CRITICAL FACTORS IN HEALTHCARE REFORM

What the Politicians aren't telling you.

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The US healthcare system spends more dollars than any other developed country yet ranks the worst in healthcare outcomes. According to a study conducted by the Commonwealth Fund, which regularly ranks healthcare systems across the world's 11 most developed countries, the US is also the worst performer. Not only has the US spent significantly more than other developed countries at 16.6% of GDP compared to 10% GDP for every other nation, it has done so consistently for the past twenty years all while life expectancy is continually declining. David Blumenthal, president of the Commonwealth Fund states these findings are due mainly to a lack of insurance coverage, administrative inefficiency, and underperforming primary care. [1]

Although these points are valid, they do not include any discussion related to the 800-pound-gorilla-in the room, **PROFIT.** Profit derived from the big private insurance and pharmaceutical industries is a critical underlying root cause of the healthcare crises we face today. The money generated from these companies is used to fund political campaigns effectively shaping and influencing critical health care policy making decisions. No good can result from a dynamic where ***profit*** holds priority over our ethical responsibility to provide societal health care and yet that is what is happening with large "for-profit" insurance and pharmaceutical companies who through their large political contributions, set the price and conditions associated with health care with little regard for the needs of the patient or that of the provider. The truth is that the costs associated with the overall healthcare "pie" are being divided up in a highly inefficient, disproportionate and frankly unethical manner with ***profits and administrative costs*** gobbling up the Lion's share.

Aside from these profits, studies show ***administrative costs*** currently account for 30% of the total healthcare dollars spent in America.[2] This is twice the amount being spent by Canada. It is interesting to note that only 15.9% of dollars spent is associated with the actual hands on care administered by the doctor to the patient.[3] Yet ongoing efforts to reduce overall costs are primarily focused at lowering reimbursement to hospitals and physicians, all while administrative work continues to increase, i.e.

billing, contract negotiation and increasing requirements associated with quality care outcome measure submission and documentation.

Although most would agree that universal healthcare is critically needed, any plan that is to be successful in achieving this goal must first focus on preserving the primary resources utilized in its provision (the physician) while eliminating unnecessary costs associated with profit and administrative costs. This paper will examine the real cost associated with physician salaries, why Medicare for All is not a viable economic solution for the country as a whole or for physicians, and offer ideas and methods already being utilized in successful, developed countries around the world with the goal of creating a universal healthcare plan that can economically and sustainably support everyone.

Real Cost Comparison- Physicians vs. Other Professionals

Although most physicians don't enter the profession for the money, altruism is inconsistent with economic rationality. People typically behave altruistically because they get some benefit, or utility, from doing so.[4] Very few would consider investing staggering amounts of money, energy, and time in order to become a physician who works for free or even a marginal return. In order for the supply of the resource (in this case the physician) to remain sufficient to meet the demands of the healthcare system, the basic rule of rational economic decision-making applies. The marginal utility received (revenue, satisfaction, lifestyle, etc.) from delivering these services must exceed the marginal cost of becoming and remaining a physician. [5]

Physicians are considered one of the highest paid professions coming in closely behind investment bankers and entrepreneurs. But like investment bankers this appearance can be grossly misleading. When factoring in the "real cost" associated with becoming a physician; coupled with the utility (revenue and job satisfaction) returned, a very different picture emerges. Real costs include the exertions of all the different kinds of labor that are directly or indirectly involved in making it, together with the time required waiting for saving the capital used in making it.[6] This includes the direct cost of education, the lost opportunity costs associated with the time spent in medical school and residency without offsetting revenue, non reimbursed labor costs associated with educational training coupled with reimbursed labor by the hour as a physician who typically expends quite a bit more than a 40 hour work

week. Breaking these costs down into an easy to understand wage per hour summary will give a better understanding of earnings of physicians as compared to other professionals.

