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The Case for A Non-Profit Single-Payer Healthcare System

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Introduction

Our current fragmented, dysfunctional, for-profit health care system is broken. Internationally we rank poorly in both process and outcomes; yet, we are by far the most expensive health care system in the world. Not only we do we not get a bang for our bucks; but for many of us from a moral perspective we are morally bankrupt, allowing far too many people to suffer and die unnecessarily.

The solution is a non-profit single-payer healthcare system, Medicare for All, which has been proposed federally by Senator Bernie Sanders (2016), introduced in The House of Representatives as H.R. 676 (Wikipedia. National Health Care Act), and, for instance, in California as Senate Bill 562 (California Legislative Information, 2017; California OneCare, 2017; jpmassar, 2017; Morone, 2017; Pollin, 2017). The obstacles are enormous, basically going up against right-wing market ideology and legislatures bought and paid for by our for-profit health industry and their lobbyists. Whether federally or by state, the fact that obstacles exist does NOT change the fact that our current system is broken, that we are ALL at risk (e.g., Barlett, 2004; Brill, 2013).

We Are All At Risk

I could write an entire paper just documenting numerous cases where people who thought they were well-insured, discovered all too late they weren't. The following are just a few examples:

1. Patient negotiates fees with surgeon, anesthesiologist, hospital, assuming assistant surgeon, as customary, will be paid by surgeon. Assistant surgeon bills $117,000 for 3-hour surgery and gets it (Rosenthal, 2014).

2. A woman doubled over with pain goes to emergency department at hospital. After multiple tests discovered not appendicitis; but ovarian cyst. Insurance company refused to pay as they determined wasn't emergency. The person was supposed to diagnose herself, ultimately stuck

with $12,596 hospital bill. I guess she could have waited, if appendix burst, well, that's her bad luck. The policy of not reimbursing emergency room visits if turn out not be an emergency is growing (Kliff, 2018; see also: Abelson, 2018; Chou, 2018).

3. Between 33 percent and 80 percent of cancer survivors exhaust their savings to finance medical expenses. Up to 34 percent borrow money from friends or family to pay for care. For those who fall into debt, the level of debt is substantial. Bankruptcy rates among cancer survivors are 260 percent higher than among similar households without cancer (Ramsay, 2016).

4. "It's not uncommon for patients who visit an in-network hospital to learn later that they've been treated by out-of-network providers, resulting in thousands of dollars in charges. And while the Affordable Care Act generally caps what consumers must spend out of pocket when using providers within their plan's network, it doesn't protect consumers from large bills from outside providers. Those providers may be free to charge the consumer for the balance of the bill that the insurer did not pay, known as 'balance billing'" (Bernard, 2013).

5. "A long night spent struggling with what turned out to be a whooping cough infection left the Encinitas resident so exhausted that he fell and hit his head. He was taken to a hospital emergency department by ambulance. Doctors there recommended that he stay overnight for observation, a precaution to make sure he did not have a more serious injury. After leaving on Feb. 5, everything seemed fine until he received an $18,700 bill in the mail. He learned that, although he had spent the night in a bed at Scripps Memorial Hospital La Jolla, he was never technically admitted as an inpatient. Medicare pays less for observation stays than it does for people who are admitted, and Scripps was billing him for the remainder of the costs he incurred (Sisson, 2016)."

6. And, as a final example, an outrageous one, the treatment of 9/11 First Responders. Most were police or fire department employees, covered by insurance; yet, their insurances didn't cover much of their care. Finally, Congress passed legislation 10 years later to cover them, though only certain conditions, too little too late for many who had already died and those remaining who had suffered. These were our heroes. If anyone deserved top quality care, it was them (Wikipedia. Health effects arising from the September 11 attacks).

Above is just the tip of the iceberg. Read on.

