

Health Reform by the End of 2009?



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Executive Summary

With health care costs consuming an ever-increasing proportion of the U.S. gross domestic product, the Obama administration has committed to significant reform by the end of 2009. In order to reduce costs, the President's proposal focuses on changes to the existing system, including:

- expanding the use of health information technology,
- expanding research on the efficacy of treatments,
- investing more in preventive care,
- reforming the payment system, and
- reforming the private insurance market.

However, because the health care market is significantly different from other markets, and because deeply ingrained behaviors among both consumers and providers affect use – and over-use – that drive the cost of services, the question remains whether reform that addresses only those issues will be enough to affect health care costs in any significant way.

Why Health Care Costs Matter

Health care costs are rising rapidly. The Center for Medicare and Medicaid Services (CMS) estimates that health care-related expenditures consumed approximately 16.1 percent of our gross domestic product (GDP) in 2007, the most recent year with available data. In terms of actual expenditures, we spent over \$2.2 trillion on health care, which equates to roughly \$7,420.80 per person. At the current rate of growth, the CMS expects that health care expenditures will reach 20.3 percent of our GDP, or approximately \$13,100.30 per person, by 2018. Many believe that rising health care costs are a significant drag on the American economy and are making competition in the global market place difficult for American business.

The Obama Response

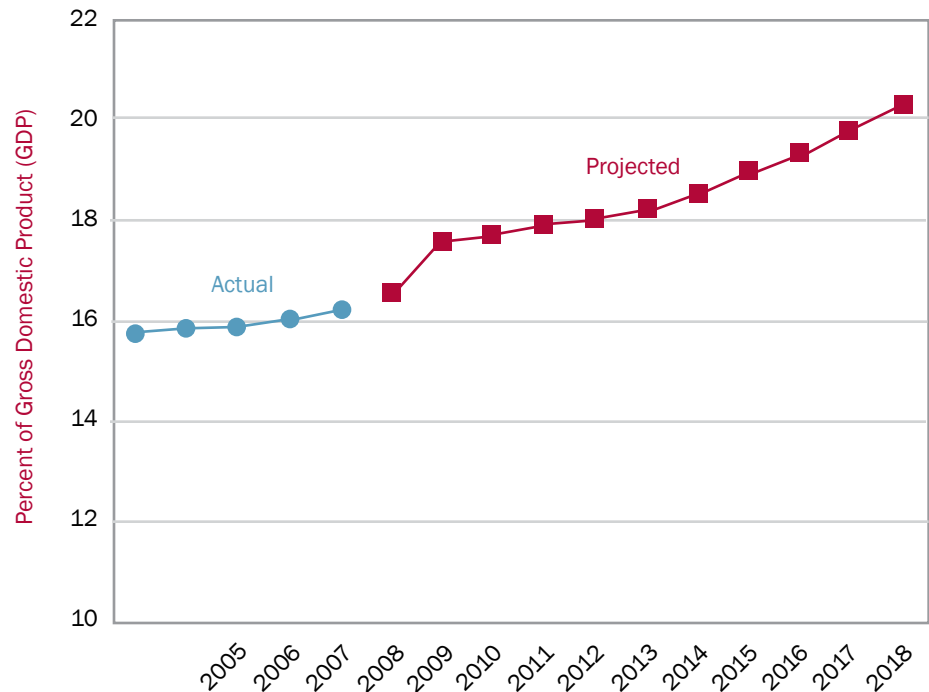
In a February 2009 address to Congress, President Obama echoed this basic concern when he stated that: "... the cost of our health care has weighed down our economy and the conscience of our nation long enough. So let there be no doubt: Health care reform cannot wait, it must not wait, and it will not wait another year." Others in Congress agree, including Senator Max Baucus (D-MT), Chairman of the influential Senate Finance Committee, who publicly declared that "We will have health reform by the end of 2009."

On the campaign trail, President Obama outlined a number of basic ideas for health reform. Most recently, in a Chicago speech to the American Medical Association in June,

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Actual and Projected National Health Expenditures as a Percent of Gross Domestic Product (GDP), United States, 2003-2018



he outlined the general architecture of his health reform proposal:

1. expanding the use of health information technology and electronic medical records;
2. expanding research on the comparative effectiveness of treatments and providers;
3. investing more in prevention and preventive care;
4. reforming our payment system to reward and incentivize excellence; and
5. reforming the private insurance market at the federal level, most notably with a nation-wide policy of “guaranteed issue,” where no one applying for health insurance can be denied due to a pre-existing condition.

