Single-Payer Health Care in the United States: Feasible Solution or Grand Illusion?

The adoption of a single-payer health care system, a recurring dream of progressive American reformers, now enjoys sustained attention in the run-up to the 2020 national elections. Some compelling arguments support the case for single payer, and its political prospects may indeed be on the rise, but myriad obstacles beset it, and a full-throated Democratic endorsement of it carries disquieting risks. (*Am J Public Health.* 2019;109:1506–1510. doi:10.2105/AJPH.2019.305315)

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See also Donnelly et al., p. 1482.

The Affordable Care Act (ACA) is assuredly "a landmark in US health reform and a landmark in US social policy legislation,"[1(p290)] but nearly 10 years after its passage few would deny that the US health care system has plenty of room for improvement. On a continuum from center to left, 4 reform options stand out: incremental improvements to the ACA, expansion of eligibility for Medicare and Medicaid, a social insurance route to universal coverage, and—the longtime favorite of "the most vocal group" of health reform advocates[2]—the adoption of a single-payer system.

All these strategies have their adherents of course, but a striking feature of the reform debate in anticipation of the elections of 2020 is the prominence of single payer, an approach often dismissed as (perhaps) an admirable policy but a political impossibility all the same. But, given the Democrats' success in the congressional elections of 2018, the salience of the party's stance on health care policy in explaining that success, and the surge in both the party's resolve and (so far) its unity as it mobilizes to defeat Donald Trump and his Republican enablers, can the political past of single payer still be accepted as policy prologue?

POLICY DISTANCE

Achieving a single-payer system has stood high on the policy agenda of many left-leaning health care reformers for decades, and on 1 criterion of public predominance—the share of health care spending raised and spent by governments—the US system has evolved in that direction. Although "only" about 37% of the US citizenry has public coverage, the combined spending of Medicare, Medicaid, and other national and state programs accounts for roughly half of the dollars in the system, and if one adds money the Treasury forgoes by means of tax expenditures plus the sums governments spend for health care coverage for their (public) employees, the share is close to 60%.[3]

On the other core criteria, however, the US system continues to fall short: for private workers and their dependents employer-based coverage prevails, and in the employer-based system private (mainly for-profit) insurers are dominant. Meanwhile, single payer remains a largely unacquired taste in the US Congress, and state efforts to adopt such a system within their borders have failed. Most conspicuously, Vermont, which had passed single-payer legislation in 2011 and was supposedly on track to implement it, abruptly pulled the plug in 2014 because the looming shift from private to public funding triggered projections of tax increases that looked politically unsustainable. In 2016 a ballot initiative for single payer in Colorado met defeat by a margin of 79% to 21%.

A common (perhaps predominant) explanation for this lack of progress cites brute and brutal politics: single-player proposals always succumb to massive interest group opposition. The upsurge in attention to single payer on the left of the Democratic party and in the media as the national elections of 2020 approach, therefore, invites inquiry into whether the balance of power among interest groups portends déjà vu all over again or whether perhaps that balance is changing—internally, as a consequence of changing politics in or between organizations; externally, as a result of new policy "tastes" among the public as registered in opinion polls; or both.

A SHIFTING BALANCE OF POWER?

The first step toward an answer is of course to identify the groups that stand for and against single payer and the resources they bring

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to the fight. The pro side consists mainly of 3 organizational categories: those whose mission focuses on promoting a single-payer system (e.g., Physicians for a National Health Program, the Campaign for Guaranteed Health Care, and Health Care-NOW!), health reform groups that include single payer among other options on their agenda (e.g., National Nurses United, the American Public Health Association, the American Medical Student Association, Health Access, and MoveOn.org), and progressive organizations that lean left on a range of policy issues and endorse single payer as part of their health policy portfolio (the American Federation of Labor and Congress of Industrial Organizations [AFL-CIO], Public Citizen, the National Organization for Women, the Green Party, the Gray Panthers, and the National Association for the Advancement of Colored People). The major sources of opposition are insurers, providers, and businesses, a trio of sectors that recently formed the Partnership for America's Health Care Future with 28 members, including America's Health Insurance Plans, PhRMA (Pharmaceutical Research and Manufacturers of America), the American Medical Association, the American Hospital Association, the Blue Cross–Blue Shield Association, and the American Federation of Hospitals.

