

## Market-based failure: a second opinion

Part two in a two part series

**Editor's note:** The September issue of the Massachusetts Nurse included the first part of this compelling article on health care costs in this country. To maintain a sense of continuity, we have re-printed a portion of this first installment. This article by Robert Kuttner first appeared in The New England Journal of Medicine on Feb. 7, 2008.

A popular strategy among cost-containment consultants relies on the psychology of income targeting. The idea is that physicians have a mental picture of expected earnings—an income target. If the insurance plan squeezes their income by reducing payments per visit, doctors compensate by increasing their caseload and spending less time with each patient.

This false economy is a telling example of the myopia of commercialized managed care. It may save the plan money in the short run, but as any practicing physician can testify, the strategy has multiple self-defeating effects. A doctor's most precious commodity is time—adequate time to review a chart, take a history and truly listen to a patient for example. You can't do all that in 10 minutes.

Harried primary care doctors are more likely to miss cues, make mistakes, and—ironically enough—order more tests to compensate for lack of hands-on assessment. They are also more likely to make more referrals to specialists for procedures they could perform more cost-effectively themselves, given adequate time and compensation. And the gap between generalist and specialist pay is widening.

A second cost-containment tactic is to hike deductibles and copayments, whose frank purpose is to dissuade people from going to the doctor. But sometimes seeing the doctor is medically indicated, and waiting until conditions are dire costs the system far more money than it saves. Moreover, at some point during each year, more than 80 million Americans go without coverage, which makes them even less likely to seek preventive care.

The system also has inflationary effects on hospitals' revenue-maximization strategies. Large hospitals, which still have substantial bargaining power with insurers, necessarily cross-subsidize services. The emergency department may lose money, but cardiology makes a bundle. So hospitals fiercely defend their profit centers, investing heavily in facilities for lucrative procedures that will attract physicians and patients. For the system as a whole, it would be far more cost-effective to shift resources from subspecialists to primary care. But in an uncoordinated, commercialized system, specialists might take their business

elsewhere, so they have the leverage to maintain their incomes and privileges—and thereby distort cost-effective resource allocation.

Defenders of commercialized health care contend that economic incentives work. And indeed they do, but often in perverse ways. The privately regulated medical market is signaling pressured physicians to behave more like entrepreneurs, inspiring some to defect to “boutique medicine,” in which well-to-do patients pay a premium, physicians maintain good incomes, and both get leisurely consultation time. It's a convenient solution, but only for the very affluent and their doctors, and it increases overall medical outlays.

Other doctors opt out by becoming proprietors of specialty hospitals, usually day surgeries. In principle, it is cost-effective to shift many procedures to outpatient settings that are less expensive but still offer high-quality care. In a government-organized universal system, the cost savings can be usefully redirected elsewhere. But in our system, the savings go into the surgeons' pockets, and their day hospitals often have a parasitic relationship with community hospitals, which retain the hardest cases and give up the remunerative procedures needed to subsidize those which lose money.

A comprehensive national system is far better positioned to match resources with needs—and not through the so-called rationing of care. (It is the U.S. system that has the most de facto rationing—high rates of uninsurance, exclusions for pre-existing conditions, excessive deductibles and copayments, and shorter hospital stays and physician visits.) A universal system suffers far less of the feast-or-famine misallocation of resources driven by profit maximization. It also saves huge sums that our system wastes on administration, billing, marketing, profit, executive compensation, and risk selection. When the British National Health Service faced a shortage of primary care doctors, it adjusted pay schedules and added incentives for high-quality care, and the shortage diminished. Our commercialized system seems incapable of producing that result.

Despite our crisis of escalating costs, dwindling insurance coverage, and deteriorating conditions of medical practice, true national health insurance that would not rely on private insurers remains at the fringes of the national debate. This reality reflects the immense power of the insurance and pharmaceutical industries, the political fragmentation and ambivalence of the medical profession, the intimidation of politicians, and the erroneous media images of unsatisfied patients in universal systems. ■

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