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Session 110D
A Single-Payer Health Care System for the United States

Track: Health
Moderator: Bryan F. Miller
Debaters: Hobson D. Carroll
Don R. McCanne†

Summary: Attendees learn the major issues on both sides of the single-payer health care issue. They learn the challenges associated with a massive conversion of our health care system and explore the economic impact of such changes.

MR. BRYAN F. MILLER: This session came about through my participation on the Health Section Council, and because I was tired of seeing endless panel discussions. I wanted to try something a little different. This is set up as a debate format. We'll be presenting two somewhat opposing views on the prospect of a single-payer health care system. We'll have each of our speakers respond for perhaps two or three minutes to a set of questions. I'll ask the questions in full here. Each of our speakers has prepared remarks, but they also may take an opportunity to rebut statements made by the other speaker. At the end we do hope to provide some time for questions and comments from the audience.

At this point let me introduce our first guest speaker for his opening comments. Don McCanne, M.D., received his B.A. at the University of California at Riverside and his M.D. from the University of California at San Francisco. After serving two years as a medical officer in the U.S. Army, he practiced for over 30 years in San Clemente, Calif. Don is a charter diplomate of the American Board of Family Practice and a charter Fellow and life member of the American Academy of Family Physicians. He has served as chief-of-staff of his community hospital and as chairman of the board of a community bank.

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Don has dedicated his remaining productive years to health care reform activism, speaking and writing on a universal health care program and other policies for expanding health care coverage, access and affordability. He served as president of Physicians for a National Health Program for two terms in 2002 and 2003.

DR. DON R. MCCANNE: Physicians for a National Health Program is a group of physicians who are dedicated to health care reform that best serves the purpose of patients, as opposed to a medical association, which tends to be oriented toward improving the lot of the physician. If you look at reform proposals, you can identify stark differences in ours. We're concerned about the fact that we have such great resources devoted to health care today, but we're not delivering, as far as coverage, access, equity, outcomes and quality. We have a system that falls far short of what we could accomplish if we used our resources better, and that's what our program is all about.

MR. MILLER: Hobson Carroll, a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries, is president of Vector Risk Analysis, LLC, a single-person consultancy working mostly in the U.S. medical market with particular emphasis in the self-funded arena, but with occasional projects involving development of medical products in other countries. In addition to various periods of consulting activity, his background includes working as group actuary for several U.S. insurance companies, as well as extensive experience in medical reinsurance worldwide. The latter has allowed him the benefit of studying the health care systems of other countries while seeking to find elements of best practice for adaptation to other geographic settings including the United States. For the past four years, Hobson has been an invited lecturer on the U.S. medical system and the drivers of medical trend at a master's level actuarial program course in health insurance taught at London City University. He is a graduate of Coe College in Cedar Rapids, Iowa.

MR. HOBSON D. CARROLL: I think the U.S. health care system is a little bit more like my home state of Minnesota's weather than it is Anaheim's—very cyclical with extremes, very changeable, and with the occasional storm of controversy, chaos and all the other things that make Minnesota weather a wonderful thing to experience. And things do certainly change, I think, in the health care system.

Of course, our system does change continuously. We've heard in several other sessions about the cyclical nature of the challenges our health care system faces, but it does seem like things have been sort of peaking and that maybe this time we really need to do something about it. My comments later, and the questions, are going to be dealing with defining terms. I'm very sticky about defining terms. I think that that forces clarity and allows for a discussion and analysis of how things inexorably are linked. You can't talk about a single-payer system without talking about what all of that means.

I like Howard Bolnick's definition that was in a session yesterday on the goals of the U.S. health care system, because I think that's as important as using words to talk about a kind of system. He used this definition: "universal access to high-quality, cost-effective health care." It was very important for me to accept this challenge from Bryan when I was able to conclude that I didn't have to defend the status quo. I only had to reflect and react to what a single-payer system might look like.

MR. MILLER: Let's follow with a discussion along the lines that Hobson's just mentioned, defining our terms, making sure that we come to agreement or at least agree to disagree on some of the basic phrases and terms that are bandied about. Let's go first to the definition of a single-payer health care system. Don, what does that mean to your organization?

DR. MCCANNE: Our organization published the first single-payer proposal in *New England Journal of Medicine* in 1969. Last summer, we published the physicians' proposal, which is basically single-payer, in the *Journal of the American Medical Association*. Single-payer is a system in which all current funding sources—insurance plans, public programs, Medicare, Medicaid and so forth—are eliminated and replaced with one single payer. It's federally funded but administered on a state or regional level. It would be much like taking Medicare, fixing it so it works better, moving the administration to the states and funding it through the tax system. So it's equitably funded, comprehensive coverage for absolutely everyone through a single-payer program.

MR. CARROLL: Well, of course, this is the fundamental question, and it does tie to the other three questions in this session because they're linked so clearly. I agree. I would read single-payer system to mean that a single entity is responsible for the financing and administering of the payment for medical care services in the country. That leaves open to question: Who do the physicians and the hospitals work for? How are prices going to be set? But, at any rate, that also comes later in the questions. Clearly these terms generate a lot of need for additional clarification so that we know how they're going to interact. I guess I would certainly agree with that as a definition to go forward with.

MR. MILLER: Let's move on to the term "universal health insurance coverage." What do we mean by that? And also, is it important to have?

