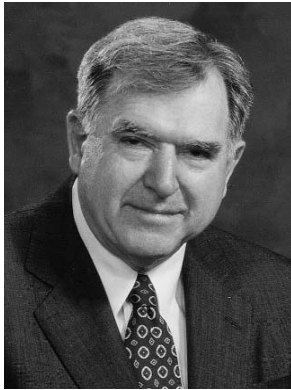


# Book Hours on Health and Medicine

## A Second Opinion: Rescuing America's Health Care

Arnold S. Relman

This presentation was given at the House of the Academy on November 29, 2007.



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It's an honor to have this chance to discuss the health care situation with friends and colleagues here at the Academy.

In 1977, soon after assuming the editorship of the *New England Journal of Medicine*, I became aware that investor-owned companies were beginning to reshape the U.S. medical care system. Attracted by the opportunities for profit afforded by the cost-plus reimbursement policies of employment-based private insurance plans and of Medicare, chains of for-profit hospitals and ambulatory facilities of all kinds suddenly appeared on the scene. They started to change the health care system from the essentially not-for-profit social service that it was when I started out in medicine just after World War II to an industry focused primarily on generating income for investors, managers, and physicians.

In 1980 I first called attention to this development in an article in the *New England Journal of Medicine* entitled "The New Medical Industrial Complex." I wrote that this new

investor-owned medical care industry threatened to shift the fundamental orientation of our health care system. It was also causing the not-for-profit sector of health care to behave as if it, too, were investor-owned, because it had to compete with investor-owned hospitals for income and market share.

The commercialization of medical care institutions was also changing the behavior of physicians – attracting them into all sorts of financial arrangements with the corporate providers of care and the manufacturers of drugs and medical devices. Physicians control the use of most medical resources and

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are paid primarily on a fee-for-service basis. There was a real possibility that they would let their own financial interests transcend their commitments to patients. Of course, it has to be acknowledged that physicians have always been concerned about their income and some, over the years, have been much too concerned. But the appearance of investor-owned medical care institutions had begun to weaken the traditional wall between business and the professional practice of medicine. In my view, this did not bode well for the future of our health care system because it would drive up costs, threaten the

quality and accessibility of medical services, and undermine patients' trust in their doctors.

The reaction to that first article surprised me. Although my account of the historical facts was never seriously challenged, few experts shared my concerns about their implications. Most health economists saw, in the rise of investor-owned care, nothing more than a rational response to changing market incentives. Most other social scientists totally ignored the threatening implications of investor-ownership in health care and saw the rapid growth in costs and provider income simply as further evidence of the domination of the health care system by doctors and hospitals, which they had been decrying for years.

In December 1985, at the 1664th Stated Meeting of this Academy, I took another look at the growing influence of commercialization on our medical services in a talk entitled "What is Happening to our Health Care System?" Despite efforts to contain costs in both the public and the private sectors, by 1985, the fraction of the economy devoted to health care had risen fairly steadily from about 6 percent in 1966, the time when Medicare first appeared, to about 11 percent in 1985. All signs pointed to a continuing rise in costs that would exact a heavy toll from the federal budget allocated to Medicare and from the business employers who were paying most of the health care insurance premiums of their workers. By then, about one in four non-public general hospitals, most private psychiatric hospitals, and the majority of private insurance plans had become investor-owned businesses. Meanwhile, investor-owned ambulatory care facilities had continued to multiply. I estimated, at that time, that about 20 – 25 percent of all expenditures on personal medical care were going to investor-owned businesses, and this fraction was increasing rapidly.

There were no hard data, but a number of other people who were looking at the growth

of the investor-owned sector in health care came to the same conclusion. Meanwhile, there was no doubt that rising costs were limiting the access of the poor to medical care. At the Academy meeting in 1985, I predicted that within a few more years, or perhaps a decade, there would be an inevitable political backlash against this inequity that would result in some sort of national health insurance system as a means of controlling costs, ensuring quality, and providing access to health care for all.

