

Virtual Mentor

American Medical Association Journal of Ethics
November 2012, Volume 14, Number 11: 897-903.

OP-ED

A Single-Payer System Would Reduce U.S. Health Care Costs

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We Have Not Yet Solved the Health Care Crisis

The Affordable Care Act (ACA) is introducing insurance reforms that will improve the lives of millions of Americans, but we need to go much further to solve the crisis in health care.

Without correcting the fundamental structural flaws in health care financing, overall health care costs will remain poorly controlled. Though our clinical outcomes are mediocre by comparison [1], the average per capita cost of health care in the United States is twice that of other modern nations [2]. Increasingly, these costs are being borne by patients and government, driving personal bankruptcies and ever more austere public policies [3, 4]. Under the ACA, 30 million people will still have no coverage [5], and countless more will have inadequate coverage [1].

For most Americans, the glory days of “Cadillac health plans” are over, if they ever existed. The declining actuarial value of plans offered by employers means that the ACA will still leave those who need health care with financial hardships and high rates of bankruptcy, in spite of the subsidies for premiums and out-of-pocket expenses. (The actuarial value of a plan is the percentage of a patient’s predictable costs within the covered list of services that would generally be paid by the insurance company.) In order to participate in one of the ACA’s new health insurance exchanges, insurance companies are required to offer at least one “silver” and one “gold” plan, with 70 percent or 80 percent actuarial value, respectively. An insurance policy with a 70 percent actuarial value would, by definition, leave patients responsible for 30 percent of the overall cost of the care on the list of covered services. Many other medically necessary services, such as home and long-term care, dental treatment, hearing aids, and basic vision care, will not be covered and are therefore not captured in out-of-pocket maximums.

Health insurance exchanges are envisioned to function like many familiar online marketplaces, such as Travelocity or Amazon. The fate of the ACA’s health insurance exchanges may not be determined entirely until after the upcoming elections. At the moment, only a handful of states have fully committed to implementing exchanges [6]. States that do not implement an exchange will have an exchange implemented for them by the federal government, assuming Congress allocates the appropriate resources. They will be available on January 1, 2014, for uninsured individuals and small groups to compare insurance plans.

Comparison shopping makes sense when buying a product like an automobile, about which individual preferences vary widely. With health insurance, however, we all need the same thing: affordable access to high-quality health care. We need to be able to select our own physicians, but the complexities of selecting an insurance company distract us from genuinely beneficial health care activities. Given the currently dominant role of insurers in our health care, the exchanges are a step forward. But what we need is a leap forward, changing the insurance companies' role and allowing us to focus on our health, not our insurance.

In the 6 years since Massachusetts adopted legislation very similar to the ACA, the cost of health care has continued to drive patients into financial ruin [7]. The state has achieved nearly universal coverage, but, like the ACA, its legislation has yet to effectively address cost and sustainability. Its newly enacted cost-containment law relies heavily on unproven measures such as capitated payments and wellness programs, offering little promise of success [8].

We will not solve our health care crisis as long as private insurance plays a dominant role. We should correct the flaws of the current Medicare program and extend this coverage to all age groups. This approach was well described in 2003 in the Physicians for a National Health Program's "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance" [9].

Major Deficiencies Remain

The Dartmouth Atlas of Health Care has repeatedly documented "glaring variations in how medical resources are distributed and used in the United States" [10]. They attribute much of this variation to supply-sensitive care, that is, care determined by resources and capacity rather than by medical need, and conclude that supply-sensitive care "accounts for more than half of all Medicare spending" [11], some of which is of no medical value and a waste of resources.

A second problem is that the uniquely American plethora of private insurance companies drives a squandering of resources. Legions of staff manage independent computer systems. Each insurance company devotes an enormous number of personnel to responding to emerging regulations from a variety of disparate governmental programs. The expense of this redundancy is considered "overhead" and passed along to the consumer. The intent behind those regulations could instead be implemented once, in a single system servicing the entire country.

Each insurance company develops its own programs for utilization management, prior authorizations, and evidence-based drug formularies to compel the use of that plan's preferred vendors and pharmaceuticals, consuming resources but adding little proven value to health outcomes. No two "evidence-based" formularies have the same drugs on their lists. It's virtually impossible for a physician to remember which low-molecular-weight heparin is preferred by which insurer. Medical groups and hospitals all dedicate staff to managing within this environment, eroding their profits and contributing to a demand for higher reimbursement.

Cost-containment efforts today are focused on the back end of delivery, placing economic pressures on individual physicians and patients who cannot realistically be expected to pursue systemwide solutions [12]. This is the illogic behind “pay for performance” and “consumer engagement.”

In a cynical denial of the responsibility for national planning, patients and physicians are expected to be able to control costs today. Information about the prices of treatment regimens is seldom available at the point of health care delivery, especially not for the complex needs of the desperately ill who consume the lion’s share of resources. It is inhumane to ask someone dealing with the most dangerous phase of a major illness to attempt a cost-benefit comparison of a variety of therapies and health care providers.

