© Jones and Bartlett Publishers
NOT FOR RESALE OR DISTRIBUTION

CHAPTER 2

Where Are We?

As more of us are being told we are sick, fewer of us are being told we are well. People need to think about the benefits and risks of increased diagnosis: the fundamental question they face is whether or not to become a patient (Welch et al., 2007, p. 2).

American health care is always in a state of flux as new scientific knowledge and clinical experience change our prescriptions for illness and wellness. As a society, we respond by changing the ways health care is delivered. The way we choose to provide those services increasingly impacts many aspects of our society, from health status to employment to economics to recreation to professional concerns to our perceptions of our own well-being. This chapter reviews the current status of the U.S. health care system from three points of view:

- Current outcomes and costs
- Industrializing structures for delivery
- Medicalization of our society.

CURRENT OUTCOMES AND COSTS

There is a growing consensus that not all is well with U.S. health care. Medicare trust funds are forecast to disappear over the next decade. Health care expenditures are projected to rise to around 20% of the gross domestic product (GDP) by 2015 (Borger et al., 2006). More and more small companies do not provide health benefits, whereas larger companies are shifting significant portions of health insurance costs onto employees and retirees. Politicians on both sides of the aisle are calling for change (Clinton,

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 24

2004; Gingrich, 2003; Gingrich & Kennedy, 2004). At the same time, health professionals' control over health care is being threatened by outsiders calling for more reliance on government programs, more consumer-centered care, or both. Each recommendation has the potential to change markedly the roles and status of health care professionals.

High Comparative Costs and Low Comparative Outcomes

The United States spends far more on health care per capita and as a percentage of GDP than other developed countries, but does not seem to be much better off for it. **Table 2-1** illustrates this by comparing a dozen countries on these two resource input dimensions and on two outcome dimensions, male life expectancy at birth and infant mortality rates. Similar rankings result when looking at a number of other outcome variables. The health care systems of these other countries offer virtually universal coverage but range from mostly private insurance to a national health service. The high U.S. costs and low U.S. outcomes do not seem to be associated with any one specific organizational or financing approach. Yet that is about all that experts seem to agree on.

Consumers in six countries (Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States), especially those experiencing illness, were asked to rate their experience in terms of several factors (Davis et al., 2006; Frogner & Anderson, 2006):

- Patient safety: Perceived error rates were highest in the United States; laboratory errors highest in Canada.
- Effectiveness: The United States ranked best overall and best on preventive care and care for the chronically ill.
- Patient-centeredness: The United States ranked last in almost all respects.
- Timeliness of care: The United States and Germany were quick to receive specialist and elective surgical care, but the United States and Canada had the longest waits for primary care visits.
- Efficiency: U.S. patients reported use of emergency departments because a primary care provider was not available and also reported unavailability of medical records and test results and duplication of tests.
- Equity: The United States lagged in terms of perceived inequities for both poor and average income respondents.

6048

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 25

© Jones and Bartlett Publishers
NOT FOR RESALE OR DISTRIBUTION

TABLE 2-1 Selected International Comparisons of Health Inputs and Outcomes

	Health Expenditures as % of Gross Domestic Product 2004	Health Expenditures in US Dollars per Capita 2004	Practicing MDs per 1,000 2004	Inpatient and Acute Care Beds per 1,000 2004	Population Life Expectancy at Birth 2003 2003	Infant Deaths Per 1,000 2004
United States	15.3	$6,120	2.4	2.8	77.5	6.9*
Switzerland	11.6	4,077	3	3.8	80.6	4.2
Canada	9.9	3,165	2.1	3*	79.9	5.3*
France	10.5	3,159	3.4	3.8	79.4	3.9
Australia	9.6	3,120	2.6*	3.8	80.3	4.7
Belgium	10.1*	3,044*	4	4.8	78.8	4.3
Germany	10.6	3,043	3.4	6.4	78.6	4.1
The Netherlands	7.7	3,041	3.6	3.3	78.6	4.1
Sweden	9.1	2,825	2.9*	2.2	80.2	3.1
United Kingdom	8.1*	2,508	2.3	3.6	78.5	5.3
Japan	8.0	2,249	2	8.4	81.8	2.8

* 2003 data
UK expenditure data is for the United Kingdom, but life expectancy and infant mortality is for England and Wales.
Source: OECD Health Data 2006. Copyright OECD 2006.

