American Health Care

As a medical student, I often feel personally responsible for our nation's health. At family gatherings, I am invariably called upon to answer for it; with increasing frequency. Like my uncles, Americans know our health care system is in crisis, but within our national dialogue on health care, it seems that we as Americans have lost sight of the core values that form our identity as Americans. These values include a desire for strong, safe families, the freedom to accomplish our individualized dreams, taking fair responsibility for oneself, and giving everyone who does so a chance to succeed. Indeed, finding one's personal success is the American Dream. Promoting these ideals should be a goal of our society, as well as the system that attends to our society's health, for few Americans who lack health can realize their dreams.

Sick-Care, not Healthcare

America's health care system falls far short of this goal. Indeed, when 1,000 Americans were recently asked about the biggest threat to the American Dream, the most common answer was "high health care costs." Over many decades, our system has shifted from our values, to the point where it promotes treatment rather than health, views patients as the sum of their diseases, and reduces the art of healing to figures on a balance sheet. In effect, what Americans have is not a health care system, but rather, a sick-care system. What will rescue our system is a realignment of our health care system with our values, through a return to patient-centered care where and the promotion of health. In this essay, I hope to show how our financing structure and incentives have resulted in higher costs and lower quality, and the ways in which the doctor-patient relationship has been eroded by the commercialization of health care. I will then discuss a solution that emphasizes access to quality care and the separation of care from profit as the reform needed to rescue our health care system from its critical state. I hope to show that through such a unique, American solution, one which supports our values, we can return to a system that truly promotes health, and allows every American his chance to pursue a dream.

Walk into any major emergency department, and you'll likely be greeted by a chaotic scene: Doctors and nurses with little time, many patients, and only minutes to prevent death. You'll also see a large number of patients who would be better served by primary care. These patients present not with heart attacks or gunshot wounds, but ear infections, sore throats, asthma, and arthritis. They are the underinsured.

Structural Deficits

The most significant flaw in our system is the inadequacy of insurance. Much has been made of America's "uninsurance crisis." I believe this term to be misrepresentative: In America, 47 million lack insurance, and 100 million are underinsured, but within the former group, only 7% lack insurance voluntarily. For the remaining 93%, insurance is unaffordable, and therefore unavailable. Thus, all but a small minority are not simply uninsured, but rather, uninsurable. It follows that the current crisis cannot be blamed on those without coverage; it is instead rooted in insurers' inability to offer enough Americans insurance. Alongside the uninsureable are the underinsured, who live unaware that their coverage will prove insufficient when faced with catastrophic illness. They comprise the majority of the newly bankrupt. For both groups of underinsured Americans, the vast majority of whom work, pay taxes, and hold US citizenship, our system has failed, and has kept these and other Americans from realizing their dreams.

For individuals without health coverage, access to preventive and primary care is scant or non-existent. However, basic acute care is available anyone in America under The Emergency Medical Treatment and Active Labor Act (EMTALA) and other so-called "anti-dumping" laws. Thus, rather than prevent or manage disease in the underinsured, our system opts to preferentially treat the late complications of advanced disease. Naturally, this is both more expensive and less effective.

Furthermore, the higher costs associated with acute care are typically more than "self-pay" patients without health coverage can afford. As a result, doctors and hospitals go uncompensated for more than $40 billion of care yearly, and these costs trickle down on to all taxpayers and insurance consumers. Since the effects of this vicious cycle are manifested nationally and locally, so-called "spillover" effects of community underinsurance are an additional result: Decreased emergency and burn care, difficulty recruiting doctors, hospital closures; these consequences are felt by the

underinsured and insured alike. This provision of care without coverage demonstrates that the problem of the underinsured is not a crisis of funds (or lack thereof), but rather, one of allocation. More simply, Americans don't need more money for their health care, they need more health care for their money.

