emphasis away from business activities such as advertising and acquisitions.

Most importantly, for patients and their families, an NHP would mean that sickness and health would be entirely divorced from financial concerns. Our health-care system would again be centered on the mission of health.

As pulmonary and critical care physicians, we aim to utilize the highest quality evidence, in conjunction with our understanding of the pathophysiologic and social determinants of health, to provide the best care for patients. By taking such an evidence-based approach to the realm of policy, we conclude that only a single-payer system can address the problem of rising health-care costs, while simultaneously ending the grave inequalities that continue to plague our critically ill health-care system.

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COUNTERPOINT:

Should Pulmonary/ICU Physicians Support Single-payer Health-care Reform? No

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I would like to thank the editors of CHEST and my opponents in this debate for inviting me to discuss this matter of great importance to pulmonologists and critical care physicians. Rather than decreasing

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health-care costs as promised, the ACA has led to large premium increases and cancelled policies for people who had insurance and were satisfied with their insurance. These results were predicted.[1] My opponents in this debate suggest a single-system payer as a solution. I respectfully disagree.

Health-care providers compete with each other for the patronage of health-care consumers. Providers can compete by increasing quality or convenience or by decreasing price. Over time, ceteris paribus (all other things being equal), a competitive health-care market will see increases in quality or convenience at lower prices. The term "single-payer" is a euphemism for monopoly. A monopoly requires legal barriers against new competition entering the market. Monopolies have no reason to improve quality or convenience and have no reason to lower price as customers have nowhere else to go for a needed good or service. Over time, ceteris paribus, a monopoly will offer a declining quality of product or service at less convenience to customers at ever-increasing prices. There are no exceptions to these rules. The aforementioned argument ought to settle the issue, but some people do not accept a priori analysis and want empiric evidence.

Medicare is a large single-payer segment of the total health-care market. It is a popular program, but since the beneficiaries get something for nothing, what is not to like? The Social Security Administration estimated that the average annual cost of health care was $442 per person in 1962, which was shortly before the creation of Medicare.[2] The Social Security Administration further found that 90% of seniors paid for their health care out of pocket. This study prompted The New York Times on August 2, 1964, to complain that the average cost of a hospital stay was approximately $285 per week.[3] Fifty years later, the problem we see is that very few young people can afford health care. The average cost of a hospital stay in 2010 was $9,700 ($1,379 in Consumer Price Index–adjusted 1964 dollars) per day.[4] A week in the hospital now exceeds the median annual household income.

Another example of what a single-payer health-care system would look like in the United States is the Veterans Health Administration system. When I entered "VA scandal" into Google, I got 27,800,000 hits. A Washington Post headline from June 23, 2015, reads: "One year after VA scandal, the number of veterans waiting for care is up 50 percent."[5]

How will physicians fare under a single-payer system? The experience with Medicare does not give physicians reason to be optimistic. Regulations were light and reimbursement was generous at the inception of Medicare to ensure support for the program by physicians. Now that the legislation is firmly established, Medicare no longer requires the support of the American Medical Association or physicians in general. Physicians have seen declines in real reimbursement, along with increases in administrative burdens and regulation consistent with the previously mentioned rule of monopoly behavior. Pay for performance is a new reimbursement cut disguised as quality assurance. There are always half the providers in the bottom half of any statistic regardless of how high the actual quality may be. Adult pulmonologists and critical care physicians have little choice but to accept whatever payments are offered by Medicare.

The best solution to the health care problem is to let people make choices without interference by the government. This approach is known as the free market. Markets exist wherever two or more people exchange goods or services. Free markets are unhampered or unhindered by government. Figure 1 illustrates a market. The supply curve is characterized by a positive slope: the quantity offered increases at a higher price. The demand curve is characterized by a negative slope: the quantity bid decreases at a higher price. These curves must intersect. The intersection defines the price P and quantity Q at which the market clears. At the market clearing price, there are no unsatisfied buyers or sellers. Everyone ends up with what they value

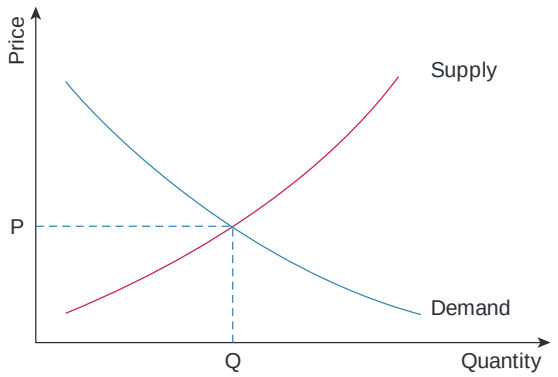

Figure 1 – Price discovery in a free or unhampered market. Supply is generated by providers of goods or services. Demand is generated by consumers of goods or services. The intersection of supply and demand occurs at the price at which the number of willing buyers exactly matches the number of willing sellers. This intersection determines the price (P) and quantity (Q) at which the market clears. The market price changes as the subjective priorities of buyers and sellers change over time.

