Single Payer Systems: Equity in Access to Care

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Overview of Presentation

- Trends in coverage and access
- International comparisons
- Thoughts on equity
- Concluding comments

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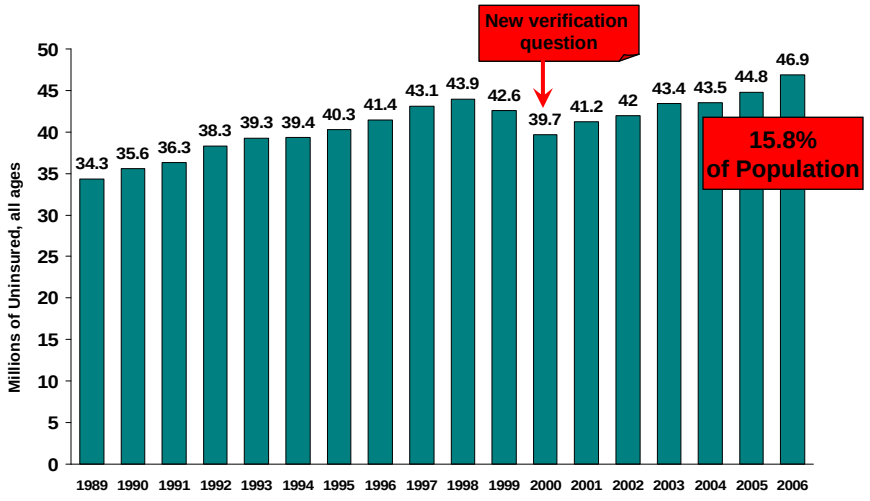
Recent Trends

Drivers of Health Reform

- Increasing number of uninsured
  - Drop in employer-sponsored coverage
  - Kids' impact moderated by SCHIP
  - No safety net for adults
- Increasing number of underinsured
  - Higher out-of-pocket costs
- Lack of national efforts for reform
  - Iraq, immigration, etc., dominating Congress

Continued Increase in Uninsured



Source: U.S. Census Bureau, Current Population Surveys (March), 1989-2006

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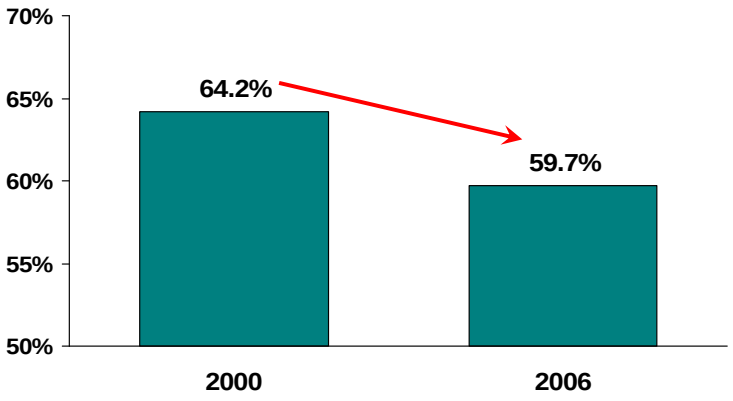
Drop in Employer-Sponsored Coverage (U.S.)



Source: US. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2006.

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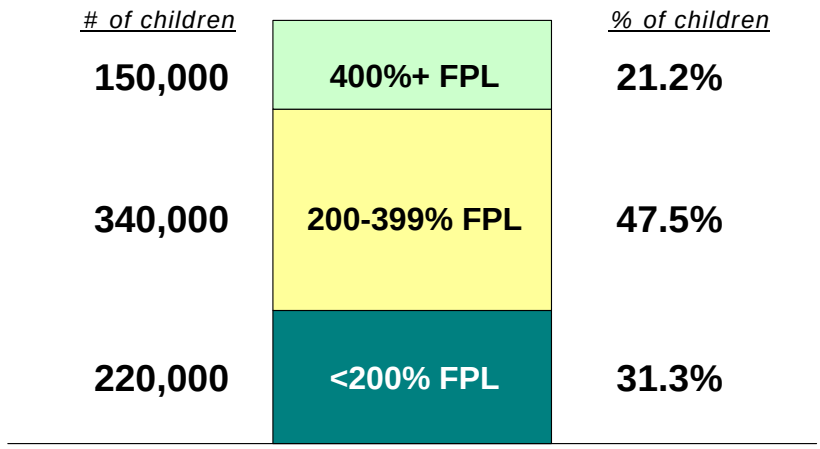
Increase in Uninsured Children 2005-06



