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Would National Health Insurance Benefit Physicians?

By Devon Herrick

Physicians for a National Health Program and other groups advocate a single-payer health care system as a way to improve quality and increase access to health care. The idea may be appealing to many physicians, frustrated by constraints on their medical practices that may reduce the quality of patient care. However, rather than improving the conditions physicians face under our current system of multiple payers, national health insurance would make matters worse.

More Time for Patients? Physicians say they spend too much time and effort billing, negotiating fees and interpreting numerous insurance contracts. Since the advent of managed care, physicians also complain they are under pressure to spend less time with each patient. But American doctors are actually spending more time with each patient than in the past.

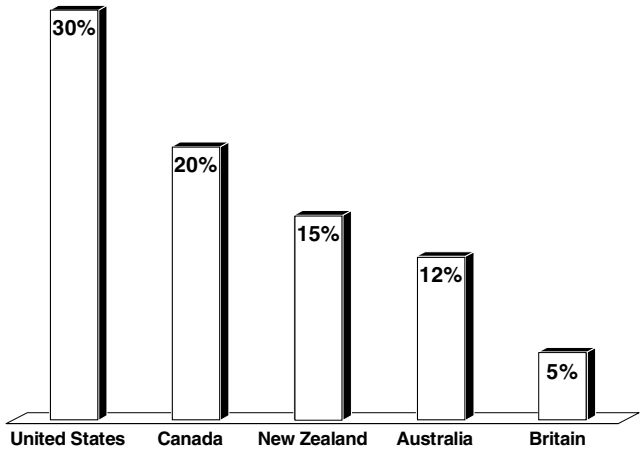
According to surveys published in the *New England Journal of Medicine*, American physicians spent an average of 18 to 20 minutes with each patient in 1998, up one to two minutes from 10 years earlier. They also spend more time with patients than doctors in other countries. [See Figure I.]

While Canadians make 6.6 visits per capita to a physician each year, compared to the U.S. average of 6.0 visits, the British average is 5.4 visits, somewhat less. However, with 29 percent and 59 percent fewer physicians per 1,000 population, respectively, Canadian and British doctors must deal with far more patients than their U.S. counterparts. They average seeing about 40 percent more patients per year than American doctors (3,143 in Canada and 3,176 in Britain, compared to 2,222 in the United States).

Less Paperwork? According to Mark Litow, consulting actuary for Milliman & Robertson, writing in *National Underwriter,* doctors in the United States spend an average of $8 to $18 to process paperwork and file an insurance claim. Twenty to 30 percent of claims have to be refiled, adding even more fees. These are major factors reducing doctors' work satisfaction. Some doctors think that eliminating administrative tasks would allow them to spend more time with their families without reducing their incomes.

FIGURE I

Patients Spending More Than 20 Minutes with Their Doctor



Source: Karen Donelan et al., "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs*, Vol. 18, No. 3, May/June 1999. Commonwealth Fund 1998 International Health Policy Survey. Response reflects most recent doctor visit.

However, physicians working under national health insurance also complain about time-consuming administrative tasks and overwork. For example, before resigning in frustration, English neurologist Michael Gross worked 4,000 consecutive days on call at the Surrey & Sussex Healthcare Trust, where he shared a six-foot by nine-foot office and one telephone line with four other people.

Certainly, doctors in the British National Health Service are more dissatisfied than their American colleagues: a recent survey found that eight out of 10 family doctors would quit the NHS if they could. And hundreds of family doctors recently announced plans to close their offices for a day to protest working conditions.

What about Physician Compensation? U.S. physicians also complain that they are expected to do more while receiving reduced compensation. According to *Medical Economics*' 1999 Continuing Survey, 44 percent of office-based physicians received a portion of their annual compensation from lower, capitation payments from insurers in 1998.

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Like managed care, one way National Health Insurance reduces health expenditures is by squeezing the compensation of doctors, nurses and other health care workers. But a single-payer system can squeeze physicians' compensation much more effectively. According to a Commonwealth Fund analysis of physician incomes, adjusted for differences in the cost of living and inflation, derived from Organization for Economic Cooperation and Development data, doctors in other industrialized countries earn much less than physicians in the United States.

On the average, doctors in Canada and Germany earn about half as much as their U.S. counterparts; physicians in Austria, France and Britain less than one-third as much; and physicians in Finland, Norway and Sweden just one-fourth as much.

A single-payer national health insurance scheme can pay health care workers less because it is a monopsony, or single purchaser, of health care services. Just as a monopoly seller can raise prices above the market level, monopsonies can reduce the price of a good below its market level. In contrast, in a competitive health care market purchasers and providers have a more equal role in determining prices.

Physicians in Charge of Their Practices? One way that countries with national health insurance attempt to limit demand for medical services is by reducing the number of physicians, particularly in medical specialties.

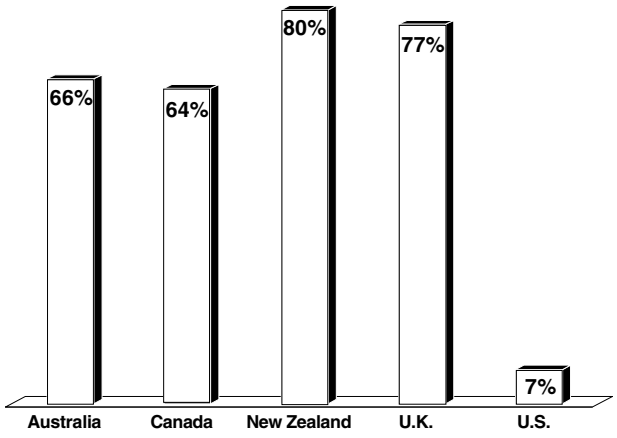
For instance, health authorities in Canada reduce the number of physicians by limiting medical residency positions to a number only slightly above the number of Canada's medical school slots. Medical students are required to complete a Canadian residency program in order to practice there. Yet, medical students who opt to study medicine abroad because they are unable to gain admission to Canadian medical schools have difficulty winning a Canadian medical residency slot unless they commit to practice for a number of years in an underserved (i.e., undesirable) area — usually as a family health practitioner.

Quality of Care? Patient queuing, or rationing by waiting, is another way to limit the utilization of health care and thereby reduce costs. The problem is widespread and a major problem for their practices, according to surveys of physicians in a number of countries. As Figure II shows:

- Approximately two-thirds of Australian and Canadian physicians sampled believe delays in care are a problem.
- More than three-quarters of British and New Zealand physicians sampled agree.
- But only 7 percent of American physicians say delayed treatment is a problem.

FIGURE II

Physicians Who Think Waiting to Receive Care Is a Problem in Their Practice



Source: Robert J. Blendon et al., "Physicians' View on Quality of Care: A Five-Country Comparison," *Health Affairs*, Vol. 20, No. 3, May/June 2001.

Delay of care is tantamount to denying care — yet one in five British physicians knows someone who has been harmed by delays in receiving treatment, while one in 20 knows someone who died as a result of being denied treatment.

Conclusion. Physicians in the United States are frustrated that paperwork resulting from our system of multiple payers consumes resources that could be used to improve the quality of care. Most industrialized countries have adopted national health insurance and have reduced or eliminated competition in the medical market place. They may have less paperwork, but they also have lower compensation and a heavier workload. Furthermore, it is apparent that they have not provided the same quantity or quality of care that Americans receive.

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