Health System Reform

A Provider or a Patient Perspective?

David N. Mirvis, MD

Most important issues can be viewed from many different perspectives. In civil law, the plaintiff and the defendant present the same event from two vantage points and the outcome will be very different depending on which view is adopted by the court. The same is true for health care. Physicians (or groups of physicians) may have one view, other providers a second view, hospitals a third view, insurance companies a fourth view, and patients a fifth view. While the issue being deliberated is the same, the arguments and the proposed solutions may be widely disparate.

TWO ISSUES

In this article, I will examine two issues related to health system reform from the perspectives of providers and patients. (Although I will focus on physicians, the controversies to consider may apply equally to other members of the health care provision team as well.) The two issues are health care financing and the effects of health system reform on availability of high-technologic, high-cost procedures. This analysis will then lead to a discussion of important issues facing our profession in this era of impending major reform of our health system.

Health System Finance Reform

A cartoon in a recent issue of a major national magazine portrayed two physicians walking in a hospital corridor. One says to the other, "I don't mind if they introduce alternative forms of health care as long as the traditional fee schedules remain in place." This, unfortunately, represents a common lay view of the physician's perspective on health system reform, ie, protection of our own interests.

A major, and perhaps *the* major, stumbling block lying before the Clinton Administration's health system reform efforts is the projected cost of expanding health insurance coverage to all Americans. Currently, approximately 34 million Americans do not have health care insurance[1] and another 20 million or more are "underinsured," ie, have insurance that could be inadequate should catastrophic illness occur.[2] Providing financial coverage to these citizens should result in a significant increase in total health care costs. The increase may be estimated as the product of the number of newly covered citizens and the current cost per comparable citizen, minus some figure representing factors such as the amount of out-of-pocket and charitable care already provided, excess costs of emergent care of uninsured persons, etc. Although this formula represents a significant oversimplification, it does depict the major issue: providing more care to more citizens will cost more money.

This commonly presented view of health system finance reform represents, I believe, a provider's perspective. The issue centers on paying providers, whether physicians, allied health personnel, or hos-

From the Prevention Center, Department of Preventive Medicine, University of Tennessee, Memphis, and the Veterans Affairs Medical Center, Memphis.

pitals, for more work based on current operational procedures.

The finance issue may also be viewed from a patient's perspective. In 1991, the mean cost for providing health care to each citizen, ie, each current or prospective patient in the United States, was $2868.[3,4] This cost exceeded that in Canada by $953 (33%), in Germany by $1209 (42%), and in England by $1825 (64%).[4] These nations provide, in essence, comprehensive care to all citizens. Thus, when viewed from the patients' perspective, there could already be sufficient funds within the health system to provide comprehensive coverage to all Americans.

The reasons for the greater expenditures in the United States lie largely within the health provision system,[5] ie, within the purview of the providers. Problems deriving from a market-driven finance system that is a conglomerate of numerous independent and often conflicting and inefficient subsystems rather than a single unified national program with national programmatic and financial planning all result in increased cost without commensurate health production.[5] One example is the considerably higher administrative costs in the United States than in Canada,[6] provider-side expenses that do not directly result in enhanced health care services.

Reinhardt[7] has also emphasized the difference between patient and provider views. He has posited that health care expenditures are not in reality the costs of providing health care services but, rather, the price society is willing to reward providers for providing services.

[T]he statement that health care expenditures this year reached, say 10 percent of gross national product (GNP), does not imply that American patients have cut out for themselves a slice equal to 10 percent of the proverbial national pie. Rather, the statement signifies that in return for whatever services and supplies the providers did transfer to patients this year, they (the providers) were allowed to claim for themselves 10 (or 11) percent of that national pie as a reward.[7]

Thus, health care costs represent to a significant extent provider- rather than patient-oriented issues.

The difference between provider and patient perspectives on health care financing may be illustrated by the differences in physician fees in Canada and the United States. Hospital and physician fees are significantly higher in the United States than in Canada.[8,9] Physician fees for identical procedure–related services are 134% higher in the United States, while those for non-procedure-related services are 82% higher.[8] Thus, there is considerable flexibility in the relationship between expenditures and services provided by the health care industry.[7]

Furthermore, despite these high per capita costs, Americans express greater dissatisfaction with their health care system than do citizens of most other Western countries. In a 1990 survey of citizens of 10 nations reported by Blendon et al,[10] 60% of Americans indicated that "fundamental changes" were needed in their health care system in comparison with only 38% of Canadians and 35% of West Germans; 66% of Americans stated that they preferred the Canadian system to their own. Thus, patient satisfaction, a key yardstick of health system function from the patient's perspective, is low despite higher costs than in any other country.