710,000 New Uninsured Children

Note: 200% to 399% of the federal poverty level (FPL) is apx $40,000-$80,000 in annual income for a family of four in 2006. Source: Kaiser Family Foundation 2007

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Country Classifications of Health Systems

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SHADAC
STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Comparing Five Country Systems

- Social Health Insurance Models
  - Germany
  - Netherlands
- Single Payer Systems
  - United Kingdom
  - Canada
- Private Multi-Payer
  - US

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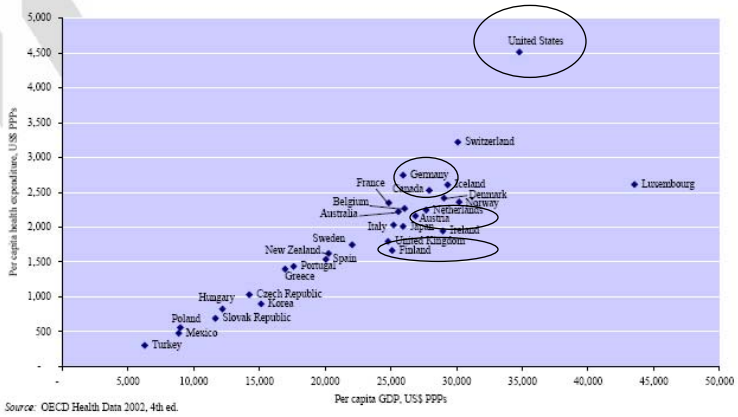
Today's challenge: finding the "right" level of spending

Figure 1. Per capita GDP and per capita health expenditure, 2000



Source: OECD Health Data 2002, 4th ed.

OECD 28 OCDE

Germany: Social Health Insurance

- Public insurance mandatory for citizens < €48,000
- Covers preventive services, inpatient and outpatient hospital care, and physician services
- Administered by over 200 non-profit Sickness Funds (SFs)
- Financed by compulsory contributions to the SFs from employees and employers based on wages
- Private health insurance: civil servants, self-employed, those earning > €48,000; Financed by risk-related premiums and co-payments
- Private expenditures on health = 23.1% of total HC $

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Netherlands: Social Health Insurance

- Each person is required to purchase individual private health (community rated premiums with risk adjustment) from competing plans
- Mandated national benefit set including dental and drugs
- Financed by income-related contribution that are compensated by employer compensation – employer-based financing
- About 2/3 of all citizens receive a government subsidy to help pay for coverage in the private market
- Private expenditure = 37.6% of HC $

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Canada: Single Payer Model

- Universal mandatory coverage
- Standard benefits for medically necessary hospital, physician, and surgical-dental services (no dental or prescription drugs)
- Federal funding to each province and territory to administer their own public programs
- Most providers private (i.e. not government employees)
- Financed from general income tax and social security contributions
- Private expenditures = 30% of total HC $

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United Kingdom: Single Payer

- National Health Service (NHS) is universal mandatory coverage
- Comprehensive benefits includes preventive services, physician services, inpatient and outpatient hospital services
- Cost-sharing limited to prescription drugs and dental services
- Most providers are public and salaried
- Financed through general income tax
- Private expenditure on health = 13.7% of HC $

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Private Voluntary - US

- Private voluntary health insurance with supplemental public coverage for select populations (elderly/disabled, low-income children and families
- No standard benefit package
- Most private insurance is employer-based – with employers paying on average 74% of premium cost/employee 26%
- Financed by tax subsidy to employers who offer; Public insurance is financed by the federal and state governments and through tax revenue schemes
- Private expenditure on health = 55.3% of HC $

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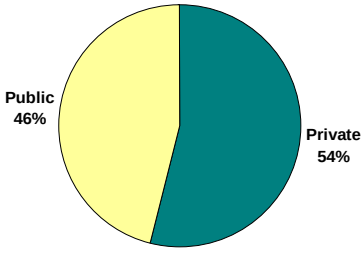
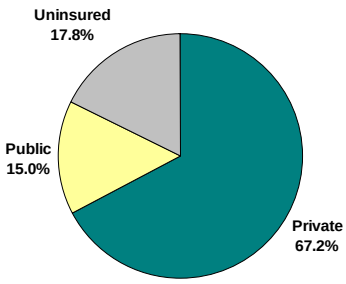
US Health Care Financing and Coverage

Total Health Care Spending, 2006: $2.1 Trillion



SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Non-elderly Health Insurance Coverage, 2006



