

UNIVERSAL ACCESS, LOWER COST

WHY THE U.S. NEEDS A SINGLE-PAYER HEALTH CARE SYSTEM



A Report from Chairman Bernard Sanders
Subcommittee on Primary Health and Aging
U.S. Senate Committee on Health, Education, Labor & Pensions
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UNIVERSAL ACCESS, LOWER COST: WHY THE U.S. NEEDS A SINGLE PAYER HEALTH CARE SYSTEM

KEY FINDINGS:

- The United States ranks 42nd in life expectancy among countries around the world.¹
- Today millions of Americans – one in five sick people – visit the emergency room for care they could have received from their primary care practitioner. In fact, nearly half of emergency room patients in the U.S. would have gone to a primary care provider if they had been able to get an appointment at the time one was needed.²
- In 2012, the U.S. spent nearly 18 percent of its Gross Domestic Product (GDP) on health care. This is compared to 12 percent in France, 11 percent in Denmark and Canada, 9 percent in the United Kingdom and Norway, and less than 7 percent in Taiwan.³
- The U.S. spends about \$3,000 more per person per year than many of the Organisation for Economic Co-operation and Development (OECD) countries.⁴

Introduction

Many Americans receive the best health care in the world, including state-of-the-art screenings, cutting edge treatments, and life-saving drugs. At the same time, millions of Americans have little or no access to even the most basic health care services. While the U.S. spends nearly twice as much on health care as any other country in the world, our health overall is worse than other high-income countries. The reality is that the staggering amount we spend on health care does not result in better health.

We can do better. We can provide access to high quality, affordable health care to all

Americans and save money at the same time. The successful health care systems in other countries can serve as examples of ways to improve our system to expand access, eliminate red tape, lower costs, and improve the health of our population. America can improve the value of our health care system—achieving better health, better patient and provider experience, and lower costs – by adapting aspects of other countries' successful systems to our own.

It is time for the U.S. to join the rest of the industrialized world and guarantee access to health care as a right of all people, not just a privilege for those who can afford it.

HOW THE U.S. HEALTHCARE SYSTEM STACKS UP TO OTHER COUNTRIES

The U.S. lags behind many other high-income countries in the performance of its health care system in terms of health outcomes, cost, health care coverage, access to care for patients, and administrative burden for providers.

Health Outcomes

The United States ranks 42nd in life expectancy among the world's countries.⁵ Among the 34 OECD countries, the U.S. ranks 31st in infant mortality.⁶ Compared to Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom, America ranks last in patient safety, efficiency, cost-related access, equity, and long, healthy, and productive lives. Compared to these other countries, the U.S. is tied for last in overall access and is next-to-last in quality of care.⁷ The U.S. also ranks last among 16 industrialized countries on national rates of mortality

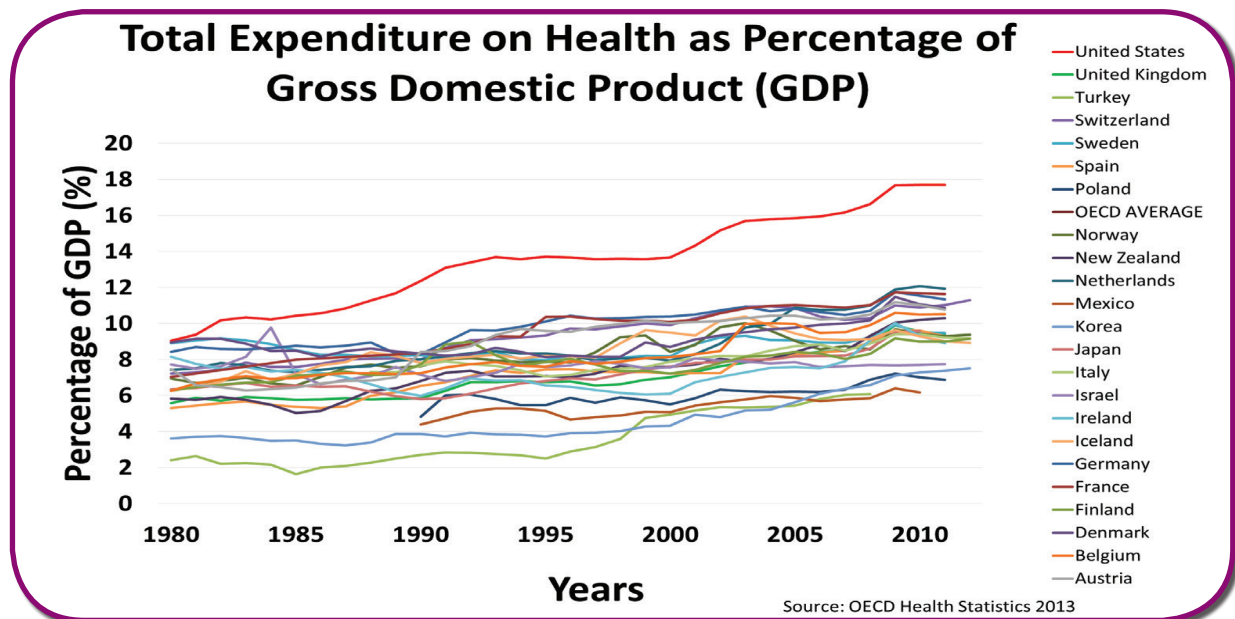
amenable to health care (deaths before age 75 that could have been prevented or treated with timely and effective care). The amenable mortality rate is 68 percent higher in the U.S. than in leading countries. Nearly 91,000 premature deaths could be prevented if the U.S. had the amenable mortality rate of France.⁸

