Healthcare Review

A POLICY BRIEF ON THE SINGLE PAYER SOLUTION

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This proposal outlines the negative costs, both economic and human, of the current employer-based health insurance system in the United States and offers a single payer solution that expands Medicare to the entire population. Though President Obama's proposed healthcare plan might marginally improve our current system, reformers must continue to push for change that will improve and expand access to care. The Obama plan has been attempted on the state level in Massachusetts, Vermont, Tennessee, and Minnesota. All four attempts have failed, proving to be ineffective and leaving behind considerable statewide deficits. In a single payer system, on the other hand, private industry remains intact. Funding is provided by raising estate and income tax levels by 2 percent. A single payer solution would streamline health insurance funding and put an end to the regressive costs imposed on lower-income families and individuals by the current system. Though the single payer solution might not currently be politically viable in the United States, the potential it has to cure the fundamental problems of our employer-based system makes it the best long term option.

Introduction

Although health care has reemerged as a major issue with the election of Barack Obama as the 44th President of the United States, the current debate misses a critical point. Few remember that in 1971, President Nixon proposed that employers either provide required health insurance for their workers or help subsidize their Medicaid, ideas virtually identical to the main tenants of the Obama plan. In truth, Nixon's plan was meant to undercut more progressive proposals made by Democrats like Senator Ted Kennedy, who called for compulsory national health insurance in his 1972 book, entitled "In Critical Condition."

Today, the health care debate seems more antiquated and irrational than it was in 1971. The modern progressive President and his party support an ineffective, Nixon-like reform, while only a handful of Congressional members call for an overhaul of the broken system.

Reformers must face reality. Our current health insurance system, or lack thereof, is a poor solution to a problem that affects millions of Americans. There have been a number of unsuccessful state-level attempts to fix the system in the style of Obama's proposal. Yet, the only way to stop growing health care costs and provide affordable, comprehensive insurance coverage to all is to remove private profit from the system. Currently, insurance companies attempt to minimize costs, thereby maximizing profit, by covering the healthiest and weeding out those who need care most.

A single payer system, in which insurance is paid for by taxes to the Federal Government, would save enough money to cover all Americans, lower costs for those who have insurance, and improve medical care. This is not the same as socialized health care because practices and hospitals remain private, a single payer system only streamlines the payment process. Though such a plan may not be politically viable in the United States today, it will become clear several years after the implementation of the Obama plan that the insurance system needs a heart transplant, and not another Band-Aid.

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Economic Costs

Although many Americans believe that the free market is more cost-efficient than government, our employer-based health insurance system is a severe economic drain. The United States spent $6,102 per capita on health care costs in 2007, and in total since 2000, health care costs have risen 40 percent.[1] These figures dwarf those of the rest of the world, including the next highest spender, Switzerland, which only spends $3,847 per capita on health care.[2] Our 1.9 trillion dollars in health care spending was not only 16 percent of the U.S. GDP in 2004 - almost twice the Organization for Economic Cooperation and Development (OECD) average - but even the public portion of the expenditure alone ($2,468 per capita or 7 percent of the GDP) was above the OECD average. Private insurance accounts for 56.2% of health care expenditures and public insurance for 43.8%; the U.S. health care system is not as market oriented as much of the rhetoric would suggest.[1] But what has this spending accomplished?

Higher spending has not brought about higher life expectancy rates. Denmark spends significantly more on health care than Japan does, but the average life expectancy for a Japanese citizen is 81.25 years, compared to 77.79 years for a citizen of Denmark. The average life

expectancy of a U.S. citizen is 77.85 years, ranking 48th in the world. To put this in perspective, the average life expectancy in Cuba, which only spends $236 annual dollars per capita on health care, is 77.41 years, less than half a year behind the United States.[3] Although certain variables lower the average U.S. life expectancy, such as the average American's higher exposure to fast food and gun violence, Cuba has nearly twice as many daily smokers as the United States.[4]

A 2007 Commonwealth Fund study ranks Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States based on the quality, access, and other measures of health care.[5] From this study, one can see that not only have the world's largest annual health care expenditures failed to make U.S. life expectancy competitive with other countries that spend less, but the U.S. also has noticeably higher rates of patient dissatisfaction. According to the Roper Center polls, these dissatisfaction rates doubled between 1997 and 2000.[6] In addition, the employer-based American health care system is often confusing and difficult to manage. This includes dealing with HMOs, which require determining pre-existing conditions, and eligibility and provider issues resulting from job changes.

