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## In Dire Health

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**By Arnold Relman**

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Most people assume that insurance is an essential part of the health-care system. Some think it should be provided through public programs like Medicare, while others prefer to see it purchased from private insurance companies, but the majority believe that insurance is needed to help pay the unpredictable and often catastrophic expenses of medical care. That is why so much public policy focuses on extending coverage to as many people as possible and controlling its cost. I think this emphasis on insurance is mistaken. We would have a much better and more affordable health-care system if the reimbursement of medical expenses through public or private insurance plans was replaced by tax-supported universal access to comprehensive care, without bills for specific services and without insurance plans to pay those bills.

Insurance is not simply a mechanism for spreading financial risks and paying for medical care. Because it usually tries to limit payments to providers, insurance often is an intrusive third party in the doctor-patient relationship and, particularly with private insurance, restricts the freedom of doctors and patients to select the services, specialists, and facilities they want to use. At the same time, insurance coverage tends to encourage the “moral hazard” of overuse of elective services, by reducing patients’ awareness of costs and limiting their out-of-pocket expenditures. Furthermore, all insurance plans have administrative expenses, and most private plans take profits that add to the cost of their premiums. The billing and collecting operations that are an integral part of any insured health system are a major expense for doctors and hospitals as well. Billing and collecting through insurance also offer abundant opportunities for fraud and abuse, which skim off as much as 5 percent to 10 percent of the total expenditure on health care.

For-profit insurance companies, which control most of the private market, are the greatest problem. They have a direct conflict of interest with their customers, because a plan’s net income is increased by avoiding coverage of patients with serious illnesses (who, of course, are most in need of insurance), restricting access to services, and limiting coverage of expensive medical conditions. Provisions in the new Affordable Care Act, which take effect in 2014, will prevent private insurers from denying or dropping coverage because of illness, but the act will

also put many more people into for-profit insurance plans, which will still be permitted to raise premiums. According to the Centers for Medicare and Medicaid Services, the business costs and profits of these plans currently take more than \$150 billion from their premiums before paying for medical services and are projected to increase more rapidly than national expenditures on health care. Additionally, the private insurance industry adds costs to doctors and hospitals that must spend tens of billions in billing and collecting from multiple plans, each with its own rules and regulations.

Apologists for the for-profit insurance industry claim that its high overhead costs are justified by greater control of providers' charges, the provision of preventive services, and the promotion of the quality of medical care. No credible evidence supports these claims. The rapid turnover of membership in private plans makes continuity of oversight by insurers nearly impossible and limits the effectiveness of preventive and quality-promoting programs. Despite insurers' efforts to control costs in the private sector, they continue to rise more rapidly than in public programs.

The private insurers' "managed care" plans did stabilize the costs of care in the private sector for a few years in the mid-1990s by limiting patients' choices of physicians and hospitals, monitoring physicians' recommendations of expensive procedures, and reducing elective hospitalizations. However, a backlash from patients and physicians forced the plans to change these tactics, which were seen as an intrusion into the practice of medicine. By the end of the decade, private health costs had resumed their rapid rise. Private for-profit health insurance has now grown into a huge industry that exerts a powerful self-serving influence on national health policy.

Public insurance through Medicare also has its problems. Although its overhead costs (less than 5 percent of expenditures) are much lower than those of private insurance (about 15 percent to 25 percent of expenditures), it also encourages overuse of elective services. Medicare also struggles with constantly rising expenditures. According to the Congressional Budget Office, the program's costs will almost double over the next decade. The increase has caused a federal budget crisis requiring urgent efforts at cost control. Payments to hospitals are being cut, and more medical costs are being shifted to Medicare beneficiaries. Provisions in the Affordable Care Act authorize trials of new forms of payment and new organizations of physicians and hospitals to receive these payments (accountable-care organizations). The administration of these trials, though, will require so much new bureaucracy that their number will be severely limited—even if Republican opposition in Congress doesn't block their implementation. Most experts think that without major reforms, Medicare's rising costs will not be sustainable much longer, but there is little agreement on what reforms will rescue the program or whether any of the proposed cost-saving measures will succeed.

