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Considering "Single Payer" Proposals in the U.S.: Lessons from Abroad

Sherry Glied
Dean
Robert F. Wagner Graduate School of Public Service
New York University

Morgan Black
Project Coordinator
Mount Sinai Health System

Wiley Lauerman
Research Assistant
Robert F. Wagner Graduate School of Public Service
New York University

Sara Snowden
Project Coordinator
Mount Sinai Health System

ABSTRACT

ISSUE: When discussing universal health insurance coverage in the United States, policymakers often draw a contrast between the U.S. and high-income nations that have achieved universal coverage. Some will refer to these countries having "single payer" systems, often implying they are all alike. Yet such a label can be misleading, as considerable differences exist among universal health care systems.

GOAL: To compare universal coverage systems across three areas: distribution of responsibilities and resources between levels of government; breadth of benefits covered and extent of cost-sharing in public insurance; and role of private insurance.

METHODS: Data from the Organisation for Economic Co-operation and Development, the Commonwealth Fund, and other sources are used to compare 12 high-income countries.

KEY FINDINGS AND CONCLUSION: Countries differ in the extent to which financial and regulatory control over the system rests with the national government or is devolved to regional or local government. They also differ in scope of benefits and degree of cost-sharing required at the point of service. Finally, while virtually all systems incorporate private insurance, its importance varies considerably from country to country. A more nuanced understanding of the variations in other countries' systems could provide U.S. policymakers with more options for moving forward.

TOPLINES

- While many believe that all universal health care systems are highly centralized, most are not.
- Some universal health care systems cover broad benefits with no cost-sharing but most offer narrower benefits or incorporate cost-sharing.
- Private health insurance plays a major role in many countries with universal coverage.

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BACKGROUND

Despite the gains in health insurance coverage made under the Affordable Care Act, the United States remains the only high-income nation without universal health coverage. Coverage is universal, according to the World Health Organization, when "all people have access to needed health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship."[1]

Several recent legislative attempts have sought to establish a universal health care system in the U.S. At the federal level, the most prominent of these is Senator Bernie Sanders' (I–Vt.) Medicare for All proposal (S. 1804, 115th Congress, 2017), which would establish a federal single-payer health insurance program. Along similar lines, various proposals, such as the Medicare-X Choice Act from Senators Michael Bennet (D–Colo.) and Tim Kaine (D–Va.), have called for the expansion of existing public programs as a step toward a universal, public insurance program (S. 1970, 115th Congress, 2017).

At the state level, legislators in many states, including Michigan (House Bill 6285),[2] Minnesota (Minnesota Health Plan),[3] and New York (Bill A04738A)[4] have also advanced legislation to move toward a single-payer health care system. Medicare for All, which enjoys majority support in 42 states, is viewed by many as a litmus test for Democratic presidential hopefuls.[5] In recent polling, a majority of Americans supported a Medicare for All plan.[6]

Medicare for All and similar single-payer plans generally share many common features. They envision a system in which the federal government would raise and allocate most of the funding for health care; the scope of benefits would be quite broad; the role of private insurance would be limited and highly regulated; and cost-sharing would be minimal. Proponents of single-payer health reform often point to the lower costs and broader coverage enjoyed by those covered under universal health care systems around the world as evidence that such systems work.

Other countries' health insurance systems do share the same broad goals as those of single-payer advocates: to achieve universal coverage while improving the quality of care, improving health equity, and lowering overall health system costs. However, there is considerable variation among universal coverage systems around the world, and most differ in important respects from the systems envisioned by U.S. lawmakers who have introduced federal and state single-payer bills. American advocates for single-payer insurance may benefit from considering the wide range of designs other nations use to achieve universal coverage.

