Column Fixing healthcare: Which single-payer system would be best for California?

As California embarks once again on establishing a statewide single-payer healthcare system, it's important to remember that there are different ways of doing that. (Getty Images)

By **David Lazarus**

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It's misleading to say that California could have a single-payer healthcare system just like in other developed nations. Other nations approach their single-payer systems in a variety of different ways.

Canada's system is different from Germany's, which is different from Britain's. Each country ensures that all residents have access to high-quality and affordable healthcare. But they take different roads to get there.

"Healthcare needs to be widely available, easily accessible and cheap, like electricity or tacos," said Joe Flower, a San Francisco Bay Area healthcare consultant and author of "Healthcare Beyond Reform: Doing It Right for Half the Cost."

He called the U.S. healthcare system, with millions of people lacking coverage or saddled with high-deductible plans, "both morally wrong and stupid economics."

Legislation has been introduced by state Sen. Ricardo Lara (D-Bell Gardens) declaring California's "intent" to establish "a comprehensive universal single-payer healthcare coverage program and a healthcare cost control system for the benefit of all residents of the state."

As I wrote on Friday, this may be more feasible than earlier legislative attempts because President Trump and Republicans in Congress want to convert federal funding for Medicaid to block grants. While this probably would reduce funding for covering low-income people, it presents the unintended benefit of giving states more latitude in how the money is spent.

In other words, California's version of Medicaid, Medi-Cal, could be more easily integrated with a statewide single-payer plan. Medi-Cal covers about a third of Californians.

So the question becomes: What sort of single-payer system would be best for the state's nearly 40 million residents?

There are three basic approaches, as outlined by T.R. Reid in his excellent book "The Healing of America: A Global Quest for Better, Cheaper and Fairer Health Care." Each has pluses and minuses:

Beveridge Model: Named for British social reformer William Beveridge, this is the system established in postwar England, Spain, New Zealand and most Scandinavian countries. Under this model, the government finances coverage through tax payments and also runs hospitals and clinics.

Pro: No doctor bills. You show up, get treated, leave. Con: Choices may be limited and certain costly treatments may be unavailable.

Bismarck model: Named for Prussian Chancellor Otto von Bismarck, who originated the idea in 1883, this approach relies on payroll deductions to fund nonprofit insurers and requires that they cover everyone. Coverage and medical pricing is strictly regulated by the state.

Aside from Germany, you'll find variations of this system in France, the Netherlands, Switzerland and Japan.

Pro: Plenty of flexibility in choosing insurers and healthcare providers. Con: Doctors may seek higher fees through private clinics.

National Health Insurance model: Combining elements of both Beveridge and Bismarck, this is the system Canada started rolling out in 1947. All citizens pay into a government-run insurance program that deals directly with doctors and hospitals.

Pro: Costs are greatly reduced by administrative savings and efficiencies. Cons: Some treatments may be limited; long wait times for some patients.

Robert Field, a professor of health management and policy at Drexel University, said he generally prefers the Canadian-style approach because it eliminates most private insurers. “When you get private companies involved, it just adds another layer, which can drive up costs,” he said.

However, Field said a German-style approach, with nonprofit private insurers serving as a conduit for coverage, might make more sense for California.

“This would make it easier to incorporate Kaiser,” he said. “It’s one of the most successful private systems in the country, and you wouldn’t want to kill the goose that continues to lay golden eggs.”

A Kaiser spokesman declined to comment on the prospect of a single-payer system, steering me instead to the California Assn. of Health Plans, an industry group. Charles Bacchi, the organization’s president, said the state’s health insurers have consistently opposed efforts to introduce a single-payer system.

“It’s very difficult to have a one-size-fits-all system,” he told me.

Critics of a state single-payer plan cite a 2008 study by the Legislative Analyst’s Office projecting a $40-billion shortfall in funding. However, that study was based on outdated national (not California) data from as far back as 1998.

It also concluded that the shortfall could be closed if California employers and employees paid a combined tax rate of 16% rather than the 12% envisioned by a single-payer bill under consideration at the time. That legislation was written by former Democratic state Sen. Sheila Kuehl, who now serves as a Los Angeles County supervisor.

“Our analysis in 2008 was specific to a specific bill,” said Ben Johnson, an official with the Legislative Analyst’s Office. “We don’t believe it’s appropriate to use that 2008 analysis for the current debate.”

Clearly there’s room for creativity in setting things up. Field proposed carve-outs for Kaiser and other so-called integrated systems so they could continue operating in their own ecosystems — with pricing and regulations consistent with other insurers and medical providers.

The consensus among most experts I spoke with was that the German-style Bismarck model would represent the easiest transition for California.

While it might not offer the same level of savings as the Canadian approach, it would maintain a role for the private sector while also addressing universal access and affordable pricing.

Nancy Kane, a professor of management at the Harvard School of Public Health, said “single-payer” is a misnomer. Americans should instead embrace the idea of “single financing” — that is, a government role in fundraising for coverage but not necessarily serving as the insurer.

"A tax system, rather than premiums, is less regressive," she said. "And it makes participation mandated without having to mandate anything."

Louise Parker, a professor of healthcare management at the University of Massachusetts in Boston, agreed that financing coverage through payroll taxes is the easiest way to ensure that everyone's covered, and also that everyone participates.

"There's no way not to have a mandate," she said.

Ultimately, California could structure a single-payer system any number of ways. It could simply emulate Medicare Advantage if state officials didn't want to start from scratch.

It could join with other states in creating a more extensive single-payer network. California, Oregon and Washington could establish a West Coast regional system, or California could couple with New York, say, for a bicoastal risk pool.

"We absolutely cannot continue to do what we've been doing," Parker said. "Our current system is going to fail."

It's time for California to lead the nation to a better system.

David Lazarus' column runs Tuesdays and Fridays. He also can be seen daily on KTLA-TV Channel 5 and followed on Twitter @Davidlaz. Send your tips or feedback to david.lazarus@latimes.com.

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