2-9-2004

Single-Payer National Health Insurance: Physicians' Views

Danny McCormick  
*Harvard University*

David U. Himmelstein  
*CUNY School of Public Health*

Stephanie Woolhandler  
*CUNY School of Public Health*

David H. Bor  
*Harvard University*

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**Recommended Citation**  
Single-Payer National Health Insurance

Physicians’ Views

Danny McCormick, MD, MPH; David U. Himmelstein, MD; Steffie Woolhandler, MD, MPH; David H. Bor, MD

Background: Forty-one million Americans have no health insurance and, despite the growth of managed care, medical costs are again increasing rapidly. One proposed solution is a single-payer health care financing system with universal coverage. Yet, physicians' views of such a system have not been well studied.

Methods: We surveyed a random sample of physicians (from the American Medical Association Masterfile) in Massachusetts, regarding their views on a single-payer health care financing system and other financing and physician work-life issues that such a system might affect.

Results: Of 1787 physicians, 904 (50.6%) responded to our survey. When asked which structure would provide the best care for the most people for a fixed amount of money, 63.5% of physicians chose a single-payer system; 10.7%, managed care; and 25.8%, a fee-for-service system. Only 51.9% believed that most physician colleagues would support a single-payer system. Most respondents would give up income to reduce paperwork, agree that it is government's responsibility to ensure the provision of medical care, believe that insurance firms should not play a major role in health care delivery, and would prefer to work under a salary system.

Conclusions: Most physicians in Massachusetts, a state with a high managed care penetration, believe that single-payer financing of health care with universal coverage would provide the best care for the most people, compared with a managed care or fee-for-service system. Physicians' advocacy of single-payer national health insurance could catalyze a renewed push for its adoption.

Arch Intern Med. 2004;164:300-304

The number of uninsured Americans is at 41 million. After several years of sluggish growth, medical care costs are again increasing rapidly, despite the widespread adoption of managed care. One proposed solution to these dual conundrums is a single-payer health care financing system with universal coverage (ie, single-payer national health insurance [NHI]). Such a system would cover every American for all necessary medical care. In theory, it would control costs by shrinking administrative overhead and profits associated with private health care firms. Physicians' views about single-payer NHI could be either a barrier to or a catalyst for such reform.

As clinical leaders and patient advocates, physicians are well positioned to provide expert opinion on how well the health care system functions for patients. In addition, because the structure of health care financing influences physicians' work lives, incomes, and professional satisfaction, physicians have substantial personal interests in health care reform.

In recent surveys, physicians have expressed concern about access to care, their own ability to provide high-quality care under managed care systems, and managed care's incentives to limit services, especially under capitation payment systems. Physicians also express dissatisfaction with managed care's negative effects on the patient-physician relationship, time spent with patients, physician autonomy, availability of resources to care for patients, administrative paperwork, compensation, and research and teaching. Yet, there is little recent information on physicians' views on single-payer NHI or its principal alternatives.

We assessed the views of physicians in Massachusetts, one of the states with...
the highest penetration of managed care, regarding single-payer NHI and related health care financing and physician work-life issues.

**METHODS**

**STUDY SAMPLE AND DATA COLLECTION**

We obtained, from the American Medical Association (AMA) Masterfile, a random sample of physicians in Massachusetts (mailing address) in 2001. Inactive physicians were excluded.

We mailed a survey to 2000 physicians, with a single follow-up letter to nonrespondents. A brief letter requesting study participation accompanied the survey. The letter was printed on Cambridge Hospital stationary and signed by the chiefs of the departments of medicine, pediatrics, and pathology and by one of us (S.W.). No other organization or personal names appeared in the letter. The post office returned 213 surveys as undeliverable, leaving a total sample of 1787. Of these 1787 physicians, 904 responded to the survey (50.6% response rate). The survey was conducted between March 18, 2001, and October 18, 2001.

To assess potential nonresponse bias, we compared the self-reported sex, year of medical school graduation, and medical specialty of the respondents with those of all 27527 Massachusetts physicians in the AMA Masterfile.

**QUESTIONNAIRE DEVELOPMENT**

We developed an 11-item survey on physicians' belief about which health care financing mechanism would be best for patients (single-payer NHI, managed care, or fee-for-service care), views on health care financing and key physician work-life issues that would be affected by the adoption of single-payer NHI, and demographic and professional characteristics. The questionnaire is available from the authors.

