HOW MUCH WILL HEALTH CARE REFORM COST?

MUCH of the current apprehension about health care reform stems from the assumption that a universal and comprehensive health care system would necessarily cost more than we are now spending. The assumption is reasonable; after all, we would be expanding coverage, and you can't get something for nothing. But this view presumes that we are now getting our money's worth. I will here argue that this is far from the case — that, on the contrary, we are now spending so much on health care that we could cover all medically indicated care for all Americans without any additional spending.

In 1990 (the most recent year for which figures are available) the United States spent nearly $670 billion on health care, or $2,566 per American citizen. All other Western countries spent far less; for example, Canada spent $1,770 per citizen, and the United Kingdom only $972.[1] This year the United States is expected to spend an astonishing $3,380 per citizen (a total of over $900 billion), and the gap in cost between the American health care system and the others is growing.[2]

Why does health care for Americans cost so much more? It is not that we are sicker or suffer from more expensive illnesses. All the Western countries are afflicted by nearly the same constellation of illnesses at roughly the same rates; for example, heart disease, cancer, and strokes are the major killers in all of them. It is not that we are aging disproportionately; all the Western countries have aging populations. And it is not that we have unique, more expensive technology. The same technology is available in all the Western countries — although, to be sure, it is more widely disseminated in the United States. Nor is our health care better; by all the usual, albeit crude, measures of health outcome — for example, life expectancy, infant mortality, childhood immunization rate — the United States does somewhat worse than most Western countries. The only plausible explanation lies in the system — in the way health care is paid for and delivered in this country. Clearly, our system is peculiarly inefficient and inflationary.

There are three principal reasons for this remarkable predicament. First, unlike most other Western countries, the United States treats health care as a market commodity, not as a social good. It is distributed according to the ability to pay, not according to medical need.[3] The more you can pay for, the more you get; if you can pay for a lot, you may get far more than you need. Defensive medicine adds to the list of marginal or unnecessary services. Furthermore, doctors and hospitals are reimbursed largely on a piecework, fee-for-service basis, which preferentially rewards high-technology care delivered by expensive specialists and subspecialists.[4] Not surprisingly, given the incentives, we consistently produce too many such specialists and subspecialists, and they can to a large extent generate their own business.[5]

Despite our treating health care as a commodity, the market is far from a classic one.[6] The health care industry is largely protected from the usual consumer constraints by the existence of third-party payers. In addition, people are not inclined to shop for bargains in health care, particularly when they are sick and dependent on their physicians' judgment. Thus, the health care market has few limits on its expansion.

The second reason our health care system is so inefficient and inflationary is that it is not really a system at all. Instead, it is a nonsystem, consisting of a multitude of arrangements that are more or less independent and that often work at cross purposes. Each element in this jumble tries to lower its costs by shifting them to others. In particular, the 1200 or so private insurance companies compete not by lowering premiums or increasing benefits, but by insuring only the best risks, limiting the coverage of those they do insure, dropping those who acquire expensive illnesses, and resisting claims. For its part, Medicare shifts costs to the private sector, and states shift the costs of the poor to the cities. Increasingly, all payers are shifting costs to patients in the form of higher deductibles and copayments. The system, then, resembles a giant shell game, in which costs are passed off among the parts, and savings for one are costs for another.

Primarily because of all this fragmentation and cost shifting, our administrative costs are extraordinarily high and rising faster than the costs of any other component of the system. In 1987 over 20 percent of health care costs went toward administration, including the overhead for our huge insurance industry and the costs of billing and marketing. In contrast, administration accounted for about 10 percent of Canada's health care costs.[7]

And third, unlike most other Western countries, the United States does not attempt to limit the total amount spent on health care by establishing a global cap. Instead, we have an open system, in which health care competes for resources with all other sectors of the economy. Since the health care industry is lucrative and largely insulated from the usual disciplines of the marketplace, it has been able to absorb an ever-growing fraction of the gross domestic product. Indeed, it has become the black hole of our economy.

Over the past decade or so, most efforts to contain costs have involved some form of managed care. Managed care can be defined broadly as any effort by a third party — government, private insurers, or big business — to contain costs by controlling the delivery of care. For example, indemnity insurers may require second opinions or utilization review before agreeing to cover certain expensive procedures. Increasingly, however, the term "managed care" has come to mean care provided in health maintenance organizations (HMOs).

