

# Single Payer—Fifty Players?

## Alternative Payers for Universal Health Insurance

THOMAS BODENHEIMER

Over the past two years, the single-payer concept has become a serious contender for the universal health insurance model that can solve the United States' health crisis. "Single payer" means that one institution in each geographic area receives virtually all money spent on health care and pays hospitals, physicians, health maintenance organizations (HMOs), and other health providers.<sup>1</sup> Business executives, labor leaders, politicians, and health analysts are interested in the single-payer model because of its international track record in solving simultaneously the problems of health access and health cost inflation. A number of single-payer bills have been proposed in Congress and in various state legislatures.<sup>2</sup> Polls taken in 1988 and 1990 indicate that over 60 percent of the American public is sympathetic to the single-payer concept.<sup>3</sup>

Two political drawbacks reduce the attractiveness of the single-payer approach, however: first, the need to raise taxes to finance universal health insurance under a single payer (which has been considered elsewhere<sup>4</sup>), and second, a deep-seated distrust of government. This distrust is manifest in such frequently heard responses to the suggestion of a single-payer system as "Government made a mess of Medicaid, it created a complex and inadequate program for Medicare, and the Veterans Administration hospitals are a disaster. If government has done such a terrible job of running health programs, why do you want to give it even more power? If you like the Post Office, you'll love the single-payer health system."

In part, the distrust of government is misguided and promoted by the dominant conservative ideology in the United States.<sup>5</sup> Each governmental program has its own history and its own peculiar failures that should not be attributed to an all-encompassing notion that "whatever government touches is bad." Moreover, a number of government programs *are* successful. Social security is highly popular, and Medicare, in spite of its difficulties, in fact commands strong public support as well.<sup>6</sup> The administrative costs of the Medicare and Medicaid programs are far lower than those of private health insurers.<sup>7</sup>

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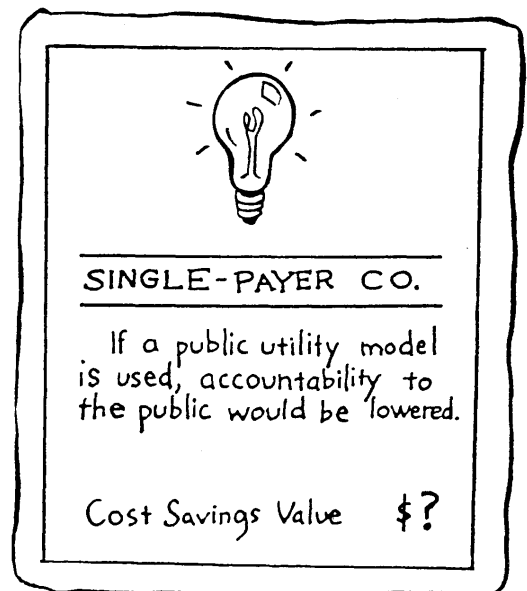
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On the other hand, the public's distrust of government is amply justified by the unethical and illegal activities of some government officials, as in the recent savings and loan scandals, as well as by government coverups of unpopular activities ranging from the Vietnam War to the Watergate scandal to the Iran-contra affair.

For reformers who support the single-payer concept the response to such public distrust of government must be twofold: on the one hand, the government is not quite as bad as that; but on the other hand, it could be a lot better, and we ought to look for some creative approaches that could minimize governmental ineptitude. Supporters of the single-payer approach must seriously ask themselves: do we want to cede control of the entire health system to the federal or state governments? If so, why? And if not, then who should be the single payer? Before confronting these questions, let us review why we favor a single payer at all.

### Why Do We Want a Single Payer, Anyway?

Health care reformers working for universal health insurance have one overriding goal: to efficiently insure everyone in the United States, on an equal basis, for a comprehensive array of health care services of the highest quality, with reasonable control over costs. The single payer mechanism is seen as the means to this goal; it is not the goal itself.



Four major reasons can be cited to explain why the single-payer structure can best realize this goal: (1) Only with everyone in a single insurance system is there a chance to achieve equality in medical care; (2) international experience demonstrates that only a single payer (or closely coordinated payers acting together, the equivalent of a single payer) can control medical cost inflation;<sup>8</sup> (3) only a single payer can achieve the administrative efficiencies that allow the nation to extend comprehensive health insurance to everyone without incurring burdensome new costs;<sup>9</sup> and (4) a single payer provides the potential for greater public input into major health care decisions—for example, the proportion of the GNP to be dedicated to health care or the priorities given to low-cost preventive and primary care versus high-cost interventions in late or end-stage disease processes.