President Obama’s most significant recommendation for change is the development and implementation of a national health insurance exchange, modeled after the universal coverage system being implemented in Massachusetts. His plan does not require individuals who are satisfied with their health care to make any changes. The federal exchange would function much like a national benefits office, assisting individuals and small businesses in purchasing health coverage from the private health insurance providers that participate in the exchange. All of the plans offered through the exchange would be required to offer a minimum benefits package, and individuals who could not afford the premiums would receive government subsidies to make sure that every American has access to health insurance coverage. This new exchange would be designed to augment rather than replace employer-sponsored health coverage, Medicare, Medicaid, or SCHIP (State Children’s Health Insurance Program).

While the details are still being worked out, the most controversial element proposed is that the array of options available to exchange consumers should include a “public plan,” i.e., a government-run health insurance product, which many believe could easily be achieved by allowing people under age 65 to “buy in” to Medicare or a Medicare-like program through the

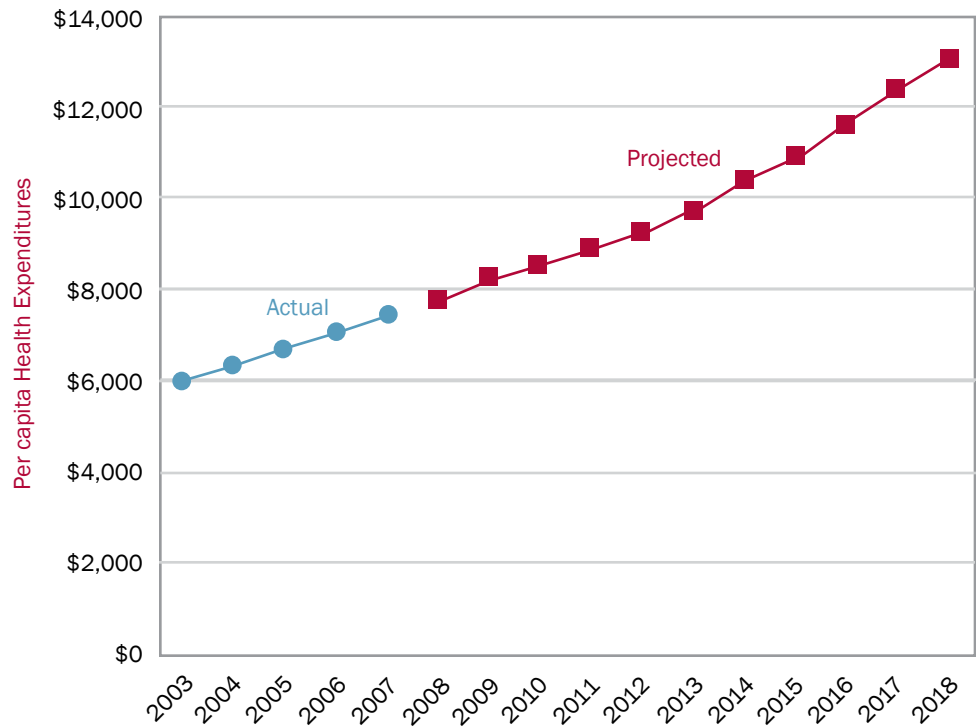
exchange. There are, of course, a number of other proposals also being circulated. With few exceptions, most proposals recommend making changes to improve the health care market place – with varying degrees of government involvement – primarily by achieving universal or near-universal coverage, improving administrative efficiency, and enhancing competition.

Key Drivers of Health Care Costs

A core premise of President Obama’s plan (as well as many other proposals) is that making changes to the health care marketplace will slow or reverse the trend of rising health care costs. While these changes are clearly necessary, it remains an open question whether they will be sufficient to reduce the long-term cost trends. Most health policy experts point to three principal drivers of rising health care costs: (1) excessive administrative costs resulting from a fragmented system; (2) high prices for health care services that purport to compensate for our lack of universal coverage, complex payment policies, and ineffective competition in the health care market, and (3) excessive health care use, especially the use of specialty health care services.

The changes proposed by President Obama and others will likely help attenuate some of the upward cost pressure associated with the first two drivers. How much they will impact the myriad of factors that lead patients and providers to use health care services in more cost-effective ways is much less clear.

Actual and Projected National Health Expenditures Per Capita, United States, 2003-2018



A Different Market

An underlying assumption in President Obama’s proposal, like many others, is that patient and provider behaviors will adapt if we can only “fix” the health care market place by enhancing competition, promoting innovation, and enhancing the value of our health care dollar. Much of the current policy debate rests on an assumption that health care is just like any other consumer good. That is, the factors that motivate consumers and providers of health care services are the same as or similar to those that influence people when they buy or sell a car, a house, or a cell phone. There are, however, many reasons to believe that health care is different from other consumer goods.

