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# The Top 10 Myths About U.S. Health Care

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## Introduction

### So you think you really know the U.S. health care system?

When many people, including those within the health care industry, talk about our health care system, there are a number of underlying myths that seem to permeate their discussions. But do these myths really hold much truth, and do they really provide us with the proper knowledge base with which to understand much of what is happening in our health care system? Indeed, many of these myths abound in much of the popular media, from the film, As Good As It Gets with Helen Hunt and Jack Nicholson that attacked managed care to the xenophobic chest thumping we saw about the U.S. having the 'greatest' health care system in the world during Clinton's 1994 health care reform debate.

That is not to say that some of these myths may be grounded in other truths. Yes, some managed care companies have treated their patients in especially egregious ways, and the U.S. health care system has significant positive characteristics, particularly in terms of our ability to produce profound scientific discoveries. But in many instances, we, as citizens, use these myths as a type of shorthand to understanding our complex health care system. We tend to accept these myths as truth without bothering to question their basis. Some of these myths may at first seem very surprising or unbelievable, which leads us to believe that many, in fact, know very little about our health care system, yet we are all dependent upon that system to some degree at key points throughout our lives.

What we want to do here is to dispel some of our most accepted myths with the available evidence and in so doing construct a better understanding of how our health care system truly functions. While these are not exhaustive and we suspect that many other myths need attention, this is a first step toward making more of us better and more educated health care consumers.

### 1. PPOs are better than HMOs.

With the growth of managed care and health maintenance organizations (HMOs) over the last 10-15 years has come an increasing resentment and dissatisfaction with this form of delivery and payment for health care. This has occurred despite a rich body of research that points to managed care as an important factor controlling costs in the U.S. health care system during that period (World Health Organization, 2000). At the same time, HMOs have been able to meet or exceed the quality of traditional fee-for-service health care and PPOs ("Do HMOs Make a Difference?" 2000; Phillips, Fernyak, Potosky, Schauffler, & Egorin, , 2000). Still, the U.S. population fears HMOs and reports being more satisfied with other types of plans (Blendon R. J., Brodie, M., Benson, J. M., Altman, D. E., Levitt, L., Hoff, L., & Hugick, L.1999; Employee Benefit Research Institute, 1999). For a number of reasons, including those noted earlier, HMOs have been given short shrift when compared to PPOs. First, care in PPOs is typically not managed or coordinated by a primary care provider. Yes, the individual has total freedom over physician choice, but more often than not, primary care providers are the most appropriate provider to see. Primary care providers are trained to provide differential diagnoses of illness. For example, chest pain can result from a number of conditions, from angina to indigestion. It is the role of the primary care provider to differentially diagnose that condition and send the patient on to a cardiologist or gastroenterologist. The patient in a PPO will often go directly to the wrong

specialist without the guidance of a primary care provider. From a health system standpoint, repeated use of inappropriate providers can only increase health care costs over time.

In addition, PPOs tend to have far higher out-of-pocket expenses versus HMOs, which can often surprise patients. Even for inpatient hospital procedures, the out-of-pocket expenses for an HMO patient are quite small. PPO patients, on the other hand, typically have at least a $250 annual deductible and then no additional out-of-pocket expenses if they use PPO providers. However, should they use nonPPO providers, their share of the after-deductible costs can increase by as much as 20%, and in some states, those providers may balance-bill the patient for costs over and above what their insurer will pay for the procedure. What is also interesting to note when comparing HMOs to PPOs to nonPPO providers is that a given physician may be an HMO provider for plan A at the same time that they are PPO provider for plan B and a nonPPO provider for plan C. In fact, some physicians are both an HMO and PPO provider for the same insurer. What this means for the patient is that the same level of quality is being provided, regardless of whether they have an HMO, PPO, or otherwise. There really is little distinction, then, in the level of care received by patients across plan type. This supports the research that has demonstrated little quality differences between HMOs and other types of health plans. This, combined with the relative advantages of HMOs in terms of out-of-pocket expenses and care coordination, points to significant benefits for HMO patients compared to PPOs.

## 2. All managed care/insurance companies are extremely profitable.

For the past several decades, the concept of managed care has driven the effort to redesign how health care services are delivered. However, while managed care had flourished in the 1980s and 1990s, recent years have seen a financial crisis within managed care. As a result, managed care insolvencies are becoming more prevalent throughout the country.

