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Frequently Asked Questions about Medicare-for-All

Doesn't the U.S. have a privately financed health care system?

No. Nearly two-thirds of U.S. health care spending is already [financed by taxpayers](#) and the percentage will continue to rise. (Lower estimates exclude two large sources of taxpayer-funded care: health insurance for government employees and tax subsidies to employers to provide coverage.)

Isn't Medicare-for-All/single-payer health care another way of saying "socialized medicine?"

No. Current proposals for Medicare-for-All, where the U.S. government would be the primary payer, would be similar in many ways to today's Medicare, but with improved access and accountability. Health care delivery would still be provided by private doctors and hospitals, not by government owned facilities.

Won't a Medicare-for-All system result in rationing and long lines?

Not at all. Our health system currently rations care based on ability to pay. As a result, [tens of thousands of people die](#) each year because they lack health insurance. Wait times are a function of capacity and management of patient flow, which will improve under a single-payer system.

Wouldn't Medicare-for-All require huge new costs for taxpayers?

No. The increase in taxes required to finance Medicare-for-All would be offset by a reduction in out-of-pocket costs and premiums. Total health care spending in future years would actually be lower than under the status quo. This would be due, in part, to more effective cost controls under a single-payer Medicare-for-All system, including allowing the government to [negotiate with hospitals and pharmaceutical companies](#) to ensure Americans are getting fair prices.

Wouldn't it be unaffordable to cover people who are currently uninsured?

Not at all. Nearly one-third of current [health spending is squandered](#) on [administrative tasks](#) related to our fragmented system, which has hundreds of different health plans. This money would be better invested in patient care. Nearly [\\$600 billion could be saved](#) with simplified single-payer administration, enough to cover all of the nearly 30 million people who are currently uninsured (even with the ACA) and to eliminate co-pays and deductibles for all.

Won't rising numbers of elderly and/or obese Americans bankrupt a single-payer system?

Not true. Europe and Japan already have a [larger proportion of elderly people](#) than America faces, even with the aging of the baby boomers. Germany and Japan have adopted single-payer programs for long-term care coverage precisely because of single-payer's greater potential for efficiency and cost containment. The best way to address the issues of obesity, smoking, and other public health epidemics is through public health measures.

Isn't U.S. health spending higher than other nations because of more and better quality care?

Incorrect. Many [Americans struggle to access care](#) (doctor, hospital, surgery, etc.) at much higher rates than citizens of other comparable nations, and [our care is lower quality](#) on many measures. In fact, [the U.S. ranks last](#) out of 16 industrialized countries for deaths that could be prevented with proper medical care. Around half of the [difference in health spending](#) between U.S. and Canada is due to [higher U.S. administrative costs](#).

Don't employers fund the majority of health care in the U.S.?

No. Private business funds [less than 20 percent](#) of total health spending. Government employees have taxpayer-funded coverage through the Federal Employees Health Benefits Program (FEHBP) and employer payments for private insurance receive a substantial tax subsidy.