Middle-income Americans, even when insured, spend a much larger proportion of their income on health care costs than wealthy Americans do. In 2003, 14 percent of all health care spending in the U.S. came from private, out-of pocket payments to health care providers from patients' insurance premiums, deductibles, co-pays, and coinsurance.[7] This type of expenditure is a regressive tax; a high income earner pays the same dollar amount as a low-level worker. Even with employer-based insurance, each worker in 2005 paid an average of 18 percent of the costs of his or her health insurance, approximately $564 per year.[8]

The current health care system also generates economic waste via a hidden tax levied by the uninsured. This "tax" occurs when hospitals must provide emergency care for anyone, regardless of the person's ability to pay the cost of care. The annual cost of emergency care for uninsured patients is almost $100 billion, not only raising taxes for all Americans, but also out-of-pocket hospital costs for all patients. In addition, uninsured Americans are about 50 percent more likely than insured Americans to go to the hospital for a condition that could have been treated or prevented.[9] This hidden tax is especially relevant to uninsured children. Nearly 10 percent of uninsured children are taken to the emergency room to avoid costs their parents cannot pay. In 1996, Florida instituted a program to insure children. In the areas covered by the program, taxpayers saved $13 million because emergency room visits dropped by over two-thirds.[6]

An uninsured patient could go to the emergency room with a mature stage of cancer, which could have been treated more quickly, easily, and cheaply had it been detected in its earlier stages by a general practitioner. Thus, the lack of preventative care for the uninsured is cost-inefficient. Free clinics, while helpful, usually do not fill this gap for the uninsured, as many people cannot miss work for an entire day to stand in line for a simple referral to another physician. After an emergency room visit, the uninsured patient is often charged a substantial fee that he cannot pay, hundreds of dollars for room fees or over $50 for a bandage. To compensate for the cost of treating those who are unable to pay, hospitals may overcharge those who can pay. Thus, even though the uninsured poor can go back to the hospital and explain that they cannot pay the exorbitant bill; people with inadequate insurance are hit with enormous costs as well, though their insurance will only cover expenses up to a certain limit.

Human Costs

Not only is our current health care policy economically irresponsible and inefficient, but the system also carries moral repercussions. The number of uninsured Americans is staggering. In 2005, that number rose to 46.6 million, or 15.9 percent of the population.[11] This figure only accounts for Americans uninsured throughout the entire year of 2005; the statistic drastically rises if the temporarily uninisured are included.

Of those 46.6 million Americans, 8.3 million are children under the age of 18, indicating that 11.2 percent of minors lack health insurance.[11] This number has been constantly rising. In 2005, 360,000 more children lived without health insurance than in 2004.[11] In this case above all others, the words of Franklin D. Roosevelt ring true: "The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little."

The ineffectiveness of current healthcare policy leaves many children without proper health care. Minors are often the most negatively affected by a lack of insurance. Many may go without crucial immunizations. Preventable and treatable conditions such as asthma, become major problems. The majority of uninsured children with asthma will not see a doctor once this a year, and preventable asthma attacks force these children into the emergency room at an astonishing rate.[12] When parents cannot afford

simple drugs like antibiotics, children stay home sick from school, causing them to fall behind for weeks or more due to treatable infections. Uninsured children also lack a family doctor and the stability that comes with personal care, which helps promote a healthy lifestyle, encourages a balanced diet, and discourages destructive habits like smoking.[13]

Furthermore, it is very difficult to pay for health insurance for an entire family. Eighty-eight percent of all American employees contribute to their employer-based health insurance costs. For family coverage, the payment averaged a full 29 percent of the total costs—much more than the 18 percent the same employee would pay on average for his own health insurance alone.[8]

Although certain government programs have been designed to help families insure their children, these programs are flawed in a number of ways. Medicaid, a safety net providing low-cost health insurance for economically qualified children, seems like a viable solution. Unfortunately, it only covers a small proportion of children who cannot afford insurance. Though the program has made considerable strides in providing health care for some of America's lower-income minors, it has been unable to solve the egregious problems that plague our current system. Two major plans to fill the gaps in the American health insurance system are to expand Medicaid to help those who are eligible to receive coverage and to allow more people to become eligible. With this Medicaid safety net already in action, though, why are 11.2 percent of children and 15.9 percent of the overall population currently uninsured?

The first problem is that many of those eligible do not have the means to apply. This can include the lack of an internet connection, lack of a car to drive to a government office (especially where public transportation is lacking), lack of knowledge of Medicaid, or lack of sufficient English skills to apply. For example, 2.9 million Latino children do not have insurance (about 20 percent of the entire demographic population in the U.S.), yet over 70 percent of these minors are eligible for Medicaid.[13]

The second problem with Medicaid is that many who should be eligible are not. Children living just above the economic cutoffs of the program can go without insurance for years while the family experiences financial difficulties. At the same time, middle-income children often lose health insurance when a parent changes jobs or shifts his or her health care plan. When the child turns 18, Medicaid ends. This is one reason young adults are one of the most uninsured demographics in the United States.