A second failure of the insurance structure is the misalignment between the goals of health and the incentives that have the power to direct the practice of medicine. As described above, ours is a sick-care system, prioritizing the treatment of the ill at the expense of the continued health of the well. The cornerstone of health is primary care, which is mostly paid for on a fee-for-service (FFS) basis. While the logic of this arrangement seems sound – compensation should be based on work – the spread of FFS has greatly undermined America's health in two ways. First, FFS increases expenses by making doctors likely to over-utilize care by adding an entrepreneurial motive to the clinical decision-making process. Physicians, particularly those in smaller practices, are likely to increase their level of "service" and to drift from evidence-based medicine. On the large scale, these small increases add up to a significant balance of extra, arguably unnecessary care.

In addition to increasing costs, fee-for-service reimbursement decreases the quality of care. Rather than incentivize health, FFS pays for treatment, and doctors lose sight of prevention: office visits are shortened in order to see more patients, and doctors often rely on prescriptions when reassurance, teaching would work just as well. Hypertension is a disease with devastating complications—heart attack, stroke, kidney failure. The best clinical practices tell us hypertension should be dealt with early to avoid terrible (and costly) complications, and there are highly-effective pharmaceuticals to do so. However, for many patients with new hypertension, a 5-10 pounds of weight loss would be just as effective, by decreasing the mass of fat cells secreting the same artery-squeezing substances targeted by the best blood pressure drugs. This cures hypertension, and fights many other disease processes. Further, unlike a new drug, weight loss has no negative side effects, and requires little follow-up care. It is at least as good an option as drugs, but in practice, weight loss promotion takes extensive counseling. For physicians, who can prescribe three or four times faster than they can counsel, fee-for-service reimbursement tells them to do just that.

FFS is not the only reason for physicians' over-reliance on medications, but it is clear that the current system of incentives fails to encourage health promotion and penalizes doctors for spending time to involve patients in the decision-making process. This is only a small casualty, however, compared to Americas diminishing capacity for primary and preventive care. Since reimbursement focuses on "service," much of primary care – counseling, answering patients' questions by phone or email, even taking the time to build trust – goes largely uncompensated. The standard of living for primary physicians is declining, and American medical students are moving out of primary care and into rarefied subspecialties. Indeed, fellow medical students who describe interest in dermatology receive oohs and ahhs from their peers, whereas those considering family medicine provoke different responses – "hmm," or "good for you!"

The last factor I will identify as a cause of our current situation is the commercialization of health care, which has to increased costs, hobble America's global competitiveness, and damage the doctor-patient relationship.

Proponents of profit-driven health care argue that competition nurtures the innovation needed to improve health promotion and manage of disease, and therefore, save money. This argument is not without merit, but in practice, competition proves a destructive force to health care. In the highly mutable health care market, the leading edge of insurance is a complex of dozens of investor-owned corporations offering hundreds of different schemes of coverage. In the marketplace, these corporations compete with for market and investor share, and this requires significant investment. Huge staffs of underwriters, and claims processors improve the profit margin on insurance products" and carefully identify low-risk clients, a practice known as cherry-picking. Salespeople and advertising campaigns increase profit yield and satisfy investors. The fact that the business of private insurance in the US employs 20 times more administrators per enrollee than Canadian health plans shows the profitability of health coverage. Profits come at the expense of health. Sales and administration do nothing to improve care, and divert resources, roughly 30 cents of every health care dollar (versus 10 to 15 in Canada) to overhead. Totaling roughly $300 billion annually, this money that should be invested in keeping Americans healthy, rather than wealthy. In fact, it is doing neither, for as

health insurance premiums (and profits) soar, Americans fall out of the system. This further increases cost, by refining the pool of those willing to pay for insurance for the sick and sickness-prone, a process known as adverse selection. It also strains the US economy, as large employers grapple with the decision to drop group insurance coverage, or face the reality of falling behind globally. Last year, Toyota surpassed GM as the world leader in Automobiles, and every Ford Windstar produced in Canada rolls off the assembly line for $1,500 less than in the United States. The tensions placed on the American economy in sustaining an inefficient, fragmented system are nearing the breaking point.

