

Single-payer healthcare: hopes, dreams, realities

Sameer Lakha, MD

Department of Anesthesiology, Perioperative, and Pain Medicine

The Mount Sinai Hospital

BRI-LC 2018



Goals

During this session, we will:

- Enumerate the basic taxonomy of “single-payer” healthcare systems
- Identify “single-payer-esque” systems of care in the American healthcare ecosystem
- Outline the major dimensions along which healthcare systems can be critiqued and compared
- Identify resources for further education
- Discuss and explore audience-selected themes in more detail

Outline

- Introduction
- What is single-payer?
- What is free-market healthcare?
- Outcomes, data, and costs
- Tradeoffs in healthcare
- Tradeoffs beyond healthcare
- Politics and elections
- Innovation, sclerosis, and truth-seeking

What is single-payer?

What is single-payer?

- No single-answer:
 - Does government pay for all/most medical services (think Canada)?
 - Does government directly employ all/most medical providers or operate facilities (think UK)?
- Many possible permutations:
 - Is a private system allowed alongside (think VA)?
 - Is government system “mandatory” or opt-in (Medicare vs “public option”)?

What is free-market healthcare?

What is a free market?

One useful conception:

- The customer is free to choose a service, a provider, spend money and bargain as able, and to make tradeoffs
- The supplier is free to determine the services offered and the prices at which they will be sold

Name some regulations in healthcare

Go on, I dare you...

Not even including the ACA

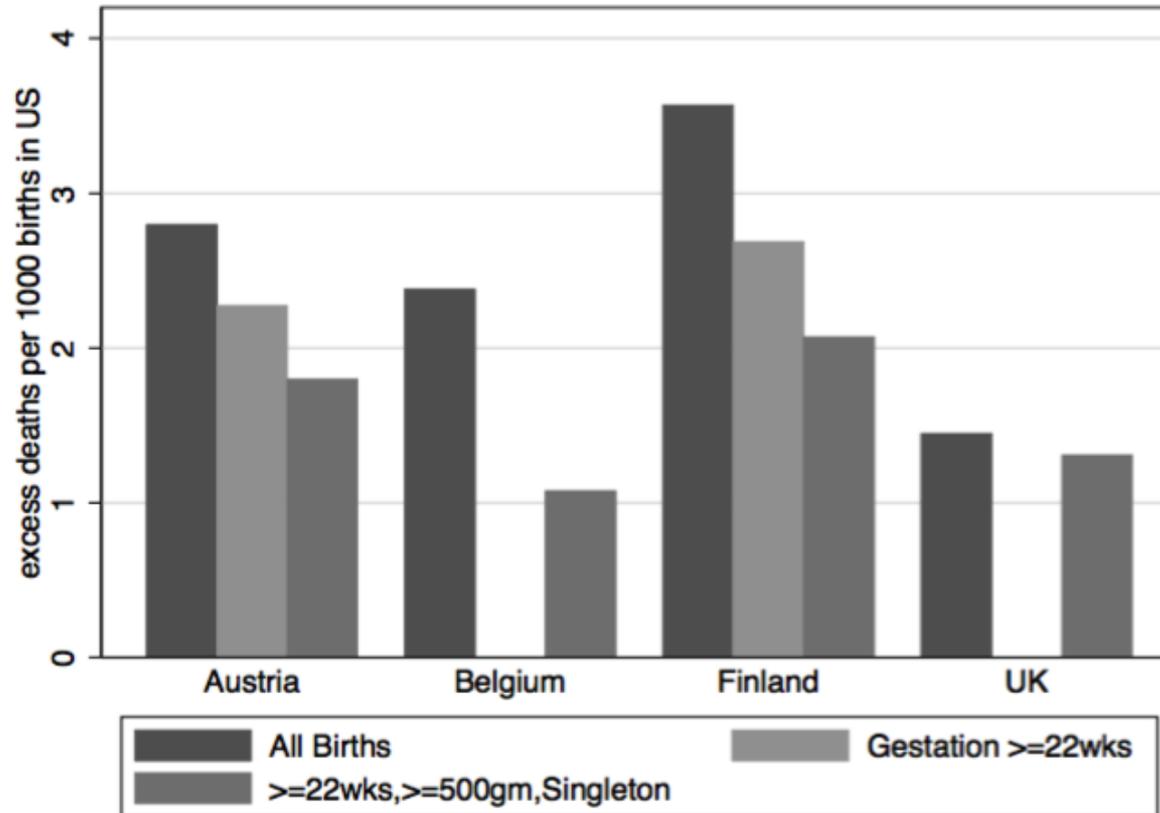
- Financing regulations
 - Medicare
 - RUC
 - CPT/FFS based billing requirements
 - Par/non-par rules
 - Medicaid
 - Private health insurance regulation
 - ERISA
 - HIPAA
 - COBRA
 - Minimum benefits regulations
 - Underwriting restrictions
 - Tax exclusion for employer-sponsored plans
 - Patient billing requirements (i.e. itemized or not)
- Information regulations
 - HIPAA
 - Documentation requirements for billing/compliance
 - HITECH/EMR mandates
- Physician/provider regulations
 - Conflict-of-interest/anti-kickback/Stark Law
 - National Provider Databank
 - State licensing and credentialing requirements
 - Various reporting and special training (“opioid seminar”) requirements
 - Scope of practice
- Research regulations
 - NIH crowdout
 - IRB requirements
 - Regulation of animal use in research
 - Research COI requirements
- Facility regulations
 - EMTALA
 - Health/safety requirements
 - OSHA
 - TJC
 - Corporate practice of medicine
 - Mandatory admissions screenings for HIV, abuse, homelessness
 - Level of service for LEP patients
 - Balance billing restrictions
 - Antitrust considerations on hospital mergers
 - Bundled payments encouraging hospital mergers
- Drug/device regulations
 - FDA approvals
 - FDA marketing restriction
 - State-level marketing restrictions (“sunshine laws”)
 - Need for prescriptions at all
 - DEA scheduling
- Education regulations
 - DOE regulation of medical schools as universities
- Miscellaneous
 - OSHA, FLSA, and everything else to do with having employees at all
 - TJC/other bodies enabled by need for accreditation for CMS
 - Role of courts in setting malpractice standards

Paint by numbers!

