How would hospitals get paid under single payer?

Dispatcher: 911, what's your emergency?

Caller: America's healthcare system is broken and people are dying! (ambulance siren)

(00:06):

Welcome to **Code WACK!,** where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host **Brenda Gazzar.** This time on **Code WACK!** How does running a hospital like a business run counter to providing reliable and affordable health care? How would having Medicare for All change the way hospitals are financed and what would it mean for patients, doctors, and the hospitals themselves?

To find out, we spoke to **Dr. David Himmelstein**, a distinguished professor of public health at CUNY's Hunter College and a lecturer in medicine at Harvard Medical School. He also serves as a staff physician at Montefiore Medical Center in the Bronx and is the co-founder of the single-payer advocacy group Physicians for a National Health Program. This is the second of a two-part series with Dr. Himmelstein.

Welcome back to Code WACK!, Dr. Himmelstein.

(00:56):

Himmelstein: Thanks for having me.

(00:57):

Q: In 1987, you co-founded Physicians for National Health Program. What inspired you to do that?

(01:03):

Himmelstein: Well, the experiences of our healthcare system really making it so difficult to care for patients and many of my patients at public hospitals where I work, being unable to get the care they needed and deserve. At the same time, seeing that our country has ample resources to provide excellent care to everyone if they were distributed in a reasonable way and I spent some of my time during my career working at fancy private hospitals. During my residency, one or two months we rotated through a fancy private hospital and one month a year I used to be the attending physician, the staff physician on the wards at Mass General Hospital, one of Harvard's banner teaching hospitals. So I saw excellent care that was available to privileged patients and often resources at those hospitals that went unused because the hospitals actually oftentimes had surplus resources. And (in the) meantime, the public hospitals where I spent most of my time working, patients weren't getting the care they needed.

(02:03):

So my partner, Steffie Woolhandler and I looked around at what alternatives there were for how to finance health care and we saw that other countries really did it better and they had lessons to teach us about how you could construct a healthcare financing system that was both fairer, more efficient and improved health outcomes.

Q: "Can you give an example?"

Himmelstein: We particularly looked at Canada because Canada's health care system in many ways is very, very similar to that in the U.S. In fact, until we passed Medicare and Medicaid in the mid 1960s and Canada passed its national health insurance scheme around that same time, our healthcare systems and financing systems were almost identical. So it was easy to see how we could make a transition to national health insurance schemes like Canada, which is not perfect, but has huge advantages. So we really used that as an initial model and thought about what it would take to transition the U.S.

(02:59):

Q: Got it. Great. It's no secret that hospitals, even nonprofit ones, are big businesses today in America. How are the incentives of running a business at odds with community needs for reliable access to affordable health care?

(03:13):

Himmelstein: Well, hospitals want to take in more money than they pay out to their staff and their suppliers. They want to make a profit at the end of the year, whether they're nonprofit or not and that's actually pretty much required, necessary if the hospital is going to keep going under our current financing system because in order to upgrade its facilities, stay modern, buy new equipment, renovate the rooms and wards when they get outdated, keep the ORs up to date, hospitals need to have money in the bank to pay for those new investments and the way you get money in the bank under this system is to take in more money each year than you pay out. Or the other alternative is to say, 'well, we'll borrow the money,' but the only way you're able to borrow it is if you assure the bondholders or the banks that you'll pay them back from the surpluses from the profits you accrue in future years, so our system says to hospitals, you have to make a profit or your future is in doubt.

(04:13):

Q: Right. Thank you. What toll do standard business practices like mergers and acquisitions, consolidation and corporatization take on patients and doctors today?

(04:22):

Himmelstein: Well, increasingly the people who run hospitals have not just said, 'well, we want to make sure our hospital can survive, but we're going to really run up a huge surplus and become an extremely successful business and that's going to allow me personally to be paid much more.' So when I was first a doctor, the hospital CEO was paid like a doctor – handsomely paid. Now they're routinely paid in the millions, sometimes tens of millions of dollars.

Oh, wow.

Himmelstein: So if you make a huge profit, you're able to say, 'well, I ran this business so wonderfully that the hospital is making a big profit and I deserve a huge paycheck and I can build the empire and assemble more power that way.'

Q: And what about the patients?

Himmelstein: And it impacts the care in multiple ways so increasingly the hospitals control what the doctors do. So 30, 40 years ago, the doctors were pretty much independent of the hospitals so the doctors mostly were not paid by the hospitals, they were paid directly by their patients and the hospitals didn't rule over the doctors. Nowadays, most doctors are employees of the hospitals where they work or of group practices that are kind of a subsidiary of those hospitals. So the hospitals can really dictate to doctors much more what they need to do and they've really passed down many rules, regulations, surveillance about what we need to do that's going to be profitable for them.

