

THE PSYCHOLOGY OF HEALTH REFORM

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If we are to achieve health reform—that is, affordable, sustainable, and constantly improving health care available to all—we need to start looking as much to the psychology of the issue as to the economics and politics.

Psychology tells us that we almost always want to take actions that, at least for the moment, make us feel good. Yet, cost-conscious health reform must curb unsustainable growth in costs and is therefore guaranteed to take something from someone. If we slow the rate of growth of health costs, arithmetic demands that we either deny individuals some services or, more likely, pay providers and intermediaries less money. In the latter case, talent might move to other industries, so we still get less care. Very few doctors, hospitals, politicians, voters, patients, insurers or even health policy reformers want to play that game.

Why not? We all want to make the world a better place, and it's a lot easier to feel good about increasing benefits than reducing them, almost regardless of costs. You're a doctor. Do you want to go home to your spouse and brag, "Honey, let me tell you about the care I denied today"? You're the head of Health and Human Services. Do you want to be known for denying people access to some new expensive drug that they believe will make them better? You're a politician. How long will you last in politics if you vote to pay providers less or deny benefits to individuals?

None of this should surprise us. We don't need formal training in psychology to know that positive trumps negative. We find it more fun to give our kids gifts than to deny them something they want. We're more tempted to indulge ourselves than abstain. And we're tempted to let health costs rise automatically under existing programs and policies rise rather than rein them in and spend the saving on other needs, whether investment in our children or paying down our national debt.

Analysts and would-be reformers often blame the politicians for their failure to act, but we are just as trapped by this psychological barrier. We want more health care for children and better quality. We want nurses to be treated better and for doctors to have more time to treat us like humans. We want everyone to have the best health care possible.

Look at most health studies sponsored by funders like foundations. Those studies seldom address cost head-on, and when the cost factor is considered, it is typically as a footnote to a discussion about how to improve access or care or insurance coverage. At least until recently, a typical funder wanted to hear about how its grants directly helped individuals or persuaded government to spend more on families, not how it helped lower the rate of cost growth (even though lower costs make insurance more affordable).

The complication is not that we can't provide people more and better health care over time. It's that the psychological wish to do more than we are doing runs headlong into an existing promise that we will do more than we can do. Relative to infinite care a zero cost, good care at reasonable cost doesn't always look so good.

A first line of defense against psychological angst is to dodge it by pretending that we can have it both ways. We look for changes that reduce costs while increasing quality and access. We want costs to go down with no loss of benefits or benefits increase at no additional cost.

If you work in government, your member of Congress or cabinet secretary especially wants you to provide information on changes so efficient that everyone wins, such as spotting and eliminating needless health care.

That's part of the appeal of the Obama administration's current proposal to invest in comparative cost effectiveness and electronic health records. Initially we spend more, with the actual denial of payments held in abeyance for further reformers. Don't misunderstand me: considered appropriately, such investments likely will improve the efficiency of the health care sector. In their hyped-up versions, however, these steps are oversold, the political equivalent of the perennial chimera of balancing the budget through future unspecified attacks on waste, fraud, and abuse.

There is a long-range way to adapt health policy-making to our psychological needs, but it still entails a short-run psychological cost. It requires a one-time cutting of the Gordian knot, not simply trying to convert it from a double to a single knot. Tough steps to curb automatic growth in health care spending entail such elements as converting to vouchers, strong regulation, caps on payments, caps on subsidies, single payments to integrated groups for all of an individual's coverage and higher individual payments out of pocket. I'm not advocating all of these here, some have serious drawbacks. But each does attempt to redefine the base from which we measure progress.

A good health policy process must fulfill our psychological need to build more than tear down. As long as new legislation works off a base of unsustainable growth, we will continually be disappointed in the outcome.