

Conclusion — All Those Levers and No Fulcrum

The pragmatic method is primarily a method of settling metaphysical disputes that otherwise might be interminable. Is the world one or many?—fated or free?—material or spiritual?—here are notions either of which may or may not hold the good of the world; and disputes over such notions are unending. The pragmatic method in such cases is to try to interpret each notion by tracing its respective practical consequences. What difference would it practically make to any one if this notion rather than that notion were true? If no practical difference whatever can be traced, then the alternatives mean practically the same thing, and all dispute is idle. Whenever a dispute is serious, we (need to) be able to show some practical difference that must follow from one side or the other's being right.

— *What is Pragmatism* (1904), from series of eight lectures dedicated to the memory of John Stuart Mill, *A New Name for Some Old Ways of Thinking*, in December 1904, from William James, *Writings 1902–1920*, The Library of America; Lecture II

WHERE TO STAND

As the first part of this book illustrates, we are offered many, many levers that we might use to try to move health care delivery in one direction or the other. All levers, however, require a strong fulcrum, a solid base against which the lever's force can be exerted. In the United States, there is a clear absence of a reliable fulcrum. The federal government is the least reliable of all. Bureaucrats know that the efforts of lobbyists, senior White House staffers, or chairs of congressional committees can undermine in a few days what has taken months of study and consensus-building to achieve. At worst, one's program, even one's agency, can disappear from the budget overnight. State offices are subject to the same risks, although the governors sometimes stand more firmly because the state must meet its financial obligations, rather than print money or borrow more heavily.

Other potential fulcrums are likewise unreliable. Insurers pass on added costs. Providers continue to maximize revenue. Employers opt out of defined benefit programs. More and more patients go bare (i.e., without insurance). More and more of the costs of providing coverage and care accrue to state and federal governments through Medicare, Medicaid, and other programs. Thus, the downward spiral continues.

Fitting Into Our Culture of Individualism

There are practical, pedagogical reasons for the on-one-hand and on-the-other-hand approach Harry Truman objected to when he called for a "one-handed" economist. Each of us brings a value system to any policy analysis, and those values inevitably get mixed up with the objective information that a scholarly approach offers decision makers. We are therefore understandably reluctant to declare one approach, one solution, one system to be absolutely and unequivocally superior.

It is clear, however, that there are things that fit well into the culture of the United States, and others that do not. One of our current cultural problems is that loud sets of voices are calling for one extreme or another with almost religious zeal. Reagan (1999) pointed to the horns of one health care dilemma. On one hand, some would prefer that the federal government be the single purveyor of health care, but in a country that has long valued individualism and a free-market economic system, it seems that there has to be some acceptance somewhere of some market forces in the

process. On the other hand, it is clear that health care has been and will continue to be a highly imperfect marketplace. No matter how much information U.S. consumers receive, it is unlikely to be sufficient for them to make good decisions about all aspects of personal health care. Furthermore, it is clear that many segments of U.S. society cannot generate sufficient income to participate in that marketplace, whereas others may lack the cognitive skills or other attributes necessary to participate fully and effectively in an unfettered health care market. Advocates of a single-payer system, who have been fond of saying that the United States is the only developed country without a national health system, are unlikely to see the United States fall in line with other nations anytime soon. Yet the current dependence on employers as the basic source of funding for care for workers and their families, while working and especially during retirement, is collapsing in the face of increasing international competition.

The Limits of the Free-Market Approach

Those who argue that insurance, because it insulates health care consumers from any economic consequences, has been responsible for waste and overutilization have a strong point. Their efforts to shift more costs to the consumer will pay off some in terms of reduced utilization. There are three issues with that approach, however, in addition to the risk that for lower income individuals it will likely lead to underutilization with negative long-term consequences. The first is that much of its impact may already have been achieved with the increases in deductibles and co-pays already in force, and the marginal effect may be much smaller than anticipated. Second, information on quality and price is so opaque that the market cannot function very effectively until major changes take place to get realistic and relevant information into the hands of the consuming public. Those changes do not yet seem to be underway with respect to (1) hospital prices and (2) quality outcomes for specific physicians.