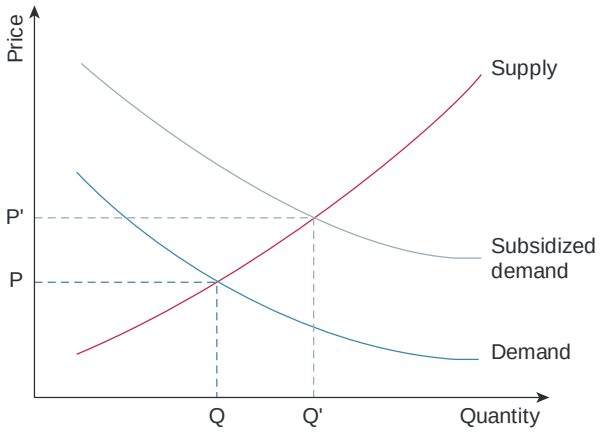

Figure 2 – Effects of subsidies on markets. Both the native demand (blue) and the subsidized demand (gray) curves are illustrated. The subsidy or discount of the purchase price leads the buyer to accept a higher price from the seller than otherwise would occur. The subsidized demand curve intersects the supply curve at a higher price (P^0) and higher quantity (Q^0). The higher quantity is the intent of the subsidy and the higher price is the inevitable and unintended consequence.

greatest. Note that not every buyer makes a purchase and not every seller makes a sale. Buyers who did not make a purchase valued money equal to the market clearing price more than the good or service. They might have a different purchase of higher priority, or they might wish to save for the future. Contrary to what some say, this scenario is not a failure. After every exchange on the free market, both buyer and seller are better off.

Any attempt to force the price or quantity to different values than those set by the price discovery process of the market will leave unsatisfied buyers, sellers, or both. Every government intervention with the market takes one of two forms. The first form is a regulation by which the government prevents two people from making an exchange that they voluntarily would make. This intervention leaves both of them worse off in their view. The second form of intervention forces two people to exchange when one or more does not wish to; usually one person benefits at the expense of the other person. The market always leaves the participants better off, in their own view, than government intervention; there are no exceptions.

Consider the pharmaceutical acetaminophen. This medication is wonderful; it is not free, but it is within the reach of anyone who wishes to obtain it. The availability of acetaminophen is made possible by the free market. One might dismiss this example as not being representative. After all, acetaminophen is dirt cheap. It is dirt cheap because the government has not made a mess of the market for acetaminophen. Consider another drug, colchicine, which has been known since antiquity. Overnight, the US Food and Drug Administration managed to make this previously easily obtained medication priced so high as to be inaccessible by many patients through the use of patent monopoly.[6]

Contrary to popular belief, Medicare is not insurance (pooled risk). Medicare is a subsidy by which the government discounts the purchase price of health care and rebates some of the discount to health-care providers. The discount can be 100% in some cases. Figure 2 illustrates the effects of subsidies. The subsidy makes the purchase price appear lower to buyers than it is to sellers. Sellers are able to capture a higher price than they would otherwise, which moves the demand curve higher. The subsidized demand curve intersects the supply curve at a new point with higher quantity and higher price. The higher quantity is the intent of the subsidy, but the unintended higher price cannot be avoided. There are no exceptions.

The United States has a dysfunctional health-care system, but it is not a market failure.[7] No matter how well intended, government regulations and subsidies have caused inevitable price increases throughout the health-care economy. Prices are no longer determined by supply and demand; prices are determined by whatever amounts lobbyists can convince Medicare to pay. The unintended effects of government intervention have priced health care beyond the reach of the average person. When the average person cannot afford health care, subsidies cannot solve the problem. Insurance can solve outlier catastrophes, but insurance cannot solve routine maintenance. The problem is lack of choices rather than too many choices. A single-payer system will expand the scope of government monopoly in health care to the detriment of both providers and consumers of health care.

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Rebuttal From Drs Gaffney, Verhoef, and Hall

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We welcome this important debate, which is unfolding at a critical political juncture. Dr Berdine's[1] counterpoint has usefully broadened our discussion beyond the issue of single payer to the larger question of the role of the free market in health care.

Dr Berdine[1] argues that in an unhindered competitive health-care marketplace, the market will clear at a price and quantity of goods/services that, as if by definition, leaves all parties maximally satisfied. This argument is little more than a tautology that would, if possible, result in a health-care dystopia that society would not accept. Low-income individuals might "choose" to spend their money on food instead of asthma inhalers. By Dr Berdine's logic, this scenario is as it should be, and any intervention by government would only make things worse. Those dying of status asthmaticus might beg to differ, if they were able, as might patients with hypertension who suffer strokes because they elected to cover their rent instead of paying for physician visits.

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He argues that government involvement in the health care realm has "priced health care beyond the reach of the average person."[1] It is a rather curious point, because the United States already has a relatively privatized and unregulated health-care system (compared with other high-income nations) while also having the highest costs.[2] Furthermore, $375 billion of our expenditures can be attributed to wasteful administrative costs associated with our multipayer insurance market.[3]

Dr Berdine[1] does make a good point when he notes that government-granted patent monopolies can result in high drug prices. To address this issue, a single-payer national health program would directly negotiate with pharmaceutical companies over drug prices. Indeed, the Veterans Health Administration pays 40% less for prescription drugs compared with Medicare, indicating that substantial cost-savings could be achieved by facilitating such negotiations.[4]

A free market for health care is not only undesirable: it is, as economists have noted for decades, a fantasy. Fundamentally, the degree of information asymmetry between the buyer (the patient) and the seller (the provider) prevents health care from conforming to the theoretical tenets of free-market economics. Kenneth Arrow famously contended that the uncertainty intrinsic to health care makes it unique from other goods and services.[5] The health economist Bob Evans has argued that not only has there never been a pure free market in health care but that "inherent characteristics of health and health care make it impossible that there ever could be."[6] On the contrary, he argues, attempts to inject market mechanisms into health care are fundamentally about redistribution. As health-care costs are shifted from public to out-of-pocket sources, those with higher incomes invariably benefit.

The US divergence from other high-income nations is a disaster. We contend with uninsurance and underinsurance, a lack of coverage for critical benefits, worse outcomes, and higher overall costs. As others have noted, the savings made possible through a single-payer system[7] would allow extension of health care as a social right to the entire nation. In contradistinction with a fantastical health-care free market, such a program is both attainable and desirable.

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