EditorialOpinion

Healthy Choices

Should those with unhealthy lifestyles pay more for their health insurance or their health care? There is no public consensus on this issue, according to a Harris Interactive poll conducted for The Wall Street Journal Online's Health Industry Edition. The survey findings show a mix of values:

• A 46 percent to 37 percent plurality of adults say we should not require people with unhealthy lifestyles to pay higher premiums than people with healthy lifestyles, and a virtually identical 47 percent to 36 percent plurality feel that we should not require people with unhealthy lifestyles to pay higher deductibles or co-payments for their medical care.

• However, when questions are asked about different types of health risks, attitudes vary depending on which risk is involved. Majorities believe that smokers should pay more than non-smokers (by 58 percent to 31 percent) and that people who do not wear seat belts should pay more than people who do wear seat belts (by 53 percent to 33 percent). On the other hand, majorities do not believe that people who are overweight (by 52 percent to 27 percent) or people who do not exercise regularly (by 52 percent to 27 percent) should pay more.

There is a huge divide between those with a college education, who are much more supportive, and those with only a high school education or less, who are much more strongly opposed, notes Humphrey Taylor, chairman of The Harris Poll.

This matters, Taylor adds, because education is strongly correlated with healthier lifestyles. People with less education are much more likely to smoke, be overweight, not wear seat belts and not exercise. Men are also much more supportive than women.

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Not only is there apparently no consensus on how to allocate health costs in accordance with personal responsibility, but there is also a stubborn lack of agreement on how to contain the cost of health care.

An unwillingness to confront the difficult tradeoffs inherent in containing health care costs and expanding health insurance coverage, coupled with how the U.S. finances most health care, contributes to the seemingly intractable nature of the cost-coverage conundrum, according to a commentary from Center for Studying Health System Change (HSC) President Paul B. Ginsburg, Ph.D., and Vice President Len M. Nichols, Ph.D.

The authors — both economists at HSC, a nonpartisan policy research organization funded by The Robert Wood Johnson Foundation — identify three key factors:

• Cost-containment and quality-improvement efforts are essential if Americans are to get better value for the the $1.4 trillion annually spent on U.S. health care.

• If we are to cover everyone, we cannot cover everything, and we need to make informed choices about which medical services are more beneficial to patients than others.

• Even if we slow cost trends, significant public funding will be needed to expand coverage to uninsured Americans, whether through tax subsidies, expansion of public coverage or a combination of both approaches.

Both public and private leaders consistently have avoided the idea that real cost containment involves real sacrifice — patients going without services that may provide some benefit or physicians, hospitals and insurers settling for smaller incomes or profits.

Ginsburg and Nichols explain:

"In our view, a more clinically based form of rationing is needed to avoid pricing health care out of the reach of an increasing proportion of Americans. Though some deny it, we ration care today. The uninsured get much less care than the insured and suffer worse health outcomes because of it, and the insured with ample means get more care than the lower-income insured, although without clear outcome differences. The challenge is to ration in a way that is more efficient and equitable."

Ginsburg and Nichols point out that how the U.S. finances most health care makes cost containment difficult. Health insurers' financial obligations are defined in terms of what treatments physicians and patients decide to pursue—providing an environment in which treatment decisions can be made with little regard for treatment costs. When someone else pays—the health insurer—patients have little price sensitivity and almost no incentive to economize.

The impact of low patient out-of-pocket costs — coupled with payment systems that encourage providers to deliver more services — is probably magnified by limited information about the effectiveness of many medical tests and procedures.

The two suggest that greater reliance on evidence-based practice guidelines and institutionalized technology assessment could help inform private benefit package design and differential patient cost-sharing requirements.

In contrast to systems that decide for the patient what services are unavailable because of limited clinical value, a system more compatible with American values would continue to allow broad patient and provider choices, coupled with extensive information about likely clinical value and higher cost sharing when the values are small. ❒