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 26

The number of physician visits and hospital days per capita was lower in the United States than the Organisation for Economic Co-operation and Development median, and input prices for health care worker wages, hospital supplies, and drugs were much higher in the United States. Anderson et al. (2003) noted, "U.S. policy makers need to reflect on what Americans are getting for their greater health care spending." They conclude, "It's the prices, stupid." Administrative costs for our system, estimated as high as 30% of overall health care costs, are also high when compared with the rest of the world (Woolhandler et al., 2003).

Overinsurance and Overutilization Arguments

Cannon and Tanner (2005) argued that the basic American problem is overutilization and would explain away comparative international differences because:

- Data definitions and collection methods are not comparable
- Health care is partly a consumption good that normally rises with income
- The U.S. infant mortality is increased by our efforts to save low-birthweight infants that would be stillborn elsewhere
- There is little proven relationship between longevity and health care expenditures
- Our cost figures include the costs of medical research and innovation that are not incurred elsewhere.

They argue that disease-specific data are a better measure. On the mortality-to-incidence ratios for AIDS, breast cancer, colon cancer, and breast cancer, for example, the U.S. system looks very good.

Alan R. Hubbard (2006), assistant to the president for economic policy and director of the National Economic Council in the George W. Bush Administration, opened an April 3 *New York Times* Op-Ed column entitled "The Health of a Nation" by noting that private health care premiums had risen 73% in the most recent 5 years. He observed the following:

> *Health care is expensive because the vast majority of American consumers use it as if it were free. Health insurance policies with low deductibles insulate people from the cost of the medical care they use—so much so that they often do not even ask for prices* (p. A17).

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 27

Ironically, relevant prices for major interventions are not usually available to consumers, even when they do ask for them.

A similar point of view has been expressed by R. Glenn Hubbard (2006), former chair of the Council of Economic Advisers, who saw rising health care costs as one of the biggest threats to the nation's future prosperity. "Despite our national investment of $1.9 trillion, we get highly inefficient care—spectacular in certain respects, but rife with error, disorganized, and unaffordable or inaccessible to many." He proposed that all health care costs be individual (rather than corporate) tax deductions. He believed this would accelerate the use of health savings accounts (HSAs). To support this, he argued for uniform national health insurance standards and open national health insurance markets. He used the banking reforms that allowed multistate banking as a positive parallel example and disagreed with the President's Advisory Panel on Tax Reform, which had recommended a cap on the tax deductibility of employer purchases of health insurance. That recommendation was aimed at motivating employers to offer only basic, more affordable plans. He recommended giving consumers more choices of providers, greater use of health information technology, and medical liability law reforms (Cogan et al., 2005).

If the United States spends more on health care than any other nation without topnotch results, does that mean we are spending too much? The overspending can be in price or the quantity of services provided, probably some of both. U.S. health care wages are the highest in the world. Research also shows that an increased supply of health professionals leads to more utilization, some of which may be unwarranted, yet attempts to restrict the supply of specialists using licensing systems have led to charges of illegal restraint of trade. Like health care, professional education is a confusing mixture of a public good and a matter of personal consumption. There are many alternative ways—certificate of need regulations, for example—to try to control overuse or underuse by trying to influence the supply or demand for heath care services.

Cutler et al. (2006) concluded that if 50% of the increase in longevity between 1960 and 2000 is attributable to our increased medical care expenditures, we have gotten an acceptable return on our money. They suggest that the cost of a life year gained was reasonable, especially for those less than 65 years old. They caution, however, that the returns from added expenditures, especially for older people, have diminished over time.

