SINGLE PAYER HEALTH CARE SYSTEMS

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Overview

• Overview of term “Single Payer”

• Examples of Single Payer Health Care Systems around the world

• Vermont proposal for Single Payer

• A few pros/cons and a few comments….

Thanks to Mary Cobb, SHADAC doctoral student, for her assistance.
Some Definitions

**Socialized Medicine:** Medical and hospital services that are provided by a *government* and paid for by *taxes*.

**Single Payer Health Care System:** Universal coverage through a single, *publicly-financed* insurance plan that provides comprehensive health care.

**Universal Health Care:** System that ensures that all people obtain the health services they need without suffering financial hardship when paying for them (*World Health Organization, 2014*).
Centralized Single Payer System

- Concentrated Financing
- Government is dominant payer
- Funded primarily through taxes
- Providers, hospitals can be mix of public and/or private
- Universal access – *No uninsured!*
- Minimum to no OOP spending
- Private insurance is limited
A few more….  

- Government is the revenue collector – system organizers – generally one central authority

- Core benefit package required but not all services covered (dental, vision, alternative medicine)

- Most countries consider access to healthcare as a right (either legal or moral)

- Patients can usually choose providers but generally some gatekeeping provided
Variation in Single Payer Systems

- **Payment Models** – price regulation, FFS, captitation and/or global budgets
- **Service Delivery** – providers and facilities can be public or private sector, or some of each
- **Financing** – general tax revenue or a specific earmarked tax (payroll tax is common), additional premiums if authorized
- **Private Supplement** – some countries allow option to buy private insurance as a supplement or alternative to the national system but generally limited to what it can cover
- **Benefit Designs, Co-payment Requirements** – these also vary, for services and pharmaceuticals
COMPARING MODELS-FINANCING
Four Financing Models

1. Canada  Public Health Insurance Program
2. UK    Public Health Service
3. Norway National Health Insurance
4. Germany Social Health Insurance

All could be considered a form of Single Payer

- All provide universal coverage
- All treat coverage as a right
- Mostly publicly financed
- Limited role of private health insurance
Follow the Money: Canada

Regionally-Administered Public Health Insurance

Public 70%  Private 30%

Central govt income/corporate taxes
Provincial income/sales taxes
Provincial lottery proceeds

Provider Choice
- Any provider nationwide
- Any provider in province
- Any provider in network/plan
- Patient chooses/registers with a GP

Out of pocket

Sup Private Ins

-65% buy supp. coverage for non-covered services but no cost-sharing for covered services – mostly through employers
-Premiums charged in 3 provinces
-Providers mostly private
-Provincial level benefit sets
-Hospitals operate under global budgets
Follow the Money: England

National Health Service

- Payroll Tax: 18%
- Central govt Tax Revenue: 76%

Provider Choice

- Patient chooses and registers with GP
- Out of pocket
- Sup Private Ins
- -11% buy Supp. Ins. for private facilities/elective surgery
- -No general cap for OOP
- -GP mostly private/hospitals public
- -GP as gatekeeper

Public 94%
Private 6%
Follow the Money: **Norway**

**National Health Insurance**

- **Central Government Taxes**
- **4 Regional Health Authorities**
  - Secondary/Tertiary Care
- **19 Counties**
  - PH/PH Dental
- **428 Municipalities**
  - Primary Care

**Provider Choice**

- Patient chooses and registers with GP

**Out-of-Pocket**

- 10% Supp. Ins. mostly via employers for quicker access
- Cost-sharing ceiling approx. $350 yr.
- GP private/hospital public
- GP as gatekeeper
- National benefit set
- Per capital grants to cities
Follow the Money: Germany

Social Health Insurance

Public 70%  Private 30%

Federal General Taxes

Employee/er Payroll Tax

134 Private Sickness Funds

Out-of-pocket

Provider Choice

Any provider in province

Private Insurance

-11% of population *opt out* of SHI and purchase private insurance
-Sickness Funds can charge premiums
-Buy-in to SHI for low-income/unemployed
-Individual Insurance Mandate
-National benefit package
Single-Payerness

Concentration of Financing (HHI)

Private Share of MD and Inpatient

Canada

UK

Norway

Germany
COMPARING MODELS-OUTCOMES
Wait Times for Specialist Appointment

<table>
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<tr>
<th>Country</th>
<th>Less than 4 mos.</th>
<th>More than 4 mos.</th>
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<tbody>
<tr>
<td>Canada</td>
<td>39.0%</td>
<td>29.0%</td>
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<tr>
<td>Germany</td>
<td>72.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Norway</td>
<td>46.0%</td>
<td>26.0%</td>
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<tr>
<td>United Kingdom</td>
<td>80.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>USA</td>
<td>76.0%</td>
<td>6.0%</td>
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</table>
Access to Doctor or Nurse When Sick or Needed Care