Although there are many forms of HMO, they all have in common payment by capitation rather than through fees for service. A group of providers agrees to supply all necessary care to its enrollees for a set monthly premium — regardless of how much care

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they actually deliver. If the costs to the HMO are lower than the premiums, the HMO profits. Cost containment is supposedly achieved by the greater use of primary care doctors who function as gatekeepers, regulating access to the more expensive components of the system, such as specialist consultation and hospitalization.[8]

The economic incentives of HMOs are the opposite of the incentives in the traditional fee-for-service system. The fewer services the HMO provides, the better it does financially. Not surprisingly, owners of HMOs often tightly regulate the amount of care provided, using a variety of methods, many of which are highly nettlesome to both doctors and patients. Have HMOs been successful in containing costs? It is very difficult to know, since only 15 percent of Americans are enrolled in HMOs, and HMOs are embedded in a larger fee-for-service system, to which they can shift costs in a variety of ways. For example, an HMO may agree to send its patients to a particular hospital in return for a discount, but the hospital will offset the discount by increasing charges to patients with indemnity insurance. What evidence we have, however, suggests that HMOs generally have lower premiums but have not been notably successful in slowing the rate of inflation.[8,9]

Nevertheless, the Clinton administration seems to be making HMO-like health plans the cornerstone of its efforts to contain costs. It hopes to devise a system, termed "managed competition," that would foster price competition among these plans.[10] In my view it is highly doubtful that managed competition would contain costs while maintaining quality. The plans might well collude to increase prices rather than compete to lower them. Insofar as they did compete, they might do so by stinting on services, which would require still more micromanagement of physicians. And the oversight of the system would require another layer of bureaucracy. Thus, we would see an exacerbation of the present trend in our health care system to divert dollars from the actual delivery of health care to extraneous administrative functions.

It is time to acknowledge that market forces are simply not suited to distributing health care efficiently according to medical need, no matter how successful the market may be in distributing toothpaste or computers. If we regarded health care as a social good rather than as a commodity, as other Western countries do, we could devise a more rational system for delivering it. Both to increase coverage and to contain costs would require the following three fundamental changes:

First, we would need to place a global cap on health spending. This could be set by Congress as a percentage of the gross domestic product, and allocated to regions or states according to relevant demographic variables, such as the age of the population. Such a cap would control costs at the level of overall funding, not through intrusive micromanagement at the level of the individual doctor–patient interaction.

Second, we would need a Canadian-style single-payer system to fund the delivery of health care. A single-payer system is not only more efficient than multiple payers, but it also eliminates cost shifting.[11] Those who doubt the capacity of the government to collect and distribute money efficiently should remember that Medicare's administrative costs are far less than those of the private insurers.[7,12] Where would the money come from? It is already in the system, and all of us are the ultimate payers. We pay for health care through our paychecks, deductibles, copayments, and the prices of goods and services. Although the notion of funding health care through an earmarked tax on income is politically perilous, such a system might well be less costly (and ultimately more acceptable) to most Americans than the present relatively inefficient and regressive methods of funding, including employer-based methods.

Third, we need to minimize price competition rather than increase it. This seems counterintuitive if the aim is to contain costs, but when prices for health care are determined by the market, costs nearly always rise, and the type of care provided reflects financial incentives rather than human needs. It would be preferable to keep prices constant and compete on the basis of patient satisfaction.

If we had such a system — with a global budget, a single payer, and competition on the basis of quality and not price — then we might for the first time really get our money's worth. And since we are spending far more per citizen than any other country, that would mean Americans would have the very best medical care in the world. There would be no need for the queues or de facto rationing experienced in some countries that spend much less on health care. The assumption that an expanded health care system would necessarily cost more money, then, is simply not true; what it would cost is the political will to redesign the system.

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SOUNDING BOARD

A DECLARATION OF INDEPENDENCE FOR HEALTH SYSTEM REFORM

ALTHOUGH the *New England Journal of Medicine* is owned, published, and copyrighted by the Massachusetts Medical Society, the editorial by its executive editor, Dr. Marcia Angell, "How Much Will Health Care Reform Cost?"[1] should dispel doubts, if any exist, that the *Journal* has editorial independence from the Society.

