THE SINGLE-PAYER HEALTHCARE SYSTEM

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By: Barbara L. Daniels, FACMPE
Abstract

Medical Practice Managers and their teams encounter daily the growing inefficiencies plaguing our healthcare system. Administrative conundrums are becoming an overwhelming burden. Physicians are working harder, like hamsters on a wheel, just to maintain their incomes. Our nation is struggling to find ways to control rising healthcare costs. Frustrated citizens can’t afford the healthcare they need. Aging citizens show great concern regarding their ability to obtain and afford care. The manager’s hands are tied as the system continually creates further complications.

Following research through the plethora of information on the topic from multiple varied professional journals, periodicals, research and surveys, written by an overabundance of remarkably intelligent and credible authors, with due acknowledgments, this paper’s intent is to make a case for a single payer system. The magnanimous initiative needed to resolve our current system’s mess certainly in the end will never produce perfection, but much literature has been written on one solution that makes sense. This paper attempts to demonstrate an educated viewpoint that the development and implementation of a single-payer healthcare system could be beneficial in the United States as it has the potential to create a more efficient administrative process, it could allow physicians to provide cost effective, high quality healthcare, permitting them to concentrate more on patients and less on administration and defensive medicine, and would provide universal coverage for all.
The Single-Payer Healthcare System

The inefficiencies of our current pluralistic healthcare system characterized by multiple payers with varied rules and myriad benefit packages, countless waste of duplicate processing and the sine qua non practices of defensive medicine are only a few indicators of the widely-known need for healthcare system reform. (Hsiao, 2011) Since the publication of the Flexnor Report in 1910, one of the most important developments in American medical education, research, and service (Richmond & Fein, 2005), followed by the inception of health insurance by Justin Ford Kimball in 1929, thru Harry Truman’s Commission on the Health Needs of the Nation and his legislative proposals for national health insurance in 1948 (Richmond & Fein, 2005), leading on to President Obama’s Accountable Care Act, each consecutive era has made efforts to vigorously consider the issues and restructure the current discombobulated health care system and control medical inflation. Recognizing the progressive acuity through the years of scientific developments and advances in medicine, famous medical historian, Richard Shryock, wrote:

Hence there gradually evolved in educated minds, a syllogism of some such form as this: medical science cannot prevent or cure certain major diseases. Many people continue to suffer from these very diseases. Ergo, medical science does not serve the people as it should. The most obvious explanation was to be found in the mounting costs of service. Here, again, it is to be noted that it was the very progress which physicians had made in science which involved them in new difficulties in the practice of their art. Technical improvements led to simultaneous increase in the demand for medical services and in the price that
must be paid for them. And so the more that people trusted medical aid, the less they could afford it. Here was a serious and unexpected impasse in the public relations of the profession (Richmond & Fein, p.40).

In 1932, the Committee on the Costs of Medical Care developed a visionary that was so far ahead of its time that the United States Department of Health, Education, and Welfare republished it thirty-eight years later, in 1970, stating that the old problems had not gone away and “now is the time for action”. (Richmond & Fein, p.13) Nearly 45 years later, we have yet to find an amenable solution.

Though not a new concept, the single-payer system has shown through research to be an effective solution. This model of healthcare system, though existing in many different forms, has been in effect in many areas of the developed world for decades. The challenge, however, lies not only in national agreement, but in the planning for the total overhaul of a magnanimous mess, as indicated by Dr. Julius Richmond and Rashi Fein in their co-authored book, “The Healthcare Mess”. (2005) The title of this book epitomizes the plethora of articles on the topic. In a survey of physicians by Danny McCormick, David Himmelstein, Steffie Woolhandler and David Bor from the Harvard Medical School Department of Medicine, it was found that most physicians agreed it is society’s responsibility to provide everyone with good medical care, regardless of ability to pay. (McCormick et al, 2004) In a research study on healthcare systems authorized by the Vermont Legislature in May 2010, William Hsiao and a team of analysts from Harvard University summarized that the greatest savings as well as the ability to provide universal coverage could only be produced by a single-payer system – one insurance fund,
covering everyone with standard benefits, and all providers receiving uniform rates through a single claims-processing system. (Hsiao, 2011)

Much research indicates that the development and implementation of a single-payer healthcare system could be beneficial in the United States as it would create a more efficient administrative process, it would allow physicians to provide cost effective, high quality healthcare, permitting them to concentrate more on patients and less on administration and defensive medicine, and would provide universal coverage for all.