For example, once considered among one of the most financially stable nonprofit managed care organizations, Harvard Pilgrim Health Care (HPHC) was placed in receivership in January 2000 by the Massachusetts insurance commissioner on the basis of large, projected losses (Brewster and Ginsburg, 2000). The recent financial insolvency of Harvard Pilgrim is merely an indication of an environment of financial instability within managed care.

This financial instability is caused by a number of factors. Federal and state mandates, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Act of 1997, as well as a number of state specific amendments, continue to significantly and negatively impact the solvency of managed care organizations. Increasingly, state legislators are requiring managed care to provide services for infertility, chiropractic care, massage therapy and coverage for experimental procedures whether the majority of consumers desire the coverage or not. For example, the state of Florida currently has adopted over 50 of these types of mandates, and the number is increasing. Comparatively, a recent Maryland study researched the impact of Maryland's 29 mandates and found that the additional mandated benefits increased the average premium by between $150 and $200 annually (William H. Mercer, Inc., 1998). Managed care has two ways to respond to the cost of mandates as well as other factors that affect cost, such as rising pharmaceutical and medical care costs. It can either absorb these costs or pass them on to its customers. However, insurance rates and profit potential are closely monitored and regulated by state insurance agencies, so passing all of these costs on to customers is difficult. Insurance regulators do not always adequately consider actuarial data, and managed care companies are not allowed to raise their rates sufficiently to maintain fiscal solvency. In addition, there are often significant gaps between when insurers must adopt mandates and when, and how much, insurers are allowed to adjust their rates to reflect the costs of these mandates. All of these factors, then, are barriers to significant profitability within the managed care industry.

## 3. Health care fraud is the most significant reason for increasing health care costs.

There is no doubt that health care fraud has existed and currently exists within the U.S. health care system. Health care fraud burdens the nation with enormous financial costs, while threatening the quality of health care. But to what extent is fraud driving the increase in health care costs?

The United States General Accounting Office (GAO) estimates that annual losses due to health care fraud range from 3 to 10 % of all health care expenditures, which is approximately $30 billion to $100 billion based on estimated expenditures of over $1 trillion (U.S. General Accounting Office, 1996). This estimate is expected to increase as political and market forces encourage managed care to abandon its tools to encourage cost-efficient and high quality care.

In addition, waste and fraud cost the U.S. government's Medicare program $13.5 billion in 1999. That means that Medicare lost approximately eight cents out of every dollar to fraud, compared with 14 cents on the dollar in 1996 (Bender, 2000). The crackdown on Medicare fraud began in 1993 with the realization that situations existed where clinics had neither the equipment nor the staff to provide the services for which they were billing Medicare.

While health care fraud is a significant factor that results in the increase in health care costs, clearly additional factors should be considered that influence the cost of our health care system. For example, drugs and other medical supplies comprise about 11% of our total health care expenditures and spending for prescription drugs increased by almost 19% in 2000 (Pear, 2001). In fact, prescription drugs account for almost half of the increase in health care expenditures, and spending on these drugs is expected to double by the year 2006 ("Spending on Drugs Seen Doubling by '06", 2001). One recent study indicated that employer-based insurance premiums increased in 1999 largely due to hospital spending (in- and outpatient, 47%), prescription drugs (27%), and physician spending (25%), ("Tracking Health Care Costs: Hospitals Surpass Drugs as Key Cost Driver", 2001). As a result, a combination of all these factors, including fraud, are the significant forces that increase U.S. health care system costs.

## 4. Health plans don't do enough to guarantee health care quality.

There are no consistent results that indicate a significant difference in quality between managed and nonmanaged health care (Levitt & Lundy, 1998; Dudley, Miller, Korenbrot, & Luft, , 1998; Hellinger, 1998). Indeed, studies have found that there is no evidence that managed care plans "uniformly" lead to poorer quality of care (Miller & Luft, 1997). However, many states are requiring managed care plans to measure and report to the state both member satisfaction and performance measures. These data sets are often referred to as the Health Employer Data and Information Set (HEDIS), which are sponsored by the National Committee on Quality Assurance (NCQA). It is the leading organization that accredits health plans by measuring their performance through a number of quality indices. NCQA evaluates how well a health plan manages all parts of its delivery system, both providers and administrative services, and publicly reports the results of such measures. Its accreditation standards evaluate practices within six different areas including: quality improvement, physician credentialing, members' rights and responsibilities, preventive health services, utilization management, and medical records. As a result, by using national standards to measure and evaluate the quality of managed care, "HMOs are in a better position to reduce variations in practice patterns than un-managed fee-for-service" (Ignagni, 1997).

