

INTRODUCTION

It was 10 P.M. when an ambulance rolled into a local emergency room. In the ambulance was Roger, a forty-five-year-old factory worker, husband, and father of two children ages ten and thirteen. His wife had called 911 because he had been complaining of chest pain for about eighteen hours. His father had a history of heart disease, diagnosed at age fifty. Though Roger was concerned that he might be having a heart attack, he still thought that it could just be indigestion and did not want to come to the hospital for fear that he would have to stay overnight. Roger had health insurance through his employment, but the deductible for a hospitalization was \$350, and his copayment was 15% of the total bill, which he did not have. When the diagnosis of a large heart attack was made within minutes of his arrival, Roger was immediately taken to the catheterization laboratory by one of my partners, and the blockage in his heart artery was opened using a balloon and a stent.

Over the next two days, tests indicated major heart damage that was likely permanent because of his delay in coming to the hospital. He was diagnosed as having heart failure as a result of the large heart attack and was finally discharged from the hospital six days later. He was prescribed numerous medications and was asked to see me, a cardiologist, in two weeks. Roger did not have prescription drug insurance, so the medications cost about \$400 for the first month and each month thereafter. I saw Roger several times in the office over the next year. As predicted, the damage to his heart was very extensive and permanent. He required the insertion of a defibrillator to protect him from sudden death as a result of an unstable heart rhythm.

He was unable to return to work because of the demanding physical aspects of his job. The company was “unable” to find a suitable job for

Roger, so he was fired. He has tried to find other employment but has been unsuccessful. His wife has gone back to work as a secretary, making about \$12 an hour with minimal health benefits. It costs her about \$450 per month to purchase health insurance for Roger, with high deductibles and no drug benefits. For financial reasons, Roger can only purchase about one-half of his medications. He comes to see me periodically for cardiac care but has a copayment of \$35 for each visit, making it difficult for him to keep all of his appointments. He cannot afford to have an EKG, stress test, or blood work as a result of insufficient coverage and the high copayments. I give him samples of his medications whenever I can and often do not charge him for tests that I can do in the office. He is anxious to go back to work, but it is difficult to find a job that is appropriate for his skills and his medical condition. He is going back to school to try to learn a new trade. Roger is unable to play sports with his children and to enjoy a full lifestyle in view of his physical disability. His long-term prognosis and life expectancy are only fair as a result of the size of the heart attack. His savings, what little there was, are gone, and he is at his wits' end. He worked hard all his life and provided for his family the best he could.

Roger is facing a substantially shorter life span than normal. It will be filled with hospitalizations, frequent medical testing, consumption of numerous medications daily, great expense, and anxiety. His wife and children will likely be deprived of his ability to earn a reasonable income and the enjoyment of having Roger with them for many years. He may end up on Medicaid, if he qualifies, or perhaps Social Security disability, at which point we will all be paying for his long-term care—which will be very expensive. His life is ruined because he delayed coming to the hospital when he first experienced chest pain. He was most concerned about his inability to pay the \$350 deductible and his hospital copayment!

This is not an unusual story. Many physicians encounter similar situations daily in all specialties of medicine: the fifty-year-old woman with a large breast mass that turns out to be advanced cancer; the sixty-year-old man with rectal bleeding who has cancer of the bowel; the forty-five-year-old man who has an infection on his leg due to a relatively minor injury that now has spiraled into bacteria in his blood and low blood pressure from an overwhelming infection. Many times these patients do not come to the doctor because of fear of the expense. Other very serious problems arise as a result of patients being unable to afford their medications; there-

INTRODUCTION

fore, they take them less frequently to make them last longer. Patients often do not come for scheduled visits or preventive care as a result of the expense. These visits could detect illnesses before they become serious and life threatening. Later detection results in more complicated treatment, which is more expensive and has a smaller chance of success.

