Commentary

Managing Healthcare Organizations

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From the perspective of a medical student, the surrounding terrain of health care delivery seems strangely uneven. Managed care organizations only manage to care for the healthiest people and leave the sickest individuals out in the cold. The most technologically advanced nation spends the most money on health care per person, but lags far behind the rest of the world in terms of basic health measures. American pharmaceutical companies design new drugs based on research funded by taxpayers, yet the costs of these same drugs once they are developed are greater in the United States than in other countries. It is a strange new world indeed.

According to the Organization for Economic Cooperation and Development, the United States spends more money on health care than any other developed nation, utilizing 13.9% of the Gross Domestic Product, or $4095 per person in 1997. The second biggest spender on health care was Switzerland whose total expenditure was roughly half of what Americans spent at $2611 per capita. On average, the United States spends twice as much per person than any other nation. These costs have risen dramatically since 1960 when our expenditures were a mere 5.2% of the GDP, at $149 per person. Moreover, while we pay more for health care, we also provide coverage for a smaller fraction of our population. In stark contrast to virtually every other industrialized nation, the United States does not have universal health coverage, leaving nearly one-sixth of our population without access to basic preventive care. The uninsured are more likely to have hospital or emergency room visits and to have exacerbated illnesses that could have been ameliorated through access to a primary care doctor.

Two of the most crucial public health indicators are life expectancy and infant mortality. You might expect the United States to be at the forefront in these areas since basic health indicators should improve with the advancement of medical knowledge and technology. Yet, the data indicate otherwise. While all countries show improvement in absolute numbers for infant mortality and life expectancy, relative progress in the United States is not so impressive. In the case of infant mortality, we ranked 12th among 28 industrialized nations in 1960; 35 years later we ranked 23rd. During this same time period, the rank for life expectancy at birth in the United States dropped from 16th to 19th place for males and 13th to 17th place for females. In short, not only are America’s basic health statistics unimpressive, but there has been a downward trend relative to other nations over the past few decades.

Part of why these basic health care problems may not be apparent to the average American is due to the bimodal distribution of health access in this country. Individuals from a high socioeconomic background are more often adequately served by the current health system, receiving quality preventive care with appropriate subspecialty treatment. The basic health statistics for this subset of the population rival those of other industrialized nations. However, access to health care in communities where the population is of a lower socioeconomic status is particularly deplorable in the United States, and these groups exhibit birth mortality and life expectancy significantly worse than those for other groups in the country and the world at large. For example, in 1996, the infant mortality rate in Washington, DC was 21.7 per 1,000 live births as compared with Havana at 7.9 per 1,000. While disparities in health status have not entirely been eliminated in other nations, those countries with universal health systems have greatly reduced the differential access to health care faced by individuals with varying socioeconomic backgrounds.

So, the United States pays more for health services than other countries while managing to insure a smaller fraction of its population. What do we get for our money? One of the greatest facets of the American health care system is its responsiveness to crisis. Health care responsiveness is the one area that the United States tops the World Health Organization’s rankings. Among the many positive facets of our current system that should not be compromised is the respect, autonomy, confidentiality and access to social support networks that doctors can offer their patients. However, these successes are not sufficient until the benefits of our health system are extended to cover the entire population more equitably. The focus of this commentary is to discuss the historical context for current problems in health care, and debate the merits of some commonly discussed solutions.

Chief Complaints and Past Medical History of Health Insurance in America

Two major issues plaguing health care delivery are uninsured and underinsurance. Uninsured individuals are unlikely to be able to afford health care in the event of a major accident or illness. They are more likely to require expensive hospital or emergency room visits due to exacerbated illnesses that could have been ameliorated through access to a primary care doctor. They are also more likely to be diagnosed with late stage breast, colorectal or prostate cancers, which are often treatable if diagnosed at an early stage through preventive screening. The other major problem is underinsurance, in which necessary services are not covered by a patient’s plan or specific physician recommended procedures are denied by an administrator.
One often hears about situations in which a patient isn’t satisfied by the quality or scope of care provided by his or her managed care organization, a problem that stems in part from our country’s employer-based insurance system. In other words, the person receiving the goods (the employee) is not the person who pays for it directly (the employer and the federal government), so there is no incentive for the insurance company to provide better services. The employer wants to purchase the cheapest plan to offset company costs, while the insurance company wants to provide the fewest services by covering the healthiest people so they can turn a profit. The patient is not interested in cost because he or she doesn’t pay out of pocket for most services and seeks only the most comprehensive health care. Moreover, the interests of the insuring organization itself can taint the nature of the physician-patient relationship. Managed care organizations sometimes create a conflict of interest in which there is a financial incentive for the doctor to withhold medical care from the patient. Competition in the classical sense might lead to the production of the most efficient services at the lowest cost. However, it is not the case here.

