Commentary: For

Better Health for All, Economic Efficiency

By Ed Weisbart, MD

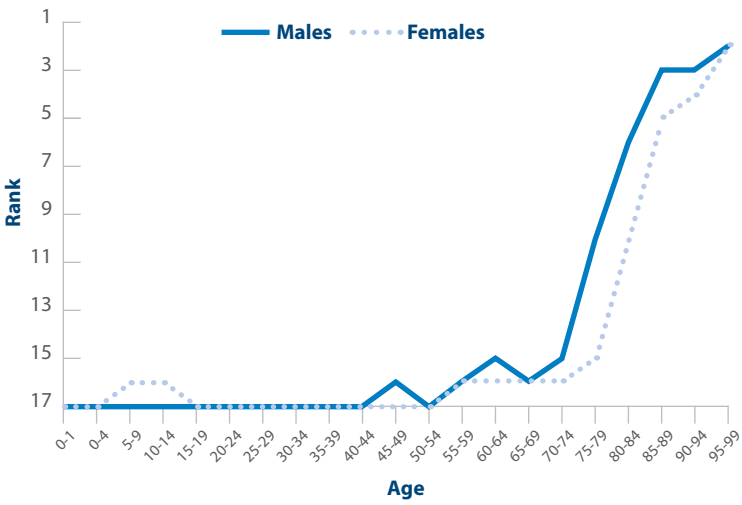
In the 1940s, Winston Churchill is rumored to have said "Never let a good crisis go to waste."[1] If he did say this, he was referring to the unlikely trio of himself, Stalin and Roosevelt creating opportunities in the midst of a global crisis. The world was changed by their combined capacity to imagine a better way forward.

Another global crisis is upon us, and once again we need to imagine a better way forward.

The pandemic has unmasked the hazards of linking health insurance to employment, along with our health care system's long-standing inefficiencies, poor outcomes and injustices and disparities.

FIGURE 1

Ranking of U.S. mortality rates, by age group, among 17 peer countries, 2006–2008 *(Top of chart is highest rank)*



Source: Woolf SH, Aron L. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. National Research Council (US); Institute of Medicine (US). Washington (DC): National Academies Press. 2013.

Ed Weisbart, MD

Ed Weisbart, MD, CPE, FAAFP, is chair of the Missouri chapter of Physicians for a National Health Program and an assistant professor of clinical medicine at Washington University School of Medicine. He can be reached at pnhpmo@gmail.com.

The same war that drove Churchill to seek such unusual bedfellows also drove American businesses to attract and reward employees with access to lifesaving medical care through employer-sponsored health insurance. Decades later, we are still locked into a failing system of job-based coverage. For many workers, losing that job for any reason—your own underperformance, your own entrepreneurship or a major change in the economy—jeopardizes your continued access to health care.

Our strategies to address COVID-19 must also address these systemic faults with our system. Let us do that by building on the successes of Medicare, improving its obvious shortcomings, and providing that to all of us.

Why Base a Solution on Medicare?

Medicare is far from perfect, but even in its present state it brings tremendous value.

Medicare patients may worry about surviving the pandemic, but they have the peace of mind that their health insurance will be there even in the worst of times. If Medicare already covered all Americans, the pandemic would not require emergency legislation to ensure access to affordable screening, prophylaxis and treatment for coronavirus. Even in the most desperate days of Italy's catastrophe, Italians were not afraid to seek treatment due to cost, or worried about personal bankruptcy from medical bills.[2] Universal health care is not a panacea and certainly did not shield Italy from the coronavirus, but it did shield Italians from some of the worst economic consequences.

Traditional Medicare offers a national network including virtually every hospital and 93% of non-pediatric primary care physicians.[3] I know octogenarian Floridians on Medicare who have flown to St. Louis for world-class subspecialty care, never having to ask for permission from their insurance company. Every American should have the freedom to choose their own health care.

Improved Health

Even outside of a pandemic, Medicare has a favorable impact on Americans' health. After worst-in-class mortality rates for the first 65 years of our lives, American mortality rates quickly improve to the best in the world upon reaching the age of Medicare eligibility. (Fig.1) This should make us enormously

continued on page 22

Better Health for All… *continued from page 18*

proud; it's only possible because we have many of the world's best physicians, nurses, pharmacists, hospitals and the rest of the delivery system. We just don't let everyone in until age 65.

Medicare also reverses racial disparities in life expectancy. In Missouri, African-American lives are 3.3 years shorter than those of whites.[4] Nationally, 86% of the causes of these premature deaths are from conditions amenable to medical prevention and treatment.[5] That suggests that part of the life expectancy gap is related to the fact that African-American Missourians are 40% more likely to be uninsured than are white Missourians (14% vs 10%)[6] along with a broadly different mix of insurance products.

