SINGLE-PAYER HEALTH CARE: EVERYBODY IN, NOBODY OUT

Laurel Gamm, MD
June 23, 2018
Objectives

- Illustrate inequities in health care access
- Discuss other problems with our current system
- Learn how a single-payer system would help create equitable, high quality healthcare for ALL
- Learn how you can advocate for such a system
Disclosure

- I am board member and past co-chair of Physicians for a National Health Program Minnesota
- A 501(c)3 organization dedicated to building a movement to create an innovative health care system that will cover all Minnesotans in an equitable and economically feasible manner”
- We are subsidiary of PNHP, a larger umbrella group founded in 1987
PNHP Mission Statement

Physicians for a National Health Program (PNHP) advocates for universal, comprehensive single-payer national health insurance.

PNHP believes that access to high-quality health care is a right of all people and should be provided equitably as a public service rather than bought and sold as a commodity.

The mission of PNHP is therefore to educate physicians, other health workers, and the general public on the need for a comprehensive, high-quality, publicly-funded health care program, equitably-accessible to all residents of the United States.

Equitable accessibility requires, in the view of PNHP, removal of the barriers to adequate health care currently faced by the uninsured, the poor, minority populations and immigrants, both documented and undocumented.

PNHP views this campaign as part of the campaign for social justice in the United States. PNHP opposes for-profit control, and especially corporate control, of the health system and favors democratic control, public administration, and single-payer financing.

PNHP believes this program should be financed by truly progressive taxation. PNHP actively opposes current changes in the health care system that are designed to maximize the profits of investors and the incomes of high-level executives rather than to serve patients.

PNHP's goal is the restoration of what it views as the primary mission of physicians, acting as professional advocates for our patients.

PNHP is an independent, non-partisan, voluntary organization.
Defining Health Equity

- “Everyone has the opportunity to attain their highest level of health.” --APHA

- “Inequities are created when barriers prevent individuals and communities from accessing these conditions (social determinants of health---housing, healthcare, transportation, food) and reaching their full health potential.” -ibid

- “Social determinants of health are mostly responsible for health inequities…unfair and avoidable differences in health status.” --WHO
My experiences with health inequities

- Medical school
- Residency
- Clinical practice in family medicine and emergency medicine
- Clinical work in Central African Republic
- Today
Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Social integration</td>
<td>Community engagement</td>
<td></td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Support systems</td>
<td>Discrimination</td>
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</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Community engagement</td>
<td>Health care system</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td>Hunger</td>
<td>Discrimination</td>
<td>Quality of care</td>
</tr>
</tbody>
</table>

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Kaiser Family Foundation
Health Disparities—MN example

Figure 10.1 shows Childhood Immunization Status (Combo 3) by race. The Multi-Racial group had the highest rate of childhood immunizations, and this rate was significantly above the MHCP statewide rate (71 percent). The only other racial group that had a rate significantly above the MHCP statewide rate was the White racial group at 76 percent. The Black or African American and American Indian or Alaskan Native racial groups had rates significantly below the statewide MHCP rate, with the American Indian or Alaskan Native racial group having the lowest rate.

Figure 10.1: Childhood Immunization Status (Combo 3) Statewide Rates by Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Rate (± Confidence Interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaskan Native</td>
<td>54% (±)</td>
</tr>
<tr>
<td>Asian or Pacific Islander or Native Hawaiian</td>
<td>65% (±)</td>
</tr>
<tr>
<td>Black or African American</td>
<td>76% (±)</td>
</tr>
<tr>
<td>Multi-Racial (n=170)</td>
<td>78% (±)</td>
</tr>
<tr>
<td>White (n=2,137)</td>
<td>76% (±)</td>
</tr>
<tr>
<td>Unknown (n=638)</td>
<td>69% (±)</td>
</tr>
</tbody>
</table>

MHCP Statewide Rate = 71%
Example: Factors associated with being under-vaccinated

- Low socioeconomic status
- Paying for immunizations
- Lack of health insurance
- Low parental education
- Younger maternal age
- Large family size
- Not remembering vaccination schedules and appointments
- Delayed well child visits
- Sick child delays
- Inadequate provider support
- Lack of available health structures
- Transportation and accessibility issues for immunization clinics
- Lack of knowledge about vaccines and diseases
- Negative beliefs/attitudes
- Fear/safety concerns
- Skepticism/doubts about medical information provided

*Falogas ME and Zarkadoulia E, “Factors associated with suboptimal compliance to vaccinations in children in developed countries: a systematic review.” Current Medical Research and Opinion, Vol 24(6):2008*
Insurance and Health Equity

- A lot more than health insurance determines whether someone will achieve good health.
- **BUT**, our health insurance “system” erects barriers that perpetuate disparities and thwart equity.
  - Through lack of insurance
  - Through “churning”
  - Through under-insurance (co-pays and deductibles)
  - Through differential reimbursement to health care facilities serving the under-served
  - All while profiting off the inequity
Insured — difficulty affording care

More Insured Americans Now Report Difficulty Affording Health Care

AMONG THE INSURED: In general, how easy or difficult is it for you to afford to pay...

