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The United States Healthcare System: The Most is Not Necessarily the Best

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The United States (US) healthcare agenda is the major domestic debate of President Obama's presidency. He had made revamping of the US' pluralistic medical delivery system a cornerstone of his campaign and at his inauguration he prompted both the House of Representatives and the Senate to design legislation to fix it by focusing simultaneously on its deficiencies in access, its high cost and its less than optimal quality.

And well he should. By consensus it is a mess. Celebrated for its innovations with respect to the adoption of technology and the high standards it meets with regard to the training of health professionals, American healthcare is a mosaic of initiatives and regulations tied predominantly to private practitioners and non-governmental reimbursers (save for Medicare for the aged and Medicaid for the poor). It excludes nearly one sixth of the population who lack insurance or are not eligible for public assistance. Moreover, it consumes one sixth of the economy and nearly every year its share of all expenditures rises faster than the rate of inflation.

Expense Versus Results

It is by far the most expensive system in the world, about 50% higher in percentage of GNP than in most other developed countries. And by nearly every quality index, American healthcare lags behind the current experience of other nations comparable in wealth. The US has a lower life expectancy for both men and women than Japan and most of Western Europe, and a higher infant mortality rate, too. Much of the added costs go to meet the anticipated rewards sought by stockholders of private insurance companies and to meet the expectations of procedurally-oriented medical specialists whose compensation depends on the volume of work they recommend and generate. Incidentally, on average, the incomes of American orthopedists, gastroenterologists, cardiologists and radiologists are higher than their counterparts in most other nations and the rate of increase in earnings of these physicians is advancing faster still than the annual growth in healthcare expenditures.

Picture 1. Vice President Joe Biden speaks to seniors during a healthcare town hall meeting at Leisure World in Silver Springs, Maryland, Wednesday, September 23, 2009. Also in attendance were Secretary of Health and Human Services Kathleen Sebelius, and Director of the White House Office of Health Reform Nancy Ann De Parle.
(Official White House Photo by David Lienemann)

At this juncture, a comprehensive health bill is still under debate. A plan to offer a public health insurance option to compete with private insurance in order to enroll those presently uninsured was initially a minor component of a sweeping array of proposals. But it has galvanised opinion not only among legislators but also in the populace itself, engendering sometimes ugly demonstrations mixing fact and fantasy about the

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implications of the “public option”. This issue goes to the heart of the ongoing tension about what and how a country with a legacy of self-reliance and rugged individualism (which served it well as it developed a largely virginal continent) now has to come to terms with the postindustrial obligations of a state committed to equality not only of opportunity but also of obligation which is a hallmark of a mature polity.

Political Battle Lines are Drawn

So the Democrats favour enhancing access while the Republicans by and large object to any innovation that limits choice and adds cost. Any compromise legislation that accommodates itself to a resolution of these competing claims might represent a victory for Obama’s desire to make social change. Yet it will fail, nonetheless, because the matter of quality will not be addressed in a meaningful way. That is because the various legislative initiatives fail to relate to the fact that utilisation is controlled by doctors. Their impetus to do more outflanks the insurance companies objective to reimburse less.

The incorporation into practice of truly outstanding advances in techniques, procedures and pharmaceuticals is enticing and is an attraction in itself. And it is made more compelling as a generator of activity by the specter of malpractice risk. These two factors operate in concert. Technologic improvements have caused a sea change in medical education. Now the older techniques of the art of medicine including history and physical exam have been bypassed in favour of the objective measures afforded by imaging tests among other innovations. And the notion that failing to obtain such tests constitutes a susceptibility to an eventual malpractice suit has established defensive medicine as a protective sensibility. It is perceived as a means of insulating the doctor from the threat of an assertion of incompetence using tort action to besmirch a reputation, increase cost and heighten anxiety. The looming presence of malpractice considerations and the behaviour of physicians it promotes have aligned patients and doctors together against the political allies of plaintiff lawyers. Many of whom are prominent Democrats, who fret about changing a system which would lessen the contributions to their re-election campaigns from their plaintiff lawyer benefactors.

Defensive Medicine Hikes up Costs

It is reckoned that the costs of care engendered by defensive medicine may approach a trillion dollars. But the costs to physicians of defensive medicine no way counterbalance the benefits they receive because they are paid by the “piece work” they do. The cost of all judgments per annum of settlements both out of court and court verdicts nationally per annum for all physicians is only four billion dollars and the total cost of their collective malpractice premium is less than 50 billion dollars each year.

Convenient misconceptions about malpractice serve to legitimate defensive medicine. Yet they are not borne out by the facts. Among all physicians less than one third will ever be sued. And less than one third when sued will eventually lose the case. Among radiologists many, many more will be sued for a complication or a misdiagnosis of a test or procedure that was not indicated clinically than for not doing a test that was indicated. And the leading cause of malpractice suits for all specialists, not just radiologists, is a failure to diagnose breast cancer in a woman under fifty years of age, a group for which the limitations of mammography are well known among physicians but not generally appreciated by patients.

Conclusions

Thus healthcare in the US will continue to be expensive and wasteful, remaining as an aberrant manifestation of a social policy of misdirected aims and assumptions until quality incentives are redesigned in a meaningful way to serve common rather than selective interests. That will require uncoupling physician incentives from utilisation at the very least. However, if doctors and the public continue to operate according to the “pathophysiology of malpractice”, do not expect any fundamental improvement in cost and quality until the first term of the next president and even then one should not be too optimistic.

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