Prescription for a Better Health Care System

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INTRODUCTION
In 1991, total U.S. health expenditures reached $750 billion or over 11 percent of the Gross National Product (GNP). Health care spending grew at an annual rate of 13.4 percent between 1985 and 1990. It is expected that the cost of health care will continue to grow at a rate between 11 percent and 15 percent through 1995 (above statistics from Sheeline 1991, p. 58). In addition, the United States' health care system is about one-third more costly than the system provided by the next biggest spender, Canada (Dentzer 1991, p. 50). What these statistics indicate, and what is readily apparent to nearly everyone in the U.S., is that there is a major crisis occurring in the United States' health care system. Employers have attempted to address the problem of rising health care costs by employing several methods of both cost reduction and cost shifting which are essentially aimed at short-term results only. Examples of these techniques are: higher deductibles (the portions of doctors' bills the employee must pay out-of-pocket), required second surgical opinions, and health maintenance organizations.

In order for the health care problem to be controlled or managed effectively, society, especially employers, must look beyond the obvious dollar-based symptoms and instead address the structural problems of the system and view cost containment as a dynamic process. The United States' current health care system did not evolve into what it is in a short period of time. Consequently, getting it under control will not happen quickly either. Solutions designed to remedy the problems in our health care system will require a society-wide effort. This article will explore the fundamental reasons for the present crisis in the American health care system and present ideas for comprehensive cost containment.
THE PROBLEM
Cost Shifting

Cost shifting is one of the most important factors contributing to high
health care costs. Costs are shifted from four sources: the uninsured, Medic­
aid (a federal-state health care coverage program for the poor), Medicare (a
federal health insurance program for the elderly), and deep discounts given
to large managed care plans. More than 37 million Americans lack health
insurance, yet they still require and receive medical care. It has been estimat­
ed that one-third of the increases in health care costs are attributable to
overpricing of health care services (Verespej 1990, p. 23). Through these
charges, physicians and hospitals are often trying to recover losses suffered as
a result of providing services both for the uninsured and for those insured by
the government. When reimbursing a health care provider for services, the
government often covers only a portion of the actual costs. As the uninsured
population increases as a result of rising insurance costs, and Medicaid and
Medicare continue to cover a smaller portion of the actual cost for treating
government-insured patients, more unpaid physician and hospital costs must
be recovered from full-paying patients.

Managed care (primarily health maintenance organizations, preferred
provider organizations, and self-funded plans established by large employers),
while a viable option for managing health care costs, is actually one of the
most significant contributors to the problem of cost shifting. Large organiza­
tions that use managed care are able to negotiate low prices with health care
providers since they have substantial bargaining power due to their size. Com­
panies which are not large enough to negotiate prices, however, are suffering
as the large organizations achieve greater and greater cost savings for them­
selves and their employees (Coddington 1990, p. 113).

Insurance Carriers

According to a poll conducted by The New York Times in 1983, the public
held insurance companies accountable for the majority of increases in
medical care costs (Latham 1983, p. 19). In the past, the role of the insur­
ance companies has been fairly simple. Like other businesses, insurance
companies forecast expenses and revenues. Their costs are insurance
claims; their revenues are premiums received from insured parties. Howev­
er, the role of the insurer has been changing in light of the crisis in the
American health care industry. Insurers can no longer act as a pseudo­
intermediary between health care providers and patients. Rather, they are
being forced into the role of regulator. Insurers are being called on to
determine what treatments are justifiable and what fees are appropriate for
services (Latham 1983, p. 20).
This new role is not one insurers want. It not only increases their responsibility, but it also puts them in an awkward position with health care providers. They may be judging how a health care provider or facility conducts business based on limited knowledge and little or no expertise (Latham 1983, p. 21). One way insurance carriers are trying to make the transition into this new role less painful is through medical cost-management. Rather than simply watching over what the health care providers are doing, they are taking part in the discussions and decisions which drive the actions of the health care providers—such as physicians' fee discussions and methods of benefit allocation (Latham 1983, p. 21).

Today, health insurance and cost-shifting are caught in a vicious circle. Medical care received by uninsured or underinsured individuals is subsidized by full paying patients through higher costs and fees. As the cost of health care rises, so does the need for more protection through insurance. However, as insurance costs rise, more and more people become under- or uninsured. Consequently, the cycle begins again.

