Failures in Healthcare Delivery

Introduction

Healthcare has become a focus of policymaking the United States in addition to the global community in recent years. With globalization integrating the economies of countries around the world, the wellbeing of each country’s population within the context of their healthcare system is being thoroughly analyzed during recent decades. The US in particular has the most expensive healthcare system in the world, spending $8,508 on per capita health expenditures in 2014 (Davis 2014). However, it has become apparent to US policymakers that the US healthcare system is monetarily and structurally inefficient. The Journal of the American Medical Association reaffirmed this fact by publishing figures suggesting that over 20% of total healthcare expenditures were attributed to overtreatment, failures in care coordination, failure to execute care processes, fraud, abuse, and pricing failures, all of which result in the mistreatment of a patient. Despite patient safety systems and preventative care practices, it was estimated that in 2011, wasteful spending from failures of care delivery cost between $102 billion and $154 billion (Berwick 2012). Failures in delivery range across many aspects of public policy, including arranging specific systems to prevent medical errors, improving the efficiency and avoidable wasteful spending within the system, mobilizing advocacy groups and collective action to promote a more cohesive system, and improving the equity in the system to give care access to a wider portion of our population. Despite some of these particular issues being unavoidable to an extent, it is estimated that 44% of these issues
could be prevented annually (Lallemand 2012). The primary goals of establishing a more efficient delivery system are to 1) decrease the number of individuals who suffer financially and physically from care mishaps, 2) to decrease the cost on hospitals, companies and the government from failures in delivery, and 3) to reduce the waste of the current system to induce higher overall wellbeing and welfare to the American people. With the health and wellbeing of the American people at stake, solving failures in the delivery of healthcare has implications socially, economically, and formulates the identity of our country as one of the world’s superpowers.

The policies that create failures in healthcare delivery in the United States are a product of the American political system and structure. The two-party system that dictates the American political process generates polarization in ideas and policy. As demonstrated through Arrow’s Impossibility Theorem, there is not one decision that truly reflects the decisions and ideologies of everyone. The current distributions of each ideology minimally overlap: the Democratic bell curve is strongly skewed to the left, while the Republican distribution of ideology is right-skewed. This dispersal of ideas generates collective action issues within the political world, and more specifically, different ideas in how to attempt to create healthcare reform. Our current healthcare policy generates inefficiencies by not fully implementing one cohesive plan to solve as much of the system failures as possible, but instead is compiled of fragmented pieces of different ideological plans. In this aspect, current policies and the attempts made by both parties to dominate our current political process hinders our ability to fully solve issues of welfare in health care, but at the same time it is a necessary vehicle to bring about reform.
Current Literature

Current academic literature on failures in healthcare delivery is focused in a couple of areas. One of the main studies that records unwarranted variation in medical practices was studied at Dartmouth University, within their Atlas of Health Care project. The project details the statistics of use of resources and medical care in over 300 different regions, and 3436 hospital service areas. The study as well as other current literature of this topic focuses in three different areas that cause failures in health care delivery. The first, “variations in effective care and patient safety,” records systematic underuse of the effective care methods. One such example of a failure in this area is the use of beta-blockers on heart attack patients after they are discharged from the hospital. Dartmouth’s data showed that the candidates eligible for the beta-blockers received them between 40%-83% of the time. The second area is “variations in preference-sensitive care.” Preference-sensitive care denotes a condition where the patient dictates which course of action they wish to pursue. Despite the nature of these decisions, the medical opinion of the doctor tends to override the potential for patient preference. The Dartmouth study revealed that the decisions made that were allegedly preference-based deviated based on location or region. The influence of medical opinion generates variations in specific areas on treatments, more specifically, creating a risk for elective surgery. The third area of study of variation is within “supply sensitive care.” This service area is determined by the per capita quantity of different medical resources that are distributed to geographical areas of the country. For example, areas that have more doctors allow patients to have greater access to diagnostic tests and longer stays in hospitals and ICUs. Current literature is seeking a solution for the variation in effective care and patient safety,
preference-sensitive care, and supply sensitive care. While previous research projects in this area highlight improvements in patient safety, reducing overall insecurities within each area, and cutting underservice. The implications of these “improvements” have not been noticed yet in the American health care system. The Dartmouth study specifically identified that one of the biggest issues in healthcare delivery is assessment of evaluative health services. It appears as though a higher frequency of services used in specific areas does not increase longevity, so increasing frequency of services should not be the focus of issues with healthcare delivery. The results of the study suggested that one method of fixing evaluative health services is to begin a comparative study of practice patterns, following patients over time to establish a better system to elicit survival, decrease complications from treatments, and increase quality of life (Wennberg 2002).