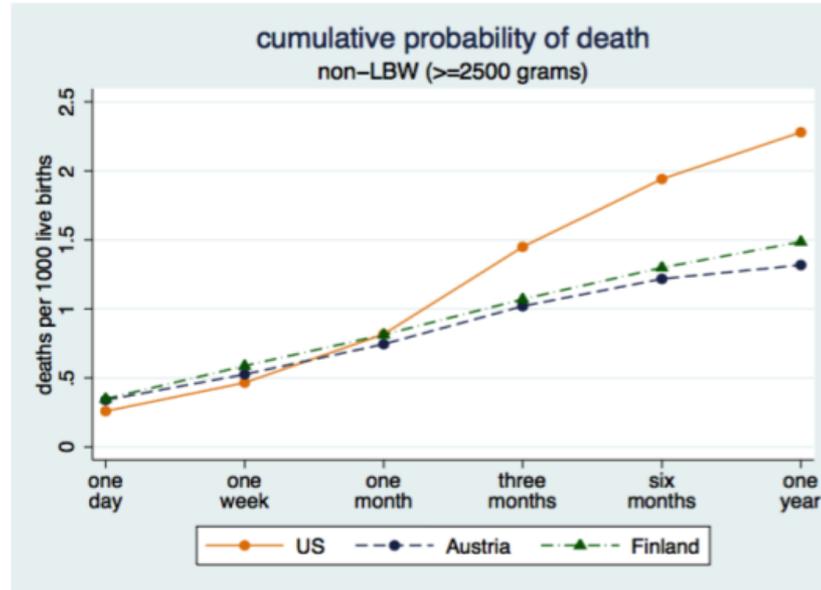
Infant mortality

- Differences in reporting (birthweight, gestational age, multiple conception/IVF)
- Gaps are larger the further away from the healthcare system you go
- Mortality for pre-term infants is substantially *lower* in the United States – NICU care!
- More births in US are low-birthweight/premature
- US mothers are higher risk (obesity, drugs, age)

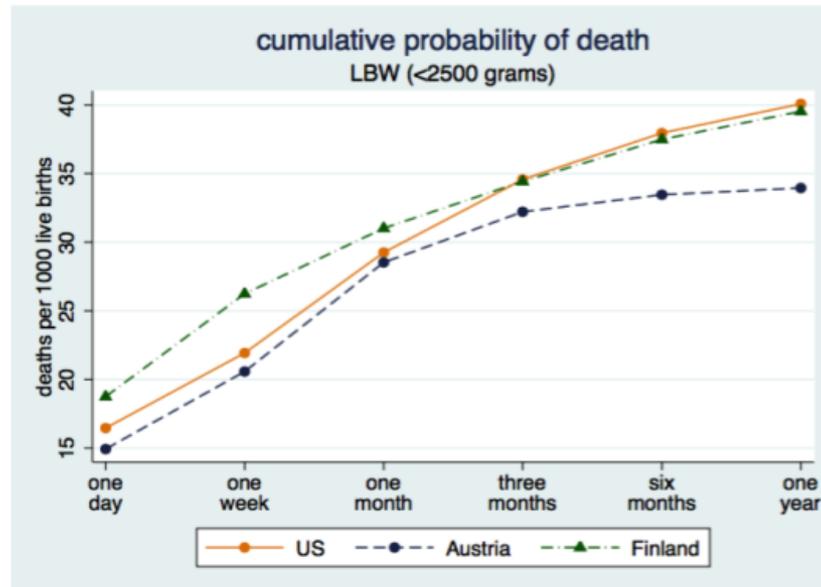
Figure 1: US IMR disadvantage: Full sample and restricted samples



(a) Normal birth weight only (≥ 2500 grams)

