Chapter 5
Our Failing System: A Reasoned Approach Toward Single Payer

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Other than Quentin Young MD [1], physicians in the United States are an unhappy lot.[1] There are many explanations, but the bottom line is it's hard to be happy working in a profoundly dysfunctional system.

The percentage of American physicians who reported spending more than 5 h per week on paperwork and administration has skyrocketed from 47 % in 2012 to 80 % in 2013. More than a quarter of us now report spending more than 16 h per week in this way.[2] Fully 52 % of our primary care physicians report that the time required by them or their staff for pharmacy authorization is a major problem, compared to 21 % in Canada, 17 % in France, and 9 % in the United Kingdom.[3] No one went to medical school to become expert at shuffling paper.

The American health care system also fails to perform well in far more critical manners. Our life expectancy ranked 51st in 2013.[4] Health care is certainly not the only driver of life expectancy variations, but it is the one most directly under the influence of physicians. Americans are more likely to die of causes amenable to health care than in any other modern nation [2].

Our system also fails to perform financially. In 2011 our per capita health care expenditure was $8,950, roughly double that of any other modern nation. Canadians, for example, spent $4,780. In Great Britain, health care cost $3,280 per person.[5]

[1] Commonwealth Fund Survey of Primary Care Physicians. November 2012.

[2] Medscape – Physician Compensation Report.

[3] Commonwealth Fund Survey of Primary Care Physicians. November 2012.

[4] CIA World Fact Book, accessed Dec. 3 2013.

[5] OECD (2013).

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Combine these two failures, and "American exceptionalism" takes on a dark meaning. The same data revealed that the Japanese spent $2,940 per capita, one third of what we spent, and yet their life expectancy was 11 years longer than ours.

According to an analysis of OECD data by Gerald Friedman, professor of economics at the University of Massachusetts-Amherst, up to 40 % of the variation in life expectancy among modern nations can be explained by how much each nation spends on health care. The United States is an exception in this; for our level of spending, we should be living 4 years longer than we do today. Or, we should be spending $6,700 less per person for our current life expectancy.[6] Either way, we're not getting results commensurate with the costs demanded by our system today.

Why are our costs so high? Is it the aging baby boom taking its toll? Is it our tobacco culture? Our obesity epidemic?

We happen to be among the younger of modern nations, and we smoke less than most others. Barely 13 % of us are over age 64. Nearly 15 % of Canadians, 16 % of British, and over 23 % of Japanese are aged.[7] While we have high rates of smoking in some states (my own state of Missouri boasts the lowest cigarette taxes in the nation and a smoking rate of 25 % among adults), as a nation less than 15 % of us smoke. 15.7 % of Canadians, 19.6 % of British, and 20.1 % of Japanese adults smoke.[8]

We lead the world in obesity, with over one third of us having a BMI above 30. We have already seen the direct consequences of growing rates of diabetes and hypertension, but we are just beginning to see the more expensive consequences of renal failure and cardiovascular diseases. Left unchecked, our leading position in obesity will clearly exacerbate the strain on our health care system, but does not explain our current situation.

Thirty seven percent of Americans report having cost-related problems accessing care; either they did not see a physician when sick, did not get some of the care that physician recommended, or they did not fill or skipped a medication because of cost. All other modern OECD nations report these problems at roughly one third (4–22 %) our current rate. Uninsured Americans fare the worst in the modern world, with 63 % reporting cost-related access problems. Those in the United States with health insurance do better, with only 27 % reporting these problems, but even that better number is still more than six times as high as Great Britain's 4 % rate [3].

Consumed by rising malpractice rates, collapsing reimbursements and increasingly bureaucratic demands on their time, physicians in the United States often fail to recognize their leadership opportunity to drive our national debate towards these real issues of health care. Physicians could recapture the moral high ground and advocate for equitable access to patient-centric care. A career in medicine makes

[6] Friedman, G. Presentations at PNHP-MO, March 2014.

[7] Ibid.

[8] Ibid.

physicians uniquely able to see how tragically easy it would be to better treat hypertension and prevent the high-cost strokes, heart attacks, and renal failure.

> One of my well-established hypertensives recently came in for an office visit with a blood pressure of 190/124. When I asked her what happened, she told me that she had three grandchildren living with her but could no longer afford both her rent and her medications. She had been homeless previously, felt she herself could bear that again, but refused to let her grandchildren experience that. She became tearful and asked me, "So, Dr. Weisbart, how long can I live without taking my blood pressure medicines?"

