Letters to the Editor

Access to Care

To the Editor:

We should be ashamed that, in a country with our vast wealth, we deny any citizen health care—especially working families who can't afford adequate private health insurance, make too much to qualify for Medicaid, or are too young for Medicare. I will attempt to make the argument that if we would commit to universal care and a new system for health care payments, we could largely eliminate our access-to-care problem. Our current payment system, utilizing insurance principles and methods, wastes at least 30% of our health care dollars. Affluent North Carolinians, those covered by Medicaid and Medicare, have access to excellent medical care. Medicare and Medicaid access is beginning to be compromised because of inadequate reimbursement and administrative hassles. Our working families, the economic middle class, have the most difficult access-to-care problems. The data clearly show that lack of health insurance translates into diminished quality of life.

In America some things are off-limits to our free enterprise system. We don't directly buy and sell children, wives, or organs for transplantation. (Embryonic stem cells may become an exception!) To solve our access-to-care problems we need to construct a new system to pay for medical care. The new system would blend private enterprise and government regulation. We have world class medical technology, research, and clinical care. Our outdated medical payment system fails to utilize fully the power of modern computing and displaces patients and physicians from the determination of medical necessity.

Many of the current proposals to deal with our access-to-care problems and to find ways to make the uninsured less visible remind me of the old cliché about rearranging the deck chairs on the Titanic. Our large number of uninsured may well be the iceberg that rips a fatal gash in our great medical ship and sinks it in the treacherous seas of single payer and government control. Health care is too important to trust to the politicians. We must keep a large private sector influence and individual responsibility as essential parts of the control mechanisms in the new payment system. A single payer would stifle creativity and probably require a bureaucracy as bad as our current insurance system.

In America we spend more than a trillion dollars and we still have 42.5 million uninsured. Health care consumes 14% of our Gross Domestic Product (GDP). As a simple economic proposition, America can no longer afford to have 42.5 million uninsured. The system we use to maintain this pool of uninsured and underinsured simply costs too much to maintain. If we would eliminate the massive loss of our resources to our archaic payment system, we could have enough to care for all of us. The administrative overhead required by our system of insurance payments consumes at least 30% of every private health care dollar. Not to mention the uncounted trees that give up their lives to supply the paper to record the hassles that fuel our current dysfunctional system. Moving the money through our inefficient system from payers to providers of services taxes both payers and providers. Typical insurance company overhead is 12-15%.Provider overhead to deal with HMO's and insurance companies is at least 10-15%. Published data in 2000 on HMO overhead range from 14% for PacifiCare to 33% for CIGNA. Hospitals spend from 15-30% trying to get paid for services provided. A virtual army of insurance clerks is employed by all concerned to keep the system going.

We need a system to pay for care—not a system to pay for insurance companies, or HMO operating and underwriting costs. First, we must make a national commitment to universal care. With universal care we eliminate medical underwriting and the need for an insurance function. This should provide us the opportunity to move, or retrain, millions of intelligent highly skilled people from medical administration to medical care.

We do not need a government-controlled system to provide care for every American. We can have universal care with multiple payers. Universal care does not have to mean a single payer system. We can create an efficient privately managed payment system. I believe we need multiple purchasers of care: individuals, employers, associations, governments, and public/private partnerships. We need multiple payers for creativity, control, and adequate resources. Conventional wisdom has it that the only way to have universal care is to have a single government payer. This is clearly not true. We require universal immunizations to attend our public schools. These immunizations are paid for by many different sources.

A consortium of large banks could best manage the payment system. It would operate much like our current credit/debit cards. Funds would be transferred from patient

to provider at the time of service. Banks require from 1-3% of the transaction to profit from their credit card business. Much of the new system would function like a debit card so the money float would be a large item available to cover expenses. Everyone would be required to have a biometric "smart card" for medical payment. Individual subsidy rates would be determined largely as they are determined now for Medicaid eligibility. The process would be electronic and would gather IRS-type encrypted data. Privacy could be maintained just as with bank accounts and credit cards now. Only the bank's computer needs to know how much to charge each payer. Medically necessary basic covered services would be paid at the point of service. Sophisticated electronic fraud and abuse systems would monitor correctness of the payments.

