

Market-Based Failure — A Second Opinion on U.S. Health Care Costs

Robert Kuttner

U.S. health care expenditures rose 6.7% in 2006, the government recently reported. According to the Centers for Medicare and Medicaid Services, total health care expenditures exceeded

\$2.1 trillion, or more than \$7,000 for every American man, woman, and child.¹ Medicare costs jumped a record 18.7%, driven by the new privatized drug benefit. Total health care spending, now amounting to 16% of the gross domestic product, is projected to reach 20% in just 7 years.

Relentless medical inflation has been attributed to many factors — the aging population, the proliferation of new technologies, poor diet and lack of exercise, the tendency of supply (physicians, hospitals, tests, pharmaceuticals, medical devices, and novel treatments) to generate its own demand, excessive litigation

and defensive medicine, and tax-favored insurance coverage.

Here is a second opinion. Changing demographics and medical technology pose a cost challenge for every nation's system, but ours is the outlier. The extreme failure of the United States to contain medical costs results primarily from our unique, pervasive commercialization. The dominance of for-profit insurance and pharmaceutical companies, a new wave of investor-owned specialty hospitals, and profit-maximizing behavior even by nonprofit players raise costs and distort resource allocation. Profits, billing, marketing, and the

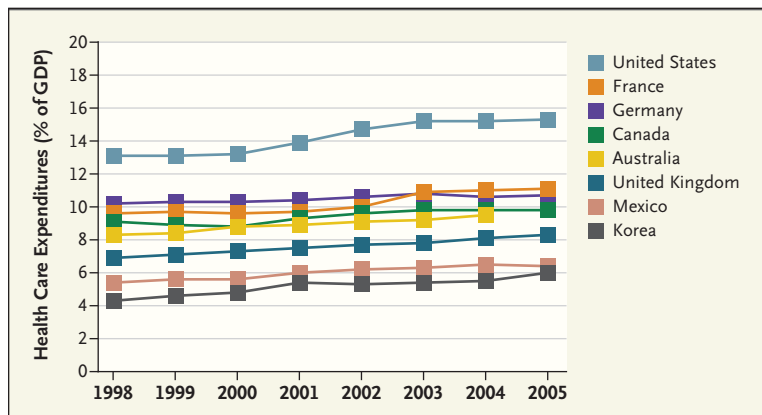
gratuitous costs of private bureaucracies siphon off \$400 billion to \$500 billion of the \$2.1 trillion spent, but the more serious and less appreciated syndrome is the set of perverse incentives produced by commercial dominance of the system.

Markets are said to optimize efficiencies. But despite widespread belief that competition is the key to cost containment, medicine — with its third-party payers and its partly social mission — does not lend itself to market discipline. Why not?

The private insurance system's main techniques for holding down costs are practicing risk selection, limiting the services covered, constraining payments to providers, and shifting costs to patients. But given the system's fragmentation and perverse incentives, much cost-effective care is squeezed out,

resources are increasingly allocated in response to profit opportunities rather than medical need, many attainable efficiencies are not achieved, unnecessary medical care is provided for profit, administrative expenses are high, and enormous sums are squandered in efforts to game the system. The result is a blend of overtreatment and undertreatment — and escalating costs. Researchers calculate that between one fifth and one third of medical outlays do nothing to improve health.

Great health improvements can be achieved through basic public health measures and a population-based approach to wellness and medical care. But entrepreneurs do not prosper by providing these services, and those who need them most are the least likely to have insurance. Innumerable studies have shown that consistent application of standard protocols for conditions such as diabetes, asthma, and elevated cholesterol levels, use of clinically proven screenings such as annual mammograms, provision of childhood immunizations, and changes to diet and exercise can improve health and prevent larger outlays later on. Comprehensive, government-organized, universal health insurance systems are far better equipped to realize these efficiencies because everyone is covered and there are no incentives to pursue the most profitable treatments rather than those dictated by medical need. Although the populations of most countries that belong to the Organization for Economic Cooperation and Development are older than the U.S. population, these countries have been far more



Health Care Expenditures in Selected Countries.

The growth rate of medical expenditures has been slowest in nations with universal health insurance systems. Data are from the Organization for Economic Cooperation and Development. GDP denotes gross domestic product.

successful at containing costs without compromising care (see graph).

