, essentially have total control over aggregate expenditure.

Aggregate expenditure for single-payer health insurance systems is typically determined through an annual budgeting process. In multi-payer systems, it is more difficult to monitor and control aggregate spending. This is because different insurers may use different utilization monitoring, payment, and information systems. This can lead to “cost shifting”—having one insurer pay more than another payer for a similar product.

The high degree of government control over aggregate spending in single-payer insurance systems leads to greater political determination of total health expenditure levels. In the UK, It was widely argued that it has led to under-investment in health care [[5]](https://www.sciencedirect.com/science/article/pii/S0168851003000502?casa_token=VgiUhMk8C5kAAAAA:E6CvVZjGOqBHx082fWCLJfBqDrPO9u5RlA-DZjX9us0XMmgsI7embky3MW9kktHkol5y9C_Cx6g#BIB5). Others have observed that politicians may be more likely to increase health spending in election years [[6]](https://www.sciencedirect.com/science/article/pii/S0168851003000502?casa_token=VgiUhMk8C5kAAAAA:E6CvVZjGOqBHx082fWCLJfBqDrPO9u5RlA-DZjX9us0XMmgsI7embky3MW9kktHkol5y9C_Cx6g#BIB6). The recent increases in the level of health spending in the UK enacted by the Labor Government demonstrate the degree of political control over health spending levels

**Diversity in services can be provided with multi-payer systems.**

**Hussey and Anderson 03**

Hussey, P., & Anderson, G. F. (2003, April 26). *A comparison of single- and multi-payer health insurance systems and options for Reform*. Science Direct. https://www.sciencedirect.com/science/article/pii/S0168851003000502?casa\_token=VgiUhMk8C5kAAAAA%3AE6CvVZjGOqBHx082fWCLJfBqDrPO9u5RlA-DZjX9us0XMmgsI7embky3MW9kktHkol5y9C\_Cx6g

If risk selection could be avoided or limited despite the difficulties, it is possible in multi-payer systems to design insurance packages to provide services that are appropriate for certain risk groups. Specific insurance products could be tailored to meet specific needs and wants of specific types of individuals. For example, insurers could offer case management benefits to insurance pools containing a high proportion of persons with chronic conditions. Other insurance pools could offer unrestricted access to specialists, or coverage of alternative therapies. Insurance products can also be tailored to an individual’s level of risk aversion. For example, a medical savings account or plan with a high deductible may be preferred by less risk-averse people, while those who are more averse to risk-taking may prefer a more comprehensive benefit package with little or no cost sharing. Groups of individuals that tend to engage in healthy behaviors could be financially rewarded through lower insurance contributions. For example, an insurance policy could be offered exclusively to non-smokers. However, tailoring insurance policies to risk groups can lead to the effects of adverse selection unless it is prevented effectively.

Another way multi-payer insurers can offer diversity is to selectively contract with certain providers in order to provide a specialized level of service for their beneficiaries. For example, insurers could selectively contract with hospitals and physicians charging low rates in order to provide an affordable benefits package. In Switzerland, individuals can pay higher premiums in exchange for better hospital amenities [27]. Insurers could also contract with higher-quality, higher-priced providers to offer a high-end option to beneficiaries. It is also possible for single-payer insurers to selectively contract with providers, but attempts to date have had limited success. Countries such as the UK and Sweden have enacted a ‘‘quasi market’’ of competition among providers for single-payer funds. However, these systems have typically seen little change in historical relationships between purchasers and providers [28/32]. In the UK, little competition was noted in response to the Conservative government reforms to introduce competition into provider payment, with the government apparently reluctant to let hospitals fail by not obtaining a contract [28/30]. In the UK, as in many other single-payer insurance systems, doctors and other health care workers are civil servants. This can introduce rigidity in the process of adjusting the supply of health care labor to meet needs due to civil service rules. In Sweden, historical relationships between the regional purchasers and hospitals have also generally persisted, with few observed instances of competitive behavior (although significant productivity gains have been observed in the hospital sector due to new financial incentives).

