YANKEE DOODLING **Douglas Kamerow**

Our perfectly designed US healthcare system

An interregnum thought experiment

The interregnum between a presidential election and the inauguration is a time of feverish activity, in which the president elect and his staff decide who will help them govern and what they will try to do first. The press and pundits speculate breathlessly on who will be appointed and what they will do first. As I write this, for example, we have just learnt that the new administration's secretary of health and human services is likely to be a respected former US senator, Tom Daschle. He has written a book about healthcare reform, which is likely to be his assignment when he starts in January.

I've been musing about the United States and how perfectly designed our current healthcare system is. Perfectly designed, of course, as every system is, to achieve exactly the results it gets, as quality improvement guru Don Berwick famously said. In its own way, it is really rather remarkable. Here's a thought experiment to illustrate what I mean.

Suppose you have a big industrialised country that has lots of money to devote to health care: around $2 trillion a year. That is $6400 (£4300; €5100) per person, far more than any other country spends on health care. And let's say that the country leads the world in technological advances, developing everything from computers to new scanners before anyone else. We'll also give you a large and enormously profitable drug industry to develop and test new products. And some of the world's best health and healthcare researchers, well funded by the world's richest health research institutes and foundations. To make sure that all this largesse is fairly distributed, we'll even make this mythical country a democracy, where the voice of the people rules.

Your assignment, should you choose to accept it, is to take all these resources and design a scenario (notice that I didn't say a system) in which both healthcare process measures and health outcomes in the population are paradoxically poor by international standards. So, despite the money, the technology, and the research talent, you have to find a way to keep neonatal mortality from falling and life expectancy from rising; a way to deliver suboptimal care for people with chronic diseases; and to keep delivery of appropriate preventive services uneven and inconsistent. In general, you have to ensure that you are getting poor value for your healthcare dollar.

This is not easy to do. Most countries would fail, but in the US we did it. The foundation of the scheme is disparity. Firstly, deny health insurance to 47 million people to delay or prevent access to health care. Add another 16 million who are underinsured, so that a catastrophic health event bankrupts them. Create broad disparities in income, so that some people can't afford to pay for insurance or health care. And tie most health insurance to employment, so that when people lose their jobs they risk losing their insurance.

Secondly, make sure that there are no national systems of care or planning to allocate resources evenly across the population. This will allow every facility that wants a magnetic resonance imaging scanner to get one, even if the city already has dozens, and will lead to a high proportion of unnecessary scans, perhaps 20% to 30%. And while we're at it, let's make sure that electronic healthcare records are adopted by less than 20% of doctors. That will ensure that medical records and health information are not transferred with the patient, which makes for many more needless tests and miscommunications. It will also impede improvements in continuity of care and patient safety.

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Thirdly, spend lots of money, say $300bn or so a year, on drugs and devices and allow drugs to be advertised directly to the consumer to keep demand high for new, expensive ones. The drug industry knows that every dollar spent on advertising to patients yields $4 in increased revenues.

Finally, none of this will work unless we make sure that no one is around to coordinate patients' care, to serve as their medical "home" and deliver necessary preventive treatment and care for acute and chronic disease from cradle to grave. Most countries in the world entrust this job to primary care doctors, who generally make up about 60% of the medical workforce. In 1949, 59% of US doctors were general practitioners, so we really had to work hard to eliminate them if we were going to achieve our goals. Again, it wasn't easy, but we did it. We made primary care less prestigious than specialty practice. Our multiple payers ensured that most of doctors' time would be spent on paperwork rather than on care of patients. We paid primary care doctors less, a lot less, than subspecialists. And, in a recent clever touch, we dramatically increased the cost of medical school, so that students graduate with hundreds of thousands of dollars of debt, precluding them from choosing a career in primary care. Bingo. Now we have a situation where only 30% or 35% of doctors are generalists, and the number is sinking fast.

So there you have it, Mr Health Secretary Designate. That's how we did it. Good old American ingenuity. It's a mess, for lots of reasons. But it's our mess. How to fix it? Stay tuned.

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Cite this as: *BMJ* 2008;337:a2702

A related news story is available on bmj.com (see *BMJ* 2008;337:a2711).