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MARKET RESEARCH

The Harris Poll® PEOPLE

3 Volume

8 Issue

May 13

2003

The Health Care Debate We Are Not Having

The March issue of *EyeNet*, the magazine of the American Academy of Ophthalmology, features an essay by Humphrey Taylor, chairman of *The Harris Poll*® (and a trustee of the American Academy of Ophthalmology), on this topic.

Taylor argues that the United States, like countries almost everywhere, faces a serious health care crisis of public confidence and that the biggest reason for this crisis is barely understood. There is a serious mismatch between the potentially infinite demand for medical care and the finite resources that we want to spend on obtaining it. As a result, every country rations care, whether by limiting reimbursement or limiting the supply of services. But no governments have been willing to tell their voters that their systems ration care. They perpetuate the myth that the “system can be fixed,” implying that there is no need to ration care (even though the fixes often involve more rationing.)

Taylor argues that leaders should explain why it is necessary to ration care (even if they don't use the “R” word itself) and that every country needs to have a major national debate about *how* they should ration care, *who* should do it, and *what criteria* should be used to do it. Without such a debate, expectations will greatly exceed performance and the public will always be deeply dissatisfied.

All Health Care Systems Are In Trouble

Our health care system is in real trouble, but we are not even discussing the fundamental cause of our problems. In almost every rich, developed country, there is a sense that the health care system is in crisis. This is a big change since 1990 when a Harris survey in ten countries found that substantial numbers of people in some of them (Canada, the Netherlands, West Germany and France) were reasonably happy with their systems and felt “only minor changes” were necessary to improve them. Not any more. In most countries, including Canada, most people now believe that something is seriously wrong with their systems. Many people have difficulty getting the care they need; costs are growing much too fast; there are long waiting lists; hospitals, doctors and nurses are under too much pressure; there are too many medical errors; too much poor quality care; and, in the United States, forty million people with no health insurance and many more with inadequate insurance.

After our 1990 survey, I wrote that we already knew that the American health care system was the most expensive in the world but that we now realized that it was also the most inequitable, least cost-effective, and most unpopular system of the ten countries we had surveyed.

The U.S. health care system is not the most unpopular today, but that is only because the health care systems of many other countries have become far more unpopular than they used to be. But the U.S. system is still uniquely expensive, inequitable and inefficient (with its very high administrative costs). This of course is a criticism of the American system, not of American medical care.

Wealthy, developed countries have many and varied health care systems. Almost every country's system is unique in some respects. Some have national health services. Most have universal, or almost universal, health insurance. And yet they all seem to be in some sort of crisis. Whatever this crisis is, it seems improbable, therefore, that it can be solved by tweaking the system or by changing to a system used in another country. There seems to be something wrong with all systems.

The Mismatch Between Supply and Demand

What is common to all health care systems is the mismatch between demand and the available supply. In every country, the public would like to have (and often feels it should be entitled to get) all the health care that it needs. Furthermore, physicians, hospitals and other providers would like to be able to provide all the care, all the drugs, all the surgery and all the wonders of modern medical technology to all the patients who might benefit from them. Unfortunately, the costs of satisfying the wishes of patients and providers are more than society wants to pay—whether in taxes, insurance premiums or out of pocket. There is a big gap between demand and supply, between what we'd like and what we are willing to pay for. Finite resources meet potentially infinite demand.

When I first heard Bill Rosenberg of PricewaterhouseCoopers say that “good health is a state of incomplete diagnosis,” I thought it was witty: a cute joke. But I now realize it is a profound statement about contemporary medicine. With every passing year, we have new and better tests to identify diseases earlier and new and better ways of treating them. We lower the “at risk” levels of blood sugar or cholesterol to define more people as needing care. We lower the age at which mammography is thought to be beneficial.

Consider dermatology. Every year for the last several years my dermatologist has cut pieces off my balding scalp to prevent me from getting melanoma. But my parents never had this done. None of my family ever had melanoma as far as I know. But my dermatologist says it's a good thing to do. Maybe he's right. It's covered by my insurance. So why not?

Consider dentistry. Originally you only went to dentists when you had a toothache. Sometimes dentists would remove a rotten tooth. Then they learned to fill cavities. At some point dentists learned how to do root canals and to make crowns and bridges. Then came regular check-ups, with regular X-rays to find problems, which as yet caused no pain. With fluoride we prevent most cavities, but dentists discovered and began treating gum disease. Orthodontists and braces became the norm. Then came teeth whitening and new cosmetic dentistry to give us all beautiful smiles. And now we have new and better (and more expensive) implants.