**A single-payer system deprives Americans of a right to secure alternative health care.**

**Moffit 20**

Moffit, R. E. (2020, November 17). *Single-payer is not the solution to America's Health Care Problems*. The Heritage Foundation. https://www.heritage.org/health-care-reform/commentary/single-payer-not-the-solution-americas-health-care-problems

Reform is necessary. However, the substance of reform, as the Catholic Church has long emphasized, must aim to secure simultaneously the good of the individual person and the common good of society. The single-payer solution is not the answer and opposition to it is not tantamount to opposition to either universal access to coverage or universal access to care. Every person should have access to health coverage and care, and government financial assistance to the poor and the sick can ensure that objective. However, when it comes to the financing and delivery of health care, a multi-payer system of private, competing health plans would better serve those objectives, while expanding personal choice for individuals and families, lowering costs and improving quality.

Nonetheless, with the onset of the pandemic, many prominent “progressives” in the House and Senate, such as Sen. Bernie Sanders of Vermont and Rep. Alexandria Ocasio-Cortez of New York, have argued that the national medical emergency and its economic consequences justifies the abolition of America’s unique combination of public and private health insurance coverage and replacing these arrangements with a single-payer system of national health insurance. The leading Congressional single-payer bills in the House (HR 1384) and the Senate (S. 1129)—dubbed “Medicare for All”—are broadly similar in content, and crystal clear in their legislative language.

The House and Senate measures would transfer vast regulatory authority to the Secretary of the U.S. Department of Health and Human Services (HHS) and other federal officials. Both would abolish nearly all existing private and employer-sponsored health programs. In substance, both bills would ignore the principle of subsidiarity, centralizing virtually all authority over health care financing and delivery in the federal government, and thus overriding state government authority and the intermediary institutions of civil society, local associations and organizations, in providing coverage and care.

These bills would explicitly deprive Americans of any right to secure alternative health care coverage, regardless of their personal preferences. Both would also impose restrictions on doctors and patients who wish to contract with each other outside of the newly established national health insurance system. The relevant language of each measure is broadly similar: If a physician or other medical professional contracts with a patient outside of the national health insurance system, the doctor must refrain from receiving government reimbursement from treating all other patients for a specified period of time, thus guaranteeing that few, if any, physicians would be able to operate independently of the government program. In substance both measures would render virtually all doctors and patients fully dependent on the powers of the federal government.

In addition, in both bills the federal government would define the kinds of health care benefits and medical services all Americans must have, including mandatory coverage of abortion, along with participation requirements for physicians and other medical professionals to provide these services or face exclusion from the national program. In substance, both measures would violate the sanctity of life, personal freedom of conscience and religious liberty.

**A single-payer system lacks business support.**

**Harvard School of Public Health 21**

*Why a single-payer health care system lacks business support*. Harvard School of Public Health. (2021, June 17). https://www.hsph.harvard.edu/news/hsph-in-the-news/why-a-single-payer-health-care-system-lacks-business-support/

Research indicates that a single-payer [health care system](https://www.hsph.harvard.edu/news/multitaxo/topic/health-systems/) in the U.S. would save the country or individual states money in the long run, but many employers are opposed to such a system, even though it is costly, according to news reports.

A June 10, 2021, Marketplace article noted that employers paid 67% of medical premiums for family coverage plans in March 2020 and contributed an annual average of almost $14,000 per family. The article examined several possible reasons companies prefer the current system, including that offering health insurance gives large established companies a competitive advantage over startups and fledgling companies when recruiting employees.

[William Hsiao](https://www.hsph.harvard.edu/william-hsiao/), K.T. Li Professor of Economics, Emeritus, at Harvard T.H. Chan School of Public Health, noted that industries that are heavy with younger workers, such as the tech industry, are likely to oppose single-payer systems because health insurance premiums tend to be lower for younger people. Hsiao added that some companies may worry that their workers would demand higher pay if the company wasn’t covering their health insurance, while other companies may be ideologically opposed to having a government-run health system.

**The economics just don’t work, especially in more populated areas.**

**Ohanian 19**

Ohanian, L. (2019, April 16). *The Extremely Bad Economics of Single-Payer Healthcare for California*. Hoover Institution. https://www.hoover.org/research/extremely-bad-economics-single-payer-healthcare-california

“Medicare for All.” “Healthcare is a right, not a privilege.” “You will never be denied treatment under single-payer healthcare.”

