What's Ailing Health Care?

James C. Capretta

In the past half century, the practice of medicine has been radically transformed by new techniques and discoveries, but the institutional arrangements for financing and delivering health care have barely changed at all. This is the obvious yet startling point with which David Gratzer begins his recent book *The Cure*, and it is at the heart of the paradox Gratzer sees in American health care: "Everyone agrees it is the best in the world, but no one likes it."

The Cure: How Capitalism Can Save American Health Care
By David Gratzer
Encounter ~ 2006 ~ 325 pp.
$25.95 (cloth)

Crisis of Abundance: Rethinking How We Pay for Health Care
By Arnold Kling
Cato ~ 2006 ~ 120 pp.
$16.95 (cloth)

Medicine and the Market: Equity v. *Choice*
By Daniel Callahan and Angela A. Wasunna
Johns Hopkins ~ 2006 ~ 320 pp.
$35.00 (cloth)

The transformation of medicine could hardly be overstated. For most of human history, the physician's role was often little more than to offer a comforting presence in the face of a disease with no known cure or treatment. But thanks to a succession of medical breakthroughs, many of which occurred in just the last few decades, physicians today are no longer passive comforters; they have at their disposal an arsenal of treatments and diagnostic techniques to address many previously deadly or debilitating conditions. The discovery and refinement of effective antibiotics has been truly revolutionary, improving the treatment of infectious diseases and making surgical procedures safer. New imaging technologies, from CT scanners to the latest MRI machines, make it possible to see inside the living body with astonishing clarity. We now take for granted vaccines for diseases that once felled millions. The list goes on and on.

The declining mortality rates of some of history's most dreaded diseases attest to these medical break-

throughs. Heart disease is no longer the killer it once was—the death rate has dropped nearly 60 percent since 1950 thanks to new surgical techniques and pharmaceutical treatments that can bypass, open up, and prevent clogged arteries. In the last thirty years, cancer survival rates have jumped with early detection and effective treatment. A diagnosis of testicular cancer—which afflicted Lance Armstrong before his remarkable run of Tour de France victories—was a death sentence thirty years ago; today, according to Gratzer, 96 percent of those diagnosed survive thanks to effective chemotherapy.

The medical revolution has not just saved lives; there has also been a marked improvement in the quality of life for millions of Americans. As Gratzer, a practicing psychiatrist, knows well, people with schizophrenia and major depression who would have been confined to a life of misery and isolation in state mental institutions just forty years ago can now function independently in society thanks to new drugs. And for the elderly, the onset of cataracts once marked the beginning of a long decline in health, as impaired vision slowed movement; today, cataract removal surgery is performed so routinely it is hardly worth noting. Newer procedures can also make eyeglasses unnecessary altogether and allow seniors to see more clearly in their later years than they ever did in youth. Similarly, hip- and knee-replacement surgeries have given new mobility to millions of older people who, in earlier times, would have been forced to rely on canes and walkers as their joints failed.

The paradox, of course, is that while medical breakthroughs have vastly improved the length and quality of life for millions of Americans, there is a growing sense of frustration and restlessness about the American system of health care. It is not without cause. Costs continue to escalate rapidly, putting stress on family and government budgets. Workers worry about how changing jobs will affect their health insurance coverage. Bureaucratic bungling plagues health care delivery. Lack of an electronic infrastructure leads to stacks of paperwork and confused billing arrangements—and sometimes deadly mistakes. Fragmentation of institutional arrangements—separate organizational structures for hospitals, labs, physicians, therapists, drug dispensers—leads to uncoordinated, and sometimes dangerous, care. Contraindicated prescriptions from physicians are common. And, though few of us realize it, the American hospital is among the most dangerous places for a healthy person to be, as preventable infections are common.

Anecdotal evidence of these problems abounds. The *Wall Street Journal* recently documented the tragic story of Monique White, a lupus victim who got caught in the complexity and bureaucratic rules govern-

ing income eligibility for Medicaid services. When she was cut off from the program because her income was too high, she couldn't afford necessary care, and her health deteriorated badly. Caught in a downward spiral in which she was too sick to get steady work but not poor or disabled enough to qualify for government support, she ultimately succumbed to a combination of ailments that could have been prevented with proper care. Eight days after she died, a form letter from the Tennessee Medicaid program arrived at her home, reporting that her eligibility for coverage had been restored. While her case is extreme, it is the kind of case which has many middle-class Americans wondering if there isn't a better way to organize health insurance.