This issue brief uses data from the Organisation for Economic Co-operation and Development (OECD), the Commonwealth Fund, and other sources to compare key features of universal health care systems in 12 high-income countries: Australia, Canada, Denmark, England, France, Germany, the Netherlands, Norway, Singapore, Sweden, Switzerland, and Taiwan. We focus on three major areas of variation between these countries that are relevant to U.S. policymakers: the distribution of responsibilities and resources between various levels of government; the breadth of benefits covered and the degree of cost-sharing under public insurance; and the role of private health insurance. There are many other areas of variation among the health care systems of other high-income countries with universal coverage — such as in hospital ownership, new technology adoption, system financing, and global budgeting — that are beyond the scope of this discussion.

SYSTEM ORGANIZATION

A common misconception among U.S. policymakers and the public is that all universal health care systems are highly centralized, as is the case in a true single-payer model. However, across 12 high-income countries with universal health care systems, centralization is not a consistent feature. Both decision-making power and financing are divided in varying degrees among federal, regional/provincial, and local governments. U.S. single-payer bills give most legal authority for resource allocation decisions and responsibility for policy implementation to

the federal government, but this is not the international standard for countries with universal coverage. Rather, there are significant variations among countries in how policies are set and how services are funded, reflecting the underlying structure of their governments and social welfare systems.

Countries with universal health care typically organize their systems in one of three ways: as a largely federal system, as a system with centralized control but also regional flexibility, or as a system that devolves most control to the regional and local governments (Exhibit 1).

In largely federal systems, nearly all aspects are managed at the national level. And while this type of system is proposed under U.S. single-payer bills, it is actually more common in smaller but wealthy countries, such as the Netherlands, Singapore, and Taiwan, which have populations similar in size to individual U.S. states, and where almost all government policies are managed and financed at the national level. Among larger countries, France's health care system is one in which the national government plays the central role. The Netherlands makes use of private insurers as intermediaries between the national government and providers.

Exhibit 1. Health System Structure in 12 Countries

Structure	Country	National financing role	National policy-setting	Regional/ Local financing role	Regional/ Local policy-setting	Administration
Largely federal	France[a]	X	X			Public
	Netherlands[b]	X	X			Public funds and premiums flow to competing private, for-profit insurers
	Singapore[c]	X	X			Direct pay
	Taiwan[d]	X	X			Public funds flow directly to providers
Central policy with regional flexibility	Australia[e]	X	X	X	X	Regions (in public system)
	Denmark[f]	Block grants	X	X	X	Regions
	England[g]	X	X		X	Local clinical commissioning groups
	Norway[h]	X	X	X	X	Municipalities
Regional control under broad national constraints	Canada[i]	Block grants	Minimal	X	X	Provincial governments
	Germany[j]	X	X	X	X	Public funds flow to competing, not-for-profit insurers (sickness funds)
	Sweden[k]		X	X	X	Counties/municipalities
	Switzerland[l]	X	X		X	Public funds and premiums flow to competing, not-for-profit insurers

Data: a. Isabelle Durand-Zaleski, "The French Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 59–67. b. Joost Wammes et al., "The Dutch Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 113–19. c. Chang Liu and William Haseltine, "The Singaporean Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 139–45. d. Tsung-Mei Cheng, "The Taiwanese Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 163–71. e. Lucinda Glover, "The Australian Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 11–19. f. Karsten Vrangbaek, "The Danish Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 39–47. g. Ruth Thorlby and Sandeepa Arora, "The English Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 49–57. h. Anne Karin Lindahl, "The Norwegian Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 129–37. i. Sara Allin and David Rudoler, "The Canadian Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 21–30. j. Miriam Blümel and Reinhard Busse, "The German Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 69–76. k. Anna H. Glenngård, "The Swedish Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 147–54. l. Isabelle Sturny, "The Swiss Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 155–62.

Countries that use the second type of health care system maintain centralized control over most resource allocation and policymaking but allow for some freedom at the regional and local level in how funds are used. These countries include Australia, Denmark, England, and Norway.

The third type of health care system gives regional or local governments most of the authority to allocate resources and make policy decisions as long as they work within constraints established by broad national regulations. The systems in Canada, Germany, Sweden, and Switzerland all follow this general approach.