U.S. Health Care in International Comparisons

Given the power of the health insurance industry we are basically inundated with lies about other nation's health care systems. International studies rank the U.S. poorly on numerous measures. Not only we rank poorly on infant mortality and life-expectancy; but on chronic conditions. For instance, diabetics do better in the United Kingdom (Mainous, 2006). The list goes on (Chen, 2016; Garrett, 2018; Harrison, 2018; Institute of Medicine, 2013; OECD, 2017; Sawyer, 2017; Schneider, 2017; Tikkanen, 2017). Statistics on cancer ranking the U.S. at the top are deceptive. We do much more screening than other nations, catching cancers at earlier stages, sometimes this is beneficial; but often just involves treatments that are costly and can even lower our quality of life (Wikipedia. Lead time bias; Wikipedia. Length time bias). Pap smears detect cell dysplasias (abnormalities). Most won't progress to cancer. Prostate cancers are often so indolent that men will die years before they would have had an effect. Early interventions may save some

lives; but result in infection, pain, impotence, and incontinence. According to the National Breast Cancer Coalition:

> *For every 2,000 women invited for screening over a 10 year period, one will have her life prolonged and 10 healthy women, who would not have been diagnosed if they had not been screened, will be treated unnecessarily. The evidence of a mortality reduction from screening is conflicting and continues to be questioned by some advocates, scientists, policy makers and members of the public. In fact, the absolute risk of a woman dying from breast cancer is less than 1% without any screening. Looking at this another way, 995.6 out of 1,000 50-year-old women will not die of breast cancer within the next ten years. This number rises to 996 out of 1,000 with regular mammography screening (National Breast Cancer Coalition, 2013; see also: Houssami, 2017).*

The evidence is mounting that for those insured in the U.S., both over-diagnosis and over-treatment are often as threatening to our health as under-treatment of those who are underinsured or uninsured (e.g., Brownlee, 2007; Welch, 2011).

However, if the monies wasted on our current system were re-directed to actual treatment, where current interventions for cancer are advantageous, they would be covered. And, as discussed below, the data from a single-payer system has the potential to be used for improving health care.

Myths About Canadian Health Care

A recent article in *The Atlantic* stated if we were to adopt the Canadian health care system: "5,400 fewer babies would die in infancy, and we'd save about $1.3 trillion dollars in health care spending. . . And, perhaps as a result, more than 50,000 preventable deaths would be avoided." The article does point out slightly longer wait times for non-emergency/urgent care; but this is based partly on their lower spending. If we were to maintain our current level of spending, this could be avoided (Khazan, 2014; Cecere, 2009). As a specific example. average life-expectancy for cystic fibrosis is 10 years longer in Canada than U.S. (Stephenson, 2017). On almost every measure of health care outcomes Canada does as well or better than the U.S. (Eisenberg, 2005; GAO, 1991; OECD, 2017; Robinson, 2008; Sawyer, 2017; Schneider, 2017; Tikkanen, 2017).

Canadians Seeking Health Care in U.S.: Of course Canadians get health care in the U.S. Most are either working here, attending university, touristing, or retirees wintering in Florida to escape the harsh Canadian winters. The same can be said of Americans falling ill or suffering injuries while abroad. In fact, "The U.S. Centers for Disease Control and Prevention has estimated that about 750,000 U.S. patients travel abroad each year for medical treatment. That's a larger proportion of the U.S. population than even the highest estimates of Canadians seeking treatment abroad" (Martin, 2017).

However, the question is how many Canadians seek health care in the U.S. while residing in Canada and the answer is very few and many of these are for highly specialized health care, which, is often paid for by the Canadian single-payer health care system (Katz, 2002; Lee, 2016; McCann, 2014). Only a few years ago, the only place to receive a heart-lung transplant was Pittsburgh. Is that proof that health care everywhere else in the U.S. was deficient? It is more

cost-effective with better outcomes for highly specialized care to have centers of excellence in areas such as heart surgery, cancer care, neonatal intensive care, and others, so Canadians seeking highly specialized care can seek it in the US or elsewhere in Canada, sometimes the travel distance is much shorter to the U.S. (Hillner, 2000; Luft, 1990; Jollis, 1997).

