ENDING THE CHAOS IN OUR HEALTHCARE SYSTEM

Six Points for Reform Can Help Us Focus on Avenues for Change

BY MICHAEL D. CONNELLY

For the past two decades we have witnessed the unrelenting spread of chaos throughout our nation's healthcare system. Under the current U.S. system for delivering and financing care, more than 44 million Americans have no health insurance and the nation's annual health costs have reached $1.2 trillion.[1] George Halvorson, in his book *Strong Medicine*,[2] describes it as the most wasteful, complex, redundant healthcare system in the world, in which as many as 25 percent of all the procedures performed are unnecessary. He goes on to state that our organizational model has been locked into the inefficient, splintered nonsystem of the 1940s, with millions of independent service providers competing with each other for their piece of the healthcare dollar, often at the expense of both quality and cost. The much publicized Institute of Medicine Report[3] offers additional evidence to support this critique of our health delivery model.

It is time for our nation to articulate a healthcare policy for our country that discourages this waste and effectively promotes affordable, accessible healthcare for all. The Catholic Health Association (CHA), with 2,000 member organizations, and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing 115,000 doctors, have joined in a commitment to systemic reform. We believe it is immoral that, in this prosperous nation, working people find themselves without insurance if employers refuse to cover them or they are downsized out of a job. It is intolerable that the elderly, whether poor or middle income, must negotiate a confusing array of regulations and costly options to find dependable care when they become frail or disabled, and 11 million children receive inadequate care because they are not covered by insurance.[4]

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The American Public's Confusion

The complexity and the personal nature of healthcare make it a difficult topic to discuss objectively in our culture. In a recent article, Daniel Callahan notes:

> Yet even after reviewing all the more obvious reasons why the United States—alone among all the developed countries of the world—does not have universal healthcare, there is still a lingering mystery. We have no trouble understanding the need for universal education, fire and police protection, and for national defense. For every other developed country, it is obvious that healthcare belongs among them. For us, it is not clear at all. . . . Our American individualism and self-righteousness about health behavior do not create good soil in which to grow universal healthcare coverage. Nor is there anything on the cultural horizon to indicate that any serious change is in the offing.[5]

Our citizens seem to fear the interference of "Big Brother" government, and this is unfortunate because some sectors of our society truly need government leadership. From history we know the benefits of government leadership in education, the environment, labor practices, and gun control. Without a doubt, consistent national policies are as essential in healthcare as they are

in these areas. But to gain public support for healthcare reform, we need to better articulate the shortcomings of the existing delivery model and more clearly frame potential solutions to those shortcomings.

Our Current Economic Model

We must ask how well the current system is working in light of the following disturbing facts.

First, we spend more than 14 percent of our gross national product on healthcare, yet Germany, England, and Canada cover all their residents with an outlay of only about 9 percent. Even with these substantially smaller expenditures, these nations have universal healthcare insurance.

Second, the proliferation of centers devoted to specialties, such as cancer franchises or heart hospitals, has further fragmented the delivery system. These healthcare "boutiques" are designed to increase the volume of services; they drive up costs and duplicate services among providers.

Third, the model operates under thousands of complex and conflicting payment formulas issued from commercial insurers, the federal government, and state governments. These formulas make collecting fees an expensive nightmare for providers. Payment incentives also discourage providers from offering preventive care, which is the most effective way to improve people's health.

Fourth, the financial incentives in the economic model pit providers against each other (e.g., outpatient surgical centers against hospitals, hospitals against physicians). This model bureaucratically obstructs access to care with barriers like preauthorization requirements and at the same time encourages the proliferation of profitable but unneeded services through fee-for-service payments. For example, we have more MRI centers in some of our cities than Canada or Germany has in its entire country.

Fifth, the proliferation of malpractice litigation has created a costly and ineffective system for assisting harmed patients. Malpractice litigation does little to discourage malpractice because of its arbitrary nature. A legal finding of malpractice is based on a hypothetical standard of care that is subjective and easily manipulated. Consequently, the possibility of litigation discourages honest and candid disclosure of poor practices. Again, the recent Institute of Medicine study reinforces this observation.

Perhaps a more profound impact than the cost and ineffectiveness of our large malpractice system is the serious harm it has done to trust and the relationships among providers, payers, and patients.

Individual Choice Versus the Common Good

Some of our cities have more MRI centers than Canada or Germany.