6048

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 28

Continued High Cost Inflation Rates

The Office of the Actuary, Centers for Medicare and Medicaid Services, and the Department of Health and Human Services are responsible for providing estimates used to assess the financial viability of those two huge government programs. Its report, *National Health Care Expenditures Projections: 2005–2015,* concludes that health care spending is likely to outstrip economic growth (GDP growth) throughout the next decade. Although there will be ups and down because of specific interventions such as Medicare Part D drug coverage, there will be little affect on aggregate health care spending, which will grow at a rate 2% higher than the overall economy. By 2015, it forecasts, national expenditures on health care will reach 20% of the GDP. The government share will gradually increase, leaving health expenditures financed about equally between government and private sources (Borger et al., 2006). **Table 2-2** summarizes historical and forecast data on health expenditures in terms of dollars, dollars per capita, percentage of GDP, and price deflators for both health expenditures and GDP.

Except for the period from 1995 to 1998, the inflation rate for health care costs and health insurance premiums has been well above the inflation rate of the consumer price index and of workers' earnings for at least the last 18 years, as **Figure 2-1** illustrates. No wonder workers and employers feel squeezed by the rising costs of health care.

Disappearing Health Benefits

Employee health benefits (75% paid by employers, including government employers, in 2003) are disappearing at an increasing rate. Between 2000 and 2004, the percentage of insured nonolder people (0 to 64 years old) in employment-based health programs dropped 5% to 61%. In Indiana, Missouri, South Carolina, and Wisconsin during that period, the percentage dropped 9% to 10% (State Health Facts, 2005).

Official federal policy has been to encourage employees to participate in HSAs. The theory is that workers will choose health insurance coverage with high deductibles and coinsurance and will put the premium money saved into tax-exempt (income and interest) savings accounts that could be used in case of heavy expenses, for retirement income, or for other uses. These plans have gotten off the ground slowly because employers have been concerned about the problem of *adverse selection,* namely that younger, healthier employees would choose the HSA option, leaving employees who are at

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 29

TABLE 2-2 U.S. National Health Expenditures (NHE), Share of GDP and Price Deflators, Selected Calendar Years 2000–2015

NHE Spending Category ($ billion)	2000	2005*	2007*	2010*	2015*
Total	1358.5	2016.0	2325.7	2887.3	4043.6
Physician and Clinical Services	288.6	429.9	496.5	610.7	849.8
Other Personal Health Care	37.1	58.1	67.8	89.2	134.8
Dental Services	62.0	87.4	101.3	124.9	167.3
Other Professional Services	39.1	55.8	64.0	78.5	109.4
Hospital Care	417.0	616.1	709.1	882.4	1230.9
Nursing Homes, Home Health Care	125.8	170.6	192.2	232.8	320.5
NHE Per Capita ($)	$4,729	$6,683	$7,376	$9,173	$12,357
NHE as % of GDP	13.8%	16.2%	16.8%	18.0%	20.0%
HCFA Implicit Medical Price Deflator (2000 base)	1.000	1.205	1.248	1.453	1.752
GDP Implicit Price Deflator (2000 base)	1.000	1.119	1.171	1.260	1.298

*Projected
Source: Author created. Data from CMS accessed 02/05/06 at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj.2005.pdf

higher risk drawing from a different and smaller risk pool. Early returns from postal employees showed that the employees signing up for HSAs were much younger than those who chose or kept traditional coverage.

Some employers are also concerned about the "portability" feature of HSAs. If the worker leaves, the premium dollar saved goes with the worker rather than staying to help cover the remaining employees' health insurance claims. Many employers see health benefits as a cost necessary to attract good employees and reduce employee turnover. Portability can run counter to that objective (Freudenheim, 2006a).

