

Closer Look at Other Health Care Systems Exposes Myth of Universal Health Care Through Single-Payer

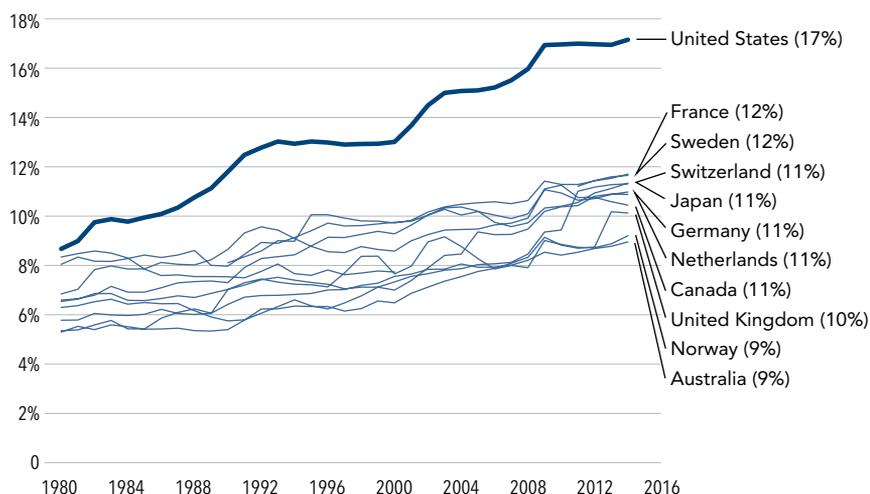
In the debate on health care, the two words most confused or misunderstood are “universal” and “single-payer.” They often are used interchangeably, and even standing alone, are defined incorrectly. This confusion or error has completely skewed the dialogue on what is an ideal model for California health care and how to improve health care in California.

Very few, if any, would disagree that all the citizens and legal residents of a state or country should have access to quality, affordable health care. That is the widely accepted definition of “universal” health care—when all citizens and legal residents have access to health care.

There are many ways of achieving universal health care. One of those ways is through a “single-payer” model wherein the government is the single payer for the health care of its citizens and legal residents. What has confused the dialogue in California in the last year and even in the greater debate on health care in the United States, is a misunderstanding that the two terms are the same or that universal health care can be achieved only through a single-payer model. In fact, this is simply untrue, because most countries that have been able to achieve universal health care (as defined above), have not done so using a single-payer model. Furthermore, there are very few countries, arguably two in the entire world, that have achieved universal health care through a single-payer model. Even those two countries are realizing that a single-payer model is unsustainable.

A true single-payer health care system prohibits private health insurance. Health care in such a system can be delivered through either public and/or private hospitals and health care providers, but the payment for the health care must be made by a single entity, usually the government. However well-intentioned a single-payer model is, it violates an individual’s personal freedom and choice. It increases health care costs because it creates a false belief in consumers of health care that health care is free. It eliminates cost sharing of any kind by the consumer, thereby increasing demand for a “free” service with

U.S. Spends More than Other Countries
Health Care Spending as % of GDP 1980–2014



Note: Australia, Germany, Japan, Netherlands and Switzerland data is for current spending only and excludes capital formation of health care providers.

Source: The Commonwealth Fund from Organisation for Economic Co-operation and Development (OECD) Health Data 2016.

no consequence to the consumer. The “free” medical services are overutilized, thus requiring rationing of care across the board, which is why countries with a single-payer system, such as Canada, have a wait time crisis on their hands.

Wait times for routine surgeries in the United States that could be performed within a week or a month of an injury, have a four- to 12-month waiting period in the single-payer countries. A single-payer system also results in decreased quality of care because competition is eliminated. Under a single-payer system, each type of health care provider is designated a set payment amount; thus there is no financial incentive to provide higher quality of care or be innovative in the care provided. In addition to all these inherent deficiencies, a single-payer system is extremely costly and risky, especially at the state level, since states cannot deficit spend like the federal government.

