CRITICAL CHOICES

(Reflections On The Cost of Medical Care) and a prescription for change

" Voters Sick of Current Health Care System, Want Federal Government to Prescribe Remedy" - Wall St. Journal, June 28, 1991. "Religious Leaders Focus on Health Care" - Holland Sentinel, Aug. 3, 1991. Richard Darman, Budget Director, says the White House should come up with a comprehensive health reform plan before the 1992 elections.- Wall St. Journal July 1991.

Pressure for a major change in our health care system is clearly on the rise. In a poll conducted for the Wall St. Journal NBC/WSJ Networks by pollsters Peter Hart, a Democrat and by Robert Teeter, a Republican, 69% of the voters support a plan guaranteeing everyone the best health care available, even if it takes a tax increase to pay for it. They say they would support adoption of a universal, government paid health care system such as Canada's. Louis Harris and Associates conducted a poll for the Baxter Foundation and to the statement "On the whole the health care system works well and only minor changes are necessary to make it better," only 10% of 1250 Americans responded affirmatively, whereas to the same question 56% of Canadians and 27% of Brits were affirmative.

Universal Health Care has been on the American political agenda ever since World War I. At that time the American Medical Association proposed universal health care, managed by the federal government. The labor unions killed that plan. Now how the tables have turned! Never before however, has a National Health Care System been given as solid bipartisan support as it enjoys now. In the 50's and 60's Great Britain and the Scandinavian countries were adopted as models. Now Canada is promoted; Germany is mentioned.

Great Britain and Scandinavian countries support a system run by the federal government in which doctors are salaried on the basis of the number of patients in their care, or panel. Hospitals are nationalized and on strict budgets. Doctors in effect triage proceedures based on their merit and the number still available in the budget. For example a close friend of mine who trained in Great Britain in chest surgery says they were allowed 2 cat scans a wk. They had to sit down as a group and decide which 2 patients, of all of theirs recommended to have a cat scan were the most deserving.

In Canada's health plan a budget is made for each province and the national government supplies about 1/3rd of that amount. The provinces raise the remaining ~~two thirds~~ one half and negotiate a budget for doctor expenses with the provincal medical association. The medical association negotiates fees with it's doctor members. Hospital budgets are set by negotiation with the provincial gov't. Any deficits are taken out of fees, until the next negotiating session. Doctors who care for patients in the system cannot take private patients. In Great Britain they may.

Germany's program is similar to that of Austria and France; possibly the Netherlands. Employers and Employees must contribute a percentage (now each 13% in Germany) of their pay to a non-profit sickness insurance fund. This fund negotiates fees with the doctors associations, while negotiating a straight per diem rate with hospitals regardless of diagnosis. Each trade has it's own sickness fund. Everyone has free physician and hospital care and free choice of physician. Those who earn above $37000 annually may opt out but have to buy private insurance.

When discussing medical costs inevitably doctors greed is mentioned as a major factor. One writer says he would rather deal

with a businessman who drove a Lincoln and called himself a businessman than deal with a businessman who drove a Cadillac, and called himself a saint. Average fees in the USA for Anesthesiologists, radiologists, and surgical specialists, are three times as high as in Canada, both in American dollars. Family practitioners and Pediatricians fees are about 1/3rd higher. Actual income of American doctors is only 33% higher because of a much larger overhead, and lower volume. The largest overhead factor is handling insurance forms. There are a host of non-standardized forms each payor having their own requirements. Medicaid, Medicare and the Blue Cross plans in particular demand a form be made out in codes for diagnosis, location of doctor and location of disease, doctors specialty, proceedure done, and some of these are divided into sub-codes. Codes change regularly. Some doctors subscribe to a billing service which accepts computer information directly and in turn rebills the insurance company or gov't by tape. This is more convenient but still cumbersome and requires computer and soft ware.