The third constraint on the free-market approach is that some purchasers are quite capable of researching a medical condition and some are not. Even for the population that is capable (and those supporting a single-payer system have often underestimated the ability of today's public to research health care and understand what they find), this is not a cross-sectional problem, but a serial one. With one episode of care, the consumer may seek to make an informed market decision, because he or she:

- Has the technical information and the background to interpret it
- Has the market information on price and quality of providers of care for this medical condition
- Has the mental acuity to interpret it and make an appropriate decision
- Feels confident enough in their knowledge to act on it
- Has access to a primary care provider to test out their conclusions.

Yet six months later, he or she may have a set of symptoms that leaves them completely baffled and they have to rely completely on the recommendations of their primary care provider or a local specialist, especially if they are in pain and sedated at that moment. Yes, they may be capable of rational consumer decision-making behavior in the first instance, but not in the latter. In the second situation, they are going to have to rely on their agents, their physician, and, to a lesser extent, their insurer for such a decision.

If one has lived with gout for years, for example, they may be about as knowledgeable about the condition as most providers, but what if they then have intestinal polyps and their personal physician sends them to a specialist who says, "I have this new technology that is less invasive than what is usually done and insurance will pay for it and you are a perfect candidate for it"? Are they going to demur and go out and do a survey of methods and the market? Probably not. More likely, they will say yes and then look it up when they get home. If they cannot find out much about what it will cost and how effective it is and they are told that it is safe, then they are likely to keep the appointment and let their insurer cover it—especially if they have other things to worry about, like a consulting report that is due. The impact on health care costs of the market approach will be felt, but it will also be limited.

THE PHYSICIAN'S DILEMMA

What will these proposed changes do to the status of American physicians? Many of them would clearly contribute to the industrialization of the health care sector and weaken physician bargaining power. For example, if most medical centers were required to quote a single price up front for treating a medical condition and that single price covered the professional, technical, and inpatient components of that treatment, the physicians

would have to bargain for their share, and they would likely be in a relatively weak position. In fact, it seems likely that specialists ultimately would be placed on salary in community settings, just as they currently are in many academic medical centers. Some physicians might counter this development by setting up their own specialty hospitals, but one might anticipate further Stark amendment-type constraints if that response became very widespread.

More information on process, price, and quality, more bundling of pricing, more evidence-based protocols, requirements for reduced waste and more intense case management would all in part constrain physician autonomy. At some point, health system policy makers will have to reconsider the patient-physician relationship and its attendant agency issues and try to reach an appropriate balance between industrialization and professionalism. One answer is for physicians to provide more assertive leadership when it comes to defining and maintaining the physician's role, especially the role of the primary provider, without trying to get back to the old monopolistic mind set that once tainted state and local American Medical Association efforts.

THE ERISA PROBLEM

Trying to make rational sense out of the health care system is difficult enough, but effectively having two complete sets of regulatory requirements, one under state insurance laws and one under ERISA, does not make sense, especially because the current responsibility for health and welfare in the United States rests principally with the states. At the time that the ERISA law was passed, it was necessary as an enabler of nationwide collective bargaining by large employers and large industrial unions, but in an era when we have so many "model uniform codes" for so many types of commercial and personal business transactions, it would not seem to be an insurmountable obstacle to come up with and adopt a model uniform code for employer-based health insurance. The likely fly in the ointment is the health insurance industry itself, as the dual system blunts the ability of the states to attempt any universal or mandated coverage requirements; however, the benefits of a uniform system are so great that legislatures, unions, and major corporations might be persuaded to fall in behind it and move it ahead.

