SOCIETY OF ACTUARIES

Article from:

Health Watch

May 2008 – Issue No. 58

The Crisis in American Health Care

by Ian Duncan

At the recent SOA Annual Meeting in Washington, D.C., I participated in a panel discussion about the crisis in American health care. I was asked to represent a position that there is no crisis. The following article is taken from my prepared remarks.

I am delighted to participate on this panel about American health care. I represent several different perspectives:

1. I am a health actuary who works with clients in the area of managed care outcomes, in several different countries.

2. I actually purchase health care on behalf of my employees.

3. In my career I have lived in four different countries under four different health care financing systems. So I have a broader perspective than most individuals.

4. I was trained as an economist before I became an actuary, and I am interested in the power of markets to provide signals that optimize behavior and maximize satisfaction.

5. Finally, I was recently honored to be appointed by Governor Deval Patrick of Massachusetts to the Board of the Commonwealth Connector Authority, the government agency charged (under Governor Mitt Romney's reforms) with assuring the provision of affordable health-care to the previously-uninsured who are now required by law to purchase coverage. I am also on the board of a New York Health Insurer that has been particularly successful in providing coverage to independent workers, 60 percent of whom previously had no health insurance.

Ian Duncan, FSA, FIA, FCIA, MAAA, is president of Solucia, Inc., Hartford, Conn. He can be reached at *iduncan@soluciaconsulting.com*.

I say all this to establish my *bona fides*, since I am defending a position that I suspect has relatively little support, especially among the wider public.

Let's begin with the title of this panel: the crisis in American health care. I agree that there are some serious issues in American health care, but these are issues that the system could correct on its own, without wholesale, radical change. Stop and think a moment: what exactly do we mean when we say that there is a crisis? Turns out, when you examine the proposition, there isn't a consistent view of what "the crisis" is. There are many different problems to which critics point—access, affordability and the uninsured. But crisis is not a collective noun for a lot of problems. Crisis is an overworked word—there has certainly been a dumbing down of the crisis concept in my lifetime. Back in 1938—before I was born and when the word was used more sparingly—Munich was labeled a crisis, because the world was on the verge of a world war. The Cuban Missile Crisis, which I do remember, was a very scary time (adults appeared to be upset and whispered a lot). That deserved the crisis label. But now, everything is a crisis. There's Hurricane Katrina, obesity, diabetes, poor school performance, the sub-prime mortgage defaults, and the list goes on. The BBC had a headline recently on their Web site: "Obesity Crisis: The New Global Warming?" which manages to capture two crises for the price of one. This hysterical approach may help to sell newspapers (an industry that, due to falling circulation is in, well, crisis!) but doesn't make for sober substitution of facts for appearances. So we should examine what causes a problem to escalate from just that—a problem—to the level of a crisis.

I said I was glad to be invited to speak on the panel as an employer. As an employer, I have to deal with many costs in my business. And they are all a problem. But my health plan expense is small in comparison to other expenses. If you want to talk about problems, let's look at some of those that I face. First, I employ actuaries, who

are not a cheap resource. Then, there are all the other services like computers and internet and communications. These are expensive resources with which you receive differing degrees of bad customer service when things go wrong, which they invariably do (not the actuaries, of course). But all of my business expenses pale in comparison to the different government departments that I deal with. At least when I deal with my vendors there is competition and I can get a vendor's attention because the market gives me alternatives. Not so with government.

The single biggest monthly expense in my business, after salaries, is government in its many forms. We hear a lot about the crisis in health care expenses facing employers; I don't understand why we don't hear more about rising taxes, because for me the latter is a bigger issue. To me it contrasts sharply with my health care expenditures. In neither case do I like paying the bills. But at least I get a tangible benefit for my health care expenditures. I have bargained with my employees for a health plan that they are willing to live with, and a level of expense that I can afford to absorb in the business. When my carrier comes back at the end of the year and asks for a premium increase, I have the flexibility to change plans, carriers, and contribution strategy—I have a lot of flexibility. Contrast that with the problems I have with expenses over which I have no control and no room to negotiate, like taxes. My employees have a lot of flexibility too—they can come into my office and ask for different benefits. Ultimately, if they don't like my plan, they can quit and go work for an employer who offers a more attractive plan. That, I would submit is the genius of the U.S. system. It offers employers and employees flexibility, leading to a negotiated result that isn't necessarily what each party wants ideally, but is a compromise that each party can live with.

One of the crises we hear about that is easy to dismiss is the percentage of the gross domestic product (GDP) that is spent on health care. This is largely a crisis manufactured by those

with a political objective of trying to change the system, since the percentage of GDP spent on health care doesn't have much effect on the average worker or the average employer. The principle of revealed preference says that if U.S. consumers and employers choose to spend relatively more of their incomes on health and relatively less on widgets, this decision will raise the percentage of GDP going to health. The market determines the percentage and, while we may not agree with individual preferences for expenditures, the market achieves equilibrium. "But," I hear you saying, "the United States spends so much more than other western democracies!" The difference between the United States and all other systems when it comes to health care expenditures is that all other countries impose artificial caps, to a greater or lesser degree, on their expenditures. The United Kingdom has starved its National Health Service of investment for years, because the government as funder has so many other calls on its revenue. The result is patient dissatisfaction, long waiting lists, dismissal of thousands of junior doctors, etc. The United Kingdom has recently increased significantly the funding of its health service in response to public pressure. However, one difference between the United Kingdom and United

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States that actuaries will appreciate is that health service workers in the United Kingdom are all employees of the government and therefore, eligible for the government's unfunded pension scheme. As the number of workers retiring increases, the call on the extra funding to pay for pensions will increase more than proportionally. Contrast this with U.S. (private) health care providers who generally fund their pension plans. Canada is an example of a country that actually *forbids* its citizens to spend their own money on health services (for which there is clearly a pent-up demand). Did you know, for example, that Canadians can purchase MRI's for their pets but not *themselves*?[1] So I would submit that the hysterical commentary one reads about the percentage of GDP spent on health care has it exactly wrong: the United States provides a guide as to what a free market would result in, while other countries are spending at less than the optimal level.