Although many view the high cost of health insurance as a major problem in the health care system, closer scrutiny indicates it is a symptom of the other problems. Expanding their role to include cost-management is essentially the only way for insurance companies to help reduce the escalating cost of health care.

**Hospitals**

In general, people believe that a hospital should provide the best care possible, when it is needed. They feel profit should not be the primary objective of a health care facility; rather, the welfare of the patient should be first and foremost in health care providers' minds. Most hospitals want to furnish patients with the best care available. They feel the best way to do this is to respond to the needs and requests of physicians in terms of equipment and technology (Latham 1983, p. 17). However, hospitals are often at the mercy of physicians and of their own lack of knowledge. Many times hospitals are unable to determine the justification for certain technology. They are forced to trust the judgment of physicians, who may not be acting in the overall best interest of the health care facility. Hospitals are thus in a double bind. If a hospital does not provide what patients and doctors want, patients may take their business elsewhere; however, the cost of the new technology must be passed on to the patients.

Although hospitals have increasingly come under fire for contributing to the rising costs in the health care industry, one fact is consistently ignored: hospitals are not earning huge profits. Hospitals are being attacked for being profit-motivated, yet it would be more accurate to say
that many are survival-motivated. The rates hospitals charge for small items may seem outrageous to the average consumer; however, items such as bandages, aspirin, toiletries, and other consumable items are easily prorated on a per patient basis. On the other hand, the costs of labor and technology are less easily prorated. Therefore, hospitals may “overprice” small accountable items as a way of covering the cost of nurses, orderlies, technicians, pharmacists, and technical equipment.

One reason hospitals are not earning a substantial net profit (or, in some cases, any profit at all) is due to their sources of revenue. Many major insurance carriers (such as Blue Cross/Blue Shield) do not cover the total cost of an insured patient’s stay. Medicare and Medicaid also cover considerably less than established rates for hospital stays (Latham 1983, p. 17). In light of these facts, one wonders how any hospital stays in business when so many of its customers do not pay the going rate. The most frequently used method, as mentioned above, may be to charge more for accountable items. Another tactic is to shift costs to the patients who are paying in full.

Hospitals face other problems as well: high labor costs, shortages of skilled workers, and the need to care for an increased number of older patients. Hospital care constitutes 40 percent of the medical dollar and represents a large portion of the increases in overall health care costs (Latham 1983, p.18). It must be noted, however, that physicians determine the level and kind of care needed for each patient and decide how long the patient should be in the hospital.

As noted earlier, a final factor in hospital cost is the sophisticated technology employed. Technology has been advancing in the health care field at a fast pace. However, this technology is not cheap; its development and use must be paid for by those who use it. Patients who use or are treated with specialized technology usually benefit because they get the best possible care. Physicians who use specialized technology may benefit as well (Coddington 1990, p. 70). However, technology can lead to abuses. The physician may order unnecessary tests such as CAT scans and EKGs that increase the patient’s bill and improve the physician’s bottom line. Some physicians may “suggest” a hospital stay so they can conduct further tests. When such tests are unnecessary, these practices cost patients and insurance companies thousands of wasted dollars each year.

Physicians

Physicians belong to one of, if not the, single most prestigious professions in the United States. As a result, society has pretty much left the medical profession alone to set its own educational, governing, and financial standards. No regulatory agency oversees the prices physicians charge. Consequently,
physicians may price their services at whatever levels they deem appropriate (Latham 1988, p. 12). This lack of regulation has led to continued increases in physicians’ fees. In the decade between 1980 and 1990, costs of physician services increased by $101 billion which represents an average growth rate of 12 percent per year. Inflation during this same period was 7 percent (above statistics from Coddington 1990, p. 39). Several factors are contributing to the continually higher increases in medical fees. Although each factor in itself is relevant, it is important to note that it is a combination of these factors which leads physicians to reach decisions in billing matters. Graph 1 shows the factors constituting physicians’ fees.