Multiple studies exist attempting to compare actual realized physician earned dollars/hour with other professions. One wildly liberal comparison showed physicians making about 0.03 cents more per hour then teachers when all factors were considered.[7] Although this study was fundamentally flawed due to its vast overestimation of total number of hours worked over a lifetime, it does bring attention and focus to the simple fundamental truth that physicians invest large sums of money, and return considerably more labor than the standard 40 hour week while sacrificing vast opportunity costs before earning a cent. Physicians don't typically work according to a time clock. Working weekends, and nights and holidays is a common occurrence and many of these hours are not reimbursable as they are spent performing administrative duties, traveling to multiple sites, or simply waiting on procedures or patients to be transferred to the operating room.

The following is a realistic comparison of two professionals' salaries and average wage/hour estimates projected over a lifetime with retirement set at 65 years of age. Tom and Mary are the same age. Tom decides to become a physician anesthesiologist and Mary chooses to become a nurse. They both begin school at the same time and each will have 43 years to work toward their lifetime-realized income. They both attend undergraduate school together and each receives Bachelor of Science degrees in chemistry and nursing respectively. Since they both have equitable college loans from undergraduate studies, the comparison will begin as their paths diverge. For ease of comparison, no adjustments have been made to these numbers for cost of living or taxes withheld for either party.

Following graduation, Mary works as a registered nurse and averages 40 hours a week.

Mary Lifetime Earnings and Wage/Hour based on 43 years service		
Lifetime Years	**Yearly**	**Lifetime**
Salary/Year	$75,510.00	$ 3,246,930.00
Hours/Year	$ 2,080.00	89440
Wage/Hour	**$ 36.30**	**$ 36.30**

The Bureau of Labor Statistics states she will be paid a yearly mean salary of $75,510.00 for 2,080 hours of work /year.[8] Upon Mary's 65 birthday she will have accumulated a lifetime total of 89,440 hours worked and a gross lifetime wage earnings of $3,246,930.00 which equates to an average hourly wage of $36.30.

At the same time Mary begins earning a profitable salary, Tom begins to accrue mounting debt. Tom attends a four-year state medical school in Kansas with an estimated tuition of $34,592/Year[9] plus an additional $18,750/Year in living expenses to total $213,368.00 over the next four years. Upon completion of medical school Tom begins his residency in anesthesia and for the next five years will earn a small salary. The hours associated with medical school and residency were grueling with many nights and weekends spent at the hospital or on call working and studying for exams. With clinicals, together with evenings, nights, weekends and holidays along with in-house "Call" rotations, he easily averages 80 hours a week throughout this time.[9] This routine of long hours and time away from home continues, as it does for most physicians, throughout his first ten years of work as an anesthesiologist. Tom receives a small salary of $59,300/year during his five year residency program.[10] Although this salary assists with living expense and interest on school loans, the high number of hours he continues to average is comparable to an hourly wage of about $14.25/hour throughout this time period.

Tom Medical School Investment Debt	
Year 4-Yr 8	**Tom**
	No Salary
Medical School Tuition at $34, 592/yr	$ (138,368.00)
*Room and Board, Text books, Transportatio, clothing, etc X4 Years	$ (75,000.00)
Total Cost Medical School	**$(213,368.00)**

* What's the real cost of medical school? AMSA. https://www.amsa.org/2018/11/10/real-cost-of-medical-school/. Published December 11, 2019. Accessed August 10, 2019.

Nine years following Mary's entry to the workforce, Tom completes his education and training and is eager for his investment to bring a fruitful return. Tom is now a Board certified Anesthesiologist with medical school debt of $213,368.[9] The small salary received in residency over the past five years of $296,500 has helped with living expenses and loan repayments at a 6% rate of interest that began following medical school. This loan will be amortized over the next 30 years adding an additional $247,161.63 in interest payments.[11] Opportunity costs missed over the nine-year period are added equaling $679,590.00, which is the amount he would have made had he chosen Mary's career path with the income of a nurse over that period of time.[8] The real monetary cost of education investment for the career choice of becoming a physician has come to a whopping grand total of $630,251.63.

