Minding Ps and Qs: The Political and Policy Questions Framing Health Care Spending

William M. Sage

Within five years of Medicare's enactment in 1965, liberal social activists Barbara and John Ehrenreich conjured a new demon — the "medical-industrial complex" — which they associated with large, profit-seeking entities that were supplanting individual physicians, acquiring political influence, and plundering public funds.[1] The choice of words, of course, echoed those of conservative President Dwight Eisenhower, who in his televised Farewell Address three days before leaving office in 1961 had warned the nation of a "military-industrial complex." If one edits Eisenhower's original text to substitute "healthcare" for "military," parallels emerge between the American public's fear of Communist invasion or thermonuclear war and its fear of disease or death in their potential for serious economic mischief.

> Our healthcare must be mighty, ready for instant action.... Until the latest of our social welfare laws, the United States had no healthcare industry.... But now we can no longer risk emergency improvisation of national healthcare; we have been compelled to create a permanent healthcare industry of vast proportions. Added to this, fourteen and a half million men and women are directly engaged in the healthcare establishment. We annually spend on healthcare security more than the net income of all United States corporations.
>
> This conjunction of an immense healthcare establishment and a large healthcare industry is new in the American experience. The total influence — economic, political, even spiritual — is felt in every city, every State house, every office of the Federal government. We recognize the imperative need for this development. Yet we must not fail to comprehend its grave implications.
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> In the councils of government, we must guard against the acquisition of unwarranted influence, whether sought or unsought, by the healthcare-industrial complex.... Only an alert and knowledgeable citizenry can compel the proper meshing of the huge industrial and healthcare machinery with our non-health care methods and goals, so that security and liberty may prosper together.[2]

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This "healthcare-industrial complex" has prospered beyond expectation, with spending exceeding $3 trillion and accounting for nearly 18% of GDP and approximately 10% of employment by 2014.[3] Measured against other developed countries or against "best practice" guidelines, health care in the U.S. costs far more than it should for the benefits it provides. At the same time, the health of the American public lags those same benchmarks, particularly in terms of obesity, physical inactivity, and the associated burden of chronic disease. I have often described these as the challenges of the ballpoint pen and the drive-through French fry — two similarly shaped objects that represent in turn the inefficiency of fragmented care based on "doctor's orders" and the poor lifestyle choices of the American public. Solve either of these problems and the cost curve will begin to bend; solve both and health care expenditures should become sustainable for a nation as wealthy as ours.

Collectively, health care spending was long viewed as the acceptable price of scientific progress given our national wealth. Roughly two decades ago, however, the governmental contribution to rising medical costs began to force budgetary tradeoffs for scarce tax dollars and add unacceptably to public debt — often because organized health care interests could extract sizeable rents through aggressive lobbying. More recently, analysts have suggested that continued cost growth in employment-based coverage is crowding out cash raises in the private sector and decreasing standards of living for American workers.

The cost problem is even more disturbing at a personal level. Illness is (very) unevenly distributed, and severe illness can be impoverishing because it simultaneously imposes expense and diminishes earning capacity. Even with "Obamacare," coverage is not universal. Prices for recommended care are very high, and cheaper alternatives are seldom available. Paying for a single high-cost diagnostic test or meeting the annual cost-sharing obligations under a basic health insurance policy can be crippling. Our poorer citizens enjoy less welfare support generally than in other countries, and health disparities favoring the rich and white are large and growing.[4] And it is even harder for individuals than for society as a whole to decide that "enough" health care has been received, especially for potentially serious medical conditions.

Health care spending is about science and ethics, markets and government, freedom and community. Whether one is an Ehrenreich or an Eisenhower, *these are inherently political conversations.* None are easy to sidestep, and few ever end. But they do *change*, and tracing the evolution of political conversations about health care spending and their relationship to the formation of policy is a valuable exercise. Minding the Ps of politics and policy in each of the conceptual-temporal phases discussed below enables one to identify the Qs — the key questions that must be confronted going forward to achieve substantial, sustained improvement in the affordability of the U.S. health care system.

