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The Predicament of American Health Care

Harvey Fineberg

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The predicament of American health care today is a concern for virtually every citizen in this country. When we think about American health care, as a matter of perspective, it may be useful to remember where we've come from. At the beginning of the twentieth century, life expectancy at birth in the United States was only about forty-eight years. Infant mortality (deaths among newborns before the age of one) was greater than one hundred per one thousand live births. From 1900 to the year 2000, life expectancy increased by more than 50 percent (greater than seventy-five years), and infant mortality in the United States declined by an order of magnitude, to less than ten. Heart disease, which is the major killer, has actually diminished by half in

its age-specific mortality since the 1950s. As a cause of death, stroke similarly decreased by more than 50 percent in that period of time. If you think about the broad sweep of progress and the outcomes of health in the United States over the twentieth century, it is historically unprecedented, dramatic, and stunning. Never before in human history had anything like that improvement in population health been achieved.

Thinking about our current health-care system, how many of you would say that you are very satisfied or somewhat satisfied with the health-care system of the United States? It looks like about 20 percent. How many would say that you're somewhat unsatisfied or very unsatisfied with the health-care system of the United States? That looks like about 80 percent. Now, particularly for those of you who are unsatisfied, what is it about our health system that makes you unsatisfied?

What things stand out as something you'd say is a problem with our health care today? The lack of health insurance for all Americans, the high cost of services that are sometimes of poor quality, disparities in care, and lack of emphasis on preventive medicine are key components of the predicament of health care in America today.

In 2003, there were 46.5 million Americans without health insurance, and the number is increasing. This figure, keep in mind, is not a reflection of the number of people who in the course of a year may go without health insurance; it reflects the number who lack health insurance for the *entire* year. If we take into account the number of people who at any one time do not have health insurance because of changing jobs, or graduating from school, and so on, that number would about double.

People today are rightly concerned about the rising cost of health care and of prescription drugs. Right now in the United States we're spending more than a trillion and a half dollars a year for health care. We in the United States spend more money on health care than the poorest half of the world spends for everything. Right now, about one in every seven dollars in the economy goes to health care, and it seems like there's no end in sight. So we have a big problem with cost.

But why is cost a problem? Why do we care about the cost of health care relative to what people spend for travel or binoculars? So what if we spend a trillion and a half dollars a year on keeping well. Recently, we had a very interesting debate about the cost of health care at the annual meeting of the Institute of Medicine. One argument put forward was that cost *per se* is not a problem; another was

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that cost is a real and growing problem. What is it about the expenditures that is causing so much concern? Part of the problem of cost is affordability. But you could argue that distribution of cost is mainly an exchange problem, a task of moving resources to where they are needed. One concern about costs is that consumers don't really have a choice. If you have a serious illness, you go to the hospital, whether you like it or not, or else you may die. Collectively we are demanding care that is technologically more sophisticated and that from the provider's point of view is increasingly complex and costly to provide.

One concern is the expectation and pressure to keep people alive at all costs. The problem of the end stage of disease, its cost and human burden, raises profound questions of profes-

sional ethics and individual choice. From the vantage point of cost, approximately one quarter of the total Medicare expenditures are in the last year of life.

Interestingly, malpractice probably does *not* play a big part in increasing health-care costs, although it is a significant burden on doctors and contributes to declining professional morale and loss of practitioners, particularly in selected geographic and specialty areas. Malpractice deserves notice as a problem, but not as a cost driver.

Compared to other economically developed countries, the United States spends much more on health care. For example, compared to Germany and Switzerland, we spend 50 percent more per capita in dollar equivalent purchasing power. We spend twice as much per capita as Sweden and more than twice as much per capita as the United Kingdom. The question then is what are these expenditures buying us? What's our life expectancy compared to other countries in the world? Answer: not in the top ten. What's our infant mortality compared to other countries in the world? Answer: not in the top twenty. What are we doing in terms of quality of care as judged by people getting the care? In this audience, about 80 percent of the people said they're somewhat dissatisfied or very dissatisfied with our health-care system. In a number of other countries, including Canada and parts of western Europe, there's a lot of dissatisfaction, but it's not as high as in the United States. Interestingly, if you ask people the question a little bit differently, if you ask are you satisfied with your personal physician, a much higher proportion of Americans will say, yes.

Part of the cost driver is that what we expend when we go to buy health care is often not our own dollars. Those of us with insurance that offers first dollar coverage are spending the money of everyone who is part of our insurance group. The health-care market is far from an economically functional market with informed consumers, competition, and free choice. In a market that works, the person who makes the decision to buy, the person who receives the product and experiences the good or the bad, and the person who pays for that product is the same person. You decide, for example, that you're going to go to the market and buy some grapes; you pick out the bunch, you pay with your money, and you eat them. By contrast, in health care, it is often the professional who decides what you

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do most of the time. It is the doctor who decides on the treatment and orders the tests. It is the insurer who pays. It is you the patient who gets whatever degree of satisfaction from the experience. But you have less than full control over the basic decisions that produced those results.

Health care today in the United States is very costly, and relative to what many other countries seem to be buying for their expenditures, we seem to be buying less for ours. On average, we don't have the quality of care and the outcomes that we should. At its best, U.S. health care compares favorably with any in the world, but on average, we have some serious deficiencies.

