Good isn't good enough: Why the United States should develop a new NHRS system of health care delivery

> "Good is the enemy of great. Greatness is not a function of circumstance. Greatness, it turns out, is largely a matter of conscious choice and discipline."
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> —Jim Collins[1]

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The United States has the best educated and trained physicians, nurses and other health professionals in the world. However, despite having the best health care providers, the cost of care and overall health outcomes are not as good as other high-income nations. In 2021, the U.S. spent 18.3 percent of its Gross Domestic Product, or $4.3 trillion, on health care.[2] This is $12,914 per person.[2] This equates to nearly twice as much as the average of Germany, and four times as much as South Korea.[3] Notwithstanding these exorbitant expenditures, the U.S. has the worst overall health outcomes of any high-income nation, and Americans are more likely to die younger, and from avoidable causes, than those in those other countries which have universal health coverage. This includes having the lowest life expectancy at birth, the highest death rates for avoidable or treatable medical conditions, the highest maternal and infant mortality, and extremely high suicide rates.[3]

The U.S. has the highest number of people per capita with multiple chronic conditions and obesity; people tend to see physicians less often than those in most other countries; and, the rate of practicing physicians and hospital beds per 1,000 population is among the lowest in the world.[4] We clearly need to do better.

In 2021, Kumar and Adashi reported that the U.S. carries $140 billion in unpaid medical debt which is held by collection agencies. This means one in three U.S. adults are carrying medical debt.[5]

Why is this happening when we have such well-trained and educated medical professionals? Simply put, it's because the U.S. does not have a National Health Care System. We have an incrementally developed and disorganized health provider and payment approach to providing health care.

The U.S. has evolved into a unique patchwork of health care delivery, not seen elsewhere in the world. The basic features of this patchwork of subsystems, include the absence of a central agency to govern health care delivery; unequal access to health care services; a lack of health insurance and medical coverage for all; health care delivery affected by market conditions; the existence of multiple payors; third-party insurers functioning as intermediaries between the care of patients and finance and payment for that care; differing processes among the various payors and providers; new and expensive technology; legal interference and controversies; and multiple care and service settings, to name just a few.

Incentives in the current insurance-based health care market are to collect premiums and pay for as little health care as possible. Insurance companies are able to do this through high deductibles, prior authorizations, claim denials, and narrow physician and hospital networks.

Insurance companies have the ability to incentivize and collude, almost as a legal, price-fixing cartel with high prices for drugs and hospitalization. In addition, profit-driven private equity groups have taken over many aspects of health care as a lucrative for-profit financial industry.

According to Brock and Buchanan, "Much of the concern over 'for-profit' health care has a much wider implication than 'for-profit' as a narrow legal status term. It is now often said that health care in America is being transformed from a profession into a business like any other because of the growing dominance of those types of motivation, decision-making techniques, and organizational structures that are characteristic of large-scale commercial enterprises,"[6] which are predominantly motivated and driven by financial profit.

The current U.S. health care system drives profits to concentrate wealth and power in the hands of shareholders of insurance companies, drug companies, and large hospital corporations and their executives and private entrepreneurs. Competition between health insurance companies to pay for the health care needed is a market failure. This non-system of health care results in myriad issues for patients, physicians, and other health care providers, including access to care; unfair competition for patients due to revenue goals; considering health care a commodity rather than a right; incentives and organizational controls that adversely affect the physician-patient relationship; conflicts of interest; and the ill effects of the medical-industrial complex that exert adverse influence on health care and public policy.

Delivering and providing health care should be based on caring, relief from suffering, medical professionalism, and high quality health care. It should be defined as a public good, delivering the right care, at the right time, as determined by the physician and health care team. This would provide patients with the trust that when care is needed, it will be available and delivered with the patient's needs paramount to how it will be paid for. In addition, those providing the care and services need to know that they will be fairly compensated, and not have their care decisions second-guessed by an insurance company.

"Follow the money and hype in medicine and you will find that in the United States we prefer treatment to prevention."