Analysis

Within the rankings from the Mirror, Mirror study by the Commonwealth Fund, the US ranks last in efficiency of healthcare system compared to the 11 other industrialized countries that participated in the study, including Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the UK. The National Scorecard report described efficiency within the healthcare system as, “an efficient, high-value health care system seeks to maximize the quality of care and outcomes given the resources committed, while ensuring that additional investments yield net value over time.” One of the measurements used by this particular study was the percent of GDP that was affected by total expenditures on health. In the US, health costs represent 17.7% of GDP spending, which is over 6.5 percentage points higher than any other of the industrialized countries that the US was compared to. The failures in policy
create this lack of efficiency, with other indicators of healthcare efficiency placing the US at the bottom of the ranking system. Additionally, measurements included time spent on medical bills and paperwork for administration and patients, patients who had to be re-hospitalized or sent to the emergency room for treatment complications, and whether a primary care practice had “multifunctional clinical information technology,” including EMR medical record systems. In 2014, the average percentage of additional time that doctors spent getting patients medication of treatment due to coverage restriction was 52%. This is over 26 percentage points higher in excess time than any of the other 11 countries in the Mirror, Mirror study. Interpreting these statistics and externalities of the US healthcare system, it was indicated that US healthcare policy causes poor performance on national expenditures, untimely access to results of tests and various patient records, re-hospitalization, and the tendency for patients to visit an emergency room for an issue that could be seen by a regular doctor (Davis 2014).

There have been efforts made within the US government and the private sector in response to the efficiency issues of health care delivery. One of the ideas to make the system more efficient is the concept of “accountable care organizations.” Instead of using government agencies, policy organizations and elected officials to reform the health care system, ACOs allow for the main actors and those affected by healthcare, or the patients and physicians, to change the health care delivery system themselves (Dove 2009). Accountable care organizations are an attempt at reforming certain failures in health care delivery, however, out “current payment systems undermine efforts to invest money and effort in delivery-system improvements that can sustainably reduce costs,” (McClellan 982). The organizations are groups of volunteers who hold positions within the healthcare
system such as doctors, hospitals, and providers to coordinate care to prevent unnecessary repetition of services, one of the issues of the US system, and medical errors. Accountable care organizations have a base in primary care, but also include integrated delivery systems and networks of various medical groups. The implementation of ACOs is through different payment methods, such as fee-for-service or limited or substantial capitation arrangements. The responsibilities of ACOs include being collectively accountable for quality and costs of patient care, reduction of overall cost, and more progressive and sophisticated measurement systems to monitor progress in these areas. The legislation controlling the implementation of ACOs within reformation of the system allows many different groups with a range of different characteristics to participate in the reform. The Congressional Budget Office scored the legislation surrounding the implementation of ACOs, estimating that it will save approximately $5 billion in the next ten years in the cost of failures in delivery of healthcare. Broader implementation of ACOs will yield these improvements in care and cost savings (McClellan 2010). Medicare specifically offers multiple programs to attempt to improve efficiency, including Medicare Shared Savings Program, Advance Payment ACO Model, and Pioneer ACO Model. This is a great advancement in the realm of care efficiency, however, due to the volunteer nature of this program, its positive impact is not at its full potential in curing the inefficiencies of the system.

Areas of government regulation also impact the efficiency of a particular program, highlighting one of the collective action issues in healthcare efficiency. The government reserves the right to regulate care through regulation of prices through hospital and physician charges under Medicare program, regulation of hospital
investment and capacity, regulation of access, through the form of mandated insurance benefits and laws that make it illegal for hospitals that include emergency services to refuse treatment, and regulation of information within the healthcare system. Historically, efficiency within healthcare has been a competition between self-regulation and government regulation. Striking a balance between the two is an issue of the polarity of our political system. The party in power legislatively can control the ratio of self-regulation of the industry compared to government regulation of the industry. In addition to differences in ideology in care regulation, healthcare is a rapidly changing industry, and the reason for such rapid changes in policy, as stated by Kenneth Arrow, is that “it is hard to make regulations flexible enough to meet a wide variety of situations and yet simple enough to be enforceable,” (Haas-Wilson 2003). Efficiency remains a necessary addition to healthcare reform, and though measures are being taken to help improve this aspect of the system, the statistics remain that the US is still lacking in this area of delivery issues as a result of the political process.