California and the United States are fortunate not to have a single-payer model, which is why there is not a prevalence of care rationing or unreasonable wait times for patients to

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be seen by providers or specialists, or for surgery. In fact, in a comparison of 11 countries, the United States comes in first for the shortest wait times to be seen by a specialist (while Canada, a single-payer health care system, comes in second to last), as well as first for shortest wait times for elective surgeries (while Canada comes in last). The United States has the second most MRI machines per capita in a nine-country comparison, while Canada has close to the least.

Unequal Comparisons

Unfortunately, when compared to other countries, the United States spends more on health care than any other nation and yet ranks low in health outcome. The problem with the comparison, however, is that it is not an equal and fair one, and is based on data provided by the countries, which have different measurement standards or function under different medical standards. An example of this is the infant mortality rate and life expectancy rate used to measure the overall success of a country's health care.

In determining the ranking of a country's health care system, both the infant mortality and life expectancy rate are given great importance. This provides incentive to countries to keep the infant mortality rate low and the life expectancy rate high. Cuba is an example of a country that's aware of the importance of such ranking. It also is an example, not only of a single-payer system, but of a socialized health system wherein all health-related facilities and services are run by the government. In Cuba, the abortion rate is high. In 2010, data compiled by the United Nations revealed that Cuba had the second highest rate of abortions among countries that permit abortion—30 abortions for every 1,000 women of child-bearing age, while the United States had 17 abortions per 1,000. Cuba's high abortion rate keeps the infant mortality rate low. Women's pregnancies are monitored by Cuban physicians who recommend termination of pregnancies when certain abnormalities are found—many abnormalities for which U.S. physicians would not recommend abortion. Similarly, the U.S. life expectancy is lower than that of other countries because U.S. physicians make every effort to maintain even a complicated pregnancy to birth. This results in children with abnormalities and health complications being born and living with their ailments. As a result, they die at an earlier age than individuals without such health complications. Also adding to the problem of skewed data on infant mortality rates is reporting infant deaths as stillbirths rather than deaths.

Regardless of reporting inaccuracies and differences in medical standards that may skew data results, there is no doubt that the U.S. and California health care systems need repair. But rather than focusing on repair, due to the frustration with the rising cost of health care, the recent narrative that has arisen and taken hold in California and the United States is that a single-payer health care system is the solution. The recent attacks on the Patient Protection and Affordable Care Act (ACA) at the federal level, including the reduction of the individual mandate penalty to \$0 and the elimination of cost-sharing reduction subsidy payments, have only further fueled the argument that single-payer health care should be implemented.

Whether it's at the national level or at the state level, single-payer advocates support their argument by comparing the U.S. and California health care systems to those of other countries. Such comparisons are problematic for the reasons stated above regarding skewed data, but also are concerning because the nature and the state of health care systems in other countries that are idealized often are misunderstood.

For example, proponents of single-payer in California want to achieve universal health care in California, but define universal health care as health care for every resident of the state regardless of immigration status. Yet the countries single-payer proponents point to as having universal health care (which in fact by the widely accepted definition of universal health care do have it) do not provide health care to undocumented immigrants. Similarly, proponents of single-payer health care point to many countries to emulate as examples of single-payer, yet the majority of those countries do not have a single-payer health care system, but rather a multi-payer system, which is what California and the United States have.

Reality Check Needed

In an era of too much information and a lot of misinformation, before idealizing and replicating health care systems, Californians need to ensure that a health care system they are considering replicating here is truly what they believe it to be. As will be detailed below, a closer look at health care systems around the world that are touted to be single-payer systems or ones that have achieved universal health care will lead to the conclusion that a single-payer health care system in other countries is very rare, does not result in more accessible health care, and is definitely not sustainable. A closer look also will reveal that countries which have achieved universal health care for all citizens and legal residents exempt many types of coverage and services that Californians believe to be essential health care and for which they expect health plan coverage, such as prescription medication, ambulance transport, and physical, occupational and speech therapy, as well as other services.

If implementation of single-payer health care 55 years ago in the nation's northern neighbor is any lesson to California, it's that California shouldn't emulate a system that is slowly being abandoned. Canada's own Supreme Court has stated that Canada's health care system has violated patients' "liberty, safety and security." The last thing California needs is to replace its health care system with one that will lead the state into a health care crisis as well.