Exaggerated Wait Times: Exaggerated estimates of wait times come from studies by the Fraser Institute, a right-wing think tank with substantial funding from the Koch brothers and US Pharmaceutical Companies (Wikipedia. Fraser Institute). The Fraser Institute studies use a highly flawed methodology (McCann, 2014). Though wait times can be longer in Canada than in the US, that is, for Americans who are highly insured, there is NO evidence they compromise health outcomes. Emergency and life-threatening conditions are cared for within appropriate time parameters and over the past decade Canada has successfully implemented programs to reduce wait times for elective procedures, and the effort continues (Canadian Institute for Health Information, 2017; Health Council of Canada, 2011; Longhurst, 2016).

Canadian Doctors Moving to U.S.: The number of Canadian doctors moving to the U.S. is actually quite small and many return to Canada (Canadian Health Services Research Institute, 2008; Freeman, 2016). And many American doctors are moving to Canada. Reasons include dealing with insurance company bureaucracies, "In the US, thanks to insurance company loopholes and technicalities, American family physicians aren't paid up to 30% of the time, whereas under a single-payer system, only about 2% of billings aren't covered . . . Even referrals are a headache since insurance companies often pay only for specific hospitals and specialists" (Glausser, 2014). In Canada, doctors don't have to worry about whether patients can afford care and can focus on their medical needs instead of their finances (CTVNews.ca Staff, 2015; Luthra, 2017; Palmer, 2017).

Though on most measures the Canadian Health Care System is superior to ours, international rankings place Canada above the U.S.; but below several other nations (Chen, 2016; Garrett. 2018; Institute of Medicine, 2013; OECD, 2017; Sawyer, 2017; Schneider, 2017; Tikkanen, 2017). According to 2015 data, $5,782 dollars per person (10.4% OF GDP) were spent by Canada, compared to the U.S. $11,916 (16.9% of GDP) (Canadian Institute for Health Information, 2018). According to Palmer (2017):

> *No system is perfect but that said, the Canadian system has the framework and the organization to be able to solve what problems exist and to solve the health care problems for Canadians. That structure doesn't exist in the US. And that's a big problem. 'What we have in place in the United States is a structure that is chaos. There are multiple insurance companies, multiple payers all acting under different rules that they set for themselves. Also acting under the premise that a virtually unregulated free market can effectively and efficiently [deliver] health care – and that's just not true. Health care is just not a field in which a free market works well.' (Palmer, 2017)*

For more about the Canadian health care system and innovations that could improve it, innovations easier to carry out in a single-payer system, see Rachlis, 2005.

Funding, Cost, and Administrative Waste

According to a recent 2018 Milliman Research Report, the cost to a family of four for an average employer-sponsored preferred provider organization plan is $28,166. Since inflation has been minimal, comparing the 2016 data from the United States Census Bureau which found the median income for families with four people to be $90,746, the cost of health care, on average is greater than 30% of total income (Garrett, 2018; Girod, 2018; Institute of Medicine, 2013; OECD, 2017; Papanicolas, 2018; Schneider, 2017; Tikkanen, 2017; United States Census Bureau, 2017, Table F-8: Size of Families).

