

SINGLE PAYER Meets **MANAGED COMPETITION**

The Case for Public Funding and Private Delivery

by DAVID DEGRAZIA

Common sense and empirical evidence suggest that single-payer health insurance, combined with competitive private delivery, would be the most cost-effective way of achieving the major, widely accepted goals of health care reform. Among the current presidential candidates, Kucinich and Gravel have the most promising reform proposals, with Edwards's and Obama's as fall-backs.

American health care is a terrible mess. Over 46 million Americans—about 16 percent of the population—lack health insurance; millions more are underinsured.¹ Those lacking health insurance face serious consequences. The Institute of Medicine puts it bluntly: “Uninsured children and adults suffer worse health and die sooner than those with insurance.”² Moreover, an estimated eighteen thousand unnecessary deaths occur every year in the United States due to lack of insurance.³ A further consequence for many families is threatened financial security. Meanwhile, the cost of foregoing needed medical services is enormous: an estimated \$65–\$130 billion per year,⁴ exceeding what some leading experts consider necessary to cover all the uninsured.⁵ Lack of reliable, continuous access to

health care is an intolerable feature of our health care system.

Other features are also dispiriting. Despite not covering nearly one of every six Americans, we spend *far* more on health care per capita (including the uninsured), and as a fraction of gross domestic product, than do citizens of any other country.⁶ Since 2000, overall health care expenditures have risen at roughly 10 percent per year.⁷ Ford and General Motors buckle under the strain of paying health insurance premiums. Meanwhile, insured patients frequently complain that insurance companies restrict their choice of doctors and impose bureaucratic hassles. And for years there has been a widespread perception—whether accurate or not—that managed care has damaged quality of care.⁸ On the whole, the public is increasingly dissatisfied with American health care.⁹ Considering this widespread dissatisfaction, and with Democrats reclaiming power in Congress, it's no surprise that health care reform is back as a leading issue of domestic policy.

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Every candidate in the 2008 presidential field was invited to a health care forum in Las Vegas on March 24, 2007. No Republican candidate accepted the invitation. The seven Democrats who participated promised measures to achieve universal coverage, but their strategies feature important differences.¹⁰ Hillary Clinton, Barack Obama, John Edwards, Christopher Dodd, and Bill Richardson all intend to retain employment-based health insurance while introducing such measures as employer mandates, individual mandates, and the expansion of public programs. Dennis Kucinich and Mike Gravel, by contrast, favor abolishing employment-based insurance. Both advocate immediate adoption of a single-payer system of national health insurance—a tax-funded system that enrolls everyone by virtue of citizenship or residence—although Mike Gravel wants to combine the single-payer system with a voucher approach. (These and other measures will be explained in the next section.) Meanwhile, Obama and Edwards have expressed openness to an eventual move away from an employment-based system to a single-payer system.

At a first cut, then, we can distinguish reform proposals that embrace employment-based insurance, necessarily preserving a multiplicity of private insurers, and proposals that abandon employment-based insurance while embracing single-payer financing (which, as we will see, may or may not preserve a role for private insurance). Which direction is more promising? What would a promising reform plan look like in greater detail?

To begin to answer these questions, we need to identify the goals of health care reform. Although perfect unanimity on this matter is impossible, the following four goals enjoy widespread support among Americans and will serve as benchmarks for evaluating proposals for reform: (1) achieving universal coverage; (2) establishing cost controls; (3) enhancing—or at least not diminishing—patients' freedom of choice while mini-

mizing bureaucratic hassle; and (4) sustaining the quality of care.¹¹

But are these goals simultaneously achievable? Are they compatible? The best evidence that they are compatible and achievable is the fact that numerous countries have achieved them fairly well. The health care systems of these countries—including the United Kingdom, Germany, the Netherlands, France, Italy, Sweden, and Canada—all face difficulties, often because of meager funding. But looking at the big picture, all of these countries have universal coverage *while spending far less on health care than we do*. Meanwhile, patients in these countries enjoy considerable freedom of choice, seem less hassled by paperwork and other bureaucracy than we are, and enjoy a quality of care that appears comparable to that enjoyed by well-insured Americans.¹² The basic goals of health care, though in tension with each other, are compatible and achievable—not to utopian levels, but satisfactorily. The urgency of reform must not be obscured by overly pessimistic assumptions.

My thesis is that a single-payer system of national health insurance appears to be the most cost-effective way of achieving the major goals of health care, and is therefore the most morally defensible reform model. If I am right, then the proposals of Kucinich and Gravel are the most promising. If, however, a single-payer system is politically unachievable until we complete less drastic reforms within an employment-based system, then Edwards and Obama might offer a better long-term strategy. As we will see in any case, the single-payer approach (whenever implemented) offers the most advantages and the fewest disadvantages *when integrated with managed care in delivery*.

