

# Sharing Responsibility for Health Care Successes and Failures

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Many of us in the health care sector have been devastated by the news of the horrific murder of Brian Thompson, the CEO of UnitedHealthcare. As we try to comprehend the unjustifiable loss related to this tragedy, we're simultaneously seeing an outpouring of social media posts celebrating or seeing some sort of poetic justice in his death. Even those people who condemned the murder were quick to contemplate a motive—that the US health care system is broken.

While people have reason to be angry at many aspects of our nation's approach to coverage and care, this justified anger should stop short of endorsing violent retaliatory acts.

As we attempt to forge ahead, we must remind ourselves of the goals of the healing professions and health care delivery: to improve the quality of life and well-being of individuals and populations. From the health perspective, there has never been a better time to be a patient, as modern expertise, medical services, and interventions to prevent and treat disease have led to impressive reductions in morbidity and mortality. Irrespective of these remarkable advances, the amount of medical spending (how much we spend), not our health (how well we spend), garners most of our attention. Now, in the wake of a tragedy that has captured the national conscience, might be the time to reframe the dialogue from how much we spend to how well we spend our medical care dollars.

The US health care system is part and parcel of our capitalism-based economy. The goal to maximize profit (or surplus margins in the case of nonprofit organizations) influences nearly all stakeholders. The recent rapid growth of private equity investing in the medical care sector and the subsequent consequences (market consolidation, higher service volumes and prices, and aggressive focus on efficiency, cost reduction, and revenue maximization) reveal an emphasis on profits that may take priority over health.

Although capitalism is deeply entrenched in how Americans experience health care, the market is no longer working in the eyes of many Americans. Their dissatisfaction has manifested into a wave of anger unleashed at insurers. We can no longer pretend that, left undirected and unchecked, the market will efficiently and equitably deliver public goods like medical care.

**“ IT IS WISE TO DIRECT YOUR ANGER TOWARD PROBLEMS, NOT PEOPLE—TO FOCUS YOUR ENERGIES ON ANSWERS, NOT EXCUSES. ”**

—William Arthur Ward

Although investors and stockholders may reap high monetary returns, many individuals feel the pain resulting from the world's highest health care prices. Health insurers are the face of a system and a frequent object of consumers' wrath, but other stakeholders, including providers, health sciences companies, and middlemen such as pharmacy benefit managers, must share the blame in contributing to unsustainable levels of medical care spending. These escalating costs necessitate the implementation of policies aimed at lowering spending, such as utilization management, drug formularies, and patient cost sharing—the drivers of widespread discontent—that produce negative patient outcomes and worsen health disparities. The trade-off between the goal of improving health and the need to constrain medical care cost growth will be unrelenting, given the rapid pace of scientific research yielding extremely expensive but life-changing clinical innovations. Meanwhile, the lack of a profit motive driving implementation of low-cost, generic, and nonpatented clinical interventions must be overcome through incentivization of their use.

There is no question that the financially driven American system does cause real (but potentially preventable) clinical, emotional, and economic harm. Many Americans report that health care is inaccessible, in that they either cannot afford health insurance, can't find a clinician, or are confronted by strategies used by payers explicitly designed to deter care. For those with access, many find

care unaffordable, such that they may delay or refuse its use. For the many Americans who receive care that they can't afford and their insurance won't cover—fully or at all—medical debt, personal bankruptcy, and online fundraisers frequently follow. (Medical expenses are the leading reason for personal bankruptcy and online fundraisers.<sup>1</sup>) Further, the trillions of dollars spent annually on medical care constrain spending on important social determinants of health (eg, housing, education, healthy food), further eroding the nation's health and increasing downstream medical expenditures. Our work and that of many others have clearly demonstrated that cost-related nonadherence to medical services leads to worse outcomes, especially for those in underserved and older populations.<sup>2</sup>

Although many Americans perceive being mistreated by the health care system, praising a vigilante is utterly indefensible and will not help fix our problems. The perpetrator of this horrible crime is not a heroic outlaw. We need to follow the advice of writer William Arthur Ward, who implores us to direct our anger and energies on answers. We spend more on medical care than any other country (17% of the US gross domestic product<sup>3</sup>), highest by far among other wealthy nations,<sup>4</sup> yet the *Lancet* recently forecasted that the US global rank in life expectancy will decline from 49th to 66th (of 204 countries) by 2050.<sup>5</sup>

Spending more is not the answer, and we cannot and should not make available every clinical service to anyone who wants it. Instead, we need to spend smarter; we spend on the wrong services, in the wrong places, at the wrong time. Although others have proposed regulatory changes such as spending targets,<sup>6</sup> we must also consider nonregulatory, market-based solutions, as the incoming majority political party historically has not had much of an appetite for regulation.

Moving from a revenue-driven to a health-based delivery system would require a change in both how we pay for care and how we engage consumers to seek care, as most current US clinician payment programs and consumer benefit designs do not prioritize access, equity, and improved patient outcomes.

This shift must start with an honest and rigorous assessment of which clinical services are high value (producing more health for the money spent) and which are low value (offering little to no benefit, potentially causing unnecessary costs and harm). For-profit arrangements could still be possible, but profits would be tied to the provision of services known to yield improved health (the desired outcome) and no longer be determined by process measures such as the amount, intensity, or location of services provided, some of which are not associated with better health.

Currently, most strategies that deter access are focused on high-priced services regardless of their clinical value to the individual patient at hand. Programs that remove barriers and make it easy for clinicians to prescribe (eg, no prior authorization) and patients to afford (eg, no cost sharing) high-value services would protect patients from those services that do not improve clinical outcomes.

While plans claim to be using this approach with prior authorization, in practice, they too often fail to do so, as services that have been

demonstrated to have no clinical benefit in many instances—vitamin D testing of average-risk individuals, unnecessary diagnostic testing prior to low-risk surgery, and cancer screenings not concordant with evidence-based guidelines, among many others—account for hundreds of billions of dollars of wasted spending per year.

The savings incurred from a reduction in the use of unnecessary and potentially harmful care could be reallocated to higher reimbursement and more generous coverage of higher-value services, which could mitigate the number of patients' complaints over delays and denials of necessary care.

In the past 2 decades, federal and private insurers have recognized the need to reform provider-facing incentives away from fee-for-service reimbursement to alternative payment models that enhance efficiency and focus more holistically on keeping individuals and populations healthy. More than ever before, we also appreciate the important role that consumer-facing strategies such as education/literacy programs, shared decision-making, price transparency, and value-based insurance designs play in achieving these goals. When health-driven incentives for patients and clinicians are synchronized,



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the effects of these highly complementary components on the utilization of clinical care are greater than the sum of the parts.

The ultimate test of health transformation will be whether it improves health, enhances equity, and addresses rising costs. While the benefits of aligning incentives that make it easier for both consumers and clinicians to access services that produce better health, and remove incentives that don't, are clear, it will take a concerted multistakeholder effort to change a status quo that often provides incentives to spend more (or less) but not spend well.

Apart from diffusing the heated rhetoric inflamed by a heinous crime and bringing a murderer to justice, we must acknowledge the pain of those struggling to navigate a broken health care system. We must launch a broad, multistakeholder initiative to refocus our enormous medical care resources toward more effective, efficient, and equitable care, with the ultimate goals of improved health and financial security for Americans and fiscal sustainability for those who invent, produce, and provide the services. ■

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