Health Care's 2-Liter Bottle

By Earl *"Trey"* Washburn, MD

In health care or soft drinks, we consume as much as we can get. We should be ready with a solution - short of comprehensive care - If and when the health care system collapses.

IN THE 1950S AND 1960S, Pepsi Cola fought a futile marketing battle to unseat Coca Cola as the king of soft drinks. The Pepsi people rightly identified the Coca Cola bottle as one of the greatest corporate logos of all time (one you could hold in your hand, no less). They kept trying to put Pepsi in a bottle that would be even more attractive to consumers than the classic Coke bottle. This never worked.

In the early 1970s, Pepsi did some research on how much soft drink people would consume if they had unlimited access. Astonishingly, people will drink as much as they can get without any obvious limits. Armed with this knowledge, Pepsi launched big bottles (up to 2 liters) and quickly caught up with Coke for the first time. For some products and services there is no satiety, especially when the consumer is sheltered from the cost.

In a companion article in this magazine, Professor Emanuel Gale proposes changes for our sick U.S. health care system. Prof. Gale asserts that a single-payer, universal coverage plan that provides comprehensive benefits, choice of providers, control of expenditures and assurance of quality of care for all "is feasible and less expensive than the current destructive system."

Other observers note that we may be approaching a "perfect storm" of conditions that will allow politicians to consider universal coverage again for the first time in a decade. We see rising unemployment, employers cost-shifting health insurance to employees, millions of uninsured, double-digit inflation of health insurance costs and states cutting back on Medicaid support. Perhaps this is the time to give single-payer coverage another look.

I truly doubt that anyone connected to health care would argue that our current system is doing very well. Clearly we face a lot of problems, many of which seem to worsen by the week. But Professor Gale's hope for an egalitarian, comprehensive, single-payer system based on wellness cries out for some reality testing. The Pepsi lesson looms large here.

Early in his article Prof. Gale notes "the economic laws of supply and demand are inoperative" regarding pharmaceutical costs. This is just one of many examples that health care is consumed according to the same basic rules as soft drinks: people will consume as much as they can get. This is even truer if the "consumer" is not the "payer."

Nevertheless, we cannot simply dismiss Prof. Gale's concerns or proposals. Health care in our country is under siege from several quarters. Clearly, some sorts of changes must be made. How might we change our system without bankrupting ourselves? What should a new and better health care system look like?

Prof. Gale hopes that we can change our system at the state level because vested interests

will prevent a national solution. Our California Medical Association tried this exact approach a decade ago with Proposition 166. We were way ahead in the polls until the last month before the election. Suddenly those vested interests materialized and crushed Prop. 166 with a last minute media blitz. CMA bought a $3 million lesson on how hard it is to effect a change at the state level.

What could happen to change our political will regarding health care system reform? I fear we will find consensus for change only when our system fails across the board and not before. That time may be closer than we think. Our colleagues in many other states are facing a liability insurance crisis that needs a national MICRA solution, but the trial lawyers will fight that every step of the way. As I write this (on July 4) the only level 1 trauma center in Las Vegas has closed, there are no neurosurgeons left in West Virginia and several states are facing wholesale losses of doctors willing to deliver babies.

From the French Revolution to the fall of Soviet Communism, history teaches us that change in large social systems is often sudden and severe rather than incremental. While we continue to push for appropriate changes in our current system, organized medicine needs to be working with the other major players (hospitals, nurses, pharmacists, physical therapists, etc.) to develop a visionary plan for a new health care system that we all can support.

If health care suddenly collapses like the Berlin Wall, there will be too little time to develop such a plan from scratch. Now is the time for us to develop a model for future action in some sort of think-tank setting, so we are ready when the time comes. Once major parts of our health care system are in disarray, our politicians won't be able to wait for us to hammer out our differences.

What might such a visionary plan look like? First, it cannot be truly comprehensive. All of the countries with national health systems are running into the same problem we are: people will consume as much health care as they can get. This is a growing problem in Germany, which has the longest established national health care plan of all. It is a problem in the U.K. and in Scandinavia. These countries may not be paying as much as we are for health care, but their costs are spiraling upward as well. We are all stuck on the same escalator.

A better, semi-comprehensive model comes from the Oregon Medicaid Plan. Oregon got a federal waiver to structure its Medicaid based on available resources. A citizens' panel prioritized all medical services with items such as obstetrical care, immunizations and trauma care near the top and items such as cosmetic surgery and bone marrow transplants at the bottom. The projected costs for all services were calculated, and the prospective funding applied from the top of the list downward. When the money ran out, a line was drawn. All services above the line were provided to Oregon Medicaid patients; all services below the line were not. Some application of this approach is the only way we will be able to cap public sector health care spending.

(Please note: this is not to say that the services that fall "below the line" are any less appropriate or important. The decision was simply based on what was affordable with the available funding and what was not.)

Imagine a future in which we do have a single payer system that covers everyone in our country. This system provides "basic health care" such as most primary care services, obstetrics, newborn care, immunizations, acute illness care, etc. Some higher-end services might be covered as well: most routine surgery, cardiology evaluations and the like. However, there would be well-defined exclusions such as: most organ transplantation, "life-style" treatments, and other very high-tech, very high cost medical services such as total joint replacement and implantable defibrillators.

Many people will still want the "premium" services, but they would not be part of the basic package. (Sounds sort of like your cable hook-up!) For those who want more than basic health services, private health insurance will still be available for individual

purchase, or individuals can pay cash for premium services - if they can afford it.

Basic vs. premium health care may make us cringe, but some permutation of this approach is the only viable solution.

If we offer "health care in the 2-liter bottle," people will naturally take all they can get until the bottle runs dry for us all.

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