In fact, Canada — often the model for single-payer advocates — does not have a national health insurance system at all. Instead, the provincial governments administer the system, and provinces receive federal financing in the form of per-capita block grants. However, the regulations that accompany these block grants may appear quite limiting to U.S. policymakers, placing restrictive bounds on the behavior of the provinces. For example, provinces are prohibited from incorporating any cost-sharing in their plans and must cover a broad range of health care services for all legal residents, including those who move between provinces. These restrictions guarantee a nearly uniform level of coverage across the country and limit the potential for provinces to shrink benefits in a race to the bottom.

BENEFITS COVERED BY PUBLIC INSURANCE

One of the most significant differences among countries with universal health care systems is the scope of benefits funded by the government through public insurance. All countries with universal health systems provide a publicly funded, basic benefits package that covers physician, diagnostic, and hospital services, as well as inpatient pharmaceuticals. Yet coverage for mental health care and outpatient pharmaceuticals, as well as the extent of cost-sharing, vary considerably among countries (Exhibit 2).

The first group of countries offers highly comprehensive benefits and covers most services, which are largely free at the point of delivery. This model most closely aligns with many single-payer bills in the U.S. Countries with these broad benefits packages include Denmark, England, and Germany. Yet even these countries have some out-of-pocket requirements. For example, all three countries require modest copayments for outpatient prescription drugs (averaging approximately $12.50 per item, with maximum caps in both Denmark and Germany).[7] Additionally, there is often some cost-sharing for dental services. Germany also requires modest copayments for inpatient care, but cost-sharing payments are capped at 2 percent of income for most, 1 percent for those with chronic illnesses.

The second group of countries offers a moderate-to-comprehensive public benefits package with more pervasive cost-sharing. This is the most common benefits structure, used by Australia, France, the Netherlands, Norway, Singapore, Sweden, Switzerland, and Taiwan.

In contrast to both the first and second groups of countries, Canada's public system fully covers a narrower, basic set of benefits. Additional services are covered either publicly through provincial governments or through private insurance.

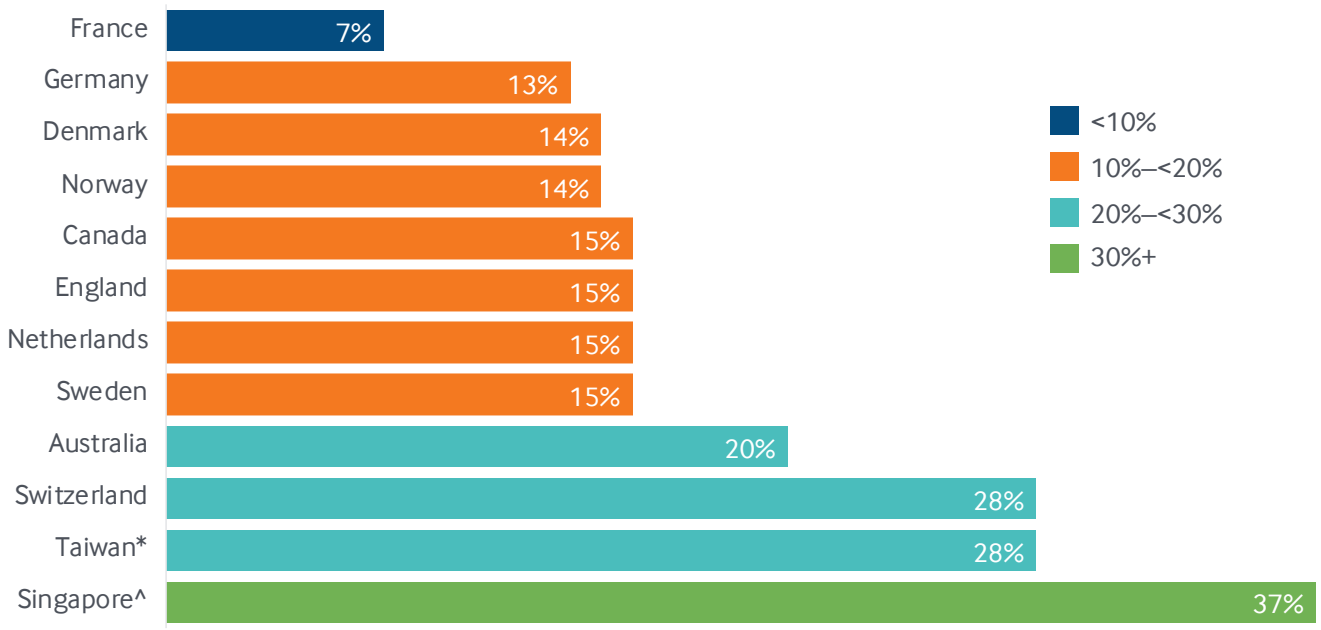
As Exhibit 3 shows, these differences in the scope of benefits and cost-sharing explain the variation in the share of national health expenditures paid out of pocket across countries. For example, while most services are free at the point of care in Canada, the lack of universal coverage for pharmaceuticals raises the share paid out of pocket by Canadians (15%). Additionally, high cost-sharing levels in Switzerland, Taiwan, and Singapore have led to significantly higher out-of-pocket spending (28%, 28%, and 37%, respectively) than other nations with similarly comprehensive public insurance coverage.

