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OBAMA'S $1.8 TRILLION HEALTH CARE GAMBLE

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To grasp what universal health coverage under President Obama means for access to quality health care we begin by noting the critical but often misunderstood difference between costs and expenditures and the ways in which the two are reduced. Simply put, health care costs relate to the cost of acquiring the resources to provide health care services. Health care expenditures relate to the payments made for services rendered.

For the health-care provider, payments are really revenues and as anyone in a for-profit business knows there must be some gain -- revenues > costs – for the business to survive. Absent subsidies, grants, or donations, a non-profit organization cannot survive if revenues < costs.

There are two ways to reduce expenditures: (a) do not use health care services and (b) do not pay for services rendered. Option (a) makes sense if a person has no need for the available services. It makes no sense if a person simply postpones needed health care and his/her health condition deteriorates to the point where more costly intervention is required. Thus the emphasis on regular checkups, preventive care, and a sensible lifestyle.

Option (b) covers bankruptcy, no pays, and third-party payers who do not reimburse the full cost of the care provided. This option makes sense for the patient and the payer. It makes no sense for a provider unless the care is given freely.

No pays and below-cost third-party reimbursement can be reversed through vigorous collection efforts. In the end, however, unpaid balances must be written off as bad debts. Third-party payers including Medicare, Medicaid, and private insurers are adept at not fully reimbursing providers for the care rendered. This practice reduces their expenditures but does not reduce the cost of providing that care. If in the short-run reimbursement < cost, providers may render care selectively or silently shift the cost to others who seek care from those providers. If this condition persists, the provider may no longer provide health care to anyone. That harsh reality may turn away capable and eager young men and women from entering the health-care professions and together with the loss of older professionals may reduce the quality of care available. Or it may channel the young into those subspecialties where the gains make worthwhile the sacrifices made to prepare themselves professionally.

Costs can be reduced in two ways: (a) replace more expensive resources with less expensive ones and (b) improve efficiency in delivering care. Under option (a) a hospital may for example substitute a licensed practical nurse for a registered nurse or purchase supplies in bulk through a purchasing consortium. A physician in an office-based practice might for instance employ a nurse-practitioner instead of a physician partner or relocate to a building with lower heating and air-conditioning costs. Driven by the need to re-align costs and reimbursement and by the cold logic of option (a) the U.S. health-care system depends more and more on walk-in clinics staffed by nurse-practitioners to deliver primary care.

Under option (b) rendering care more efficiently is more complicated than improving productivity in manufacturing washing machines or soft drinks in a capital-intensive assembly-line process. Anyone familiar with fine furniture, for example, knows that hand-crafted furniture is more expensive than mass-produced furniture precisely because it is more labor intensive Health care is labor-intensive because literally every patient is different. The economies of scale available in mass-production manufacturing simply do not apply.

Even so, waste is ever-present in every process, whether capital-intensive or labor-intensive. Because health care is labor intensive, waste originates largely in labor utilization. Wherever found, wasted labor resources means labor is not producing what it was employed to produce -- a nurse who momentarily is idle because a patient is late in keeping an appointment or is a no show, a physician waiting while a lab completes vital tests or a technician repairs a piece of equipment. This problem is difficult to manage because it involves complex human interactions and rests primarily in the hands of supervisory staff to monitor the process, re-arranging schedules and assignments as the situation unfolds without interfering with the care.

The Obama plan promises to extend coverage to everyone without increasing health-care expenditures by reducing the cost of care through efficiencies in the ways care is delivered. Central to this plan is the adoption of an electronic system to share medical records across the entire health-care system. A system like that means every provider must be linked together electronically in ways similar to the internet wherein there is no central depository and every user bears the full cost of maintaining records on every patient served in a standard format that makes the information accessible to any authorized person in need of that information.

Such an electronic system reduces the cost of health care only if the cost of maintaining and sharing medical records is less than the cost of replicating whatever information is needed at the moment. Savings are possible but problematical. Does it make sense to wait on retrieving information when the patient suddenly presents in need of immediate emergency care, if the information retrieved is dated, the information is inaccurate, when the system shuts down due to a virus or power outage? Protocols will have to be developed that uniquely identify every patient, prevent access to all but those authorized to use that information, protect information suppliers from malpractice suits involving providers who misuse shared information, and comply with Health Insurance Portability and Accountability Act.

Massive systems are both a blessing and a curse. When they work well they offer substantial benefits. When they fail they impose large costs. Before a final decision is made to provide universal health care coverage, Obama and the Congress should spend one week observing how hospital care is provided and at least one day on how patient and billing records are maintained and processed.

Health care spending contributes $1.8 trillion to total GDP of $14.3 trillion. Ignorance is no excuse for re-structuring health care without first-hand information on how much is spent on it, how much it costs to provide that care, and the complex process by which the care is delivered.

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