When I was in grade school in the early 1960’s, I remember being proud about learning of Ohio’s high ranking among the states in so many categories. Ohio was an innovator, a leader in the nation. Since then, we have been falling behind in so many ways, not only in the loss of good paying industrial jobs and a high standard of living. We are on th road to end up like a Mississippi or Louisiana if we don’t do something to make Ohio a place people want to live and work. A single payer health care system would be an important step in returning Ohio to the upper ranks of states and improving the lives of its citizens. We need a single-payer health care system to reinvigorate growth in Ohio, and the first thing we must do is get beyond all the Left-Right divide that too often is based upon a false understanding of how our systems work, in particular what a single-payer system is and how it would operate—which is efficiently and humanely. Therefore, I have gathered some facts about single payer that come from peer reviewed research corroborated by many organizations. Below Part I of this fact sheet is information from Physicians for a National Health Program, and though related to a national plan is equally relatable to a plan if implemented by a state, our state, Ohio.

**Part I**

**Facts about a Single Payer System You Might Not Know**

**The health care delivery system remains private.** As opposed to a national health service such as the Veteran’s Administration System, where the government employs doctors, in SPAN’s state-based health insurance system, the government is billed, but doctors remain in private practice.

**A state health care program could save approximately billions on paperwork alone.** Because of the administrative complexities in our current system, over 25% of every health care dollar goes to marketing, billing, utilization review, and other forms of waste. A single-payer system could reduce administrative costs greatly.

**Most businesses would save money.** Because a single-payer system is more efficient than our current system, health care costs are less, and therefore, businesses save money. In Canada, the three major auto manufacturers (Ford, GM, and Daimler-Chrysler) have all publicly endorsed Canada’s single-payer health system from a business and financial standpoint. In the United States, Ford pays more for its workers health insurance than it does for the steel to make its cars.  
  
**Under SPAN’s single-payer proposal, your access to health care doesn’t depend on your job.** Whether you’re a student, professor, or working part-time raising children, you’re provided with care. Not only does this lead to a healthier population, but it’s also beneficial from an economic standpoint: workers are less-tied to their employers, and those that dislike their current positions can find new work (where they would be happier and most likely more productive and efficient). Ohio would also attract businesses because job-creators would not have the cost of providing health care to its employees. Ohio might begin to attract and retain young professionals in the state rather than losing them to other states.

**Myths about a State-Based Health Care Plan**

**The government would dictate how physicians practice medicine.**   
In countries with a national health insurance system, physicians are rarely questioned about their medical practices (and usually only in cases of expected fraud). Compare it to today’s system, where doctors routinely have to ask an insurance company permission to perform procedures, prescribe certain medications, or run certain tests to help their patients.

**Waits for services would be extremely long.**   
Again, in countries with national health plans, urgent care is always provided immediately. Other countries do experience some waits for elective procedures (like cataract removal), but maintaining Ohio’s same level of health expenditures (if we chose to do so), waits would be much shorter or even non-existent.

**People will overutilize the system.**  
Most estimates do indicate that there would be some increased utilization of the system (mostly from the millions people that are currently uninsured and therefore not receiving adequate health care), however the staggering savings from a single-payer system would easily compensate for this. (And remember, doctors still control most health care utilization. Patients don’t receive prescriptions or tests because they want them; they receive them because their doctors have deemed them appropriate.)

**Government programs are wasteful and inefficient.**   
Some are better than others, just as some businesses are better than others. Just to name a few of the most successful and helpful: the National Institutes of Health, the Centers for Disease Control, and Social Security. Even consider Medicare, the government program for the elderly; its overhead is approximately 3%, while in private insurance companies, overhead and profits add up to 15-25%.

