

# ACEP NEWS

## It's Time for Single-Payer

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*"You can always trust the Americans to do the right thing, once they've tried everything else."*

Winston Churchill's iconic remark, reportedly issued at the dawn of America's entry into World War II, is equally applicable to the present American health care debate and the crisis that spawned it. Regardless of whether you are elated or disappointed with June's historic Supreme Court decision upholding the constitutionality of the Affordable Care Act, it is certainly no panacea for the problems facing U.S. health care. Even with the law intact, and despite its best intentions, it will still leave some 25 million uninsured, underinsure millions more, expand the corporatization of health care, and do little to control the escalating costs of care over the long term. So it's clear we need to do the right thing: the creation of a national, universal, publicly funded health care system, free of the corrupting power of profit-oriented health insurance, and at the same time capable of passing constitutional muster. In short, the right thing is an expanded and improved Medicare-for-All program, otherwise known as single-payer.



**Dr. James C. Mitchiner**

Don't be so shocked. For the last 30 years, we have tried all the alternatives, and none of them have worked. We have experimented with HMOs, PPOs, high-deductible health plans, health savings accounts, pay-for-performance, capitation, and disease management. These ideas have been promoted in various iterations, often with great fanfare, by public and private payers alike, yet none of them have shown long-term success at bending the cost curve. And the promise of the latest reforms *du jour*, such as Accountable Care Organizations and Patient-Centered Medical Homes, is speculative at best. American health care is unique among the world's democracies in that it was never planned in terms of enabling legislation or explicit constitutional authority. As others have stated, our employer-based insurance system, which now covers about 160 million Americans, was an accident of history. Its lineage can be traced to FDR's wage and price control policies during World War II, where employers were permitted to offer workers health insurance in lieu of higher wages as a job inducement. This benefit has evolved piecemeal into the Rube Goldberg complexity that is contemporary employer-sponsored health insurance, with some 1,200 private plans each doing the same things – medical underwriting, coordination of benefits, claims adjudication and denial,

marketing, public relations, lobbying, litigating, and paying shareholder dividends and inflated CEO salaries while forcing individuals to pay a higher share of premiums, increased deductibles, expanded copays, or a combination of all three. Taken as a whole, private insurers' activities are duplicative, inefficient, wasteful of scarce health care resources, conducive of job lock, and completely misdirected in supporting the 21st-

century health care agenda that America needs and deserves.

The objective of the ACA's individual mandate was to remedy a flaw in the market for health insurance: the expectation by the uninsured that the costs of their inevitable illnesses would be benignly transferred to those fortunate to have coverage. If you believe that guaranteed issue and community-rating requires 100% participation in the health insurance market to sustain financial viability, clearly the most efficient mechanism to achieve this is not through an individual mandate, in which the heavy hand of government coerces people to do what they otherwise would not. If the federal government has a professed welfare interest in controlling health care costs, it can – and should – accomplish that goal through a more economically efficient single-payer mechanism.

Given that the primary business objective of a for-profit insurer is to make a profit, the fundamental question we should be asking is this: What is the marginal value of private health insurance? That is, what advantage vis-à-vis a single-payer model like Medicare does our system of private, profit-oriented health insurance convey to patients, providers, and employers? What exactly do private insurers *do*, above and beyond what Medicare does, that is deserving of their inflated premiums? To my knowledge, there is no evidence that commercial insurance provides easier access or less hassle-free care, is more cost effective, produces care of higher quality, or has better consumer satisfaction ratings than Medicare (if anyone has evidence to the contrary, from the peer-reviewed health policy literature, please advise). And according to a recent poll, most Americans prefer to keep Medicare as it is, rather than switching to a premium-support financing mechanism as advocated by Rep. Paul Ryan (R-Wis.). Whatever bad things you can say about our government, at least the Feds are not required to make a profit but *are* required to answer to all taxpayers, rather than private shareholders who are concerned only with the bottom line.

