

On the Critical List: The US Institution of Medicine

United States' medicine, once regarded as the best in the world, is in a sorry state of health. The US ranks lowest on almost every dimension of health system performance relative to other major westernized nations.¹ It not only lags well behind Japan, Western Europe, and Australasia – it even falls behind Poland, the Czech Republic, and Slovakia.² Twice as many Americans die before the age of 60, as compared with Europeans³; infant mortality in the US is double that of many countries in Europe, and life expectancy at birth is lower³; Japan has over 3 times as many acute care hospital beds,⁴ and Greece has over twice as many doctors.⁴ America has a health care system that is, frankly, third-rate.

To add insult to injury, the US has by far the most expensive health care system in the world. We spend \$7,290 *per capita* on health care annually, more than double the Organisation for Economic Co-operation and Development average. The UK by contrast spends \$2,992 and ranks second in international comparisons.¹

To explain why we have the most expensive health care system in the world and yet one of the lowest performing, we need to take a perspective that focuses on the US institution of medicine as a whole. We expose the hidden rules by which this institution operates and discuss how its powerful organizations shape, control and perpetuate this ailing system.

THE US INSTITUTION OF MEDICINE

The US institution of medicine is not a single, comprehensive and cohesive system of health care. Instead, it is comprised of a myriad of large and powerful organizations, including insurance companies, Health Maintenance Organizations (HMOs), corporate for-profit hospital chains, and pharmaceutical companies. This institutional structure is large and vast, and has over the years become ever more labyrinthine. For example, there are hundreds of health insurance companies, each with a bewildering array of policies – a system of health insurance so vast that many

insured have no idea of the type and extent of their coverage.

SETTING THE “RULES OF THE GAME”

Not only is the institutional structure large, it is dynamic, and actively creates, shapes, and maintains the institution of medicine. It does this through what we call setting the “rules of the game”; that is, by imposing the terms by which the system operates.

Insurance companies have set the rule “restrict choice and coverage.” They enact this through their elaborate system of copayments and deductibles, exclusion clauses and loopholes, each designed to deter patients from claiming the health care they need, and to override physicians' medical judgment.

HMOs have set the rule “manage care.” This rule serves to restrict patients' utilization of health care by limiting the number of treatments patients receive, days spent in hospital, and choice of provider. This rule denies patients access to the full range of treatment options that they need.

The pharmaceutical industry has set the rule “charge as much as we want, because insurance will pay.” This rule has resulted in prescription drug prices that are much higher than anywhere else in the world – nearly 60% higher than in Canada, and nearly 100% higher than in Europe.⁵ Moreover, this rule has led to patients being prescribed sometimes unnecessary, often useless, and even potentially dangerous drugs – a recent study found that 85% of all new pharmaceuticals either do not work or have serious side effects.⁶

Corporate hospital chains have set the rule “test as much as we want, because insurance will pay.” Under this rule, they extend the patient's range of tests and procedures, even when excessive or unnecessary. At the same time, fearing litigation, physicians are compelled to perform “defensive medicine” – a practice unknown in the rest of the world.⁷ This medical liability environment adds to the staggering array of unneeded and potentially harmful diagnostic tests. The resulting unwarranted hospital admissions and medically unindicated interventions further inflate the cost of health care.

In setting these “rules of the game,” the large and powerful organizations that make up the US institution of medicine shape the system to their own interests and distort health care. In creating the system they want, the institution

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of medicine has shifted the balance of health care provision in its own favor.

COMPLEXITY AND QUAGMIRE

Since each organization is acting largely independently and setting its own “rules of the game,” what has emerged is a bloated, inefficient health care system, now mind-boggling in its complexity. This in turn has spawned an administrative quagmire that generates a mountain of paperwork inconceivable in any other health care system in the world. Johns Hopkins Hospital for example, has to bill more than 700 different payers and insurers, each with their own stipulations regarding services covered, reimbursement, documentation, and pre-approval.⁸ Unsurprisingly, administrative costs account for more than 30% of our health care spending, compared with other advanced nations whose expenditure on health care administration is only 10%.⁹

This complexity is highly conducive to opportunist behavior, allowing organizations to take advantage of the system and make “supernormal” profits. We only have to look to US pharmaceutical companies’ profits which are the highest in the world, and at a median profit rate of nearly 20%, 4 times that of the average Fortune 500 company.¹⁰

As each organization has created its own “rules of the game,” the institution of medicine has grown into a complex entity that few really understand. This very complexity actually works to the advantage of the organizations that comprise the system, creating an operating environment that allows them to siphon off billions of dollars. It is one of the main reasons why the cost of health care has spiraled out of control. Indeed, over a 5-year period contributions to company health insurance soared by 143%, and out-of-pocket costs by 115%.¹¹

INERTIA AND STATUS QUO

This is the ideal operating environment for the organizations that have created it, since this complexity and resulting confusion help them perpetuate the system and preserve the *status quo*. Although each organization sets their “own rules of the game,” they are also strongly and deeply interlinked, and cooperate and collaborate to protect the system of health care that they have devised, so that it remains intact and continues to serve their own interests. For example, they vigorously oppose the formation of a regulatory authority – an American version of the UK’s National Institute for Clinical Excellence – which seeks independently to test and evaluate the relative merits of drugs and medical procedures, since such a body would weaken their control and ability to shape the health care system.¹² Through these strong and entrenched relationships, they work together to stabilize the system and create institutional inertia.

Both the complexity and inertia are designed to restrict policy makers’ ability to reform US health care, since it makes it almost impossible for them to dismantle the system, and easy for the institution of medicine to resist reform.

REFORMING THE “RULES OF THE GAME”

The sum of the “rules of the game” devised by these organizations has resulted in a fragmented, haphazard and broken system of health care. Reform is long overdue, and demands root and branch transformation of the “rules of the game” governing the US institution of medicine. This requires us to understand these rules, who is setting them, and how these rules are being used to exploit the system of medicine. Only then can we begin to heal our ailing health care system.

If fundamental reform is not forthcoming and institutional inertia persists, by 2015 one-fifth of the country’s expenditure will be spent on health care, and yet we face the possibility of falling even further in international rankings, and find ourselves overtaken by China, which in 3 years will extend health care to all its citizens.

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