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 30

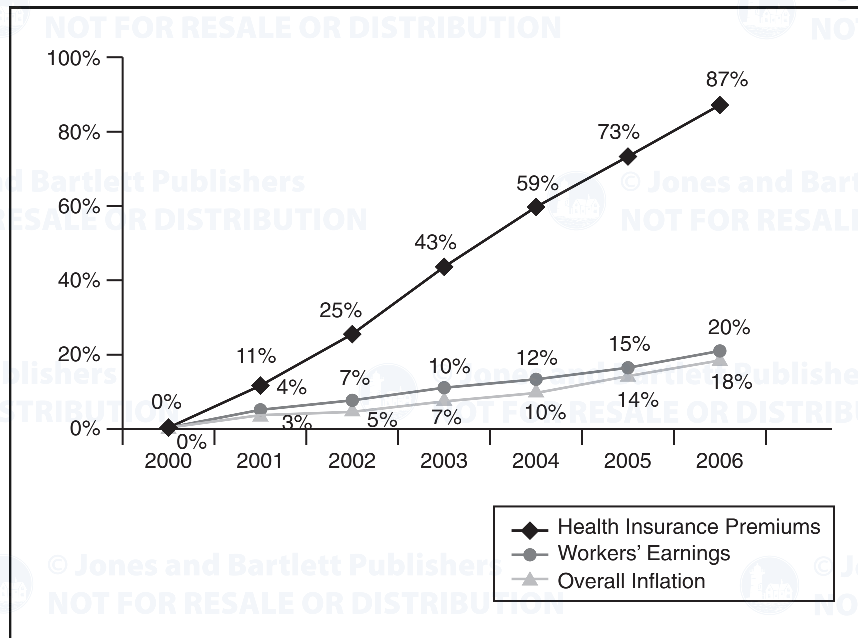

FIGURE 2-1 Cumulative Changes in Health Insurance Premiums, Overall Inflation, and Workers' Earnings, 2000–2006

Source: "Employer Health Benefits 2006 Annual Survey—Chartpack," (7451), The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, September 2006.

A MORE SYSTEMATIC EVALUATION

Taking stock of where we are means that we must evaluate our health care system systematically according to a number of criteria—cost, quality, outcomes, and equity. In 1980, Donabedian suggested the following classification when evaluating quality of care:

- Access
- Technical management
- Management of interpersonal relationships
- Continuity of care.

One could easily amplify these categories, but they are a useful starting point (McLaughlin, 1998). All of these factors involve tradeoffs with the cost of care and with one another.

6048

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 31

Access and Availability

If you were in a serious auto accident, you would want the ambulance there fast to stabilize you and transport you to a trauma center. You would want that ambulance *available.* If we are in danger, we supposedly are guaranteed *access.* If the situation is life threatening and the hospital participates in Medicare or Medicaid, it must take us regardless of ability to pay. For less serious situations, for emergent medical conditions, and for prevention, there are no such guarantees. The local capacity to care for us and the ability to ensure that payment will be made (either through insurance coverage or out of pocket) are both necessary conditions of obtaining care. Unfortunately, a significant proportion of our population lacks access, availability, or both. **Figure 2-2** shows the number of nonolder U.S. residents lacking health insurance coverage from 2000 through 2004. That number has risen from more then 39 million to more than 46 million. Although federal safety net spending, including Medicare, has increased 15% over the same period, spending in real dollar terms has expanded only slightly because of a 14% inflation in health care costs. Spending has failed to adjust for the additional uninsured, most of whom are young and poor (Holahan & Cook, 2005; Kaiser Commission on Medicaid, 2005). As employers shift more and more of the costs of health care to their employees or to public sector programs and as Congress and the Administration try to reduce budget deficits by cutting "entitlement programs," access problems mount.

There are numerous other perceived access problems. Although coverage for children has improved and the older population receives considerable benefits from Medicare and Medicaid, the working population has become worse off. Even before employer coverage decreased, the biggest access problem was with the *working poor*—those who earn too much to qualify for Medicaid but have little or no access to employer-subsidized health insurance and are unable to pay their share of the costs, even when employment-based insurance is available. Even under subsidized programs such as the Maine and Massachusetts programs, there has been slow enrollment by the working poor (Belluck, 2007).