SOURCE: SHADAC Analysis of the 2007 Annual Social and Economic Supplement to the Current Population Survey

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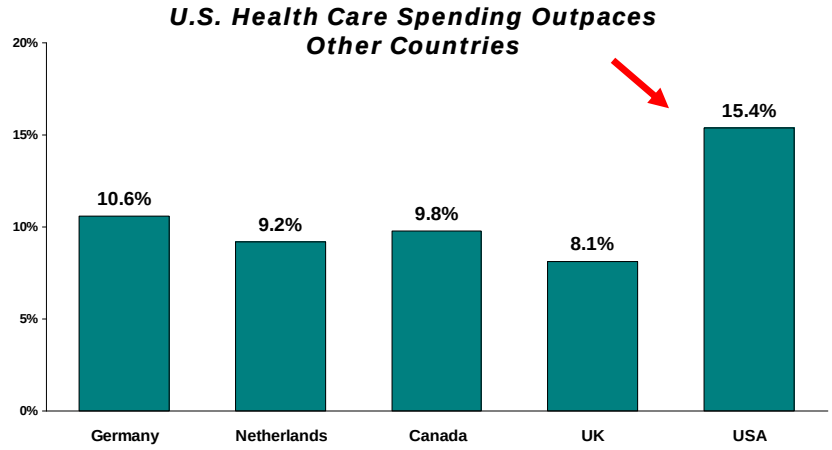
Total expenditure on health: % of GDP (2005)



SOURCE: World Health Organization, available at http://www.who.int/whosis/en

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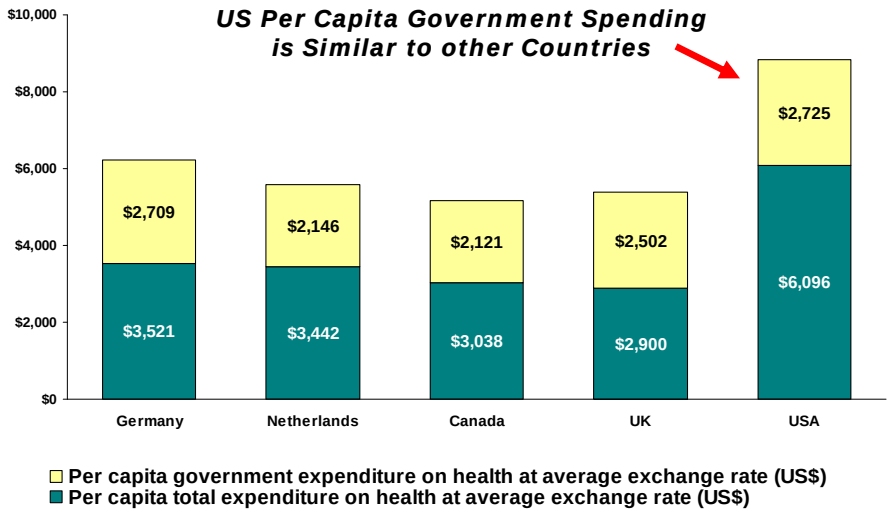
Total Per Capita Spending (2005)



SOURCE: World Health Organization, available at http://www.who.int/whosis/en

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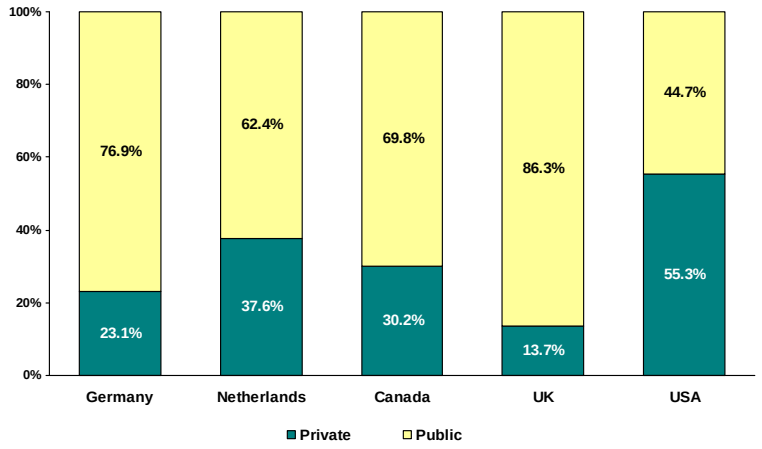
Distribution of Private and Public Spending

