



Challenging Times Lie Ahead

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MOST ACROSS THE POLITICAL AND PROFESSIONAL spectrum agree—these are challenging times. Huge budget deficits compounded with an overstretched health care system demand change. If realistic change is to protect some of the patient/physician relationship, it is critical that individual Minnesota physicians: self-educate, organize, prioritize, and present our concerns to health care policy makers in a well informed and personal manner. Those with interest in a myriad of proposed health policies include patients (constituents), legislators, third party payers, medical corporate structure, non-physician providers, and physicians—not necessarily in that order, though at times it may seem so.

The concerns we have for our patients and profession are pressing. Make no mistake, the health care policies we must soon create in order to “fix” this will have significant impact. Impact which falls not only upon those whom we care for now, but also upon the new thousands who will find themselves either out of work without insurance, or displaced from previous insurance, and onto state or federal health care programs. Current state and federal programs (Medicaid) are factually known to many of us to be economically unsustainable from an independent medical practice standpoint. Worse yet, these poorly reimbursing programs, for some, appear on the chopping block for deficit reduction—leaving no safety net at all—save the emergency room (not really free care). New health policies will certainly affect us as practicing physicians—so I suggest, as an interested party, we review the facts.

As Dr. Noel Peterson, MMA president, summarized in a recent issue of *Minnesota Medicine*, physicians have been operating on low reimbursement structures for quite some time. When Dr. James Young of West Metro and I served on the 2007 Reform Pooled Insurance Committee at the Legislature, many members were surprised to learn that physician Medicare Reimbursement Structure was based on a mean cost of service as determined in 1989 minus 10 percent. A 3 percent raise was provided in year 2000. Yes, the state of Minnesota has increased payments to health plans each biennium for Medicaid patients over nine years from 2000 through 2008; however, the health plans only passed on one increase in payments to providers. Historically, low physician payments in Minnesota's public health care programs include Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare.

In truth, nearly 25 percent of patients have some form of reimbursement that does not cover the cost of providing care, and such programs are not truly viable solutions in the financial equation of many practices. According to 2005 data, 40 percent of Minnesotans were covered by private, self-insured plans; 27 percent by HMOs, indemnity, or BC BS; 14 percent by Medicare; 12 percent by MA, GAMC, MnCare, and MCHA (high risk); and, 7 percent were uninsured.

To place health care costs in perspective to the financial sector bailout, estimated health spending in 2007 was about 25 percent of total federal spending of \$2.7 trillion, or about \$675 billion. Entitlement programs make up 56 percent of the budget, vs. only about 10 percent in 1948, and nearly zero before the New Deal of the 1930s. Health care is so costly that about 18 percent of Americans under age 65 lack health insurance. A plausible estimate of duplicative or unnecessary cost (largely driven by demand): about one-third, or \$225 billion. For this extra cost, by many measures, we receive no large benefit in national well-being, although we receive comparatively prompt care and few queues. On some measures, such as breast cancer survival, we do better than many countries; on others, such as life expectancy, we do worse. However, such oft quoted statistics may relate more directly to the manner in which the data was recorded (often different abroad vs. U.S.), and lack of accounting for ethnic differences for any given health care outcome in a given population (such as fetal mortality). Many well-intentioned in the policy arena espouse virtues of “quality care” and demand “pay-for-performance” (incentives/penalties) without evidence of effectiveness and without consideration to counterproductive effects on a dedicated, well-trained medical workforce. Evidence-based studies do show factors that correlate best with population statistics and patient-centered health outcomes: patient education, and patient financial/cultural/social status. Yes, you read that correctly—poverty and low status are bad for your health. More to follow next issue. ♦



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