We have clear evidence that Medicare coverage reduces and even reverses racial health disparities. For example, every American who needs dialysis can enroll in Medicare regardless of age. Once on dialysis, African-Americans enjoy the same insurance as all other Americans and survive longer than whites on an age-matched cohort.[7]

One argument in favor of our private insurance industry is the proposition that it makes health care more affordable. But private health insurance has shown an unimpressive track record of controlling costs. Over the past decade, the cumulative growth in per-enrollee spending in Medicare has increased 21.5%; the comparable figure for private health insurers is 52.6%,[8] a relative difference of 244%. (Fig. 2)

Medicare has provided American seniors with decades of success, more individual freedom, better health outcomes and greater economic efficiencies. Each of these attributes of Medicare could be available to all of us.

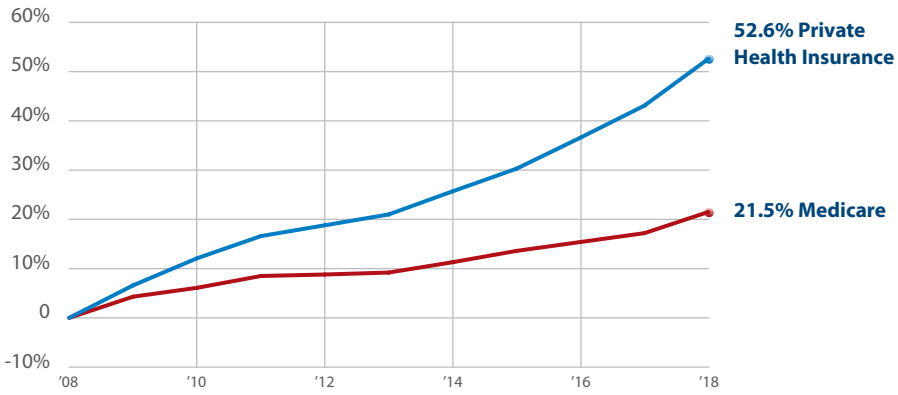
Improved Medicare for All is a public-private partnership without the waste of today's corporate insurance middlemen. Proposed legislation, HR1384 and S1129, would improve the flaws with traditional Medicare and provide that to Americans of every age. With such robust universal insurance, the niche for commercial insurers virtually disappears, simplifying both the patient experience and independent medical practice.

Medicare for All would:

- **Provide first-dollar coverage** of all medically necessary care, funded by an equitable tax model;
- **Include all essential benefits** like dentistry, optometry, audiology, pharmacy and long-term care;
- **Transition hospitals to global budgets** instead of today's complex schemes, reducing their operating overhead and aligning their business interests with the public health imperatives of their communities;
- **Streamline physician reimbursements** with fee-for-service, salary or capitation. Every physician and medical group would be free to select the model they prefer. Rather than having to accept employment in a large system, physicians would find the business of running a practice far less onerous and be more able to retain their independence if that were their preference;
- Adopt **one clinically based formulary** with ready access to evidence-based medical exceptions;
- Include many more features as defined by the Working Group on Single-Payer Program Design.[9]

FIGURE 2

Cumulative growth in per-enrollee spending, 2008-2018



Kaiser Family Foundation data presented at Axios

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Economic Savings

Despite all of these benefits for patients and physicians, I would not be on board with Medicare for All were I not convinced that it is the most prudent strategy. Hundreds of independent economists,[10] including dozens of the most prestigious,[11] all came to the same conclusion: the U.S. would either break even or, more likely, have considerable economic savings by switching to Medicare for All. These studies do not even account for the indirect benefits, such as savings on workers' comp, improved health or increased productivity.

Perhaps the most telling and quantifiable measure of the impact of single payer on medical practice comes from an analysis of the average number of characters per ambulatory progress note in electronic medical records.

The two strategies that drive the economics of Improved Medicare for All are the same two strategies employed by most successful businesses: structural efficiency and meaningful price negotiations.

Medicare operates with an overhead of 2.3%, as compared to the 12-18% overhead of commercial insurers.[12] Medicare achieves these low levels of overhead because—unlike private insurance companies—it does not need legions of staff for sales, advertising, account management, aggressive utilization management, redundant information systems, eight-figure executive salaries and shareholder profits.

Some critics claim that Medicare for All would hurt physicians and hospitals financially. However, neither Medicare for All bill proposes using the current Medicare fee schedule. Instead, the bills establish a "physician practice review board to assure ... fair reimbursements for physician-delivered items and services."[13] These boards would be regionally representative and also bear responsibility for quality assurance and cost effectiveness.