This paper is hardly the first to defend single-payer financing. But I intend to update the argument, connect it to the current political scene, and make it accessible to a broad audience without idealization or oversimplification. More originally, I defend the

merger of single-payer financing and managed competition.

Why Reform Is Needed

Our health care system's problems and the various reform proposals are best understood with some sense of how we got here.¹³ In 1929, a precursor to Blue Cross that covered hospital care for Dallas teachers and Henry Kaiser's insurance program for employees were both founded. These programs helped to establish the link between insurance and employment that is idiosyncratic to American health care. Blue Shield later added coverage for physician services. When wages were frozen in World War II, employers were permitted to offer health insurance to attract workers. Meanwhile, employers' payment of health premiums was exempted from taxation while employees were tax-exempted for the value of their insurance benefits. The upshot: the federal government was underwriting health insurance, much of the cost of which was invisible to workers. These incentives and competition among employers expanded the health insurance market, which was quickly flooded with for-profit insurers.

In 1965, our two largest public health insurance programs were created to take care of the millions who remained uninsured. Medicare, administered federally, covered all American citizens age sixty-five or older. Medicaid was administered by states and had varying eligibility requirements, although the federal government shared costs. This program covered many individuals who had neither employment-based nor individually purchased insurance. Because Medicaid eligibility depended on income level and employment status, the population of Medicaid "recipients" was ever-changing, whereas whoever became a Medicare "beneficiary" remained so for life. Not surprisingly, Medicaid's administrative costs have always exceeded those of Medicare—suggesting that universal coverage of an easily identified population costs

less than coverage that is scaled to income.

The next quarter century saw steady increases in public and private expenditures on health care. These trends generated pressure to control costs by shifting away from traditional fee-for-service medicine. Hence the growth of health maintenance organizations (HMOs), which introduced various alternatives to fee-for-service payment. But expenditures continued to climb along with the number of uninsured Americans.

In 1992 Bill Clinton was elected president with a mandate for reform. The central idea of his managed competition proposal was to retain employment as the primary basis for health insurance while permitting within each geographical region a few large health plans to compete for enrollees. A publicly financed plan would pick up individuals otherwise left out. As is well known, the Clinton proposal ran into political obstacles and never made it to either floor of Congress. This defeat was so devastating that, until very recently, politicians were reluctant to propose the sort of system-wide changes that might achieve universal coverage.

The most important legal development since the Clinton proposal was the State Children's Health Insurance Program (SCHIP) of 1997, which has provided coverage to some previously uninsured children. Also during the 1990s, managed care continued to grow, and for-profit managed care organizations quickly came to dominate. Meanwhile, the ranks of the uninsured have grown relentlessly. In general, managed care and the free market have proven quite incapable of achieving the basic goals of health care, despite the incentive of making employer-paid insurance premiums tax-exempt. Hence the urgency of reform.

The Proposals

The reforms currently on the table fall into six types, which can also be combined in various ways.

Market reforms. The American Medical Association has proposed insurance market regulations, including modified community rating (in which only age and gender would affect premium rates) and guaranteed insurance renewability. These features, the AMA contends, would encourage “consumers” to remain longer with the same insurers, lowering the latter’s administrative costs and thereby leading to lower premiums.¹⁴

Tax credits. A tax credit for the purchase of health insurance is an amount that can be subtracted from the tax one owes. A refundable tax credit—a measure Richardson sup-

ports—permits those who owe no income tax to receive a government payment that can be spent to purchase insurance. One way to ensure funds for tax credits would be to end the federal income tax exclusion of employer-provided insurance. This system deprives the government annually of well over \$100 billion of tax revenue. It is also a regressive tax structure: it exempts those fortunate enough to have insurance through their work from paying progressively income-graduated taxes on the employer-paid premiums.¹⁵

Individual mandates. These would legally require adults who lack health insurance to purchase it for themselves and their dependents. In April 2006, Massachusetts—whose former governor Mitt Romney is now a Republican candidate for president—passed such a law with full implementation expected soon,¹⁶ though without the income-related subsidies necessary to achieve universal coverage.¹⁷ Democratic candidates Clinton and Edwards favor individual

Employer mandates. Also supported by Clinton and Edwards, this measure would require employers to “play or pay”: either provide health insurance for their workers or pay into a fund that would cover those not otherwise insured.

