U.S. Health Care—Where To Look For Reform

by Sam Gutterman

Introduction

The continued growth of health care costs in the United States has maintained its position as the most expensive health care system in the world. But cost is not the only challenge facing this system. Access—the human face of the system—is one whose effect can in part be assessed by the large and growing number of uninsured and underinsured. Consequences include a lack and low quality of care, personal bankruptcy and impeded labor mobility. Another, often overlooked challenge, is the maintenance and enhancement of quality of health of Americans. All three of these interrelated factors (cost, access and quality) have to be considered in any evaluation of policy changes to the system.

The desirable objective of a health care system is deceivingly easy to summarize—the enhancement of health over both the short- and long-term at an affordable cost. The challenge to make changes is due in part to the massive size of our health care system in relation to our total economy, its resultant entrenched interests, and the significance of the outcomes of the system as they relate to all of our lives. A complicating factor is that the underlying economics of health care is unique, a result of the almost unlimited demand for quality care, due to the high but intangible value that each individual gives to her or his family's health.

Key Elements Of A Desirable Health Care System

The history of the U.S. health care system is littered with attempts at reform on a national or statewide basis, in attempts to meet the interests of one or more of its many stakeholders. These efforts have been initiated by both the private sector and by government. Each effort has focused on one or more of our basic health care factors. For example:

- *Cost*—Limitations on reimbursement for services, managed care and capitation programs, medical savings accounts and high deductibles plans, preventive care and wellness programs, tax-deductibility of health insurance premiums and medical costs, disease management, anti-fraud and waste programs, and medical malpractice reform.
- *Access*—Group health insurance, Medicare (including drugs) for the aged and disabled, Medicaid for the poor, state Comprehensive Health Insurance Plan (CHIP) plans for the uninsurable, and children's insurance coverage mandates.
- *Quality*—Research, diagnostics and treatments, medical education, and physician/nurse specialization.

While successful in some respects, most have at best tempered overall trends. And many well-intended changes have had negative consequential effects in other areas; any proposed solution has to be thought through thoroughly before introduction. Although it is tempting to address all three of the key factors at the same time, a big bang approach may be too much to tackle at once.

Then there was the so-called Hillarycare effort of 1994 that tried to fix all three of these factors. That effort was doomed to fail because 1) it attempted a radical total solution while failing to develop a sufficiently wide constituency for change; and 2) its premiums were labeled as taxes.

Cost

The control of costs is crucial, although attempts at solutions have proven problematic at best. Health care costs have consistently grown faster than our overall economy, now making up about one-sixth of our Gross Domestic Product (GDP). Reform difficulties abound. For example, almost a decade ago, Congress thought it had set up a system to control and reduce the big-ticket item of Medicare reimbursements of physician fees; yet that has proven to be a political hot potato, and lobbying pressure has overridden most of the planned cutbacks in reimbursements. In fact, most efforts at controlling costs have been outflanked by key players able to get around the limitations imposed, for example by increasing the number of procedures or upcoding

diagnostic codes—increasing the average reimbursement amount per procedure—when reimbursement per procedure is limited.

It was once thought that if only the cost of physicians and other medical personnel who are more highly compensated than those in other countries could be reduced—the cost problem would be overcome. The amounts that hospitals have charged patients without insurance are exorbitant and sometimes go unpaid anyway. In summary, hoped for cost savings have often proven to be a mirage—if a participant doesn't get payment in one way, other ways are often found.

In most parts of our economy enhanced technology lowers costs. But the opposite has occurred in the delivery of health care—due to health care's unique underlying economics—where the customer's demand for services is not usually limited by its cost. Who wants substandard care, especially if a third party is paying for part or all of it? Why should providers ignore best practice involving the newest technological tools, especially if it might end up in a lawsuit? In fact, technology has been one of the most significant sources of health care cost increases. But this doesn't have to happen; researchers should aim in addition at cost-saving technologies.

The use of expensive diagnostics primarily for defensive medical purposes that add little value should be discouraged. Defensive medicine has increased costs, but it can be difficult to distinguish between what is defensive and what is necessary. To do so, a gatekeeper is needed, but such a gatekeeper is never popular, whether an insurer, a physician or reimbursement guidelines. In part, defensive costs are due to fears or habits by risk-averse physicians in fear of medical malpractice suits. We as a society have to stop feeling that any negative medical result is someone's fault and should result in a lawsuit, while not losing the sense of responsibility for the many decisions that medical professionals have to make every day. Can money be saved in this area? Of course, but common sense—together with professional practice—may be more important.

