What is Single Payer?

Presented by

David Burress

President, Ad Astra Institute of Kansas

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TOPICS

- Definition(s) of single payer health coverage
- Affordable health insurance versus universal health coverage
- Single payer as an ideal type
- World experience
- Advantages of single payer
- Disadvantages of single payer

Single Payer is an insurance and finance system, not a health care delivery system.

- The health care system has these parts:
  - Manage finances (e.g. insurance; fee for service)
    - Collect revenues
    - Pay bills
  - Deliver services (e.g. socialized medicine; private organizations; nonprofits)
    - doctors, hospitals, drugs, devices...

What is strict Single Payer?

- One insurance plan
- One insurance organization
- Covers “everyone”
- Covers all “necessary medical care”
- No out-of-pocket expenses
- No private insurance premiums, only taxes
- No private health insurance companies
  (except to cover luxuries)

What countries have strict single payer systems?

- NO country has a perfectly strict single payer system.
  - E.g. there are always out-of-pocket fees.
- EVERY SINGLE industrialized country comes closer to single payer than the US
  - E.g. by hyper-regulating plans to make them all alike
- ALL of them have much better cost containment records than the US.
- ALL of them have better health results.
  - However finance systems aren’t the only reason.

What is not-so-strict single payer?

- “One plan” and “one organization” sometimes becomes “a system of highly regulated very similar plans”
- “Everyone” might be citizens only, or everyone who pays taxes, or people over 65, or ...
  - Main point: coverage isn’t optional. You are in or you are out.

Not-so-strict SP (continued)

- "Necessary medical care" always has a more-or-less bureaucratic definition
  - That's true for ALL health insurance, not just single payer
  - Sometimes the rules are unfair.
- "No out-of-pocket expenses" generally becomes "low out-of pocket expenses."

Not-so-strict SP (continued)

- "No insurance premiums" can mean "mandated means-tested premiums."
- "No insurance companies" can mean "supplementary insurance companies" or "highly regulated insurance companies"

Medicare/Medicaid, for example

- One plan (or more, for each for 50 states)
- Everyone (if over 65 or poor)
- All necessary care (except dentistry, hearing aids...)
- No out-of-pocket expense (except fees, copays, coverage limits, ...)
- No premiums and insurance companies (except for medigap, drug coverage, ...)

Universality is the most important feature in Single Payer systems

For those who are covered,

COVERAGE IS UNIVERSAL.

You cannot be excluded.

You cannot opt out.

Universality is multidimensional

- Full enrollment: all individuals in the reference group are covered
- Equal rights: terms of coverage and application of terms are identical across all individuals
- Comprehensiveness: coverage is complete across all types of medically necessary services
- Equal access: individuals have a free choice of medical service providers
- Effective outreach: strong efforts are made to ensure that care is actually received
- Equitable delivery: any wait listing is reasonably minimal in amount, equitably applied across persons, and prioritized by medical need

Why is universal coverage important?

- Ethics: health care is viewed as a right
- Community: we are all in this together
- Revenue sufficiency: since you can't opt out, you can't easily avoid contributing
- True insurance: complete assurance you will still be covered next year, as will your family
- Full insurance: protection against medical bankruptcy

But what's most important about universal coverage is:

- Eliminating negative competition between private insurance companies.
  - Insurance companies are profit seeking.
  - They are forced by competitive pressures to focus on avoiding paying claims.
  - They spend 15% to 30% or more of your premiums on avoiding claims.
  - Providers spend similar amounts making claims.

How insurance companies avoid claims

- They "cherry pick" in many ways, e.g.:
  - Underwriting (i.e., refusing to cover sick people)
  - Marketing only to well people or healthy groups
  - Exclusions: pre-existing conditions, etc.
  - Copays, deductibles, etc.
  - Maximum limitation on coverage
  - Arcane procedures & opaque contracts
  - Rescissions (dropping your policy when you make a claim because of "false data")
  - Arbitrary claim rejections, stonewalling, etc.

Insurance company counter-arguments

- US medical technology as the world's best
  - True, but poorly and unfairly managed
- Typical US health care as the world's best
  - False by almost any measure
- US waiting lists as world's shortest
  - False. US has above average waiting times.
- Universal health care already available at ERs
  - False. ERs won't do major diagnostics or treatment
- Insurance competition as efficient
  - False because of cherry picking & negative competition
- US bad health as caused by lifestyle
  - False. Good US record on tobacco and cholesterol; not the worst on obesity

So what about rationing?

- All systems have significant amounts of wait-list rationing.
- All systems have at least some degree of dollar rationing.
- The US system is below par on both accounts.
- Single payer tends to replace dollar rationing with wait-list rationing.

