

THE PRESENT SCENE

JONATHAN TROBE, EDITOR

The United States' Health Care System: Problems and Solutions

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Abstract. The problems facing the U.S. health care system are not new; they have been discussed for the last 60 years. The problems have not been solved because, due to fears of government involvement, we have been reluctant to impose central planning and management on the system. Reliance on the free market and fee-for-service reimbursement to allocate health resources, to contain costs and to determine who has health insurance has failed. The result is that the U.S. spends more per capita on health services than any other country in the world, but lags behind many other countries on such health indicators as life expectancy and infant mortality. Several criteria for evaluating proposals for health reform are offered and ten such proposals are discussed. It is likely that, in the short run, the U.S. will adopt reforms that require the least change in the current system. However, these changes will not address adequately the fundamental problems with the system and, ultimately, major changes will have to be undertaken. [This article is followed by an editorial by Dr. Jonathan Trobe relating its concepts to the objectives set forth in the recently proposed Clinton Health Plan.] (*Surv Ophthalmol* 38:310-317, 1993)

Key words. health care systems • public health

When I am asked about the organization of health services in the United States, I answer the way Mahatma Gandhi did when he was asked what he thought of western civilization: "I think it would be a very good idea."

Problems With the Current System

The problems of our health care delivery system are not new. Consider the following statement:

"The problem of providing satisfactory medical services to all the people of the United States at costs which they can meet is a pressing one. At the present time many persons do not receive service that is adequate either in quantity or

quality and the costs of service are inequitably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency, and social waste. Furthermore, these are largely unnecessary. The United States has the economic resources and organizing ability and the technical experience to solve this problem."¹

That was written in 1932 by The Committee on the Costs of Medical Care. We still have not solved the problems, largely because we have been reluctant to impose a central planning and managing authority — a ministry of health — on our health system. That is, we have not wanted government to tell us what to do, where our doc-

tors should practice, and how much they should be paid. Instead, we have relied on the free market to allocate health resources and have preserved the fee for service system. As long as we adhere to those choices, the problems will exist – and worsen.

In classical economic theory, the free market system is the ideal method of allocating resources to fulfill the needs of the population. Why doesn't the free market work in health care? There are two dominant reasons: 1) health insurance insulates consumers from the cost of care, and 2) providers are able to induce demand, that is, determine the volume and type of services that will be given to patients. To see where the market has failed in health care, let us examine each of its components.

Hospitals: Before World War II, hospital building was relatively inexpensive and could be undertaken even by individuals. After World War II, as expenses grew, the federal government determined there was an undersupply of hospitals and, with the Hill-Burton Act of 1946, provided massive subsidies to communities interested in building hospitals. Unfortunately, these subsidies, granted without any rational plan, did not integrate the hospital system with ambulatory care or give communities any incentives to share services or coordinate hospital operations. There are now too many hospital beds in this country. The occupancy rate of the typical community hospital is 66%; a 1990 study estimated that there were 194,000 excess beds.² There are too many small hospitals, with 46% having under 100 beds,³ and too much duplication of high technology. For example, there are several cities in the U.S. that have more MRI scanners than all of Canada.

The hospitals are under severe financial pressures. Many have been losing money because of low occupancy rates caused by over-bedding, a shift to outpatient services, reduced lengths of stay, and reduced reimbursement from third parties. About 760 hospitals have closed in the past ten years,⁴ most of them in rural or inner city areas, not because their communities do not need them, but because of an unfavorable "payer mix," consisting of the underinsured or completely uninsured.

Long-term care: Chronic or longterm care, once called the "Bermuda Triangle of health policy,"⁵ has been a serious fiscal casualty of the free market health system. Nursing homes have traditionally been funded either by individuals who spend out of their own pockets or by Medicaid. Of 53 billion dollars spent in 1990 on nurs-

ing homes, Medicaid provided 46%.⁶ Even middle class elderly are using this welfare program to support their nursing home care. Most of the current proposals for new health care financing do not even mention longterm care, because that would "break the bank."

