Single-payer National Health Insurance

by Michael McCally MD, PhD

WE AMERICANS HAVE created a healthcare system that fails to meet our needs while annual costs of this system increase at double-digit rates. Consumers and employers bear most of this burden. In their efforts to control costs, insurers and health plans limit patients' access to care and reduce payments to providers. Because of hassles from insurers, shrinking incomes, and huge increases in malpractice insurance premiums, some physicians are actually abandoning the practice of medicine. Consequently, around 40 million Americans do not have access to healthcare.

The current public debate centers not on whether the system must be fixed, but how. Each party—patients, doctors, hospitals, employers, insurers, and health plans—defends its own needs and priorities. Recent polls confirm that healthcare is a major concern of American citizens. Healthcare reform initiatives have appeared on the ballot in many states, including Oregon. Reformers propose either incremental or universal change.

The studies I describe below demonstrate that a combination of single-payer and universal national health insurance is the only reform option that can provide high quality healthcare for all without increasing overall healthcare spending. *(Please see Jeff Kruse article for opposing view -ed.)*

The Single-payer Solution

Single-payer insurance would establish, in each state, a government fund to pay hospitals, physicians, and other healthcare providers, replacing the current multiple-payer system of private insurance companies and health plans. The plan would provide coverage for the nearly 40 million Americans who have no health insurance. It would improve access to care for the millions of under-insured who pay high out-of-pocket co-payments and have no coverage for long-term care or prescription drugs.

On average, the United States spends more than twice as much on healthcare as do other developed nations and yet millions of Americans are left uninsured and underinsured. Why is the United States so different? The short answer is that we alone treat healthcare as a commodity to be distributed according to market forces rather than as a social service to be distributed according to medical need. In our market-driven, increasingly for-profit system, investor-owned firms compete by avoiding unprofitable patients and shifting costs back to patients, employers, or other payers. The incongruous result is that health plans now seek to avoid sick people.

The Benefits of a Single-payer System and Universal Coverage

Although the single-payer plan does not itself guarantee free choice of provider or all possible benefits, most single-payer plans would offer patients a considerably broader choice of physicians and hospitals than we get with many insurance plans today.

A single-payer system would relieve businesses and providers,

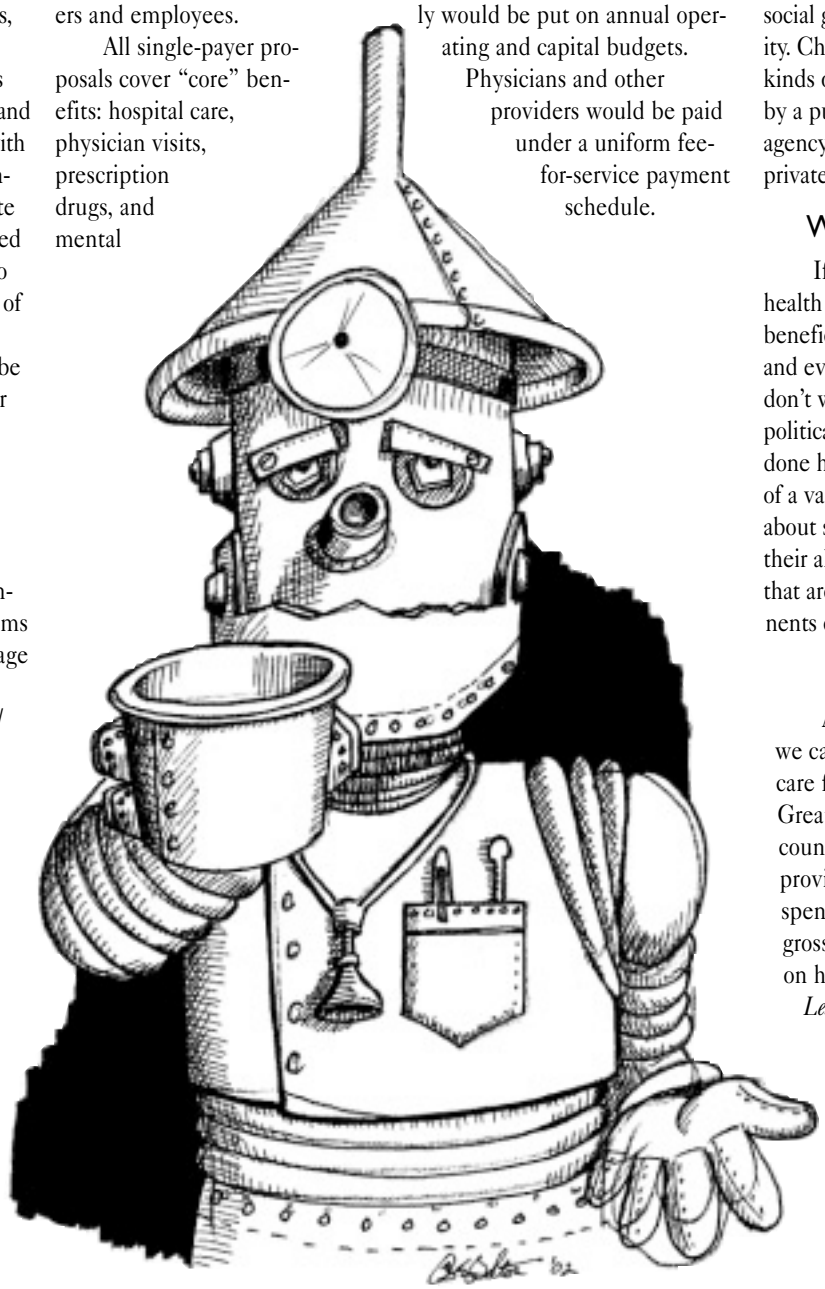
especially doctors, of the administrative hassles and expense of dealing with multiple health plans. Administrative interference in clinical decision-making is a common physician complaint about the present system. Doctors must get approval for procedures, hospital admissions, and choices for clinical care. The phone calls and delays are time-consuming and costly, occasionally interfering with the timely care of patients. A single-payer system would eliminate the health insurance and managed care industry "middlemen", who are naturally forceful opponents of single-payer proposals.

