

Healthcare Reform is Here to Stay

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Abstract

Shih, et al. (2008) describes United States (U.S.) healthcare “as a cottage industry” favoring “high-cost, intensive medical intervention ... over higher-value primary care, including preventive medicine and the management of chronic disease” (p. ix). It appears little has changed since 2000 when the World Health Organization (WHO) rated U.S. healthcare 37th out of 191 countries (Dutton, 2002). The rating placed heavy emphasis on cost and access to care, overlooking higher echelon treatments discussed by Shih, et al. (2008). The tide has finally shifted and change is coming. This paper will discuss the present state of U.S. healthcare, suggest changes that support universal coverage, and outline methods of funding. Comparisons to other countries such as France, Canada, and the United Kingdom are used to help mold a new plan, which places heavy emphasis on the primary care gatekeeper, practice guidelines, generic medications, cost sharing, and electronic media. If the plan is managed correctly it should improve the quality of U.S. healthcare and reduce costs.

Healthcare Reform is Here to Stay

If the United States (U.S.) were rated for ingenuity or advanced technology it would be close to or hold the number one position. This feature of U.S. healthcare is widely accepted but seldom discussed. For example, Tanner (2008) writes, “One out of every three Canadian physicians sends a patient to the United States for treatment each year, and those patients along with the Canadian government spend more than \$1 billion annually on health care in [the United States]” (p. 5). In addition, the Cleveland Clinic treats over 5,000 foreigners a year, the Mayo Clinic treats approximately 7,200, and the John Hopkins Medical Center sees more than 6,000 (Tanner, 2008). These numbers support world recognition of high-end U.S. medical care.

In 2000, however, the World Health Organization (WHO) rated the U.S. health care system 37th out of 191 countries (Dutton, 2002). In the same report Canada, United Kingdom, and France were ranked 30th, 18th, and 1st respectively. Even countries like Singapore (6th), Oman (8th), Columbia (22nd), Saudi Arabia (26th), United Arab Emirates (27th), Morocco (29th), Chile (33rd), and Costa Rica (36th) scored higher than the U.S. (World Health Organization, 2010a). Cuba was rated 39th.

According to Tanner (2008), WHO used five criteria to determine its ratings. These included a countries health level (disability adjusted life expectancy), equality of health care distribution, responsiveness level (access to service, choice of doctors, etc.), equality of responsiveness distribution, and financial fairness (household contribution as a percentage of income and health care dollars spent per capita). Of the five criteria, only health level and responsiveness level measured quality of care. The U.S. scored 24th and 1st in these areas. The other three measurements focused on equality and cost. The United States scored 1st in costs. It

appears the U.S. system is very responsive to its patient but fails to provide equitable care or control costs.

The WHO report set the stage for change and U.S. citizens appear ready. This paper will discuss the present state of the U.S. health care system, suggest changes that support universal health care, and outline methods of funding.

U.S. Healthcare: A Brief Summary

This paper summarizes United States healthcare via five subheadings, which include costs, coverage, demographics, access, and provider pay. To put things into global perspective, each subheading will provide a table comparing the United States to Canada, France, and the United Kingdom.

U.S. Healthcare: Economics

The United States health care system is based on an entrepreneurial model and financed through private insurance (60%), government programs (13% Medicare, 10% Medicaid, and 1% military), and self pay (Anderson & Squires, 2010). 16% of the population is uninsured (The Commonwealth Fund, 2010). Up to 92% of private insurance programs are purchased through the employer.

The United States spends \$6,714 per capita or 15.3% of its GDP on health care (Anderson & Squires, 2010). Pharmaceutical costs account for 17.7% of total health care spending (Peterson & Burton, 2007). Cost sharing insurance arrangements and uninsured cash payments account for 12% (\$890 per capita) of U.S. health care expenditures (The Commonwealth Fund, 2010). Table 1 provides a four country economic comparison (The Commonwealth Fund, 2010).

Healthcare Coverage

According to The Commonwealth Fund (2010) 84% of the U.S. population has healthcare insurance. The type of coverage, however, varies from plan to plan but most programs cover preventive care, provider visits, inpatient hospital care, and medications. Unfortunately, some plans have such high deductibles that clients routinely delay necessary treatment (The Commonwealth Fund, 2010). Some plans cover physical, occupational, and speech therapy. Optometry and dental care is rarely covered. Table 2 provides a four-country healthcare coverage comparison (The Commonwealth Fund, 2010).