What many people don’t realize is that the government already pays for the majority of health care costs. While employers may foot the bill for the premium in this insurance system, the federal government actually covers much of this price tag unless people were able to access the subsidy regardless of whether or not they owed any taxes. Another potential problem is that unless credits cover the full cost of the premium, insurance remains unaffordable for the indigent, taking a back burner to the immediate basic human needs of food and shelter. Individual policies cost an average of $2,542 annually and family coverage is approximately $6,740. Therefore credits of $1,000 for individuals and $2,000 for families, or 25% of an insurance premium, figures commonly discussed by the major political parties, are unlikely to improve the health insurance situation for most families living in poverty.

Another idea is the concept of medical savings accounts (MSAs), which are high-deductible insurance policies linked with a tax-deferred savings account, effectively an IRA earmarked for health costs. Individuals purchase a health plan with a deductible ranging from $1,500 to $2,250 for individual coverage and $3,000 to $4,500 for family coverage, and each year they can allocate a fraction of this deductible to the tax-deferred savings account. Policyholders can withdraw money for medical expenses but they are penalized when funds are removed for non-medical expenses if they’re under age 65. Four years ago, Congress authorized insurance companies to offer a maximum of 750,000 MSAs on a trial basis, designated for individuals who work for small companies or are self-employed. At the end of 1999, insurance companies had sold only about 45,000 of these accounts. This program might appeal to younger and wealthier people who can pay for additional care not covered by the deductible. In the long run, however, this program may be bad public policy, because it essentially provides a tax break for people more likely to be healthy.

The fatal flaw of both tax credit schemes and MSAs is that they would send people into an insurance marketplace where carriers still weed out those with health problems by allotting unaffordable premiums to individuals most likely to be sick. Therefore, these tax reduction and MSA plans function merely as bandaids to superficially address the fundamental problems underlying our health care delivery system.
The Case for Single Payer Insurance

One promising proposal to this intractable health insurance issue is the concept of single payer health insurance, a system advocated by the Physicians for a National Health Program (PNHP), which would address many of the basic inequities of our current system. The basic concept is that administrative savings from having a single government health insurance plan would save enough money to cover all of the uninsured and provide more complete care to the underinsured. Intriguingly, government analysis supports the premise that eliminating inefficiency could provide sufficient funding for an expanded, universal health care system. Yet, this proposal still has not come to light in the public eye.

The program advocated by PNHP would provide all medically necessary services, such as long-term, home care, mental health, prescription drugs, medical supplies and preventive care for all Americans based on need, rather than ability to pay. Hospital billing would be replaced with direct annual payments from the government covering basic operating expenses. A separate budget would be designated for hospital expansion, the purchase of equipment, marketing, etc. Individual physicians would choose from three reimbursement options: fee-for-service, salaried hospital positions and salaried positions within group practices or HMOs. Fee schedules would be established by negotiation between representatives of the fee-for-service practitioners, such as the state medical society, and a state payment board.11

Financing for the program would come from the federal government via a public insurer at the state or regional level, thus eliminating an individual’s premiums, co-payments, and deductibles. The money that would have previously been collected as premiums is instead absorbed as a payroll tax of 7 percent from employers and 2 percent from employees. Another element of the financing would be an additional $2 per pack tax on cigarettes. The net result is that 90 to 95 percent of people would pay less overall for health care. The additional funding necessary to cover the underserved and uninsured would be provided by savings due to the single payer model.10

