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A National Health Program
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In 2016, a group of physicians proposed a "Single-Payer Health Care Reform," drafted by a 39-member Working Group and published in the June 2016 *American Journal of Public Health*. It has been endorsed by over 2,525 physicians and over 186 medical students, but the numbers have not been updated in 18 months.

The abstract of and in part the introduction to the draft proposal stated:

Abstract

"Even after full implementation of the Affordable Care Act (ACA), tens of millions of Americans will remain uninsured or only partially insured, and costs will continue to rise faster than the background inflation rate. We propose to replace the ACA with a publicly financed National Health Program (NHP) that would fully cover medical care for all Americans, while lowering costs by eliminating the profit-driven private insurance industry with its massive overhead. Hospitals, nursing homes, and other provider facilities would be nonprofit, and paid global operating budgets rather than fees for each service. Physicians could opt to be paid on a fee-for-service basis, but with fees adjusted to better reward primary care providers, or by salaries in facilities paid by global budgets. The initial increase in government costs would be offset by savings in premiums and out-of-pocket costs, and the rate of medical inflation would slow, freeing up resources for unmet medical and public health needs."

Introduction

"In the United States the right to medical care remains a dream deferred, despite passage of the Affordable Care Act (ACA). The U.S continues to spend strikingly more on health care than other industrialized nations, while our health outcomes lag behind. Even with the ACA fully implemented, an estimated twenty-seven million will remain uninsured, while many more face rising copayments and deductibles that compromise access to care and leave them vulnerable to ruinous medical bills.

"We propose a single-payer National Health Program (NHP) covering all Americans for all needed medical care. The design of such a program has been previously described, but intervening developments – notably the proliferation of large integrated delivery systems – require revisions.

"The NHP can be conceptualized as an expansion of Medicare to the entire population, with correction of that system's deficiencies – most glaringly, high cost sharing, limitations on coverage, and subcontracting to wasteful private plans. By dramatically reducing administrative costs and other inefficiencies, the NHP could eliminate both uninsurance and underinsurance without any increase in overall health care expenditures. It would sever the problematic link between employment and insurance, and minimize patients' and physicians' paperwork burden. Although the system we envision would be publicly financed, it would rely largely on existing private hospitals, clinics and practitioners to provide care. However, because investor ownership of health care providers is known to compromise quality and divert funds from clinical care to overhead and profits, the NHP would not include such providers."

As a practicing physician for forty-five years, I cannot disagree with the goals of this proposal. However, many of the assumptions of the proposal are not valid.

The goal is a "publicly financed National Health Program (NHP) that would fully cover medical care for all Americans."

A partial Response

The model of the one-payer system is Medicare. Unfortunately, many of the problems in healthcare today are a product of the institution and design of Medicare without quality standards to address the cost and the appropriateness of care. In its first twenty-five years, Medicare costs were more than ten times what were expected. While the goals of the NHP are admirable, the proposals assumptions for savings are just that 'assumptions," which will not be realized. As with the cost overruns of Medicare from 1965 to 1990, there is no reason to expect the same experience with this one-payer, Medicare-like NHP model.

Assumption: Number One: "…while lowering costs by eliminating the profit-driven private insurance industry with its massive overhead…"

The expectation that cost savings will be created by changing healthcare management from private enterprise to government control reflects a political, philosophical position rather than a rational examination of the facts. Government control as the answer to all public policy issues is the classic Democrat Party position. It is as flawed as is the Republican Party belief that healthcare costs are primarily driven by malpractice lawsuits.

Advocates of a public plan assert that Medicare has administrative costs of 3% (or 6 to 8% if support from other government agencies is included), compared to 14 to 22 % for private employer-sponsored health insurance (depending on which study is cited), or even more for individually purchased insurance. They attribute the difference to:

- superior efficiency of government,
- private insurance companies' expenditures on marketing,
- efforts to deny claims,
- unrestrained pursuit of profit, and
- high executive salaries.

