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LETTER TO THE EDITOR

CORRECTING THE RECORD ON MEDICARE FOR ALL

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Block and Bedell's description of Medicare for All in the September 2019 SGIM *Forum* includes some important oversights, errors, and misconceptions.[1] They ignore the well-documented savings on administrative costs in hospitals and physicians' offices that could be realized by a single payer reform. For instance, Duke's health system at present employs about 1,600 billing clerks whose efforts would be unnecessary if that system were funded through a global budget rather than per-patient payments. Currently, administration accounts for one quarter of total U.S. hospital expenditures, twice the share in Canada or Scotland's single payer systems. Similarly, much of the time (and expense) doctors and their office staff devote to documentation, dealing with prior-authorization requirements, varying referral networks and formularies, and collecting co-payments would be saved. Most analyses of the costs of implementing single payer reform have concluded that savings on providers' and insurers' overhead would offset any costs of added care due to expanded and upgraded coverage.

Block and Bedell's projection of a surge in the utilization of outpatient specialist care is at odds with the findings of studies of previous coverage expansions. Physician visits, surgical procedure rate, and inpatient admissions did not increase in the wake of the implementation of Medicare or the ACA.

They imply, incorrectly, that funding for clinical care in hospitals—and hence clinicians' salaries—would decline because the prices paid for services would be below those currently paid by commercial insurers. As noted above, The Medicare for All bills in Congress would fund hospitals through global operating budgets (much as we currently fund fire departments). That payment strategy would effectively abolish "prices" for individual services—just as it makes little sense to ask the price of a fire department responding to a fire alarm. Hospital budgets would reflect the actual costs of delivering care, and substantial savings on billing and bureaucracy would allow more generous clinical funding at hospitals' current level of total expenditures.

Similarly, Block and Bedell's implication that doctors' incomes would go down ignores projections of the economic effects of single payer reform. While estimates vary, most foresee some increase in physicians' take home pay (after accounting for savings on office overhead). Canadian doctors' incomes rose substantially after single payer reform was implemented in that country.

References

1. https://www.sgim.org/File%20Library/SGIM/Resource%20Library/Forum/2019/SGIM-Sept-1.pdf.

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