In addition to national accredition standards, market forces are facilitating improved quality within managed care. For example, Blue Cross of California recently announced that it is dropping its system of rewarding physicians in its HMO networks solely for controlling costs and utilization of services. Instead, the health plan will base provider bonus payments primarily on patient satisfaction and the quality of care given by the provider (Pallarto, 2001).

At least one survey of over 500 physicians indicated that managed care has had "significant negative effects" on the quality of medical care by affecting the physician-patient relationship (Feldman, Novack & Gracely, , 1998). These physicians suggested that financial incentives from the managed care industry motivated them to influence the care they prescribed to their patients, although studies have shown no difference in quality between HMOs and fee-for-service arrangements (Levitt & Lundy, 1998). These physicians indicated that they felt "pressured to limit patients' access" to expensive, unnecessary, and experimental services. As a result, some physicians may choose more cost effective, proven, and nonexperimental procedures as a way to reduce the perilous overuse, underuse, and misuse that characterize the fee-for-service health care system. However, ultimately the responsibility for health care delivery rests with the provider within the context of their encounter with their patient. While health plans have a responsibility to their members to use their premiums responsibly and within the context of their contracts, providers have a responsibility to recommend medically necessary care for their patients without

regard to their own financial interests. Clearly, there are currently in place mechanisms and processes to ensure that quality health care is provided through health plans.

## 5. Greater use of newer prescription drugs keeps people from having to go to a hospital.

Over the past few years, a barrage of advertisements for new prescription drugs has piqued America's appetite for ways to address their health concerns. The Pharmaceutical Research and Manufacturers of America (PhRMA), the pharmaceutical industry's trade association, asserts that these new drugs "give value" by keeping patients out of the hospital or reducing total health care costs ("The Value of Pharmaceuticals", 1998). This may be true for some of these prescription drugs and for certain diseases, but a careful review of the evidence does not suggest that new prescription drugs help slow the rate of overall cost increase. Evidence touted by PhRMA to support this myth is nothing more than a simplistic comparison of rising pharmaceutical expenditures with decreasing hospital and physician services expenditures since 1994 ("Outlook 2001", 2001). A recent review of the evidence on the cost-effectiveness of pharmaceuticals finds that compared to other interventions such as medical procedures, public health screening, or health education and counseling, pharmaceuticals as a whole are not more cost-effective (Neumann, Sandberg, Bell, Stone, & Chapman , 2000). These studies measured the benefits of pharmaceuticals against the total costs of health care, of which hospitalization is a major component. Others note that some of these, ". . . new drugs do not save anybody money" (Kleinke, 2001) and provide little overall benefit. Although it is true that some of these new pharmaceuticals can be beneficial in a number of instances and may be worth their additional cost, it is likely that many of them will be prescribed where they are not indicated, which will produce no additional health benefits and at an increased cost to the patient and the health system.

## 6. Advertisements for prescription drugs help people make optimum decisions about their health care.

There can be no doubt that the barrage of direct-to-consumer advertising by the pharmaceutical industry has heightened Americans' awareness of new and existing prescription drugs. Unfortunately, providing consumers with more information than they may need tends to be just as unproductive as not providing them with enough information. Most of this advertising is delivered to consumers who do not need these drugs, and in the process, may create additional demand for drugs when they are not indicated, or worse yet, may confuse consumers about which drugs may be most appropriate for their condition. In a way, these advertisements are taking the place of an informed health care provider giving counsel to patients on how best to address whatever ails them. In addition, it contributes to the prescription-drug-focused-mentality that is pervading the health care system. This pervasive mentality sees in a magical pill the promise of better health, when much of getting better as humans is predicated on what we eat and how we exercise. How is the wise consumer able to sift through the myriad drug ads they see in almost every medium-television, magazines, city buses-to determine which drug is appropriate for them?