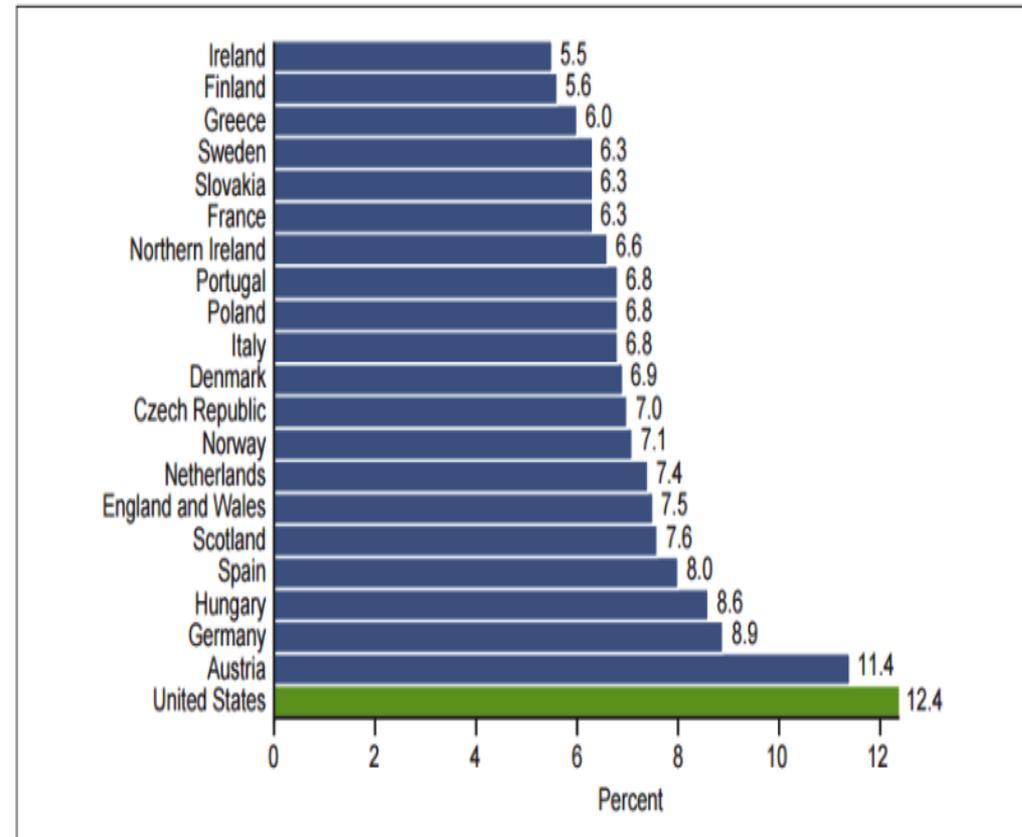


(b) Low birth weight only (< 2500 grams)



The percentage of births that were born preterm was much higher in the United States than in Europe.

Figure 3. Percentage of preterm births, United States and selected European countries, 2004



NOTE: Excludes births at less than 22 weeks of gestation to promote comparability between countries. Preterm births are those from 22 to 36 weeks of gestation.
SOURCE: NCHS linked birth/infant death data set (for U.S. data) and *European Perinatal Health Report* (for European data).

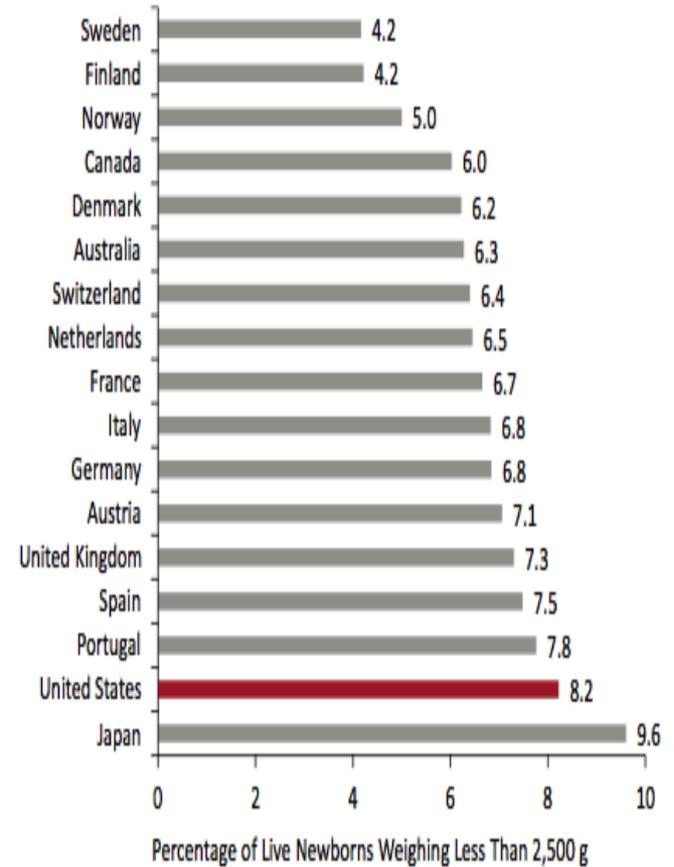
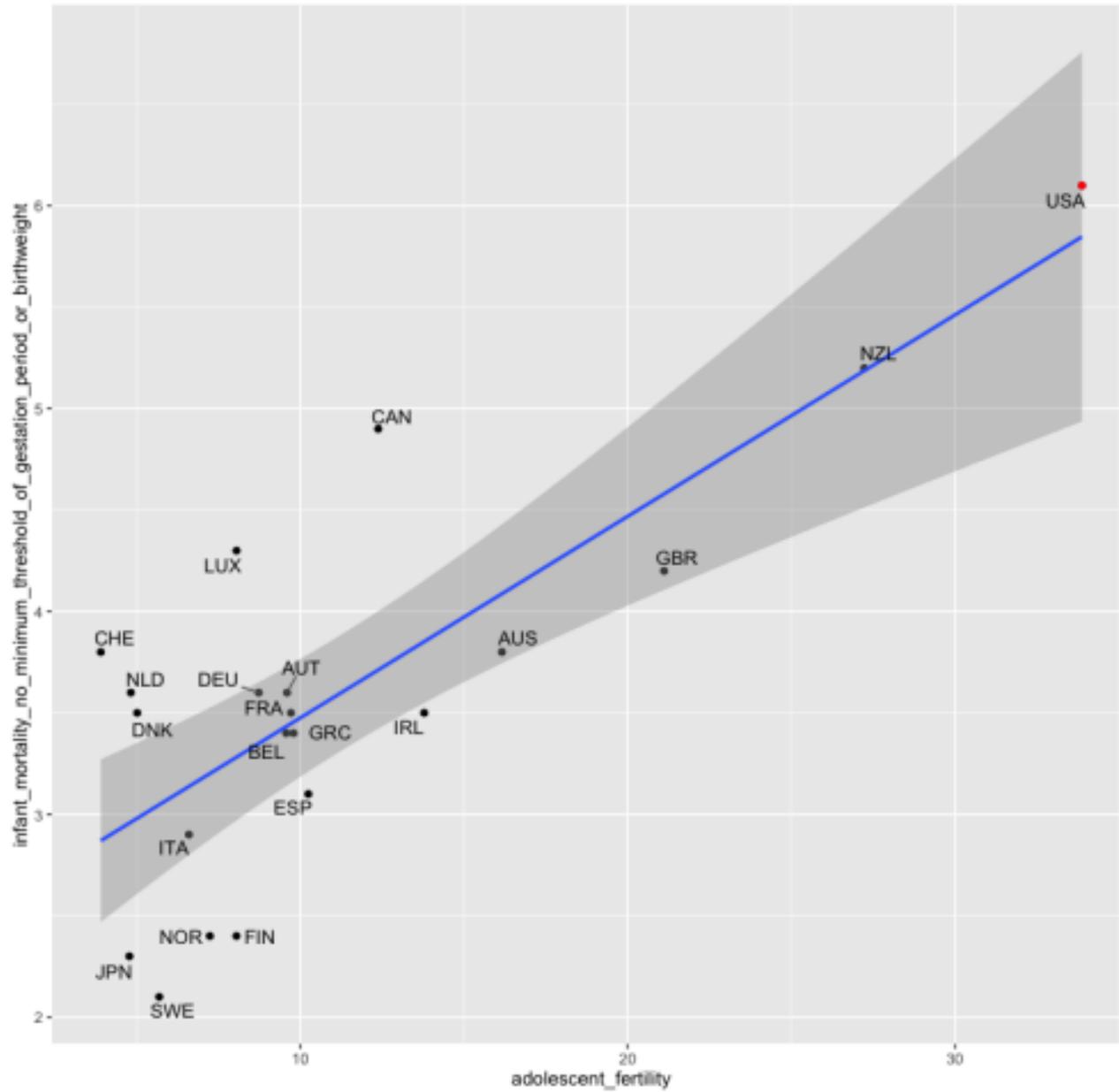