US has greatest share of private spending
But Canada private spending greater than UK and Germany



SOURCE: World Health Organization, available at http://www.who.int/whosis/en

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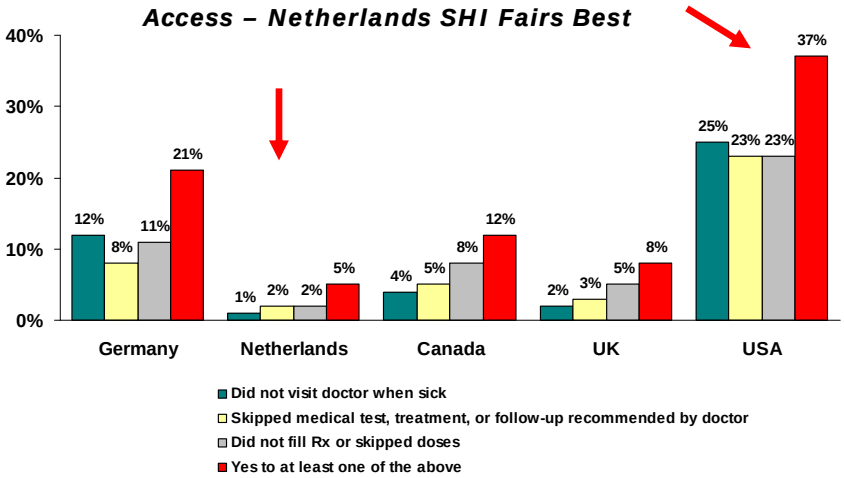
Barriers to Access

US Outlier in Terms of Barriers to Access – Netherlands SHI Fairs Best



SOURCE: Commonwealth Fund International Health Policy Survey, 2007

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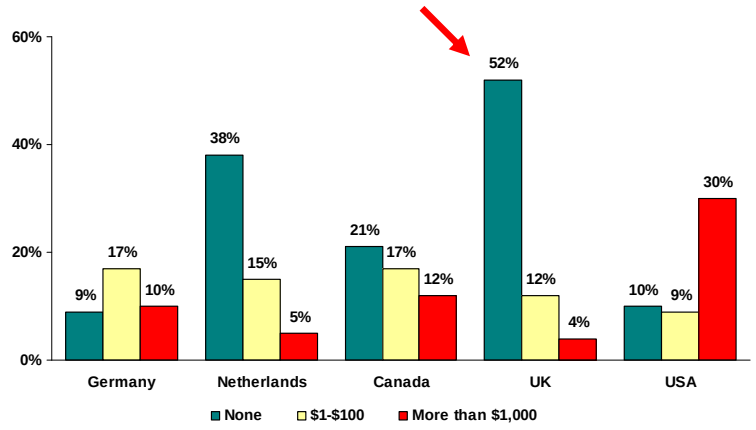
Yearly Out-of-pocket Expenses for Medical Bills

Over 50% of UK Citizens had NO medical bills:
1/3 of U.S. citizens paid more than $1,000



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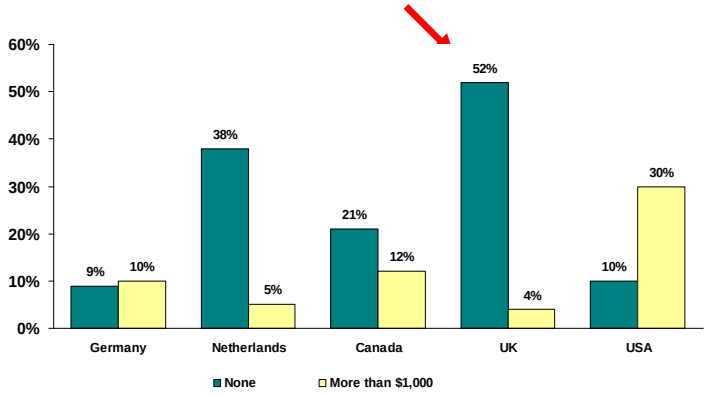