Under a single-payer system, every American would receive a basic package that would include inpatient and outpatient care, primary care and specialty physician services, emergency care, preventive and restorative care, mental health and substance abuse services, dental care, prescription drugs, home health care, and long-term care. Doctors and other providers would be paid based on a fee-for-service schedule, as negotiated with state governments, with funding coming from progressive payroll taxes paid by both individuals and employers. Quality would be monitored and publicly reported, with financial incentives awarded to providers who followed clinical guidelines endorsed by their medical specialty societies. All services provided would be publicly accountable. Medical decision making at the bedside would be left to the physician.

Conceptually, single-payer is imbued with many myths and misconceptions.

### **Myth #1: Single-Payer Is One-Size-Fits-All**

The No. 1 myth – the alpha myth – is that single-payer represents a choiceless, one-size-fits-all, government-run health care monopsony. This is a blatant falsehood. Single-payer is simply a more efficient and more equitable way of *financing* health care – and nothing more. By consolidating the administrative functions of insurance, it eliminates bureaucratic duplication and reduces administrative waste, saving time and money for employers, providers, state governments, and consumers alike. It would remove the profit motive from *financing* care, but not from *delivering* it. Single-payer would efficiently provide for all Americans – regardless of age, health condition, income, or employment status – universal health care that is portable, affordable, equitable, nonterminating, publicly accountable, and funded through progressive taxation, which for the average family would imply a small additional payroll tax that is much less than its current outlay for insurance premiums. A single-payer system would not supplant the private practice of medicine; you could go to a primary care doctor, specialist, hospital, pharmacist, and lab of your choice.

### **Myth #2: Canadian Health Care Would Be Bad for America**

Americans love to repeat anecdotes about the supposedly lousy medical care our northern neighbors receive from their single-payer system, by demoralized and overworked doctors who work at ill-equipped hospitals with out-of-date technology. This is rubbish. Do Canadians often wait for weeks to see a specialist? Yes. Do Americans also wait? Yes. There is no evidence that Canadians are dropping dead in the streets while waiting for their emergency bypasses or appendectomies, nor is there any evidence that Canadian physicians are emigrating to the U.S. or other countries *en masse*. Further, there is no evidence that the quality of care in Canada, across the board, is inferior to that practiced in the U.S. Despite comparable rates of smoking and alcoholism, Canadians on average live longer than Americans by more than 2 years, and their infant mortality rate is less than ours. Finally, consider this: Canadians spend much less than we do for health care, both in per-capita dollars and as a percent of GDP, so I have no doubt that if we were to adopt a Canadian-style system and fund it to the tune of \$2.6 trillion annually, we would not have 9-month waits for MRIs, even if every one of them was clinically indicated.

### **Myth #3: Market-Based Medicine Trumps Single-Payer**

Some argue that our private, market-based system is fundamentally sound, that it should be freed of government regulation and tweaked to promote greater competition based on price, and thus choice of health insurance plans. Really? Does anyone seriously believe that purchasing health care services is fundamentally no different from buying a new car or a flat-screen TV? (If so, I suggest he or she take a course in health economics.) And would anyone seriously believe that Americans want a choice of health insurance, when what they really desire is a choice of doctors and hospitals? What could be more American, more consumer-friendly, and more constitutional than the ability to choose your health care provider based on whatever criteria you deem important? So why not cut out the middleman and let doctors, hospitals, and other providers compete on such things as quality, service, reputation, convenience, and other personal preferences, rather than having private insurers make these choices for us?

Just consider what "The Market" has done for health care in the last 30 years: a steady increase in the number of uninsured; a decrease in the choice of providers; diversion of resources into more profitable hospitals and services; consolidation of HMOs into health care oligopolies; underfunding of less profitable endeavors, such as public health, trauma centers, and mental health services; unaffordable prescription drugs; dissatisfied patients; frustrated physicians; and of course, an inexorably increasing trajectory of health care costs.