Exhibit 2. Scope of Coverage and Point-of-Service Payments in 12 Countries

	Country	Benefits	Cost-sharing
Comprehensive, free or low-cost at the point of service	**Denmark**[a]	Mental health, dental, outpatient drugs	Drugs only, capped at about $600
	England[b]	Mental health, outpatient drugs, rehab	Drugs only, about $12.50 per prescription
	Germany[c]	Mental health, dental, sickness pay	Hospital days and drugs, about $12.50 each
Broad public insurance with moderate cost-sharing	**Australia**[d]	Inpatient, outpatient, drugs	Specialist visits $60; drug costs vary by income ($5–$35)
	France[e]	Rehab, drugs, some dental	Cost-sharing mainly covered by universal supplemental coverage; some doctors balance bill
	Netherlands[f]	Drugs, pediatric dental	$465 deductible (excludes primary care); coinsurance for some services (varies by income)
	Norway[g]	Subsidized dental and drugs	Copayments for visits and drugs, capped at $240 or less
	Singapore[h]	Comprehensive	Deductibles
	Sweden[i]	Subsidized dental and drugs	Copayments for visits and drugs, capped at $120 or less
	Switzerland[j]	Some mental health, drugs	Copayments and deductibles
	Taiwan[k]	Comprehensive	Up to $1,200 per inpatient episode
Narrow national benefits package, no cost-sharing for publicly insured services	**Canada**[l]	Inpatient, outpatient, drug coverage varies by province	No cost-sharing for publicly-insured services; private coverage (i.e., for drugs) may include cost-sharing

Data: a. Karsten Vrangbaek, "The Danish Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 39–47. b. Ruth Thorlby and Sandeepa Arora, "The English Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 49–57. c. Miriam Blümel and Reinhard Busse, "The German Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 69–76. d. Lucinda Glover, "The Australian Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 11–19. e. Isabelle Durand-Zaleski, "The French Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 59–67. f. Joost Wammes et al., "The Dutch Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 113–19. g. Anne Karin Lindahl, "The Norwegian Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 129–37. h. Chang Liu and William Haseltine, "The Singaporean Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 139–45. i. Anna H. Glenngård, "The Swedish Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 147–54. j. Isabelle Sturny, "The Swiss Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 155–62. k. Tsung-Mei Cheng, "The Taiwanese Health Care System," in *International Profiles of Health Care Systems, 2016*, ed. Elias Mossialos et al. (Commonwealth Fund, 2017), 163–71. l. Sara Allin and David Rudoler, "The Canadian Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 21–30.