Other advantages of single payer

- Potentially lowest administrative costs
  - System costs of collecting revenues
  - System cost of dispursing payment
  - Provider's cost of billing and collecting
- Strongest possible starting point for cost containment--central authority can:
  - Negotiate with drug companies
  - Set standards for health care providers
  - Change incentive sructures

Percentages of GDP

COUNTRY	System type	*Total health care expenditure*	*Out-of-pocket user fees*	*Direct cost of insurance administration*	Per capita healthcare expenditure
USA	Mixed	15.3%	1.7-2.0%	1.2%	$6,401
Australia	Single payer + supplem. Insurance	9.5%	1.2-1.9%	0.3%	$3,128
Canada	Single payer	9.8%	1.2-1.5%	0.4%	$3,326
Germany	Social insurance funds	10.7%	0.8-1.4%	0.6%	$3,287
United Kingdom	Socialized medicine	8.3%	0.50%	0.3%	$2,724
Data year		2005	c.1996-2005	2005	2005
Sources	[1]	[2]	[3]	[4]	[5]

Performance measures

COUNTRY	Deaths amenable to healthcare per 100,000	Same day appointments for serious primary care	Access restricted by cost during year	Overall performance ranking/ 1=best	Adult tobacco use
USA	110	46%	37%	6	16.9%
Australia	71	63%	26%	3.5	17.7%
Canada	77	32%	12%	5	17.3%
Germany	90	58%	21%	2	24.3%
United Kingdom	103	57%	8%	1	24.0%
Data year	2002-2003	2007	2007	c. 2005	2004
Sources	[6]	[6]	[6]	[6]	[5]

Disadvantages of single payer

- Perceived costs of getting from here to there
- More major change than any other proposal
- Most Americans don't know what it is.
- Strict Single Payer is an ideal. All real systems have compromises that reduce performance.

Disadvantages of single payer, continued

- Political issues
  - United opposition of big business, Republican Party, and the two largest spending lobbies (Drugs and Insurance)
  - Perceived contrary to free market ideology
  - Opposed by centrist Democrats
  - Absence of a major national advocate
  - Absence of a strong grassroots movement

What's the difference between single payer and all those other buzz words?

- Socialized medicine
- National health insurance
- Universal health coverage
- Affordable health care
- Medical cost containment

Socialized medicine

- "Socialized medicine" usually means that doctors work directly for the government, as in England, Spain, the US Army, the Veteran's Administration.
- To free market ideologists, "socialized medicine" also includes Medicare, Medicaid, and single payer systems.
  - A more accurate term would be "socialized health insurance."

National health insurance; Universal health coverage.

- These two terms have approximately the same meaning:
  - Everyone is covered.
- That could be done with:
  - socialized medicine, or
  - a single payer system that pays the bills for private medical care providers, or
  - a highly regulated, highly subsidized private insurance system that approximated single payer.

Affordable health insurance

- "Affordable health insurance" is something of a weasel phrase. It does NOT mean "universal health insurance."
- It applies *only* when people are making choices about what insurance to purchase.
- Even if insurance is "affordable" (according to the government), some people won't purchase it and won't be covered.
- Under single payer, there is no purchase choice.

Affordable health insurance plus individual mandates...

- ... is almost an oxymoron. If the mandates are truly enforced then affordability/choice doesn't come into it.
- Massachusetts has this kind of plan.
- 5.4% of Massachusetts residents are not covered by any health insurance [7].
- And costs are rising faster than in the rest of the US.

Cost containment

- US health care is incredibly wasteful and expensive.
- Cost issues are driving the health care debate.
- Congress and Obama are taking the "affordable coverage" approach.
- That is cramping their room for maneuver.

Cost containment, continued

- "Affordability" approach means subsidizing the currently uninsured.
- The more people you add the more it costs the government.
- That approach adds greatly to costs (and to profits of insurance companies).
- Most experts say a single payer approach actually SAVES costs.

The medical cost catastrophe

- 16% of GDP is direct cost of health care
- Twice as high as many other countries
  - For inferior care
  - Meaning at least 8% of GDP is being wasted
- Increases 1 percentage point every 3-4 years
- Major drag on economic competitiveness
- Indirect value of bad health care equals an *additional* 5 to 10% or more of GDP
- Bottom line: at least 1/7 of GDP is wasted

Locus of waste: 3 systems basic to health care access

- Fund raising system minor source of waste
  - Payroll taxes and general taxes
  - Employer and individual premium contributions
  - Tax subsidy
  - Copays, other out of pocket …
- Payment system major source of waste
  - Medicare, Medicaid – fairly efficient
  - VA, military –fairly efficient
  - Private insurance – where the waste is concentrated
- Delivery system immense source of waste
  - Doctors, hospitals, drug companies…

Sources of 8% excess direct cost in the US (as % of GDP)

my estimates

- 1-2% Excess bureaucracy [8a, 8b]
  - Insurance company overhead ~1%
  - Providers compliance costs ~1%
- 1% Inflated drug prices [9]
- ~1% Simple fraud [10]
- >4% Bad medical delivery systems[11]
  - -- Overtesting and overtreatment
  - Specific controllable medical errors
  - General lack of cooperation or orientation to quality

Sources of excess indirect cost in the US (as equivalent % of GDP)

my estimates

- ~1% Lost productivity [12]
- >5% Lost QALYs [13]
  QALY = quality-adjusted life years
- >1% Lost companionship [14]
- >2% Foregone value of being fully insured [15]

How could single payer contain direct costs?

