



Current Efforts to Reform Health Care Financing

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IN AN ARTICLE PUBLISHED ONLINE with the previous issue, we gave a broad overview of the reform efforts being tested in the health care market. This article explores the implications for the health care system if the single payer system is enacted in California.

Since the Nixon Administration in the mid 1970s, physicians have been unhappy with managed care. They have chafed at restraints imposed by utilization review and third party quantization of quality and outcomes. Few physicians have not expressed the hope that managed care would simply disappear.

Well, we are about to get our wish. Employers are relentlessly retreating from the uncontrollable cost of defined benefit coverage for health care. Those still committed to providing health care benefits are considering defined contribution plans, similar to 401K packages, in their retirement benefit. These defined contribution health plans have high deductibles and co-payment designs. That means significant increases in non-collectable payments as patients face unexpected health care service costs.

Today, employers see a misallocation of resources that bears little relationship with favorable outcomes under the current system.¹ Medicare data demonstrate marked variations by region in the use of hospital resources and ambulatory diagnostic testing for the care of chronically ill elderly patients. Studies demonstrate that lower utilization of acute care hospitals and less frequent physician visits actually lead to better results for patients.²

In a recent poll,³ an overwhelming 80 percent of respondents were dissatisfied with the amount the nation spends on health care, estimated to be \$2.2 trillion, or \$7,129 a person for those less than age 65, this year. The average yearly cost of the most common type of insurance plan for families offered by employers hit \$11,765 last year, with the average employee paying \$3,226 of that total. Average premiums have risen 87 percent since 2000, while workers' earnings have risen 20 percent. The American public is literally being priced out of the health care market.

Single Payer (Universal) Coverage

In the abstract, it is not difficult to make a case for converting our health care financing to a single payer system similar to Canada's. America spends more than twice as much per person on health care as do other industrialized countries. We are also the only such country not providing universal health insurance coverage.

From a return on investment point of view, despite the disproportionate spending, America's rate of infant mortality ranks highest among 10 Organization for Economic Cooperation and Development (OCED) industrialized nations. Our cancer mortality rate

ranks fourth behind Japan, Sweden and Australia. We rank seventh in cardiovascular mortality.

Without reform, health care spending in the United States will double over the next 10 years to more than \$4 trillion, or one in five dollars of gross domestic product, in 2015.

Serious efforts to reform health care have occurred so far in a vacuum. The assumption is that we can move from the current employer-based financing system to an alternative without inconveniencing the public and requiring all of us to re-think the type of health care services that we deem to be acceptable.

Despite increasing dissatisfaction with the current system, the public is deeply ambivalent about alternatives. When polled⁴ about their preference to convert to a universal/single payer system, 56 percent responded affirmatively. However, support for changes to the system dropped to about one-third or less when respondents were asked if they would support universal coverage if it included restrictions on the doctors or treatments they could have, or if it cost them more than they are now paying in taxes or premiums.⁵

The ambivalence is well grounded. Countries with single payer systems routinely rely on supply constraints to control health care spending, including limiting the number of hospital beds, controlling the spread of medical technology, and restricting the number of physicians while controlling their incomes.

What happens if California adopts a single payer system similar to Canada's? Sen. Sheila Kuehl's Health Insurance Reliability Act (SB 840), which was vetoed last year, is an example. We have had almost 50 years of experience to project how a similar system would affect our delivery system here in California.

Hospitals

Hospitals are not the cost fulcrum on which the Canadian system is leveraged. In Canada, hospitals are paid through annual, global budgets negotiated with the provincial and territorial ministries of health, or with a regional health authority or board. In short, they do not compete.

Since publicly funded health care began in Canada, health care services and the way they are delivered have changed from a reliance on hospitals and doctors. They have shifted to alternative care in clinics, primary health care centers, community health centers and home care treatment using medical equipment and drugs, and public health interventions.

This dramatically differs from America's hospital-centric and high tech diagnostic and treatment system design. While the number of hospital beds per capita in the U.S. was in the bottom quartile of OECD countries in 2002, the average U.S. expenditure per hospital day was \$1,850 in 1999, three times the OECD median.^{6,7}

OECD data show that U.S. hospital services are more expensive, staffing costs are significantly higher, patients are treated more intensively, and hospitals are less efficient.

Hospital admissions per capita were lower in Canada than in the United States in 2000. In addition, Canada's health system delivers far fewer highly sophisticated procedures than does the U.S. system. For example, the U.S. system has four times as many coronary angioplasties per capita and about twice the number of kidney dialyses.

Physician⁸

Physicians' incomes are much higher in the United States than they are in other OECD countries. This disparity, when translated throughout the entire health care industry labor cost structure, is the primary cost driver for the U.S. system. America's disproportionate labor cost is the prime factor in the discrepancy in total system cost with other OECD countries.⁹

In 1996, the most recent year for which data are available for multiple countries, the average U.S. physician income was \$199,000. The comparable OECD median physician income was \$70,324. The ratio of the average income of U.S. physicians to average employee compensation for the United States as a whole was about 5.5. Germany's was the next highest, at only 3.4; Canada, 3.2; Australia, 2.2; Switzerland, 2.1; France, 1.9; Sweden, 1.5; and the United Kingdom, 1.4.