**Graph 1: Components of Growth of Physician's Costs**
(Coddington 1990, p. 44)

General price inflation is responsible for about 30 percent of the increase in physicians’ costs that occurred over the past decade, while growth in population and the aging of the population account for approximately 10 percent (“Demographic Trends”). More people require more care, and higher costs result. In addition to growth, the structure of the United States’ population has been changing as well. The population is aging steadily, and with the generation of baby boomers reaching 65, this trend will continue. Senior citizens (persons sixty-five years of age and over) see their doctors about twice as often as those sixty-four or younger (Coddington 1990, p. 39). These trends indicate that an already overburdened
system of government coverage for the elderly may continue to deteriorate as the number of government-insured patients grows.

As Graph 1 indicates, 15 percent of the increases in physicians’ costs are attributable to increased utilization. In 1981, annual physician contacts per person were 4.6. In contrast, the number of contacts grew to 5.3 by 1988 (Coddington 1990, p. 40). The aging of the general population explains a portion of this trend. In addition, Americans want the best care available to them. Many people believe the only way to obtain this quality care is to seek it actively—visiting many doctors in search of the best (Coddington 1990, p. 40). As one physician stated: “With the British and Canadian system, everyone is treated the same. But, in this country, I get the impression that patients know there is something out there to get, and they keep pushing until they get it. I don’t like it. When I buy something, I like to know that I am being treated the same as everyone else” (Coddington 1990, p. 40).

Physician practice expenses are another contributing factor to the rising costs of physician services (“Increases in Real Operating Expenses”). Of these expenses, non-physician personnel represent the single largest contributor to cost increases (1990, p. 41). In the face of an increasingly complex health insurance industry, physicians are hiring individuals to concentrate primarily on handling insurance claims. A physician in such a practice summed up the individual’s role quite clearly, “...one well-paid person to do nothing but insurance for seven physicians, [is] well worth it... She gets the job done and we get to manage the office and practice medicine” (Coddington 1990, p. 41).

Malpractice premiums are another major portion of physician expenses. Physicians want, and need, to protect themselves from lawsuits, and individuals are becoming increasingly inclined to bring lawsuits against those they feel have wronged them. Despite their prestigious role, physicians are particularly vulnerable to such lawsuits. Mistakes and negligence often result in damages that are irreparable and/or cause “pain and suffering.” Such lawsuits can result in multi-million dollar settlements for which the physician is financially responsible. In order to protect themselves from financial catastrophe, doctors invest huge sums of money in malpractice insurance.

Finally, increases in real physician income account for 15 percent of the increase in the cost of physician services (see Graph 1). Average physician net income in 1988 was $145,000 (Coddington 1990, p.41). Between 1985 and 1989, average wages rose 18 percent while during this same period, physicians’ pay rose by 39 percent (Garland 1991, p. 65). This trend is illustrated in Graph 2.
An average doctor's income is more than three times that of the average full-time worker. Considering the long years of schooling and residency, as well as the long work week doctors face, such a huge gap may not be alarming. However, price controls for doctors should not be a taboo subject in our society.

Purchasers

The three purchasers of medical care are the U.S. government, business and industry, and individuals. The problems created by the government as the nation's largest single purchaser of medical care are numerous. In recent years, doctors have been less willing to work with government-insured patients than they have in any previous decade. This is because government reimbursement accounts for only a portion of the actual cost. For physicians and hospitals, this creates a major disincentive for treating government-insured individuals. Costs that are increasingly unmet by government coverage are being shifted to the private sector, placing an even larger burden on the financial resources of businesses and individuals who are paying for health care (Latham 1983, p. 22). The deficiencies in the system of government coverage...
are becoming more and more apparent as many government-insured individuals are being forced to shoulder more of the burden for their health care bills and may actually lose coverage altogether (Latham 1983, p. 22).

Business and industry, the second largest purchaser of health care, accounts for about 30% of total dollars spent (Relman 1992, p. 99). Businesses have not traditionally dealt seriously with the issue of medical costs. An MIT study done for the Department of Health and Human Services came to the conclusion that “corporations were neither greatly concerned nor strongly motivated to do much about their health benefit costs” (Latham 1983, p. 23). According to this report, businesses are more concerned with employee satisfaction than with the affordability of services covered when designing and providing benefits packages. Businesses often use elaborate fringe benefit packages as a means of attracting and retaining good employees. Thus, in many cases, benefits have become a bargaining tool on which businesses are willing to spend huge amounts of money. In order to contribute to the effort to control medical care costs nationwide, businesses have to want to take control of their health care costs. In recent years, more and more businesses have felt this inclination. The most promising method of doing this will be for businesses to start managing health care, rather than writing it off as overhead expense.

