Single-Payer National Health Insurance
Physicians’ Views
Danny McCormick, MD, MPH; David U. Himmelstein, MD; Steffie Woolhandler, MD, MPH; David H. Bor, MD

Background: Forty-one million Americans have no health insurance and, despite the growth of managed care, medical costs are again increasing rapidly. One proposed solution is a single-payer health care financing system with universal coverage. Yet, physicians’ views of such a system have not been well studied.

Methods: We surveyed a random sample of physicians (from the American Medical Association Masterfile) in Massachusetts, regarding their views on a single-payer health care financing system and other financing and physician work-life issues that such a system might affect.

Results: Of 1787 physicians, 904 (50.6%) responded to our survey. When asked which structure would provide the best care for the most people for a fixed amount of money, 63.5% of physicians chose a single-payer system; 10.7%, managed care; and 25.8%, a fee-for-service system. Only 51.9% believed that most physician colleagues would support a single-payer system. Most respondents would give up income to reduce paperwork, agree that it is government’s responsibility to ensure the provision of medical care, believe that insurance firms should not play a major role in health care delivery, and would prefer to work under a salary system.

Conclusions: Most physicians in Massachusetts, a state with a high managed care penetration, believe that single-payer financing of health care with universal coverage would provide the best care for the most people, compared with a managed care or fee-for-service system. Physicians’ advocacy of single-payer national health insurance could catalyze a renewed push for its adoption.

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the highest penetration of managed care, regarding single-payer NHI and related health care financing and physician work-life issues.

**METHODS**

**STUDY SAMPLE AND DATA COLLECTION**

We obtained, from the American Medical Association (AMA) Masterfile, a random sample of physicians in Massachusetts (mailing address) in 2001. Inactive physicians were excluded.

We mailed a survey to 2000 physicians, with a single follow-up letter to nonrespondents. A brief letter requesting study participation accompanied the survey. The letter was printed on Cambridge Hospital stationary and signed by the chiefs of the departments of medicine, pediatrics, and pathology and by one of us (S.W.). No other organization or personal names appeared in the letter. The post office returned 213 surveys as undeliverable, leaving a total sample of 1787. Of these 1787 physicians, 904 responded to the survey (50.6% response rate). The survey was conducted between March 18, 2001, and October 18, 2001.

To assess potential nonresponse bias, we compared the self-reported sex, year of medical school graduation, and medical specialty of the respondents with those of all 27527 Massachusetts physicians in the AMA Masterfile.

**QUESTIONNAIRE DEVELOPMENT**

We developed an 11-item survey on physicians’ belief about which health care financing mechanism would be best for patients (single-payer NHI, managed care, or fee-for-service care), views on health care financing and key physician work-life issues that would be affected by the adoption of single-payer NHI, and demographic and professional characteristics. The questionnaire is available from the authors.

To determine what physicians view as the best health care financing mechanism for patients, we asked “Which one of the following three structures would offer the best health care to the greatest number of people for a fixed amount of money?” Simon et al.24 asked the same question in a previous survey of the highest penetration of managed care, regarding single-payer NHI as the best system for patients and agreement with each of the 4 health care financing and work-life statements (for insurance role, we used disagreement) in multivariate logistic regression models that controlled for AMA membership, medical specialty, and sex—the only variables that were significantly associated with beliefs about the best health care system. Agreement with a statement was defined as either “agree strongly” or “agree somewhat,” and disagreement was defined as either “disagree strongly” or “disagree somewhat.” Data were analyzed using SAS statistical software.25

For analyses of physician specialty, we grouped general internists, family practitioners, general practitioners, pediatricians (nonspecialists), and geriatricians in the category of primary care. We considered medical and pediatric subspecialists as medical/pediatric subspecialists. All surgeons (orthopedics, general surgery, urology, and obstetrics and gynecology) were analyzed as a single group. Specialties other than one of these or psychiatry were combined into a heterogeneous group (other). We categorized respondents by decade of graduation from medical school. Because of the low numbers of respondents, we combined all decades before 1950; similarly, we also combined the few respondents graduating in 2000 with those graduating in the 1990s for these analyses. For analyses comparing study respondents with all Massachusetts physicians, we recategorized the 148 specialty categories appearing in the AMA Masterfile according to the previously described scheme.

**RESULTS**

**CHARACTERISTICS OF RESPONDENTS**

Table 1 summarizes the demographic and professional characteristics of respondents. Slightly more than two thirds of our sample were men. Their mean year of graduation was 1979 (average, 22 years in practice), and the median, 1982. Most physicians by specialty were in primary care, followed by other, surgery, medical/pediatric subspecialty, and psychiatry.

Respondents did not differ from all Massachusetts physicians with regard to sex, but were slightly older and more likely to list a primary care discipline or psychiatry as their specialty (Table 1).

