The American Healthcare System

By David M. Cutler
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America is the largest, most diverse society on the planet, and our medical system reflects that. We spend almost US$2 trillion per year on healthcare, nearly one in every seven dollars in the economy, yet we are still one of the few nations where all citizens do not automatically have medical coverage. For many Americans, health insurance is a perk most often tied to their job, or it comes as a result of a government programs such as Medicare and Medicaid.

It is ironic that the United States, a nation that spends the most money per capita on healthcare and has the most technologically advanced medical system in the world, is not the healthiest society on earth. Of course, the medical system is not entirely to blame. The variance in our healthcare outcomes is a product of both public health and social issues. As a society, we are fatter, under more stress, and less active than people in other countries, and our medical system has to batter against public health and cultural issues that go to the root of how Americans live. Maybe we should have chosen the European model – more vacations and fewer possessions – but we did not. So, we live with some of those problems. But let me put that aside and come to the real healthcare problem, which is this: American healthcare professionals know how to keep us healthy, but often they can not give patients the care they need because the medical system gets in their way.

The American medical system is highly fragmented, with complicated rules (often set state-by-state and city-by-city) and a combination of private and public bureaucracies that decide which patient can get what treatment. An American doctor has to be a genius to know the rules for treating or taking care of each patient without getting questioned by the insurance companies or others. On the other hand, Americans are more

comfortable with fragmentation than other nationalities. As a nation, we are suspicious about a 'single' anything – like a single-payer system for health insurance. But in healthcare, our cultural preference comes at a high price. Most Americans are unhappy with our healthcare system. Even Americans who are covered think the US medical system is broken. The majority of them want to tear it up and start over. From where we are now, our challenge is twofold: We have to find a way to cover all our people; and we have to figure out how to get better value for the US$2 trillion we currently spend on healthcare.

One urgent national need is to find a way to cover all of our people. Part of the problem is money. Simply: If the government has enough money, we can subsidize the uncovered and get them covered. If we do not have enough money, we can not. Right now, it costs an average of US$12,000 to insure a family of four. The income required to make this a sensible purchase is far higher than the average income earned by an American family, meaning expensive subsidies by taxpayers if every American is to be insured. Maybe we can fudge this a little in the short term, but over the long term, we have to figure out where the money is going to come from. Americans are not very excited about paying more taxes and pouring more money into a healthcare system they rightly feel is broken in the first place. So, what to do? The answer hinges on what we economists call *rationalizing* the healthcare system. Rationalizing the system means figuring out how to save money while delivering better care to more people. Right now, many independent estimates say that we overspend by 50 percent on healthcare, wasting US$1 trillion a year. That is a lot of money to waste. But the solutions do not come in a neat policy package. Blanket allocation of care is never a good idea. For starters, there is no guarantee that we will make efficient decisions about what is most critical. The vast bulk of people who are insured do not get enough of the things they need to stay healthy – adequate management of chronic diseases, medications, treatments, and screenings when they need them. We need to provide more of some things even as we provide fewer of others.

Broken as the system is, there are initiatives that can make a significant impact towards rationalizing our medical system. While no single one of them is the complete answer, by putting into action five or six strategies simultaneously, we can at least be rowing the boat in the right direction.

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One thing we can do is **wire up the medical system.** With good information technology in the medical sphere, we will be able to eliminate all sorts of duplicative tests, we will know what really needs to be done for individual patients, and patients will be engaged with their care. Doctors will be much more efficient when they have computerized their patients' medical records and can get away from writing everything on small scraps of paper that have to be physically transferred from place to place. Wiring the medical system will be an expensive proposition – the best estimates are that it will take five years and cost US$150 billion to US$200 billion to install. That equates to perhaps ten percent of a single year's US medical spending. At least part of the money will have to come from the federal government, since the government pays for nearly half of medical care.

