Public testimony for Task Force on Universal Health Care

10/12/2020

Submitted by Legislative Committee of HCAO-Action

Contact person: Charlie Swanson. List of committee members in Appendix 1

The Legislative Committee of Health Care for All Oregon-Action has been an active collaborator with Oregon state legislators in designing and advocating for universal health care for many years. This collaboration began with submission of HB 3510 in the 2011 session, and includes a bill in every long session up through SB 770 in 2019, which established this task force. Even before the 2011 legislation, some current committee members were a critical part of putting the single payer Measure 23 on Oregon's 2002 ballot. Among those who helped in 2002 and was still helping with the Task Force bill in 2019 was Betty Johnson, who, as Sen. Dembrow mentioned at the September Task Force meeting, passed away this May.

Thank you for volunteering to serve in this important work. We are following the Task Force carefully and wish to be helpful and supportive.

SB 770 was purposefully written to direct the Task Force to design a single payer system. HCAO-Action is part of a large section of the Oregon citizenry who believe that a single payer system is the most effective way to fulfill the purpose,[1] values, and principles laid out in SB 770—and is the best way to provide universal health care for Oregonians. Although the literature backing up this viewpoint is vast, our committee believes that a concise statement might be of use to the Task Force.

Why Single Payer rather than generic universal coverage?

SB770 lists nine purposes to be served.[2] Although the first two purposes name "health" as a purpose, the others are important. They primarily address equity, including economic equity (purposes #3-6). Critically important is #6 – *"removing any financial incentive for a health care practitioner to provide care to one patient rather than another."*

It is of course true that a universal coverage system could involve multiple payers, instead of the single payer system mandated in SB770. However, in any other system, different patients would be covered by different insurers. Both cost-effectiveness and equity would inevitably suffer. Without very robust regulation, rules and reimbursement rates will not be uniform, permitting inequities and, in some designs, profit-taking or other ways to divert health care resources to unintended ends. Appendix 3 is a selected bibliography of resources explaining

[1] See, for example, a 2019 poll of Oregon citizens showing a majority want either public insurance or public provision of health care - https://variedstrengths.com/

[2] See section 3 on p. 4 of SB 770 at https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB770/Enrolled

further why advocates throughout the country have chosen single payer as the best approach to achieve equity, affordability, and quality.

Two of the nine SB 770 purposes address quality of care, including measuring improvement. A single-payer system can gather data easily and naturally, and can more readily make appropriate changes to improve quality. Experience in other countries also shows that single-payer tends to lead to higher quality for the money – **universal systems using well-regulated private insurance for basic care spend an average of 31% more to achieve the same quality**. Evidence for this is presented in more detail in Appendix 2.

When asked at the August 21 Task Force meeting what was important to make a healthcare system efficient, Dr. Chunhuei Chi responded that a single risk pool is very important. He did not bring up any other specific item. Though other aspects of the system need consideration, we agree with Dr. Chi that none is as important for efficiency, and we believe that no other characteristic is as important for equity.

SB 770 states that the Task Force is to recommend the design of a universal health care system *"that is equitable, affordable and comprehensive, provides high quality health care and is publicly funded and available to every individual residing in Oregon."* The bill goes on to say that the recommended system must *"be a single payer health care financing system,"* for all of the reasons stated above and in Appendix 2 below.

Thank you for agreeing to focus on this challenging task. Oregonians will be grateful!

Appendix 1. Health Care for All Oregon-Action legislative committee members

This submission is from Charlie Swanson, Chair of the Legislative Committee of Health Care for All Oregon-Action, along with the following members:

Sandra Coyner
Frank Erickson
Rose Hart
Mark Lindgren
Chris Lowe
Diana Scholl
Debby Schwartz
Marc Shapiro
Kathy Showalter
Betsy Zucker

Appendix 2. Quality and Affordability in a Health Care System

The goal of SB 770 was to establish a Task Force to investigate how to design a health care system that achieves equitable high quality care for all Oregonians for an affordable price. The bill was written with a single payer system in mind because evidence from around the world indicates that sort of system is most likely to achieve the goal. We present data below to back up this claim. A system that provides necessary healthcare at lower costs allows more money to address the social determinants of health, an important goal of SB 770.

How can we judge healthcare quality for society as a whole? One method of judging access and quality that is rigorously justified is the health access and quality index (HAQ), which is essentially a measure of how well a health care system does in treating 32 diseases and health conditions for which there are effective treatments within a high quality system. A group of researchers used the Global Burden of Diseases, Injuries, and Risk Factors Study 2016 to calculate the HAQ for 192 countries in 2016.[3]

To judge cost-effectiveness, in addition to a quality measure, we need data regarding health care expenditures. For this, we use per capita health care expenditures in purchasing power parity dollars for 2016, which is available for all Organisation for Economic Cooperation and Development (OECD) countries.[4] Quality tends to go up as expenditures increase, so we limit our analysis to countries with per capita expenditures of at least $3,200 (less than one third of that of the U.S.), all of which have a higher health access and quality index than the U.S.

