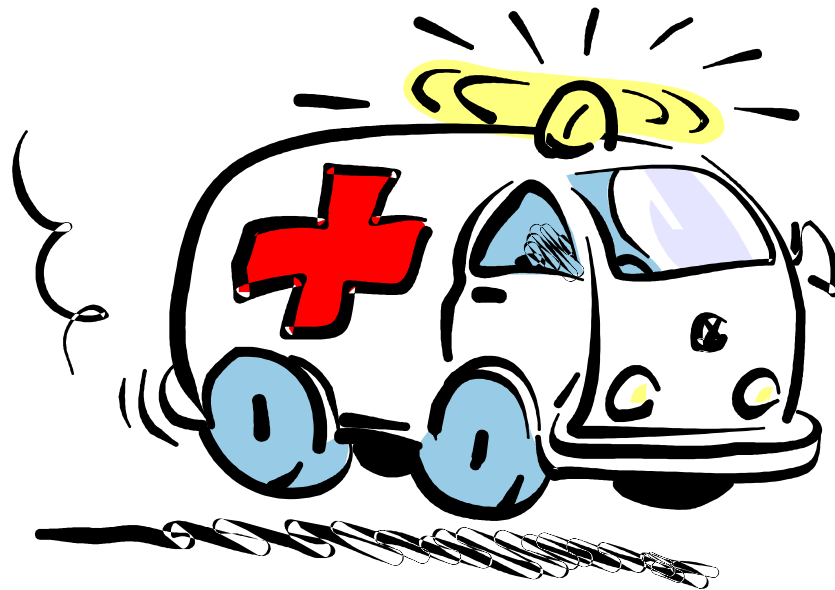


Theoretical Models for Delivering Universal Health Care: An analysis of important concepts



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Introduction

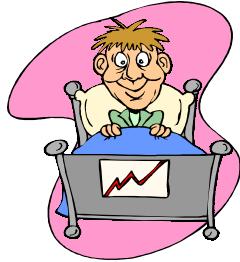
The issue of the uninsured continues to be a major problem in the United States, despite the health state of the economy. Every campaign, politicians pledge to address the situation, but little is accomplished. The lack of action can partially be blamed on fundamental disagreements on the best solution for achieving universal health care. There are numerous theoretical approaches, each with its own strengths and weaknesses. The purpose of this primer is to introduce the different universal health care philosophies and to examine their merits, specifically within an American context.

Single-Payer System

Basic Concept

Any discussion of universal health care logically begins with the system known as single payer. By definition, a single-payer health-care system is one in which the medical costs of the citizens of a nation are financed by one source, usually the federal government. The underlying philosophy of single payer is that every citizen should have equal access to health care and that eliminating the profit motive by involving the government in financing makes this possible.

An example of a single-payer medical system is found in Canada where the national government is responsible for providing basic medical coverage to all of its citizens. Under the



Canadian program of National Health Insurance, the federal government, through tax revenue, grants money to the provinces to be used for health care. The provinces themselves determine how the money should be distributed and are free to supplement the revenue via their own mechanisms.

Citizens then visit private physicians of their choosing who are reimbursed by the government based on negotiated fee-for-service rates. The government has a set of established services that it agrees to pay for, without any co-payment by the individual. Services not covered (such as dental care) must be paid for by the individual, either out-of-pocket or through private insurance.

Single payer is not necessarily the same concept as “socialized medicine.” Under socialized medicine (such as in the United Kingdom), the government controls all aspects of the health care system, from financing to delivery. Citizens needing medical care go to government-owned and operated clinics where they are seen by government-employed physicians. On the other hand, single payer simply refers to a situation where the government collects and distributes the money used by individuals for health care. It does not necessarily mean that health care is controlled by a single entity.

Advantages

The advantages of a single-payer medical system are numerous and appealing. First and foremost, every individual will receive necessary medical coverage, regardless of age, health, employment, or socio-economic status. This is of particular significance in the United States, where 43 million people are uninsured during a time of record prosperity. The large gaps in coverage have occurred despite the fact that the U.S. spends over \$4,000 per person on health

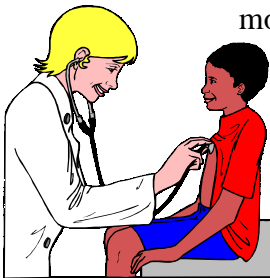
care, nearly twice the amount of any other industrialized nation. A single-payer system ensures that ability to pay is not a factor in receiving adequate health care.

