

Beyond Financing and Payments: Problems Faced by the U.S Health Care System

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1. Introduction

This chapter is focused on policy analysis, not system description. It is written partially in the first person and indeed is a personal view of what is currently going on in my country, the United States of America. The positions that I take are based on over 40 years of study in the field of health policy analysis. My first major work in it was the textbook “**Health Care Delivery in the United States**” (Jonas, 1977), which was the first book of its type. As of the autumn of 2009 it was in its 9th edition and known as “**Jonas-Kovner’s Health Care Delivery in the United States**” (Kovner and Knickman). Planning for the tenth edition was getting underway at that time. I stepped down from active participation in the book following the publication of the 7th edition in 2002. I have devoted the bulk of my time since then to work in health, wellness, and exercise promotion. But I still manage to keep up with the problems and prospects of the U.S. health care delivery system, and I am delighted that Dr. Rout gave me the opportunity to write this chapter for his book.

I began the opening chapter of the first edition of “Health Care Delivery of the United States” with the following quotation (CCMC):

“The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency, and social waste. Furthermore, these conditions are, as the following pages will show, largely unnecessary. The United States has the economic resources, the organizing ability, and the technical experience to solve this problem.”

This is a chapter that I originally wrote for a book entitled, Health Care Systems Around the World: A Global Survey, edited by Dr. Himanshu Sekhar Rout. It was published by New Century Publications, New Delhi, India, in 2011.

I followed it with this quotation that from the beginning of a paper entitled “Crisis is American Medicine” (Battistella and Southby):

“In terms of gross national product the U.S.A. spends more on health than does any other country. But costs are rising at such a rate that more and more people will find it difficult to get complete health care. This particularly applies to the poor, the old, the Negroes [sic], and other disadvantaged groups. Doctors and hospital beds are distributed most unevenly both in broad geographic regions and between States. There are indications, too, that the quality of care has been inferior, especially in terms of antenatal and infant mortality. The whole organization of medical care in the U.S.A. has failed to respond to changing disease patterns, the move from country to cities, industrialization, and the increasing proportion of old people in the population.”

“But,” you might say, “I thought that you said that the first edition of your book was published in 1977. These descriptions sound as if they could be accurate as of today.” And I would say “except for the ‘Negroes’ anachronism, sadly you are correct.” In fact, most unfortunately, the descriptions above were already historical when that first edition of my textbook was published. The first is the opening paragraph of the Final Report of the Committee on the Cost of Medical Care. That Committee, appointed by the U.S. President Herbert Hoover in 1928, published its Final Report in 1932. The second is drawn from a paper published in The Lancet in 1968.

Yes indeed, they are still accurate and if anything the problems are getting worse. As will have been described in the primary chapter in this book on health services in the United States, in 2007 total expenditures on health care services amounted to over 16 percent of Gross National Product and are continually rising. (This number is about 50 percent higher than that for most of the other developed countries all of which have one form or another of a comprehensive health care cost coverage system.) Up to 50 million out of a population of approximately 300,000,000 have no coverage for health care costs. As many as 85 million more have inadequate coverage for costs, and many move in and out of both groups over relatively short periods of time (Gottschalk).

2. The Political Battle in 2009

Payment for health services in the U.S. is called “health insurance.” However, most people use health/medical services at one or more time in their lives and many who have cost coverage use them regularly. The word “insurance” usually

refers to a system of collectively paying a sum of money to a given beneficiary as compensation for a personal and/or financial cost or loss in case of the occurrence of a relatively rare event, such as a home fire or an automobile accident. Furthermore, “health insurance,” at least in the United States, provides little coverage for either *health promotion* or *disease prevention* services. This in a society in which, for example, the at least partially preventable negative health condition of obesity has reached epidemic proportions (irony of ironies in a world in which perhaps one-third of the total population is *under-fed*). Thus the mechanism is more accurately called a “sickness cost payment” system. But since the convention is to call it “health insurance,” with the understanding just spelled out here that is the term used in this chapter.

In 2009 the political battle in the US was not in fact over “*health care* reform,” since even aside from the “insurance” issue the US health care *system* focuses almost entirely on treating people once they get sick. And the battle was not about sickness *care* reform either. Forgetting about *health* and *health care*, the sickness care system is itself quite ill, as we shall see below. However, the battle for the most part was narrowly confined to attempts to reform the health insurance system. We shall return below to a consideration of just some of the broader health/sickness care system problems that will/would remain in place whatever sickness care payment system problems might be enacted into law. But first, let us briefly examine the present U.S. health insurance system.