Advocates for market reform often cite the lack of information available to consumers about cost and quality, and suggest that if we could make this information more readily available and “transparent,” consumers (and, presumably, health care purchasers) would endeavor to increase the value they get for their health care dollar. It is true that any serious examination of a hospital’s or provider’s price list will leave the best-educated health economists scratching their heads. However, a price list is unlikely to help even the most well-informed consumer when the precise nature of the services to be provided cannot be spelled out with certainty prior to treatment. Since a great deal of uncertainty remains in the practice of medicine, things do not always go exactly as planned: Additional problems may be discovered in the course of treatment, or providers may have to address adverse effects of the care they provide. So it is not surprising that patients often struggle in making health care decisions at the start of or during the course of a treatment.

A related challenge is that consumers face an imbalance in power and information when it comes to health care decision-making. Consumers must rely on the extensive training of their health care providers for guidance, and they don’t always have sufficient knowledge to be able to judge the relative value versus the cost of a given procedure. Nor are they always the final decision-makers, since most medical procedures and treatments must

ultimately be prescribed by a licensed provider. Who should decide what is the most appropriate or the most cost-effective care?

Social and Cultural Habits Make a Difference

Many advocates believe that most physicians should (and do) talk with their patients about their care options, and that they are generally successful in convincing them about the best course of care. But there is also a growing body of evidence that different groups of people hold cultural beliefs and values about health and illness that influence how providers and patients alike respond to health problems. Of particular importance are cultural beliefs that “more is better” and “higher tech care is better care,” which can encourage inappropriate and over-use. Recent cutbacks in health education and related problems in health literacy have further complicated provider-patient communication. President Obama’s plans to provide better access to information about the comparative effectiveness of various services and procedures, as well as to promote so-called “medical homes” to improve the coordination of care, are noble steps in the right direction. But they fail to address a fundamental tension regarding the real “end consumer.” When it comes to health services, is the decision-maker the patient or the provider . . . or both?

Years of research have also documented that individuals’ need for and use of health care is inextricably connected with their social environment. Social epidemiologists have shown that poverty not only facilitates the spread of some diseases, it also is a major determinant of its victims’ ability to access quality health services.

Our popular culture also promotes and reinforces poor health habits, ranging from eating non-nutritious food, to leading sedentary life styles, to encouraging overtly risky behavior.

Provider Behavior Affects Use

The culture of medical practice itself also contributes to higher use. Perhaps the greatest change has been the cultural shift from healing to “doctoring.” This has been most obvious in the historical decrease in the amount of time doctors spend with their patients, driven largely by payer and provider productivity concerns. However, there is evidence that clinical outcomes and satisfaction for both patients and providers are higher when more time is involved in the medical encounter.

Changing incentives, defining new standards of care, and expanding the use of health information technology to reduce the paperwork burden may make it easier for physicians to spend more time with patients. These changes may even make it easier for providers to address more preventive health care needs, as President Obama is advocating. But a system that is more reliant on these “harder” technologies is unlikely to change the “softer” skills necessary for high-quality patient-provider communication. To do so will require fundamentally changing the culture of medical practice to value “healing” over “treatment,” something not easy to do within a traditional policy perspective on health services.

The health care industry has played a role in shaping our cultural values about health as well, by helping to define an ever-increasing range of human conditions as illnesses in need of care, by advertising their services and products as potential treatments, and by creating a cultural perception that modern medicine is the “magic bullet” for whatever ails the human condition. Not surprisingly, despite a dramatic increase in health consciousness, as well as public health programs that promote healthier choices over the past three decades, most Americans still take good health for granted until they’re faced with a significant health challenge.

Will Reform Be Enough?

While the reforms that President Obama and others are debating right now will change some of the arrangements in our health care system that contribute to the rising cost of health care, the proposals address only the more tangible economic concerns

such as: How care is financed, how bills are determined or paid, how information is processed, or how quality care for a given condition should be defined. Clearly, change is necessary. But we also need to address the many social and cultural issues – many of which are direct outgrowths of our current fragmented system – behind the problematic ways that both patients and providers use our health care system.

It appears that we may indeed have some form of major health reform by the end of 2009. The future of our economy may well depend on it. Whether the result is President Obama’s plan or a synthesis of current proposals, it remains to be seen whether the reforms will be enough to stem the rising tide of health care costs in the United States in the long run.

Further Reading

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- George Halvorson. 2007. *Health Care Reform Now! A Prescription for Change.* San Francisco: Jossey-Bass.
- Arnold S. Relman. 2007. *A Second Opinion: Rescuing America’s Health Care.* New York: The Century Foundation.
- White House Website on health care reform progress: <http://www.healthreform.gov/>.

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