Gratzer is an articulate advocate for a strong infusion of market principles into American health care to address the interconnected problems of rising costs, inferior quality, consumer dissatisfaction, and widespread inefficiency. He is joined in this crusade by scholar Arnold Kling, author of *Crisis of Abundance*. Kling's analysis goes a step further than Gratzer's. He suggests that another cause of America's health care woes is the strong and growing preference for ready access to "premium medicine": numerous referrals to specialist physicians, increasing use of expensive diagnostic technology, and far more frequent surgical procedures. Kling's evidence for this trend is compelling. In 1990, Americans got 1.8 million MRI scans and 13.3 million CT scans. By 2003, the numbers had jumped to 24.2 million and 50.1 million, respectively. Between 1975 and 2001, there was a 700 percent increase in the number of practicing radiologists, a 470 percent increase in specialists in pulmonary disease, a 385 percent increase in neurologists and only a 26 percent increase in general surgeons.

In the right circumstances, some of this specialization and technology can genuinely benefit patients' health. But Kling highlights the all-too-frequent tendency in American health care to use specialist referrals and expensive diagnostics simply to rule out low-probability diagnoses. The results of a test often have no bearing on the treatment plan.

Kling illustrates his point by recounting his own experience. At age 45, a routine urine sample turned up a small amount of blood, sometimes an indication of bladder cancer. Kling researched the probability that a non-smoking male under age 50 would have bladder cancer, even with such a test result, and ruled out the need for further, more expensive, investigation. His physician, however, insisted on a cystoscopy, which turned up no signs of cancer.

Kling suggests that what drives the unnecessary use of expensive technology is a strong cultural inclination to make use of whatever tools are available—"whatever it takes"—

to resolve a health problem, particularly if someone else is paying. The problem, of course, is that all of this specialization and technology is expensive, and rapidly rising costs are making insurance less affordable and secure.

Gratzer and Kling both note the problems caused by the employment-based health insurance system dominant in the United States. As Gratzer explains, this system developed almost accidentally. Health insurance emerged as an employment benefit during World War II because government wage and price controls led employers to offer non-cash incentives to attract workers. Such arrangements were soon excluded from taxable income to the employee, which opened up the floodgates, and before long nearly every employer of any size was offering health coverage to employees. The rest, as they say, is history.

Building private insurance around employer groups has some advantages. Workers are not usually hired because of their health status, so businesses with many employees provide convenient settings for pooling good and bad health risks. Moreover, private insurance sold to larger groups has lower administrative costs than individually-purchased insurance.

But Gratzer and Kling correctly note that the distortions in health care caused by the heavy reliance on employment-based insurance now far outweigh those advantages. First, the tax-exemption for employer-based insurance has provided a strong incentive for employers to substitute generous coverage for cash wages. As a result of this generosity, employer-sponsored insurance often covers some portion of almost all medical care instead of providing protection against just catastrophic expenses. This insulates consumers from understanding the actual costs of the care they seek, as their insurance companies process and pay most of the bills. Doctors and hospitals have a much stronger financial incentive to do whatever is necessary to get paid by insurance plans than to please the patient by providing quality care in a convenient way, so that *what can get covered* (including expensive diagnostic tests) becomes more important than *what is most necessary*—a way of thinking that ironically costs insurers more, not less.

Second, tying insurance coverage to employment puts employers, not those who are covered, in the driver's seat. Employees upset with their health insurance plans have little market power, other than complaining to their bosses. It is not surprising, then, that insurers are frequently accused of indifference to patient concerns and prone to erecting bureaucratic barriers to care. Moreover, no one in the insurance system has an incentive to invest in *prevention.* With high job turnover, it simply does not pay to build the infrastructure neces-

sary to keep people well if the financial benefit from that investment will accrue to some future insurer selling its product to a different employer.

Third, employment-based insurance is not portable; every time a worker switches employers, he or she must switch insurance plans, too. But what if someone is in between jobs? Or a seasonal worker? Employment-based insurance is stable for workers employed by large businesses, but quite unstable for everyone else. There is now a federal law (known as COBRA, for the Consolidated Omnibus Budget Reconciliation Act of 1985) allowing some workers to pay to remain on an employer's plan temporarily after leaving their job, but it cannot address the myriad circumstances that lead millions to go without coverage, even if frequently just for short periods of time.