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What follows is a retelling of the recent history of health spending and health policy. Although cost concerns in health care long predate the events described,[5] by the late 1980s the unique upward trajectory of post-Medicare U.S. health care spending had been established, recessions and tax cuts were eroding federal and state budgets, and efforts to harness market forces to serve policy goals were accelerating. From the initial writings on "managed competition" by Enthoven and Kronick, through the failed Clinton health reform effort in the early 1990s, to the passage of the Affordable Care Act in 2010, the policy narrative of health spending acquired a superficial consistency.[6]

On closer examination, however, it becomes apparent that the cost problem has been repeatedly reframed in political discourse even during this relatively brief period. The clearest transition has been from a narrative centered on rationing necessary care to one

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committed to reducing wasteful care — although the role of accumulated health law and professional self-regulation in perpetuating waste remains largely unrecognized and the recently articulated commitment to population health seems an imperfect proxy for explicitly developing social solidarity with respect to health and health care in the United States.

ter them, and proliferate acute care hospitals where patients could receive them — made expanding "access" an expensive proposition.[7] Physicians, moreover, seemed able to "induce" demand for their services almost at will, so that each new graduate joining the medical workforce added cost to the system rather than making it more competitive, as basic economics would predict. [8]

If physicians are assumed to provide scientifically optimal medicine, any unnecessary cost must come from elsewhere. A series of allegations therefore targeted forces external, or at least tangential, to the doctor-patient relationship. Chief among them was "defensive medicine," a loosely defined, imperfectly quantified belief that physicians fearing malpractice lawsuits routinely performed expensive tests and procedures of little clinical benefit. In addition to greedy trial lawyers, common villains in the profiteering narrative included pharmaceutical and health insurance companies — large corporate entities that lacked the individuality, local connections, and familiar ethics of physicians and charitable hospitals.

Phase I Cost Control: "The Best Health Care in the World"

When an economic downturn in the early 1990s threatened jobs and the health insurance that stable employment confers, universal coverage re-entered the national policy agenda for the first time in a generation. The obstacle was cost: in harm to business (if mandated of private employers) or in higher taxes or ballooning deficits (if publicly financed), with the third-party presidential candidate Ross Perot bringing the arcana of government borrowing into mainstream consciousness. Health care had reached 12%(!) of US GDP by 1990, and serious commentators wondered how much more we could afford.

Progress

Could the expected cost of universal coverage be reduced? Not without jeopardizing the quality of care, answered the cognoscenti, because — as virtually every American politician routinely declared — health care in the United States was "the best in the world." Correspondingly, the prevailing health policy narrative of the time declared that new technology, much of it scientifically miraculous, was the principal driver of high health care spending. America's decision to prioritize "supply" — to develop new treatments, train specialized physicians to adminis-

Power

There were supplementary explanations for high and rising spending. Medicare's deference to physicians and lack of structural safeguards against cost overruns had bred an unholy alliance between America's seniors — active, single-issue voters with considerable political influence — and an array of special interest providers seeking to do business with government on terms favorable to them.[9] Passage of the Medicare Catastrophic Coverage Act of 1988, a modest attempt to place Medicare on a sounder actuarial footing by raising premiums for higher-income seniors, provoked such a strong backlash that Congress was forced to repeal it before its effective date. This sent a shockwave through the Beltway that discouraged policy innovation, and made Medicare into an untouchable "third rail" for the health reform debate that followed.

Profiteers

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of little clinical benefit.[10] Absent an acute crisis in the availability (mid-1970s) or affordability (mid-1980s) of physicians' malpractice insurance, reducing costly defensive medicine became the principal argument in favor of tort reform. In addition to greedy trial lawyers, common villains in the profiteering narrative included pharmaceutical and health insurance companies — large corporate entities that lacked the individuality, local connections, and familiar ethics of physicians and charitable hospitals.