In addition to the conflicted impact of the economic model on our delivery model is our cultural obsession with unlimited choice. The current delivery model clearly promotes our society's preference for preserving individual choice rather than promoting the common good, and the combination of our preference for unlimited choice with exploding healthcare technological advances is a dangerous mix. New pharmaceuticals and innovative technologies in reproduction, genetics, and life-sustaining treatment for various diseases are becoming available faster than society can determine how to use them responsibly. As a result, providers offer services whose efficacy is uncertain and which are, in some cases, inappropriate. We offer these services because people want unlimited choice, but is this a wise use of resources? Is it reasonable, given the fact that 44 million people lack access to basic care? Given the advances and complexity of healthcare, the common good will require us to develop a more rational model of making choices for services which better recognizes we cannot afford unlimited options in healthcare.

Finding a New Model

One step to gaining consensus on the need for a new national health policy is to clearly frame the issues around health reform. In this context I would like to suggest a framework of six elements, which allows us to see the big picture for reform and yet also allows us to focus more narrowly on a few specific strategies. This combination of a big-picture vision and related focused strategies allows us to incrementally experiment with solutions designed to promote the broader scale of reform. This approach to reform illustrates that there is substantial opportunity to improve our existing delivery model through selected national policies without making healthcare a more government-dominated activity.

1. Access Our current system of access is fragmented, inchoate, and expensive. One's right to access depends on a variety of arbitrary categories: age (Medicare), financial status (Medicaid), military status (VA), employment status (commercial/charity), and disability status (Medicare). This fragmented model has created confusion and expense for consumers, providers, and insurers. It would greatly simplify the health system if everyone had a right to healthcare through a *single medium* of access. The scope of coverage may vary, the costs may vary, the

providers may vary, and the financing may vary, but everyone should have access to health coverage through a single point of entry—a card issued at birth. National policy could transform this moral right into a legal right and, in conjunction with other changes, could incrementally make affordable healthcare for all a reality in this country over a defined time span.

2. The Scope of Health Coverage The current system has thousands of different health insurance plans. This is a tremendous source of confusion and expense for everyone. How many people even know what their health insurance covers until they try to use it? A few standardized plans created by national policy (perhaps 10 or 12) could greatly enhance the cost efficiency of administration and the public's understanding of their benefits.

Reducing plan choices would give us the opportunity to design coverage models that encourage better allocation of resources. It would, in effect, begin to "rationally" limit choices—for example, the plans might not cover unproven clinical treatments because we don't have the resources to fund care when we are unsure of its efficacy. This is a very sensitive issue that has multiple perspectives. My point in raising it is to suggest that our society needs to decide how it wants to handle its choices in this area. Ignoring these difficult choices will not make them go away. Government leadership in reorganizing our health insurance plan designs could greatly reduce costs, help us face these inevitable choices more rationally, and make the system more usable.

3. Financing and Payment for Coverage The current system is a complex mixture of federal, state, county, employer, and individual financing and payment. Both the collection of the funds and the payment formulas for the care provided drive the behaviors in today's health system. Unfortunately, the incentives created by this system are contradictory and fragmented. For example, the formulas discourage preventive healthcare and encourage caregivers to spend less time with patients. On the other hand, the formulas encourage procedures (particularly expensive procedures), and they promote futile care; for instance, there are almost no limits on end-of-life care. In fact, our litigation system promotes unnecessary and futile care and our economic system rewards it.

The funding side of this equation is comparably complex and inefficient. Approximately 55 percent of the funding for our systems comes from private funds, including out-of-pocket payments, private health insurance, and other private funds; and 45 percent comes from public funds, including federal funds, state and local funds, Medicare, and Medicaid.[6] However, these payments are disconnected from patients' use of the services. This third-party separation complicates our efforts to promote positive incentives. Again, this is an area for which a more rational approach to both funding and payment models could be developed. One narrow and powerful advance in this area would be to make the payment formula for all providers uniform. This idea of a uniform payment methodology applies only to the *formula*, not to the level of payment. For example, every provider could be paid under a DRG formula. The formula would be standardized but different payers such as private insurance companies and the federal government would still be free to negotiate different rates under the standard formula.

The number of dollars spent in this country on billing for healthcare services under thousands of different formulas is a tragic waste. It is comparable to allowing builders and engineers to use whatever electric system they wish in every building they construct. Our government mandates a single model for electrical outlets because it benefits everyone. A similar value—a much greater dollar value—would be created with a single payment formula for health services. These policy changes would not even need to make healthcare a more government-controlled activity. Rather, they would simply create an industry standard for the provider-payment formula in the healthcare industry.