**VIEWS ON HEALTH CARE FINANCING AND WORK-LIFE ISSUES**

Most physicians agreed that it is the responsibility of society through its government to provide everyone with good medical care, regardless of ability to pay, with more than half indicating strong agreement (Table 2). Only a few believed that the insurance industry should continue to play a major role in the delivery of health care, with only 6.8% strongly agreeing with this concept.

Regarding work-life issues, two thirds of physicians agreed that they would accept a 10% reduction in their fees for a substantial reduction in paperwork. A smaller majority indicated a preference for payment under a salary system if the salary were guaranteed to be within 10% of their previous income.
Physicians who agreed with the statements regarding government responsibility for health care were significantly more likely to support single-payer NHI (odds ratio [OR], 8.0; 95% confidence interval [CI], 4.6-13.8), even after adjusting for AMA membership and medical specialty. Similar results were noted for agreement with the statements regarding a reduction in fees for a reduction in paperwork (OR, 4.0; 95% CI, 2.9-5.5) and a salary system of pay if salaries were held to within 10% of previous levels (OR, 3.5; 95% CI, 2.6-4.8) and for disagreement with a continued health care delivery role for the insurance industry (OR, 3.3; 95% CI, 2.4-4.6).

Managed care has become the dominant mechanism for the organization and financing of health care in Massachusetts and the United States. Yet, in Massachusetts, among the most highly managed care–penetrated states in the nation, most physicians reject managed care and view single-payer NHI as the best system for their patients. This view is broadly based, cutting across sex, medical specialty, age, and medical society membership. We also found that most physicians would give up income to reduce paperwork, believe that it is government's responsibility to ensure the provision of medical care, reject a major health care delivery role for health insurance firms, and, surprisingly, would prefer salaried compensation.

Our findings are consistent with most of the few previous peer-reviewed studies that have directly assessed physician support for single-payer NHI, although all were either conducted with selected groups of physicians or performed years ago. Recent studies have found support for single-payer NHI in most (57%) academic physicians and among medical students. Two older surveys of physicians reached similar conclusions. In contrast, 2 surveys restricted to family physicians found that 40% supported single-payer NHI. Interestingly, in one of these surveys, 65% disagreed that corporate managed care is the best way to provide health care.

Massachusetts physicians' overwhelming support for government's role in ensuring access to health care, and their rejection of a major role in health care delivery for the insurance industry, may derive from day-to-day experiences interacting with inadequately insured patients and with managed care plans. Physicians' expressed willingness to give up 10% of their fees in return for a reduction in paperwork, believe that it is government's responsibility to ensure the provision of medical care, reject a major health care delivery role for health insurance firms, and, surprisingly, would prefer salaried compensation.

Overall, nearly two thirds of physicians believed that a single-payer health care financing system was superior to fee-for-service care and managed care in a competitive market. Figure 1 shows the proportion of physicians selecting each option; managed care was viewed least favorably. Of 904 respondents, 850 (94.0%) provided answers to this question.

The belief that single-payer NHI would provide the best health care to the most people did not vary by physician year of graduation, or Massachusetts Medical Society membership (Figure 2). Members of the AMA were somewhat less likely to select single-payer NHI than nonmembers. Female physicians were somewhat more likely to select single-payer NHI than their male counterparts. Psychiatrists were most likely to favor single-payer NHI, and surgeons were least likely. Nevertheless, a plurality of surgeons chose single-payer NHI, as did most physicians in all other specialties.

Our sensitivity analysis suggests that the small differences between our sample and the overall physician population of Massachusetts had little effect on our findings. Adjusting our results for differences in year of graduation and specialty mix decreased the proportion favoring single-payer NHI from 63.5% to 62.0%. While almost two thirds of physicians selected single-payer NHI as the best system, scarcely half (51.9%) thought that most of their colleagues would support it.

### Table 1. Personal and Professional Characteristics of Study Participants and Massachusetts and US Physicians in the AMA Masterfile