### **Myth #4: Single-Payer Would Stop Medical Innovation**

To my knowledge, there is no correlation between innovation and a country's method of health care financing. Many technologies and medical advances we now take for granted originated in nations with national health insurance, for example, CT scans and MRIs (Great Britain), laparoscopic cholecystectomy (Canada), percutaneous coronary angioplasty (Germany), and *H. pylori* treatment (Australia). The largest single source of funding for medical research in the U.S. is a government agency – the National Institutes of Health – which provided almost \$31 billion in funding for medical research in fiscal year 2012. And in terms of per-capita drug R&D costs, the U.S. lags behind Britain and Sweden.

### **Myth #5: Single-Payer Is Impossible to Enact Politically**

Perhaps this is true – for now. But if social change depended solely on what was politically pragmatic, women would not have achieved the right to vote in 1920, civil rights legislation would not have been enacted in 1964, and Medicare would have failed in 1965. We should always be careful to distinguish between what's desirable and what's doable. The fact that tort reform is certainly desirable, but not politically doable at the present time, has not stopped ACEP from investing significant time and financial resources to advocate for change. Public opinion polls have consistently shown that the level of public support for single-payer is 60% plus. A survey of physicians published 4 years ago showed that single-payer garnered 59%

support among the 2,193 physicians polled (support among emergency physicians was even higher, at 69%). Despite this, there is no question that moving to a single-payer system will face enormous obstacles. What is needed, as columnist David Lazarus of the Los Angeles Times pointed out, is a "massive infusion of political courage and the willingness to forsake political purity."

### **Myth #6: We Can't Afford Single-Payer**

Given our current system, perhaps the better statement would be "we can't afford *not* to have single-payer." The most recent financial projections portend no overall decrease in the cost trajectory for health care over the next 8 years, even if the ACA remains intact. Under a single-payer model, a modest increase in taxes would be overshadowed by savings from elimination of insurance premiums, offsets from economies of scale, decreased out-of-pocket payments, and the disappearance of cost-shifting. The annual savings from transforming to a single-payer system are estimated to be \$400 billion. If you look at the cost curves for U.S. and Canadian health care, they were identical until the mid-1970s, when Canada's health system was fully implemented. From then on, the curves diverged, with America's climbing much faster than Canada's. When Taiwan converted to single-payer in 1995, the costs went up in the first year, as expected, and then leveled off to a reasonable increase of about 3% per year.

### **What Does This Mean for Emergency Medicine?**

Well, consider the ED as a *de facto* single-payer environment. Patients come to us by choice without needing to first check with their health plan (assuming they have one) to see if their ED visit is covered. We see them without asking them to pay in advance for their ED services, and their care is not predicated on their job, income, or insurance coverage. As emergency physicians, we have more autonomy than our primary care colleagues in terms of making diagnostic and therapeutic decisions without the nonsense of "pre-authorization" or other interference from an insurer who is interested only in the bottom line. While it's nice to be able to make medical decisions without checking on insurance status, it would be even nicer if we actually got paid for every ED patient treated. Private insurance companies simply have no incentive – in fact, it's not at all consistent with their business model – to pay for EMTALA-mandated services provided by out-of-network emergency physicians.

Looking again to Medicare as a single-payer model, consider how we emergency physicians interact with Medicare vs. private insurers. In 29 years of practice, I have *never* had to seek permission from a CMS official to admit a fee-for-service Medicare patient, have *never* had a consultant refuse a referral for a Medicare beneficiary, and have *never* had a pharmacist call me to say the prescription for my Medicare patient was not covered by the formulary. This is not true for some of my patients in managed care plans, including those who were sick enough to be admitted but had to be transferred because my hospital (which the patients self-selected) did not participate in their plan.

Single-payer is the *only* remaining option to simultaneously and synergistically expand access, control costs, preserve choice, and reduce disparities. There is simply no other efficient and constitutionally safe way to do this. Any other proposals are nothing more than tinkering around the edges and based on blind faith that some kind of future financial salvation will somehow save us from the impending health care meltdown. A single-payer, improved Medicare-for-All program would overhaul our dysfunctional health care financing system so that it works best for patients – and for physicians.

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