An important human cost of having 46 million uninsured Americans is that our country's infant mortality rate is the second-worst in the industrialized world, with only Latvia having more deaths within the first 24 hours following birth. The level of some 5 deaths per 1,000 births is primarily due to the lack of prenatal care for uninsured mothers; those in at-risk communities receive fewer checkups and more complications thereby arise. In this trend, the African American community has an infant mortality rate of almost double the national average, with 9.3 deaths per 1,000 live births. With a better system to insure soon-to-be mothers, we may be able to cut the level to that of Scandinavian countries and Japan, 2.5 to 3 times lower than ours.[14]

The most important statistic we should be aware of is that 18,000 people in America die unnecessarily each year due to a lack of health insurance.[15] This staggering figure certainly contradicts the Federal Government's commitment to the overall health of its citizens.

A Single Payer Proposal

As shown, our current health insurance system is not only inefficient, but also immoral in its treatment of average Americans. It is an incredibly inefficient system in need of serious reform. But what is the way forward? How can we improve overall care that we receive, while allowing health insurance to cover more people? A Medicare style single payer system appears to be the most efficient way to fund health care in the United States. Details of the plan to implement single payer health insurance in the United States are as follows:

All 300 million American residents will be insured with a plan that covers all forms of care—prescription drugs, dental care, rehabilitation, home care, mental health services, vaccines, and work-related health care. Individuals in the new system will have insurance comparable to an employer-based or private healthcare plan.

The new program, like Medicare, will only affect insurance payments, retaining our current private health care system. Doctors and hospitals remain private and free of government influence. The only significant change in a single payer system would be the way that we pay for health insurance in the United States. Through an estimated estate and income tax increase of just 2 percent, we will be able to both streamline our health insurance funding and effectively put an end to regressive costs imposed on lower-income families and individuals by our current system of health insurance.

A Harvard Medical School and Public Citizen study has found that the United States spends $399.4 bil-

lion on health insurance bureaucracy each year—31 percent of all health care spending in our employer-based insurance system goes to overhead, paperwork, advertising, and other related expenses. The same study also found that universal health care, of virtually any type, would save Americans $286 billion dollars annually. In other words under a single payer plan, Americans could save 72 percent of the money that is lost to administrative expenditures under the current system.[16]

Just $80 billion is enough to expand coverage to all uninsured people, meaning funds will remain to provide prescription drugs for seniors, and drastically improve the quality of care we receive in the United States.[17] This will alleviate concerns with the prescription drug benefit Medicare Part D, particularly if Medicare has the ability to negotiate prices with drug companies, a separate but important issue.

After providing adequate plans to those currently without insurance, over $100 billion would still remain from the regained administrative costs and could be used to improve hospital facilities, hire more family doctors and nurse practitioners, and digitize medical records. Money could also be used to improve the accessibly of care to those most underserved by the current system, by allowing for the hiring of more translators and the creation and enhancement of health programs in underserved areas.

The Canadian health insurance system, a general model of this single payer plan, only spends 16.7 percent of health care spending on administration, compared to the 31 percent under the American employer-based private insurance system.[17] However, many conservative voices in the United States denigrate Canadian health care, arguing that Canadian citizens often have to wait in long queues for care. This argument is inherently flawed and misleading, because while, on average, Canadians do wait longer after being referred to a specialist, they actually receive significantly more care from general practitioners than individuals do in the United States.

Unfortunately, the people who would stand to lose the most under these kinds of pragmatic and cost-saving reforms are also those whose opinions are most visible in the media, by virtue of the considerable wealth of the American healthcare establishment. Middle to lower-income citizens who do not have either the financial capital or personal connections to spread their story in the media are largely ignored. The privatized system allows blame to be shifted from the market to individuals for their inability to afford health insurance, even if these individuals legitimately cannot afford insurance.

As previously stated, under the proposed single payer system, doctors remain medically independent. Doctor-patient confidentiality will remain intact, and every American will still be able to choose his or her own doctor. The manner in which we currently decide to visit a particular physician will not change; the most popular doctors will have longer waiting lists, and most people will have family physicians for years at a time.