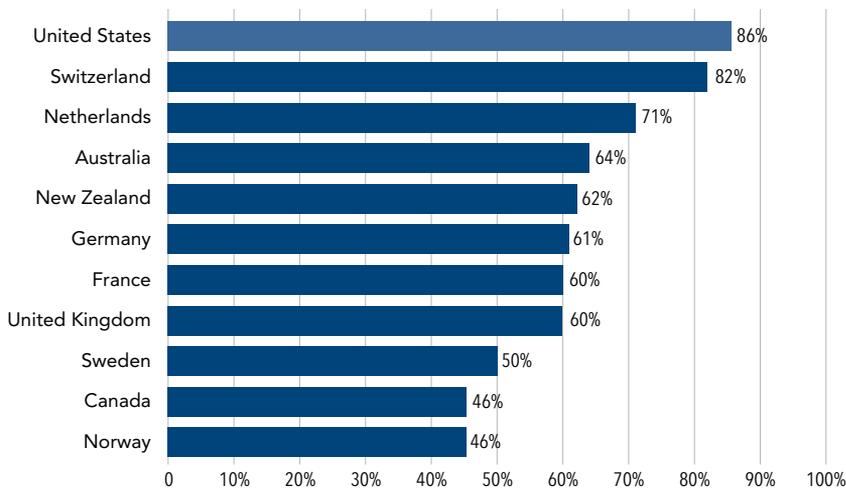
California

In comparing California to other countries, it's important to realize that the state is significantly larger than the majority of the countries to which it is compared. California not only has a large population of approximately 39.25 million people, but that population is extremely diverse, which only makes health care delivery even more complicated.

California has the largest minority population in the United States. It has a nonwhite majority, with Hispanics representing

U.S. Does Well on Getting in Quickly to See Specialists

% Who Waited Less than 4 Weeks for Specialist Appointment Among Adults Age 65 or Older



Base: Saw/needed to see a specialist in the past 2 years.

Source: 2014 Commonwealth Fund International Health Policy Survey of Older Adults in Eleven Countries.

38.8% of the population and whites 38%. California also has the highest number of Asians and Hispanics of any state in the country. With 20% of all minorities in the United States living in California, health care providers in the state not only have the burden and obligation to ensure proper communication in many different languages, but also have to address and attend to the diverse health care needs of such a heterogeneous population.

Of the 39.25 million people living in California, approximately 6.8%, or 2.7 million people, are uninsured and of this 2.7 million, approximately two-thirds are undocumented immigrants. This means of the 37.45 million citizens and legal residents in California, only 2.4% are uninsured. This statistic is important because other countries that are considered universal health care countries do not count undocumented immigrants in their calculation. If they did, the majority, if not all countries, would not be considered providers of universal health care. Thus, under the prevalent and commonly accepted meaning of universal health care, California is much closer to universal health care coverage than is reported.

Canada

Canada, whose health care system commonly is referred to as Medicare, often is pointed to as the example of a country with both universal and single-payer health care. Depending on the definition of both those terms, however, as mentioned above, it may be neither of those things or both of those things. Public health care in Canada is available to Canadian citizens and permanent residents, but not to anyone who is living illegally in the country. Health care services are paid for mostly through general taxation, but delivered by mostly private providers rather than government employees. Citizens and residents must apply for the government-run public health insurance, which pays health care providers.

Although it is revered as a model of universal health care by supporters, the Canadian health care system does not provide coverage for prescription drugs, home care or long-term care, prescription glasses or dental care, physical therapy or ambulance services, and provides only limited coverage for mental health care. Thus, health care for any of these services is not provided by the government, but by the people themselves, directly or through private insurance they obtain. In addition, some surgeries which in California would be deemed basic and essential care, such as circumcision of a male newborn, are not covered at all if the operation is not therapeutic.