Given the lack of comprehensive medical benefits despite the enormous expenditure, it is obvious that health care costs in the United States are out of control. The popular perception is that providing universal coverage through a single-payer system would cause spending to swell to an even greater level. However, this is not necessarily true. For example, the United States spends approximately 14% of its Gross Domestic Product (GDP) on health care while Canada spends about 10%. The Congressional Budget Office calculated that implementing single-payer in 1991 would have saved the country \$225 billion by 2004. Similarly, the Lewin Group, an independent research organization, determined that the state of Maryland would save \$345.8 million a year by implementing a proposed single-payer system.

How can costs decline while coverage expands? Quite simply, the centralized billing procedure allows for a significant reduction in administrative overhead. Under our current fragmented health care system, where each insurance company has its own distinct set of procedures and regulations, administration accounts for more than 20% of health care costs. In contrast, Canada spends around 2% on administration. A single-payer system would streamline the health care bureaucracy, allowing more money to be devoted to patient care. Additionally, money would also be saved because complete access would allow certain conditions to be treated at earlier stages or prevented altogether and because the government would be able to reduce the cost of prescription medication by purchasing quantities in bulk from pharmaceutical companies.



Along with expanding coverage and saving money, single-payer health care allows for greater physician and patient autonomy, something that has been affected by the managed care movement in the United States. That is, patients are free to see any physician they choose and physicians are free to treat the patient in the manner that they think is best for the patient.



Finally, the profit motive, which currently serves as the driving force behind health care in this country would be eliminated. Health care decisions would be based on the needs of the patient and not based on what would maximize revenue for large corporations.

Disadvantages

However, the single-payer system also has some drawbacks that may make it unattractive to some people. The disadvantage that stands as the greatest obstacle to single payer in the United States is political in nature. At a time when many people feel that the private sector is better equipped to deliver services to the populace, it will be difficult to convince politicians and their constituents that government should take over the role of financing health care, especially when it would mean increased taxation.

Also, because health-care financing would be a function of the federal government, it could be sensitive to fluctuations in the mercurial political climate. At any time the nation's health-care system could be subject to budgetary adjustments that may have a serious impact on delivery.

Additionally, single payer virtually eliminates the need for private insurance companies. These wealthy and influential corporations would do everything in their power to prevent single payer from becoming a reality. And, they could use the argument that moving to a government

financed system would lead to the loss of a large number of private-sector jobs. But, it is worth mentioning that many of the unemployed could be re-trained to fit the changing needs of the industry.

Although they would still be an important player in the health care industry, pharmaceutical companies may see a drop in their profits because of government's expanded role in purchasing prescription medication. Speaking for the entire populace, the government would be able to negotiate lower prices for drugs, possibly by purchasing in bulk. The reduction in profits for the pharmaceutical companies might mean less money devoted to research and development, and a minor slow down in technological advancement. Moreover, an argument can be made that money drives innovation. Consequently, weakening or eliminating the profit-motive may cause technological slow downs throughout the entire medical field.

Another argument against single payer is that if physicians are paid according to fee-for-service (as in Canada), there may be no incentive for doctors to try and control costs. In a sense, the situation would be similar to the one that brought about major changes in health care in the later part of the 20th century. Managed care came into prominence because physicians were unable to control their costs. Having the government reimburse physicians on a fee-for-service basis may encourage exploitation of the system. However, guidelines could be put into place to address this problem.

Lastly, it may not be easy to change some of the negative perceptions Americans have about a single-payer health care system. Long lines, inefficient bureaucracy, restricted choice, and lack of quality care are some of the inaccurate complaints against single-payer systems, like Canada's. Although many of these complaints are applicable to America's current medical system, changing people's pre-conceived notions about single-payer will be challenging.

Multi-Payer System

Basic Concept

A multi-payer system of universal health care coverage seeks to provide a safety net while allowing for other alternatives. Everyone has access to health care through a single-payer scenario. However, individuals and/or employees can choose to purchase private insurance in its place. The private plans would have to meet a set of guidelines mirroring the services offered under single payer.

Advantages

In many ways, multi payer is analogous to the current system of education in the United States. Every child is eligible to go to a public school, the costs of which are subsidized. But if parents are not satisfied, they can place their children in private schools. The trade-off is that attending private school requires independent financing.

The American educational system is shaped to provide both a safety net and options. Multi-payer health care is appealing because it is structured in a similar way. People will never have to worry about being without medical coverage, regardless of employment, age, socio-economic status, or health. But they also know that if they find flaws in the system there will be somewhere to turn. This idea of choice is important because many Americans do not like to feel locked into any one system.