Well, that was almost twenty-two years ago, and we're still waiting for the political backlash I had predicted. Meanwhile, the investor-owned sector has continued to grow along with the cost and inequity that I thought would soon generate a movement for major health reform. I suppose that I could claim at least some vindication because about eight years later, in 1993, the new Clinton adminis-

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tration introduced a bill to extend coverage to almost everybody and to control costs. The plan was based on what was then called "regulated competition" among managed-care insurance plans. It was a kind of political backlash, but it never even got out of Congressional committee and within a year was killed by opposition from the investor-owned health care and health insurance industries, by conservatives in Congress, and by resistance from the American Medical Association.

For a few years after that, health costs were held in check by a strong HMO insurance industry, which forced primary care physicians to limit referrals to specialists, constrained expensive testing and elective admissions to hospitals, and discounted payments to all providers. But growing resistance to these constraints from patients, physicians, and

the media soon brought a return to insurance plans that allowed more freedom of choice. By the end of the 1990s, HMOs were fading. Health costs had resumed their climb, and it was apparent that neither existing market forces, nor any politically acceptable legislative reform would resolve our health care problems any time soon.

It was then that I decided to begin work on a book summarizing my own view of what was wrong with the system, and how it should be reformed. Despite the multitude of publications on the subject, I was persuaded that few of them saw the problem in its full perspective or offered a workable comprehensive solution. I was also aware that studies of the health care system were usually written by economists, social scientists, or business experts, and that their ideas are shaped more by their own disciplines than by familiarity with medical care as it exists in real life. Practicing physicians, with few exceptions, have not been inclined to write books about the health care system. It seemed to me that firsthand familiarity with the practice of medicine and with medical institutions should be of considerable help in thinking about health reform, and that my experience might produce a book quite different from most of those written by non-physician health care experts. I could claim no special wisdom, but had been fortunate enough to study U.S. medicine up close for many years while it was being converted to an industry. Indeed, I was personally involved in many of the events surrounding that transformation.

So I undertook this book with the hope that it would help readers to take a fresh look at what was happening to our health care system. That is what the book's title, *A Second Opinion*, is intended to suggest. It's short—only about 200 pages—and it's addressed to lay readers and written in simple nontechnical language. It's a primer intended to clarify matters that have far too often been obfuscated by the experts. In my view, the issues are not really that complicated, the essential facts not that numerous or mystifying, and the options for a real solution relatively easy to sort out.

The book begins with an introduction in which I say, "Failure to provide health insur-

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ance coverage for all is sometimes seen as our most important problem, but high costs are really at the heart of the U.S. dilemma." I suggest that what makes U.S. health care so expensive is the extent to which the insurance and delivery of our medical care is governed by commerce and private enterprise, rather than by public regulation and social need. To deal with that problem, and to develop a health care system that covers everybody and provides good quality care at a cost we can afford, we must change not only our system of insuring and paying for health care, but also the way we organize and deliver that care. The rest of the book is a development of those themes.

### Commercialization of U.S. Medicine

Our health care system has changed from the modest sized, low-tech social service it was when I graduated from medical school in 1946 to the vast, high-tech service industry it is today. The two primary agents of that change were, first, the post-World War II explosive growth in medical science, technology, and education; and second, the rapid influx of huge sums of money from private and public insurance plans. Eli Ginzberg, the late brilliant health economist at Columbia University, described this as "the monetization of health care." He said it was the necessary antecedent to the commercialization of health care, and he was right. Cost-plus insurance payments attracted investor-owned businesses that exploited the many opportunities for profit in the new specialties and the technical procedures that characterized the postwar explosion in medical science.

The law also weighed in on the side of commercialization when, in 1975, the Supreme Court ruled that the learned professions were not automatically protected from anti-trust law. In effect, the Court held that, at least

under some circumstances, medical practice should be viewed by the law as a form of interstate commerce, and therefore subject to anti-trust regulation. In my opinion, this issue still awaits further legal clarification. Those with a legal bent should read Chief Justice Warren Burger's oft-quoted footnote 17 to the opinion he wrote in the 1975 Virginia Bar Association case. He said he wasn't sure how far this concept could be extended to the practice of medicine; he said he was applying it only to the facts of this case. Although Burger didn't say it, the implication was that the Court would have to think more about this. Well, they haven't. A number of anti-trust cases were instituted against medical organizations, including the AMA, and

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were settled in lower courts, and there has been no opportunity for the Supreme Court to revisit the issue. When the medical organizations lost all of these cases, the AMA rapidly retreated from its former ethical stand about medicine not being a business and doctors not making money from business ventures and said, in its guidelines starting in 1980, that medicine is both a business and a profession. Now the AMA says that it's acceptable for doctors to make money by investing in businesses and in the products that they prescribe so long as they disclose this to their patients and so long as it doesn't harm the patients. That's a sad state of affairs for those who, like me, believe such behavior undermines the professional values of medicine.

