B. THE "CRISIS" IN ACCESS, COST, AND QUALITY

HEALTH AND MEDICAL CARE REFORM IN THE UNITED STATES: ETHICAL QUESTIONS AND CONCERNS

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President's Council on Bioethics, Staff Background Paper

2008

The reform of health and medical care in the United States has been a topic on our national agenda for decades now. . . . [A]t present, we seem to be witnessing a remarkable coalescence—of the public, health professionals and organizations, and policymakers—around the conclusion that the American "system" of health and medical care is ailing. Three problems—of access and coverage, of quality, and

of cost—are usually cited as the signs and symptoms of this increasingly worrisome state. . . . [W]e offer a purely descriptive account of the problems of access, quality, and cost, in order to illustrate their complexity and to draw out their implications for ethical questioning. . . .

I. The Problem of Access to Health and Medical Care

In [2010], according to the Current Population Survey of the U.S. Census Bureau, [50] million Americans were uninsured. This statistic is often cited in ways that suggest that it—and it alone—constitutes the whole of the problem of access to health and medical care in the United States. . . . There are other dimensions to the problem of access. The underinsured, who have some coverage but are inadequately protected against high out-of-pocket costs, are the subjects of a growing literature. Difficulties with the supply and geographical distribution of health care professionals, along with some types of health care facilities (for example, emergency rooms), are also constituents of the problem of access. Our focus here, however, is on the uninsured. . . .

According to one estimate, some 18,000 premature deaths per year in the United States (as well as a number of other serious health conditions) could have been prevented by better access to health care.[3] To be sure, the uninsured do have access to emergency room care . . . , but care through this source tends to be less than optimal. Conditions are often treated only when they have become very serious. Moreover, the use of emergency care by the uninsured exacerbates the burdens placed on often strained emergency rooms and centers. . . . Those hospitals and professionals incur costs that eventually lead to higher charges for the insured or to increasing outlays of federal and state funds for uncompensated care. . . .

The preceding review of statistical data underscore[s] one conclusion: the situation of the uninsured in the United States is a complicated one, far more so than the oft-cited figure of [50] million reveals. As this review has shown, that number does not capture how long the uninsured lack this essential component of access to care, nor does it provide important information on who the uninsured are. The number of individuals who lack insurance for a year or more is lower than [50] million—probably somewhere between 30 and 40 million. Nor is it the case that the uninsured are all poor and thus unable to purchase insurance. More than one-third have household incomes above the median national income. Moreover, about a fifth are not citizens. . . . It is also noteworthy that the rates of uninsurance are higher among the poor and among African-American and Hispanic communities. . . .

II. The Problem of Health Care Costs and Financing

Just as few, if any, would dispute the fact that there are many millions of uninsured Americans, so too would few take issue with the claims that health care costs

3. See the Institute of Medicine report *Hidden Costs, Value Lost: Uninsurance in America* (2003). Other scholars point out, however, that it is difficult to establish clear evidence of causation (as opposed to correlation) between insurance status and health status. . . .

in the United States are high compared to other industrialized nations and that these costs are increasing in seemingly unconstrained ways. These facts are cause for concern on a number of fronts. Such broad measures of population health as infant mortality and life expectancy, for example, indicate that the U.S. does no better, and in some cases does far worse, than similar countries that spend less on health care: we may not be getting good value for our money. . . . [T]he current situation is made more worrying still by the historical trends in the growth of health care spending. . . . According to some estimates made by the Congressional Budget Office, if current trends continue, health care spending could rise to almost 50 percent of total Gross Domestic Product (GDP) by 2082. . . .

There is much controversy, of course, over the causes of those increases and the ways we might address those causes. Here, we simply lay out some well-known facts about health care spending in the United States: as a portion of GDP and per capita; as it affects employees and employers; and as it affects federal and state budgets.

