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Michigan COMMENTARY

Toward True Cost Containment and Beyond

by Gerald A. Faverman and Peter Pratt

In a *Commentary* published in December we outlined what we believe Governor John Engler's health policy agenda is likely to include. As we wait for the first actions of the new administration, we want to look at the bigger picture. The observations we offer are not partisan, but we acknowledge that there will be winners and losers. Our hope is that one of the winners will be society.

THE FAILURE OF COST CONTAINMENT

Everyone agrees that our health care system cannot continue much longer on its present track. The system is failing in part because our cost containment efforts are failing. What passes for cost containment in our multipayer system is in most cases cost shifting. The goal of any health care purchaser is to limit expenses, not to the system as a whole but to his/her company. The purchaser does not answer to the system as a whole. Health care providers who are not paid adequately by some purchasers pad their bills to those who will pay adequately. This creates a fundamental deceitfulness in health care to which virtually all participants are a party and prevents honest scrutiny of how best to contain costs **for the system.**

There is another important reason for the failure of cost containment: Most efforts are misguided. The overwhelming majority of cost containment measures undertaken by insurers, businesses, and other payers are attempts to limit health care use by the worried well. Employee cost sharing and utilization review are the primary strategies here. The worried well, however, consume only a small portion of our health care bill—the 70 percent of persons who expend the fewest health care dollars account for just 10 percent of our health care expenses. The 5 percent of persons who use the most health care dollars are responsible for 55 percent of the total health care bill. Few of our cost containment efforts are directed at these, the very sick among us. As long as we are unwilling to curb health expenditures where they are highest, we will never have true cost containment.

TRUE COST CONTAINMENT

As a social good, health care ranks high, but we cannot allow health care to continue to consume a larger and larger share of the gross national product. Education, housing, the environment, and our crumbling infrastructure all compete for the dwindling resources that health care leaves to them.

We have to decide on a level beyond which we will not allow health care spending to rise. For example, we could allow health care costs to rise at a rate that is less than the rate of inflation. This would mean that no one will receive less than the year before, and costs will come under control.

This can be accomplished with a universal health budget under which the entire system receives so much and nothing more. Such budgets have led to true cost containment in West Germany and Canada. This was achieved without nationalizing the hospitals and making physicians employees of the government.

As noted health care historian Paul Starr points out, universal health budgets actually permit less government regulation. Once governments are able to ensure that expenditures remain under a ceiling, they are less driven to intervene in specific health care decisions. In the United States, however, payers' failed cost containment efforts have engendered more and more regulation. Starr concludes, "We have ended up, amazingly, with less equity, less efficiency, and less autonomy for private decision makers."

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BEYOND COST CONTAINMENT

Obviously, we cannot look at health care costs in isolation from the delivery of care and the health of the population. Unfortunately, this is exactly the direction in which our health care system is moving, toward one in which, increasingly, the most expensive procedures benefit few of the population. Still, setting a limit on health care costs will create havoc unless we are willing to make fundamental changes in the way we look at health and deliver care.

Our medical liability system must be reformed. The aims of our current medical malpractice system are (a) to punish negligence so that the health professions are self-correcting; (b) compensate victims of negligence for their losses; and (c) pay victims for noneconomic damages (pain and suffering). There must be a meaningful cap on noneconomic damages if we are ever to bring the costs of the liability system under control. There are better ways to discipline negligent practitioners than forcing all practitioners to pay high malpractice premiums. We must see the enormous costs associated with medical malpractice as money that could be diverted to caring for the poor and needy. If high malpractice awards force a hospital to close, who benefits?

We must invest our health care dollars where they will do the most good. Keeping people alive when they have no hope of maintaining any quality of life is to deny care to others who may benefit greatly from it. We have done a wonderful job convincing ourselves that health is defined as living forever, and our health care system mirrors this unattainable goal. Our health care system must be changed so that rather than allowing some of us to live too long in ill health, more of us live healthier, fuller lives. More of our resources must be devoted to keeping people healthy rather than waiting for them to get sick. Health promotion and disease prevention must be at the forefront of our new health care. Prenatal and postnatal care, well baby and child care, nutrition, physical fitness, smoking cessation, substance abuse prevention and treatment—these disciplines have resided on the outskirts of mainstream medical care for far too long. They must become part of the core.

This is only fitting, as personal behavior has come to be seen as the central determinant of one's health in the late twentieth century. What you eat, drink, and smoke and how much you exercise play a much greater role in the length and quality of your life than the medical care you receive should you become ill. Medical care cannot undo a lifetime of bad habits. Our health care system should be more responsive to this central truth. It should focus more on helping us undertake and maintain healthy behaviors. Traditional acute care medicine must join with public health and behavioral medicine if it is to meet the true health needs of the majority of our population.

As we become more and more aware of the true determinants of our health, we may, in time, ask less than immortality of our health system. Taking more responsibility for our own health may be the first step in breaking our culture's addiction to our overly expensive acute health care system.