There is, however, a practical alternative to health insurance and the fee-for-service system with which it is usually associated: a not-for-profit system in which a public single payer provides universal access to comprehensive private care delivered by primary-care physicians cooperating with medical specialists in group-practice arrangements. Like health systems based on insurance, this system would not require that patients have much "skin in the game" and therefore might pose a moral hazard that would lead to overuse of elective services. However, unlike insurance-based systems, physicians would be paid by salary rather than fee-for-service, so it would give physicians no financial incentive to recommend unnecessary procedures. Each group's management would determine and pay salaries, under federal

regulations that would cap the fraction of the group's budget allocated to salaries but would allow management to determine individual compensation. Furthermore, in this insurance-free system, primary-care physicians trained to avoid unneeded care would counsel patients.

Successful examples already exist of systems that are based on a single payer and group practice centered on primary care. They are self-insured, not-for-profit staff-model HMOs such as Kaiser Foundation health plans, Geisinger Health Plan, and the plan designed by and for the New York hotel and restaurant workers' union. In self-insured plans, there is no third-party insurer to pay the charges; these plans assume the insurance risk of providing their members with the medical care for which they contract. These plans support a multispecialty group practice that provides a specified range of comprehensive medical services. Their members usually choose a primary-care physician in the group who directs their treatment and refers them to specialist colleagues and other personnel in the group as needed. Some plans have no bills for individual services; others charge small token fees for each visit. Evidence shows that plans like these deliver quality, cost-effective care.

The recently reorganized Veterans Affairs medical-care system, once viewed unfavorably, now is often cited as another example of a single-payer system that provides comprehensive care by teams of salaried physicians and other health professionals, without insurance reimbursement. The federal government funds the program, but its patients contribute modest payment for some services.

In the system I envision, there would be no bills, although there might be small token fees at the point of service to discourage overuse for trivial complaints. Regulated private accountable-care organizations of salaried physicians that delivered the treatment would be responsible for staying within budgetary limits set by the agency that paid them on a per-capita basis. Physician groups would be nonprofit; low-cost public reinsurance would compensate them for any losses due to caring for extremely sick patients. Net income could not be used to enhance salaries or make capital improvements but could be applied to upgrading patient services. Physician groups could be expected to pay hospital costs, or hospitals could be separately paid by the single payer, but all hospital charges would be regulated.

Congress would not have a separate health-care system. Everyone, including legislators and government officials, would be in the system and would pay their share of the progressive, designated health-care tax that supported the program. This would, among other things, prevent legislative underfunding. People would be free to choose their primary-care physician and physician group and could change doctors and group membership as they wished. They would also be free to pay for any medical services they might choose outside the publicly funded program.

The envisioned system would be much less expensive than the hodgepodge we now have, because the profits and overhead costs of private insurance would be gone. Without bills, there would be little or no fraud and abuse and less administrative hassle. Without fee-for-service, physicians would have no incentives for unnecessary elective services. And with medical care based on nonprofit groups of cooperating specialists centered on primary-care physicians, there would be good reason to expect services to be efficient and of high quality.

Given what we know about the added costs of private insurance and given informed estimates of the costs of fraudulent billing and of unnecessary and duplicated services, a conservative

guess of the total savings from eliminating these problems might be one-third or more of the entire cost of medical care. In any case, these savings would amount to many hundreds of billions—far more than enough to pay for the cost of providing good care for everyone. A reformed system based on group practice could also reduce the cost of defensive medicine (procedures done in response to concerns about malpractice liability). This would probably add a substantial amount to the projected savings. The federal government would have ultimate control over rising costs, because it would set the rate of the designated, progressive tax that funded the entire system and would thereby determine how much could be spent on health care each year. At the beginning of reform, the health tax would presumably collect an amount close to the current total cost of health care. Subsequent tax rates would reflect the new system's needs and its savings.

