



BRIEFLY

Failure of the legislature to pass a bill aimed at saving the market for individual health insurance may increase the chances of success for an initiative that would require all residents, except the poor, and all businesses to finance a system of single-payer health care in Washington.

Health Care 2000, the diverse group supporting the initiative, claims that replacing private insurance companies with a single state trust fund that pays for the services of all licensed and certified health-care providers will be more efficient.

The public would do well to review that initiative with a skeptical eye.

Single Payer Plan Proposed, Skepticism Advised

As the organization backing a single-payer system for health care in Washington completes its proposed ballot initiative, state lawmakers are still trying reach a compromise on a bill aimed at rescuing the market for individual health insurance.

Failing to pass effective legislation may play into the hands of Health Care 2000, the group behind the single-payer initiative.

Even if a bill is passed, though, the frustration and anger of various physicians, hospitals and consumers in hassling with managed-care insurers may well generate enough signatures to put the initiative on the fall ballot.

The Washington State Medical Association's executive director, Tom Curry, says a third of the association's members want a single-payer system. The Washington State Hospital Association's president, Leo Greenawalt, says rural hospitals are in such bad shape that they may see a single-payer system as the only way to survive.

Some might say that a single-payer system could not be worse than what we have now, and surely would be better, but they should be careful what they wish for. Single-payer systems run by the Canadian provinces have led to long waits for care and in some respects to a level of care that Americans probably would not tolerate. In a recent warning to Americans, published Jan. 28 in *The Wall Street Journal*, British Columbia physician William McArthur, currently a senior fellow in health policies at the Fraser Institute, remarked on the relative scarcity of CT scanners, MRIs and cancer radiation machines in Canada. And he said, "A survey of teaching hospitals in British Columbia, Washington state and Oregon revealed that at least 18 surgical and diagnostic procedures readily available in the U.S. are unavailable in Canada."

Initiative supporters insist that their proposed single-payer system "is very different from the Canadian one in many ways." Even so, the public would do well to review the initiative with a skeptical eye. There are reasons to doubt whether it will work as well as promised. If it turns out that it cannot control the high costs resulting from virtually unconstrained consumer demand for health services, heavier controls will have to clamp down on service supply. That will lead to long lines.

"Health Care 2000" will seek voter approval of a state-run health trust fund that will pay for health care for all Washington citizens. Among the organization's members are health-care providers, including three past presidents of the Washington State Medical Association, unions and consumer groups such as the Washington State Council of Senior Citizens and the Council of Aging and Long Term Care of Eastern Washington.

The trust fund, called the Washington Health Security Trust, would pay for a comprehensive package of health benefits, including at a minimum those listed in the initiative. For those benefits, consumers may go to any licensed or certified health-care providers – physicians, naturopaths, chiropractors,

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acupuncturists and others. They would pay no deductibles nor suffer any annual caps, though some co-pays will apply.

Money to pay for health services would flow into the trust from taxes on employers, initially set between 7 percent and 9 percent of payroll, and taxes, called “premiums,” on individuals and families — \$75 a month for individuals, \$150 for families. Low-income people and the poor would be subsidized or pay nothing. Providing the state can obtain waivers, Medicare and Medicaid funds also would go into the trust. Initially, trust funding would amount to \$20 billion a year. If the trust needs more money, the Legislature would have to raise taxes.

A board of seven trustees, appointed by the governor and confirmed by the Senate, would manage and regulate the system, within the initiative’s guidelines. To keep the system fluid and adaptable, the board is given a lot of freedom to fill in the details of how it would work.

In effect, initiative organizers will ask voters to *trust* that the board, with the help of a citizens advisory and a technical advisory committee and other, ad hoc, committees as needed, can make the system work well.

Among other things, the board would “work with standing committees to balance benefits and provider payments with revenues, and develop effective measures to control excessive and unnecessary health care costs.”

How and how well the board would control costs is key to making the system work well, and whether it can pull that off is open to question.