FIGURE 2-2 Low birth weight in 17 peer countries, 2005-2009.

NOTE: Values (if present) averaged over 2005-2009.

SOURCE: Data from OECD (2011), OECD.StatExtracts: Health Status (database).



Life expectancy

- Much of the “gap” comes from smoking, obesity, homicide, car accidents
- US performs well on areas least susceptible to “lifestyle”

Life expectancy by obesity rate in developed euro/anglo countries and US states

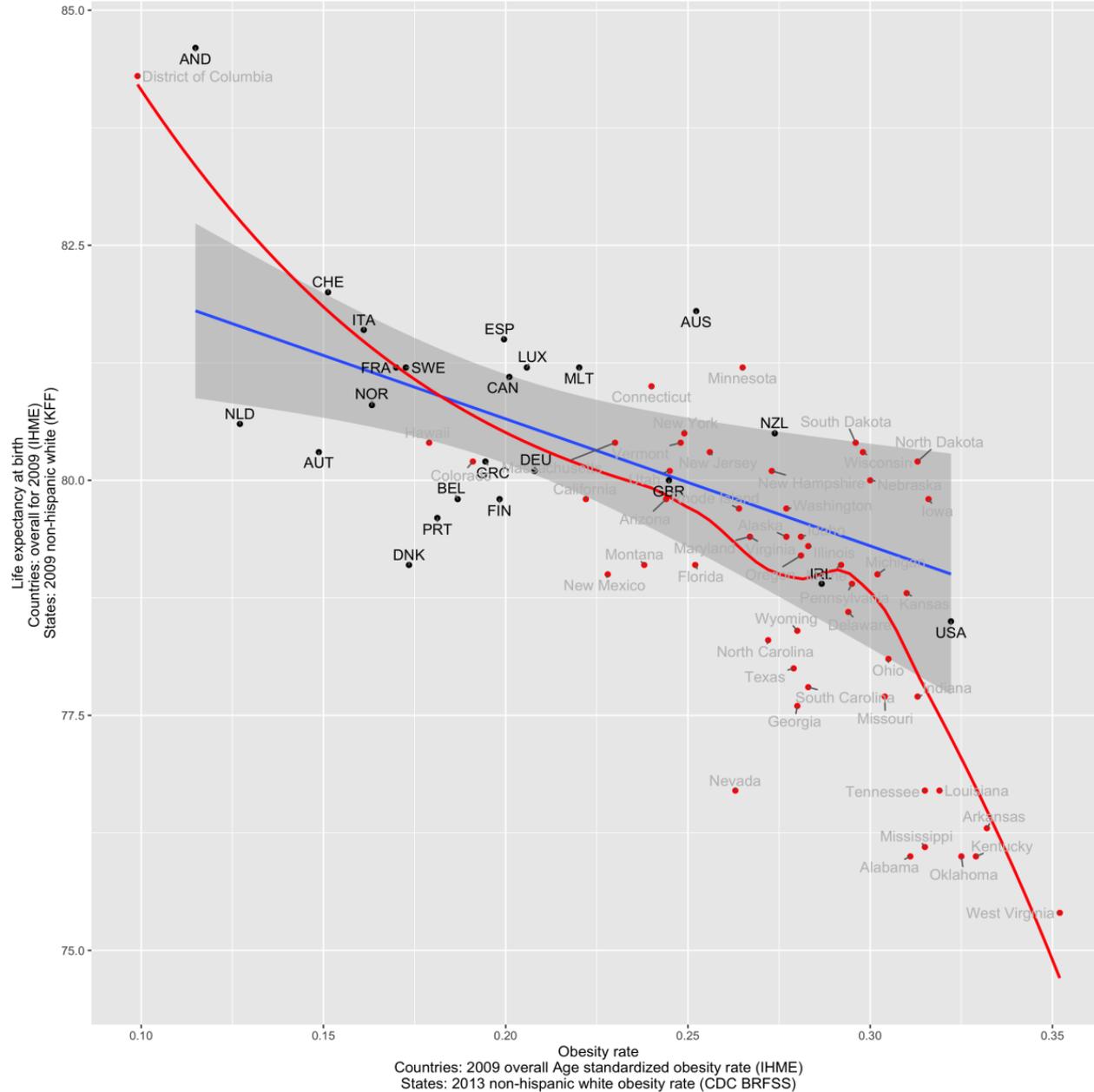
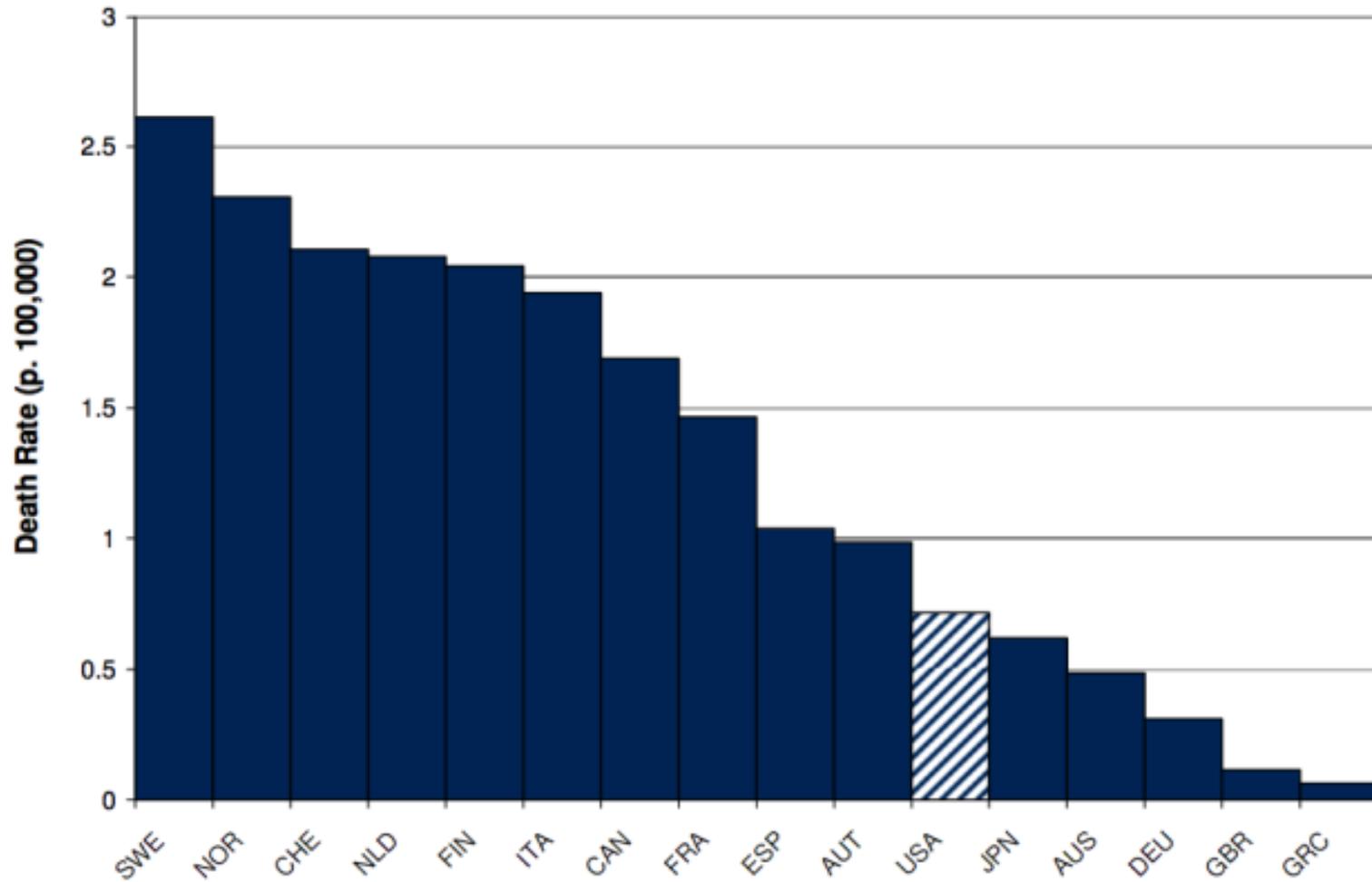
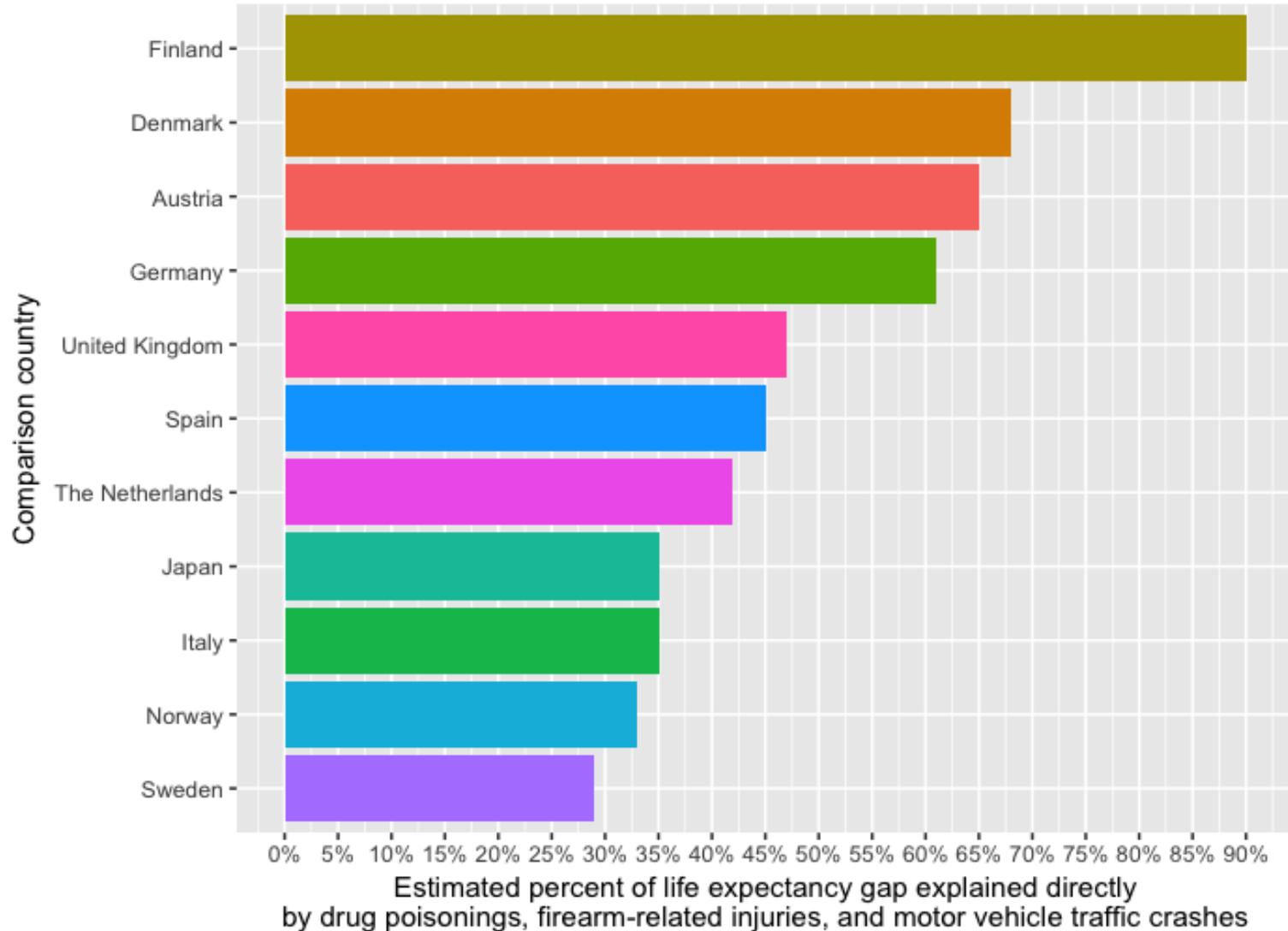


