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Beyond "Sicko"— Thoughts on Health System Reform

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Abstract
The documentary "Sicko" has reignited the debate on health care reform in the U.S. Michael Moore's film raised no new issues, but put faces and stories to longstanding problems of access to health care in this country. With a presidential election looming next year, it is possible that the political and public will can be catalyzed to change the health care system. In this Issue Brief, we asked five LDI Senior Fellows to comment on some of the issues raised by "Sicko," and to offer their thoughts on the prospects for health system reform.

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Leonard Davis Institute of Health Economics

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Beyond "Sicko"— Thoughts on Health System Reform

Editor's Note: The documentary "Sicko" has reignited the debate on health care reform in the U.S. Michael Moore's film raised no new issues, but put faces and stories to longstanding problems of access to health care in this country. With a presidential election looming next year, it is possible that the political and public will can be catalyzed to change the health care system. In this Issue Brief, we asked five LDI Senior Fellows to comment on some of the issues raised by "Sicko," and to offer their thoughts on the prospects for health system reform.

The film points to countries where health care is provided at no or minimal cost to the individual. The economic theory of moral hazard suggests that people use more health care when they do not directly share the cost. Is this principle likely to be an issue in other countries, and if so, how do those countries deal with the inefficiencies that result?

CAPLAN: I know of no evidence that the citizens of nations with universal coverage "overutilize" health care services. Some of these systems tightly regulate access to specialty care by requiring referrals from primary care physicians, so they use gate-keeping to discourage overuse. Others strictly control expenditures on high technology and on expensive drugs; you can't overutilize resources that are not there. To give a bit of credit to the nations with universal coverage, they also tend to be more oriented toward prevention so they have well-baby programs, visiting nurses, some house calls, good physical exams for kids. This cuts back on overuse since demand is somewhat controlled by providers, not consumers. Lastly, the financial incentives to indulge overuse in terms of doctors, time and energy do not exist in salaried systems of compensation. The U.S. seems to be far more prone to inefficiency in the use of services then do the nations of Western Europe, Australia, New Zealand, Japan or Singapore.

PAULY: As a matter of fact, the usual measure of generosity of coverage—average percent of national health expenditures people pay out of pocket—is lower in the U.S. than in many countries we think provide free care. Our current percentage is about 11%, which is less than Canada (drugs aren't always covered) and much less than the Netherlands and Switzerland (copays for outpatient care and drugs). By comparison, France and Cuba are tied at about 9%.

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Not all moral hazard is inefficient. We want insurance that increases access to care for populations (the sick poor, mostly) who we think will consume too little care without it. The problem in the U.S. is that while middle class insurance is actually quite generous (and should be, given what it costs), insurance is less common among the sick near-poor; those who most need it are least likely to have it.

In this country we do not control moral hazard among the middle class well, but when we do control it, we often use increased patient cost sharing. As noted, the Swiss and the Dutch also do this, but most countries control it by limiting budgets, capping expenditures and provider incomes, or limiting the availability of real resources. This leads to lower spending but longer waiting lists in most countries (e.g., 7 months for knee replacement in Manitoba), or, in the few countries where moral hazard is not well controlled, such as France, very high tax burdens to finance medical insurance.

The film leaves us with the impression that health care professionals in other countries are more satisfied in systems providing universal health care coverage. In your experience, is this the case, and if so, how can we harness the considerable resources and power of health professionals to change the U.S. system?

AIKEN: There is little evidence that health care professionals, on average, are more satisfied in countries with universal health insurance coverage. Universal coverage can positively affect satisfaction to the extent that doctors, nurses, and other providers have more flexibility in providing a range of resources that patients need to stay healthy and cope effectively with illness. However, the form of insurance coverage is not as important to provider satisfaction as are methods of paying providers, overall provider remuneration, adequacy of resources available for care, inclusion of the full range of providers within the payment scheme, and extent of professional autonomy. Universal coverage provides the potential for greater central control over the health care budget and over its allocation, which often leads to greater physician dissatisfaction in countries with universal coverage. Nurse dissatisfaction is widespread across countries with and without universal health insurance resulting from cost containment policies that adversely affect patient-to-nurse staffing ratios, create poor work environments, and exclude nurses from full participation in health care.