Indeed, research has shown that the glut of these ads are detrimental to the physician-patient relationship (Wilkes, Bell, & Kravitz, 2000). This advertising creates a biased view of the options available to consumers. The ads do not focus on the other--perhaps less expensive and more widely used--prescription drugs that are available for those same conditions. That evidence alone suggests that these ads are marketing and not informative. Their aim is to sell a particular prescription drug and not to provide comprehensive information to consumers about their options regarding the treatment of a particular ailment. This creates a slanted view of treatment options, which the patient then takes with them to their physician. Within the physician-patient relationship, consumers have begun to demand specific drugs because of these ads, which then places physicians in a difficult position if they believe the drugs are contraindicated for that consumer's condition. Physicians, on the other hand, are themselves often barraged by pharmaceutical company representatives espousing the benefits of their particular prescription drugs over those of their competitors'. These twin pressures on physicians only exacerbates the lack of autonomy that they feel is being taken away from them.

Clearly, the aim of these advertisements is to promote one prescription drug over another and to create demand for that drug in the process. Eli Lilly even admits to such with their 'new' drug Sarafem for premenstrual dysphoric disorder (PMDD). Sarafem happens to be the same compound as Prozac (fluoxetine), a serotonin reuptake inhibitor commonly prescribed for anxiety and depression. Lilly has

repackaged and remarketed the same drug in an attractive pink and lavender capsule in order to create another market for Prozac, which has a patent that expired in August 2001 (Vedantam, 2001). Unfortunately, these advertisements assume the role of the health care provider; yet they do not provide a balanced view of the actual treatment and prescription drug options available to consumers. Only health care providers can, and do, provide this of information to consumers, yet because of these advertisements, they often feel a subtle and not-so-subtle pressure to prescribe these drugs, lest they risk losing patients. These advertisements do not, then, result in optimum decisions being made about consumers' health care.

## 7. Most of the uninsured are either unemployed or not able to work.

In 1999, approximately three quarters (75.3%) of the uninsured persons between the ages of 18 and 64 were employed at some point during that year. However, among the poor, those who worked were more likely to be uninsured than those who did not work, likely due to public programs for health care like Medicaid. Most of the working-age individuals without health coverage are working and are still unable (or perhaps unwilling) to purchase health coverage. In addition, lacking health coverage is correlated with lower income, with 75.9% of households earning less than $25,000 per year having coverage compared to 91.7% of households earning over $75,000 ("Health Insurance Coverage", 2000). This is consistent with surveys which show that small employers with larger percentages of lower paid employees are less likely (or perhaps less able) to provide health coverage ("Employer Health Benefits - 2000 Annual Survey", 2000). The impression many Americans have of an uninsured population is that it is predominantly unemployed is simply not true. Many uninsured adults are still unable to obtain health coverage even though they may be working and gainfully employed. Low wages, high health premium costs, and the unavailability of health coverage through an employer are all likely reasons for the continuing dilemma of a large number of working uninsured adults.

This is situation is even more pronounced among small employers. Surveys of employers have shown that they are far less likely to provide health coverage for their employees than are larger employers, with the smallest firms the least likely to provide health coverage. For example, 99% of firms with over 200 employees provided health coverage, while only 67% of firms with up to 200 employees offered health coverage in 2000 ("Employer Health Benefits - 2000 Annual Survey", 2000). It is encouraging to note that this figure has been increasing over the last three years, particularly for the smallest employers, or those with only three-nine employees. Small employers overwhelmingly identify the high cost of premiums as the primary reason why they do not offer health coverage to their employees.