—Louise Aronson[8]

The evolution of the current non-system of health care

The U.S. Constitution was written in 1788 when there were only 13 colonies and four million people in the country. The right to health care was not included in the Constitution.

Since that time, the right to health care has become widely recognized worldwide as a basic human right. Article 25 of the 1948 Universal Declaration of Human Rights adopted by the United Nations General Assembly provides that "Everyone has a right to a standard of living adequate for health and well-being…, including…medical care…and the right to security in the event of sickness and disability."[7]

As written, the Constitution was not designed to address today's governance needs; nor did the authors recognize medicine or health care as a key national issue. That is because at the time, doctors were available, were independent, and received payment primarily on a barter basis. The author's primary goal was the creation of an effective constitutional structure of the country's political institutions with federalism and the separation of powers; the establishment of a national government and state governments, restraining the influence of both with different branches having separate functions and the necessity to share power. Federalism was adopted, and the sharing of power by national and state governments with each state chartered by the federal government, and governed by a governor, elected legislature, and local government representation in cities and counties was ensconced.

However, now that we have 50 states and nearly 332 million people, there inevitably exists great variance from state to state. The provision of health care and corresponding regulations are often state and local responsibilities with no unified governmental power or governance structure or system.

The federal government has long used its authority to regulate international and interstate commerce, and to tax and spend for the general welfare and protection of health. Legal doctrines that once supported the states' ability to protect the health of their respective residents now adversely affect the capacity of national and local governments to provide and protect people's health and wellness.

As a result of the federalism approach to health care, a unique payment system has evolved as a predominantly capitalist financial system. This U.S. non-system of health care is unnecessarily fragmented. This results in an expensive, disorganized health care conglomerate that is administratively managed and overseen by many government departments and agencies. While we continue to pursue periodic changes, providing necessary health care for all at an affordable cost remains unachievable.

By the numbers

Myriad organizations and individuals are involved in health care, including providers involved in the provision of preventive, primary, subacute, acute, general, specialty, auxiliary, rehabilitative, and continuing care, along with educational and research institutions, medical suppliers, insurers, payors, and claims processors, to name just a few. Health care delivery in the U.S. is massive with about 10 million employees in various health delivery settings, including about 744,000 doctors of medicine (MDs), 2.2 million nurses, 168,000 dentists, 226,000 pharmacists, 700,000 medical administrators, and 325,000 rehabilitation therapists.[9] In addition, there are 5,760 hospitals, 16,100 nursing homes, and 4,300 inpatient mental health facilities.[9] Health care professionals are trained in 193 allopathic and osteopathic medical schools,[10] 71 dental schools,[11] 130 pharmacy schools,[12] and more than 2,600 nursing programs[13] throughout the U.S.

According to the most recent numbers, in 2021, 36.7 percent of people in the U.S. are insured through government programs—Medicare, Medicaid, Military and VA, and Indian Health Services, 48.5 percent have employer-based health insurance, 6.1 percent have other private insurance, and 8.6 percent are uninsured.[14]

Health insurance can be purchased from nearly 1,000 predominantly state-based health insurance companies,[15] many of which have a plethora of different medical plans. In addition, legions of government agencies are involved with financing health care, medical and health care services research, and regulatory oversight of health care delivery services. The U.S. has maintained a mostly private system of financing and delivery of health care. In practice, prices are determined by the payors, not the providers or patients.

The majority of hospitals and physician clinics are private businesses, independent of the government. No central agency monitors budgets and/or the availability and utilization of services.

U.S. health care does not consist of a network of interrelated components designed to coherently work together. This federalism approach to health care in the U.S. is cumbersome, and limiting, without uniformity and equality, especially when it comes to access to, and cost of, care.

Capitalism in health care

The U.S. is the most successful capitalistic country in the world. The primary element of capitalism is to make a profit. Capitalism works best when the seller sets a price and the purchaser can accept or reject the seller's goods in a free market. Illness, health care, and suffering do not afford the patient with the option or choice to purchase a product or service as they do not have control over illness or their need to purchase care and services. Obtaining health care is not like purchasing other products or services.