- The cost of health insurance each month:
  - 2015: 63% Easy, 27% Difficult
  - 2017: 58% Easy, 37% Difficult

- Copays for doctor visits and prescription drugs:
  - 2015: 69% Easy, 24% Difficult
  - 2017: 64% Easy, 31% Difficult

- The deductible you pay for care before insurance kicks in:
  - 2015: 57% Easy, 34% Difficult
  - 2017: 50% Easy, 43% Difficult

NOTE: Don’t have to pay (Vol.) and Don’t know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Polls
29% Struggle to Pay Medical Bills

Figure 3
Most of Those Who Struggled to Pay Medical Bills Report Major Impacts on Their Family

In the past 12 months, did you or anyone in your household have problems paying or an inability to pay any medical bills, such as bills for doctors, dentists, medication, or home care?

Yes 29%
No 70%
Don’t know/Refused 1%

ASKED OF THE 29% WHO SAY THEY OR A HOUSEHOLD MEMBER HAD PROBLEMS PAYING MEDICAL BILLS IN THE PAST 12 MONTHS: Overall, how much of an impact have these medical bills had on you and your family? (percentages based on total)

Major impact 17%
Minor impact 11%
No real impact 2%

Note: For the second question, Don’t know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 13-19, 2017)
Those with Problems Paying Medical Bills Report Engaging in a Variety of Actions to Pay off Bills

**Among the 29% who say they or a household member had problems paying medical bills in the past 12 months:** Percent who say they or someone else in their household did each of the following in the past 12 months in order to pay medical bills

<table>
<thead>
<tr>
<th>Action</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cut spending on household items</td>
<td>73%</td>
</tr>
<tr>
<td>Put off vacations or major household purchases</td>
<td>71%</td>
</tr>
<tr>
<td>Used up all or most of their savings</td>
<td>61%</td>
</tr>
<tr>
<td>Taken an extra job or worked more hours</td>
<td>58%</td>
</tr>
<tr>
<td>Borrowed money from friends or family</td>
<td>41%</td>
</tr>
<tr>
<td>Increased their credit card debt</td>
<td>37%</td>
</tr>
<tr>
<td>Taken money out of long-term savings accounts</td>
<td>31%</td>
</tr>
<tr>
<td>Changed living situation</td>
<td>25%</td>
</tr>
<tr>
<td>Sought the aid of a charity or a non-profit organization</td>
<td>23%</td>
</tr>
<tr>
<td>Taken out another type of loan (other than a mortgage or payday loan)</td>
<td>14%</td>
</tr>
<tr>
<td>Borrowed money from a payday lender</td>
<td>12%</td>
</tr>
<tr>
<td>Taken out another mortgage on their home</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Note:** Question wording abbreviated. See topline for full question wording.

**Source:** Kaiser Family Foundation Health Tracking Poll (conducted February 13-19, 2017)
Some Americans Report Putting Off or Postponing Care Due to Costs

Percent who say, in the past 12 months, they or a family member living in their household has done each of the following due to cost:

- skipped dental care or checkups: 32%
- relied on home remedies or over-the-counter drugs instead of going to see a doctor: 29%
- put off or postponed getting health care they needed: 27%
- skipped a recommended medical test or treatment: 23%
- not filled a prescription for a medicine: 21%
- cut pills in half or skipped doses of medicine: 16%
- had problems getting mental health care: 12%

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 13-19, 2016)
Impacts of Illness

- Lost Work Time
- Lost Earnings
- Unemployment
- Medical Bankruptcy

These effects can occur irrespective of insurance status


Who is impacted most by out-of-pocket costs?

Median U.S. Family Wealth, 2016 ($)

- White: 171,000
- Black: 17,409
- Hispanic: 20,920

Urban Institute
Who is impacted most by out-of-pocket costs?

**Median Liquid Retirement Savings, 2016 ($)**

- **White**: 157,884
- **Black**: 25,212
- **Hispanic**: 28,581

Urban Institute
Who is impacted most by out-of-pocket costs?

Who is impacted most by out-of-pocket costs? 

Percent Ownership of Occupied Units

- **White, non-Hisp**: 76%
- **Black**: 24%
- **Hispanic**: 46%
- **AI/AN**: 53%
- **Asian**: 56%

American Community Survey, 2012-16
Who is impacted most by out-of-pocket costs?