SOURCE: Commonwealth Fund International Health Policy Survey, 2007

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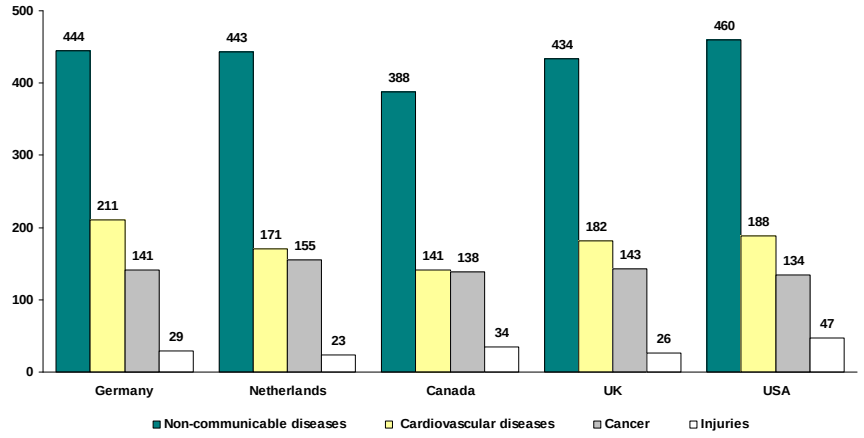
Age-standardized Mortality Rates per 100,000 Population (2002)

Similar rates across countries: US better in Cancer Mortality



SOURCE: World Health Organization, available at http://www.who.int/whosis/en

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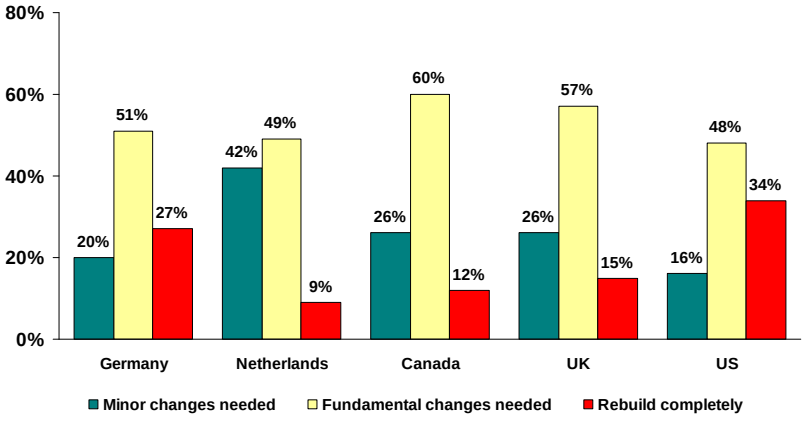
Satisfaction with Health System

More than half of each country's Citizens believe fundamental change or complete overall is needed



SOURCE: Commonwealth Fund International Health Policy Survey, 2007.

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Summary of Country Comparisons

- US is outlier on health care spending and on barriers to access to care
- Health outcomes are similar across countries with US fairing best on cancer outcomes, worst on injury outcomes
- Other country system rank high on some indicators, low on others – no clear “best” system

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Health Care Goals and Equity

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WHO Health Care Goals

- Equity in access to health care service, including financial access to essential public and private services
- Financial protection: prevention of individuals from falling into poverty as a result of contributions to health care or a catastrophic expenses, and
- Health Status: protect and improve the health status of individuals and populations by ensuring *financial access* to essential health services.

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Equity in Financing

- Move toward equalization in the ratio of health to non-food spending is identical regardless of their income or health status
  - 5-10 % of income?
- Tax incidence: those with greater incomes should contribute more to finance the system
  - Single payer systems with income tax system more able to achieve equitable financing
- Protection against catastrophic loss
  - Pooling risks and maximizing prepayment

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Equity in Access

- All citizens should have the same access to care regardless of income, health status, race/ethnicity, age, geographic location, employment status
- Equal access to core benefits
  - Uniform benefit set
- Equal access to best treatment protocols and unbiased care
  - How care is provided at the site of care

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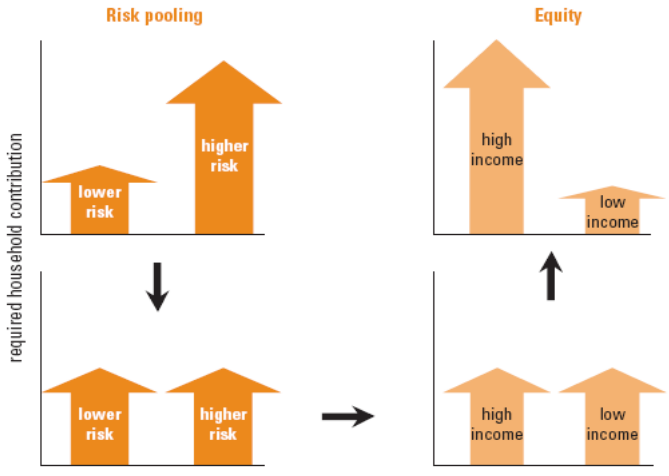
Risk Pooling and Equity

FIGURE 2.4 Models of cross-subsidization for pooling risk and increasing equity of household contributions for health services



Source: ILO/STEP 2002.

