

## *Chapter Thirteen*

# Managed Care

### **MYTH NO. 13: SINGLE-PAYER NATIONAL HEALTH INSURANCE IS THE SOLUTION TO THE PROBLEMS OF MANAGED CARE**

Although the term *managed care* means different things to different people, in all its guises it involves interference in the doctor-patient relationship by third-party bureaucracies (employers and insurance companies, for example) whose primary interest is in controlling costs. Most doctors and many patients want a different system. But would they really be better off under single-payer national health insurance? Because of doctors' frustrations with managed care, a national health system might seem appealing. Some believe it would reduce administrative paperwork, overhead costs and allow physicians to spend more time treating patients. However, physicians in countries with national health insurance also express frustration. They are able to spend even less time than U.S. physicians with each patient, face more obstacles to providing care and receive even less compensation. Despite American physicians' frustration with uninsured patients and managed care, these problems seem to pale in comparison with the lack of resources and bureaucratic hassles experienced by their national health insurance counterparts.

### **THE MANAGED CARE REVOLUTION IN THE UNITED STATES**

In 1980 fewer than ten million people were enrolled in HMOs. Today nearly seventy-two million are, about one in four Americans.<sup>1</sup> Three-fourths of all

employees with health insurance are covered by some type of managed care. What difference has this change made?

For starters, it has meant fewer choices for patients and doctors. Only a few years ago, a person with private health insurance could see any doctor, enter any hospital or (with a prescription) obtain any drug. Today things are different. In general, patients must choose from a list of approved doctors covered by their health plans. Yet, employers switch health plans and, even if they don't, employees often switch jobs. So long-term relationships between patients and physicians are hard to form. Moreover, many people cannot see a specialist without a referral from a "gatekeeper" family physician and or even get treatment at a hospital emergency room without prior (telephone) approval from their managed care organization. Patients who fail to follow the rules may have to pay part or all of the bill out of their own pockets.

Under managed care, freedom of choice has been curtailed even more for doctors than for patients. Not long ago, most doctors ordered tests, prescribed drugs, admitted patients to hospitals or referred them to specialists and performed procedures based on their own experience and professional judgment. No longer. Now doctors who want to be on the "approved" list must agree to practice medicine based on a health plan's guidelines. For most doctors, the guidelines mean fewer tests, fewer referrals and fewer hospital admissions. Since the advent of managed care, many doctors complain that they are under pressure to spend less time with each patient. Doctors also say they spend too much time and effort on billing, negotiating fees and interpreting insurance contracts.

How well has managed care succeeded in controlling costs? That's not clear. There is some evidence of success in the 1990s. But by the end of the decade, managed care plans faced a backlash from patients and doctors. In response, the plans began to loosen their control over patient access to specialists and expensive treatments and the rate of increase in health care costs began to rise.<sup>2</sup>

There is also evidence that people dislike the idea of managed care more than they dislike managed care itself. Polls show that, although 80 percent of people are satisfied with the care they receive from their HMO, 45 percent have negative opinions about HMOs in general.<sup>3</sup> Another recent survey tracked people who were unaware of their true insurance status. People who thought they were HMO members even if they were not were more likely to say they were dissatisfied than those who thought they were not in an HMO even though they were.<sup>4</sup>

### **EFFECTS OF SINGLE-PAYER HEALTH INSURANCE ON PATIENTS**

American advocates of single-payer health insurance say that such a system would resolve virtually all of the major abuses of managed care.<sup>5</sup>

Would it? Consider the principal patient criticisms of managed care: (1) you may not be able to see a specialist when you want to; (2) you might not obtain expensive tests; (3) you may experience obstacles getting approval for surgery; and (4) you may have difficulty getting approval to enter a hospital. Yet, the problems American HMO enrollees face are minor compared to the hurdles faced by patients in other countries.

Almost all single-payer systems require patients to go through a gatekeeper who decides whether the patient gets a referral to a specialist. They also limit the number of specialists. Access to expensive technology is more difficult in single-payer systems than for patients in any managed care organization in the United States. Expensive technologies are rationed, including equipment necessary for diagnosis and treatment, such as MRIs. Admissions to hospitals are often cancelled or delayed.