A second important strategy is to **undertake a sustained study of comparative effectiveness.** Are newer drugs really better than older drugs? Are newer procedures really worth much relative to older procedures? If we can track effectiveness of care over time, we can get a handle on the new drugs, the spiffy diagnostics, new medical devices, and treatment protocols to determine which really deliver better results.

A third strategy is to **do a better job of managing chronic diseases by** spending more time and energy on prevention. The poster child is perhaps diabetes. We know how to keep the disease better controlled and make sure people do not get kidney disease, lose limbs, or suffer vision deficits. But the information and financial incentives are not in the right place. No one gets paid money for preventing serious illness.

That leads to the fourth set of reforms – **to change the incentives in medicine.** We can pay doctors not just for what they do, but for what they do well. We can give insurance companies incentives to focus more on taking care of the sick than on coming up with rationales to insure only the healthy. If we can keep the sick

Facts & Figures

The United States is the only major industrial country that does not unify the provision of medical services and insurance through a central national strategy. Nor does it guarantee health coverage to all residents or citizens.[1] Despite these facts, 44.7 percent of the total expenditures on health are government financed, mainly through state-run Medicare and Medicaid programs that cover senior citizens and families with low income, respectively. On average, US$2724.70 out of the total per capita health expenditure of US$6096.20 is paid by governmental agencies. Healthcare spending amounts to 18.9 percent of the federal and state government budgets.[2]

Private health insurance plans – provided by employers, unions, or purchased individually – cover 201.7 million individuals. Government health insurance covers 80.3 million people. Even with Medicare and Medicaid, the number of uninsured persons in the United States grew from 14.2 percent in 2000 to 15.8 percent, or 47 million, in 2006. Among them, 8.7 million were children.[3]

Ambulatory care in the United States is provided mainly at physicians' offices, but also by outpatient departments at hospitals and ambulatory units. There were over 1,169 million visits to these providers in 2005, at a rate of 3.94 visits per person, up 38.2 percent since 1995. The country's 4,936 community hospitals represent the largest group of providers for hospital care. The average hospital has 164.5 beds, with slightly more than half of them comprising more than 100 beds. Average hospital stays for premature babies are the longest with up to 26.2 days, depending on the newborn's exact condition.[4]

Access to emergency care is an increasing area of concern. A June 2006 report by the Institute of Medicine[5] suggests that emergency capacity is becoming increasingly constrained and that most emergency departments regularly need to divert ambulances to alternate hospitals. Staff shortages contribute to this issue. In 2006, 118,000 positions for registered nurses were vacant.[6]

