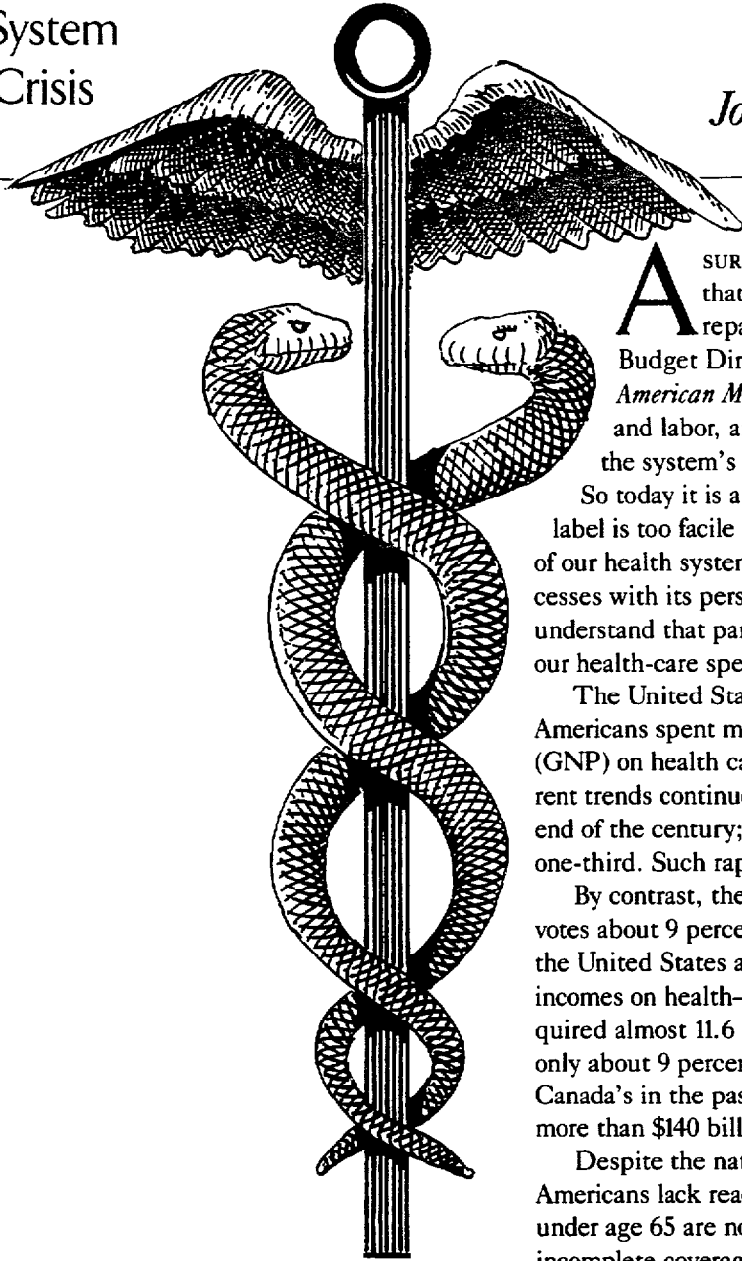




THE HIGH COST OF HEALTH

A System
in Crisis

Jonathan Ratner



A SURPRISINGLY BROAD consensus has emerged in Washington that the nation's health-care system is in sore need of repair. Such diverse voices as Office of Management and Budget Director Richard Darman, the editors of the *Journal of the American Medical Association*, Members of Congress, leaders in business and labor, and health-policy analysts have joined in acknowledging the system's widespread troubles.

So today it is a commonplace that our health system is in crisis. But this label is too facile if it suggests imminent collapse. Rather, the painful paradox of our health system—the coexistence of American medicine's continued successes with its persistent gaps and inefficiencies—is becoming more acute. To understand that paradox better, we must explore the high, and rising, level of our health-care spending.

The United States leads the world in health-care expenditures. In 1990, Americans spent more than 12 percent of their nation's Gross National Product (GNP) on health care—\$671 billion in all, or \$2,660 per person. Should current trends continue, health care will consume about 15 percent of GNP by the end of the century; by 2030, according to Darman, its share will be more than one-third. Such rapid growth is probably unsustainable and surely undesirable.

By contrast, the world's second-biggest health-care spender, Canada, devotes about 9 percent of its national income to health care. As recently as 1970, the United States and Canada spent roughly equal proportions of their national incomes on health—about 7.4 percent. By 1989, however, U.S. health care required almost 11.6 percent of GNP, whereas Canadian health care absorbed only about 9 percent. If U.S. health-care spending had increased only as fast as Canada's in the past two decades, then the United States could have allocated more than \$140 billion this year to other uses.

Despite the nation's burgeoning health-care expenditures, millions of Americans lack ready access to regular care. More than 31 million Americans under age 65 are not covered by private or public insurance. Millions more have incomplete coverage, lacking insurance for particular services or protection in case of catastrophic illness. Lack of insurance does not prevent a person from

JONATHAN RATNER is Assistant Director for Medicare and Medicaid Issues in GAO's Human Resources Division.

obtaining medical services altogether, but studies suggest that, on average, an uninsured person forgoes about 40 percent of the care received by the typical insured person.

Incomplete access is not the only shortcoming. A growing body of evidence suggests that we are not getting good value for our health-care dollars. Other industrialized democracies seem to do better: France, Germany, Australia, and Canada, for example, all spend much less per capita on health, yet manage to ensure access for all citizens and maintain adequate quality of care. In fact, these countries' records on two standard measures of public health, life expectancy and the rate of infant mortality, match or surpass the U.S. record. Of course, by spending more, Americans have available to them more private hospital rooms and more computerized tomography (CT) scanners. Nonetheless, judged by broad indicators of health, the United States seems to spend more and get less.

What makes the system sick

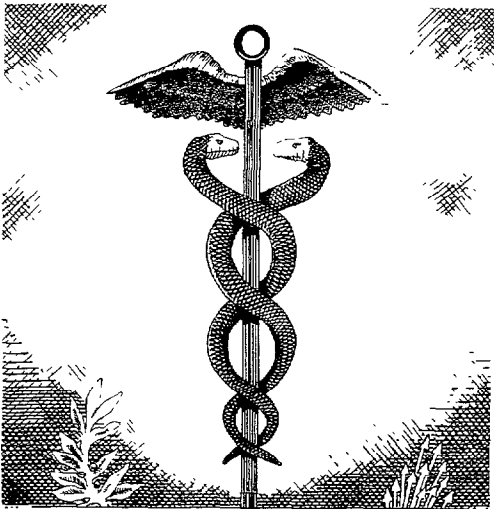
This situation has arisen partly because of financial incentives that encourage unnecessary spending. Insured patients, insulated from much of the cost of procedures, readily allow their doctors to perform tests and treatments regardless of the costs. Physicians have little incentive to economize because reimbursement is often automatic. Some physicians may order tests or perform procedures that offer little or no benefit—because the extra work brings in more income, because they fear costly lawsuits if they fail to order every possible test or treatment, or simply because the results might prove helpful, however infrequently.