3. “Health Insurance” in the United States

As will have been noted in the descriptive chapter on the U.S. system, in the United States virtually all persons 65 years of age and older have a significant proportion (but not all) of the costs of their sickness care paid for under the Federal (national) government’s “Medicare” program. Some of the very poor, depending upon which state they live in, have some of their sickness care costs paid for by a combined Federal/state program called “Medicaid.” Large numbers of U.S. military service veterans (although not all) have access to reasonably comprehensive care from the U.S. Veterans Administration which, since it is entirely owned by the U.S. Federal (national) government, in essence operates a system of “socialized medicine.” The over 2,000,000 persons in state and Federal prisons and jails also receive their sickness care services from what amounts to a “socialized medicine” system. Virtually everyone else who has sickness cost payment coverage of one sort or another receives it through a private, for-profit “health insurance” company.

From the time of the failure of the attempt to reform the sickness payment system under U.S. President William Clinton in 1994, the health insurance industry has become evermore profitable and evermore politically powerful.

Thus although at the time of writing (fall, 2009) it is not known what, if any, kinds of changes will be enacted for the United States, it was likely that the then-present system would not be changed very much. It is ironic that in the United States proposals to create a national health insurance system go back to the Presidential election of 1912. At that time Theodore Roosevelt (a distant cousin of President Franklin Delano Roosevelt, 1933-45) who had been President from 1901 to 1909, included such a proposal in his campaign platform as a then third-party candidate for re-election to the post. (He lost.) It is even more ironic that even the most relatively progressive sickness care payment reform that could have come out of the U.S. Congress in 2009-2010 – some sort of “public option” that might or might not compete with the private, for-profit insurance sector – would not come close in comprehensiveness and coverage to the original “Teddy” Roosevelt plan for all industrial workers of a century earlier!

4. Significant Problems beyond those of the Payment Mechanisms

The balance of this chapter is devoted to a brief review of a series of major problems that afflict the U.S. health care system that would not be touched by any of the “reforms” of the sickness care payment system being considered by the U.S. Congress in the fall of 2009. Indeed they would be only marginally affected by even a revolutionary change in the payment mechanism, such as that called “single payer.” The latter is a government-run or very highly regulated private not-for-profit, payment system, as is found in all other developed countries. It would stand in sharp contrast to the loosely regulated private, for-profit (and highly profitable) payment system, dominated by a few very large insurance companies, that is found in the United States.

To begin an examination of the question of what “health care reform” US style in 2009 would not accomplish and could not accomplish, what criteria might we use to define a “good” health care delivery system? I took my Master of Public Health degree at the Yale School of Public Health in 1965-66 under one of the founders of the discipline of health policy analysis in the United States (then called “Medical Care”), the legendary Prof. E. Richard Weinerman. We were taught that one set of measures for evaluating the structure, function, and cost-effectiveness of a health care delivery system was denominated by “The Three C’s and the Three A’s.” They were, respectively: “Comprehensiveness, Coordination, and Continuity,” and “Affordability, Availability, and Acceptability.”

“Comprehensiveness” referred to care that would include the entire essential health promotive, disease preventive, and treatment services. “Coordination” of services meant that the various providers of the various kinds of services, and the

facilities in which they work, would be interconnected with one another, both through personal communication and the medical record. “Continuity” meant that each patient would be able to receive comprehensive and coordinated care from one set of personnel and facilities over time, unless the patient chose to change providers or moved. Further, in the latter cases there would be a standardized medical record that could follow the patient, if they chose to take advantage of that fact.

“Affordability” means just what it says, that costs and charges for health/sickness care services would be reasonable. “Availability” means that both the personal and facilities equipped to provide care as defined by the “Three C’s” and the “Three A’s” are reasonably accessible and fairly evenly distributed across the country, with obvious allowances for the problems of providing effective care in rural areas. Finally “Acceptability” means first just what it says from the patient’s perspective and second, that from the professional perspective it is care of the highest possible quality.

To see where the U.S. system might stand in relation to the six criteria, let us return to the two quotes presented at the beginning of this chapter to gain a perspective on what the problems are. Let us bear in mind that the documents from which they were taken were published respectively in 1932 and 1968. Let us also bear in mind that I learned of the “Three C’s and the Three A’s” more than 30 years after the first quote was written but two years before the second one was. The bottom line is, to put it in the U.S. vernacular, “we ain’t close” and no version of “health care reform” c. 2009 would bring us much closer. We will go sentence by sentence.