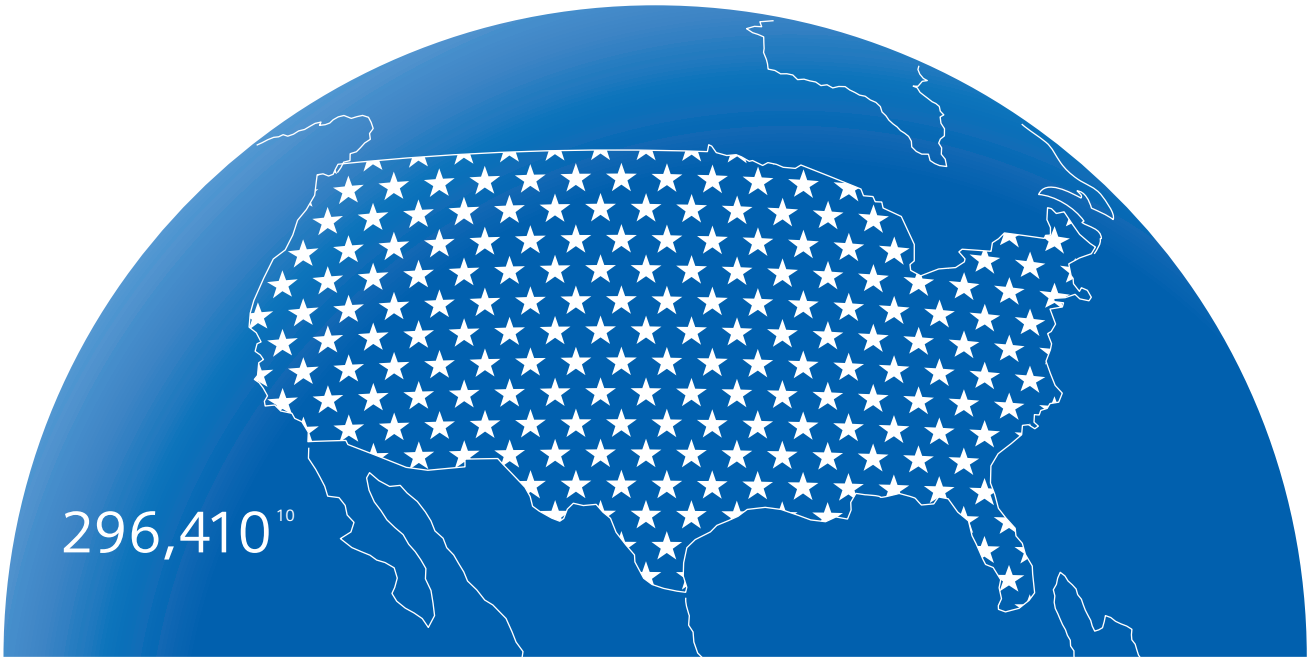
Cardiovascular diseases are most prevalent, amounting to 16.8 percent of total hospital discharges and 36.86 percent of deaths in 2003. The national bill for patient care for cardiovascular diseases is also the highest and amounted to US$208.6 billion, without even taking into account economic costs such as lost work time or lower productiveness of patients. Statistically, cancer only follows at rank eight with 4.91 percent of discharges and ranks sixth with a national healthcare bill of US$67.6 billion. Cancer mortality in 2003 was 22.75 percent of all deaths.[7]

Obesity is the main health-risk factor for Americans. 2004 statistics show that 31.1 percent of males and 33.2 percent of females over 15 years of age are obese – both the highest rates among the Group of Eight (G8) countries. With 24.1 percent of the male population smoking, the United States ranks second lowest among G8. On the other hand, 19.2 percent of women smoke, the second highest rate among G8 countries.

Vaccination compliance is rather high at 93, 96, and 92 percent for measles, diphtheria tetanus toxoid and pertussis, and hepatitis B, respectively, for one-year-olds.[8] On the other hand, compliance with preventive medical checkups is low. One example: Despite the fact that breast cancer is the second most frequent cause of cancer death among women, only 62.6 percent of US women age 40 and older have had a recent mammogram, with participation largely depending on educational background, health insurance coverage, and ethnic background.[9]

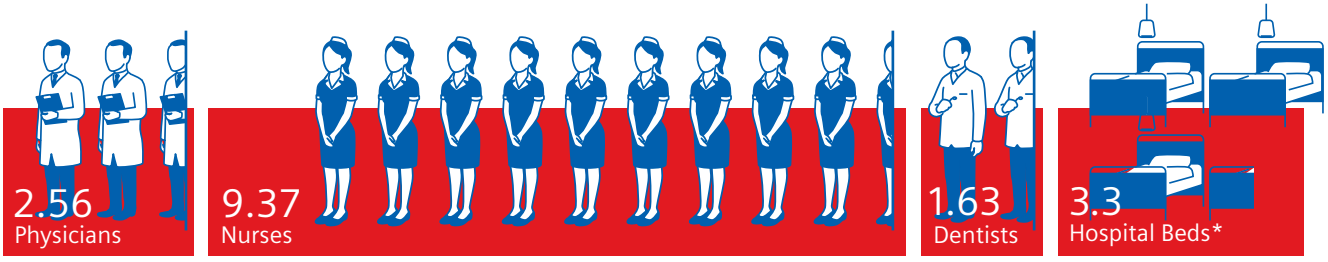
Data referring to 2005 unless indicated otherwise

