Lecture 11.2: The Healthcare System April 16

I: Health care and Reform

1. Stage I: Physician as professional and small business: fee for service
2. Stage II: Third party reimbursement
   - Physician is manager of the healthcare service
   - Reimbursed by indemnity insurance coverage and employers
   - the government steps in with Medicare (1964)
     - the nation's single largest source of payment: 40 million covered
     - "an interim step toward universal medical coverage" (the next step never taken)
   - pre-payment and DRGs (c. 1988?)

   Problems: not everyone HAD health insurance: still an access problem
   health care costs continued to rise: 13% of GNP.

3. In 1993 the new president proposed a reform of h/c: the Health Care Security Bill. Attempt to create a system out of our patchwork: the 4th such attempt in that century. Promise: equity, access and cost containment. Model:
   - Employer mandate
   - health alliances regionally dividing the country
   - managed care organizations/ managed competition mediating care
   - provision of a basic minimum of coverage; maximum of co-pay; but allowing two-tiered system
   - central administration, reducing overhead (but not "single payer")

Clinton's reform failed without even being brought before the Congress.
   - Physician resistance
   - insurance lobby
   - suspicion of government
   - residual cold-war fears of "socialized medicine"

4. Stage III: Managed care

H/c is the 7th largest "industry" in America. But:
   - . not run according to "industry" standards of efficiency
   - . no set amount for health care, so no control over expense to society

How it works: MCOs serve as
   - . intermediaries between payers (employers and gov) and providers
   - . source of income for individual and organizational providers
   - . focused on populations ('covered lives')—not individuals
   - . payers as proxies for individual patients in choosing health plans

The promise: "I'll do it cheaper!" How?
   - . reduce the physician's scope of decision
   - . expand the responsibility of the "health team"
   - . decide among tx options on the basis of c/b outcomes
   - . grade providers and channel patients toward quality
   - . provide incentives to your providers to reduce costs
     - --capitation and risk shifting
     - --limit referrals to specialists

--utilization reviews
--denial of [payment for] services
--pre-approval by plan for expensive treatments

If the cost constraint works—the money saved goes—not to cover the uninsured, as suggested in the Clinton plan—but to the shareholders; for the new MCO is a for-profit, publicly traded company.

II: Managed Care and the Market Model

The promise/objective of managed care: to deliver cost-efficient and high quality care.

But what counts as quality, and who determines it?

Market in commodities: the customer—eg, for ball bearings-- balances cost and quality.

I know what I want; I check out what the product costs; I weigh my priorities for cost and quality, and choose between high quality and low cost.

The customer is the person who pays for the product—and uses it.

To improve quality: the producer can

--improve the process of production, via standardization, reducing waste, efficiency

--improve the quality of the raw material

--buy only from the best suppliers, with strict quality control

--consolidate and render more efficient the production units

The result is a better product for the same cost, or the same product for lower cost;

and the difference between cost and price is PROFIT.

Market medicine: the MCO is the producer-analogue of the product of health care. The providers occupy the role of suppliers. Often the care is provided by the physician; but many of the decisions associated with the care are no longer the prerogative of the physician alone.

MCO strategies: to eliminate waste and redundancy in the h/c delivery system:

Consolidate services
eliminate excess capacity and duplicated services
introduce standards to control variation in the "product"

- protocols for specific diagnoses
- formularies (specifying what drugs may be prescribed)
- increasing the "productivity" (= no. of pts in phn's case load)
- buying up hospitals and closing the ones which duplicate services
- replacing/eliminating "suppliers" that don't meet efficiency
    - standards

Problems: A: some practical problems:

Medical outcomes are hard to quantify; medicine is as much an art as a science. There are a lot of variables besides the "diagnosis" that determine the outcome. Protocols, practice guidelines and obligatory plans of care may yield different results across specialty areas, combinatory diagnoses, and across individual cases.

B: some theoretical problems:

In traditional businesses it is the customer who is the final arbiter of the quality of the product; and **the customer is identical with the consumer.**

But: the MCO purports to serve two sets of customers: the **payer,** and the recipient of care, the **enrollee** in the managed care plan. These are different stakeholders, and they may have—DO have—different expectations to which the product must conform.

So who is the real customer?

The payer mediates the expectations of the enrollees to the MCO; any expectations which the enrollee has which are not passed on by the payer to the producer aren't gonna be met.

Additional problem: the enrollee per se isn't the recipient of care; it's that subset of the enrollee population that actually gets sick during the period covered by the managed care contract. If the **enrollee is well**, his priority may well be cost. If he **gets ill,** his priority is the amount and adequacy of care.

Who is the physician's customer? Let's accept that it is the payer who is the MCO's customer; it is on the payer's behalf that the MCO has undertaken to constrain costs. But surely the patient is the physician's customer? But: the MCO pays; therefore the MCO is the physician's customer.

What is the role of the patient, if the patient isn't anybody's customer? The patient is the raw material analogue in the health care process, turned from ill-patient to well-patient by the operations of the providers.

—and you can always control for quality on raw material too, by eliminating from the people you cover anyone who might be expensive. Exclude people with pre-existing health conditions. Do your best to insure only young healthy people with long life-expectancies.

Result: = 48 million uninsured, plus many more who are under-insured.

Additional theoretical problem: the health of a population – the covered lives-- (not of individuals) is now the objective of the h/c system.

"**dehippocritization**." The physician, less and less in the position of the entrepreneur with complete control over the conditions of his practice, is in the functional analogue of the worker on Ford's production line, turning the raw material of the ill patient into a well patient. (And indeed, if we take Kaiser seriously, the closer we get to this model, in this country—the better the healthcare is. After all—it was the good example of Kaiser that led us to think about HMOs as a good model in the first place.)

III: So that is our current state of play.

Health care costs continue to rise as a percentage of GDP Compared to other developed nations (and indeed, some developing nations) the indications of health status remain unsatisfactory compared to other nations, most of whom spend less on health care than we do.

While employer-based health insurance remains the major source of reimbursement for health care services, major employers are retrenching on health benefits.

Government reimbursements for medicare and Medicaid are reduced every year. The number of uninsured remains high, leading to overutilization of emergency rooms.

Once again we face the question of whether to reform our h/c system, and if so, how to do it. The remainder of this year (and heaven knows how much of the next few years) will be occupied with another national discussion on health care reform, in which the question of universal health care is going to resurface.

What a decent society desires is excellent and equitable health care. We spend something like twice as much as our nearest competitor in cost, and our advances in medical science are justly renown. But in quality, distribution and outcomes, not so hot.

Our last attempt to change our system didn't work out so hot. Will we do any better this time?