Incremental expansion of existing public sector programs. This strategy—some version of which is favored by Richardson, Dodd, and Edwards—would enlarge Medicare, Medicaid, and/or SCHIP until universal coverage is achieved. For example, Medicare might be extended to those fifty-five and older, and SCHIP could be modified to expand enrollment of children. In principle, after

two or three such extensions, universal coverage is achievable. Although a proponent of this approach might favor demoting the private insurance industry from prominence—which would clear the way for expanded public programs to merge and cover all Americans, effectively creating a single-payer system—most prefer to leave private insurance largely in place.¹⁸

Managed competition. This strategy, familiar from Bill Clinton’s reform proposal, might naturally combine with individual and employer mandates. A leading option is to adopt the Federal Employees Health Benefits (FEHB) model.¹⁹ While the federal government organizes and manages the system that insures nine million workers and their families, competing insurance companies provide the insurance. Private fee-for-service insurers and more integrated delivery systems (such as HMOs) offer packages of benefits at various premiums. If approved, these plans then compete for enrollees among federal workers, who are free to enroll in any compet-

Patients in many other countries have considerable freedom of choice, seem less hassled by bureaucracy, and enjoy a quality of care comparable to that enjoyed by well-insured Americans. The basic goals of health care reform, though in tension, are achievable.

ing plan. In the present proposal, all Americans could enroll in any of these plans. Two leading proponents suggest a national, quasi-governmental, nonpartisan commission to administer the system and recommend levels of funding and insurance benefits to Congress.²⁰

One specific version of this model is a health care voucher system.²¹ In this approach—recently endorsed by Gravel—every American under sixty-five would obtain a voucher that would guarantee and pay for the health benefits offered by a qualified, competing insurance plan. Individuals would be able to select any qualified plans while remaining free to purchase services beyond those provided by the plan selected. Funding for the vouchers could flow from an earmarked value-added tax, tying benefit levels to tax rates so as to motivate fiscally prudent decisions about the extent of services vouchers would cover. According to leading proponents of this approach, employer-based insurance would likely fade away over time, and means-based programs such as Medicaid and SCHIP would be eliminated. Once the voucher plan is inaugurated, no one would be added to Medicare, so that program would phase out, too.

Difficulties for Multiple Payers

Despite their various advantages, these proposals share certain difficulties inherited from the private, mostly for-profit insurance industry that they would permit to remain largely in place: massive expenditure on administration, the siphoning off of health care dollars to profit-making, and probably adverse selection.

First, the administrative costs of private insurance—especially for-profit, private insurance—are much higher than those associated with public insurance. (I will provide evidence for this claim in the next section.) If these very high administrative costs are necessary to gain the alleged comparative benefits of private

insurance, the onus is on proponents of private insurance to explain why.

Second, for-profit insurers, which constitute a majority of private insurance companies today, necessarily seek profits, which require that earnings exceed expenditures. This money could instead go to patients in the form of expanded coverage or better care. Nothing intrinsic to health care demands for-profit financing, so siphoning off health care dollars for profiteering looks from the standpoint of health care's major goals like wasteful discretionary spending. (More on this later, however.)

Perhaps the most serious disadvantage of leaving the private insurance industry largely in place is that it preserves *adverse selection*, which leads insurers to avoid insurance risks and limit their coverage. Adverse selection in health care occurs when a disproportionate number of people in poor health select a particularly generous insurance plan.²² Where insurance companies compete as payers, they typically differ in the services they cover and in reimbursement rates. Suppose plan A covers outpatient psychiatric services while plan B does not, or A reimburses more generously for such services. Patients with psychiatric problems may gravitate to A, which results in A enrolling many people who need extensive services. This is very costly for the company that administers A. Given variations in different plans' terms, and given that patients may choose from among these plans, the threat of adverse selection encourages health plans to offer less generous benefits and to advertise to wealthier, healthier groups, or to find other ways of avoiding those who most need health care.

Now, a system could address the threat of adverse selection by requiring that each plan cover the same services and charge the same premiums, deductibles, and so on, and by guaranteeing that anyone can enroll in any plan. Standardization of the basic terms of each plan in a system of truly open enrollment tends to level the playing field. But if the terms of each

plan are to be uniform, why have different plans at all?

A champion of competing plans might reply that each is to *deliver* health care, never merely provide insurance (as Blue Cross and Blue Shield do). Competition in delivery, the argument goes, will promote quality, thereby justifying higher administrative costs. This may be correct. Note, though, that each move identified for avoiding adverse selection—standardizing prices and covered services, maintaining open enrollment, and requiring competing plans to deliver services—steps in the direction of a single-payer system. Later we will return to the prospect of merging single-payer financing with competition among private delivery plans.

Cost-Effectiveness

Considerable evidence shows that the single-payer approach is the most cost-effective way to achieve basic health care goals. Note that cost-effectiveness is not simply a matter of finances. It involves a relation between controlling costs—one of the four goals I identified above—and other goals or values. My claim is that, given appropriate standards for the achievement of the other major goals (universal coverage, patient freedom, and quality), a single-payer system is probably the most affordable way to achieve them. While a precise statement of the appropriate standards lies beyond the purposes of this paper, I suggest roughly the following: universal coverage for all citizens and residents with reasonable access to care even in the least populated areas; broad choice of providers and far less bureaucratic hassle than Americans now face; and quality of care—however measured—no less good than insured patients typically enjoy today.