The Society agrees that the continuing escalation in health care expenditures is stifling and unsustainable. Although some of our members may disagree, the Society officially supports Health Access America, the plan proposed by the American Medical Association for health-system reform.[2] As president of the Society, I have a perception of health care reform that is the antithesis of Dr. Angell's proposal, which calls for a Canadian-style single-payer system, a global cap on health spending, and governmental price setting.

As Professors Enthoven and Stid have observed, citing the book *Continental Divide* by the distinguished political scientist Seymour Martin Lipset, the political culture of the United States is "profoundly different" from that of Canada.[3] Our Declaration of Independence holds as inalienable rights "life, liberty, and the pursuit of happiness." In contrast, the goals of Canada's Fathers of Confederation were "peace, order, and good government." Hence, fundamental differences between our cultures make centralized decision making acceptable to a larger proportion of Canadians than of Americans. Enthoven and Stid believe a viable reform proposal for the United States has to respect "self-reliance, local decisions, private action, pluralism, multiple competing systems, and individual choices."[3]

Before we embrace the Canadian single-payer system, we should take particular note of several of its characteristics. First, there is not a nationwide "single payer" in Canada. Canada has a "multiple-payer" system administered by its 10 provinces to support its publicly funded health expenditures. Second, 27.8 percent of 1991 health expenditure in Canada was from private insurers and out-of-pocket spending by its citizens — two other "payers" — for services not covered in the publicly funded universal-coverage plan.[4] Third, publicly funded health expenditures are not financed solely by the Canadian federal government. Such spending is jointly financed from general tax revenues collected at both the federal and the provincial levels, with the latter bearing the larger share.

Actually, one part of the existing U.S. health care system is identical to the Canadian system with respect to those characteristics of financing and payment: Medicaid. As with Medicaid, in which federal mandates without increased federal funding have increased the burden on state financing, the provincial responsibility for funding the Canadian system has steadily increased, rising to 46 percent in 1991 from 42.1 percent in 1987.[4] Indeed, the percent increase in Medicaid expenditures in the United States between 1990 and 1991 was 33.2 percent, the largest growth for any category of health expenditures (as compared with growth of 10.9 percent for Medicare and 8.2 percent for private funds).[5]

Finally, in a recently published study Torrey and Jacobs revealed that whereas household spending on health care in the United States is about double that in Canada, the personal tax burden of Canadians (from which the bulk of health care funding is derived) is almost twice that of Americans. The authors assert that net personal consumption of health care is similar between the two countries.[6]

A global cap on national health expenditures would be simply unworkable for the United States. It is one thing for federal and state governments to limit their direct expenditures for programs such as Medicare, Medicaid, and health insurance for their own employees. However, it is quite another thing for government to place a cap on the total health care expenditures of all Americans. Such a cap would require the government to limit the amount of their own money that private citizens could spend on health products (even aspirin) and services.

Governmental price setting (which Dr. Angell presumably means by the phrase "keep prices constant") is also a beguiling, albeit chimerical, solution. Prices should reflect costs. Camouflaging health care costs by keeping prices constant will be no more successful at containing growth in health expenditures than effectively removing price as a consideration, as has been the case most of the time the existing third-party system has been in effect. The solution to our flawed market problem should be to make cost, and thus price, along with quality, a really meaningful consideration in decision making about health care.

We can achieve necessary cost containment by promoting cost awareness in ways that are compatible with our cultural heritage — ways that also build on the widely recognized strengths of our existing health care system. Moreover, in our quest to control growth in health expenditures, it would be a tragedy to jeopardize our research institutions and medical centers, which serve as an interface between the known and the unknown as we strive to unravel the mysteries of disease for ourselves and future generations. Let's not throw out the baby with the bath water.

Medicine, once a charitable profession, must not become a merciless business. Corporate business practices have supplanted benevolence in our profession. We should all be reminded that a patient's ability to pay is secondary to that person's need to be served, and nobody should be denied medical care because of preexisting illness.

The most effective way to lower the cost of health care is to stay healthy. The physician's pen is the instrument responsible, in large part, for the high cost of health care. At present, in most instances the cost of

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services and goods is not known by the doctor. Doctors and patients must make their choices on the basis of quality and cost. High prices for services of comparable quality will recede; that is economic competition.