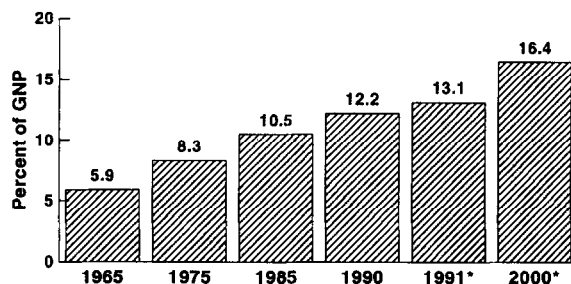
Physicians: In the physician sector, the biggest planning issue is the problem of maldistribution, both geographical and by specialty. Physicians do not go where they are needed, but where quality medical centers are located, where reimbursement is best, and where there are very good schools for their children. In 1990, there were 1,935 medical manpower shortage areas that affected 12.5 million people.⁷ Even if people in these areas were insured, who would treat them? Physicians are unfavorably distributed by specialty as well. Only 34% choose a primary care specialty, whereas 55% is considered ideal in terms of the country's needs⁸ and is the current percentage in Canada.

A further problem is that physicians are growing disenchanted with practicing medicine, losing their autonomy, and facing an increasing bureaucratization and a financial squeeze. Insurance companies hassle doctors about why they are admitting patients rather than treating them as outpatients, when they may admit them, how long patients may remain in the hospital, and how much they may be charged. These maneuvers, part of what has been called "micro-management," are very vexing, but they are the natural outgrowth of a health system that lacks "macro-management," or central planning. Uwe Reinhardt, a well-known health economist, has said that "by fighting for the principle of free enterprise in medicine, physicians have unwittingly surrendered much of their clinical freedom."⁹ In macro-managed systems, such as HMOs, where there are global budgets, capitated payments, and salaried physicians, there is no need for the third parties to "nit-pick" the way there is when physicians are paid fees for services.

Health care financing: The United States is unlike most other developed countries in linking the receipt of health insurance to employment. Before World War II, the private insurance industry consisted mainly of the various Blue Cross and Blue Shield Plans, which were established to protect patients from expensive hospital bills and to prop up hospitals. After World War II, commercial insurance companies began to compete with "the Blues" by offering lower cost insurance to the better risk groups (younger, employed groups), and avoiding the bad risk groups – the

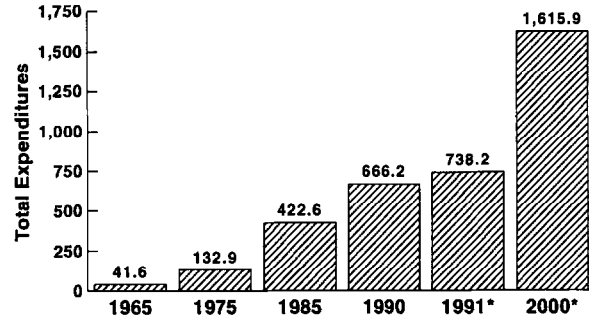
elderly, the sick, the disabled, the poor, and the unemployed. In response, the Blues were forced to pursue a similar strategy to remain competitive. This left the higher risk groups unable to obtain private health insurance at an affordable price. In order to rescue some of these groups, Congress passed Medicare and Medicaid in 1965. But Medicare, the social insurance program for the elderly, was accepted by the medical community only because it would continue the existing hospital reimbursement system and provide the "usual and customary" fees for service to physicians. By adding health insurance in this way for millions of people, Medicare contributed to the inflation of medical costs. Medicaid, on the other hand, has become an underfunded federal-state collaboration to finance care for the poor that is shunned by many providers. Finally, many poor people remain totally uninsured, being ineligible for Medicaid because most states set Medicaid eligibility well below the federal poverty level.

