"Original Sin" and U.S. Health Care Reform

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The U.S. health care system often works well for persons with financial means and for many providers, but several countries achieve better outcomes at lower costs. This series of articles describes a vision and makes important recommendations to improve coverage and control costs; reform health care delivery and payment to promote person-centered; high-value primary care; and address social and environmental determinants of health (1–4).

The recommendations include both commonly proposed and novel approaches to health reform, all of which are backed by thoughtful reasoning and often strong evidence. Nevertheless, powerful forces hinder many ideas for reform. Pharmaceutical and device manufacturers fight rigorous economic evaluation of their products (5). Hospitals, health systems, and insurers consolidate to reduce competition that could promote consumer choice, lower price, and enhance quality (6). Managed care grows despite decades-old evidence of worrisome effects on costly, vulnerable patients (7). Provider organizations support barriers to entry and limit competition (8). Politicians and policymakers rarely engage voters in complex issues of health reform.

Accordingly, the recommendations in these articles face many barriers to implementation. Moreover, the effects of potential reforms are interdependent—implementation of 1 recommendation often affects the benefits, costs, and likelihood of implementing other recommendations. The interdependence of reforms is illustrated by the idea of eliminating tax exemption for employer contributions to health insurance. Economists have long criticized this exemption as reducing consumer and employer incentives to control health care prices and use. Yet, the private funds pushed into the health care system by this exemption subsidize the costs of the underinsured and uninsured that are inadequately covered by government payment. If those private funds were reduced, the system would quickly unravel. Therefore, the failure to adequately finance care for persons without private coverage makes it harder to address the inefficient incentives generated by employer-sponsored health insurance. Such connections among policies threaten the effectiveness of the health reform approach articulated in these articles if the recommendations are only partially implemented.

Accordingly, it is critical to understand which reforms are more and less important and which may follow naturally if others are initiated first. This issue is especially important because the argument can be made that the fundamental origin—one might call it an "original sin," or the idea that human failings stem ultimately from Adam's failing in the Garden of Eden—of problems in the U.S. health care system is our failure to directly finance health care access for so many Americans. Instead, because we have uninsured persons and underfund Medicaid and likely Medicare, we subsidize private coverage to incentivize private spending to make the system work. Unfortunately, this creates incentives for price increases and overuse in private health care, especially for specialized services where competition fails to limit costs. High prices for specialized services that exceed costs produce profits that, in turn, promote excessive incentives for entry—of hospitals into well-insured markets and of physicians into highly paid specialties. Hospitals adorned with unnecessary luxury as well as training programs laden by institutional service are examples of wasteful sequelae of these economic rents. Judge Richard Posner has highlighted such waste as the hidden costs of monopolies and similar distortions of competitive markets, with profits eventually converted to social waste (9).

Rational policies also mediate the wasteful sequelae of incentives for overuse resulting from subsidies for insurance. To control overuse, we develop costly bureaucracies, including managed care that replaces the financial incentives for overuse with those for underuse, in response to which we incur costly efforts to ensure quality. Moreover, extant approaches to risk adjustment under prospective payment incentivize directing care toward lower-cost patients that may have lower value, perhaps especially in competitive markets (10). Such rewards for risk selection also challenge proposals to address unmet social need through the health care system. To mitigate concerns of risk selection and compensate for inadequate funding for government programs, including the funding of biomedical research, we then tolerate reductions in health care competition that lower quality and increase costs (6). Failure to directly finance universal coverage thus contributes to many of the problems faced by the U.S. health care system.

Seen through the lens of the American College of Physicians' recommendations, how might addressing an original sin of failure to directly finance universal coverage in the United States facilitate progress on other recommendations? First, fully funding health care for the uninsured and underinsured would immediately undermine the case for continued tax exemption of employer contributions for health insurance. This would reduce the cost paid by employers to insure their employees because premiums would no longer need to subsidize the care of the uninsured and underinsured and would attract more workers to jobs providing insurance. The removal of tax exemption would encourage greater use of copayments, or better yet, reference pricing to discourage low-value care. Greater employer and employee

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sensitivity to price would reduce reimbursement for more costly providers, decreasing excess use under fee-for-service and the need to narrow networks to negotiate price and for utilization review to reduce overuse.

Although reduced health care spending would relieve pressure on consumers and taxpayers, the costs of financing health care for persons receiving public assistance would be real and visible. Yet, financing such reforms through progressive taxes and reductions in wasteful spending could leave most Americans better off and would hopefully increase willingness to invest in addressing other social needs. The power of special interests would still need to be addressed but would be diminished by reducing the large economic rents to powerful interests generated by the current system.

Original sin has been understood differently and debated widely among Christian theologians (11). Yet, it does not require theological genius to understand that 2 wrongs do not make a right or economic genius to understand that distorted incentives may produce cascading inefficiencies across the economy. Implementation of the American College of Physicians' recommendations, with an emphasis on promoting transparent, direct financing of universal access, holds great promise for replacing the current system of opaque and distorting subsidies with one that better serves all Americans.

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