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Health care reform: without a correct diagnosis, there is no cure

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Personal perspective

A persistent headache is a symptom, but the underlying cause can be anything from a migraine to a brain tumor. Good medicine means identifying and treating the cause as well as the symptom. The same is true in health care reform. Though most Americans are satisfied with their own health care, they also see the need for substantial reform. Unfortunately, the well-meaning plans currently presented to Congress are the wrong therapy because they mistake the symptoms for the underlying disease. Nearly everyone agrees on the symptoms: rapidly growing health expenditures, diminished access to affordable insurance causing many to be uninsured, and inadequate quality and outcomes for the dollars spent. But what are the root causes? While there are many contributing factors, three merit special attention. First, there is our inefficient and inequitable system of tax-advantaged, employer-based health insurance. While the federal tax code promotes overspending by making the majority unaware of the true cost of their insurance and care, the code is grossly unfair to the self-employed, small businesses, workers who stick with a bad job because they need the coverage, and workers who lose their jobs after getting sick. This employer-based system arose not by thoughtful design but as an unforeseen result of price controls during World War II and subsequent tax policy. How this developed and persisted despite […]

The physician's voice

At least 27 percent of health care costs are created in the last year of patients' lives, a percentage that has fluctuated little over time. One obvious solution would be expansion of the hospice movement as an alternative for cost-sensitive, high-quality, end-of-life care, but even this has been contentious.

are more than just paying medical bills — they also compete among themselves and between employers and providers to make profits; for its scale, this is uniquely American (2). Outside the United States, non–free market insurance plans and other social safety net programs hold down the rate of rising health care costs. In Japan you can see a doctor at little expense or get an MRI for $98 (8), but what T.R. Reid doesn't say in his recent article is that costs are also lower in Japan because health care salaries are truly dreadful. It seems we are hampered in reforming health care by our own historical affluence and by an unwillingness to take health insurance out of the free market — they are linked inextricably.

Although I am not an alarmist by nature, certainly a shift away from free market insurance to one gradually dominated by government would risk capricious wage and price controls, much like what happened when Philadelphia was conquered by the dominance of Independence Blue Cross and U.S. Healthcare Inc. in the early 1990s (9). If, for example, we pegged all provider reimbursements to current Medicare rates tomorrow, virtually every hospital in America would be under water, and, to restore solvency, all other costs for ancillary goods and services would have to fall, leaving various sectors of the human economy without jobs. On the face of it, this concern principally underlies general worry over government proposals to form a new public insurance program for the uninsured. It may not happen and government may just subsidize free market insurance plans with new tax revenue, but even this approach is not financially viable without voluntary or legislated cost containment.

The scale of this new tax burden could be partially offset by adjusting insurance copayments. Copayments are another way to bend the curve on incremental costs. The question is, can they be adapted to our cultural norms regarding unfettered access to health care. The Rand Health Insurance Experiment, now 25 years old, foretells that patients with health insurance seek more access unless copayments rise (10). Copayments are a form of cost sharing, and they do reduce clinical usage, but there is a wrinkle. Higher copayments cause some patients to forego medications, critical tests, or preventive care. This perversity can be minimized by value-based insurance design, where copayments are kept low for high-value health care services and raised for everything else (11); this strategy could be applied selectively across all insurance plans, perhaps adjusted for income or age, and probably deserves more attention.

Finally, the flurry of debate over health care reform neglects one other related point, and it is one of my favorites. Holly Smith once remarked that the continued existence of diseases for which we have no answers is the most pressing health care problem of our times. If health care were universally available tomorrow, even at no cost, people would still be sickened by many diseases from which they will die (12). More and better clinical science is fundamental to restoring health and lowering costs. Science, after all, is the only pathway to transforming technologies that are truly more affordable because they are decisive. Unfortunately, no one can easily absorb this latter message with all the dirt and twigs in the air.

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Though most Americans are satisfied with their own health care, they also see the need for substantial reform. Unfortunately, the well-meaning plans currently presented to Congress are the wrong therapy because they mistake the symptoms for the underlying disease. Nearly everyone agrees on the symptoms: rapidly growing health expenditures, diminished access to affordable insurance causing many to be uninsured, and inadequate quality and outcomes for the dollars spent. But what are the root

causes? While there are many contributing factors, three merit special attention.

First, there is our inefficient and inequitable system of tax-advantaged, employer-based health insurance. While the federal tax code promotes overspending by making the majority unaware of the true cost of their insurance and care, the code is grossly unfair to the self-employed, small businesses, workers who stick with a bad job because they need the coverage, and workers who lose their jobs after getting sick.