In comparing the U.S. health care system with health care systems in other advanced countries, I noted that although most of these countries experienced the same developments in medical science and technology we did, they had, to varying degrees, universal, publicly regulated health insurance plans already

in place. Public regulation in other countries has prevented private enterprise from securing more than a marginal position in their health systems. Only recently have the rising costs of health care and the sales pitch of an increasingly globalized medical-industrial complex tempted other countries to follow us down the garden path of commercialization. So now you have developed countries like Sweden, Canada, and the United Kingdom and relatively undeveloped countries like India asking, what can privatization do for us? The answer, as the next chapter of the book demonstrates, is "nothing of social or economic value to the community – only the enrichment of the privatizers."

### Consequences of Commercialized Health Care in the United States

Rapidly rising costs are the central problem. We now spend well over \$2 trillion a year, more than 16 percent of our total economy, on health care, and expenditures have been rising at more than twice the growth rate of our economy. It's clear that we cannot sustain this trend much longer. I estimate that at the present time, somewhere between 40 percent and 50 percent of all health care related expenditures are being paid to investor-owned facilities and investor-owned organizations. The Congressional Budget Office recently declared that the growth of Medicare costs is the most serious threat to the integrity of the federal budget. Business employers are also warning that although they want to help with their employees' health insurance costs, they cannot continue to do so at anything near present levels without endangering the survival of their businesses. General Motors is a case in point; its CEO says that its growing health costs simply cannot be sustained.

Rising costs make health insurance less affordable, so there are now nearly 48,000,000 citizens without insurance, and probably at least half again as many who are underinsured. The lead headline story in today's *Wall Street Journal* is about how hospital costs bankrupted a well-insured but seriously ill employee whose insurance simply ran out when the hospital bill rose to \$2,000,000. How much of the rising cost of health care can be attributed to factors other than commercialization – the aging of the population,

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the increase in the prevalence of chronic illness, the moral hazard of low-deductible insurance, fee-for-service payments to physicians, and the proliferation of expensive new technology – is a legitimate question. However, we do know that in many other advanced countries, these same factors exist to varying degrees, although health expenditures in these countries have been much lower than ours. The unique difference between our health care system and those of these other countries is that theirs is more organized and regulated by government, while ours is more driven by market forces and much more commercialized.

That commercialization plays an important role in U.S. health care costs is also suggested by our knowledge of how businesses work. Investor-owned health care businesses, like any other businesses, seek to reward their investors by increasing the value of their stock. That's basic. To do that, they must drive up their net income. Investor-owned health care institutions usually have higher overhead costs than public or private not-for-profit institutions. To generate higher income, investor-owned institutions must either sell more services or price them higher, or curtail expenses. There is no evidence to support the claim often made by advocates of for-profit health services that such services are lower-priced or of higher quality. To the contrary, the limited number of well-controlled, head-to-head comparisons between investor-owned and not-for-profit facilities tends to show either no significant difference in price and quality or, more often, differences favoring the not-for-profit sector.

## The Revolt of the Payers

The history of attempts by government and by private payers to control health care costs goes back to the Nixon administration when the private HMO movement began. HMOs reached their high point in the 1990s following the defeat of the Clinton “managed competition” plan, and for a short time, they succeeded in restraining the cost of private insurance. But their success depended on limiting the choices afforded to doctors and patients, and they soon lost popular support. In the public sector, Medicare tried to control its costs by folding piecework payments to hospitals into single DRG (diagnosis-related groups) payments for each category of clinical problem. Later, it tried to control payments to doctors by establishing standard fee schedules according to the complexity or intensity of the services.

Both approaches had some effect in controlling costs, but not much and not for long. The reason is obvious: even when fees are bundled or fixed, the number and choice of services remain largely under the control of physicians. In a system dominated by entrepreneurial incentives and investor-owned enterprises, physicians and health care facilities will continue to maximize their income by providing more of the services that are profitable. Medicare is an example of a low-overhead, single-payer system, and its failure to contain costs (its costs are rising almost as rapidly as in the private sector) is powerful evidence that cost control will require a change in the care delivery side of our health system as well as in the insurance side.