However, the U.S. health care delivery system attracts a variety of private entrepreneurs driven by the pursuit of profits which results in a multiplicity of financial arrangements for health care services. Health insurance companies are designed to insure against risk, therefore there are multiple payors making individual determinations regarding how much to pay for each service. This is combined with numerous consultants and organizations offering expertise in planning, cost containment, quality, restructuring, etc. This non-system of health care services results in the U.S. having the highest administrative costs of any country in the world and adds directly to the cost of care.

There is almost no standardization or organization in this kind of fragmented non-system. It is not subject to aligned planning, direction, and coordination from a central agency, such as a coalesced entity with the expertise, financing, funding, budgeting, planning, integration, coordination, authority, medical expertise, and responsibility for health care delivery in the U.S.

However, universal health care for all in the U.S. seems impossible any time in the near future given the current state of divisive politics and the federalist system of governance.

An established alternative

Finance and banking are essential to a successful nation. In 1913, the U.S. faced similar issues to what health care faces today. As a result, the U.S. Federal Reserve System was created and established by the Federal Reserve Act to conduct research on the economy, supervise banks in local regions, provide financial services, and monitor financial system risks in order to support a healthy economy. The primary purpose of the Federal Reserve was to foster a sound banking system, conduct national monetary policy, supervise and regulate banks, maintain financial stability, and to enhance the stability of the American banking system.

Today, there are three key entities to the Federal Reserve System—a Board of Governors; 12 regional Federal Reserve Banks; and the Federal Reserve Open Market Committee working collaboratively to promote the health of the U.S. economy and stability of the U.S. financial system. It has five key functions to promote the health of the U.S. economy and the stability of the U.S. financial system: conducting monetary policy; supervising and regulating financial institutions and activities; promoting financial system stability; promoting consumer protection and community development; fostering payment and settlement system safety and efficiency. Member banks in each region elect six of the nine directors of Regional Banks that are owned by the private banks, and seven members of the Board of Governors are appointed by the President of the U.S. Because of its public/private design it is often referred to as a hybrid system.

The Federal Reserve System created a balance between the private interests of banks and the centralized responsibility of government. It is under public control, with numerous checks and balances. Congress oversees the entire Federal Reserve System and it must work within the objectives established by Congress. Congress gave the Federal Reserve the autonomy to carry out its responsibilities without political pressure. Each of its three parts—the Board of Governors, the regional Reserve Banks, and the Federal Open Market Committee (FOMC), operates independently of the federal government. The Federal Reserve System maintains balance between the private interest of banks and the centralized responsibility of government.

It was developed, and continues to develop, as an interesting blend of public and private interests and centralized and decentralized decision-making.[16]

A National Health Reserve System

There is a way to develop, operate, and manage the U.S. health care system that would provide excellent and nearly universal coverage while having multiple payors, including employer-based health insurance, i.e., maintaining the private option for almost half of the total U.S. population. This would be through the development of a quasi-independent apolitical National Health Reserve System (NHRS) that I proposed in *The Pharos* in 2020[17] and 2021.[18]

A NHRS would provide the U.S. with a health care system modeled after the Federal Reserve System, allowing for government funded care for half of the population, and private employer-based insurance for the other half. The role of the NHRS would be to govern, integrate, coordinate, and manage a nationwide system of health care, both private and governmental and would be led, governed, and managed by experts, including physicians, nurses, health professionals, patients, and others using data, experience, evidence, and planning to operate a national health care system independently with transparency and quasi-independence from politics.

As previously published, the NHRS would:

- Establish uniform charges for medical care, procedures, and pharmaceuticals based on the actual cost of the service, not allowing for cost shifting, and minimizing administrative and overhead costs. Rural and Urban hospitals and providers would be evaluated in their cohort.
- Oversee all governmental and non-governmental insurance entities.
- Coordinate medical, residency, and fellowship training and utilize manpower needs data for allocating positions in specialties.
- Control costs, approve of resource allocation decisions and stockpiling.
- Support academic health centers and teaching hospitals to promote excellent clinical care, health professional education, research and scholarship, and public policy.
- Oversee construction and expansion of medical facilities.
- Ensure the availability of a private health insurance option, a public national insurance option, as well as options for the uninsured and underinsured.
- Manage the development and disbursement of existing and new pharmaceuticals, including installation of a national formulary based on efficacy, safety, benefits, and cost.