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To best achieve the goal of universal, equitable health insurance, while addressing the widespread distrust of government control, who, then, should be the single payer? Because the United States is far too large for a single payer at the federal level, we will assume that the single payer resides at the state level; to promote equality among states, a proportion of the funds could be collected at the federal level and transferred to states according to formula.

#### Some Single-Payer Candidates

**1. A private company.** This option would utilize the public utility model, in which an industry with a natural tendency toward monopoly (such as telephone, gas and electricity, or transportation) is given monopoly status by the government and in return is regulated more tightly than competitive private enterprise. Public utilities are private businesses regarded as “so impressed with peculiar public interest as to justify intensive government regulation of practically every detail of their activities.”<sup>10</sup>

The public utility model would eliminate the argument that too much control of the single-payer health system resides in government. On the other hand, accountability to the public would be lowered, because the management’s primary loyalty would be to the company’s stockholders or other financial interests, rather than to the public. Because they are monopolies, public utilities have enormous clout and can often evade strict regulation by government agencies. In health care, the major candidates for public utility status as single payers would be the largest private insurers and HMOs in a given region. Overall, considerable risk is involved in placing so much power in the hands of one private company.

An alternative method for utilizing a private company in the single-payer apparatus is the fiscal intermediary concept currently functioning in the Medicare and Medicaid programs. In the early years of these programs, however, some fiscal intermediaries, who tended to be

Blue Cross or Blue Shield plans, engaged in some questionable practices.<sup>11</sup> The use of fiscal intermediaries is also likely to increase administrative costs.

**2. A governmental department.** The structure farthest removed from the public utility approach is the Canadian method of placing the single payer directly within a government department. Such an option runs directly into the political problem of big government, and means a complex and cumbersome decision-making apparatus involving the governor, the legislature with its committees, plus political and technocratic departmental personnel. It also bogs the single payer down in the quagmires of the state budget, which are increasingly contentious and paralyzing.

**3. A government commission.** Keeping the single payer within government but separating it from the departmental apparatus of the executive branch is another option. A commission that would include members representing interests involved in health care—both provider and consumer—could be appointed or elected. Depending on how commissioners are chosen, this option could afford some measure of public accountability. But the commission concept does not circumvent the problem of tying health financing to the legislative tax and budgetary process and thereby linking the fiscal fate of health care to the vagaries of government revenue-expenditure-deficit politics. The budgetary difficulty might be overcome by earmarking revenues for the health insurance system and guaranteeing certain revenue increases each year according to formula.

**4. A public fund with decentralization of decisions to smaller regions.** One mechanism for diffusing the distrust of big government is to decentralize the financing of health care. A statewide fund could be established that would collect all health revenues, but would hold no decision-making authority. The statewide fund would distribute its money to different regions of the state according to a strict formula; these regional funds would become the actual single payer for each geographic area.

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Alternatively, the statewide fund might collect only some of the health revenues, while other funds are collected directly by the regions, in a fashion similar to the process used by Canada’s federal and provincial governments. California, for example, has a district hospital law which allows voters in a geographic area to tax themselves in order to operate a hospital for their community. However, any mechanism that allows regional financing all but guarantees inequities, as wealthier regions tend to

# Physicians for a National Health Program

## Proposed National Health Program Summary

**PNHP's proposal** would remove all financial barriers to medical care. Every American would be covered for necessary medical care by a public insurance plan administered by state and regional boards. PNHP envisages a program that would be federally mandated and ultimately funded by the federal government but administered largely at the state and local level. The plan borrows many features from the Canadian national health program and adapts them to the unique circumstances of the United States.

**Coverage.** Coverage would include standard medical care as well as care for mental health, long-term illness, dental services, occupational health services, and prescription drugs and equipment.

**Payment.** Patients would receive a National Health Program (NHP) card entitling them to care at any hospital or doctor's office. Patients would not be billed for approved medical care. They would not pay any deductibles, co-payments, or out-of-pocket costs. All approved costs would be paid by the NHP.

**Hospitals.** Most hospitals and nursing homes would remain privately owned and operated and would receive an annual "global lump sum" from the NHP to cover all operating costs. Global operating budgets would be negotiated with the NHP board. Funds for capital expansion would be distributed separately by regional NHP boards on the basis of health planning goals.

**Physicians.** Private doctors would continue to practice on a fee-for-service basis, with fee levels set by the NHP board, and would submit bills to the NHP. Physicians could bill patients only for services not covered by the plan. HMOs would receive a yearly lump sum from the NHP for each patient. Neighborhood health centers, clinics, and home care agencies employing salaried doctors and other health providers would be funded directly from the NHP on the basis of a global budget.