Other suggestions to lower the cost of health care are as follows: constrain unbridled entrepreneurialism in the medical marketplace, create a more realistic understanding of the limitations of medical treatment, and curb terribly inflated administrative costs. It is obscene that salaries and perquisites in our health care system have patterned themselves after those of corporate America. Another recommendation is to share the cost of health care by requiring the consumer to pay a deductible, a copayment, or nothing on the basis of the annual calculations of the Internal Revenue Service.[7] Finally, relief from the emotional and financial burden of the medical liability system is a priority on everyone's health care reform agenda. The current system is unfair to both patients and physicians.

Our society and its political leadership must appreciate that, by and large, physicians, nurses, other health care workers, and hospitals are motivated by the highest ideals in serving, not profiteering. In reality, it costs money to serve and to offer the best health care. Paying for services associated with human suffering is not as popular as paying for those associated with human pleasure.[8] Health-system reform will prove too costly if it comes at the cost of independence.

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I am indebted to Ms. Corinne Broderick, William Lybrand, Ph.D., and Mr. David Pomeranz of the Massachusetts Medical Society staff for their helpful review of the manuscript.

Editor's note: The above is published unabridged and virtually unedited. Please see the Correspondence section for additional commentary on the Angell editorial.

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CORRESPONDENCE

REFORMING OUR HEALTH CARE SYSTEM

To the Editor: Why doesn't Dr. Angell (June 17 issue)* come out and say that we are going to have to deny care? It is acceptable, perhaps, to deny care when it is not needed, but the discussion of this should be public and not hidden under criticisms of the health care system and things over which it has no control. A global budget means rationing and should be discussed as rationing. I do not know how you can have competition on the basis of quality, because measuring quality is not a simple matter, and to do this for every provider physician in the United States is an expensive and massive task that will keep many bureaucrats happily employed.

JEROME K. FREEDMAN, M.D.
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*Angell M. How much will health care reform cost? N Engl J Med 1993; 328:1778-9.

To the Editor: I was disappointed with the simplistic analysis by Dr. Angell that obscures so many countervailing facts. The reference to a "Canadian-style" system conveniently leaves out the negatives, such as inflation of medical costs equal to our own, waiting lists and use of the United States as a "relief valve," higher utilization rates, and no native medical-technology industry to speak of. There are no incentives in the Canadian system for continuous quality improvement or maximization of system productivity.

The managed competition model, on the other hand, entails a fundamental restructuring of the marketplace so that organized systems of care will compete on the basis of quality, service, and price. It's not that market forces don't work in health care; they have not been allowed to operate. A single-payer model would freeze the status quo of health care organization and delivery into place, making them unable to evolve into the health care systems of the future. The primary control in the system is budgetary, translated into price controls. Given the current infrastructure of U.S. health care, this would probably lead to more overutilization than we have now and to rapid pressure for budget increases, explicit rationing, or both. Moreover, current fragmentation of services and poor information management would be perpetuated. Dr. Angell's notion that a "global cap" would somehow result in efficient reallocation of currently wasted medical resources to unmet needs is fantastic. How could this possibly be effected?

NICK KORNS, M.D., M.P.H.
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To the Editor: Given the careful past analyses in the *Journal* of various models for reforming health care delivery in the United States, Dr. Angell's support for a Canadian-style single-payer system is very surprising. I am concerned that she would take this position without pointing out the severe problems currently being encountered in Canada under her system of choice.[1-5] These problems include lack of sufficient funding, attempts to implement a "social contract" with a fixed goal by bypassing the contract with physicians that is already negotiated and signed, promises to both patients and physicians that cannot be kept, and marked and arbitrary pay cuts for physicians.

JAMES A. ROBB, M.D.
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1. OMA blasts NDP cost-cutting plan for docs. Medical Times (Ontario Medical Association). Vol. 2. No. 4. May 1993:1.
2. Drastic cuts will bar new docs from practicing. Medical Times (Ontario Medical Association). Vol. 2. No. 4. May 1993:1.
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4. Hospital care and the social contract: a position paper. Don Mills: Ontario Hospital Association, May 10, 1993.
5. Legislation will give government unilateral powers to ration medical services. Press release of the Ontario Medical Association, Toronto, June 15, 1993.