Although Canada spends significantly less on health care than California does, its people pay a steep price for health care in other ways. They pay it in time waiting to see a specialist for care, and they pay

it in pain and suffering waiting for surgeries that Californians would consider to be routine. In fact, in December 2017, the latest data on Canadian health care revealed that Canada's wait times are at an all-time high with individuals waiting at least 4 months for surgery and in some provinces an average of almost 10 months. If those numbers weren't frightening enough, there currently are more than 1 million procedures for which Canadians are on a wait list, waiting to receive treatment (Fraser Institute, *Waiting Your Turn: Wait Times for Health Care in Canada, 2017 Report*).

Although Canada has a population that is approximately 3 million less than California's and provides narrower health care coverage than California's (such as an exemption of prescription medication, which is a large cost driver in the United States), Canada's single-payer system has led to significant rationing of medical care. The wait times are an example of how Canadian health care is not only failing to improve, it is worsening. In 1993, the wait time for a procedure was approximately 9 weeks. That has now doubled in 2017 in some provinces, and more than quadrupled in other provinces.

Unlike other countries with universal health care, Canada has tried to remain true to its single-payer model and has prohibited private health insurance in most provinces. This prohibition famously led to a 2005 Canadian Supreme Court case where a Canadian man was forced to wait for almost a year for a hip replacement surgery on a wait list. (*Chaoulli v. Quebec* (2005) 1 S.C.R. 791). When he tried to pay out of pocket to hasten surgery, he was denied, as it was illegal at the time to pay privately for procedures provided under the Canadian single-payer health care system. The Canadian Supreme Court held that the health care system in Canada had failed this man and

struck down a Quebec law that banned private health insurance. The court stated: “The evidence in this case shows that delays in the public health care system are widespread and that in some serious cases, patients die as a result of waiting lists for public health care.” The court concluded that “the prohibition on obtaining private health insurance is not constitutional where the public system fails to deliver reasonable services.”

Province by province, case by case, Canada’s single-payer system is eroding because there is a recognition by some Canadians that their health care model is unsustainable and is a violation of their “liberty, safety and security.” In fact, Canada’s single-payer model is again under attack, this time in the British Columbia Supreme Court, and the case (*Cambie Surgical Centre et al. v. Medical Services Commission et al.*) will likely end up in the Canadian Supreme Court. These cases further confirm that Canada’s single-payer system is not a health care model that California should emulate. Just as health care coverage does not necessarily equate to health care access, universal coverage under a single-payer model does not equal access either, and in Canada’s case, has proven to limit access due to rationing and excessive wait times.

Cuba

Universal health care in Cuba is a right guaranteed by the government. What is not guaranteed is the quality or innovation of that health care. Cuba is an example of a single-payer health care system because it has a nationalized universal health care system wherein the government is the only payer of health care and private health insurance is prohibited. Cuba’s population consists of 11.4 million individuals and all health services for them are government-run.

Cuba is looked to as an example of a health care system that has been able to keep health care costs down, while keeping infant mortality rates low and life expectancy high—although the question to ask is, at what price? It’s not that health care in Cuba can’t be great. It can be, but mostly for government officials or foreigners who seek lower-cost plastic surgeries. Medical tourism is a booming business in Cuba and the government recognizes that—which is why it ensures that data that ranks Cuba’s health care system, such as the infant mortality rate and the life expectancy rate discussed above, continue to remain positive, even if it means the abortion rate is one of the highest in the world.

On the surface, Cuban health care may seem admirable. It has well-educated physicians who make annual visits to citizens’ homes for a physical and all health care is completely free to Cuban citizens. It has twice as many physicians per capita as the United States, and has created its own pharmaceutical industry, which manufactures many of the basic medications necessary. But again, other than the annual visit, most of the positives of Cuban health care are to support the booming business of health care. Much of the medication is exported and many of the Cuban physicians (who make approximately \$60 a month since there’s no private alternative and no competition) often work outside of the country, either as part of Cuban foreign aid or as a financial

benefit to the Cuban government. In 2015, the Cuban government made \$8.2 billion from its medical workers overseas.

A visit to a hospital in Cuba for the poor and middle class reveals the poor state of hospitals in Cuba—broken windows and cockroaches, lack of updated medical equipment, partly due to the U.S. economic embargo, and lack of basic medication, such as antibiotics or aspirin. Cuba’s health statistics look good on paper, but its single-payer health care system is not one that the United States or California should ever consider emulating.