"Compulsory" insurance doesn't guarantee coverage or access any more than the elective system we have today. For example, auto insurance is compulsory, yet nationally something like eight percent of drivers are uninsured. The number of citizens in Massachusetts without health insurance prior to the passage of mandatory coverage was slightly over six percent.

We hear a lot about the problem of access to services as a source of the crisis. Let me illustrate with another story. A company that we consult with performs case management and second opinions. A patient who had had neurosurgery to insert a brain stent suffered an event that appeared to require further neurosurgery. His family asked for a second opinion. My client assembled a team of leading specialists who identified two non-invasive alternatives: one was gamma-knife surgery, and one was use of a linear-accelerator. Oh, one key fact I overlooked, the patient lives in Canada. My client tells me that there is only one gamma-knife available in all of Canada, and no linear accelerators. Unfortunately the gamma-knife belongs to the Princess Margaret Hospital in Toronto (where my daughter was born, coincidentally). The hospital ran out of money after buying the equipment so it isn't used. My client referred the patient to the United States where there are plenty of these devices, as well as linear accelerators. Why is this story interesting? Well, the international comparison illustrates that access is a major problem in systems other than the United States. More importantly, it illustrates another strength of the U.S. system—the flexibility that comes from the market and multiple players. The way financial incentives work in the United States, a gamma-knife wouldn't be purchased without some assurance that it would provide a return, and it certainly would not be allowed to stand idle. Our providers have a degree of certainty of financing that results from the private bargaining between participants in the system. Providers know that they have a reasonable expectation that they will have patient volume and financing if they decide to invest in a device like a gamma-knife. And anyone interested in discussing problems of access in Canada should call Gary Mooney, an FSA formerly from Toronto, who retired a couple of years ago and moved to Kingston, Ontario. Gary had to spend two years waiting for a physician practice that had a vacancy and was willing to accept him as a patient. The same thing happens with the government-funded sector in the United States. Those of you who work in Medicaid will know that states cap their budgets arbitrarily and simply stop paying claims when they reach the budgetary limits. This happened a couple of

[1] During the panel discussion, one of the speakers challenged this statement and said that, while historically true, this is no longer the case. It is my understanding that the laws that prevent private payment for publicly provided services are still in place, and that the Chaoulli decision found that patients had a right to services. A waiting line for services was found to be unconstitutional. The decision appears to have been interpreted in some places to allow patients to pay for their own care, but law in this area is very unclear.

years in a row in a state that had better remain anonymous, until election year when the legislature miraculously found $1.2 billion in additional funding, and providers couldn't submit enough claims to use up the budget.

I would agree that there are problems in U.S. health care. But the system is resilient, flexible and allows for negotiation between parties who can make alternative decisions if they don't like an outcome. And the U.S. system is the largest driver of innovation in the world. Many of the wonderful advances in medical care that we see--huge improvements in survival rates for heart patients, for example—are the results of U.S. innovation. And rates for things like survival after diagnosis with different types of cancer are higher in the US. So, when it matters (i.e., when you are seriously ill) the U.S. system delivers the best care in the world.

There is one area of potential concern that may deserve the title crisis, though. But this area is not limited to the United States, rather, it is of international concern. That is the growing cost of entitlements, primarily (but not solely) to the senior population. Even a casual look at the demographics predicts a looming future problem--possibly even a crisis—because politicians have made promises that their budgets cannot deliver. One reason that the economics of health care, particularly health care for the elderly, are tricky is that they involve what are essentially personal services—often of highly-skilled (and therefore expensive) resources. Anyone with experience of consulting will know that an hourly rate for professional services (and what are clinical staff when they deal with patients, if not consultants?) can be several hundreds of dollars. Looked at from the perspective of hourly billing rates, it always mystifies me why people are surprised at the cost of the health care system. Combine a growing senior population with non-scaleable personal services, and it is no wonder that health care costs are growing fast. Other industries have undergone cost and efficiency revolutions in my lifetime. Think of banking, or computers, or supermarkets. All of these are examples of industries in which the model used to be personal services, but which have shifted significantly to automation and self-service. We have yet to find a way to do this in health care. Other than drug therapy, the system is not scalable in its present form. So as demand grows, the cost rises proportionally. Until we solve this problem, this area is a looming crisis for all countries, not just the United States. But the solution will probably come from the U.S. system because we provide funding and incentives for innovation. In the private system, the ability of employers, employees, providers and insurers to bargain together allows us to come up with a compromise that, while no agent may be entirely happy, is at least acceptable to all.

So concerns and problems? Yes. Crisis? No. The word is over-used and should be struck from our vocabulary. Let's leave the system to get on and fix itself, because tinkering by regulators and politicians simply creates more problems.

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