4. Administration of Health Insurance Coverage Our current system is a blend of both government and private insurance coverage. This balance is healthy and works relatively well. There are those who would argue that it should be more private and those who would argue it should be more government directed. However, given the scale of the problems we face in healthcare, it is my conclusion that reform in this area is not crucial. So assuming we are able to make the reforms in the other elements of the system, this balance should probably be preserved with little change under system reform.

5. Providers of Services Our current system is a blend of providers from the private, not-for-profit sector, the government sector, and private ownership sector. This balance also appears to be healthy. However, the promotion of teams for care, the promotion of cooperation across the continuum of services, and the promotion of self-directed care need significant improvement. The economic payment model and the promotion of more flexible caregiver relationships through deregulation could help individuals better negotiate today's

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How many people even know what their health insurance covers?

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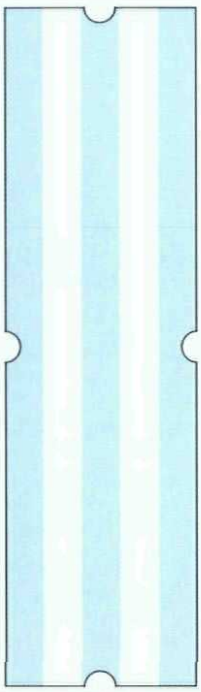

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complex health system. For example, direct consumer access to preventive screenings such as cholesterol testing and numerous other services could be enhanced. The focus should be on consumer access to these services, supported by appropriate education and not on provider-regulated access. Thus, reform in this area would be limited, focusing on promoting integrated delivery of services and encouraging consumer access to more self-directed care.

6. Quality and Regulatory Oversight This area is a mixture of federal regulations, state regulations, and private accreditation. Obviously there needs to be careful oversight of the health services sector. The current potpourri approach, however, is fragmented and contradictory. A more comprehensive view needs to be invented to better coordinate this responsibility. As piecemeal legislation on patients' rights and insurance company regulation proliferates, it is obvious there is major public concern in these areas. We need to step back from existing oversight structures and build a more consistent approach to quality oversight from a national perspective. One significant opportunity in this element might be malpractice reform. We might consider handling medical malpractice like we handle workers' compensation. We would achieve better reporting of accidents and errors (so we could more easily correct them) and we could devote more of the dollars spent in this area to the injured patients rather than to the attorneys and court costs, which now consume an inordinate portion of these dollars.

OUR CALL

For religiously sponsored and other values-based healthcare providers, today's healthcare model is fundamentally disturbing. Unless we step back as a nation and address many of the conflicting incentives and regulations in healthcare, our current model will not only continue to deteriorate, but it will continue to escalate in cost. The social *injustive of our current system* is a particularly disturbing issue for those in healthcare who view it as a ministry, and they have a special obligation to call for its reform.

Our nation was founded on the conviction that everyone benefits when all people have the opportunity to attain the best life possible. The beginning of a new millennium is an appropriate time to return to that founding philosophy and set aside the political bias, inertia, and fear that have crippled attempts to transform our deeply flawed system.

We must persuade policymakers to recognize access to healthcare as a right of all members of our society. Fulfillment of that right will require systemic healthcare reform. I have attempted to identify some specific areas to focus that reform initiative. These suggestions are intended to stimulate the dialogue and focus us on systematic reform of our broken delivery model. Our nation, which has successfully addressed so many seemingly insurmountable problems, can create a more coherent healthcare model in which care is available to all and providers can concentrate more appropriately on their original mission—providing needed care to their communities. □

NOTES

1. Sylvia Fubini, "2000 Industry Outlook," *Healthcare Trends Report,* January 2000.
2. George C. Halvorson, *Strong Medicine,* Random House, New York City, 1993.
3. Institute of Medicine, "To Err Is Human: Building a Safer Health System," Washington, DC, November 29, 1999.
4. "Accessible and Affordable Healthcare for All," paper prepared for CHA by Health Policy Alternatives, Washington, DC, August 1999.
5. Daniel Callahan, "It's the Culture, Stupid," *Commonweal,* February 11, 2000, p. 8.
6. "National Health Expenditures, Percent Distribution and Per Capita Amounts by Source of Funds: Selected Calendar Years 1970 to 2008," Office of the Actuary, Health Care Financing Administration, Washington, DC, November 1998.