Paperwork

The predations of the accused profiteers fed a general belief that "waste, fraud, and abuse" — again loosely defined but excluding bona fide clinical activities — was a major drain on health care coffers.[11] The political consensus to eliminate it through stricter oversight resulted in a general bureaucratic escalation. More regulation on the payer side required greater investment in both compliance and evasion on the provider side, a pattern that was most pronounced in government reimbursement programs but that was replicated by private insurers seeking to reduce their claims payouts — which in turn provoked public concern over both profits and high administrative costs crowding out payment for necessary medical services (the poorly named "medical loss ratio").

This "Phase I" conceptualization of the health care cost problem had its intellectual apotheosis in a 1994 book by Dr. William Kissick.[12] Portraying health policy as an "iron triangle" of cost, access, and quality, Kissick argued that society's "finite resources" could never meet its "infinite demand" for medical care. Although Kissick's cost dilemma was largely a testament to medicine's success, his formulation was unappealing to both politicians and physicians. For government to solve the health care cost problem, it had to reach a definitive political settlement regarding limits that had failed in the 1970s under the rubric "health planning," and was patently unachievable in the 1990s.[13] For the profession to solve the cost problem, it had to endorse forms of rationing that ran contrary to established ethics and threatened to drain patient care of its greatest satisfactions, both psychic and material.[14]

Only one U.S. state confronted the purported cost drivers of health care head-on. Through an explicit, highly visible process that included both clinical-technical expertise and democratic participation, the Oregon Health Plan (OHP) broadened Medicaid to a larger group of beneficiaries but guaranteed coverage only for condition-specific treatments meeting cost-effectiveness standards.[15] Rationing health care patient-by-patient was a radical reconceptualization of health insurance, though the approach suffered by accepting reported costs as real costs, not questioning the organization or efficiency of care delivery, and failing to invest in health at the population level.

OHP's reception in Washington, D.C., was hostile, with the first Bush administration denying a Medicaid waiver on Americans with Disabilities Act grounds, but likely viewing any formalized process of health care rationing as defeatist and un-American. Oregon itself struggled with the harshness of the priorities its analysis had generated, and by the time OHP received a waiver from the Clinton administration, much of its prioritization process had been eviscerated, and what little data-driven rationing remained was supplanted shortly thereafter by moving Medicaid beneficiaries into private managed care.[16]

Dissonance between policy rationale and political reality also plagued the unsuccessful effort to expand coverage nationally in 1993-94. The Clinton administration's political advisers led it down the path of "managed competition," mandating coverage through employers that would be provided by private health plans competing on cost and quality in a structured marketplace.[17] While managed competition has much to commend it, and had formed the backbone of the embryonic coverage expansion that President Nixon did not remain in office long enough to gestate, it was at odds with the administrative cost critique emphasized by President Clinton's health reform czar, Ira Magaziner. If administrative expense and profiteering were the major sources of excess spending, a single-payer plan would have been a more suitable policy prescription. But a centrist Democrat following a dozen years of Republican rule could not easily embrace "socialized medicine," particularly when balanced budgets had acquired political salience. Nor would the Clinton White House consider rationing care using explicit controls on coverage. Prominent bioethicists drawn to the reform effort by the perceived necessity of ethically allocating scarce medical resources were soon diverted to other tasks.

Phase II Cost Control: The Kaiser Fallacy

In the 1990s and 2000s, the United States tried to contain health care costs using private "managed care." The poster child for managed care has always been Kaiser Permanente, a group-model HMO with a 75-year history that — most everyone agrees — delivers excellent health care to its members. It is only a slight exaggeration to say that President Nixon signed the HMO Act of 1973 to help Kaiser-like organizations overcome the AMA's longstanding opposition to prepaid practice, and that proponents of managed competition in the 1980s imagined a world of competing Kaisers. But the factors that made Kaiser suc-

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cessful were not generally understood 20 years ago, especially in the Beltway, and were hard to replicate outside of California using private physician practices and community hospitals.