With forty-eight million people uninsured, fifty-one million people on Medicaid, and at least sixteen million people (probably more) underinsured, more than one-third of the United States population is without adequate health insurance. *The United States is the only industrialized country in the world that does not mandate quality health insurance for all of its citizens!*

Many books, journals, newspaper articles, and televised documentaries have been written and produced discussing the healthcare crisis in this country from the standpoint of quality, cost, access, and comparisons with other industrialized countries of the world. Usually, these discussions focus on isolated aspects of the healthcare system, such as insurance companies, hospitals, pharmaceutical companies, physicians, the indigent or uninsured. We have all heard the statistics of how the United States has the most costly system by far, with forty-eight million people uninsured, high infant mortality rates, decreasing access to care, quality of care issues, long waits in emergency rooms, insurance premiums escalating faster than the cost of living, and many other concerns. Few, if any of us, believe our system is fair, affordable, compassionate to the indigent, worth the costs, and as safe as it should be. Most of us feel the healthcare industry is on “life support” and about to take its last dying breath. It seems that everyone knows someone like Roger or has an anecdote about some negative aspect of our healthcare system. They are only too glad to share their stories when prompted. Many of these stories contain valid criticisms, but we need to gain an in-depth understanding of the system and how it really works in order to achieve a more accurate view of the problems we confront. Only then can we decide how to fix the system without further injuring a relatively fragile healthcare industry or destroying it altogether.

Since beginning medical school in 1967, I have seen incredible changes in all fields of medicine, but I have extensive firsthand knowledge of the innovations in cardiology. Coronary bypass surgery, angioplasty, stents, pacemakers, revolutionary drugs, and more have extended a high quality of life to tens of millions of people. As a practicing cardiologist for almost thirty years and the managing partner of a twenty-two person cardiology

group for twelve years, I have seen dramatic changes in the business of medicine as well and have been directly involved with organized medicine, insurance companies, hospital finance and strategic planning, malpractice insurance financing, and the day-to-day running of a busy practice.

Most people who have written about the healthcare financing subject have been economists, reporters, government employees, policy makers, and think tank representatives. They have gone about the task of trying to define the problem by conducting interviews and pouring through tons of statistics. They have not lived the problem for thirty-five years as I have.

This discussion will not be a bleeding-heart (no pun intended) enumeration of the virtues of physicians and the healthcare system, but rather a well-annotated, detailed look at the healthcare “industry”. However, I feel strongly that medicine *is* a noble profession, and it is very painful for me to see the system functioning poorly, not providing high-quality care to all Americans, and costing so much that people often must choose between food and healthcare.

In order for policy makers, legislators, and, yes, us, the American people, to fix the system of healthcare financing and improve the quality and efficiency, we must first understand it completely and be willing to engage in a national debate regarding what we want.

The purpose of this book is to provide information so that readers can clearly understand the healthcare financing system in the United States and participate in the debate. Having been in discussions with lawmakers and numerous consultants over many years, I am convinced that many of them lack a deep understanding of large pieces of the problem, and some have little knowledge of any part of the entire problem. This is the only concise and comprehensive book discussing all the relevant issues. I will try to be objective and annotate the information when possible and provide real-life examples of issues confronted by me and my practice. Since our system is often compared to other industrialized countries, in particular Canada, I will explore the similarities and differences when they are relevant.

If you lack a comprehensive understanding of the issues and do not take part in what should be a national discussion, you will lose the opportunity to express your desires as to how you want your healthcare system to function and how it will be financed. Your personal health, longevity, and quality of life are at stake, as well as your money. The system is on life support and is in danger of not surviving, and, if it fails, we will all pay the price.

CHAPTER 1

The Problem: Economics 101

This chapter will explore the costs of healthcare in the United States and other industrialized countries, in particular Canada. To determine why we spend more per capita than other countries, I will analyze the costs of personnel, drugs, and administering the entire system, which together constitute the vast majority of expenses of the United States and Canada. One theory is that we utilize more services and drugs per capita than Canada and other industrialized countries. I believe this is not the case and that the most important differential is pricing, both for physicians and non-physician professionals, as well as the unit pricing for drugs. I will show that physician fees for service and the hourly wage for non-physician professionals are much higher in the United States. The other huge factor is the cost of administering our complex system compared to the single payer system in Canada and most other countries.

