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THE ONGOING “SHAKEOUT” IN THE U.S. HEALTH CARE SYSTEM

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Health care in the United States is like the Infiniti M35 luxury sedan -- arguably the best in the world¹ but increasingly out of reach for many Americans. To hold down those costs private insurance companies, especially those that underwrite health insurance policies for the employees of American companies, have been reducing the reimbursement paid to the providers of health care. Medicare and Medicaid have long since adopted the same strategy.

As a consequence, health care providers including hospitals and physicians have been laboring under a system that all too often does not provide enough reimbursement to cover the cost of making that service available. Providers of all types are beset with no pays, turn their overdue accounts to collection agencies to retrieve at least some of what is owed them, and are handed bankruptcy judgments that deny them what is needed to continue providing care. Hospitals for too many years have been bleeding cash, depleting reserves, and finding it ever more difficult to get the financing required to continue.

To cope with that problem many hospitals have been shifting the cost from nonpaying patients to paying patients, in some cases dumping patients, and curtailing the range if not the quality of the care available. Physicians are refusing service to patients who are unable to demonstrate ability to pay, notably Medicaid patients. In many instances of late they have been setting up free-standing specialty hospitals where they can be more selective as to the patients they admit because these facilities function without emergency departments – the huge open door to care for Americans without the means to pay for what they need. On top of all of that, providers face the threat of huge malpractice judgments whenever they fall short of delivering care that meets community standards for that care.

In the extreme, hospitals are being sold, services realigned, and physician practices closed in a process that elsewhere is referred to as the “shakeout.” This “shakeout” is an ongoing process that is having a profound impact on access to care.

¹ See *Consumer Reports*, April 2006 (p. 7). In *World Health Report 2000, Health Systems: Improving Performance* (p. 155) the U.S. health care system is ranked first in the world in terms of seven measures of responsiveness: dignity, autonomy, confidentiality, prompt attention, quality of health amenities, access to social support networks during care, and choice of care provider.

There are less expensive, acceptable alternatives to the Infiniti M35. There are none to the U.S. health care system unless Americans are willing to pay more for the care they expect or demand less. The additional monies can come only from two sources: higher insurance premiums or government support. Cutting reimbursement is not the answer in the absence of effective cost-cutting measures by providers that do not compromise quality of care. Would that health care were more like computer manufacturing: cheaper and better year in and year out. Unfortunately, high-tech in medicine equates to high cost.

Efforts to reduce the cost of providing expensive inpatient care by emphasizing preventive medicine and greater responsibility for the choices that effect a person's health and well-being such as what one eats and how active a life style one maintains come to naught in this "shakeout" unless reimbursement covers the reduced costs. However, should we expect insurance companies and employers who provide health coverage to their employees to pass up the opportunity to rein in their own costs by further cuts in reimbursement? Should we expect state and federal officials to pass up the prospect of finding a measure of relief from rising Medicare and Medicaid costs through continuing rollbacks in reimbursement?

As the "shakeout" continues, access to care narrows not just for nonpaying patients but for paying patients as well because in the years ahead there will be fewer providers able to survive financially in a system that is driven by ever lower reimbursement. For example, for years there have been well-publicized chronic physician shortages in rural areas due in part to better financial opportunities elsewhere. Less well known by the public is that there are unfilled residency positions at U.S. medical schools in, for instance, pediatrics because today's medical students are savvy enough to know that pediatricians keep extraordinarily long hours and compared to their professional colleagues in other subspecialty areas are among the lowest paid. If the "shakeout" continues, who will care for the children not yet born if not other providers with less formal education and training than pediatricians who are less expensive to retain?

The U.S. health care system is financially broken, is plunged in a downward spiral that cannot be reversed without addressing the driving force behind that spiral – partners in the system whose self-interest is directly linked to lower reimbursement. The "shakeout" will continue until the necessary remedy is put in place and like the Infiniti M35 the remedy cannot be purchased on the cheap.

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