Even more importantly, policymakers turned to managed care without reframing the cost problem they were trying to solve. Although the shift hinted at the importance of "delivery system reform" to cost control, many viewed the failure of the Clinton administration's effort primarily as confirming the weakness of government as a limiting force. Handicapped by politics and by legal requirements of due process, it could not exclude greedy or incompetent providers, it could not resist special interests, and it could not ration care. Perhaps, they thought, private health plans looking out for their own financial interests would be better at saying, "No!"[18]

Patchwork

Organized systems of care such as Kaiser seemed uniquely able to streamline the delivery of care without sacrificing quality and safety. Health services research begun in the 1970s had revealed substantial, unexpected geographic variation in medical treatment that was not associated with either greater needs or superior outcomes.[19] "Best practices" were seldom available, and clear advances in medical knowledge took years to diffuse into communities and alter the habits of local physicians. "Fragmentation" was also structural: most physicians continued to work in undercapitalized solo or small-group practices; hospitals competed for physician referrals by amassing expensive technologies with little attention to their necessity; and the results of care were essentially unmeasurable.[20] Kaiser's physicians and hospitals, by contrast, were dedicated to their members, coordinated care among themselves, avoided duplication, followed standardized guidelines, and could be held accountable for both costs and outcomes as a unit.

Prepaid Care

The core logic of the HMO approach involved a convergence of coverage and care at the health plan level, with plans receiving an annual "capitated" premium (i.e., a per enrollee payment) and taking responsibility for providing necessary care to a defined population of members. State Medicaid programs, and to some degree Medicare, pursued similar strategies as the private sector, anticipating that it would be easier to deal with a small number of competing health plans than legions of individual providers.

In Kaiser itself, physicians are salaried and the organization tracks member health and health care rather than processing claims to "reimburse" itemized services. Kaiser even assumes liability at the health plan level for malpractice claims against its affiliated physicians. In this way, patients enjoy one-stop shopping while the worst impulses of providers to over-treat, and of insurers to undertreat, are counterbalanced. In return for these benefits, members of Kaiser-like managed care organizations give up their right to coverage of services from unaffiliated physicians and hospitals. Services received within the organization, however, are covered on very favorable terms, with low deductibles and co-payments.

Prevention

The managed care era brought the potential cost-savings of preventive care into serious policy debate. Preventive care is undervalued by physicians and hospitals, who are more likely to be called on when serious illnesses arise and who are better paid to respond to them. As the term implies, "health maintenance organizations" are intended to prevent disease as well as treat it. Because members receive care exclusively from the HMO over a period of years, the theory goes, the HMO has a financial incentive to invest in prevention, including regular screening, early diagnosis, and prompt treatment. Preventive care is also usually free to members so that they will access it routinely.

Purchasers

Managed care was supposed to control cost in part because purchasers would become as organized as integrated insurer-providers. For this reason, the Clinton health reform had created "health alliances" (originally called "health insurance purchasing cooperatives") that were the policy progenitors of the ACA's insurance exchanges. Pooled purchasing, the advantages of which had already been demonstrated by large employers, saved money by creating more stable risk pools, generating economies of scale in enrollment and administration, and conferring greater bargaining power on the buyer. The cost disadvantages of employer purchasing were that it attenuated the connection between available coverage and individual preferences, and that it added a large taxpayer subsidy to health care that further reduced price consciousness.