It may be argued, however, that these other nations that spend less per capita do not provide the same quality of care as that in the United States so a financial comparison is neither adequate nor appropriate. There is, however, little evidence to suggest that the health of citizens of those nations is inferior to that of Americans. For example, major measures of population health, such as infant mortality rates and longevity, are better in many nations that spend considerably less on health care than does the United States.[4] Indeed, some segments of the US population have a life expectancy similar to that of underdeveloped, third-world countries.[11] Furthermore, 3-year survival rates after nine of 10 major surgical procedures, including high-risk operations such as cardiac valve replacement, are higher in Canada than in the United States despite significantly lower costs.[12]

Procedure Availability

A second and related issue that may be viewed from two perspectives is the effect of health reform on the availability of various types of specialized, "high-tech," expensive procedures. This may result from changes in provision systems or finance systems. Emphasis on managed care schemes or primary care models with significant gatekeeping[13] may limit tertiary care referrals by policy or by incentive systems.

Finance systems may likewise limit referrals through selective financial disincentives or by limiting the facilities needed for procedures. The Canadian health system is commonly criticized on this account.[14] For example, only 35% of patients in Canada undergo coronary angiography after acute myocardial infarction compared with 65% of patients in the United States.[15] This decreased availability and utilization is often cited as evidence of reduced efficacy of the Canadian health provision system and a reflection of inferior care directly related to lower expenditures.

This concern also represents a provider perspective. From a patient's perspective, it is the improvement in health that results from procedures that is critical, not the number of procedures performed. Hence, health systems should be compared, not on inputs (eg, dollars, numbers of procedures), but on outputs (eg, the health of the population). When this standard is ap-

plied, differences in health systems with different utilization rates of tertiary care procedures decrease or disappear. For example, mortality rates and rates of reinfarction after acute myocardial infarction are identical in Canada and the United States despite the aforementioned difference in procedure utilization rates.[15] Conversely, the high utilization rates in the United States are often criticized as reflecting a large amount of inappropriate use.[16] Thus, the issue should be the availability and efficacy of "appropriate" testing, not simply "more" or "less" testing.

It is also relevant to recognize that very different utilization rates exist in different regions of the United States. For example, hospitalization rates in Boston, Mass, exceed those of New Haven, Conn, by 34%, but no differences are demonstrable in the health of citizens of these two cities with hiqhly developed health systems operating under similar provision and finance systems.[17] Indeed, differences in utilization rates for some procedures within the United States are greater than differences between the United States and either England or Norway, despite very different health systems.[18] Thus, provision systems are but one cause of highly variable utilization rates.

PHYSICIANS' CHOICES

These examples illustrate two of many possible cases of differing perspectives. Similar comparisons could be presented for topics such as health care research funding and manpower training. What perspective do physicians have and what perspective should physicians and others in the medical profession adopt?

Studies of professional behavior suggest that individual physicians exhibit both provider- and patient-oriented behavior.[19] Most physician behavior is directed toward the good of the patients, ie, physicians do act as the patients' agents. However, evidence also suggests that a significant part of physician practice patterns is mediated by their own interests. For example, financial rewards for increasing billings in an ambulatory care center resulted in a 23% increase in laboratory tests and a 16% increase in roentgenograms per visit.[20] Similarly, reducing procedure fees results in increased volume so that overall costs and personal income are stabilized.

Data from the Congressional Budget Office, for example, suggest that increases in test or procedure volume offset 56% of the cost savings expected from a fee reduction,[21] resulting in a "behavioral offset" when projecting changes in global expenditures resulting from fee changes. McGuire and Pauly[22] have suggested, as one model of physician behavior, that physicians alter their degree of advocacy for possibly appropriate or marginally appropriate tests and procedures based on their personal interests.

Thus, physicians do behave in a complex manner, with a mixture of patient- and provider-mediated actions. The self-interest of physicians may be manifest in financial as well as nonfinancial concerns, such as personal and professional autonomy.[23,24] It is inevitable that both types of behaviors shall coexist in a delicate balance. This balance may be appropriate or inappropriate. An appropriate balance is one that provides, for example, adequate incentives for bright students to enter the medical profession and for physicians to work as diligently as they must to provide care for their patients. Thus, behaviors that are pro-provider may also be propatient so that the two forms of behavior when in an appropriate balance need not be mutually exclusive. In contrast, an inappropriate balance between provider and patient perspectives exists when, for example, personal financial incentives result in inappropriately excessive or inadequate diagnostic testing or when ownership of health care facilities by physicians results in real or perceived conflicts of interest.[25,26]

