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The Virtues and Vices of Single-Payer Health Care

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The 2016 U.S. presidential campaign has produced many surprises. One unexpected turn is the reemergence of single-payer health insurance on the public agenda. Senator Bernie Sanders has made Medicare for All a centerpiece of his platform. His opponent for the Democratic party's presidential nomination, former Secretary of State Hillary Clinton, has criticized Sanders's plan as unrealistic. An old debate has thus reopened. What are the virtues and vices of single-payer reform? Is it a realistic option for the United States or a political impossibility?

First, a note on language. "Single payer" is often used loosely to refer to everything from Canadian national health insurance to the British National Health Service (NHS) and even Obamacare — though depicting the Affordable Care Act (ACA) as a "slippery slope" to single payer is bizarre, given that it relies on private insurance. U.S. observers often mistakenly lump all foreign health systems together under the single-payer label — a classification that grossly oversimplifies the range of models in place elsewhere.[1,2] In some rich democracies (Germany, the Netherlands, and Switzerland among them) people enroll in multiple insurance plans, which are typically highly regulated and are operated by private companies or nonprofit associations. Alternatively, in the NHS, the government traditionally owned most hospitals and directly employed many physicians.

Most U.S. single-payer advocates instead have in mind emulating Canada, where all legal residents in each province or territory receive coverage from one government insurance plan for medically necessary hospital and physician services. Canadians can obtain private policies for supplemental services not covered by the government plan. The government does not directly employ most doctors, nor does it own most hospitals, though their payments come from the single provincial insurance program. Canadian national health insurance arrangements — and Taiwan has a similar system — resemble traditional U.S. Medicare, with public financing for privately delivered services.[3] Sanders is not the only presidential candidate to find this model appealing. Donald Trump has praised the Canadian program, though recently he suggested it wouldn't work here.

Proposals for U.S. single-payer reform have a long history. A 1943 bill subsequently endorsed by President Harry Truman in 1945 envisioned national health insurance funded through payroll taxes. That bill and subsequent efforts by the

Truman administration to pass universal insurance went nowhere. However, Medicare, conceived in the 1950s and enacted in 1965, embodied the single-payer model. Medicare's architects saw it as the cornerstone of a national health insurance system. They believed that Medicare would eventually expand — with children perhaps the next group to join the program — to cover the entire population. That aspiration was never realized. Meanwhile, Congress created Medicaid as a separate program for some categories of low-income Americans, including families with dependent children, further fragmenting the insurance pool.[4]

Single payer enjoyed strong support during the early 1970s among liberal Democrats such as Senator Ted Kennedy (D-MA), yet it never came close to passing. Subsequently, its political fortunes faded. Democratic policymakers increasingly pursued incrementalism (primarily through Medicaid expansion) and more conservative models that relied on private insurance (managed competition) as the only feasible reform routes. Medicare itself underwent a transformation as the role of private insurers in the program grew substantially. The 2010 ACA represented both a landmark achievement in expanding access to insurance and the culmination of a turn away from single payer. In 2009, the House of Representatives did pass legislation creating a Medicare-like government insurance program that would be available to the uninsured in competition with private plans. But this "public option" couldn't clear the Senate. Even with a Democratic president and large Democratic congressional majorities, a narrow remnant of single payer failed to pass.

Nevertheless, the single-payer approach enjoys a dedicated following among groups such as Physicians for a National Health Program, and Sanders's embrace has generated renewed attention for the idea. Regardless of the outcome of the 2016 election, the single-payer debate will persist. The enduring appeal of Medicare for All is understandable, given the fragmented, inequitable, costly, profit-driven, and wasteful nonsystem that prevails in the United States. The ACA's shortcomings are sufficiently serious, single-payer adherents argue, that Obamacare has left unsolved many of U.S. medicine's major problems. For all the ACA's considerable achievements, health insurance and medical care are still unaffordable for many people. In a country where nearly 30 million persons remain uninsured, where health insurance is increasingly thinned out by rising deductibles and cost sharing, where even insured patients face staggering bills and the prospect of medical bankruptcy, where myriad insurers and payment systems generate astonishing complexity, and where more money is spent on administration than on heart disease and cancer,[5] it's no surprise to hear calls for sweeping change.