Tom's Real Cost of Education-Investment

Yr 4-Yr 8	Total Medical School Debt not counting interest	$ (213,368.00)
Yr 8-13	Residency-Income $59,300/year X 5 years	$ 296,500.00
Yr 4-13	Lost opportunity Earnings- (Mary's Salary-$75,510.00 Multiplied by 9 Years)	$ (679,590.00)
Accrues Yr 5	Total Loan Interest Over 30 Years @ 6%	$ (247,161.63)
Total Real Investment to Become Physician		**$ (630,251.63)**

Tom begins work as an anesthesiologist and according to the Department of Labor will be making a yearly salary of $267,020.[12] Over the next 34 years remaining in the comparison Tom will accrue a Lifetime earning of $9,078,680 minus his "Real Cost of Education" as calculated in the previous example to equal $8,448,428.37. This seems like quite a bit but when total hours of work are calculated into this equation you begin to see something quite different. Tom's hours during this time period were not equivalent to the nursing profession. During his first nine years of combined medical school and residency, Tom averages eighty hours per week. In the first ten years following licensure in his profession he continues to put in long hours. It is only as he enters his second ten years that he begins to slow down to seventy hours/week and finally 60 hours a week for the remainder of his career.[13,20]

Tom Lifetime Return on Investment (ROI) and Wage/Hour

Lifetime Years	34 years	Lifetime Earnings (Utility)
Salary/Year/34 Years	$ 267,020.00	$ 9,078,680.00
Real Cost of Education	Real Cost of Education totalled in previous example	$ (630,251.63)
SubTotal	Net ROI	$ 8,448,428.37
Hours/Year	*Varies* *See Hours Table*	159120
Wage/Hour		**$ 53.09**

Tom's Lifetime hours total 159,120 with a net lifetime wage earnings of $8,448,428.37. This equates to an average hourly wage of $53.09 as compared to Mary's wage of $36.30. Suddenly this investment isn't looking nearly as profitable as it originally appeared.

Tom and Mary Hours of work provided over 43 year

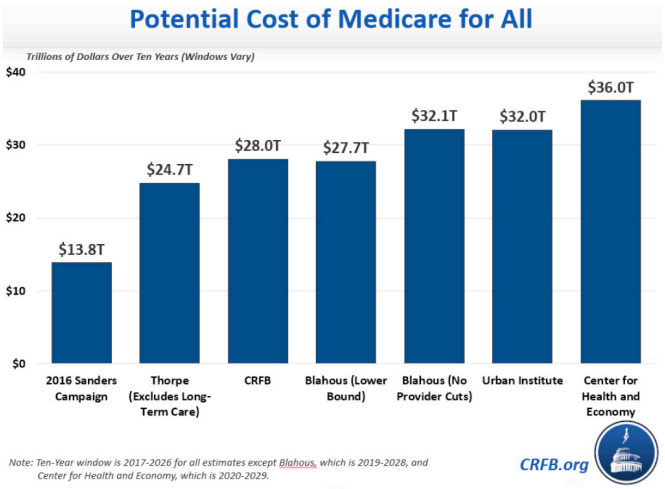
*Hours per Week	Years	Description	Tom	Mary
	0	Undergrad		
80	4	Med School	16640	8320
80	5	Residency	20800	10400
80	10	Yr 1-10	41600	20800
70	10	Yr 10-20	36400	20800
60	14	Yr 20-34	43680	29120
Totals	**43**		**159120**	**89440**

* American Medical Association. (2019). *How many hours are in the average physician workweek?*. [online] Available at: https://www.ama-assn.org/practice-management/physician-health/how-many-hours-are-average-physician-workweek [Accessed 8 Sep. 2019].

Many Politicians are pushing Medicare for All stating it is the solution to universal healthcare. The following subsection will explain why it is not economically beneficial for hospitals or physicians nor is it economically feasible for the country.