Healthcare Demographics

The average U.S. life expectancy is 78 years and the most common causes of death are cardiovascular disease, cancer, and stroke (World Health Organization, 2010b). Infant mortality rate per 1,000 live births is 4. The mortality rate (per 1,000 citizens) during the first year of life is 6, by age five it is 8, and between 15 and 60 it is 107 (World Health Organization, 2010b). The World Health Organization (2010b) reports U.S. deaths caused by communicable illness at 36, non-communicable illness at 450, and from injuries at 50 (per 100,000 citizens). Every year approximately 110 deaths per 100,000 patients occur as a direct result of medical care (Anderson & Squires, 2010).

The World Health Organization (2010b) estimates that 92% to 96% of one-year-old U.S. children are immunized. The same report suggests that 33% of U.S. adults and 8% of U.S. children are obese and that roughly 23% of the adult population smokes. On average, adults 15 years old and older consume approximately 8.5 liters of alcohol per year (World Health Organization, 2010b). Table 3 provides a four-country healthcare demographic comparison (Fried & Gaydos, 2002; The Commonwealth Fund, 2010; World Health Organization, 2010b).

Access to Care

For every 1,000 U.S. citizens there are 2.7 physicians and 3.1 acute care hospital beds (World Health Organization, 2010b). The average physician visit per capita per year is 4 and the average length of hospital stay for acute care is 5.6 days (Anderson & Squires, 2010). A Schoen, et al. (2009) survey of primary care providers found that only 29% of U.S. physicians make arrangements for after hour patient care. Table 4 provides a four-country access to care comparison (The Commonwealth Fund, 2010; World Health Organization, 2010b).

According to Blendon, et al. (2001) “waiting times for [specialists and surgical] care emerged as a key concern among physicians in all countries but the United States” (p. 237). For example, Blendon, et al. (2001) reports that over half of patients needing a hip replacement can have it done within one week. In Canada and the United Kingdom the wait could be over six months. In addition, the U.S. performs 4.3 cardiac catheterizations per 1,000 citizens compared to 2 in Canada and 0.06 in the United Kingdom (Anderson & Squires, 2010). The United States manages two to three times the number of patients receiving dialysis and performs up to two times as many knee replacements when compared to Canada, UK, and France (Anderson & Squires, 2010). Table 5 provides a four-country access to higher echelon care comparison (Anderson & Squires, 2010; Blendon, et al., 2001).

Provider Pay

Most providers are paid through a fee-for-service regiment, salary, or capitation plan and on average a general practitioner in the United States makes \$161,000 per year (Peterson & Burton, 2007). The American Medical Association (2009) reports top salaries of \$202,547 for pediatricians, \$204,370 for family practice, and \$209,845 for internal medicine providers. Specialists make considerably more with upper incomes of \$426,000 for urologists, \$492,762 for

gastroenterologists, \$512,500 for orthopedic surgeons, and \$600,000 for radiologists. The pay gap between primary care and specialty care has created a residency shift away from general practice. In turn, this has created a primary care provider shortage and led to quick specialist referral and fractionated care.

With the exception of providers working in managed care, there are no formal gatekeeper duties for the U.S. general practitioner (The Commonwealth Fund, 2010). Table 6 provides a four-country comparison of primary care pay (Peterson & Burton, 2007; The Commonwealth Fund, 2010).

Perceived Problems in U.S. Health Care

Shih, et al. (2008) describes U.S. healthcare “as a cottage industry” favoring “high-cost, intensive medical intervention ... over higher-value primary care, including preventive medicine and the management of chronic disease” (p. ix). U.S. healthcare is expensive and appears lopsided, favoring the wealthy. Perhaps this is why WHO ranked our healthcare system 37th out of 191 countries.

Can the U.S. establish a basic plan that covers everyone? The stakeholders in this scenario are many and include the federal government, state government, insurance industry, pharmaceutical companies, medical community, employers, and citizens. Creating a healthcare plan that provides universal coverage while containing cost is probably the biggest challenge facing our nation.

