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EDITORIAL

Misaligned Incentives in America's Health: Who's Minding the Store?

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We share Woolf and Johnson's pain.[1] The American health care system simply fails to deliver the health benefits commensurate with our investment. We have no one to blame but our collective selves, however. Each group of constituents is intent on trying to do its best while responding to misaligned incentives. Clinicians are working harder and are under increased scrutiny to show that they are up-to-date with evolving treatment guidelines. Scientists are making extraordinary advances in our understanding of the basic mechanisms underlying bodily functions and how they malfunction in disease. Private research and development enterprises are harnessing cutting edge technologies (eg, combinatorial chemistry, high-throughput screening, genetic/proteomic profiling) to translate these basic science insights into potential diagnostics and treatments. Payers are increasing incentives to clinicians to provide appropriate care according to evidence-based guidelines. Yet our health indices are poor by any reasonable metric. We fail to provide health insurance to a large segment of the population; we fail to deliver effective services about one half the time to persons who need them; and we fail to organize our society to reduce unhealthy behaviors. So what is the way forward?

H. L. Mencken once said, "There is always a well-known solution to every human problem—neat, plausible, and wrong."[2] We agree with Woolf and Johnson that better balance in our social investment would likely improve the overall health of the population. We should not assume, however, that closing the treatment gap will be easier or less costly than developing new health technologies; indeed, history would suggest such is not the case. After 1 year, one half of new patients with chronic conditions no longer take their regular medications. Health Plan Employer Data and Information Set (HEDIS) measures suggest that among those with access to care, many effective services remain underutilized, even with the incentive of public reporting.[3] Perhaps more disturbing is that effective population-based strategies are even more broadly ignored. The *Guide to Community Preventive Services*[4] identifies many effective techniques for healthy behaviors, improving the sociocultural environment, improving delivery of vaccines, and other health care services. All could increase longevity and quality of life, yet all are underutilized, and the research to identify and

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evaluate community-based strategies remains badly underfunded.

Improving the health of the American public will require a societal commitment at all levels, a systematic and structural reengineering of the public health and health care enterprises that support their working together synergistically, and alignment of incentives across all stakeholders, including government, private payers (eg, employers and insurers), health care delivery organizations (eg, managed care organizations, pharmacy benefits managers, nursing homes) and patients, and consumers.[5] If everyone is focused only on his own task, no one is responsible for ensuring that our nation's investments are well utilized, let alone best utilized, to improve health. The health of Americans depends on healthy communities and population health interventions, as well as access to and delivery of effective clinical interventions. Yet our investment approach is to decentralize the process and the means to accomplish our goals. These processes interact in an exceedingly complex and unfathomable fashion. One striking result is that a large proportion of our population does not have medical insurance coverage. How can we improve the health of the American public when everyone does not have ready access to appropriate preventive care and treatment services?

The hue and cry over increasing health care costs (as a proportion of our gross domestic product) misses the point. It is not the magnitude of the spending—it is unlikely to go down—but whether we can reward activities that will move us in a coherent direction toward improving the quality of health care delivery and use of preventive services. One salient example is that the great majority of government-funded biomedical research is not allocated to translational research, ie, how to increase the effectiveness and efficiency of health care delivery. If one half of our basic and clinical scientists were to turn to translational research, who would fund them? If pharmaceutical companies measured their success by improvement in health indices in at-risk populations as well as profitability, would the financial returns support their viability? More generally, if large additional resources were poured into our current health care enterprise, would we actually reduce the uninsured and reengineer our health care delivery system? Or would we seek more high-tech care, more specialized services, and use those resources for overhead, marketing, and providing returns to the stockholders of publicly owned health care companies? Our patchwork of health care companies (eg, managed care, pharmacy benefit managers, biotechnology, diagnostic and pharmaceutical companies) is not financially rewarded for improving health. In the current American business environment, health care companies need to meet fiduciary responsibilities and be responsive to the expectations of their stockholders as well as potential investors. Such corporate accountability is not in and of itself either wrong or necessarily bad. If history teaches us anything, these incentives have been most reliable in supporting technological innovation. We also know, however, that social welfare will unlikely be maximized by purely free market incentives.

So where do we begin? First, we need a forum to understand and gain consensus on how we will assess the value we receive for our health dollar. There is general agreement that resources are constrained; yet, we frequently deliver costly services that result in only marginal health improvements while more cost-effective services are underutilized. Clinicians and patients seek therapies that provide any modicum of potential benefit, while large populations do not receive important services that would substantially improve their health. Second, we need to agree on achievable goals. Third, we need a way to identify systematically the opportunities—the potentially innovative new technologies, methods for closing the health care treatment gaps, and population health approaches—to improve health. Armed with this roadmap, we need to convene our leaders to reexamine our priorities. How do we invest the resources available to maximize the health of Americans? Do we even agree that should be our societal goal? How much of our research investment should go to basic and clinical science, how much to translation research, how much to population health research? Similarly, how should we allocate our resources for interventions at the individual, institutional, and population levels? The current business model in America focuses on profitability—"the business of business is business." Alternative approaches, however, have more formally incorporated the impact of corporate decisions on social welfare (eg, "green" companies). A shift toward a hybrid system that includes the social goals as part of the business strategy would require a major cultural transformation, but such a shift may, in the long run, be better for both investors and society.

The solutions will not likely emerge from the individual constituency groups, each of which has a rightful claim to resources to accomplish its mission. We need a national dialog to agree that the goal of the public health and health care enterprises is health. We need all parties to recognize that their success must be measured in units of health, not simply dollars, publications, and services. Although there remains deep suspicion of big government solutions in many quarters, it is not possible for such an effort to move forward without strong leadership from the federal government.

Woolf and Johnson recognize that they have created a false dichotomy. Indeed, industry is keenly

interested in improving the appropriate delivery of services. Adherence programs, reminders, disease management, educational programs, the provision of drugs at no or nominal cost, and other quality improvement efforts are now a mainstay of the pharmaceutical business model. Incentives are now often provided to enhance the appropriate delivery of services. The sad truth is that these initiatives have had only modest impact. The *Guide to Community Preventive Services* has reviewed the impact of access to care, reducing cost of care, educational interventions, reminders, and other strategies for enhancing the delivery of effective preventive services.[4] Even though multicomponent interventions are often used, large gaps remain. Most are effective at only relatively modest levels, not at the levels suggested by Woolf and Johnson. Many intensive interventions do not have sustained effects and can be costly as well.

We believe that effective, practical interventions will be enthusiastically embraced and implemented. Clearly, we need more effective strategies to close the gap, but this effort is not a zero sum game. More effective interventions coupled with better delivery should yield greater health benefits.

Although the American free enterprise system successfully invests in innovative technologies that can be marketed, this system, which works so well in for-profit enterprise, has its weakness in channeling resources into those innovations at the expense of other, more effective translational or population health initiatives. Despite efforts to align such incentives as pay-for-performance and quality performance metrics, the current system is ill-suited to deal with the fundamental problems of access to care, translational initiatives for which reimbursement is not available, and delivery of appropriate care. We are making strides, but great leadership will be required for us to have a rational system for investing in the nation's health. At the same time, breakthroughs in science hold great promise for innovative drugs, vaccines, and diagnostics that may reduce the burden of diseases for which current treatments only slow disease progression. How we balance our investment in the promise for tomorrow vs the needs of the present is a tricky business that affects all sectors of American life, not just health care. What is clear is that striking the balance is an ongoing enterprise. It's time we got started.

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