As we noted in chapter 8, a recent study in the *British Medical Journal* compared services delivered by the British NHS with that of the California HMO, Kaiser Permanente. The study found the NHS provides far fewer services and less access to diagnostic tests and specialists than Kaiser, for only slightly less money.<sup>6</sup>

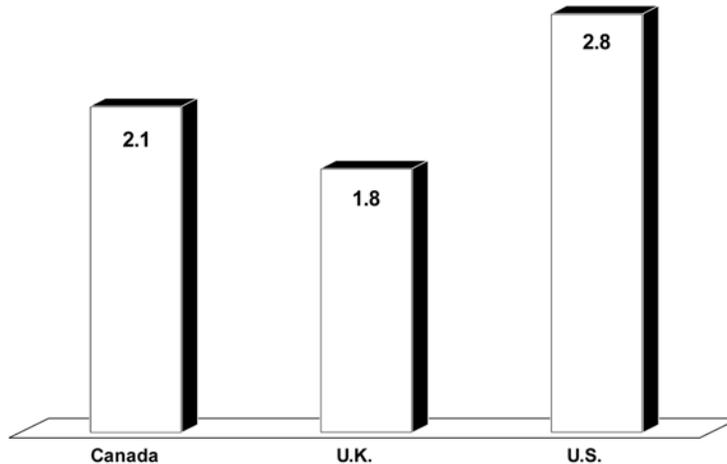
To make matters worse, advocates of single-payer insurance would take away an important right that all managed care patients currently have, the right to purchase their own care. Denied access to a specialist, U.S. patients can always go out of network and pay the cost themselves. Denied access to a diagnostic test, patients can pay for the test from their own resources. If the American advocates of single-payer insurance get their way, these private pay options will be outlawed.

### EFFECTS OF SINGLE-PAYER HEALTH INSURANCE ON DOCTORS: LIMITING THE NUMBER OF PHYSICIANS

In countries with national health insurance, governments often attempt to limit demand for medical services by having fewer physicians.<sup>7</sup> Dr. Lorne Tyrrell, president of the Association of Canadian Medical Colleges, says Canada needs about 540 new physicians each year to account for population growth and another 1,950 to counter attrition.<sup>8</sup> However, since 1980 Canada has as a matter of policy reduced the number of students accepted by its sixteen medical schools to 1,577 per year, which is only 63 percent of the number it needs.<sup>9</sup>

There are approximately five qualified applicants for every one accepted to Canadian medical schools, and Canada has 35 percent fewer physicians per capita than the United States (see figure 13.1). Some students, unable to gain admission, have opted to study medicine in other countries. Despite the short-

FIGURE 13-1

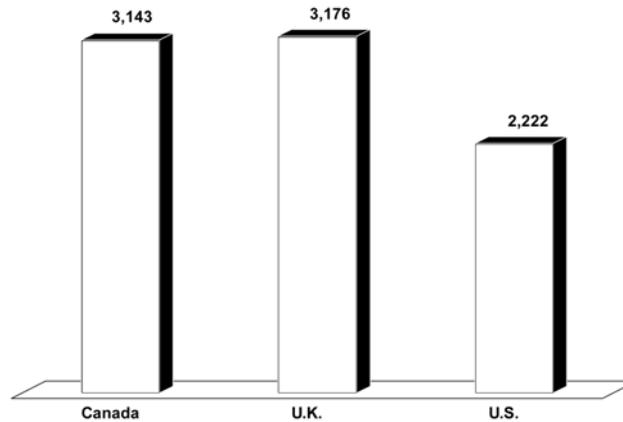
**Physicians per 1,000 People**

Sources: Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey and Varduhi Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs*, Vol. 22, No. 3, May/June 2003, pp. 89-105.

age of physicians, few of these foreign-trained Canadian doctors will ever be allowed to practice in Canada. Medical students are required to complete a Canadian residency program in order to practice there. But health authorities limit the number of residency slots to 100 for each 100 graduates of Canadian medical schools. For instance, the four medical schools in Quebec may only recruit a combined total of eight foreign medical graduates each year.<sup>10</sup> In most cases, the only way a foreign-trained physician can gain admission to a residency program is by promising to practice for a number of years in an underserved area.<sup>11</sup>

By contrast, about 16,000 students a year graduate from U.S. medical schools and enter graduate medical training. In addition, more than 5,100 foreign-trained medical graduates enter residency programs each year in the United States. Around 23 percent of these are U.S. citizens trained abroad while almost 40 percent are U.S. permanent residents. About one-third are non-U.S. citizens. There are virtually no restrictions on the number of graduate medical education programs, and no restrictions on the number of specialists.<sup>12</sup>

**FIGURE 13-2**  
**Patients Seen Annually**  
 (Average per physician)



Source: Gerard F. Anderson and Peter S. Hussey, "Comparing Health System Performance In OECD Countries," *Health Affairs*, May/June 2001.