To determine what physicians view as the best health care financing mechanism for patients, we asked "which one of the following three structures would offer the best health care to the greatest number of people for a fixed amount of money?" Simon et al.28 asked the same question in a previous survey of academic physicians. Response categories were "fee-for-service system in a competitive marketplace," "managed care system in a competitive marketplace," and "single-payer system with universal coverage." We also assessed respondents' beliefs regarding their physician colleagues' support for single-payer NHI.

We performed a sensitivity analysis to determine the potential impact of nonresponse bias. We recalculated the proportion of respondents who would have selected single-payer for our sample by sex, AMA and Massachusetts Medical Society membership, medical specialty, and year of graduation from medical school. For all comparisons of categorical variables, we used the χ² test for subgroup comparisons and considered 2-tailed P=.05 as statistically significant.

We also assessed the relationship of belief in single-payer NHI as the best system for patients and agreement with each of the 4 health care financing and work-life statements (for insurance role, we used disagreement) in multivariate logistic regression models that controlled for AMA membership, medical specialty, and sex—the only variables that were significantly associated with beliefs about the best health care system. Agreement with a statement was defined as either "agree strongly" or "agree somewhat," and disagreement was defined as either "disagree strongly" or "disagree somewhat." Data were analyzed using SAS statistical software.

For analyses of physician specialty, we grouped general internists, family practitioners, general practitioners, pediatricians (nonspecialists), and geriatricians in the category of primary care. We considered medical and pediatric subspecialists as medical/pediatric subspecialty physicians. All surgeons (orthopedics, general surgery, urology, and obstetrics and gynecology) were analyzed as a single group. Specialties other than one of these or psychiatry were combined into a heterogeneous group (other). We categorized respondents by decade of graduation from medical school. Because of the low numbers of respondents, we combined all decades before 1950; similarly, we also combined the few respondents graduating in 2000 with those graduating in the 1990s for these analyses. For analyses comparing study respondents with all Massachusetts physicians, we recategorized the 148 specialty categories appearing in the AMA Masterfile according to the previously described scheme.

**RESULTS**

**CHARACTERISTICS OF RESPONDENTS**

Table 1 summarizes the demographic and professional characteristics of respondents. Slightly more than two thirds of our sample were men. Their mean year of graduation was 1979 (average, 22 years in practice), and the median, 1982. Most physicians by specialty were in primary care, followed by surgery, medical/pediatric subspecialty, and psychiatry.

Respondents did not differ from all Massachusetts physicians with regard to sex, but were slightly older and more likely to list a primary care discipline or psychiatry as their specialty (Table 1).

**VIEWS ON HEALTH CARE FINANCING AND WORK-LIFE ISSUES**

Most physicians agreed that it is the responsibility of society through its government to provide everyone with good medical care, regardless of ability to pay, with more than half indicating strong agreement (Table 2). Only a few believed that the insurance industry should continue to play a major role in the delivery of health care, with only 6.8% strongly agreeing with this concept.

Regarding work-life issues, two thirds of physicians agreed that they would accept a 10% reduction in their fees for a substantial reduction in paperwork. A smaller majority indicated a preference for payment under a salary system if the salary were guaranteed to be within 10% of their previous income.
Physicians who agreed with the statements regarding government responsibility for health care were significantly more likely to support single-payer NHI (odds ratio [OR], 8.0; 95% confidence interval [CI], 4.6-13.8), even after adjusting for AMA membership and medical specialty. Similar results were noted for agreement with the statements regarding a reduction in fees for a reduction in paperwork (OR, 4.0; 95% CI, 2.9-5.5) and a salary system of pay if salaries were held to within 10% of previous levels (OR, 3.5; 95% CI, 2.6-4.8) and for disagreement with a continued health care delivery role for the insurance industry (OR, 3.3; 95% CI, 2.4-4.6).

Managed care has become the dominant mechanism for the organization and financing of health care in Massachusetts and the United States. Yet, in Massachusetts, among the most highly managed care–penetrated states in the nation, most physicians reject managed care and view single-payer NHI as the best system for their patients. This view is broadly based, cutting across sex, medical specialty, age, and medical society membership. We also found that most physicians would give up income to reduce paperwork, believe that it is government’s responsibility to ensure the provision of medical care, reject a major health care delivery role for health insurance firms, and, surprisingly, would prefer salaried compensation.