Performance: The U.S. spends a higher percentage of its gross national product (GNP) and more money per capita on health care than any other nation in the world. For example, this country spends 40% more per capita than does Canada, which is often used as a reference point.¹⁰ In 1965, the U.S. spent 5% of GNP; in 1991, 13%; in the year 2000, a projected 16% (Fig. 1). In absolute amounts, the U.S. spent 41.6 billion dollars on health care in 1965, and is expected to spend one trillion, six hundred billion dollars in the year 2000¹¹ (Fig. 2). Can this country afford it? Consider the proportion of after-tax profits that businesses spend on health care:



*Projected
Source: Health Care Financing Review, Fall, 1991

Fig. 1. National health expenditures as a percentage of Gross National Product (selected years). * = projected. Source: Health Care Financing Review, Fall 1991.



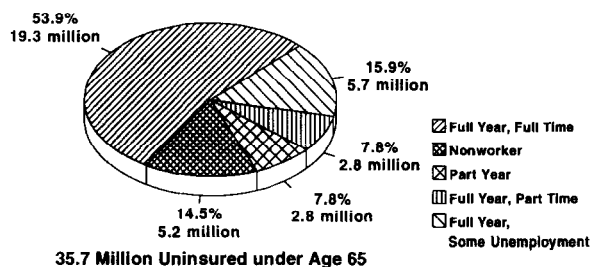
*Projected
Source: Health Care Financing Review, Fall, 1991

Fig. 2. National health expenditures (in billions of dollars, selected years). * = projected. Source: Health Care Financing Review, Fall 1991.

in 1965, it was 14%; in 1989, it was 101%. That is, businesses spent more on health care than they made in after tax profits!¹²

As it spends more than any other country in the world on health care, how well does the U.S. health system perform in terms of such widely used measures as life expectancy and infant mortality? In 1988, Japanese males lived almost 76 years, U.S. males only 72 years; Japanese females lived 82 years, U.S. females, 78.¹³ In the same year, Japanese infant mortality was 4.8 per 1,000 live births; U.S. infant mortality was 10.¹⁴ Another failing of our system is the big disparity in these measures between whites and blacks. In 1989, white American males lived 72.7 years, while the figure for black American males was only 65 years.¹⁵ Infant mortality is twice as high for blacks as for whites.¹⁶

Health insurance coverage: In 1990 there were 35.7 million uninsured Americans, 65% of whom live in families where a member was working full-time (Fig. 3), often either in a self-employed business or in a small firm¹⁷ (Fig. 4). So, if health insurance is a reward for participating in the economic system, the system is not working. Small businesses are a particular problem — they simply cannot afford to provide their workers with health insurance. Without insurance, their workers cannot be admitted to the hospital until they have an emergency, and, since they frequently cannot afford ongoing care from a physician, they use the emergency room as their only source of care. Once they are in a hospital, they get less care than those who have insurance.¹⁸ Apart from this, they create a huge financial



Source: EBRI Special Report, Feb. 1992

Fig. 3. Nonelderly population without health insurance by work status of the family head. Source: EBRI Special Report, February 1992.

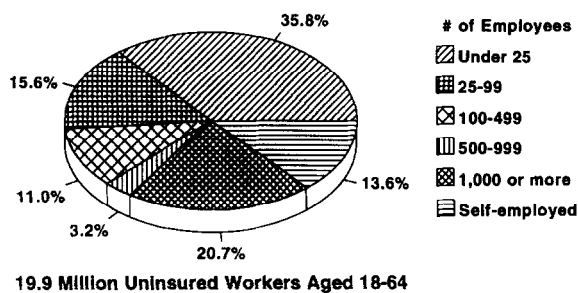
problem for hospitals and physicians who must shift the cost of care to the insured.