### EFFECTS OF SINGLE-PAYER HEALTH INSURANCE ON DOCTORS: MORE PATIENTS, LESS TIME

Because there are fewer physicians, doctors who practice medicine under single-payer systems must see larger numbers of patients for shorter periods of time. As figure 13.2 shows, U.S. physicians see an average of 2,222 patients per year, but physicians in Canada and Britain see an average of 3,143 and 3,176, respectively.<sup>13</sup> Family practitioners in Canada bear even higher patient loads—on the average, more than 6,000 per year.<sup>14</sup> Thus, it is not surprising that 30 percent of American patients spend more than twenty minutes with their doctor on a visit, compared to 20 percent in Canada and only 5 percent in Britain.<sup>15</sup>

In a recent survey, 30 percent of Canadians reported having difficulty finding a family physician. The survey also found<sup>16</sup>

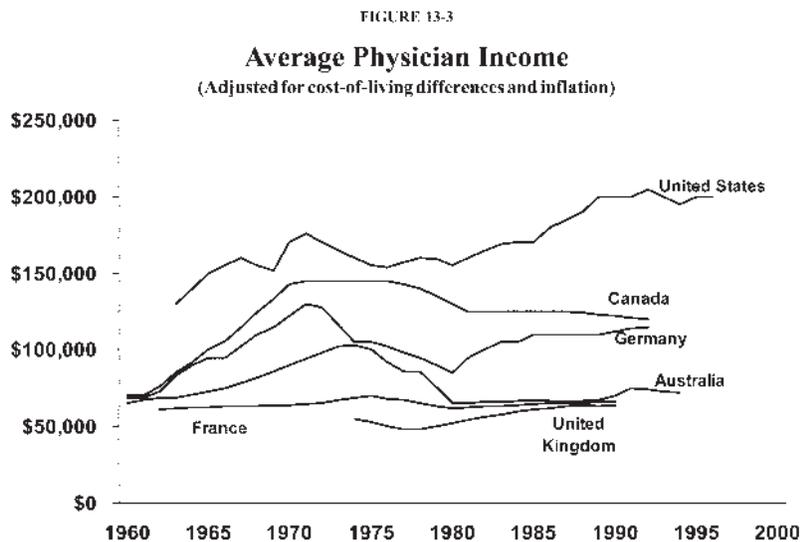
- Most family doctors' practices are full, and about 73 percent of all family practitioners do not routinely accept new patients.
- Of Canadian family physicians, more than 15 percent announced plans to stop practicing medicine in Canada in order to retire, practice in another country or for "other reasons" within the next two years.
- An additional 12.6 percent planned on taking a leave of absence or relocating their Canadian practice within the next two years.

The College of Family Physicians of Canada, which conducted the survey, concluded that the country needs 3,000 more family physicians now and predicted the shortage would worsen.

### EFFECTS OF SINGLE-PAYER HEALTH INSURANCE ON DOCTORS: PHYSICIAN COMPENSATION

Like managed care organizations, one way single-payer systems try to reduce 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 because it is a monopsony, a single buyer of a given good or service. Just as a monopoly seller can raise prices above the competitive market level, a monopsony buyer can reduce wages and fees below the market level.<sup>17</sup> As the Physicians' Working Group for Single-Payer National Health Insurance approvingly notes, "Such single source (monopsony) payment has been the cornerstone of cost containment and health planning in Canada and other nations with universal coverage."<sup>18</sup>

A Commonwealth Fund analysis compared physician incomes across countries after adjusting for differences in the cost of living. It found that doctors in other industrialized countries earn much less than those in the United States. As figure 13.3 shows, on the average doctors in Canada and Germany earn about



Sources: Gerard F. Anderson, "Multinational Comparison of Health Care: Expenditure, Coverage and Outcome," Commonwealth Fund, October 1998, and *OECD Health Data 1998*.

half as much; those in Austria, France and Britain earn less than one-third as much; and those in Finland, Norway and Sweden earn one-fourth as much.<sup>19</sup>

Advocates also would discourage a physician's entrepreneurial activities. As proposed by Physicians for a National Health Insurance Program, for example, doctors would be paid a negotiated fee for their work and the services of their support staff. As a cost-saving measure to reduce "medical inflation," physicians would not be reimbursed for office-based procedures such as an MRI scan. The reason for this approach is to minimize "entrepreneurial incentives,"<sup>20</sup> a euphemism for profiting by meeting patient needs.