The United States also ranks last in equity measurements amongst the top 11 industrialized countries. The Institute of Medicine defines equity within the healthcare realm as, “providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.” Those who are recognized as “low” or “lower” income in the United States were found to not visit a doctor when it was necessary, not getting recommended tests, treatments, and follow up care, and skipping on prescriptions due to high costs. A study conducted by the Commonwealth Fund, updated annually, categorized efficiency by grouping adults in the US into above the country’s median income, and below the median income level. It was
found that out of the percent of the population that fell below the median income line, 39% required treatment by a doctor for a medical condition but not receive this treatment due to the high cost. This is 16 percentage points higher than any other of the 11 industrial countries, with the UK’s percentage of the lower income population experiencing this hardship at just 1%. Additionally, the US ranks particularly low pertaining to access to care measures, specifically for adults who have lower income. It becomes difficult for Americans with incomes below the national average to get treatment, follow-up care, or consistently fill prescriptions (Davis 2014). In the eyes of many policymakers, particularly liberal-minded agents, the government must implement a degree of paternalism to protect its citizens through regulation and control of the policies. Those who believe in paternalism and providing a safety net for all citizens, not only those who have access or can afford it, are moving towards writing policy for a more equitable healthcare system.

One of the main contributors to the issue of equity is price competition within healthcare. Antitrust legislation works to protect competition and consumers through counteracting anticompetitive business conduct and anticompetitive consolidation. The legislation attempting to limit the negative consequences in both of these areas, including the Sherman Act of 1890, the Clayton Act of 1914, and the Federal Trade Commission Act of 1914, enable firms to exercise greater market power. A rise in market power is directly coordinated with price competition, creating many of the equity issues within the US system of healthcare. In a study comparing California hospitals from 1986 to 1994, it was confirmed that increased price competition reduces the ability of hospitals and physicians to earn the revenues that are necessary to cross-subsidize healthcare costs for
those who cannot afford care. Independent of price competition, the polarization of the legislative powers in the United States impacts the enforcement of antitrust legislation. The Antitrust Division of the United States Department of Justice, the Federal Trade Commission, states’ attorney’s general, and private plaintiffs enforce the antitrust policies. The Federal Trade Commission’s current membership has a ratio of 3-2 for Democratic members compared to Republican members. Considering this body’s important role in enforcement, the inequitable party divide allows for party ideology infringement on enforcement policies. The political process often yields “losers” within the network of firms and constituents, and politicians seek to combat this balance by attempting to influence antitrust policy enforcement. One empirical study of this theory found that political pressure and the number of mergers, or a combination of competitors or companies to reduce competition and raise prices within the market, challenged by the Federal Trade Commission to have a positive association (Haas-Wilson 2003). The politically penetrable nature of antitrust legislation and enforcement, while attempting to protect firms and consumers, is a direct contribution to the US’s poor ranking against other industrialized nations in healthcare equity.

In terms of welfare, healthcare delivery issues force policymakers to determine which aspects of a citizen’s health and general care are deemed “necessary” to be provided by the government. While this seems to be a straightforward question, the political process is intertwined into the idea of welfare due to the setup of our political system. As globalization has increased and the government plays a larger role in many lives, healthcare has fallen under the umbrella of the government’s responsibility to ensure that its citizens fall above a standard of living and welfare. However, how much
influence the government should have over policy changes or what the policy changes are specifically differs in ideology between the two parties within our political system.

Within each ideology, health care reform ideas to attempt to fix the inefficiencies in the current system have been at the forefront of political issues within the last few years. Republicans generally hold the conservative perspective that government oversight of healthcare is not generating proper reform, but simply expanding the corrupted system, and that government-run universal healthcare is causing inefficiencies in the system of substandard health care. Republicans emphasize cost-cutting efforts to make the system more effective, such as the management of health needs of individuals through Flexible Saving Accounts (FSAs) and Medical Savings Accounts (MSAs). Additionally, the Republican Party platform promotes a reformation of malpractice law, to bring to light mistakes made in this field pertaining to medical errors (On the Issues 2015: Republican Party).

While the conservative view focuses on the spending aspect of healthcare delivery failures, Democrats tend to focus on equity and welfare to ensure access to affordable healthcare for all who are discriminated against in the current system by the grounds of health status, socioeconomic status, age, identity, or geographic location. By refusing to privatize or voucherize Medicare and providing medical insurance to those with preexisting conditions, Democrats are seeking to expand coverage to give all of America access to good healthcare. Additionally, to supplement the Republican plan to reduce government spending, Democrats are looking to reform the prescription drug program and invest in stem cell and other medical research to make healthcare affordable for the individual (On the Issues 2015: Democratic Party). The variation in ideas across the two
parties for healthcare reform and policy in general makes it difficult to pass legislation and raise the living standard to increase welfare within society.