Unfortunately, innovations that promote health seldom help insurers. Turnover in the insurance market is constant, and there is little incentive for an insurer to invest in its clients, who they may leave. Instead, the incentives which prove the main driver of insurance practices act to minimize payments for care, termed "medical losses." Indeed, dropping coverage for expensive patients, so-called "pit spitting" (the counterpart to cherry picking), is a common practice within for-profit insurers. Without going into detail, suffice it to say that compared to Medicare, or not-for-profit HMOs, even the best investor-owned HMOs deny more claims and less often meet basic standard of care. One analysis extended these differences to their predictable clinical outcomes, showing that if the 24 million women between ages 50 and 69 all were enrolled in investor-owned health care plans instead of not-for-profit ones, an additional 5925 deaths from breast cancer would be expected from lower rates of mammography.

Along with worsening the overall picture of America's health, the commercialization of medicine has harmed doctor-patient relationship. On average, doctors' standard of living is falling, and as they too struggle to achieve the American Dream, doctors become more susceptible to the financial influence of the pharmaceutical and insurance industries. Enlisted in the profit-building process, by favoring a particular drug or minimizing the need for a certain test, doctors cease to be advocates for their patients. Patients know this. They are wary of the drug reps, hate the HMOs, and see doctors as increasingly driven by financial gain. My training as a medical student stresses building trust and rapport with my patients, and I am anxious that my patients may jeopardize their health in the absence of a trusting therapeutic partnership. Further evidence of the erosion of the doctor-patient relationship is the rise in malpractice lawsuits. Patients' relationships with their doctors are known to play as large a role in litigation as the care they receive. In fact, therapeutic trust in medicine is considered so essential as to be explicitly protected by law. In spite of this, the growing role of investors in care decisions is causing American patients are lose faith in their doctors.

In the above discussion, I've tried to highlight the ways in which our health care system has strayed from its intended goals to support Americans to live healthy productive lives. In the next, I will attempt to illustrate how a new American Health Care system, one that guarantees access to quality, affordable health care to all Americans, and that realigns health care incentives with health goals, can prove a unique solution to our health crisis, and restore support for Americans' core values.

The Move to HealthCare

In the highly contentious health care debate numerous buzz-words and coverage schemes exist, each with their own emotionally-charged connotations and fervent supporters. Instead of applying labels in describing a solution, I will emphasize the essential features to guide the development of an American health care solution.

As was discussed, the key flaws in our current system lie in underinsurance of our nation, misplacement of incentives, and the cultural changes resulting from commercialization of care. The first component of health reform must be ensuring all Americans access to high-quality affordable care. They should have free choice of available providers, which will best utilize capacity, unconstrained by "preferred" networks. Under a reformed health care system, expensive infrastructure that increases costs for the sake of investors would be eliminated, along with needless fragmentation, and all health care financing could be simplified under one funding arrangement. I think it is important to state that this financing configuration is yet to be determined, and could lie anywhere on the continuum of public and private entities. Necessarily, financing decisions would be made by a panel of recognized experts, with explicit recognition of the need to serve the interests of all stakeholders in the health care system. There is no logical

basis for equating streamlining of health care financing with socialization, or with the existing health care system of any particular country. In fact, like so many corporate restructurings seen in the public and private sectors, it represents a rational optimization of efficiency.

