# What is Single Payer?

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**Summary: Today we take a step back to review a fundamental issue – the definition of single payer. Also its typical features and options. Why? Because sometimes we get lost in technical details, and forget the big picture. And too often experts get confused, and thus confuse others.**

**Comment by Jim Kahn:** It drives me to distraction when health policy researchers, journalists, medical journals, and critics misrepresent single payer. This has come up several times in recent months. I guess it's understandable, with all the misinformation that's floating around. But I'm eager to settle on a single, correct definition. Here's my attempt…

## DEFINITION:

One entity (a public agency) pays for health care. This agency receives all funding and disburses all payments for standard comprehensive coverage. Private insurers are prohibited from this role.

All patients and providers deal with just one payer for the standard coverage. This is especially important for providers, offering the simplicity of a single payment source.

## TYPICAL FEATURES:

These elements are typical in single payer, if not in the definition, in order to achieve overall goals of universal, equitable, efficient, and affordable access to care.

**Everyone is covered**. Universal, lifelong – meeting a fundamental human need, and part of single payer's efficiency.

**Everyone has identical comprehensive coverage / benefits.** This is hugely different from our current system, with myriad and varied restrictions on benefits according to health plan.

**Payment rates are the same for everyone**. Again, this is vastly different from today, with up to 10-fold differences in payment levels for the same services, creating strong economic forces for unequal **access.**

**Cost-sharing is minimal**. No deductibles, and co-pays either not used or small with low-income exemptions. This avoids financial barriers to care.

**Capital spending (investment) decisions are made by the payer, not by providers**. This assures that capacity is increased where most needed.

**Negotiated drug & medical equipment prices.** A single payer negotiates a single set of prices, directly with manufacturers. Currently prices vary widely across insurers and plans, and intermediary PBMs distort the market and extract profits.

**Long-term care**. In most single payer plans, long-term care (both institutional and community-based) is included as an essential care need.

**A single electronic health record,** focused on clinical care rather than billing. With much simpler billing, a universal EHR would reduce the burden on providers and facilitate exchange of medical information and enable effective public health tracking and intervention.

## DO WE HAVE SINGLE PAYER NOW? NOT MUCH

**Veterans Affairs (the VA) has a single payer (the federal government).** With full-time staff, the VA resembles a national health service. Access to and quality of care is better than average. Some patients have private insurance as well, and recently more VA funds have been used for community providers, but still, a single payer.

**Medicare is not a single payer**, even though it's the predominant payer for seniors. **This is a common misunderstanding**. Medicare is not a single payer because from the perspective of providers, it's just one of many payers, losing the efficiencies and equity enhancements of single payer. The large role of private insurers in Medicare Advantage further distances Medicare from single payer.

## CHOICES UNDER SINGLE PAYER:

**Provider payment mechanisms**. Fee-for-service is the most common proposed approach for individual providers, but they can also be paid with salaries. Hospitals and other institutions may be paid via global budgets. Indeed, capitated provider groups (without intermediaries, and not-for-profit) may be possible, though controversial and require very strong rules to prevent undertreatment and gaming.

**Supplemental or complementary insurance.** Many nations permit focused (small scope) additional insurance, e.g. to speed access to specialty care. These are fraught, potentially undermining standard coverage, but satisfying demand for service enhancements. In other countries, they take many forms and work acceptably (not materially reducing access for the broad population) … but can they in the US?

**Parallel single payer systems**. A single payer approach may permit having a second system in tandem, such as the VA. Two independent systems, each meeting the definition of single payer from the perspective of participating providers and patients.

**Opting out**. Providers can practice outside of the single payer system, accepting direct payments for services. But they are not permitted to both participate in single payer and accept payment for the same services. That is: either fully in or fully out.

So, now that we've clarified, let's get back to winning the long-running battle for an efficient and equitable system to pay for health care – single payer (you know what I mean!).

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