### EFFECTS OF SINGLE-PAYER HEALTH INSURANCE ON DOCTORS: PHYSICIAN DISCONTENT IN BRITAIN

Dr. Michael Gross, a prominent neurologist, reported that he was on call 4,000 consecutive days at the Surrey & Sussex Healthcare Trust near London. After thirty-one years without a computer, and sharing one telephone with four other doctors, he finally resigned from the NHS when his neurological department was abolished.<sup>21</sup> His case is not surprising or isolated. Conditions in Britain's NHS are dismal by U.S. standards. British workloads are heavier and compensation is lower. Physicians have expressed growing dissatisfaction.<sup>22</sup> For example:

- In 2001, hundreds of family doctors announced plans to close their offices for a day to protest working conditions.<sup>23</sup>
- Between 20 percent and 25 percent of new doctors leave the NHS within five years of qualifying to practice medicine in Britain; many migrate to other countries or leave the medical profession altogether.<sup>24</sup>
- A study of medical graduates in Northwest England found that almost one-fifth had become disillusioned with the NHS and left over a ten-year period.<sup>25</sup>
- A survey of Scottish GPs found that 60 percent were considering leaving medicine for other careers because of working conditions.<sup>26</sup>

### A BETTER ALTERNATIVE TO MANAGED CARE: HSAs<sup>27</sup>

As noted in the introduction, someone has to choose between health care and other uses of money. That someone may be: (1) a government-created bureaucracy, (2) a private-sector bureaucracy or (3) patients making their own decisions in consultation with doctors. The first is the method of single-payer

national health insurance. The second is the method of managed care. And the third is envisioned in the creation of HSAs.

Even though savings accounts from which patients can pay medical bills directly have existed for a decade in South Africa<sup>28</sup> and for two decades in Singapore,<sup>29</sup> they are a relatively new idea in the United States. At the end of 2003, for example, only about 70,000 people had a tax-free MSA and an estimated 1.5 million had an HRA. The number of these accounts, which we described in chapter 10, is quite small for a country of almost 300 million people.

Despite our limited experience, the very idea of patient power generates intense opposition among people and organizations, ranging from Senator Edward Kennedy to Families USA to Consumers Union. We know from participation in public debates that critics often have very little direct knowledge about HSAs or similar accounts. They have never seen one. They have never owned one. They don't know anyone else who has ever owned one. But this lack of knowledge and experience has in no way tempered the knee-jerk zeal of the opponents.

Rhetoric aside, careful studies of the accounts do not bear out the arguments of the critics. Although critics claim people skimp on needed medical care in order to save money, the evidence shows otherwise. A Rand Health Insurance Experiment, conducted more than two decades ago, randomly assigned people to high-deductible (about \$3,000 at today's prices) health plans and plans that made health care free of charge. Both groups had similar health outcomes even though those with high-deductible plans spent less on health care.<sup>30</sup> Similarly, a National Center for Policy Analysis study of South Africa found no evidence that MSA holders skimp on needed care.<sup>31</sup>

Although critics claim that HSAs will not control costs, in the Rand experiment patients with high deductibles spent about 30 percent less on health care. Similar results have been reported from South Africa.<sup>32</sup> For prescription drugs in particular, a second NCPA study concluded that patients managing their own health care funds saved just as much as those in managed care, but without the cost of managed care.<sup>33</sup>

Although critics claim that health accounts help only the healthy and the wealthy, studies also rebut this criticism. A separate Rand study found that when given a choice of MSAs or managed care plans, the families that chose MSAs had lower incomes and greater health care needs than families that chose managed care.<sup>34</sup> The Urban Institute has concluded, "on average, lower-wage workers would benefit from switching to MSA/catastrophic plans."<sup>35</sup> The NCPA's study of the South Africa experience concluded that MSA holders were not healthier as a group.<sup>36</sup>

Critics also charge that patients with health accounts will pay higher prices because they do not have the bargaining power of large institutional buyers.

