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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Is a One-Size-Fits-All Healthcare Plan the Right Approach?

Dr. Birnholz:
Ask just about anyone on any side of the health reform debate and your answer to, “How are things going?” will still be close to identical. It’s not going great. Costs are insanely high, access to care is perpetually challenged, and resources—well, they’re way overextended. But how to improve things, that’s the big question, isn’t it? Could a system reboot, say in the form of a single-payer plan, be the answer or a much, much bigger problem?

Welcome to Voices from American Medicine on ReachMD. I’m Dr. Matt Birnholz, and joining me in our continuing coverage on the merits and drawbacks of single-payer healthcare is Dr. Asim Shah, Executive Vice Chairman and Professor of Psychiatry at Baylor College of Medicine. Dr. Shah is also the Chair of the Division of Community Psychiatry at Baylor, and he coauthored a recent op-ed article in the Houston Chronicle questioning whether a one-size-fits-all healthcare plan was the right approach, which—spoiler alert—it was not.

Dr. Shah, welcome to you.

Dr. Shah:
Thank you.

Dr. Birnholz:
So, to start, Dr. Shah, I want to learn more about your background and the experiences that put this single-payer debate into sharper focus for you. What’s informed your current views?

Dr. Shah:
So, I’m a psychiatrist, and a lot of time in health insurances, mental health is a separate angle, and before Affordable Care, a lot of health insurances would not even include mental health. Thank God the Affordable Care Act at least includes all kind of health. That made me think about these options, which is either healthcare for all or single-payer or Affordable Care Act. That’s how we started looking into this.

Dr. Birnholz:
I want to talk about the article then. This article that you wrote, how was it received by peers in your profession, if not the broader public?

Dr. Shah:
We got a lot of good feedback that people liked it and they agreed with us. Having said that, the few, maybe handful, who didn’t like it, that feedback was pretty harsh because they were very vocal in expressing their opinion that we are talking about one angle and they were thinking about party lines. Although, to me, this is not a party line question, whichever party you belong. This is a humanitarian question. This is a health question as opposed to any single party.

Dr. Birnholz:
Well, why don’t we dive then into the position you’ve taken on this issue that you’ve written about? Why won’t a federally implemented national health plan work in this country, at least from your vantage point?

Dr. Shah:
I think we don’t need to go too far. We can just go across the border in Canada. Canada has a single-payer healthcare system. UK has

that too, but Canada is just next door to us. What do we see in Canada with healthcare? Absolutely, people do have healthcare without paying anything. It is covered for everybody. I think the biggest problem is that there are long wait times for surgeries, for procedures, to see a specialist, and there is no respite for that.

We in this country have been used to seeing physicians, especially if you have you insurance, very easily, very quickly, whenever we want, especially if you have decent insurance. If we go from one extreme to another extreme, which is in Canada in my opinion, that will be very, very difficult for the population to adapt and absorb. That is one. And second, it has not shown to be more effective. In some ways, single-payer healthcare, if it's run by government, becomes more expensive than universal healthcare. Why? Because any time the government is managing money it becomes more expensive because they have their own rules and regulations and other checks and balances, but those things make things expensive.

Dr. Birnholz:
So, from a care perspective, you do not believe that quality will substantially improve. Another, of course, argument in this debate is whether healthcare costs can come down. What are your thoughts on that?

Dr. Shah:
So, that's also debatable because it will be one entity, meaning if healthcare is single-payer, then the government will be managing it, which is Medicare. Medicare is good right now. Actually, Medicare is much better than Medicaid in many ways, but right now, as long as we have Medicare, it is not necessarily completely single-payer. People do have options even in Medicare to choose their prescription plan insurance or some other sub-insurances and all. It is unclear that if we do a single-payer healthcare system they will continue to have those options, because if they do have those options, sometimes it is a good bargain for some people. Secondly, the other issue is that the reimbursement if it's a single-payer for physicians is a problem and for small hospitals even a bigger problem, as I expressed in my op-ed. They may suffer a lot. Small hospitals sometimes get different benefits from Medicare, but if it's single healthcare, everybody is getting the same benefit or same reimbursement. I'm in Houston, so if Houston Hospital is getting similar reimbursement as opposed to somebody sitting in Lubbock, Texas, it may not be easy for the Lubbock Hospital to operate.

Dr. Birnholz:
I want to ask, as a psychiatrist, you are often confronted with patients whose insurance, whether it's employer-sponsored or self-sought, is not covered very well for mental health services. How did that not influence your views in terms of whether an overhaul would be needed to ensure that people have better access to mental health care services?

Dr. Shah:
Of course, I certainly believe that overhaul is needed. I never said that overhaul is not needed. I think the question was whether a single-payer healthcare system is the answer, and to me, the answer to that is no, single-payer is not the answer, but of course an overhaul is needed. Affordable Care Act is part of the overhaul. It is not perfect, but the biggest success of Affordable Care Act, if you ask anybody, people who even oppose it, is only 2 things: preexisting conditions and age limit until 26, and those 2 everybody across the aisle would agree are the 2 big successes of the Affordable Care Act. And those things have helped our field in psychiatry, that in the past people were denied care because if you had depression, they were not going to give you insurance, but not anymore, so that's good. The other issue with psychiatry or mental health is that when a patient is admitted, in all insurances, even if it's Medicaid or state-run programs, they usually give you days that you have to keep the patients 3 days, 5 days; after that you have to discharge. These insurance companies don't do that for a person who has chest pain or so but only for mental illnesses because it's not physical; you cannot see it. So, those are the fights we have to fight with insurance companies, and a lot of reforms need to be done, so the overhaul is definitely needed but not in the form of single-payer.