However, on a per-person basis Medicare's administrative costs are actually *higher* than those of private insurance--this despite the fact that private insurance companies do incur several categories of costs that do not apply to Medicare. If recent cost history is any guide, switching the more than 200 million Americans with private insurance to a public plan will not save money but will actually increase health care administrative costs by several billion dollars.

Assumption Number Two: "Hospitals, nursing homes, and other provider facilities would be nonprofit, and paid global operating budgets rather than fees for each service."

The inherent distrust of "profit" – read that "distrust of capitalism" -- in this model and in all government-run health care models is again a tenet of the Democrat Party. The transfer to public funded and managed responsibility from private and even private, nonprofit, models have always resulted in decreased efficiency, decreased quality and increased cost. There is no reason to think that the transfer to public management as is proposed will result in dramatic cost decreases. Of course, placing providers on lower and often "low" salaries can decrease the per-provider cost of care but will unlikely decrease the total cost of care as in this setting providers typically decrease productivity thereby actually resulting in increased costs by the requiring of more providers to produce the same services.

Assumption Number Three: "Physicians could opt to be paid on a fee-for-service basis, but with fees adjusted to better reward primary care providers, or by salaries in facilities paid by global budgets."

The carrot held out by all proposals to transfer control to government is that primary care is going to be rewarded. Sadly, that never happens. Primary care reimbursement continues to be driven down and even the ACA imposed ruinous taxes on primary care organizations which were efficiently managing care under health-maintenance-organization models of care.

Assumptions Number Four: "The initial increase in government costs would be offset by savings in premiums and out-of-pocket costs, and the rate of medical inflation would slow, freeing up resources for unmet medical and public health needs."

This is magical thinking: more care will cost less. In the future healthcare will result in increased costs directly caused by technological advancement and increased public demands for more care. The drivers of healthcare cost will not magically go away.

Assumption Number Five: The elimination of co-pays and deductibles will result in decrease in cost of care.

Co-pays and deductibles were always intended to decrease the accessing of care but never worked. People either paid these fees and accessed care or accessed care and did not pay these fees neither of which resulted in a decrease in demand for care. There is no reason to believe that the elimination of these fees will somehow magically decrease the demand for and the cost of care.

Assumption Number Six: Cost savings will be realized by "…an expansion of Medicare to the entire population, with correction of that system's deficiencies – most glaringly, high cost sharing, limitations on coverage, and subcontracting to wasteful private plans.

"Subcontracting to wasteful private plans" refers to the Medicare Advantage (MA) Program which is providing excellent expanded services and care to Medicare beneficiaries. This program and the healthcare providers who participate in it have been penalized 4% a year for the past seven for a total 28% in decreased revenue to this program. In addition, the ACA imposed a heavy tax on these plans in addition to the 28% reduction in revenue. Any claim that the MA is an excessive subsidy of private subcontracting of Medicare services is absolutely invalid.

Assumption Number Seven: "ineffective services would be excluded from coverage."

In a national medical conference, led an executive of the Centers for Medicare and Medicare Services (CMS), a question was raised by a physician to wit, "You indicate that you only support evidence based care, correct?" The answer was, "Yes." A follow-up question asked, "Then why is CMS paying billions of dollars a year for services which are not only not 'evidenced based,' but which are contradicted by evidence-based medicine?" The CMS excusive responded, "To what do you refer?" The answer was "Chiropractic care." The CMS executive responded, "Those services are paid for because they are legal."

The final response was, "Ah, I see, you are not in favor of evidence-based medicine, you are in favor of legal medicine." Sadly, physicians fear that "ineffective service" which "will be excluded from coverage," will end up including many legal but unscientific services thus compounding the problem rather than solving it.

In reality this plan appears to be another version of government controlled healthcare where costs savings are achieved by penalizing providers who are attempting to care for the most vulnerable of our citizens.

In coming articles, we will discuss more issues related to the proposed National Health Program which is an admirable idea but at this stage of development is unlikely to fulfill its goals or promises.