Why emphasize costs in relation to the other goals? Because doing so counters two popular misconceptions: (1) that covering the currently uninsured (without unacceptable sac-

rifices in patient freedom and quality) would necessarily cost much more than status quo spending, and (2) that public insurance cannot control costs (without unacceptable rationing).

Before considering the evidence for cost-effectiveness, let us note that it *makes good sense* to expect it of the single-payer approach. What a system of multiple insurers has to do is quite different from what we would require of a single payer. In a pluralistic financing system, most of the payers will have to advertise, elaborate their unique restrictions of coverage, determine patient eligibility, bill patients, try to collect on bad debts—all while paying massive executive salaries and trying to maximize profits. Meanwhile, physicians, group practices, and hospitals have to spend much time and money wading through the bureaucratic complexities of multiple payers with different rules, rates, enrollees, and so on.

A single payer, by contrast, can concentrate on reimbursing providers for patient care. Profit-making is not a goal of the enterprise; breaking even is just fine. There is no need for competitive advertising because there is only one system. Everyone is permanently eligible for services, eliminating in one stroke much unnecessary bureaucracy. Patients need never have medical debts for services covered in the public program because the government will finance the care. There is no need for experts to decipher the rules and regulations of different payers because the single payer will apply the same rules to all enrollees. Billing patients—which requires armies of administrators in competing payers and burdens providers who have to deal with them—is unnecessary. (Patients would receive bills only for services not covered by the universal plan.) Physicians and other professionals have the fee-for-service option of submitting standardized forms recording services rendered, which will then be reimbursed by the public insurer. Alternatively, professionals can receive salaries or other forms of remuneration in group practices or

health plans that are paid a lump sum per year to assume full responsibility for a particular person's care (a capitation approach). A third option is to work on a salaried basis for institutions such as hospitals that receive a monthly global budget for all necessary activities. None of these payment schemes requires billing patients.

Global budgeting and other planning are also crucial to controlling costs. A single-payer system will have standardized fees for those professionals who choose the fee-for-service option, and the fees will be based on annual negotiations between the public insurer and professional representatives. Hospitals' global budgets will encourage fiscal discipline. Drug prices, as explained below, will be rea-

vidual's particular health profile—rather than the “community rating” that enables wide pooling of risk (which is the traditional idea behind insurance). Fear of adverse selection motivates skimping on benefits, so as not to attract too many expensive patients. Moreover, there are free-rider problems with multiple payers.²³ If plan A wants to improve a doctor's efficiency, it may consider providing her some useful but expensive new technology. But if she has contracts with several insurance companies, the other plans besides A would benefit from the new technology for free. So A has a reason not to seek quality improvement. Another difficulty is that plans are economically discouraged from promoting long-term health

Despite various advantages, current reform proposals share difficulties inherited from the private, mostly for-profit insurance industry: expensive administration, profit-making, and probably adverse selection.

sonable and negotiated annually. Careful budgeting will encourage sensible limiting of the supply of high-technology equipment, helping to avoid situations in which equipment that has been purchased but is underutilized motivates providers to artificially create demand (encouraging questionable fee-for-service use of MRIs, for example). In general, global budgeting forces priority setting in an explicit, comprehensive way, which encourages sensible spending.

In addition to savings from streamlined administration and responsible budgeting, the single-payer approach avoids economic incentives that discourage high-quality care and segregate the health care market, making it harder for those who most need insurance to get it. As we have seen, private insurers have reason to seek enrollees who are relatively healthy and wealthy. The profit-making imperative of for-profit insurers motivates “experience rating”—the practice of basing premiums on an indi-

vidual's particular health profile—rather than the “community rating” that enables wide pooling of risk (which is the traditional idea behind insurance). Fear of adverse selection motivates skimping on benefits, so as not to attract too many expensive patients. Moreover, there are free-rider problems with multiple payers.²³ If plan A wants to improve a doctor's efficiency, it may consider providing her some useful but expensive new technology. But if she has contracts with several insurance companies, the other plans besides A would benefit from the new technology for free. So A has a reason not to seek quality improvement. Another difficulty is that plans are economically discouraged from promoting long-term health

with short-term costs if enrollees are unlikely to remain with a given plan long enough for it to realize the savings. All of these problems are avoided if there is only one payer, which will insure the whole population and realize the savings and benefits of efficient delivery and long-term health promotion.

Might these problems also be avoided by the best possible multiple-payer, managed competition approach? Perhaps. The problems associated with adverse selection and experience rating can be avoided if competing plans are required to offer the same benefits with the same premiums and deductibles, if enrollment in any plan is truly open to all, and if insurance is portable. The free-rider problem is avoided if each doctor is limited to working with a single plan. And the problem of discouraging long-term health promotion with short-term costs is avoidable if plans are sufficiently good to encourage enrollees to remain with the same plan

for a long time. But the requirements needed to ensure these favorable conditions are far more likely in a single-payer system, which generally permits more regulation than pluralistic financing systems. Finally, the single-payer financing system is the simplest and, as the evidence of the next subsection demonstrates, the least costly way to achieve and maintain universal coverage.