I never want to hear a question like that again.

> A colleague in Kentucky recently saw a 64 year-old woman with two obvious TIAs and an ipsilateral neck bruit. He recommended a full evaluation and possible endarterectomy, but she declined. She had no insurance and chose instead to "pray and wait" until turning 65 and getting Medicare.

Although we physicians hear these stories every day, our legislators seldom have direct access to them. Society grants physicians the privilege to hear these stories; it is therefore incumbent upon us to help our legislators understand how policy decisions that undermine universal access place American citizens (our grandmothers, friends, and neighbors) into untenable dilemmas. The voice of physicians is uniquely able to impact the dialogue.

Follow the Money

Professor Paul Batalden MD at Dartmouth famously once quipped, "Every system is perfectly designed to get the results it gets." Ours gets us excellence in technology but little drive towards public health.

We have chosen to put the health insurance industry at the center of American health care, yet the economics of the health insurance industry do not line up with advancing population health. Most insurers anticipate a 20–25 % turnover in annual membership as employers change insurers and patients change jobs. That means that they require a 2–4 year return on their investments in improving health, or they will be helping their competition. Most leaders in the industry are highly ethical and compassionate, but their fiduciary obligations would be violated by investing in health outcomes that don't deliver a return in that time frame.

We lead the world in virtually every metric of technology: CT scans and MRI exams, to name just two [4]. We have the best 5-year survival of virtually every type of cancer [5]. We have the world's highest rates of coronary bypass graft surgeries.[9]

Our business model drives us towards technology. An entrepreneurial physician can invest in a new imaging service, mechanical device, or specialty hospital and generate his or her own market demand. The Dartmouth Atlas Project has documented glaring variations in how medical resources are distributed and used in the

[9] OECD health data 2013.

United States. Much of this is more related to the availability of a service rather than the medical needs of a community. Most of the <variations in> spending was due to differences in use of the hospital… and to discretionary specialist visits and tests. Higher spending on these services does not appear to offer overall benefits [6].

In some ways, this is a source of tremendous pride for our nation. Our unequivocally strong results at treating diseases that require advanced technology are the envy of the world. Wealthy foreign nationals from countries with less robust health care technology are famous for visiting our tertiary care centers [7].

That same business model, unfortunately, does not align as strongly with the kinds of aggressive public health programs that are needed to improve the lives and life expectancies of our population. Our diabetics get more lower extremity amputations than those in almost any other nation.[10] We claim a "culture of life", yet our infant and maternal mortality rates rank worse than most other nations [4].

These are not problems that can be solved by building another imaging suite or opening another specialty hospital. They require the tireless hard work of primary care, prevention, education, lifestyle modification, and fundamental public health. They require access to health care, another vital area where the United States ranks worst among modern nations.[11]

Our costs are out of control for two big reasons – pricing and bureaucracy. A brilliant expose of how health care is priced in the United States consumed nearly the entire March 4 2013 issue of Time Magazine in an article by Steven Brill, "Bitter Pill: Why Medical Bills Are Killing Us [8]."

The pharmaceutical industry provides us with a microcosm of our system.

When Congress passed Medicare Part D, it included specific language barring the federal government from negotiating the prices of drugs. All one needs to know about the corrupting influence of money on politics is encased in that one sentence.

The retail price index for a basket of 2010 in-patent pharmaceuticals that cost $100 in the United States would cost $61 in France, $50 in Canada, and only $46 in the United Kingdom [9] . Per capita pharmaceutical spending the United States in 2011 was $995, more than double the average of other OECD nations. Canadian spending was $751. New Zealand spent under $300.[12]

One recent example illustrates many of the issues behind this.

In late 2013, the FDA approved Brisdelle, the first non-hormonal therapy for hot flashes associated with menopause. Hot flashes can be nearly disabling; a meaningfully improved treatment strategy would be welcome relief for millions. The new drug, Brisdelle, is a 7.5 mg formulation of paroxetine. Paroxetine is more familiar for its original branding as the antidepressant Paxil. With Paxil's patent long since expired, generic paroxetine is widely available at many community pharmacies for $4 per month.

[10] OECD Health Data 2013 (2009 or most recent available) per The Commonwealth Fund.

[11] Nolte E, op cit.

