

The Health Care System in the United States: Integrating Cost and Quality

The actual practice of medicine by physicians takes place within a large and complex system of healthcare financing and delivery. The healthcare system includes consumers, patients, clinicians, providers, regulators, individuals, corporations, private employers, government, and so on. Without giving a detailed history and description of this system, there are some important points for physicians to recognize.

The United States offers the highest quality of care in the world, for most but not all individual patients. Approximately 15% of Americans have no health insurance and therefore have limited access to the best care and services. The lack of insurance for so many citizens is a national problem that thus far has eluded a comprehensive solution. Furthermore, on a number of health measures pertaining to the population as a whole (e.g., life expectancy and infant mortality), the U.S. lags behind other developed nations.

For those who have insurance and access, the costs are very high. The United States has the highest per capita spending on healthcare, as well as the highest percentage of Gross National Product dedicated to this sector. Moreover, for a long while healthcare was relatively immune from the nation's fiscal constraints. In fact, between the years 1970 and 1994, the overall rate of inflation in the United States was 282%, but for medical services the rate was 521%. Also, the percentage of our Gross National Product devoted to healthcare jumped from 7% in 1970 to 15% at present. (Education, by contrast, has remained steady at about 6%.) For the federal government, health expenditures as a percent of the budget have climbed from 11% in

1973 to 20% in the mid-1990s.

This is not always an easy notion for physicians: that success in healthcare is measured in costs as well as in quality. But this is the reality in our society.

Public resources are tight, whether one speaks of spending on education, housing, healthcare or other societal programs. Corporations are competing in global markets where prices are critical. Like all large and small employers, they are struggling to control their expenses, including health insurance and other personnel costs. Individuals need to watch their spending on personal items.

The systems of healthcare financing in the United States, from the early forms of private insurance in the 1930s to the passage of Medicare and Medicaid in the 1960s, inevitably resulted in escalating healthcare costs. In all these programs, the reimbursements were directly related to services that were provided. The incentives were very clear: the more services that a practitioner or institution would provide, the greater the reimbursements. This method of payment left all portions of the system from the patients to the physicians to the institutional providers with no true economic incentives to decrease any cost in the system.

Along with the insurance system, the increase in healthcare costs is related to several factors, including the rise in unit costs, new technology, a growing elderly population, and an expanding number of providers in certain sectors. Still, a large part of the problem is our increasing capacity to

provide care of marginal utility. The healthcare services for which we pay are not all equally necessary or beneficial.

Even while healthcare costs were climbing, society—led by government and private sector payers—was demanding two things from the healthcare system: high quality care, and cost containment. In marketplace terms, a product's quality and cost are combined in the “value” of that product. While at times it may seem so, the demand for cost containment does not reflect a willingness to sacrifice overall quality of care. Rather, the demand is for a system that offers good value, i.e., high quality and cost-effective care.

With regard to quality, it is universally accepted that physicians are the principal players. Our society offers physicians a great deal of respect and financial rewards. Physicians historically have practiced autonomously, with little structured oversight. But over time the other players in the healthcare system—those who pay the bills and represent the interests of consumers—have asserted their rights to scrutinize the performance of physicians to ensure that the goal of high quality care is being achieved.

For physicians, there are two implications: 1) their work is subject to measurement and assessment, by their peers as well as by non-physicians; and 2) the dimensions of quality extend beyond the traditional domain of clinical care to also include interpersonal and service aspects of their relationships with their patients. (These themes are explored further in the module on Quality Assessment and Improvement.)

What about cost containment, an equally compelling societal demand? Conceptually, there are four alternative strategies for controlling healthcare costs, each with its own set of issues.

These alternatives revolve around the four key parties in healthcare: patients, government, insurers, and providers.

1) **Patients and consumers** spend more out-of-pocket. This strategy is counterproductive to improving health, as studies have shown that higher out-of-pocket expenses are a detriment to persons in need seeking care. Also, it can be ineffective as a cost containment strategy, since consumers who can afford to can buy supplemental insurance to cover their out-of-pocket expenses. This is what happened when Medicare required beneficiaries to pay deductibles and co-payments, but private insurers offered supplemental insurance to cover these costs.

2) **Government** sets a budget and regulates the entire system. Many physicians and other observers of the healthcare system desire a national health program whereby public funds pay for services and governmental authorities replace private health plans. Such a system may yet come to pass, but it, too, will face the fundamental challenge of providing high quality care while controlling its costs. A government financed system would probably resort to measures such as controlling capacity by restricting entry into the professions and their specialties, by limiting the allocation of capital, and by setting unit prices. Canadian and European national plans are increasingly confronted with budgetary problems related to the lack of aligned incentives between the payers and the providers of care. They are studying managed care in the United States to learn ways to control costs, coordinate care, improve customer service, and enhance physician satisfaction.

3) **Payers**—insurers and public sector programs—control the flow of dollars to providers. This is what has happened in the U.S.

In the 1970s and 1980s cost control was seized upon by the new players in the insurance sector, the managed care plans (or HMOs as they were called then). The early successful HMOs were staff-model and group-model plans, in which the insurer and the physicians were part of the same company, or where they were closely aligned through contractual arrangements. Later, the insurance industry involved independent practitioners through Independent (or Individual) Practice Association (IPA)-model HMOs. These health plans controlled costs mainly by paying their participating physicians according to discounted fee schedules, by imposing utilization controls over their providers (e.g, 1-800-call-in lines for pre-authorization of care), and by limiting direct access to specialists. The plans were successful, but physicians for the most part did not embrace cost containment as their responsibility.

4) **Clinicians and providers** take responsibility and determine the best ways to reduce costs. This is the direction in which the healthcare system is moving, as providers take on financial

accountability through capitation and other risk-sharing formulas. Physicians no longer dismiss cost containment as someone else's problem, but they lead the way in incorporating cost-effectiveness as a consideration in the delivery of care. This does not rule out a role for health plans, nor does it preclude a national health program. It implies that, no matter how the larger healthcare system is structured and who is paying the bills, the responsibility for delivering care that is both high quality and cost-effective resides with physicians. Towards this end, physicians may partner with health plans and other parts of the healthcare system, as each makes its contribution to meeting the larger goals.

Many experts agree that the next phase in the evolution of the healthcare system is the growth of more comprehensive physician-driven managed care.