The managed care experiment failed. Competing Kaisers never materialized. In retrospect, it was asking too much.[21] Closed-panel HMOs prosper in a few parts of the country where both patients and physicians are acculturated to them. Moreover, they require massive capital investment. Physicians in private practice elsewhere were not about to migrate en masse to corporate entities whose facilities were unbuilt and whose businesses were untested. The flawed alternative

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was to assemble "virtual" HMOs by contract, leaving physicians and hospitals as structurally fragmented as before but relying on financial incentives to break providers of their profligate habits. And interposing "gatekeeper" physicians and preauthorization requirements between patients and the specialized care they were accustomed to receiving. Making things worse, the insurers and intermediaries who stepped forward to serve the market were often new, for-profit entities with ambitious executives and strict earnings targets. Given the high level of annual churn in enrollment, long-term investment in health proved unprofitable, and public confidence in quality and trustworthiness evaporated.

The backlash came quickly.[22] Faced with employee unrest (and buoyed by a sound economy), private employers retreated as active purchasers while politicians, encouraged by lobbyists protecting provider interests, seized on the shift in public opinion. Nearly all states passed "patient protection" acts. Congress was more restrained, but one high-profile law it enacted — the "Newborns' and Mothers' Health Protection Act of 1996" — made abundantly clear from its title and content (guaranteeing generous private coverage for post-delivery hospitalization) that even transparent, scientifically reasonable measures limiting care for generally healthy and economically secure individuals were politically unacceptable.[23] Private rationing would be no easier than public rationing.

When the dust settled on "Phase II," little progress had been made, and cost growth — which had briefly stalled — accelerated again. Streamlined organizations like Kaiser remained rare, with most managed care gravitating to large Blue Cross plans that contracted unselectively (and sometimes unaggressively) with every hospital and nearly every physician. Under these conditions, premiums for prevention-oriented HMO-style products became unaffordable, and — boosted by the rising political fortunes of conservative Republicans who blamed costs on moral hazard and the welfare state — health insurance coverage itself became seen as the problem rather than the solution.

The result was a far less transparent shift of financial responsibility from insurers and employers to insured workers and patients in the form of high deductibles and co-insurance. This movement (ironically called "consumer-directed care") was billed as cultivating savvy buyers who had "skin in the game," but served mainly to conceal continued growth in health care costs by moving it from visible premiums to less visible individual and family debt. By the time this was generally known, a national economic collapse unrelated to health care had intervened, and a new Democratic administration took over — promising universal health coverage as a prerequisite to financial security and opportunity.

Phase III Cost Control: Information, Incentives, and Value

The Patient Protection and Affordable Care Act of 2010 (ACA) was an ambitious and risky endeavor. It attempted to expand health coverage to nearly all citizens, but not saddle the country with even more debt than existing entitlement programs — notably Medicare — had already created. It maintained many of the premises of 1990s-style managed competition, yet never spoke the words "managed care" above a whisper. Most importantly, it simultaneously engaged all three parts of the health reform puzzle — health insurance, health care delivery, and the underlying health of individuals and communities.

Skeptics immediately labeled it a giveaway to a few and a takeaway from the rest, and whether the ACA can credibly offer something to everyone remains an open question. But there were reasons beyond overconfidence why universalizing an already-too-costly health care system was the majority's political choice. These included three related beliefs, each backed by research: that the insured were already paying a lot for the uninsured, that these shifted expenditures were made greater (and their benefits diminished) by lack of attention to "social determinants" of health, and that perverse incentives and lack of information made the existing health care system massively wasteful. Rhetoric regarding the "best health care in the world" receded; "delivery system reform" became a consensus objective.[24]

Productivity

By 2010, the intellectual mantle of health care cost control had passed from the Kissicks of the post-Medicare generation, alighted briefly on conservative theorists of health savings accounts, and wrapped itself firmly around the Institute for Healthcare Improvement (IHI) and its founder, pediatrician and former Harvard Community Health Plan quality leader Don Berwick. Examining quality, management, and the rise in chronic disease, IHI distilled its reform goals into a "Triple Aim": improving the patient experience of care, improving the health of populations, and reducing per capita costs.[25]