In order to understand and compare the relative costs of healthcare in various countries so that we can clearly see the problem facing the U.S., it is imperative that we define the terminology we will use and delineate the cross-country comparisons.

When we speak of international comparisons, we are usually talking about information generated within the Organization for Economic Cooperation and Development (OECD), which is a thirty-member consortium of industrialized nations that share information on many aspects of their societies, one of which is healthcare data. This entity includes the United States, Japan, Canada, France, the United Kingdom, and other

countries primarily in Europe. The last complete OECD report, published in 2005 and based on 2003 information, revealed the total U.S. healthcare per capita (per person) expenditure to be \$5,635. The average for all thirty countries was \$2,306. The U.S. expenditure was about 2.4 times the average of all the countries.¹ The numbers represented are in what is called “Purchasing Power Parities” (PPP), which is based upon a formula that attempts to equilibrate each country’s standard of living and thereby equalize its citizens’ purchasing power so comparisons can be made. The reference currency is the U.S. dollar.

To look at the cost differentials in a slightly different way: We are spending about \$3,300 per person per year more on healthcare than the average industrialized OECD country and about \$1,800 more than the next highest country, Norway. In any event, the amount of money spent on healthcare in the U.S. is huge in comparison to other industrialized countries, and therein lies the problem we are confronting. It is as simple as that!

The real issues are: Why are our costs so high? Can we do anything within reason to reduce them? And are we getting our money’s worth?

The cost of healthcare is the product of the cost of a unit of care times the number of units (cost/unit \times # of units). For example, the cost of caring for an outpatient of mine during a year would be the number of office visits multiplied by the cost of each visit, the number of tests multiplied by the cost of each test, and the number of drugs multiplied by the cost of each drug. Data from the OECD indicates that the number of physician visits, hospital days, and admissions per year per capita is less in the U.S. than the median for all thirty countries.² *Therefore, if the number of encounters or units of care is less than most of the other industrialized countries, it must be the prices per unit that are the driving force behind our huge cost differences.* These findings that apply to the OECD, in general, also apply to Canada and, in some instances, the reduced utilization in the U.S. is striking.³

In an effort to analyze our costs more closely and to draw reasonable conclusions, I will compare our healthcare system expenses to those in Canada. I have chosen Canada because we are in close proximity, speak the same language (or nearly so), and have both open borders and much in common. I will take each element of the healthcare expenditure and calculate the excess cost in the U.S. based solely upon the differential created

by increased expense for salaries, unit drug pricing, and administration. Later in the book, I will take each of these differentials and discuss them in further detail.

The Canadian System

In column 1, I have listed the breakdown of Canadian expenses as documented by the Canadian Institute for Health Information in 2003. In column 2, these values are converted into U.S. dollars Purchasing Power Parity (PPP), and the analysis will use the conversion throughout. Column 3 demonstrates the Canadian expenses per capita. Column 4 shows the increases the Canadian system would face if it had to “play by American rules”. The discussion of this continues below.^{4,5}

	1	2	3	4	5	6	7
	Canadian expenses in \$Canadian in billions	Canadian expenses in \$U.S. PPP in billions	Canadian expenses per person in \$U.S. PPP	Increased expenses in \$U.S. PPP billions	New Total Canadian expense \$U.S. PPP in billions	Increased expenses per person (Canada) \$U.S. PPP	New Total Canadian expense per person \$U.S. PPP
Hospitals	37.2	30.0	949	19.5	49.5	617	1566
Drugs	20.1	16.2	513	11.0	27.2	348	861
Physicians	16.1	13.0	411	4.7	17.7	148	559
Other professionals	13.2	10.6	337	3.8	14.5	121	458
Other institutions	11.4	9.2	291	6.0	15.2	189	480
Capital	5.6	4.5	143		4.5		143
Administration	4.9	4.0	125	41.0	45.0	1,298	1423
Public health	6.9	5.6	176	3.5	9.0	109	285
Other spending	7.4	6.0	189		6.0		189
Total	122.8	99.0	3,134		188.5	2,831	5965