Cost

America spends far more on health care than any other industrialized country. In 2012, the U.S. spent an average of \$8,900 per person each year on health care.⁹ That is about \$3,000 more per person per year

"The French have easy access to primary health care, as well as specialty services, at half the per capita costs of what we spend in the U.S."

– Victor Rodwin, PhD, MPH, Professor of Health Policy and Management, Robert F. Wagner School of Public Service, New York University, New York, NY



than many of the other OECD countries where every person is covered. In 2012, the U.S. spent nearly 18 percent of its GDP on health care. This is compared to 12 percent in France, 11 percent in Denmark and Canada, 9 percent in the United Kingdom and Norway, and less than 7 percent in Taiwan.¹⁰

Patient Experience

Americans who are fortunate enough to have insurance must navigate a health care system that is fragmented and bewildering. Individuals have to make sure that the provider they would like to see will accept their insurance or find a provider that will. Patients complain that they are treated like a series of medical problems rather than a person, frequently getting shuffled from one provider to another.

Furthermore, patients in the U.S. often have difficulty seeing a doctor when they need one. According to The Commonwealth Fund International Health Policy Survey of 11 industrialized countries, only 57 percent of Americans were able to see a doctor or nurse the same or next day, and nearly 20 percent of Americans had to wait six days or more.¹¹ Patients in the U.S. also report higher out-of-pocket expenses than many other countries and more access challenges, particularly on evenings and weekends.¹²

Today millions of Americans—one in five sick people—visit the emergency room for care they could have received from a primary care practitioner. In fact, nearly half of emergency room patients in the U.S. would have gone to a primary care provider if they had been able to get an appointment at the time one was needed, and there is little coordination or follow-up provided in these settings.¹³

Even after the implementation of the Affordable Care Act, over 40 million Americans remain uninsured.¹⁴ For those without insurance, access to health care can be even more challenging. People without insurance must sometimes make the very difficult decision about whether to spend their money on seeing a doctor, feeding their families, or heating their homes. Uninsured individuals delay needed care which can result in poorer health and added costs when serious conditions arise.¹⁵



Provider Experience

Health care providers in the U.S. spend a significant amount of time on paperwork leaving less time to see patients. Why is this the case? Most health care providers in the U.S. contract with multiple insurance companies because their patients are covered by different insurance plans. They want to be able to treat patients and get paid to do so. Each insurer typically has its own provider network which means making referrals can be complicated. Different insurance plans also cover different prescription drugs. As a result, a health care provider treating two patients with the same problem but different health insurance plans may have to refer them to different specialists, prescribe different drugs, and get paid different amounts for

the same care provided to each patient.

The complexity of these different prices and contracts adds enormous expense to the health care system and administrative burdens for medical practices. American doctors spend more than 3 hours in a typical week dealing with insurance companies, nurses and medical assistants devote more than 20 hours per physician per week, and clerical staff provide over 53 hours per physician per week on insurance-related activities.¹⁶ Inefficiencies due to administrative complexity cost the United States over \$190 billion per year.¹⁷ Many American health care providers say that simplified billing, referring, and prescribing would allow them to focus more on the needs of their patients.