Many U.S. insurers do reward physicians for following standard clinical practices, but these incentives do not aggregate to an efficient national system of care. After more than three decades of managed care — and the same three decades of studies by Wennberg and colleagues identifying wide variations in practice patterns — consistent practices are still far from the norm.² Commercial incentives are not fixing what's broken.

Instead, cost-containment efforts have fallen heavily on primary care physicians, who have seen caseloads increase and net earnings stagnate or decline. A popular strategy among cost-containment consultants relies on the psychology of income targeting. The idea is that physicians have a mental picture of expected earnings — an income target. If the insurance plan squeezes their income by reducing payments per visit, doctors compensate by in-

creasing their caseload and spending less time with each patient.

This false economy is a telling example of the myopia of commercialized managed care. It may save the plan money in the short run, but as any practicing physician can testify, the strategy has multiple self-defeating effects. A doctor's most precious commodity is time — adequate time to review a chart, take a history, truly listen to a patient. You can't do all that in 10 minutes. Harried primary care doctors are more likely to miss cues, make mistakes, and — ironically enough — order more tests to compensate for lack of hands-on assessment. They are also more likely to make more referrals to specialists for procedures they could perform more cost-effectively themselves, given adequate time and compensation. And the gap between generalist and specialist pay is widening.³

A second cost-containment tactic is to hike deductibles and copayments, whose frank purpose is to dissuade people from go-

ing to the doctor. But sometimes seeing the doctor is medically indicated, and waiting until conditions are dire costs the system far more money than it saves. Moreover, at some point during each year, more than 80 million Americans go without coverage, which makes them even less likely to seek preventive care.⁴

The system also has inflationary effects on hospitals' revenue-maximization strategies. Large hospitals, which still have substantial bargaining power with insurers, necessarily cross-subsidize services. The emergency department may lose money, but cardiology makes a bundle. So hospitals fiercely defend their profit centers, investing heavily in facilities for lucrative procedures that will attract physicians and patients. For the system as a whole, it would be far more cost-effective to shift resources from subspecialists to primary care. But in an uncoordinated, commercialized system, specialists might take their business elsewhere, so they have the leverage to maintain their incomes and privileges — and thereby distort cost-effective resource allocation.

Defenders of commercialized health care contend that economic incentives work. And indeed they do — but often in perverse ways. The privately regulated medical market is signaling pressured physicians to behave more like entrepreneurs, inspiring some to defect to “boutique medicine,” in which well-to-do patients pay a premium, physicians maintain good incomes, and both get leisurely consultation time. It's

a convenient solution, but only for the very affluent and their doctors, and it increases overall medical outlays.

Other doctors opt out by becoming proprietors of specialty hospitals, usually day surgeries. In principle, it is cost-effective to shift many procedures to outpatient settings that are less expensive but still offer high-quality care. In a government-organized universal system, the cost savings can be usefully redirected elsewhere. But in our system, the savings go into the surgeons' pockets, and their day hospitals often have a parasitic relationship with community hospitals, which retain the hardest cases and give up the remunerative procedures needed to subsidize those which lose money.

A comprehensive national system is far better positioned to match resources with needs — and not through the so-called rationing of care. (It is the U.S. system that has the most de facto rationing — high rates of uninsurance, exclusions for preexisting conditions, excessive deductibles and copayments, and shorter hospital stays and physician visits.) A universal system suffers far less of the feast-or-famine misallocation of resources driven by profit maximization. It also saves huge sums that our system wastes on administration, billing, marketing, profit, executive compensation, and risk selection. When the British National Health Service faced a shortage of primary care doctors, it adjusted pay schedules and added incentives for high-quality care, and the shortage diminished. Our commercialized

system seems incapable of producing that result.

Despite our crisis of escalating costs, dwindling insurance coverage, and deteriorating conditions of medical practice, true national health insurance that would not rely on private insurers remains at the fringes of the national debate. This reality reflects the immense power of the insurance and pharmaceutical industries, the political fragmentation and ambivalence of the medical profession, the intimidation of politicians, and the erroneous media images of dissatisfied patients in universal systems.⁵

Sometimes, we Americans do the right thing only after having exhausted all other alternatives. It remains to be seen how much exhaustion the health care system will suffer before we turn to national health insurance.

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