One of the primary causes of failures in healthcare delivery in the current system is the decentralization of the delivery system, and how a lack of coordination of activities among health professionals leads to multiple equity, efficiency, and welfare issues. Convincing individuals to promote the common interest over their own self-interest can solve many of the problems in health policy; however, this level of cooperation is difficult to achieve, hence the collective action issues that surround health policy. Part of the debate within the issue of equity and healthcare is the nature of healthcare as a good. The question as to if the government should standardize healthcare to approach equity is under debate if healthcare is categorized as a club good (non-rival but excludable) or a private good (excludable and rival). If the good is defined as a public good, then providing a safety net to handle inequality is a useful method of dealing with the market failure that creates limited access to healthcare for some. Labeling healthcare as a non-rival and non-excludable good means that more than one person can enjoy the good at once and specific groups or individuals cannot be excluded from healthcare due to various circumstances or characteristics. In order to improve the apparent failures in healthcare delivery, it is necessary to fully establish healthcare as a public good. This will create a system of reporting and reviewing medical efforts, ensure patient safety as a standard, and shape a social norm as healthcare as a favorable government-assisted good. The nature of collective action issues in terms of framing effects, heuristics, probability neglect (treating a health implication with less severity than deserved), and loss and risk aversion, prevent individuals from wanting to supply healthcare as a public good (Siegal
However, solving these collective action issues could promote a more monetarily and socially efficient system that can benefit all of America, not only those who experience under coverage or the negative externalities of the system. The decentralization of the healthcare system is one of the first fixes in mobilizing towards a public good. Currently, activities in different areas of healthcare are not coordinated. By creating a design, monitored by the government, that has multiple levels focusing on knowledge, tools, research, and leadership about safety, all levels of healthcare can coordinate to raise standard of care, lower costs, and create a national standard of healthcare that is not biased by location, socioeconomic status, or access. This could include nationwide public mandatory report systems, voluntary report systems on smaller scales, standardizing safety procedures, and raising performance standards through the use of oversight organizations. Instead of a healthcare system that is fragmented and wasting resources, lives, and money, one coordinated system could eliminate as much of the byproduct and externality effects as possible within our industrialized country (Burns 2002).

The legislative process also contributes to collective action issues, while allowing the American political climate to influence future prospective healthcare policy. One of the most prominent examples of the negative impact of the structurally biased format of American political systems on healthcare delivery failures was investigated in a study done by Sven Steinmo and Jan Watts. The study originally looked at the criticism of the failure of the Clinton national healthcare plan of 1993. Steinmo and Watts found that the plan failed similarly to the attempts made at comprehensive national healthcare reform in 1948, 1965, 1974, and 1978. They established that the polarized structure of American
political institutions is the reason that the US is the only democratic country that does not have a comprehensive national health insurance system. The factors that contributed to this development include the influence of powerful, polarized interest groups, where historically physicians, hospitals, businesses, insurance companies, and other political forces have publicly opposed NHI policies with force. The institutional design of the constitution places political factions against each other in an effort to protect the minority factions from their more powerful majority counterparts. The bias towards strong political parties has exacerbated attempts at progressive reform, making it important to note that the increase in factions within the political system means that more interests have stake in the conversation of reform, making it less likely to collaborate on policy.

Reform has also been combatted by fragmented political power. This is a result of the American checks and balances system, size and diversity of America, and the Congressional reforms that have amounted over time. The fragmentation has increased over the last 20 years, allowing decentralization of institutional power to prevent meaningful, cohesive reform from passing. The final trend that contributed to the failure of Clinton’s bill is the stringent nature of Congressional rules, which prevent meaningful collaboration and often yield policy standstills (Harrington 2008). The failure of Clinton’s fundamentally sound healthcare bill represents the continued struggle of political figureheads to reach a comprehensive, solid conclusion as to how to solve the failures in our healthcare delivery system using the legislative process.

Conclusion

The impact that policymakers have on the failures in healthcare delivery in our current political context is an example of how public policy has failed, succeeded, and
continued to impact the lives of Americans on a daily basis. The United States maintains an incredibly expensive yet inefficient healthcare system that struggles with accessibility, excessive spending on unnecessary malpractices and inefficient policies, regulation, in addition to patient safety and care practices. The fundamental connection between the failures of the American system is lack of ability to find a balance between the two parties that dominate the American political system. While the American political process has generated some policies that positively impact the system, such as regulatory accountable care organizations to solve inefficiency issues, the creation of meaningful healthcare reform has been prevented due to failure to cohesively regulate, the negative impact of price competition, competing ideology about solving common policy issues, and the legislative process. In order to eliminate the monetary and social inefficiencies of the system, patients need to have more influence in their own care to balance the power in this area of the political system. Readjusting the goal of care to focus on the patient rather than economic competition and profit incentives would limit the negative effects of the polar ideologies within our political system. Patient-centric incentives are the only way to refocus healthcare reform and solve failures in healthcare delivery resulting from the political process. It is clear that no matter how it is accomplished, the US healthcare system is in dire need of reform to create a more sustainable, efficient, and equitable system to benefit the government, various firms, and our citizens alike. The future of the American healthcare system is not a reputation as the most expensive yet most unbalanced system of the 11 similar industrialized countries, but instead to be known as the most efficient, equitable system that spreads welfare throughout our entire population.
Works Cited


