Background

A first step in considering hospital needs in a single-payer system is to define as clearly as possible what is meant by the term "single payer system." Importantly, it is essential to separate universal coverage from single-payer financing.

This paper takes two approaches to the definition: categorizing the systems in other nations and identifying the central feature the LRPC believes is essential to such an approach.

Outside the United States, the industrialized, Western nations generally have universal coverage including virtually all of the resident population. There are, however, two distinct patterns for organizing and financing health care services.[1]

Single-payer systems exist in Australia, Canada, Finland, New Zealand, Sweden, and the United Kingdom. In these nations, funds for health services are raised primarily through taxes and paid from a single source for hospital services.

Several other industrialized, Western nations with universal insurance coverage have highly structured and regulated insurance programs. They are not single-payer systems because multiple payers purchase hospital services although the amounts paid by the several sources may be highly regulated and vary little across payer. This approach is generally called "Social Health Insurance.[2]" Nations using this approach include Austria, Belgium, France, Germany, Israel, Luxembourg, Netherlands, and Switzerland.

A number of other European nations used the Social Health Insurance approach after World War II but have converted to a tax-funded, single-payer approach: Denmark in 1973, Italy in 1978, Portugal in 1979, Greece in 1983,[3] and Spain in 1986. When this list is combined with the nation's that have historically had single-payer systems, 11 Western, industrialized nations with a combined

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[1] The distinction between single-payer and social health insurance approaches was developed by the European Observatory on Health Systems and Policies.

[2] In a recent review of "Social Health Insurance Systems in Western Europe," the European Observatory on Health Systems and Policies reports seven core components for the approach: (1) The raising of funds is tied to the income of members, typically in the form of a percentage of the member's wages; (2) The Sickness Funds are private, not-for-profit organized directed by boards at least partly elected by the membership; (3) The State requires the same comprehensive benefits package for all subscribers; (4) Nearly all hospitals and all physicians, regardless of how they are organized, have contracts with the sickness funds; (5) A corporatist model of negotiations is used at the regional and/or national level with organizations representing various stakeholders; (6) Sickness funds and providers negotiate directly with each other over payment, quality of care, patient volumes, and other contract matters; and (7) Subscribes to a sickness fund can usually obtain care from nearly all physicians and hospitals.

[3] The Greek system that began moving from social health insurance to a single-payer system in 1983 has made such incomplete progress that it was not included in comparisons of single-payer systems.

population of over 250 million persons use the single-payer approach for health services.

Thus, while both single-payer and social health insurance approaches have been used to obtain universal coverage, the Long-Range Planning Committee believes *the distinguishing feature of the single-approach is a single, centralized authority for collecting and disbursing funds.*[4]

To increase its understanding, the committee reviewed summaries of ten single-payer health systems:

Australia
Canada
Denmark
Finland
Italy
New Zealand
Portugal
Spain
Sweden
United Kingdom

All of the reports were prepared by the European Observatory on Health Care Systems except two: Australia, prepared by their Department of Health and Ageing, and Canada, prepared by The Institute for Civil Society. Roger Hunt, president and CEO of BroMenn Healthcare System in Illinois, who has held executive positions in both the US and Canada, also provided a briefing on the Canadian system. A table summarizing the major characteristics of these systems as understood by the committee is included as attachment A.

Based on the review of single-payer systems in other nations, fourteen relatively common themes were identified:

1. Single-payer systems are not uniform. Each has developed distinctly in order to fit the nation's culture, history, and governmental institutions.

2. All Western industrialized counties with single payer systems are smaller than the United States. The larger nations have 60 million persons; the smaller have less than 5 million. However, the presence of a more than

[4] Some have used the term single-payer or "virtual" single-payer to describe a financing system in which the government would collect tax and premium revenues and provide people with a certificate that could be exchanged with multiple insurers who would be required to provide a uniform benefits package, standardized administrative and transaction systems, and prescribed payments to providers and practitioners. This paper does not explore the "virtual single-payer" approach.

ten-fold difference in the size of the population covered suggests single-payer systems are scalable.

3. All counties with single payer systems use 2 or 3 tiers of administration to decentralize decision-making, especially decisions on the delivery system.

4. All countries with single payer systems have parliamentary governments.

5. Spending per capita is consistently lower than in the US.[5] The committee notes that this does not imply that spending under any single payer system in the US would necessarily be at a reduced level. American preferences and expectations are quite different than those in other nations.

6. Except for Denmark and Portugal, life expectancy for both males and females is greater than in the US.

7. Benefits are generally defined only as "medically necessary services" with a limited number of exclusions rather than a detailed list of covered services.

8. All of the single-payer systems have been revised at least once a decade (for political or operational objectives).

9. Weighted capitation is increasingly replacing historical budgets for allocating funds to local communities

10. Prospective payment approaches, that adjust budgets or are paid per discharge, are increasingly replacing historical spending-based budgets for hospitals. This has been done to create "internal" market incentives for efficiency and effectiveness and to provide the population with a broader choice of hospitals.

11. In the single-payer nations, most physician specialists are salaried and hospital-based and require referral or access through a primary care gatekeeper who practices in the community but does not admit patients to hospitals.

12. The percentage of health care spending from private payments by patients is increasing in most single-payer nations because outpatient prescription

[5] In the July/August 2004 issue of Health Affairs, Gerard Anderson et al report the following total health spending as a percent of GDP citing data from the Organization for Economic Cooperation and Development (Paris: OECD, 2005): Australia 9.1%, Canada 9.6%, Denmark 8.8%, Finland 7.3%, Italy 8.5%, New Zealand 8.5%, Portugal 9.3%, Spain 7.6%, Sweden 9.2%, United Kingdom 7.7%, and United States 14.6%.

drug use is increasing rapidly and usually includes a copayment (that may be waived for low-income persons).

13. The single payer nations have developed broad policy objectives and the means of using their funding allocations to address health status improvements, access to primary care, and the more limited availability of high cost, capital intensive technologies.

14. Financing of long-term care services in most single-payer nations is a combination of personal and local community funds.

Recognizing that the United States has several health care financing and/or delivery systems that could be considered as possible models for any single-payer proposal, the committee also heard presentations on the Veterans Health Administration[6] and the Department of Defense[7] and reviewed characteristics of both Medicare and Medicaid that hospitals might wish to retain in a single-payer system.

[6] Presentation by Dennis (Max) Lewis, Assistant Deputy Under Secretary for Health Operations
[7] LTC John Butler, Medical Service Corps, United States Army.