Figure 1. Age Standardized Death Rates at Ages 50+ From Influenza, 2000-2004



Percent of US male life expectancy gap explained by selected accidents and homicides (2012)

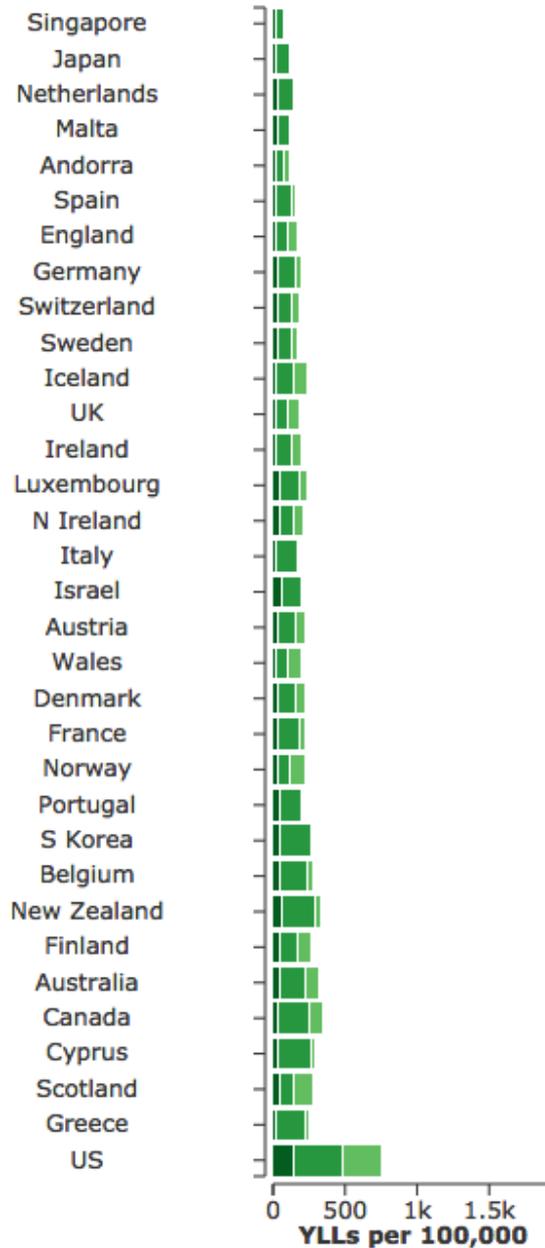


Estimates by CDC researchers (Fenelon et al 2012)
Note: excluded Portugal for visibility (>200pct)

Males, Age-standardized, 2015



Females, Age-standardized, 2015



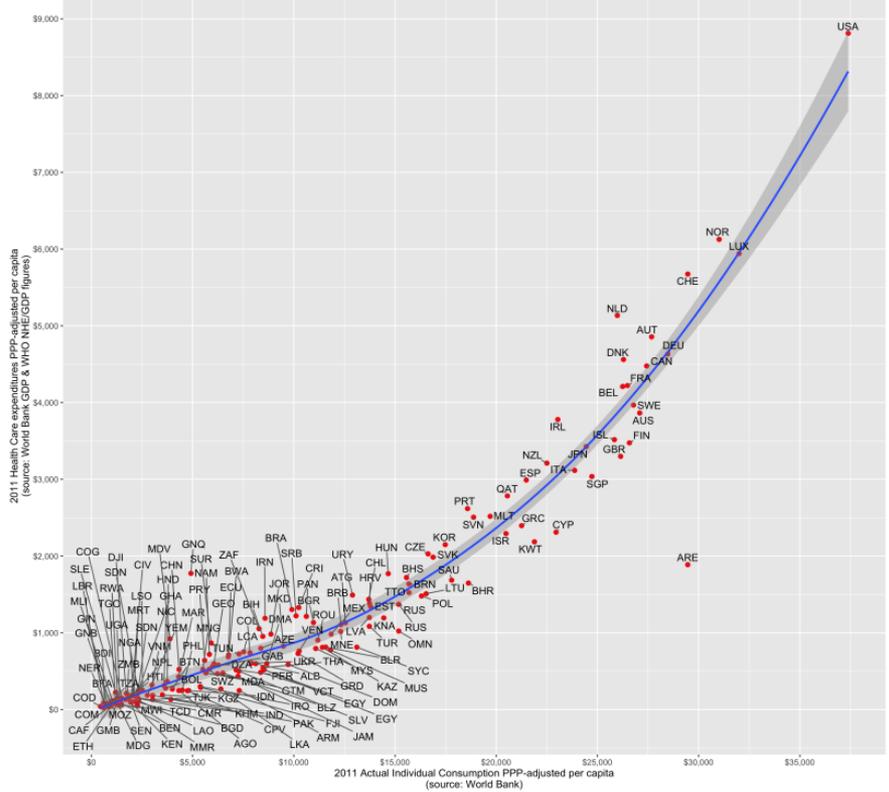
- Singapore
- Japan
- Netherlands
- Malta
- Andorra
- Spain
- England
- Germany
- Switzerland
- Sweden
- Iceland
- UK
- Ireland
- Luxembourg
- N Ireland
- Italy
- Israel
- Austria
- Wales
- Denmark
- France
- Norway
- Portugal
- S Korea
- Belgium
- New Zealand
- Finland
- Australia
- Canada
- Cyprus
- Scotland
- Greece
- US