CHAPTER EXERCISE: TRADEOFFS

It is popular to talk about a country, if not a world, divided over values, but that is not the entire story. This book illustrates that there are many tradeoffs—tradeoffs everywhere one turns. **Table 15-1** lists a number of these showing the two sides, the impacts of the current status quo, and some possibilities for responding to them. The fact that these tradeoffs have been issues for as long as they have shows that they are currently at an equilibrium position (or an impasse). Some would argue that having a less than rational system with unresolved conflicts and continuing inefficiencies is not all bad because it provides high-income employment. It does that, but one might also question how productive much of that employment is.

In Table 15-1 a number of potential tradeoffs were purposely omitted. Add others as you identify them. Add new lines for those additional tradeoffs that you perceive to be important in the near future and come to class prepared to discuss your candidates for inclusion.

CONCLUSION

We expect that managing tradeoffs, rather than implementing radical changes, will be grist for health policy analysts' mill for some years to come. Each time a new program or regulation is proposed to deal with one aspect of health care access, cost, and quality, the policy analyst must present to the interested parties the tradeoffs that have to be made, their magnitude, and their consequences, intended and otherwise. The policy analyst will have to look at the desired impact, the unintended consequences, the distributional effects, the ethical issues, the technologic impact, the financial feasibility, the political feasibility, and the best way to implement the proposal, and from that come up with a justified recommendation to the parties involved, the politicians, and the public. Such analyses do not necessarily lead to earth-shaking decisions, but they are necessary if we are to make things better rather than worse. There will be much work to do. How successful it will be, in all likelihood, will be a matter of leadership as much as anything else; however, those who would lead, especially from a professional position, must participate both in effective analysis and in rational leadership.

TABLE 15-1 Illustrative List of Tradeoffs, Impacts, and Some of the Proposed Solutions

Tradeoff	Versus	Current Impact	Proposed Solutions
First-dollar coverage	Catastrophic insurance	Many see payouts, motivating participation, but not enough money for both	Major medical option Means testing (spend-downs and Medicaid) Risk pools for high-risk patients
Universal coverage	Willingness to pay	Uninsured, underinsured High administrative costs Government, which is already covering up to 45%, continuing to gather more under tent	More categorical programs Basic coverage package, plus add-ons Expand programs such as the State Children's Health Insurance Program (SCHIP) to cover more individuals
Selective underwriting	Community rating	Adverse selection Lifetime limits Prevention disincentives	Minimum coverage for all with add-ons allowed
New drug safety and efficacy	Rapid deployment of effective technology	Current focus on drugs for continued use A lack of new drugs to fight acute illnesses	Sponsored development Stronger postmarketing surveillance
Direct-to-consumer advertising	Health education campaigns	Higher drug costs Overutilization Misallocated research funds Disease mongering	Constraints on proportion of costs in advertising Redefining health Health education (counter detailing)

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TABLE 15-1 Illustrative List of Tradeoffs, Impacts, and Some of the Proposed Solutions (*continued*)

Tradeoff	Versus	Current Impact	Proposed Solutions
Liability for vaccines' effects	Vaccine development and production capacity	Inability to respond to surges in demand Failure to develop new vaccines and production methods	Limited liability Support for not-for-profit producers Subsidies for standby capacity
Linked electronic medical records	Consumer privacy	Medical errors Duplicate tests Slow responses to acute problems	Designing in privacy safeguards Firewalls
Needs to train new health professionals	Desire to increase faculty incomes and cross-subsidize research	Overstressed learners Poorer quality of care	Better funding of supervision Reduced charges for learner-produced services
Customized care for complex patients	Strong move toward use of evidence-based practices Friction between suits and coats	High variability of practice patterns	Stronger physician and government leadership Exception reporting Better evaluation, communication, and dissemination
Use of high end technology in low end settings	Rapid testing and deployment Visibility of large medical centers	High treatment and capital costs Resistance to disruptive technology	Development of more flexibility in system capacities and operating costs
Investment driven by utilization growth	Certificate of need	Efforts to increase demand Duplication of services Reduced competition	Wider disease-specific catchment areas Capital rationing Global budgeting