Exhibit 3. Out-of-Pocket Expenditures as a Percentage of Total National Health Expenditures in 12 Countries



Note: Per capita health expenditures in selected countries in 2016 (in U.S. dollars).
Data: Statista, 2016, except * OECD Health Statistics, 2016, and ^ World Bank, 2015.

THE ROLE OF PRIVATE HEALTH INSURANCE

Under a true single-payer system, one government-run insurance carrier would finance the entire health care system, rendering private health insurance unnecessary. However, nearly every universal health care system incorporates private health insurance. The role played by private insurance varies, depending on three aspects of public insurance coverage: comprehensiveness of covered benefits, cost-sharing, and access to providers and hospitals.

Even when they have public insurance coverage, people may choose to purchase complementary private health insurance to cover out-of-pocket expenses. Or they may choose to purchase supplementary health insurance to gain access to benefits excluded by the public insurance plan. Supplementary insurance also may facilitate faster, more convenient access to a wider range of providers and hospitals. Canada, England, Germany, the Netherlands, Norway, Singapore, Sweden, and Taiwan have supplementary private health insurance. France has complementary private health insurance. Australia and Denmark have both.

In Switzerland, mandatory, government-subsidized private insurance comprises the entire universal coverage scheme — it is the primary form of health insurance. In Australia, England, and Germany, some people purchase private health insurance that fully substitutes for the public insurance program (Exhibit 4). In Australia, the purchase of such substitute coverage is deliberately encouraged through tax incentives and penalties.

Although private health insurance plays a smaller role in most other health care systems than it does in the U.S., it is nowhere entirely absent (Exhibit 5). In Canada, two-thirds of the population holds private insurance, mainly through employers.[8] In France, employer-sponsored complementary health insurance is ubiquitous.[9] Even in Sweden, about 10 percent of adults have employer-sponsored private insurance to ensure quicker access to specialty and elective services.[10]

Exhibit 4. Structure of Substitute Primary Private Health Insurance

Countries	Features
Australia[a]	• Government incentivizes the purchase of private health insurance through a tax rebate. Failure to enroll in private health insurance by age 30 results in a 2% penalty added to the base premium in each subsequent year (56% of the population purchases such coverage). • People who earn above a certain threshold pay an income tax surcharge if they do not buy private insurance. • Private hospital coverage is supplementary, allowing access to any hospital or provider (47% hold this coverage).
England[b]	• 11% of the population purchases (usually employer-sponsored) private health insurance as a full or partial substitute to public insurance. • Private insurance enables faster and more convenient access to care and a free choice of specialists. • Most private plans do not cover mental health care, maternity care, emergency care, or general practice.
Germany[c]	• 11% of the population purchases private health insurance as a full substitute for public insurance. • Germany's 42 private health insurance companies offer plans that are nearly identical to the public plans but have risk-adjusted premiums and cover copayments for services such as dental care.

Data: a. Lucinda Glover, "The Australian Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 11–19. b. Ruth Thorlby and Sandeepa Arora, "The English Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 49–57. c. Miriam Blümel and Reinhard Busse, "The German Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 69–76.

Exhibit 5. Role of Private Health Insurance (PHI) and Private Health Expenditures in 12 Countries

	Role of PHI	Percent of population with PHI	Private health expenditures (% of total)*
Australia	C, S, P	56%, 47%†	32%
Canada	C	67%	30%
Denmark	C, S	37%, 25%‡	16%
England	S, P	11%	21%
France	C	95%	21%
Germany	C, P	23%, 11%^	15%
Netherlands	S	84%	19%
Norway	S	10%	15%,
Singapore	S	69%	60%
Sweden	S	10%	16%,
Switzerland	P	29%	36%
Taiwan	S	<1%	12%–35%

Data: *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017); Roosa Tikkanen, personal communication with authors, Dec. 20, 2018; and * Statista, 2016. Per capita health expenditures in selected countries in 2016 (in U.S. dollars).
Notes: C = complementary, P = PHI as primary form of insurance, S = supplementary. † 56% complementary, 47% supplementary. ‡ 37% complementary, 25% supplementary. ^ 23% complementary, 11% primary.