Many improvements in coverage for children came with the State Children's Health Insurance Program in 1997 and have occurred despite reduced private insurance coverage for children. Racial disparities in insurance coverage remain, with the highest rate of uninsurance occurring among Hispanic children (21% in 2004) and African American children (13.4% in 2004). Overall, 11.3% of U.S. children remained uninsured

6048

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 32

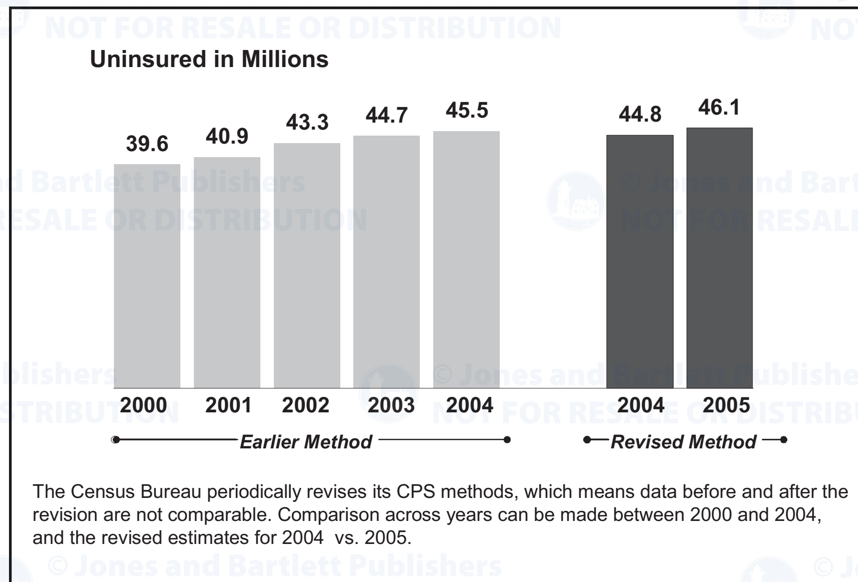

FIGURE 2-2 Number of Non-Elderly Americans Uninsured 2000–2005

Source: "Covering the Uninsured: Growing Need, Strained Resources" (#7429-02), The Henry J. Kaiser Family Foundation, January 2007.

throughout 2004, but 25.6% were uninsured at least part of the year. Children uninsured for all or part of the year were more than twice as likely to receive no medical care that year (SHADAC, 2006).

Meanwhile, racial discrepancies still abound. Why are black infants as much as three times as likely to die as white infants in many states? Why was a child between 1 and 14 years old about three times as likely to die in 2003 in Alaska, Wyoming, and South Dakota as a child in New Hampshire, Massachusetts, or Rhode Island and more than twice as likely to die in Arkansas, Alabama, Oklahoma, New Mexico, and Mississippi? Why in the same year was the heart disease age-adjusted death rate in Mississippi and Oklahoma virtually twice what it was in Minnesota and some 30% above the national average (State Health Facts, 2006, 2007)?

One hopeful sign is the report from Centers for Disease Control and Prevention that there was no statistically significant difference in the vaccination rate of children 19 to 35 months in 2005, whether black, white, Hispanic, or Asian/Pacific Islander (Centers for Disease Control and Prevention, 2006).

6048

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 33

Access—Structure

The United States stacks up pretty well in the developed world in terms of the total supply of services available, but services are distributed very unevenly. This is, however, a problem almost everywhere in the world. Urban centers attract trained personnel with job opportunities and educational and cultural opportunities for their families. Rural areas everywhere tend to lack personnel and facilities. That is why in 2004 a third of U.S. patients could see a primary care physician the same day; however, a sixth had to wait 6 or more days, and 16% reported going to the emergency room for a condition that could have been treated elsewhere if a regular doctor or source of care was available (Schoen et al., 2004). Over time, this rural problem has lessened as the supply has increased and primary care physicians and even some specialists have moved to smaller communities in response to market forces (Rosenthal et al., 2005).

Access—Process

For U.S. respondents, the limitations on access were perceived primarily as financial. When asked in 2001 about prescriptions not filled, doctor visits needed but not made, and treatments, tests, or follow-ups missed, all because of costs and problems paying medical bills, 35% to 40% of U.S. respondents with incomes below average reported experiencing such problems, almost double the rates in Australia, Canada, and New Zealand and six to nine times as large a proportion as in the United Kingdom. For the U.S. uninsured, the rate exceeded 50%. More than half of below-average income U.S. respondents and a quarter of those with above-average income were delaying dental work because of the cost; however, these rates were also high in all of the five countries except the United Kingdom (Blendon et al., 2002). People everywhere seem to use every reason possible to avoid going to dentist.