England

The National Health Service (NHS) is the publicly funded national health care system for England with approximately 80% of health care funding coming from government expenditures, mostly through the general taxation system, and about 18% from payroll taxes. England is not a single-payer health care system even though it often is incorrectly identified to be. If anything, it is closer to socialized medicine with government financing for mostly publicly owned and operated hospitals. But England’s is not truly socialized medicine either because private insurance is allowed and even encouraged. Citizens and residents of England are entitled to health care under the NHS. Undocumented immigrants, however, are only entitled to free treatment in an emergency department and for certain infectious diseases.

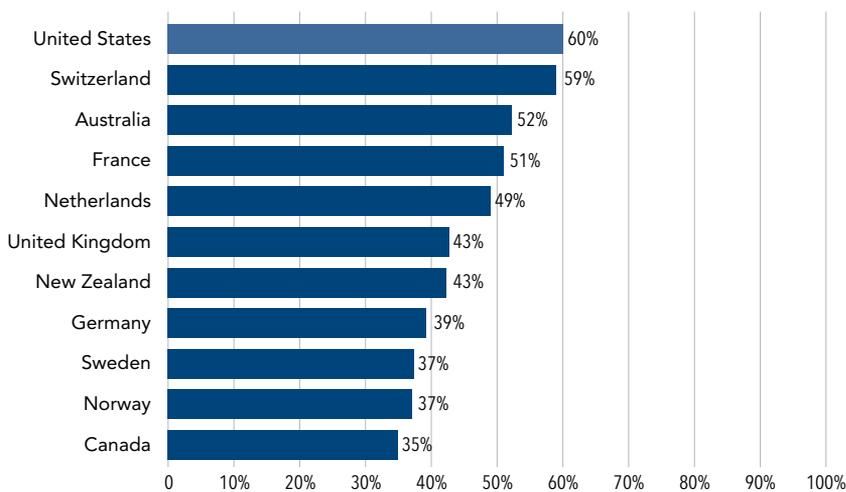
The NHS is severely underfunded and as a result uses waiting lists much like Canada to slow down and ration the care that the English need. Although there is a private insurance sector, only about 11.5% of the population obtains private insurance. Private insurance is taken by those who want to avoid the waiting lists or obtain luxurious accommodations or elective care. The problem, however, is that with high premiums and large deductibles, private insurance does not make much sense when large deductibles are met only when serious ailments occur and serious ailments such as cancer get priority in the national health system anyway.

There is no doubt that the English pay less for health care than Americans, but again, cost is not the only factor. Waiting to be seen, worrying for months while waiting, suffering in pain while waiting to see a specialist, being assigned an appointment date over which the patient has little control, being put back in line waiting for months if the patient changes the assigned appointment date, and suffering in pain while waiting for surgery should all be a consideration in the debate on health care. Worry, pain and inconvenience may not be computed easily as a health care statistic and thus may not be as conducive to comparisons as the cost of health care, but to those suffering, those factors can mean the world.

The Care Quality Commission (CQC), an executive body of the United Kingdom Department of Health, released a report on October 9, 2017, “The state of health care and adult social care in England.” The report notes that “with the complexity of demand increasing across all sectors, the entire health and social care system is at full stretch” and that the NHS is “strain[ed]

U.S. Does Well on Wait Times for Elective Surgery

% Who Reported Wait Times for Elective Surgery Was Less than 1 Month



Base: Needed elective surgery in past 2 years.

Source: 2016 Commonwealth Fund International Health Policy Survey.

at the seams” with future quality “precarious.” Thus, England’s mostly government-run health care model with limited private choice and competition is no better than the Canadian single-payer model. Both systems suffer from extensive wait times and rationing of care.

Australia

The Australian health care system, otherwise known as Medicare, is a multi-payer system publicly funded by both the government and by private health insurance, similar to California, but with a greater percentage of public funding. Approximately two-thirds of all health care expenditures in Australia are government expenditures, while a smaller percentage comes from private health insurance. Medicare is funded mostly by general revenue, but also partly funded by a 2% income tax on all taxpayers with exceptions for low-income earners. An additional tax, called the Medicare Levy Surcharge, is a 1% to 1.5% tax on high-income earners who do not obtain private health insurance. Essentially, the surcharge is an incentive to drive high-income earners toward private insurance to relieve the burden on Medicare and rely more heavily on the private health system.