Physician Salaries

A salary survey from 2002 noted that U.S. physicians on average earned about 1.5 times the amount of Canadian physicians after expenses (\$179,000 vs. \$117,000).⁶ Part of the explanation for the higher salaries is that, in many instances, the U.S. fees for service in U.S. dollars PPP are about twice those in Canada for similar procedures. Therefore, if Canada had to incur a similar relative cost of U.S. physician salaries, the additional cost of physician expenditures in Canada would be about \$4.7 billion or a total expense of \$17.7 billion. Whether this additional expense is reasonable is the subject of a later chapter. For now, we will just keep track of this number.

Drug Costs

The cost of prescription drugs is a significant part of the total healthcare expenditure, amounting to about 16% of the total budget or \$20 billion in Canadian currency.⁷ It is estimated that the per unit Canadian drug costs are about 60% of those of the U.S.^{8, 9} In other words, on average the cost per pill or dose of injectable medication is significantly lower in Canada compared to the U.S., corrected for PPP. This is already known by many Americans who are purchasing numerous drugs from Canada as a result of the lower prices. It is also estimated that the number of units of consumption per capita is similar in both countries.¹⁰ Therefore, the additional expense in the U.S. attributed to drugs would be the costs per unit. According to this analysis, if Canada had drug pricing similar to the U.S., the additional cost in Canada would be about \$11 billion, and the total cost would be about \$27 billion. Again, hold on to these numbers, as we will discuss pharmaceutical issues in another chapter.

Hospital Analysis

In 2003 the U.S. spent about \$515 billion or 31% of its healthcare budget on hospital care. The cost of hospital care in Canada was about \$37 billion or 30% of the total healthcare expenditure.¹¹ Canadian hospital expenses are made up of non-physician salaries and benefits (68%),

Private Insurance—Caring for Profit

Background

In 1973, the Health Maintenance Organization Act created an insurance system whereby patients could pay a premium to a federally approved insurance company and receive care from their panel of physicians and hospitals preselected by the company generally based upon negotiated pricing. The patient was assigned a primary care physician (PCP) who acted as a gatekeeper through whom any tests, referrals to specialists, and hospitalizations would have to be approved. In exchange for this level of control, the patient was given a lower premium than he or she was paying for standard indemnity insurance where no controls existed.

This system of coverage caught on at various speeds in different parts of the country. It was very widely accepted in California and became the basis of much of its healthcare insurance. It spread to other areas of the country and morphed into less restrictive plans known as Preferred Provider Organizations (PPOs) and Point of Service (POS) care depending upon market acceptance and needs as assessed by the parent insurance organizations. An in-depth analysis of these various organizations is not possible in this book. Suffice it to say that the underlying premise of these entities has been to bring down the cost of care or at least to reduce the rate of annual increases. These HMO plans were quite effective during the early and mid-1990s, but, by the year 2000, the rate of increase of costs was once again higher than general inflation.

The most effective mechanism used by the insurance companies was to demand shorter hospital stays by using a series of tables compiled by consulting companies that defined how long someone should be in the hospital based upon his or her admission diagnosis. The insurance companies would then disallow payment for any and all days beyond that point, unless there was a very good reason for the “delay” in discharge. This was extremely effective in making hospitals and physicians look carefully at what was accomplished each day and in making sure that no delays took place. This was not a perfect system, but it certainly made physicians and hospitals function differently.

The system also required preauthorization for certain expensive tests and for any admissions other than emergencies. We learned how to do outpatient cardiac catheterizations and pacemaker insertions, shortened the hospital stay for a heart attack from three weeks to about three to five days, and learned how to perform a whole host of surgical procedures without admitting patients to hospitals.