Two further reasons to expect cost-effectiveness: First, a single-payer system features *monopsony*—that is, concentrated purchasing power—enabling the negotiation of lower prices. This is crucial, for example, in negotiating with the formidable pharmaceutical industry in order to secure more reasonable prices for medications in this country. Second, a single-payer system could more easily implement a universal information technology system, whose many advantages would include easy and efficient retrieval of any patient's medical records.

Having considered several theoretical reasons to expect a single-payer system to be more cost-effective than pluralistic financing systems, let's turn to the evidence.

The Evidence

Consider, first, two U.S. government studies. Examining various reform plans, the Congressional Budget Office (CBO) found that only the single-payer plan was likely to achieve universal coverage while saving money (in comparison with then-current spending).²⁴ A General Accounting Office (GAO) study reached the same conclusion.²⁵

Second, Medicare—essentially a single payer providing universal coverage for the elderly—has lower administrative and overall costs per patient than any other approach to health insurance we have tried. It is well known, for example, that the overhead for Medicare is much lower than that for private insurance companies.²⁶ As explained earlier, Medicare's overhead is also cheaper than that of Medicaid, a means-tested

program requiring more complex administration. Further, the funneling of some Medicare recipients through private insurers has resulted in higher expenditures than those associated with traditional, fee-for-service Medicare²⁷—exactly as one would expect given independent evidence for the higher administrative costs of private insurance.

Third, to take just one international example, Canada's single-payer system has much lower administrative costs than those of the U.S. system and much lower total health care costs per capita.²⁸ Meanwhile, studies consistently suggest that the quality of care in Canada is, on average, no lower than in the United States.²⁹ As for costs, a debate over administrative savings is noteworthy. One detailed analysis estimated that U.S. spending on health care administration in 1999 was \$1,059 per capita, but only \$307 per capita in Canada, suggesting a total excess of administrative spending in the United States of \$209 billion.³⁰ A critical reply contended that the United States' excess administrative costs in 1999, as compared with Canada's, were only \$159 billion.³¹ Note: a conservative estimate of the annual administrative savings of single-payer financing is *only \$159 billion!*

One finds further support for the assertion of cost-effectiveness in the detailed studies of leading scholars. In the mid-1990s, Norman Daniels studied four health care reform plans proposed by members of Congress, including a single-payer proposal, as well as the American health care status quo. On every measure Daniels considered—extent of coverage, comprehensiveness of benefits, patient choice, cost controls, and efficiency—the single-payer proposal outperformed competitors.³² Jack Hadley and John Holahan's 2003 study estimated that covering the American uninsured in public programs would cost about half as much as covering them with private insurance.³³ In a 2004 report, the Institute of Medicine commented that “[s]ingle payer mod-

els, much like Medicare, are generally considered to have substantially lower administrative costs than private insurance plans, since the need for advertising, underwriting, and much eligibility and billing work disappears.”³⁴ In their 2005 book, Julius Richmond and Rashi Fein contended that the single payer offers “the most effective, efficient, and equitable health care insurance system”—although concerns about political feasibility ultimately led them to favor a different approach.³⁵ I have found no scholarly studies that cast significant doubt on the cost-effectiveness of the single-payer plan.

Filling in Our Sketch

Our sketch so far indicates that the publicly financed system would provide universal coverage. There would be no billing of patients for services provided within the system. Hospitals, clinics, and nursing homes would have global budgets to cover all expenses (or perhaps some of these institutions, most feasibly nursing homes, could be paid on a capitation basis). Physicians and other professionals could either work fee-for-service with fees standardized annually, draw a salary from an institution with a global budget, or work for a capitated health plan. Now for further detail.

A key feature is the elimination of out-of-pocket payments for services provided within the tax-funded system. Premiums and deductibles create barriers to access and add substantially to administration. Their value is primarily symbolic: they promote an image of cost-sharing. Even copayments may be unwise for the same reasons. Some single-payer advocates may favor copayments, believing that what they save by inhibiting frivolous seeking of services will be more than copayments cost to administer. Then again, copayments may sometimes inhibit needed care until medical problems worsen—at which time treatment is more costly and possibly less effective. But whatever we decide

about modest copayments, generally speaking the most efficient way to pay for medical services is through taxation, which minimizes monetary transactions and associated administration.

