

How to Save the US Health Care System From a Complete Collapse

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THE US HEALTH CARE SYSTEM is on the verge of collapse. The US spends more than any other country in the world on health care (nearly one-fifth of its gross domestic product and nearly \$4.8 trillion in 2023)¹ and ranks poorly among other high-income countries when ranked for indicators of health care quality

by agencies such as The Commonwealth Fund.² Issues in all dimensions of health care—quality, access/coverage, and costs—abound, with 5 dominating: (1) uneven quality and access to health care, (2) a significant portion of the population lacking health insurance coverage, (3) a system that remains focused on illness rather than wellness, (4) uncertain value of health care technologies being rapidly introduced in the market, and, finally and most importantly, (5) unsustainable spending on health care. In his excellent evaluation of health care systems across the world, Ezekiel J. Emanuel, MD, PhD, compares the US health care system with other countries and delves into reasons why it underperforms.³ The US system is primarily a poor performer because it is more complex, is costlier, and offers limited choices to health care consumers. In the 1950s and 1960s, the US offered the best medical care in almost all areas, but now we only excel in specific areas such as cancer care, innovations in payment models and care delivery for those with chronic illness, and provision of mental health care in private settings. The system performs poorly in patient choice, infant and maternal mortality, and many other indicators of health care quality.

Moving to a socially planned system or converging to a single system that is well planned and orchestrated vs the patchwork of multiple systems we currently have may seem a particularly daunting task to achieve in the US, but there are other things we can do that may be less wasteful, simpler, and more efficient and that ultimately deliver better outcomes for everyone. I focus here on 3 areas where changes could make the system more efficient and sustainable.

The first is addressing the big elephant in the room: the complexity of the US health care system. This complexity is burdensome—for example, one has to determine what coverage health care consumers are eligible for, which physicians are in network, how much patients owe in

deductibles and co-payments, and how to dispute inaccurate bills. There is very little time for patients to ensure they are receiving the care they need, and physicians spend much more time on administration than their counterparts in other countries. This complexity is expensive, with some estimates attributing more than \$500 billion annually to administrative costs of health care in the US.⁴ We can simplify health care in 3 areas by addressing (1) the differing ways individuals in the US get insurance, (2) the complexity of insurance benefits design, and (3) relationships among insurers, hospitals, and physicians in the US.

The government and health care payers need to consistently reevaluate reimbursement schedules, shift to alternative payment models, initiate pay-for-performance measures, and continue to focus more on targeting high-risk, high-cost patients for cost-effective care management—all strategies that could make our current health care system more efficient, effective, and equitable in the long run.

So how do we simplify coverage? One could narrow insurance options to either employer-sponsored insurance or Medicare and, within Medicare, allow for a fee-for-service or managed care plan. One could also reduce myriad health insurance benefit designs. Most countries that have some

type of universal health care coverage have limitations on range of services, co-payments, balance billing, out-of-pocket expenses, network formation, etc. For example, the Dutch insurance companies all cover the same basic benefits and have the same minimum deductibles with exemptions for primary care provider visits. The only variance is in premiums, supplemental coverage, and the physician/hospital networks. Thus, patient choice is primarily focused on just a few features and is simple. We need to further reduce plan variability and define a few plans with standardized benefits, co-pay and deductible levels, drug benefits, and other parameters to reduce employer and employee costs as well as facilitate better insurance options.


Simplification also needs to occur at doctors' offices, hospitals, and other health care facilities. Endless paper registration forms are filled out by hand, recording medical problems, emergency contacts, etc. In the digital era, this is wasteful. The government should mandate that all physicians, urgent care centers, hospitals, and other providers offer digital registration by card or biometric identification, which links to insurance eligibility, benefits, etc. Implementing a standardized electronic medical form and eliminating cost-ineffective processes such as prior authorization are also warranted. Simplifying physician order flow and electronic health record systems and rapidly shifting to alternative payment models where physicians are held accountable for total costs of care could reduce inefficient tests and treatments.

The second area where the US needs change is in emphasizing and increasing reimbursement for primary care. The US has too many adult-focused specialists who are reimbursed very highly. Specialists also expend more resources than primary care physicians when treating patients with similar conditions. Strong primary care systems enhance performance: The Netherlands, Norway, and the United Kingdom have strong primary care models in which primary care physicians assume responsibility for more services than their US counterparts, and nurse practitioners and mental health nurses deal with patient quality of life and counseling issues. Primary care cooperatives provide extensive after-hours triaging so patients use the emergency department less. Patients are penalized for going directly to specialists without referral, emphasizing coordination. The US should, like many of these countries, make primary care physician visits free or minimal cost for patients without deductibles or co-payments (and increase co-payments for specialists). Insurers need to change payments to primary care physicians to incentivize them to assume more coordinating responsibility, and they could do so by shifting to capitation with financial responsibility for patient care costs. Almost 80 cents of every health care dollar in the US go toward chronic illnesses.⁵ It is time to seriously implement the patient-centered medical home model that has been widely touted to make the current health care system more sustainable. The key ingredients necessary to implement this model are (1) creating multidisciplinary teams to manage

patients' cases; (2) identifying high-risk, high-cost patients who need care management; (3) educating patients and families about how the patients' conditions are treated and teaching patients self-management; (4) instituting frequent, proactive outreach to patients to help with adherence as well as deal with exacerbating factors; and (5) implementing same-day appointments and home visits for rapid responses to preempt and address disease complications. Using data on patient outcomes and practice performance to iterate and shape these models is essential.

Finally, the US needs to join the rest of the world in regulating drug pricing. Although the US has less than 4.5% of the world's population, it incurs over 40% of drug expenditures in the world.⁶ Most other countries have some type of drug price regulation, and many use rigorous cost-effectiveness analysis to inform these decisions. Many countries use independent benchmarks for acceptable prices: (1) The benchmark establishes a maximal price for drugs, and companies can set prices below that, or (2) pricing methods could involve negotiations over a final price.

The government need not conduct these negotiations; many countries use nongovernmental organizations to accomplish this. A review of other countries also suggests that drug price regulations do not lead to significant delays in access to new drugs, as widely feared.⁶ Also, the opposition in the US to strategies such as using cost-effectiveness analyses to guide pricing and reimbursement decisions seems unwarranted given the success many of these other countries have had in controlling drug costs using these strategies. Differences in time to market came mostly from when drug companies submitted new drug applications. Negotiation strategies coming from the government have been shown to dramatically decrease drug spending in many countries.⁶

Many of these changes will require regulations and processes in place to accomplish these goals, but they need to be initiated to make the current health care system more sustainable. Some may argue that this would bring too much government control into individuals' lives, but we have reached the point where this has become more of an issue of preserving basic human rights and quality of life for everyone in the US, something that just cannot be achieved without some level of government stewardship. The recent move by the Biden administration to negotiate the prices of 10 very expensive medications is a welcome move in this direction.⁷ The government and health care payers need to consistently reevaluate reimbursement schedules, increase primary care, lower specialty care, shift to alternative payment models, initiate pay-for-performance measures, and continue to focus more on targeting high-risk, high-cost patients for cost-effective care management, all strategies that could make our current health care system more efficient, effective, and equitable in the long run. 

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