MEDICARE FOR ALL

The cost for Medicare for All over the next ten years has been estimated between $13.8-36 Trillion dollars.[14]



This is a staggering sum. Most people think of Medicare as a system that works very well for them and believe that universal healthcare can be achieved simply by expanding it to include everyone. Most people loving the idea of Medicare for All are wrong. Medicare for All is devastating to providers. Quite bluntly, Medicare does not reimburse for the basic cost of providing the service and is not sustainable as the single paying source for hospitals and physicians. It literally costs more to provide the service then Medicare pays for the service provided. That is a simple recipe for market failure and bankruptcy.

The CMS Medicare Actuary projects that by 2019, over 80% of hospitals will lose money treating Medicare beneficiaries. If these data are correct, Medicare for All would mean that over 80% of hospitals would lose money when treating all of their patients.[15] Medicare rates of reimbursement for anesthesiologists are worse than for hospitals at about a third or fourth what is paid by private insurance companies. In current practice, this lower rate is tolerated and absorbed as long as there are other insurances in the overall payer mix reimbursing at sufficient rates to raise the overall average and offset the loss. The average reimbursement rate collected, taken by combining all payers and dividing by the total number of patients must be higher than the marginal cost to produce the service. If the marginal cost is greater than marginal revenue, then production must be stopped or different sources of revenue must be generated somehow.[16]

Regardless of payer mix, Medicare for All would drastically reduce physician salaries by a significant amount unless other factors were built into the system to offset the reductions. And if these factors ***were*** built in, then the overall cost to the country itself would increase significantly more leaving an incredible tax burden on society. Considering the previous example, these reductions could easily drop Tom's

average hourly income below Mary's. Currently physician groups with Medicare patients accounting for higher than 40% of their payer mix already suffer from reduced revenues and struggle to meet the demands of costly overhead. Although practices with higher existing percentages of Medicare patients in the mix would not suffer as much, every practice will ultimately be devastated. The drastic reduction of revenues, increased administrative costs, rising costs of medical tuition, and the quantity of hours invested in becoming a doctor, leads to an irreconcilable imbalance between the marginal utility received and the marginal cost of becoming a physician. If these imbalances were to prevail, the results of this disproportionate swing would affect the supply side of the healthcare market (the physicians entering and remaining in the field and hospitals providing the place of service) leading the market to fail.

Alternative Plans

Don't throw the baby out with the bathwater.

It is important to both protect the Affordable Care Act (ACA) and provide solutions to its acknowledged deficiencies. It is cost-prohibitive and has significant gaps in coverage leaving still many uninsured. But we must recognize its valuable critical components and expand upon them as a simple framework. This framework outlines standards related to delivery of care; more specifically how that care is delivered and who is covered. By building on these inherent strengths, solutions can be found to address the other deficiencies such as cost and coverage gaps without making the mistake of "*throwing the baby out with the bathwater*". Latest estimates show that 27.4 million nonelderly individuals in 2017 remain without coverage and these numbers continue to rise.[17] These deficiencies can be substantially improved by inserting the ACA framework into a more financially feasible economic system thoughtfully created that offers universal coverage while eliminating profit and cuts administrative costs.

Profit can be eliminated by forming private non-profit insurance plans—with government and physicians working together to arrive at a universal fee schedule as well as exercising various degrees of regulatory control over insurance coverage, and pricing.[18] The key element to this working is for the government to be required to actually work with physicians and other fee for service providers in negotiating these universal fee schedules. Governments cannot be allowed to have the unilateral power to set these rates themselves. Certain processes must be contrived in order to ensure both entities are

equally represented so the fees will remain fair. Physicians in other countries have utilized unions to negotiate on their behalf.

