

WILL WE LEARN FROM THE EXPERIENCE OF OTHERS?

The whispers within the Washington DC beltway have become audible noises. National health insurance, or some national health scheme, is being discussed at length by presidential candidates again. How beneficial it would be, they say, to have a single payer, to have health insurance coverage for all, to include the 43 million Americans who currently are uninsured. Indeed, it would be wonderful, were it not for a few problems most difficult to overcome.

Let us look at the experience of other nations who have a national health insurance scheme. Nearest to us is Canada. Indeed, Canada has a health insurance program that encompasses nearly all of its residents. What is the quality of that coverage? In a New York Times International article of January 18, 2000, James Brooke describes in graphic terms conditions at Canadian hospitals that would not be acceptable here in the United States. Patient's beds lining the halls of a 3-year-old hospital in Montreal, awaiting major surgical procedures, waiting lists to get on waiting lists, limited national drug formularies, newspapers decrying the state of affairs, these are the issues the Canadian health services have to deal with. Some Canadians have an alternative solution: they can escape to the United States and pay for timely care, but only if they are able to afford it. In some instances, the Canadian government has even authorized payment for necessary care in the United States when such care was either not available, or not available in a reasonable time frame in Canada.

Until recently, such escape was not available to citizens of the United Kingdom. To be sure, there are choices as well. One can purchase private health insurance to receive priority treatment; the option of being treated privately on a self-pay, fee-for-service basis is available in private hospitals, but if one cannot afford such luxuries, well, then there are waiting lists to get on waiting lists.... and the offer to "take a seat". While the waiting lists for care have been reduced somewhat, the waiting lists to get on the waiting lists have increased, according to an article in the New York Times by Sarah Lyall. Recently, the British National Health Service (NHS), responding to a national outcry because of waiting periods in excess of one year to receive specialist care, allowed more than 40,000 patients to seek care in other countries of the European Community.

Long waiting periods for care, even reasonably urgent care, have plagued nearly all countries with a national health care scheme. In the United Kingdom, France, Germany and the Scandinavian countries, supplemental private health insurance companies thrive. In all of these nations, government committees determine what services are covered. In most of these countries, specialist care can only be obtained with a referral from a primary care gatekeeper, and there are significant disincentives for primary care physicians to refer. In some instances, primary care physicians have to pay back to the government for referrals in excess of certain limits at the end of a fiscal year.

Most countries in Europe that have national health schemes do not give individuals the choice of opting out. Health insurance premiums are simply deducted from the paychecks by employers.

Next year is an election year. Healthcare will, without a doubt, be a major issue for all the candidates. Medicare reform and the addition of a drug benefit have attracted significant

attention, but numerous approaches to universal health care will be bandied about. When one considers Congress' fumbling over the Medicare drug benefit, the possibility of Congress devising a cogent national health insurance and healthcare scheme becomes a nightmare rather than a dream.

It is fair to say that none of the industrial nations has found a good solution to the healthcare issue. What worked twenty years ago is no longer acceptable to a much more sophisticated patient population today, nor will the solutions acceptable to much smaller nations necessarily work for a country of three hundred million people, some of whom have to travel distances greater than the diameter of some European nations to reach secondary or tertiary care.

Clearly, the "take a seat and wait" approach to healthcare is not acceptable to American patients. Rationing of scarce healthcare resources is also not yet an acceptable solution in today's healthcare environment.

To date, no nation has been able to create a healthcare system that encompasses the three essential features: universal coverage, high quality of care and controllable healthcare costs. Experts in the field of healthcare economics believe that only any two, but not all three of these criteria are achievable. If we assume that belief to be correct, then we must assume that either universal coverage or high quality of care is not achievable, given that available resources are limited.

What, then, are the answers to the looming crisis?

They are manifold, and they require adjustments on the parts of patients, insurers and physicians alike. If we are to preserve a semblance of rationality in healthcare, many things will have to change. First and foremost, the environment in which physicians' practice has to change. We cannot continue to practice expensive, protective medicine because of an out-of-control legal system. We, patients, relatives of patients and physicians, must once again accept the fact that death is a natural consequence of life, and that the prolongation of life at all costs is against nature. We also must accept that less than desirable results are not necessarily someone's fault. We, as physicians, must accept the fact that there are "best practices" with respect to treatment of diseases, and that the establishment of such "best practices" does not cause us to lose face, or diminish our own value.

The healthcare insurers' market place must change. The immature market with hundreds of health plans is clearly inefficient and contributes significantly to the rising costs of healthcare because of its administrative inefficiencies. A mature market, with only a small number of large insurers who can take advantage of economies of scale, albeit under proper scrutiny from governmental agencies, appears to be a viable alternative to a single payer, national bureaucracy.

If not already, group practices, whether single or multiple specialties, will become the model of the times. Solo practitioners will simply not be able to meet the many requirements of a practice even in the near future.

A rather telling indication that not all is well with our healthcare "system" is the fact that, according to a 2003 survey by Merritt, Hawkins & Associates, 25 percent of all final-year

medical residents surveyed indicated that they would choose a field other than medicine if they had a chance to start their education again. In 2001, only 5 percent of those surveyed felt that way.

The idea of a governmental administrative behemoth administering the healthcare of 300 million people in a territory as vast as the United States is, at best, utopian.

We will have the opportunity, on a small scale, to observe the effect of universal coverage in the State of Maine. In early June, both houses of the Maine legislature approved universal healthcare coverage for the State of Maine. Governor John Balducci, a Democrat has signed the bill, as he was its leading proponent.

Whatever the answers to our healthcare problems may be, I do not believe that the solution lies in a national system of health insurance and healthcare administration. Perhaps a cooperative venture between the Federal government and the private insurance sector might bring a workable hybrid system into existence.

As always, your comments and contributions are most welcome.

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