Our current system is complex and costly. It holds thousands of varied payers, each with their own rules and myriad benefit packages. In an article appearing in multiple leading medical journals by Steffie Woolhandler, Terry Campbell, and David Himmelstein on what is termed “the U.S. Health Care Crisis”, Woolhandler, et al, embodies the daily activity of the current plight: eligibility determination, cost-sharing, and benefit limits, interpreting insurance cards, determining prior-approval requirements as well as acquiring approvals, dealing with prescribing to multiple formularies based on plans, varying co-payments, referral networks, delays in reimbursement, and then reworking claims rejected due to each payer’s own myriad of reasons, complicating and stalling payments while boosting their interest income, sometimes discouraging pursuit of claims, are all current administrative tasks needing to be completed with every physician encounter. (Woolhandler, Campbell, and Himmelstein, 2004) With a single-payer system, the administration of patient care could all be remarkably simplified. According to Hsiao, his project manager Anne Knight, the founder of Policy Integrity, Steven Kappel, and Nicolae Done, a Harvard research analyst, in their development of the soon-to-be implemented plan for Vermont, a single-payer system works as a one-card system
THE SINGLE-PAYER HEALTHCARE SYSTEM

with one insurance fund, publicly financed, that provides equitable benefits to citizens with uniform rates and mechanisms paid to all providers. (Hsiao et al, 2011)

The greatest savings, as observed by Beauchamp and Rouse, could be recognized by the simplification and standardization of the medical arena’s daily accounts receivable operations. (Beauchamp & Rouse, 1990) By consolidating insurance functions, the single-payer system simplifies claims administration through the elimination of costs inherent in multiple payers split between governments, employers, and individuals, all with various payment schedules (Hsiao et al, 2011). Jui-Fen Rachel Lu along with Hsiao performed a study on the current system in Taiwan, stating that this single-payer strategy has proven to reduce administrative costs along with economies of scale with operating costs around 2 percent of total healthcare spending compared to the current United States 20 percent. Additionally, the Taiwanese prove a 70 percent satisfaction rate with their current system. (2014)

Henry Aaron in the New England Journal of Medicine discusses the “administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason”, further using the words “staggeringly complex” with “mindboggling administered prices and other rules that can only be regarded as weird” (Aaron, 2003). He further explains the plight of the system and the constraints to its revision due to the distrust of centralized authority and the overwhelming American desire for freedom of individual choice. Hsiao claims that the solution to this may lie in private sector claims administration, ensuring incentives for innovation and efficiency found only in competition, protecting from proven
inefficiencies of government control, producing potentially greater administrative savings. (Hsiao et al, 2011)

Woolhandler, Campbell, and Himmelstein researched the costs tangled in the United States’ current auditing system, outlining the processes involved in claims micromanagement. They recognized that the gross fragmentation of current payers allows for much fraud and abuse with claims information being spread amongst many payers. (2004) Jui-Fen Rachel Lu and William Hsiao together surveyed Taiwan’s single-payer system. Through the NHI, they identified, the system provides comprehensive information facilitating reductions in abuses in coding, overuse of tests, as well as potential fraudulent claims (Lu & Hsiao, 2014). The United States’ control is that of micromanagement, writes Woolhandler’s team, with its myriad auditors, investigators, and regulators, completely “obscuring the fundamentally inefficient structure” that necessitates and promotes it. (Woolhandler et al, 2004) An estimated savings of five percent in the overall administrative costs, according to Hsiao, could be recognized in the near elimination of fraud and abuse. (Hsiao et al, 2011)

Though the administrative costs in the United States are estimated by Woolhandler at 60 percent higher than Canada, (1991) Aaron argues in his own comparison of the cost of healthcare administration between the U.S. and Canada that Woolhandler’s “problematic methodologic approach” offers exaggerated differences between the two countries’ administrative costs. (2003) Though the precise magnitude of this gap is open to debate, there is no argument amongst the varying authors that the problem is quite concerning and needs resolution. In the consideration of a single-payer system, however, one must take into account the limits imposed by United States’
history, laws and regulations, politics, and economics (Aaron, 2003; Feldman, 2009). The current system, however distorted, presents an enormous challenge overcoming its many obstacles.