[12] Commonwealth Fund. Accessed Nov 28 2013.

The dose, however, is the critical factor. When used as an antidepressant, paroxetine was manufactured in dosages ranging from 10 to 40 mg, so those are the only dosage forms available for $4 per month.

Brisdelle is on the market at a slightly lower dosage, 7.5 mg. As that particular dosage of paroxetine was never approved for depression, there is no 7.5 mg strength of paroxetine on the market. It is difficult to believe there would be a clinically meaningful difference between 7.5 and 10 mg dosages in the safety or efficacy of treating menopausal hot flashes.

There is, however, quite a cost difference. Thirty tablets of 10 mg generic paroxetine are widely available for $4 per month; the same quantity of Brisdelle is priced at $150 for 30 tablets.[13]

In most circumstances today, pharmacists routinely offer patients a generic substitute if a physician writes for a brand name drug and does not indicate that such substitution is inappropriate. That substitution requires the pharmacist to have a generic that is FDA approved as chemically identical to the original prescription. As there is no direct generic equivalent to the 7.5 mg dosage form, a generic "substitution" would require the pharmacist or patient to call the prescriber and get an entirely new prescription. The time that work requires is onerous enough to frequently inhibit the effort.

Our bureaucracy is similarly unbridled. Between 1970 and 2010, we have seen a marginal growth in the number of physicians in the United States. In contrast, the number of administrators has increased by over 3,000 %. Health care marketing, contract negotiations and maintenance, information technology, etc. all drive medical overhead and administration, now considered to consume 31 % of our health care dollar. That means that a $1,300 monthly health insurance premium includes $400 for things that are unrelated to actual health care [10].

The diversion of these funds into the insurance industry also indirectly damages our nation's health. Families plagued by the rising cost of insurance are less able to send children to college. According to the County Health Calculator created by Steven Woolf MD, we would save 92,850 lives per year if 5 % more people had some college education and 4 % more had incomes higher than twice the federal poverty level. We would also prevent 915,000 cases of diabetes and eliminate $6.1 billion in diabetes costs every year [11]. Our uncontrolled system is not just making us poor, it's making us sick.

The core issue plaguing our health care system is the lack of alignment between the economic model we have chosen and the public health demands of our large and diverse nation. Unlike any other nation, we have chosen a market-based model of health care, wherein we juggle roughly 1,500 different insurance companies, government agencies, and others. This creates enormous redundancies and gaps, bureaucracies and Band-Aid solutions, a drive towards expensive yet insufficient insurance products, and extraordinary cost without extraordinary results. And it leaves tens of millions of us without any health insurance at all. Our healthcare system also poses barriers to communication and coordination of care.

[13] Brisdelle pricing from GoodRx.com, accessed Dec. 8, 2013.

The Affordable Care Act

These problems are partially mitigated by the Affordable Care Act. Vital new regulations of the insurance industry – guaranteed issue, ending rescissions and lifetime/annual maximums, etc. – are at long last accomplishing much of the Patient Bill of Rights [12]. Even the most aggressive opponents of the ACA favor retaining these features (Table 5.1).

However, the ACA will not do as well at addressing the financial challenges burdening most Americans. Sixty-two percent of bankruptcies in the United States are driven by medical expenses that make us more vulnerable to other economic insults, such as the 2008 recession and real estate collapse. Seventy-eight percent of medical bankruptcies occur among people who were insured at the onset of their bankrupting illness [13].

Many hope that the insurance reforms in the ACA will provide meaningful protection from medical bankruptcy, but the early evidence does not support that hope.

In 2008, Massachusetts implemented a state-wide health insurance reform even more generous than the ACA. In 2007, the year prior to implementation, Massachusetts saw 7,504 bankruptcies from medical expenses. In 2009 the number rose to 10,093 [14]. Much changed in the national economy during 2008, but at a minimum this evidence gives pause to the hope that the Affordable Care Act will end medical bankruptcies.

The value of the ACA's health insurance marketplaces is still emerging. Most users are expected to select a "silver" plan with an actuarial value of 70 %, leaving the individual responsible for 30 % of the cost of health care. The ACA may reduce the number of Americans without any insurance, but it is also normalizing under-insurance.