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. (%) of Study Participants (n = 904)</th>
<th>% of Massachusetts Physicians (n = 27,527)</th>
<th>% of US Physicians (n = 797,236)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male sex</td>
<td>625 (69.1)</td>
<td>69.6</td>
<td>75.0</td>
</tr>
<tr>
<td>Active member</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMA</td>
<td>267 (29.5)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>MMS</td>
<td>519 (57.4)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Decade of medical school graduation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1940s and before</td>
<td>20 (2.2)</td>
<td>2.7</td>
<td>2.4</td>
</tr>
<tr>
<td>1950s</td>
<td>67 (7.5)</td>
<td>5.7</td>
<td>6.4</td>
</tr>
<tr>
<td>1960s</td>
<td>143 (16.0)</td>
<td>12.0</td>
<td>13.4</td>
</tr>
<tr>
<td>1970s</td>
<td>183 (20.5)</td>
<td>19.7</td>
<td>21.2</td>
</tr>
<tr>
<td>1980s</td>
<td>220 (24.7)</td>
<td>27.6</td>
<td>28.9</td>
</tr>
<tr>
<td>1990s</td>
<td>240 (26.9)</td>
<td>29.2</td>
<td>25.5</td>
</tr>
<tr>
<td>2000s</td>
<td>19 (2.1)</td>
<td>2.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Medical specialty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care*</td>
<td>333 (36.8)</td>
<td>32.5</td>
<td>35.6</td>
</tr>
<tr>
<td>Medical/pediatric subspecialty†</td>
<td>109 (12.1)</td>
<td>13.9</td>
<td>11.4</td>
</tr>
<tr>
<td>Surgery</td>
<td>131 (14.5)</td>
<td>18.1</td>
<td>21.3</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>101 (11.2)</td>
<td>9.2</td>
<td>6.5</td>
</tr>
<tr>
<td>Other</td>
<td>230 (25.4)</td>
<td>26.3</td>
<td>25.0</td>
</tr>
</tbody>
</table>

Abbreviations: AMA, American Medical Association; MMS, Massachusetts Medical Society; NA, data not available. *Indicates general internal medicine, general pediatrics, family practice, general practice, or geriatrics. †Includes internal medicine and pediatric subspecialties.

### BEST HEALTH CARE FINANCING SYSTEM FOR PATIENTS

Our findings are consistent with most of the few previous peer-reviewed studies that have directly assessed physician support for single-payer NHI, although all were either conducted with selected groups of physicians or performed years ago. Recent studies have found support for single-payer NHI in most (57%) academic physicians and among medical students. Two older surveys of physicians reached similar conclusions. In contrast, 2 surveys restricted to family physicians found that 40% supported single-payer NHI. Interestingly, in one of these surveys, 65% disagreed that corporate managed care is the best way to provide health care.

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Physicians have a good understanding of single-payer NHI and see it as the system most likely to address problems in these areas.

Several limitations in this study should be noted. First, this study was conducted in only one state. Yet, because Massachusetts is among the states with the greatest managed care market penetration, its physicians have substantial experience with managed care and, thus, their views may have special relevance as managed care expands in other states. Second, our questionnaire did not define the terms managed care and single payer. Managed care encompasses various organizations and contracts that differ in their details. It seems likely, however, that physicians understand the fundamental relationships denoted by this term. Similarly, the term single payer might refer to somewhat different systems, such as the system in Canada or Australia or even “Medicare-for-all.” Nevertheless, we believe that most Massachusetts physicians are familiar with the term single payer for 2 reasons. First, the Massachusetts Medical Society has studied and debated single-payer NHI several times in the past decade. Second, a statewide universal health care ballot initiative was broadly debated and narrowly defeated in Massachusetts during the 2000 election cycle.

It is also possible that because we asked physicians about 2 financing structures with which they have experience (fee-for-service care and managed care) and one with which they are unlikely to have direct experience (single payer), the support we found for a single-payer system merely reflects respondents’ dissatisfaction with their work setting. However, single-payer financing systems are widely used in other major industrialized nations around the world and much has been written about them. It seems likely that physicians are capable of a rational appraisal of the single-payer option, and able to compare it with the alternatives. Moreover, we doubt that physicians would falsely indicate that they support single-payer reform simply because of job dissatisfaction.

Another limitation of our study is the potential for nonresponse bias. It is possible that physicians who strongly support or oppose any of the health care financing models that we asked about may have been more likely to respond to our survey than those with less strongly...
held views. If this were so, respondents might not have been representative of all Massachusetts physicians. However, our study respondents differed minimally from all Massachusetts physicians. In addition, our sensitivity analysis suggests that nonresponse bias is unlikely to have greatly impacted our findings.

Last, we asked physicians which health care financing system would provide the best care to the most people. We believe that the majority support for single-payer NHI indicates that most physicians would recommend such reform for patients. However, it is possible that some who view single-payer NHI as the best option for patients might not personally support single-payer NHI if, for example, they placed a higher priority on factors other than the interest of patients.

Because of their central role in the health care industry, physicians have the potential to influence debate on reform of the US health care system. The large number of Americans who lack health insurance has recently prompted many medical societies, including the AMA 32,33 and medical opinion leaders 34-37 to renew calls for universal health insurance. Most of these commentators have recommended incremental reforms or have articulated no specific mechanism to achieve universal coverage. Our study, however, finds that most physicians in Massachusetts believe that a single-payer NHI system would best serve the interests of patients, although only half believe that their colleagues support such a system. If physicians elsewhere in the United States hold similar views and take an active role in advocating for single-payer NHI, they could provide substantial impetus for such reform.

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REFERENCES