Today [as of 2016], the United States spends about [$3.3] trillion per year on health care, which amounts to [18] percent of GDP and about [$10,000] per person. Of course, compared with the poorer nations of the world, all of the wealthier nations spend a greater proportion of their income on health care. The United States, however, spends more on health care—both on a per capita basis and as a percentage of its GDP—than *any* other nation in the world. . . . National spending on health care as a share of GDP increased from about 5 percent in 1960 to our current level of [18] percent today and is projected to continue to grow. . . . The cumulative effect of those growth rates is this: The United States has experienced a *twenty-fold increase* in health care expenditures—a four-fold increase over the consumer price index over the same period. . . .

Of course, the rising share of health care as a portion of GDP may not necessarily be cause for concern. As mentioned above, as countries become wealthier, their citizens tend to spend more money on health care, and there is no way to determine *a priori* what the "appropriate" level of spending on health care may be. Moreover, the percentage of GDP representing health care also depends on the size and character of what happens in other sectors of the economy. Above all, the costs by themselves do not tell us anything about the quality or value of the care being provided. . . . Nevertheless, as the cost of health care rises so quickly relative to growth in GDP, it cannot fail to strain private and public budgets and to make it ever more difficult to solve or ameliorate other problems. . . .

For individuals, rising health care costs lead to increased premiums and to insurance plans that attempt to restrain *their* costs by using higher deductibles, copays, and the like. Because individuals and families in the United States tend to get their insurance through their employers, who choose and purchase coverage from an insurer, those employers are often in the middle between the insurance companies and their employees who actually use the insurance. For this reason, employers are often the parties that complain most loudly about rising costs. They also tend to look to devices for holding down costs through cost sharing and the like. In [2017] the average cost of [group] insurance (including both the part of the premium paid by the employer and the employee) was [over $6,000] per year for an individual and [over $18,000] per year for a family. . . .

Most economists argue that, despite appearances, employers are not really paying the insurance premiums of their employees. Rather, the insurance premium is simply part of the total compensation package for the employee. Because of the tax exemption for health insurance, it makes sense for an employee to take part of their compensation as (untaxed) health benefits. For most Americans, our employer picks the insurance company, chooses the plan, and sends in the check, but the employer does not bear the final cost of the insurance premiums. That comes out of whatever the total amount of compensation the employer is willing to pay to the employee. In times of rising health care costs, that means that more of the total compensation has to go to insurance and less can go to increased wages. . . . Rather than coming out of corporate profits, the increasing cost of health care has resulted in relatively flat real wages for 30 years. That is the real health care cost-wage trade-off. . . .

Increased health care costs also put a burden on federal and state governments, primarily through Medicare and Medicaid. . . . [P]ublic funds, including Medicare, Medicaid, Veterans health care, and other programs account for about 45 percent of total health spending in any given year. For the governments that pay for these programs, rising health care costs mean some hard choices: reducing benefits, restricting eligibility, cutting other public programs, raising taxes.

For the states, health care costs are already the single largest part of state budgets. . . . Not surprisingly, states have tended to respond by cutting other programs, most commonly funding for public higher education. . . . For the federal government, rising health care costs . . . could threaten to swamp the budget. . . .

III. The Problem of Health Care Quality

In light of the fact that the United States spends much more on health care than other countries, it is reasonable to ask: Are we getting good value for the money? But with respect to the question of the quality of our health care, we find significant division between, on the one hand, those who cite the technological marvels produced in America and the outcomes in the treatment of complex diseases and, on the other hand, those who look to various aggregate measures of population health and find significant defects. . . . Of course, these seemingly opposed arguments are not mutually incompatible: America could produce the world's best technologies while also failing to provide the right care in many routine instances, not to mention the problems of the uninsured. And so we ask: What do we know about the quality of American health care?

On the one hand, it is true that by many measures of population health, the United States does quite poorly: infant mortality rates are higher in the United States than in many other comparable nations, and life expectancy rates are also low compared to other industrialized nations. A study by the World Health Organization (WHO) found that the United States ranked 37th . . . behind many other industrialized nations, all of which, as we have seen, spend far less per capita on health care than the U.S. does. . . .

