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Cost containment at any price? — experience in the USA

UNTIL the recent rounds of cash restraint on the National Health Service (NHS) provoked clinicians into taking notice of health costs, few paid much attention to the price of health care in the UK, still less to the issues of value for money and costs versus quality. Things are different in the USA, where the ever-rising costs of care have stimulated concern over a much greater period — particularly among those who have to pay.

Enormous expansion in the American health care industry over the past 50 years has seen an increase in costs from 3.5% of gross national product to around 10.7%, with more than $360 billion spent in 1983.[1] Inflation adjusted per capita spending increased from $51 to $524 in that period. These pressures have resulted in a series of new approaches to the financing of care, cost control, quality measurement, and obtaining 'value for money'. Some of these ideas have crossed the Atlantic to appear in the government's green paper on primary health care[2] and an insight into these methods and their outcomes is valuable if we are to judge whether the experience in the USA has lessons for the NHS.

Quality measurement and cost control have long been associated in the USA. From the beginnings of Medicare in 1965, Congress required that 'hospital utilization review' committees be established with the principal aim of preventing overuse of the health service by providers. Health insurers quickly took up the challange — belatedly followed by the physicians — so that by the mid-1970s considerable developmental work was underway. The emphasis was on quality but with the driving force of control of both utilization and cost.

Many of these experimental utilization-control projects stemmed from Congressional legislation which established 'professional standards review organizations'. By the late 1970s these numbered 195, each typically covering hospital care provided for populations of about one million people.[3] Separate funding arrangements and the methodological difficulties of measuring effectiveness usually meant the exclusion of primary care from these experiments. Individual programmes were able to show improvements both in utilization of resources and quality — improving diagnostic techniques, reducing inappropriate treatments and improving service provision in underused services. Generally, however, it was difficult to determine any cost savings since the programmes were themselves expensive.

The change in political administration in the USA swept away professional standards review organizations and replaced them with a more radical and wide-ranging cost-control programme. New legislation in 1981 established a prospective payments system for hospitals based on 'diagnosis related groups' — groups of 'similar' conditions for which resources were to be provided on a cost-per-case basis rather than the previous cost-plus retrospective reimbursement. In the retrospective payments system it was in the physician's or institution's interest to expend resources on a patient. Diagnosis related groups brought a different problem. Since an institution foots the bill for any over-spend on a case that institution's interests are best served by minimim use of resources and early discharge — 'quicker and sicker'. Furthermore, incentives also exist to selectively admit more profitable cases and to create more specialized services, thereby impeding access to those with a poor health insurance plan or no money. One immediately obvious result of such specialization is the increase in 'free-standing' surgical centres from three in 1970 to more than 450 by 1985.

Although prospective reimbursement initially related only to publicly financed care it soon combined with two other trends to provoke extensive changes. Most major employers in the USA include health insurance as part of remuneration. In 1976 these costs

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costs amounted to $578 per employee but by 1984 they had tripled to $1700. Cost-sharing and co-insurance rapidly became widespread, the employee often having to make a substantial contribution to the family health care bill. In addition, the economic recession added significant stresses. Since health insurance at discount rates can only be obtained by major companies, redundancy often results in immediate loss of health cover.

The 1981 legislation also encouraged real competition to enter the arena for the first time. Hospitals formed into chains or became 'for profit' institutions. Those that have retained charitable or 'not for profit' status have had increasing difficulty obtaining capital from the financial markets, that is, from banks and investors, even though recent evidence suggests that 'for profit' health plans have 10% higher costs than 'not for profit' plans.[4]

Most important has been the growth in managed care, which involves continuing responsibility for care rather than *ad hoc* arrangements where patients go to any doctor they choose. Physicians linked together as 'independent physician associations' and centres joined to offer packages to insurers and employers as 'preferred provider organizations' or as larger 'health maintenance organizations'.

All of these new trends have cost containment as the priority and evaluation of care has taken a back seat. The first effects are now becoming apparent. Health maintenance organizations seem to have reduced inpatient stays by up to 40%[5] and costs by 25%, probably by being less technical and shifting more care to the outpatient ('ambulatory care') side of the equation. However most health maintenance organizations care for a very skewed population — those who can afford the insurance premiums or those with an employers' contribution. Thus the clientele are usually young, fit and in employment. Few are elderly or chronically sick and only a small proportion (about 5%) of the 20 million patients currently enrolled are covered by Medicare or Medicaid. In this way health maintenance organizations are able to maximize ('cream off') their profits. Whether there has been an overall cost saving remains unclear; analysis of data to 1981[6] suggests that health maintenance organizations at most make a once-and-for-all reduction in costs.

It is estimated that about 15% of the population in the USA have no formalized health cover — the 'medically indigent'. Not all are poor. Many are in low paid jobs, have inadequate insurance or are only insured for part of the year. In a 'for profit' system one might expect these people to fare badly and Lurie[7] found (perhaps not unexpectedly) that termination of insurance benefits reduces health status by dissuading people from treatment for chronic problems such as hypertension.

In addition, Lohr[8] and her colleagues have shown some effects of cost-sharing. Payment for services does not deter the well-off from seeking care for a range of problems from the major to the self-limiting. Cost-sharing does, however, dissuade the poor from seeking appropriate help and it dramatically reduces the access to health care of poor sick children — in the Rand study by more than 40%.[8]

Despite this worrying picture there may yet be scope for improvement. The scenario runs thus — health maintenance organizations and 'for profit' hospitals have successfully 'creamed-off' the profits and success has led to expansion and increased capacity in the health service. Unused capacity does not make a profit therefore there must be a constant search for new clients. However, most of the healthy are already provided for so that patients must be attracted who are supported by other funds — mainly Medicaid and Medicare.

When the professional standards review organization programme was dismantled it was replaced by the 'utilization and peer review organization' programme. Written into the legislation is a requirement that those providers who accept Federal funds must also accept quality assurance programmes. Competition and cost containment have thus driven the argument full circle in the search for clients and the measurement of quality is on the agenda once more.

This complex interplay between legislation, efforts to contain costs and the search for value for money has much in common with current concerns in the NHS. The evidence from this short review suggests that cost containment measures in a 'for profit' environment may achieve savings but do so at the expense of the disadvantaged sick. Enthusiasm for radical and uncontrolled experimentation with the financing of the NHS should be tempered by that knowledge.

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Informed consent

FOR generations of doctors the Hippocratic maxim *Primum non nocere* conveyed the message that above all else one's treatment should do no harm. This precept known to medical philosophers as that of non-maleficence is a negative attribute clearly of lesser medical value than the positive one of beneficence, in which at least some improvement in the patient's health may be expected. This ideal of doing good and having good done is the image of medicine which has appealed to most doctors and their patients since the time of the Greeks. And so modern medical historians looked again at the old maxim and decided that the message in the *Corpus Hippocraticum* should really be interpreted as 'help, or at least do no harm'. Beneficence was given classical priority over non-maleficence. Children could safely be taught that 'Doctor knows what is best for you', while doctors could decide not only which treatment was most appropriate, but which information should be withheld if it were considered harmful. As often as not, information was withheld simply because it was thought that it might worry the patient, or perhaps more significantly because if he learned the risks of an operation this might dissuade him from consenting to an intervention considered to be in his best interests by his surgeon.

This paternalism could extend to what Richard C. Cabot (1868–1939), a young physician at the turn of the century, described in his own practice as 'benevolent lying', before he decided to follow a path of immutable honesty with his patients for the rest of his career.[1]

The problem of full and honest information given to the patient