Another attractive aspect is that many of the benefits of single payer will still be applicable. Health care spending will decrease significantly. The Lewin Group estimated that the state of Maryland would save \$207.2 million by implementing a multi-payer plan. Although this is less than would be saved under single payer, it is still considerable. In addition, patients opting for the publicly funded plan would not be restricted in choosing their doctor, and physicians would be able to select the course of treatment that they deemed appropriate. And, much of the profit motive that defiles our current health care system will be removed.

Multi payer is also more politically practical than single payer because it does not completely eliminate insurance companies. Politicians may see some resistance from this



powerful interest group, but the objection would not be as intense as it would be if a single-payer option became a possibility. The decreased resistance would make reform more achievable.

Disadvantages

However, keeping private insurance companies around ensures that some profit-motivated behavior will remain in health care. Individuals who choose to bypass publicly financed coverage will be susceptible to the many abuses that plague contemporary American medicine. Patients still may be limited in choice of provider and physicians may have to make treatment decisions based on economics and not science. And, far too many resources will still be wasted on administration.

An additional drawback is that the incorporation of single payer brings with it several limitations (which are discussed in the single-payer section). The health care budget may be at the mercy of a changing political climate. This could have profoundly negative consequences on the general public. Also, many private-sector jobs could be lost with the reduction in power of insurance companies, physicians may have little incentive not to unnecessarily utilize resources, and technological advancements could slow down.

Tax Credits

Basic Concept

One of the most popular current proposals, especially among politicians and the private sector, is the idea of establishing tax credits for the purchase of private health insurance. A tax credit is an amount of money subtracted from taxes owed. For example, if a person owes \$5000 in taxes, a \$300 credit would reduce the amount they have to pay to \$4700. A tax credit is different than something that is tax deductible. If something is tax deductible its dollar amount is reduced from the overall income used to determine the amount of tax owed. So, if an individual's income is \$40,000 and they have a tax deduction worth \$1000, they will pay the tax rate of the group that earns \$39,000.

Under our current health-care system, the majority of Americans receive insurance through their employer. The amount paid by the employer for health care is excluded from an



individual's taxable income. Those who are self-employed or whose employers do not pay for insurance are not eligible to deduct insurance premiums from their income.

Additionally, people without employment-based health care generally have to pay more for coverage. The current tax exemption and the ability to pool risks by purchasing in large groups allow employers to negotiate lower prices with insurance companies. Individuals who are self-employed or who are not covered by their job are not afforded this luxury.

Any plan that uses tax credits for the purchase of health insurance would attempt to eliminate the barriers faced by those who don't receive coverage from work. The specifics of the plan may vary but the essence is that people would have the option of receiving a tax credit to be used for paying private health insurance premiums.

Advantages

Tax-credit schemes attempt to expand health care access without making major adjustments in the current system. They are relatively simple in scope and would be easy to implement. Very little restructuring would be necessary. Because of all this, tax credits are extremely attractive to politicians. While health care would become more accessible to the average person, insurance companies would not have to surrender their domination of the industry.

Also, the American Medical Association endorses the use of tax credits for the purchase of private insurance. Because of their influence, which has been wielded to block every previous attempt at universal health care, the AMA's support is significant to the passage of any important medical legislation.

Tax credits also retain the air of choice that surrounds health care in the United States. Philosophically, there is a debate over whether health care is a right or a privilege. Some would argue that medical care should be left to the individual, and that society should not have to pay for one person's health problems, especially if preventable behaviors played a role in the development of these problems.

The United States has operated under the former perspective throughout its history, leaving health care up to the individual. Tax credits allow people to have increased access but they do not mandate health care. If a person does not wish to purchase health insurance then they do not have to. The choice is left up to them. Furthermore, people have the ability to pursue the health-care plan of their preference. Tax credits will not interfere with this autonomy. In fact, depending upon the tax-credit structure, patients will probably have more choice among plans because much of the purchasing power is transferred from employers to individuals. These aspects are in accordance with traditional American beliefs about the rights of the individual.

Disadvantages

The most significant drawback to using tax credits to facilitate the purchase of insurance is that there is no guarantee that every citizen of the United States will have medical coverage. It is possible that the tax credit may not pay the entire cost of the insurance. For many, the costs that they would have to pay out of their own pocket may still be too much to purchase coverage. Similarly, even if the tax credit pays for the whole cost of insurance, some may not be able to afford the initial cost while waiting for the refund on their tax return. Finally, many low income

individuals do not file returns, often because they do not owe any taxes. These people would be shut out of participating in the new system.