DR. MCCANNE: I think there's generally a consensus throughout the nation that we need universal coverage, but that does mean a lot of different things to different people. From our perspective, a single payer is automatically universal coverage by definition because it covers absolutely everyone residing in this country. There are other ways of providing universal coverage, but each model has its strengths and weaknesses. I don't think I'll go into those yet. I think we'll get to them.

MR. CARROLL: I don't think there are any short answers for the definition itself. It means different things to different people, as Don alluded to. I also think that we'll

have to get into the terms of comprehensive universal coverage, but I think if we focus on the "who" aspect just for a moment, it might not be as easy in the definition and certainly within our political environs. Do we mean (a) all citizens of the United States of America, wherever they are? Do we mean (b) all U.S. citizens and all legal permanent residents in the United States? Do we mean (c) U.S. citizens, legal, permanent residents and legal, temporary residents or visitors? Or do we mean literally anybody who's inside the territorial limits of the United States at any moment in time? That, in itself, begs questions about setting up coordination of benefits (COB) against other country care. I think that becomes important. Maybe there's a need for it.

If we have such a system, we'll need to have a new kind of international treaty on caring for other people who are in our countries, which then leads to people coming here to get care. That would be a burden, so I think that's important. As far as the question of whether it's important to have, I think there's very little argument against the importance of universal coverage as both a desirable and an attainable goal for any health care system, certainly ours.

However, the coverage element does need to be defined. Personally I believe that universal coverage is extremely vital for taking care of the sick uninsured. This probably looks like such an obvious statement as to border on the ridiculous or the ridiculously obvious, but what I mean there is that we need to be covering all the uninsured, and particularly the unsick uninsured, with their contributions to the cost, in order to address this issue.

MR. MILLER: Moving on with the concept of universal health insurance, is universal health insurance coverage a possibility without having a single-payer system?

DR. MCCANNE: It is. Here in California we did a study that was requested by the California State Senate of nine different models of health care reform funded by an HRSA grant, and various academic institutions were involved. I participated with the UC San Francisco medical school in preparing a single-payer model. Rick Brown of UCLA and Rick Kronick of UCSD prepared an employer mandate with a public program that would cover everyone that falls through the cracks on the employer mandate. It would cover everyone. It would be universal. It just happens that building on the current system of employer-sponsored private plans, plus having a public program, is a very expensive way to do it. It leaves inequities in place. It leaves administrative inefficiencies in place. And it inevitably is not quite as comprehensive as a universal single payer.

But the study showed that although theirs was the most expensive way of providing health care reform in California, ours was the least expensive. It would actually provide truly comprehensive services for absolutely everyone, including the undocumented—eye, dental, podiatry—everything for everyone, and would reduce

costs for Californians by over $7 billion. It's a model that you really need to look at, since it affects many of the people in the room here and their employment.

MR. MILLER: Hobson, how about that question, universal health coverage without a single-payer system?

MR. CARROLL: Well, yes, of course, I believe that that's possible. I think that due to the probable ramifications of the functioning of a true single-payer system, it's likely the only practical way that we're going to attain a workable universal coverage in this country. I was talking to Don beforehand, and I haven't actually read the full proposal, or one of the latest versions of their proposal, because I'm anxious to find out how they get providers to do all this.

Germany, the Netherlands, France and many other countries around the world all have serious problems, just like the United States has, but, nonetheless, have universal coverage without having a single-payer system. I'll point that out. They're often perceived as having single-payer systems, but they are by no means single-payer systems, and they provide universal and reasonably comprehensive care with pretty good medical outcomes for one-half to two-thirds the cost of the U.S. system (maybe it's closer to that one-half end). I think a proper adaptation of bits and pieces for several of those systems woven into a modified U.S. system could very well be the answer, at least theoretically. Unfortunately, a lot of what we're going to be talking about is theoretical, because we can all design things that would work in an ideal world. Unfortunately, we don't very often have the chance to start with a tabula rasa and design it that way.

MR. MILLER: Let's move on to some more practical issues. Presuming we were to move in the direction of significant reform to the current system, let's talk about benefits. Could an equitable standard benefit package be agreed upon? And who decides what it would be? Who decides who would pay what toward the program?

DR. MCCANNE: That's really a difficult problem. Right now it's common to hear proposals talk about a basic program, make sure everyone has basic coverage. If you want extra coverage beyond that, leave that to the private sector. Last week, at Stanford Medical School, I debated the chairman of the board of the California Medical Association and Professor Victor Fuchs, economist at Stanford. He is making a proposal, along with Ezekiel Emanuel, for a basic program. This would provide vouchers that provide 100 percent coverage for the basic program, and various insurers could offer that. He feels that's an answer, but when I asked him what "basic" is, he said their proposal is a work-in-progress. I think that pretty well sums it up.

Our proposal is macro-management of the funds through global budgets and so forth, leaving micro-management to the patients and their health care providers and physicians. We don't think you need to define as precisely what can or can't be done, although we do have to identify outliers that are abusing the system, have an

educational process in place and maybe even a punitive process for those who fail to respond. But you can cover basically all that's beneficial.

MR. MILLER: Hobson, what about benefits in a universal coverage system?

