**////Title: Single-Payer Health Care: Financial Implications for a Physician**

**////Standfirst:**

When considering proposed reforms of the US health care system, some physicians dismiss a single-payer system that would provide health care for all residents, as they believe their incomes would be reduced. In a recent study, Daniel Bryant, M.D., finds that state-based single-payer schemes may actually lead to increased personal incomes for physicians. His work also provides a template for evaluating the financial consequences for physicians within a single-payer health care system.

**////Main text:**

Patients forced into personal bankruptcy, baffled by the choice of insurers and plans, blocked from seeing doctors out of network, and denied recommended care; workers locked into jobs for the health care benefit; businesses burdened with the cost of those benefits and the labor negotiations involved; physicians ‘burned out’ from billing-related chores and corporate demands; rural hospitals forced to close or reduce services; health care standing compared to other countries lowered… These and many other problems with the health care system in the United States have prompted policymakers to propose reforms.

One of these would replace the current system based on employment, age, income, and a combination of public and commercial payers with one that is publicly funded, privately and publicly provided, and covers everybody. At the national level, Medicare for All is an example of this so-called single-payer model, while over twenty states have developed similar plans at the local level.

Crucial to enactment and success of any reform will be the support of physicians who provide the care. In the case of the single-payer model, polls have shown that many physicians are in fact supportive. However, many other physicians, though they may admire the goals of universal coverage and simplification, are understandably concerned about the effect such a system might have on the financial stability of their practices and their personal income.

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To move beyond that reactive concern in the case of state-based plans, and to develop a template for evaluating the financial consequences for physicians of single-payer health care reform in general, Daniel Bryant, M.D., has done a quantitative analysis and reported his findings in his recent study, ‘Single-payer Health Care: Financial Implications for a Physician.’ Bryant is a former staff physician at Maine Medical Center and Mercy Hospitals in Portland, Maine, and was an Assistant Professor in the teaching program at Maine Medical Center.

He first developed a simple, plausible, if less-and-less commonly seen scenario: a hypothetical primary care physician’s practice supported by a staff of three: one full-time equivalent nurse, receptionist, and bookkeeper. Upon researching the literature, Bryant then determined average values for the mix of Medicare, Medicaid, and commercially insured patients, along with practice financial data in the present system. He found that an approximate gross practice income for this scenario is $500,000, and the pre-tax personal income is $250,000. Bryant also considered insurance-related expenses, including staff health insurance costs, personal health insurance costs, and bookkeeper expenses.

He then calculated what this physician’s reimbursement for their Medicare, Medicaid, and commercially insured patients at Medicare rates would be in a single-payer system, along with their reduced insurance-related expenses and their new income from the billable hours freed up by reduced insurance-related administration. He selected single-payer plans developed in Colorado, Massachusetts, Ohio, Pennsylvania, and Vermont for comparison, because they included adequate funding details, such as income and payroll taxes.

After tabulating and processing this information, Bryant then compared the physician’s calculated net income in the five single-payer plans to that in the current system. As a consequence of setting remuneration at Medicare rates, he found that gross practice income was lower in the single-payer plans than in the current system. This is the situation anticipated by those opposed to a single-payer system.

However, net personal income prior to health care taxes was higher due to the savings from reduced insurance-related costs. Also, in four of the single-payer schemes, initial net income turned out to be greater than that in the current system, despite the new health care taxes. In the case of Colorado, it fell just $780 short. In addition, if the physician spent the time freed up from insurance-related duties on seeing additional patients, the total net income would be higher in all five plans.

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Bryant does point out several limitations to his study. Firstly, the results depend to a large extent on the assumptions and estimates made.Secondly,the plans studied did not include specific plan costs to be funded, meaning that actual funding needs could not be verified.Thirdly,a number of potentially significant variables were ignored, including additional savings for the physician in a single-payer plan, such as reduced malpractice, workers’ compensation, homeowner’s, auto, and property insurance, and elimination of charity care and bad debt; other taxes, such as excise, inheritance and sales tax, mentioned as income sources in some of the plans; and other forms of physician income, such as investments, side businesses, and rents, that could be subject to health care taxes. Finally, the results of this study may not be generalizable to other practice models, such as partnerships, hospital employment or other settings, or for physicians with significantly different payer mixes.

In conclusion, Bryant observes that, more important than the specific numerical inputs and results found in this study is the process of incorporating all the factors involved, not just reimbursement rate, when evaluating the financial impact of single-payer plans. In fact, he recommends that this study be followed up with the development of a calculator, based on this or a similar process, into which physicians could enter their own financial data, including expenses, gross and net income, payer mix, plan taxes and premiums. Taken together with other ethical and practical considerations, this would give physicians a tool for evaluating single-payer plans, while also giving the health care reformers who design them a tool for anticipating physician acceptance of their plans.

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