Reforming the Current System

Reform of the health care system was one of the most significant issues in the 1992 presidential campaign. During that campaign and the last congressional term, scores of proposals were made to address the problems that plague the system. Before discussing the range of proposals, it is useful to consider the objectives of health reform, which can be used to assess these proposals.

OBJECTIVES OF HEALTH CARE REFORM

- **Universal access:** Is everyone in the U.S. going to have coverage or will some groups still remain uninsured? Is there a single plan that will cover everyone or will there be multiple plans? If



Source: EBRI Special Report, Feb. 1991

Fig. 4. Workers without health insurance, aged 18-64, by firm size. Source: EBRI Special Report, February 1991.

there are multiple plans, are they all required to provide a minimum set of benefits?

- **Emphasis on prevention and primary care:**

Are there incentives to emphasize primary care, or are high cost, high technology services implicitly favored? Does the financing model encourage epidemiologically-based planning and service provision?

- **Elimination of unnecessary care:** Are there incentives to limit services to those with proven clinical effectiveness and those covered by practice guidelines or does the system allow wide variation in the amount and type of services?

- **Financing efficiency:** Is financing a crazy quilt of multiple payers with different standards or is there a manageable number?

- **Cost containment:** Are there incentives for efficiency and appropriate utilization? Are there caps on expenditures? Is there a way to control capital planning and budgeting so that there is some limitation on new building and technology? Does the plan lead to lower administrative expenses?

- **Quality of care:** Is quality sacrificed to cost containment? What safeguards are included to assure quality?

- **Public accountability:** How is the plan governed? Is the program structured to allow inputs by patients and providers? What role do public officials play?

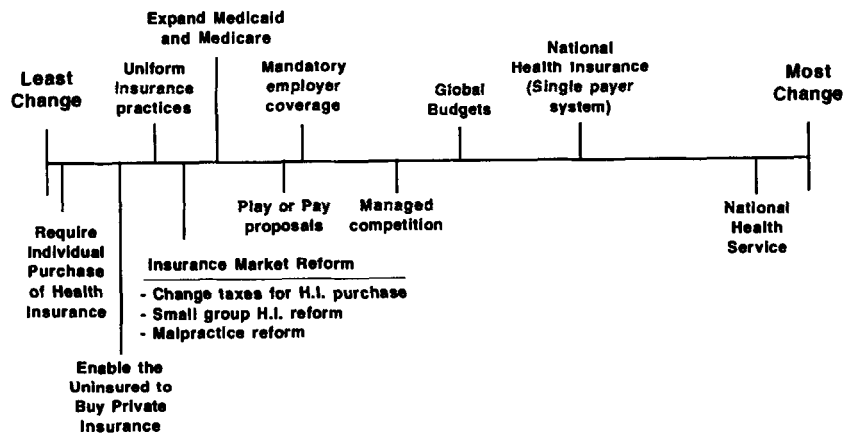
- **Patient and provider satisfaction:** Is the proposed plan acceptable to patients? Will providers participate in the plan? Will both groups have confidence in the care?

PROPOSALS FOR HEALTH CARE REFORM

The proposals that have been introduced in Congress can be arrayed on a spectrum based on the amount of change they will require of the current health care delivery system (Fig. 5).

- 1) *Require individual purchase of health insurance.* Such proposals seek to impose financial discipline on health care consumers by having individuals rather than employers purchase health insurance. When employers buy insurance and there are no co-pays, consumers cannot really tell how much medical care costs. Studies show that without co-pays, consumers use more care than they do when cost sharing is imposed.¹⁹ The most "free-market" oriented plans would eliminate employer purchasing of health insurance and force individuals to buy their own insurance, using tax credits as an incentive. The poor would receive government subsidies to purchase private health insurance. It is argued that under

Fig. 5. Spectrum of proposed plans in terms of amount of change required in delivery system.



such conditions, consumers would purchase less insurance and would use less health care, so that costs would go down.

Such a plan might lower costs, but would leave many patients with unmet needs. It would also fail to address any of the other problems currently facing the system.