"Sicko" portrayed the positive impact on generalist physicians' satisfaction of recent British policy reforms to improve their compensation and practice autonomy. In Canada, physician and nurse dissatisfaction is primarily related to provincial cost containment measures that result in implicit rationing of care and full-time nurse positions in hospitals. Many Canadian physicians and nurses now practice in the U.S. as a result. Countries with universal coverage are no better at workforce planning than the U.S. and are as likely to suffer from shortages of doctors, nurses, and others because of under-investment in health professions education.

GRANDE: Relatively few studies have compared U.S. physician satisfaction to those in other nations. Of the few conducted, many compare Canadian and U.S. physicians and find few major differences. The negative portrayal of other nation's health systems in the U.S. media and the use of rhetoric such as "socialized

medicine" leave many U.S. physicians and the public believing that health professionals in other countries practice under poor working conditions. "Sicko" makes an important contribution by chipping away at these myths and gives health professionals a better sense of what it might look like to practice in an environment where money is not exchanged at the point of service and wealth is not a prerequisite for receiving care.

The film tells us little about how health professionals could become positive agents of change in the U.S. Historically, physicians have been major opponents of health care reform. While reform plans have been offered by several medical organizations in recent years, they typically protect the economic interests of physicians. Perhaps a new era of leadership will emerge from the medical profession less focused on a "guild" mentality and more devoted to a social ethic that would put patient interests above those of the profession. The white coat can still be a positive catalyst for change under the right leadership.

The film portrays the health care systems in Canada, the U.K., France, and Cuba as efficient, effective, and caring. How accurate is this portrayal? What lesson can we take away from these international comparisons that might inform our own health care reform debate?

ROSOFF: I have never been to Cuba or studied its health care system, so I don't know if Moore's depiction is accurate. Like others who have seen the movie, I doubt that the average Cuban citizen receives the high-quality health care shown in "Sicko."

From my research on the other three systems, I believe they are marked by a high level of morale and dedication among health care workers. They have limited but generally adequate resources to get the job done and they try hard to provide the best health care they can. Although people in all three systems have complaints, overall public satisfaction with these countries' systems is quite high.

In the U.S., physicians' compensation (relative to other workers) is higher than in other countries. Thus, the prestige that once went along with simply being a physician is now interwoven with the status that comes from being highly compensated. This is not to say that many health professionals are not still driven by higher motivations; but we have muddied the waters. By creating a system that emphasizes financial rewards, we have set ourselves up to pay a high dollar price for health care and to find that people without the financial means to pay for care fare badly.

The U.S. system relies heavily on financial inducements to motivate institutions and practitioners to strive for excellence. However, other nations' experience shows that caring and commitment can also be called forth by promoting professional ethics, civic duty, and altruism. The question then becomes whether, having gone so far down the financial incentives path, we are bound to stay on it forever. What would it take to change this aspect of our health care system? I believe such change is essential to achieving universal access without unacceptable cost and/or diminution in quality of care.

AIKEN: I have visited Cuba and agree that the health care there is very impressive in terms of providing excellent preventive services and health promotion, probably the best continuity of care of any system in the world, and care of good quality across the entire spectrum of primary, chronic, and acute care. Cuba has excellent medical and nursing education and trains more health professionals than it needs, exporting some to countries with shortages. Cuba's primary challenge is its fragile economy and thus limitations to resources that can be invested in health and health care. Yet its health outcomes are excellent by international standards.

"Sicko" focused more on the package of social services available in France than on the quality of health care, which has some limitations. Nursing is underdeveloped in France compared to other industrialized countries in terms of higher education qualifications and nursing research, which would be expected to undermine quality of care, particularly in hospitals.

The strongest lesson for the U.S. is that these countries have integrated social, medical, and health care services to a much greater extent than the U.S., which has resulted in consumer satisfaction and possibly better health outcomes. These countries have a more seamless, more accessible system of human services than the U.S. Ideally if the U.S. implements major health reform, attention should be given to the more seamless integration of social services with health care. Cuba is the only country among those portrayed with an adequate health care workforce and the only country that is largely self-sufficient in the production of doctors and nurses. This accomplishment by a relatively poor and small country suggests that richer, larger countries could also achieve greater self-sufficiency in health care workforce and thus reduce their reliance on health professionals from the developing world.

Many political commentators have said that changing the U.S. health care system will be an incremental process, rather than a matter of large-scale reform. What can we do to "fix" the present system?

