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STATE HEALTH ACCESS DATA ASSISTANCE CENTER

SINGLE PAYER HEALTH CARE SYSTEMS

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Presentation to the Minnesota Medical Association
August 19, 2014

Robert Wood Johnson Foundation

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

Province

Out of pocket

Sup Private Ins

Provider Choice

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

-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

Public 94%

Private 6%

Central govt Tax Revenue-76%

Payroll Tax-18%

National Health Service

Out of pocket

Sup Private Ins

Provider Choice

Patient chooses and registers with GP

-11% buy Supp. Ins. for private facilities/elective surgery
-No general cap for OOP
-GP mostly private/hospitals public
-GP as gatekeeper

Follow the Money: **Norway**

National Health Insurance

Public 85%

Private 15%

Central Government Taxes

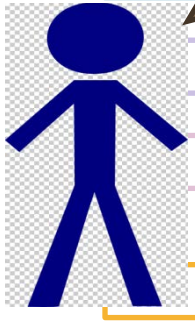
4 Regional Health Authorities
- **Secondary/ Tertiary Care**

19 Counties
- **PH/PH Dental**

428 Municipalities
- **Primary Care**

Out-of-Pocket

Provider Choice



Patient chooses and registers with GP

Sup Private Ins

-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

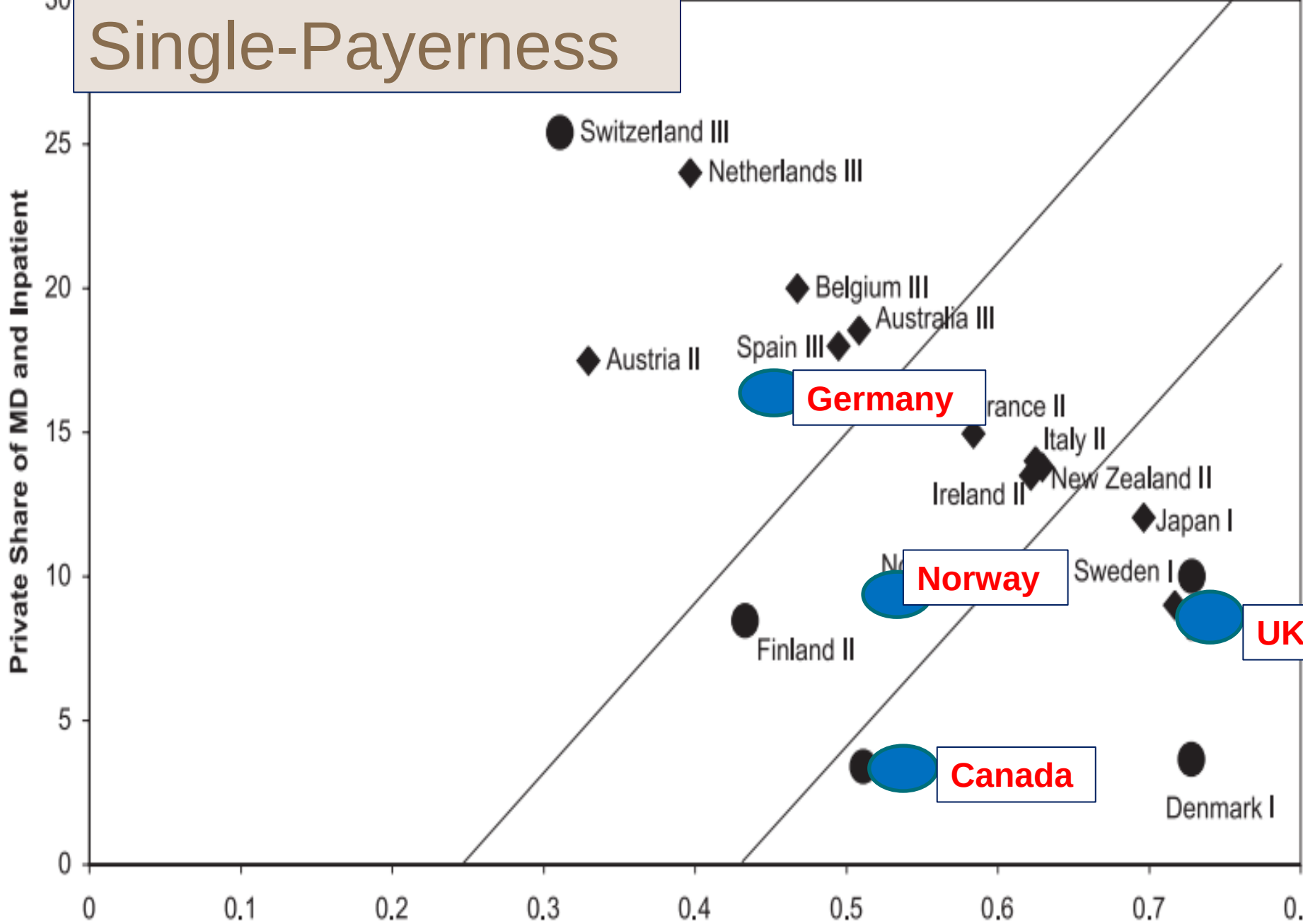
Private Insurance

Provider Choice

Any provider in province

-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

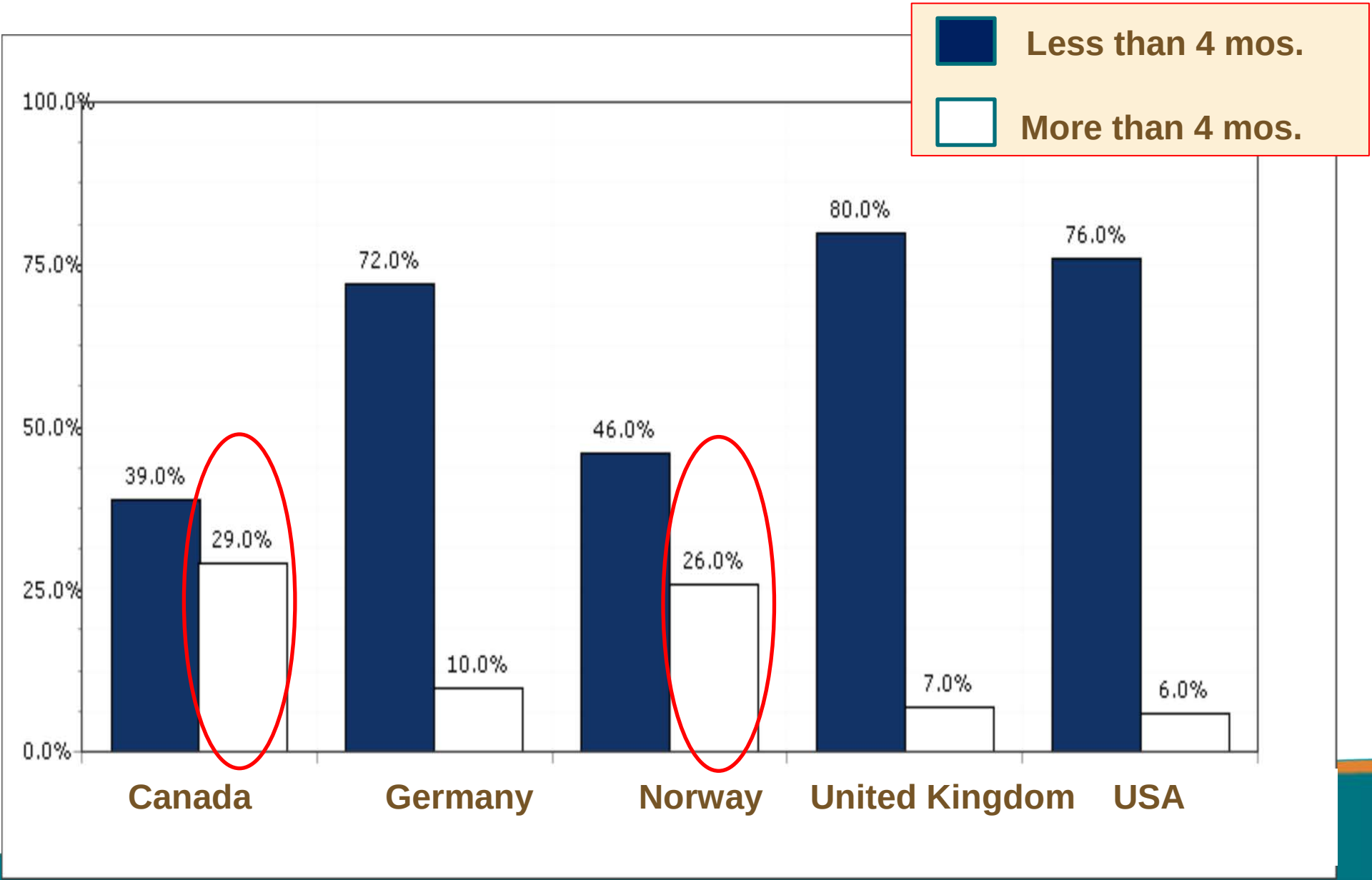
Single-Payerness



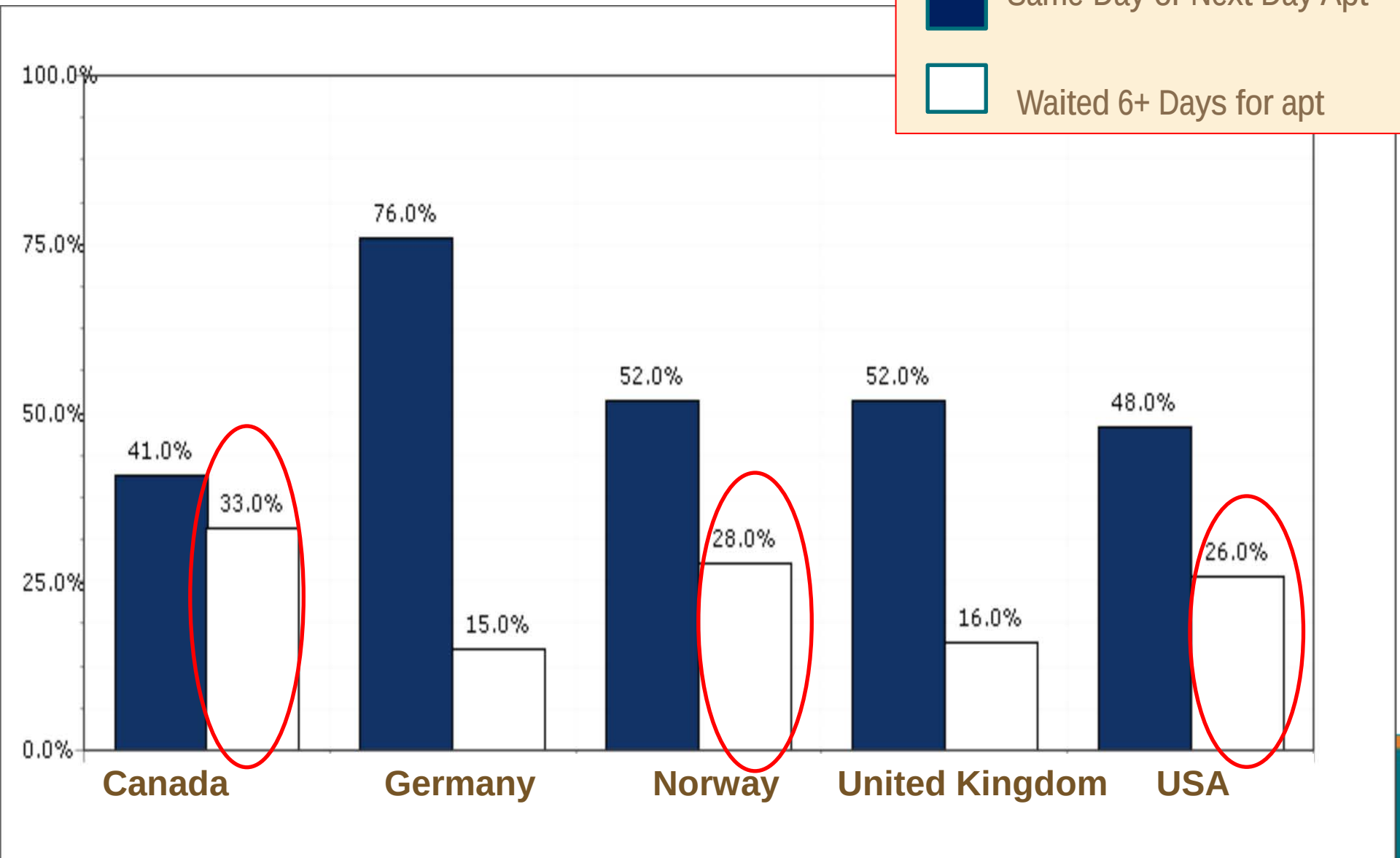
Concentration of Financing (HHI)