5. From the CCMC Final Report

A. “The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one.”

Yes indeed, it was pressing in 1932, it was pressing in 1968, it was pressing in 1994 when, as noted, the last attempt at reform of the sickness payment mechanism under President Clinton failed. There are some people in the United States who receive very satisfactory medical service. They are people like me, for example, who live in or near a major metropolitan area (in my case New York City) and have a “good” health insurance plan paid for, for the most part, by their employer. But if one lives in a metropolitan area *without* adequate health insurance, that is often not the case. One will find it very difficult to get care from private practitioners, and if local government services, which are getting evermore scarce and poorly funded, are not available, they have nowhere else to turn. (There is no national plan for effectively providing health services to the rural population.) With ever rising costs of sickness insurance premiums

(charges) and ever-increasing gaps in what services private insurance will pay for (such as “pre-existing conditions” that one had before they enrolled in their current plan) many people even with insurance find the costs to be ones they *cannot* meet. So we certainly do still have the problem of not providing satisfactory medical service to *all* of the people.

B. “At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequably distributed.”

Let us just address the quality problem. In 2000 the Committee on the Quality of Health Care in America of the Institute of Medicine of the U.S. National Academy of Sciences published their report To Err is Human (Committee on the Quality, 2000). In it they concluded that each year in the United States, at a time when the population was about 282,000,000 (it is now about 305,000,000) there were somewhere between 44,000 and 98,000 deaths due to avoidable medical errors. The following year the Committee published a comprehensive set of recommendations for reform of the U.S health and sickness care system (not just the payment mechanisms) (Committee on Quality, 2001). Nothing close to following those recommendations has been accomplished and the current reform proposals for the most part do not address the quality-of-care concerns raised by the Committee. Certain local health care systems around the country have addressed specific issues of quality assurance and presumably there has been some decrease in the truly horrific “deaths due to medical errors” figures. But overall, the problem remains, and remains unaddressed.

C. “The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency, and social waste.”

Yes, and let us just briefly address the matter of “economic inefficiency.” The sickness care payment mechanism is handled for the most part, as we have said, by a set of private, for-profit, insurance companies. Each has its own set of regulations, requirements, eligibility standards, paper and/or electronic forms to be filled out and so on and so forth. Filling out and processing these myriad forms requires hundreds of thousands of personnel, both at the provider end and at the insurer end. It has been estimated that US\$350 billion could be saved annually simply by replacing the private, for-profit health insurance system with a single-payer system (PNHP).

D. “Furthermore, these conditions are, as the following pages will show, largely unnecessary. The United States has the economic resources, the organizing ability, and the technical experience to solve this problem.”

This was true in 1932 and it is true now. But what the U.S. also has now, especially since the failure of the Clinton Health Plan in 1994, is a sickness care

system that is dominated by a group of very large, very politically powerful, highly profitable “health insurance” companies which simply don’t want things to change. They are very strong supporters, both ideologically and in many cases with political campaign contributions, of key legislators in both political parties. They have powerful allies in the highly profitable pharmaceutical and medical equipment manufacturing industries. They are concerned with the strong possibility that if a truly public payment system is introduced that with it will come truly effective cost-containment mechanisms that would cut into their profits.

In the 1930s the strongest resistance to change came from the medical profession. In 1934, President Franklin Delano Roosevelt was developing the plan for the Social Security System to, for the first time, provide an old-age pension system. The medical profession, through the American Medical Association (AMA), threatened to lead a political battle to prevent the enactment of Social Security if any kind of national health insurance program were included in it. FDR thus dropped the health insurance initiative. An independent initiative for national health insurance undertaken by President Harry Truman in 1948 was also killed by the AMA.

In 2009 by contrast, many of the medical profession’s members were all in favor of major changes in the structure and function of the health care delivery system, including wanting to make it much more focused than it is presently on health in addition to sickness. But the corporations that would be most negatively affected by any real reform are even more politically powerful now than the medical profession was back then. Thus real system reform is not on the agenda.

6. “Crisis is American Medicine”

Let us now turn to the Battistella and Southby summary of how things stood in 1968.

A. “In terms of gross national product the U.S.A. spends more on health than does any other country. But costs are rising at such a rate that more and more people will find it difficult to get complete health care.”

This is certainly still true. As noted above, the U.S. spends at least 50 percent more of its GNP on health and sickness care than most other developed countries (Gottschalk). An increasing number are either without health insurance altogether or have inadequate coverage in relation to their needs. It has been estimated that up to 60 percent of personal bankruptcies in the United States are due to an inability to meet health care costs.

