Quality of Care Under Single Payer National Health Insurance

Quality Attribute	*Why* Is this Critical to Quality	*How* Single Payer is Uniquely Poised to Address
Access	• Poorest quality care is care denied • Low threshold encourages timely care and minimizes patient judgment/decision biases	• Everyone ensured access; only plan for true universal insurance and access. • Able to control cost globally (w/ fences) so no reliance on access barriers to maintain affordability.
User-friendly, Simple	• Improves satisfaction and respects time of -patients and providers • Enormous resources wasted/diverted w/ complexities, duplications, confusion.	• A "no depends" system--no complicated rules, no variations by age, geography, medical condition, marital status, etc. • Avoids eligibility determinations, enrollment complexities.
Single Standard	• Discrimination, inequality should not be structured into system design workings • Advocacy of most advantaged works to benefit of all	• By definition single system with fair rules for all • Generates database to identify disparities and track effectiveness of interventions
Continuity	• Personal knowledge of patient is key to appropriate, conservative, efficient care • Trusting relationships are critical to health and health care	• No switching for change in employment, divorce, new managing care plan • Ensured reimbursement permitting provider financial stability.
Choice	• Intrinsic and inherent satisfaction resulting from ability to freely choose provider • Patient choice means providers must compete on quality rather than patient assignment	• Avoids negative features and restrictions which managed care uses to exercise control over choice of provider and hospitals. • Uniform reimbursement and benefits package enables portability and ability to choose
Nursing	• High quality nursing is major aspect of quality in multiple settings including inpatient, chronic disease outpatient, long term care. • Demonstrated outcomes impacts of adequate nursing staffing ratios	• Stable source of funding for hospitals via global budgets • Potentials for national standards, support for nursing education, less frustrations with arbitrary financially-driven anti-nurse decision-making
Time	• The currency of primary care; to enable quality listening, thoroughness, minimize errors • Role in patient and provider satisfaction	• All patients would be covered, ensuring provider is reimbursed for his/her time w/ each. • Greater potential for support of teamwork resulting from continuities of patients, staff, funding

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Caring/Commitment	• To offset growing antagonisms, alienation, from commercialization and comodification of care • No regulation or financial incentives can substitute for or equal protection of professional ethical caring for patient.	• Elimination of greed, profit, corporate controls as the commanders and motivators of health care system • Restoring ability of professionals to advocate for patients and a better system, rather than current structured antagonisms
Information Systems	• Necessary for overcoming fragmentation of clinical information (medications, clinical history and tests) • Transformative efficiencies to prevent error, deliver decision support, improve quality and production efficiency of documentation.	• Role and necessity of national standards, federal leadership in funding IT, demonstrated VA leadership, other countries lead • Ability to collect and aggregate data for quality oversight
Communication	• Most medical errors related to communication shortcomings • Vital for effective coordination among patients, primary care, specialists, other staff	• Better positioned to overcome trade secrets/secrecy inherent in private control • Necessity for struggle of public servants to offset bureaucratic practices
Continuous Improvement	• Proven value over past decades in health and non-health industries. • Key role of process-mindedness, data, systems redesign	• In business of health for the long haul thus ROI on quality investment • Noteworthy successes of CQI in public sector (VA, Navy)
Accountability	• Need for meaningful data that can be scrutinized for internal learning and external oversight • Requirement for honesty and transparency related to errors and adverse events	• Public system by definition pubically accountable, especially if democratic decision-making, organized advocacy efforts, vigilant media scrutiny, • Role that Medicare, Medicaid (and hence public insurance data) has played in outcomes evaluation and review of allocation decisions.
Prevention Oriented	• To avoid spending disproportionate energies on end stages of illness that might have been prevented with earlier interventions • Imbuing a culture of seeing bigger picture and treating disease at community rather than just individual level.	• Unlike private plans where prevention does not pay due to frequent patient switches, greater incentives for prevention • Public system can be best integrated with public health at local and national levels

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