Along with the huge numbers of uninsured, many feel that the greatest flaw of our health-care system is the amount of spending. Implementing a tax-credit plan that relies on the current structure of private insurance would not reduce costs. Having the market determine the price of health care has allowed the amount of money being spent to balloon to record levels. Individuals who are paying a monthly premium for insurance have no incentive to reduce spending. They may feel that since they have already paid for health care they have the right to use as much of it as they want. Moreover, the continued dominance of private insurers guarantees that administrative budgets will be elevated.

The problems of covering everyone and slashing spending are not solved by tax credits because the profit motive remains in health care. The balance of power in the health-care industry will remain with private insurance companies who are looking more at boosting revenue than treating patients. If anything, tax credits will cement the domination of the dollar in health care by bringing more people into this system.

Because the profit motive has not been removed from health care, the probability is that insurance companies will continue to restrict choices in order to maximize revenue. Tax credits do not address the issue of patient choice of providers and physician autonomy in treatment. Physicians and patients may still be burdened by the problems that they face today with private insurance corporations. The horror stories of doctors not being able to prescribe the medication that is best for their patient or workers being unable to see the physician that they feel most comfortable with would likely continue.

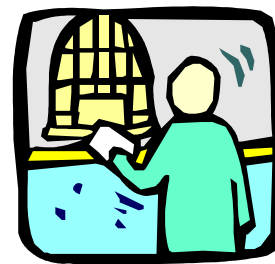
Medical Savings Accounts

Basic Concept

Medical Savings Accounts (MSAs) represent a relatively new approach to health care that has grown in popularity during the last decade. The prevailing philosophy behind MSAs is that the costs of health care are inflated because people are overinsured. Broad insurance coverage encourages people to unnecessarily spend valuable medical resources. Since they have already paid for insurance, patients do not hesitate to see doctors for even the smallest problem, provided that it is covered by their health plan. This superfluous utilization of medical care drives up prices for everyone.

Under the current tax code, employer-provided health care is excluded from a person or family's taxable income. Medical Savings Accounts work by having employers (or the government) deposit money that would be used for regular insurance coverage into a tax-free savings account for the individual. Some of the money in the MSA is used to purchase a high-deductible, low premium catastrophic-insurance plan. The rest of the money is for other health care. Costs that go beyond funds available in the MSA are paid for out-of-pocket. Any money in the account not spent by the individual can accumulate for future use.

When people are forced to pay from their own pocket they have an incentive to try and reduce costs. However, minimizing costs is not an option when serious medical problems arise,



leaving the individual extremely vulnerable. Medical Savings Accounts operate by trying to find a balance between these principles of economic efficiency and patient protection. Saving money by utilizing fewer medical resources will bring prices down, making care more accessible for everyone. Yet, people will still know that if something critical happens to them and they have high expenses, they will be protected.

Advantages

From a theoretical framework, MSAs are advantageous because they encourage people to consume finite medical resources judiciously. This should lead to a decrease in overall medical spending because the costs for unnecessary health care are absorbed by the individual. Patients will be loath to see the doctor simply because their head hurts or will be less likely to demand prescription medication for a common cold.

Following from this, individuals may be quicker to embrace healthy or to avoid unhealthy behaviors, in an attempt to avert minor ailments. In insurance there is a concept known as moral hazard whereby people participate in riskier activities because they are insured. Forcing people to pay out-of-pocket for some health care reduces moral hazard. The result may be seemingly insignificant changes that improve overall health (like washing hands before eating).

MSAs will also allow the consumer to have more choices in the health-care market because people, not employers, will pay for routine health care. Naturally, individuals are going to look for the health care that offers the highest quality at the lowest price. Empowering the consumer with the ability to shop around gives providers motivation to improve their services, both medically and financially.

Disadvantages

Unfortunately, MSAs do not solve the problems of the low-income uninsured, who will most probably be unable to pay for out-of-pocket costs. The situation will then resemble the current predicament, where indigent citizens are able to get emergency treatment, but have little or no access to preventive or basic medical care.

Another flaw is that MSAs inherently discourage preventive medicine by making patients pay for routine visits to the doctor. Imagine the problems caused by women not going for periodic mammograms or by parents not taking their children for yearly check-ups in order to save money. The consequence could be a lot more people suffering from preventable illnesses. The sacrifice of inexpensive prevention for costly treatment would be paid for by all of society.

Medical Savings Accounts rely heavily on the consumer to bring down medical costs, by decreasing consumption and through thoughtful selection of high quality, low cost health-care providers. The assumption is that citizens will use traditional free market strategies to make educated choices. However, patients may not have the expertise to assess the quality of health care. Market forces will only drive down costs if people are well informed. If the public is not able to acquire the necessary knowledge, quality of care may suffer. And, there will not necessarily be a drop in costs. Of course, all of this assumes that a more open market will reduce the price of health care, something that has yet to be proven.

