

## What is a “single-payer” system?

About one year ago, I attended the 40<sup>th</sup>.reunion of my medical school class. Inspired by the Spring Clinical Day Luncheon Lecture by Edward O. Wilson, a winner of both the Noble and Pulitzer Prizes, we remained at our table for over one hour following the talk discussing what went wrong with the health system. The issue of a single-payer system arose and well over 90% of the physicians at the table voiced strong support. Then someone started to ask about the devilish “details” and many began to voice second thoughts, largely concerning whether the government or insurance companies were the worse threat to health care access, innovation, and quality. Everyone had an idea what a single-payer system was but nearly everyone’s idea was different.

Not long after I graduated from medical school, after completing a three-month assignment in West Africa, I stopped in Spain. While there, I ran low on cash and wanted to purchase a few gifts. I was directed to a bank to cash some travelers’ checks. The visit to the bank took over one hour and involved over five clerical and professional personnel. I had to complete a detailed form to not only request the cashing service but also another to exchange the money into local currency. Moreover, the bank charged me hefty fees for both transactions and I received an unfavorable exchange rate. Today, no matter what language I speak or country I come from, I can hand the merchant from whom I wish to

purchase the gift my credit or debit card. Within a few minutes, he or she receives assurance – with a favorable exchange rate for me – that the money to pay the merchant is resting within my account in Charleston, WV and he or she will receive it shortly.

There are millions of customers, credit card plans, banks, and merchants throughout the world. They are link by a single-payer system of this type that for a fee of a few percentage points can provide such efficient, effective, and convenient service. The health care system often charges a fee of up to 30% for such a payment service and the institution and practitioner providing the service may or may not receive – often after much hassle - payment three or more months later. (A solo physician pays on the average \$28,000 annually with automation, and \$70,000 annually without, for such service.) That is an obscene waste of resources and few would oppose a single-payer system similar to the one used in the banking system. Moreover, it could easily accommodate a huge number of greatly scattered and varied health institutions, practitioners, plans, and patients.

However, in most cases when one uses the term “single-payer”, they mean “single-plan”. That is quite different. It involves what services for which the plan will pay, what restrictions will apply regarding the permissible sources of care, waiting time, quality etc., costs, funding sources, service reimbursement rates/ policies, etc. There are

tradeoffs that practitioners, institutions, patients, politicians, and citizens need to weigh. This is the real crux of the debate.

I have observed, and participated in, several single-plan systems over the years. They include the U.S. Postal Service and Bell Telephone System of the 1960s, military medical care system including Tricare, Sears Home Maintenance Agreement, and Medicaid. My experiences are both good and bad. There are things I like and things I hate.

Today an individual can receive a vital automobile or machine part from Japan virtually overnight. The single-plan postal system of the 1960s would have required two weeks for the part to arrive from Hoboken, New Jersey. Without competition from other plans, it probably still would. Today a business manager on a remote hunting trip can resolve a crisis back at the business, through a conference call with the parties involved via his or her cell phone. In the 1960s, he or she would have had to travel an hour to a gas station pay phone and hold multiple, individual conversations with each party to resolve the problem. Hampering the conversations, would be static, poor audio quality, and busy signals. I am not sure how much the Bell System would have advanced without competition. Both systems did (and do) a wonderful job providing access to most Americans but had limited motivation to spur innovation, effectiveness, efficiency, quality, and convenience. I appreciate what they did (do) but I am also happy they did not remain a single-plan.

I still have a Sears' Home Maintenance Agreement. There is one simple reason. It is cheap and provides catastrophic coverage when a major appliance fails. The service repair personnel are nice folks and appear reasonably competent. However, I have to wait weeks to get a repair scheduled and completed. Meanwhile, I have to haul my wet clothes to a Laundromat or keep a fire and space heaters active. Moreover, I have to spend hours of time frustrated on the phone speaking to multiple Sears' representatives who all "value my business" but are unable to resolve my problem in a timely manner. Thankfully, my need for repair services is rare. If local vendors performed most of these repair services, they would be completed within a few days. However, taken together the cost for all repairs over several years would be far more than I pay. I accept the tradeoff but would never do so if the services were fairly predictable and frequent, as often is the case with health care.

The professionals that have provided health services to my family and I within the military and Department of Veterans Affairs health care systems are among the most friendly, compassionate, and competent I have met. Their sophistication and quality of care is often superior to that available elsewhere. The underlying bureaucracies that support these systems are a different story. The result is often significant waiting times, unavailable drugs, supplies, and equipment, incomplete and fragmented care, and sub-

standard facilities. The recent Walter Reed Army Hospital situation is a case in point and cost two dedicated health professionals their careers over matters that they had little control. I am sure they advocated as aggressively as they could for deficiencies to be corrected as politicians and bureaucrats in the executive and legislative branches squabbled over whose friends would get the repair contracts.

I had mixed experience with Tricare. They seemed to handle routine services competently but referral services proved a nightmare. With the national campaign to promote colon cancer screening, and a positive family history, my primary care physicians convinced me to obtain a long overdue colonoscopy. After nine months of numerous phone calls and letters back and forth between Tricare and my physician – as well as my phone calls and inquiries –, I abandoned my attempt to obtain Tricare authorization and received the procedure through another payment mechanism. Tricare agreed I fully met the criteria. They claimed my physician failed to provide them documentation that my physician assured (and showed) me they had been sent, and resent. They finally authorized the wrong service and repeated attempts to correct the error proved futile. If I was unable to obtain timely authorization for the procedure, I hate to think about the chances for those not use to dealing with medical bureaucracies. In that regard, a single-plan system scares me; I would like to keep some options open.

Finally, there is Medicaid that promised the poorest and most disenfranchised segment of the population access to high quality medical care. In some cases, it has provided such. However, overall it has produced an expensive, confusing mess that has resulted in implicit rationing, limited preventive care, inappropriate emergency room care, episodic “on-off” coverage, sub-standard reimbursement and cost-shifting, to mention a few ills. I have no love for a single-plan of this type despite the repeated promises and attempts to fix the plan. Unlike Medicare (which currently is facing similar emerging threats), it was never adequately funded to responsibly procure the access and quality it promised. I know I do not want a single-plan like Medicaid, subject to the propensity of politicians to promise me the world while not raising my taxes.

My entreaty is that whenever the words “single-payer” appears in print, a mandatory disclosure footnote is required so the readers have some idea what it means..

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