Individuals who purchase their own private health insurance policies are the third largest buyer of health care. Those who fall into this category have little influence; they are forced to buy what the market has to offer.

SOLUTIONS

Competition

At this time there is little competition in the health care system. Health care providers have extensive control over services provided and thus their income. When there aren’t enough patients for them to treat, physicians may be inclined to “overservice” those patients they already have. In such cases, patients are often at a disadvantage due to their lack of medical knowledge. Physicians may take advantage of this lack of expertise and render services that are unnecessary and yet very costly for the patient, knowing the patient’s insurance policy will cover the cost (Menzel 1983, p. 134).

In 1987, there were 560,000 active physicians in the United States (a 22 percent increase over 1980). During this same period, the United States’ population grew by only 7 percent (above statistics from Coddington 1990, p. 46). According to a Medical Economics Survey conducted in 1987, 45 percent of doctors reported that they were not practicing at “full capacity” (Coddington 1990, p. 48). When physicians are faced with a reduced number of patients, they may try to generate demand for their services in order to maintain a
certain level of business activity. Other businesses attempt to generate new services and obtain revenues from them when the market itself fails to produce enough demand; it can be assumed that physicians do the same. As with other businesses, some of these new services will be worth the added price, and some will not.

In a traditional competitive market, when new firms enter the market, the price of goods and services is driven down. However, this is not true in the United States’ private health care industry. Rather, as the number of physicians and hospitals increases, the prices they charge increase as well (Greenhut, et al. 1985, p. 169). The most widely accepted explanation for this occurrence is the concept of “targeted income/demand creation” (Greenhut, et al. 1985, p. 169). Health care providers have some “target income” in mind and, according to the notion of demand creation, “... if the number of providers increases, each provider can maintain income by advising patients to consume additional services (e.g., more diagnostic tests)” (Greenhut, et al. 1985, p. 169). By increasing the amount of treatment they provide, doctors and hospitals are able to reach or maintain their targeted income levels.

Although some studies suggest a surplus of physicians exists, others contradict these findings. In fact, allocation of physicians may be the problem, not the number of physicians themselves. First of all, countless small rural communities in the United States are in need of doctors. Secondly, physicians, on average, work nearly 60 hours per week (Coddington 1990, p. 49). With an increased supply of physicians in the community, the stress and long hours doctors face might be reduced. As working conditions for these health care providers improve, the care they are able to provide should improve as well. Finally, a greater supply of physicians should mean greater access to health care for many communities (Coddington 1990, p. 49).

Competition in medical care can be stimulated in several ways. The price elasticity of demand for health care coverage is one source of competition in the health care system. At this time, there is essentially no price competition for services in the health care industry. However, the demand for coverage is more price elastic. Individuals, when seeking health care coverage among insurance carriers, are inclined to “shop around” to find the most appropriate and affordable plan (Menzel 1983, p. 135). Health care providers have no control over demand creation in this situation. Competition is stimulated as insurance carriers provide a variety of health care coverage plans and compete among themselves for market share.

Another method of competition stimulation is through employer-sponsored health coverage. When employers offer a wide range of health coverage packages for their employees and charge the same for each plan, employees are induced to shop around for the package that most closely
meets their health care needs or wants. Increase in choices increases competition (Menzel 1983, p. 134).

Taxing health care benefits provided by employers may be another way to increase competition in the health care system. When these benefits are included in taxable income, employees may be inclined to shun the more expensive and less efficient plans offered by their employers. Competition in the health care system should increase as insurers compete among themselves to provide the most cost-efficient plans that will appear most attractive to careful buyers (Menzel 1983, p. 135).

In the face of increased competition, health care providers will be inclined to offer more affordable health care in order to maintain their level of business. Indeed, businesses generally try to gain a competitive advantage in their market in one of two ways, either through cost advantages or through product differentiation. As traditional health care is fairly standardized, physicians and hospitals are likely to seek more cost advantages (i.e., lower prices) in the future in order to maintain or gain an edge over their competitors.