In Canada billing is to one agency. Forms are minimal and all patients charges can be sent in once a month on the same form. This simplification of billing, along with malpractice fees about 1/10th of American doctors premiums, plus the lack of the necessity to keep extensive records because of the threat of malpractice, accounts for most of the overhead difference.

Are doctors fees in USA out of line and doctors incomes as well. You be the judge ! I managed to persuade an agency of accountants who manage the accounts of significant numbers of doctors in western Michigan, to supply me with average annual incomes for specialties for the year 1990. Topping the list were Cardiologists who did no surgery except Angioplasty. They earned a greedy average of $544,000 in 1990. There was quite a drop to

to orthopedists at 285,000 annually. Next were anesthesiologists at 216,000, opthalmologists 215,700, Obstetricians 193,000, and general surgeons at 145,000. Non-M.D. podiatrists at 141,000, led Neurologists at 140,000 and Internists at 110,000. Family practitioners and Pediatricians were neck and neck at around 95,000 each. In other countries there is nowhere near the disparity of income amongst doctors in different specialties. The Canadians especially claim this makes for a far better distribution and allows doctors to choose their field on the basis other than the financial factor. Our U.S. Congress appointed a commission to study this problem and they passed the problem to a group of experts headed by the Harvard School of Public Health. Their conclusions were responsible for the new fee schedule to be put into effect for Medicare January 1992. They essentially agreed with the Canadians. Resource Based Relative Value System RBRVS

In the U.S.A. 87 % of our doctors are specialists and 13% family practitioners. In Canada the ratio is reversed. Many of our specialists do some general practice and generate their specialty work from their own practice. This tends to create a greater willingness to do proceedures for which they are trained. In Canada and Great Britain specialists practice only their field, and all their patients are referred. This according to Canadians and Brits tends to make their specialists better than ours. They do admit that our general doctors probably do a better job than theirs. Theirs have no hospital privileges. Ours have better training and have to see fewer patients to make a living wage. Although several of my Canadian doctor friends complain about the loss of their autonomy under their system, they also claim that practicing in a system without a financial obligation of the patient toward you as their doctor, is more fun. A profession should be chosen for service first

and an income secondarily they say they have learned unintentionally. American colleagues argue that cutting doctors fees will not cut medical expenditures significantly because doctors fees constitute only 18% of medical costs. Cutting fees 20% only reduces medical expenditures 3 %.

American doctors fees have risen about 10% because of malpractice premiums. The major effect malpractice has had on medical costs is not the premiums but the severe and often ridiculous caution it has introduced. An overabundance of laboratory tests and monitoring devices are used to protect oneself, and the cost of excessive record keeping is seriously underestimated. Foreign doctors, Canadians in particular, say they would have to cut back their practices 20% if they were required to comply with our standards. Cat Scans for chronic headaches, x-rays for the record, and building extra operating rooms directly next to delivery rooms are examples of how malpractice threats raise costs. A universal adage of American doctors is " whatever you do, cover your behind".. Malpractice in Canada is arbitrated outside the Tort system.

While it can be argued that the most productive economy can best afford to spend more of it's output on health care, the question arises concerning payback. We spend about $600. more per capita than Canada, and 1000 dollars more per capita than Japan, Germany, or Great Britain. Payback evaluation is more subjective than objective, and the only two measures commonly used are life expectancy and infant mortality. Here our rates compare unfavorably despite our increased spending. Caution is necessary in interpreting these statistics since they say much more about social conditions in our country than they do about medical care. Per capita homicides, veneral disease and aids, teen age pregnancies and unwed mothers (68 to 70% of all blck births), crack