Reprinted from the *New England Journal of Medicine*
September 9, 1993

To the Editor: Dr. Angell avers that the solution to the alleged problems in American medical care consists in the abolition of market forces in medicine. She wishes to replace the morality of a person's honest effort in earning the right to trade with a physician or other health care professional with that of a loaded weapon, the government, that is aimed at the head of each physician as well as each patient. She terms this a "social good."

If Dr. Angell or any other reader wants to understand the consequences of removing the market from medicine, that person need only study the history of medicine under collectivized cultures to discover that not only does it not work, but also it cannot work. It cannot work because it is antithetical to human nature.

The market, properly defined and explained, is not evil; it is good. Although not the cause of human progress, it is the effect of humans who are left free from the coercive forces of governments and criminals. When humans are protected from physical coercion, they are left free to develop honest means to produce and trade their products, including intellectual products such as medical knowledge. When producers vie for patients' dollars, the ultimate results are high quality and the lowest possible price. If trade in medicine becomes illegal, however, as Dr. Angell advocates, the only alternatives are military-style governmental coercion or criminal gangs. After that, it does not take long to understand that the first victims of such a scam are physicians, and ultimately their patients. This, however, is what Dr. Angell considers a social good.

There is another name for the cure for medicine — one that is usually cursed but is in fact an objective social good. It is a cure that respects the rights of each individual, regards all property as private, and forbids the initiation of physical force in all human relationships. It is a multithinker system, a multiproducer system, and a multiprovider system. It is also a moral system. Its name: laissez-faire capitalism.*

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*What is capitalism? In: Rand A. Capitalism: the unknown ideal. New York: New American Library, 1967:11-34.

To the Editor: Dr. Angell's editorial widely misses its mark. Although it thoughtfully identifies problems facing health care today, it ignores fundamental economic principles. Although it recognizes that market forces have been inefficient in distributing and pricing health care, it proposes handcuffing those forces by minimizing price competition through government regulation and payment. Instead of making market forces more efficient, it would make them less so. This will not work.

The free-market economy is today's de facto economy. This is so through neither luck nor fate, but simply because the market is the most effective way of distributing goods and services. Price controls, such as those President Nixon tried in the 1970s, simply do not work. A single-party payer plan, with minimal competition, is simply inefficient.

The system Dr. Angell proposes exists today. It is the Veterans Affairs system. The supply of health care is regulated, and payments are equalized. The results are notoriously inefficient, with patients waiting hours and months for routine appointments. To extend this system to the whole country is simply unacceptable.

Government should reform the system so that market principles apply. Then efficiency would be rewarded, and inefficiency would be punished. Only then would costs truly be kept to a minimum.

Raul Grosz, M.D.
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To the Editor: If I were still teaching college economics, I would mark a large, exasperated "F" on any student's paper that included this sentence: "Market forces are simply not suited to distributing health care efficiently according to medical need, no matter how successful the market may be in distributing toothpaste or computers." The truth is, if health services in America were allowed to be traded as freely as toothpaste or computers, doctors would be too busy lowering prices and competing for customers to give the naive economics of the *Journal* more than a passing chuckle.

Our system *is* "inefficient and inflationary," but not "peculiarly" so, and not because it relies too heavily on market forces. On the contrary, our system, like those of Canada and other countries suffering from medical inflation, is excessively dominated by government. State and federal governments purchase 42 percent of all health care services in America — nearly $400 billion in a $900 billion health economy. Medicare and Medicaid alone are projected to swell to $220 billion apiece by 1997, more than doubling in just four years.

All the price controls, global budgets, and single-payer insurance schemes in the entire statist cookbook won't do a thing to stop this massively inflationary spending spree. Forty centuries of human experience suggest that such foolish expedients will wreck the world's finest health care system.

In the words of that estimable economist P.J. O'Rourke: "If you think health care is expensive now, wait until you see what it costs when it's free."