The expenses of starting and operating the ACA's health insurance marketplaces have already started to arrive and are anticipated to add roughly 3 % to our administrative burden. Vermont is anticipating 100,000 citizens to use their exchange, including 72,000 who had insurance before the ACA, at an initial cost of $170,000,000 or $6,071 per newly insured person. These numbers are exclusive of

Table 5.1 ACA's patient bill of rights

Ensuring coverage for consumers with pre-existing conditions
Ensuring the right to choose your doctor
Ensuring fair treatment when you need emergency care
Making sure your policy can't be canceled unfairly
Ending annual and lifetime limits
Enhancing access to preventive services
Ensuring your right to appeal health plan decisions
Ensuring health coverage for young adults
Protections under "Grandfathered Plans"

the additional $92,000,000 anticipated in 2015–2018 and $218,000,000 of additional costs over 5 years for integrated eligibility system, staffing, operations, etc.[14]

Other aspects of the ACA – information system adoption, payment model experiments, and delivery model innovations – are being widely adopted far in advance of a compelling business case. It remains speculative whether we can achieve improved population health and quality of care and limiting cost while retaining a private insurance model of health care finance.

In short, we receive modest benefits for an extraordinarily high cost system.

Lessons from Around the World

Every nation organizes their health care in a unique manner, but there are a handful of common principles. These are best summarized by the Canada Health Act's five main principles: Public administration, comprehensiveness, universality, portability, and accessibility [15].

- All modern nations other than the United States publicly administer their health insurance, much like Medicare is administered in the USA. They are typically accountable on a regional basis and are subject to regular public audits. Some nations, such as Germany, also involve highly regulated non-profit insurers.
- Rather than relying heavily on premiums, copays and deductibles, they are typically financed through their tax structure.
- All medically necessary health care services are comprehensively covered. This includes the primary and specialty physicians, mental health care, diagnostics, pharmaceuticals, ambulatory care, acute/emergent care, hospitalization, rehabilitation, and more.
- Every modern nation other than ours has found it feasible to provide these services to all citizens, often including non-citizen residents.
- Moving within the country – relocating to a different state or province – does not undermine the above guarantees.
- Lastly, single payer systems create the possibility of aligning facilities with the health care needs of the community. They are able to plan in such a way that all insured persons have reasonable access to health care facilities. As a corollary, all physicians and hospitals are provided reasonable compensation for their services.

Beyond these common characteristics, each nation has a unique blend of solutions. The broadest division among them is in how the delivery of care is organized. Many have chosen to preserve the private delivery of health care, where physicians and hospitals are free to organize themselves much as happens today in Canada. Those single payer systems are classified as "National Health Insurance" as the nationalization is focused on the insurance functions, not the delivery services.

[14] Independent Review of Health Benefits Exchange (HBE) and Integrated Eligibility (IE) Solutions, July 2013.

In addition to nationalizing the insurance functions, other countries have also nationalized their delivery model. These "National Health Service" forms of single payer typically see physicians directly employed by the national government. The prototype for this model is in Great Britain, where specialists are employed by the government. Most primary care physicians in Great Britain remain privately organized but carry national contracts [16]. The closest version of this in the United States would be the way care is organized within our Veterans Administration, where both primary and specialty care physicians are employed directly.

Medicare Today

Prior to 1965, less than 50 % of seniors had health insurance and were frequently thrown into poverty, disability, or premature death. They were not generally included in employer-sponsored plans, and the commercial insurance industry considered them "bad risks". The Social Security Administration identified the high cost of medical care as the greatest single cause of economic dependency in old age [17].

By 1965, with the continued aging of the country and escalation of both hospital costs and insurance premiums, two-thirds of the nation supported the passage of Medicare. "Public confidence in the social security system was an important contributing factor; many advocates made a point of stressing that Medicare would utilize the "tested" and "proven" mechanism of social security [18]."

Medicare continues to prove its popularity among Americans across a diverse range of people. A recent poll showed that 76 % of Americans, and 62 % of self-identified Tea Party members, agreed that "the benefits from government programs such as Social Security and Medicare are worth the costs."[15]

Part of the popularity of Medicare is due to its meeting many of the above criteria: Public administration, comprehensiveness, universality, portability, and accessibility. A private market has emerged to fill the gaps between those goals and what Medicare actually provides today.

Publicly administered, Medicare does not have to carry many of the costs inherent in the commercial insurance industry.