**Nationalization of Health Care**

The idea of a national health insurance system has been gaining support in recent years. According to Joseph McKenna, a national health insurance program must examine and address shortcomings in the current health care delivery system and its financing mechanisms which limit or prevent access of all citizens to comprehensive health care (1989, p. 46). There are essentially four viable methods of universal health insurance. While all encompass the notion of nationalized health care, they differ both in how they approach nationalization of care and how they limit costs. In the Canadian-style system, a tax-supported, government-run system would pay all medical bills. Under this plan, costs are controlled through the government budgeting process. Under a different plan, proposed by the Bush Administration, deductions for the middle class and tax credits for low-income families would enable many of the uninsured to buy basic health insurance. Costs in this system would be controlled in this manner: as the number of uninsured is reduced, cost-shifting is limited, and insurance then becomes more affordable.

In a full-scale managed competition system, employers would require their workers to join one of the comprehensive health coverage plans they would provide. Under this system, the company would negotiate prices with health care providers, and employees would choose whichever plan best suited their needs. Finally, in a “play or pay” system, employers would have to provide minimum health coverage for all their employees or pay new taxes to finance a government-run plan. In this system, payers and providers would negotiate prices to limit costs (much like managed care systems). In addi-
tion, limits set by the government would be placed on the amount of growth allowed for health care spending (Faltermayer 1992, p. 49).

In the past, businesses have appeared to assume a passive role in controlling health care costs. However, as companies realize they must effectively control the allocation of benefits to their employees, a new level of concern has emerged. Employers have been looking to national health insurance as one way to solve the problem of soaring medical costs in the United States. Chrysler Corporation chairman Lee Iacocca has stated, "More and more business people are not just whispering but talking out loud about making health-care financing a government responsibility.... We've waged a war on health care costs for more than ten years and lost it" (Nelson-Herchler 1989, p. 45). The Canadian-style system of nationalized health care seems to be winning the most approval among companies discussing a national plan.

Companies shy away from proposals that require them to provide health care coverage for their employees. An example of this kind of health care plan was introduced by Senator Edward Kennedy (D., Mass.). His bill required employers to give all employees who work at least 17.5 hours per week physician services, hospital care, catastrophic insurance, prenatal and well-baby care, and mental health benefits (Nelson-Herchler 1989, p. 46). This legislation has not received support from businesses as they view it as too narrow and not aimed at the root of the problem: the high costs of health care services. Essentially, national health insurance looks increasingly attractive to employers as they feel it will cost them less, even though it will cost the country more.

Reduction of Services to the Poor

Another solution proposed to reduce the cost of medical care is reduction of services to the poor. The American public associates Medicaid with the national system of welfare (Schramm 1987, p. 60). Although Americans feel health care should be available to everyone, their attitude toward welfare in general is less tolerant. Fifty-nine percent of Americans believe that "welfare benefits make poor people dependent and encourage them to stay poor" (Schramm 1987, p. 62). In light of this attitude, one might think Americans would be in favor of reducing government health care benefits for the poor. However, proposing reductions in the Medicaid system is not a stance many individuals are willing to take. Many politicians are fearful of appearing callous and unsympathetic if they introduce these reductions. Since Medicaid covers pregnant women, children, the disabled, and elderly under a minimum income level, reducing their health care coverage would seem cruel.

Medicaid does not need to be reduced, however, but rather restructured. If functioning ideally, Medicaid would reduce the number of underinsured individuals receiving medical care at the expense of full-paying patients.
Instead of the costs being passed on to full-paying patients, the government would cover the expenses. Such a system of Medicaid would reduce cost shifting and in turn lower the cost of health care nationwide.

Proposals have been suggested to alter the Medicaid program. One of the most widely supported has been a plan to alter the existing income qualifications for low-income individuals seeking Medicaid coverage. In other words, make Medicaid more available to those Americans who are too poor to afford decent health care but are not poor enough to qualify for government coverage. When health care providers are more fully reimbursed for treating patients, they should find it unnecessary to overcharge for services in order to cover losses. With fewer uninsured people receiving medical care, hospitals and physicians should be able to charge the true cost of treating their patients, rather than what it costs to treat patients plus a subsidy for uninsured individuals. Although taxpayers may have to pay more to cover this increased coverage, it is likely this increase in taxes would be offset by nationwide reductions in health care costs.