Dick Armey
U.S. House of Representatives
Washington, DC 20515

To the Editor: I agree with Dr. Angell — we need a national health care system "with a global budget, a single payer, and competition on the basis of quality and not price." However, I disagree with her on one small point. She writes that "all health maintenance organizations have in common payment by capitation rather than through fees for service." The Group Health Cooperative of Puget Sound is a noteworthy exception to this rule. The physicians employed by the cooperative do not receive capitation payments or fees for service. They receive a salary, and so they do not have financial incentives to either undertreat or overtreat their patients.

The cooperative has three other noteworthy features. First, its members elect the trustees who oversee the management of the cooperative. Second, at annual meetings, members may participate in setting the level of the cooperative's monthly premium. They may also decide whether megabucks should be spent on the latest forms of medical technology. Third, medical care is managed by the cooperative's primary care physicians — i.e., they handle routine matters when they can and refer patients to specialists when such referral is medically appropriate.

The structure of the cooperative gives consumers substantial control over the quality and cost of their medical care. That structure also allows physicians to practice in an environment that minimizes the intrusion of financial consider-

ations into medical judgments. I therefore believe that cooperative health care should be a prominent feature of any plan to reform our health care system.

SCOTT G. BEACH
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To the Editor: Dr. Angell argues that "if we regard health care as a social good rather than a commodity, as other Western countries do, we could devise a more rational system for delivering it." The concept of "social good" needs to be at the very foundation of a reformed system. It would establish as a moral imperative the provision of basic health care services. Currently, it is not a right. Presidential leadership must clearly articulate the broad outlines of health care reform, including the right of every American to basic services. This can be done without delay, while the details of the plan are being spelled out.

Since this is our fifth attempt at reform in this century, I am not optimistic.[1] In 1945, President Truman recommended national health insurance to Congress. And like the current administration, Mr. Truman spoke of the "desire of the public for health security." After its defeat, he wrote of his disappointment in those "who promoted lobbying by medical organizations to further their own interests."[2]

As the French say, *"Plus ça change, plus c'est la même chose."*

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Dr. Angell replies:

Contrary to the contention of Dr. Freedman, rationing of medically justified services is not a necessary feature of a global budget. Our present wasteful, open-ended system is much more likely to bankrupt itself and lead to draconian rationing than is an efficient, adequately funded, closed system.

Canada's system is not without problems, as Drs. Korns and Robb point out, but it has achieved important goals that still elude us, including basic coverage for everyone, low administrative costs, and no third-party interference with the practice of medicine. Unlike the U.S. system, the Canadian system enjoys the strong support of the public, as well as more support from its doctors than in the United States.[1]

Elsewhere in this issue of the *Journal*, Dr. Morse[2] draws an analogy between the Canadian system and Medicaid, but there are important differences. Medicaid applies only to the poor, a politically powerless group. Services are mandated by the federal government, but the states determine eligibility and funding, which they may severely restrict. Medicare is a better analogy. It applies to everyone who lives long enough, just as the Canadian system applies to everyone. Thus, everyone has an interest in making it work. Medicare's administration is far more efficient than that of the private insurance sector, and the system is relatively popular with the population it serves, as evidenced by the fact that the elderly strongly resist any proposals to fold Medicare into a larger system.

Dr. Hurt resurrects Ayn Rand's libertarian capitalism, which is totally inappropriate for health care. What would he wish for people who are both poor and sick? Furthermore, he forgets that society grants physicians a monopoly for their services and subsidizes their training and the research they depend on. Physicians owe something to society in return.

Korns, Grosz, and Congressman Armey also celebrate the market. But how would a market explain the fact that medical costs rise as the number of providers grows, not the reverse? And why is our overall system, the most market-driven in the world, so expensive? The fact is that markets naturally expand, yet we want the health "market" to contract.

Mr. Beach is correct when he says that HMOs may pay their doctors salaries (or fees for service), but the organization is paid by capitation. In my view either a fee-for-service delivery system, as in Canada, or a capitation system, as in HMOs, could work in a reformed system, but fee-for-service payment would require some way of controlling fees and volume, whereas capitation payment would require some way of preventing undertreatment.

The chief point of my editorial was that we Americans are spending so much on health care now that we could have the best system in the world if the same amount were allocated differently. Dr. Morse refers to the heavier tax burden on Canadians, but of course Americans spend much more on health care than Canadians; it simply comes out of their pockets in more ways.

MARCIA ANGELL, M.D.

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