Moreover, providers are not the only source of opposition, and national policy is not the only field of battle. Asked about single payer in New York State, Governor Andrew Cuomo declared, "You pass it I'll sign it," but then added, "no sane person will pass it. . . . You'd double everybody's taxes. . . . Every union is against it. The hospitals are against it. The Civil Service Employees Association is against it. The 1199 health-care union is against it."[4]

The resources these combatants marshal can be captured in 3 categories: The first is conventional—money (e.g., campaign contributions, purchase of media time, enlistment of expert staff to write white papers and to lobby) and the legitimacy that accompanies and lubricates efforts to persuade the public that the groups in question are on their side. A second resource is coherence—do the groups agree internally (in their individual organizations) and externally (among members of the groups in the coalition) on what they want and on what they are prepared to trade in a policy package? The third is commitment—how much of their political capital are the groups prepared to invest in the struggle for or against single payer?

This canvas of the balance of power—of the identities of the groups and the resources they command—is highly unfavorable to single-payer reform. Most of the single-issue single-payer groups are fairly new, poorly endowed, and local or state-based, not national, in scope. Moreover, the universe of groups that favor single payer is sharply split on how that policy should be defined, on which elements of (myriad) versions are worth trading off for others, and on the wisdom of imposing "litmus tests" to assess the fidelity of political candidates to real single-payer approaches. Finally, although single-issue single-payer groups have their eyes (and resources) unblinkingly on the prize, those for which single payer is but 1 item on a larger policy agenda may hesitate to devote large sums of political capital to this particular fish among the others they have to fry. Despite strong support for single payer among many of its constituent unions, for example, the national AFL-CIO has approached the issue gingerly, mainly from concern about the future of labor-run Taft Hartley plans and about diverting political capital from the fight to kill the "Cadillac tax" included in the ACA but long postponed.[5]

The con side presents a very different power profile. In an economy in which health care consumes more than 17% of the nation's gross domestic product, it is not odd that insurers, providers, and business, as sectors and in concert, enjoy massive political influence. They succeeded, for example, in defeating the Clinton reform initiative in 1993–1994 and might have derailed the Affordable Care Act in 2009–2010 had not the Obama administration and leading congressional Democrats (mindful of the Clinton episode) negotiated agreements with them before the legislative game heated up.

These groups have tangible material reasons for opposing single payer and are little susceptible to bargaining over nuances and variations. A single-payer program would put for-profit private insurers out of the business of selling basic coverage; would almost surely pay less for the services of physicians, hospitals, and drug producers; and would entail sizable new taxes, a good share of which would likely fall on the business community. Furthermore, because the stakes of single payer are so salient for these groups, they can be expected to spend and lobby heavily against it, are unlikely to fall prey to divide and conquer strategies, and (quite the contrary) will doubtless show solidarity in potent alliances such as the Partnership for America's Health Care Future.

POWER AND POLICY IN CONTEXT

Inspection of the balance of power among interest groups, commonly held to be the most reliable gauge of the prospect for single payer, seems to place the chances for that reform somewhere between slim and none. There is a problem with looking too fixedly at the balance of power among groups, however: power is contextual, and the fields in which groups contest are not entirely of their own making and choosing. Some features of the interest group context are confirming, to be sure, but others are countervailing.

Among contextual considerations that tend to confirm the balance of power unfavorable to single payer, 3 stand out. The first is historical. Virtually every notable US health care reform in the last 2 decades has served to strengthen, not weaken, the role of the for-profit insurance industry. Examples include Medicare Part C (which now enrolls roughly one third of beneficiaries in competing private plans), Medicare Part D (which requires that the drug benefits adopted in 2003 be covered solely by competing private plans), Medicaid managed care (which now covers about 80% of beneficiaries, most of them in private plans), the income-linked subsidies in the ACA (by means of which recipients buy private coverage in a health exchange, state or federal), and federal encouragement for health savings accounts. History is not predestined to repeat itself, but its rhymes cannot but bruise the sensibilities of those who seek a diminution, not to say the elimination, of private insurers as sources of coverage.