- Develop a centralized electronic health record (EHR) for all that includes a billing and collection repository with all patients issued a health card to be utilized for clinical record management, billing, and collection. This centralized EHR will provide health information nationally for usage by the NHRS' geographic boards and health policy scholars.
- Oversee interstate health care organizations and integration.
- Assume responsibility for telemedicine and telehealth at an interstate level and function.
- Oversee and manage ambulance and other patient transport services.
- Ensure all aspects of care are available to all who need them including preventive services, screenings, immunizations, vaccination programs, inpatient and outpatient hospital care, maternity care, dental care, eye care, mental health care, palliative care, long-term care, rehabilitation and physiotherapy, home health care and community-based nursing care, wheelchairs, hearing aids, and other assistive devices for those assessed as needing them.
- Oversee the interstate collaboration and cooperation necessary to provide universally accessible health care.
- Develop policies and make decisions based on experience and extensive use of data and evidence.

The NHRS would have three key organizational elements:

- A seven member Board of Govenors appointed by the President of the U.S. and approved by the U.S. Senate, serving 14 year staggered terms with a Chair and Vice Chair appointed by the President including 4 physicians representing generalist doctors, academic medical centers, multi-specialty practice, and rural health, one nurse, and three health care insurers, from Medicare, Medicaid, and employer-based insurers.
- A 12 member Health Care Policy Committee representing health policy experts with three-year terms from the 12 geographic regional multi-state centers and a nine member Board of Directors with six self elected members by the 12 member committee, and three members appointed by the Board of Governors. Physicians would be appointed to at least five positions. Each Health Policy Center would have at least one branch and each would have its own board of directors which would be appointed by the Health Policy Committee or the Board of Governors. This group would serve as a link between the NHRS and the health care system and would bring to their duties a wide variety of experiences in the current health system to contribute to the governance and organization of health care policy and health care delivery.
- A Health Care Operations Committee with a seven member Board of Directors serving one-year terms with five Presidents from the Health Care Policy Committee and two appointed by the Committee. The Committee would have three groups of Directors: Group A would be three physicians; Group B would be nurses and other health professionals; and Group C would represent patient and the public. All would be appointed by the Health Policy Committee.

The organizational structure would be determined by the NHRS Board of Governors, but would likely have Divisions: Office of the Board of Governors; Office of the Health Policy Committee; Office of the Health Operations Committee; Board Committees; Advisory Councils; Divisions of Supervision and Regulation that would include health care professionals, finance, health care delivery, health policy and affairs, information technology, research and statistics, health affairs, legal, etc.

Funding for the NHRS would be through the federal government and would include an annual fee paid by states to cover the costs related to their respective state needs based on population and geography; fees paid by hospitals; fees paid for licensing of health professionals nationally; and other sources.

The NHRS will coalesce and group the complicated and disorganized components of health care delivery. It will promote the health of the people according to an organization with structure, leadership, and authority. It will focus on the development and monitoring of health policies; oversight of the health care system and health care; promotion of a safe, efficient, accessible, and financially responsible system; and development and implementation of rules and regulations that act to form a unified and comprehensive health care delivery system.

The overall goal of the NHRS would be to improve the health of the nation and to remove obstacles that interfere with patient care through the creation of a new, contemporary U.S. health care system and organization.

Getting to a solution

Doctors, nurses, health professionals, and patients must provide the much-needed leadership to improve

health care and health care delivery in the U.S. Doctors, and other health care professionals, with their education, training, knowledge and experiences in caring for patients, relieving suffering, and improving health, are best prepared to lead in this endeavor. From their experiences, they clearly know best what needs to be done. These trusted professionals can provide the leadership to get people to want to do, and then do, the right thing for patients and the health care delivery system. The responsibility of these leaders is to commit to a clear vision for health care delivery in the U.S., and pursue it with vigor, dedication, and a commitment to serve the suffering.

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