Dentistry, as it was practiced even twenty years ago, was, compared to today's high-tech dentistry, a classic case of “incomplete diagnosis.”

Dentists and dermatologists are not unique; indeed, they are the norm. Every year we invest billions of dollars in developing new medical technologies which will enable us to test more people for more conditions, and treat them. And of course, this is very big business, not only for the companies developing and selling the new technologies, but also for the doctors, technicians, nurses, and hospitals that do the testing and provide the care.

Our system is more demand-driven and supply-side driven than need-driven. Sadly, we are still a long way from having evidence-based medicine, but we certainly have economics-based medicine, or a health care system driven by the profit motive - for both better and for worse. This is good in many ways, apart from the prosperous employment of the millions of people who provide care or work in the health care industry. New tests detect diseases earlier. Better drugs, devices and surgical procedures relieve pain and prolong and improve the quality of life

of many people. A nice smile is better than rotten teeth or dentures. But we do this at an ever-increasing cost, and we are very reluctant to pay for the ongoing inflation of health care spending.

The Gap Between Demand And Finite Resources

With the development of new treatments and tests and more knowledgeable, and therefore more demanding consumers, the gap between demand and finite resources seems to be growing. Every year we are likely to disappoint more people because we won't pay for all the technology and care that doctors would like to provide and patients would like to have.

Another problem is that most people are not aware that this problem, this gap, exists. Our leaders don't talk about it. There is no national debate on the issue. Instead we debate the details of the Patient's Bill of Rights, the price of prescription drugs and the design of a possible Medicare drug benefit. Obviously, these are very important issues, but they are not the central issue that we should be debating. The central issue, in all countries, should be how we should allocate finite resources or, to put it bluntly, *how we should ration care*.

We Ration Care But Do Not Admit It

Virtually all experts (and in, my experience, all health ministers) recognize that we ration care now. We ration it by what is reimbursable (by both the public and the private sectors). Many countries ration supply by limiting the numbers of doctors, hospital beds or high-tech equipment. In the U.S. we ration by price and the use of high copays, coinsurance and deductibles, and we ration by not providing insurance coverage to forty million people.

However, we don't tell the public that we ration care. Governments and politicians are loath to use the dreaded "R" word. They, and almost all who debate health care policy, talk as if there are solutions to our problems that would make rationing unnecessary. Increasing productivity, reducing errors, lowering costs, improving lifestyles and prevention, and cutting waste, fraud and abuse are all admirable goals which would make the money go further—but never far enough to avoid the need to ration care.

Because we ration care now, and will always have to ration care, you would think there would be a big national debate about how to ration care, on what **criteria** to use, and on what **mechanism** to use in making rationing decisions. Two countries have set up new organizations to consider the issue of cost-benefit trade offs: the National Institute for Clinical Excellence (NICE) in Britain and the Pharmaceutical Benefits Advisory Committee (PBAC) in Australia. And the German government has just announced it will set up a "German Centre for Quality in Medicine" which will develop guidelines and undertake cost-benefit analysis. With one notable exception, we in the United States have totally failed to engage in such a debate. The one exception was the Oregon Medicaid program. In Oregon, there was intense discussion and a prolonged debate about which treatments and procedures should or should not be reimbursed, based on cost and efficacy (the impact on mortality and quality of life). Without such a debate we cannot hope to close the gap between expectations and reality. We need to manage expectations.

Is Health Care A Common Or A Private Good?

Uwe Reinhardt has raised the question of whether health care is, or should be, more a common good (i.e. an entitlement) or more a private economic good, where you get what you are willing and able to pay for. We should debate that. The United States is no different, in avoiding the debate about rationing, than other countries. To listen to Tony Blair, you would think that throwing more money at the National Health Service and training more doctors and nurses

Health Care News

3 Volume

8 Issue

2003
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would “solve” the system’s problems. It may improve the service, but the gap between finite resources and rapidly growing demand would still be there.

One rare exception to the reluctance to engage in this debate goes way back to the early 1960s, when the British Minister of Health, Enoch Powell, said that “there is virtually no limit to the amount of health care an individual is capable of absorbing.” If only more politicians were equally as blunt today.

When I have asked politicians, here and abroad, why they don’t engage in this debate, they say that talking about rationing is unpopular, and that the public would not appreciate their candor. One response is that if you don’t want to use the “R” word, call it “prioritization” or something else (just as we call Medicare price controls “prospective payments”). But my main reply is that when you ration something as important as health care (or ask the private sector, through managed care, to do this for you) and don’t admit that you are rationing it, two things are certain: The public will continue to think that the health care system is in bad shape, and they will blame their leaders for it.

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