EDITORIALS

How to Control Health Care Costs

Allan S. Detsky, MD, PhD^{1,2,3}

¹Institute of Health Policy Management and Evaluation, University of Toronto, Toronto, Canada; ²Department of Medicine, University of Toronto, Toronto, Canada; ³Department of Medicine, Mount Sinai Hospital, Toronto, Ontario, Canada.

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Several years ago my wife and I received a visit from a Toronto police officer at our home in the early morning hours. He came at our request because we reported that our car had been stolen during the night. I recall instinctively running out to the spot on the driveway where the car had been parked; looking down at the pavement incredulously as if it would somehow magically reappear. In fact, this was our second car theft (both Acuras), the first one occurring a few years earlier.

At the end of our encounter, I asked the police officer the following question: “With so many cars being stolen in Canada, why don’t car manufacturers, insurance companies, or law enforcement agencies take action?” He answered in the following manner. “Think of all of the people who will be affected by the theft of your car today. Someone (likely in a foreign country) will be driving your two-year old blue Acura. Someone will be paid for stealing and delivering that Acura to the new “owner”. A car manufacturer and dealer will sell you a new car. You will soon be driving a new car (we switched to Saab). Your insurance company will pass on the cost to millions of people (diluting the rise in your insurance cost), thus increasing its revenue. Even the government will be happy with the sales tax it receives when you purchase your new car. And I get to drink coffee with you nice people in your living room this morning. If you think about it, there is no one on that list who is not made better off.” This vignette nicely captures situations where no individuals face disincentives in a chain of events that collectively leads to harm. It can be used to describe the predicament that the U.S. healthcare system faces today.

Traditional economic markets allocate goods and services according to market forces that reflect the preferences and incomes of consumers, and cost of labour and capital and technological possibilities facing producers. Markets use prices to connect supply with demand, allocating capital, labour, and goods and services in a way that maximizes overall community “welfare”. In some cases, like communication devices, computers, and televisions, these markets

work to improve the overall quality and reduce costs over time. In other cases, like airline transportation, cost issues predominate while quality suffers (Google “United Breaks Guitars”).

But the market for healthcare is different.¹ First, insurance and public subsidies have separated consumers from the true price of health care at the point of service delivery. Second, there is an asymmetry of information between healthcare professionals and consumers. Third, there is more at stake. I can always replace my car but can’t replace my health. Finally, society has deemed that healthcare is a merit good, one that all individuals have a right to consume regardless of their income or wealth.

The net result of these market distortions is similar to the policeman’s description of the chain of people who were affected by the theft of my car. People perceive that they are made better off by consuming ever-more healthcare services. But overall, society is made worse off by consuming more health care, and less of other goods and services, than it really wants.² The U.S. healthcare market has no friction, no blow back, no speed bumps on the road to ever expanding consumption.

There are three obvious ways to control healthcare costs. The first would be to curb consumption by “outlawing” health insurance (or at least not encourage its purchase via the use of tax subsidies³) so individuals face the full costs at the point of healthcare delivery. Countries with less developed economies where the market for health insurance has not evolved contain costs in this manner. A variation of this concept is catastrophic insurance where individuals have very high deductibles, forcing them to face the full cost of health care services up to a high maximum amount, but retain coverage for exceptionally large healthcare expenses. The rationale behind this approach is that it achieves equity with respect to payment for serious, expensive illnesses while inducing consumer discipline in cases of lower, more common expenditures. Catastrophic insurance has been proposed several times over the past 50 years under various guises.⁴

The second approach is to simulate market forces that induce consumer discipline with substitute incentives or friction. Managed care uses third party decision makers for approval prior to utilization. Another approach attempts to mimic the way prices reflect consumer preferences for specific services by having insurers pay more for the same

service in cases where benefit and need are higher (e.g. pay a higher price for angioplasty and stent placement in the setting of acute myocardial infarction than for a patient with stable angina).⁵ This approach, which is sometimes called “value-based payment”, attempts to simulate the way most markets work whereby consumers who are willing to pay more for a specific good or service bid up its price (think house purchases). However, just as managed care uses third parties to give prior approval, value based pricing is done by proxy; consumers’ preferences are replaced by third party evaluation.

The third approach is global budgets with top-down overall constraints on healthcare expenditures. This requires a system of government that identifies who is responsible for healthcare and enables that entity to execute this strategy. Global budgets are often coupled with bilateral monopolies whereby a single purchaser (e.g. government) negotiates prices with single organizational structures like physicians’ associations or hospitals. Most of the developed world uses some variation of this strategy while perhaps allowing a secondary private market to flourish for those who choose to pay for “extra” care. While many of the countries who use this approach, including my own (Canada), complain that health care spending is too high, all have a substantially lower percent of gross domestic product devoted to health care and per capita spending than the US. But the way they measure value is often political. For example, in Canada provincial governments, who hold jurisdiction over health care are almost certain to lose elections if they are perceived to do a poor job delivering it.

In this issue of *JGIM*, Marmor and Oberlander argue that the United States is a major exception to the practice of using global health care budgets to control costs.⁶ They state that “American policymakers and analysts have embraced an ever-changing array of panaceas to control costs including managed care, consumer-directed healthcare, and most recently delivery-system reform” with a series of names that largely reflect wishful thinking like health maintenance organisations (HMOs). For the most part all of these attempts at simulating market forces have failed to contain costs. They predict that the latest fad, accountable care organisations (ACOs), will suffer a similar fate.

I would agree with most of their commentary with the exception of the following sentence. “Belief in “American exceptionalism”—that as a nation we are too different culturally, socially, and politically to learn from other countries—has reinforced America’s tendency to look inward for solutions to control healthcare spending.”

America is exceptional politically, though perhaps not socially or culturally. What makes it exceptional is its system of government which is specifically designed to prevent action such as global budgeting or monopolistic purchasing.⁷ While this may be an overstatement, my evidence is the following: the United States of America has not pursued the easiest and most obvious way to control

healthcare costs despite widespread public support for containment of the sector and many examples around the world where this mechanism has worked (sort of). I believe that Americans need to “raise the white flag” and admit they simply cannot contain healthcare costs. Instead they need to adopt a strategy of “chronic disease management”.

Still, ACOs are a good idea. Even their name, which Marmor and Oberlander might characterize as wishful thinking, is a good idea because it sets the objectives explicitly. Accountability is important. In my clinical world I notice that people feel responsible for what happens on their watch. Physicians who care for patients for eight hours primarily care about what happens for those eight hours and less so for the time thereafter. Physicians who cover a service for a month have longer time horizons. ACOs will lengthen the time horizon for healthcare organizations, especially when combined with the provision of the Affordable Care Act that forbids de-insuring people. ACOs will also broaden the work force used to provide care thus inducing different behaviours aimed at achieving long-term health gains. The word “care” is important, as it is defined as “to be concerned or interested” and “attentive assistance or treatment to those in need” thereby clearly defining the relationship between the ACO and its enrollees. Finally, the word “organization” is important because as anyone knows, current healthcare is anything but organized. ACOs have the potential to improve quality by increasing coordination and matching the right discipline to the right patient.

Therefore, I applaud the people who developed the concept of ACOs, and do so even louder for those who are attempting the daunting task of implementation. At the same time, and you didn’t hear it from me first, ACOs will not control or contain healthcare costs. They are nevertheless a good idea.

Corresponding Author: Allan S. Detsky, MD, PhD; Department of Medicine, Mount Sinai Hospital, Room 429, 600 University Ave., Toronto, Ontario, Canada M5G 1X5 (e-mail: adetsky@mtsinai.on.ca).

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