In any case, there is substantial evidence that much care is excessive. For example, recent studies have reported that a sizable proportion of surgical procedures—such as 14 percent of coronary bypasses and 20 percent of pacemaker implants—are unnecessary.¹

Overtreatment is only one cause of the escalation in spending. Incomes have been rising, enabling people to buy more health care. Also, the population is aging, and older people incur higher health costs than younger people.

Another cause is the rapid advance in medical technology. While new technology often means more effective care, it may also require equipment that carries a big price tag. The very availability of new procedures and services tends to create demand, adding to overall health-care spending. And new technology sometimes leads hospitals to engage in a medical “arms race,” as they add equipment and services in order to retain patients and doctors. Such arms races, and the wide diffusion of new equipment, are fueled by payers, who often routinely reimburse providers for these services—offering, in essence, a blank check.

Rising health-care spending has hit both business and government particularly hard. Over the last two decades, health insurance has been the fastest-growing component of wages and benefits. In 1989, U.S. corporations spent as much on employee health care as they received in after-tax corporate profits. Large employers have responded by passing costs along to their employees through higher deductibles or reduced coverage. Some small firms have eliminated employee insurance entirely. Many companies are also cutting retirees' health benefits, which have become far more expensive than businesses anticipated when they promised these benefits to employees 15 or 20 years ago.



Governments at all levels are being squeezed as well. Since 1980, health spending has been the second-fastest-growing component of the federal budget, outpaced only by interest on the public debt. For state governments, Medicaid is the fastest-growing budget component: In the 1980s, Medicaid's share of state budgets grew by roughly 50 percent.

Failed treatments

Not surprisingly, all major payers—private insurance companies, businesses, and governments at all levels—have tried to contain health-care spending. But their various cost-containment initiatives have failed to stem the tide. This is partly because reforms have been piecemeal rather than comprehensive. While some new policies have been more effective than others, they all have been applied only to one or another corner of the health-care market. Their partial and uncoordinated implementation has meant that no private effort, no state initiative, and no federal measure—nor the cumulative effect of them all—has substantially slowed the growth of national health spending.

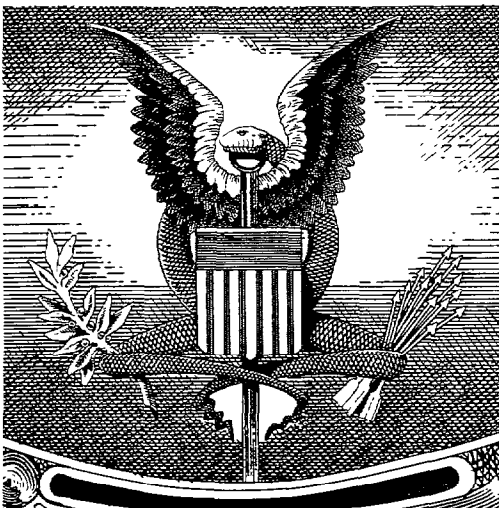
Some efforts have succeeded in cutting spending for a specific payer or category of services, but only by shifting costs to another payer or into another category. For instance, Medicare's Prospective Payment System (PPS)—a cost-containment initiative instituted in 1983—has helped dampen increases in Medicare spending for hospital care. But PPS's impact on the nation's health spending overall has been more modest, because it applies only to Medicare patients and only to inpatient hospital care. The narrow scope of PPS has encouraged a shift to physicians' services delivered outside the hospital, which has spurred the growth in spending beyond the reach of PPS.

Some initiatives may achieve one-time savings but fail to flatten the trend in overall health spending. For example, utilization review—a gatekeeping practice intended to prevent unnecessary medical treatment—may reduce the number of less-than-essential hospital admissions and medical procedures and thereby produce significant savings at the outset. The impact levels off, however, once the initial cut has taken effect.

Similarly, managed-care approaches, such as health maintenance organizations, reduce—at least in theory—unnecessary services by regulating all the care a patient receives. But managed-care programs seem unlikely ever to cover a large enough proportion of Americans to moderate overall spending, and managed care does not seem to greatly restrain those forces, such as the rapid spread of new technologies, that promote spending but originate outside the individual managed-care program.

A prescription for reform

Further piecemeal reforms, this record suggests, are unlikely to significantly curb the overall growth of health-care spending. GAO has suggested that the United States look beyond partial cost-containment initiatives and consider developing a comprehensive set of reforms that would encompass the entire health-care system.² One important step would be to examine the strategies of other industrialized countries, such as Canada, Germany, France, and Japan,



some of which have been relatively successful in designing policies to restrain health-care spending. The United States need not adopt another nation's system in order to learn from these countries. The systems differ—they may rely on a single public insurer or a mix of public and private insurers—but they share several common elements:

- *Universal coverage.* No one in these countries lacks health insurance.
- *Uniform rules.* Where more than one insurer is involved, all payers—public or private—play by essentially the same rules. The rules set uniform standards for benefits packages, claims procedures, payment rates, and eligibility for coverage. As a result, physicians and hospitals typically handle all patients the same way, regardless of who is paying the bill. The standardization thus prevents cost-shifting, as well as cutting administrative costs.
- *Caps or targets for total health-care spending and its major components.* Some countries set explicit targets for all spending in major health-care sectors. For example, in Canada, the provincial governments control hospital spending overall by negotiating a fixed budget for each hospital. The hospital has to determine how best to provide care while living within this budget.³ Germany controls spending on physician care by establishing a schedule of fees for each type of physician service and by setting a target for overall spending on physician care. If physicians increase the number of services they provide, and spending threatens to exceed the target, the fees are reduced to keep actual spending within the target.⁴

These three elements constitute a broad strategy that merits further evaluation. Many specific features would need to be decided through debate—for example, how large a role the government should play, whether employers should be required to provide coverage, and who would pay for expanding coverage to the uninsured.

The larger debate on U.S. health-care reform is well under way. With this in mind, the *GAO Journal* asked a dozen health-care authorities this question: “What are the most promising steps America could take to bring escalating health-care costs under control?” The responses that follow illustrate the range of proposals now on the table.

1. Studies of inappropriate procedures include C. Winslow and others, “The Appropriateness of Performing Coronary Artery Bypass Surgery,” *Journal of the American Medical Association*, 260(4), July 22/29, 1988, pp. 505-509. A.C. Enthoven, “What Can Europeans Learn From Americans?” *Health Care Financing Review*, 1989 Annual Supplement, pp. 49-63, provides additional citations.

2. See *U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform* (GAO/HRD-91-102, June 10, 1991).

3. See *Canadian Health Insurance: Lessons for the United States* (GAO/HRD-91-90, June 4, 1991).

4. A GAO report on the policies used to control health-care spending in France, Germany, and Japan will be issued in the fall of 1991.

“The key point is that we should receive appropriate value for our money.”

