

STFM for All

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On April 30, 2019, the US House of Representatives held its first-ever hearing on “Medicare for All,” the groundbreaking and controversial proposal to transform the US health system to a single-payer model.¹

What would this mean for family medicine, the health care system, and our patients? Whatever your politics, family medicine educators should understand the potential implications of what would be a fundamental change in US health care.

In the three domains of health policy—access, cost, and quality—US health care suffers from the triple shame: inadequate access, high cost, and poor outcomes. Being uninsured confers worse health outcomes and poor access to care; the US mortality rate is higher than other comparable Organisation for Economic Cooperation and Development (OECD) countries; we spend almost two times more than most countries on health care.²

Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death.

—Dr Martin Luther King, Jr

Of course, social determinants of health are a major driver for US health outcomes but we also suffer from a lack of unified mission in our health care system. There is not a singular goal of health; rather the health care system is a major economic engine; and generating revenue and profits are key drivers that do not exist in other western health systems.

The last decade has been one of incremental change in health policy. Significant health legislation (Affordable Care Act, Health Insurance

Portability and Accountability Act, and Medicare Access and CHIP Reauthorization Act) has contributed to policy shifts, including insurance expansion, electronic health records, and a move to value-based purchasing. But none have produced fundamental disruptive change in the health care marketplace. A single-payer proposal offers a game-changing alternative.

Medicare for all would fundamentally dismantle employer-sponsored insurance, negate the health insurance industry, and remove administrative inefficiency of contracting, negotiation, and claims management. It would also provide universal coverage along with a mechanism to establish national-, regional-, state-, or local-level goals for health outcomes.

But at what price? The financial costs are significant, although we already spend \$3.5 trillion per year in our current system. These costs would be borne by a single entity—the government—and would require a massive transfer of funds from employers who currently pay for health insurance, as well as a significant increase in taxation.

The government would negotiate prices, offering a rational construct for health care costs (and obviously a platform to control costs), likely reducing payments to hospitals, physicians, pharmaceuticals, and every entity in the health care economy.

And single payer doesn't fix our problems of geographic access, poverty in rural and urban America, inequities in income and education, or racial and ethnic disparities. The frustrations of accountable care, electronic health records, and physician burnout would likely persist.

But, every country with a single-payer system understands that primary care is the key to a national health system. Only primary care has the potential to provide care to all geographies and ages at an affordable cost and with proven improved health outcomes.^{3,4}

Will it be easy? Will it even happen? For years the answer has been simply “No.” Our nation’s market-based health system generates tremendous wealth and is a massive economic driver. Coupled with the American belief in the power of the free market, single-payer health care was seen as simply un-American.

But now, it is a conversation. And there is political power in the will of the American people—power that transcends health care lobbyists, the insurance industry, and even the medical profession. We will see.

Clearly we have been on the side of change in American life.

Family medicine has succeeded because we identified with reforms that are more pervasive and powerful than ourselves.

We need to perpetuate the reform ethos to expand our numbers, to join with other primary care physicians and specialists in working for a national health program that will give equal access to everybody, regardless of ability to pay.⁵

Family medicine has always been outside of the mainstream, even as we have spent decades working toward legitimacy and the establishment of academic medicine. Now is

another counterculture moment for family medicine. We have an opportunity to advocate for universal health care, create a primary care foundation, work in a health system focused on health, and address social injustice.

There has never been a better time to be a family physician. I’m proud to serve as your STFM President and I promise to honor our history and uphold our ideals while fighting for our future.

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