If one includes Medicare, Medicaid, VA, Military, Tricare for military families, Indian Health Service, health insurance for employees of all levels of government, and health insurance covered by contract with companies doing business with various levels of government, approximately 65% of health care in the U.S. is funded through taxes (Harrison, 2008). As a percent of GDP this equals the next most expensive health care systems which cover everyone with high quality care. Over 10% of doctor office and hospital costs involve the excess administration necessary to deal with multiple payers (Casalino, 2016; Himmelstein, 2014; Ubel, 2016) and at least 20% of health care costs go to for-profit health insurance companies, including bloated salaries, stock dividends, and administrative bureaucracies (Frakt, 2018). An average doctor devotes 15 hours per week to the excess paperwork demanded by our fragmented, dysfunctional, for-profit system, hours that could be devoted to actual patient care. Much of the equipment in hospitals and especially rural hospitals is paid for by Medicare and Medicaid (Alexander, 2018; Ross, 2018). And Medicare pays for residency training of specialists (Rampell, 2013). It is impossible that the 30% or more of health care dollars that go to excess administration and profit could deliver equal or better care than if the monies were actually directed to health care (Harrison, 2008). In fact, the current system limits our choices, delays care in many cases, forces people to choose between seeing doctors and/or buying medications or paying basic necessity bills. And Illness and medical bills contribute to a large and increasing share of US bankruptcies (Dobkin, 2018; Himmelstein, 2005; Himmelstein, 2009; Sanger-Katz, 2018). So, basically, we pay for our healthcare through our taxes and then pay again both monetarily and health-wise. As for Medicaid, one paper found that some insurance companies are reaping spectacular profits off the taxpayer-funded program in California, even when the state finds their patient care is subpar (Terhune, 2017).

Given the excess administrative costs built into our healthcare system (Frakt, 2018), by just removing these, the costs of hospital stays and other medical costs will be substantially reduced. Just one absurd example should be enough, according to Professor Uwe Reinhardt: “We have 900 billing clerks at Duke. I’m not sure we have a nurse per (each) bed, but we have a billing clerk per bed…it’s obscene (Putsch, 2008).” However, a non-profit single-payer system will actually provide a global budget for hospitals based on a careful analysis of their operations, so, the risk of hospitals closing is pure propaganda from the for-profit industry, not a valid claim.

In other nations sick and injured people and their loved ones can focus on getting better. In the US we are deluged with bills, paperwork, and fighting with insurance companies, a never ending nightmare just when we are at our most vulnerable (Rice, 2018). A non-profit single-payer system *WILL NOT COST MORE THAN OUR CURRENT SYSTEM. IT WON'T INVOLVE NEW DOLLARS.* People don’t understand that “benefits” included with our jobs are really part of our total compensation (Heathfield, 2018; New Mexico State Personnel Office, 2014). Whether an employer offers health insurance or not affects our salaries. In the past few years wage increases

have flattened out and/or changes in health insurance, premiums and deductibles have grown. So, remove the employer from the equation and have a modest percentage of income, smaller than our share of premiums, covering our entire families, with no deductibles and copays, NO PAPERWORK. By rolling Medicare, Medicaid, and a percent tax on incomes, similar to the current taxes for Social Security (FICA) and Medicare, into one system, we could achieve universal coverage with access and choice determined by us and for the vast majority costing less than our current system. Additional sources of revenue have been proposed, such as a modest tax on financial transactions (Friedman, 2013; Friedman, 2017a; Friedman, 2017b; Sanders, 2016). Of course, given the power of the insurance lobby, Washington may refuse; but the money is there and we should fight for it.

We are the only health care system in the world designed first and foremost to make a profit, not to care for people. In the past few years, for instance in California, health care costs have increased by 240% compared with 40% for the Consumer Price Index (California Health Care Foundation, 2017; Huffman, 2017). In no way can the introduction of newer technologies come close to explaining this. In fact, one study found after adjustment for price inflation, 50% of the increase could not be explained by increases in population size, aging of the population, changes in disease prevalence or incidence, or service utilization (Dieleman, 2017).

Extortionist Level Drug Pricing

The recent scandal of raising Epipen prices to $800 is just one example. But even the original $400 for a packet of two Epipens was outrageous given they cost between an estimated $8 - $30 for a two-pack and sell in the UK for $69. In fact, the Epipen was developed for our military (Bloomberg, 2016; Mangan, 2016; Nutting, 2016; Ramsey, 2016; Seipel, 2017; White, 2016). Numerous studies have shown that claims by pharmaceutical companies of the cost of developing new drugs are grossly exaggerated (Light, 2011; Medecins Sans Frontieres, 2014; Prasad, 2017; Public Citizen, 2001; Public Citizen, 2017; Relman, 2002). In fact, over 95% of the basic research is funded by the government and even 50% of new classes of drugs (Light, 2005). The pharmaceutical industry is among the most profitable industries, only equaled by banks; but outdistancing carmakers, oil and gas, and media (Anderson, 2014).