Furthermore, pretending that health care is a commodity does not make it easier to reduce it to something simplistic like a spreadsheet comparing airline tickets. Neither the full cost nor the relevant quality is readily available for comparison-shopping.

The ACA began an important discussion of cost containment through the modernization of broad systems such as electronic health records, prevention, and accountable care organizations. While these may hold promise, there is little reason to anticipate their leading to the savings necessary to reverse the crisis [13, 14].

A Single-Payer System Would Improve Resource Allocation

A single-payer system offers several strategies that have succeeded in other countries. As Marmor and Oberlander have written, “they may not be modern, exciting, or ‘transformational.’ But they do have the advantage of working” [15].

Consolidate fragmented finances. It’s been said that when you are trapped in a hole, the first rule is to stop digging. Certainly don’t dig faster.

Profound administrative excesses divert resources into activities that do not improve health outcomes. They often represent the entire careers of countless highly skilled and compassionate people who could be spending their time delivering health care rather than impeding it.

Insurance companies have balked at the ACA’s requiring them to spend at least 80-85 percent of their revenue on delivery of health care. (In contrast, more than 98 percent of Medicare’s expenditures are clinical [16].) Estimates vary, but one-quarter to one-third of our current costs are driven by insurance company overhead, profits, and the administrative costs embedded in clinical settings. Roughly half of these costs would be recovered under single-payer and could be reallocated to the delivery of meaningful health care services [17, 18].

A single-payer model would eliminate the inefficiencies of fragmentation by converting public programs such as Medicare, Medicaid, and CHIP into a single

administratively efficient financing system. Streamlined billing under single payer would save physicians vast amounts in overhead [19].

In addition to reduced billing expenses, physicians would also enjoy a meaningful drop in their malpractice premiums. Roughly half of all malpractice awards are for present and future medical costs [20], so if malpractice settlements no longer need to include them, premiums would fall dramatically.

Use bulk purchasing to negotiate lower costs. We spend more but use less of most services [21] than other member nations of the Organization for Economic Cooperation and Development. In other words, our prices are much higher [22]. As health care economist Uwe Reinhardt noted,

prices for identical products or services in the U.S. tend to be, on average, twice or more than the prices of the same products and services paid in other countries.... Prices are high here because the payment side of the health system is so fragmented that few payers have sufficient market power to bargain for lower prices from an increasingly consolidated supply side [23].

Drug formularies vary widely among health plans. The medical evidence behind the formulary selections is the same in Florida and Alaska, yet the drug lists are sometimes as different as the geography. Although pharmacy benefit managers work within the boundaries of medical evidence, they also consider the prices they have negotiated and the local drug market shares on their formulary selections. Any industry's power to negotiate prices depends upon its purchasing volume.

Only a single-payer system enables the kind of bulk purchasing of drugs and medical devices that would give the buyer power. A model for this structure exists today in the United States: the Department of Veterans Affairs. Due to governmental authority to negotiate drug prices for the VA, it pays roughly half of the retail price of drugs [24].

Negotiations with clinicians should ensure adequate reimbursement of expenses plus fair profits, while ensuring value for taxpayers. A recent careful analysis found that this model is effective and does not lead to a loss in physician income [25].

Adopt responsible, rather than profit-driven, strategies. The United States has little national planning of health care resource allocation. Uncontrolled costs consuming an ever-increasing percentage of the GDP create the appearance of inadequate resources, but the experience of other nations [20] belies this. Under a single-payer system, regional planning of resource allocation would be aligned with public health needs rather than duplicating services and driving up medically questionable utilization. Investing in health care buildings and equipment for reasons other than anticipated need duplicates services and drives up utilization. Intelligently planning

capital investments to match community health care needs is the key to aligning utilization of services with public health priorities.

According to the Physicians' Working Group for Single-Payer National Health Insurance, "Capital spending drives operating costs and determines the geographic distribution of resources. When operating and capital payments are combined, as they currently are, prosperous hospitals can expand and modernize while impoverished ones cannot" [9], threatening the viability of safety-net institutions that serve vulnerable populations. This self-stimulating relationship is dependent upon market opportunities, often not the same as public health priorities. Regions with excess capacity inevitably have excess utilization [10]; better planning could also ensure adequate capacity in underserved areas. Divorcing capital from operating budgets eliminates the ongoing pressure to reap future capital growth by limiting reimbursement to clinicians. Capital, operating, and educational budgets would be nationally funded, regionally administered, and nonfungible. Applying national planning to regional budgeting would right-size capacity.

Today's fragmented system is akin to requiring each household in a community to anticipate their needs for the coming year and negotiate their own fees and scope of services with the local police and fire departments. Imagine instead how much of their budgets these life-saving community services would be obliged to devote to marketing to and negotiating with each household and the rampant disparities in service that would result. That is precisely what is happening today in health care, and it is absurdly wasteful. For police and fire departments, we have recognized that it is significantly less wasteful to give all citizens the same "coverage" for set prices and to administer it with regional coordination. Global budgeting is the only sensible strategy for such unpredictable yet universally needed services.