(05:47):

Q: So how do you feel knowing that that's the case today?

(05:50):

Himmelstein: Well, I think most doctors are really horrified at it so that's the root I think of a huge amount of doctor burnout and dissatisfaction. The bureaucratic stuff they've imposed on doctors is crushing. The average doctor is now spending, oh, something like 20%, 30% of their total time on paperwork, much of it imposed by their hospitals.

(06:12):

Q: Wow. That's a lot of time.

(06:14):

Himmelstein: Yeah, we've become box checkers and our incomes in many cases depend on doing what's profitable for the hospital. So you now have hospitals saying you can make bonuses of $30,000 or $40,000 a year if you do what's called coding. You attach diagnoses that are profitable for the hospital to your patients.

(06:34):

Q: Wow. How do you think that affects the behavior of doctors?

(06:38):

Himmelstein: Oh, I think if you're offered $40,000 for doing what the hospital wants, most of us try and do it.

(06:45):

Q: Wow. So attaching a diagnosis to somebody who you, I mean, would you say that people would do it even if they don't think their patients have that diagnosis?

(06:51):

Himmelstein: Well, what they do, and I think this is routinely done, is stretch the limits. So it's not that they don't have that diagnosis, but there are these arcane rules about what makes money for hospitals. So if a patient had asthma 10 years ago but they no longer have any asthma symptoms, if you write down in the chart 'asthma not active at this point,' that counts. That's profitable for the hospital. It's medically not meaningful at this time. So you're not lying, you're not doing anything to harm the patient, but you make the hospital and maybe the insurance plan affiliated with the hospital lots of extra money and some of that's going to trickle down to you.

(07:29):

Q: Interesting. Thank you. So we touched a little bit about this in the last episode, but can you explain how hospitals are financed today and how they would be paid under Medicare for All?

(07:39):

Himmelstein: Well, at this point, hospitals bill patients or their insurance plans for each hospital stay generally, and depending on what the insurance is, they may get more or less. So a patient with pneumonia, with insurance from a private insurance plan, generally the hospital gets paid more than the same patient if they're covered by Medicare and much more if that patient is covered by Medicaid. And if they're uninsured, the hospital will bill a patient themselves and try and collect from them. And sometimes hospitals get some money for uninsured patients from government funds. So there are multiple streams of payment. There's private insurance, there's Medicaid, there's Medicare and patients themselves, both the uninsured and then co-payments and deductibles that patients have to pay even if they are insured in many cases. So the one impact of that is that some patients bring in more money than other patients do.

(08:38):

If you have private insurance, the hospital gets paid more than if you have Medicare and Medicare more than if you have Medicaid. And in most cases either of those more than if you're uninsured. Single payer would really change that in

two ways. One is everyone would have the same insurance, so there'd be no distinction among patients so there'd be no more for Sally than for Alice. And that's one important piece. But the second is in countries like Canada where everyone has the same insurance, generally hospitals don't bill for each patient and each time they're admitted, they get paid one lump sum amount each month for their operation, much like a fire department gets paid in the U.S. So the Canadians and people in many other countries have said, 'why would we bother trying to figure out how much it costs to care for Sally and how much it costs to care for Alice?'

(09:31):

Our concern is what does it cost to run the hospital and take care of everybody whom they take care of. So we'll just pay the hospital a lump sum and that eliminates a huge amount of paperwork both for the hospital and for the organization doing the payer. So for the hospital, it means you don't have to keep track of who got every bandaid and aspirin tablet, try and figure out what you can squeeze out of each patient's care and for the payer, it means again, you don't have to pay for that stuff and go over each of those bills in that kind of detail.

Hmm, I see.

That came home to me many years ago visiting a friend who was hospitalized at Toronto General Hospital, at that time a big really what's called tertiary care, so a highly specialized hospital with a full range of services.

(10:19):

And the billing office at that hospital when we looked was three or four people whose main job seemed to be to send bills to Americans who happened to wander across the border, and when we got back to Boston where I was living at the time, we went and looked at the billing office at Massachusetts General Hospital, which was roughly the same size and same range of services and back then they had 352 full-time equivalent personnel in the billing department. Not because they were inefficient, but because that's what they needed to do to get paid and since then, they've accumulated I think many more people than that. So the difference in the way a single payer system would pay for hospital care is really twofold. One is that there would be no financial distinction among patients. And the second is that you'd eliminate the need for the kind of detailed billing and paying that drives up the administrative costs and causes tremendous waste in our healthcare system.

(11:18):

Q: Right. I've heard people kind of who oppose single-payer, who have concerns about it, say things like, well, if I am willing to spend more money, if I have and I'm willing to spend more money, why wouldn't I get the convertible, for example, instead of the Toyota Corolla? But is that really a fair analogy in the case of single payer, are they missing out on better care If it's all one comprehensive insurance plan?

