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We generally reimburse caregivers for treatment, but not for prevention, even knowing that much of our health care cost is occasioned by smoking, obesity, and other preventable root causes of illness. We practice medicine defensively and expensively—often with unnecessary and inappropriate diagnostic tests—because we fear litigation. Our pharmaceutical industry, beholden to its shareholders, markets “me-too” drugs, at great advertising expense, because paradigm-shifting drugs emerge only infrequently. (With the advent of “personalized medicine,” i.e., prescriptions dictated by a patient’s genome, the economic basis of the industry will become even more challenging.)

As the “boomers” age, more will end their lives in an ICU, the costliest of health care settings. But how many of us wish to spend our last weeks in such a place? Whatever the setting, we continue to make too many errors and have too much inefficiency in the delivery of health care. In the main, this reflects the lack of national standards and lack of a nationally interoperable electronic medical record, as well as the fear of litigation, which causes practitioners and hospitals to obscure rather than to learn from their mistakes. One bright spot is the increasing use of “pay for performance” and “no pay for avoidable errors” approaches, but these schemes are largely experimental, with many challenges as to where the truth lies in complex clinical settings.

Most physicians are paid piecemeal, such that they are more likely to do too much rather than too little. Of course, the huge tuition debt of graduating medical students doesn’t help the cost of care. With a mean debt payoff of more than $200,000 confronting the great majority of American medical students just as they are about to initiate independent careers, it is no wonder that most opt for subspecialty rather than primary care careers—and for wealthy suburbs rather than inner cities or small towns. (We need to offer loan-forgiveness programs on a large scale for graduates who will spend a few years doing what the country most needs—i.e., primary care for the disadvantaged and clinical research to bring the “bench to the bedside” in an era of awesome scientific promise.)

The end result of all of this is that our nation spends a great deal more on health care per capita than any other industrialized country but lags woefully in appropriate and well-coordinated care and timely care; the proportion of citizens who have long, healthy, and productive lives; and the equity with which all of our peoples are treated. In fact, the real issue here is not that we spend too much on health care—maybe 20 percent of our GDP is fine—but that we are getting so little for it. It will not do to address each of the Lorax’s rocks independently and incrementally. The whole mess must now be fixed at once. … UNLESS.