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Before the Subcommittee on Primary Health and Retirement Security

Roundtable discussion on "Health Care in Rural America: Examining Experiences and Costs "

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3:30PM

Good Afternoon Chairman Enzi and members of the subcommittee on Primary Health and Retirement Security. My name is Deborah Richter. I am a practicing family physician in rural Vermont and I also have an addiction medicine practice in Burlington VT. I want to thank you for asking me to participate in the roundtable discussion of "Health Care in Rural America: Examining Experiences and Costs."

I am particularly interested in the topic examining experiences because I see the inadequacies of our health care system every day.

Regarding the subject of costs however, I wonder whose costs we are referring to?
When I think of costs mostly it is in reference to system costs, that is, how much the U.S. spends on health care in total. This year it is projected we will spend $3.5 trillion on health care [1]. As you've heard many times, we spend on average twice per capita what other countries spend.[2] All of whom cover everyone while enjoying a longer life expectancy and [3] better health outcomes. [4]In every other industrialized country health care is a public good.

There are many reasons we spend more per capita on health care not the least of which is our enormously complex financing system which consumes 31 % of total health care costs.[5] Much of these costs are necessary under a multiple payer system where each payer has different rules, regulations and levels of reimbursement. But under a one payer publicly funded universal system such as the one embodied in Senator Sanders' Medicare for All bill, simplified billing and administration could be reduced by $500 billion.[6]There have been multiple studies showing that we are spending more than enough money to cover all Americans with comprehensive coverage.[7]

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1 Centers for Medicare and Medicaid Services, 2018.
2 Organization of Economic Cooperation and Development (OECD), 2018
3 OECD, 2018
4 OECD 2018

5 Woolhandler, S., Campbell, T., Himmelstein, D, "Costs of Health Care Administration in the United States and Canada" NEJM, Aug,2003.

6 Woolhandler, S., Himmelstein, D., "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs", Annals of Int. Med., April, 2017.
7 How Much Would Single Payer Cost; A Summary of Studies Compiled by Ida Hellander, http://www.pnhp.org/facts/single-payer-system-cost

If we then focus on payer costs this would include the tax payer for 2/3 of the financing of health care[8], Medicare, Medicaid, the VA, public employees' health insurance and the tax subsidy for private employers to pay for health insurance for their employees. The remainder comes from out of pocket payments from the public and employers paying for private health insurance. But we must acknowledge that every penny ultimately comes from Americans' pockets. Taxes, out of pocket payments, higher prices for goods and lower wages if our employer pays for health insurance all come from us.

But there are other costs to the lack of a health care system.
Those are the ones I witness every day. I will give you a few examples from my practice alone in the past year. I am one physician among thousands and I can give you dozens of examples. If we do the math it is not hard to see how 37,000 patients died from lack of insurance [9].

Three examples:

1) An uninsured 60-year-old delayed seeking care despite being unable to swallow solid food and losing 100 pounds. 18 months later he was diagnosed with Stage4 esophageal cancer. He has since died.

2) An uninsured 40-year-old woman with a large mass in her breast delayed seeking care for a year until the mass stated to bleed. She has an aggressive form of breast cancer.

3) A 52-year-old woman suffering from severe shortness of breath delayed seeking care due to mounting health care bills from another family member. She was working full-time. They have a $5000 deductible.

The un- and underinsured are more likely to die from preventable illnesses than their well insured counterparts. And many of them who delay care like the patients mentioned above, incur much higher costs than they would have had they sought care earlier. I need not mention the human cost of these tragic cases.

We also can't ignore the economic cost of the way we finance health care in our country. The patient with the breast mass was saving to build a house with her fiance. She couldn't afford to do that and pay for health insurance. Millions of people make these sorts of economic decisions every day. When they do, the economy suffers. We are a consumer driven economy so there is an economic multiplier effect to the regressive way we finance health care.

I would like to also mention that all of the above problems with our current health care system are magnified in rural America as they are older sicker and poorer. [10]This is particularly true of the impact of the opioid epidemic which started in rural America. [11]The Centers for Disease Control and Prevention (CDC), find that the rate of death from opioid-related overdoses is 45 percent higher in rural vs urban areas.

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8 Woolhandler, S., Himmelstein, D., "Paying for National Health Insurance and Not Getting It", Health Affairs, Vol 21. No. 4, 2002.
9 Woolhandler, S., Himmelstein, D., "The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?", Annals of Int Med, Sept, 2017.
10 Wagnerman, K. "Health Care in Rural and Urban America". Georgetown University Health Policy Institute, Oct.,2017.
11 Toliver, Z, "The Opioid Epidemic: Testing the Limits of Rural Healthcare", Rural Health Information Hub, May 2016.

The majority of treatment programs are funded through taxes - mainly Medicaid programs. But this problem is straining rural health systems ability to respond. Many patients wait months to get treatment for substance abuse, some give up trying. There are also indirect costs to opioid use disorder. The foster care system is bursting at the seems. [12]
Other costs include corrections costs which again are greater on a per capita basis in rural vs urban America.[13]

When we are looking to reduce health care costs now and in the future we must first address the primary care shortage. Primary care represents most of the medical office visits in any one year. [14]In a nutshell primary care is most of the care to most of the people most of the time. Yet we represent less than 8% of total costs. [15] We know that when a population has free access to primary care, people live longer and they cost the system less.[16] As you must know there is a severe shortage in primary care particularly in rural and poor communities. [17]Much of this is due to an aging workforce with 1/4 over the age of 60 in 2017.[18]. With fewer medical students choosing primary care we will see this shortage worsen by 2025 [19] In addition demand has increased due to an aging population and with the expansion of the ACA. Added to that, the burnout rate in primary care is causing physicians to retire earlier than they might have.[20]

As a practicing family physician I can see why physicians are burning out. The administrative burden placed on us when dealing with multiple payers with different rules, regulations and reimbursements would drive anyone mad. Doctors report that for every hour of patient care they spend an hour with administrative tasks. If we have any hope of rescuing this dying profession we had better address the administrative burden facing our primary care practitioners.

In sum, as a physician who has practiced in the US health care system for the past 30 years I would say that in my experience, unless we address the system as a whole we will not solve any of the pressing problems in health care. We need to regard health care as a public good and make it accessible to all. We have wonderful health professionals and hospitals in this country. We are spending enough money, We need a program of expanded Medicare for All Americans.

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12 Stein, P., Bever, L., “The Opioid Crisis is Straining the Nation’s Foster Care System”, Washington Post, July 2017.
13 Sullivan, R., “The Fiscal Impact of the Opioid Epidemic in the New England States”, New England Public Policy Center, May 2018.
14 Center for Disease Control, National Center for Health Statistics, 2015.
15 Koller, C., “Getting More Primary Care- Oriented: Measuring Primary Care Spending” , Milbank Memorial Fund, July 2017.
16 Friedberg, M.,et.al,”Primary Care: A Critical Review of the Evidence On Quality And Costs of Health Care”, Health Affairs, Vol 29, No. 5, May 2010.
17 Petterson, S., et.al., “Unequal Distribution of the U.S. Primary Care Workforce “, American Family Physician, June,2013.
18 Petterson S, McNellis R, Klink K, Meyers D, Bazemore A. The State of Primary Care in the United States: A Chartbook of Facts and Statistics. January 2018.
19 Petterson, S., et al, “Projecting US Primary Care Physician Workforce Needs 2010-2025”, Annals of Family Medicine, 2012
20 Pechham, C., Medscape National Physician Burnout & Depression Report 2018, Jan., 2018.