2) *Enable the uninsured to buy private insurance.* Proposals such as the one advocated by former President Bush maintain the current employment-based system of financing, but mandate insurance coverage for the uninsured through the private sector. Vouchers would be used to cover the poor and tax credits would be used to cover the non-poor uninsured. Thus, the existing private insurance system would be used to cover those people not currently served. Universal coverage might be achieved by such a plan if the tax credits and vouchers were adequate. However, without creating any other changes in the delivery system, such a plan would probably increase total costs substantially and not address hospital efficiency, appropriate use of services, physician distribution, and quality of care.

3) *Uniform insurance practices.* Various proposals seek to increase the administrative efficiency of the financing system. One such approach is to require that the 1,500 health insurance programs currently paying physicians and hospitals use similar forms and reimbursement methods. Such proposals, while they may save some money, do not offer substantial change.

4) *Insurance market reform.* One proposal seeks to restrain employer purchases of health insurance and to impose discipline on consumers by changing the tax laws to employers. Under such a plan, employers would be allowed to shelter from taxes only a specified level of health insur-

ance expenses per employee; anything over that amount would be taxable. This would provide an incentive to employers to provide less health insurance coverage to their employees, and thereby a lower use of services. The concern is that serious patient needs might go unmet because of the reduction in insurance coverage.

Other proposals would contribute to universal access by improving the ability of small employers to purchase insurance through special pooling arrangements. Some plans would require all insurance companies to charge the same premium to all applicants for insurance, regardless of health status ("community rating"). Such proposals would certainly improve the chances to obtain insurance coverage, but they would benefit only those who could afford the premiums.

Physicians are very supportive of another proposal — reform of the malpractice system. It calls for alternative conflict resolution through a state or private agency and elimination of contingency fees to lawyers. Although tort reform may eliminate certain aspects of "defensive medicine" and reduce malpractice insurance premiums, it would not reduce overall costs by more than 3% to 5%,^{20,21} and would not increase insurance coverage or improve the efficiency of other parts of the health care system.

5) *Expand Medicaid and Medicare.* Some proposals seek to expand Medicaid, a stigmatized and underfunded program, by allowing the uninsured to "buy in." Other plans seek to replace Medicaid with a new public fund. Still other proposals call for expansion of Medicare to cover children under 16 years of age. While these proposals deal with the issue of universal coverage, they leave other problems untouched.

6) *Mandatory employer coverage.* In order to

achieve universal coverage, some reform proposals include a government mandate for employers to provide a certain amount of insurance coverage to their employees. One variant of such mandated coverage is the "play or pay" option, which gives employers the option of providing a certain package of benefits through a private insurer ("play") or contributing a certain percentage of payroll to a public program which would cover their workers ("pay"). The other variant requires all but the smallest employers to provide a certain level of coverage to all employees who work more than 17.5 hours per week.

Critics of these mandated programs raise concerns about governmental intrusions into the affairs of the private sector and the potentially disastrous impact that these required payments would have on small and marginal employers. The play or pay concept is criticized by those opposed to greater governmental involvement in health care because it would probably lead many employers to drop costly private insurance and pay into the governmental insurance fund.

7) *Managed competition.* The premise of "managed competition" is that small purchasers of insurance cannot wield enough marketplace power to negotiate low-cost, high-quality health care options for their clients. This plan envisages the formation of large purchasers by aggregating small employers into larger units in geographical areas. These purchasing organizations would then deal with selected insurance companies, provider groups, hospitals and HMOs and contract for care under the most favorable terms they could negotiate.

Managed competition attempts to improve the efficiency of the health insurance market by using the power of government and large purchasing organizations to "structure and manage the demand side" of the market.²² The government would not only select the purchasing units, but also would define a minimum benefit package to be offered by all insurers, HMOs and other health plans. It would also stipulate how universal coverage is to be achieved.

