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FAQ Supplemental: Administration

What happens to investor-owned hospitals under national health insurance (NHI)?

"The NHI program would compensate owners of investor-owned hospitals, group/staff model HMOs, nursing homes, and clinics for the loss of their clinical facilities, as well as any computers and administrative facilities needed to manage NHI. They would not be reimbursed for loss of business opportunities or for administrative capacity not used by NHI. Investor-owned providers would be converted to nonprofit status. The NHI would issue long-term bonds to amortize the one-time costs of compensating investors for the appraised value of their facilities. These conversion costs would be offset by reductions in payments for capital that are currently folded into Medicare and other reimbursements." (Physicians' Proposal, JAMA, August 13, 2003.)

Why is it important to prohibit hospitals and health systems from retaining an operating surplus?

Allowing hospitals and other health institutions to retain surplus operating funds delegates health planning decisions to those institutions. It means that financially successful ones can expand and modernize, while those with no surplus will decay and eventually close. As a result, institutional leaders must focus on financial success - the essence of a market-driven medical care system. This market mechanism breeds most of the bad behaviors that we decry in medicine. Allowing the market to determine success, indeed survival, means that institutional leaders must avoid unprofitable patients, services, and communities (which will exist under any payment system that we can imagine), and embrace profitable ones. It means that instead of capital investments going to the areas of greatest need they will be directed to areas most likely to produce future surplus. At present, nearly 70% of all health care funds - and hence capital funds - come from public sources. This figure would rise under a single-payer system. Decisions about capital investments - which are the key decisions about the future of health care - should be made by an explicit, community-controlled process, not by the market.

Answer contributed by PNHP co-founder Dr. David Himmelstein

What is PNHP's view of ACO's?

While the term ACO remains at best vaguely defined, the concept is hauntingly similar to the capitated managed care experiment that proved disastrous in the 1990s. In both instances, providers receive a set annual payment to cover the costs of all care, and get to keep whatever they don't spend on patients. The obvious winning strategy, from a business point of view, is to recruit relatively healthy patients, offering luxurious care for the healthy and minimally ill and subtle cues that those with expensive illness would be better off elsewhere.

Neither risk adjustment nor quality monitoring schemes are up to the task of blunting these incentives. An ACO can game risk adjustments by ferreting out additional diagnoses that may be clinically unimportant but would up its capitation payment, and make its outcomes look better as well. The Dartmouth group has already shown that more expensive providers label their patients with more diagnoses in this way. Quality monitoring efforts measure only a tiny slice of what's important in medicine. Overarching measures of quality like death rates and family/community well-being are either too rare to measure in a statistically reliable manner, too subtle to capture with current or foreseeable measurement strategies, or too biased by differences in the baseline health of enrollees. Evidence from the U.K. shows that providers will improve on the aspects of care that are measured, but neglect those that are not, and it's far from clear that monitoring of quality measures has actually improved quality or can prevent abuses.

In sum, the ACO strategy remains an untested theory for health reform. Considerable experience with similar reforms in the past suggests that this ACO strategy will lead to yet another health policy dead end.

Answer contributed by PNHP co-founders Drs. Steffie Woolhandler and David Himmelstein

What does PNHP have to say about the primary care workforce shortage?

Countries with strong health care systems have at least half of their physicians in generalist primary care practice: 50 percent in Canada, 70 percent in the United Kingdom (Starfield, B, Is primary care essential? Lancet, 344: 1129, 1994).

In 2008, less than 8 percent of U.S. seniors chose family medicine, a 50 percent decline since 1997; only 199 U.S. seniors matched into primary care internal medicine, 248 into IM/Peds, and 53 into Primary Peds. The percentage of international medical graduates (IMG's) in our three primary care specialties is now 73 percent for IM, 68 percent for Peds, and 55 percent for Fam. Med. (Pugno, P, et al. Fam Med, 40 (8): 563, 2008). I don't believe that we have more than about 30 percent of our physicians in primary care. Only 20 percent of internal medicine graduates become general internists, and most pediatric graduates go into sub-specialties (Bodenheimer, T. Primary care—Will it survive? N Engl J Med, 355 (9):861, 2006).