“Americans appear to have traded freedom of choice among providers for the sake of choice among insurers.”

—Tsung-Mei Cheng, LLB, MA, Health Policy Research Analyst, Woodrow Wilson School of Public and International Affairs, Princeton University, Princeton, NJ

SOLUTIONS: WHAT CAN OUR COUNTRY DO?

Many industrialized countries have single-payer health care systems that offer universal coverage and access to providers. These countries achieve better health outcomes and accomplish all of this at a far lower cost than the United States. There are several different single-payer models, and many countries, when examining how to strengthen their health care system, have adapted the single payer approach to meet its country's needs.

“Single payer” is a term that describes how a country pays for its health care. In a pure single-payer system, one entity is the payer.

This entity collects health care fees and pays for all health care expenses. The prices are negotiated by the payer, so there is a set price for tests and procedures. In some countries, the central government is a single payer to private providers who deliver care. This model is used in Canada, and it is also used by the Medicare program here in the U.S. In some countries, like the United Kingdom and Taiwan, the central government plays the role of both payer and provider of health care. This is similar to the Veterans Health Administration in the U.S. Some countries have a mix of single-payer coverage financed by the government covering basic services and supplemental coverage offered through multiple nonprofit or private payers.



“Working within a single-payer insurance structure helps us to better address and tackle many of the health care challenges shared by all developed nations, including rising costs, variation in quality, and inequities of access.”

— Dr. Danielle Martin, MD, MPP, Vice-President Medical Affairs and Health System Solutions, Women's College Hospital, Toronto, Canada

There are numerous features of successful single-payer systems that contribute to their success. The second half of this report will highlight four key elements of high performing single-payer health care systems that the U.S. should adopt.

“Residents living in remote mountainous areas and offshore islands, and the poor, the disabled, the aged get pretty much the same access and health care as anyone else.”

– Ching-Chuan Yeh, MD, MPH, former Minister of Health for Taiwan; Professor, School of Public Health, College of Medicine, Tzu-Chi University, Hualien City, Taiwan

STRENGTH #1: UNIVERSAL COVERAGE

One of the main advantages of single-payer health care systems is universal coverage. Single-payer health care systems provide health insurance to virtually all of the country’s citizens. This means that the number of uninsured citizens in countries with single-payer systems is almost zero as compared to the U.S. where 40 million people currently lack health insurance.¹⁸ While the Affordable Care Act provides an important new opportunity for people to get health insurance, millions of Americans will remain uninsured even after its full implementation. Everyone needs health care whether they have insurance or not. As a result, providing people with coverage is important not only for promoting physical and mental health but also financial health too. Millions of Americans today have medical debt or are forced into medical bankruptcy because they are uninsured or underinsured.

STRENGTH #2: BETTER BARGAINING POWER & PRICE NEGOTIATION

The U.S. has over 5,700 hospitals and about 835,000 practicing doctors, all of whom negotiate their own prices with hundreds of different health insurance companies.¹⁹ As a result, the price of common procedures and surgeries vary greatly by the provider performing the surgery, the hospital in which the surgery is performed, and the patient’s insurance company. The cost to the patient can range from almost nothing to thousands of dollars, and it is difficult, if not impossible, to know the charge for services ahead of time.

For every medical service administered in the U.S., providers have to first negotiate a separate price with each insurer, bill the correct insurer when the service is performed, and bill the patient for the costs that are not covered by that insurer. To accomplish this, doctors’ offices and insurance companies build large billing and claims departments which further creates administrative headaches and added costs.

Most other industrialized countries have a system where one set of prices is negotiated across the entire system which greatly simplifies billing procedures and lowers costs. Canada, for example, has such a system and its per capita health care administrative costs are



one-third of those for the United States.²⁰ The money saved in avoiding complex billing procedures means that there is more to spend on direct patient care or on other important services that can also improve people's health.

