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Universal Health Care for Americans

Frank Clemente*

We face a great irony in America today. The United States has the best health care in the world and is envied by all countries for its technological and research capabilities as well as its potential to deliver health care, yet our country has the worst health care delivery system of the industrialized world. We are best in health care and worst in delivering it. We rank 17th in the world in infant mortality and tenth in life expectancy. In 1991 in inner-city Detroit, an infant in the first year of life had less chance of surviving than infants in many third-world countries.

We have 32 million Americans with no health insurance and tens of millions more who are underinsured. Many families, even some with health insurance, have been bankrupted or face bankruptcy because of health care costs. Health insurance underwriting policies, because of economic conditions, preclude people with preexisting health conditions or even because of a person's occupation. A male hairdresser, for instance, may wrongly be denied health insurance because he is "suspected" of being homosexual and is therefore considered more susceptible to contracting the human immunodeficiency virus and developing the acquired immunodeficiency syndrome.

The Medicare system is facing catastrophe. According to a recent study, Medicare will probably be bankrupt at the turn of the century (1), and no one knows where the money will come from to fill those needs. Health care inflation is skyrocketing, running at two to three times the general rate of inflation. Health care expenditures are currently 12% of our gross national product (GNP)—two times the size of the defense budget. Some estimates show that by the year 2010 over one-third of our GNP will be going to health care. This is an enormous industry.

All these problems with our health care system are wreaking havoc on our hospitals. A recent General Accounting Office (GAO) study on trauma centers (2), which included Henry Ford Hospital, Mercy Health Services, and several other hospitals in Detroit, reported that 15 of the 35 trauma centers studied have closed in the last five years. Trauma centers serve an increasing number of people without health insurance and are being bankrupted because of the cost of uncompensated care. Long-term care is another problem: for hospitals, Medicaid and Medicare reimbursements are 75% to 90% of what it costs to deliver the service. Even for hospitals that remain open, cost-reduction efforts needed for survival mean an increasing number of hospital workers being laid off or underpaid for the important work they do.

What is encouraging about all of these problems is that health care is now moving from being a low-income problem to a middle-class problem. This is important, for as health care becomes a middle-class problem and affects a broader number of Ameri-

cans, there will be a great public outcry for significant change in our health care system.

To solve this health care crisis we need to learn the lessons of other countries. All other industrialized countries provide universal and comprehensive care to their people, even South Africa, although it still fails to provide health care for its native black Africans.

One proposition is that every American be given an "American card" to allow them to go to the physician and the hospital of their choice and to give them universal, comprehensive coverage that would save money, be more efficient and more equitable, and still deliver top quality health care. This is a proposition that Congressman John Conyers, Jr., (D-MI), started with a few years ago when he requested the GAO to compare the Canadian health care system with that of the United States. The GAO is the watchdog arm of Congress. Because the GAO works for everybody, both Democrats and Republicans, it is the most objective source Congress has to find out whether or not a proposal will work. The integrity of the GAO is based on its being non-partisan and nonjudgmental.

Health Systems: Canada Versus the United States

The GAO found many similarities between the two health systems (3). First, contrary to popular belief, Canada does not have a socialized medicine system. Its system is much like ours in that it is a third-party payer system. The government is a third party, and it pays to the hospitals and to the physicians on behalf of the people who are a part of that system. A total of 95% of Canadian physicians are in private practice. They bill the government, as is done here in America, on a fee-for-service basis. A total of 90% of the hospitals in Canada are either private or non-profit, and the other 10% include veterans hospitals and some provincial psychiatric hospitals.

On the two major health indicators, life expectancy and infant mortality, Canada does significantly better than the United States. Canadians tend to live two years longer than Americans, and their infant mortality rate is one-third better than ours.

The key features of the Canadian health system include universal access, portability of insurance between jobs and regions, and public administration on a nonprofit basis. To assure uni-

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versal access, every citizen of Canada is issued a card through a program that is administered on a provincial level, not nationally. The card allows them to seek care when they need it and from whom they need it regardless of their economic status or their health care status (a preexisting condition is irrelevant). Care is comprehensive which means there are no copayments, no deductibles, no extra costs for services. It is against the law for a physician to bill a patient for any additional service, and thus there is no discouragement of seeking care based on extra cost. Inpatient, outpatient, and physician services all are covered.