And I would like to touch on Texas and Medicaid expansion. Texas is one of those few states which didn't get Medicaid expansion. Over 30 states, 33 states got it. We are one of the worst states when it comes to healthcare. So many people in Texas are uninsured, underinsured. It is almost impossible to get Medicaid in this state. You can get Medicaid if you are pregnant, if you are on dialysis, but otherwise, it is not easy—or if you're a child you can get CHIP or Medicaid, but otherwise, you cannot get Medicaid. How do these people get help? How do they get healthcare? Who's going to do something about that? That's the question still to be answered.

Dr. Birnholz:
Very important question indeed, Dr. Shah. For those tuning in, this is Voices from American Medicine on ReachMD. I'm Dr. Matt Birnholz, and I'm speaking with Dr. Asim Shah about the single-payer healthcare debate.
So, Dr. Shah, I want to come back to one sticking point. You've used the term one-size-fits-all as a label for the proposals that we are seeing on national health plans. Do these proposals ultimately reduce to that, or are they more nuanced than this?

Dr. Shah:

There are a lot of nuances in that, and that is the reason our title one-size-fits-all is the wrong approach because in some ways single health payer is one-size-fits-all also, so even if we are going to work single healthcare hypothetically, you can have a lot of branches to it, a lot of changes to it, it's just not that easy to say that we will give Medicaid to everybody; we will have a single healthcare; we will give insurance to everybody. There are more nuances to it. It's just not that easy. And we found that out after Affordable Care Act, that while there are some good things with it, there are certain bad things with it also, so we need to learn from our experiences and take the good things from ACA, from others, and apply that and even learn from our neighboring countries like Canada. I think what is good in their system is that you can get timely preventive care, hopefully, but the issue more so is when you're about to get emergency care or surgery or so, there's a long wait line. That's something we need to learn that that's not going to work in our system.

Dr. Birnholz:
Right. And I want to come back to the ACA because in your article that you coauthored, you wrote, "We believe the answer is not to drastically overhaul our entire healthcare system but to build in a true bipartisan fashion on the successes we've seen under the ACA." So let me ask you on that front, in the context of a very highly partisan political climate right now, is this idea of building on the ACA more or less likely in your view than a more aggressive move towards or against single-payer systems?

Dr. Shah:
So, I think if you call it ACA, nobody's going to do anything about it because then it will be party line because the other name of ACA is Obamacare and then the party line comes. Perhaps a better solution would be to take things from ACA, just like the pre-existing condition, the age limit and insurance for most or all, and if they want to change the name to something different, that's fine, but it needs to have elements of ACA because there are a lot of good things in ACA; but if you keep it as is, I think the simple answer to your question is party lines are going to play more important than anything else, and people will think that if we are working on revamping ACA, we are accepting ACA, and I don't think Washington is ready to accept that, or at least half of Washington is ready to accept that.

Dr. Birnholz:
What about single-payer models working at the state level? What are your thoughts on that, Dr. Shah?

Dr. Shah:
It will be similar but less of a concern because you can handle things a little bit better than state; although, if you are looking at that, you can look at Medicaid, which is a state-level program, and what is the success rate of Medicaid. Medicaid is actually, perhaps, one of the worst programs in terms of success rate because physicians don't want to take Medicaid because the reimbursement is too low and the needs are too high, whereas Medicare is a more successful program and physicians and hospitals are open to taking Medicare, so Medicare works better at a provider level as opposed to Medicaid.

If you look at further details of the program, prescriptions were better for Medicaid as opposed to Medicare, so they both have their own pluses and minuses. And again, if you are looking at a state program, you need to compare it with Medicaid. It is doable, but again, you need to incorporate a little bit from Medicare, little bit from Medicaid and a little bit from ACA and make a new statewide program. But you can use the example of Massachusetts. Everybody is insured maybe except for 2, 3, 4% of people in Massachusetts. How did they do that? This is a state-run program, right? So, it is, perhaps, the model one can use.

Dr. Birnholz:
So, Dr. Shah, let me then close with one 30,000-foot-view question, and that's looking at this current context of soaring healthcare costs, access is limited, overextended providers, etc., etc. If an overhaul is the wrong move from your view, what's the most practical way for us out of this mess? It's obviously a very complicated issue. How do we make meaningful steps forward?

Dr. Shah:
Yeah, I mean, that's really a bigger question, and there's no simple answer. One answer could be, like I mentioned, what they do in Massachusetts, MassHealth. So, in other words, Medicaid is given to people who are less than 100% of federal poverty level, which comes out to be 12,490. In Massachusetts they are giving free insurance to people even who are close to 300% of federal poverty level, so that's the higher group, and that group is the one which suffers the most because they are making some money, not enough to buy insurance or pay for insurance or pay for Affordable Care Act, especially if it's more expensive. If it's cheaper, perhaps, yes, but if it's going to get more expensive, it is difficult, so we should learn from MassHealth. If MassHealth, Medicaid and some parts of Medicare are combined, one can create either a state program or federal program—I would think state program would be easier because there would be less politics and it would be easier received; we already have it in 1 state as opposed to a federal program, which I don't think is going to succeed because voting would be on party line, and it's going to be a problem whichever side brings it.

Dr. Birnholz:
Well, with those closing comments, I very much want to thank my guest, Dr. Asim Shah, for joining me to share his perspectives on single-payer healthcare and the route forward.

Dr. Shah, it was great having you on the program.

Dr. Shah:
Thank you very much. My pleasure.

Dr. Birnholz:
For access to this and other episodes on Voices from American Medicine, visit ReachMD.com/voices where you can Be Part of the Knowledge. I'm Dr. Matt Birnholz. Thanks for joining us.