These are some of the slogans that you will hear from politicians, including all current Democratic presidential candidates. In the most extreme versions of “Medicare for All” plans, such as that advocated by Bernie Sanders, private health insurance would be eliminated in favor of a government-run, single-payer plan.

All of these presidential candidates are looking to California to see if the state implements a single-payer system. Governor Gavin Newsom, as well as many California Democratic lawmakers, support a single-payer plan as presented in 2017’s SB-562. This proposal would have eliminated private insurance and consolidated all existing health plans, including the state’s Medi-Cal plan, into a new state-run network. Under this plan, there would be no medical co-pays and no deductibles. Californians would then either be in the state-run program or need to pay purely out of pocket for medical care. Private insurance would be illegal.

With the current Democratic supermajority, there are in principle more than enough votes to pass such a plan. And if a plan similar to SB-562 was implemented, it would lead to extremely costly healthcare and extremely low consumer satisfaction. High costs and low satisfaction are the entirely predictable outcomes of eliminating competition, eliminating consumer choice, and in particular, of doubling down on perhaps the biggest problem in US healthcare: that consumers have very little incentive to economize on medical spending.

Analysts estimate that a single-payer plan would cost California between $330 and $400 billion per year. If this sounds like a lot, it is. In covering a population of roughly 40 million, this would amount to about $10,000 per person per year. To give you a relative idea of the cost, this would approximately double the entire state budget.

The cost estimate is also understated, because such a plan would draw in new residents from other countries and other states who may have very expensive conditions. This could easily increase costs by 5 percent or more, for an additional $20 billion.

Any sensible reform of US healthcare must confront the problem that the consumers of healthcare do not have sufficient incentives to control costs. A California single-payer plan doubles down on this issue because it would eliminate virtually all incentives for consumers to control costs. No co-pays and no deductibles mean increased demand for virtually all healthcare, and extraordinary rationing of healthcare.

Ironically, one of the main sales pitches for single-payer healthcare—“You can’t be denied”—is false. Current and future procedures that are deemed by those running the state’s health board to be “too expensive” will indeed be denied or severely rationed. And you may need to wait in line a long time before receiving healthcare. The healthcare market does not magically avoid the economic realities of all other markets. If society provides a good at zero cost to the consumer, then the good will be allocated by rationing rather than price. No ifs, ands, or buts.

If you think that the only restricted procedures will be extremely expensive, experimental procedures, then you need to think again. Britain has one of the oldest continuously operating nationalized healthcare systems, the National Health Service (NHS), and is now restricting one of the most common eye surgeries, cataract operations, because the NHS believes them to be of “limited clinical value.” Really?

More broadly, recent statistics from Britain showcase just how significant these problems are in practice, and just how poorly the UK healthcare system functions. Data from the NHS shows that nearly a quarter of a million British patients have been waiting more than six months to receive medical treatment. And don’t think that grossly unreasonable waits only affect elective procedures. Only 84 percent of patients in British hospital emergency rooms are seen within four hours following admission. The country’s goal is to see 95 percent of patients within four hours, which is a goal that has not been achieved since 2015. It is now so obvious that the goal cannot be realistically met that the United Kingdom is considering eliminating the goal.

Young doctors in Britain, who make up nearly half of British physicians, are so fed up with working conditions that they are threatening to go on strike. Physicians in the United Kingdom complain that patient overcrowding within the system is tantamount to “third-world medical conditions” and remark that it is similar to “battlefield medicine.”

Not surprisingly, some doctors who are being trained in England are choosing to practice medicine in other countries rather than facing the alternative of dealing with the remarkably deficient National Health Service.

UK physician brain drain has been going on as long as the existence of their national healthcare system. This has now become so extreme that 35 percent of existing British doctors are imported from other countries, most from very poor countries.

Staffing problems, which are obviously critical now, will become extreme in another decade. A recent report forecasts a shortfall of 250,000 medical staff by 2030. And keep in mind that predictions such as these are almost always too optimistic.

This means that the current completely unacceptable waiting times for treatment will increase, and increase considerably. According to January NHS England data, almost 25% of cancer patients didn't start treatment on time despite an urgent referral by their primary-care doctor. If you are wondering what “on time” means, then think of how airlines pad travel times. For the NHS, “on time” already means 62 days after referral.

