What’s Next in Health Care?

Has Medicare ceased to serve the nation, or does it simply need reform? Are we destined to pay out-of-pocket for declining care, or are our medical options more accessible and plentiful than ever? School of Public Health faculty members Helen Ann Halpin, James C. Robinson, Thomas G. Rundall, Richard M. Scheffler, and Stephen M. Shortell offer their perspectives on the future of health care in the United States.

The prospects for solving the problems of access, quality, and cost in the U.S. health care system seem dim in the near term. The country’s economy is sluggish, state and federal tax revenues are down, and spending on social programs, including health care, is being cut, not expanded. While the federal government is projecting the biggest budget deficit in history, the Republican-controlled Congress is unlikely to look to government to solve the country’s social ills. In addition, health care costs are rising at double-digit rates, making health insurance even less affordable to low-income working Americans, who make up 80 percent of the uninsured.

In the short term, we can expect that state governments will cut Medicaid rolls and put off expansions of the Child’s Health Insurance Program; city and county governments will be unable to meet the demands for medical care from a growing uninsured population; employers that offer health benefits will pass on some of the cost increases to their employees in the form of higher out-of-pocket premiums and cost-sharing; and Congress will continue to talk about a prescription drug benefit for Medicare, yet the resulting legislation will likely provide far less than what is needed.

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Without a reliable crystal ball, it is risky to predict the future. What is clear, however, is that health care reform will be an issue in the 2004 presidential election. The current political reality does not mean that we should stop working on new proposals to reform the system into one that is more efficient, equitable, and gives Americans the choices they desire. We must be ready with a viable solution that has a broad base of support when the next policy window opens.

The reality beneath the rhetoric is that the quality of health care is the highest it has ever been. The pharmaceutical, biotechnology, and medical device industries are putting out one diagnostic and therapeutic technology after the other, most of which raise quality and costs. This stuff works. If we want it, we have to pay for it. The resulting higher premiums make health care finance painful for middle class Americans—both directly for their own care and indirectly to subsidize the care of less-fortunate citizens.

New technological opportunities, of course, are only half the story. As the economists note, there is also a demand side to this market that will ensure a permanent revolution of rising expectations: everyone must have access to everything that has been proven to work. Woe to the bean counter, bureaucrat, or cost-benefit analyst who gets between the American consumer and that which the consumer wants to consume. Clearly there is a lot of administrative waste and inappropriate care in the U.S. health care system, but, when given a choice between accepting the waste and further empowering corporate or bureaucratic reformers, the American people have chosen and will choose the lesser of evils.

James C. Robinson, Ph.D., M.P.H., Professor of Health Economics

The press, the pundits, and the politicians are having a field day trashing the American health care system. Health care costs and health insurance premiums are rising, as is the number of people without insurance. Quality of care seems to be falling, at least if we focus on malpractice lawsuits and estimated numbers of medical errors. Can things get any worse? Wouldn’t we all rather be sick in Canada or Britain?

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Thomas G. Rundall, Ph.D., Henry J. Kaiser Professor of Organized Health Systems

Resentment of public and private health plans continues to grow among many physicians, who perceive payments to be inadequate and constraints on decision making as eroding their professional authority. In response, some doctors are developing their own version of consumer-directed health care by withdrawing from participation in health plan contracts and dealing directly with their patients.

This strategy is likely to grow and become more elaborate over the next few years. More physicians will refuse to sign contracts with health plans, requiring their patients to pay for care in cash and seek insurance reimbursement on their own. In wealthy areas, we will see more doctors requiring patients to pay a retainer fee. Other physicians will target HMOs and government health plans that they view as underpaying and overregulating.

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Indeed, recent data indicate that this trend is already well under way. A recent survey conducted by researchers at UCSF found that only 58 percent of California’s doctors are accepting new HMO patients while the percentage of specialists with HMO patients fell from 77 to 62 percent between 1998 and 2001.

Other data suggest that this “backing away” by doctors from some forms of managed care is part of a broader pattern of change. Research from the Center for Health System Change shows that between 1997 and 2001 the proportion
of physicians in the United States serving Medicaid patients decreased from 87 to 85 percent. The percentage of Medicare seniors reporting delay or denial of needed care rose from 9 to 11 percent. Similarly, the percentage of privately insured people between the ages of 50 and 64 who reported access problems increased from 15 to 18 percent.

Policymakers will need to monitor closely physicians’ participation in public and private health plans. Access to care for all Americans is at stake.

Richard M. Scheffler, Ph.D., Distinguished Professor of Health Economics & Public Policy; Director, Nicholas C. Petris Center on Health Care Markets & Consumer Welfare and Robert Wood Johnson Foundation Scholars Program

My view, supported by the recent doubling of the National Institute of Health budget, is that the most powerful and dominant force that will affect the future of the health care system in the United States is biomedical research.

This increase of funding will undoubtedly lead to important new medical technologies, the use of which health economists internationally believe is responsible for more than half the increase in health care spending. This means the current growth rate for health care expenditures will continue and perhaps accelerate in the decade ahead. From the current level of 14 percent of the Gross Domestic Product, it is reasonable to anticipate that within 10 years, this figure could approach 18–20 percent.

How will we pay for this increase in spending? I think the answer for the current system in the United States involves both public and private financing. One lesson I have learned in teaching international health policy is that each country’s health care system clearly needs to fit its culture and economic system. Given that the United States will, for the foreseeable future, be a market-driven system with appropriate regulations and a role for government, it would seem that our health care system will follow a similar pattern.

While on the public side I anticipate success in increasing Medicare coverage (especially in the area of prescription drugs), in the private sector I predict that health coverage financing will continue to move from defined benefit plans to defined contribution plans, where the employer will not necessarily guarantee a certain health care plan or health care coverage, but will more likely guarantee a certain defined contribution, leaving the additional cost of coverage to the employee.

It is most likely the case that we will have a fragmented, public-private health system with an increasing role for consumers as they pay for a larger share of the costs.

While many factors will influence health care spending, I believe the most important is the demand for health care. The recent increase in the percentage of the population who are 65 and older, the aging of medical technologies, the rapid increase in the costs of medical technology, and the continued increase in the number of chronically ill individuals all play a role. This increase of funding will undoubtedly lead to important new medical technologies, the use of which health economists internationally believe is responsible for more than half of the increase in health care spending. This means the current growth rate for health care expenditures will continue and perhaps accelerate in the decade ahead. From the current level of 14 percent of the Gross Domestic Product, it is reasonable to anticipate that within 10 years, this figure could approach 18–20 percent.

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The latest band-aid solution is “consumer-driven” health care. Faced with significantly increased premiums, employers are pushing costs onto their employees with the expectation that employees will then choose cost-effective health plans and physicians. But without more effective risk adjustment for differences in health status and better information upon which to base choices, this “driver” alone is not likely to have much sustainable impact.

The challenge in our pluralistic health system is to develop aligned financial incentives for all of the major parties—purchasers, plans, providers, consumers, and suppliers—that will encourage and reward desired behavior. We need to involve all of these groups in fundamentally changing the way in which health care is organized, delivered, and consumed.

Finding a durable solution will take time. I expect that 10 years from now we will have a better-functioning health system in the United States than we have now. While we may have to go through a painful decade of change in the process, there are some encouraging signs—including promising “pay for performance” experiments demonstrating that it is possible to derive greater value for the money we are investing in our health system without sacrificing our desire for choice.

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