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The lessons of Canadian national health insurance are as straightforward as they are neglected. Having a single government-operated insurance plan greatly reduces administrative costs and complexity. It concentrates purchasing power to reduce prices, enables budgetary control over health spending, and guarantees all legal residents, regardless of age, health status, income, or occupation, coverage for core medical services.[1,2] Canadian Medicare charges patients no copayments or deductibles for hospital or physician services. Controlling medical spending does not, the Canadian experience demonstrates, require cost sharing that deters utilization. The Canadian system is hardly perfect. All countries struggle with tensions among cost, access, and quality; at times, Canada has grappled with fiscal pressures, wait lists for some services, and public dissatisfaction.[1] Yet its problems pale in comparison to those in the United States.

The substantive virtues of single-payer programs are compelling. But so are their political liabilities. Medicare for All, which aims to constrain health care spending, faces intense opposition from insurers, the medical care industry, and much of organized medicine. It would trigger

fierce resistance from conservatives and the business community and anxiety in many insured Americans fearful about changing coverage and the specter of rationing. The ACA's comparatively conservative reform approach inspired false charges of "socialized medicine," "pulling the plug on grandma," and "death panels." It takes only a little imagination — or a look back at the history books — to predict the reactions that an actual single-payer plan would evoke.

Single payer would also require the adoption of large-scale tax increases. Although Americans would save money by not paying premiums to private insurers, the politics of moving immense levels of health care spending visibly into the federal budget are daunting, given the prevailing antitax sentiment. Furthermore, converting our long-established patchwork of payers into a single program would require a substantial overhaul of the status quo, including the ACA.[4] Then there are the familiar institutional barriers to major reform within U.S. government, including the necessity of securing a supermajority of 60 votes in the Senate to overcome a filibuster.

An audio interview with Dr. Oberlander is available at NEJM.org

In short, single payer has no realistic path to enactment in the foreseeable future. It remains an aspiration more than a viable reform program. Single-payer supporters have not articulated a convincing strategy for overcoming the formidable obstacles that stand in its way. Nor have they, despite substantial public support for single payer, succeeded in mobilizing a social movement that could potentially break down those barriers. The pressing question is not about whether Medicare for All can be enacted during the next presidential administration — it can't — but where health care reform goes from here.

It's possible that some states could, through waivers that begin in 2017, consider adding a public option to their marketplaces or even adopt single-payer systems. Yet Vermont's recent struggles to make a modified single-payer plan work underscore the challenges to state action. At the federal level, incremental steps toward Medicare for All, such as expanding program eligibility to younger enrollees, are conceivable — though challenging in this political environment. Moreover, the fight over Obamacare is not over. Preserving and strengthening the ACA, as well as Medicare, and addressing underinsurance and affordability of private coverage is a less utopian cause than single payer. I believe it's also the best way forward now for U.S. medical care.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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What Do I Need to Learn Today? — The Evolution of CME

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The point at which a clinician takes ownership of his or her own learning agenda is a pivotal moment in professional growth. But as postgraduate medical education evolves to become more learner-centric, new approaches and expectations have created pressures on the continuing medical education (CME) system and left some physicians frustrated.

Now that information is ubiquitous, simple information exchange has relatively low value; in its place, shared wisdom and the opportunity to engage in problem solving in practice-relevant ways have become key. Physicians seeking professional development can recognize when they're actively learning and tend to embrace activities that allow them to do so. Education that's inadequate, inefficient, or ineffective, particularly when participation is driven by mandates, irritates physicians who are forced to revert to "box-checking" behavior that's antithetical to durable, useful learning.