Single-payer health care

More physicians are considering it, but is it a realistic option?

BY KIM KISER

Richard Horecka, MD, admits he was skeptical when several medical students and residents brought a resolution on single-payer health care to the Minnesota Academy of Family Physicians (MAFP) House of Delegates in 2013. The family physician from Benson, Minnesota, thought it would go down in defeat in the same way resolutions to support such a system had at the academy’s national meetings. “I thought it would be a big fight,” he told a gathering of physicians and medical students who came to discuss the issue last summer at the University of Minnesota. “But there was almost unanimous support.”

That’s because, rather than asking for MAFP’s endorsement, the resolution simply called for the academy to study the pros and cons. So when the MAFP board decided to create a task force to explore single payer, Horecka volunteered to lead it. “I realized as a physician who had been practicing for 30 years, I knew very little about single payer. And instead of being closed-minded, it made sense to me, and to many of our members, to become informed about it,” he says.

The task force, which included family physicians from all over the state as well as medical students and residents, met throughout the year. At those meetings, some of Horecka’s beliefs were challenged. He became convinced that single payer wasn’t “socialized medicine,” in which care is provided and funded by the government, or a “government takeover of health care,” as some have accused it of being, and that such a system just might work in Minnesota. “I learned that the misconceptions we had in the past about the Canadian or British system were just that—misconceptions,” he says. “I think single payer can be
something we could comfortably live with and not have a dramatic change in the way we practice medicine.”

The push for single payer
The debate over single-payer health care has been going on in Minnesota for more than 20 years; during nearly every legislative session, proposals start and stall. However, it wasn’t until 2007 that physicians truly engaged in the discussions. That year, the Minnesota chapter of Physicians for a National Health Program (PNHP) formed. Their goal: to move to a comprehensive single-payer system that provides coverage for all.

More than 900 physicians and medical students in Minnesota have signed PNHP’s resolution supporting single payer. “We have representation across the specialties,” says Dave Dvorak, MD, an emergency medicine physician who has been a member for the last four years and is an outspoken proponent of single payer.

Dvorak’s work in both the ED and in a clinic that served a low-income population convinced him of the need for single payer. In both settings, he met patients who couldn’t afford care even though they had health insurance: There was the young man with an ankle fracture who did not have surgery because he couldn’t come up with the $3,000 he needed to pay his deductible; the woman who didn’t refill her epi pen prescription because of the $200 cost and ended up in the ICU following an anaphylactic reaction; the single mom with a high-deductible policy who spent 40 percent of her income one year on premiums and costs for a two-day hospitalization. “It convinced me this was a system that had to change,” he says.

He says the Affordable Care Act (ACA) hasn’t solved that problem. Although it has brought more people onto the health care rolls, many have found they can only afford policies with high deductibles. “We’ve entered the era of the $5,000 deductible,” Dvorak explains. “Patients think they have insurance coverage until they get sick and realize they have to come up with $5,000 to pay bills and their budget doesn’t allow for it.” A Minnesota Department of Health and State Health Access Data Assistance Center (SHADAC) study found that in 2013 nearly 19 percent of Minnesotans reported forgoing medical care—not filling prescriptions, putting off recommended tests and procedures, not following up with their physicians—because of the cost; 28 percent reported problems with paying medical bills or getting needed care because of costs. Dvorak notes that this is neither a new phenomenon, nor the fault of the ACA. “All you really need to do is look back over 10 to 20 years to see that these trends [the consequences of high-deductible health plans] have been accelerating,” he says.

In addition to concern for patients with inadequate coverage or high deductibles, frustration with the administrative work required by insurers is driving physicians toward single payer. “The whole idea of prior authorization and visit limits and restricted networks—when you add it up, the burden falls on doctors and that’s reaching somewhat of a breaking point,” says Chris Reif, MD, MPH, a family physician with Community-University Health Care Center and a member of the MAFP task force.

“Think those two things: administrative work getting worse and worse and seeing more people with insurance but who still have these big burdens—they compromise my job and mission to provide care,” he explains.

Those who favor single payer see it as solving both problems. They also see it as a way to streamline an insurance industry that currently includes Medicare, Medicaid, the VA, self-funded plans and more than 1,000 private insurers—all of which have their own drug formularies, provider networks and prior authorization requirements.

Dvorak cites a 2003 New England Journal of Medicine article that noted 31 percent of health care dollars go toward administration in the United States, compared with 16.7 percent in Canada. “The money spent on overhead would be
redirected toward health care,” he says. A 2012 Lewin Group analysis estimates that with a single-payer system, everyone in the state would have a basic level of coverage and that total health spending would be reduced by $4.1 billion a year.

**A feasible option?**

Although PNHP makes the case that reallocating money spent on overhead and administration, consolidating the public dollars currently received and imposing a modest tax on individuals (based on one’s ability to pay and in lieu of premiums, deductibles and co-pays) would adequately fund a single-payer system, some argue that such sources may not be sustainable. Lynn Blewett, PhD, a professor in the University of Minnesota School of Public Health and director of SHADAC, who also spoke at the August gathering, noted that a single-payer system could be more vulnerable than our current system during a recession, when tax revenues are lower.

