

Overtreated: A system Designed in the 1940's

Our healthcare system as we know it today was established in the 1940s, during World War II. At the time, because of the war, it was impossible for employers to raise wages, so offering health benefits was a way that employers could distinguish themselves and attract the best employees. That set a precedent that picked up speed and momentum, and so much critical mass that it became the standard way things were done. This precedent led to a number of consequences, one of which is that the political conversation in this country around healthcare has not really dealt with the true nature of how healthcare should work in a country such as ours.

In order to fix a broken healthcare system—or devise one in the first place—the policy making conversation must start with consensus among the parties as to the basic assumptions and parameters that will apply equally to everyone and form the basis of a system that is as fair and equitable as humanly possible.

The most basic of those assumptions and parameters, and the one that should have formed the basis of our healthcare system all those decades ago is this: no matter what kind of a system is envisioned, at the end of the day we all pay for healthcare in this country; the young are going to pay for the old, the healthy are going to pay for the sick, and by extension, the wealthy are, in some measure, going to pay for the poor.

Go anywhere in the world where governments have had long histories of dealing with this precise issue and they will all agree that this is the immutable truth about healthcare. The sooner those countries came to a consensus on that issue, the faster problems could be solved and a coherent system established.

If a nation has not built that kind of political consensus, it's almost impossible to set up a workable system. People and politicians must accept the inherent inequity of those parameters and move on before a real conversation about creating as fair and equitable a system as is possible given the imbalance of the original parameters

In this country, our political conversation around healthcare has never actually focused on these self-evident truths, and until we do—until we accept that despite the fact that it is inequitable, that the young pay for the old, the healthy pay for the sick, and the wealthy in some measure pay for the poor—it is going to be impossible to figure out how to devise a system that addresses the major issues of accessibility, affordability, and quality of outcome.

Will we ever get there? Can we reach that kind of national consensus? Can we get beyond the political partisanship, the divisive cries of “socialized medicine,” “prioritized Social Security,” “Death Panels,” and other manufactured taboos?

It's unfortunate that we can't simply have a frank conversation about national healthcare without the partisan bickering and posturing. We would find that the challenges we face are no different than those faced by Germany or England or Canada. But it's a matter of

actually having that conversation, it is the only way we really figure out what the driving assumptions and parameters are around our healthcare and establish a fair, equitable system within those constraints so we can move forward and start improving our system, reduce costs and increase accessibility.

Other than the public debt and our national deficits, dealing with our healthcare system is clearly the single-biggest fiscal challenge that we face. Healthcare amounts to at least \$2.5 trillion out of an approximate \$14 trillion a year economy. This is a huge slice of the U.S. economy, and is growing at double-digit rates. If those expenditures continue to expand at the current rate, it will eat up the entire economic output of this country. The sheer economic force of it will require that the conversation around how to do it better keeps going.

The United States is arguably the wealthiest country in the industrialized world. We spend more on healthcare than any other country. How can our infant mortality rates be increasing? How can our life expectancy not be as good as other countries? The relevant statistics do not paint an optimistic story. We spend more than anyone else and our outcomes are not keeping pace, in fact, they are getting worse.

Health spending as a share of U.S. gross domestic product (GDP) has climbed steadily over the past half-century. Today, it constitutes 18 percent of GDP, up from 14 percent in 2000 and 5 percent in 1960, and we are well on our way to 21 percent by 2023, based on current projections. This increased dedication of economic resources to the health sector, however, is not yielding commensurate value in terms of improving population health or patients' experiences with care.

On average, the U.S. spends twice as much on health care per capita, and 50 percent more as a share of GDP, as other industrialized nations do. And yet we fail to reap the benefits of longer lives, lower infant mortality, universal access, and quality of care realized by many other high-income countries. There is broad evidence, as well, that much of that excess spending is wasteful. Stabilizing health spending and targeting it in ways that ensure access to care and improve health outcomes would free up billions of dollars annually for critically needed economic and social investments—both public and private—as well as higher wages for workers.