There is great uncertainty that managed competition, which still relies heavily on the ability of private sector competition to contain costs, will be any more effective than previously unsuccessful competitive solutions.

8) *Global budgets or expenditure caps.* By placing a ceiling on the amount of money available for hospital or physician services in a year, global budgets or expenditure caps would restrict increases in the cost of health care to a pre-

determined level. These spending limits create incentives to reduce utilization of services to appropriate levels and to allocate capital and personnel resources efficiently. Such limits also result in explicit rationing of resources, with limits placed on the use of high technology procedures and specialized services.

While spending limits are probably the most effective means of cost containment, they also raise fears about reduced quality and access to care. Spending limits must therefore be accompanied by other measures to assure quality and access. Explicit rationing will not be favorably received by patients or providers, who tend to be oblivious to the current rationing of care based on ability to pay.

9) *Single payer systems.* Single payer systems are generally equated with national health insurance programs under which the federal government pays for all care and covers everyone. Such programs are usually financed by payroll or other taxes rather than through employer contributions. It is possible, however, to create a single payer system through state governments or even through employer contributions to a single private insurance company at the state or regional level.

The key features of a single payer system are: 1) All citizens would be covered by the same, comprehensive package of benefits; 2) All reimbursements to providers would be made on the same basis with no opportunity for providers to cost shift or otherwise treat people differently based on their insurance coverage; and 3) The single payer would wield great power in influencing the organization, size and structure of the delivery system — how providers are to be paid, their form of organization and range of services, quality assurance procedures, and their numbers and specialties.

A single payer system would resemble the Canadian health system, often held up as a model for the U.S. to follow. While the financing of care would be governmental, the delivery of health care would remain a predominantly private sector enterprise. Not only would such a plan meet the criteria of universal access, cost containment, and financing efficiency, it could be readily designed to meet the criteria of appropriateness and quality of services, public accountability, and preventive care orientation. A major drawback of the single payer system, however, is that it may not meet the criterion of patient and provider satisfaction, owing to the major role given to government and to the probable

reductions in provider autonomy and patient choice.

10) *National Health Service*. Exemplified by the British system, a national health service (NHS) implies a socialized health care system in which government pays the bills, owns all the facilities and employs the personnel. Establishment of an NHS is not viewed as a likely shortterm scenario for the U.S., since it would involve a major dislocation of the current system and likely would not be acceptable to many of the participants in the system.

What Should We Expect?

Reforms that merely "tinker" with the current system (to the left of managed competition on the continuum shown in Fig. 5) cannot adequately satisfy enough of the important objectives of a good health care system. Yet, what is the likelihood that a major overhaul will occur? That depends on the answers to more basic questions: 1) Can we afford the substantial expenditure needed to extend coverage to the entire population? 2) How much free choice in selecting physicians or health plans are our citizens willing to give up? 3) Are we willing to let government run all health insurance programs? 4) Will the necessary "players" be willing to cooperate enough to allow the system to work?

Most learned observers believe that a partial solution — one that lies on the left side of Fig. 5 — is most likely in the short run. But once the insurance market reforms, tax incentives, and the various methods to insure more people are put in place, we will still be left with major disparities in the quality of health care received by the poor and non-poor, problems with access in rural and inner city communities, discrimination in care based on the type of coverage one carries, and seriously escalating health care costs. At some point, the fee for service, free market system must go, and the U.S. will have to join all other industrialized nations on the right side of the spectrum in Fig. 5.

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The opinions expressed in this essay are those of the author and not necessarily of the editors. It is acknowledged that a number of opinions exist on this topic, and may be explored in future articles.

Editorial

In this essay, written before the Clinton Health Plan (CHP) was announced, Professor Lichtenstein lays out a spectrum of potential health care reforms in the current United States system. Measuring each reform against a set of objectives, he concludes that a greater governmental role is ultimately the best solution, but market reform is most likely to be adopted in the short run.