EDUCATION

US health care system: we can do better

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Medical science has made enormous advances in the last 200 years. The question could be asked, however, have we applied these advances to the betterment of the human condition? How can we extend these miracles to everyone and not just some? What are the obstacles or impediments to this task? Certainly physicians care deeply about the health and well-being of people—that is why we went into medicine in the first place. Hospitals also generally have patient care as their first priority. Health plans were originally developed to enhance the health status of specific populations. Our government leaders profess to have the good of the population at heart. So, with all these elements on board, where then is the problem of extending the best possible health care to all of our citizens? Despite all our efforts over the years, why do we in the United States have the most expensive system in the world and one where the end product doesn't always seem to justify the cost?

Given the plethora of innovators, brain power, know-how, wealth, and dedicated individuals in this country, we should be able to possess the best health care system in the world. But do we? Why do we lag behind so many other countries, developed and developing, in many metrics of a healthy population and quality of life? Why are we the only developed country on the planet that does not provide universal health care to all our citizens?

Up until the middle of the 19th century the United States was a largely rural country. In 1800 the US population was 5.3 million and only 322,000 people lived in communities of >2500 people.[1] Physician training was spotty at best and was devoid of accepted qualifications and standards. Physicians were often viewed as quacks or charlatans. Most of the care was practiced in the home and little of it was based on science. Hospitals, which arose from almshouses or quarantine stations of the 18th century, were originally established for the old, the dying, or orphans and were generally places to be avoided.

The latter half of the 19th century saw enormous advances in many areas including anesthesia, operative technique, x-rays, and antisepsis. In Europe, medical giants such as Virchow, Lister, Rokitansky, and Pasteur pushed forward the range of knowledge while in the United States, Osler, Halsted, Cushing, the Mayo brothers, Oliver Wendell Holmes, and countless other scientific geniuses did the same. The hospital was evolving from being a place where people went to die to a place where the best in medical care was available along with the top-notch doctors. Institutions such as Massachusetts General and Johns Hopkins were what we would call today "centers of excellence." Indeed, patients began to want to go to the hospitals for their care. With these advances the hospitals began to attract a more socioeconomically advantaged patient who could pay for care and also attracted the munificence of wealthy citizens. There was also an increasing awareness that hospitals were becoming more of a public responsibility. In 1910, 37% of hospital patients in the United States were in publically supported hospitals.[2] As the prestige and safety of hospitals increased, physicians wanted to admit their patients and, because of improving quality and reputation, hospitals could charge more for their services.

Around the turn of the 20th century there were >4000 hospitals in the United States.[3] Most of these were independent of each other and handled their own management and funding. A symbiotic relationship between hospitals and physicians developed that continues to this day, albeit sometimes contentiously. The physicians, who both wanted and needed to admit their patients, were usually not employed by the hospital but rather were private practitioners who had little control over the management of the hospital. They could, however, set their own fees. At the same time the hospitals had little control over the physicians. Because it had been recognized that the quality of physicians was, in general, clearly inadequate and the training inconsistent, the Carnegie Foundation commissioned what was to become the Flexner Report, published in 1910, which blasted the system of medical education in general and designated many schools as inadequate and in need of closing. In response, the number of medical schools decreased from 131 in 1910 to 81 in 1922. While the number of physicians decreased, the quality of the graduate physician increased dramatically.

The first 50 years of the 20th century saw the advent of 2 major changes that had a dramatic impact on the health care system: the Department of Veterans Affairs (VA) system that currently has 153 hospitals and the passage of the Hill-Burton Act of 1946. The VA was begun in 1932 and was a combination of several other government agencies including the National Health Service. By 1945 the number of hospitals had increased to 120. Under General Omar Bradley's leadership the system of affiliating the hospitals with medical schools was launched. It is estimated that fully half of the physicians in the United States received some of their training at a VA hospital. Currently the system is affiliated with 105 medical schools. The Hill-Burton Act, designed to be a safety net for people without means or insurance, funded the construction of about one third of the hospitals in the country.

