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EXECUTIVE EDITION FOR COMMUNITY HOSPITALS

SINGLE PAYER...

by Jim Burnette, President/CEO, HospitalMD

Discussions about the problems with our current healthcare "system" abound; especially with the growing cost and the extent of access. No one would disagree about the progressive, unbridled cost. Problems associated with access however, are more problematic since access can refer to (1) convenient availability (proximity); and (2) patient choice of (a) provider, (b) how much service is needed or wanted, and (c) how to pay for these services.

A controversial approach promoted by some in political and policy debates is a "single-payer system" ("SPS") as a better method of paying for services and increasing access. SPS has become a euphemism for "Medicare for all" as the only strategy; and the federal government as the only entity capable of reducing cost and ensuring access.

ARGUMENT FOR SPS

The "simple" argument (pitch) for SPS is that everyone is entitled to healthcare including the amount of healthcare provided as determined by government (not you), and that the government subsidizing a significant portion of the cost is the best vehicle. A SPS further guarantees that everyone has equal access (proximity, choice, how much they are willing to pay, and how they are willing to pay) and without regard to pre-existing, current, or future health conditions.

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THE SPS PITCH

SPS proposals generally provide that individuals enrolled for benefits are entitled to have payment made to an eligible provider for a list of covered services. This sounds appealing, but what do these provisions really mean? No one seems to know, or is not saying. And regardless of how one characterizes SPS, the meaning is the same. SPS in any form is a "pig in a poke".

WHAT IS A PIG IN A POKE?

"A pig in a poke" is a Southern colloquialism that refers to something that is sold or bought without the buyer understanding what he is buying, without knowing its true nature or value, and especially when buying without inspecting the item beforehand. A more contemporary expression would be "dumbing down" the buyer. The expression may sound benign, and the image may appear amusing, but the expression describes the paradox of what would likely be even more exorbitant future costs, and the likelihood of less access and service under the disguise of reducing costs.

HOW DO WE MAKE SENSE OF SPS?

The pitch sounds good. So, what is wrong with a SPS? Let's look closer to what kind of pig we are "buying" since we are going to pay for it, own it, and live with it. Here are a few. The starting place is with the origin of healthcare insurance. The first healthcare "insurance" came about in the 1920s when Baylor University Hospital (Texas) created what it called an "insurance" plan as a clever idea to generate steady, predictable cash flow to fund its costly, capital-intensive hospital services. This plan was not insurance, and included no component of insurance (risk). It was actually "prepaid" healthcare. Naturally, the idea caught on, and when the federal government launched Medicare, healthcare "insurance" became an "entitlement". And all political entitlements are unpredictable with little accountability. Healthcare represents a lot of money (1/5 of our total GDP) with huge motivation and opportunity for waste and abuse; and with no "safety net" for effective correction or reversal.

A Pig in a Poke is a phrase for something that is bought or sold without the buyer knowing its true nature or value; and especially when buying without inspecting the item beforehand.

Actually, concurrently reducing cost and increasing access doesn't make sense. Furthermore, this cost and access problem is not even defined accurately. In a market-based economy there is a direct relationship between the cost of services, the method of providing services, and how much service is provided. Reducing cost and increasing access are contradictions. If access (utilization) increases, aggregate cost will increase unless in an extraordinary way the unit price declines to offset

aggregate cost (not likely and unrealistic).

SPS is actually "similar" to, and extension of, our current Medicare payment system. So let's use Medicare as a "proxy" for what the future of SPS might look like. How has Medicare performed?

- Price growth outpaced utilization growth in the 1980s and 1990s. Since 2000, utilization grew faster than price, and utilization has been further energized in recent years under the Accountable Care Act (ACA).
- Out-of-pocket expenditures (in addition to premium cost) have grown steadily (almost doubled) from an average of $601 in 1970 to $1,124 in 2017.
- In 1987, the public sector healthcare spending accounted for 32%; and 45% in 2017.
- In 2017, administrative expenses as a % of total expenditures grew from 2.8% to 7.4%.
- In 1970, total healthcare spending was 6.9% of GDP. It was 17.9% in 2017.

Do we need more evidence? No. We know enough about the economics of Medicare today to know that the only way to reduce the cost of future Medicare is "rationing". We can look north of our border to Canada and across the pond to Great Britain to observe SPS in action. In a 2005, four Canadian justices noted that "access to waiting is not access to care", and overturned Quebec's ban on private health insurance finding that the ban interfered with life and security because the government was failing to deliver health care in a reasonable time. A couple of years ago, an outbreak of winter flu created a national crisis resulting in Britain's health service cancelling tens of thousands of surgeries. The media reported that Emergency Departments resembled "Third World" conditions, and ambulances waited for hours to unload patients in emergent conditions because capacity had been reduced.

WHAT CAN WE CONCLUDE, AND WHAT CAN WE DO TODAY TO PREPARE?

There is no way to predict the magnitude or impact of SPS. It will arguably have a greater adverse outcome than Medicare. But I believe it is premature to worry and become distracted by SPS. The immediate need is to learn how to compete in today's world of Medicare (see the April 2019 issue of HospitalMD insight™ Executive Edition: What Happens if Medicare Becomes the Only Payer?). It points out the many reasons the community hospital can compete today, and actually be profitable and financially viable long-term. I welcome talking with you about how I see this happen. My thoughts are not academic nor speculative. They are based on assisting community hospitals to become profitable over the years. And if you can be profitable under Medicare today, you can be profitable under SPS.

Jim Burnette is the Founder and CEO of **HospitalMD**. Jim has worked in healthcare for more than 20 years. His mission is to strengthen small community hospitals across the nation and help them thrive in today's rapidly changing healthcare climate. Jim is a graduate of Georgia Tech and resides in Peachtree City, a small community right outside Atlanta.

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