This employer-based system arose not by thoughtful design but as an unforeseen result of price controls during World War II and subsequent tax policy. How this developed and persisted despite its unfairness and maladaptive consequences is a powerful illustration of the law of unintended consequences and the fact that government can take six decades or more to fix its obvious mistakes.

Second, in health care as in other markets, real progress depends on innovation. Yet health care markets rarely conduct successful experiments with new ways of paying for and organizing health care delivery. Why? Although health care markets have some unique attributes, these are not the explanation for lack of successful innovation. Rather, health insurance markets suffer from overregulation, which limits innovation in both insurance and new ways of delivering medical care.

Third, we have Medicaid and Medicare. These enormous federal programs address critical needs by delivering health care to the poor, the disabled, and the elderly. These programs pay providers by administrative pricing formulas that are well documented to promote both overuse and underuse of appropriate care, have led to rising expenditures decoupled from better health, and obligate massive future deficits that everyone agrees are unsustainable. They are also rife with fraud and abuse.

And yet the current political debate and the several and incomplete versions of "reform" proposals do little to address these core problems. Proposals such as those that would create a new public insurance program, for example, would likely magnify them and create a new generation of problems that will be as difficult to fix as Medicare has proven to be.

Why does the current set of reforms fall short? One reason is that all changes must pass through the political process. For example, any effort at Medicare reform rapidly morphs into a struggle for influence between insurers and pharmaceutical companies, big-city academic health centers and hospitals in rural areas, specialists and primary care providers, federal and state governments, and on down the line. Sadly, innovators — and all too often patients — get lost in these power struggles. Any reform effort that fails to correct the acknowledged fiscal and organizational flaws of Medicare and Medicaid while extending the political gridlock that attends it to a broader segment of the health care system is doomed to failure.

The physician's voice

Now that a vote on health care reform will not occur until at least the fall, we should seize this opportunity by stepping back, making the right diagnosis, and then applying therapies that address the underlying disease.

Some have offered novel approaches to "payment reform," but none of these can realistically claim to both increase quality and reduce costs, while being acceptable to Congress. One proposal would create a new executive branch commission to propose changes to Medicare benefits and price controls that Congress could only override with a supermajority vote. While such an experiment might have the potential to reduce political gridlock, it would centralize power in a manner that seems exceptionally risky for a field that accounts for one-sixth of our economy and affects the lives of hundreds of millions of people. I anticipate many new advances in diagnostics, therapeutics, and devices over the coming decades. Optimal development and application of these will flow from a decentralized and innovative health care market and will be suppressed by a system that relies on politics and an all-powerful commission.

Some have proposed that comprehensive reform must be achieved quickly, capitalizing on a sense of crisis. I see unacceptable risks to this approach. Instead of achieving a far-reaching and necessary solution for our economy and the nation's health, the necessity of pleasing enough special interests to get a bill passed will exacerbate our long-term crisis of cost and access. Who can tell what deals within a thousand-page bill that few, apart from lobbyists, have read will influence the state of health care for decades to come?

Now that a vote on health care reform will not occur until at least the fall, we should seize this opportunity by stepping back, making the right diagnosis, and then applying therapies that address the underlying disease. Here are a few ideas, based on the diagnoses discussed above, that may work. As with any therapy, these should be introduced as pilot programs, to be extended only if data reveal the desired outcomes. While such an approach will not fulfill the wish to produce a dramatic cure through a single stroke of legislation, it may avoid the pitfalls of the latter approach and have a greater likelihood of reducing the number of uninsured while controlling costs and enhancing outcomes. I propose this without any relationship to the partisan politics of the day that substitutes slogans and misinformation on both sides for meaningful analysis.

First, make the tax shelter for health insurance, currently limited to employers, independent of employment. This single, and morally imperative, step would enable the uninsured to use tax-sheltered money to buy health insurance for themselves while permitting insured employees, who are currently limited to a few employer-selected health insurance choices, to become more central in decision making.

Second, identify and eliminate the many barriers to entry and innovation in the health care and insurance marketplace. Eliminating what are often hidden barriers to competition will encourage entrepreneurs to offer lower-cost ways of financing and delivering health care, approaches that will deliver greater health care value for the dollars spent.

Third, make a serious effort, despite the context of widespread political demagoguery, toward deeply reforming Medicare and Medicaid. As one of many possible examples, try giving some Medicare and Medicaid enrollees earned income credits so they can make cost-conscious decisions among competing health plans. The sicker and less affluent should receive larger transfers, so they can buy adequate coverage. Among other benefits, such an experiment could break the logjam in payment reform and reliance on fee for service and centralized price controls.

