VERMONT MEDICAL SOCIETY RESOLUTION

Resolution in support of a single-payer, national health program

Submitted by Jane Katz Field, M.D.
for adoption at VMS Annual Meeting on November 7, 2020

WHEREAS, 27.5 million Americans lacked health insurance in 2018[1], and

WHEREAS, compared to ten other high-income countries, the U.S. ranks last in health care affordability, and has the highest rate of infant mortality and mortality amenable to health care[2], and

WHEREAS, employer-sponsored health plans are increasingly unaffordable for workers since 85% of these plans include an annual deductible and the average deductible was $1,573 for single coverage in 2018[3], and

WHEREAS, in 2018 the U.S. spent $3.6 trillion on health care, or 17.7% of GDP[4]twice as much per capita on health care as the average of wealthy nations that provide universal coverage[5], and

WHEREAS, illness and medical bills contribute to 66.5% of all bankruptcies, a figure that is virtually unchanged since before the passage of the Affordable Care Act (ACA), and 530,000 families suffer bankruptcies each year that are linked to illness or medical bills[6], and

WHEREAS, overhead consumes 12.2% of private insurance premiums[7], while the overhead of fee-for-service Medicare is 2%[8], and

WHEREAS, providers are forced to spend tens of billions more dealing with insurers' billing and documentation requirements[9], bringing total administrative costs to 34.2% of U.S. health spending, compared to 16.7% in Canada[10], and

---

[1] *"Health Insurance Coverage in the United States: 2018," U.S. Census Bureau, September 2019.*
[2] *Schneider, et s., "Mirror, Mirror 2017: International comparison reflects flaws and opportunities for better U.S. health care, "Commonwealth Fund, July 17, 2017.*
[3] *Claxton, et al., "Health benefits in 2018: Modest growth in premiums, higher worker contributions at firms with more low-wage workers," Health Affairs, October 2018.*
[4] *"National Health Expenditures Fact Sheet 2017," U.S. Centers for Medicare & Medicaid Services, December 2018.*
[5] *https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start*
[6] *Himmelstein et al., "Medical bankruptcy: Still common despite the Affordable Care Act," American Journal of Public Health, March 1, 2019.*
[7] *National Health Expenditure Accounts, U.S. Centers for Medicare & Medicaid Services, December 2018.*
[8] *Himmelstein et al., "Healthcare paperwork cost U.S. $812 billion in 2017, 4X more per capita than in Canada," Annals of Internal Medicine, Jan 21, 2020*
[9] *Morra, et al., "U.S. physician practices versus Canadians: spending nearly four times as much money interacting with payers," Health Affairs, August 2011.*
[10] *https://pnhp.org/news/health-care-paperwork-cost-u-s-812-billion-in-2017-four-times-more-per-capita-than-in-canada/*

WHEREAS, the U.S. could save over $600 billion annually on administrative costs with a single-payer system[11], and

WHEREAS, billing-driven documentation that contributes to physician burnout would be greatly reduced under a single-payer reform[12], and

WHEREAS, the savings from slashing bureaucracy would be enough to cover all of the uninsured and eliminate cost sharing for everyone else[13], and

WHEREAS, a single-payer system could control costs through proven-effective mechanisms such as global budgets for hospitals and negotiated drug prices[14], thereby making health care financing sustainable, and

WHEREAS, a single-payer reform will reduce malpractice lawsuits and insurance costs because injured patients won't have to sue for coverage of future medical expenses, and

WHEREAS, a single-payer system would facilitate health planning, directing capital funds to build and expand health facilities where they are needed, rather than being driven by the dictates of the market, and

WHEREAS, a single-payer reform will dramatically reduce, although not eliminate, health disparities. The passage of Medicare in 1965 led to the rapid desegregation of 99.6% of U.S. hospitals[15], and

WHEREAS, a single-payer system will allow patients to freely choose their doctors, gives physicians a choice of practice setting, and protect the doctor patient relationship, and

WHEREAS, there is single-payer legislation in both houses of Congress, H.R. 1384 and S. 1129, therefore

---

[11] *Himmelstein et al., "Healthcare paperwork cost U.S. $812 billion in 2017, four times more per capita than in Canada, "Annals of Internal Medicine, Jan 21, 2020*

[12] *Downing, et al., "Physician burnout in the electronic health record era: Are we ignoring the real cause?" Annals of Internal Medicine, July 3, 2018.*

[13] *Pollin, et al., "Economic analysis of Medicare for All," Political Economy Research Institute, University of Massachusetts Amherst, November 30, 2018.*

[14] *Marmor and Oberlander, "From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy," Journal of General Internal Medicine, March 13, 2012.*

[15] *Himmelstein and Woolhandler, "Medicare's rollout vs. Obamacare's glitches brew," Health Affairs blog, Jan. 2, 2014.*

BE IT RESOLVED that the Vermont Medical Society express its support for universal access to comprehensive, affordable, high-quality health care through a single-payer national health program; and be it further

RESOLVED that the Vermont Medical Society will support a national health program provided it meets these core criteria and principles:

a) **Promotes universal, equitable coverage for all US residents (regardless of immigration status);**

b) **Provides comprehensive and high quality coverage for all medically necessary or appropriate services, including inpatient and outpatient hospital care, primary and preventive care, long-term care, mental health and substance use disorder treatment, dental, vision, audiology, prescription drug and medical devices, comprehensive reproductive care (including maternity and newborn care, and abortion),**

c) **Prioritizes affordability for all, including: no cost sharing (no premiums, copays or deductibles), a ban on investor-owned health care facilities[16], and prescription drug prices to be negotiated directly with manufacturers;**

d) **Reimburses physicians and health care practitioners in amounts that are sufficient,**
fair, predictable, transparent and sustainable, while incentivizing primary care;

e) **Allows for collective participation by physicians and other practitioners in negotiating rates and program policies;**

f) **Promotes global operating budgets for hospitals, nursing homes and other providers. Continues to move away from fee-for-service reimbursement models to more flexible payment models that incentivize better outcomes and more coordinated care;**

g) **Allocates capital funds for hospitals separately from operating budgets;**

h) **Eliminates the role of private health insurance companies, thereby greatly reducing administrative costs and burdens on clinicians;**

i) **Allocates funding for graduate medical education that assures adequate supply of generalists and specialists**

j) **Reforms medical school costs to reduce the amount of debt recent graduates face;**

k) **Protects the rights of healthcare and insurance workers with guaranteed retraining and job placement;**

l) **Provides high quality software (EMRs) developed in public sector and provided free to all practitioners;**

m) **Creates a legal environment that fosters high quality patient care and relieves clinicians from practicing defensive medicine; and**

n) **Is funded through a publicly financed system, based on combining administrative savings and the current sources of public funding, with modest new taxes based on individual's ability to pay**

[16] *https://www.ncbi.nlm.nih.gov/books/NBK216759/*