MR. CARROLL: I said I was going to always talk about definitions. I think this is obviously one of the critical ones. I would start with: What's beneficial? Someone is going to determine what's beneficial. Is that left at the local doctor level? We know that medical care differs greatly by region of the country now. Who's going to establish protocols for best treatment practice and that sort of thing? Someone's going to have to do all this. Someone's going to have to make a decision about what it means.

Again, what is the universality? What is the comprehensiveness? I don't think those are things that can be left to be micro-managed. The two primary examples of single payer that we would, I think, allude to in this country, are Canada and the United Kingdom. Now they are not the same at all. Canada does have local provincial administration and some differences, but for the most part I think we would consider that a single-payer system. The United Kingdom, of course, has a single-payer system with a single provider, in effect. When I'm over there talking to my colleagues about global budgets, things left to local, regional and some of the health centers that they have there, they don't seem to have worked the bugs out of that system. Maybe if we came to it fresh, we could do it better. I would venture to say, though, that the bureaucracy that would result from such a system would invariably get so bogged down by politics and by the lobbyists in this country that it would make it a very challenging goal to come up with any kind of a standard, equitable benefit plan.

MR. MILLER: Continuing on the economic discussion, what could be done to mitigate potentially massive economic disruption to the current industry if a single-payer system were implemented?

DR. MCCANNE: Well, that is an issue. In some of our models of reform, we've included transitional retraining programs because there would be significant displacement in the health insurance industry.

MR. CARROLL: Again, we're held back to some extent by the full meaning and intent of the single-payer system, but with the definitions that we've been working with, I think clearly there would be significant economic turmoil given the number of persons who do work in the insurance industries—HMOs and other financial intermediaries of the medical expense world. How long would the transition take? What kind of transition plan would be there would obviously be, again, a point of contention in any plan that would be done. I think there would be a lot of administrative hassle during that transition period when patients or insureds would have to bear some pretty big messes. I'm not sure that the result actually would

gain much over a more moderate modification of the current system to achieve an approximation of universal coverage.

MR. MILLER: Turning now from the health insurance industry to the providers, how would you see providers being compensated under a single-payer system, and who would decide that compensation? Would providers be allowed to operate outside the single-payer system, and would this lead to a multi-tiered medicine?

DR. MCCANNE: As I mentioned, we propose that the program be administered on a state or regional basis, and we believe that negotiation is the proper way to establish rates. That's negotiations with providers or physician groups. It would include integrated health systems such as Kaiser, establishment of global budgets for hospitals, and this would be between the public administrator of the program and the providers. We don't believe that allowing providers to operate outside of the single-payer system is a proper approach, and this is controversial.

Currently Canada is really the only nation that prohibits physicians from delivering covered services outside of the system. But obviously anything that's not covered by the system, such as cosmetic surgery and penthouse suites in hospitals and so forth, would be funded outside of the system. For those services that are covered by the system, if you allow a parallel private system, as we see in England now, it allows people to buy their way to the front of the queue. It allows the wealthier to obtain actually better services, and you do end up with at least two-tiered care. We believe that the $1.8 trillion that we're currently spending on net health care is enough to provide that first-tier level of care for absolutely everyone.

MR. MILLER: Hobson, what about the providers in such a system?

MR. CARROLL: Well, first I would say that I agree that the money that we're spending now should be enough to fund a pretty good health plan for everybody if we squeeze the fat out of the system. I think we're probably more able to do that on an incremental basis by appropriate changes to the current system. I think that this is one of the hidden-iceberg issues of the discussion subject. Again, the Canadian and the U.K. systems do have significant price controls on providers. They have to try to make their budgets work, and that leads to dissatisfaction with at least some providers.

In the United Kingdom, about 12 percent of the population has private policies that lets them jump to the front of the queue. They don't jump to the front of the public queue, but they get it taken care of more quickly than the people in the public queue. There's a lot of murmuring about two-tiered medicine amongst the population over there when that happens. They're very proud of their national health system in England, and most of the people still are. It does work pretty well. It does have some significant problems, and they come from a different cultural tradition than does this country. I think that all the parties to the discussion (providers as well as government, business, employers and the insureds) all have

to contribute to any solution that we have. Providers who think that a national system could do anything but place tight controls on the practice and pricing of medicine and medical treatment are operating with, I dare say, a questionable set of assumptions.

The cultural and political environment engendered by a single-payer national system, and its unquestioned related requirements, would surely lead to opt-outs, if allowed, by providers to provide services in private or opt-out insurance arrangements. This could potentially lead to severe cycles of deterioration in the public system and would likely lead to multi-tiered medical treatment and contribute to a hastening development of class distinction and ultimately political warfare between the haves and the have-nots of private higher-tier medicine.

MR. MILLER: Sticking with the financing, there are a couple more questions on that aspect of it. Can private-sector resources be shifted smoothly to a fully public program without a traumatic impact on the economy and on society?

DR. MCCANNE: Our model is universal health insurance, but we believe that the health care delivery system should be maintained as it is, the public and private system, that it's fine to have private ownership and profits in health care. There are some in our organization who would prefer to see all the investor-owned segments of the delivery system converted to nonprofit, but the big issue is the mechanism of funding health care, the insurers, and we think that insurers have to exit and leave us with a single national health insurance.

MR. MILLER: Okay. What about resources moving from a private to a public system?

