

American Pie

A physician argues that national health insurance will provide good care and a far more equitable distribution of resources.

By Steffie Woolhandler, M.D., Associate Professor of Medicine, Harvard Medical School and Cambridge Hospital, Co-Founder of Physicians for a National Health Program.

I started college as an economics major but quickly found the discipline was too dry; we used to joke that an economist was someone who lacked the personality to become an accountant. So I made what I thought was a 180-degree turn and decided to become what I called “a people’s doctor.” I was going to take care of poor people and the oppressed, senior citizens and children. I was going to be out there delivering hands-on care. But I hadn’t been in medicine for long before I realized that financing gets in the way of delivering care. We may have great doctors, great hospitals, and great research, but, over and over, health care financing impedes our work.

Sigmund Freud pioneered the idea that things aren’t always what they seem. As an internist, I would paraphrase Freud as follows: everything in human life is sex, except sex—which is aggression. But I would go a step further and say that in the public health and policy field, everything about human life is health, except for health care—which is finance. So I want to touch on health care financing—both how the system is broken in this country and how we as physicians can help fix that system to benefit our patients.

Today’s 44 million uninsured Americans represent only the tip of the iceberg; many people with only partial insurance still can’t get all the care they need. That’s one way to view the current health care crisis. The other way to look at it is in terms of the rising cost of health care. This year it’s expected to increase about eight percent, after nine to ten percent jumps in previous years. And this means that the health care crisis will not disappear. We are in an unstable system, at least partly because of what these rising health care costs mean to employers.

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I was recently a visiting professor at McMaster University in Ontario. To get there, you have to drive about 40 miles south from Toronto to the city of Hamilton. En route, you pass a field where, as far as the eye can see, there’s

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nothing but Ford Freestars. Up the hills, down the hills, in the valleys: Ford Freestars. It turns out that every Ford Freestar in North America is now manufactured in Ontario. We hear a great deal about the two million U.S. jobs lost to China, but we hear less about U.S. jobs migrating to places like Canada, where employee benefit costs related to health care are much lower. For employers in the United States, employee benefit costs represent eight percent of payroll; but in Canada they're only a fraction of that. So we have an untenable situation in this country with rising employee benefit costs interfering with the competitiveness of U.S. firms.

During the past few years, I've been doing research with colleagues at Harvard Law School, in which we interviewed people in five federal bankruptcy courts around the nation to find out whether there were medical contributors to their bankruptcies. And we discovered that medical bills contribute 40 to 55 percent of all bankruptcies in the United States, devastating literally millions of people every year. The transcripts of our phone interviews with these people reveal dreadful stories. When they became sick or injured, they lost their jobs, their health insurance, their retirement savings, their kids' college funds, their homes—all because of our broken health care financing system.

The other side of this story is the underinsured, many of them senior citizens. By the year 2005, the average senior citizen will have to devote 35 percent of his or her income to health care, despite the existence of Medicare. Now that's only if we continue with the *current* Medicare program, which provides defined benefits, such as a certain number of hospital days.

If we were to enact the Republican Party proposal advocated by President Bush, we would replace employer- and government-promised benefits with vouchers, which recipients could supplement with their own money to purchase health insurance. If we adopt such a model, by 2025, the average senior citizen will be spending *43 percent* of his or her income on health care, despite the existence of Medicare. These voucher-like payments are a key policy initiative right now in Washington and in the business community. They are, in short, a way to reduce the total amount of insurance available to patients.

Another side of this crisis is the profound bureaucratization of health care. We've witnessed a 2,500 percent increase in the number of health administrators over the past few decades. The business orientation in medicine is eroding patients' coverage. And it's taking away many of the elements that physicians find rewarding about medicine, including our ability to take good care of our patients.

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If we were to compare total health spending in the United States with that in other developed nations, we would find an interesting dichotomy. U.S. health spending can be split into two categories. The first is private spending, and the second is the tax-funded part of health spending—not just Medicare and Medicaid, but also the benefits of government workers. The second category also includes the so-called tax-subsidy to private health insurance, the amount of money lost to the Treasury because health benefits are not taxable as income.

Sixty percent of U.S. health care is tax funded. And it turns out that the tax-supported share of health care in the United States already exceeds the total health expenditure in every other nation in the world—and yet the United States lags three years behind the best-developed nations in terms of life expectancy. And then we take an average of another \$1,400 out of our individual pockets for private expenditures. Clearly, the United States already has the money within the health care system to provide excellent health care for everyone.