According to the U.S. General Accounting Office, the elimination of private insurance bills and administrative waste will save 10% of health-care spending. This amount would be sufficient to cover basic health care for all of the uninsured and eliminate co-payments, deductibles and exclusions for the underinsured without an increase in our total spending. While it is true that other countries with a universal health system, such as Great Britain and Canada, are facing difficulties, one must remember that our system is better funded—the United States pays roughly double what these other countries do per person. Moreover, the Congressional Budget Office projects that single payer insurance would reduce overall health costs by $225 billion by 2004, even with the expansion of comprehensive care to all Americans factored in. Single payer insurance is the only serious health proposal that projects this kind of savings.10

A major counterpoint to the single payer scheme is that some individuals fear that a massive and expensive government bureaucracy would drain the health care system, allowing quality of services to suffer as a result. However, in actuality, our privatized system is much less efficient than analogous government programs. Private insurers absorb 8 percent of revenues for overhead, while government run programs such as Medicare or the Canadian National Health Program, have overhead costs in the range of 2 to 3 percent.11 This objection to single payer insurance seems absurd when you consider the resources drained on administrative costs (24.8% of the overall budget within hospitals clinical units)2 advertising and marketing budgets of hospitals and health insurance programs, exorbitant CEO salaries within HMOs and many other expenditures that are extraneous to the delivery of quality health care in our current system.

Another concern is that countries with universal health coverage such as Canada often have wait lists or queues, and Americans fear that they would have to wait for a long time to receive treatment for deadly illnesses. However, this perception is not entirely accurate. Individuals in Canada may wait longer for treatments that are not emergencies, because priority is given to the sickest in their country. This strategy is similar to the way emergency rooms are utilized in the United States. A person with a gunshot wound will be seen immediately while a patient with an ear infection may remain significantly longer in the waiting room. Moreover, even insured Americans often wait weeks or months to see their doctors. Many health maintenance organizations channel specialist appointments through primary care gatekeepers, which can delay nonemergent treatments for even longer.

Two significant obstacles hindering the progress of a single payer scheme in the United States include the immense private stake that several industries have in maintaining the status quo as well as the public perception that radical change might debiliate the current health system.

Perhaps the ideal national health insurance system could be explored without creating an abrupt change in national policy. If states are encouraged to develop their own coverage systems, the most successful of these could be utilized as a national model. This philosophy is embodied in The States’ Rights to Innovate in Health Care Act of 2000 (H.R. 4412), a piece of legislation currently under consideration that would offer grants of $3.75 million for up to 10 states to assist in the development of a state plan for comprehensive and cost-effective health care with simplified administration.13 As scientists and physicians, we should be in favor of this rational strategy to find a cure for an ailing health system.
Changing the Status quo

One possible reason why legislators are slow to recognize the problems with health care delivery is that all government employees are covered under the Federal Employee Health Benefit Program. It is noteworthy that this group is the only one that specifically petitioned Congress not to change their health program during the health reform debates of the Clinton administration. It would be appropriate to allow American citizens the right to the same health care access that federal employees are allowed. Federal workers are informed about several health plans that are available to them. The government allots a certain number of dollars for the employee’s health program and tells the person they can keep the difference if their choice costs less than the allowed amount and must pay the difference if the selected health plan is more expensive. In theory, a citizen should be able to choose among an HMO, an MSA or a fee-for-service plan. In practice, costs for this system may be very steep, depending how effectively the government can negotiate group insurance rates.

The major reason why changing the system is so difficult is that insurance companies, doctors, hospitals, and drug companies fear a different system might lower their incomes and profits, and these groups all have powerful political action committees and lobby groups on Capitol Hill. The single largest barrier is likely to be the insurance companies, who make significant political contributions to preserve the status quo. According to a report issued by the consumer organization, Public Citizen, the pharmaceutical companies have already spent $65 million on advertising to defeat the prescription drug legislation and Medicare reforms currently in Congress. Interestingly, they have spent these funds under the name of a front group, “Citizens for a Better Medicare”, that was only recently linked to the pharmaceutical industries through IRS reports.

A recent report from the World Health Organization ranked the United States 37th in overall health system performance, yet we maintain a steadfast belief in the health delivery system. A single payer program would allow the government to provide better care for more people at a lower cost, allowing doctors more autonomy to make medical decisions. Fifty-six percent of physicians support a national health program, and the majority of Americans support a universal comprehensive national health plan as indicated by opinion polls. It is likely that if more citizens were made aware of the current crisis in health care delivery, and the potential for improvement through a national health care system, then elected officials could be pressured to institute basic reforms.

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