addicted babies, are all much worse in our country, than in other inductrialized nations. Our social problems have become medical problems. Poverty is said to be the single most important cause of our high infant mortality, 10/1000 compared to Canada's 7/1000; and of our life expectancy 78/yrs. compared to 80 for Canadians. Increased automobile deaths/capita alone account for the majority of the difference in life expectancy. In Livonia, Mich., a middle class suburb of Detroit the infant mortality rate is 4.9 per 1000. In Central Detroit it is 42/1000. It is generally agreed that Universal access to medical care is impeded primarily by the cost factor. The premise that universal access would alleviate much of the effect of poverty on health is also seldom contested. However, trying to prove this by statistics is sometimes very confusing . For example, infant mortality for blacks nationwide is 18/1000, for whites only 8.6, but for Hispanics only 7.9. Furthermore 11.1% of black mothers receive no prenatal care, only 5.1% of white mothers and 12.7 % of Hispanic mothers receive no prenatal care. Immunizations are free in our country at the public health depts. In Canada immunizations are not a covered benefit because they too give them in their public health dept. clinics. Though they are free in the USA, Hispanics on medicaid (welfare) utilize the privilege far more than black parents. These facts are sometimes used to claim that behaviour is as much if not more of a factor than access.

Nevertheless, availability of health care is primarily an American defect, and not a problem in other industrialized nations. It is not only a problem of the poor, but of the middle class as well. To quote Dr. Kevin Grumbach (New Eng JR Med.) "The American health delivery system is a lot like a hospital gown. At first glance it appears to give adequate coverage, but when looked at

from another angle, embarrassing segments of population remain exposed. There are about 35 37 million persons uninsured and a great many more under insured. 90% of the 25 million uninsured adults are employed. Medical costs are escalating much faster than the cost of inflation, in fact they are exploding around 19% a year. Employers are finding it necessary to cut benefits which leaves a balance to pay on medical bills. This often makes it mandatory that both mother and father work full time and neglect the family in the process. Medical care for the un and under insured and those paying a large balance on bills , is deferred or avoided. Things like pre-natal visits, or mammograms are not an emergency and don't get done. Each premature birth we prevent saves an average of $22,000. The American Academy of Pediatrics declares we need national universal access to pre-natal and infant health care to reduce our infant mortality and protect our nations future. The AMA says infant mortality, being a social problem with health consequences, will not be solved by making health care free, unless we adopt all the programs of other socialist nations; which include transportation, nutrition, home care and visitation, substantial subsidized housing , day care for employed mothers intensive education, and other services, such as paying mothers to come in and be checked pre-natally. These services are cited as a primary cause of the much poorer economic conditions in socialist countries. Some of these services are available now in our contry but overlapping programs, numerous agencies and determining elgibility, involves discouraging red tape and inadequate help. A single universal program avoids this. drains their economy!

We all admire the free enterprise system, and it is our answer to cost control. Yet competitiveness in medical care increases costs rather than decreasing them. Controls such as choice of whether or not one buys a product, or knowledge about what

he or she is buying, exist in daily purchases. These same axioms do not apply in medicine, and so there are no controls. Hospitals struggling to stay alive for convenience or local pride, compete with hospitals close by. Holland and Zeeland, Grand Haven and Muskegon Hospitals for example. In Kalamazoo rates are 40% higher than in Grand Rapids since each of two hospitals has an ICU, a Neonatal Intensive Care Unit, a Cat Scanner, Heart Surgery Units, Laser Units, and each has a helicopter. In North Dakota there are six open heart surgery units for 640,000 people. It is estimated that of the 7000 hospitals in the USA, at least 1000 could close without any effect on medical care in the area.

A root cause of expense in medical care is advancing technology. Paradoxically, much of this technology originated in countries having socialistic medical systems. Cat Scans came from a company the Beetles owned in England. Artificial joints were also introduced and used there. Magnetic Resonance Imaging, Lithotripsy or (stone crushing), the use of light energy and lasers, and many laboratory analyses we use began in Germany. Many new drugs have come out of Switzerland, England, or Germany. Much technology such as the use of sound energy(ultra sound-echocardiography), and fiber optics (bronchoscopes, gastroscopes, arthroscopes, urethroscopes) were a result of discoveries far removed from medicine, often related to war. However, sophistication and application of these technologies to medicine more often developed from American Companies chasing an open American medical market. If they had a budgeted central government market only to pursue, they might not have been applied to medicine as thoroughly and life expectancy the world over would be less; private medicine claims.