Basic Plan Concept

A new plan must be mandatory for all citizens regardless of their ability to pay and should cover a percentage of costs associated with physician visits, hospital fees, and prescriptions medications. In addition, the plan should include preventive care such as

immunizations and dental and optometry exams. Dental treatments should be limited to yearly screening exams, cleanings, extractions, and cavity care. Optometry care should cover general exams at two-year intervals. For those who want additional coverage, they can purchase supplemental plans. In France, 90% of the population does.

A cost effective program will use primary care gatekeepers, practice guidelines, generic drugs, and patient cost sharing. It should also embrace the electronic age and what it brings to modern healthcare.

Gatekeeper

It is time to put the meaning behind the words “primary care provided.” In the existing system, it is easier to refer patients to specialists than take the time to manage the condition. In fact, the present reimbursement structure pays the same to see a viral illness as it does for a patient with diabetes, heart failure, and lung disease. The United Kingdom provides an excellent solution for this crisis. It offers providers financial incentives to keep a patient’s chronic condition within acceptable guideline (chronic diseases like diabetes, hypertension, hyperlipidemia, etc.).

Provider and patient opposition to the gatekeeper concept argue that the primary care providers won’t refer patients in an appropriate amount of time. To counter this argument, the new plan should let patients seek a second opinion from another primary care provider. If the opinion is different, a referral should be made.

U.S. examples that expand on this concept can be found at the VAMC and Kaiser Permanente. In both systems, patients are assigned to a pod that includes providers, psychotherapists, clinical pharmacists, dentists, optometrist, nurse care coordinators, and administrative staff. The team concept leads to better communication and coordination of care,

which in turn leads to better outcomes and reduced costs. Preventive care and chronic illness monitoring (between office visits) is often performed by the nurse care coordinator who communicates closely with the providers.

Practice Guidelines

Evidence based medicine (EBM) is considered the standard of care. France embraces this concept and actually mandates 454 practice guidelines (Fried & Gaydos, 2002). Failure to comply with the guidelines can result in fines and practice restrictions. EBM protocols help establish timelines for tests, imaging, treatments, and referrals. Using EBM standards lead to better outcomes and contain costs. A centralized single electronic source for these protocols should be established and available to all providers.

Arguments against the forced use of EMB guidelines revolve around provider treatment discretion. To counter this line of reasoning, future plans should establish medical review boards that evaluate treatment deviation request. A provider and patient can move forward with non-board approved treatments but must do so without state supported funds.

Formulary Drugs

Pharmaceutical costs account for 17.7% of the total per capita costs per person per year in the United States (Peterson & Burton, 2007). Generic medicines and drug use protocols (practice guidelines) are key to containing and reducing this cost. Insurance companies and managed care systems like Kaiser Permanente, Group Health, and the VAMC already understand this concept. When costs got out of control in France, they focused on generics and increased co-payments for medications that fell out of established guidelines (The Commonwealth Fund, 2010).

The pharmaceutical industry will oppose this concept stating that the newest most effective drugs will fail to make the list. Rarely, is a new drug appropriate for first line therapy. A pharmaceutical board, however, should be established to evaluate requested deviations and when appropriate allow funding. Whenever a provider and patient decide to use a denied medication, the patient must pay 100% of the medication costs.

Pharmaceutical companies may threaten to stop new research based on the generic medication shift. This is a significant threat and the U.S. may need to establish research grants directed toward the pharmaceutical industry. Of course, the scope of support should be limited to issues such as hypertension, coronary artery disease, and antimicrobial treatment and not erectile dysfunction.

Cost Sharing

Cost sharing performs two functions. First, it decreases unneeded spending. Second, it helps cover costs associated with care. France relies heavily on cost sharing to control costs. For example, citizen's pay 20% of hospital based care plus a co-payment of \$29 per day, 30% of any outpatient physician visits, and between 0% and 100% for prescription medications based on established drug effectiveness criteria (The Commonwealth Fund, 2010). This process creates patient ownership in their care. They understand the cost and are more prone to take an active role in cost containment. The argument against this concept revolves around delayed treatment. In other words, patients will delay seeing a provider or having a test done due to costs. To counter this argument, the system must establish tightly controlled criteria that exempt those who simply can't afford these costs.