Portability of health insurance is a big problem in the United States. Many people with a health condition cannot change jobs for fear the insurance carrier at the next employer might exclude them because they have a preexisting condition. No such problem exists in Canada. Citizens can move to a different region or province and remain covered, no matter what.

The feature of public administration on a nonprofit basis means that all the money runs through a single administration, in this case the federal government. The federal government gives money to the provincial government which negotiates physician fees and costs of hospital services and then pays the bills. Thus the operation is highly streamlined. Contrast that to the United States, where we have at least 1,200 insurance carriers, 73 Blue Cross/Blue Shield associations, Medicare, Medicaid, and a large network of health maintenance organizations (HMOs) across the country. Everybody's trying to figure out who owes, who's eligible for what, how much it costs, what can be excluded, etc.

Because there is no access problem in the Canadian health system, the GAO first studied how successful Canada has been in terms of its cost containment. Up until 1971 the United States and Canada generally had the same kind of health delivery system. Health care expenditures were also similar, 7.4% of the GNP for Canada and 7.5% for the United States. In 1971 Canada instituted national health care and the United States continued its programs begun in 1965, Medicare for the elderly and Medicaid for the poor. The first major finding of the GAO study is the difference in GNP devoted to health care. In 1989, health care expenditures in the United States had risen to 11.6% of the GNP, whereas in Canada expenditures were 8.9%, a gap of 2.7% in GNP. In terms of dollars, if the United States had kept its health care spending at the same percentage of GNP as Canada does today, the cost savings would be about \$135 billion in 1991 alone. Remember, Canada is covering everybody, whereas we have 32 million uninsured and millions of Americans pay billions of dollars in copayments and deductibles, all expenses included in the Canadian system. On a per capita basis, Canada is spending 3.7% on health care whereas the United States is spending 4.5%. In terms of dollars, for each person in the health care system in the United States, we spend about \$700 more per person compared to Canada.

Cost savings

The GAO found that the greatest savings are being achieved in three main sectors: 1) the hospital sector, a 32% difference between cost of hospital care in Canada versus the United States;

2) the physician sector, a 29% difference; and 3) in the administration of insurance plans, a 17% difference.

Administrative sector—A major factor in cost savings is reducing administrative waste. The Canadian National Health System is a big paperwork reduction act for everyone, for hospitals, for the government, for the physicians. Here the GAO found the largest amount of savings. For example, Massachusetts Blue Cross/Blue Shield, which insures a few million people, employs over 6,000 people. Canada, which insures 26 million people, employs fewer people than Blue Cross/Blue Shield of Massachusetts due to an enormous reduction of paperwork. Canada spends \$18 per person each year on paperwork whereas we spend \$95 per person on paperwork. Spread that out through the entire economy and tens of billions of dollars are saved. In the United States, physicians spend hours filling out forms. Hospitals have huge billing departments filled with people devoted to billing Blue Cross, billing Medicaid, billing Medicare, billing dozens of other insurers. In Canada this complicated—and costly—billing is done away with by streamlining it under a single-payer system. The billing department at the Toronto General Hospital is so small that a United States television crew sent there to film a story literally could not find it. The difference in administrative savings is truly remarkable.

Physician sector—Because Canada spends much less on health care per person, many assume that Canadians receive worse care, that they are not seeing the physician as often because there are not as many physicians, and that the physicians there are unhappy and want out of the system. The GAO study found that not only do Canadians see their physicians more often, there are actually more physicians per person compared to the United States. Canadian physicians were found to be relatively happy with the system, and the cost of delivering services in the physician sector was found to be one-third less in Canada than in the United States. How is Canada reducing the physician costs? Administrative savings is one major area, and a second area, which scares many American physicians, is that Canada does set fee limits. Basically, the provincial government negotiates physician fees with the Provincial Medical Association. The government has a set limit to spend each year and physicians can receive only a specified amount for the various services performed. Physicians cannot receive any more than the set fee and cannot bill their patients for extra services. The result has been a substantial drop in real fees by 20% since 1971. The physicians have made up some of that difference in two ways: 1) by saving a large amount of money on billing, and 2) by increasing utilization. The increase in utilization may not necessarily be good, so there are a few problems there.

The GAO found that the net income of Canadian physicians is relatively close to that of United States physicians in the general internal medicine area, whereas there is a difference in income for physicians practicing in specialty areas of medicine. Overall, there were lower professional expenses for Canadian physicians as a percentage of gross income, 36% versus 48% for the United States.