Another feature of the single-payer approach is broad choice of providers, in the sense that patients may seek the services of any health professional working fee-for-service or join any qualifying health plan. (A health plan, however, is likely to have its own restrictions.) On the whole, I suggest, such freedom would improve on the American status quo, with its many economic and institutional restrictions and barriers to access. Moreover, the elimination of billing would *greatly* reduce the hassle confronting patients. The single-payer approach, then, seems likely to achieve the goal of patient freedom.

Will there be any role for private insurance outside the public program? There certainly will be if important categories of services, such as dental or optometric services, are excluded from the public package. Moreover, within the covered categories, there will be some demand for services beyond what is covered, such as cosmetic surgery or psychotherapy for persons who lack any relevant diagnosis. Such services could be provided for a fee or via ancillary private insurance.

Should American health care preserve more of a role for this industry, as the United Kingdom does, by permitting coverage that *duplicates* what the public plan covers? Drawbacks of this option include possibly fragmenting the market if too high a percentage of the public opts for redundant private insurance; less political support for robust coverage in the public plan; and incentives for physicians to cater to those with private insurance if its reimbursement rates are higher. Then again, allowing duplicative private insurance would be less disruptive to the health care status quo in this country, for whatever that's worth, than switching to a single-payer plan without this prerogative, and would increase options for

providers and the rest of us. If we are to favor this approach—an issue I leave open—then the public program must be good enough that relatively few will be tempted to purchase the redundant private insurance.

Another feature that has only been touched upon is tax-based financing. What tax scheme is optimal is open for discussion. I suggest an earmarked health care tax both to protect the funds from being appropriated for other purposes and to permit public awareness of health care spending. Perhaps a progressive income tax would be simplest and fairest. The crucial point, though, is this: Although overall taxes will rise to fund single-payer financing, the elimination of out-of-pocket expenses, employer premiums, and so on—combined with the savings on administration, absence of profit-making within the system, and the like—can be expected roughly to offset the tax in-

There is no reason to think quality would suffer. Indeed, some evidence suggests it would not. A single-payer system would reform the way we finance health care but need not change the delivery.

creases. That is, we can expect to spend no more on health care *per person on average* than we would in our current system, yet we would better achieve health care goals. Although medical utilization will rise—appropriately, since everyone will be able to get care when they need it—the savings will roughly offset the increased expenditure needed for universal coverage.³⁶

Any honest detailing of the single-payer approach must acknowledge its major disadvantages. These will emerge when I discuss objections. Once they are apparent, I will propose a way of addressing most of them that harnesses the power of market competition without abandoning the advantages of single-payer financing.

Responses to Objections

The single-payer approach equals socialized medicine. This is false. Socialist institutions involve not only public funding but also government employment. Although in a single-payer system health care is publicly funded, it is mostly privately delivered. Anyway, the charge of socialism is lame. Were it compelling, we should oppose public libraries, public schools, and the military's medical system.

Patients do not like severe restrictions on their freedom. Yes, so they should like a system that, as the American College of Surgeons noted, appears to be the best way of preserving patients' choice of physicians³⁷ and generally affords greater freedom from hassle than they currently face. As suggested earlier, the single-payer approach is likely to promote patient freedom.

What about freedom to choose among delivery plans offering different levels of care? Earlier we found that the threat of adverse selection motivated standardizing the range of services covered by plans funded by a single payer. This is a price worth paying to avoid adverse selection. Remember, though, that patients will remain free to purchase services or insurance beyond the public package. Indeed, the value of such freedom of choice—and considerations of political feasibility—may exert some downward pressure on the range of services publicly covered, keeping it more modest than might be justified if these considerations were not acknowledged.

Doctors will oppose it. They will have relatively little reason to oppose it. The system will greatly reduce their administrative burden—a major sav-

ings of time, energy, and expense. It will trust them to deliver medicine appropriately without micromanaging middlemen from remote insurance plans. Doctors will have the option of working independently and for fees or under the terms of a qualifying health plan or hospital. In a recent poll, 63.5 percent of doctors who were asked to identify the health care system that would provide the best care for the most people selected the single-payer system.³⁸ While it does not follow that these doctors preferred the single-payer system overall, they evidently appreciated its ability to deliver high-quality care to the most people.

Doubtless some doctors will resent having fees standardized. But the special interest of maximizing physicians' income is surely less important than the widely accepted goals of health care. Doctors will always earn a good living—especially in a country spending at American levels on health care. And good doctors will take satisfaction in practicing medicine well within a system that serves the interests of patients and society as a whole. Reduced administrative burden and expense should be icing on the cake.

Of course, in saying that doctors have little good reason to oppose the single-payer approach, I am not denying that many doctors may oppose it nevertheless. Any proposal for significant health care reform faces that possibility.

A single-payer system will require rationing. All health care systems have to ration—at the very least they must limit access to exorbitant care of dubious benefit, such as “last chance therapies” available only in clinical trials.³⁹ Our present system rations by restricting access on the basis of economic and insurance status, restricting care through managed care, and limiting covered services in public programs. Yes, a single-payer system will ration, but it will do so more intelligently and fairly than we do now.