In McCormick’s team’s survey of physicians from Massachusetts, many physicians expressed dissatisfaction with a multitude of factors in the nation’s current healthcare system, with over two-thirds emphasizing their willingness to decrease their salaries by 10 percent in exchange for a substantial reduction in paperwork (2004). One fear of the single-payer system amongst physicians is the lowering of provider payments. The reimbursement decrease set for implementation in Vermont, as noted by Hsiao, would only reflect the expected reductions in the physicians’ administrative costs, leveling payment rates currently varying greatly across payers, says Hsiao. Eliminating the majority of this administrative conundrum would potentially enable physicians to provide higher quality healthcare, relieving another considerable concern amongst the surveyed physicians, permitting them to concentrate more on patients and less on administration and defensive medicine. This could also prove to be more cost effective (Hsiao et al, 2011).

President Emeritus, Ian Morrison of the British Medical Journal writes that physicians are reaching burnout, with many feeling that retirement is the only way out. (2000) In a survey of physicians from Germany, Canada, and the United States, nearly 64 percent of the respondents agreed that the single-payer healthcare financing structure providing universal coverage is the best solution and provides the best care for the most people. (McCormick, Himmelstein, Woolhandler, and Bor, 2004). Morrison writes an appropriately named article titled “Hamster Healthcare” in which he discusses the need to
redesign health care, recognizing that physicians around the world are being inundated with the administrative monstrosity of our current system. “Like hamsters on a wheel”, he states, the current system is requiring physicians to see more patients and fill out more forms just to maintain their incomes. Morrison notices that there are many reaching the point of burnout in a system that is just not sustainable (2000).

Another concern and considerable cost factor recognized by McCormick’s team is the over-treatment required through the necessary practice of defensive medicine. Robert Blendon, along with his team of eight, surveyed physicians from Germany, Canada, and France. Blendon’s team found that nearly sixty-one percent of American physicians state that they sometimes or often treat patients more than necessary out of fear of being sued. (2014) Though the systems in Europe do not seem to have fully resolved this issue, the single-payer system passed in Vermont, to become effective one year following the implementation of the ACA, will operate under a no-fault system of medical malpractice. According to Hsiao, this maximizes savings, estimated at two percent of total healthcare spending, abating overtreatment under the threat of costly lawsuits in response to perceived negligence. (Hsiao et al, 2011) He states that a new compensatory program will be built in for medical errors.

A single-payer system could maximize the efficiencies of centralized records, reducing waste and duplication of services, which currently attribute to 30 percent of all health spending, according to Hsiao. (Hsiao et al, 2011) This comprehensive information would allow for monitoring and improvement of clinical quality and health outcomes. (Lu & Hsiao, 2014) Furthermore, Hsiao summarizes that the single-payer system would result in lower spending by employers, by the state, and by household. (Hsiao et al,
By virtue of Hsiao’s previous internationally recognized work on health care financing and social insurance as Professor of Economics at Harvard School of Public Health, the methods applied to this research and study of Vermont’s newly selected system make this information of great value.

Many articles point out the fears of the American public towards the inability of Canada and other countries’ single-payer systems to provide timely healthcare for their citizens. Citizens in these countries report lengthy wait-times to acquire needed healthcare. Henry Aaron, in his editorial on the administration comparison, believes that waiting times arise more from resource limits, and not necessarily from the single-payer structure. (2003) Taiwan reports no changes in waiting times in their seven years of working within their single-payer system. Lu believes that this is largely the result of their shared cost system. Canada’s practice of providing free care leaves question as to potential encouragement of overuse, thus saturation of the system, which coupled with Aaron’s research may assist in understanding their difficulties with the system. Lengthy wait times don’t seem to be only an issue of the single-payer system, however.

Physicians in the United States state that often they are unable to provide services to patients in a timely manner through the current multi-payer system, attributed largely to non-coverage by insurances and unwanted financial burdens by the patients. (Blendon et al, 2014). This could also be largely influenced by administrative time consumptions due predominantly to necessary prior-authorization requirements.