Private insurance companies typically offer hundreds or thousands of different benefit packages, combining variations in copayments, networks, formularies, approvals, and promotional materials. This market-driven structure requires an exhaustive and highly redundant commitment in human resources and capital investment. The business demands driving this effort are more clearly aligned with the insurers' fiduciary obligations than improving the health of the population. Medicare offers a single benefit design for all beneficiaries, enabling a far greater percentage of its resources to be devoted to paying for care. For example, managed

[15] CBS News/New York Times poll, April 14, 2010.

care companies reported overhead rates of 16.1–26.6 % in the first half of 2013,[16] whereas Medicare operates with a roughly 2 % overhead.

Privately administered health insurance policies have arcane exclusions and restrictions that are virtually impossible for patients to understand until they discover in their moment of need. And then it is too late to turn to the free market for a new product. They regularly categorize high-expense medical procedures as non-covered benefits under the dual dark umbrellas of "experimental" or "cosmetic".

Seventeen year-old Natalie Sarkisyan's death in 2007 made headlines when Cigna HealthCare denied the request from multiple physicians to perform a liver transplant to treat a complication from her recurrent leukemia. Cigna ultimately reversed the denial after a great deal of media attention, but she died a few hours later [19].

It is beyond our scope to analyze whether the denial or approval of her transplant was medically justified. The reversal under intense public attention, however, exposes the arbitrary nature of many insurance company benefit determinations. They justified their initial denial of payment based upon language in their benefits documentation; they classified the procedure as "experimental" and therefore not among the services Ms. Sarkisyan's family purchased when paying insurance premiums. The family ultimately sued Cigna but the case was thrown out of court due to previous Supreme Court rulings that shield employer-paid healthcare plans from damages over their coverage decisions [20].

The health insurance industry favors its chief executives with generous compensation packages. In 2012, Coventry' CEO Allen Wise received $12.0 million; Cigna's David Cordani received $12.9 million; United HC's Steve Hemsley received $13.9 million; Wellpoint's Angela Braly received $20.6 million; and Aetna's Mark Bertolini was graced with $113.3 million.[17] In contrast, the president of the United States of America has an annual salary of $400,000. Sylvia Mathews Burwell, US Secretary of Health and Human Services, earns less than half that amount ($199,700).

At least in health care, public administration is a bargain.

Despite its efficiencies, Medicare is an imperfect solution today, even for those who depend upon it. Most seniors have found that the current Medicare benefit design does not fully meet their needs. Several medically needed services – nutrition, dental, durable medical equipment, vision, hearing, and long-term care – are simply not included in the benefit design. They also learn that Medicare includes significant cost-sharing, with inpatient deductibles over $1,200, monthly premiums for Part B of over $100, and income-adjusted premiums for the optional drug benefit [21].

Seniors often purchase Medicare supplemental insurance from a private insurer to bridge some of the coverage gaps identified above. In addition, many purchase a wrap-around policy to cover their deductibles and co-insurance.

These common purchases identify the market's voice about the limitations of the current Medicare program and can be used to identify needed improvements.

[16] SEC Filings/Reports to Shareholders for Q1-Q2 of 2013. Calculated as 100 % – Medical Loss Ratio.

[17] Modern Healthcare. May 13 2013.

Medicare Tomorrow: A Solution Hiding in Plain Sight

The most obvious difference between the United States health care system and those in virtually every other modern nation has to do with the financial structure of funding and distribution. While there are countless variations, the rest of the modern world uses a "single-payer" system in which "a single public or quasi-public agency handles all health care financing. Delivery of care may remain in public or private hands, depending on the particular system [22]."

Other than the Affordable Care Act, the most popular piece of health care legislation in the recent history of the United States Congress is HR676, "The Expanded and Improved Medicare for All Act." First introduced by Representative John Conyers (D-MI) in 2003 with 25 co-sponsors, as of this writing the bill enjoys 58 co-sponsors. In short, this act would correct the shortcomings of the current Medicare program and provide it to all Americans, regardless of age. Several economic analyses show that this would be far less expensive than our current fragmented multi-payer model, while providing universal access to comprehensive care.

Although HR676 is unlikely to ever pass unchanged into law, it serves as a "North Star", identifying broad strategic solutions to many of the structural problems inherent in today's environment.