George D. Lundberg

A PRINCIPAL OBJECTIVE for this nation for the 1990s is to provide access to a basic level of medical care for all Americans. Indeed, surveys show access to be the second-biggest problem facing American health care. The number-one problem—as seen by leaders in industry, labor, and government, as well as by physicians and the public—is cost. Because of this perception, I do not believe that meaningful health-care reform with universal access will come about unless it is tied to a bona fide program of cost control. Successful cost containment will become the gateway to universal access.

No modern developed society has controlled health-care costs, but some do better than others. The United States has done least well of all; medical care has consumed a progressively higher percentage of our Gross National Product (GNP) since 1955. The causes of this runaway trend range from inflation in general to specific aspects of the nation's health and health-care systems. Among these are the increasing number of elderly people and tiny surviving newborns; new technology; heightened expectations; inappropriate use of diagnostic and therapeutic procedures; an increased number of health-care professionals (particularly too many specialists); wasteful spending for marketing and administration; epidemics such as substance abuse, violence, and AIDS; and defensive medicine as a response to professional liability.

Any proposed solutions to our cost problems should take all of these causes into consideration. Here are some of the options:

- Educate physicians and the public as to when various procedures for diagnosis and treatment are—and are not—appropriate. A related stronger move would be to link insurance payments to adherence by providers and patients to recognized clinical guidelines.
- Establish nationwide systems of marketplace competition with strictly managed care.
- Use high deductibles and high co-payments to encourage restraint on the part of patients demanding care while providing each patient with actual cost information before proceeding with a medical action or procedure.
- Require approval by the major payers before bringing expensive new technologies into service, and require additional professional approval for individual use of large-ticket items. Such approval should depend on whether the procedure is safe, efficacious, and cost-effective.
- Cap health-care expenditures by federal law at a certain percentage of the GNP. (Just what that percentage should be is open to debate; I suspect any such fixed percent would slide over time.) Similar approaches involve setting overall caps on medical expenses on the national or state level or setting goals for particular areas of spending—loosely speaking, a prospective expense budget.

GEORGE D. LUNDBERG, M.D., is Editor of the Journal of the American Medical Association.

- Limit the number, types, and location of health-care professionals, health-care facilities, or both, emphasizing primary care and disease prevention.
- Apply the Medicare classification system of Diagnosis Related Groups—which specifies a fixed payment for a given diagnosis—to patient admissions in all hospitals, regardless of payer.
- Apply Medicare’s “resource based relative value scale”—a fee schedule for specific medical procedures—to all payments to physicians, regardless of payer.
- Stop providing futile care that merely prolongs dying.
- Enact meaningful tort reform to diminish the practice of defensive medicine.
- Ban advertising and marketing for health-care facilities and professionals as inflationary and a waste of money.
- Only as a last resort, if all else fails, establish a completely nationalized system with strict budgeting.

I do not know which of these options would work best; each has its own upsides, downsides, and trade-offs. The best answer may be some mixture of the top nine or 10 listed methods. The next logical step is to use research models based on existing scientific data to project the likely effectiveness of each of these methods or combinations. The main point, however, is that we should, in fact and in image, begin to receive appropriate value for our health-care money.

“Prevention, early treatment, and universal access must be at the heart of any cost-reduction effort.”

Reed V. Tuckson

I AM HOPEFUL that the growing interest in reforming the U.S. health-care “system,” fueled by the unacceptable escalation in medical-care costs, will result in significant changes. The developing consensus for reform is particularly welcome in light of the disgracefully large number of U.S. citizens who now receive either inadequate medical care or no care at all. As cost-cutting measures are considered, policymakers should keep in mind that one important way to eliminate unnecessary medical costs is to ensure the universal availability of comprehensive health care that helps individuals prevent disease—or at least assists health-care professionals in making diagnoses and delivering treatment at an early stage of illness.

REED V. TUCKSON, M.D., was Senior Vice President for Programs at the March of Dimes Birth Defects Foundation when he wrote this piece. He is now President of Drew University of Medicine and Science in Los Angeles.

The relationship between the prevention of disease and the avoidance of subsequent medical-care costs is both logical and well documented. For example, as pointed out in a recent report from the U.S. Public Health Service titled *Healthy People 2000*, each year coronary artery disease affects 7 million Americans, causes 1.5 million heart attacks and 500,000 deaths, and makes necessary 300,000 coronary bypass procedures at a cost of \$30,000 each. Yet, to an extraordinary extent, this disease is preventable; with proper prevention efforts, many of these costs could be avoided.

The same is true of the costs required to care for low-birthweight babies. According to a report from the Institute of Medicine, a component of the National Academy of Sciences, every dollar the nation spends on prenatal care for pregnant women at high risk of bearing low-birthweight babies could save \$3.38 in infant care later. The March of Dimes has calculated that, for 1988 alone, \$317 million could have been saved if adequate medical care had been given to the 900,000 American women who went without it during the first trimester of their pregnancies.

The cost benefits of childhood immunization are also well established. The first 20 years of measles vaccine use yielded a savings of \$5 billion; in 1983 alone, \$60 million was saved through the administration of the combined vaccine for measles, mumps, and rubella. Unfortunately, immunization levels are now dangerously low. Increasing numbers of children are at risk for congenital rubella syndrome, which has an average lifetime care cost of \$354,000.

Because comprehensive and coordinated primary care is not now universally accessible, this nation incurs enormous and unnecessary hospital costs—not to mention a huge toll in human misery. A study conducted during my tenure as Commissioner of Public Health for Washington, D.C., estimated that, of the uninsured patients entering D.C. hospitals who were suffering from a chronic disease and were not being treated by a single coordinating practitioner, as many as 50 percent would not have required hospital admission if they had received appropriate ambulatory care or had followed previous medical advice. Overall, the poorer the patient, the more likely it was that hospital admission could have been avoided.

If the United States is to contain medical costs without doing further violence to the health of millions of its citizens—especially Americans of color and the poor—then at a minimum the nation should:

- use its communication skills and resources to encourage citizens to promote health and prevent disease in themselves, their families, and their communities;
- provide universal access to comprehensive, coordinated health care that emphasizes prevention, early diagnosis, and appropriate medical intervention; and
- ensure that providers and clinical facilities are available in urban and rural areas to meet the needs of those now underserved. To this end, the National Health Service Corps and the public health system should be expanded at both the national and the state levels.

Certainly, regulating the behavior of health-care providers and payers will be another important part of any strategy to hold down health-care costs. But, on its own, such regulation will not yield a sufficient reduction in spending; nor will it necessarily lead to the desired social outcomes or adequately serve the health of the American people. The agenda I have outlined here—prevention, early treatment, and universal access—must be at the heart of any cost-reduction effort.