Sadly, waiting times do matter. Only 81% of UK breast cancer patients survive at least five years after diagnosis, compared to 89% in the United States, and just 83% of patients in the United Kingdom live five years after a prostate cancer diagnosis, compared to 97% in the United States.

For anyone thinking about how to reform health care—irrespective of your politics—think of all of the thousands of commodities and services that you and your family privately purchase within the marketplace. In how many of those markets are you restricted or denied the opportunity to make these purchases? How often do you need to wait six months to obtain the good or service that you would like to purchase? How often do you see the suppliers of the goods and services that you buy bailing en masse in the United States, moving to another country to set out their shingle and start over?

Roughly never. Ever. Why never? Because markets work. It is that simple. The statistics summarized here from the United Kingdom are chilling. They should not be repeated in California or anywhere else. There are infinitely better ways to reform US healthcare. I’ll discuss those in a forthcoming COYM column.

**A single-payer system means ridiculous waiting times for all citizens.**

**Atlas 17**

Atlas, S. W. (2017, September 25). *Why Single Payer Health Care is a terrible option*. CNN. https://www.cnn.com/2017/09/25/opinions/single-payer-failure-opinion-atlas

In those countries with the longest experience of single-payer government insurance, published data demonstrates massive waiting lists and unconscionable delays that are unheard of in the United States. In England alone, approximately 3.9 million patients are on NHS waiting lists; over 362,000 patients waited longer than 18 weeks for hospital treatment in March 2017, an increase of almost 64,000 on the previous year; and 95,252 have been waiting more than six months for treatment – all after already waiting for and receiving initial diagnosis and referral.

In Canada’s single-payer system, the 2016 median wait for a referral from a general practitioner appointment to the specialist appointment was 9.4 weeks; when added to the median wait of 10.6 weeks from specialist to first treatment, the median wait after seeing a doctor to start treatment was 20 weeks, or about 4.5 months.

Ironically, US media outrage was widespread when pre-ACA 2009 data showed that time-to-appointment for Americans averaged 20.5 days for five common specialties. That selective reporting failed to note that those waits were for healthy check-ups in almost all cases, by definition the lowest medical priority. Even for simple physical exams and purely elective, routine appointments, US wait times before ACA were shorter than for seriously ill patients in countries with nationalized, single-payer insurance.

Those same insured patients in single-payer systems are dying while waiting for the most critical care, including those referred by doctors for “urgent treatment” for already diagnosed cancer (almost 19% wait more than two months) and brain surgery (17% wait more than four months). In Canada’s single-payer system, the median wait for neurosurgery after already seeing the doctor was a shocking 46.9 weeks – about 10 months. And in Canada, if you needed life-changing orthopedic surgery, like hip or knee replacement, you would wait a startling 38 weeks – about the same time it takes from fertilization to a full-term human life.

Americans enjoy the world’s quickest access to the newest prescription drugs, in stark contrast to patients in single-payer systems. In Joshua Cohen’s 2006 study of patient access to 71 drugs, between 1999 and 2005 the UK government’s guidelines board, NICE, had been slower than the United States to authorize 64 of these. Before the ACA, the United States was by far the most frequent country where new cancer drugs were first launched – by a factor of at least four – compared to any country studied in the previous decade, including Germany, Japan, Switzerland, France, Canada, Italy and the UK, according to the Annals of Oncology in 2007.

In a 2011 Health Affairs study, of 35 new cancer drugs submitted from 2000-2011, the US Food and Drug Administration (FDA) had approved 32 while the European Medicines Agency (EMA) approved only 26. Median time to approval in the United States was about half of that in Europe. All 23 drugs approved by both were available to US patients first. Even in the most recent data, two-thirds of the novel drugs approved in 2015 (29 of 45, 64%) were approved in the United States before any other country. And yet, only months ago, NHS in England introduced a new “Budget Impact Test” to cap drug prices, a measure that is specifically designed to further restrict drug access even though the delays will break their own NHS Constitution pledges to its

Despite what some might suppose about the likely strength of a government-centralized system, the facts show that single-payer systems cannot even outperform our system in something as scheduled and routine as cancer screening tests. Confirming numerous prior OECD studies, a Health Affairs study reported in 2009, before any Affordable Care Act screening requirements, that the United States had superior screening rates to all 10 European countries with nationalized systems for all cancers. Likewise, the single payer system of Canada fails to deliver screening tests for the most common cancers as broadly as the US system, including PAP smears and colonoscopies. And Americans are more likely to be screened younger for cancer than in Europe, when the expected benefit is greatest. Not surprisingly, US patients have had less advanced disease at diagnosis than in Europe for almost all cancers.