The FDA's patent of a drug creates a monopoly.

> *A monopoly exists when a specific person or enterprise is the only supplier of a particular commodity. . . Monopolies are thus characterized by a lack of economic competition to produce the good or service, a lack of viable substitute goods, and the possibility of a high monopoly price well above the seller's marginal cost that leads to a high monopoly profit (Wikipedia. Monopoly).*

The object of patents is to encourage research and innovation in order to benefit the public. The public is certainly does NOT benefited from extortionist level prices and profits. A single-payer health care system will be able to negotiate drug prices, allowing reasonable, not extortion level profits.

In 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act. Billy Tauzin, as chair of the U.S. House Committee on Energy and Commerce, which oversees the drug industry, played a key role in shepherding the bill through Congress, including

prohibiting the government from negotiating lower drug prices and banning the importation of identical, cheaper, drugs from Canada and elsewhere. Even with bargaining the pharmaceutical industry would have increased profits from the addition of a large number of people able to purchase drugs; but greed has no bounds. Tauzin resigned from Congress after the bill was passed and became head of the Pharmaceutical Research and Manufacturers of America at a salary estimated at $2 million per year. Does this raise any red flags (Ludwig, 2015; Wikipedia. Medicare Prescription Drug, Improvement, and Modernization Act)? The VA, Kaiser Permanente, Blue Cross, everyone else pays less for drugs than Medicare because they can negotiate. In fact, some drugs are actually cheaper if purchased directly from a local pharmacists, bypassing the profits and additional administrative costs from the Pharmacy Benefits Managers created by the bill (Ornstein, 2017). Gag orders often prohibit a pharmacist from discussing pricing with customers (Pear, 2018). By negotiating prices the Medicare donut hole could be eliminated (Congressional Budget Office, 2007a; Consumer Union, 2006; Families USA, 2007; Gaffney, 2018; Health Markets, 2018; Light, 2012; Light, 2013).

Complete Coverage, Dental, Home Health Care, Nursing Homes

A non-profit single-payer system will also include dental care, home health care, nursing homes and skilled nursing facilities. Poor painful teeth lead to poor nutrition which affects our diet which affects overall health. It affects our self-image, our ability to concentrate, our productivity, whether as students or workers, and, of course increases the need for health care (CDC, 2018). Quality home health care, allowing people to stay in their homes, is both cheaper than nursing homes and maintains a better quality of life (Ball, 2018; Gerace, 2011; NPR, 2018). With global budgets, nursing homes will have the requisite number of trained health care providers rather than employees in billing offices. Currently new hospitals are being built where each patient will get his/her own room. We could do the same for nursing homes. Just because one is infirm shouldn't mean the loss of privacy and dignity. We could have such a system given that the monies now going to profits and bloated salaries for administrators, even for non-profit nursing homes, would go to actual care (Zimmerman, 2011).

Good For Business

A non-profit single-payer system will reduce job lock. Currently, many talented individuals are stuck in jobs that are not a good match because they need to maintain health insurance. Imagine some talented individuals wanting to start their own firm, one has a chronic health condition or ill child, the cost of health insurance for individuals or small firms would either be prohibitive or come with high deductibles and copays, not leaving monies for investing in the company, so they stay with their current company (Baker, 2015). Health insurance reduces the competitiveness of American companies in international competition, both upping the overall production costs and devoting time and energy in negotiating yearly insurance contracts for employees. Especially small businesses, the backbone of our economy and largest employer overall, are negatively affected by our current system. If one chooses to ensure its employees, the increased costs put it at a disadvantage against those who choose not to (Johnson, 2012; Leenson, 2017; Reinhardt, 1989).