Managed Competition

Basic Concept

Managed competition is the name given to a health care philosophy that seeks to combine market forces with patient pooling to improve access. Under this type of system, the government establishes a minimum set of benefits that any insurance plan must offer. Employers and/or individuals join health-care purchasing cooperatives (or health alliances) that negotiate with several different private insurers to deliver these benefits. Patients select among the plans offered by their health alliance. Premiums are priced the same for everyone in the plan, regardless of health status. Regulations are often in place to prevent insurance companies from rejecting patients because of their condition. Most, if not all, of the premium for basic coverage is paid by the employer or in special cases by public subsidy. More comprehensive plans require patients to pay out-of-pocket for anything beyond minimum coverage.

Managed competition operates on the belief that with proper consumer protection, market forces can increase health-care coverage for everyone. The idea is that grouping people into health alliances gives them bargaining power to obtain insurance at reasonable prices. Requiring companies to offer a standard set of minimum benefits ensures that patients won't select a low quality plan simply to save money. However, insurance companies still manage health care, allowing them to pursue the large profits they desire.

Advantages

This system is beneficial to small employers who currently do not offer health benefits to employees and to individuals who pay for health care out-of-pocket. The formation of health alliances allows these people to have the same advantages that large employers currently have. Consequently, health care becomes more affordable and more accessible.



Sick or unhealthy people also benefit from managed competition because their health-care spending should decrease. Joining a purchasing cooperative will provide them with the same price coverage as healthy people. Normally, these people would have to pay very high premiums or would be outright rejected by insurers.

Insurance companies would be more likely to accept a managed competition model of health care than a single-payer system. Reforms that attempt to increase medical access face a lot of political hurdles. The insurance companies are potentially very daunting obstacles. Any system that allows them to continue to prosper will face one less barrier.

Disadvantages

However, strengthening the insurance companies' hold on the health care market leaves the public vulnerable to the same problems that plague our current system. Insurance companies are still going to be motivated by maximizing profit, even if it is at the expense of the patient. The cost-cutting practices that they presently employ will continue. Patients are not going to be able to visit any doctor, but are going to be restricted to choosing a doctor that is approved by their plan. Physicians will face the same limitations on patient treatment. Their medical decisions will be closely scrutinized by administrators, with an emphasis on cost effectiveness not medical

efficacy. Additionally, too much of health-care spending will be on administration and not enough will be on actual treatment.

Managed competition inherently creates a potentially ugly situation that serves as a major limitation. In general, insurance companies make money from healthy people who don't require many resources and lose money from sick people who require a lot of treatment. Because insurance providers will most likely have to accept both sick and healthy patients, there will be an incentive to offer substandard services to more expensive, unhealthy individuals. When a sick patient is choosing among plans offered by their purchasing cooperative they will select the one that offers them the best care for their illness. A plan that has poor treatment options for the illness will not be selected by the patient. The result is that the insurance company saves money by not having to treat this patient and their potentially expensive ailment.

Similarly, insurance providers will have little reason to improve technology and treatment for the unhealthy. Most of their focus toward the sick will be on trying to convince those who are ill not to enroll in their plan. If a company improves treatment options for heart disease, for example, they face the possibility that more patients with a history of heart disease will want to join their plan. This will cost them money. Along the same lines, in an attempt to attract healthier (i.e. more profitable) individuals, insurance companies may increase their quality of routine services. The result is overspending on the healthy and underspending on the sick.



Another problem with managed competition is that it does not eliminate the probability that the rich will receive better health care than the poor. Employers would pay only for very basic medical coverage. Any patient that wanted to increase the quality of their plan would have to pay out of pocket. Obviously, the wealthy benefit most from this, giving them greater access to better health care.

Ultimately, managed competition may not be a practical option in the United States because of history. In 1994 President Clinton attempted to reform the health-care system through a model of managed competition. The memory of the plan's failure may cause politicians to be apprehensive about supporting a similar proposal.

Mini-Glossary

- **Deductible**-The amount of money that a person must pay before the insurance company contributes their share.
- **Fee-for-service**-A payment plan where doctors receive reimbursement based upon each service they perform.
- **Moral Hazard**-When individuals behave in riskier manners because they are insured.

- **Out-of-pocket costs**-Health care charges that are paid directly by an individual
- **Premiums**-A periodic (usually monthly) charge for insurance.
- **Tax-credit**-An amount of money that can be subtracted directly from the amount of taxes owed.
- **Tax-deduction**-An amount of money that can be subtracted from a person's income when determining tax rate.

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