Foreword

Between the Forty-Yard Lines: Health Care Reform and its Impact on the Changing Landscape of Urologic Practice

Kevin R. Loughlin, MD, MBA
Consulting Editor

Late last year, I had the opportunity to attend a Zoom interview of David Gergen. He has served in the administrations of both political parties and has been a keen observer of how things get done within the Beltway throughout his distinguished career. He is, in my opinion, a man of uncommon wisdom. During the interview, he shared that he thought that in Washington, DC most things get accomplished "between the forty-yard lines." I think it is an apt metaphor for the current political environment regarding health care reform, which is the underpinning for the changing landscape of urologic practice.

As we enter this year with a new president and a new congress, one of their major tasks will be health care reform. For the last several decades, this issue has dominated medical practice, and its lack of resolution has perpetuated an uncertainty that has permeated every aspect of our profession.

Virtually every topic that Dr Kapoor has selected for inclusion in this issue of *Urologic Clinics* on physician burnout: clinical research, workforce exigencies, physician leadership, the expanding role of advanced practice providers, and the growth of integrated care models, just to name a few, is a response to the economic exigencies that are the consequences of our unsettled and inefficient health care delivery.

Dr Kapoor, long a thought leader in urologic clinical practice, has created this issue that will serve as an ecphoneme for the challenges facing urologic practice now as well as provide insights into where we are headed in the future with possible solutions. The confluence of urologist burnout, workforce issues, the aging of the population, the incorporation of physician extenders, scribes, and telemedicine is changing urologic practice in profound, immutable ways.

As the new executive and legislative branches assume power, it is incumbent upon urologists to remain informed and engaged. The options for health care reform are fairly clear. There are those who are enthusiastic for some kind of single-payer health care, whether it is called Medicare for All or Universal Health Care, whereas others call for an expansion of Obamacare. Few want to maintain status quo.

A thorough evaluation of all our health care options is beyond the scope of this article, but I think certain premises seem obvious. Most people agree that access to health care is an essential component for a modern society. A reasonable underpinning for any future health care system would appear to be (1) transparency of costs, (2) competition, (3) access to care, (4) choice of provider and health care facility, and (5) protection of those with preexisting conditions.

Urol Clin N Am 48 (2021) xi–xiii
https://doi.org/10.1016/j.ucl.2021.02.003

Former presidential candidate and Louisiana governor, Bobby Jindal, has opined that, "President Biden will be unable to pass a 'public option,' and Republicans will be unable to repeal the Affordable Care Act."[1] Is this a prediction of continued legislative gridlock?

However, it would appear that choices in the future likely will be permutations of Medicare for All versus an expansion of Obamacare. It is important to recognize that universal health care and single-payer health care are not synonymous.

CURRENT SINGLE-PAYER TRIAL BALLOONS

Recent single-payer health care proposals, at a state level, have not met with success. In November 2016, Amendment 69, ColoradoCare, proposed a single-payer, government-run system and was soundly defeated by an almost 4-to-1 margin.[2]) Despite outspending its opponents by an almost 5-to-1 margin, ColoradoCare gained very little voter traction. Post–election analysis showed that a major reason for the lack of voter traction was cost and that Colorado voters understood that a $25 billion tax increase to provide "free" health care was a fantasy.

In Vermont, Green Mountain Health (H.202) would have required an 11% increased payroll tax and was abandoned.[3] In California, S.B. 562, Healthy California, was estimated to have a cost ranging from $331 to $400 billion and was not pursued.[4]

The term "Medicare for All" has often been used imprecisely by the media and some politicians. There really are 2 models for Medicare for All: the pure model and the hybrid model[5] The pure model of Medicare for All aims to establish a national insurance program operated by the federal government and explicitly prohibits private insurance for services covered by the publicly funded government plan. The hybrid model allows private insurance plans that adhere to federal regulations, including those sponsored by employers, to operate alongside and within a government-run Medicare program.[5] It is also important to realize that no Medicare for All plan would actually cover all Americans. The pure model proposed by Senator Sanders provides that both the Veterans Health Administration and the Indian Health Service would remain intact.[5]

LESSONS FROM THE CANADIAN EXPERIENCE

First, it should be acknowledged that the population of Canada is 37 million, whereas the population of California is 39 million and the United States is 329 million.[6] The origins of Canadian universal care began in Saskatchewan in 1947. This evolved into 13 provincial and territorial plans financed by per-capita block grants from the federal government.

These plans culminated in the Canadian Health Act of 1984, which initially outlawed private insurance and allowed no additional charges by physicians.[7] It should be recognized that the legislation was 14 pages compared with 900 pages for Obamacare, and the Canadian legislation was passed by a vote of 177 to 2.