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Concerns with Single Payer in US

1. US Aversion to taxes
2. Persistent Health Disparities
3. Political Process in US System

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1. U.S. Aversion to taxes

- Concern that we would not accept the tax levels required to fully fund a comprehensive benefits and access for all
  - We seem to better accept hidden taxes (employer subsidy) and cross subsidies (cost shifting) – we still pay but it's not a TAX
- Possible outcome is two-tier system of care
  - Inequity in benefit
  - Inequity in access to certain providers
  - Income inequity

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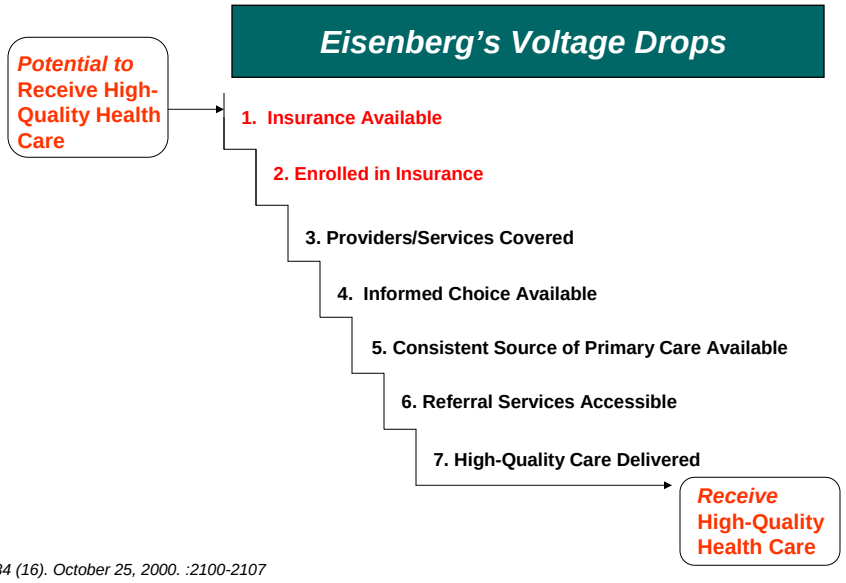
2. Insurance Does Not Equal Access



JAMA 284 (16). October 25, 2000. :2100-2107

Persistent Inequities in US System

….that won't be solved by Universal Coverage

- Disparities in physician access
  - Urban vs. Rural
  - Inner City vs Suburbs
  - State vs State
- Disparities in physician practice patterns
  - Wenberg
- Race and ethnic disparities in access and treatment

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Medicare as Single Payer Example

- Non-whites less likely to be screened for colorectal cancer (Ananthakrishnan 2007)
- Hispanics diagnoses with depression were less likely to receive treatment and those who were treated were less likely to receive psychotherapy (Crystal 2003)
- Blacks and Hispanics less likely to receive pneumococcal and flu vaccinations than whites (Winston 2006)

Universal coverage is one component needed to achieve EQUITY

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3. Politicization of Decision Making

- No consensus in US on role of government in health care
- Concern with current state of politics, stakeholders, lobbyists, and money
  - Medicare prescription drug bill
    - Donut hole
    - Law prohibiting federal government from negotiating drug prices
  - SCHIP
    - Reauthorization delayed and funding put in jeopardy

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Concluding Thoughts (1)

- The US must join other countries to achieve universal coverage NOW
- Universal coverage can be achieved independent of financing mechanism
- US must find its own unique model of reform to achieve universal coverage

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Concluding Thoughts (2)

- Citizens of almost every HC system think fundamental reform is needed
  - No system is superior in all aspects of comparisons
- Single payer may not be the right vehicle for Universal Coverage in the US
  - Concern about the taxes required to support it
  - Concern that other social inequities will persist with limited resources to address them
  - Politics of health care could dominate the future design and process

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Concluding Thoughts (3)

- A hybrid social insurance with private sickness funds or private regulated insurance may be a more appropriate model
  - Maintains some elements of a market and competition
  - Maintains the role of employers in financing health care
  - Moves toward universal coverage
  - Could retains role of state in “buying” coverage for low-income populations
- Reform toward Universal Coverage is complicated but needed and achievable!

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Contact Information

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