In addition, an inappropriate balance exists when financial or nonfinancial professional incentives are significantly greater than those needed to ensure that services are maintained and they, directly or indirectly, impede access to health care.[27] For example, if physicians decline to see patients because reimbursement is less than what they are accustomed to despite highly satisfactory net incomes, an inappropriate balance may be claimed. That significant leeway in the financial incentives available for American physicians exists is suggested by international comparisons.[7] Physicians in the United States have a greater mean income compared with the mean of the population than in any other country. In 1992, the ratio of the mean income of physicians to the mean income of the general population was approximately 5.12 in the United States; in Canada, the ratio was 3.47; in England, 2.39; and in West Germany, 4.28.[28] None of the nations has a shortage of physicians despite lower financial incentives.

Furthermore, physicians' incomes continue to rise at a rate significantly higher than that of the general population.[29] Much of this increase results from increased charges per encounter rather than an increase in services provided,[29] so that much of the increase in income (a provider perspective) does not result in a commensurate increase in health care provided (a patient perspective). Thus, as noted above, the relationship between payments to providers and the amount of health care provided is very elastic; increasing health care expenditures does not necessarily lead to the provision of more care, while reducing fees need not necessarily result in rationing care.

Appropriateness data likewise suggest areas for improvement from patients' perspectives. As many as

20% of cardiac catheterizations and 7% of coronary artery bypass grafts have, for example, been found to be of uncertain appropriateness and 4% of each are inappropriate based on peer-developed criteria.[30,31] The unnecessary risk to the patient from these procedures is clear. There is, in addition, a major economic implication of tighter adherence to appropriateness criteria. At a mean cost of more than $32 000 per coronary bypass procedure,[32] each inappropriate procedure that is avoided can provide, at current US expenditure rates, medical care to more than 10 citizens for 1 full year. Thus, the opportunity costs of performing unneeded procedures and tests are significant.[33]

CHOICES FOR THE PROFESSION

The issue of perspective also exists for the medical profession as a whole. Just as individual practitioners should strive to achieve appropriate, patient-centered behavior, so should the profession promote a patient-oriented attitude.

Several compelling reasons exist for the profession to adopt a highly patient-oriented view of health care reform. First, it is the right thing to do. Millions of patients are not adequately covered under the current health financing system in a nation that has the human and technical resources and ability to treat them. As concluded by Greenberger et al,[34] ". . . we must reaffirm the sanctity of humankind, the primacy of the patient, and the importance of good health for all our citizens." To do so is to accept our social responsibility, defined by Blumenthal[35] as ". . . the willingness of physicians, individually or in groups, to act in the best interest of others, particularly when they derive no personal gain from doing so or when such actions involve some personal cost."

Second, successful implementation of systematic reform to improve this condition will depend on the functions of the medical profession. We, as physicians, control more than 70% of all health system expenditures[36] and only we can practice medicine. Efforts to expand access to meet patients' needs will thus necessarily be directed at our activities, and the success of these efforts will depend on our responses.

Third, the status of our profession in society depends on our acceptance of a public-minded rather than a professional-minded orientation. Professional autonomy, a major driving force in physician behavior, is granted by society in response to the confidence that the public has that we will act in their best interest, ie, that a fiduciary relationship exists between medicine and society.[23,24] This is largely a matter of trust because the public as a whole cannot fully evaluate or understand the esoteric nature of medical practice. This public trust then forms the basis for the special legal and societal status granted physicians.

Thus, it is the public that grants us professional autonomy. If it senses that we inappropriately favor ourselves over its needs, then the public can withdraw that autonomy and further erode our professional prerogatives. Examples of this that have occurred recently include enactment of regulations requiring national reporting of malpractice actions and the limitation of ownership of health care facilities by physicians in response to public concerns over the pecuniary self-interest of some physicians. The public may be viewing us, as suggested by Blendon,[37] as used car salesmen. Promoting patient-centered issues will, in contrast, support a positive image of our profession that will, in turn, be in our long-term best interest.

Such patient orientation requires a different analysis of health care reform options. The major relevant health care issue or goal becomes the good of the patient. In this model, then, significant changes in provision systems, including physician payment mechanisms, that result in greater health should be pursued. Advocacy efforts of physicians should be directed toward improving health, not toward maintaining professional interests beyond those needed for the health of the public. The result is a values framework for health system reform in which patient-oriented concerns, such as access, quality, and personal cost become primary.

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Reprint requests to the Department of Preventive Medicine, University of Tennessee, 956 Court Ave, Room F208, Memphis, TN 38163 (Dr Mirvis).

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