“We must move aggressively to organize what is now a fragmented delivery system.” *Philip Briggs*

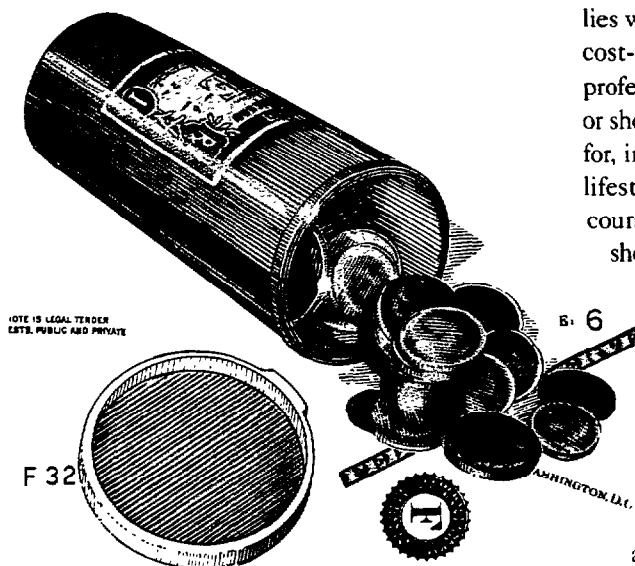
THE UNITED STATES has the most advanced medical technology and the most highly trained physicians in the world. Our medical-care system performs feats that just two years ago would have been considered medical miracles. But we pay a high price for that system—12 percent of our Gross National Product and growing. If we are to sustain our advanced system of medical care while slowing the rate of health-care inflation, we must move aggressively to organize what is now a fragmented delivery system and to help bring into balance the demand for and supply of efficient, effective medical care.

First, we must deal with the problem of unnecessary and potentially harmful health-care treatment that costs the U.S. billions of dollars each year. Some of this treatment is given because physicians do not know what works and what does not. Accordingly, we should pursue research on outcomes associated with particular treatments and disseminate that information to physicians. We should also eliminate financial incentives that might encourage the provision of inappropriate care.

Many commentators have argued that the responsibility for controlling costs lies with the individual consumer, who should purchase health-care services cost-effectively. But a consumer of health-care services is not a trained medical professional and is ill-equipped—particularly when sick—to decide whether he or she is receiving the right treatment. What the individual can be responsible for, in addition to a reasonable amount of cost-sharing, is the pursuit of a healthy lifestyle. Health and Human Services Secretary Louis Sullivan has already encouraged Americans to prevent disease and promote health; the government should expand on these educational efforts.

Another promising cost-control approach is managed-care programs. These plans involve arrangements with selected providers for a comprehensive set of health-care services, explicit criteria for the selection of the providers, formal programs for ongoing quality assurance and utilization review, and significant financial incentives for those covered to use providers associated with the managed-care plan. While the success of these arrangements is not yet proven, I believe they will, over time, prove extremely effective and become the norm for both the private and public sectors.

The health-insurance industry must also do its part and move to manage costs rather than merely process claims. This effort, already under way in some companies, must be combined with others to reduce the administrative costs and hassles of our private health-insurance system. The insurance industry must continue to promote electronic claims processing and other system changes made possible by new technology. This is especially important because the American desire for diversity and choice will continue to create higher administrative expenses than those of other industrialized countries.



PHILIP BRIGGS is Vice Chairman of the Board of Metropolitan Life Insurance Co.

Even with improved health-care outcomes information, a healthier population, and a more efficient delivery system, Americans will face significant obstacles to reducing health-care inflation. We must cope with an aging population and the continued introduction of expensive technology. In addition, we must deal with horrendous social problems—primarily among the poor, who often require expensive hospital services for preventable conditions such as premature labor, substance abuse, or injuries from violence.

The American health-care system faces significant challenges over the next decade. I remain convinced that all parties, acting together to improve the current system, can build one that meets the diverse needs of Americans while moderating our health-care costs.

“We must accept the idea of multi-tiered health care, just as we accept multi-tiered education and housing.”

Carolyn K. Davis

CONTROLLING HEALTH-CARE costs in the United States will require action in at least six major areas.

First, we must encourage states to enact reforms to reduce malpractice liability. Model legislation exists, but as yet most states have lacked the will to take action. The example of our Canadian neighbors shows that we can significantly reduce malpractice costs by, for example, limiting lawyers’ acceptance of contingency fees, conducting trials by judge rather than by jury, and setting caps on awards for “pain and suffering.”

Second, we must encourage the use of “living wills.” Attempts to extend a patient’s last few days and weeks of life can mean high-technology heroics that respect neither the quality of life nor the dignity of death. Honoring a living will’s directives to forgo futile care not only carries out the patient’s wishes, but also significantly reduces expenses incurred in the final weeks of care.

Third, we must finance and promote further research into the effectiveness of standard medical tests and treatments. If we know which procedures bring about the best medical results, we can establish specific guidelines for appropriate practice. Many studies have demonstrated that at least one-third of many procedures and tests performed today are unnecessary. The establishment of clear-cut, acceptable protocols could save billions of dollars.

The fourth step, which would expand upon the outcomes research just mentioned, would be to establish uniform standards for recording clinical data. The

CAROLYNE K. DAVIS is National Health Care Advisor for Ernst & Young, an accounting and consulting firm in Washington, D.C. Formerly, she was Administrator of the Health Care Financing Administration, which oversees Medicare and Medicaid.

standards would apply to all data collected and processed by computerized hospital record systems at each point of service. Such a standardized system would require major investments, but it would be essential for monitoring the safety and effectiveness of types of care. It would also provide ongoing data that could be used in developing and refining practice protocols. Eventually, this would lead to more cost-effective care.

Fifth, we need to test new methods of delivering care on the state level. As new models of management and delivery of services are developed, the states can serve as laboratories for demonstrating the efficiency and effectiveness of these ideas. For example, the state of Arizona, operating with federal permission, tested an innovative managed-care approach for its entire Medicaid program. We must be willing to encourage states to pursue such experiments.

Sixth, we must increase preventive-care services. Because, at least initially, these services represent added costs, any expansion must be slow and incremental. But these programs will bring significant savings over time. For example, for every additional dollar we spend on needed prenatal care for pregnant women, we save three dollars later in reduced health-care costs for infants—clearly a worthwhile expenditure. To play on the old adage, we must “spend money to save money.”

Preventive care must go hand-in-hand with efforts to teach consumers how to change their lifestyles to lessen the likelihood of major illness. Incentives, such as lower health-care insurance premiums, could be used to reward such lifestyle changes. For example, some insurance companies already offer reduced premiums for customers who do not smoke.

As useful as such changes will be, ultimately we must alter society’s expectations concerning health care. Americans’ desires—for more technology and more tests on the one hand and for lower costs on the other—are inevitably mutually exclusive. We must be willing to accept more management of care through regulated delivery systems such as health maintenance organizations. And we must lower our resistance to limitations on care services.

Above all, we must accept the idea of multi-tiered health care, just as we now accept multi-tiered education and housing. That idea, of course, assumes a reasonable minimum standard of basic services. Other countries, such as Germany and Canada, have shown that it is possible to ensure basic health care for everyone, with limitations on the scope and style of services. Then, those who can afford extra services may purchase them.