A second consideration is conceptual. Although public opinion polls register impressive

popular support for a single-payer program, enthusiasm declines in direct proportion to the degree of detail with which respondents become acquainted. A widely cited Kaiser Family Foundation poll in late January 2019, for example, found that 56% of respondents were initially favorable to single payer, that 71% endorsed guaranteed health insurance for all, and that 67% applauded the elimination of premiums and other cost sharing. Enthusiasm waned, however, when those polled were queried about the elimination of private health insurance (37% approved), higher taxes (37%), a threat to Medicare (32%), and possible delays in medical tests and treatments (26%). Moreover, 55% of respondents believed that a Medicare for all plan would allow them to keep their current plans.[6]

The universe of single-payer approaches, and of popular perceptions of their meaning, runs a mile wide but an inch deep.[7] Are single payer and Medicare for all synonymous? If some version of the approach were adopted, could citizens select or retain private coverage? (What about Medicare for all modeled on Medicare Part C?) The incendiary nature of these issues became clear in the first half of 2019 in the convolutions of presidential aspirant Kamala Harris: having opined in January that single payer should "eliminate all of that" and "move on" from private insurance, a proposal that evoked demurrals from several other leading contenders, the candidate backtracked. In June, having endorsed the elimination of private coverage in a debate among Democratic candidates, she quickly explained that she had misunderstood the question.[8]

Third, institutional factors complicate the quest for single payer. The complexities begin of course with separation of powers, which compel any major reform to win a majority in the House of Representatives, a filibuster-proof 60 votes in the Senate, and the approval of the president. Moreover, the metacontext of these machinations is a steady, decades-long decline in popular trust in the capacity of the federal government to "do the right thing all or most of the time." Affirmative responses to that question, which hit an all-time high of 77% in 1964, have fallen to around 20% to 25% today. The trend augurs poorly for (among other things) the large tax increases a single-payer system would demand. Proponents have long contended, sensibly enough, that a dollar is a dollar, whether in the form of a tax or a premium, but consistent cultural skepticism suggests that something more than money is at issue.

Also at issue are the inhibiting effects of a high degree of trust by citizens that their health coverage and care are in better hands with private employers and plans than they would be with government. Instructive is a journal entry from 1955, in which Arthur Schlesinger Jr[9(p.17)] recalls a chat between Adlai Stevenson and Harry Truman: "Truman said 'Do you want to know what the issue of the campaign is?' He went to the window and pointed at a passerby. 'The issue is, who's looking after that guy? . . . What we have to tell the country is that we Democrats intend to look after the ordinary guy.'" As the Democrats prepare for the 2020 national elections, it is doubtful that single-payer reform delivers that protective message.

It requires no political genius to write the oppositional script. First, a critical spotlight on what single payer really means reminds portions of the populace that they like their private employer-based coverage more than they may have been inclined to acknowledge, whereupon the usual corrosive buzzwords—"rationing," "waiting lines," "government takeover," and "loss of freedom to choose"—drive home their predictable terror. The capacity of government in a single-payer system to "turn health care expenditure on and off like a tap"[10(p520)] or like a "spigot" that policymakers may use to control costs[11(p596)] presumably aggravates such anxieties.

Moreover, the parade of horrible imaginings stretches beyond mere loss of single-payer reform. In an arrestingly titled article ("Medicare for All Is a Trap"), William A. Galston warns that if Democrats opt to please their single payer–prone base in primaries at the cost of alienating the broader electorate in 2020, they risk committing an "unforced error [that] could give President Trump his best chance to win reelection."[12(pA15)]

COUNTERVAILING CONTEXTUAL CONSIDERATIONS

All the same, countervailing contextual considerations should be not be discounted. First, public opinion may be changing in ways favorable to single payer. Recent polls find an impressive degree of support for socialism over capitalism, especially among the youngest cadre of voters. Generational change, forever in play, is in the nature of the case hard to assess prospectively and gains clarity only in the hindsight of scholars who labor to retrofit the laws and trends disclosed by their earlier research into past and present.

Moreover, as Harold Macmillan (British prime minister from 1957 to 1963) supposedly said, "Events, my boy"—aka happenstance—matter too. Interest groups may lose legitimacy and influence as a result of exogenous shocks—for instance, exposure of the shoddy safety standards of automakers, of the toxic emissions of polluting industries, and of the blatant mismanagement of financial resources by Wall Street firms. Amid growing public aggravation at high health insurance premiums and deductibles, surprise medical bills, and other affronts, the private health insurance industry may likewise be courting a comeuppance. But public demand for and the policy supply of reforms in this case are not likely to trigger the elimination of the offending industry and its replacement by a governmental system but rather (as in the noted cases) tougher regulation of the industry's behavior.

Second, amorphous stirrings in public opinion might crystallize into a policy-critical election. The category of election that political scientists commonly call "critical"—one that ushers in a partisan realignment durable over a generation or so—does not necessarily coincide with elections that introduce major policy departures independently of stable shifts in the power of parties. The elections of 1964 and 2008 created the conditions in which Medicare (and Medicaid) and the ACA, respectively, became law. In neither case did the programs derive from a no longer containable demand for health care reform. Blendon et al.[13] point out that although health care has stood in the top 6 issues of concern to the public in presidential elections since 1988, only once (1992) was it in the top 2 issues, and in 2008 it ranked third.