This "value-based" analysis was bolstered by authoritative reports from the Institute of Medicine and others that demonstrated major safety lapses, a "quality chasm," and nearly a trillion dollars in annual waste.[26] In asserting that the component parts of the

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Triple Aim are simultaneously achievable, Berwick's formulation had an immediate advantage over Kissick's. Instead of requiring a definitive political settlement regarding limits on resource use (e.g., the ACA's apocryphal "death panels"), the Triple Aim called only for iterative, incremental improvements — hard tradeoffs being premature when so many mutually beneficial efficiency gains are possible.[27]

Processing

A clear divergence between health care and ostensibly efficient industries is the latter's much greater use of 21st century information and communications technologies. To its proponents, Health IT can facilitate coordination of care using Electronic Health Records and Health Information Exchanges; communicate information that is more timely and accurate; offer alerts to improve safety and decision support to boost quality; expand access to services through inexpensive telehealth modalities; and measure processes and results to enable efficient production, informed consumer choice, and public accountability. The George W. Bush administration created the Office of National Coordinator for Health IT by executive order in 2004, and its funding increased substantially under HITECH (part of the American Recovery and Reinvestment Act) and the ACA. Early supply-side assistance to developers of platforms and software eventually gave way to a demand-side "pull strategy" with financial incentives for "meaningful use" by hospitals and physicians, but overall enthusiasm has remained strong.

Payment

Fee-for-service medicine can be blamed for many perversities in the existing health care system. Procedures are overused. Physicians neglect simple preventive measures in favor of complex therapeutic ones. Because health professionals and health facilities bill separately, production is uncoordinated. Avoiding complications reduces profit rather than raising it. Defensive medicine enhances revenue without adding value. Maximizing "reimbursement" adds to administrative overhead and increases the potential for fraud. For these reasons, "alternative payment systems" and "risk-based contracting" are universally praised, if incompletely specified, by the current generation of policymakers.[28] Depending on the size and nature of the organization receiving it, "value-based" payment can include care bundles or episodes, "reference pricing," and various forms of "shared savings" ranging from modest bonuses for efficient performance to globally capitated payments that place providers at full financial risk.[29]

Performance

"Accountable care" has replaced "managed care" in the cost-control lexicon. Quality assessment before the 1990s was largely an academic exercise, and entered the policy mainstream only when the public began to doubt the loyalty and competence of physicians who seemed increasingly in thrall to managed care organizations. But one cannot pay for value unless one can measure it, and avoiding another backlash requires an information-rich environment for both patients and providers. Performance metrics, therefore, have proliferated in the post-ACA health care system. New metrics range across care processes, clinical outcomes, patient experiences, and population health improvement, and are adaptable to both traditional settings and new delivery models such as accountable care organizations and patient-centered medical homes.[30] Nearly half the states have also put in place All-Payer Claims Databases to facilitate quality measurement and empower both consumers and regulators, although the states' power to mandate reporting by self-insured ERISA plans was recently limited by the Supreme Court.[31]

Prices

High service and input prices contribute significantly to overall U.S. health care spending.[32] Patients seldom know the price or quality of their care in advance of receiving it. Policies to make quality more transparent to consumers began in the 1990s to help monitor the cost-cutting activities of managed care organizations. Making price more transparent began in the 2000s, in part to facilitate prudent purchasing in high-deductible health plans. Still, recent analyses have exposed hospital pricing that continues to be both exorbitant and arbitrary.[33] Pharmaceutical prices are also notably higher in the U.S. than abroad; sharp increases in prices for established drugs as well as new biological entities have renewed interest in government negotiating or controlling prices. Corporate consolidation amplifies these pricing concerns — large hospitals can gain market power or dominant hospitals and dominant insurers can lock out competitors for their mutual benefit — which may require stronger antitrust enforcement to prevent.[34] More generally, arbitrary and variable pricing suggests that many health care providers do not understand their own cost structures, which bodes poorly for improving productive efficiency.