Three recent studies (Mercatus, 2018; Rand, 2019; and Urban Institute, 2016) projected payments to physicians would remain close to the current $688 billion; their estimates under Medicare for All were $681 billion, $673 billion and $774 billion respectively.

In fact, Medicare for All would provide hospitals with tremendous savings. Today, hospitals in the United States spend 25% of their total budget on administration and billing, more than double what is required at comparable institutions in single-payer nations.[14]

Similar excesses exist in American physician office overhead; U.S. physicians spend two to three times as much as our Canadian colleagues on billing.[15] The overall average Canadian clinical payment per physician in 2018 was $344,978; in family medicine $280,763; psychiatry was $278,069; dermatology was $384,786; ob-gyn was $391,743; ophthalmology was $768,958.[16]

Malpractice insurance costs are far less onerous in Canada. The Canadian Medical Protective Association reports that 2019 malpractice premiums for family medicine in Quebec were $1,583; in British Columbia and Alberta, the rates were $3,420.[17] The 2019 average internal medicine premium in Missouri the same year was $13,425.[18]

Perhaps the most telling and quantifiable measure of the impact of single payer on medical practice comes from an analysis of the average number of characters per ambulatory progress note in electronic medical records. Epic, one of the world's most common EMRs, is implemented differently in every institution around the world. Epic carefully optimizes each unique installation in every institution, optimizing the software to meet the particular needs of the specific setting. In 12 other modern nations, these notes average 1,000 characters. In the United States, the average is 4,000 characters.[19] Here, our charting is structured to optimize reimbursement and protect against malpractice claims. Elsewhere, it is primarily focused on meeting the clinical requirements of a medical record.

When faced with an opportunity to relieve many of the pressures on medical practice, let's ensure that every American can get all medically necessary care, and reduce the economic drain that has taken over our national economy. The imperative to move forward with Medicare for All is clear.

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continued on page 25

George Hruza, MD, Installed as MSMA President

George J. Hruza, MD

SLMMS past president **George J. Hruza, MD, MBA, FAAD, FACMS**, was installed as 2020-2021 president of the Missouri State Medical Association at their virtual House of Delegates meeting on April 4.

Dr. Hruza is medical director of the Laser and Dermatologic Surgery Center in Chesterfield, and is adjunct professor of dermatology at Saint Louis University. He previously was an associate professor of dermatology, surgery and otolaryngology and director of dermatologic surgery training at Washington University School of Medicine. He has trained 21 Mohs surgery fellows.

Active in SLMMS, Dr. Hruza was president in 2008 and served on the Council from 2002 to 2009. He received the SLMMS President's Award in January 2015 in recognition of his advocacy work in response to insurance companies narrowing their provider networks and terminating many physicians from Medicare Advantage programs.

Dr. Hruza just completed a term as president of the American Academy of Dermatology. He also has served as president of the American Society for Dermatologic Surgery (ASDS) and the American Society for Lasers in Medicine and Surgery (ASLMS). He has authored more than 160 scientific articles and book chapters and four textbooks on laser surgery, and has lectured on dermatologic surgery and laser surgery on five continents.

He earned his medical degree from New York University, where he completed his dermatology residency. He also completed an internal medicine internship at New York Presbyterian Weill Cornell Medical Center, a laser surgery fellowship at Harvard University and a Mohs surgery fellowship at the University of Wisconsin-Madison. His MBA is from Washington University.

Herluf G. Lund, Jr., MD, Elected National President of the Aesthetic Society

Herluf G. Lund, Jr., MD

Herluf G. Lund, Jr., MD, FACS, has been elected president of the Aesthetic Society, an organization dedicated to aesthetic plastic surgery with over 2,600 members worldwide.

A partner in St. Louis Cosmetic Surgery in Chesterfield, Dr. Lund was a SLMMS Council member from 1997-2000, including one year as treasurer (1999) and one year as secretary (2000). A member since 1991, Dr. Lund remains active in SLMMS, serving on several committees and as a Third District Delegate from SLMMS with the Missouri State Medical Association.

The Aesthetic Society works to advance the science, art and safe practice of aesthetic plastic surgery and cosmetic medicine through education, research and innovation.

While COVID-19 has supplanted Dr. Lund's original goals for his presidential year, he said, "My priorities now are to help plastic surgeons and their patients return to delivering and receiving the treatments and services they desire and to do so in an as safe of a manner as possible."

Better Health for All… *continued from page 23*

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