POLICY IMPLICATIONS

Currently, single-payer bills in the U.S. tend to share the same key goals: centralizing the financial and regulatory structure of the system, expanding the public benefits package, and eliminating private health insurance entirely. However, these three features are not the norm across countries that have achieved universal coverage for health care.

In contrast to single-payer proposals in the U.S., many universal health systems delegate significant financial and operational responsibilities to regional authorities, as long as they comply with federal regulations. In addition, the comprehensiveness of the universal public benefits package varies greatly by country. Finally, virtually every country with universal health coverage offers complementary, supplementary, or substitute private health insurance, which is purchased to ease the burden of cost-sharing, expand access to hospitals and providers, and cover benefits excluded under the public insurance scheme.

Given that other countries have achieved universal health coverage using a range of strategies, U.S. legislators can benefit from strategically adapting and adopting aspects of these systems to the specific needs of the country.

NOTES

1. World Health Organization, "Health Systems: Universal Health Coverage," WHO, n.d.

2. Michigan Legislature, "House Bill No. 6285" (State of Michigan, July 2018).

3. Minnesota State Senate, "S.F. No. 219" (State of Minnesota, Jan. 2017).

4. New York State Assembly, "Bill No. A04738A" State of New York, 2017).

5. David Weigel, "'Medicare for All' Has Broad Support — but Pollsters Worry That It Hasn't Been Tested," *Washington Post*, Mar. 19, 2018.

6. Henry J. Kaiser Family Foundation, *Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage* (KFF, Mar. 27, 2019).

7. Karsten Vrangbaek, "The Danish Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 39–47; and Miriam Blümel and Reinhard Busse, "The German Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 69–76.

8. Sara Allin and David Rudoler, "The Canadian Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 21–30.

9. Isabelle Durand-Zaleski, "The French Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 59–67.

10. Anna H. Glenngård, "The Swedish Health Care System," in *International Profiles of Health Care Systems,* ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 147–54.

ABOUT THE AUTHORS

Sherry Glied, Ph.D., is dean of the Robert F. Wagner Graduate School of Public Service at New York University. From 1989–2013, she was professor of Health Policy and Management at Columbia University's Mailman School of Public Health. Dr. Glied served as assistant secretary for Planning and Evaluation at the U.S. Department of Health and Human Services from July 2010 through August 2012. She is a member of the Institute of Medicine of the National Academy of Sciences and of the National Academy of Social Insurance and is a research associate of the National Bureau of Economic Research. Dr. Glied's principal areas of research are in health policy reform and mental health care policy. She is the author of *Chronic Condition* (Harvard University Press, 1998), coauthor (with Richard Frank) of *Better But Not Well: Mental Health Policy in the U.S. Since 1950* (Johns Hopkins University Press, 2006), and coeditor (with Peter C. Smith) of *The Oxford Handbook of Health Economics* (Oxford University Press, 2011).

Morgan Black is a project coordinator at the Mount Sinai Health System, who manages quality improvement initiatives for value-based care. Morgan is also a Master of Public Administration candidate at New York University's Robert F. Wagner Graduate School of Public Service.

Wiley Lauerman is an undergraduate research assistant at New York University's Robert F. Wagner Graduate School of Public Service. He is also a Bachelor of Arts candidate at New York University's College of Arts and Sciences majoring in Global Public Health/Sociology.

Sara Snowden is a program coordinator at the Mount Sinai Health System, who manages quality assurance and process improvement efforts. Ms. Snowden is also a Master of Public Administration candidate at New York University's Robert F. Wagner Graduate School of Public Service.

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For more information about this brief, please contact:
Sherry Glied, Ph.D.
Robert F. Wagner Graduate School of Public Service
New York University.
sherry.glied@nyu.edu

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