Populations

The chronic disease burden associated with poor nutrition, insufficient physical activity, and other lifestyle factors, combined with overall population aging, threatens a substantial increase in health care

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spending.[35] Health care and public health — historically related fields that drifted apart in the 20th century — have been brought together again by a series of challenges such as AIDS/HIV, tobacco control, biopreparedness, pandemic influenza, substance abuse, environmental exposures, and child and adult obesity. Drawing on research mapping the social determinants of health and documenting disparities that unfairly burden low-income and minority populations, the ACA has accelerated the coalescence of individual and population health management. ACA-related population health initiatives include accountable care organizations, community workforce investments, and hospital-generated community health needs assessments.

Although the Triple Aim reflects a profound rethinking of health policy, it is too soon to tell whether the payment reform and information exchange that embody "Phase III" cost control will prove effective remedies for waste and inefficiency. A welcome post-ACA dip in health care spending may have been only transitory, and early returns on accountable care organizations and bundled payment programs are mixed.[36] Incentives and information may bring people to the table and begin conversations, but may not change behavior. Recognized problems include overshoot in the number and complexity of accountability metrics and "meaningful use" standards, difficulties attributing outcomes when several providers share responsibility for a given patient's care, rewarding inefficient providers for improvement rather than efficient providers for achievement, and limitations associated with using claims data rather than clinical data to monitor and improve performance.[37]

The role of government in fostering efficiency is also unsettled. The current generation of reforms is more market-oriented than collective, with President Obama tending to equate the interests of "consumers" with those of "the American public."[38] This bias has already endangered the ACA's "Cadillac tax" on very expensive employee health benefits, a reform widely supported by health policy experts but lacking the social solidarity needed to justify it politically. Dislodging long-standing industry practices also seems to require a top-down approach in many instances, particularly through Medicare policy. However, lack of attention to why the health care system is so *persistently* inefficient, notably its accretion of self-protective professional regulation at the state as well as the federal level, decreases the likelihood that missteps in the reform process will be self-correcting.

In other words, health care cost control depends critically on resurgent belief, both medical and social, in compassion and community as well as clinical capability and consumerism. It cannot be coincidental that both Don Berwick and Avedis Donabedian, luminaries of health care quality improvement, came late in their careers to emphasize personal service and social consciousness over technical achievement. Berwick's view, recently stated, is that "[w]ithout a new moral ethos, there will be no winners." Donabedian, in an interview conducted shortly before his death, put it even more directly: "The secret of quality is love."

Looking Ahead to Phase IV: Revisiting Law and Culture

A truism of management consulting is that "culture eats strategy for breakfast."[39] Three cultures are relevant to health care: professional, personal, and political. Engaging these cultures is likely to lie at the heart of any successful effort to reconcile health care spending with other critical uses of public and private resources.

At the professional level, changing the culture is made easier by a new generation of *practitioners*, who are more diverse in their professional skills and training, and more willing than their predecessors to embrace clinical redesign and population health management.[40] However, it also will be necessary to re-examine and begin to unwind a century of regulatory and self-regulatory *protectionism* that constitutes the deep legal architecture of the health care system, and that may largely be responsible for its inefficiency.[41]

At the personal level, genuine *participation* by individuals in setting health goals, exploring medical and non-medical options, and managing health-related decisions is indispensable to obtaining better value from the health care system. For situations in which a market framework is appropriate, health care *products* must be available that meet individuals' needs,

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are sold on a fully assembled basis, and include warranties for basic quality and safety like other complex consumer goods.[42]

At the political level, promoting health and providing health care must become expressions of *patriotism* in America, as they are elsewhere in the world.[43] In particular, the crippling multi-generational effects of endemic *poverty* on education and health, and therefore on economic and social opportunity, can no longer be ignored.[44] This collective commitment is necessary not only to salvage scarce financial resources from low-value health care uses — only some of which constitute pure "waste" — but also to identify higher-value social uses and channel saved resources toward them.

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