As part of the cost-sharing concept, premium reductions should be awarded to patients who maintain a set body mass index, don't use tobacco, keep their diabetes and cholesterol

within acceptable guidelines, and don't have lifestyle acquired illness like HIV, hepatitis C, liver disease, coronary artery disease, and chronic lung disease (acquired through documented IV drug use, alcohol use, smoking, obesity, etc.).

Electronic age

A standardized electronic medical record (EMR) program needs to be adapted for all clinics, hospitals, and insurance companies. The EMR will promote better communication and continuity of care, decrease repetitive testing and medication errors, and allow quicker payment to medical facilities. In Taiwan, patients carry a medical card to each physician visit. The card provides up to date information on past and present medical history to include tests and medications. It even pays the provider at the conclusion of the visit.

Opposition to computerized medical records revolves around confidentiality and identity theft. This is a valid argument and must be addressed. I would counter, however, that most of this information is already on the Internet in multiple locations in some form. By consolidating the charts, security could be better managed.

In addition to a standardized EMR system, e-mail communication and telemonitoring are big tools in chronic illness management. For example, a hypertensive diabetic can use a phone line to transmit blood pressure, pulse, and glucose readings to the nurse care coordinator. This information can be consolidated and presented to the provider who can adjust medication as needed. Telemonitoring opens communication between the patient and provider team. Of course, there will need to be some form of provider reimbursement to cover cost and expense to the clinic.

Financing Health Care

Financing universal health care is the crux to its success. The United States is not ready for delayed treatment or rationed care like seen in Canada and the United Kingdom. A system like France, however, has some merit. In France 76.6% of its total health care expenditure is covered by its quasi-public financed health care plan. Of this 43% comes from employer and employee payroll taxes, 33% from a national income tax, 8% from sales tax, 2% from state subsidies, and 8% from social security accounts (The Commonwealth Fund, 2010). Employer and employee payroll tax is set at 13.55% of the employees wage. The employer pays 12.8% and the employee pays 0.75% of this amount. For those ineligible for its mandated coverage, France pays their insurance premium through a tax on tobacco and alcohol and supplemental insurance (The Commonwealth Fund, 2010). The collected money is held in the quasi-public insurance fund which is managed by employee and employer representatives (Dutton, 2002). These representatives negotiate fee schedules with the hospitals and physician groups (Dutton, 2002). France spends 11.1% of its GDP on healthcare compared to the 15.3% spent by the U.S. (Anderson & Squires, 2010). Embracing the France model won't be cheap but it has potential to reduce present U.S. healthcare costs.

A future plan must address tort reform, malpractice laws, emergency medical treatment and active labor act (EMTALA), and excessive hospital charges. Costs associated with malpractice insurance and over treatment for fear of a lawsuit undermine the whole healthcare reform process. Paramedics need the authority say "no" when asked to transport a cold and triage at the emergency room needs to turn the cold away. These people can be seen at the clinic the following day. Finally, adopting universal healthcare should reduce excessive hospital charges associated with insufficient reimbursement. For example, the \$10 aspirin charge should

become a distant memory. This will only hold true, however, if the plans remuneration is enough to at least cover costs.

Opposition to this type of financing revolves around business costs and lost jobs. In other words, if an employer is forced to pay 12.8% of an employees wage they will simply reduce the work force. In reality, 55% of U.S. healthcare is already financed through an employer (The Commonwealth Fund, 2010). According to Dutton (2002) the employer presently pays up to 27% of an employees wage. A move toward the France model, therefore, would reduce an employer's healthcare cost by more than 50%. For those who don't presently provide insurance, there will be a cost.

Conclusion

Most everyone believes basic healthcare is a right and should be afforded to all U.S. citizens. The level of care and how to finance it, however, is open to debate. The gatekeeper and pod concept promote continuity of care and cost containment. A nurse care coordinator keeps patients treatment up to date. Practice guidelines promote quality of care and prevent unneeded tests or imaging. Generic drugs keep pharmaceutical cost manageable. Cost sharing allows patients greater insight into costs. Finally, the electronic age is key to patient management without requiring excessive unneeded clinic time.