Many of these advances occurred as a result of new and improved technology, but it is likely that a major impetus to create these new techniques was a direct result of the pressure exerted by the managed care companies. I can recall having endless meetings with hospital administrators, nurses, other physicians, and ancillary personnel to devise and implement techniques to reduce lengths of stay. We met with success in most instances and gradually saw overall decreases in hospital days. This was a very good thing that would not have happened without the prodding and financial penalties imposed by the insurance companies. However, they did not offer any insight into how to accomplish these efficiencies. It was completely an issue of constant economic persuasion. In general, most of the reductions of hospital days were safe and reasonable and involved decreasing waste. We all remember some of the problems, however, such as “drive thru deliveries,” where mothers would be in the hospital for less than twenty-four hours after giving birth.

At the outset of the managed care “revolution,” I, as the managing partner of a large cardiology group, attended numerous meetings with founders and senior executives of several HMOs that were trying to start up in southern New Jersey. I can tell you that, in the beginning, the HMOs had no idea how to bring down costs, except to act as a bully by denying virtually every request that came to them for non-emergency care with the

EPILOGUE

I have tried to set forth the financial issues confronting the U.S. healthcare system in an objective format so that everyone can understand and be able to engage in a meaningful dialogue regarding how to fix the system or, at the very least, express their views and desires rationally. As this discussion draws to a close, I believe there is a need for me to explain where I stand on these issues as a practicing physician, a consumer of health services, and a citizen who pays taxes.

When I started to think about the issues of healthcare financing in a global fashion several years ago, I was struck, as many of us have been, by the enormous disparity between the U.S. and the rest of the world. As a former engineer, I believe there is a logical, mathematical explanation for everything. I thought if I could just peel back the layers of this complex problem in a non-biased fashion, I could find the “truth” and explain the differences. I took the position, having read medical literature for more than thirty-five years, that we as a society—the medical “industry” itself, most specifically—have not been providing healthcare dramatically differently by comparison to any other industrialized country. Physicians have all taken care of patients in a relatively similar manner from a medical standpoint. There were no miracle cures that physicians in other countries have had that we did not. Information has been shared openly and generally without bias among the countries of the world. We have all learned from one another’s experiences. So why should we be spending more than twice on healthcare than other industrialized countries? I felt that analyzing all the components of the system would have to yield a logical explanation, which would then enable us to find the “answer” and ultimately to fix the problem. Most books and articles have dealt with one or two highly-charged issues (pharmaceutical and insurance company profi-

teering, poor healthcare for the indigent, the growing uninsured population) that have been sensationalized, but a comprehensive analysis has not been set forth.

As a physician, I believe it is my duty to heal and care for people regardless of their financial status and ability to pay. I do this every day in my practice. Having said that, there is still a need for physicians to earn enough money to pay for our offices, staff, malpractice and health insurance, supplies, etc. Likewise, hospitals have the same obligations and responsibilities.

I also believe that comprehensive healthcare is a “right”, and the U.S. is surprisingly alone in the industrialized world in not accepting this premise. This country takes the position that healthcare is a commodity that you can purchase if you have enough money.

In 1948, the United Nations General Assembly adopted the Universal Declaration of Human Rights, which states in Article 25:

- (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
- (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Furthermore, in an effort to explain and enhance the Universal Declaration of Human Rights, the U.N. General Assembly, in 1966, also adopted the International Covenant on Economic, Social and Cultural Rights, which states, in Article 12:

- (1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

EPILOGUE

- (2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Although it is true that some of the general precepts of these declarations are in effect in the U.S. (we have some prenatal and perinatal programs for the indigent, industrial health and OSHA, and public health programs for disease prevention and treatment of epidemics), we do not provide for (1) or (2d), and (2a) is poorly done for the indigent. Actually, the U.S. is one of six countries of the 155 in the U.N. that has not yet ratified the covenant, so one could argue that we are not bound by its provisions. We are, however, in the company of South Africa, Sao Tome, Pakistan, Laos, and Belize.