Medicare's basis for reimbursing doctors form the foundation of the single payer plan's reimbursement system. Medicare Part A (Hospital Care) pays hospitals based on their projected expenses after a physician issues a diagnosis to a patient. Since 1992, Medicare has been instituting the Medicare Fee Schedule (MFS), a method of determining how much to pay doctors for their services for Medicare Part B (Medical Insurance). MFS then quantifies each medical practice in terms of Relative Value Units (RVUs) based on the estimated cost of the treatment. The RVUs also vary slightly depending on the Geographical Adjustment Factor (GAF), which makes sure hospitals are adequately repaid when the specific procedure is more expensive in their area due to factors such as transportation or climate.[18]

This Medicare Fee Schedule will maintain its role in the newly expanded Medicare program, determining the correct amount to compensate hospitals for their equipment and labor. The Medicare officials will review the paper or electronic forms that doctors fill out after procedures and verify the RVUs of the treatments. This will simplify the work of physicians and hospital employees, because they will only have one party to bill, and hospitals will not have to look into a patient's insurance history before agreeing to treat him or her. For example, doctors in Canada's single payer system spend a fraction of the time on billing forms compared to our physicians' average of 134 personal hours each year.[19]

Under the system new governmental administrative positions will be created for Medicare workers, whose jobs will pertain solely to health insurance, including jobs such as processing payments and reimbursing the expenses of hospitals and doctors. This will compensate for individuals previously employed by private insurers. The new health insurance system will employ individuals from insurance corporations skilled at examining claims and also experienced healthcare economists.

Average physician income will stay about the same and will keep pace with inflation, as seen in examples from other countries. In Germany and Canada, for example, average physician income is above the average worker's income by the same ratio as in the United States.[20] Although the average physicians income will stay

relatively constant, there will be smaller gaps between the incomes of primary care and specialist physicians. Currently, the U.S.'s ratio of primary care/specialist income is 0.62, while Germany and Canada's are 0.73 and 0.74, respectively.[20] Today, Medicare still preferentially reimburses specialists compared to primary care physicians, a practice that will be altered under a new single payer system.

Any health care reform intended to expand coverage and access must also include sufficient primary care physicians and nurse practitioners for three critical reasons. First and foremost, primary care is more cost-efficient. Second, the most common health issues facing Americans today, heart disease being the most significant, are better managed by long term primary care than by more costly post-symptomatic treatments performed by specialists. Finally, it is crucial for children to grow up with access to a family doctor and maintain a relationship with a doctor throughout their life. Family doctors not only treat symptoms, but also instill in their patients better life habits with regards to nutrition, exercise, stress management, sexual health, and smoking.

Critique of the Obama Plan

The Obama plan includes a number of components. First, it aims to stop insurance companies from discriminating based on pre-existing conditions, a common practice under the current system. This law would have a significant impact, by allowing for a significantly larger number of people to be eligible for private coverage.

Second, it provides a tax credit to small businesses worth half of their care costs, encouraging them to cover their workers. If a small business has "catastrophic" health care costs due to serious health issues among employees, the Obama plan helps cover them.

Finally, the plan forces medium to large-sized companies to 'play or pay,' meaning that they either provide insurance for their employees, or pay into a federal fund to subsidize a new government health care plan. According to President Obama, this legislation will reduce costs for those who already have insurance and provide an affordable plan for those without.

This type of employer mandate has been tried and has not succeeded on the state level in Massachusetts, Vermont, Tennessee, and Minnesota. In 1988, Massachusetts implemented a mandate for employers to buy coverage, including students and the self-employed. As a result, the number of uninsured citizens of Massachusetts continued to rise. It is currently significantly higher than the number of uninsured in 1988. Even the current Massachusetts reform is a stopgap measure and not a comprehensive solution. In another case, the number of uninsured in Oregon has stayed constant, even though the state created an employer mandate and expanded Medicaid in 1989.

Like Obama's plan, these employer mandates offer subsidies for low-income people to purchase insurance, but health care costs inevitably continue to rise. The subsidies then must grow to help low-income citizens buy coverage, straining the budget. In Massachusetts, for example, the subsidies have cost some $150 million more than the original projection.

Overall, the Obama plan is a small net positive for reform. That said, the plan fails to target what makes health insurance expensive in the United States: the corporate insurance system that wastes more than a quarter of every health care dollar. In order to make a profit, the insurance industry must do whatever possible to cut costs, which means covering as many healthy people and as few sick people as possible. This is faulty logic and immoral. The only real solution to improve health care is to largely eliminate the roughly $400 billion industry that is corporate insurance.[21]

Conclusion

Today's discussions of health care reform are dominated by myths and irrational fears as reason appears to sit by the wayside. Unfortunately, the continuing debt incurred by health care costs may one day force drastic reform. For now, the system remains dysfunctional, at best. Past attempts to fix the corporate insurance system have failed. A single payer plan may not be politically viable in the United States for a number of years, but it remains the best alternative. This is not socialized medicine, but rather socialized insurance, following the legacy of the two greatest social policies in U.S. history: Social Security and Medicare. Health care reform is a moral and economic necessity for the United States in the 21st century.

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