Expecting the U.S. to lose its first place position in healthcare cost per capita, however, is unrealistic. Creating a basic yet comprehensive universal healthcare plan won't change this. It will, however, increase access and if ran properly decrease cost.

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Table 1

Healthcare Economics

	Health care system	Financing	Out of pocket	Per capita cost/Year	GDP %
Canada	Federal, providential and territorial management (national health service model)	70% public health insurance plan (general taxation) 66% of population has supplemental insurance	\$580/person/year	\$3,678 (\$2,591 from public health insurance plan)	10%
United Kingdom	Government ran National Health Service (NHS)	87% NHS funding (general taxation is primary source) 12% of population has supplemental insurance	\$343/person/year	\$2,760 (\$2,408 from NHS health care funds)	8.4%
France	Federal management (mandated insurance and national health service model)	79% quasi-public financed health insurance (employer and employee payroll tax and national income tax are the primary source) 90% of population has supplemental insurance	\$246/person/year	\$3,449 (\$2,750 from public health insurance funds)	11.1%
United States	Private, Federal, and State management (entrepreneurial and national health service model)	60% private insurance (95% obtained through an employer with varying degrees of employee responsibility) 23% government health care programs (general taxation)	\$890/person/year	\$6,714 (\$3,074 from government health care programs)	15.3%

Table 2

Healthcare Coverage

	Population covered	What is Covered	What is not covered
Canada	100%	Medically needed physician and hospital services	Medications, dental, vision, home health, and ambulance service coverage is providence dependent and often restricted to the disabled and elderly
United Kingdom	100%	Medications, physician fees, dental care, psychotherapy, and rehabilitation	Most cosmetic surgeries
France	99%	Outpatient care, hospital care, and prescription drugs	Extremely limited dental and optometry care coverage Preventive immunizations are only available to at risk populations
United States	84%	Policy dependent	Policy dependent Majority of health plans do not cover dental and eye care, cosmetic or elective surgery

Table 3

Healthcare Demographics

	Life expectancy	Top 3 causes of death	Percentage of smokers	Obesity percentage	Avoidable deaths/ 1,000 population related to medical care
Canada	80.4	Cancer, cardiovascular disease, and cerebrovascular disease	21%	23%	0.77
United Kingdom	79.1	Cardiovascular disease, cancer, and external causes	25%	24%	1.03
France	80.9	Cancer, cardiovascular disease, and external causes	32%	17%	0.65
United States	77.8	Cardiovascular disease, Cancer, and Stroke	23%	33.2%	1.10

Table 4

Access to Care

	Physicians	Physicians / 1,000 citizens	Primary care visits/year	Acute hospital beds /1,000 citizens	Average hospital stay for acute care	Dentists / 1,000 citizens	Pharmacists / 1,000 citizens
Canada	62,307	1.9	5.8	2.7	7.2	1.2	0.8
United Kingdom	121,126	2.1	5.0	2.6	7.5	0.4	No data
France	227,683	3.7	6.3	3.6	5.4	0.7	1.2
United States	793,648	2.7	4	2.7	5.6	1.6	0.9

Table 5

Availability of Higher Echelon Care

	MRI machines/ million citizens	Cardiac caths performed/ 1,000 citizens	Average time to cardiac cath lab	Patients on dialysis/ 1,000 citizens	Average time to hip replacement surgery
Canada	6.7	1.96	2 to 6 weeks	0.63	112 to 162 days delay
United Kingdom	8.2	0.06	2 week goal	0.39	211 days
France	5.7	No data	No delay	0.59	No delay
United States	25.9	4.34	No delay	1.14	No delay

Table 6

The Healthcare Provider

	Average yearly salary	Method of payment	Gatekeeper incentive	Ave work hrs per week	Arrangements for after hr care	Provider friendly tort
Canada	\$107,000	Fee for service, salary, capitation, or blended	Yes	47.5 hrs	43%	Yes
United Kingdom	\$118,000	Fee for service, salary, capitation, or blended	Yes	31.8 hrs	89%	Yes
France	\$92,000	Fee for service	Patient Only	48.8 hrs	78%	Yes
United States	\$161,000	Fee for service, salary, capitation, or blended	No	43.6 hrs	29%	No