Universal coverage would require universal participation. With universal coverage we would not need the insurance companies to maintain a pool of millions without insurance, cost-shifting to pay for the uninsured, or expensive non-productive utilization review. Informed consumers, patient choice, evidence-based care, competitive pricing, and individual responsibility would be required to make the system affordable. Building these attitudes and habits of mind in patients and providers would have to become a national priority. We created the 1-800 precertification managed care clerks because the system could not trust patients and providers. We can and must restore trust. Patients and physicians should determine if the covered service was medically necessary.

Everyone would have an Electronic Health Services Payment Card (EHSPC). These biometric electronic smart cards would range from full self-pay, to income-indexed government subsidy, to full government pay. Payment information could be on the smart card to facilitate income-indexed, first-dollar payments to help with cost control and to ensure patient involvement in treatment decisions. Research shows that first-dollar co-payment inhibits use about equally for "necessary and unnecessary" care.

Informed patient choice would be central to the payment system. Case management, especially for chronic illness, would be a paid service. Here would be a wonderful place to utilize our new information technology tools. The system would not pay for inappropriate care, and this would be known up front. This practice is already in place with some of the information management technologies currently in use. To help ensure quality care for some individuals we would need to develop a group of highly trained Public Health patient advocates. The program would only pay for well-defined comprehensive basic care. Prices would be established by a national commission similar to the current Medical Practice Cost Commission (MEDPAC). Extras and uncovered items would be self-pay. These would need to be paid for with the patient's private resources. Providers would be free to contract for reduced prices to meet competition and not be prevented from accepting the MEDPAC price from other patients for the same service. Efficient and effective providers would be rewarded by patient choice.

Full self-pay and the self-pay component of the income-indexed government subsidized group could use some of the concepts of Medical Savings Accounts to help spread the risk of periodic large medical bills. The bank's computers could very easily manage all of this. Credit insurance and savings deposits are very profitable businesses for banks. This program could become a significant driver to boost our nation's low savings rate. Essentially the current insurance company's surplus would become individual savings. Remember, the Group is universal and the float on a trillion dollars is substantial. Medical underwriting would not be required. At any given time the banks could know and adjust the fund balances. They would not need to wait for political decisions. Adjustments would be made automatically by predetermined formulae. In addition to the income-indexed first dollar co-pay by the patient there would be a multi-tiered time limited cap on out of pocket expenses. The Bank's computers, since their databases would contain all payments, could calculate the amount of each payer's share of the over-the-cap pool. This amount would be applied to the cardholder's current bill. Similarly, the Bank's computers would apportion the charges to the government-subsidized accounts and the full government-pay accounts. Actually, what CMS does now for Medicaid and Medicare payments (although they don't understand it in these terms) is not far from this model. They use retrospective reimbursement instead of real-time cash transactions. Every eligible person is entitled to medically necessary covered services.

Clearly, our new data base management developments demonstrate that we have the Application Service Providers (ASP) technology to handle the real-time transactions. Electronic program integrity and utilization management functions would be applied at time of service. Only clearly covered services would be paid. An efficient external review process could adjudicate disputed claims. Disputed claims would be minimal with clear definitions of covered services.

Wild as it may seem, nothing I've suggested would be impossible after we make the commitment for universal care. Microsoft, Oracle, Sun Microsystems, and Computer Associates could quickly provide the software. The health insurance industry lobby will be a major obstacle. With the payment system described, there would be no need for an insurance function in the payment for health care. Some of them like Electronic Data Systems (EDS) could subcontract with the banks for parts of the process just like EDS with North Carolina Medicaid. It would take some time and interesting national debates to develop the software. Bridge funding and appropriate compensation for the health insurance industry would have to be worked out. And we would have to hear from Harry and Louise again!!

America has excellent medical care for most of our

citizens. If we free ourselves from our archaic energy and resource consuming payment system, we can have excellent care for all! Wouldn't it be wonderful if American Medicine could lead our country to universal care! We could all return full time to patient care freed of payment hassles.