When coverage is provided to their employees, small employers often have less generous and more expensive plans than large employers. Since small employers obviously have fewer employees, they are less able to spread health risks across a large group of individuals, as are large employers, or those with more than 50 employees. In terms of benefits, small employers are more likely to have annual caps on prescription drugs, particularly for small employers' HMOs ("Employer Health Benefits - 2000 Annual Survey", 2000). But in addition to these financial barriers, small employers may have other barriers to providing coverage, including a lack of knowledge about what coverage options are available to them or the federal income tax treatment of these benefit costs. For example, 57% of small employers did not know that health insurance premiums are 100% tax deductible, and 61% did not know that health insurers might not deny health coverage to them even though the health status of their employees may be poor ("Small Employer Health Benefits Survey", 2000). In sum, small employers are at a distinct disadvantage when it comes to purchasing health coverage for their employees, both in terms of the costs involved and the lack of information they have regarding these benefits. But even large employers are feeling the strain of increased health care costs and have either reduced their health care benefits or increased the employees' share of these expenses in response (Winslow, 2001).

## 8. We do not ration health care in the U.S.

Many often note the differences between the U.S. health care system and those of other western industrialized nations, particularly with regard to the amount of explicit rationing that occurs in those other systems. We hear of the long waits for certain types of elective surgeries in the British National Health System or the numbers of Canadians crossing the U.S. border for diagnostic procedures because of the long waits. But do we not have our own types of implicit rationing here in the U.S.? Indeed, for certain

segments of the U.S. population, access to health care can be nonexistent or quite limited. For those individuals, there can be no doubt that rationing of health care occurs in the U.S. health care system.

In the U.S. Census recent survey of those without any type of health care coverage-the uninsured-14% of Americans were without any health insurance coverage in 2000 ("Health Insurance Coverage", 2001). These 38 million individuals do not have access to any type of public or private health care coverage. If they do get sick or require hospitalization, they might utilize the emergency room of a local public or teaching hospital in order to receive care, usually necessitating a lengthy wait or a lengthy trip just to get there. Indeed, many rural areas lack any type of public hospital, and if these uninsured have the means to travel to an urban area that has such facilities, they may be turned away if their condition is not emergent or because they don't reside in that community. Research has shown that having access to a regular source of medical care is a strong and consistent predictor of health care utilization, and those without a regular source of medical care were less likely to use any type of preventive care (Aday, 1999). In addition, those without insurance are far more likely to postpone seeking health care (Davis, Rowland, Althman, Collins & Morris, 1995).

But even for those persons with health care coverage, access to health care can be difficult, if not impossible. There can be significant nonfinancial barriers to accessing the health care system, be it geographic, cultural, temporal or physical. Some of these barriers may be particularly relevant for those who are in low paying, part-time or service oriented positions. For example, individuals in low-wage or part-time positions often are not paid for time visiting a physician or receiving other health care. That alone is a disincentive to visiting the doctor. For others lacking an automobile, simply traveling to the physician may take much time, which may only be exacerbated by limited availability in their work schedule or by few transportation options. NonEnglish speaking individuals may have additional language barriers that can burden their communication with providers or prevent the individual from even seeking health care. Even financial barriers can limit access for those with health coverage, especially if they are unable to pay deductibles, co-payments, or premiums. Again, the U.S. health care system does, in fact, ration health care and does so for both those with and without insurance.

## 9. Individuals have little control over the leading causes of death in the U.S.

In the U.S., the leading causes of death are primarily chronic health conditions, such as cardiovascular disease, cancer, chronic obstructive pulmonary disease, and diabetes. These causes make up almost two thirds of all causes of death in the U.S. and are largely preventable (Chronic Diseases and Their Risk Factors, 1999; see also Deaths: Preliminary Data for 1999, 2001). Cardiovascular diseases, which consist principally of ischemic heart disease and stroke, account for about 40% of all deaths each year in the U.S. and are the most common cause of death among men and women in all racial and ethnic groups, although the prevalence is higher among black versus white adults. Deaths from cardiovascular disease, however, are due in large part to relatively unhealthy lifestyles resulting from tobacco useand insufficient physical activity and poor nutrition. Indeed, interventions as simple as controlling hypertension can reduce the incidence of stroke and fatal stroke by up to 40%, while another study demonstrated that a diet low in saturated fat and supplemented with polyunsaturated fats and antismoking counseling reduced coronary heart disease by 47% and total mortality by 30% ("Coronary Heart Disease: Reducing the Risk", 1998). Yet even with this evidence, more than half of Americans have cholesterol levels that are higher than the recommended 200 mg/Dl standard.

