Nurses' Guide to Single Payer Health Care

Quality nurse staffing through single-payer

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Nurse union builders struggle with the need to build a broad movement of nurses that welcomes RNs of all political stripes, and our belief that a single payer system is the only reform that will work. To some, building a broad movement and fighting for single payer may seem contradictory, or at least difficult.

Talking to nurses about how a single payer system would transform hospitals and their financing, opening the way for health care workers and communities to be decisive in the budgeting priorities of hospitals and health systems, is something on which we might place more attention.

As nurses, we are tempted to think that the way hospitals operate and the way hospital care is paid for has always been the way it is now, and will always be that way. But many of us remember when hospitals were reimbursed for anything they billed for, then when prospective payment via DRGs came into effect in the early 1980s, and some of us even remember when Medicare and Medicaid transformed hospital financing in the 1960s, a giant step in recognizing health care as a human right.

As corporate medicine and the drive for profits grew in the 1990s, managed care made cutting costs the focus of hospital budgeters and administrators. Since nurses were the largest labor cost for hospitals, nurses were the first to be cut. In the mid 1990s, the re-engineering of nursing took place, eradicating primary care nursing and leading to layoffs, downsizing, displacement, and a shortage of nurses willing to work at the hospital bedside. All of this endangered patients' lives, which has been well documented by respected researchers.

Hospital financing has changed before and it can change again.

We campaign for mandatory nurse-to-patient ratios under the current system of hospital financing in which patient care is not the priority. One of the first questions politicians ask us is "what will ratios cost?" Our position is that saving patients' lives cannot be submitted to cost/benefit analysis, and that ratios are affordable, even under the current hospital financing system. According to the former editor of the *New England Journal of Medicine*, only 50 cents of the health care dollar reaches health providers under today's system dominated by the for-profit insurance industry. However, suppose the prevailing system eliminated the private insurance industry, thereby saving at least 30 percent of the health care dollar and redirecting that funding to direct patient care?

Instead we have become used to hospitals prioritizing:

- Marketing their services to the well insured
- Employing huge numbers of staff dedicated to billing, aimed at high reimbursement
- Employing huge numbers of administrators dedicated to cost cutting
- Refusing to admit patients without insurance and discharging patients quicker

Under a single payer financing system, the substantially enriched funding for direct patient care would be budgeted with strong input from health care workers and unions.

Single payer legislative proposals have in common a concept of a democratically designated public entity that would budget according to public health needs, plan health services, distribute technology rationally and eliminate duplications, and make decisions based on input from all real stakeholders. Such an entity would function at the national level, regional, state and local levels, and could be developed on a community basis to determine budgets for hospitals. There is a rich history in the U.S. of community health planning which can be tapped to transform the new health care system down to the neighborhood level.

Single payer advocates call this global or negotiated budgeting. Health workers, professionals, and community and patient advocates would negotiate with the health planning entity for their hospital's annual budget.

Good staffing practices with nurses' and health worker unions having a strong say and staffing ratios are budgeted as a top priority.

The hospital's areas of medical and research expertise, determined objectively, would be funded appropriately.

Unnecessary surgeries, hospitalizations and treatments would end.

Patients would be hospitalized for as long as their physicians and members of the health care team determine is necessary, with appropriate follow-up care carefully planned.

With equitable hospital care policies and equitable health access, many of the persistent health disparities among the medically underserved would end. The special needs of deserving patients, such as the chronically ill, the frail elderly, the disabled, etc., can be given the special attention they deserve and can be funded accordingly.

Public health systems would be fully funded and no longer be the "last resort" for patients rejected by private hospitals.

A single payer system that eliminates the private insurance industry is the only reform that can meet the above needs, and should be supported by RNs whose main concern is safe patient care. This is realistic and winnable if the most trusted profession raises our collective voice! ■

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