Five years ago, the Institute of Medicine published its landmark report on errors in health care: *To Err Is Human*. The report estimated that every year in the United States tens of thousands of people die in hospitals because of medical errors. Other studies examining the problem also found shortcomings in quality. For example, in 2003, a report published in the *New England Journal of Medicine*, by Beth McGlynn and her colleagues at the RAND Corporation, looked at the care received by thousands of people in thirty different communities around the country. They considered a number of specific medical conditions where there are specific guidelines about how patients should be treated. These include testing for diabetes, measurement and control of high blood pressure, and treatment of people with heart attacks, among others. The general conclusion across the board was if you are a patient in the United States today with one of these conditions and you go to your doctor in one of these communities, on average, you have about a fifty-fifty chance of getting the care that is indicated for your condition. Overall, 46 percent of the people in that study did not receive the recommended standard of care.

In some cases, failure to meet the standards of care can mean the difference between life and death. For example, it is well established that most persons who have myocardial infarctions should be treated with a kind of agent called a beta-blocker, which slows the nerve impulses and reduces the work burden on the heart. Clinical studies have demonstrated repeatedly that this is a life-saving intervention. The McGlynn study found that

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beta-blockers were prescribed for fewer than 60 percent of people recovering from a heart attack. I have a theory about why beta-blockers are underprescribed: they are simply too cheap; they cost pennies per dose, and nobody has a reason to promote them. If they were the “purple pill,” I can assure you that we would be demanding beta-blockers. But it is up to the doctor to prescribe them, and physicians are not doing it often enough. The situation is similar for diabetes: people have about a fifty-fifty chance of receiving basic tests indicated for the care of persons with diabetes.

The United States has a triple problem: we are spending a lot of money, our quality is substandard, and we have 46.5 million people without health insurance. That number of uninsured has a cost impact on the health-care system because those people do not stay completely out of the system. They delay care, but when they get seriously ill, the cost of caring for them is higher than if they had received preventive or earlier therapeutic care.

Another dimension of the quality problem is to improve training at every level in the medical profession. We are not doing a good job in sufficiently educating for quality, which has a number of dimensions beyond the mastery of a current body of knowledge. It requires educating people who have a lifetime capacity for learning.

We also need to place more emphasis on training across the professions because the treatment of people with chronic diseases often requires a team. Caregivers must be able to respond to the needs of patients with chronic illnesses – 100 million plus people in the United States, with the number increasing as the population ages.

On a positive note, there is a very encouraging degree of experimentation now going on in medical education, particularly in terms of improving the clinical elements of training. The difficulties here are in part the changes in the nature of practice, as patients on average spend much less time in the hospital than they ever did before. Hospital-based training, then, is not the sufficient model that it previously was for clinical education. And there is a lot of room for improvement. As part of what we call the “quality chasm series” in the Institute of Medicine, we are working on a whole array of related elements of quality improvement, and education is a big part of it. A year ago we brought together leaders from different professional schools (pharmacy, nursing, social service, and medicine) for a summit meeting on education for quality.

Many other countries face shortfalls in quality of care, as measured against the kinds of standards that I have been discussing. In Australia, for example, a study that replicated an assessment in U.S. hospitals found similar levels of error and similar problems. The United Kingdom is also dealing with the challenge of reducing errors and improving quality. Its National Health Service has made a commitment to put an automated record system into every general practitioner’s office within the next two years. General practitioners will be linked to a database system for their patients and their prescriptions, with automatic checks of the side effects and the incompatibilities of different medications that a patient is taking. In the United States, incorrect medication is still the most frequent source of error, though individual hospitals and care groups have model systems in place.

Some countries are working more aggressively than we are at the present time in acknowledging the problems of health-care quality and taking steps to solve the problems. The current administration has championed automating health-care records. The questions are what is the best mechanism and what resources are needed to accomplish this.

The mix of uninsured patients, high cost, quality that’s less than our patients deserve, disparities in care, and underinvestment in prevention represents the ingredients of the American dilemma in health care. Looking at the three at the top – insurance, cost, and quality – you cannot solve one without solving them all. We need a comprehensive approach that looks at all three together. There is an ambivalence in this country about whether health is a social good or a market good, and from that philosophical difference follows many other distinctions. We need leadership with a political will and skill to bridge those philosophies, to find common ground for solutions. From the Right we need acceptance that the idea of universal coverage is necessary and required as a society. From the Left, we need a recognition that there are individual responsibility and income-related burdens of care that will affect decisions about utilization.

The health predicament in America will not be resolved quickly or easily. However, unless we commit as a nation to making progress on its several dimensions, we will never work our way out of the predicament. ■

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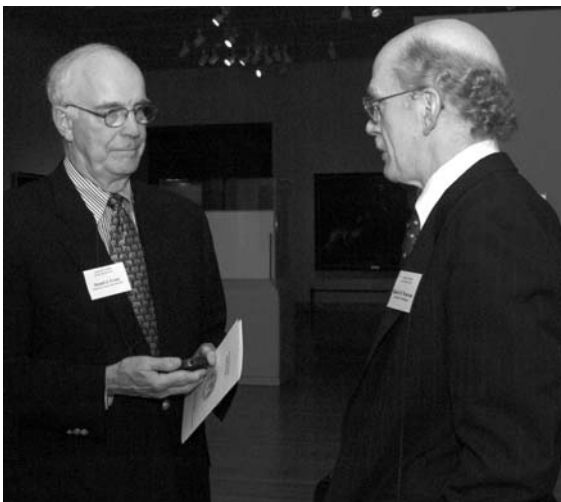
Harvey Fineberg speaking on American health care.



Patricia Gill, Gordon N. Gill, co-chair of the Western Center (University of California, San Diego), and John R. Hogness, former Vice President of the Western Center (University of Washington), who was honored for his service to the Academy and for his long and distinguished career in medicine and higher education.



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