Editorial Commentary by Peter J. Levin

Controlling Health-Care Costs

The key ingredient is professional responsibility

Few people go to medical school to fight the government and insurance companies, but that's what doctors have to do for their patients and for the public's health.

THE AMERICAN HEALTH-CARE SYSTEM was built on physicians practicing independently or in small groups, with fees for service paid directly by the patients or their families. Nowadays, fee-for-service medicine is out of favor because it is viewed as inefficient, costly, and uncontrollable.

Actually, health-care costs are out of hand because third-party payers—government agencies, insurance companies, and employers—have chosen to change payment methods for doctors and hospitals without considering patient needs or medical effectiveness.

Such changes raise a question for Americans: "Whom would you trust more to make the right decision for your health, the secretary of Health and Human Services, the CEO of a health-insurance company, or doctors you choose and compensate?"

Third-party payers' one concern—unrelenting upward pressure on costs—has continued. The result has been to disenfranchise physicians as professionals with the freedom to decide on the best ways to care for patients. Undaunted, the payers have imposed and expanded treatment paradigms on providers to reduce their flexibility and make costs more predictable. No other country requires that most routine medical practices follow preset guidelines.

In the Beginning

During and after World War II, employers added health insurance as a fringe benefit to attract workers without raising pay. Costs for care grew; the poor and the elderly were less able to pay their health-care bills. In 1965, Congress enacted Medicaid and Medicare to cover hospital and medical bills for the needy and those over age 65. The programs' costs were grossly underestimated at their inception.

From 1965 to the early 1980s, there was a steady increase in the costs of care, but few significant attempts to curb them. Eventually, however, projected costs frightened bureaucrats and Congress. Medicare adopted the Diagnosis Related Group system, which paid hospitals a fixed fee for providing care for a particular diagnosis and its treatment. This was expected to influence the behavior of hospital administrators and physicians to be more attentive to controlling expenses. Many insurance companies followed Medicare's lead and now pay based on the same model.

Physicians' costs were also rising. In 1988, Medicare introduced the Resource-Based Relative Value Scale system to pay physicians based on time spent, mental effort, technical proficiency, geographic area, and other factors. Payments were to be adjusted annually based on the complexity of the service, practice overhead, and malpractice costs.

Fee-for-service medicine, long stigmatized as costly, inefficient, and a barrier to good care, was said to encourage overtreatment and illicit profits. But overtreatment was facilitated at least as well by Medicare and Medicaid—programs designed to deliver money, not audit doctors.

As early as the 1970s, federal health-care officials were encouraging prepaid group practices, called Health Maintenance Organizations, which were paid a monthly premium to cover comprehensive health services. Experts believed that the HMO culture would favor preventive care and best practices by physicians, resulting eventually in lower costs. HMOs put doctors on salary and largely eliminated fee-for-service care.

Some HMO-type organizations have succeeded in retaining enrollees and physicians, while others have lost money and reputation. Traditional insurance companies responded with a similar institution, the Preferred Provider Organization. For cost control, enrollees could use only physicians in the provider network who agreed to accept HMO-approved fees and practice guidelines. Most health insurers today have a list of providers that their enrollees must use. If they go outside their network, they will pay more from their own pockets.

Doctors used to be afraid of socialism, and now they have been corporatized. They and their patients are now awash in a sea of uncertainty, paperwork, and computer-based electronic communications, so that care will be delivered according to standards set and regularly changed by the government and insurance carriers.

Few people go to medical school to fight the government and insurance companies, but that's what they have to do for their patients and for the public's health.

The federal government initiated a program encouraging and subsidizing physicians to install electronic health-records systems. There is also a stick: Medicare deducts a percentage of its payments to physicians who do not file electronically.

Uniquely Ineffective

Regulatory and financial complexities have driven physicians into corporate practices for mutual defense in a system where insurance companies and the federal government set standards as to what care is appropriate and at what price. No other nation has adopted the U.S. system. Many European countries and Japan pay physicians fees for service. Premiums and provider payments are sometimes handled by government agencies, and sometimes by private insurers. Most of these systems negotiate payments with national medical and hospital associations, so that all doctors are paid according to a national fee schedule.

This system leaves room for independent solo and small-group practices. Patients can understand their insurance costs and the rules for out-of-pocket payments.

Cost pressure should not drive physicians out of managing patients' care, but U.S. payers and providers have never considered setting prices through negotiations among physicians' groups, government agencies, and insurance companies.

If the U.S. system is to function more effectively and fairly for patients, doctors should be autonomous. The more that decisions about appropriate care are left to physicians and their patients and not to computer-driven paradigms or insurance companies whose profits are at risk, the better it may be for patients and our health care system. ■

PETER J. LEVIN was the dean of the schools of public health at the universities of Oklahoma, South Florida, and SUNY Albany; executive director of Stanford University Hospital; and chairman of the Florida Hospital Cost Containment Board.

Editorial page editor THOMAS G. DONLAN receives e-mail at tg.donlan@barrons.com.