Altering societal expectations is a long-range goal that must proceed concurrently with the efforts listed above. All in all, this six-point approach amounts to incremental reform of our health-care system, which should eventually provide for substantial cost savings.



“The key to bringing costs under control is to change perverse incentives and artificial restrictions.”

Stuart Butler

WHY DO PRICES rise much faster in one sector of the economy than in other sectors? Typically for either of two reasons: consumers don't see—or care about—the price they pay; or government regulation restricts supply.

Both reasons apply in health care. Company-provided health plans, encouraged by tax benefits for both employer and employee, subsidize consumer demand and give patients the illusion that they do not pay for their care. And state insurance mandates artificially restrict the supply of low-cost health insurance plans. The key to bringing costs under control is to change these perverse incentives and artificial restrictions, so that real competition driven by consumer choice can at last operate in health care.

To begin with, we must reform the tax treatment of health care. Congress should end the tax exclusion for company-based plans and use the revenue (about \$50 billion) to finance a system of refundable tax credits for health-care spending by individuals and families. People would receive credit on all expenditures for health care, including insurance premiums as well as out-of-pocket expenses. These tax benefits would apply whether they bought insurance through their employers or from some other source.

These changes would burst the inflation bubble in several ways. First, although the credits would shield most families—especially lower-income families—from the full cost of their medical care, people would have the incentive to seek the best value for their money because they, not their employers, would pocket the savings from wise purchases of insurance.

Second, the changes would reduce demand for overly broad insurance plans. Because the current system gives a tax break only for company-provided insurance, not for out-of-pocket medical expenses (except when these reach high levels), it encourages employees to press for insurance that covers even the most minor medical services and to resist employer attempts to introduce higher deductibles or co-payments. Making the tax treatment the same for out-of-pocket spending as for insurance payments would remove this perverse incentive, prompting people to reduce their insurance coverage and to cover minor costs out-of-pocket. This would decrease insurance overhead by eliminating the paperwork for small claims. And as out-of-pocket spending became more acceptable for minor health-care services, consumers would become more conscious of the actual costs of such services and more likely to shop around for good prices.

Third, allowing consumers the same tax break whether they obtained a health plan through their employer or elsewhere would stimulate more competition among plans. With the change, consumers could get tax relief even if they

STUART BUTLER is Director of Domestic and Economic Policy Studies at the Heritage Foundation in Washington, D.C.

buy a plan through their union, their farm bureau, their alumni association, an HMO or other provider group, or any other source. The result would be more competitive pricing.

As for government regulation—the second factor in rising costs—the solution is to reduce or eliminate state insurance mandates. Americans typically must pay more than necessary for health insurance because states require insurance companies to include services that many enrollees would not buy if they had any choice. Many individuals and small businesses cannot afford insurance at all because of these mandates.

Some states have cut the cost of insurance significantly, however, by allowing “no frills” plans to be marketed. If other states wish to cut the cost of medical care and insurance, they should streamline or eliminate mandates. Not only would that force health providers to compete for the patient dollar, but it would also allow Americans to receive the range of services they want, not the services of the most politically potent provider organizations in the state.

“Organized, integrated health-care plans . . . can offer the greatest impact on costs and effectiveness.”

David M. Lawrence

DESPITE AN EXPLOSION of programs and strategies aimed at cost control, health-care costs continue to soar at an unprecedented rate. The primary reason is that most so-called solutions do little more than overlay administrative controls on an unwieldy and fragmented system. While these approaches initially may be effective in reducing waste, they fail to address the underlying inefficiencies and perverse incentives that encourage ever-escalating costs. Nor can these piecemeal approaches protect and promote the quality of care that both providers and patients believe our health-care system should offer.

The key to controlling both cost and quality in the long term lies in finding ways to promote the growth of organized, integrated systems of care that incorporate appropriate financial incentives. Group-practice health maintenance organizations, or HMOs, illustrate the potential of such systems. For several decades, prepaid group practices (including Kaiser Permanente, the organization I represent) have effectively and efficiently served local communities. The concepts on which prepaid group practices are built can, and must, be applied on a broader scale.

DAVID M. LAWRENCE, M.D., is Vice Chairman and Chief Executive Officer of Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals, headquartered in Oakland, California.

Prepaid group practices exemplify two key concepts. First, they are organized systems: The components of health care—physicians, hospitals, home health services, administrative support, and insurance—are integrated into a coherent whole. This provides opportunities for economy and efficiency through, for example, unifying medical records; consolidating appointment systems; and linking medical laboratories, X-ray departments, physical therapy departments, pharmacies, and other functions. Such integration can significantly lower costs and improve quality.

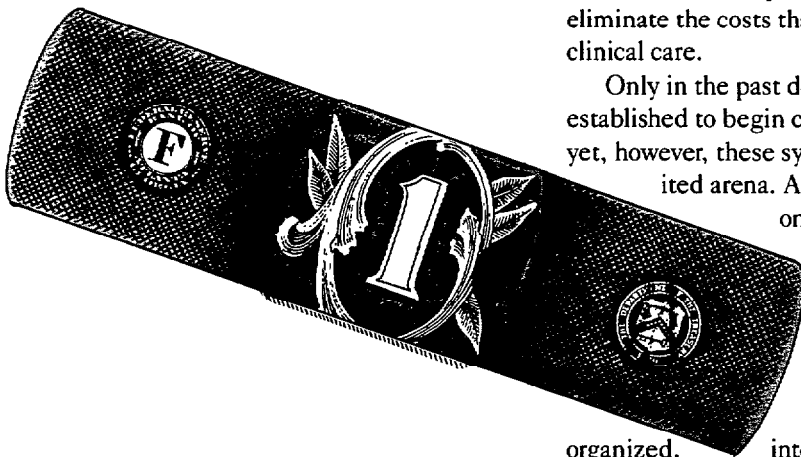
The other primary concept is the use of incentives to promote effective care without overspending. One such incentive is prepayment to providers: Patients pay a fixed amount in exchange for all needed treatment. Unlike the traditional fee-for-service structure, this arrangement does not link the amount of money a physician makes to the number of health services he or she performs. Because the choice of treatment does not affect the physician's own income, the physician's chief concern is to treat patients in the most clinically effective way. Similarly, the use of prepayment—as opposed to the open-ended, after-the-fact reimbursement procedures of traditional programs—provides the incentive to budget resources carefully and to seek solutions that are cost-effective as well as clinically appropriate.

Incentives such as these work best within an organized system, where physicians and nonphysician managers together can assume a broad responsibility and accountability for the health plan's overall performance. This sense of shared purpose and culture is essential to managing quality and thereby controlling costs.

Organized systems offer another unique advantage: They are the health-care setting best suited to the use of the innovative business principles of total quality management. We can benefit from the lessons learned by American and Japanese business and industry. For example, the traditional reliance on after-the-fact inspection, which measures how well delivered services conform to predetermined standards, does offer a means of quality control. Most quality assurance systems are designed to do just that. On the other hand, by constantly measuring and assessing what we do as we do it—in other words, monitoring the entire health-care process—we can influence quality immediately and begin to eliminate the costs that come from poorly designed programs and less effective clinical care.