ROSOFF: Changing the health care system is not just a question of what will work best; it's also a question of what is politically feasible. Some powerful groups have a vested interest in preserving our present system of employment-based private insurance (or think they do). Prime among these groups are insurers and health plans, including managed care organizations. Our current free-enterprise system reflects America's near-religious devotion to competition. I believe in competition too, but our health care system suffers from over-reliance on it. I would like us to try a new model in which competition among health care providers is preserved but meaningless competition among health plans–which doesn't work well because consumers generally don't have the information, expertise or patience to make savvy choices–is reduced. The model I envision would have more federal government involvement and control. Like Medicare, it would let patients choose their doctors, hospitals and other providers; and it would support meaningful choice by assuring that good information on quality, patient satisfaction, and costs was available. Such a system would be more efficient and satisfactory than what we have now, but I doubt we'll find the public and Congressional will to make such a major shift. So, we're limited to incremental change.

But incremental change is better than the status quo. Massachusetts' reforms to assure that all people in the state have insurance are a good step. Some states will follow suit; others lack the will and resources. SCHIP [State Children's Health Insurance Program] could be expanded to bring health care to more children. Better laws and enforcement could limit insurers' arbitrary coverage denials, helping curb the abuses "Sicko" highlighted. Insurance is state-regulated, however, and not all states will step up and take action. The high degree of state autonomy in the U.S. is a key factor relegating us to piece-meal, rather than system-wide, change.

PAULY: If we measure the size of a reform by how much it costs or redistributes, there are very few small reforms that will matter. Relaxing insurance regulations or bumping up SCHIP coverage may both provide more benefit than cost, but their effect will be tiny on either national health expenditures or life expectancy. The medium-sized change that I favor is one that reduces or caps the tax subsidy to generous health insurance for the middle class, and provides income-related vouchers for lower-income people to help them buy either public or private insurance (depending on what they like). The gross governmental cost of the kinds of voucher-subsidy plans needed to make a dent in the uninsured is about $100 billion, which is more than an increment in the federal budget (and is more than $1,000 a year for the average tax-paying household) but which is small relative to the $2 trillion total spent on medical care and insurance. This would leave most people with large group employment-based insurance but would shift much of the small firm workforce to their chosen mix of private or government-run individual insurance. My view is that we should try something like that and see if it helps, and only move to "blowing up the system" if it fails.

You cannot entirely prevent insurance "abuses," either by insurers or by insured people making claims for care they did not really need. You can enforce regulations against insurer or consumer fraud, and you can, as in the above proposal, give people more choices so they can stay away from mean or stupid (though perhaps cheap) insurers. In addition to providing public information on hospital infection rates, we should provide public information on insurer complaint rates.

If the U.S. health care system is as broken as the film suggests, why have reform efforts all failed? What steps are needed to build the public and political will to allow fundamental changes to the way we pay for and finance health care in the U.S.?

CAPLAN: The system here is broken–too few people covered for the amount we spend, plus lousy long term care and poor preventive services. We need a moral vision that can command the assent of liberals and conservatives. If access to health care can be seen as a key component of equal opportunity for all, if it can be seen as something that must always be available and of high quality then we have a chance at reform. Without a common moral commitment to make health care available to all, at least a minimum package of services, we won't get any further then we have in the years since Medicare was enacted.

GRANDE: Big ideas face many obstacles in the American political system. Most importantly, legislators are often not loyal to or elected around a single party

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platform. As a result, the American system is highly effective at preserving the status quo–at times a virtue, at other times a major impediment to progress. In addition, powerful stakeholders that derive nearly $2 trillion in income from the current system are extremely influential in Washington and able to scuttle reform as it navigates its way through the long legislative process. While each stakeholder claims to support reform, each major group has differing preferred solutions that protect their own economic interests and consensus among these powerful interests remains elusive. Meanwhile the public does not know what to believe from the steady stream of rhetoric coming from economic and political interests.

The key to overcoming these challenges and building public and political will for reform is strong presidential leadership. Newly elected presidents possess a unique political mandate, high approval ratings, and the bully pulpit needed to advance "big ideas." With an overwhelming majority of Americans currently insured, only a strong president can build the public will. Despite the financial insecurity many Americans face due to health care, opponents of reform can easily stoke fear around change as evidenced by the famous "Harry and Louise" ads that helped derail the Clinton reform effort. A president has to galvanize the public around a collective approach to health care built around a sense of social solidarity sorely missing in U.S. health policy—an approach Michael Moore correctly identifies as a "we, not me" approach.

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