

From my perspective

The government and the private sector are slowly and incrementally developing a new and, hopefully, improved health care system. As difficult as it may be for many surgeons to accept, what is evolving is, in many respects, similar to a single-payor construct. I realize use of this term is verboten in many circles, but it would be foolhardy to view the situation in any other way.

If we defiantly turn away from this reality, we will only harm our profession and the patients we serve. Without the medical community's participation, the government will continue to assume this responsibility, and we may wind up with a system that is centered on what's best for the economy rather than on what is best for the American people.

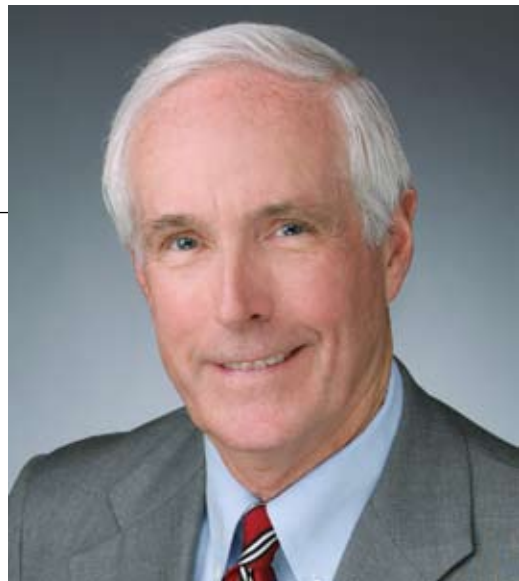
Ongoing government involvement

Multiple societal changes that have transpired over the last several decades have expanded the government's role in administering the health care delivery system. For example, more people are meeting the age requirements for Medicare eligibility. In 2005, Medicare served 35.6 million elderly Americans, and this number will soar as the Baby Boomers begin seeking benefits.

Enrollment in other government-sponsored programs has grown as well; as of 2005, Medicare, Medicaid, and military health programs provided coverage to 45.5 million working-age individuals and their dependents. An additional 18.2 million had jobs in the public sector, which includes state, federal, and local governments, as well as public schools and state universities. They, too, receive health care coverage through government-supported health plans.

In addition, the government provides tax incentives to businesses that provide health insurance coverage to their employees. According to the Agency for Healthcare Research and Quality, the tax subsidy cost the federal government approximately \$208.6 billion in 2006.

As Daniel Gross wrote in a recent issue of the *New York Times*, "By various measures, the United States is about halfway toward a system in which the government and tax payers fully fund health care. And trends are pushing



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the government to become more involved each year.”*

Clearly, the existing system is economically unsustainable. As a result, the government has continued to institute policies aimed at controlling the health care cost behemoth—first through methods to control prices such as the resource-based relative value scale; then by controlling the use of resources through managed care in the private sector; and, more recently, through efforts to promote competition among providers and link payment with performance.

New government involvement

In order to develop the pay-for-performance model, the government is incrementally implementing steps to encourage physicians to abide by set standards and to participate in the quality measurement system. As acknowledged previously in this column, pay for performance or some other manifestation of value-based purchasing is seemingly inevitable.

And, of course, we should bear in mind that

*Gross D. Economic view: National health care? We're halfway there. *New York Times*. December 3, 2006; Section 3, Page 4.

approximately 46.6 million Americans lacked health insurance in 2005—slightly more than the number of Americans who are covered by state and federal health insurance programs. When these individuals fall ill, they often land in our overstressed emergency rooms or receive uncompensated care. In other words, all patients get care, but not all are served. As the Democrats take control of Congress this year, we are likely to see renewed emphasis on providing health insurance coverage to the uninsured.

The Administration has repeatedly opposed efforts to resolve this problem through government-sponsored programs. However, the continued push from the Centers for Medicare & Medicaid Services toward pay for performance is in many respects a move toward a single-payor model. Indeed, one of the driving concepts behind value-based purchasing is that consumers, employers, and private insurers will use a common set of outcomes data generated through pay for reporting and pay for performance to determine which physicians and other providers offer high-quality, cost-effective care. So, in essence, we will have at minimum a single point of reference for determining who is in a position to offer value-based care.

The College's role

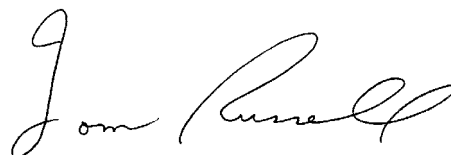
Ideally, however, this single point of reference will be based on analysis of information from the most knowledgeable and experienced sources. As you know, the College is striving to participate in this process and provide risk-adjusted outcomes data on surgical procedures through its ongoing ACS National Surgical Quality Improvement Program.

In addition, the American College of Surgeons intends to play an active role in the government's attempts to address the inaccessibility of health insurance coverage for so many citizens. Our Health Policy Steering Committee continues to analyze potential proposals. Moreover, we intend to increase our visibility in the nation's capital by moving the Washington Office closer to Capitol Hill and into a facility that will allow for greater collaboration among the surgical specialty societies. We also anticipate creating a Health Policy Institute within the Washington Office, which will be charged with studying the issues and

offering scholarly recommendations on how the health care delivery system can best be improved. Our goal in all these endeavors is to ensure that surgeons—not MBAs or economists—are the ones determining how surgical care is delivered to our patients.

Again, I realize that the term “single-payor” carries negative connotations for many surgeons. Typically, it conjures images of government controls that disrupt the timely delivery of care. In many countries that have government-run national health insurance systems, these problems are prevalent. Perhaps the U.S. should more carefully examine these systems and determine the causes of the pitfalls. It is quite possible that government is not necessarily the best manager of health care and that an independent board would be a more competent administrator.

In any event, the reality is that we are slowly inching our way toward a single-payor system. Our objective, therefore, should be to ensure that surgeons and other health care professionals are key players in the design of our health care system, so that our patients receive timely, effective, professional care centered on meeting patient needs.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.