Primary care has been declining in this country for many years, as a result of multiple factors, including more attractive lifestyles and reimbursement in the non-primary care fields; student perceptions of the demands, rewards, and prestige of generalist practice; and uncertainty of the health care environment. The American College of Physicians in 2007 declared that: "Our primary care infrastructure is at grave risk of collapse."

Single-payer national health insurance will provide an opportunity to restructure the U.S. physician workforce, and strengthen and rebuild primary care. We should have at least 50 percent of our physicians in primary care fields. Useful approaches include reimbursement reform, loan forgiveness programs for graduating medical students entering primary care residencies, increased funding for graduate medical education (GME) teaching programs in primary care, and reallocation of GME training slots by specialty.

Answer contributed by PNHP past president Dr. John Geyman

How will we keep doctors from doing too many procedures?

This is a problem in any system that reimburses physicians on a fee-for-service basis. In today's health system, another problem is physicians doing too little for patients. So the real question is, "How do we discourage both overcare and undercare?"

One approach is to carefully control new capital expenditures. Once a hospital or imaging center purchases a multimillion-dollar CT scanner, it will try to generate enough scans to pay off the fixed cost. Explicit health planning should be done to assure that expensive machines and facilities are sited where they are needed and not where they are redundant and likely to generate overuse.

Another approach is to compare physicians' use of tests and procedures to their peers with similar patients. A physician who is "off the curve" will stand out. A related approach is to set spending targets for each specialty. This encourages doctors to be prudent stewards and to make sure their colleagues are as well, because any doctor doing unnecessary procedures will be taking money away from colleagues.

In addition, expert guidelines by groups like the American College of Physicians, etc., can help shape professional standards, which will certainly change over time as treatments change. This really gets to the heart of "how do you improve the quality of health care," which is a longer topic. Suffice it to say that single payer, universal coverage provides a framework for achieving thoughtful quality improvement.

How will the Health Planning Board operate?

A health planning board would be a public body with representatives of patients and medical experts. The representatives would decide on what treatments, medications and services should be covered, based on community needs and medical science, and allocate capital for major new investments based on assessments of where the need is greatest.

Does the way in which we classify live births exaggerate the difference in infant mortality between the U.S. and other countries?

In 2005, the U.S. ranked 30th in the world in infant mortality. The most rigorous investigation of infant mortality in the U.S. and Europe found that even excluding infants < 22 weeks, the U.S. has appallingly high infant mortality (5.8 per 1,000 births versus 3.0 in Norway and Sweden).

Much of the excess mortality is related to the much higher proportion of premature births in the U.S, the period when infant mortality is greatest. If the U.S. had the same distribution of births by gestational age as Sweden, nearly 8,000 infant deaths would be averted each year, and the U.S. infant mortality rate would be 1/3 lower. The Infant mortality rate in the U.S. for preterm (< 37 weeks) births is comparable to that of European countries, but for infants born at 37 or more weeks, the U.S. infant mortality rate is the highest.

(Behind International Rankings of Infant Mortality: How the United States Compares with Europe, Marian MacDorman and T.J. Mathews, IJHS, Vol 40, No 4, 2010).

What about ERISA? Does it stand in the way of states implementing universal health care plans?

No. ERISA (the Employees Retirement Income Security Act) prevents a state from requiring that a self-insured employer provide certain benefits to their employees. However, a single-payer plan would not mandate the composition of employer benefit plans. It would replace them with a new system that would essentially be "Medicare for all." The state would require employers to pay a payroll tax into the health care trust fund, which is clearly legal.

Universal health care may work for small countries like Switzerland and Canada, or for institutions like the Veterans Administration, but could it really work when scaled up to meet the needs of a large country like the U.S.?

Medicare is a national program that works reasonably well. There is no reason whatsoever that would make it hard to scale up. Indeed, Medicare was initiated (and administered for tens of millions of enrollees) before computers became available. Scaling it up 7- or 8-fold should not prove difficult.

In Canada, health care is administered at the provincial level. The Ontario Health Insurance Program, which includes the city of Toronto as well as rural areas, is a good example. Since much of the program we envision would be regionalized, with regions similar in size to Ontario, that program seems a sound indication that scale should not be problematic.