MR. CARROLL: Well, I think this is a sibling to an earlier question. I think that generally the answer is no, although it depends on the definitions of the system and the proposal that would be implemented. Maybe it's possible to do it. It might be a bit of a rough road. I don't think there has to be that much disruption, though, if we simply move to universal-mandated coverage using one of the methodologies. My personal preference is an individual mandate, and we must never forget that, as I've said before, that in a large sense our system is tax-based if only because of the tax sheltering of employee benefits. We can't get away from the fact that the tax system has something to do with the way we provide our services, not just what's done by payroll taxes.

I realize that there are all kinds of statistics that allegedly show the inefficiency of the U.S. private or commercial system in comparison with Medicare or with Canada. Some of Dr. McCanne's papers allude to these studies. But there are plenty of counterarguments of these studies, not the least of which is that the comparisons are normally done on a percentage-of-claims basis, and the distribution of claim size for Medicare is substantially different than that for commercial populations. I'm talking about the resource allocation here. It costs 2 percent of the Medicare claims

to administer them. Well, that doesn't include all the costs of the people involved at all levels of administering Medicare. More importantly, fine, it's 2 percent, but it covers one-fifth of the commercial population. Roughly, in 2002, there were 160-some-odd-million people, commercial and 32-33 million people, Medicare. If you restate it as an amount per head, you see a substantial change in the ratio of the so-called cost and efficiencies of the private system. Also, the private system does a lot of things that Medicare doesn't do—for example, adjudicate claims instead of just writing checks.

DR. MCCANNE: I'd like to expand just a little bit on the administrative cost, because the administrative waste in our current system is very fundamental in our proposal. As Hobson mentioned, 2 percent is commonly given as the administrative cost for Medicare, whereas you're all aware that the administrative costs and profits of private health plans are considerably greater. But it's not just the administrative costs of the insurers; it's the administrative burden that this places on our entire health care system. It's tremendous, and much of the administrative waste occurs there. There have been different analyses of administration of health care in the United States, but it's something over $400 billion. That's the equivalent of our national defense budget, just for paperwork in health care. Much of that is recoverable by eliminating the fragmentation of the system of funding health care and switching to a single payer.

Various estimates have been made, but, based on 2003 numbers, the closest, most carefully worked-out estimate is about $286 billion. That was in an article by co-founders of our organization, Dr. Steffie Woolhandler and Dr. David Himmelstein, published in the *New England Journal of Medicine* last summer. Those numbers have been substantiated by Uwe Reinhardt, Princeton economist. Many of you know who he is. They're very credible numbers. Now, there has been some argument about the numbers. Henry Aaron disputes the numbers a little bit. He prefers his back-of-the-envelope calculation instead of this very carefully done study, but the point is the number is huge, and that $286 billion is recoverable administrative cost that can be much better used.

MR. MILLER: Also in the financing realm, is there a way to improve the equity and universality of financing an employer-based health care system, short of converting to a fully public one?

DR. MCCANNE: Yes, there are a lot of things that can be done. I think most of the people in this room know what the various things are as far as trying to increase equity, improve coverage and tax policies. But, as you make these various changes, as you get closer and closer to an equitable, efficient system, you're getting closer and closer to what is, in effect, a single payer. This is really not a very good market for insurers as far as serving as organizations that pool risk, but, rather, it's a market for administration, but a much smaller administration than what the insurance industry is providing today.

MR. MILLER: Hobson, you mentioned an individual mandate, a program such as that. Is there a way to maintain equity at the same time as universality?

MR. CARROLL: I think so. Again, everything is sort of dependent on the political question, but I think we can do it. We need universal coverage. I prefer something like the German system where basically everybody has to be covered, and then you provide mechanisms for taking care of people at different income levels and under different circumstances in order to let them participate, either through actual programs or through vouchers, and they buy things in the individual system.

In order to make that system work more equitably and to actually enhance competition in services that we actually need, instead of a single-payer system, I think we need what I call an all-payer system. By that I mean a system where a provider can set a charge basically, with maybe some small exceptions, for a service, but they are going to charge that service to all payers.

I really think it's important to do away with the cost-shifting of the federal government. It's a tax without representation, without accountability and without responsibility, and they do it for the obvious reason that they don't want to have to raise the price to something that's fair to providers because that means they have to pay for it out of the budget somewhere. And that means they have to face the public. So they're hiding that and transferring it, and I think that same thing goes on in the private system. I also think that we need a single regulator—not necessarily a single payer, but a single regulator.

A lot of administrative costs are due to the fact that we have umpteen million regulations out there, and they're all different. They're all different by state and sometimes even by locale, and I would comment that I certainly agree with the amount of administrative waste that's in the system, but much of that can be recouped simply by a more efficient use of what we're doing now. Some people argue that that will come with a number of initiatives that are out there. Donald Berwick, chairman of the Boston-based nonprofit Institute for Healthcare Improvement, estimates the United States could cut 15 to 30 percent by simply operating more efficiently and improving quality. If we ever get to a standard form of "electronification" of a lot of this stuff, we actually will start to recoup some of that administrative stuff.

I am sorry I don't have the exact reference, but I know I read this a couple of weeks ago. A hospital administrator was commenting about the fact that for every day that a Medicare patient is in the hospital, he has a clerk spend something like five hours doing paperwork, every day for every patient. It was so huge that it seems it can't be true. Even the government system creates some of the administrative costs that aren't in that 2 percent, by the way, of the Medicare claims payment administration, which is basically the cost to pay the administrator to cut the check.