Why Should Immigrants, including Undocumented, Be Covered?

For those opposed to undocumented aliens receiving health care, numerous studies have found

that they contribute significantly to our economy and pay taxes. In fact, an Institute of Medicine study estimated the productivity loss to our economy due to lack of insurance at up to $130 billion in 2000 and if insured the cost of care at up to $69 billion, both would be much higher today (Institute of Medicine, 2003). The Institute of Medicine series of studies on the effects of uninsurance included immigrants, both documented and undocumented (Institute of Medicine, 2009). So, it costs our economy more to not insure everyone. If injured on the job, a job contributing to our economy, shouldn't they receive care? More importantly, despite President Trump's push to build a wall, it would be virtually impossible to eliminate them, so, we risk exposure to infectious diseases, e.g., in restaurants, day care centers, in elevators, etc. If not a moral obligation, then enlightened self-interest should prefer they be treated rather than remain contagious (Congressional Budget Office, 2007; Edsall, 2016; Federal Reserve Bank of Dallas, 2003). Not only immigrants use disproportionately less medical care than their representation in the U.S. population would indicate (Goldman, 2006); but they actually contribute to Medicare's solvency (California Healthline, 2015; Flavin, 2018; Zallman, 2013).

Surveys have shown that the majority of Americans support a non-profit single-payer health care system; but only if it doesn't include illegal immigrants (Rasmussen, 2009). U.S. law requires providing emergency care to anyone (Wikipedia. Emergency Medical Treatment & Labor Act). Unfortunately, the uninsured "receive fewer needed services, worse quality care, and have a greater risk of dying in the hospital or shortly after discharge," even from trauma care (Institute of Medicine, 2002). And as the number of uninsured increases, the quality of health services in a community decrease (Institute of Medicine, 2009).

Besides the fact that they have contributed to the system, besides the risks of infectious diseases, besides the immorality, besides the effects of uninsured on availability of quality care in a community, denying care to anyone lacking proof of insurance could put us all at risk in an emergency. Imagine you suffer a heart attack or an injury and have no proof of insurance. The uninsured get less follow-up care, so their risk of another emergency is high. So, besides the immorality, it isn't rational to be against a program that will benefit us and our loved ones just to ensure that others don't benefit as well, enlightened self-interest.

Healthcare Doesn't Meet the Assumptions of a Market Model

Healthcare DOESN'T fit into a market-based system, regardless of how hard those who profit from it at our expense try to fit a square peg into a round hole (Arrow, 1963). Market economics require "free" access to information and, of course, the ability to evaluate it; but how many of us with cancer understand the basics of medicine, can evaluate peer-reviewed journal articles, know how to search the literature, even have the time or ability to focus when ill? And if in a car accident or suffering a heart attack, how many will be able to call around to various emergency departments to price shop? And how would one even price shop, not knowing once there what will be necessary (e.g., Mehrota, 2017)? And, as explained above, we already pay through our taxes what covers everyone in several other nations with a high level of quality care. It would take a separate article just to explain why health care doesn't fit in market economics. And how does 65% of health care costs from tax dollars fit into a free market model? One excellent book explains the basic assumptions of a market model and why health care just doesn't fit into it:

> *Thomas Rice (2015). "The Economics of Health Reconsidered," Fourth Edition. Health Administration Press. Used copies of earlier editions are available on Amazon*

marketplace at reasonable prices. The basics don't change between editions, just more up-to-date examples, and criticisms of earlier editions are dealt with.