Conclusion

The ACA has begun the process of much needed change. Now we need to go further in reforming health care finance to enable all Americans to achieve their fundamental human right to comprehensive coverage. The rest of the modern world has run the laboratory studies for us; now is the time for us to adopt this well proven solution.

References

1. Organisation for Economic Co-operation. OECD Health Data 2012: frequently requested data. <http://www.oecd.org/els/healthpoliciesanddata/oecdhealthdata2012-frequentlyrequesteddata.htm>. Accessed August 8, 2012
2. Organisation for Economic Co-operation. Data: health expenditure and financing. <http://stats.oecd.org/Index.aspx?DataSetCode=SHA>. Accessed August 6, 2012.
3. Himmelstein DU, Warren E, Thorne D, Woolhandler S. Illness and injury as contributors to bankruptcy. *Health Aff (Millwood)*. 2005;Suppl Web Exclusive:W5-W73.

4. Himmelstein D, Thorne D, Warren E, Woolhandler S. Medical bankruptcy in the United States, 2007: results of a national study. *Am J Med.* 2009;122(8):741-746.
5. Congressional Budget Office. Estimates for the insurance coverage provisions of the Affordable Care Act updated for the recent supreme Court decision. <http://www.cbo.gov/publication/43472>. Accessed August 8, 2012.
6. So, where do states stand on the Medicaid expansion? *MSNBC.com*. http://leanforward.msnbc.com/_news/2012/07/24/12707197-so-where-do-states-stand-on-the-medicaid-expansion?lite. Accessed October 2, 2012.
7. Himmelstein DU, Thorne D, Woolhandler S. Medical bankruptcy in Massachusetts: has health reform made a difference? *Am J Med.* 2011;124(3):224-228.
8. Howe P. Mass. Gov. Patrick signs health care bill. *New England Cable News*. http://www.necn.com/08/06/12/Mass-Gov-Patrick-signs-health-care-bill/landing_newengland.html?blockID=752369&feedID=7512. Accessed August 8, 2012.
9. Woolhandler S, Himmelstein DU, Angell M, Young QD; Physicians' Working Group for Single-Payer National Health Insurance. Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. *JAMA.* 2003;290(6):798-805.
10. Dartmouth Atlas of Health Care web site. <http://www.dartmouthatlas.org>. Accessed August 7, 2012.
11. Dartmouth Atlas of Health Care. Supply-sensitive care. <http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2937>. Accessed October 10, 2012.
12. Marmor T, Oberlander J. From HMOs to ACOs: the quest for the holy grail in U.S. health policy. *J Gen Intern Med.* March 13, 2012. Epub. <http://www.springerlink.com/content/m86245k22018507n/fulltext.pdf>. Accessed October 3, 2012.
13. DesRoches CM, Campbell EG, Vogeli C, et al. Electronic health records' limited successes suggest more targeted uses. *Health Aff (Millwood)*. 2010;29(4):639-646.
14. Congressional Budget Office. *Budget options volume 1: health care* [2008]. <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>. Accessed August 6, 2012.
15. Marmor, Oberlander, 1217.
16. Kaiser Family Foundation. Medicare Spending and Financing. <http://www.kff.org/medicare/upload/7731-03.pdf>. Accessed August 7, 2012.
17. Woolhandler S, Campbell T, Himmelstein DU. Costs of health administration in the U.S. and Canada. *N Engl J Med.* 2003;349(8):768-775.
18. Kahn JG, Kronick R, Kreger M, Gans DN. The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals. *Health Aff (Millwood)*. 2005;24(6):1629-1639.
19. Morra D, Nicholson S, Levinson W, Gans DN, Hammons T, Casalino LP. US physician practices versus Canadians: spending nearly four times as much

- money interacting with payers. *Health Aff (Millwood)*. 2011;30(8):1443-1450.
20. Felice C, Lambrakos L. Medical liability in three single-payer countries. Physicians for a National Health Program. http://www.pnhp.org/facts/medical_liability_in_three_singlepayer_countries.php. Accessed August 8, 2012.
 21. Organisation for Economic Co-operation. Health care utilisation. http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_PROC. Accessed August 8, 2012.
 22. Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It's the prices, stupid. *Health Aff (Millwood)*., 2008;22(3):89-105.
 23. Reinhardt UE. Where 'socialized medicine' has a U.S. foothold. *New York Times: Economix*. August 3, 2012. <http://economix.blogs.nytimes.com/2012/08/03/where-socialized-medicine-has-a-u-s-foothold/>. Accessed October 3, 2012.
 24. Zaneski CT. VA buys drugs cheaply, many veterans benefit. *Baltimore Sun*. May 5, 2004. http://articles.baltimoresun.com/2004-05-05/business/0405050160_1_medicare-drug-buying-power. Accessed October 3, 2012.
 25. Duffin J. The impact of single-payer health care on physician income in Canada, 1850-2005. *Am J Public Health*. 2011;101(7):1198-1208.

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