Also, a state-based single-payer system wouldn’t truly encompass everyone because employers that self-insure are governed by the federal ERISA law, rather than state law. As such, they would be exempt from participating. “The states have no regulation over self-insured plans,” Blewett says. In order for that to happen, “there would need to be some kind of waiver or change to the pension law that oversees self-insured plans.” Critics also argue that single-payer advocates don’t take into account the full effect a switch to single payer would have on the health insurance industry, which employs approximately 20,000 people in Minnesota. The Lewin Group estimates about 16,700 of them, as well as those who handle insurance functions for hospitals and clinics, would lose their jobs if the state were to move to single payer. Minnesota single-payer advocates have recognized the need to devote resources to the retraining of those displaced workers.

**What’s next?**

Blewett says creating a single-payer system in Minnesota would be difficult because

(continued on page 20)
school enrollment and recruitment of international medical graduates in order to control costs is to blame. “They overshot the market a bit and ended up with far fewer doctors than intended,” Kurisko says. (The Canadian Institute for Health Information notes that although the number of doctors per capita has been rising since about 2006, there is still a shortage in rural areas and many Canadians still do not have a primary care physician.)

When Kurisko was practicing in Thunder Bay, the Ministry of Health considered 13 radiologists to be an adequate number to serve the area. The community had only three, all of whom were members of his practice. “We were desperately overworked,” he recalls.

When Kurisko went to the hospital’s CEO to ask for a Rolloscope to allow them to read a larger volume of X-rays, he was told there wasn’t money in the budget and to take his case to the Ministry of Health. Three years later, the hospital got a Rolloscope but couldn’t pay a clerk to load the films. “It was a microcosm of how the health care system works. Everything is allocated by the Ministry of Health. They’re the payer and they control the purse strings.”

In contrast, when he and his partner asked for a Rolloscope at St. Frances, they had one within a month. “Why the difference? The hospital and radiology group are functioning based on profit. It makes sense to invest capital to improve services to deliver better and more care,” he says.

Kurisko admits physicians have a point when they talk about the fact that Canada has fewer administrative burdens than the United States and that nearly everyone has access to health care. However, because of the waiting times for some procedures, more and more people are going outside the system for care—most often to the United States—if they can afford it.

Recently, he brought his own father to Minnesota for a procedure.

Kurisko says many don’t realize the two systems are similar in one very important way: they both rely on third-party payers. “Someone else is paying the bills, so people live with the fantasy that they can have unlimited access to all the health care they’d ever want with no attention to cost at all,” he says. “That’s simply not realistic.”—K.K.

Lee Kurisko, MD

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The many faces of single-payer health care

In a talk to physicians about single-payer health care last summer, Lynn Blewett, PhD, a professor in the University of Minnesota School of Public Health, described four countries’ systems. In all of them, government pays for the majority of care and private health insurance plays a limited role. Here’s a snapshot of what they look like:

**England**

The National Health Service funds 94 percent of health care. Approximately 11 percent of residents have supplemental insurance (usually an employment benefit) to pay for elective surgeries, consultations and stays in private facilities.
- System is funded through general tax revenue and payroll tax
- Most physicians are in private practice, but hospitals are publicly owned; general practitioners serve as gatekeepers
- Nearly all health expenditures are paid for by public sources
- Outpatient drugs have a co-pay.

**Canada**

Universal public insurance program is administered by the provinces and territories; about 67 percent of Canadians buy private supplemental insurance for expenses that aren’t covered.
- System is funded through general tax revenues; three of Canada’s provinces (Alberta, British Columbia and Ontario) charge additional premiums
- Most physicians are in private practice
- Approximately 70 percent of total health care spending is paid for by public sources. The remainder is paid for out of pocket or through private health insurance (eg, dental care, over the counter and prescription drugs, vision care).

Dvorak says PNHP will work with Sen. John Marty, who has introduced legislation to create a single-payer system every year since 2009, to get legislative approval to seek a state innovation waiver from the federal government. The waiver would allow Minnesota to redesign aspects of the health care system, as long as they met the larger goals of the ACA. The first waivers will be granted in 2017.

Last year, after the MAFP task force presented its report on single payer to its House of Delegates, the House passed a resolution to continue the task force for another year and to promote single payer
as one financing method that could meet the principles of health care reform laid out by the national academy (coverage for all, access to high-quality affordable care without the risk of financial ruin, good stewardship of community resources, less administrative burden and liability reform, among others).

Reif says they’re hoping to invite not only family physicians but also pediatricians, internal medicine physicians and other primary care providers to take part in the discussion about single payer. “I’m imagining this is a conversation that will be on the agenda in Minnesota and nationally for years to come,” he says. “The more professional doctor groups that will be part of it, the more beneficial it will be.”

Kim Kiser is an editor of Minnesota Medicine.

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**Germany**

Statutory health insurance system is made up of 134 private sickness funds and provides universal coverage; about 11 percent of the population opts out and instead purchases private health insurance coverage
- System is funded through federal taxes and taxes on employers and employees (or retirees); some sickness funds charge premiums
- Most physicians are in private practice
- Nearly 58 percent of health expenditures are paid for by the sickness funds; the remainder is paid for out of pocket and through private insurance

**Norway**

National health service provides coverage for all (administered through Ministry of Health and Care Services and four regional health authorities; individual municipalities are responsible for organizing and delivering care); less than 10 percent of the population has private supplemental coverage (usually purchased by employers for employees to ensure faster access to specialists)
- System is funded through general tax revenue
- Most physicians are in private practice
- Public spending accounts for 85 percent of health care expenditures; out-of-pocket spending (co-pays) accounts for the remainder (cost-sharing ceiling of $340 in 2013); private supplemental insurance accounts for less than 1 percent of health care spending.