MR. MILLER: Sticking with the concept of a single-payer system, one of the issues that we've talked about a lot this week is affordability. Who would be responsible for affordability, both at the societal level and also at the individual level?

DR. MCCANNE: For society, we believe the government. We believe the system needs to be funded through the tax system, and we think that we can run a good health care system through a global budget for the entire health care system, indexed to some reasonable index of inflation. As far as controlling health care costs for the individual, we don't think you need to put the individuals in charge of their own health care in the sense of making them sensitive to health care costs so that they'll reduce their utilization of health care services.

Just about every study that's looked at this objectively has shown that increased cost-sharing decreases utilization of beneficial services. Yes, it does decrease utilization of less effective services as well, but the impact on the utilization of beneficial services is very significant. There is a brand new study in, I think, the *Journal of the American Medical Association* this week on copayments for prescription drugs and employer-sponsored plans. It showed that increasing copayments significantly reduced the utilization of drugs for major chronic disorders and then reduced even greater the utilization of drugs for symptomatic relief, which is a major goal of health care. We don't think that's good policy.

MR. MILLER: Let me follow up on that with you, Don. We talked earlier about the consumer-driven health plans. I gather, based on the comments you've made, that your organization doesn't see a great benefit in those types of plans.

DR. MCCANNE: That's correct. Of course, health savings accounts with high-deductible plans are kind of the "in" thing today. I think, again, many people in this room realize that that's not going to work for a major sector, that the people that will fall through the cracks in that are precisely those individuals who have the greatest health care needs. If they have very modest incomes, placing the consumers in a position where they're sensitive to cost will impair their access to care because of the financial barriers that it erects. So we don't think this trend toward consumerist health care is proper policy.

MR. MILLER: Hobson, what about affordability?

MR. CARROLL: Really another way to word this is: What are the limits to the benefits to be provided to people in the system? What do we mean by affordability in the first place? There I'm going to be a little contrary, and it ties a little bit to what Dr. Hughes talked about in the general session. If you have an affluent society that is taking care of other needs, which is arguable, who's to say that spending 15 percent or 18 percent or 20 percent of the gross domestic product (GDP) on medical care isn't all right if that's what that society wants to do?

On the other hand, obviously you don't want to waste stuff because there's opportunity cost, and I wouldn't be the first person to say we haven't taken care of the other needs yet, to be turning around and spending money. I think it's also true that in that $1.4 to $1.7 trillion (depending on which year we're talking about) that we're spending, if I'm not mistaken, that includes every single thing that they classify as something spent for health care. This includes, I assume, Botox, Lasik, cosmetic surgery, everything; even perhaps over-the-counter drugs, I'm not sure. A lot of that could be called elective, so maybe we shouldn't be talking about that putting pressure on the system.

I think accountability still needs to be a part of this in terms of the responsibility when it comes to the affordability. I was thinking of the example that he mentioned about the compliance with the drugs. I think I saw an article written about that article. One of the answers I think that the private system could have, as well as maybe a public one, is we have to be more creative with some of the products that we design. One of the things I'm thinking about lately is, I guess for lack of a better term, a diagnosis-based reimbursement scheme. In other words, if you have chronic diseases–diabetes, asthma, whatever— maybe they shouldn't have copays for at least the maintenance-type drugs. Maybe we should be varying copays by the type of diagnosis rather than just a flat type of drug. And there are other kinds of solutions that the private system could help bring to this if we would get innovative about it.

MR. MILLER: Let's talk about rationing of services. Would there be significant rationing of services in a single-payer system, and what about price controls?

DR. MCCANNE: Uwe Reinhardt likes to say that the United States has the worst rationing of all nations, but ours is unique in that we ration by ability to pay, whereas other nations ration on the basis of capacity. There were two studies published by the Organization for Economic Cooperation and Development (OECD) this past year that are excellent studies, and you should all look at them. They're studies of queues for elective surgery in various OECD nations, and that kind of represents rationing. How long do you have to wait to have an elective surgery done? All nations do emergency surgery immediately. Well, they demonstrated that about half of the nations don't have problems with queues for elective surgery. The others do, and they're addressing these problems. They demonstrated that those that are successfully addressing the queues are doing it by adjusting capacity. So they're doing it on the supply side rather than the demand side, which doesn't work very well at all. We need a lot of that in this nation.

As you're aware, we have not only some areas with inadequate capacity, but we have a problem with excess capacity. You have areas such as Boca Raton, which has 30 percent higher health care costs with no improvement in outcomes whatsoever. That's because we have excess capacity in the system. So, we do need to work on that. We think we can do that much better through an integrated funding system where we allocate our resources more effectively and budget for

capital improvements. That's a little bit of intervention, but we really need that considering the amount of waste and unmet need that we have in our system.

MR. MILLER: Hobson, what about the rationing of services and price controls?

MR. CARROLL: Well, as implied by some of my previous answers, I guess I say yes to both of the questions. Would there be significant rationing? And what about price control? I think there would be in any foreseeable scenario, certainly at some point in the future, if not initially. I would like to make a comment about the rationing in the United States. We don't call it that, but we certainly have it. I guess I would say to some extent it's not quite the way it's let on. I think that the suggestion that there are people in the United States that do not, in fact, receive health care services is true, but I think the situation is that there are people who do not receive the services that they or their advocates believe they should be getting when they want to get it and where they want to get it.