The board is given various ways to control costs. Virtually all fall on the supply side of health services.

For instance, the initiative says, “The board shall work with providers to develop and apply scientifically based (health-service) utilization standards, to use (patient) encounter and prescribing data to detect excessive utilization, to develop due process for enforcing appropriate utilization standards, and to identify and prosecute fraud.”

All that means that the board will try to stop providers from giving unnecessary and ineffective care. And it means physicians and other providers will have to say no to consumers who want more service than they should have.

But the initiative also says, “The board shall pursue due diligence to ensure that cost containment measures shall not limit access to clinically necessary care, nor infringe upon legitimate clinical decision-making by practitioners.”

And Health Care 2000 executive director Cindi Laws says that means providers will have the last say about providing service. If they deem it clinically necessary, they’ll do what they think best.

So it would seem that in the end, control of service costs would rest with the judgment and character of physicians, mental-health professionals, naturopaths, chiropractors, massage therapists and every other licensed or certified provider.

It’s reasonable to doubt how well they can say no to consumers. “As a group, physicians have not done a good job of saying no,” observes Dr. Geoffrey MacPherson, Northwest medical director for PacifiCare, a large insurer operating in Washington. “Physicians are very averse to saying no; it’s inherent in us. We’re helpers.”

Dr. MacPherson also says research shows that the provision of medical care has not depended on illness but on the availability of medical resources. In the Dartmouth Atlas of Health Care 1998, Dr. John Wennberg makes this statement:



“The reality of health care in the U.S. is that geography is destiny. The amount of care consumed by Americans depends more on where they live – the local supply of resources and the prevailing practice style – than on their needs and preferences.”

This suggests what the board may have to do if providers lack the courage to say no: clamp down on funding such resources as medical equipment, as apparently the Canadian provinces have done.

A few weeks ago, the Health Care 2000 website had a questions-and-answers page, which included this promise: “Health care financing will be centralized, allowing for ‘global budgeting’ for new technology and other overhead costs. Expensive new technology will be bought out of genuine community need, not out of need to compete with other clinics and hospitals.”

Presumably, the trust’s board, not the market, will determine “genuine community need.”

This likely will lead to rationing medical care by time. “At a median level,” wrote Dr. McArthur, “Canadians wait six weeks to see a specialist after their family doctors ask for the consultation. Having seen the specialist they will wait a further seven weeks before treatment is provided. In between, they will wait for tests, most of which rely on technology that is limited in supply. The median wait for magnetic resonance imaging is 11 weeks; five weeks for a CAT scan.”

According to the Fraser Institute, the Canadian “government’s inability to fund the health care system sufficiently to overcome the inefficiencies of centralized control has resulted in widespread rationing of services.”

Of course, there are other ways to cut costs. One is to trim the benefits package. Another is to cut payments or payment increases for providers. We already have a government program that has used this technique — Medicare. According to 1999 Congressional testimony on behalf of the American Medical Association, Medicare has overseen “more than a decade of cuts in physician payments. For example, in the past six years from 1991-1997, overall Medicare physician payment levels fell 10 percent behind the rate of growth in medical practice costs. Many individual services and procedures faced even deeper cuts.”

Washington State Medical Association director Curry believes that the political pressures on public health-care systems result in increasing benefits and eligibility, and that the economic pressures result in paying providers less. He predicts that a single-payer system “will kill folks at the delivery end.”

The Health Care 2000 initiative, sponsored by Dr. S. Jeanne Bramhall, a Seattle psychiatrist, is in the process of obtaining a title and summary from the state Attorney General’s office. That completed, anyone objecting to the title has five days to register a court challenge. Then Thurston County Superior Court has five days to decide whether to allow the title or to rewrite it, after which the initiative’s supporters may begin printing and circulating petitions. They must gather 179,248 valid signatures to qualify the initiative for the November ballot.

Meanwhile, legislators have until March 9, when this legislative session ends, to pass a bill that will draw major insurers back into the individual market.