A publicly financed system will cause long waits for services like Canadians have. This charge is dis-

torted. Generally speaking and as a matter of policy, Canadians who urgently need care are prioritized, so that only those who *can* wait do. (There have been tragic exceptions, however, just as there are exceptions to the American policy that all who need emergency room care will receive it.) Moreover, while Canadians sometimes come to the United States for medical services—a fact cited to support the claim of intolerable waits—a couple of reality checks are in order. First, a careful analysis suggests that the frequency of Canadians coming to the United States *specifically for medical services*—as opposed to coming for some other reason and then needing medical services during their stay—is tiny.⁴⁰ Moreover, Canadian waits occur within a system that is spending much less per person than we spend. Spending at current American levels with the cost-effectiveness of public financing could do much to address the problem.

If services are free, patients will overutilize them. Copayments, which I have left on the table for further discussion, would discourage unnecessary care-seeking. This problem can also be addressed in other ways. Any genuine threat of overutilization must exist in countries like the United Kingdom and Canada where services are free at point of entry. But these countries spend much less than we do while achieving health care goals fairly well. Possibly the mechanisms these countries have developed for discouraging overutilization can be put to use in the United States. Part of the solution, no doubt, is for providers to take responsibility for discouraging and even turning away patients who do not genuinely need medical attention. This should be easier in health plans that are paid on a capitated basis, which eliminates financial incentives for unnecessary care.

Quality will suffer. As far as I know, there is no hard evidence to support this claim. Indeed, it is contradicted by some of the empirical evidence cited earlier. A single-payer

system will reform the way we finance health care but need not change the way we deliver it. Quality is an issue of delivery. With a mixture of fee-for-service financing, capitated payment, and global budgets, delivery can remain much the same.

Would standardized fee schedules and salaries discourage “the best and brightest” from entering medicine? I doubt it, for two reasons. First, the incentives of earning a good living while being able to practice medicine well in a system that’s doing its job seem likely to attract better doctors than the incentive of maximizing income in a dysfunctional system. (“Best and brightest” does not mean “greediest and most shallow.”) Second, other countries with single payers do not seem to have major problems with quality of care despite spending much less on health care than we do.⁴¹ And spending at current American levels would permit better remuneration.

On the other hand, even if there is no empirical evidence suggesting that quality would suffer under a single-payer system, there may still be cause for concern. Suppose the entire system consisted of professionals working either for fees outside of any health plan or on a salaried basis within a plan. There might not be enough economic incentives to promote the high-quality care that we want—especially for those receiving salaries (and no bonuses or the like to encourage excellence and efficiency). Promoting competition among the plans, and permitting plans to motivate their professionals with a variety of payment schemes, seems more likely to discourage lackluster delivery and encourage excellence. I will return to this idea.

Biomedical research will languish. Why? Nothing inherent to the single-payer approach prevents adequate public investment in research, and private sector research will continue. Take pharmaceutical research. Like the British, we can reward innovation and discourage both “me, too” drug research and patent manipulation

(both of which waste many millions of dollars in our current system).⁴² We can also spend much more than the British and still save money. Will drug companies refuse to take the financial risks of drug development unless current American-level prices are maintained? Even with these risks, American drug companies have among the highest profit margins in the business world. The proposition that somewhat lower profit margins—a consequence of annual negotiations between industry and the public insurer—would destroy their incentive seems exaggerated. The challenge will be to find sufficient incentives for pharmaceutical companies within a system that annually standardizes drug prices.

Fee-for-service payment discourages innovation in how patients are treated and how quality of treatment is monitored. There is some truth to this objection. But it applies only to the independent, fee-for-service segment of a single-payer system. Professionals employed in hospitals, health plans, or other institutions working within global budgets or on a capitated basis have at the very least an incentive to break even, motivating discovery of more cost-effective methods. Insofar as the system will promote competition among health plans and among hospitals, there will be the further incentive to compete successfully for patients, who can choose among providers on the basis of satisfaction. None of this, by the way, is to trivialize the intrinsic incentives of practicing medicine well and enjoying the esteem of colleagues and patients; these incentives drive many professionals. But extrinsic, economic incentives are helpful to most professionals and essential to some.

Fee-for-service payment reduces efficiency by encouraging the provision of individual rather than integrated services. Fair enough, but as with the previous objection, this applies only to the independent, fee-for-service portion of the delivery system. On the whole, this difficulty can be satisfactorily addressed through competition

among health plans and other institutions.

Harnessing Competition

Let's take stock. The most significant objections to the single-payer approach, especially when envisioned as a fee-for-service system, are concerns about inadequate incentives for high-quality, innovative, and integrated care. The solution, I suggest, is to harness some of the power of economic competition without permitting the sort of market that leads to adverse selection, excessive diversion of funds away from patient care, and millions of people without insurance. Thus we return to the idea of managed competition. Competition encourages excellence and efficiency in delivery. Managing the competition can prevent market fragmentation while reducing waste. My proposal, therefore, is single-payer financing and managed-competition delivery.