Homelessness and Racial Disparities, MN

- General Population
- Homeless Population

<table>
<thead>
<tr>
<th>Race</th>
<th>General Population</th>
<th>Homeless Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>85%</td>
<td>38%</td>
</tr>
<tr>
<td>Black</td>
<td>5%</td>
<td>39%</td>
</tr>
<tr>
<td>AI/AN</td>
<td>1%</td>
<td>8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4%</td>
<td>7%</td>
</tr>
</tbody>
</table>

American Community Survey, 2014
Impact of a $400 emergency

Figure 12. Respondents who would completely pay an emergency expense that costs $400 using cash or a credit card that they pay off at the end of the month (by family income, race, and ethnicity)

Federal Reserve, 2015
The Land of 328,556 Uninsured

- 6.1% of Minnesotans are uninsured
- 4.2% of MN children
- 17.5% of foreign-born individuals

American Community Survey, 2016
% Uninsured by Race, MN, 2016

American Community Survey, 2016
Uninsured Rates, Hennepin Co, 2016

% Uninsured by Race, Hennepin County, 2016

- White: 4.9%
- Black: 11.7%
- Hispanic: 28.0%

American Community Survey, 2016
Uninsured Rates, Hennepin Co, 2016

Percent Uninsured by Education Level

- Bachelor's +: 2.6%
- Some College: 7.6%
- HS or GED: 10.6%
- < HS: 22.5%

American Community Survey, 2016
How has this affected my patients?
Our system is not merely inequitable

- But also
  - Achieves worse (or no better) health outcomes than other developed countries
  - Is expensive and administratively wasteful
International Comparisons

- U.S. ranks
  - 31st in life expectancy (79 yrs)
  - 36th in health-adjusted life expectancy
  - ~40th in infant mortality (5.9 deaths/1,000 livebirths)
  - ~45th in maternal mortality (14 deaths/100,000 LBs)

Most recent WHO or CIA databook statistics
Compared with UK, Canada, Australia, Germany, Japan, Sweden, France, Netherlands, Switzerland, Denmark, in 2016 the US had:

- Lowest life expectancy (78.6 yrs vs 80.7-83.9 yrs)
- Highest infant mortality (5.8 per 1,000 LBs vs 3.6)
- Highest obesity rate; 2nd lowest smoking rate

International Comparisons

- Compared with these same countries, the US had:
  - Highest healthcare spending as proportion of GDP (17.8%, compared with 9.6-12.4% elsewhere)
  - Lowest insured rate (90%, vs 99-100% elsewhere)
  - Highest drug prices ($1443 per capita vs $463-939)
  - Highest administrative costs (8% vs 1-3% elsewhere)*
  - Highest health care professional salaries (med school debt was not discussed!)

* All told, administrative expenses in US health care are much higher

We’re not “Overusing Healthcare”

- High US spending relates to high prices and administrative waste, not excess utilization.
- High US health care spending relative to other countries occurs despite similar utilization patterns for:
  - Pneumonia
  - COPD
  - Acute MI
  - Coronary bypass
  - Joint replacements

Single-Payer — The Idea

- Equity — Everybody in, nobody out!
- Comprehensive coverage, including
  - Medical care
  - Dental
  - Mental health and substance abuse
  - Long-term care
- First-dollar coverage, progressive public funding
- Free choice of doctor/provider (no networks)
Single-Payer Saves Money

- International comparison demonstrate this
- Economic models in the US demonstrate this

- Achieves savings through
  - Reducing administrative burden
  - Eliminating insurance profiteering
  - Bulk drug price negotiation
  - Global budgeting
  - **NOT** through erecting barriers to care
Single-Payer Bills on the Table

- Minnesota — The Minnesota Health Plan
  - Chief authors — Sen. John Marty, Rep. David Bly
  - SF 219, HF 358

- Nationally, “Improved and Expanded Medicare for All”
  - Chief sponsors — Rep Keith Ellison, Sen. Bernie Sanders
  - HR 676, SB 1804
A Caveat

- Many politicians and groups are trying to capture the popularity of single-payer and apply it to plans that do not measure up

- True single-payer does not:
  - Preserve a role for private health insurance
  - Require people to remain in provider or hospital networks
  - Rely on “Pay for Performance,” “Accountable Care Organizations,” or other managed care tools (which have not demonstrated reliably that they improve outcomes, improve equity, or reduce costs)
Single-Payer and Health Equity

- Single-payer is not a panacea
- But it levels the playing field dramatically on
  - Access
  - Cost
  - Quality
- Which allows us to better move the needle on other social determinants of health
- We are part of a broader movement for social justice
How can medical students get involved?

- Join PNHP nationally and PNHP-MN
- Join and become leaders in single player organizations
- Attend the HEALTHCARE-NOW Single-Payer Strategy Conference, June 22-24 downtown Minneapolis
- Advocate for single-payer in your social, faith-based and business and professional groups, as well as with your elected representatives
Thank you!

- Learn More:
  - www.pnhp.org
  - www.pnhpminnesota.org

- Feel free to contact me — lrlgmm@gmail.com — with interest in PNHP-MN summer internship or single-payer advocacy

- Videos of Interest:
  - Minnesota Videos
  - National Video