[1] *USA Background Data*. Espicom Business Intelligence 2007
[2] www.who.int. Last accessed March 3, 2008
[3] www.census.gov. Last accessed March 3, 2008
[4] *USA Background Data*. Espicom Business Intelligence 2007
[5] *Hospital-based Emergency Care at the Breaking Point*. Institute of Medicine, June 2006
[6] *USA Background Data*. Espicom Business Intelligence 2007
[7] *USA Background Data*. Espicom Business Intelligence 2007
[8] www.who.org. Last accessed March 3, 2008
[9] www.cancer.org. Last accessed March 5, 2008
[10] www.census.gov. Last accessed March 3, 2008
[11] Projection: *USA Background Data*. Espicom Business Intelligence 2007



Population in Thousands

Life Expectancy at Birth



Number per 1,000 Resident Population (in 2000)

* in 2003

Total Expenditure on Healthcare as Percentage of GDP

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from getting sicker, we should be able to save money. As a result, big employers – in other words, those who have enough employees to be able to negotiate health insurance costs, terms, and coverage with insurers – will get lower rates, and over time, insurance should become less expensive as we keep people out of the hospital. Not because we decree that we will not pay for their stays, but because if they stay well longer, they will need less hospitalization.

None of these approaches are mutually exclusive. The right thing is to try all of them. I think of these as classic supply-side strategies that make the flow of 'product' (in this case healthcare) much more efficient. We figure out what works – getting better information technology, paying doctors in a smarter way, etc. – and then commit to those areas. I believe that the bulk of the evidence supports the idea that these supply-side strategies will be beneficial.

There are other voices that believe we should be doing more to limit *demand* for healthcare. The argument is that Americans are wasteful of their healthcare dollars because most of us receive them as a benefit, not as a bill. If healthcare were like other markets, where people take charge of what they get and what they buy, healthcare would work better. This idea does not work for me. I am not a big fan of putting consumers in charge of paying a lot of money for their healthcare, because I do not think they will do it very well. We know, for example, that people are very bad at undertaking actions with costs in the short term and benefits only down the road (witness saving for retirement). But is that not the hallmark of caring for chronic disease? People need help managing their chronic illness; leaving them adrift is not the way to go.

Others say, "Let's only cover the things that are medically necessary." The problem is that the medically necessary list is long, and the optional list is far too small. In healthcare, it is very difficult to draw bright lines between what is medically valuable and what is not. Some things are valuable for some patients and not for others. Allocating medical care is a very difficult proposition, no matter where and how it is proposed.

The commonality in these strategies for changing the American medical system is getting the money and knowledge right. Under the right circumstances, we could implement many of these strategies and see significant changes within five years that would get the healthcare system flowing in the right direction. If we rationalize healthcare we can deliver a healthier America and gradually reduce the average cost of family health insurance down from US$12,000 to US$10,000 and even lower, making it easier to cover everyone in the country and make the US system the best and most sensible healthcare system in the world.

The opinions brought forth in this article do not necessarily reflect those of Siemens Healthcare.

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Honored for his scholarly work and his mentorship of graduate students, Professor Cutler's work in health economics and public economics has earned him academic and public acclaim. He has served on the U.S. government's Council of Economic Advisers and the National Economic Council and has held positions with the National Institutes of Health and the National Academy of Sciences. Currently, he is a Research Associate at the National Bureau of Economic Research and a member of the Institute of Medicine. Professor Cutler is the author of *Your Money or Your Life: Strong Medicine for America's Healthcare System,* published by Oxford University Press. He was recently named one of the 30 people who could have a powerful impact on healthcare by *Modern Healthcare* magazine and one of the 50 most influential men aged 45 and younger by *Details* magazine.