Key Provisions of HR676

- Patients would have freedom of choice of clinicians and hospitals. No longer would patients need to consult their insurer's directory, as virtually all providers would be "in network". Rather than today's model that drives physicians and hospitals to "optimize their payer mix" by shunning low-reimbursement insurers, all patients would represent equal economic opportunities for physicians and hospitals.
- Comprehensive benefits, including primary care, subspecialty care, prevention, dietary and nutritional therapies, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long-term care, palliative care, mental health services (at parity with medical services), full non-cosmetic dental, substance abuse treatment, chiropractor, basic vision, hearing and hearing aids, and podiatry. Insurers are prohibited from selling health insurance coverage that duplicates the benefits provided under HR676.
- Institutions are required to be public or non-profit, with compensation to owners for reasonable financial losses incurred as a result of the conversion to non-profit status. Private physicians and clinics can continue to operate as private entities but are prohibited from being investor-owned.

- Having a single payer enables a rational approach to health care budgeting, key to long-term cost control.
  - Three discrete non-fungible annual budgets would be established:
    - Operating budget for optimal health care professional staffing. Clinicians could be reimbursed either through fee for service or salaried positions. Interest would be due providers not reimbursed within 30 days of claims submission;
    - Capital expenditures budget for construction or renovation of health facilities, and major equipment purchases;
    - Health professional education budget, including continued funding of physician training programs.
  - Co-mingling these budgets would be prohibited, thus preventing hospitals from funding market-driven expansions and equipment purchases by decreasing their nurse:patient formulas.
  - Global budgets would be set through annual negotiations between providers and regional directors.
- The prices of pharmaceuticals, medical supplies, and assistive equipment would be negotiated nationally on an annual basis. A single prescription drug formulary, open to petition by physicians and patients, would encourage best-practices. Physicians today often need familiarity with several dozen formularies, undermining their ability to deepen their knowledge of their most-needed medications.
- The program would be funded by a new Medicare for All Trust Fund, combining current federal health care funding with modest increases in personal income taxes for the top 5 % of earners, excise taxes on payroll and self-employment, unearned income, and stock and bond transactions.
- The single payer system would reduce expenses through vastly reduced paperwork, bulk procurement as mentioned above, and improved access to preventive health care.
- The program would be administered through coordinated regional and state governance.
- A National Board of Universal Quality and Access would represent health care professionals, institutional providers of care, representatives of health care advocacy groups, labor unions, and citizen patient advocates, all without conflicts of interest. Among other things, twice a year they would address access to care, quality improvement, efficiency of administration, adequacy of budget and funding, appropriateness of provider reimbursements, capital expenditures, and staffing levels and working conditions in health care delivery facilities.
- Clerical, administrative, and billing personnel whose jobs are eliminated due to reduced administration would have first priority at retraining and job placement in the new system, and be eligible to receive 2 years of employment transition benefits with salary guarantee up to $100,000 per year, and then be eligible to begin unemployment benefits if not employed.

The New Savings from a Single Payer Model Would Outweigh the New Expenses

New annual costs would total $326 billion ($74 billion from normalizing provider payments for Medicaid patients, $110 billion for covering the uninsured, and $142 billion from increased utilization, particularly home health and dental.) New annual savings would total $569 billion ($23 billion in government administration, $153 billion in health insurance administration, $178 billion from increased ability to negotiate the prices of drugs and devices, and $215 billion from administrative cost reductions for providers). The net savings from a single payer program are thus estimated at $243 billion, covering everyone with better benefits and spending less overall.[18]

By shifting from deductibles, co-insurance, and other financial barriers to care to a tax-based model, 95 % of Americans would spend less on health care under this model.[19]

Single Payer Would Level the Global Business Playing Field for Employers and Labor

Employers would be able to book reductions in costs and rely upon other reduced financial risks.

In addition to the direct cost of the actual health benefit (8–11 % of payroll costs) they would no longer provide, benefit administration by itself is complex, expensive (up to 3.2 % of current spending) (Friedman, personal communication) and not necessary under a single payer model. The ever-growing costs of providing health care to entitled retirees would disappear. There would be concomitant reductions in the cost of Workers Compensation, liability, and automobile insurance.

The future cost of business would become more predictable, insulated from the dramatic swings that can occur today. This is particularly important for smaller employers, where one illness, one premature baby, one cancer, one major automobile accident, can dramatically increase their expense that year. The risk of hiring a new employee with unrecognized medical needs would disappear. They would have fewer disincentives for hiring productive but older and less-healthy workers. Finally, there would be one less item on the labor negotiation table, making it simpler to focus on wages.