Waste, fraud and abuse are often seen as significant contributors to high cost. Although these certainly exist, some of this waste is inevitable under a system as large as health care. Though they should continue to be pursued, they can't be counted on to be a major source of cost reduction and better control of them will not contribute significantly to high health care cost trends.

Personal incentives—for example, high deductibles can introduce a higher personal financial stake in cost control—can reduce health care utilization. Nevertheless, it has to be remembered that such incentives are usually more effective for smaller health care expense items, and not the big ticket items that have really driven increases in health care costs.

Population aging has been cited as a driver for increased cost, as health care usage generally increases with age. Although this certainly has to be lived with, it is not the key driver of increased costs. In fact, offsetting the upward sloping cost curve with age has been a remarkable increase in life expectancy that has delayed the high health care costs of an individual's last six months of life.

Universal care might help in some ways. It may facilitate a more efficient system by means of reduction in per unit administrative costs with increased volume and negotiating power with certain suppliers. But, at the same time, can a monolithic care provider influenced by political agendas and consumer driven health care be as dynamic as a full-of-choice, entrepreneurial driven system?

Cost will remain important both to the individual who has to pay for actual or expected costs—whether as a substitute for wages in an employer-sponsored arrangement, out-of-pocket cash or debt, or premiums for a private or public health program—as well as to society, representing a crowding out of the allocation of resources to other components of our economy.

Access

A great deal of the recent public policy discussions has focused on increasing access—at least in terms of reducing

the number of uninsureds, a measureable metric—rather than controlling cost. This emphasis has surfaced because it is easier to visualize and to address. Nevertheless, it should instead be examined in terms of those unable to access appropriate care, rather than the extent of coverage by private or public health insurance.

During the most recent political campaign, it was suggested that tackling access first will make success on the cost front easier. I am concerned that this assertion is problematic at best. If only access is increased, either costs will increase even further or quality will suffer. In fact, access issues arise only where costs are high in the first place. This is not to say that access issues should be ignored, but that initially, if the already high costs are not to be further exacerbated—the system may only be able to address the access of significant at-risk population segments.

Quality

Quality of care—the factor most closely aligned with the objectives of a desirable health care system—has to be considered along with cost and access. We should be proud of our health care system's achievements, including its research, advanced acute care and diagnostic capabilities. We should be proud that our system, even though not efficient at the edges, can deliver quality care in most cases. However, we are constantly reminded that our life expectancy is not the top of the league internationally; we have to continue to stride for improvements.

Of course, it is easy to improve access or to decrease costs by decreasing the quality of care provided. An example of this alternative is the growing number of physicians who no longer accept Medicare and Medicaid patients because of their low reimbursement for medical services.

Preventive care has proven to be useful in enhancing health over the long term, although up front it can be more expensive. It has to be seen as an investment rather than a cost. In contrast, the typical American demand for aggressive health care treatment at the end of life will inevitably result in continued high cost health care.

More effective use of compatible electronic computer records can—after the initial investment—help achieve a more consistent quality of care by reducing errors, enhancing patient-specific medical information available to the medical professionals treating the patient, improving outcomes research, as well as some improving cost and control. It should be assigned a high priority whatever else is done.

I include individual choice under quality, but it also has cost and access implications. On the one hand, the choice of a medical care provider is important in terms of trust and convenience—but the choice of whether to take drugs prescribed—often a significant concern of physicians—can interfere with effective care no matter who the medical provider is and what system is in place. Other potential choices abound—regarding health insurance plan, treatment regimen, level of cost-sharing, and level of optional benefits—the list goes on. Choice is important where it can enhance quality, access and cost. How it should be made available is an important design criteria for any health care system.

The R Word

Finally, I have to mention the hated R word. It isn't Recession. In this context, it is Rationing of care. Some form of rationing will be inevitable as long as the objective of the health care system is the delivery of services at an affordable cost. It might take the form of one or more approaches, including a controlled number of hospital beds or servicers, limited stays or services for a given condition, limited reimbursement for experimental drugs and treatments until proven effective or cost-justified, and increased cost-sharing or prices for services received. Its use in some form is inevitable.

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