The Australian government has recognized that the public system needs the assistance of the private system in order to be sustainable in the future. The continued increases to the income tax levy are not sufficient to pay for the Australian health care system. The income tax levy on all taxpayers was increased in 2014 from 1.5% to 2%, and is expected to increase to 2.5% in 2018. To relieve the public health system, the surcharge on high-income earners also was increased in an effort to push those individuals into the private system.

As for universality, Medicare is available to all Australian citizens and legal residents, but not available to undocumented immigrants. Additionally, although citizens and legal residents are covered under the public health system, the coverage is not as broad as most California health insurance plans. Ambulance transport, home nursing, podiatry, physical therapy, occupational and speech therapy, chiropractic treatment and prosthesis are not covered and require private insurance, also known as “extra cover,” for treatment.

Taiwan

Taiwan’s population is 23.55 million compared to California’s 39.25 million people and is very homogenous with more than 95% of the population being Han Chinese. Taiwan adopted a nationwide system in 1995 called the National Health Insurance (NHI) system. It is a single-payer health care system that has achieved

close to universal health care coverage. All citizens and legal residents are eligible for coverage by the NHI, but approximately 99% are actually registered for coverage. California has achieved a close result with a 97.6% coverage rate amongst all citizens and legal residents. Similar to the U.S. health care model, in Taiwan there is an insurance mandate to buy and a penalty for not buying, but unlike the United States, there is only one insurance option—public insurance.

It is a government-run insurance system with health care services provided mostly by private providers rather than public ones. Every service is accompanied by a copayment regardless of the age of the patient. Only cancer screenings and physical checkups of patients older than 65 are an exception to this rule. Patients who can’t afford copayments receive public assistance. The revenue for this public insurance system comes from the working population, which splits the premiums with employers, as well as those who don’t work paying a flat rate with government help or being fully subsidized by the government if they are poor or veterans.

Taiwan’s health care spending is less than half the cost of U.S. spending on health care. So why not implement such a model? For many reasons: Advanced health checkups are prevalent in Taiwan although the checkups are not covered by the NHI and are paid out of pocket by patients. In California and the United States, such check-ups and physicals are considered preventive medicine and are always covered.

Although access to specialists is not a concern in Taiwan as it is in Canada, generally an appointment with a primary care physician cannot last for more than 5 minutes. This is because Taiwan’s health care is a fee-for-service model wherein physicians are paid by the amount of treatment they provide rather

than achieving a successful health outcome. This means most patients have to schedule second and third visits for the same health concern. Not only is this inconvenient; it results in work absences and a longer time to recover from illnesses and injuries. If that wasn't bad enough, if a patient is seen by a physician too many times, the government sends someone from the Bureau of the National Health Insurance to have a little chat with the individual in an attempt to reduce the overuse of health care. Such government interference in an individual's health care would be a violation of privacy in the United States and California.

The biggest problem with Taiwan's health care system, however, is that the cost of the system is greater than the premiums currently being collected, so the government has been borrowing money from banks to pay for health care. Premiums are regulated by politicians, who are afraid to increase the premiums for fear of not being elected again, even though premiums need to rise to meet costs. There is only so much borrowing the country can do until it has to face the reality of increasing premiums to match the true rising cost of health care.

South Korea

South Korea has a government-mandated system called the National Health Insurance Service (NHIS). It is funded by contributions from the employed and self-employed, government subsidies and tobacco surcharges. Although foreigners can obtain public health care under the NHIS, they have to enroll by providing an alien registration card and immigration records. Thus, as with all the other countries above, health care is universal to all South Korean citizens and legal residents, not to everyone residing in the country; those with an illegal status are excluded from health benefits. Every citizen and legal resident is covered for basic health insurance through mandatory contributions taken out of payroll checks for the employed and from payments from those who are self-employed. South Korea's health care system is not a single-payer system. Many South Koreans choose to obtain private health insurance to gain more comprehensive coverage than that provided by the government-run system.