**Part II**

Over the past two decades, Physicians for a National Health Program (PNHP) has done peer reviewed research that should be influential to developing any sensible health policy and focused debate on the need for fundamental health care reform. Though its research deals with implementing a national program, every detail of their research translates equally well at the state level. Why does Ohio need to support SPAN Ohio’s blueprint for administering and delivering health care (not health insurance which is quite different) to its citizens? For a plethora of reasons, such as lowering overall costs, complete delivery of health care to all Ohio residents, the humaneness of such a plan, to attract businesses and people to Ohio to make the economy of our state more robust, because the profit motive is not necessarily conducive to lower cost and efficiency, and because Ohio use to be a leader in the nation and can be once again. Single-Payer Action Network has the plan that will boost Ohio’s economy and make it once again a leader in the nation and attract businesses and people, while stemming the loss of educated young people leaving the state, the brain drain to put it another way.

Though the information below is in-depth, if we are to make Ohio efficient, this kind of research and peer-reviewed, fact-based information is crucial to forging a real and efficient “health care” system in the state. Please take the time to pour over this information.

**1. Administrative costs consume 31 percent of US health spending, most of it unnecessary. We can do much better with a single payer system.**

1. Woolhandler, et al “[Costs of Health Administration in the U.S. and Canada](http://pnhp.org/system/assets/drupal/single_payer_resources/administrative_waste_consumes_31_percent_of_health_spending.php),” NEJM 349(8) Sept. 21, 2003.

**2. Medical bills contribute to half of all personal bankruptcies. Three-fourths of those bankrupted had health insurance at the time they got sick or injured. No one goes bankrupt in nations with national health care systems.**

1. [“Illness and Injury as Contributors to Bankruptcy,”](http://pnhp.org/system/assets/uploads/2007/01/MedicalBankruptcy.pdf) Himmelstein et al, Health Affairs Web Exclusive, February 2, 2005.
2. [“Medical Bankruptcy in the United States, 2007: Results of a National Study,”](http://pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf)Himmelstein, D.U., Thorne, D., Warren, E., Woolhandler, S. (2009), Am J Med, 122, 741-746.
3. [“Medical Bankruptcy Fact Sheet,”](http://pnhp.org/docs/Bankruptcy_Fact_Sheet.pdf) Himmelstein, D.U., Thorne, D., Warren, E., Woolhandler, S. (2009).
4. [“Medical Bankruptcy Q&A,”](http://pnhp.org/docs/Medical-Bankruptcy-Q-and-A.pdf) Himmelstein, D.U., Thorne, D., Warren, E., Woolhandler, S. (2009).

**3. Taxes already pay for more than 60 percent of US health spending. Americans pay the highest health care taxes in the world. We pay for national health insurance, but don’t get it. And we get worse outcomes than nations without national, publicly funded programs.**

1. Woolhandler, et al. “[Paying for National Health Insurance — And Not Getting It](http://pnhp.org/publications/payingnotgetting.pdf),” Health Affairs 21(4); July/Aug. 2002.

**4. Despite spending far less per capita for health care, Canadians are healthier and have better measures of access to health care than Americans.**

1. Lasser et al. “[Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey](http://pnhp.org/canadastudy/CanadaUSStudy.pdf),” American Journal of Public Health; July 2006, Vol 96, No. 7.

**5. Business pays less than 20 percent of our nation’s health bill. It is a misnomer that our health system is “privately financed” (60 percent is paid by taxes and the remaining 20 percent is out-of-pocket payments). If businesses did not have to over health care costs, they would flock to set up shop in Ohio.**

1. Carrasquillo et al. “[A Reappraisal of Private Employers’ Role in Providing Health Insurance](http://pnhp.org/system/assets/uploads/2007/01/ReappraisalofPrivateEmployers.pdf),” NEJM 340:109-114; January 14, 1999.