Studies show administrative costs currently account for 30% of the total healthcare costs in America.[2] These costs can drastically be reduced by minimizing and streamlining tasks associated with "back-office" expense, i.e. setting universal fee schedules, and utilizing a universal billing and medical record system such as the electronic encrypted healthcare cards already being used in many other leading countries. By eliminating profit and administrative expense associated with our existing healthcare system, overall costs are reduced while considerable capital is freed to be: directed universally, utilized more cost-effectively, prioritized toward quality of care and improvement of patient outcomes, and promoting wellness instead of illness; all while preserving the necessary supply side of our resources (the physicians).

This model doesn't need to be invented; it already exists. This particular multi-payer model and its financial implementation is already being utilized in many countries around the world. It is known as the Bismark Model. This model is in place and working successfully in countries such as France, Germany, Switzerland, and Japan among others, who each separately have been successfully providing universal coverage for years at significantly lower costs with much better patient outcomes.[18] Patients often pay small co-pays for their health care and can buy secondary insurance coverage for services not provided through the existing plan, i.e. private hospital rooms and coverage for other non-covered services. Physicians don't have to worry about multiple contracts, fee schedules, and different standards for different procedures or obtaining prior approval of services. Because the government regulates these non-profit insurance companies, fee schedules can be firmly established, administration costs are drastically reduced and valuable time and money spent on billing resources can be eliminated. This step alone will free up physicians and other healthcare providers to devote their time to performing patient care and improving patient outcomes rather than wasting their time on clerical work. Under a variation or approach similar to the Bismark Model, hospitals can be public or private and physicians can flexibly work in both private practice as well as public or private facilities.

Summary

Our healthcare system is an embarrassment as displayed by our pitifully low rankings compared to other

developed countries. Universal healthcare is not a question for debate. We all know (deep down inside) that it is our moral and ethical responsibility, as the richest nation on earth, to equally protect and care for all members of our society regardless of race, color, creed, and socioeconomic or legal status. The question is how we get this done in a self-sustaining manner without causing serious national economic collapse. The first step in fixing this mess is for everyone to come together and embrace the critical components found in the framework of the Affordable Care Act and stop allowing political gamesmanship to tear it apart. Once we are unified in accepting its key components we can work together with focus on making changes necessary for its success, beginning with methods to get the remaining uninsured covered. We then must identify critical areas where costs can be reduced while preserving sufficient payments to the providers themselves. Coming up with a transparent universal fee schedule will reduce administrative costs considerably but physicians must be allowed a weighted control over these decisions. Lastly, the 800-pound gorilla: Profit must be addressed, discussed and eliminated. No good evolves from relationships between profit and ethics which is what the US has been turning a blind eye to for years. Other countries have figured that out, the question is why can't we?

Physicians and other front-line practitioners make up the axis of our healthcare system. In order for our healthcare to improve, these providers must be seated squarely at the head of the table. Why must they be there? They need to be there so that the actual solutions formulated are relevant and meaningful as they relate to the everyday practice of healthcare delivery. Forcing the square peg (Medicare for All) into a round hole simply because it sounds good as a political stump speech is not a good idea. Had physicians been at that table, a lot of time and energy wasted on that topic could have been avoided. Medicare for all would be catastrophic for everyone not just doctors and hospitals. Simply stated, the end result of Medicare for All is bankruptcy of our hospitals, our providers, and our country. I wonder why politicians aren't letting the public know that? The general public doesn't have a clue because they don't know whom to ask or who to trust. No one asks the opinion of the physicians and hospitals mainly because the general public has lost faith in the whole broken system. There is no transparency.[19] "When consumers are not able to judge the quality of the product they are buying, they may be more willing to trust an institution that is not set up primarily to enrich its owners."[19] But trusting in the government to wield ultimate control of the costs, payments, and type of care covered will end in disaster.

By remaining open to new and sometimes strange ideas we can learn, evolve, improve, and expand on the knowledge shared from the experience of other countries. It is through this openness and awareness combined with valuable insight and input from the direct patient care providers, that a viable plan will emerge allowing for the healthcare industry supply and demand models to thrive in perpetual balance, propagating a healthy market for years to come. It is time for a unified effort aimed at building something of value rather than tearing something down.

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