Canada: 41.0% Same-Day or Next Day Apt
        33.0% Waited 6+ Days for apt

Germany: 76.0% Same-Day or Next Day Apt
         15.0% Waited 6+ Days for apt

Norway: 52.0% Same-Day or Next Day Apt
        28.0% Waited 6+ Days for apt

United Kingdom: 52.0% Same-Day or Next Day Apt
                16.0% Waited 6+ Days for apt

USA: 48.0% Same-Day or Next Day Apt
     26.0% Waited 6+ Days for apt
Out-of-Pocket Costs in the Past Year-2013
(spent $1,000 U.S or more)

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Canada</td>
<td>14.0%</td>
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<tr>
<td>Germany</td>
<td>11.0%</td>
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<tr>
<td>Norway</td>
<td>17.0%</td>
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<tr>
<td>United Kingdom</td>
<td>3.0%</td>
</tr>
<tr>
<td>USA</td>
<td>41.0%</td>
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</table>
Half of population say fundamental change needed

Health System Views-2013

Canada: 42.0% Works well, 50.0% Fundamental change
Germany: 42.0% Works well, 46.0% Fundamental change
Norway: 42.0% Works well, 46.0% Fundamental change
United Kingdom: 63.0% Works well, 33.0% Fundamental change
USA: 48.0% Works well, 27.0% Fundamental change
VERMONT’S SINGLE-PAYER INITIATIVE
Vermont: Green Mountain Care

- Gov. Peter Shumlin campaigned on single-payer, 2010
- Law enacted in 2011; state to build system by 2017
- Set up exchange as required under ACA, plan to transition
- Major aspects:
  - Funding (some new taxes, some from federal waivers)
  - Waivers for Medicaid, SCHIP, Medicare, and ACA
  - ERISA compliance (self-funded plans not included)
The Purpose of Green Mountain Care

Provide comprehensive, affordable, high-quality, publicly-financed health care coverage for all Vermont residents regardless of income, assets, health status, or availability of other health coverage by:

(1) providing incentives to residents to avoid preventable health conditions, promote health, and avoid unnecessary emergency room visits;

(2) establishing innovative payment mechanisms to health care professionals, such as global payments;

(3) encouraging the management of health services through the Blueprint for Health; and

(4) reducing unnecessary administrative expenditures.
Vermont is Unique

- Small population - 626,000
- One larger private insurer
  - BCBS covers 90% of enrollees in Exchange
- High coverage rates already
  - 6.5% uninsured in 2012
  - 3rd lowest uninsured rate in US
- Generous public coverage program
  - Dr. Dynasaur: children up to 300% FPL; Pregnant women up to 200% FPL
- History of progressive social policies and voting patterns
SINGLE-PAYER PROS AND CONS
A Few Pros

• Potential for cost control and lower admin/overhead costs

• Can negotiate or set prices for drugs and services

• Like all universal coverage models, has higher population coverage than current U.S. system

• Relying on single source of revenue may encourage more rational, deliberate trade-offs between cost and quality/quantity (Glied, 2009)
A Few Cons

• Political feasibility in US – polarized parties

• Public perceptions/concerns of higher taxes, government control, excessive rationing, socialism

• Potentially less financially-stable than a multi-payer universal coverage model potentially more dependent on fluctuations in economy

• If financed with general taxation and global budgets, vulnerable to annual budget processes.
Conclusions

• Country financing and delivery models are unique
• Yet one can find similar components in most systems
• Other countries movement toward more local decision-making and control, less centralized authority
• Few centralized single payer systems (UK)
• Most systems developed over time with a focus on universal coverage as fundamental right of citizenship
Resources

Comparing Models:


http://www.who.int/healthsystems/topics/financing/en/

http://jhppl.dukejournals.org/content/34/4/593.full.pdf+html

Vermont:
http://www.bmj.com/content/348/bmj.q102


Nathan Blanchet and Ashley Fox. Prospective political analysis for policy design: Enhancing the political viability of single-payer health reform in Vermont. Health Policy. June 2013.
https://www.clinicalkey.com/#!/ContentPlayerCtrl/doPlayContent/1-s2.0-S016885101300064X
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