

How Single-Payer Health System Reform Improves Quality

*Adopted from “A Better Quality Alternative: Single-Payer Health System Reform,”
by Dr. Gordon Schiff and the PNHP Working Group on Quality*

- ◆ Single-payer creates a **single-tiered system** that covers all people equally regardless of age, income, employment, or diagnosis. Under single-payer, every American would be covered by the insurance plan in their state or region, which would pay hospitals and doctors – who would remain private – directly. This unified system would foster universal high quality, because quality of care would have to be kept high enough to be acceptable to all citizens. Other proposals perpetuate a multi-tiered health system.
- ◆ Single-payer would allow patients to choose their physicians and to continue to see them if they changed jobs or financial status. No other proposal can assure this. This **continuity of doctors and nurses**, who can get to know and care about patients, is critical to quality, but is rapidly disappearing from the medical landscape, as HMOs/insurers hire and fire physicians, and employers’ shift plans to take advantage of the lowest price each year. These disruptions in care are built into other reform proposals.
- ◆ Single-payer reform makes health care **affordable and accessible** to all. Health care that is denied or delayed because of costs – or, increasingly, because an insurer is refusing coverage – can no longer be characterized as the “highest quality in the world.” Single-payer uses savings on administrative waste (over \$350 billion annually) to fund coverage of uninsured and to improve benefits to insured Americans.
- ◆ Single-payer reform enhances prevention, an important component of quality care. In a market-oriented health system, many preventative efforts fall by the wayside (e.g., preventing teen smoking) since the costs are immediate while the financial payoffs accrue only in the long term. Single-payer fosters a long-term community-wide purview that asks “What illness are common in our area?” and “Who is at risk?” and is able to target funds to interventions that will save the most lives in the long run.
- ◆ Single-payer makes it possible to develop a **unified, confidential, computerized medical database** that can track both patient care and provider behavior. Because of the existence and dominance of multiple private insurance companies, each with their own rules and regulations, information systems in the U.S. have been dedicated to the complexities of billing rather than on clinical care. Moreover, each insurer/HMO collects – and keeps to itself – its base of information. With single-source financing the data is all collected in one place, vastly expanding the opportunities to do research on what kinds of care improve investments in information systems that would be useful to improve quality, such as electronic medical records. Under other proposals, data is collected separately by each plan – and is proprietary. Each plan develops its own computer systems, forcing the public to pay multiple times for software research and development. The proposed “quality report cards” will be based on data collected by plans themselves, who have strong financial incentives to exaggerate successes and gloss over quality problems. They also lack the methodological rigor to permit meaningful comparisons.

♦ Single-payer improves the ability to **monitor the quality of care delivered by physicians without intrusion into the privacy of the doctor-patient relationship** or micromanagement of every medical decision. The single-payer database can be used to profile practices and identify physicians that are off the curve – by ordering excessive numbers of tests, frequently prescribing toxic drugs, or seldom treating high blood pressure, for example – rather than making every physician justify every test and treatment decision to an insurance clerk, an expensive and frustrating management strategy that takes valuable physician time away from patient care.

It is the examining physician who is best suited to evaluate individual patients one at a time – not an insurance clerk using secret algorithms. It is a publicly accountable system that is best suited to define the boundaries of available resources and guide practice with information pointing to optimal generic treatment strategies.

Single-payer also reduces the potential for financial conflicts in medical decisions – conflicts that pit the physician against the patient when the patient needs an expensive test, referral, or procedure. Increasingly, physicians are being penalized for patients with high medical expenses by losing bonuses or even being dropped from plans.

♦ Single-payer is the reform option most compatible with **reducing medical injury and with “continuous quality improvement” (CQI)**, a quality improvement strategy pioneered in Japan and now widely acclaimed within American manufacturing and medicine. When Ford started project Taurus, using this approach, it led to our number one selling automobile. CQI is based on the dedication of the managers and continuous involvement of all employees in quality improvement. By freeing health providers from billing distractions, and efforts to shift costs elsewhere, appropriate attention can be directed to making care work better. In addition, since future medical expenses are routinely covered for victims of medical injury under single-payer, the focus in malpractice cases can broaden from “Who will pay for mistakes?” to “How can we learn from mistakes and prevent them?”

♦ Single-payer facilitates **real health planning**, assuring resources are there when they are needed and not duplicated when an excess will diminish quality or inflate costs. Much managerial energy is devoted to creating demand to fill excess capacity. Currently redundant surgical suites jeopardize quality when complicated surgeries like heart bypasses are performed too infrequently to maintain proficiency. Quality of care would be better served by regionalizing specialized surgeries and tests. This is possible with single-source financing because the single-payer funds hospital budgets and specialized service directly. As the sole payer for health care in each state or region, the single-payer can also make cost-saving investments in prevention (e.g., tuberculosis control among undocumented immigrants) that are not in the financial interests of HMOs/insurance companies because of high patient turnover or ineligibility for coverage.

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