**Regulation**

Certainly one way to get control of health care is through more regulation (Dentzer 1991, p. 54). The government may choose to regulate the health care industry by imposing a standard price schedule for all hospitals. The Bush Administration supported legislation to regulate physicians' fees and to prevent physicians from referring their Medicare patients to diagnostic laboratories in which they have a financial interest. Although some of this referral may be legitimate, this situation clearly also provides an opportunity for physicians to profit from unnecessary services. Some states have taken it upon themselves to limit the amount of financial interest a physician may have in these types of health care facilities. These measures are designed specifically to limit health care spending (Relman 1992, p. 106).

**Managed Care**

Managed care has increasingly been used as a means of controlling rising medical costs. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are the two most popular methods of managed care. HMOs are prepaid health care organizations that provide health care financing and services. Individuals who enroll in HMOs pay a standard fee upfront and the HMO then assumes responsibility for health care costs incurred. HMOs have been successful for many reasons: 1) they seem to attract people who are less risky in terms of health (for example, those who lead healthier lifestyles); 2) they encourage better health maintenance among their enrollees; 3) they have the ability to keep people out of the hospital...
(mainly due to preventive health care and health maintenance); 4) they tend to select physicians who are conservative in terms of ordering tests and additional services; and 5) they provide substantial training for their physicians (Schramm 1987, p. 74).

Preferred Provider Organizations (PPOs) represent arrangements where comprehensive insurance benefits are offered to employers through a loose association of health care providers. These “preferred providers” agree to deliver services at a discounted price in return for the promise of patient volume. One of the main advantages of PPOs is that, in addition to reducing costs through price negotiations and use management, they allow more freedom of choice of providers than HMOs.

Traditional health care providers are paid for services on a reimbursement basis. This arrangement leads to paperwork overload as well as payment delays. Managed care networks reduce paperwork and promote efficiency as payment for services is received before services are rendered. In addition, HMOs generally offer extended office hours, which better accommodate HMO members. Although managed care programs restrict an individual’s choice of health care providers (HMOs more than PPOs), the advantages for businesses and individuals generally outweigh the negative aspects.

**Biomedical Breakthroughs**

Biomedical breakthroughs are another long-term solution to the problem of rising health care costs. Obviously any achievement in the medical profession that promotes better health, reduces the spread of disease, or cures previously incurable diseases is a step toward reducing medical costs. Once a medical problem is solved, it will not incur large costs aimed at its prevention or treatment. However, a long-term goal of biomedical breakthroughs must be tempered with the immediate costs of reaching such goals. Money spent on research might be better spent on treatment of present patients. It is the responsibility of the general public in conjunction with health care providers to reach a consensus concerning the allocation of funds for research.

**HEALTH CARE REFORM: EVERYONE’S RESPONSIBILITY**

**The Role of Government**

The government has a duty to fulfill its responsibilities in controlling the rising cost of health care in the United States. There are certain services all of society needs (like education and health care). However, providing these services tends to be expensive and may not always present an opportunity for profit (Dentzer 1991, p. 57). Businesses are rarely willing to incur losses in their business activities for the benefit of society. Consequently, the government must provide those services. The government has a duty to provide
access to health care for individuals who are not insured. The reasons for this are two-fold. First, ethically speaking, the government is obligated to care for its underprivileged citizens. Secondly, the government must do its part to reduce the problem of cost shifting by providing better coverage to those who are not insurable through some other means. Whether or not the government will allocate more funds to subsidize the health care system on behalf of the poor and elderly remains to be seen. This in part will be determined by the public itself — whether or not citizens actually vote for more money to be channeled into health care for these groups. However, regardless of whether more funds will be available, the government still has the responsibility of redesigning the current system of health care coverage for the poor and of striving to provide access to quality care for everyone.

During the 1992 election, the issue of health care was prominent in the minds of candidates and voters. The ability to provide a better system of health care for Americans was a critical deciding factor in determining the election outcome. Nevertheless, the Clinton administration's inability to convince Congress to support large scale health care reforms testifies to the power of vested interests and to the public's fear of change.