Gratzer and Kling persuasively argue that the tax-favored status of employment-based insurance has completely disrupted the normal relationships between buyers and sellers of services. When that happens, accountability to the consumer is lost, and quality suffers. If consumers were directly involved both in the purchase of insurance and in the purchase of more health care services, they argue, the normal marketplace drive to satisfy the customer would lead to a resurgence in quality and innovation as insurers and providers competed for business. Costs would rise more slowly, tax and other public subsidies could be distributed more equitably based on need, and insurance would become more individually owned, portable, and secure.

Gratzer and Kling are by no means alone in their fondness for a revived health care marketplace. In fact, President Bush's proposal, announced in his 2007 State of the Union address, to revamp the tax treatment of health insurance is aimed at correcting just the flaw that these two authors highlight. The president's plan would put individually-purchased insurance and employer-provided insurance on the same level, providing each with a $7,500 tax deduction (or $15,000 for family coverage) per year—but no more. Gratzer has noted in other writings his strong support for this proposal.

Despite Gratzer's and Kling's many insights, one still comes away unconvinced that their version of consumerism—Health Savings Accounts and high-deductible insurance—is the full answer to the problem of overused "premium medicine." For less expensive services and technologies, yes, consumers could force transparent pricing and cost-cutting. But what about cancer treatment? Or heart bypass surgery? In these instances, the medical processes are much more complex and the financial stakes are much higher, as are the health consequences. Do breast cancer patients, for instance, have the leverage to force an oncology practice to improve efficiency and reduce costs? At the time

of treatment, patients are not in a strong position to push for cost-cutting—and it is not clear they would have much financial incentive to do so anyway, because the costs would still exceed the insurance deductible, insulating the consumer from the marginal cost differences among treatment options.

Both Gratzer and Kling view insurance-based managed care skeptically, with some justification. The move toward heavy reliance on HMOs in the 1990s left no one happy with a red-tape approach to keeping patients from overusing services. But it remains the case that the most significant cost savings in health care are likely to come from productivity improvements among health care providers, and the push for such improvements must come from the payers of high cost insurance claims. Health insurers who are able to work collaboratively with hospitals and physicians to build integrated, well-coordinated, efficient, and consumer-friendly systems of care will gain significant market leverage in an environment where consumers have a strong incentive to seek out low-cost insurance. In effect, consumers will be purchasing insurance that has done the cost cutting for them, in advance of any need for an expensive intervention.

While Gratzer and Kling insist that a root cause of the mounting problems in health care is the failure to sufficiently implement market principles, Hastings Center scholars Daniel Callahan and Angela A. Wasunna claim the reverse: it is the market system itself that is to blame. Their new book, *Medicine and the Market*, attempts to provide a survey of market-based reforms in health care systems throughout the world, and to review the history and effectiveness of such reforms. The book contains some useful insights, particularly in its brief review of the historical roots of various approaches to health care financing, the unique institutional structures that have emerged in prominent countries, and the financial pressures that have led some countries with public systems to try modest market-based reforms. However, even this factual survey of the global scene is colored by the authors' clear intent to show "the market" has failed, particularly in comparison to the performance of government-run or state-funded systems.

Indeed, Callahan and Wasunna contend that their book provides an authoritative assessment of the relative merits of "markets" versus government control. But it offers nothing of the kind. Instead, equating current health care practice in the United States with a "market-based" system, it uses the long list of well-known and widely acknowledged deficiencies of current American health care arrangements to conclude that "market practices" have failed and more government involvement in health care is needed.

But, of course, both Gratzer and Kling—and every other advocate of market-based incentives in health care—would flatly reject any equation of U.S. health care financing with a well-functioning market. Indeed, Gratzer's and Kling's books are aimed specifically at pointing to those critical market-based reforms that could save the American system from failure.

In fact, one could just as easily argue that the United States—with its massive Medicare and Medicaid programs, phone-book-length provider payment rules and regulations, and extensive federal and state oversight of every manner of health care provider—has tried governmentally-controlled health care, and *it has failed*. Medicare is on track to single-handedly bankrupt the federal government. Its costs have risen, on average, 2.9 percentage points faster than per capita GDP growth for more than three decades, despite the federal government's ability to nearly dictate prices for all manner of services. Medicaid spending has risen almost as fast, with no end in sight, even as growing numbers of doctors refuse to see patients on Medicaid because the payment rates are too low. There is no shortage of proposals for cutting Medicare and Medicaid provider payments still further, but no one really seems to think such cuts would ultimately fix the problems in these programs. With Medicare and Medicaid—government-run entitlements in the mold of European-style health care—facing such significant structural problems, why should anyone believe that further governmental control would solve anything?