We do not provide healthcare to the Medicaid population, the uninsured, and the underinsured according to the U.N. resolutions. The people receive their care in the most inefficient fashion possible, in the emergency rooms of our hospitals, costing many times what it would to be seen in a physician's office. They lack any reasonable preventive and follow-up care, and the care itself is often demeaning. They often cannot afford to purchase needed medication and will go without necessary services that could be lifesaving because of their inability to pay for them. As a result, they have a higher mortality rate than the rest of the population (10–15% greater) and an even higher incidence of cardiovascular mortality (up to 50% higher).¹ Furthermore, as indicated earlier, these poor health conditions cause increased absenteeism from work and tens of billions of dollars

WHAT YOU CAN DO

Once you have a clear understanding of the healthcare system, I encourage you to discuss the problems with everyone you know! Start a grassroots dialogue and engage your federal legislators in the discussions. Send email questions and opinions to those inside the Washington, D.C. beltway and to your state legislators and governors so they understand your personal concerns and desires. Tell them stories of your experiences and those of your friends and relatives. Government officials, both state and federal, will be very interested in your concerns. Additionally, many state governments are now seeking ways to resolve the healthcare financing crisis (notably California, Massachusetts, Pennsylvania, and Maine). Others will likely follow the lead of these states. This gives you an excellent opportunity to have a more local impact on the problem. You can pointedly ask your state and federal legislators why we are the only country in the industrialized world that has a system that does not provide *comprehensive* healthcare for *all*. Tell them we need serious, radical changes and not merely trimming around the edges. Explain to them that there is a way to pay for this entire program of “universal healthcare” and still save money. It is possible!

SOURCES OF INFORMATION

In an effort to develop an even greater understanding of the issues involving healthcare financing and delivery, the following list of websites is being provided for you to access for additional information. They are excellent resources and provide information on all aspects of the discussion.

An organization known as the “Center for Healthcare Finance Information” has been formed. Its mission is to concisely bring important facts to public awareness, which will be updated frequently. The Center collects newly published information from many sources and forms links to this information for easy access. You can reach this important website at: www.health-finance.com.

Alliance for Health Reform: www.allhealth.org

American Student Medical Association: www.amsa.org/uhc/uhcres.cfm

Center for Studying Health System Change: www.hschange.org

Centers for Medicare and Medicaid Services: www.cms.gov

The Commonwealth Fund: www.cmwf.org

Everybody in, nobody out: www.everybodyinnobodyout.org

Families USA: www.familiesusa.org

Health Affairs: www.healthaffairs.org

The Heritage Foundation: www.heritage.org

Institute of Medicine: www.iom.edu

Kaiser Family Foundation: www.kff.org

U.S. HEALTHCARE ON LIFE SUPPORT

New England Journal of Medicine: www.nejm.org

Organization for Economic Cooperation and Development:
www.oecd.org

Physicians for a National Health Program: www.pnhp.org

President Bush's Healthcare Agenda:
www.whitehouse.gov/stateoftheunion/2006/healthcare/index.html

Public Citizen: www.citizen.org

The Right to Health Care...now!: www.righttohealthcare.org

Web MD: www.webmd.com

World Health Organization: www.who.int/en

Contacts

U.S. House of Representatives: www.house.gov

U.S. Senate: www.senate.gov

The White House: www.whitehouse.gov

Give the Gift of
U.S. Healthcare on Life Support
RESUSCITATING THE DYING SYSTEM
to Your Friends and Colleagues

CHECK YOUR LEADING BOOKSTORE OR ORDER HERE

YES, I want _____ copies of *U.S. Healthcare on Life Support* at \$15.95 each, plus \$4.95 shipping per book (New Jersey residents please add \$1.12 sales tax per book). Canadian orders must be accompanied by a postal money order in U.S. funds. Allow 15 days for delivery.

My check or money order for \$_____ is enclosed.

Please charge my: Visa MasterCard
 Discover American Express

Name _____

Organization _____

Address _____

City/State/Zip _____

Phone _____ Email _____

Card # _____

Exp. Date _____ Signature _____

Please make your check payable and return to:

Denisher Press

PO Box 71, Haddonfield, NJ 08033-9998

Call your credit card order to: 856-795-0775

Fax: 856-795-6109

www.health-financing.com