**The Role of Business and Industry**

Businesses' role in controlling rising health care costs is multifold. First of all, businesses must overhaul the way they purchase health care by becoming demanding buyers. Businesses need one major weapon in order for them to challenge doctors' and hospitals' currently indisputable reign over health costs: better information. This need for better information brings to light another prescribed role for businesses: as leaders in developing and maintaining data relevant to decision-making in terms of medical care (Dentzer 1991, p. 56). Businesses have the ability to acquire, use, and distribute data that would enable society and government to be better and more responsible purchasers of health care.

Deere & Co. of Waterloo, Iowa is one company which has taken an active role in reducing the cost of health care. In conjunction with Heritage National Healthplan (a fully owned subsidiary of Deere), Deere & Co. has decided to switch many of its local employees to a managed health care option (Young 1993, A4). This plan limits a patient's choice of doctors, hospitals, pharmacists and specialist care. By directing many health care services, Deere's Heritage National Health planners hope to cut costs. Patients who are willing to accept limits on their choices of health care providers may have better access to health care as the costs of insurance are reduced. Insurance costs in managed care plans fall as insurers and health care providers negotiate prices for care. Although this plan has been met with some appre-
hension among local health care providers and employees, the success of managed competition systems in the past is a big incentive for the shift.

*The Individual’s Role—Changes in Life Style*

A small minority of people accounts for the majority of health care costs. Hewitt Associates of New York estimates that 7 percent of all employees account for 70 percent of all health care expenses in any given year and that 71 percent of those in medical plans have claims of less than $500 annually (Verespej 1990, p. 23). Getting Americans to alter their lifestyles may be paramount in reducing the costs of medical care over the long run. An increase in public education about disease prevention is necessary in order to persuade Americans to change their lifestyles for the better (Dentzer 1991, p. 58).

Some companies offer programs that help people stay well or attempt to catch medical problems before they become serious. Many companies offer reduced medical costs and bonuses as incentives for employees to participate in company-sponsored wellness programs. A few companies are even considering “lifestyle-based premiums,” which charge a slightly higher premium to those employees who are not pursuing healthy lifestyles (Hairston 1990, p. 82). Measures like these are all designed to encourage healthier lifestyles among individuals.

Health promotion and maintenance are becoming more prominent among Americans in general. According to Robert H. DeVries, program director at the W.K. Kellogg Foundation, more attention is being paid to “nutrition and diet, proper exercise, smoking cessation, good mental health practices, restricted use of alcohol and chemicals, and better care of the environment” (1988, p. 222). With healthier lifestyles comes better health and, in turn, an overall reduction in the costs of health care.

Individuals also need to take aggressive action in deciding who treats them, how they are treated, and what methods are used. As DeVries suggests: “No longer are patients passive. They wish to be active, informed and involved in considering alternatives to their health care” (1988, p. 222). How individuals live determines how often or how much they require medical attention. Striving for good health will help keep physician and hospital use down, and, in turn, reduce costs for individuals and employers.

Individuals also need to understand their role in changing the current health care system and strive to make changes for its betterment. Although individuals are limited in their influence on the entire system itself (as they are mainly secondary purchasers through businesses), it is important to maintain the attitude that controlling costs is a group effort. In other words, individuals need to cooperate with their companies in achieving the best and most efficient health care packages. Individuals need to make use of the
CONCLUSION
Health care costs have been skyrocketing despite efforts at cost control. The failure to remedy the problem of an ineffective and expensive health care system points to an obvious conclusion: the methods of attacking this problem must change. In order to alter these methods, attitudes must change as well.

Government needs to address the true problems in the health care system, rather than the symptoms. Efforts need to be concentrated on the allocation of health care among the poor and the elderly, as well as upon on the amount provided. In addition, more (or better) regulation as well as a system of nationalized health care should be considered when searching for viable methods of controlling rising health care costs. Businesses must look beyond the "cost only" aspect of providing health care for employees and instead look at the health care system as a whole. Only then will costs be manageable and, in turn, be kept under control. Individuals play an important role in controlling the crisis in health care as well. They need to improve their lifestyles and reexamine their health care coverage purchases. Health care is an on-going concern of dynamic proportions and should be viewed accordingly. Controlling the costs of health care can only be achieved through continual management practices on the part of businesses, government, and individuals. A concentrated, cooperative effort among all players in the health care system, purchasers and providers alike, will result in the most effective method of containing costs and providing maximum quality and access to health care for all members of society.

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