COMPARING MODELS-OUTCOMES

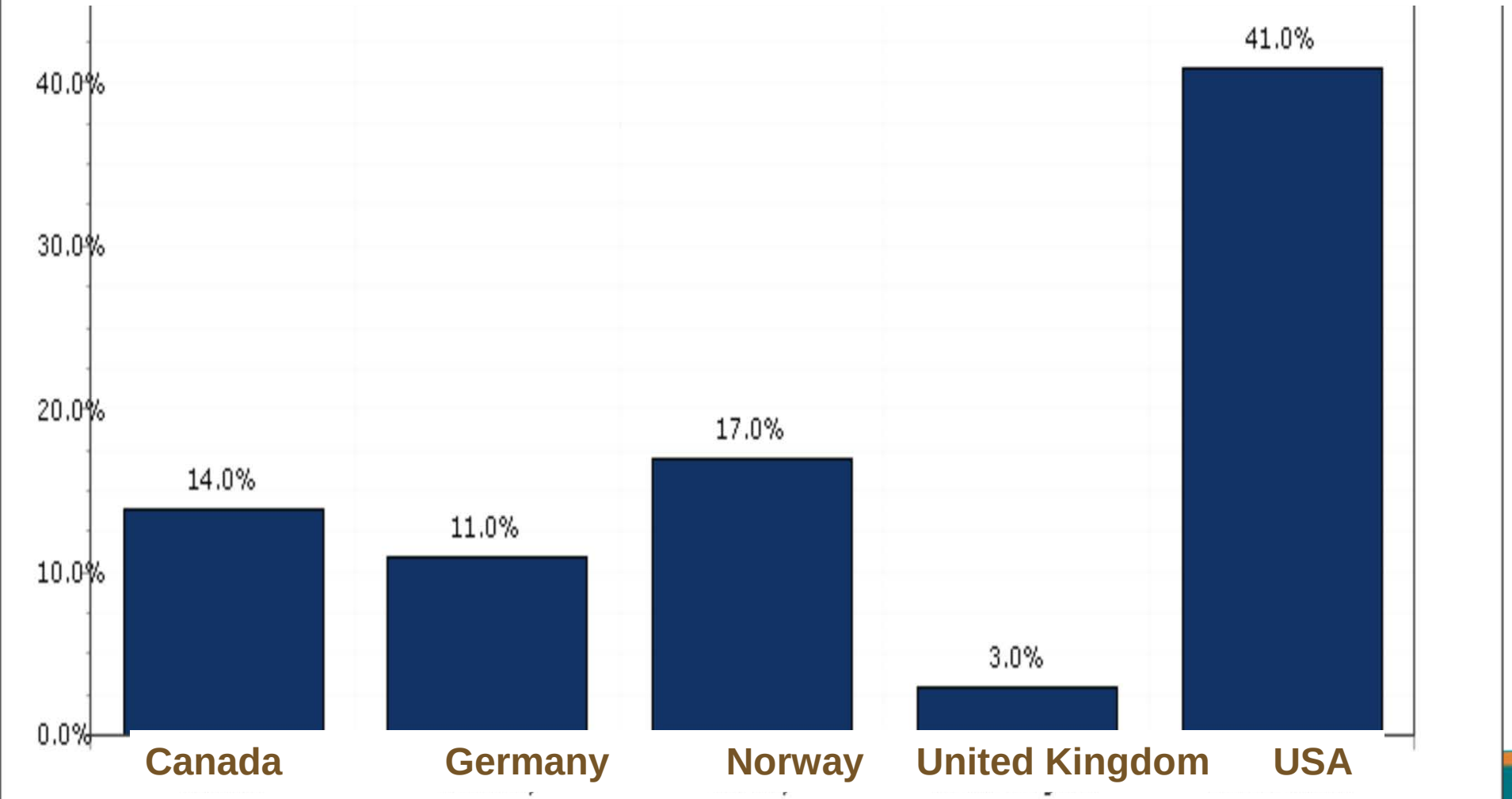
Wait Times for Specialist Appointment



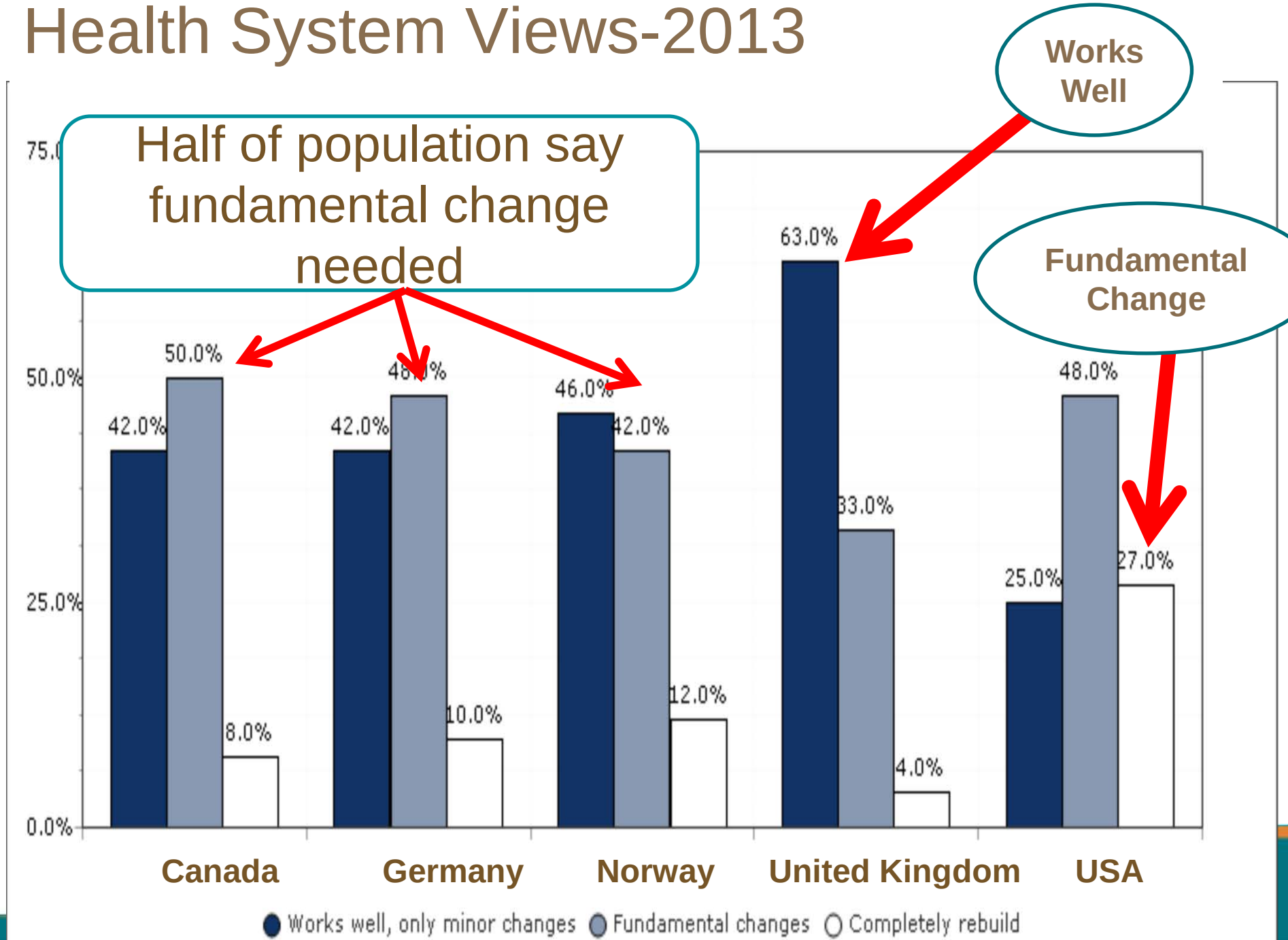
Access to Doctor or Nurse When Sick or Needed Care



Out-of-Pocket Costs in the Past Year-2013 (*spent $1,000 U.S or more*)



Health System Views-2013



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:

Commonwealth Fund. International Profiles of Health Care Systems, 2013. November 2013
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http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

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

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ttp://www.bmj.com/content/348/bmj.g102

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