(11:42):

Himmelstein: Well, you know, the data actually shows that Canadians on average get better care than Americans do and even wealthy Americans have shorter life expectancies than average in most other wealthy nations. So I think the worry that Canadians or people in other countries with this kind of egalitarian national health insurance are not getting good care is misplaced. In fact, you know, it's sort of a weird thing I guess. Rand Paul a few years ago got his hernia repaired at the Shouldice Clinic in Ontario, which is a world famous hernia repair specialty hospital and his spokesperson said, 'well, it's a private hospital. It's not part of the Canadian healthcare system,' which just isn't true. In fact, when we looked on the website of the Shouldice Clinic – they have a provincial health insurance plan. So there are 10 different plans, I guess up there that each province has its own plan, but they're all very similar.

(12:39):

Any Canadian with health insurance from their public plan can walk into the Shouldice clinic without an appointment and start their care and have their care fully covered with no co-payments, no deductibles whatsoever. So in fact, we can deliver very high quality care to the entire population if we organize and finance our care in a rational way. Now in any system, there's a top surgeon and a surgeon who you might want to not go to quite as much and the surgeon with a better reputation is going to have a little bit longer waiting list.

In fact, in New York at this point, there are surgeons with months-long waiting lists to get care. The question is whether the people at the front of the queue ought to get there because they're wealthier or because they're the people who need the care the most? And as a doctor, my view is, you know, it's the people who need the care the most, who actually ought to be at the head of the queue. And to say to a kid with leukemia, you don't deserve the top quality care because your parents aren't rich so you're going to die and the rich kid is going to live, that's criminal.

(13:47):

Q: Right. Such a good example. Thank you. So how would having a single-payer system affect patients and doctors?

(13:56):

Himmelstein: It would tremendously simplify patients' lives. So every hospital in the entire country, I mean, again following the Canadian model, would take your insurance and your insurance would be the same no matter who you are, no matter where you are. You'd have complete coverage, you would not be responsible for any of the bills. So you wouldn't have to worry about any out-of-pocket costs. You'd have the freedom to choose any hospital. Many of us now have, particularly with private coverage, have plans that limit where we can go and that would be abolished and it would mean that there'd be no financial distinction among patients. For doctors, it would simplify our lives. It would say you don't have to spend your time worrying about whether your patients can afford this. The amount of paperwork you have to do for billing and for the financial manipulations of your practice or your hospital would be tremendously cut and we'd be able to actually practice medicine without the ridiculous stuff that goes along with it today.

(14:57):

Q: Right. And just as doctors wouldn't have to worry about whether their patients could afford the treatment, patients themselves also wouldn't have to worry about that.

(15:04):

Himmelstein: Absolutely.

(15:06):

Q: And how would this affect the hospitals?

(15:07):

Himmelstein: Well, I would say to hospitals, first of all, you would need to transition many people in your staff who are doing useless and maybe even harmful things to doing useful work. So our estimate is that there are several hundred thousand people doing useless paperwork in hospitals today and we'd need to find different and hopefully useful work for them. And many of them could surely be deployed within hospitals to fill in the gaps that we have now and

the personnel shortages. So that's one thing that would affect hospitals. And one of the other pieces for hospitals is that the lump sum payment, that monthly payment you get from the National Health Insurance plan, that would be to cover your work today and whatever you don't spend on your patients that you would have to give back. So you wouldn't be accumulating any surpluses or profits. You wouldn't have an incentive for playing the kinds of games you have today.

(16:06):

Instead, if you want a new building or an upgrade of your facilities, you would apply for a grant from the National Health Insurance Program and they would judge the needs of the communities and see, you know, is this the biggest need for the billions and billions of dollars? This year some, I think $150 billion we're going to spend on new what's called capital investments in health care. Instead of that money being allocated based on which hospitals are profitable or not, it would go into a fund and there'd be a regional organization that would evaluate where the investments are most needed.

And again, to give you an example, you know, we have parts of New York that are really medical deserts at this point and where the hospitals are kind of run down and I said before the roofs are leaking. And those hospitals obviously ought to be at the front of the line for the new investments. On the other hand, Mass General, which is already kind of a medical palace, is building a new $2 billion building up in Boston. I'm not sure that would've been the highest priority in that city. So it would change hospitals' behavior by saying to them, you're not actually going to be run as a business beause your goal is not going to be having a profit at the end of the year because you won't be able to have a profit one way or the other.

(17:24):

Thank you, Dr. David Himmelstein.

Do you have a personal story you'd like to share about our wack healthcare system? Contact us through our website at heal-ca.org.

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