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To the Editor:

A word about the challenging subject of healthcare access. I believe the participants' thoughts [in the Forum : Access to Care for the Uninsured. NC Med J 2002;63(1)] were very well constructed and delivered. However, looking at the broad issue of healthcare and access to healthcare, almost always one matter is either under-reported or totally ignored. The matter is healthcare responsibility. The writings of Abu Ali Sina (Avicenna), Galen, William Harvey, and Sir William Osler are full of references to the fact that healthcare is a personal responsibility, whereas healthcase access is the responsibility of the state. Personal responsibility for healthcare is an important issue reflected in the dietary laws of Moses, the teachings of the Christian church, and Islam;s recommendations for fasting and abstinence from alcohol and food that is not Halal. We must present a balanced view of both. I fail to see the justice of the healthcare industry's cost shifting to spend billions on 500-gram crack babies and on a large segment of society that is gorging itself to death. We all know the consequences of obesity, diabetes mellitus, hypertension, cardiovascular disease, and couch-potato life style, not to mention other self-destructive behavior such as tobacco and alcohol.

Whenever we write about citizens' rights to healthcare access, we must also write about citizens' responsibility to ensure a health life style for themselves and their families. Perhaps these matters will be addressed in a future issue of the Journal.

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Health Care in Eastern North Carolina

To the Editor:

A sincere thank you to all the editors and the editorial board for the hours of dedicated service in support of the *North Carolina Medical Journal.* The *Journal's* Special Issue on "Health Care in Eastern North Carolina" was especially timely, comprehensive in scope, and quite informative, even to those who have been involved in the subject for years.

The article on hospital care in Eastern North Carolina by Ms. Marion P. Blackburn covered lots of ground, but contained some inaccurate data which needs clarification. The section on Pungo District Hospital in Belhaven was a bit disturbing at best.

With strategic planning and contruction amounting to 6.5 million dollars ongoing for six years and involving the entire service area of Eastern Beaufort and Hyde Counties, the Board of Trustees took a wrong turn in management and administration of this essential rural community hospital.

Needed services were cut, the transport unit mostly parked, anesthesia shut down, the intensive care unit turned into an "intermediate" unit, and 100-plus employees left. Community support understandably was diminished, and Pungo District Hospital was no longer progressive or dynamic in local health care. Critical Access was considered by the Board of Trustees, along with other possibilities including partnering with larger medical units. Our people refused to accept negative leadership and loss of services by our own community hospital.

The problem simply was a lack of effective leadership and poor administration and management coupled with the loss of 100 jobs and reduced services with an admitted financial loss of over 1.3 million dollars within one year. Causative factors were not poor government reimbursement, shortage of nurses, and other healthcare providers, nor willful lack of local support as alleged.

I, as Mayor of Belhaven for 26 years and as a local and regional primary care physician for 36 years, did not oppose Critical Access designation, but I did oppose loss of essential health services for our people and giving away our beds. In fact, I made the motion for Pungo District Hospital to become Critical Access after clarifying essential healthcare needs for our people.

Other areas in need of clarification are that Belhaven does not have an obstetrician and farmers were omitted from those who use Pungo District Hospital.

A change in administration occurred four months ago followed by a couple of Board changes, and now Pungo District Hospital has met all expenses for four consecutive months. Admissions are up, employee numbers are up, and healthcare services are being restored for our people.

There are no margins for error in the healthcare business. Poor management and misguided administration will close any healthcare facility in record time.

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To the Editor:

With great interest I read your special issue on health care in eastern North Carolina. As I looked at the articles I became confused over exactly what geographic region was included in this report. The articles on pediatric healthcare and cardiology mentioned Wilmington physicians and their

contributions, but the other articles completely excluded New Hanover, Pender, and Brunswick Counties from eastern North Carolina.

We would welcome the opportunity to update your readers on the great history and progress in healthcare that has occurred in "south"eastern North Carolina over the past half-century, because without this the story of our region is woefully incomplete.

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We welcome letters from our readers. We reserve the right to edit or abridge letters for space or clarity. Address your correspondence to the Managing Editor, NC Medical Journal, 5501 Fortunes Ridge Drive, Suite E, Durham, NC 27713. Or send a fax to 919/401-6899, or an email to florence_nash@unc.edu.