Malpractice is not a big part of the savings between the United States and Canada. As part of the overall savings difference in the physician sector, it is less than one-fifth of the total.

Hospital sector—The GAO found that Canada is able to achieve high savings in the hospital sector through the global budgeting scheme. Global budgets are essentially lump-sum payments distributed to a hospital like a paycheck, every other week, 26 times per year. The provincial government informs the hospital how much money it will receive in a given year for its operations, and the hospital is required to determine how to rationalize its services within that budget.

An advantage of the global budgeting scheme is greater efficiency, because the hospital knows how to plan according to its budget. It is also an incentive for a hospital to be much more efficient with its resources.

Disadvantages include more limited services and limits on availability of technology. Interestingly, the global budgeting scheme has not affected the number of hospital beds. There is still much excess capacity in Canada. However, through global budgeting, Canada has significantly limited the growth of hospital expenditures; the amount and availability of high-technology services has been limited as well.

Many have been concerned that the queues in Canada would result in people coming to the United States to seek care in Detroit, Buffalo, and other cities along the border. Perhaps the most important contribution of the GAO study is in this area. They found that the queues in Canada are for the most part not significant and exist in eight specialty areas including two principal diagnostic areas (magnetic resonance imaging [MRI] and computed tomography) and four surgical areas (coronary bypass, lens implants, hip replacements, and lithotripsy). The study found that of the 7,000 or more different procedures that physicians perform, the queue problem is in these selected services. It is not a problem for those people needing emergency care but for those needing urgent and elective care. Canada has rationalized care rather than rationed care. It has made a deliberate decision to allow its citizens to come to Detroit for cardiac operations, primarily because they pay the same rate that they would pay in Canada. For cardiac operations in the United States, Canadians pay at the Canadian rate, which is 50% or less than what a United States hospital charges an American. Canada has decided that at this point in time it is cheaper to send Canadians to the United States for such care instead of setting up a new operating unit or buying a new piece of MRI equipment.

Cost implications

The most stunning finding in the GAO report is that because of savings that could be achieved by adopting the single-payer system, the United States could insure the 32 million underinsured and uninsured and eliminate copayments and deductibles for everyone without increasing current costs. Aside from hospital global budgeting and controls on physician fees, the administrative savings alone under the single-payer system—GAO projected \$67 billion per year—would be enough to take care of all the uninsured and underinsured and to eliminate copayments and deductibles for everyone else. Add to that the global budgeting of hospitals and limitations on physician fees, the savings in the long run would amount to \$150 billion to \$200 billion a year, because the GNP curve of health care would re-

main at the current percentage and not increase. With implementation of such a system, we would probably be saving \$200 billion a year by the turn of the century.

In terms of the queue problem, we would essentially be spending the same amount of money we're spending now. We will still have the same kind of care and the same kind of technology. We have a tremendous amount of underutilized technology. Presumably, we could keep the same quality of care and avoid the queue problem that Canada has experienced.

Key Lessons from Canada

The key lessons from the GAO study are as follows:

1. We should implement universal access to health care not only because it is morally right but also because it will make the system simpler. When everyone is included in the system, no one has to figure out who shouldn't be in the system when it comes to billing, to hospital admission, etc., and the amount of paperwork can be reduced drastically.

2. We should implement a uniform payment system and have uniform fees. This will also simplify the billing process, eliminate administrative waste, and reduce the cost of health care by tens of billions of dollars.

3. In the long run, we should slow the growth of health care as a percentage of the GNP. Our population is growing older and we need serious cost control measures.

The GAO study recommends global budgeting for hospitals and controls on fees for physician services while keeping the best of the United States system. Canada has in a sense experimented for us. They have had 20 years of operating under their system and know what is good and what is to be avoided. We should keep our technology and our research which is the best in the world. We need to maintain some level of data collection, which Canada does not do, to evaluate outcomes of medical care, and we need to incorporate more managed care procedures.

Canada is considering adopting an HMO structure as a way to decrease or limit utilization. The limitation on physician fees has resulted in an increase in utilization, and Canada feels that a managed care regime would help deal with that problem.

Universal health care in America is a moral imperative and a financial necessity. It is a moral imperative for people who do not have access to care and for those who are being bankrupted by the cost of care, and it is a financial necessity for all of us who have insurance because our benefits will erode as the cost of health care increases and as our industries and businesses become less competitive.

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