Roger Feldman, the Blue Cross Professor of Health Insurance and Professor of Economics at the University of Minnesota, notes the necessary, hard-to-obtain balance between quality and quantity, suggesting that the single-payer system generally will
require a certain amount of rationing due to this difficult juggling act. More of the one compromises the other, he states. The exception, he finds, is in France’s single-payer system model of non-referrals, and cost-share through co-payments. They report anecdotally low waiting times with citizens paying out-of-pocket for an average of 25 percent of their healthcare. (Feldman, 2009) Universal coverage with low out-of-pocket healthcare costs seems like a sensible compromise.

In 2012, more than 47 million non-elderly citizens in the U.S. were uninsured. (Kaiser, 2013) An additional benefit of the single-payer system is the provision of universal coverage. Winston Churchill’s phrase “bringing the magic of the averages to the rescue of millions”, seems fitting. (Richmond & Fein, p.36) In an article written by Dan Beauchamp and Ronald Rouse for the New England Journal of Medicine, Beauchamp discusses the links between cost control and universal coverage in New York, stating that the costs associated with the lack of insurance are one of the major driving forces in medical inflation (1990). He expands on another model of the single-payer system, one that would also be a single card system, financed and paid by a single-payer, yet with multiple payers negotiating and channeling through that one payer. All rates and rules would remain standard, more tightly controlling the profitability of the external payers. But should healthcare be ‘for profit’? Profit tends to be the driving force influencing competition leading to cost-control, however, Lu states that the free market is just not effective at equitable distribution because “household incomes are not equitably distributed” (2014).

Taiwan’s single-payer system was successful at expanding insurance coverage from 57 percent of its population to coverage for 96 percent in less than two years,
without increasing its health spending (Hsiao et al, 2011). The World Health Organization ranks the U.S. 37th out of 191 countries for quality of healthcare, yet it spends a larger portion of its GDP than all of the others. (WHO, 2000) Financial barriers, sadly, currently abet notable disparities in access to health care.

There are understandable concerns amongst the public regarding how to fund single-payer universal coverage. Hsiao considers this in his research through Harvard University for the state of Vermont. He summarizes the calculated savings of the single-payer system reform; resulting just from reduced overcharges and the overuse of tests, services, and transactions costs, as well as duplicated services, he states that healthcare spending could be reduced by over 25 percent within ten years. Through these savings, Hsiao concluded, there could be enough money generated to provide for the coverage needs of the uninsured and underinsured. (Hsiao et al, 2011; Lu & Hsiao, 2014)

Much time can be invested perusing a plethora of literature on the topic of healthcare systems. In an interesting study led by Michael Gusmano from the Downstate Medical Center at State University of New York, Gusmano and fellow analysts compare different methods of coverage from France, England, and the United States. His summary: worry less about the number of payers and more about equitable access to care. He expounds on the ideologies, the barriers at the term “single-payer”. He states that many equate the term with “socialized medicine” and support of government-run health care. (Gusmano, Weisz, and Rodman, 2009) His comparisons suggest a much more complex story. Apprehensions driven by ideology, he says, cause the debate regarding this topic to appear at times somewhat fierce. It is a largely discussed, widely researched topic with a multitude of articles and analyses written through the preceding decades
emblazoning a plethora of opinions and perspectives. The old Ecclesiastic proverb rings true: there is nothing new under the sun.

Medical inflation is out of control. The system currently in place in the United States is complex and costly. Though the complex implementation process would prove quite the challenge, an adapted single-payer system could possibly work, ensuring that all are covered and carry standard coverage at a substantial cost savings to the system as well as the private citizen. The one-card system providing universal coverage, as proven elsewhere in the developed world, could be a step toward creating an efficient system in our country, enabling physicians to concentrate on what they are trained to do best, providing quality care, reinstituting “the atmosphere of mutual obligation and shared mission that characterize medical practice at its best” (Woolhandler, 2004), in a potentially cost effective, non-defensive manner, and assisting in ameliorating the problem of the uninsured by facilitating for all citizens access to equitable quality healthcare.

In summary, whichever model or method on which the system is built, though certainly to provide quibbles over methodology, the United States can learn from the experiences of other nations. Some have proven that the single-payer system can work and produce substantial savings while concurrently funding universal quality coverage. The presiding challenge, Feldman professes, is how to graft in the desirable features of each system without also importing the undesirable ones. Quality healthcare and the cost of healthcare are equally important – the issue being to find the right level of quality at an acceptable cost. (Feldman, 2009)
(Hsiao, W., Knight, A., Kappel, S., Done, N., 2011).
References