Cancer is the second most common cause of death in the U.S., and although there may be a weaker correlation between lifestyle behaviors and the prevalence of cancers, there is, nevertheless, the opportunity to reduce its prevalence with such changes. Cancers accounted for 23% of all causes of death in 1999, with lung and colorectal cancer accounting for about 28% and 11%, respectively, of all cancer deaths. Among women, breast cancer is the second most common cause of cancer-related deaths. Some of the primary behaviors associated with the incidence of cancer include tobacco use, poor nutrition, physical inactivity, and sun exposure. Studies have shown that tobacco use alone accounts for 11% to 30% of all cancer deaths and from 17% to 30% of all cardiovascular deaths (McGinnis & Foege, 1993).

Lung cancer may be the most preventable of all cancers, with fully 85% of all deaths associated with cigarette smoking. In addition to lifestyle behaviors as a cause of cancer, lack of screening and diagnosis of cancers in their early stages of development can also contribute to increased deaths due to cancer. Indeed, in 1997, 70% of Americans over the age of 50 reported that they had not had sigmoidoscopy for the

detection of colorectal cancer in the previous five years, and 82% hadn't had a fecal occult blood test in the previous year. Both of these diagnostic tools are very effective tools to screen for colorectal cancer in persons over the age of 50. Along those same lines, it has been estimated that 30% of deaths from breast cancer could be prevented if women over the age of 50 received regular mammograms (Chronic Diseases and Their Risk Factors , 1999). Clearly, there is much that the U.S. population can do to prevent many of the primary causes of death, including modifying their lifestyle behaviors and utilizing more screening and diagnostic tools to detect and prevent these diseases at an early stage.

## 10. Americans are the healthiest people in the world.

Compared against the other Western industrialized countries of the world, the United States' indicators of health are mediocre and below the median. The Organization for Economic Cooperation and Development (OECD) tracks a panoply of social, economic and health indicators for its 29 member nations, which includes the U.S. and every other major world economy. In terms of preventive care, the U.S. is below the median of 93% on the measure of immunization for DPT (diphtheria, pertussis and tetanus) by the age of 12 months, with 84%. This compares to 100% in Hungary, Korea, and the Netherlands (Anderson & Hussey, 2001).

Looking at mortality and morbidity data, the U.S. is still below the median, but not to the extent as with immunizations. Life expectancy at birth in the U.S. is 73.9 and 79.4 for men and women, respectively, while the OECD median is 74.6 and 80.5 for men and women, respectively. However, for morbidity, or how sick we are compared to the other nations, the U.S. does much worse. The OECD calculates the potential years of life lost per 100,000 persons as a measure of premature death in a given nation, or in other words, the total years of life lost before age 70 due to preventable conditions. In the U.S., the potential years of life lost are 7,351 and 4,213 for men and women, respectively, while the OECD median is 6,055 and 3,135 for men and women, respectively. Only Korea, Mexico, Portugal, Poland, Hungary, and the Czech Republic have higher figures (Anderson & Hussey, 2001).

To make matters worse for the U.S., we achieve these mediocre to poor indicators of health at a cost that is higher than every other OECD nation. Indeed, our health spending per capita and health spending as a percent of GDP (gross domestic product) are almost twice that of other nations. The U.S. has health spending per capita at $4,178, while the median was $1,783; at the same time our health spending as a percent of GDP was 13.6%, as compared to 8.2% for other countries. These indicators clearly demonstrate that our expensive health system has been woefully incapable of producing the superior health that many believe we currently maintain. They also show that we are not, in fact, the healthiest people in the world.

## Conclusion

We do not claim that this analysis has explored every myth that exists in our collective consciousness concerning the U.S. health care system. However, what we may have done is to cause the reader to think about these myths. In addition we hope that the reader begins to question other myths and assumptions and challenge other myths regarding our health system. One myth that used to exist is the belief that only allopathic physicians (i.e. MDs) could provide primary health care.

Whether we believe so or not, Americans can exert more control over their health care system, from simply urging employers to consider other health care delivery options like HMOs, to thinking twice before insisting upon that brand name antibiotic when an equally efficacious generic drug will work just as well. Can we be better and more educated health care consumers? As long as we continue to look critically at our health care system and understand what it can and cannot accomplish, then the answer can only be 'yes.'