Yet there is controversy over these facts. Some scholars argue, for example, that the cross-national comparisons fail to take into account differences in the

underlying populations in different countries. They suggest that if we control for factors like homicide rates and car accidents—both of which are higher in the United States than in other countries—the measures of population health begin to look more similar to other nations. They also point out that rates of survival after the diagnosis of various serious ailments like cancer tend to be higher in the U.S. than elsewhere. Moreover, defenders of health care in United States point to the medical technologies and innovations developed here: The United States has produced more winners of the Nobel Prize in medicine than any other country. . . . Additionally, the U.S. spends far more of its public and private monies on biomedical research and development than does the European Union. Thus, defenders of U.S. health care argue that we cannot evaluate the level of quality of health care in the United States without keeping in mind the increased quality of the technologies used in health care.

As is often noted, Americans tend to be strongly attached to medical innovation and new medical technologies, more so than citizens of other countries. And there is a respectable body of literature which argues that the benefits of new technologies far outweigh their costs (as heavy as the latter may be). The [Harvard] economist David Cutler . . . and colleagues find that the cost of treating a heart attack has increased by some $10,000 in the 1990s, but that life expectancy after heart attack also rose by about one year. The treatment for low-birth weight infants presents a similarly positive picture. Cutler and colleagues conclude that "technological changes have proved to be worth far more than their costs."[35] . . .

Of course, . . . even the best technology cannot help very much if a particular patient does not have access to it—or does not have *timely* access. [Moreover], with respect to three different indicators—patient safety, receipt of recommended care, and variations in the intensity and outcomes of treatment—evidence suggests troublesome inadequacies in the quality of health care in America.

Patient Safety: Marked and seemingly widespread deficiencies in patient safety were the focus of the Institute of Medicine's *To Err Is Human,* a report published in 2000. According to the IOM, as many as 98,000 deaths are the result of medical error each year in the United States. That is more deaths from medical error than from motor vehicle accidents (around 45,000 deaths annually), from breast cancer (also around 45,000 deaths annually), or from AIDS (around 16,000 deaths annually). . . .

Receipt of Recommended Care: In the last few decades, professional societies along with such government agencies as the Agency for Healthcare Research and Quality have sought to develop and promulgate clinical practice guidelines and clinical pathways that stipulate the evidence-based recommendations for the most effective diagnosis and treatment of a wide range of diseases and disorders, from childhood asthma to adult hypertension. Nonetheless, [the] first national,

35. David Cutler, *Your Money or Your Life: Strong Medicine for America's Healthcare System* (New York: Oxford University Press, 2004).

41. McGlynn, Asch, Adams, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine,* vol. 328: 2635-2645, June 26, 2003.

comprehensive study on quality of care for adults in the U.S. . . . found that patients received the recommended care only 54.9 percent of the time.[41]. . . As [the author] testified before the U.S. Senate, "We spend nearly $2 trillion annually on health care and we get it right about half the time. That may be the best in the world, but I think you would agree that we can and should do better."

