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**David Dranove: Code Red**

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## + INTRODUCTION +

*Our health-care system is the envy of the world because we believe in making sure that the decisions are made by doctors and patients, not by officials in the nation's capital.*

—PRESIDENT GEORGE W. BUSH, 2004.<sup>1</sup>

*Let's face it—if we were to start from scratch, none of us, from dyed-in-the-wool liberals to rock-solid conservatives, would fashion the kind of health care system America has inherited. So why should we carry the problems of this system into the future?*

—SENATOR HILLARY CLINTON, 2004<sup>2</sup>

ENVY OF THE WORLD or not, no one seriously believes that the U.S. healthcare system has fully achieved the three main goals that any nation aspires to: access, efficiency and quality. For the better part of the past one hundred years, the story of healthcare reform has been one of trying to achieve these goals. For all of our efforts, they remain as elusive as ever.

For much of the twentieth century, quality and efficiency took a back seat to access. Private sector health insurance in the United States began in fits and starts prior to the 1930s, expanded to cover 10 million Americans by the start of World War II, and then took off in the 1950s. Despite several failed efforts to enact national health insurance, the federal government played largely a secondary role in promoting access during this time. While the federal government dragged its feet, states and local governments created a modest safety net for those who could least afford to pay for their own care.

In 1965, Congress finally enacted two major health insurance programs: Medicare, which insures nearly all elderly and disabled Americans, and Medicaid, which covers the medically indigent. These programs expanded access to tens of millions of Americans while contributing to rising costs. Since the 1970s, public and private payers have focused less on access and more on cost containment. By the end of the 1990s, it looked like the cost problem had been licked (or at least mitigated) by managed care, but patients and providers rebelled. In 1999 and 2000, the Institutes of Medicine released two studies warning about problems with healthcare quality.

In the early days of the twenty-first century, we are still troubled by the same problems of access, quality, and efficiency. Despite the best of intentions, about forty-seven million Americans lacked health insurance at some time in the past year. After a brief respite in the 1990s, costs have resumed their relentless climb. And while we are healthier than ever, we have become more aware of unacceptable discrepancies in the quality of care. The \$2 trillion American healthcare system is in critical condition.

Like any patient in critical condition, the first step to finding a cure is proper diagnosis. This is what the first half of the book is all about. Beginning with the landmark 1932 report of the Committee on the Costs of Medical Care, I describe how researchers have identified myriad systemic problems with the healthcare system and their root causes. I will also describe the many attempts at cures; there is much we can learn from our past mistakes (and occasional successes.) In the second half of the book, I will talk about ongoing efforts to revive the system. In the final chapter, I offer some suggestions of my own.

## ***Directions for Change***

Unlike many other books about healthcare reform, I will not offer any sweeping proposals for universal coverage. This is not for lack of ideas. For the better part of the past century, policy analysts from across the political spectrum have presented comprehensive proposals, ranging from a market-based initiative offered by the conservative Heritage Foundation to a single-payer initiative offered by the liberal Physicians for Responsible National Health Insurance. There are many complex reasons why these proposals have failed to achieve the consensus required to become law. Perhaps the most compelling is offered by the late Columbia University policy guru Eli Ginzberg, who observes that the healthcare industry had too many power centers, including physicians, hospitals, insurers, pharmaceutical companies, and other suppliers.<sup>3</sup> I would add employers, who are the de facto purchasers of health insurance for most Americans, and patient advocacy groups, especially advocates for the elderly. It seems that no one has offered a health reform proposal that does not adversely affect at least two power centers. Insurers and suppliers oppose proposals that rely on significant expansion of government powers, while providers and patient advocates have shown little interest in market-based solutions, especially if they promote managed care. The result is perpetual legislative gridlock.

When President Clinton unveiled his Health Security Act in 1993, some of my colleagues who should have known better assured me that this proposal would succeed where others in the past had failed. Politicians insisted that the plan would get through Congress because there were new voting blocs. “Things are different,” they said. But as I thought back over the history of failed health reform and the need to appeal to multiple power centers, I realized that I had heard those sentiments before. It seemed that the more things changed, the more they stayed the same. Sure enough, optimism about the plan’s chances faded and ultimately disappeared in 1994. By November 1994, Republicans were firmly in control of Congress and national health reform was a dead issue. It has come back to life, and analysts are once again suggesting that “things are different.”

I do not expect Congress to break its century-long political logjam and enact a sweeping program for national health reform. This is not a revelation. In their remarkable 1974 study of the origins of the Medicaid program, Robert and Rosemary Stevens argue that we will at best achieve piecemeal legislation, or what I call “creeping incrementalism.”<sup>4</sup> Stevens and Stevens have proven to be correct so far, and there is nothing to suggest any immediate sea change. That is why I am not offering a single comprehensive solution. Besides I do not believe that there is a magic bullet cure for the U.S. healthcare system. But I do believe that we can revive the system and get things moving in the right direction again. For example, I believe that it is possible to cut the number of uninsured in half or better with minimal federal intervention. A number of states have taken the initiative and a polite shove from the federal government is all it will take to make this a national reality. Having reduced the problem of the uninsured to a manageable size, smaller scale initiatives can fill in most of the remaining holes in the safety net.

Many proposals to solve the access problem get bogged down in efforts to simultaneously reduce costs. There is a false premise at work here, namely that cost reduction is a necessary condition for improving other aspects of the healthcare system. The success of Medicare and Medicaid in improving access for tens of millions of Americans is *prima facie* evidence that we can focus on one problem at a time. Besides it is not obvious that we should lower costs *per se*, but rather that we should be sure to spend our money wisely. I will suggest several simple ways to make us wiser shoppers.

If we focus excessively on costs, then quality is sure to suffer. It is reassuring that employers, payers, and the government are working hard to find ways to measure and reward the highest quality providers and payers. But this movement may be stopped dead in its tracks unless we get better data and improve the methods used to analyze them. Even this will not be enough. Providers and patients must radically rethink the meaning of quality; otherwise third-party oversight will have little impact and quality will forever take a back seat to costs. I do not pretend to know how to perfectly measure quality, reward the best providers, and encourage the worst to do better. But I will offer a few suggestions for how we can do these things better.

## Is This a Sequel?

I published *The Economic Evolution of American Health Care* in 2000. Targeted to both industry experts and a lay audience concerned about America's most important industry, that book chronicled the rise and uncertain future of managed care. I think *Economic Evolution* did a good job of laying out where the U.S. health economy was heading and explaining how managed care could hold the line on costs. At the same time, I identified serious obstacles to the continued success of HMOs (Health Maintenance Organizations) in the market. While the conventional wisdom is that managed care has failed, the reality is that many managed care strategies are thriving, including the nearly universal adoption of provider networks and drug formularies, innovations in provider payments, and disease management. Even so, a public backlash against the heavy handed oversight and narrow provider networks of some managed care plans has caused a shift away from tightly managed HMOs into looser forms of managed care. The result has been a predictable sharp increase in healthcare costs. At the same time, concerns about quality have intensified and there is heightened interest in solving the access problem.

This book both updates *Economic Evolution* as well as broadens its focus to include public sector efforts to cope with quality and cost and, especially, access. There is some overlap in the two books, especially in the first half of this book where I discuss basic health economics topics such as demand inducement and moral hazard. The first half of this book also presents a lot of new material on access to care and insurance markets. The second half is strictly a sequel to *Economic Evolution*, describing new efforts to deal with cost, quality, and access via consumer directed health plans, provider report cards, and state health reform initiatives. The final chapter in which I offer recommendations is a culmination of my efforts in both books. I hope it contains something useful.