**Prescription drugs and medical equipment.** The NHP would pay pharmacists' wholesale costs plus a reasonable dispensing fee for prescription drugs. Medical equipment would be covered in a similar fashion.

**Insurance.** Private insurance that duplicates NHP coverage would be eliminated, saving an estimated \$44 billion a year in industry profits and overhead, simplifying paperwork for doctors and hospitals, and generating additional billions of dollars of savings on providers' billing and administrative costs.

**Cost containment.** Costs would be constrained through streamlining of billing and bureaucracy, improved health planning, and the NHP's ability to set and enforce overall spending limits.

**Funding.** Funds for the national health program could be raised through a variety of mechanisms. In the long run, funding based on an income tax or other progressive tax might be the fairest and most efficient solution. During the transition period, the national health program could be financed from federal funds allocated to Medicare or Medicaid; state and local funds for health care; a payroll tax on employers that takes the place of employer payments to private insurance companies; and taxes on individuals equivalent to the amount now spent on out-of-pocket payments.

*Adapted from PNHP handouts and "A National Health Program for the United States: A Physician's Proposal," by David U. Himmelstein, Steffie Woolhandler, and the Writing Committee of the Working Group on Program Design, New England Journal of Medicine, January 12, 1989:320, pp.102-108. For further information, contact Physicians for a National Health Program, 332 S. Michigan, Ste. 500, Chicago, IL 60604, (312) 554-0382.*

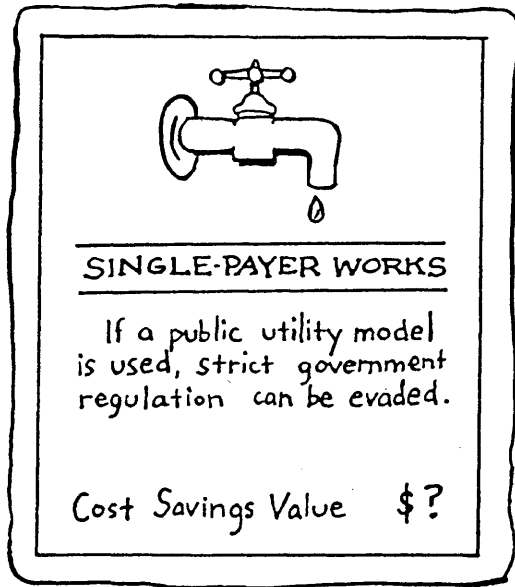
tax themselves at a greater rate to obtain a higher level of health resources than do poorer regions. On the other hand, the decentralized model would bring decision-making closer to the people and might be more acceptable than a centralized payer, particularly in more populous states. An additional drawback would be the administrative problem created when people living in one region obtain care in another region.

5. A public enterprise One institution that might be capable of allowing public accountability while separating the health system from state government is the public enterprise or public corporation. The public enterprise is a business that is controlled in full or in part by the

government, but exists as an autonomous corporate entity with separate finances. Like any corporation, the public enterprise must be financially viable and must therefore operate as a business. On the other hand, the public enterprise has overriding social goals other than financial viability, such as promoting the health of the public. Whereas the "enterprise" concept in a public enterprise means keeping the institution financially viable, the "public" notion requires public decision making and prohibits profits (net income) from accruing to private individuals.

The synthesis between the public and enterprise concepts is a delicate balance. If it tilts too far in one direction it becomes a non-public enterprise; if it goes too far the

other way, it turns into a public non-enterprise. Public decision-making is often at variance with financial viability.<sup>12</sup> For example, the enterprise-as-business might wish to raise prices in order to meet costs, but the social



goal of access to health care might argue against such price increases. Other issues that might create tension between the public and the enterprise concepts are whether or not to have high copayments and whether to have people with higher incomes subsidize lower income people and the elderly.

In a public enterprise, decision making is diffused among the government agency that created the public enterprise, the board of directors of the enterprise, its management, and its clients. The methods of choosing the board of directors could be any combination of election at-large; election from districts; appointment by the governor, with or without approval by a legislative body; and appointment (or election) by constituent organizations, such as medical societies and business, labor, and consumer groups.