The quality of South Korean health care under the NHIS has been ranked as being among the best in the world. This may be due in part to the makeup of the country's citizens and residents. Like Taiwan, South Korea is a very homogenous society with 96% of the population comprised of Koreans. Unlike California's obesity rate of 25% and the U.S. rate of more than 30%, South Korea has an obesity rate of only 3%. South Korea ranks high on life expectancy and spends less than half on health care overall than the United States.

Although a high life expectancy and low spending in health care sound good, it's important to remember that South Korea's current health care model has been in effect only since 2004 and has run into problems that will likely worsen with time. The South Korean government sets the cost of every medical procedure. This is how it keeps spending low. South Korean medical fees generally are about an eighth of what U.S. providers charge.

This low provider payment has led to physicians seeing more patients, thus leaving patients with little time to consult with physicians, and physicians performing treatment that has a higher NHIS price or providing treatment that may not have been necessary, such as a Caesarean section, and prescribing medication that may not have been necessary if there was an incentive, financial or otherwise, from the drug manufacturer to prescribe its medication.

Copays for health care also are significantly higher in South Korea than in the United States, ranging between 20% to 50% of the cost, depending on the procedure. Also, some chronic or complex conditions are not fully covered. For example, the continual testing required for cancers often is not covered and requires individuals to obtain private insurance. South Koreans who don't obtain private insurance are left without health care or a way to pay for it.

Switzerland

Unlike the countries discussed above, Switzerland has no public health insurance option and does not have a single-payer health care system. It has achieved universal health care for its citizens and legal residents by requiring the purchase of private health insurance. Citizens and residents must pay at most 8% of their personal income. If the insurance exceeds 8%, then a government subsidy is provided to make up the difference. Approximately 35%–40% of households receive a subsidy for health care.

The 90 Swiss insurance companies that compete to sell health insurance in the country cannot earn a profit on the mandatory basic plans, but are allowed to earn a profit on the supplemental plans that provide more coverage than the basic plans. The cost of premiums can differ from one insurance company to the next, but the premiums cannot differ within the same company based on gender or health condition. Deductibles and copays are both utilized under the Swiss health care system. Employers may contribute to the premiums, but do not receive any tax break for doing so. Switzerland spends approximately 11.7% of GDP on health care compared to 17.9% in the United States.

How is Switzerland able to keep health care spending significantly lower than the United States, yet rank high in health care overall? Out-of-pocket payments by individuals are the highest of any nation, followed by the United States at second highest. The Swiss pay approximately \$1,815 on average per year out of pocket for health care, in addition to their insurance premium. (Out-of-pocket costs are an average of \$1,034 in the United States.) Health insurance premiums in Switzerland are high as well, although health care costs are lower than U.S. costs in a number of ways. Switzerland has the largest numbers of practicing nurses per capita of any country and a high doctor-to-patient ratio, but health care provider wages are lower than those in the United States. This may be partly because the government largely funds medical school, so physicians do not leave school heavily in debt. Additionally, although it is a

fee-for-service model, if physicians overtreat or overprescribe, they may receive what is called a “blue letter.” If the treatment or prescriptions are not justified, the physicians may have to reimburse insurers for a portion of the overprescribed treatment or medication. In addition, government regulations set copayment percentages on brand name drugs at double that of generic drugs to keep pharmaceutical spending down.

The Cost of a Single-Payer Health Care System

What’s clear from the analysis of the above countries is that to achieve a single-payer health care system free of excessive wait times and rationing of care, a country or state would have to bear the astronomical cost of such an inherently flawed system. It is a system that pretends health care is free by requiring no co-payments and deductibles, but fails to provide cost-containment measures, instead promoting a fee-for-service model and incentivizing overtreatment and overuse of medical services.

A single-payer health care system was proposed in California in 2017 and may reappear in 2018. SB 562 (Lara; D-Bell Gardens) proposes the creation of a massive new government bureaucracy to take over health care in California. It eliminates private health insurance and employer-sponsored insurance. This government-run health care system would cover every California resident, including all undocumented immigrants. It would provide every conceivable health care service and benefit with no premiums and no cost sharing at all. The bill lists 34 categories of services the system would provide, including everything from acupuncture to chiropractic care, dental, vision, and alternative medical care.