Biogenetics ballooned by speculative stock market.

Foreign friends are grateful for our expansion of technology but they say we abuse it - and we do. Sometimes necessity of a test is determined by whether or not one has insurance. Physician approaches to common ailments vary widely and bring different costs. In a study involving Butterworth Hospital, The Cleveland Clinic, and Emory University Medical Center in Georgia, significant reductions in lab work and use of other hospital resources occured when physicians were shown their practice patterns. There was a 40% reduction associated with hip replacement surgery and with by-pass

coronary artery surgery a 98% reduction. Standards set by the legal system induce doctors to overuse technology to fortify their decisions. An agency has to sit down and formulate medical practice guidelines based on some consensus of cost/benefit ratio and abandon the American adage that everyone is entitled to the best care available even if it cost a million dollars. The free enterprise system does not apply to medicine, but neither does the Tort System.

Is it too much medicine in America or too little elsewhere? There is a fine line between quality and convenience ! Boston a city of comparable size and location to Toronto has six radiation treatment centers, while Toronto has one. After a diagnosis of say Prostate cancer, treatment in Boston begins in about 4 days. In Toronto it takes 4 months. Our success rate in treating Prostate cancer is much better. Is this treatment difference related to the delay? Last year 12 patients in Toronto died on the waiting list for by-pass surgery. By-pass surgery allegedly does not extend life, only improves quality. Does being able to play golf, attend a football game, or walk up a hill without stopping due to Angina, warrant the expense of by-pass surgery? The waiting time for a corneal transplant in Canada is 4 years. This is not a life saving proceedure ! Is a 4 year waiting period worth the savings of having it done in Canada? Cataract surgery is the proceedure causing the greatest total cost annually to Medicare! Is it necessary on an 80 to 90 year old who gets along, but who can read a lot more easily and enjoy television much more if the cataracts are removed? These cost-benefit decisions are not medical decisions! We save more premature infants and young defective children from 1 mo. to 1 yr. of age than any other country. Sweden elects to withold treatment from these children; (that is intensive care).

Kidney disease after the age of 55 is not a [illegible] in Great Britain.

Who lives?

We do kidney dialyses on diabetic patients whose vascular condition is so poor they couldn't live more than a few years even with a transplant. Should we? Life expectancy in our country after 50 and especially after 80 is the best in the world. We believe in life to the extent that the average American spends 70% of the total cost of his life's medical care in the last one month of his or her life. Would rationing be the solution? Every country with national medicine rations care. Some limit the number of each proceedure or laboratory test. Others such as Canada limit the budget and the hospitals and doctors get only so much money each quarter. If they break the budget they work for nothing. Naturally, this leads to the doctors setting their own limits. Non-critical therapies or proceedures develop long waiting lists, such things as hernia repair, joint repair or replacement, disc repair, ear tubes, allergy work ups or annual check ups. Things like annual physicals are often relegated to nurse practitioners who do a good job and reduce waiting times. Some of these therapies are never accomplished and thereby save the system considerable money. Many of the citizens of other countries are accustomed to that kind of service in other areas. Try getting a telephone in Great Britain, or mail a letter to or from Canada. The facilities and amenities in Canada and Great Britain are stark compared to ours. Those who can afford it (65%) (in Canada) have supplementary insurance to cover semi-private rooms and other amenities. Many executives are given private insurance as a perk.