Only in the past decade have enough alternative health-care plans become established to begin challenging the traditional fee-for-service arrangement. As yet, however, these systems have had the chance to operate only within a limited arena. Any step that encourages the growth of such systems can only be beneficial. We at Kaiser Permanente commend the experience of prepaid group practices to policy-makers and hope that together we can develop strategies that promote such systems.

It is clear that tinkering alone will not repair the ailing engine driving the American health-care system. Fundamental structural changes are necessary. Putting organized, integrated health-care plans in place nationwide will hardly be easy; piecing them together from existing, disparate elements is much more difficult than building programs *de novo*. But however they are put in place, integrated systems that incorporate appropriate financial incentives can offer the greatest impact on costs and effectiveness.



“Today’s economic incentives are where we should look to change the system’s behavior.” *Mitchell T. Rabkin*

HEALTH-CARE COSTS reflect the workings of a complex system, and the question is whether the behavior of that system can be steered in a more prudent direction. Because health care is so complex, one must not only look at each component of the system to fathom the many reasons why costs have escalated, but also consider the consequences of any cost-control effort as it reverberates from its targeted area throughout the entire system.

No single part of the system is *the* fundamental cause of the rise in costs. Rather, many components, individually and collectively, have engendered the cost escalations we now justifiably decry. There is one underlying theme, however: While economic incentives may not define the behavior of each component, such incentives surely exercise a compelling influence. And today’s economic incentives are where we should look to change the system’s behavior.

Cost reimbursement and fee-for-service—the predominant modes of payment in the past half-century—have not encouraged behavior that would restrain costs. Neither has the ability of employers to take tax deductions on their insurance payments, nor that of employees to receive those benefits tax-free. Nor have the many other economic opportunities that the current system provides for equipment manufacturers, pharmaceutical companies, and entrepreneurial physicians and other providers. These people and organizations are not necessarily motivated by greed, but they undoubtedly respond to the influence of economic incentives. For example, laissez-faire cost reimbursement has made it easy for the physician to order a test or procedure because it *might* do some good, and after all, “the patient isn’t paying for it.”

The resulting escalation of costs has led to a burgeoning of micromanagement controls on the part of those who pay for care. These controls are typically applied when care already delivered is paid for, apparently in the belief that if the payer doesn’t come up with the cash, next time the use of resources will be tempered and the bill lower. In the long run, this strategy encroaches on physicians’ professional autonomy and ultimately curtails their capacity to make ethical choices. And it is exacting a growing disenchantment that threatens the numbers and quality of physicians and other practitioners tomorrow.

To control costs, the way we pay for care must contain economic incentives for satisfactory quality and prudent use of resources by each participant—at a minimum, the primary physician, the specialist, the hospital, the laboratory, the patient, and the payer. The incentives must be specific and targeted to each person or organization. But they must also be interrelated to enable the system as a whole to meet the goals of both quality and economy.

I would begin with a system of negotiating agreements between payer and provider. Such agreements, to be ratified directly or indirectly by the patient, would establish in advance the extent and quality of care to be delivered. The

MITCHELL T. RABKIN, M.D., is President of Beth Israel Hospital in Boston and professor of medicine at Harvard Medical School.

payer would also develop a capitation figure—a fixed sum, standardized by age and sex of the patient, to cover all ambulatory care—and put that in the hands of the primary physician, who would coordinate each patient’s care and act as gatekeeper. Out of this fixed amount, the primary care physician would choreograph, deliver or order, and *purchase* all ambulatory care, including laboratory tests and specialty consultations. This arrangement would offer incentive for the primary physician to select tests and treatments carefully on the basis of both cost and quality. And because specialists and laboratories would depend on repeated referrals from the primary physician, the system would also encourage them to provide effective services at a fair price.

A second negotiated amount would apply to each episode of hospitalization. This prearranged payment—reflecting both the nature of each illness and the individual characteristics of each hospital, such as the extent and range of its services, capital costs, staffing, and teaching activities—would provide incentive for the hospital to keep costs within that amount.

The system would need to build in appropriate controls for risk and opportunities for benefit for providers. Individual patients would be involved through co-payment arrangements. And giving patients the option to seek additional care at their own expense would allow them to retain their freedom of choice while encouraging them to stay within the arrangement.

There is no *one* answer to the cost problem. But advance agreements among payer, provider, and patient, plus targeted yet coordinated economic incentives to encourage prudent behavior by each participant, should offer a logical resolution to the cost-shifting, cost-escalation, and inequity that now burden our system. This is a more clear-eyed approach than what we have taken in the past. By contrast, retaining today’s economic incentives and then punishing the very behavior they engender—the approach we continue to take despite our rhetoric—is not only a prescription for ineffective cost control but also a certain way to damage American medicine’s future.

“A national-level commission should be established to make the tough decisions.”

Karen Ignagni

THE MANY STRATEGIES for controlling health-care costs that have been proposed seem simply to have created a logjam in the policy-making process. Debates that focus on whether regulation or competition is *the* exclusive remedy have obscured the fact that we would do well to take the best from both approaches. Political pressures that favor either letting the states handle the issue or implementing some quick fix have hindered the development of a coordinated national strategy. And efforts that zero in on one corner of the system fail to address the urgent need for systemwide change.

KAREN IGNAGNI is Director of the Employee Benefits Department of the American Federation of Labor and Congress of Industrial Organizations.

The most effective way for Congress to address rising costs is to develop a national health-care policy that recognizes the relationship among the issues of cost, access, and quality and attempts to address all three. With such a policy in place, Congress and the nation could concentrate less on designing specific solutions for specific problems and could instead focus on the strategic question of solving the larger policy problem.

A crucial first step is to establish a mechanism whereby consumers, other purchasers of care, health-care providers, and government officials can come together to establish goals for the reform process and develop a path for achieving those goals. Given the urgency and scope of the problem, the solution is not to create yet another advisory group to study the situation. Rather, a national-level commission should be established that, like the Federal Reserve Board, has a mandate to make the tough decisions that need to be made and then see that those decisions are enforced.

Exactly what decisions would the commission face? In the cost area, this nation needs to reach a consensus on what proportion of its resources should go to health care and what changes should be made to improve efficiency. Congress should establish an overall budget for the system, which would either specify the percentage of Gross National Product to be committed to health care or set a national target for the rate of increase in expenditures. But it is the commission, *not* Congress, that should make decisions about the allocation of resources. In doing so, the commission would need to consider the problems caused by the shifting of health-care costs from one payer to another, the number of inappropriate tests and procedures being performed, the need for malpractice reform, the lack of a coordinated process for technology assessment and diffusion, and the excessively high level of administrative overhead in our system.