We don't have universal health insurance coverage. The media, especially overseas, likes to suggest that the United States has 45 million people sitting outside hospitals wanting to get in, but they won't be let in because they can't pay. That, of course, is simply not the case. On the other hand, I think we ration along those lines, and I think that the United States needs to deal with the "r" word, tough questions about what kinds of services, to whom and when, should be made and have to be made because we simply can't provide all things to all people. I'm reminded of the Oregon Medicaid program's struggle to rank services that should be provided down to the point where the money ran out. I think that's a brave and laudable struggle, and it's one that we're probably going to be faced with sooner or later anyway, but certainly under a single-payer system.

DR. MCCANNE: I'd like to say just a little bit about these 40 million that are uninsured and also the tens of millions that are underinsured. As you know, many insurance products now require significantly greater cost-sharing on the part of the patient, which is impairing access. The health policy literature is loaded with data that confirms that health care outcomes are impaired by this. People are suffering because of lack of insurance or because of inadequate insurance, and it's very real. It's not some kind of theoretical problem.

MR. MILLER: Let me jump out of order for a second because you mentioned cost-sharing. Let's talk about the potential cost-sharing from a single-payer system. Must a single-payer system preserve some cost-sharing on the part of the patient? And, secondly, can a universal system preserve risk-taking on the part of intermediaries?

DR. MCCANNE: In a single-payer system, as we perceive it, there would be no intermediaries, as far as any kind of risk pool. So, the risk becomes the general taxpayer pool as to how much of our GDP we want to devote for health care through our elected representatives. The risk isn't much of an issue.

We think that, in general, cost-sharing has a detrimental effect. There is disagreement on that. This last study I mentioned on the copays is the newest RAND study, but everyone refers to the RAND study of a couple of decades ago. You hear half of it, that by having copays you reduce costs, but you don't hear the other half. They used the same RAND data, and they showed that copays (cost-sharing) reduce utilization of truly beneficial services, and that's important to understand. We think we can fund health care without having to resort to a significant cost-sharing.

MR. MILLER: Hobson, what about that issue of cost-sharing?

MR. CARROLL: I'm the one suggesting that maybe we can still have a universal system without having a single-payer system. I don't think that risk-taking in the traditional sense could be maintained in a universal coverage system; actually I don't necessarily think that most of it is in a traditional sense now. I think most commercial insurance is provided on what I would say is an administrative risk basis, that with the large pools there's not so much in what we would call actuarial underwriting risk in the system now, with the possible exception of stop-loss insurance on the self-funded market. That is big, but, as a total amount of dollars, it isn't that big. I think that risk has many facets, and administrative and cash-flow risk and market competition are areas of business risk that can certainly still play a significant role in a system where traditional underwriting risk is largely eliminated either by fact or by proxy.

On the cost-sharing side, I would say you wouldn't have to have the cost-sharing, but I think it would be dangerous not to. Clearly, one could have a single-payer system and have cost-sharing, though if they did, I think they would probably have to have it be income-related in some manner in order to maintain the access and also create some form of additional solidarity (we heard that word from Howard Bolnick yesterday) to subsidize overall costs.

I wasn't trying to suggest at all that there's not a lot of pain in the current system from those uninsured people; I'm simply trying to suggest that the overseas perception of what goes on here is often wrong in terms of the overall problem. It's a significant problem, and it's one that we should take care of, but there is more than one way to skin that cat.

MR. MILLER: Let's jump back to the previous question, which deals with technology. Would a slowdown in innovation and technological development necessarily result from a single-payer system?

DR. MCCANNE: No. Perhaps the two greatest technological advances of the last half century are CT scanners and MRI scanners, and each of those received a Nobel Prize, appropriately. But who received them? It was shared between the Americans and the British. Well, the British have one of the lowest rates of funding of their health care system of any nation, but that did not suppress the technological

innovation that helped them develop this very important technology. We are spending $1.8 trillion this year, according to the Centers for Medicare and Medicaid Services, and there is no way that the technological and pharmaceutical industries are going to walk away from $1.8 trillion without trying to get their share. They'll continue to innovate.

MR. MILLER: Hobson, what about technology in a single-payer system?

MR. CARROLL: We're probably more at risk from the political intervention on things like stem cell research than we are in danger of having a single-payer system defray technological advances. The answer is, yes, at least to some extent. I don't think there's a lot of data on this.

There is one interesting story that I read not long ago that might address this. I'm going to read through it very quickly. There was a study done on a comparison of the German market's use of prescription drugs, and it was done by a person or an outfit named Bain. This is taken from *The Economist*, January 29, 2004, issue.

> Bain looked closely at Germany, Europe's biggest drugs market, accounting for one-fifth of total spending and of the industry's European jobs. Germans have relatively high life expectancy but get access to new drugs relatively slowly, and by many measures their overall health standards are worse than those in America. Germans spend more time in hospital and lose far more working days to sickness than Americans. Germans suffering from heart disease and breast cancer have worse mortality rates thanks to the unwillingness or inability of doctors to prescribe the newest, most effective and most expensive drugs.
>
> A decade ago Germany boasted two of the world's top drug firms, Bayer and Hoechst. Now it has none. Hoechst, for instance, merged with France's Rhộne-Poulenc to form Aventis, which itself might now disappear. According to Bain, a proper accounting for Germany's spending on drugs produces an alarming result. In 2002 Germany saved $19 billion because it spent much less per head than America on drugs. On the other hand, says Bain, in the same year Germany lost out on $4 billion from R&D, patents and related benefits that went elsewhere. It lost $8 billion because of high-value jobs that went somewhere else, plus the benefits of those jobs from the multiplier effect.