**It does not have nearly as much support as the aff is making it seem.**

**Kessler, Kendall, Horwitz 19**

Kessler, J., Kendall, D., & Horwitz, G. (2019, March 4). *The Risks of Single Payer*. Third Way. https://www.thirdway.org/memo/the-risks-of-single-payer

Even those wanting a bigger government role in health care are skeptical. Based on [polling](https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/) from the Kaiser Family Foundation, public support for Medicare for All plummets when people learn that it eliminates private insurance (support drops from 56% to 37%), requires most Americans to pay more in taxes (support drops to 37%), threatens Medicare (support drops to 32%), or leads to delays in tests and treatments (support drops to 26%). And in a [2019 CNN poll](http://cdn.cnn.com/cnn/2019/images/02/05/rel2b..-.2020.pdf), 54% of those who support coverage for everyone say private health insurance should be protected.

156 million people will lose their employer-sponsored coverage. Let’s not mince words here: Section 107 of the single payer legislation outlaws private health insurance. This is a hard circle to square. Right now, 156 million mostly-satisfied people get coverage through their employer. Those plans would be replaced under single payer in favor of a plan that they may not like. Democrats faced a huge backlash when a few million people saw their coverage change under the ACA. How about half the country?

Voters have rejected single payer when it’s been on the ballot. California’s single-payer Proposition 186 won just 26.6% of the vote in 1994. In 2002, Oregon’s single-payer ballot measure won just 21.5% of the vote. Yes, that may seem like ancient history, but in 2016, Colorado’s single-payer ballot Amendment 69 got 21.2% of the vote. It even lost by 24 points in Boulder, one of the bluest counties in America.

Republicans are eager for a fight over single payer. They know Democrats will be vulnerable to massive tax increases and loss of coverage. Rep. Kevin Brady (R-TX) summed up GOP enthusiasm when he [said](https://www.politico.com/story/2019/02/10/republicans-debate-medicare-for-all-1160681), “hearings would lay out the truth, which is that it will ban all private health care plans, including the good plans people get at work.”

 A litany of progressive leaders have voiced concerns with single payer since it caught fire among the left. Paul Krugman [said](https://www.nytimes.com/2017/09/15/opinion/politicians-promises-and-getting-real.html?emc=edit_th_20170915&nl=todaysheadlines&nlid=71461014&_r=0) that “Democrats could eventually find themselves facing a Trumpcare-type debacle.” Ron Pollack of Families USA [warns](https://www.vox.com/the-big-idea/2017/9/8/16271888/health-care-single-payer-aca-democratic-agenda), “Maybe we should hit pause before we get on this bandwagon.” Jonathan Chait [writes](http://nymag.com/daily/intelligencer/2017/09/sanderss-bill-gets-u-s-zero-percent-closer-to-single-payer.html), “A single-payer plan would be nice, in a world that looks nothing like the one we inhabit.” Former Congressman Henry Waxman [notes](https://www.washingtonpost.com/opinions/democrats-shouldnt-impose-litmus-tests-on-health-care/2018/04/08/1969b664-39b2-11e8-9c0a-85d477d9a226_story.html?utm_term=.7e3c4fdc810f), “[S]ingle-payer is no policy panacea…[and] would require tax increases at politically suicidal levels.” And *New York Times* Columnist Austin Frakt [notes](https://www.nytimes.com/2018/10/15/upshot/is-medicare-for-all-the-answer-to-sky-high-administrative-costs.html) that private plans are “more responsive to consumer demand” and offered prescription drug coverage decades before Medicare.

Democrats have the opportunity and an obligation in 2020 to make Trump a one-term president and put this country back on track. Once we do that, we can finally achieve universal coverage and lower health care costs for all. But if Democrats back a single payer plan, it will make it far tougher to beat Trump. So handle with care and be aware that there are other attractive options to accomplish that shared Democratic goals of lowering costs and covering everyone.