A part of the wasted resources is administrative costs, which we quantified in a study published last summer in the *New England Journal of Medicine*. We found that the health administrative cost difference in the United States relative to Canada is more than \$1,000 per capita. To frame this issue in the context of hospitals, Boston’s Brigham and Women’s Hospital employs approximately 300 people in its billing department; Toronto General Hospital, a similar institution, has fewer than ten. That’s because Toronto General Hospital receives its entire budget on a lump-sum basis, negotiated every year, with one-twelfth of the money deposited into its bank account every month. This provides huge administrative savings and allows the hospital and its doctors to focus on care.

In a recent *New England Journal of Medicine* article, the authors of one study divided the United States into health care spending quintiles. They found that some of the best health care in the country is the cheapest, on a par with rates in Canada. Minnesota and Washington State, for example, teach us that we can spend less and still have excellent quality.

Now, I’m from Louisiana, near Cameron Parish, a poor area that nonetheless has the highest quintile of Medicare spending. Yet there’s no way you can convince me that high-spending Cameron Parish has better medical care than the low-spending areas of Minnesota and Canada. In response to a claim that Cameron Parish gets good value for its health care dollar, we Louisianans would say, “That dog won’t hunt.”

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In fact, the authors of this study found, through complex statistical analysis, that, in the United States, the less expensive areas have a better quality of care than the high-spending areas. And their findings are consistent with those of other research. Most studies are showing that Canadians receive a quality of care similar to that of insured Americans and, obviously, much better than the aggregate quality available to the insured and uninsured in this country.

But what about political support for universal coverage? An October 2003 poll asked the American public, “Would you prefer the current system of universal insurance, like Medicare, run by the government and financed by taxpayers?” Sixty-two percent of the respondents endorsed national health insurance defined that way.

My own group, Physicians for a National Health Program, looked at physician opinion as well. We interviewed a random sample of Massachusetts physicians and published their responses in the *Archives of Internal Medicine*. When asked which type of structure would offer the best health care to the greatest number of people for a fixed amount of money, 64 percent endorsed the idea of single-payer national health insurance.

But are physicians willing to go public with their endorsement of national health insurance? You bet they are. Published last summer in the *Journal of the American Medical Association* was a proposal for single-payer national health insurance that’s universal and comprehensive. The proposal—which was endorsed by more than 13,000 U. S. physicians—called for simplified reimbursements, no copayments, and the elimination of investor ownership of HMOs and hospitals because such ownership raises costs and lowers quality, as established in a recent review in the *Canadian Medical Association Journal*.

We physicians are calling for a system we’ve dubbed “Canada deluxe,” a system with the administrative efficiency of Canada’s national health insurance—and with the approximately 40 percent higher spending level that we are used to in the United States. And this proposal is precisely what Physicians for a National Health Program is advocating: improved health planning, public accountability for quality and cost, and minimal bureaucracy.

Many people, when they saw the *JAMA* article, with thousands of doctors calling for an increased government role, were shocked. And in fact, one editorial writer commented, “Physicians for a National Health Program? That’s a little like Furriers for Animal Rights.” Nonetheless, many doctors are just not tenable and have joined with their patients in advocating for national health insurance.

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Now, because I like animal jokes, I’ll end with one to emphasize that we can’t expect better results with this crisis simply by doing the same thing over and over again. The story goes like this: Three elk hunters had hired a pilot to airlift them to a remote lake in Canada. When he dropped them off, the pilot said, “Now remember, it’s a small plane. We can only bring back one elk.”

When the pilot returned a week later to pick them up, the guys were standing there with three elk. And they said, “Look, last year you told us the rule about only one elk. We offered to pay you double to take two elk on the plane, and you agreed. This year, we’ll pay you triple to airlift out all three.”

The pilot thought it over, nodded, loaded the elk and the passengers, and took off, only to run into the top of some trees almost immediately. Luckily all on board survived, but they were injured and dazed. When one of the hunters finally gained consciousness, he asked, “Gee, where are we?” And one of his buddies replied, “Well, I’m not sure, but I think about 50 feet from where we crashed last year.”

I invite you to join with us in our quest for universal health coverage so we won’t just keep crashing year after year.