> German drug firms would have made $3 billion more in profit if they had kept pace with rivals elsewhere, and a further $2 billion was lost as the country shed corporate headquarters and the benefits they bring. The cost of poorer-than-necessary health was $5 billion. Of course, these calculations rely on some rough-and-ready assumptions. Even so, Bain arguably errs on the side of caution. It plays down, rather than up, the multiplier benefits of jobs on the drug industry, etc. In sum, it reckons that Germany's $19 billion saving is, in fact, a $3 billion net loss to their economy. When you add up all the costs, the free rider model is actually quite expensive.

This was relating to the argument that's made that the United States pays the R&D for the drugs of the world, and yet maybe the flipside of that is that maybe we derive some economic benefits that exceed that. Now, what does that have to do with the question? Well, my view is that a single-payer system would invariably bring price controls—I've said that before—in some form or another. I agree with the doctor. I'm not sure where they would go if they didn't want to stay here. But it could have some effect.

MR. MILLER: The key question is about a single-payer system in this country, as we've discussed, as opposed to a number of other countries. Are there unique characteristics about America and Americans that serve as barriers to universal health insurance coverage and/or a single-payer system?

DR. MCCANNE: No. It is true that we have not developed the political will, but I don't think it's because Americans are somehow or other a meaner, greedier society. I believe that it's primarily because 85 percent of us are relatively healthy. Most of us have employer-sponsored coverage. We're content with that. Fortunately we don't have to use it much, and we're apprehensive about the government taking over coverage that we're doing all right with. I think it's that complacency amongst the healthy working individuals that has created resistance to change. We think that if everyone understood all aspects of the health care funding, there may be a greater drive to produce change.

There are two things I want to mention. First of all, 60 percent of our health care is funded through the government already. That 60 percent alone, on a per-capita basis, is more than any other nation spends on its public and private spending combined. So, we already have government-funded health care that we're not receiving adequate value for because we're leaving it to the marketplace to use our tax dollars as they're using it, and they're using it incorrectly.

MR. MILLER: Hobson, is there something unique about this country that makes the designs that seem to be working more or less effectively in other countries doable?

MR. CARROLL: I wrote these comments or jotted down these notes before I heard the general session on Wednesday or attended Howard Bolnick's session yesterday. I agree very much with a lot of the statements. I think the answer is yes to both, but that doesn't mean they can't be overcome, at least in relation to achieving universal coverage. I would just add here that I think, Don, your start-up of the answer implied that we have to have single payer to achieve universal care, because you were saying that Americans aren't greedy; it's not that we're not altruistic and all that sort of thing. I think that's true. I think we are more altruistic than not, and I don't think that greed is preventing it, but I don't think that we have to force the situation with a single-payer system.

The American traditions of individual freedom, resistance to requirements and regulations and a sense as to limitations on government in general have created a society where dramatic change along the lines of a single-payer medical care system is not likely to succeed without a major paradigm shift in perception and acceptance. The nature of our political system is perhaps the most major obstacle to instigating the systemic changes necessary for such a major overhaul to one of our most important economic and social foundations, let alone being able to achieve the legislation and the necessary regulatory guidelines required in the first place.

Our political and cultural history forms a momentum that is difficult to counter without the use of perhaps a temporary, benign dictatorship of some kind, which we're not likely to have either. However, need is often the mother of invention, or at least variation on what you start with, and our system is certainly perceived to be moving from crisis to crisis. So, despite my general comments about our culture, I think that some form of universal coverage can and will be implemented some time in the next six to eight years, though the exact form is hard to predict. Given the history presented to us by the last 40 years of legislation, the power of lobbies and the impact of communications technology allowing for the creation and the manipulation of news and information, I am not optimistic that the result will be what any of us would deem an acceptable solution.

DR. MCCANNE: Are we close to changing the political will for reform? Actually, I personally believe we're much closer than most people realize. The reason I say that is that the nation is now concerned about affordability. Everyone is concerned. On surveys, when they ask what your number-one concern about health care is, the answer is usually affordability. Yes, they're concerned about the uninsured and access. In one survey where they asked that specific question about affordability, 98 percent of people said that they were concerned about affordability. There's hardly any issue where there's that much agreement on in this nation.

The Commonwealth Fund released a study about two weeks ago. They looked at different sectors, as far as their income levels and insured status. For the most favorable sector, those with incomes over $35,000 a year and continuously insured, 29 percent currently have financial problems due to medical bills. What do they

mean by financial problems? They're hounded by bill collectors. They've had to take out loans, a second mortgage on their homes, things like that. Of course, medical bills have become a major cause of personal bankruptcy in this nation. So that's an issue for some of them. But Americans are very concerned about affordability, and if they see that they can obtain comprehensive health care coverage that won't cost them much out of their pocket and will be a relatively painless tax-funded system, we believe that there's going to be much greater support for true reform, not just building on our current, flawed, inequitable and overpriced system.