Similarly, countries bargaining on behalf of their entire population are able to negotiate better prices ranging from lower prices for hospital care to lower drug prices from pharmaceutical companies who wish to sell their drugs in that country. The differences in price are significant. The cost of a 1-month supply of Avastin, a cancer medication, is \$8,800 in the United States compared with less than \$4,000 in the U.K.²¹ A cesarean section costs an average of more than \$14,000 in the United States and less than \$6,000 in Canada.²²

Within the United States, both Medicare and the VA benefit from some modest negotiating power and have far lower overhead expenses than private insurance companies. The administrative overhead for private insurance companies in the U.S. is over 12 percent (and as high as 30 percent for the individual private insurance market) while for Medicare it is less than 2 percent.²³

STRENGTH #3: BETTER ACCESS TO PRIMARY CARE

While the Affordable Care Act has led to millions of Americans gaining health insurance coverage, some for the first time, millions more will remain uninsured. Even for those who do gain coverage, an insurance card is only the first step; people then must be able to access a provider to get the health care services they need. Finding a provider can be difficult in many parts of the country. In fact, there are approximately 6,000 designated Primary Care Health Professional Shortage Areas (HPSAs) across the U.S. where there are not enough providers to meet the primary care medical

needs of the population.²⁴

Areas in the U.S. with a higher proportion of primary care physicians have lower rates of hospitalization, hospital readmissions, and emergency room use, resulting in lower costs.²⁵ Increasing the number of primary care physicians in a community improves its health outcomes. An increase in the primary care physician supply by just one doctor per 10,000 citizens can lower mortality by over five percent.²⁶ While specialists play an essential role in treating patients with complex conditions, too many specialists in a health care system can add costs without improving overall quality of care or health outcomes.

The United States has far fewer primary care doctors as a percentage of the physician workforce than other countries that have better health outcomes.²⁷ Just one third of the physician workforce in the U.S. practices primary care, and many of these providers are nearing retirement.²⁸ Shortages are growing across the country as fewer than seven percent of U.S. residency graduates are choosing careers in primary care.²⁹

The U.S. needs more primary care doctors. Expanding loan forgiveness programs for students choosing primary care careers through the National Health Service Corps, increasing reimbursement rates for primary care



services, and increasing primary care residency training positions through programs at Teaching Health Centers would help to create an optimal health care workforce for America.

“All Danish citizens have access to care; no one may be denied services on the basis of income, age, health, or employment status.”

– Jakob Kjellberg, MSc, Professor, Program Director for Health, KORA-Danish Institute for Local and Regional Government Research, Copenhagen, Denmark

STRENGTH #4: SUPPORT FOR SOCIAL SERVICES/INTEGRATION OF SOCIAL AND HEALTH CARE SERVICES

Medical care is vital, but there are also factors that are typically addressed outside the traditional health care system which are also extremely important to health. For example, education is a critical foundation for health and getting good jobs. People with lower levels of education face serious health disadvantages, including shorter lives, higher rates of illness, and greater disability.³⁰ Other social factors such as poverty are also associated with worse health outcomes, including premature death.³¹

In the United States, even if someone has access to care, receives an accurate and timely diagnosis, and is prescribed appropriate treatment, that treatment can fail if social supports are inadequate. For example, if a family cannot afford needed medication or does not have transportation to get follow-up care, the patient may not get better. If a family cannot afford healthy food or lives in a neighborhood where it is unsafe for children to play outside,

their health will decline.

Thus, the health of a population can suffer when social determinants of health are underemphasized or ignored. In fact, countries that spend more on social services have lower rates of infant mortality, better health, and increased life expectancy. In fact, spending on social services can have a greater impact on health than spending on health care services.³²

As can be seen from the graph below published in *BMJ Quality and Safety*, the United States spends far less on social services and far more on health care services than many other countries.³³ The fact that our health outcomes are worse than these countries may indicate that we are spending too much on health care services while not spending enough on social services.



The three Scandinavian countries shown in the graph (Sweden, Norway, and Denmark) all make proportionately large investments in social services and integrate them with medical services—and exhibit far better health outcomes than the United States. Seventy-five percent of health is due to social factors.³⁴