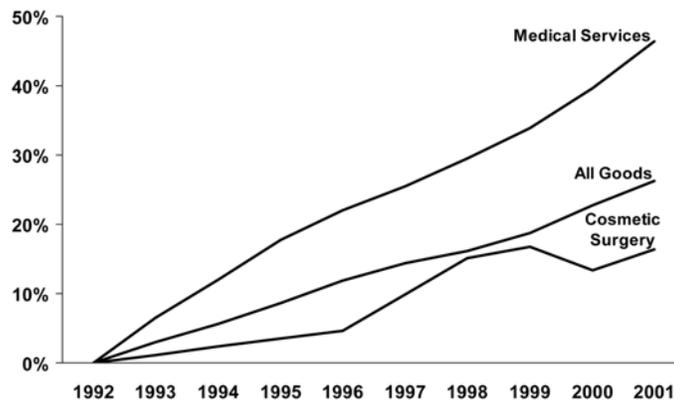
Yet, in virtually all MSA plans, patients spending from their MSAs pay the same prices their third-party insurer pay—rates negotiated with provider networks. Even when they go outside of the network, patients spending their own money often pay lower prices than large insurers because doctors are willing to give discounts if they can avoid the costs of dealing with bureaucracies.

### CASE STUDY: COSMETIC SURGERY

Prices for medical services have been rising faster than prices of other goods and services for as long as anyone can remember. But not all health care prices are rising. Although health care inflation is robust for those services paid by third-party insurance, prices are rising only moderately for services patients buy directly. As figure 13.4 shows, the real (inflation-adjusted) price of cosmetic surgery fell over the past decade, despite a huge increase in demand and considerable innovation.

FIGURE 13-4

### Price Increases for Medical Services and Cosmetic Surgery



Source: Authors' calculations using data from the Consumer Price Index (CPI) and the American Society of Plastic Surgeons.

Note: Cosmetic surgery index is calculated based on average price of common procedures weighted by their respective proportion of all cosmetic procedures. Procedures selected represent 54 percent of all cosmetic procedures performed.

Cosmetic surgery is one of the few types of medical care for which consumers pay almost exclusively out of pocket. Even so, the demand for cosmetic surgery exploded in recent years. Of the 6.6 million cosmetic procedures performed in 2002, 1.6 million were surgical procedures, nearly four times the number performed in 1992. Despite the quadrupling of the number of surgeries, cosmetic surgeons' fees remained relatively stable. What explains this price stability? One reason is patient behavior. When patients pay with their own money, they have an incentive to be savvy consumers. A second reason is supply. As more people demanded the procedures, more surgeons began to provide them. Since almost any licensed medical doctor may obtain training and perform cosmetic procedures, entry into the field is relatively easy. A third reason is efficiency. Many providers have operating facilities located in their offices, a less expensive alternative to outpatient surgery at a hospital. Surgeons generally adjust their fees to stay competitive and usually quote patients a package price. Absent are the gatekeepers, prior authorization and large medical office billing staffs needed when third-party insurance pays the fees. A fourth reason is the emergence of substitute products (see below).

Web sites help create a competitive market for cosmetic procedures. One, [www.Bidforsurgery.com](http://www.Bidforsurgery.com), is a reverse auction site that works much like eBay. Physicians submit competitive bids to perform procedures. The potential patient compares bids and quality indicators—information on residency, education, board certifications, and so forth. Patients can select a bid from among those physicians bidding or reject them all. If the patient does choose one of the bids, he or she gets a free consultation with the selected physician before making a final commitment.

A common perception is that innovation results in health care inflation. But in cosmetic surgery, innovation often lowers the cost. Take facelifts, for example. Surgical fees for facelifts increased only 20 percent between 1992 and 2001 (which in real terms is a price reduction), according to data from the American Society of Plastic Surgeons.

Holding the cost of facelift surgery in check were cheaper procedures designed to reduce the appearance of aging. Laser resurfacing (\$2,232) can replace or delay surgical facelifts in some patients. Retin-A treatments (\$124 per visit), botox injections (\$388), collagen injections (\$333), chemical peels (\$516), dermabrasion (\$1,254) and fat injection (\$1,053) are other facelift alternatives. These less invasive (and less expensive) procedures may be attractive, compared to a facelift costing \$5,007 in surgeons' fees alone. Cosmetic surgeons also have incentives to find new products to meet customer needs. Laser hair removal, for example, is now common.

The contrast between cosmetic surgery and other medical services is important. One sector has a competitive marketplace and stable prices. The other does not.

## NOTES

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