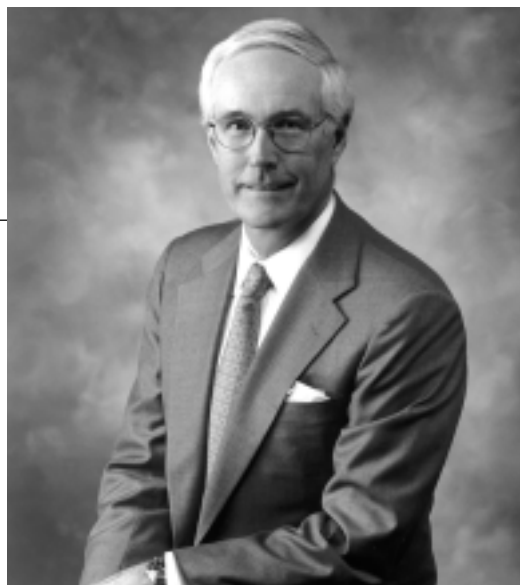


# From my perspective



**A**s the nation becomes more economically and emotionally stable after the events of last year, resolution of health care issues will once again occupy a prominent spot on the agendas of federal policymakers, medical organizations, and other stakeholders in the system. Topics that undoubtedly will be debated include health insurance reform, quality of care, and financial strains on surgeons and physicians.

## *Health insurance reform*

The continuing controversies related to health insurance reform have, of course, been driven in large part by the ongoing escalation of health care costs. For example, it has been estimated that employers that provide medical benefits to their employees experienced an 11.2 percent increase in associated costs per worker last year. Employers anticipate that those expenses will go up another 13 percent in the year 2002. Further, the nation's health care expenditures now total more than \$1 trillion a year, and, according to recent government projections, health care spending in the U.S. will double over the next decade to \$2.6 trillion, with employers covering most of the expenses. Despite these alarming economic numbers, huge numbers of people in this country have no insurance whatsoever, partly because many small businesses cannot afford to provide health insurance benefits for their workers.

Other factors will undoubtedly fuel the health insurance reform debate in the future. I would point out the fact that one of the major health insurance companies, Aetna Inc., recently laid off one-sixth of its workforce due to languishing enrollment and expectations of losing more subscribers as it raises rates and eliminates unprofitable plans.

While most players certainly can agree on the principles of insurance system reform, it is very difficult to arrive at any sort of consensus as to how to take these ideas and convert them into real, concrete changes in the system. Indeed, what is a clear-cut, positive solution to one stakeholder becomes the *bête noir* of the next. For instance, most people and organizations agree that the health insurance system should be reformed to ensure medical coverage for all Americans, regardless of economic status. How to achieve that goal, however, is the source of endless debate. Do we establish a

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single-payor system, expand and improve managed care organizations, or offer vouchers so that people can buy their own health insurance policies? Who will benefit most from implementation of any of these methods?

Presently, coalitions representing large purchasers of health care are gathering and developing novel suggestions on ways to improve their ability to offer health insurance coverage. These groups and the corporations they represent have been continually alarmed by the escalating costs and are attempting to come up with appropriate solutions to the issue. Some businesses, for instances, are offering their employees “defined contribution” benefit plans. Under this strategy, employers provide a set amount of money for each employee's health benefits, and the employee decides which type of plan to purchase using the allowance. Discussion of these and other proposals have been and will continue to be prevalent for the foreseeable future.

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### **Quality issues**

There will also be increasing pressure on all surgeons, health care practitioners, hospitals, and other providers to make certain that their interventions and actions are based on solid medical and surgical evidence. Some stakeholders, such as the Leapfrog Group, even call for differentiating among providers on the basis of some sort of an evaluation system, so that the purchasers of health care can make better choices about where to send patients for treatment. Other organizations are demanding better use of information systems and technology with the ultimate aim of someday having medical records that are completely electronic and hopefully decreasing medical errors so that patient safety can be improved. Additionally, there are growing expectations that federal agencies and health care organizations will establish guidelines for treating specific diseases and conditions, thereby enabling physicians and providers to establish best practices.

Finally, many stakeholders believe that health care consumers should become more engaged in enhancing the quality of their health care, not only in their day-to-day living habits, but also in the way they select their health plans and their providers. Engagement of the public in their own health care is certainly a laudable goal, but it is also perhaps the most difficult to realize.

### **Financial strains**

Another problem that has become endemic to the U.S. health care system is the ever-heightening financial burdens that physicians and other providers are expected to bear.

For example, physicians are paying higher malpractice insurance premiums because jury awards have risen to an average of \$3.49 million each. These hefty awards are, in turn, driving some malpractice carriers out of business. This past December, St. Paul Companies, the nation's major medical liability carrier, announced that it would exit the medical malpractice field and would no longer offer new policies because of mounting losses from medical malpractice. Meanwhile, physicians, hospitals, and others are expected to shoulder the costs through higher premiums. And the increased costs of premiums, unfortunately, are too often passed on to employers and consumers, adding approxi-

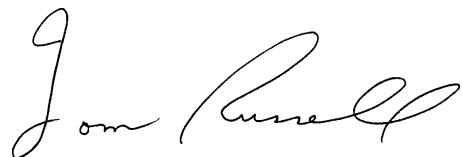
mately one percentage point to health care inflation.

In addition, reimbursement issues continue to plague the health care system. The Centers for Medicare & Medicaid Services (CMS) recently announced a delay in payment for hospital services and that the conversion factor that is used to calculate payments to physicians who provide Medicare services will decrease by 5.4 percent this year. This reduction brings payment per relative value unit down from \$38.26 to \$36.19 this year. As I noted in a previous column on this topic, the CMS cut the conversion factor because, under legislation that was enacted during the previous Administration, the annual conversion factor update is based on a "sustainable growth rate," which is tied to the business cycle rather than to health care costs (*Bulletin*, December 2001, p. 3). There clearly is a major flaw in the system under which CMS works and compensates providers.

These types of financial strains must be eased as part of any effort to reform the nation's health care system, so that the practice of surgery and medicine remains attractive to those surgeons and physicians who are committed to providing excellent care.

### **What we're doing**

How these problems will be resolved remains to be seen. I can assure all of you that the American College of Surgeons will be closely monitoring all of these issues and will respond appropriately, either independently or as part of coalitions with other organizations. Clearly, surgeons and other health care practitioners have frequently been neglected in the national debates over health care reform. We will make certain that our members are appropriately represented as the controversies unfold and issues of concern to Fellows are discussed.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).