Here, Callahan and Wasunna would undoubtedly respond that Medicare, Medicaid, and other public programs represent only 45 percent of total U.S. health spending, which is not the same as a universal system of coverage. While this is true, a strong case can be made that Medicare and Medicaid's rules have a much more pervasive influence on U.S. health care than the so-called "market practices" Callahan and Wasunna find so wanting. Medicare's dominant fee-for-service structure, in which health care providers get paid by the government for each service they provide seniors, is particularly influential in determining provider behavior, as teaching hospitals, oncology practices, clinical labs, and many other provider groups have been specifically structured to accommodate Medicare's regulatory demands and financial incentives over the years.

Certainly, we cannot fairly judge government-run health care systems by the lagging performance of America's public insurance programs. But by the same token, we cannot judge market-based health care by the unimpressive performance of America's very mixed system. The presence of the large, unreformed, government-controlled Medicare and Medicaid programs alone should

make it manifestly clear that the U.S. is not the "market acceptor" Callahan and Wasunna claim it is. And when you throw in the open-ended tax preference for employer-sponsored insurance, there is very little reason to believe conditions in the U.S. currently allow effective competitive forces to thrive.

Callahan and Wasunna also resort to circular reasoning in trying to discredit advocates of market-based reform approaches. For instance, they make a point of noting that market advocates have long promoted moving Medicare toward a more competitive model called "premium support." Under "premium support," beneficiaries would get vouchers they could use to enroll in the competing private insurance plan of their choice. More expensive options, perhaps including Medicare's current fee-for-service option, would require enrollees to pay a higher premium. Callahan and Wasunna note that no demonstrations of this idea have gotten off the ground. They fail to mention why: Proponents of more governmental involvement in health care have fought "premium support" at every turn, worried that the ensuing competition would make Medicare's fee-for-service option less attractive to beneficiaries.

To read the Gratzer, Kling, and Callahan-Wasunna books in succession is to see in the starkest possible way the philosophical gulf between those favoring more and less government involvement in American health care. But there are two points on which all should be able to concur.

First, everyone more or less agrees that reform is needed to broaden and stabilize coverage while encouraging better quality care, continued innovation, and cost efficiency.

Second, everyone must recognize that in health care, as in so much else in modern life, financial incentives matter immensely. When consumers are presented with free health care, they will demand more of it. When governments establish health care budgets, there will be waiting lists and rationing. When young and healthy people are given a choice, many will wait to get insurance rather than subsidize older and sicker workers. When government becomes the sole purchaser of medical services and supplies, the incentives for innovation are much reduced. And when health care is financed with premiums and cost-sharing, low-income families will need subsidies to stay even with everyone else. All of this is predictable and observable—all over the world.

The best health care systems are those that don't pretend these financial incentives can be repealed; they must be harnessed to work in the right direction—toward stable coverage, efficient and convenient arrangements for providing care, and incentives for continued medical

innovation to improve patient health. Unfortunately, there is no simple formula for getting these incentives right. It will take persistent effort in every arena—public programs and private insurance, at both the national and state levels—to ensure competition works to the benefit of consumers.

One such effort occurred in 2003. The Bush administration made a successful year-long push to add a new prescription drug benefit to Medicare, delivered through competing private insurers. A key provision requires Medicare beneficiaries to pay a higher premium if they choose a more expensive plan. This requirement ensures there is a strong financial incentive among the competing plans to keep their premiums low, as they know beneficiaries will be attracted to low-cost offerings. But, of course, to keep their premiums low, insurers must negotiate deep discounts with drug manufacturers.

Despite the commonsense logic of this competitive approach, most congressional Democrats opposed it. Many critics predicted that insufficient numbers of private insurers would step forward to participate and the program would collapse.

What happened? Scores of insurers joined the competitive process. Premiums came in below budget in the program's first year and fell 15 percent in the second. Almost no one predicted such results. The success of that reform's approach—a combination of public oversight and effective competition—points the way toward better American health care.

James C. Capretta *is a fellow at the Ethics and Public Policy Center. He is also a policy and research consultant for health industry clients.*