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The evolution of the insurance industry paralleled that of hospitals and physicians. The first program resembling health insurance was in the 1790s when the government required ship owners to purchase insurance for their sailors. Most historians cite 1929 as the year insurance as we now know it began. In Dallas, TX, Baylor University agreed to provide health care to 1500 Dallas schoolteachers for $6.00 per year. The Baylor plan allowed 21 days of hospitalization per year. The plan was started as a way to enhance Baylor's bottom line and was soon adopted by other institutions with the help of the American Hospital Association. This model went on to become Blue Cross, which offered its first policy in California in 1932. The plan paid the hospital on a cost-plus basis, which went on to become one of the drivers in the never-ending spiral of increasing health care costs. During the 1930s several state medical societies began selling medical insurance to cover physician care. These plans were envisioned as a way to compete with, if not eliminate, commercial plans that wanted to combine hospital care and physician reimbursement. Thus was born Blue Shield in 1939. Many physicians wanted to prevent any entity that would come between them and their patients. They were so alarmed that President Harry S. Truman, if elected in 1948, would push through a national health insurance program that the American Medical Association hired a Chicago public relations firm that coined the famous term "socialized medicine" and instilled fear into the populous that nationalizing health care would be a catastrophe. Independent practice prevailed and, in addition to the Blue Shield plan, physicians were reimbursed at the often arbitrary usual and customary fee, removing any need for plans to be competitive by reducing cost.

In response to the wage and price freezes imposed due to World War II by the Stabilization Act of 1942, employers needed some way to be more competitive in hiring and retaining employees. They accomplished this by offering company-provided health insurance, first introduced in 1943. The National War Labor Board ruled that fringe benefits *including health insurance* were not considered wages or salaries. As a result, by 1954, 30 million workers and their families had employer provided health insurance, up from 600,000 in 1946.[4] The Internal Revenue Service ruled in 1954 that since the cost of the insurance was not considered income it was exempt from the worker's income tax and the employer's payroll tax. It is estimated that this tax exclusion, the so-called Cadillac tax, today represents a cost to the government of >$250 billion per year.[5] Thus the 3 major players in health care had little incentive to try to cut costs; the hospitals were making cost-plus, the physicians were able to set fees at whatever the market would bear, and the insurance companies were free to set their premiums at an advantageous level and invest their profits.

As time went on it became clear that the cost of health care was increasing at a nonsustainable rate. In 1950 health care represented 4.4% of the gross domestic product. By 2001 it had increased to 13.9% and by 2012 it was 17.2%.[6] There were numerous attempts over the years to curb this upward trend in regard to physician fees and hospital charges but these tended to be reactive changes made to deal with only one aspect of the total issue. There was no overall plan to attempt to reform the entire system. Notably, there was also no premium placed on results or quality of care. Medicare introduced the diagnosis-related group system in 1982 with the thought that by paying a flat fee to cover a given diagnosis costs would be reduced and there would be an incentive to both physicians and hospitals to do the right thing the first time. Unfortunately, given the various modifiers and adjustments, the Medicare severity diagnosis-related group system boiled down to a continuation of the cost-plus system of reimbursement. This system still did not address outcomes so readmissions were treated as separate episodes.

In 1992, Medicare introduced the resource-based relative value scale to attempt to correlate the reimbursement with the actual cost of providing the service and to reward cognitive processes rather than only procedures. The resource-based relative value scale system places a value on each *Current Procedural Terminology* code based on physician work, practice expense, and malpractice costs. But again, these efforts have no relationship to results and outcomes and a fatal flaw is that there is little relationship between charges and costs.

This brings us again to the question of why we in the United States spend so much more than other developed countries. What are they doing that we are not? What are they not doing that we are? Why have we in the United States found it so difficult to learn from other countries' successes and mistakes? The people in these other countries are not any smarter than we are, not better physicians than we are, but they have found ways to provide basic health coverage to their entire populations and do it more economically than we do and often with better outcomes. The World Health Organization ranked the United States 37th of the world's best health care systems.[7]

To address this, I believe we need to start from the premise, as other countries have, that we as a country want to provide universal health coverage and that we find it unacceptable for >40 million of our fellow citizens to be without access to basic health care. We also need to accept that health care, while expensive, is nonetheless a priority for our citizens and our country. Economists and health care experts explore several reasons to explain why we pay so much more for health care. In spite of comments to the contrary, several studies have shown that this does not appear to be related to increased utilization. In fact, Europeans utilize their systems more often than we do. Another possibility is that providers earn more than our European counterparts. While this is true to a certain extent, the savings here would be minimal. Another possibility is that malpractice and defensive medicine is to blame. Crunching the numbers here suggests that this represents <1% of the total health care costs but may represent 15% of expenditures for physician services.[8] It would appear that perhaps a major contributor is our system of *for-profit* health insurance. A Harvard Medical School study found that 31% of health care dollars are spent on administrative costs.[9] Insurance companies in the developed (and many of the developing) countries around the world that provide universal coverage for