Who pays for healthcare? We all do.

MCMS President
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The question of who should pay for healthcare is one that has been asked for decades and a true consensus has been hard to find. Frankly, it is one to which an absolute right answer may never be found.

Our current system relies on numerous payers, the government (i.e., we the taxpayers), employers, patients, private insurers (through premiums paid by patients and employers), and even healthcare providers/facilities, when they write off charges voluntarily or because they could not be collected. While the term "single payer" is often used to refer to countries that only have government sponsored healthcare, it is somewhat of a misnomer. After all, the government programs must be funded through taxes and tax rates are often high in countries that have them, so in reality, everyone is paying indirectly. It seems that no matter how you try to package it, most of the population ends up footing the bill.

Many may feel that the question of who should pay was put to rest with the passing of the Affordable Care Act (ACA). In my last editorial, I touched upon some of the concerns with the ACA and the changes/delays to it that we have already seen. Some speculate that it was intentionally designed to fail, so that we will indirectly be pushed into a government sponsored single payer system. We've heard about studies that report lower costs and better outcomes in Canada versus the United States, at least with respect to infant mortality and life expectancy. Some argue, however, that these are poor measures of comparison due to confounding social variables. I must admit, I sometimes wonder if such a system wouldn't be easier. No more worrying about which insurance covers what, whether you're in network, or what medicines are on formulary. Based on anecdotal stories that I have heard both from physicians and patients, however, I am left questioning the true quality of care in publicly funded systems.

One of the earlier accounts I heard was from a British surgery resident who was doing a rotation in the U.S. We American residents were complaining about the number of patients on our service. She chided us, stating that on the weekends she was responsible for rounding on a ward of 150 patients. We asked how she could possibly talk to and examine

each patient and she said that she couldn't. Only the patients with abnormal vital signs were given the luxury of a cursory physical exam and extra attention. A few years ago, I met a physician from South Korea at a conference and asked him about the healthcare system there, which is a nationalized single payer system. I asked him how many patients he saw per day. He said he was "lucky" because he only had to see 50 patients on his clinic days. I asked him why this was "lucky". It turns out that he was in academics and therefore only had half day clinics, but physicians with full day clinics needed to see 100 patients per day. This makes the Canadian system, where they see 40 patients a day, almost seem luxurious.

My family has been touched personally by the public healthcare system in Germany. My uncle was hospitalized 45 minutes away from where his family lived, because that was the closest public hospital. My cousin could only visit on the weekend. When he did visit, he realized that my uncle had hardly eaten for days because he was too weak to feed himself. The staff would just set the tray in front of him and leave. The patient sharing his room told my cousin that, when he had the strength to get out of bed, he would try to help feed my uncle. My cousin was somewhat disenchanted with this situation and went to complain to the nurse. She told him that she had 30 patients to care for with no assistance and it was all she could do to make sure that everyone, at a minimum, had the correct medication.

These are only some examples of accounts that I have heard, but none of the stories that I withheld shine favorably on publicly funded systems. They all raise the concern about the ratio of patients to healthcare providers and available services in these systems. Overall, it is very telling that a significant number of patients who can afford it choose to come to the United States and pay to get care, even when they could get it for "free" in their own country.

One could argue that a privately insured, free market system would be best. Patients could choose physicians based on who they felt provided the best service for the most reasonable price. When my father was in the earlier years of his practice, Medicare was a decade old. Physicians set their fees, private insurances paid 80% for the insured patients and the patients were responsible for the remaining 20%. In cases of financial hardship, my father would write off the 20% and he would also adjust his fees for patients without insurance. He even had one patient who paid him by making tamales at Christmas time for him and the staff. This is a world that we will likely never get back to. After all, we have much more advanced diagnostic modalities and treatments than we had then and it would take a heck of a lot of tamales to pay for an MRI. Concierge medicine may be the closest that we come to this, but it is only helpful for those who can afford it.

Private insurances are not blameless in adversely affecting our healthcare system and creating distrust. It is

understandable that any business exists to make a profit, but it has always seemed to me that being in the insurance business is a form of gambling. They take people's money with the hope that unexpected circumstances won't require them to have to pay it back. Had it just been left at that, private insurance would probably be the best source of covering the costs of healthcare. Unfortunately, the quest for profits caused many companies to start employing tactics to decrease what was paid back. Many of you are familiar with these tactics and I won't reiterate them here, but in the end they succeeded in creating very nice CEO salaries, while patients were often denied care or coverage. The ACA now requires that private insurances spend 80-85% of premium money on healthcare costs. While I would not normally agree with this type of legal mandate on a business, the insurance companies brought it upon themselves.

Employers began offering health benefits as a means of attracting employees around the time of World War II. Over the next few decades, employer based coverage increased significantly, but then started to decline in the 1980's for a variety of reasons. Many of us are business owners and we understand the difficulties associated with rising business costs whether it be for healthcare coverage or any other cost. The money to cover increased costs has to come from somewhere, which becomes more difficult in medical practices with decreased reimbursement, bundling, etc. Business owners have to look at cutting salaries, jobs, other benefits, or other expenses to make up for increased costs elsewhere. One of the mandates of the ACA will require employers with 50 full time employees to provide health insurance. This caused companies to re-evaluate their current structure and many began transitioning employees to part-time or letting people go. The negative fallout of this ACA requirement resulted in a delay in the mandate until after the 2014 election period. In the meantime, the individual mandate to have health insurance was not delayed, putting the onus back on the individual to pay for coverage.

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Many argue that having patients pay higher deductibles and co-pays will spur them to utilize the healthcare system more wisely. While this may be true to some extent, the concern about those costs often also causes patients to not take medicines or put off getting care, potentially allowing their condition to progress to a more serious state and ultimately increasing the overall cost. Patient noncompliance is a well known phenomenon and increased out of pocket costs could only worsen it. Given the trend to pay for quality of care through ACOs and other measures, costs of decreased patient compliance could eventually be borne by the provider. Furthermore, if patients default on payments, it will be the providers who pay.

In reality, the issue of who should pay is much more complicated than I portray here. The fact that charges for care and medicines are much higher here than in other countries adds to the problem. Laws and regulations at both the federal and state level further convolute the system. Unfortunately, the physician seat at the table has been a small one. Your membership in organizations like MCMS, however, allows us to speak with a stronger voice. We may never find the "right" answer, but we should hope to find the best one. Whatever that is, almost everybody pays, either directly or indirectly. What do you think? We'd like to hear from you. ru

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