Lastly, reform must be the realign incentives toward promoting health, rather than treatment, and cease commercializing care. Fee-for-service has failed us, and should be reworked to keep costs low and promote the continuation of health. Essential features of this change would include the following. First, payments made on the basis of keeping patients healthy, beyond existing pay-for-performance strategies, which lack the strength to produce widespread improvement. Participating doctors would be compensated at per-patient rates. In order to prevent physicians from seeing too many patients, or from avoiding sicker, and potentially costlier patients, the rates would vary by patients' health status, and fit to models for appropriate patient flow. Furthermore, in the event of an unpredictable health catastrophe, practices would be protected, much like federally-insured banks, from risk of failure. Further, over a decade or more, measures would be implemented to encourage a shift from isolated solo practices to foundation of multi-specialty group practices, which are better equipped to provide efficient, cost-effective care to patients with a spectrum of illnesses.

It seems appropriate here to address the complex interplay between profit and health. While it remains true that profit and competition have driven many life-saving innovations, within our current health system, the two undermine each other. As has been shown, the commercialization of health care has cut access, and in so doing, driven up costs while lessening the quality of care. It has not only financially crippled America's health care system, but has also stunted our economic growth globally, and contributed to Americans' relatively poor state of health. All of this in a nation with unrivaled technological resources and by far the greatest absolute and per capita health care spending. Though to some, change seems impossible, it is clear that rescuing our health care system will require a shift in the culture of health. Profit and care must be separated, as financial concerns should have only a limited role in deciding a patient's best course of care. Further, if profit is to play any role, it must act in line with the stated goals of the health care system through which it is generated. That is to say, mechanisms of profit in the health care system must promote health. This would be possible in a system of guaranteed care, for by improving long-term health, such a system will generate economic growth. Our present system of fragmented coverage is a zero-sum game, however, and so profit, rather than driving health, instead displaces it. Ultimately, health promotion should be stimulated, but health must not be viewed as a commodity, and life or death decisions happen in the clinic, not the board room. For both ethical reasons, and, as has been seen, for established economic ones, health cannot be treated as a commodity.

I have tried to clarify in this essay the failures of our current health care system, and the ways in which reform, would be instituted. Now I hope to outline the gains to be made through this reform. I would be remiss, however, if I didn't also address the potential negative impacts of such health care reform. Like any aggressive therapy, healing our health care system holds many possible side effects, mainly related to the immensity of the change needed to escape our critical state.

Costs and Benefits

The investment in the primary care of millions more will realize tremendous savings from the prevention of illness, gains in economic productivity due to better health, and an elimination of uncompensated acute care. It will also prevent the spillover effects of underinsurance which damage to community economies. Administrative simplification will also realize savings that could be reinvested in enhancing coverage for all Americans, particularly the underinsured. The potential for reinvestment makes quantifying savings difficult, but non-partisan estimates put the five-year savings between $ 300 billion and $1 Trillion. Furthermore, lower costs to American businesses and their employees would allow American industry to compete better globally. Most importantly, however, solving our health crisis will save 22,000 Americans from premature death, and vastly improve the lives of countless others through better care.

As for downsides, at present, private health care financing employs a few hundred thousand Americans. Tthe abrupt firing of these hard-working Americans would be unacceptable. Instead, accommodations, as with all of America's major transitions, need to be made to adapt our national economy to the change of our health care. Any health insurance system will require a significant administrative infrastructure, and those who currently lead this field would be ideally-suited to the task. Employees who choose to pursue other careers would be given support for job training to help them, and could be salaried commensurate with their prior pay. Transition plans for accomplishing the change are already in existence, drawing on models used by large corporations, and even the most generous of these produce a net savings through the transition. The implementation of America's next health care system will be a sizeable task, but a wealth of research show us it need not jeopardize the economy or the livelihoods of Americans in our current system. As a long-time resident of the former Insurance Capital of the World, I do not want to see Hartford become a casualty of health care reform. As long as new policy is reached cooperatively, with participation from all of those along the chain of health care, there is no reason to believe it would.