Access—Outcomes

Americans report that the barriers to health care access are predominantly economic. Morbidity in the nonolder population is concentrated in the lower socioeconomic strata. Certainly, high morbidity contributes to loss of income, but that effect is small compared with the effects of social status on access to care. A study of white, middle-class males in the United States and the United Kingdom showed that the Americans considered themselves less healthy, and thus, the problems apparently are not confined to one socioeconomic class (Banks et al., 2006).

6048

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 34

Technical Management

The heaviest efforts to improve U.S. care have focused on the processes of care delivery. The 100K Lives campaign (see **Case 11-1**) was aimed at implementing effective measures that improve patient survival and quality of life. Still, our care system is wasteful in many ways, inconsistent in treatment and outcomes, and focused on revenue maximization rather than delivering maximum quality at a reasonable cost.

Technical Management—Structure

In the United States, most health professionals are well trained. Their credentials are carefully checked by the institutions where they work, and their licensing boards and certifying bodies require some continuing professional education. Entry by foreign physicians is relatively tightly controlled, with requirements for additional postgraduate training and testing before practicing; however, the results of this process still show providers and institutions to be poorly distributed. Poor states, rural areas, inner cities, and areas with high minority concentrations and low incomes have very different health care utilization rates from the more privileged areas of the country.

Technical Management—Process

Most systems to assure quality of care focus on the process of care delivery. They concentrate on the variability in treatment approaches among practices, among various areas of the country, and on failure to implement evidence-based practices. This focus on specific care processes, supported by measurement and reporting systems such as National Committee for Quality Assurance's Health Plan Employer Data and Information Set system, has improved the rate of conformance in the areas measured, but there is still a long way to go.

One indicator of poor resource allocation and questionable quality is variability in medical care delivery from one area to another. Wennberg et al. (2002) showed, for example, that Medicare spent twice as much per enrollee in Miami than in Minneapolis without any apparent improvement in results. Miami patients might be sicker to start with, but case mix differences are unlikely to justify a doubling of average costs in a fee-for-service program. They suggest that there is relatively little variability where the medical evidence is strong and much more where the evidence is less so, such as with hospital-based care during the last 6 months of life.

© Jones and Bartlett Publishers NOT FOR RESALE OR DISTRIBUTION

44425_CH02b_06pass.qxd:McLaughlin 8/9/07 12:07 PM Page 35

Estimates of waste in the U.S. health care system run to 30% to 40% (Milstein, 2006). Not only are tests duplicated and medical records unavailable, but there is little attempt to optimize processes and coordinate activities to maximize the use of personnel. Each specialty and department tends to operate to meet its own preferences and maximize revenue, rather than to improve system efficiency. Staff departments assigned to improve processes have fallen by the wayside during cost-cutting drives (Sahney, 1993).

Technical Management—Outcomes

Much attention has been paid to medical error rates in recent years. The 2000 Institute of Medicine report *To Err Is Human* and the follow-up report *Crossing the Quality Chasm* focused the attention of the government and a reluctant medical profession on this problem (IOM, 2000, 2001). The Leapfrog Group, an employer-oriented organization, has suggested several measures that are in the process of being implemented, including computerized physician order entry and widespread use of intensive-care hospitalists. The experience with the 100K Lives program illustrates the magnitude of the improvements that can be achieved.

Management of Interpersonal Relationships

One area the American public has emphasized has been the importance of a relationship with a personal physician. Members of the public do not want to be told whom they may or may not see. They will even pay extra to have the relationships that they think suits their needs.

Management of Interpersonal Relationships—Structure

Americans rebelled at the idea that their health maintenance organizations (HMOs) could interfere with their existing relationships with their personal physicians. They clearly value that relationship where it exists; however, a substantial number of Americans report financial and spatial access problems and use less personal services such as emergency rooms or urgent care centers. Even those with relatively poor access to care triage their own care considerably, driving greater distances for more sophisticated care, if they believe a problem may be serious.

Management of Interpersonal Relationships—Process

Much of the expressed dissatisfaction with interpersonal relationships in U.S. health care has to do with the brevity of encounters. Patients feel rushed by