Healthcare spending

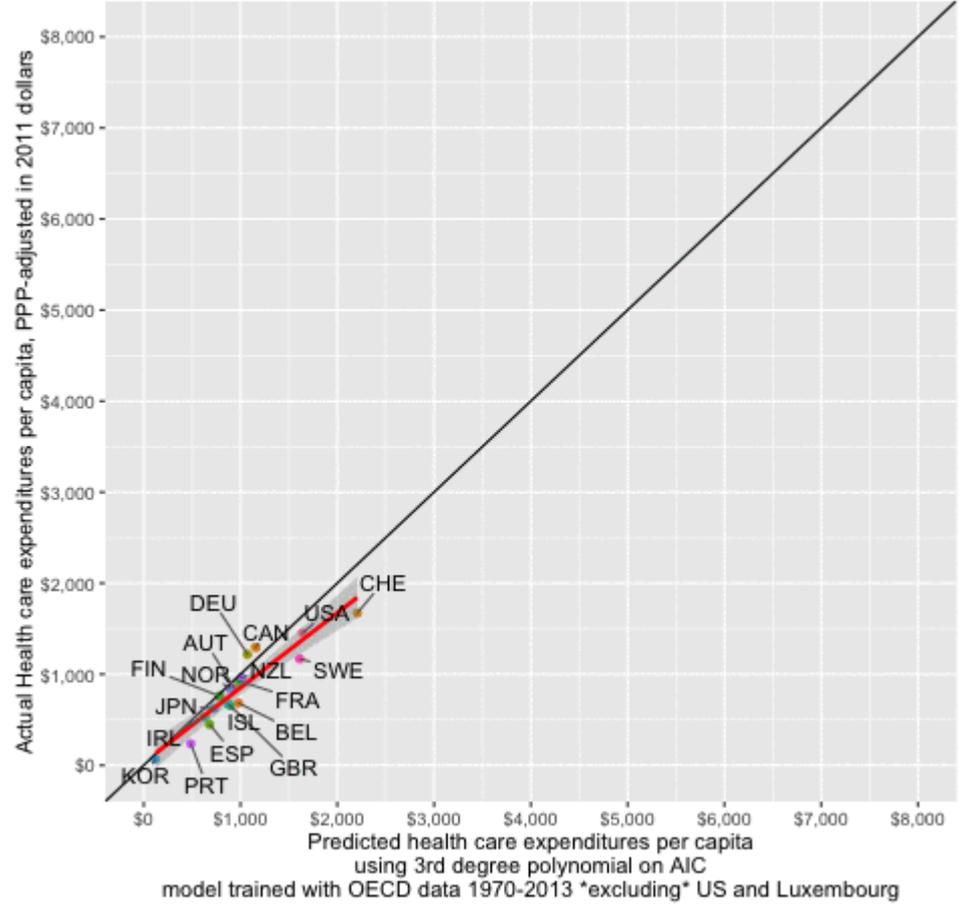
- Healthcare is a luxury good, and the US is incredibly affluent on average
- Why should a linear model with GDP per capita be the right one?



2011 Health care expenditures per capita by Actual Individual Consumption per capita



1970



Administrative costs

- Most costs are incurred per-beneficiary
 - Medicare does worse on this by its own numbers
- Medicare doesn't administer itself
 - Private contractors manage the program, the rest of the government picks up a lot of the overhead
- “The administrative cost of burning a million dollars cash is the cost of a few ounces of lighter fluid. The matches you get free from a bar.” –Michael Cannon

Rationing

Canadian Wait Times in 2017 Longest Ever Recorded



KGH



[REDACTED], MD, FRCPC
NEUROLOGIST
MOVEMENT DISORDERS CLINIC

Division of Neurology
Connell 7, Room 725
Kingston General Hospital, 76 Stuart Street
Kingston, Ontario K7L 2V7

Tel: 613-549-6666 x [REDACTED]

Fax: 613-548 [REDACTED]

Dear Dr. J. Hatarey

Fax: 613-544-7247

This letter is to inform you that we have received your referral for [REDACTED] DOB: [REDACTED].
Our current wait time for a new patient referral is approx 4.5 years. As such, we are unable to book new appointments at this time. We will hold your referral and mail an appointment slip to your patient when one is available. If this delay is acceptable in managing your patient, we will keep the patient on our list. If unacceptable, alternative referrals should go to the Division of Neurology at the Ottawa Hospital or the Toronto Western Hospital.

~~*~~ If you intend to make alternate arrangements for your patient to be seen elsewhere, please let us know as soon as possible so we can void ~~*~~ your referral. Thank you.