B. “This particularly applies to the poor, the old, the Negroes [sic], and other disadvantaged groups.”

It still does, as documented in the 2003 publication of the Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care of the Board on Health Sciences Policy of the Institute of Medicine entitled Unequal Treatment (Committee on Understanding).

C. Doctors and hospital beds are distributed most unevenly both in broad geographic regions and between States.

For example, strongly affecting geographical mal-distribution, the U.S. medical profession is highly specialized. Not only is it broken down into many broad specialties, internal medicine, pediatrics, surgery, neurology, orthopedics dermatology and so forth. But it is further broken down in to sub-specialties: cardiology, pulmonology, nephrology, hematology/oncology, ophthalmology, and so on. Many of these specialties are broken down further into adult and pediatric divisions. And then there is further sub-sub-specialization, like ophthalmologists who operate only on retinas and orthopedists who operate only on shoulders. With the development on the one hand of the understanding of the differences between adults and children at many levels, and on the other of highly sophisticated and delicate surgical techniques, such sub-specialization is often desirable from the patient's point of view. However, it does pull physicians away from the delivery of primary care, which is what most patients need most of the time.

Additional problems in this category include:

1. Specialists generating the use of their own services, e.g., where there are more surgeons more surgery is performed per capita (Kovner and Knickman, p. 420).
2. The private insurance companies emphasize payment for procedure-based medicine because it is easier to measure and count than are counseling services.
3. Primary care can be effectively delivered by teams of physicians and nurse practitioners and "physicians assistants" (Kovner and Knickman, p. 198) (The latter is a unique U.S. health profession. It was originally a product of the Viet Nam War and the challenge of providing a professional career for the large numbers of returning military medical corpsmen without requiring them to go to medical school.) However, for a wide variety of reasons such coordination can be difficult to accomplish.

D. "There are indications, too, that the quality of care has been inferior, especially in terms of antenatal and infant mortality."

See To Err is Human and Crossing the Quality Chasm discussed briefly above.

E. “The whole organization of medical care in the U.S.A. has failed to respond to changing disease patterns, the move from country to cities, industrialization, and the increasing proportion of old people in the population.”

This is still true. For example, there is a grossly inefficient distribution of functions between and among the various health professions; there are massive geographical imbalances of health manpower and facilities supply; there is a lack of coordination between and among health care facilities; there is a disconnect between major elements of the health sciences education system and the needs of both practitioners and patients; the list goes on, and on.

7. Beyond the Problem List Above

There are, then, all of the above problems which have not changed in many decades, are still with us, and in some cases like the ever-rising costs of care, becoming evermore serious and system threatening. In addition there is a group of somewhat more contemporary problems that also would not be affected by the current sickness payment system reforms being considered. In no particular order of importance they are:

1. There are serious deficiencies health sciences education and how it is funded. As noted, many medical school graduates enter their professional lives very heavily in debt. That strongly influences their choice of specialty, for most of those other than the primary care specialties (family practice, internal medicine and pediatrics) pay much better. Those speciality choices, made at least in part on the basis of outstanding loan obligations, strongly and negatively influence the distribution of physicians between primary care (most need) and the specialties (less need).
2. There are skewed priorities that direct research, both within the university-based research establishment and the pharmaceutical industry. For the former it can be entirely based on what kinds of governmental and private grant funds are available for what kind of research. For the latter it can be based upon what might prove to be the most profitable.
3. Little attention is paid to Health Promotion/Disease Prevention in much of medical practice. Little attention is paid to these subjects in medical education. Health insurance payments for such services is very limited. Since how physicians practice medicine is determined largely by how they are trained and how they are paid, this is not surprising.
4. Finally, there is the heavy emphasis on technology. From computer-controlled IV drips to computer-controlled dental anesthesia to a finger sleeve for taking the pulse to highly complex instrumentation in the hospital when less complex instrumentation could do the same job, there are myriad

elements of health services now performed by machines instead of by humans which may do nothing other than increase the costs of health care.

8. What is the primary focus of the health care delivery system?

Finally, beyond “The Three C’s” and “The Three A’s” of the 1960’s, beyond the summary statements on conditions in the 1930s and 1960s that are still very much with us, and beyond the supplementary list above there is another major issue that would not be dealt with by sickness payment system reform. Health care delivery systems can have a variety of foci. The primary focus can be on the care of patients, on treating them when they are sick, on managing chronic disease in such a way as to ensure the best possible long-term outcomes, on helping patients to stay healthy and to prevent and/or diminish the risk of disease. However, health care delivery systems are not machines, even though they may use machines in one way or another. They are heavily people-dependent for the provision of services. And some of those people may have other goals for themselves, in addition to or even in place of the “care of patients.” Those possible additional goals can be characterized as the “Three P’s:” Power, Profits, and Prestige.