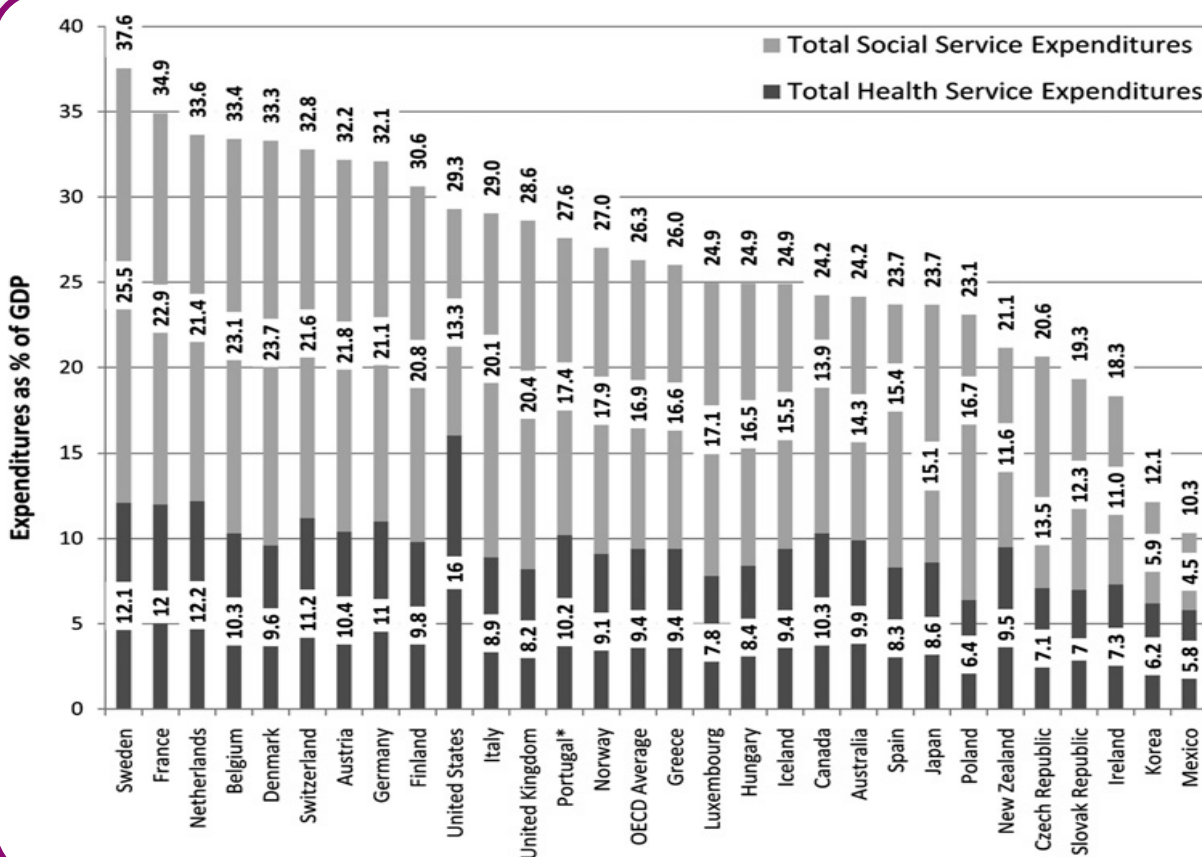
It is time that the U.S. invest in health care models and social services to improve the nation's health.

STATE LEVEL REFORMS

Vermont is on its way to becoming the first state in the country to implement a single-payer health care system. Here is how the program will work: each resident under the age of 65 (with few exceptions) will receive comprehensive health insurance from the State. The State will negotiate prices for medical services and all bills for covered services will be sent to the State or the administrator of its choosing. To finance the system, Vermont will combine federal funds for Medicaid and other programs enacted by the Affordable Care Act with another source of revenue,

possibly a payroll tax that would replace the monthly premiums employers and employees currently pay. This system will provide Vermonters with universal coverage and access.

In addition to Vermont, other states are also considering or pursuing some of the reforms highlighted in this report. Maryland has implemented the first all-payer rate setting commission that determines single pricing for hospital services, a key element in many successful single-payer models. California's legislature has twice passed a single-payer bill, but the legislation was vetoed by former Governor Arnold Schwarzenegger. Hawaii passed a single-payer bill in 2009, which was vetoed by former Governor Linda Lingle. Other states, including Pennsylvania, New York, Oregon, Delaware, Maine, Washington, and Colora-



do, have commissioned financing estimates, have pending single-payer state legislation, or have ballot efforts in progress.

CONCLUSION

Americans need a health care system that is easier to access, easier to navigate, and easier to afford. Each person in our country should be able to access the health care they need regardless of their income or where they live.

We can achieve the dream of access to high quality care for all Americans, a healthier population, lower health care costs, and more robust social programs. If our country would move toward implementing the policies discussed in this report – universal access to health care, administrative efficiencies and stronger bargaining power, expanded primary care, and enhanced social safety net programs – the U.S. would see a health care system that is less complex, more transparent, and produces better health outcomes at a lower cost.

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