Our findings are consistent with most of the few previous peer-reviewed studies that have directly assessed physician support for single-payer NHI, although all were either conducted with selected groups of physicians or performed years ago. Recent studies have found support for single-payer NHI in most (57%) academic physicians and among medical students. Two older surveys restricted to family physicians found that 40% supported single-payer NHI. Interestingly, in one of these surveys, 65% disagreed that corporate managed care is the best way to provide health care.

Massachusetts physicians’ overwhelming support for government’s role in ensuring access to health care, and their rejection of a major role in health care delivery for the insurance industry, may derive from day-to-day experiences interacting with inadequately insured patients and with managed care plans. Physicians’ expressed willingness to give up 10% of their fees in return for a reduction in paperwork suggests that administration, billing, and referral paperwork is a substantial concern, consistent with findings from previous surveys of physicians. The preference for a salaried payment system (in which salaries are held to within 10% of previous levels) may reflect physicians’ unease with the financial incentives in capitated managed care contracts. Proposals for a single-payer NHI program have focused on providing an alternative model of health care financing to explicitly address these key issues in the system. Our finding that physician preferences regarding these issues are each strongly associated with the belief that single-payer NHI would offer the best health care to the most people suggests that Massachusetts phy-
Physicians have a good understanding of single-payer NHI and see it as the system most likely to address problems in these areas.

Several limitations in this study should be noted. First, this study was conducted in only one state. Yet, because Massachusetts is among the states with the greatest managed care market penetration, its physicians have substantial experience with managed care and, thus, their views may have special relevance as managed care expands in other states. Second, our questionnaire did not define the terms managed care and single payer. Managed care encompasses various organizations and contracts that differ in their details. It seems likely, however, that physicians understand the fundamental relationships denoted by this term. Similarly, the term single payer might refer to somewhat different systems, such as the system in Canada or Australia or even "Medicare-for-all." Nevertheless, we believe that most Massachusetts physicians are familiar with the term single payer for 2 reasons. First, the Massachusetts Medical Society has studied and debated single-payer NHI several times in the past decade. Second, a statewide universal health care ballot initiative was broadly debated and narrowly defeated in Massachusetts during the 2000 election cycle.

It is also possible that because we asked physicians about 2 financing structures with which they have experience (fee-for-service care and managed care) and one with which they are unlikely to have direct experience (single payer), the support we found for a single-payer system merely reflects respondents' dissatisfaction with their work setting. However, single-payer financing systems are widely used in other major industrialized nations around the world and much has been written about them. It seems likely that physicians are capable of a rational appraisal of the single-payer option, and able to compare it with the alternatives. Moreover, we doubt that physicians would falsely indicate that they support single-payer reform simply because of job dissatisfaction.

Another limitation of our study is the potential for nonresponse bias. It is possible that physicians who strongly support or oppose any of the health care financing models that we asked about may have been more likely to respond to our survey than those with less strongly
We believe that the majority support for single-payer NHI reform for patients. However, it is possible that some who view single-payer NHI as the best option for patients might not personally support single-payer NHl if, for example, they placed a higher priority on factors other than the interest of patients.

Because of their central role in the health care industry, physicians have the potential to influence debate on reform of the US health care system. The large number of Americans who lack health insurance has recently prompted many medical societies, including the AMA,34,35 and medical opinion leaders36-37 to renew calls for universal health insurance. Most of these commentators have recommended incremental reforms or have placed a higher priority on factors other than health care reform at the US.

If this were so, respondents might not have had views. If these were so, respondents might not have been representative of all Massachusetts physicians. However, our study respondents differed minimally from all Massachusetts physicians. In addition, our sensitivity analysis suggests that nonresponse bias is unlikely to have greatly impacted our findings.

Last, we asked physicians which health care financing system would provide the best care to the most people. We believe that the majority support for single-payer NHI indicates that most physicians would recommend such reform for patients. However, it is possible that some who view single-payer NHI as the best option for patients might not personally support single-payer NHI if, for example, they placed a higher priority on factors other than the interest of patients.

Acknowledgments

This study was supported by internal funds from the Department of Medicine, Cambridge Hospital, Cambridge, Mass.

This study was presented at the 25th Annual Meeting of the Society for General Internal Medicine; May 4, 2002; Washington, DC.

Corresponding author and reprints: Danny McCormick, MD, MPH, Department of Medicine, Cambridge Hospital, 1493 Cambridge St, Cambridge, MA 02139 (e-mail: danny_mccormick@hms.harvard.edu).

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