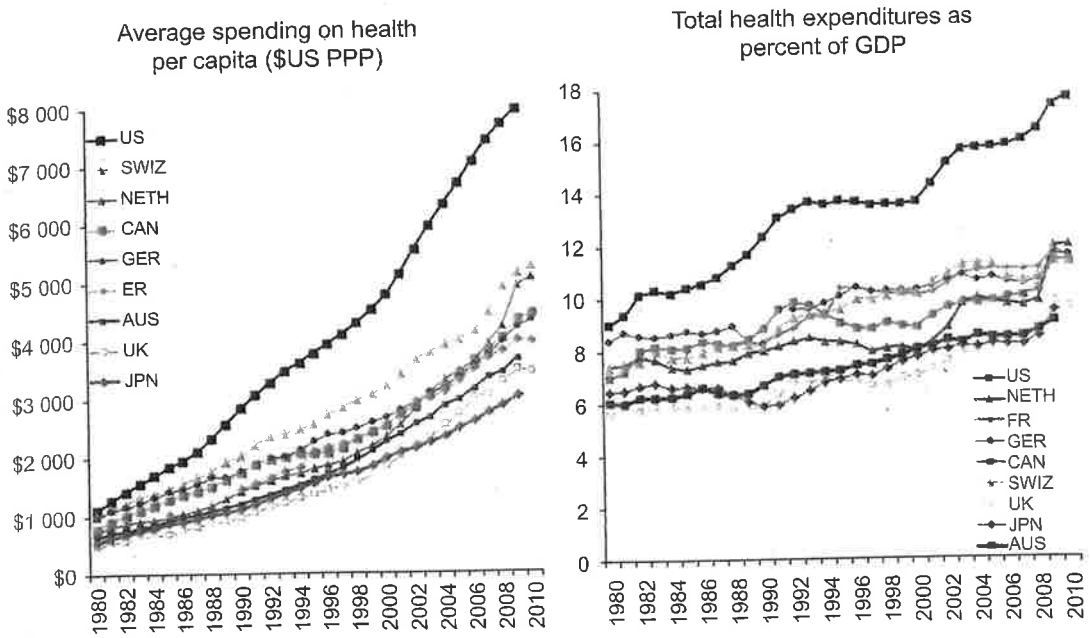
Variations in Intensity and Outcomes of Treatment: A substantial body of evidence also supports the finding of wide variations of the amount of money spent and of treatments performed between different areas of the country, but without any corresponding variations in health outcomes. In fact, the evidence seems to suggest that geographical areas that spend more actually have lower levels of quality of care. Researchers at Dartmouth led by Jack Wennberg and Elliott Fisher have shown, for example, that the amount of money spent per capita on Medicare recipients varies widely between different areas of the country, by almost as much as a threefold difference, even after controlling for differences in age, race, and sex. But, . . . the correlation with quality is low.

Many researchers have concluded that increased spending does not translate into better outcomes—in fact it may translate into worse outcomes. Wennberg and Fisher contend that much of the health care spending in Medicare, perhaps as much as 20 percent to 30 percent, does not bring added health benefits and that there may well be a similar proportion of private spending on health care that does not bring better outcomes. Economists suggest that in many cases Americans may be at the "flat of the curve," that is, at that place in a cost-benefit analysis when further resources may not only bring added benefit but may, in fact, bring less benefit. . . . Peter Orszag, director of the Congressional Budget Office, has recently written: "With health care spending currently representing 16 percent of gross domestic product (GDP), [Wennberg and Fisher's results] would suggest that nearly 5 percent of GDP—or roughly $700 billion each year—goes to health care spending that can't be shown to improve health outcomes." Of course, as Orszag observes, trying to figure out how to reduce inappropriate or unnecessary care is no easy task. . . .

Leaving aside the difficult problems of designing the right policies to make American health care more efficient, however, there is a more fundamental question about what we—as patients and as citizens—expect from modern medical technology. Do we have extravagant expectations from medical science? Are we so accustomed to having someone else pay the bill that we no longer question whether a particular intervention is worth its cost? While evaluating the cost-effectiveness of various interventions or organizing the health care system to be more cost effective will not solve all of our health care problems, it may be a necessary condition of a more sustainable system that we come to see that more is not always better.

A variety of problems—access, cost, and quality—make health care in the United States an unavoidably complicated affair, and this is not the place to elaborate specific policy proposals. But we should remember that the health care system is one in which each of us will find ourselves in various capacities at various points in our lives, and the decisions we make about the various aspects of health care reflect our identity as a nation and the type of social union we wish to create and advance. . . .

International Comparsion of Spending on Health, 1980–2010



Notes: PPP = purchasing power parity; GDP = gross domestic product.
Source: Commonweath Fund, based on OECD Health Data 2012.