One method of classifying health care systems is by looking at the dominant method of financing health care. A Wikipedia article[5] groups health care systems into five categories:

1. Universal government-funded health system (essentially single payer)
2. Universal public insurance system
3. Universal public-private insurance system
4. Universal private insurance system
5. Non-universal system – the U.S. is the only such system of interest to us

Figure 1 compares the per capita expenditures for the twelve countries that have a universal government funded system (type 1) and the four that use mandatory private insurance for basic health care (type 3 or 4) that meet our criteria above – OECD countries with per capita expenditures greater than one third of the U.S. value. All of these counties have a higher HAQ than the U.S., meaning fewer people die from treatable conditions. The only OECD countries with a lower HAQ spend less than 30% of what the U.S. does.

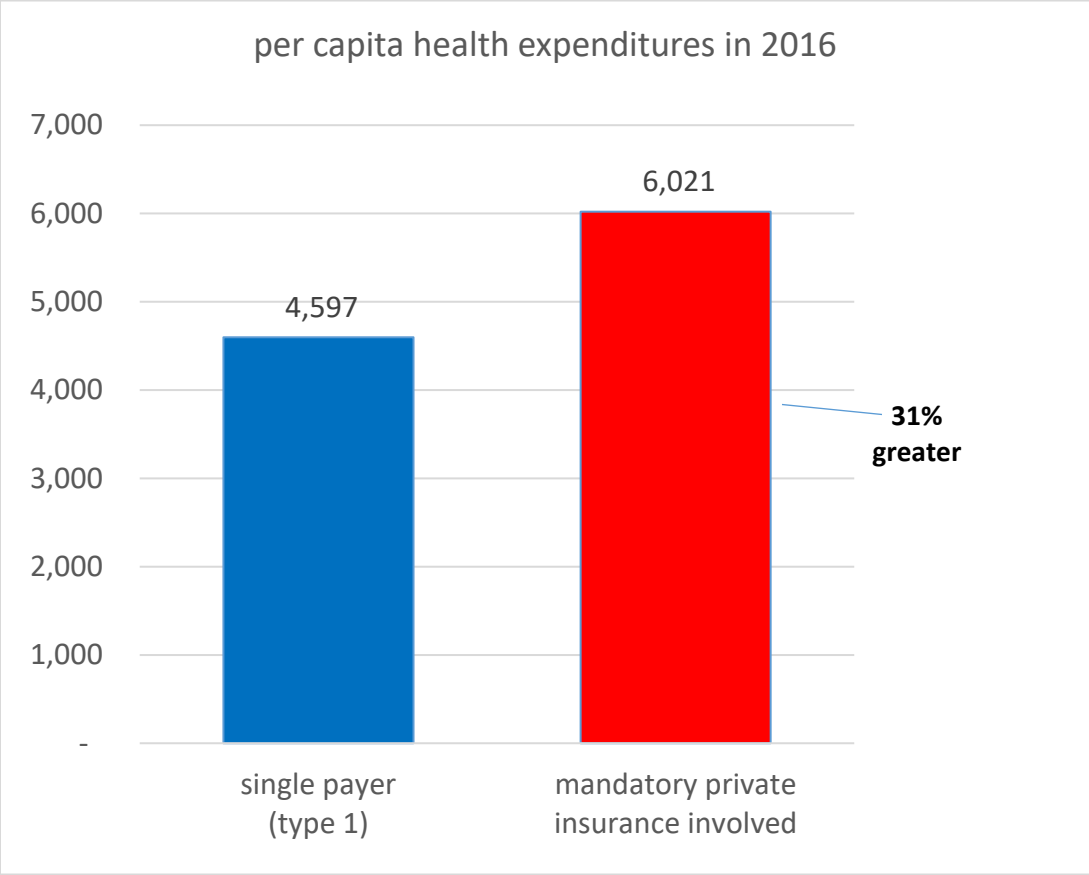
---

[3] https://www.thelancet.com/action/showPdf?pii=S0140-6736%2818%2930994-2. The index is based on success in treating 32 causes amenable to healthcare in the age range where care is expected to be effective (e.g. – tuberculosis, age 0-74; measles, age 1-14; breast cancer, age 0-74).