As much as half of the slowdown in wages increases since 1973 is due to higher health insurance premiums. Health insurance divides labor, pitting young and health workers against those older and less healthy.

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[18] Friedman, G. Dollars and Sense. March/April 2012.

[19] Ibid.

The Roads to Single Payer

The Affordable Care Act has for the first time in our nation's history established a legislative commitment to providing all Americans with access to affordable health care. While the ACA itself does not fully achieve this lofty goal, the commitment itself is a milestone to be celebrated.

We could pursue something akin to single payer by expanding the ACA's regulation of the insurance industry. Maryland has embarked on this road with uniform hospital price structures. Expanding this model could achieve an "all-payer" program akin to Germany or Switzerland. Noted health care futurist Uwe Reinhardt has advocated for this model, stating:

> An all-payer system with multiple private insurers would be likely to be more broadly politically feasible than a government-run single-payer system, such as Canada's provincial, government-run single-payer insurance systems. A single-payer system, of course, would be another alternative that would eliminate price discrimination and any cost shifting. [23]

Given how fiercely the health insurance industry would oppose adoption of an all-payer system in the United States, our political efforts would be better spent towards the more comprehensive solutions inherent in true single-payer models.

The legislative process is seldom linear [24]. Rather than expect HR676 to pass in one single leap, the more likely pathways are through strategic incrementalism. In some ways, the United States has already embarked down this road, ensuring health care access for seniors, children, veterans, and other groups. We are also committed to providing coverage for perceived high-value medical conditions such as renal dialysis, amyotropic lateral sclerosis, and a wealth of other conditions often mandated by individual states. We could continue down this path, narrowing the age gap between SCHIP and Medicare programs, adding more high-value conditions and treatments, and identifying additional populations to protect.

Canada began their path to universal health care in a single province, Saskatchewan. After a very stormy beginning, the federal government offered support to any Canadian province that followed the Saskatchewan model and met a handful of characteristics. Within a few short years, it had become a profound success across their nation and is now treasured by most Canadians.

A parallel path is possible within the United States. The Affordable Care Act permits individual states to opt out of much of the structure within the ACA, as long as the alternative they propose covers more of their citizens and is better at controlling costs. The ACA allows HHS to grant these waivers beginning in 2017. The Vermont legislature has enacted the first steps towards this option, with the full support of their governor.

While a state-based reform is an incomplete solution and not truly a "single payer" model, it is as close an approximation as is supported by current federal legislation and will bring much broader access at tremendous savings. Many other states have been making initial steps down the same road. The first states to implement this will enjoy a stimulated economy, resources freed up for other vital functions such as education, and strong competitive advantages at attracting businesses from less progressive states.

A third strategy would be to add the "public option" into the ACA's insurance exchanges and then gradually migrate existing public programs. Eventually, the demand for private insurance would become increasingly rarefied and a single payer could emerge.

One additional scenario would be to improve Medicare in the manner described above, provide it to all children under age 18, and lower the age of eligibility for adults to 55 years. Over time, the gap between the age limits could be narrowed and eventually closed, achieving universal coverage.

While these incremental strategies may be more readily achievable, they each fail to deliver the fundamentally transformative power of a true single payer until they reach the last step along their pathways. Clearly, the most elegant strategy is to simply pass HR676 and provide universal access to comprehensive health care, prevent tens of thousands of needless deaths every year, and quickly improve the ability of American businesses to compete in the global marketplace.

Many physicians want and need to lead our country to single payer. Multiple surveys over the past 14 years have documented a growing majority of American physicians prefer a single payer model to our current system. The most recent data come from Maine [25], where an impressive 64.3 % of survey respondents said they would prefer a single-payer system, up from 52.3 % in 2008 when exactly the same language was used. Similar trends have been seen in Massachusetts [26], Minnesota [27], and nationwide [28].

Our profession must more fully act upon our responsibility to improve the health and well-being of our nation. "It took me until middle age to realize the importance of advocating for my patients *outside* of the exam room (Steve Keithahn, 2013, personal communication)."

At the End of the Day

Single payer does not represent a magical panacea that would cure all of the ills with our nation's health care system. It does, however, establish an alignment between health outcomes and economic performance. In doing so, it would be the first step in a series of innovations and reforms that would help the United States recover its role as a global leader. The sooner we start, the sooner we improve.

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