MR. RYAN KYLE ZIEMANN: My opinions are my own and may not necessarily reflect that of my company. Dr. McCanne, my question is to you. I'm from Chicago, and in my own state we hear a lot of news stories. One is about a hired truck scandal. There are trucks that get hired and paid to sit for seven hours and then work for one hour. We had a government that's now been indicted on several charges of corruption that has led to waste within the state. By giving the government control of the health care system, why would we expect that it would be any different with this kind of a system?

DR. MCCANNE: If we look at Medicare, we're all offended by the fraud that occurs in the Medicare program. But that same fraud is occurring in the private sector, by providers that your insurers are contracted with and so forth, but we don't hear about it as much. You kind of tolerate it. You just consider that as part of your risk pool, and you pay for that fraud without a second thought. Whereas when it's taxpayer-funded, we're much more sensitive about that, and we're much more rigid about ferreting out fraud. Medicare has been a very efficient program, as far as utilizing the dollars for beneficial services for patients. Government versus private isn't really the big issue that's going to determine how well we spend our dollars.

MS. SANDRA L. GIBSON: I have a question for Dr. McCanne. You mentioned that under the single-payer system that you envision, there would still be negotiation on fee schedules for physicians. What would be the basis for that given our experience with Medicare, which you just cited, as our experience with a single payer? There's certainly no negotiation on price. They cut it whenever they need money. Also if there's just one payer, how is a physician going to negotiate? The state would say: this is the fee. How does the physician negotiate in that situation on price?

DR. MCCANNE: It's not a competitive negotiation. It's presenting costs and demanding fair compensation. We're going to have to lift the antitrust measures that allow effective negotiation, whether it's through the medical association or some similar organization, just as the hospitals negotiate with insurers now for their compensation. So, it's based on cost plus fair profit, and society wants their doctors paid. They want their hospitals paid because they want them to be there. We'll have the support of society. I don't think there will be a perception of greedy doctors fighting with the government over compensation. There are problems with every system, but when you step back and look at the perspective, we believe this is a much better system. This is what they do in Canada, and it works for them.

MR. CARROLL: May I make a comment here? My mother lives in Denton, Texas, and she had a Medicare physician there who said, "I'm getting out of the business." There were all kinds of news stories in the last couple of years of certain sections of the country (Colorado I think was one) where droves of physicians were leaving. They were saying, "Nope, we're out, we're out. We're not going to take the payments, the assignment, whatever they call that." It might be a problem, and maybe overall there are some gains to be made, but I think we're not going to fix that. You said they would sit down, and they would come up with a fair compensation. We can't even define reasonable and customary for hospitals now. Who's going to define reasonable compensation?

DR. MCCANNE: You negotiate it.

FROM THE FLOOR: I'm asking my question as a current MPH student at the University of New Hampshire. Would both panelists please respond, because I think public health has been more responsible for improvements in health. How would you strengthen public health under the respective systems you're advocating?

DR. MCCANNE: We emphatically concur that strong funding of our public health system must be part of the funding of our health care system. We also agree that public health has been more important than the health care delivery system in improving the health of the nation.

MR. CARROLL: I guess I started out by saying that I just didn't have to defend the status quo, and I wasn't necessarily supporting a single-payer system, but I do have a system in mind. I would concur that it's very important. I think probably the most important element of health care quality increase is education, and public health education, as well as the services provided through public health facilities, is obviously important. I'm not so sure we're doing that well on the education side in general in this country, let alone health education. I guess I would say that when we squeeze some of that fat out of the system, whether it's from a single-payer system or from some things I would do, I would want to take some of that savings and improve our depreciating-very-fast public education system in general. That area, I think, in particular needs to be expanded. There need to be more of those facilities. Of course, if we have a single-payer system, and all the providers are in it, I guess they'll be taking care of all those services.

MR. MILLER: If there's nothing else from the audience, I'll ask our panelists if they have any closing words.

DR. MCCANNE: I think you've pretty well heard the message. We have the resources—$1.8 trillion will buy a lot of health care. It's more than enough to fund comprehensive care for everyone, but the way we fund it is inequitable, and the way we allocate it is inequitable, ineffective and has resulted in many of the quality problems in our nation, perhaps more from overutilization, excess capacity, than underutilization, though they're both issues. If we establish one single risk pool and

administer it locally, after federal allocations, we can greatly improve on the efficiency of our health care spending.

MR. CARROLL: I'm going to draw from my original thoughts on a question that we didn't ask. That question was: What are we really attempting to accomplish with a revision to the current system? I think that this is really the heart of the issue, and it's not necessarily the means that are so critical, but the end, once you have clarified what that end is to be.

I admit that there are a variety of theoretical models that work in general, but the end must be defined and accepted as a laudable goal, one that is attainable, and one that is sustainable. Sustainability must be given some considerable weight, I think, because there are a lot of quick fixes that look like they work, but they have such systemic errors in them that don't show up for several years. It gets you into worse trouble down the road. If there's more than one path to the destination, then I think more practical issues come into play as well. I submit that we are looking for a way to provide a basic level of proper medical care, all of the terms of which need to be defined, to the broadest population in a manner that has an acceptable level of impact on the economy both in current and future terms. We have a challenge, no matter which path we're going on.