

The health care debate has now moved from the House to the Senate. It will still be some time before a final bill is produced. But what is becoming apparent to me and many of my colleagues is that our profession and the health of our patients is little more than a political process with winners and losers not necessarily based on what is right for the medical care of our patients. Lobbying and campaign dollars are leading the way to what may be a worse nightmare than the nightmare of medical economics we find ourselves in today.

The question we need to ask is ‘how do we provide basic health care to all Americans without breaking the bank?’ To that I will add the goal of placing the money designated for health care into the hands of those who provide the care as well as those providing the associated services and goods. This can only be done if the reimbursement is coordinated by a not for profit clearinghouse. Basically that is a single payer system with no obligations to profiteers or shareholders. It needn’t be government run but government oversight is crucial.

As a busy practicing urologist I can assure you that Medicare is the easiest reimbursement organization that I deal with. When I subtract my administrative cost of dealing with the insurance industry, it may be preferable to get paid by Medicare at its (sometimes) lower rate. Add to that the anxiety felt by both patient and physician and it is no contest. Medical decision making is often transferred from physicians to insurance company clerks.

The current House plan provides for the availability of health insurance for all as well as a broadening of the definition of who may be covered by Medicaid. It does so by increasing the financial burdens of business while reducing reimbursement to the providers of care—an already overstretched and overtaxed group. Insurance companies on the other hand are handed an increased customer base with a few mild restrictions on who may be covered. It does not dismantle the cumbersome rules and roadblocks placed in the paths of those receiving care.

The alternative would be a financial clearinghouse set up to reimburse providers at rates set by CMMS in a similar manner to how that is done today. It needn’t be government run but certainly there would be government and non government oversight to maximize efficiency and minimize fraud. 100% of every dollar would go to health care and the cost of administration of the plan. Compare that with recent reports from the Senate demonstrating medical loss ratios of insurance companies to range from 65% to 85% but never to 100%. Just the term ‘medical loss ratio’ says it all—insurance companies are there to make money for their executives and their stock holders. Health insurance companies see any money spent on health care as a loss and to be avoided if possible.

Financing the system would be simple. Premiums that are currently being paid by businesses would be diverted to the payer system. I would expect that with the loss of the profit factor, there would be plenty to pay for all who are currently covered by insurance as well as the many that are not. That is a tax that I would be happy to support. In the long term I don’t think that it would cost me, an employer, more than I currently spend.

Nor do I think that the congress would need to increase the current budget by as much as it would with the current plan passed last week.

I am not promoting the demise of health insurance companies. While basic care would be covered through extending this public option to all citizens, there will still be a place for insurance for uncovered services or other add ons. This has worked well in other countries such as Ireland. My own friend was struck ill while visiting this country and was covered under an extension policy during his three month convalescence in the U.S.

Some have commented recently that a public option would be the death of insurance companies. To that I say 'so what'? Progress often takes its toll on certain industries. I have not seen a repair shop for horse drawn carriages lately nor can I repair my eight track tape player. In the case of health care, the choice may be which industry is worth more-the insurance industry or the health care provider. I believe we have more to lose if more hospitals close and physicians take early retirement in droves.

In order for such a plan to work there needs to be a number of other adjustments in how we administer health care. Chief among them is the disconnect between the states and the federal government. Medicaid is a federally mandated but locally administered plan. It provides some revenue to hospitals but the majority of physicians can not justify working at the rates provided in New York State. \$6 is simply not worth the time to bill when a patient is seen in the hospital or in the office. Medicaid covered patients do not often receive the same quality of care as do others.

Medicaid has however been defrauded by clinics, unscrupulous physicians and medical supply companies on numerous occasions. Moving the Medicaid patient population to the federal system would simplify matters greatly. While there may be regional differences in reimbursement, there is no need to tax the state governments with the administration of health care.

Professional oversight is also of great importance to the success of such a program. Committees of physicians, hospital administrators and other health care professionals can continue to maintain standards of care through CMMS and the regional departments of health. Covered services may not entitle a person to Cadillac care but add on insurance policies can be the solution for such needs. Religious considerations do not belong in health care legislation. The abortion clause in the House bill reeks of political gaming and not equitable health care reimbursement.

Finally the SGR or sustained growth rate formula for physician reimbursement needs to be overturned and revised immediately. Reimbursement to hospitals and physicians has been taken down to bare bones. It is very simple-a growing population needs more care and that costs more money. The concept of a zero sum game was flawed from the beginning and Congress needs to address it now. Should Congress choose to cash in on the SGR debt, medical practices would fold quickly.

The system that I propose is not 'socialized medicine'. The latter term is blurted out by an assortment of Republicans and industry executives to scare patients and their independent minded physicians. Decisions regarding evaluation and treatment will remain the physician's. Payment will be determined in a manner similar to current methods. In my years in practice, the privilege of treatment and the cost of providing the latter have been increasingly problematic and blocked by insurance companies.

By its very nature, law making is a political process. But when the political process is so driven by the profit motive, the resulting laws will be flawed. We have elected a president who claimed that money will be taken out of politics. But based on the conversations heard coming out of Washington these days, money still plays a key role in forming policy.