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A number of public enterprises exist in the United States, some with positive, some with negative popular ratings. Perhaps the most troublesome in terms of image is the U.S. Postal Service. Given the Postal Service's proximity to the federal government and its absence of direct public representation, it is not an ideal model for a potentially more democratic, state-level public enterprise

that might serve as a single payer of health services. Other examples of public enterprises are the U.S. Government Printing Office, the Tennessee Valley Authority, the Pennsylvania Turnpike Authority (tolls pay for the operating expenses and service the debt), state liquor stores, the New York City Transit Authority and transit systems in about 50 other municipalities, municipal gas and electric power companies throughout the country, and the Port of New York Authority established by the states of New York and New Jersey.<sup>13</sup>

The public enterprise and the governmental commission are not entirely distinct entities, but can be seen as a spectrum of institutions that are closer to or farther from the parent government. The purest form of public enterprise operates on user fees and does not require a budgetary allocation from the government. Those public enterprises that do rely heavily on fiscal assistance from their parent government—for example, the New York City Health and Hospitals Corporation—are closer to the commission concept in the sense that they are heavily dependent on the legislative budgetary process.

**6. A cooperative.** A cooperative is a democratic association of persons who voluntarily organize to furnish themselves an economic or social service under a plan that seeks to eliminate entrepreneur profit and that strives for substantial equality in ownership and control. Cooperatives are owned by members who are their users, as distinguished from corporations, whose owners are primarily investors. Cooperatives are organized on

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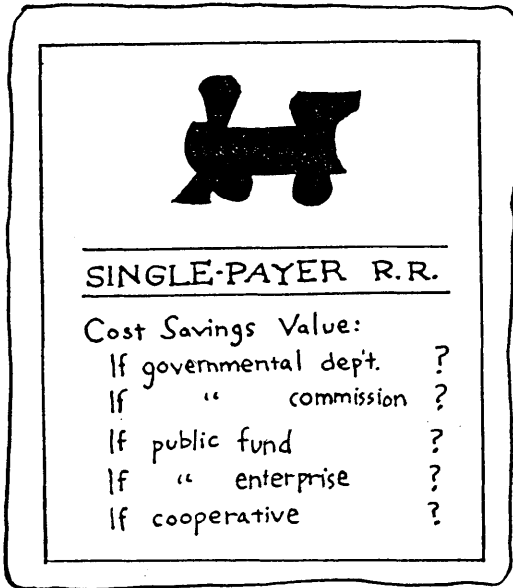
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democratic principles: boards of directors are elected by the rule of one member, one vote. Membership is voluntary; people can join or leave as they please. Generally, members share the risks, financial obligations, and benefits in proportion to the use they make of the organization. If a cooperative makes a profit, the surplus is distributed to the members according to how much they use the cooperative; in a cooperative food store, for example, the distribution would depend on how much food an individual or family purchased during that year.<sup>14</sup>

For over 150 years, producer cooperatives have thrived in the field of agriculture, bringing together farmers to market their products. Consumer co-ops also exist as retail stores, and service co-ops provide insurance, banking, transportation, and telephone service. In health care, two prominent co-ops are Group Health in Washington, DC, and Group Health Cooperative of Puget Sound in Washington State.

In order to function as the basis of a single payer of universal health insurance, the cooperative principle would have to be modified to allow compulsory, rather than the usual voluntary, membership; otherwise, the services provided would not be universal.

7. A coordinated multiple-payer system. Can multiple payers join together to form the equivalent of a single payer? The most frequently cited model is the payment structure of the West German health system during the 1980s, in which all payers and providers came together in



a body called Concerted Action in Health Care to negotiate payments and implement controls on expenditures.<sup>15</sup> Although this coordinated multiple payer has slowed the West German rate of health care inflation, it has disadvantages compared with a strict single payer in the areas of administrative efficiency and equity.<sup>16</sup> The German example is of questionable relevance to the United States, however, because the multiple payers in Germany (sickness funds) are generally quasi-public institutions without the long history of economic competition that marks the American private health insurance industry. It is unlikely that U.S. health insurance companies and HMOs, with their growing competitive practice of skimming desirable health risks in order to increase profitability, could truly cooperate in a coordinated multi-payer system.

#### We Must Experiment

The single-payer form of organization for universal health insurance has the potential to provide equality, cost control, administrative efficiency, and democracy in health care. All seven single-payer options outlined here have the potential to control health costs. The first six are also capable of ensuring equality and efficiency. The major difference among these options revolves around

the issue of democracy. The current image of the government is of an immovable, unfeeling bureaucracy that pays no attention to the people it is designed to serve. How much voice can each of these options offer the health provider community and the general public in such critical decisions as the total size and overall priorities of the health budget?

Can one or another of these single-payer options solve the fundamental American dilemma of an undemocratic democracy? It is difficult to predict which might work the best. Perhaps the most useful approach to the question of who should be the single payer is to try different versions of these options in different states. Only real-life experiments will provide the answer. □

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