In order to provide universal health coverage someone has to finance it. In Canada, Great Britain and Scandinavian countries they face the issue directly by taxation. The Ford foundation proposes taxing social security as regular income to raise the funds. Though our people would seem to favor taxation over other means, our congressmen feel a tax hike is political death. Since Canada has a more extensive social welfare program than we do, the actual

Taxing health care benefits as income to employees & teachers has been proposed.

amount of taxes used only for health care is a bit difficult to ferret out. They claim that about 19% of their tax dollars are used to support their health care system. Assuming this does not include property taxes, and that a person does not drink or smoke, in Ontario the amount of income a person earning $27,000. a yr.(Amer. Equivalent) would pay toward health care is about $2800. This assumes he spends about $18000 of the $27,000 and is paying a 15% sales tax, and the income tax on that salary is $7800. If he drives a lot of miles the gasoline at $2.50 a gallon could easily add $50.(10,000 miles at 25 mi./gal.) The $2800.00 includes the health care premium of $70 taken from his salary every mo. It does not include the 19% taken from corporate profits tax, which is similar to ours. Since Canada's graduated income tax rises to 55%, those making more than 27000 would be paying a little more. With cigarettes at $7.00 a pack, and liquor between 40 and 50 dollars a bottle(750cc) , and wine $24 for a bottle which costs us $6.00, sin is expensive. Sinners also cost more health care dollars they feel. They admit the sales and use tax (15%) on even funerals is too muc

The average American employee is according to the U. S. Chamber of Commerce costing his employer $3500. a yr. in health cost benefits. This has been rising in the last few years by 20-30% annually. In addition in this country ab out 35 million people are not covered, whereas in Canada everyone is. Canadians scream about their high taxes, but ask them about their health care system and they will tell you that Canada does only two things better than the USA; provide medical care and play hockey.

There are over 30 Bills in the Congressional hopper at present prescribing a new system of health care. Realizing that Canadians have a plan which costs about 5 to 600 dollars less an employed person, and supplies medical care to everyone, and they are happy, many of those 30 proposals are a-la-Canada like plans. Others seek only to modify our present system of private insurance. Most of the 30 these Bills recognize that Americans have higher service expectations than Canadians and trust their government less. Therefore they are employer oriented and mandate employer purchased health insurance, with only a small number of approved companies supplying policies. They prescribe one national standardized billing and payout program. Doctors fees and hospital fees are set, that is hospitals would be on DRGs for all patients and doctors fees would follow the pattern to be instituted for Medicare in January 1992. Fees would be adjusted annually for inflation and malpractice rises in costs , but an automatic cost of living increase is not a part of most plans. Medicaid would be abandoned. Companies which

choose not to comply are to be charged a penalty which will cover the cost of supplying insurance for those employees. The unemployed will be covered by the government at the same rates as MEDICARE. Additional private insurance may be purchased for luxuries.

These employer mandated bills preserve freedom of choice, keep the government out of budgeted and rationed health care and out of the financing. They maintain doctors incomes about where they are except for some redistribution, recognizing the necessity of inflation and rising costs as well. These are good "Bills" and should be implemented and assisted not fought!

FIRST and foremost let's get Malpractice out of the Tort System. It will be impossible to get doctors to help control costs without doing so, since they will continue to cover their behind.

SECONDLY let's tie fees to the cost of living in order to prevent constant bickering over fees. There will be negotiating about fees in addition but not the bitter strife and strikes seen elsewhere.

THIRD , I believe it would be advantageous to have employees whose wage is above a certain level contribute as well. Experience teaches me that when a person has no financial part in a plan he or she readily abuses it and demands the best despite the cost.

Want million $ care despite cost/benefit ratio if don't pay anything Towards it.

In practice the state medical societies, in cooperation with industry could form their own non-profit insurance companies, with labor represented as well. A similar system has been operating well in Germany for 75 years.

During the coming 92 campaigning you will hear a lot about health care reform. Republicans generally favor going slowly and expanding present programs such as WIC, Mammography screening, immunization clinics, public health clinics, and sponsoring educational blitzes. The Democrats have already labeled this "THE DO NOTHING NOW" program and they favor immediate comprehensive reform. There are however, a number of REPUBLICANS in the Democratic camp.

WATCH THE NEWS!

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