VIEWPOINT

Is Single Payer the Answer for the US Health Care System?

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The recent challenges to the Affordable Care Act (ACA), which has increased the number of individuals with health insurance in the United States but has had little effect on cost, has revived the debate about a single-payer health care system.[1] Whether a single-payer system is the answer or not depends on what question is being asked and what form single payer will take. Single payer can take many forms, and many questions can be asked. This Viewpoint considers 3 problems of US health care: the uninsured, poor health outcomes (relative to other high-income countries), and high cost. In discussing cost, it will be critical to consider the form that a single-payer health care system might take.

Regarding the uninsured, single payer in almost any form could achieve universal health care insurance coverage. But so could many less-comprehensive reforms. Despite the success of the ACA in increasing the number of individuals in the US who have health insurance, approximately 25 million US residents remain uninsured. Universal coverage requires (1) subsidies for individuals who are too poor or too sick to acquire insurance at actuarial correct premiums, and (2) compulsion (ie, a mandate) for everyone else to participate and implicitly contribute to the subsidies. No country achieves universal coverage without subsidies and compulsion. The United States could achieve universal coverage relatively promptly if it were willing to adopt these 2 principles. Public attitudes toward subsidies and compulsion have been assessed by analyzing answers to a Pew Research Center survey of the US population, which included almost 2000 adults.[2] A modest majority favored subsidies only, and a modest majority favored compulsion only. There was not, however, a majority who favored subsidies and compulsion.

> ... a single-payer system could easily provide for universal coverage, but so could less-comprehensive reforms, if the public would support subsidies and compulsion.

Would single payer improve health outcomes? At present, life expectancy in the United States is lower than in other high-income countries, and inequality in life expectancy is greater.[3] Single payer might improve health outcomes because medical care would be more equally distributed, and this might decrease mortality among the poor. Opponents of this approach may argue that attention to the social determinants of health (such as income, education, family structure, and other factors) would be a more effective way to improve health outcomes.[4] England has some better health outcomes than the United States, and spends only half as much per capita on medical care. A possible explanation is that only 10% of the English population lives in poverty compared with 17% in the United States.

Probably the most important question about single payer is whether it would result in better control over costs. The high cost of care in the United States (approximately $10 000 per person each year) contributes to several major national problems: stagnant or slow-increasing wages; reductions in state and local expenditures for education, infrastructure, and other valuable programs; and an increase in the national debt. If, over time, the United States could limit health care spending (currently 18% of the gross domestic product [GDP]) to the level of other high-spending countries (currently 12% of the GDP), more than 1 trillion dollars could be available each year to meet other private and public needs.[5]

A single-payer system would undoubtedly lower administrative expenses. US health care currently has a fragmented financing system that relies on employment-based health insurance, individual insurance, payroll taxes, income taxes, business taxes, state and local taxes, payments by patients, and the federal deficit. Costly programs are needed to raise revenue from those many sources. In addition, hospitals, physicians, and other entities and individuals that provide health care must employ armies of "back office" personnel to bill and collect for that care.

In addition, a single-payer system would have the bargaining power needed to offset the monopoly power of drug and device manufacturers and hospitals and physicians. At present, prescription drug prices in the United States are double the prices in other Organisation for Economic Cooperation and Development (OECD) countries. The expensive artificial devices required for every hip and knee replacement carry a US price tag more than 3 times that of other countries. In addition, according to a British specialist in joint replacement, the fees of US physician specialists are double or triple those of their peers in other countries (Luke Jones, DPhil [Oxon], FRCS, oral communication, October 15, 2017). Recent mergers and acquisitions by hospitals and integration with physician groups often increase efficiency, but they also increase the monopoly power of the organizations that provide care. Single payer could offset this imbalance.

Excessive expenditures for administration of the US health care system and monopoly prices for material and personnel inputs to that system account for a

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substantial portion of the higher cost of health care in the United States.[6] More than half the difference between 18% of GDP and 12% of GDP, however, is attributable to a more expensive mix of services in the United States. The analogy is not perfect, but the biggest difference between health care in the United States and other high-income countries is similar to that between food expenditures at Whole Foods and at Wal-Mart. In the United States, medical care takes the form of greater use of specialists and subspecialists, greater use of technology such as magnetic resonance imaging (MRI) scans and mammograms, and a more expensive mix of drugs (Whole Foods). US medical care does not take the form of more basic care (Wal-Mart), such as visits to physician or days in acute care hospitals, which are frequently greater in peer countries. It is questionable whether this more expensive mix produces better health outcomes. It is not difficult to find examples in the United States, such as having more than double the number of MRI scans as in the average OECD country, but with small marginal benefits. It is difficult to find important examples in Canada, France, Germany, or Scandinavia where the more economical mix results in worse health outcomes. Harvey Fineberg, former President of the National Academy of Medicine, has warned, "[W]e cannot attain superior health results by continuing to outspend others on medical care."[4]

The fragmented financing system is one of the principal explanations for the high cost of medical care in the United States. A careful consolidation of financing into some form of single-payer system is probably the only feasible solution. But single payer is easier said than done. To devise and operate 1 system for the US population (325 million) poses an enormous policy and managerial challenge. Canada, with only one-tenth the US population, found it desirable to have provincial health insurance plans rather than a national one. In the United States, that would mean 50 separate state health insurance plans. Some states might rise to this challenge; many would have difficulty; and some states would encounter major difficulties. For instance, for some states, an annual health insurance budget in the tens of billions of dollars may offer a target for lobbying, favoritism, bribery, and corruption that would probably be too difficult to resist.

To have any chance of success in the United States, single payer would have to be simple, require a minimum of bureaucracy, be based on decentralized organizations to deliver care, and provide opportunity for individuals to choose among competing health plans. Choice is critically important for patient satisfaction and its role in competition. The provision of implicit subsidies to the poor and sick should not require any bureaucratic determination of income or health status. Universal insurance, paid for by a broad general tax that everyone pays in proportion to consumption of all goods and services, would be a progressive way to accomplish this.[7]

The insurance could allow each individual (or family) to choose membership in a local health plan that takes responsibility for the individual's health and is reimbursed on a risk-adjusted per-capita payment. This system could provide the plans with incentives for efficiency and effectiveness and leave them free to organize production as they deem best. Plans could compete with each other for members on the basis of service and quality of care. Choice of plan could be open annually. Individuals who wanted to purchase more coverage than provided for in the universal plan would be free to do so with their own after-tax dollars. Congress would have control over the total health care bill by its setting of the tax rate.

Some opposition to single payer reflects concern about its effects on health care innovation. Less innovation is not always harmful because elimination of very expensive interventions that have small incremental benefits would free resources for use with greater social value. A free society should allow individuals to acquire more than the universal plan with their own after-tax dollars; the key question concerns care that is collectively paid for by single payer or some other third-party insurance coverage. Rational policy would want to limit such care to that which is reasonably cost-effective.

In conclusion, a single-payer system could easily provide for universal coverage, but so could less-comprehensive reforms, if the public would support subsidies and compulsion. Single payer might improve health outcomes by providing more equal access to medical care, but attention to the social determinants of health might be a more effective way to improve health. The strongest case for single payer is its potential to control the cost of care. The current fragmented system of financing care precludes such control.

ARTICLE INFORMATION

Published Online: December 18, 2017. doi:10.1001/jama.2017.18739

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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