The big reforms of 1965 and 2010 emerged because electoral responses to circumstances and events, and supportive institutional dynamics having little to do with health care policy per se, combined to enable policymakers who embraced the reform movement[14(p293)] to get their priorities to the top of the presidential agenda and then through Congress. The Clinton plan ran aground on fragments in the Democratic congressional majority, prompting diagnoses targeting "the institutions, stupid" for the outcome.[15] Fifteen years later "unorthodox lawmaking"—strong concentrations of power in the hands of party leaders—in those supposedly hopeless institutions carried the ACA over the goal line.[16]

In 1962, as John Kennedy worked fruitlessly to advance Medicare, few foresaw its enactment 3 years later. In 2007, as congressional Democrats pondered health reform options under the administration of George W. Bush (who declined even to support the reauthorization of the Children's Health Insurance Program), few envisioned that the ACA would arrive in 2010. Who, surveying the political scene in 2019, then, can be sure that single-payer reform will be flatly infeasible in, say, 2022? All the same, that surveyor could not fail to note that the massive electoral shift in 1932 failed to yield a presidential proposal for national health insurance, that of 1964 produced not national health insurance but "only" Medicare and Medicaid, and that of 2008 generated not single-payer reform but a multilayered public–private push for expanded coverage.

Third, single payer might gain ground in those legendary laboratories of democracy, the states. Since the elections in November 2018, some states have indeed begun to stir. Governor Newsom of California has vowed to pursue a federal waiver to permit single payer in his state. (Skeptics, however, dismiss his proposal as a strategic punt that leaves single payer in the nation's largest state to the tender mercies of the Trump administration.) Democratic legislative gains in 2018 in New York have improved the prospects for the single-payer plan long promoted by Assemblyman Richard Gottfried, who opines that if a couple of states move to single payer it is "only a matter of time before it becomes nationwide."[17]

If some bellwether succeeds, perhaps that innovation will in time diffuse to other states or serve, Massachusetts-like, as an inspiration (or even model) for national reform. For that matter, a federal government sympathetic to single payer but unable to achieve it in national policy could deploy "catalytic federalism"[18] by means of waivers that transcend their traditional Medicaid terrain and give willing states flexibility and funds to move ahead—and perhaps in due course embolden other states or indeed the feds themselves to follow suit. Finally, incremental reforms—Medicare and Medicaid for more, for instance—might, by reducing the scale of employer-based coverage and lowering (public) payments to providers, soften up the system for bigger steps such as Medicare for all. (The role allowed or assigned to private insurers in such measures is admittedly a conundrum.)

Could some combination of generational change, policy-critical elections, state innovation, and incremental steps bring single payer to life in the US health care system? Proposals that not only shrink the profits of private insurers and of medical providers but also raise taxes on corporate "citizens" and the public obviously face very long political odds. Still, the politics of health care policy are frequently mysterious and occasionally surprising. Might the inference that economist Anatole Kaltesky drew from Brexit—"In times of political turmoil, events can move from impossible to inevitable without even passing through improbable"— await broader application?[19(p3)] Never say never, but it is hard to envisage political turmoil sufficient to bring a single-payer system within the political pale.

CONCLUSIONS

The results of the 2016 presidential election have in not a few policy prognosticators undermined confidence in their ability to discern the limits of the unthinkable. That this conceptual boundary stretching should shed a newly hopeful light on the prospects for single-payer reform is understandable, especially given its potential power to combat the excesses of for-profit health insurers and to redress the bargaining power of purchasers and providers in the United States. A long, albeit dispiriting, list of political considerations—disparities in the resources, coherence, and commitment of the respective sides in the struggle as well as in the historical, conceptual, and institutional patterns that frame that struggle—suggests, however, that the resurgent enthusiasm for a single-payer system is (in the words of ee cummings) "the dawn of the death of a dream."

Although the social insurance models of France and Germany continue to deserve respectful attention, the practical route toward affordable universal coverage in the United States would seem to lie in the contours of the ACA—especially expanding Medicaid and subsidies for the purchase of coverage, fine-tuning the exchanges, and tightening regulation of the insurance industry—and enlarging those contours to include stronger public pressure on health care prices and perhaps some variant of Medicare for more. AJPH

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