Non-Profit Single-Payer is NOT Socialized Medicine

A non-profit single-payer system is NOT socialized medicine. It is Medicare for All. Delivery of health care will be by non-profit hospitals and clinics and private practicing physicians. Rather than choosing an insurance plan, if possible, or taking that offered by ones employer, one will be able to actually choose the hospital, clinic, and health care practitioner, without being locked into any network determined by the profit motive of health insurers. Unfortunately, all too often words like "socialism" are used to arouse emotions that stop people from further investigating a policy. Socialism DOES NOT apply to a non-profit single-payer healthcare system, though, as the saying goes: "A lie told often enough becomes the truth." I have lived in both Sweden and Canada. Swedish healthcare is socialized medicine. Facilities, hospitals and clinics, are owned and run by the government and medical personnel are salaried, except for dentist who operate private practices. In Canada, hospitals and clinics are privately owned and physicians work in private practices. Dental and long term care are not universally covered; but some Provinces do cover them for specific groups, e.g., dental care for children and seniors and home health care and nursing homes for seniors. International studies show both systems superior to ours; but, given American culture, a non-profit single-payer system would be more acceptable.

Non-Profit Single-Payer is NOT a Ponzi Scheme

A non-profit single-payer system is NOT a Ponzi, pyramid, scheme transferring money from the young to the old and sick. A pyramid scheme is one-way, those at the top benefit and those at the bottom lose (Wikipedia. Ponzi scheme). A single-payer system is more like a revolving door, first one is outside, then inside. All of us will eventually grow old and at some time in our lives suffer injury or illness and none of us can be held responsible for our genetics, a roll of the dice. Young people do suffer injuries, cancer, and other illnesses. If they are uninsured, they still receive at least emergency care and, thus, we pay for it. As discussed above, the level of care will be less. By removing the excess administrative costs and profits, our parents, grandparents, and others are covered as we will be in turn. When I was in elementary school, my father's taxes paid into the system as did others. Even when he was unemployed I continued with my education. When I became an adult, my taxes paid into the system so that the next generation of children would be educated and I gladly did this despite having no children of my own (Reuss, 2012).

Potential Health Services Research, Improved Care

Despite literally billions of dollars spent on medical and pharmaceutical research, problems still exist, including grandfathered interventions. Questions regarding which interventions for which conditions work still exist. Even with the absolute best clinical trials, the risk of rare but serious side-effects will not be found. Our drug laws allow any drug, once approved by the FDA for one condition, be used "off-label" by physicians for any condition. Sometimes the off-label use of a drug really does work; but often it doesn't. We don't know how many physicians prescribe an off-label drug for a specific condition, how many discontinued its use due to lack of efficacy or side-effects, nor even if improvements followed, if one could attribute them to the off-label drug or other factors. Circa 20% of all drug sales involve off-label use which adds to our overall cost of

health care (Carr, 2017; GAO, 2008; Orac, 2012; Wikipedia. Off-label use). With a non-profit single-payer system, either one standardized database for entry of all patient demographics, conditions, and treatments or a linking system for several already existing databases, has the potential to improve healthcare by assigning teams to investigate everything from surgeries to drugs, FDA approved usage as well as off-label, and vaccines. Numerous large studies have found that the risk from vaccines is minuscule compared to benefits (CDC, 2017); but having data for literally all children could allow one to look at any rare increased risk from "pre-existing conditions" and assuage the fears of parents reluctant to vaccinate their children. Of course, strong laws and enforcement will need to be developed to protect patient confidentiality; something not well-protected with employer-based health insurance.

Conclusion

Sooner or later all of us will face injury or illness. No system is perfect and there will always be anecdotes of one or a few cases where failures occurred. Unfortunately, as with the red flag of labeling something as "socialist," anecdotes play on our emotions and we fail to ask the question: "Compared to what?" For every anecdote about a case example of poor care in a Western technologically advanced nation offering universal health care, whether single-payer or socialist, one can find a far greater number in the U.S. A non-profit single-payer health care system ensures that we will be able to choose our doctors and hospitals, get the highest quality of care, without fighting with insurance companies, without being inundated with paperwork, and without worrying about finances. In addition, regardless of our employment, our families will be covered.

The choice is simple: Do we continue to fund through our taxes a system to enrich a few or adopt a non-profit single-payer system that numerous international studies have shown to cover everyone at a high level of care?

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