Universal coverage could be achieved without a single-payer system through increases in administrative efficiency and workforce productivity. But statewide evaluations in Massachusetts, Maryland, and most recently California demonstrate that multiple-payer systems cannot provide universal coverage without increasing overall cost (www.healthcareoptions.ca.gov/doc/lib.asp).

How Would It Work?

A single-payer program would receive dollars from all current government health programs and would be supplemented by a payroll and other dedicated taxes. Three proposals studied in California reallocate current revenues for Medicare, Medicaid, CHAMPUS (federal insurance program for military dependents) and Workers Compensation to the single-payer program (www.healthcareoptions.ca.gov/doc/lib.asp). Other potential sources of revenue are increases in the tobacco tax and in payroll taxes paid by employers and employees.

All single-payer proposals cover "core" benefits: hospital care, physician visits, prescription drugs, and mental healthcare. Single-payer proposals may differ on other coverage and requirements for patient co-payment. For example, single-payer proposals may differ in coverage for nursing homes, home care, and dental care. Hospitals typically would be put on annual operating and capital budgets. Physicians and other providers would be paid under a uniform fee-for-service payment schedule.



A program that provides universal coverage and community ratings of risk returns us to the original idea of insurance, namely a risk pool in which we all share equally the unequal risks of ill health. Health services become a social good, not a market commodity. Choices about the extent and kinds of benefits are made openly by a public and accountable agency, not by an unaccountable, private, for-profit corporation.

What's the Problem?

If a national, single-payer health insurance system would be beneficial for individuals, business, and even the government, why don't we have such a plan? The political impetus to get the job done has not developed because of a variety of lingering concerns about single-payer systems and their alleged problems—concerns that are reinforced by the opponents of healthcare reform.

Cost?

A common misgiving is that we cannot afford comprehensive care for all our citizens. Canada, Great Britain, Japan, and the countries of western Europe provide universal access while spending only 7 to 10% of their gross domestic product (GDP) on healthcare. *(Please see sidebar, Lessons from Britain and Canada.)* We, the wealthiest nation on earth, spend 14% of gross domestic product (GDP) and still leave millions uninsured. In fact, we

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have ample funds to provide high quality care for everyone, particularly when the administrative cost savings of a single-payer system are realized. Administrative cost savings are the new funds that would make universal coverage possible. The General Accounting Office (GAO) has estimated these savings to be 10 percent of total healthcare spending. With present U.S. total healthcare spending of $1.5 trillion, the savings available for universal coverage would be $150 billion per year. Studies in the last decade by the Congressional Budget Office, the GAO, and most recently the California Healthcare Options Project demonstrate that in a single-payer system, comprehensive care can be provided for everyone without requiring more funds than we spend now.

released (available online at http://www.healthcareoptions.ca.gov/doclib.asp.)The report confirms that only a single-payer, publicly-financed plan can provide universal access to care without increasing the level of healthcare spending.