**6. For-profit, investor-owned hospitals1-4, HMOs,5 nursing homes6,7 and home health care agencies8have higher costs and score lower on most measures of quality than their non-profit counterparts.**

1. Himmelstein, D and Woolhandler, S “[The high costs of for-profit care](http://pnhp.org/news/2004/june/the_high_costs_of_fo.php),” Commentary, Can. Med. Assoc. J., June 8, 2004
2. Devereaux, PJ “[Payments at For-Profit and Non-Profit Hospitals](http://pnhp.org/system/assets/uploads/2006/06/devereaux_costs.pdf),” Can. Med. Assoc. J., Jun 2004; 170
3. Devereaux, PJ “[Mortality Rates of For-Profit and Non-Profit Hospitals](http://pnhp.org/system/assets/uploads/2006/06/devereaux_mortality.pdf),” Can. Med. Assoc. J, May 2002; 166
4. Himmelstein, et al “[Costs of Care and Admin. At For-Profit and Other Hospitals in the U.S.](http://pnhp.org/system/assets/drupal/single_payer_resources/forprofit_hospitals_cost_more_and_have_higher_administration_expenses.php)” NEJM 336, 1997
5. Himmelstein, et al “[Quality of Care at Investor-Owned vs. Not-for-Profit HMOs](http://pnhp.org/system/assets/drupal/single_payer_resources/forprofit_hmos_provide_worse_quality_care.php)” JAMA 282(2); July 14, 1999
6. Harrington et al “[Does Investor Ownership of Nursing Homes Compromise the Quality of Care?](http://pnhp.org/system/assets/uploads/2007/01/InvestorOwnershipofNursingHomes.pdf)” American Journal of Public Health; Vol 91, No. 9, September 2001
7. Comondore, et al “[Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis](http://pnhp.org/system/assets/uploads/2007/01/nursing-homes.pdf),” BMJ 2009;339:b2732-b2732
8. Cabin W et al [“For-Profit Medicare Home Health Agencies’ Costs Appear Higher And Quality Lower When Compared To Nonprofit Agencies,”](http://org.salsalabs.com/dia/track.jsp?v=2&c=oCYKEEVUPMaR0hCkEswLVHo2P0lOS2%2Bo)Health Affairs, August 2014

**7. We must eliminate false understanding of why costs are high. Immigrants1 and emergency department visits2 by the uninsured are not the cause of high and rising health care costs. Immigrants also subsidize Medicare’s trust fund.3**

1. Mohanty et al. “[Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis](http://pnhp.org/system/assets/uploads/2007/01/Mohanty_Immigrants.pdf),” American Journal of Public Health; Vol 95, No. 8, August 2005
2. Tyrance et al. “[US Emergency Department Costs: No Emergency](http://pnhp.org/system/assets/uploads/2007/01/USEmergencyDepartmentCosts.pdf),” American Journal of Public Health; Vol 86, No. 11, November 1996
3. Zallman et al,   “[Immigrants contributed an estimated $115.2 billion more to the Medicare Trust Fund than they took out in 2002-09](http://pnhp.org/news/2013/may/immigrants-heavily-subsidize-medicare%E2%80%99s-trust-fund-health-affairs-study),” Health Affairs, June 2013

**8. 45,000 annual deaths are associated with lack of health insurance1. That figure is about two and a half times higher than an estimate from the Institute of Medicine (IOM) in 2002. The uninsured do not receive all the medical care they need — one-third of uninsured adults have chronic illness and don’t receive needed care2. Those most in need of preventive services are least likely to receive them.**

1. Wilper, et al “[Health Insurance and Mortality in U.S. Adults](http://pnhp.org/excessdeaths/),” American Journal of Public Health; Vol. 99, Issue 12, Dec 2009
2. Wilper, et al “[A National Study of Chronic Disease Prevalence and Access to Care in Uninsured U.S. Adults](http://annals.org/article.aspx?articleid=742021)” Ann Intern Med, Aug 2008; 149: 170 – 176.