Attempts to contain costs must not sacrifice quality. Health-care reform efforts should encourage the development of organizations that do not simply achieve savings by selecting low-risk patients or offering short-term discounts in price but instead truly manage care and assume responsibility for quality control. Managed-care organizations and all other health-care intermediaries should be subject to a national certification process that would require all to offer the same features. The resulting standardization would ensure that providers compete for patients not on the basis of price, but rather on quality of service and performance.

The third issue to be addressed is access. Every American, including those with catastrophic or chronic illnesses, deserves access to essential medical services. Congress should spell out a set of core benefits to which all Americans are entitled. The commission should then serve as the forum for discussions about coverage of types of services, experimental procedures, and terminal care.

The national-level coordination and goal-setting that the commission would carry out would not only help move the health-care system forward but would substantially reduce the red tape and paperwork that frustrate both consumers and health-care providers. Another important role of the commission would be to give consumers the information they need to select among health plans and providers and would ensure that all payers follow the same standards in covering specific procedures.

The approach to health-care reform I have advanced here allows for change both from the top down, in goal-setting and strategic planning, and from the bottom up, with consumers and purchasers selecting from a field of competitive health-care providers and delivery systems. This approach also creates a mechanism—the commission—to help develop the public consensus needed to take

action on reducing health-care inflation, expanding access, and improving quality of care. The growing urgency of the country's health-care crisis requires new and broad-ranging initiatives. As a nation that seeks to be economically competitive in the 21st century, we cannot afford to wait much longer.

“We can fight rising health-care costs by reducing our reliance on the health-care system itself.”

Barbara D. Matula

MOST OF US BELIEVE access to health care is a right; unfortunately, too many mistakenly believe it is free. Consumers expect medical services to be conveniently located, easily accessible and technologically advanced—all at little or no direct cost to them. In fact, the price of care is rarely discussed in advance of treatment, patients are given few alternatives, and outcomes are not guaranteed. Shopping for the best value in health care is not a realistic option.

Providers, suppliers, manufacturers, and retailers of medical goods and services in turn expect speedy and adequate payment for services rendered. They also demand freedom to deliver those services in the quantity, duration, and location of their choice, without interference.

Such expectations contribute significantly to the spiraling costs of health care without measurably improving Americans' health. If we are ever to develop a rational, affordable health-care delivery system for all Americans, we must move beyond unrealistic perceptions and demands.

The most obvious step we can take to control costs is to reduce our dependence on costly, high-tech medical interventions. At the same time, we should emphasize the more cost-effective approach of preventive care, which can lessen the need for elaborate tests and treatments.

For example, providing early and comprehensive prenatal care to pregnant women can lower the incidence of premature and low-birthweight babies. Not only does this approach reduce the number of infant deaths, but it also reduces the risk of many serious and disabling conditions suffered by tiny survivors. In turn, these low-cost services can minimize the need for neonatal intensive care, which is both more expensive and less effective than working to prevent the conditions in the first place.

In the same vein, we need to make significant investments in environmental health, accident prevention programs, early detection and treatment of disease, timely immunizations, vaccine development, and, especially, expanded research on the leading causes of premature death, avoidable diseases, and disabilities. We can fight rising health-care costs by reducing our reliance on the health-care system itself.

BARBARA D. MATULA is Director of the Division of Medical Assistance in the North Carolina Department of Human Resources.



Another promising step we can take is to actively foster the development throughout the country of managed-care systems—including health maintenance organizations, preferred provider programs, and similar arrangements—and ensure their accountability. Managed care can take many forms, from simple care coordination to complex risk arrangements covering hospitalization as well as primary care.

To gain wider public acceptance, managed-care arrangements must offer added value to the patient. Consumers will have to modify their expectations of open access to specialists, multiple providers, and duplicative (if not unnecessary) care. In exchange, they will be assured continuity of care in settings where their needs are quickly identified and appropriately met. For providers, managed-care systems may restrict the freedom to practice independently, but they can offer instead the freedom to practice in a supportive environment, focusing on the patient in a holistic rather than fragmented fashion.

Finally, no effort to contain costs will succeed until we reform the way we pay for health-care services. The current cost-based, fee-for-service system offers no incentives for any of the parties involved to hold the line on costs. Providers can easily manipulate the system to increase their income and profit. Consumers have enjoyed relative isolation from the direct cost of care until recently, as the erosion of traditional benefits and higher out-of-pocket payments have become the norm. And cost-shifting—charging different fees for a given service depending on the amounts different payers are willing to pay—makes it impossible to compare prices paid with value received.

It is imperative that we develop payment systems that are fair and reasonable, with incentives for both providers and consumers of care to hold down costs and with all payers participating equally. Just as American families must struggle to pay for health care through out-of-pocket expenses and insurance premiums, so must providers learn to live within a budget.

The move toward a rational, affordable health-care system will require compromise and contributions from all Americans. It will be anything but painless.

“Drastic efforts are necessary because there is little evidence that we now have the will to stop expanding the health-care system.”

M. Edward Sellers

CURRENT EFFORTS TO arrest the nation’s escalating health-care costs vary widely in approach. Some focus on influencing the purchase of care—for example, by forcing the increased use of “efficient” providers, by enabling uninsured patients to seek early medical intervention to prevent higher bills later, or by creating health maintenance organizations and other shared economic systems that serve as both providers and insurers. Other efforts seek to change consumer behavior—for instance, by inducing individuals to adopt

M. EDWARD SELLERS is President and Chief Operating Officer of Blue Cross and Blue Shield of South Carolina.

healthier lifestyles or by passing more of the financial burden, and thus responsibility, on to patients. And still others focus on providers—such as by developing standard (and presumably cheaper) medical procedures for treating specific problems or simply by regulating the costs of health services.

Each of these methods can claim some success; at the same time, each can be shown to have had little impact overall. There will be no fundamental change in the inflation of health-care costs until all providers, through a combination of positive and negative incentives, are encouraged to slow down health-care spending and the resulting costly expansion of the system.

Those incentives should take place at both the *micro* level and the *macro* level. By micro level, I mean managing costs and behavior within a limited group, such as the employees of a company, the residents of a county, or the policyholders of an insurance company. By the macro level, I mean efforts that cover a broader area, such as a state.

Here are two suggestions that attempt to address the problem at both levels, but which share an integrating link.

At the micro level, we must begin by changing some basic ways of thinking. First, we must eliminate the one-year mentality—the idea that the appropriate length of a relationship between insurer and consumer, or between provider and patient, is 12 months. We must also eliminate the fee-for-service mentality—the idea that we should deliver and pay for health care on the basis of procedures performed rather than the results achieved. Finally, we must correct the mistaken impression that employers shouldn't attempt to influence their employees' lifestyle choices.

Instead, we should establish a relationship-based contract in which an employer, an insurer, and a provider agree to manage the health-determining behavior and the health costs of a pool of employees over a significant period of time, perhaps a minimum of three years. That contract would base financial risk and reward—to be shared equally by those parties—on the outcome of that shared management process. In other words, if the pool of employees is generally healthy and requires fewer services, the three financially involved parties will have more money to share at the end of the time period. Issues of turnover, inflation, and the like are technical challenges that are not insurmountable.