Reducing rather than increasing the role of politics in health care decisions, while providing assistance for those in need, these pilot therapies would have the salutary effect of placing patients and innovators in a more central role as we determine the future of health care in America. And

we would then, at last, be able to align the treatment with the disease, a fundamental principle of responsible medicine.

Addendum. I coauthored an article on health care reform and its underlying issues in 1994, and although it was written fifteen years ago, some of the concepts within this article may be relevant today (1). In addition, a recent article in the *Atlantic* magazine addresses key issues underlying this discussion that I find quite compelling but could not address due to considerations of length (2).

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Academic medicine and real health care reform

In searching for ways to improve health care quality, cost, delivery, and access, the current debate has paid little attention to a group of well-established health care providers whose example might offer a reform solution. Academic health systems (AHSs) — those combining teaching and research activities with clinical delivery — have long provided high-quality care to millions of Americans, including nearly half of the uninsured, and are already located in close proximity to the great majority of the nation's population.

Spurred by the Clinton health initiative in the early 1990s, AHSs developed mechanisms to improve quality, reduce costs, and, in some cases, take financial risk for patients. In effect, over nearly two decades, dozens of these regional health systems have developed, usually, but not always, evolving from the traditional academic medical center. Today, these new entities generally consist of a medical school, multiple hospitals, major ambulatory care centers, and often contractual (if not ownership) relationships with many widely distributed and easily accessible primary care practices, rehabilitation facilities, home infusion and hospice services, and nursing homes. Most have implemented an electronic medical record, and many are putting in place "best practice" algorithms or guidelines as well as outcome measures. The faculty physician groups and hospitals contract as single entities, allowing physician compensation including bonuses to be designed to reward desired outcomes as appropriate, and they are organized to assume financial risk. Indeed, the formation of the University of Pennsylvania Health System as a fully integrated AHS as described above was formally approved by the University of Pennsylvania Trustees on June 18, 1993, as one of the first, if not the first, of these new entities. Finally, the concept of being a "must-have" health system from the standpoint of the patient, and hence the payer, has quickly evolved. Going forward, these regional health systems might be effectively used collectively as the basis for a new system of care nationally.

Key to the AHS model where the provider assumes financial risk is that savings resulting from improving care and streamlining the medical infrastructure accrue to the not-for-profit provider, not to a third party such as a private insurance company. Thus, the provider has not only the desire and the ability, but also the financial incentive, to improve medical outcomes and enhance value. Indeed, risk directly assumed by the provider was critical to the success of the Kaiser Permanente system many decades ago.

How would such a new plan be implemented? One approach would be for a payer to define the requirements needed for a health system to qualify and then contract with it to take financial risk and to deliver the care with the desired and agreed-upon outcomes. Multiple approved systems in the same region would be desirable. While gaps would exist in some geographic areas, these could be defined and efforts made to incentivize qualified systems to develop an approach to closing the gap.

How would coverage be extended to the tens of millions of uninsured and underinsured? At the present time, nearly 50% of the uninsured are provided care by the nation's academic medical centers and systems. They have been able to do this because of their commitment to provide care to anyone who needs it and their ability to identify some financial coverage for these patients as well as write off bad debt. For some institutions, this latter loss may amount to hundreds of millions of dollars per year. An improved payment methodology for the 50% of the patients already being cared for as well as new coverage for the remaining 50% of the patients now directed to these institutions would be expensive, but probably not close to the costs currently under discussion. Importantly, this would provide much-needed financial support for the nation's AHSs, which would be in the best position to apply it to improving the quality of cost-effective care that we are all seeking.

Two final comments are in order on the advantage of using the nation's AHSs to serve as the central focus of an effort to implement health care reform. These systems serve as the major source of education and training for our physicians as well as for many other providers of care, and hence this approach to health care would be rapidly conveyed to the next generations of providers. These organizations also conduct the majority of the basic biomedical research funded by the NIH. Here, too, the possibility of maximizing the translation of these advances to improving patient care also exists.

As with any other proposal to solve the immense problems in health care today, there are surely issues and holes that will need to be worked out. Indeed, one can be certain that this proposal is not a fast and easy fix, but it does emphasize an approach that provides for fundamental changes and that deserves serious consideration as the discussion of health care reform intensifies.

It is paradoxical that the much-maligned Clinton plan of the early 1990s was a major stimulus for this quiet revolution in health care delivery now under way. I believe the AHSs spawned by that initiative now represent a major opportunity to achieve real health care reform.

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