As noted and as is well-known, all of the developed countries other than the United States have highly developed health care delivery systems. Either most of the health care system is run from the national level, as in the United Kingdom, or there is a comprehensive nationally run health care insurance (payment) system run from the national level which has a major impact upon the nature of the delivery system, as in, for example, France, Germany, and Japan. In all of them there is some effort at national planning and coordination (Kovner and Knickman, p. 155). In the United States the majority of the hospitals are privately owned, whether operated to produce private profit or not (in the U.S. the latter are called the “voluntary hospitals”). While in a given region, a few hospitals may be linked to each other, most non-governmental hospitals operate as independent enterprises.

While some physicians work directly for hospitals or other health care provider institutions and are paid on a salaried basis, many are paid by their patients or their patients’ insurers on a “fee-for-service” private basis and operate as small businesses. Then there are the other small enterprises like the “drug stores” that sell pharmaceuticals (although increasingly these are part of large multi-store chains, a few of which stretch across the nation) and the related health professions such as physical therapy, optometry, podiatry, and chiropractic. The latter are also paid on a fee-for-service basis for the most part.

In this environment it is very easy to lose one's focus on the patient and his/her welfare and best interests, and begin to focus on the maximization of income and profit. It is also easy in a system that has no nationally set, patient-focused goals, whether practicing on a fee-for-service basis or working for an institution, to become focused not only on money, or even in addition to money, on the accumulation of power and prestige. This can happen in large hospitals, in medical schools, in major research establishments, in the pharmaceutical industry, and certainly in the for-profit health "insurance" industry.

It is impossible to know for sure what the distribution of motivational forces for health manpower in the U.S. there is between having a primary focus on the care of patients and having a primary focus on one or more of the "Three P's." But surely some significant chunk of the health care industry, especially the private insurance and pharmaceutical industries, does focus first on them. Then in major health care institutions like medical schools and large hospital systems, some of the focus can be found first on power and prestige, with patient welfare coming second. Just what the distribution is, is impossible to tell. But with so much of the system privately owned and operated, and significant sectors of it, especially the health insurance and pharmaceutical industries, focused first on profit, it is surely there, to the detriment of the system's patients. Current proposals for "health care system reform" would deal with none of the above.

9. Conclusion

We have dealt briefly with many of the major problems facing health care delivery in the United States beyond how to pay for them and for whose benefit the payment system should operate. It is quite obvious that the United States is a very long way from installing even a sickness care payment system that is both equitable and capable of effectively containing costs. But even if that were to happen, there is another institution that would be necessary if the series of problems that are not directly related to payment mechanisms, such as the distribution of health care manpower and facilities, is to be effectively dealt with. It is a comprehensive national planning system for health services.

There is a glaring lack of any kind of comprehensive health-and-sickness care national planning system that could begin to address many of the problems listed here and discussed however briefly above in an organized fashion (Jonas, 1986, Chap. 15). That institution might take an even longer time to appear in the United States than some kind of reasonable payment mechanism. It was under Franklin Roosevelt's "New Deal" that, growing out of the Final Report of the Committee on the Costs of Medical Care, the first comprehensive proposals for national health care planning appeared back in the 1930s. There were two Federal programs, "Regional Medical Programs" and "Comprehensive Health Planning"

that were eventually enacted into Federal law in the 1960s. However, from their beginnings both were hamstrung by limitations placed on them primarily by organized medicine and opposition from the private hospital system, and they eventually died out during the Reagan Administration in the 1980s.

“Planning,” especially “national planning,” have been made into politically dirty words in the United States, especially since the time of Reagan. Over the course of its history the United States has planned few national efforts other than military ones. And even one of the few major seemingly non-military national planning programs, that which created the national “Interstate Highway System” beginning under President Dwight D. Eisenhower in the 1950s, had a military element to it: with a then already-deteriorating national railroad system the need to have a national transportation network along which major numbers of troops and their equipment could be moved rapidly in case of major emergency.

Do I view the future of the U.S. health care delivery system as bleak? Yes I do. Do I view it as hopeless? No, I don’t, which is why I continue to write on the subject from time-to-time when I receive a kind invitation as I did from Prof. Rout, and continue to participate in the education of our future leaders in preventive medicine, as I do at my own institution. The task is monumental. But hopefully, someday our efforts will meet with success.

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