A second feared complication of insurance reform is rationing of care. Many are concerned that a system of health care that begins to resemble Canada's will experience highly-publicized waiting lines. It would be dishonest to say that this could never happen, but it is entirely accurate to say that rationing will not progress beyond current levels. Waiting-lines, the hallmark of health care rationing, are already infinite for those without. Further, an assessment of average wait times for care in Canada reveals figures close to those experienced by the American insured. The average Canadian waits four weeks to see a specialist for a non-emergent visit – less than I did as an employee of the best hospitals in New England. Most important, however, is the realization that Canadians choose to spend less than half of what Americans spend on health care, and so American health care funding would need to be slashed drastically in order to provoke the feared shortages. Further, by keeping costs transparent to Americans, in the form of constant low overhead and earmarked federal funds, the proportion and absolute spending on health care would be easily modulated in response to early signs of shortage or surplus. In our current system, this is prohibited by an arcane and bureaucratic system whose only fiduciary responsibility is the return on share holders' investments. In fact, under the system outlined herein, health care rationing could only occur in the hands of a hostile administrator who desired it to fail. This vulnerability, currently buffered by the wide distribution of control over our current system, is certainly a negative aspect. However, the interests of keeping America healthy are so widespread, and so central to American's values, as to make actively sabotaging the health of all Americans implausible within a democracy.

In the course of this essay, I've attempted to outline the displacement of Americans' core values from our health care system, precipitating a crisis in America's health. I've described how a dysfunctional system of insurance has cost Americans their dreams and crippled our ability to keep Americans healthy by cutting access, prioritizing treatment of illness above prevention and insufficient support of primary care. I've also detailed how the commercialization of care has eroded the doctor-patient relationship and shifted in Americans' opinions of the medical profession.

The role of profit in our present system is clearly not beneficial, and the importance of a system that combines access, affordability, and quality of care is paramount. Achieving these aims is crucial to returning American's core values to our health care, and only a unique, American solution can accomplish this.

As we enter a new period of change in leadership, we must reexamine our core values as Americans, and assess our ability to support these values. We must seek a health care system which prioritizes Americans' health and nurtures our contributions to America's social and economic growth. This will not be a Canadian system or a European system, it will be a uniquely American system of doctor-driven, patient-centered health care; one that Americans can take great pride in. These changes are sweeping, and cannot be made in a single electoral cycle or without support from policy makers, hospital administrators, physicians, and America's patients. In fact, they are not yet even under consideration for the immediate future. However, the crisis in health care is dire. Leaders from politics, health care, and business must begin an honest dialogue on sweeping measures for reform, and must ensure that short-term fixes pave the way for long-term ones. Without true reform, the prognosis for America's health care system, and American values, looks grim.

Bibliography:

1. Kaiser Family Foundation. "Employer Health Benefits 2005 Annual Survey", 2005.

2. Kaiser Family Foundation. "The Uninsured: A Primer", 2005.

3. Institute of Medicine. "Care without Coverage: Too Little, Too Late", 2002.

4. Himmelstein, D. et al. "Illness and Injury as Contributors to Bankruptcy." Health Affairs (Millwood), February 2, 2005.

5. Institute of Medicine. "Hidden Costs: Value Lost", 2002.

6. Institute of Medicine. "A Shared Destiny: Community Effects of Uninsurance", 2002.

7. New England Journal of Medicine, "The Costs of Visits to Emergency Departments," 1996.

8. American Medical Association, "Physician Socioeconomic Statistics," 2001.

9. National Center for Health Statistics, "National Hospital Ambulatory Medical Survey: 2000," April 2002.

10. Hopkins, J. "Health insurance costs dog would-be entrepreneurs." USA Today, August 8, 2005.

11. Associated Press. "GM to slash jobs, close more plants." Available at http://www.msnbc.msn.com/id/8129876/from/RL.2/, accessed December 2005.

12. Thorpe, K. "Impacts of Health Care Reform: Projections of Costs and Savings", 2005.

13. The Feldman Group. "Defining Our Beliefs: American Ideology Post 9/11." June 1, 2005.