The Health Care Reform Debate:
10 Myths

Health care is complex: its issues are complicated and solutions in some cases are not clear. As the 2012 Election nears, health reform takes center stage. **Dr. Paul Keckley**, Executive Director for the **Deloitte Center for Health Solutions** shares the top ten myths about the health care reform debate.

1 Myth: Most Americans like our current system. They want the current system protected at all costs.

Fact: The majority of Americans think the current system is inefficient, expensive, and wasteful, and the most satisfied constituents are seniors and those enrolled in the military health system. Our polls say the public wants to see the system fixed, using technologies that reduce paperwork, redundancy, and error, and expand the roles for pharmacists and nurses in the delivery of care.[1] And the public is increasingly concerned about its costs.

2 Myth: Most Americans understand the U.S. system and think it's better than others.

Fact: Most Americans do not understand our system. They understand the doctors, hospitals, insurance plans, and constellation of public and private health programs they use in their local communities. And only a handful has direct knowledge of systems in other countries. Notably, our polls of consumers in countries like France, Germany, Switzerland, and others reveal their constituents understand their systems more and rate their system more highly than U.S. citizens rate ours.[2]

3 Myth: There's not enough money in the U.S. health system.

Fact: There's plenty of money in the U.S. system: almost $9,000 per capita.[3] But it's spent in the places where our incentives direct: ours is a high-tech system built around cures and fixes to complicated problems. Incentives to prevent disease are modest; incentives to fix problems later are attractive. And it costs more to fix a problem than to prevent it. Little surprise only 1 in 10 students entering medical school envisions a career in primary care, and developed systems of the world have better preventive health outcomes than the U.S., especially when comparing lower income cohorts across countries. And, ours is not an organized system: it's a complicated array of highly regulated, capital intense, labor intense sectors—each setting its own rules virtually independent of others. Administrative waste is rampant because integration and coordination across silos is minimal. There's plenty of money to go around; there's no agreement on who should get the money or how to re-set the allocations.

4 Myth: Government health care programs—Medicare and Medicaid—are poorly managed and need overhaul.

Fact: The federal and state administrative costs for Medicare and Medicaid are less than the administrative costs associated with commercial health insurance: less than 2 and 5% versus 12%, respectively.[4] That said, the costs of these programs are soaring due to increased enrollments and rising costs for the health services they use. The overhaul of these programs is necessary due to the realities of demand and medical inflation, not the ineptitude of administrators.

5 Myth: There is a shortage of primary care physicians.

Fact: If the presumption is that ONLY MDs/DOs are capable of providing primary care to patients and current incentives to treat continue to be based on visits, not results, then the statement's accurate. But if new incentives for managing health, technologies to enable self-care, and practitioners including nurses, nutritionists, pharmacists, and counselors were allowed to practice to the full extent of their training, there would be no shortage. The myth presumes a reformed system where sick-care and well-care are not appropriately balanced and funded.[5]

6 Myth: The major driver of health costs is unhealthy lifestyles, and the Affordable Care Act (ACA) doesn't address this at all.

Fact: Costs associated with chronic diseases like obesity, diabetes, asthma, and lifestyle choices like drug abuse, smoking, and hang gliding contribute, but other root causes also contribute: incentives to do more tests and procedures instead of only when necessary per the evidence, underlying costs of technologies and facilities that in many cases are driven by financial or competitive opportunities rather than clinical need, and regulatory compliance costs add to the cost spiral.[6] It's not one of these; it's all of them in tandem. And the ACA has a number of provisions that address lifestyle and chronic challenges—essential health benefits must include programs to address them, the National Quality Strategy for Quality Improvement in Health Care, released by the U.S. Department of Health and Human Services (HHS), must advance innovation in finding new solutions like medical homes and accountable care, and expansion of access to primary care services are three among many new solutions. But the major presumption of ACA relative to lifestyle issues is this: access to health insurance for 32 million newly insured Americans will put a dent in unhealthy lifestyles by taking down a barrier to the system's providers and programs.

7 Myth: The ACA does nothing to lower costs.

Fact: The ACA includes a complicated set of demonstrations and pilots that "might" bend the curve—avoidable readmission penalties to hospitals, limitations on physician self-referrals and private inurement, increased transparency to equip consumers to understand treatment options and underlying evidence, and others. But its major tenet for cost reduction is often missed: by increasing access to insurance coverage for 32 million, changing incentives from fee-for-service to performance and value, and requiring use of information technologies to improve diagnostic accuracy and reduce error, it fundamentally alters the center of gravity from a paternalistic system in which patients are told what to do, to a consumer-directed system in which individuals bear more responsibility for their own decisions. Therein, cost reduction might be achieved most significantly.[7]

8 Myth: Most of the care that's recommended is necessary. And most of what the system spends is therefore appropriate and unavoidable.

Fact: To be fair, no one knows for sure. The evidence supporting most of what medical professionals do is scant, and as they develop powerful tools for mining clinical data, they're finding that the more they learn about the intersection of signs, symptoms, risk factors, co-morbidities, and genotypic predictors, the more complicated it gets.

Here's what we know: where one lives is a determinant of the quality of care received with widespread differences in standards of care comparing communities. Per the Institute of Medicine (IOM), adherence to evidence-based practices by clinicians is highly variable, with as much as 30% to be saved if evidence was consistently applied to treatment recommendations and patient management.[8] The issue is not defending waste due to unnecessary care, it's about providing tools—data and information technologies—to clinicians and consumers that are useful in making decisions, and creating an environment based on tools, not rules, where information-driven health is foundational to diagnosis and treatment. It's about medication adherence—by clinicians that appropriately prescribe and dose, and consumers who take meds as directed. And along the way, liability reform will help. So for accuracy, most of the care is probably necessary but a substantial amount isn't, and knowing the differences between the two is essential to better health and lower costs.

9 Myth: The health insurance industry is the problem, and its fate uncertain.

Fact: The health insurance industry is a convenient punching bag for policymakers and campaigns. Its role as protagonist for evidence-based care, narrower high performing networks of providers, transparency about costs and quality, and healthy living would seemingly get accolades, but criticism is more the rule than exception. So amidst the banter, there are two reasons insurance as an industry will thrive in coming years: (1) employers and consumers value financial security resulting from insurance coverage: they want to keep coverage; (2) enrollment in managed care will increase: it's ironic to "beat up" on insurance when virtually every state is implementing managed Medicaid via private plans and Medicare Part D is wildly popular, and state and federal programs like Medicare and Medicaid will increasingly embrace managed care in their program designs to lower costs and coordinate care better.[9] The demise of the industry is a myth. The transformation of the insurance industry is certain. The problem with the health system is not one sector; it is structurally flawed, fragmented, and expensive. It's not one sector's fault.

10 Myth: Health reform is about the future of the ACA.

Fact: The compelling issue about health care is cost. Regardless of the election outcome, policymakers and the industry must grapple with the system's costs as a priority. At 17.6% of the U.S. gross domestic product (GDP), 25% of the federal budget, 23% of the average state budget, and 19% of household discretionary spending, it's the elephant in the room. The big question in health reform is this: is our system performing at a level that's commensurate with the value it adds in communities, companies, and households, and if not, how can the value gap be bridged? It's about cost versus results, perception versus reality, platitude versus pragmatics, theory versus practice, and wants versus needs. It's not about physician income, offshoring the health care workforce, or political posturing to delay decision-making to get through election cycles. It's the national discussion we have to have regardless of the ACA.[10]

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