Sincerely,

[REDACTED], MD, FRCPC
Neurologist

Equality

- Cash and cronyism always favor the privileged

Effect of Income on Health Utility Index (HUI), JCUSH						
Regression model:	Canada			U.S.		
	I	II	III	I	II	III
	Controls: Demographic factors	Adds: health risks	Adds: unmet needs	Controls: Demographic factors	Adds: health risks	Adds: unmet needs
Ages 18-64						
Partial effect of income (000's)	0.0009 ***	0.0006 ***	0.0005 ***	0.0008 ***	0.0005 ***	0.0004 ***
Adj. R-Square	0.0687	0.2396	0.2749	0.0995	0.2818	0.3143
Mean of dependent variable		0.8978			0.8840	
Sample size		2663			3797	
Ages 65+						
Partial effect of income (000's)	0.0005	0.0003	0.0003	0.0008 ***	0.0006 **	0.0005
Adj. R-Square	0.0677	0.2098	0.2240	0.1165	0.2564	0.2826
Mean of dependent variable		0.7961			0.7830	
Sample size		684			1017	

Note: Complete regression results are shown in the Appendix for Model III (mean characteristics and variable coefficients). The demographic variables in Model I include sex, age group, education, whether nonwhite, whether immigrant, whether married and whether lives alone. Model II adds whether obese and other weight related variables, current and former smoking, incidence of various chronic diseases. Model III adds unmet needs and whether has regular doctor. Starred figures denote statistical significance at the following levels: *10%; ** 5%; ***1%.

Source: Joint Canada/United States Survey of Health (JCUSH) microdata file.

It's a doc-eat-doc world out there...

Make that tradeoff!

- Your patient is medically appropriate for discharge. Their family is still trying to decide on which skilled nursing facility to have her discharged to. Does she stay an extra night in the hospital to give them time to decide?

Make that tradeoff!

- A brain-dead patient's family informs you that their religious beliefs only acknowledge cardiac death. The patient remains in the intensive care unit receiving maximal medical therapy.

Make that tradeoff!

- Your laboring patient with worsening severe pre-eclampsia is decided to require a cesarean section at 10:30pm. She refuses to proceed until after midnight, so that she gets an additional night in the hospital with her baby.

Make that tradeoff!

- A patient experiences a complication from what was meant to be an ambulatory procedure and lands in the intensive care unit. Once stabilized, he adamantly requests an ICU-to-ICU transfer nearer his home 100 miles away.

Make that tradeoff!

- You're asked to come into the hospital at midnight to place a chest tube to relieve significant hemorrhage into a patient's chest cavity. He developed it from vigorous CPR. He is unlikely to survive the week, and this invasive procedure will not improve his mortality risk. It may, however, help stabilize his oxygenation so that he can be transferred from a regular unit to the ICU.

Design that policy!

- Homeopathy?
- Marital counseling?
- Drug abuse therapy?
- Abortion?
- Assisted reproduction?
- Lumbar spine fusion for low back pain?
- Gym membership?
- Dialysis at all ages?
- Euthanasia?

Choose your agent!

- You with your physician
- A private party of your choice
- The electorate, legislature, or health commission

Top 15 Priorities in 2002

<u>2002 Rank</u>	<u>2009 Rank</u>	<u>Description</u>
1	101	Severe/moderate head injury: hematoma/edema with loss of consciousness.
2	10	Type I diabetes
3	n/a	Peritonitis
4	139	Acute kidney inflammation (glomerulonephritis)
5	154	Pneumothorax and hemothorax
6	176	Hernia with obstruction and/or gangrene
7	260	Torsion of ovary
8	261	Torsion of testis
9	83	Addison's disease (adrenal gland cortisol insufficiency)
10	88	Injury to internal organs
11	62	Flail chest (detached chest wall segment, usually from trauma)
12	84	Appendicitis
13	178	Ruptured spleen
14	55	Tuberculosis
15	91	Deep open wound of neck, fracture of larynx or trachea

Source: The Oregon Health Services Commission.

An apple a day...

Determinants of health

- How much of health is actually determined by “medical care” at the margin?
- What controls would you include in an observational study of a new treatment? Which would be the most important?
- “Lifestyle factors” estimated to contribute to ~40% of cancer deaths

Doctors: what are they good for?

- The necessary cost increase for a single-payer system will deprive society of resources to address higher-impact determinants of health
- Doctors make better doctors than nutritionists/social workers/health coaches

**When the “hospital lobby” is
more than just the entrance**

Dr. Smith goes to Washington

- Time and energy spent lobbying and dealing with government mandates is lost to patients and to science
- Time and energy spent measuring processes to satisfy regulators is lost to patients and to science

Sabotage!

Can you honestly advocate a single-payer system in a country that lacks the political consensus to sustain it through multiple election cycles?

Everything old is new again

Stuck in a rut?

- Governments standardize and sclerose
 - Pain as the fifth vital sign
 - Four-hour rule for community-acquired pneumonia
 - MIPS/MACRA measures
 - “Observation status”
- Guidelines often obsolete once printed risk being entrenched longer than prudent
- How about that geriatrician shortage?

I can't get no... innovation

- US market supplies financial reward to R&D, subsidizes foreign price controls
- Everyone can't be the marginal-price consumer

Summary

1. A fair definition of single-payer healthcare is a system in which the government is the primary or exclusive direct financier of medical expenditures
2. Any discussion of single-payer healthcare must acknowledge that the current American system is far from a “free market”
3. Data that purport to shower superior outcomes or costs in single-payer regimes tend to be questionable at best, misleading at worst
4. All healthcare decisions require tradeoffs. Single-payer systems centralize decision-making away from the patients and physicians best positioned to make them.
5. By stunting growth and diverting resources from other social programs, single-payer systems risk harming health by worsening efforts to address its social determinants

Summary (continued)

6. Placing more control of healthcare in government results in medical professionals wasting time and energy on lobbying and complying with mandates
7. “The wrong people” win elections, and this fact cannot be wished away
8. Government systems are often impediments to necessary changes, and can entrench bad practices more stubbornly than private markets
9. Real-world examples of single-payer systems in the United States have proven to be no utopia. It is unlikely that expanding their reach would improve their quality.

Questions?

Sameer Lakha

sameer.lakha@gmail.com