



# Perspective

## Fiscal Responsibility and Health Care Reform

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It has been clear for some time that the primary hurdle to enacting health care reform is figuring out how to pay for it. Virtually all Republicans and some Democrats have been unwilling to sign on to

increasing taxes on high-income Americans as a partial answer. The idea of taxing the most generous health insurance benefits has met with resistance as well. The use of electronic health records and an emphasis on prevention and early treatment of illnesses have been ballyhooed as ways to generate savings to help pay for reform, but there is no solid evidence that these measures will reduce spending anytime soon, although they might improve care. Unfortunately, legislators are ignoring the option of funding reform by harvesting available savings from within the health care system itself. I believe Congress must go

back to the drawing board. Given the state of the economy and the continuing rapid growth in health care expenditures, lawmakers need the political will to devise a plan that will control accelerating costs and be budget-neutral — and to disregard the expected backlash from stakeholders (organized medicine, the insurance companies, the pharmaceutical industry, and the trial lawyers) and an uninformed public.

Time and again over the past century, there have been attempts to make the health care system more effective and efficient, the only real success being the passage of Medicare and Medicaid in 1965. Since then,

various stakeholders have managed to block any efforts at restructuring that have threatened their profits. When the U.S. economy faced its most severe test during the Great Depression, Social Security was enacted over vigorous opposition. The current crisis presents a similar opportunity to provide high-quality health care coverage to all Americans while bringing spending back in line. Comprehensive reform might also act as a government stimulus package, freeing up cash that consumers would otherwise be spending on medical care and thereby aiding the recovery.

Some drivers of health care costs (such as demographic changes) cannot be controlled; others (such as unhealthy lifestyles) are difficult to attack. However, great savings could be achievable in two areas: admin-

istrative costs and unnecessary care. In the current health care system, administrative costs are generally estimated to account for 15 to 25% of total expenditures<sup>1</sup>; if we settled on an estimate of 20%, that would amount to \$500 billion annually. The complexity of the present system, with multiple sources of coverage, is the main cause of such high administrative costs. Every insurance plan has different benefits with different copayments and deductibles, and many require preapprovals for various tests. The multiple interactions this complexity necessitates between physicians' offices and insurance companies — to get authorization and to haggle over payment — translate into personnel requirements (and associated costs) on both sides. Insurance companies also conduct extensive vetting of applicants for individual policies to determine whether any preexisting conditions disqualify them from coverage and what their premiums should be — an activity that, along with spending on marketing, further raises companies' overhead.

Unnecessary care is believed to be responsible for as much as 30% of health care spending,<sup>2</sup> or up to \$830 billion this year alone. This problem results largely from the perverse incentives built into the health care system, in which there is a clear conflict of interest. Physician remuneration depends on the volume of patients seen, particularly on the number and intensity of the procedures performed. The need for these services is determined by the very physicians who then arrange for or perform the procedures. This is not the way a

high-quality health care system should work. Unnecessary surgery and other invasive procedures may be ordered simply to augment physicians' incomes, the potential for adverse outcomes notwithstanding. Even if all physicians were highly ethical and ordered only tests and treatments they deemed truly important, it would take saints not to have their judgment skewed in favor of decisions that will provide them with financial rewards. Defensive medicine also generates unnecessary care, as do duplication of tests when data are unavailable and patients' demands for tests or treatments not in keeping with good medical practice.

The dollars lost to fraud are difficult to quantify but may be considerable; one estimate puts the cost at 3% of annual health care expenditures<sup>3</sup> — a conservative estimate that would translate into \$75 billion this year. Costs for the use of technology that has not been proved effective are also difficult to estimate but are believed to be substantial.

All told, then, administrative expenditures, unnecessary care, and fraud probably account for \$1 trillion or more in health care spending that does not go toward providing appropriate care. These are the areas in which the proper reform measures could generate savings that could pay for universal coverage.

To reduce administrative costs and simplify the system, I believe that a single-payer system that provides universal coverage is mandatory. Of course, this concept is anathema to free-marketeters and does not currently have much public resonance — largely because Americans

have been misled by negative advertising and denigration of the single-payer approach by politicians and others who label it “socialized medicine” and government interference in medical care. A new advertising campaign using the Internet as well as traditional media might help to educate the public about the benefits of this approach. A single-payer system could be run by a federal board that would be independent of the government, appointed by the president, and confirmed by the Senate. The board would function in a manner similar to that of the Federal Reserve, with the assistance of committees of experts and immunity to political interference. Regional health care entities operating under the board's aegis could be used for the day-to-day management of health care delivery.

To limit unnecessary care, physicians' incentives for increasing the volume of services must be curbed, breaking the link between income and the number of tests or procedures generated. To accomplish this task, a variety of mechanisms could be used — among them, capitation, global payments, a salary system for physicians, payment for episodes of care, and intensive monitoring of physicians' services — each of which has its advantages and disadvantages. The simplest approach, and the one most likely to succeed, is putting physicians on salary, as more than 30% of U.S. physicians already are. To end defensive medicine, which also contributes to unnecessary care, malpractice reform must also be a part of any health care reform package. A review of all malpractice claims by peer pan-

els should be a first step in the process to decide whether malpractice has actually occurred.

I believe that neither the government nor individual Americans would have to spend a penny more to reform health care, including provision of universal coverage,<sup>4</sup> if administrative costs and unnecessary care could be substantially reduced. Enough money is available in the current system to completely fund reform; it simply has to be redirected. Although overcoming opposition from the insurance industry, organized medicine, and other stakeholders to produce a sensible reform plan may seem impossible, the recent financial meltdown has changed the po-

litical landscape. Initiatives that were previously unthinkable might now have a chance if properly presented, particularly given the public concern about the ballooning federal deficit. But to ensure that cost constraints become the guiding principle of health care reform, Americans must comprehend the gravity of the situation and force their legislators to act accordingly. If Congress passes reform that does not tackle the problems of excessive administrative spending and unnecessary care, major revisions will be required in the future. Unfortunately, such revisions would come only after Americans had suffered additional economic pain.

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From Norwalk Hospital, Norwalk, CT.

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