Although the Canadian plan incorporates many attractive features, wait times have always been problematic even with their smaller and less urban population. Pipes[8] reports that the median time for a patient to be seen by a specialist after a general practitioner referral was 21.2 weeks, more than double the wait time of 25 years ago. The government has tacitly approved of patients paying private clinics out of their own pockets, and private clinics perform more than 60,000 operations a year, saving the public treasury $240 million.[8]

THE LOSS OF PRIVATE HEALTH INSURANCE FALL OUT

A single-payer system has some undeniable advantages. Physicians spend an average of 142 hours annually interacting with health plans at a cost to practices of $68,274 per physician.[9] There are 9 times more clerical workers in health care than physicians and 2 times as many workers as nurses.[10] When compared with Canada and 6 European nations, US hospital administrative costs are by far the highest.[10]

In addition, private health insurance employs about 500,000 people, and these people would have to be retrained and, in many cases relocated, if private insurance was abandoned.[11] Medicare and Medicaid pay hospitals about 87% to 90% of their actual costs, and hospitals shift costs to private insurers, which tend to pay 140% of costs.[11] Abelson and Sanger-Katz[12] concluded, "The real savings of Medicare for All would come from paying doctors and hospitals less than their cost of treating patients." Many of those private health insurance companies are major components of IRAs and stock investments for millions of Americans. Elizabeth Rosenthal[13] has further cautioned that under a single-payer system, most hospitals and specialists would lose money. She suggests that 5000 community hospitals would lose more than $151 billion.

President Biden advocates a preservation of the essentials of Obamacare with an expansion of it by including a public option that would serve as an alternative for Americans without insurance and those with employer-sponsored or individually

purchased by some consumers to receive their health insurance. As is often said, the devil is in the details; the costs of this option remain uncertain as well as whether it would actually achieve universal coverage.

THE PATH FORWARD

The purpose of this foreword is not to present a précis of health care options. Rather, it is to present, in broad brush strokes, the issues that will need to be considered in any health reform proposal. The Senate is divided 50/50 by party, and the country is divided to a degree as only rarely seen in our history. The US Census Bureau[14] reports that in 2018, 8.5% of Americans or 27.5 million Americans did not have health insurance at any point during the year. The most important message is to heed the wisdom of David Gergen. Our elected officials, on both sides of the aisle, have failed us in the past. As we enter the terms of a new president and a new congress, 1 thing appears certain: the status quo is untenable. Meaningful health care reform is long overdue. Going forward, our legislative leaders need to incorporate the views of physicians, far more than previously, as to practical solutions to the health care crisis. They need to listen to Gergen, that compromise and consensus are fundamental to all successful legislation. Yes, important yardage can be gained between the forty-yard lines, and if you work it right, you may even score a touchdown.

Kevin R. Loughlin, MD, MBA
Vascular Biology Research Program at
Boston Children's Hospital
300 Longwood Avenue
Boston, MA 02115, USA

E-mail address:
kloughlin@partners.org

REFERENCES

1. Jindal B. Can GOP find its way on health care? Wall Street Journal. December 3, 2020; section A;3.
2. Ray K. ColoradoCare suffered a whopping defeat. Here's why. Available at: https://www.coloradoindependent.com/2016/11/08/coloradocare-amendment-69/. Accessed October 10, 2020.
3. Vermont health care reform. Available at: https://en.wikipedia.org/wiki/Vermont_health_care_reform. Accessed October 10, 2020.
4. S.B. 562 The Healthy California Act (2017-2018). Available at: https://leginfo.legislative.ca.gov./faces/billNavClient.xhtml?bill_id=20172018SB562. Accessed October 10, 2020.
5. Oberlander J. Navigating the shifting terrain of U.S. Health Care Reform—Medicare For All, single payer, and the public option. Milbank Q 2019;1–15.
6. Wikipedia. List of countries by population. Available at: https://en.wikipedia.org/wiki/List_of_countries_by_population_(United Nations. Accessed October 11, 2020.
7. Naylor CD. Canada as single-payer exemplar for universal health care in the United States: a borderline option. JAMA 2018;319(1):17–8.
8. Pipes SC. Single-payer health care isn't worth waiting for. Wall Street Journal. January 22, 2018.
9. Casalino LP. What does it cost physician practices to interact with health insurance plans? Health Aff 2009;28(4):w533–43.
10. Himmelstein DU, et al. A comparison of hospital administrative costs in eight nations: U.S. costs exceed all others by far. Health Aff 2014;33(9):1586–94.
11. Medicare for all bailout. Wall Street Journal. Editorial. August 15, 2019.
12. Abelson R, Sanger-Katz M. Idea would end private insurance, then what? New York Times. March 20, 2019.
13. Rosenthal E. The costs of reform. New York Times. May 20, 2019.
14. Berchick ER, Barnett JC, Upton RD. Health care coverage in the United States: 2018. November 8, 2019. Report number P60-267(RV). United States Census Bureau.