**9. The US could save enough on administrative costs1 (more than $350 billion annually) with a single-payer system2 to cover all of the uninsured. Ohio with its own single-payer system would save on a proportional level in regard to its population.**

1. Woolhandler, et al “[Costs of Health Administration in the U.S. and Canada](http://pnhp.org/system/assets/drupal/single_payer_resources/administrative_waste_consumes_31_percent_of_health_spending.php),” NEJM 349(8) Sept 21, 2003
2. “[Proposal of the Physicians’ Working Group for Single-Payer National Health Insurance](http://pnhp.org/publications/proposal_of_the_physicians_working_group_for_singlepayer_national_health_insurance.php),” JAMA 290(6): Aug 30, 2003

**10. Competition among investor-owned, for-profit entities has raised costs, reduced quality in the US. It is patently false that the free market system is more efficient than what a state implemented plan.**

1. Himmelstein DU, Woolhandler S. “Competition in a publicly funded healthcare system.” BMJ 2007;335:1126-1129 (1 December), doi:10.1136/bmj.39400.549502.94
2. Hellander I, Himmelstein DU, Woolhandler S. “Medicare overpayments to private plans, 1985-2012: Shifting seniors to private plans has already cost Medicare US$282.6 billion.” International Journal of Health Services 2013;43(2):305–319. doi:[http://dx.doi.org/10.2190/HS.43.2.g](http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,7,11;journal,1,170;linkingpublicationresults,1:300313,1)

**11. The Canadian single payer healthcare system produces better health outcomes1,2with substantially lower administrative costs3,4 than the United States.**

1. Guyatt GH, et al. “[A systematic review of studies comparing health outcomes in Canada and the United States](http://pnhp.org/news/2007/may/quality_of_healthcar.php).” Open Medicine (2007); 1(1): E27-35.
2. Lasser KE, Himmelstein DU, Woolhandler S. “[Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey](http://pnhp.org/news/2006/may/study_shows_us_res.php).” American Journal of Public Health (July 2006); 96(7): 1300-1307.
3. Himmelstein DU, Lewontin JP, Woolhandler S. “[Who administers? Who cares? Medical administrative and clinical employment in the United States and Canada](http://pnhp.org/news/1996/january/us_health_system_h.php).” American Journal of Public Health. (1 Feb. 2006); 86(2):172-178.
4. Woolhandler S, Campbell T, Himmelstein DU. “[Cost of Health Care Administration in the United States and Canada](http://pnhp.org/news/2003/august/administrative_costs.php).” New England Journal of Medicine. (21 August 2003); 349(8).

**12. Computerized medical records1-3 and chronic disease management4 do not save money. The only way to slash administrative overhead5 and improve quality6,7 is with a single payer system.**

1. Woolhandler, et al. “[Hope And Hype: Predicting The Impact Of Electronic Medical Records](http://pnhp.org/news/2005/september/projected_savings_fr.php),” Health Affairs, September/October 2005; 24(5): 1121-1123.
2. Himmelstein, et al “[Hospital computing and the costs and quality of care: a national study](http://pnhp.org/docs/AJM-Himmelstein-Hospital-Computing.pdf),” Am J Med, Vol 123, Issue 1, Pages 40-46, Jan 2010
3. McCormick, D, Bor, DH, Woolhandler, S, Himmelstein, DU, “[Giving Office-Based Physicians Electronic Access To Patients’ Prior Imaging And Lab Results Did Not Deter Ordering Of Tests](http://content.healthaffairs.org/content/31/3/488.abstract),” Health Affairs, March 2012, 31(3): 488-496.
4. Geyman, J “[Disease Management: Panacea, Another False Hope, or Something in Between?](http://pnhp.org/dm.pdf),” Ann Fam Med 2007;5:257-260. DOI: 10.1370/afm.649.
5. Woolhandler, et al “[Costs of Health Administration in the U.S. and Canada](http://pnhp.org/system/assets/drupal/single_payer_resources/administrative_waste_consumes_31_percent_of_health_spending.php),” NEJM 349(8) Sept. 21, 2003
6. Schiff, et al “[A Better Quality Alternative](http://pnhp.org/system/assets/drupal/single_payer_resources/a_better_quality_alternative_singlepayer_national_health_insurance.php)” JAMA, 272(10); Sept. 12 1994
7. Schiff, et al “[You Can’t Leap a Chasm in Two Jumps](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497368/pdf/12042603.pdf),” Public Health Reports 116, Sept / Oct 2001