- Eliminate insurance companies. Immediate savings: 1-2% of GDP
- Assist in controlling drug prices. Possible savings: 1% of GDP
- Assist in controlling fraud. Savings <1% of GDP
- Assist in reforming medical practice. Immediate savings: 0% of GDP. Potential savings: >4% of GDP

How could single payer contain indirect costs?

- Provide universal coverage peace of mind.
  - Equivalent value: > 2% of GDP.
- Provide medical care to previously uninsured and underinsured, leading to:
  - Improved productivity. Equivalent value: 2% of GDP
  - Quality-adjusted life years. Equivalent value: 2% of GDP
  - Preserved companionship. Equivalent value: 1% of GDP
- Encourage improved medical practice over time, leading to additional gains in productivity and QALYs

Cost containment, continued

- Cost containment is a continuing struggle.
- Single payer is only part of the picture—but it could be a key first step.
  - Eliminating insurance companies: that's the definition of single payer
  - Negotiating drug prices: we need a single nation-wide buyer.
  - Reforming medical practice: we need a single authority with power to change incentives

Single Payer bottom line

- Direct savings
- 3% of GDP: likely short run
- 5% of GDP: addit. potential long run

- Indirect savings
- ~4% of GDP: likely short run
- >4% of GDP: addit. potential long run

END

Comments or questions? Contact:

David Burress
President, Ad Astra Institute
912 Holiday Drive
Lawrence KS 66049-3005
Email: david.burress@adastrainstitute.org
Web: www.adastrainstitute.org
Phone: (785)749-1218
FAX: (208)977-5833

Sources

- [1] Classified by the author
- [2] OECD (2006)
- [3] Calculated from OECD (2006), American College of Physicians (2008), and Anderson *et al.* (2002)
- [4] Calculated from OEDC (2006) and Commonwealth Fund (2008)
- [5] World Health Organization (2007)
- [6] Commonwealth Fund (2008)
- [7] Nardin et al. (2009)
- [8a] Administrative overhead = 7.3% in US, 2% elsewhere (Commonwealth Fund ,2006). (7.3%-2%)x(16% of GDP) = .8% of GDP.
- [8b] Providers compliance cost assumed equal to insurers overhead = .8% of GDP
- [9] Drug costs are 10% of US health care costs; 60% lower in countries that negotiate central prices; 60%x10%x(16% of GDP) = 1% of GDP

Sources, continued

- [10] Fraud estimated at 4+% of Government in funded medical programs, Medicare, Medicaid (Inglehart, 2009) .Rate is likely lower in other sectors. 4%x(16% of GDP) = .6% of GDP.
- [11] Bad medicine: Medicare data showing regional differences (Gawande, 2009). Bad practice areas cost at least twice as much as good practice areas, yet have worse outcomes. Hence over half of medical costs are wasted. To avoid double counting, focus on medical costs after removing previous sources of waste: 1/2x(16%-.8%-.8%-1%-.6%)of GDP = 6% of GDP. Assuming that only 2/3 of this waste can be removed in practice suggests an available 4% improvement.
- [12] Bad health costs 5% of productivity (Haveman et al. 2005). Assume at least 20% avoidable, since % Adults <65 limited in activities because of physical mental, or emotional problems in US is 33% above achievable benchmark (Commonwealth Fund, 2008).

Sources, continued

- [13] QALYs. US life expectancy 5 years behind leaders. 75 expected years of life. 5/75=4%. 4%x300M people = up to 12M estimated QALYs per year. Value of QALY=$100,000 (Jury award average). 12Mx$100,000=1.2$T=8% of GDP. Reduced for end-of-life effects, population growth effects.
- [14] Lost companionship = 20% of lost QALYs in jury award studies.
- [15] (Revealed preference argument.) US consumers willingly pay 15% to 30% overhead for private group insurance, if they can get it and have no public insurance. Persons lacking group coverage pay even more. ¼ of consumers are uninsured at some point during the year while well over 2/3 are underinsured (e.g. because there are maximums in their policies). Therefore most consumers <65 are not fully insured. It seems plausible that Americans would willingly pay an average additional 15% of health care costs in return for complete coverage against medical bankruptcy. 15%x(16% of GDP) = 2% of GDP.

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