Converting the present system to the one I have proposed would require a sea change in public opinion and government policy and would also need the support of most of the medical profession. To say the least, it would be a long and difficult process that would be bitterly opposed by the private insurance industry and its friends and by all those who fear a “government takeover” and cling to the groundless belief that the free market can best govern the health-care system. Nevertheless, there are reasons I believe this transformation has at least a chance of becoming reality.

First, physicians are flocking to join group practices in great numbers, and this could be the beginning of a major national reorganization of medical care. About 200,000 physicians (approximately 25 percent to 30 percent of all those in practice) are now employed by multispecialty groups owned by physicians or by hospitals, and this number is increasing by about 10 percent annually. Most of these groups pay their physicians at least a partial salary—only a few pay full salaries. The majority, though, still receive payment from insurance plans on a fee-for-service basis.

A rapidly growing fraction of practicing physicians are beginning to see the advantages to themselves and their patients of organized group practice with partial or full salaries. At the same time, the traditional conservatism of doctors seems to be changing. If this trend continues—and I believe it is being accelerated by the increasing number of women in medicine, who tend to favor group practice and health-care reform—we may see physicians and many medical societies urging basic reforms that would include a single-payer system. Women will soon represent half of all practicing physicians, and their attitudes will influence the profession, patients, and the general public. Legislators, now largely responsive to the financial inducements of lobbyists and vested interests, might begin to appreciate that they need votes even more than money and might become more receptive to proposals for reform that their constituents widely support.

The private health-insurance industry would be a formidable opponent of the reforms I propose, and its position would be supported by those who worry about the many thousands of jobs that might be lost if this industry were to disappear. However, a huge compensating gain in jobs could result from the expansion of employment in businesses that would no longer have to pay the ever-increasing costs of their employees' health insurance. Because health benefits were originally given to employees in lieu of salary increases, employers should be expected to share their savings with their employees in the form of increased wages to help them pay their health-care tax. However, if the new system reduced health-care costs and controlled their rate of rise

as much as expected, both employers and employees would benefit.

Private insurers would not be appeased by these developments but might be satisfied if the industry's investors were compensated for their equity interests. Some of the health-care-tax receipts could be used for this purpose over a period of time, perhaps by issuing government bonds to investors in exchange for stock in the private insurance companies.

The phasing-out of private insurance could also be accomplished through competition from a government program. Medicare coverage could be offered to those under age 65 as an alternative to private insurance in decade-by-decade steps. This would allow time for physicians to develop their group-practice arrangements and for the government to carry out trials of capitated payment to groups (that is, payment on a per-capita basis for comprehensive care). To control costs, capitated payments would ultimately have to replace Medicare's current fee-for-service arrangement, and this would mean a change in the way most Medicare beneficiaries receive their care. Instead of being subsidized by government to obtain health care on a fee-for-service basis, beneficiaries would be expected to select a group practice in a system that would meet all their medical needs at a cost no more—and probably less—than they would pay for Medicare coverage. Opponents of reform would nevertheless claim this abandons entitlements for the elderly, so it would take a lot of public education—and the medical profession's reassurance—to convince Medicare beneficiaries that they would be much better off in the new system.

Experiments at the state level could facilitate national conversion to a single-payer system. Vermont recently passed legislation to establish such a system and is working toward reorganizing the delivery of medical care. As economic pressures for reform continue to grow, other states may follow. The Hawaii Legislature is considering a universal health system, and Massachusetts is looking at replacing fee-for-service with some form of global payment. The success of state experiments like these would embolden the federal government to act on a national level.

I do not underestimate the complexity of the changes I am proposing. The odds against it are daunting. Congress might not even begin to debate major reform until the health system is near collapse. But what seems clear is that the best—possibly the only—hope for achieving universal, affordable care lies in the eventual elimination of private insurance and fee-for-service payment and in the creation of a tax-supported system based on group practice. Although this proposal makes good medical, social, and economic sense, its ultimate fate will be decided in the political arena. It cannot become a reality without an informed and aroused public bolstered by the medical profession's strong support for the reform.

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