[4] https://en.wikipedia.org/wiki/List_of_countries_by_total_health_expenditure_per_capita

[5] https://en.wikipedia.org/wiki/Health_care_systems_by_country

Figure 1. *The 2016 average per capita healthcare expenditures (in purchasing power parity U.S. $) for all Organisation for Economic Cooperation and Development (OECD) countries with per capita expenditures greater than $3,200. There are twelve countries with a primarily single payer/government financed (type 1) system and four countries with a universal systems that uses mandatory private insurance for basic services (type 3 & 4). The average health access and quality index (HAQ) is essentially the same for the two groups – 94.3 for type 1 and 94.4 for types 3 & 4. It is clear that single payer systems tend to be more cost-effective. For comparison, 2016 U.S. per capita expenditures were $9,992 and HAQ was only 88.7.*



The data of Figure 1 indicate that in order to achieve the same access and quality, countries using mandatory private insurance spend an average of 31% more than those that use a single payer system. For those interested, table 1 shows the HAQ index and per capita expenditures for the countries whose data is depicted in Figure 1.[6] Type 1 countries in Figure 1 are Iceland, Norway, Australia, Finland, Sweden, Italy, Ireland, Canada, New Zealand, Denmark, Spain, and United Kingdom. Type 3 & 4 countries are The Netherlands, Switzerland, Austria, and Germany.

[6] There are only three OECD counties that have expenditures greater than $3,200 and use a type 2 system, and they all spend between $4,500 and $4,900, with an average HAQ of 92.9.

Table 1. The details of the data from which Figure 1 is calculated. All of the data is for 2016. The table includes all OECD that spend more than $3,200 per capita, and also a few that spend less but still have a higher HAQ than the U.S.[7]

Country	Per capita expenditures	Healthcare Access and Quality Index (HAQ)	Healthcare system type
Iceland	4,376	97.1	1
Norway	6,647	96.6	1
Australia	4,708	95.9	1
Finland	4,033	95.9	1
Sweden	5,488	95.5	1
Italy	3,391	94.9	1
Ireland	5,528	94.6	1
Canada	4,753	93.8	1
New Zealand	3,590	92.4	1
Denmark	5,205	92.1	1
Spain	3,248	91.9	1
UK	4,192	90.5	1
Greece	2,223	90.4	1
Japan	4,519	94.1	2
Belgium	4,840	92.9	2
France	4,600	91.7	2
Slovenia	2,835	90.8	2
South Korea	2,729	90.3	2
Czech Republic	2,544	89.0	2
Netherlands	5,385	96.1	4
Switzerland	7,919	95.6	4
Austria	5,227	93.9	3
Germany	5,551	92.0	3
USA	9,892	88.7	5

[7] The compilation and analysis of these data was done by Charlie Swanson, Chair of the Legislative Committee of HCAO-Action.

Appendix 3. Selected Bibliography Related to Why SB 770 was written to focus on a Single Payer Financing System as the best means to achieve Universal Health Care

1. Health Care for All - California makes a compelling case for why we need single payer.
2. How I changed my Mind on Medicare for All. Dr. Li Tso, opinion contributor to The Hill. 07/14/20. https://thehill.com/opinion/healthcare/507348-how-i-changed-my-mind-on-medicare-for-all
3. Physicians for a National Health Program (PNHP) explains why the US needs a single payer health system.
4. The pandemic proves we need single payer, Medicare for All. Marilyn Albert, RN. https://nuhw.org/the-pandemic-proves-we-need-single-payer-medicare-for-all/
5. What if the Road to Single-Payer Led Through the States? https://www.nytimes.com/2019/11/08/upshot/what-if-the-road-to-single-payer-led-through-the-states.html
6. Hawaii was creating a plan for universal health care. It's time to return to it. Stephen Kemble, Hawaii psychiatrist, 10/4/2020. https://www.civilbeat.org/2020/10/hawaii-was-creating-a-plan-for-universal-health-care-its-time-to-return-to-it/
7. Cornell Economics professor Robert Frank makes the economic case for single payer.
8. Mark Dudzic makes a labor argument for single payer.
9. Medicare for All Would Improve Hospital Financing *[with global budgets].* https://www.healthaffairs.org/do/10.1377/hblog20191205.239679/full/
10. A Single-Payer System Would Reduce U.S. Health Care Costs. Ed Weisbart, MD, CPE. https://journalofethics.ama-assn.org/article/single-payer-system-would-reduce-us-health-care-costs/2012-11
11. Public Option Advocates: Time to Come Home to Single Payer. Mark Dunlea**,** Executive Director, Hunger Action Network of NYS. https://pnhp.org/news/public-option-advocates-time-to-come-home-to-single-payer/
12. From HCAO-Action – https://www.hcao-action.org/single-payer
13. From PNHP – http://www.pnhp.org/publications/would_single_payer_be_good_for_america.php
14. From Vermont Health Care for All – http://vermontforsinglepayer.org/what_is_single_payer/top_ten_reasons_for_single_payer/