A key feature of this system would be a benefit structure that rewards employees for healthy lifestyles and creates financial penalties for unhealthy lifestyles. Likewise, the employer, the insurer, and the provider would benefit from early investment in activities that improve health—such as education, prevention, wellness screening, and programs for lifestyle change. Under the most common current structure, most investments of this type don't pay off within a year, and therefore participants have little motive to use them.

At the macro level, two strategies would significantly restrain costs. The first would be to use the leverage of the federal government and major payers—employers and insurers—to declare a moratorium on essentially all the health-care system's new input costs. This would include halting hospital capital expenditures as well as restricting the licensing of new physicians except in areas where they are needed; an oversupply of physicians is now a major cause of rising costs. The moratorium—basically a tool to create urgency—would last until a new state-by-state structure is established.

Specifically, the payers who direct the bulk of the nonfederal health-care spending in each state would form a price-fixing commission, operating with legal sanction and following the model of the German "sickness funds." This commission would negotiate and set fee-for-service prices for all physicians and hospitals in the state. The only exemptions to those price decisions would be

“Universal coverage could provide for the millions without health insurance and also contain costs.”

health care obtained within the micro-level contract relationships described above. This link between the two levels of cost management would encourage cost control through the negotiated arrangements and force cost control everywhere else.

Efforts this drastic are necessary because there is little evidence that we now have the will to stop expanding the health-care system. If we depend on voluntary action, it will be years before we will induce participants in the current system to slow down their spending.

Philip R. Lee & Mark W. Legnini

THE EXPERIENCE of the United States and the example of other Western industrialized countries tell us that policymakers have three choices for containing health-care costs:

- Continue the present system of market competition;
- Implement a universal, single-payer system, similar to Canada's; or
- Initiate a regulated system that retains the multiple payers we have now but covers everyone.

The first alternative is untenable because it is not controlling costs. The United States spends a higher percentage of its Gross National Product on health care than any other country in the world—some 38 percent more than Canada, the second-biggest spender. At the same time, the United States is many years behind Canada, Japan, New Zealand, Australia, and the countries of Western Europe in extending health-care coverage to all citizens. Some progress has been made toward cost control in the Medicare program, but Medicare covers only 11 percent of the population. Meanwhile, private-sector managed-care programs, such as health maintenance organizations, have succeeded in restraining costs, but only for small groups of people and in limited geographical areas. And often, savings in one area (for example, in hospital care) are achieved only in exchange for increased costs in other areas (such as outpatient care). In all, such “micromanagement”—the tendency to address isolated areas rather than the system as a whole—does nothing to control spending overall.

In contrast, the second alternative could control overall spending by imposing a limit on total expenditures. A single-payer system might take the form of a federal program similar to Medicare but with compulsory universal coverage. Or it might be a publicly funded, publicly administered system at the state level, similar to Canada's national health-insurance system. The system could be financed by a combination of employer and employee taxes, state tax revenues, cost-sharing by patients, and sin taxes on such items as cigarettes and liquor.

This type of system works elsewhere, but it might not work in the United

PHILIP R. LEE, M.D., is Director and MARK W. LEGNINI is on the research staff of the Institute for Health Policy Studies at the University of California, San Francisco. Dr. Lee is also Chairman of the Physician Payment Review Commission.

States. A publicly funded federal system would add hundreds of billions of dollars to the federal budget and would require a significant tax increase. A state-administered system would have similar effects on the state level. The fact that the total funds required would be no more (and possibly less) than current total health-care spending by all sectors would carry little weight amid rising deficits and calls for smaller government. In addition, the U.S. public, unlike Canada's, deeply distrusts many government programs and is not likely to embrace a purely public system. For these reasons, a publicly funded option probably will not soon receive the consideration it merits.

That leaves us with the third alternative as the most feasible. Universal coverage would provide for the almost 37 million Americans without health insurance, and given appropriate controls, it would also contain costs. A regulated universal system could include mandated employer-provided insurance, a federally assisted plan (expanding upon or replacing Medicaid) for low-income and high-risk populations, and an improved Medicare program.

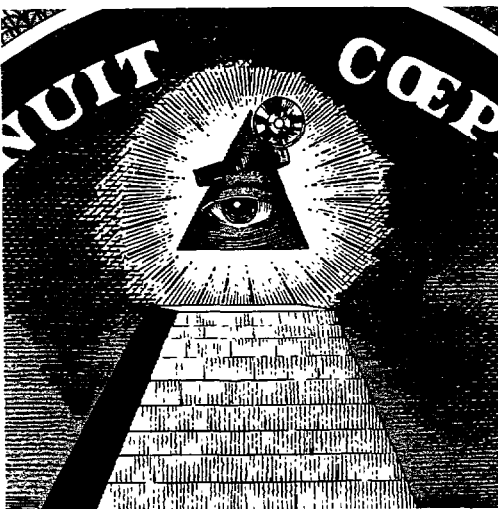
The first element, an employer mandate, would cover much of the nearly 15 percent of the U.S. population presently uninsured, since most of these people are employed or the dependents of employed workers. Specifically, if most employers were required to offer health insurance for everyone working 25 hours per week or more, almost two-thirds of the previously uninsured would be covered. (Various proposals for employer-mandated insurance have enumerated many possible arrangements—too complex to describe here—for covering the self-employed, employees at small businesses, and other special cases.) Congress should find this approach very attractive because employers, not the government, would bear the costs.

The employer mandate would, in turn, substantially reduce the size of the second element—Medicaid or a federally funded alternative—because many low-income citizens would be eligible for insurance through their workplaces. And Medicare benefits could be expanded to cover some long-term care. Funds to extend both Medicaid and Medicare could come from taxing employer-paid health insurance, increasing excise taxes on tobacco and alcohol products, or imposing a value-added tax similar to that used widely in Europe as well as in Canada and Japan.

Because it would not set limits on total spending, the system would require other mechanisms to control overall costs; these could vary from state to state. One such mechanism is strict regulation of payers, an approach now in use in some states. States that prefer a market-based system might promote cost-effective competition through various regulations and economic incentives (an approach called "managed competition").

Any comprehensive cost-control initiative should address two other issues. One is capital investment—the expansion of facilities or equipment, which tends to increase the use of costly treatments. Various approaches already exist for controlling capital expenditures; some are in limited use now, and others have been used in the past. The second issue is the oversupply of physicians, especially specialists, that drives up both physician costs and treatment rates. National policies—supported by appropriate changes in funding—are necessary to control not only the overall number of physicians being trained but also the mix of specialties.

Intense public interest about the escalating cost of care, the significant number of Americans uninsured, and alternative systems abroad indicates a window of opportunity for changing our nation's health-care system. Let us hope that we in the United States have the wisdom, compassion, and political will to seize the moment. ●



XEROXING COPY

Do not staple