YANKEE DOODLING **Douglas Kamerow**

Who will pay and who will say no?

Not everyone can get what they want from the US healthcare reforms

We are now in a difficult period in the attempt to reform the healthcare "system" in the United States. Initial optimism has waned, President Obama's popularity has plummeted, and the doomsayers are hanging the burial crepe. Shades of 1994 (the year of Hillary Clinton's failed attempt at healthcare reform).

Earlier this year there was unprecedented cooperation not only between Democrats and (some) Republicans but also within the ruling Democratic party. This has now splintered. And most of the powerful special interest groups—doctors, hospitals, big pharma, and the insurance and health plan industry—were on board as well, falling over themselves to make public concessions so as to maintain a place at the negotiating table. But those days of bonhomie are gone.

The problem is that no one is willing to give up much. And no one is willing to admit that someone will have to say no to the sometimes extravagant ways of the past. The hard part is still ahead, and two related issues loom especially large: paying for the new coverage, and saying no to inappropriate care.

Given that the US already spends a larger percentage of its gross domestic product on health care than any other major country and that we have large disparities in costs with few differences in outcomes, it is tempting to assume that there must be waste in there somewhere. Simply find the waste, cut it out, and bingo—enough funding to cover the previously uninsured. But it is not that easy. We got where we are because no one wants to be told what to do: not patients, not doctors, and not health systems. So it is no small matter to rein in the spending that has gotten out of control.

One widely chanted mantra for saving money to pay for reform is to invest in putative panaceas such as preventive medicine and health information technology. The sad truth is that appropriate preventive care, though a wise investment in health, rarely actually saves money. And instituting electronic medical records will be enormously expensive in the short run, given our many different systems and massive need for electronic infrastructure in individual practices. So not much money to be saved there, either. Which is why the independent Congressional Budget Office refuses to rate either prevention or health IT as offsetting the costs of new coverage.

Only tax money—such as the proposed tax increase on people with higher incomes or new taxes on health insurance benefits— will pay for the costs of covering the uninsured. But both are risky politically.

The second issue is control. Part of the reason that US health care costs so much is that we don't always know the best way to treat problems, and when we do we don't always do it. Comparative effectiveness research is supposed to give us this kind of information, but those with special interests have worked hard to ensure that the results of such research won't have the force of law or regulation behind them. Doing this research and not enforcing the findings is silly and wasteful. Someone, some entity, has to have the power to say no.

What it all comes down to is incentives. Given our predominantly fee for service system, there is no getting around the fact that doing more, whether you are a doctor or a hospital, leads to more charges and thus more income. Until that basic equation is altered—by creating new systems of care and giving those systems overall responsibility for expenses for a population—we will never slow the growth of spending.

So what will we do? Some argue for smaller, piecemeal reforms that will fix some of the obvious problems we have: tort reform to reduce malpractice lawsuits and the resulting practice of expensive "defensive medicine"; health insurance portability to ensure that people can take their coverage with them when they change jobs; better coverage of preventive care; and changes in tax policies to allow cheaper individual and group policies.

"The dangers of the current course are that we may not get any reform at all, which would not only miss a real opportunity but ultimately bankrupt us"

But none of these will change the basic incentive: do more, get more.

The dangers of the current course are that we may not get any reform at all, which would not only miss a real opportunity but ultimately bankrupt us. Or we could go part way and not get real reform that fundamentally changes the incentives and reorders the system. Or, finally, we could get "real" healthcare reform, which might not work, costing an enormous amount of money and not yielding corresponding increases in coverage, outcomes, and satisfaction.

Republicans are seeing blood in the water and are now working hard to kill any reform. They have no real comprehensive alternative to offer, but the public is impatient and receptive to clever negative advertising comparing healthcare reform to irrelevant government fiascos such as the response to Hurricane Katrina.

It is pretty close to panic time. Will we have healthcare reform, will we have nothing, or will we go part way? It seems to me that unless we have enough reform to cover almost everyone, create an institution that will say no when the evidence is against treatments, and change the incentives so that they are aligned for appropriate rather than just more care, we will have accomplished nothing.

Douglas Kamerow is chief scientist, RTI International, and associate editor, *BMJ*
dkamerow@rti.org

Cite this as: *BMJ* 2009;339:b3042

See NEWS, p 260