In theory, the idea of free health care of any and every kind sounds wonderful if all these services were truly free, if California had an overflow of medical providers who were willing to accept deep cuts in pay, if care wouldn’t and couldn’t be rationed, if choice wasn’t reduced and if overutilization wouldn’t increase health care costs.

But none of that is true. Health care has a huge cost and single-payer government-run health care is irresponsible because it eliminates consumer awareness of the true cost of health care. It results in overutilization of what is inaccurately believed to be a free service. No one denies this, not even the proponents of the bill. On the contrary, they concede that a single-payer model will lead to overutilization. Yet the bill is silent on how to pay for such overutilization by the entire California population.

In fact, the bill is completely silent on where the revenue to fund such a system would come from—likely because the cost would have prohibited passage of the bill. It passed the Senate Health Committee and the Senate without any explanation of how it would be funded. Senators were promised an opportunity to hear and debate the financing mechanism, but that promise was never kept. The bill passed with a simple majority vote because it included no tax, even though proponents knew that it absolutely needed a tax to finance the plan proposed in the bill.

A conservative estimate by the Senate Appropriations Committee found that the cost of a single-payer system under SB 562 would be about \$400 billion and would require an additional 15% payroll tax on Californians to fund it. To put this in perspective, the amount is more than double California’s state budget and more than triple the state’s general fund. Almost a year after it was first proposed, the bill still contains no financing mechanism but its proponents released a funding study mid-year 2017 that recommends a significant increase in taxes. The study proposes a sales tax, which would increase the already-highest state sales tax in the country by another 2.3 percentage points and would be the biggest sales tax increase in the entire history of California.

In addition to this massive sales tax, which would not alone be sufficient to fund this program, single-payer proponents proposed a 2.3% gross receipts tax or a 6.6% payroll tax, when California already has the highest marginal income tax rate in the entire country. A gross receipts tax is an archaic tax rarely proposed anymore. It is not a tax on profit, but rather a tax on total sales revenue without consideration of operating costs, expenses or profit. Gross receipt taxes result in a disproportionately high tax on low profit margin industries, in some cases completely eliminating businesses because the tax is greater than the profit margin. Low profit margin industries, such as restaurants, airlines, grocery stores and pharmaceutical distributors, are unfairly impacted by this tax.

Ensuring all Californians have access to quality, affordable health care is an admirable goal, but a single-payer model will not get California any closer to that goal. A single-payer health care system strips individuals of their right to pursue their health care in the manner they wish. It denies them the right to obtain health care outside of the public health system. It violates their personal freedom, including their freedom to choose their health care provider, and denies them the ability to gain access to care without having to suffer lengthy periods of time waiting in pain for care. The high taxes required to fund a system that has no cost-containment measures and likely will result in future increased taxes, also will ultimately result in the loss or reduction of other social services to fund the continually increasing cost of health care in California.

If a single-payer model was the best approach to achieving universal health care, then why have the majority of the countries discussed above achieved it without a single-payer model? To achieve universal health care in California, the question to answer first is, how do we define “universal”? The word “universal,” as defined by all the countries above, is health care access or coverage for all the nation’s citizens and legal residents.

If that is the definition, California is very close to achieving universal health care at 97.6 % coverage. Of the 2.7 million people without coverage in California, approximately 900,000 are citizens or legal residents. Based on how California chooses to define universal, it can then try to figure out how to provide access to health care for either the remaining 900,000 uninsured or all 2.7 million uninsured.

CalChamber Position

Rather than upending the health care system that polls say many Californians are satisfied with (except for costs), any reform to the system should focus on those who cannot gain access to affordable health care.

The CalChamber supports the following, including:

- Access to affordable health care through an insurance model or clinic model;
- Cost-containment on medication and treatment;
- Reducing administrative work for providers, such as by using uniform forms to claim reimbursement; and
- Expanding the investment by the state to increase the number of health care providers, especially physicians.



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