Lewin studied nine plans developed by various groups in California. Four were multiple-payer programs with a range of subsidies designed to encourage participation by low-income individuals and employers. Two were "play or pay" plans in which employers were required to either provide insurance for their employees or pay into a state fund that would provide coverage for their employees; and three were single-payer insurance or health service plans in which all residents would automatically be

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The California State Legislature, using funding from the federal government, contracted with the Lewin Group, a large, highly respected, inside-the-Washington-beltway consulting firm, to conduct a careful analysis of a set of nine plans, all designed to reduce the number of uninsured persons in California. The final report of the Healthcare Options Project was

covered. According to the study, all of the multi-payer plans add to current costs while covering a relatively small portion of the currently uninsured. The employer-mandate plans cover a larger portion of the uninsured, up to 86%, but at a correspondingly greater cost. The single-payer, publicly financed and administered plans, on the other hand, reduce costs 2.4 to 5% while covering everyone.

Quality?

Some are concerned about the queue or delays in receiving elective services that are seen in other nations, particularly the United Kingdom and Canada. There is no reason to expect shortages in a U.S. single-payer system. We have sufficient healthcare funds and, in fact, an overcapacity of many resources. For example, there are more MRI scanners in Orange County, California than in all of Canada.

Others argue that a single-payer system that offers universal coverage would lower the standard of care for everyone. Our current system has two alternatives: either no insurance with impaired access to all but emergency care for life-threatening illness, or mediocre care in managed care programs that markedly restrict access and choice. The affluent can get convenience and non-covered services by paying out of pocket. As the Lewin analysis makes clear, a single-payer system with presently available funds can provide a generous set of benefits.

Opponents of government administered health insurance contend that government bureaucracies are wasteful compared

Lessons from Britain and Canada

Critics sometime dismiss the single-payer concept with the claim that "Americans do not want socialized medicine." The statement is probably true but has nothing to do with single- versus multiple-payer systems. Socialized medicine is a system in which the government owns the facilities and the providers are government employees. A single-payer system uses existing private and public delivery systems, preserving private ownership and employment. A single-payer system has no more in common with socialized medicine than does our current Medicare program.

Britain has socialized medicine. The British National Health Service owns the hospitals and facilities and pays salaries to providers. A parallel, smaller private insurance system provides services to those who can afford the premiums. Canada has a national single-payer system. Canadian physicians are private entrepreneurs paid on a fee-for-service basis. The major problem with the British program is that it is under-funded. The British spend only 7.5 percent of their GDP on healthcare and obviously can afford fewer benefits. Canada spends 11 percent of its GDP on healthcare and is facing the same problems as we are—rising costs, growing and aging populations, and the imperatives of new medical technology. Although Canadians do come to this country to get more rapid service, the majority of Canadians, when asked, would not trade their system for ours.

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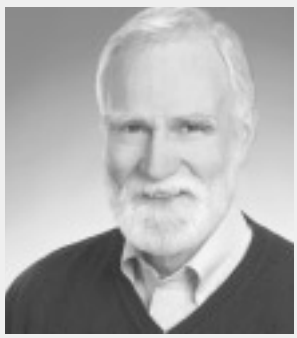
with the efficiencies of the private marketplace. In healthcare just the opposite is true. The U.S. Medicare program, which is publicly administered, operates with administrative costs of less than 2% The managed care intermediaries have administrative costs (not including shareholder profits) of 10%, including marketing. In addition, a physician's office now has the cost of a large administrative staff to manage the clinical and billing information required by dozens of managed care companies and insurers, each with its own forms, rules, approvals, and procedures. As I stated earlier, this "hassle factor" is given by physicians as a reason to leave the practice of medicine or take early retirement.

Winners and Losers?

A single-payer national health insurance program represents a major reform-and nearly everyone resists change. The winners in single-payer reform clearly would be all citizens, particularly the uninsured. The Lewin study showed that families at nearly all income levels save money in single-payer plans. Less tangible social benefits for all are improved overall population health and increased worker productivity. Losers would include those whose jobs would disappear: employees of insurance companies and administrative staff of health plans. One start-up cost of reform would be programs to retrain and transition these workers. Employers who now provide health insurance for their employees would save money; but employers, particularly small businesses who do not now provide insurance, would spend significantly more, perhaps $1,600 to $2,200 per worker.

Conclusion

It can no longer be claimed that this country cannot "afford" healthcare coverage for all its citizens. The Lewin report confirms studies conducted during the last decade. If administrative costs could be reduced to 2 to 3% of healthcare expenditures by having a single agency manage the insurance of all healthcare in the United States, the administrative cost savings would be more than enough to cover the uninsured and provide us all with high quality care. Meanwhile, we are currently committed to incremental reform, maintaining multiple payers, and for-profit systems. It's time to stop our pattern of exhausting all other possibilities and do the right thing.



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