In Canada, physicians in general practice total 76 percent of physicians in practice today. Conversely, only one third of the active physicians in the United States are in general practice, general internists, or general pediatricians.¹⁰ This disparity in physician training is getting worse, with a growing concentration of specialists and a declining percentage of primary care physicians entering practice in the U.S.

Diagnostic Technology Availability

The availability of diagnostic technology is significantly less in every country with a single payer system. For example, the US has 3.3 times the number of CAT scanners that are available in Canada. The availability of MRIs is 9.4 times greater.

This disparity of imaging technology availability will be exacerbated into the future should the current financing system remain in the United States.

Conclusion

No reasonable person should conclude that reforming the financing system for health care in California would not have a profound effect on the delivery system itself. Single payer systems in Canada and other OECD countries differ substantively from America's delivery system.

American hospitals now charge three times the rate per bed day compared with the median in OECD countries. Physician incomes are 50 percent to 75 percent lower in OECD countries than in America. The ratio of generalists to specialists will rapidly trend to parity or beyond should single payer come to California. Access to high-tech diagnostic technology will be significantly reduced and plans for growth in the development of this technology will be scrapped.

It should be noted that the less aggressive reform measures installed in Hawaii have also significantly changed the health care system in that state. The supply of hospital beds has been reduced from the current national average of 4.2 acute care hospital beds per 1,000 population to 2.1. Likewise, the access to high-tech diagnostic modalities has been significantly reduced. Hawaii has one MRI scanner per 1 million people, while the U.S. average is one per 100,000. Even Canada has one per 400,000.

Massachusetts has now initiated a system quite similar to the Hawaiian model. It will be informative to watch the effect this move will have upon the nationally recognized medical system and world-renowned teaching institutions within that state.

The difference between single payer systems and America's current system will require aggressive restructuring here in California.

Medical education will be completely revamped and reoriented to training generalists.

Hospitals will need to re-draft their business models. In an environment that devalues inpatient services, and in which pricing is dictated by the payer, there will be no advantage to developing large regional oligopolies like Sutter or Catholic Healthcare West.

There will be no incentive for hospitals to subsidize medical groups like the Sutter Medical Group or the U.C. Davis Medical Group. In fact, the entire multi-specialty group practice business model, which now depends upon revenue from in-house lab and diagnostic scanners, will no longer compute under single payer.

Resources will be redirected into community based low-tech public health and preventative care facilities and services.

The annual "juice bill" session of the Legislature dealing with scope of practice will end. Single payer will dictate broadened capabilities for health care para-professionals.

Pharmaceutical manufacturers will have to adjust to a single purchaser that will dictate product pricing. That payer will favor generics and multi-source discounted products.

Equipment manufacturers will likely abandon the market for the near future.

All of the third-party utilization management, quality assurance and outcomes scoring we have resisted in the current system will be retained and enhanced in single payer.

No one should naively assume that business in health care will go on as before. This reforming of the financing system will produce disruptive and dislocating changes.

Is this what we have been wishing for during the past 30-years?

Click here to view the 11 accompanying graphs associated with this article.

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1. Dartmouth Atlas of Health Care 2006; at www.dartmouthatlas.org/atlas/2006_Chronic_Care_Atlas.pdf
2. Center for the Evaluative Clinical Sciences (CECS) at Dartmouth Medical School.
3. USA TODAY, ABC News and the Kaiser Family Foundation; September '06
4. USA TODAY, ABC News and the Kaiser Family Foundation; September '06
5. Politicians have a track record of promising entitlements but not raising the taxes to pay for them. As Fritz Mondale and Phil Angelides demonstrated, you do not get elected if you forthrightly state that you are going to increase taxes to pay for services.
6. As a partial explanation for this high cost, the highly fragmented and complex U.S. payment system requires more administrative personnel in hospitals than needed in countries with simpler payment systems.
7. The United States also exceeded the OECD median in nurse staffing level in acute care hospitals. In 2002, there were 1.4 nurses per U.S. hospital bed, compared with the OECD median of 1.0 nurse per bed.
8. "The Supply of Physician Services in OECD Countries"; www.oecd.org/dataoecd/27/22/35987490.pdf
9. "Health Spending in the United States and the Rest of the Industrialized World" (Health Affairs, July/August 2005), Gerald F. Anderson, Peter S. Hussey, Bianca K. Frogner, and Hugh R. Waters of the Bloomberg School of Public Health at Johns Hopkins University.
10. "Managing Primary Care in the United States and in the United Kingdom," Kevin Grumbach, and John Fry; NEJM; Volume 328:940-945; April 1, 1993; Number 13.

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