How different is this proposal from other approaches? It differs from other single-payer proposals⁴³ (except possibly Gravel's, which remains vague) in forthrightly acknowledging concerns about this general approach in its paradigmatic fee-for-service form, and in addressing those concerns primarily by harnessing market forces; it also makes no promise to cover "all medically necessary services" and is likely to preserve more of a market open to individual choice. It differs from some single-payer proposals (including Kucinich's) by not making private insurance illegal, as explained earlier.

Will competing health plans include any that are for-profit? Single-payer proposals typically exclude for-profit plans, citing excessive overhead, problems associated with adverse selection, and distortions of clinical decision-making cultivated by the profit motive. I am sympathetic to these charges. Can we trust for-profit plans to serve patients adequately and not subordinate their interests to those of providers and stock-holders? I find it naïve to trust Big Business any more

than Big Government. But since the present approach would permit any individual to join any health plan—so that, by law, financial status would not impede enrollment—we could, once insurance is mandated and adverse selection blocked, allow for-profits to join the competition. If we did, that would further distinguish this approach from other single-payer proposals. For-profit plans would receive the same capitation payments from the public insurer that nonprofit plans would receive. If the for-profits waste too much money, or provide low-quality care, they should lose out in the even playing field that includes nonprofit plans.

The approach recommended here also differs from any standard managed competition proposal. Consider the specification of this approach that embraces vouchers as a mechanism. My proposal differs from the voucher proposal, as typically developed, in granting the government (or quasi-governmental body overseeing the health care system) a greater role in regulation. More specifically, my proposal (1) empowers the public insurer to negotiate annually with industry and professional groups to set drug prices and fees for services delivered by independent professionals, not just capitation rates for health plans; (2) forbids premiums, deductibles, and possibly copayments, so that no one is de facto excluded from any plan by finances; (3) forbids billing of patients for services covered in the public program, massively reducing overhead costs; (4) standardizes the benefits package in the public program to prevent adverse selection, so all plans offer the same benefits, and all independent professionals can be reimbursed for providing those same benefits; and (5) gives doctors a choice between working for a single health plan and working independently on a fee-for-service basis. This proposal offers, I submit, the best of both worlds: public financing and private delivery. Further, while this paper has focused on moral defensibility rather than political feasibility, in American culture

it is politically advantageous to integrate market competition into any proposal featuring public financing.

About Our Benchmark

The single-payer approach appears to be the most cost-effective way to achieve the basic goals of health care. I have examined the major objections to it, some of which—along with our discussion of other reform proposals—recommend a marriage between the single-payer approach and managed competition. My findings, along with replies to objections, have supported the thesis that the single-payer approach is the most morally defensible model for health care reform in the United States.

But why focus on health care goals? One might regard a particular theory of distributive justice (such as Rawlsian, utilitarian, radical egalitarian, or libertarian) as a better basis for evaluation. But the strategy of justifying a health care reform plan on the basis of a theory of justice is undermined by persistent, deep disagreement even among reasonable people about which theory is best.

Meanwhile, Americans care deeply about achieving universal coverage, sensibly containing costs, protecting patient freedom, and preserving high-quality care.⁴⁴ There is more support for these goals, surely, than for any particular theory of justice. Not that broad support directly entails the correctness of these goals; majorities are capable of prejudice and misunderstanding. But none of these goals seems susceptible to such a charge. Not to consider universal coverage a high priority verges on the misanthropic. To deny that costs matter would be impractical and romantic to an extreme. The value of patient freedom, meanwhile, seems too obvious to require defense. Equally obvious is that the quality of health care is very important.

I think these commonly held goals provide an appropriate basis for morally evaluating health care systems and reform proposals. They

form an area of overlapping consensus among all reasonable visions of just health care. On this basis, and on the strength of the evidence about cost-effectiveness, rests the case that single-payer national health insurance—especially when integrated with managed competition—is morally the most defensible reform model.

Now that health care reform has returned as a leading issue of domestic policy, we may perceive a glimmer of opportunity to transform American health care into an institution that adequately serves the American people. Dennis Kucinich and Mike Gravel favor immediate adoption of a single-payer approach (Gravel would combine it with managed competition and vouchers); others would consider it down the political road. We can only hope that sooner or later our society will enact the system that best achieves our legitimate aspirations for health care. As Churchill said, “Americans can always be counted on to do the right thing . . . after they have exhausted all other possibilities.”

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43. See especially the many fine articles by Steffie Woolhandler and David Himmelstein, including "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance."

44. Any reader inclined to be skeptical may return to note 11.