Other proposals for cost control are being considered, but in my view, they are unlikely to work. Explicit government rationing of the use of expensive technology won't work in this country because there is no effective and politically acceptable way to make and implement such rationing decisions. Lowering expectations for treating the very old with expensive technology of marginal value has been suggested as a way to control costs. It may be a good idea, but it's unworkable because it is, in effect, rationing based on age and is not politically acceptable. Another proposed solution for the cost crisis is through continued advances in medical science that will ultimately eliminate chronic diseases. But none of us will live long enough to see

this happen, even assuming it would have the desired effect. And finally, reform of the malpractice litigation system, a cost-controlling policy particularly favored by the AMA, would have only a relatively small effect on national health expenditures. Although the litigation system certainly needs reform, its costs are a minor fraction of our current health costs.

## Consumer-Driven Health Care

The latest and most popular proposal for controlling costs is so-called Consumer-Driven Health Care (CDHC). In some version or another, it underlies almost all the health policies of those who believe that free markets can solve our health problems, including the Bush administration, conservative think tanks, and many economists and business people. They argue that the best way to curb

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spending is to have people pay more of the cost and take more of a role in choosing their own care. The three pillars of CDHC are a high-deductible “catastrophic” insurance plan, a tax-free “health savings account” to help pay the costs of medical services, and more information for consumers, including physicians' fees and technical information about available treatments and their outcomes.

What's wrong with the CDHC idea? It is, first of all, unfair because it will inevitably have the greatest impact on health services for the poor. Secondly, it is based on the fallacious notion that sick patients can, and should, choose their own care as if the health care system were just like an ordinary market. In addition, CDHC does not address the factors in the delivery systems that are re-

sponsible for high and constantly rising costs; it also fragments insurance pools and loses the collective benefits of insurance; and it makes integrated, electronic medical record keeping almost impossible. Despite these fatal flaws, CDHC will probably have to play itself out for a few years, before it is finally abandoned.

## The Reform We Need

Now, I would like to propose my own solution for our ailing health care system. As a former medical educator and clinical consultant in internal medicine, I taught students and house officers that effective treatment of the patient must begin with an accurate assessment of the problem. If you don't know what's wrong, your treatment is not likely to be very helpful. So here we have a desperately sick health care system. If my diagnosis is correct, then the treatment should be aimed at remedying the system's problems that I've already described. There are two parts to my proposal.

### *Collective Funding and a Single Payer*

First, expenditures must be controlled, and the most effective method for doing that is to set a national budget. We currently spend more than \$7,000 per U.S. citizen on health care. Spent properly, this amount is more than enough to meet everyone's needs for all necessary care, acute and chronic. The U.S. problem is not lack of money. We're spending over \$2 trillion, and if we had a really efficient system – eliminating business overhead, profits, ineffective and unnecessary services, and billing fraud – we could probably spend 35 – 40 percent less to cover the same population we do now. These savings would pay for the cost of covering everyone and probably leave enough to improve the system in many other ways. The savings would pay for new health promotion programs and support medical education and research. The budget would be funded from all the present sources, public and private, that now pay for health care. These sources could ultimately be bundled together and paid into a universal, earmarked, and progressive health care tax.

Earmarking that money would be important to avoid conflicts and confusion with other tax revenues. The Canadians have that problem. Their health care expenditures are mixed together with all other social expenditures;

there is also a financial tug-of-war between the central government and each provincial government, which leaves the provinces struggling to find enough to provide good health care. Canada needs to spend more tax money to keep its excellent public insurance system viable. The segregation of health care money in the United States would be facilitated if health care were managed by a designated public/private agency, comparable to the SEC or the Federal Reserve. This agency would spend most of its budget on per capita reimbursement of the medical groups that would provide care for all those in the plan. If the agency were also responsible for paying the hospitals and other health care facilities, its reimbursement of the medical groups

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would be accordingly reduced, but I am presently inclined to believe that the capitated payment to the groups should include what the groups would pay the facilities for the institutional care of their patients. In any case, there would be no billing or collection transactions involving physicians' services, which would result in great savings.

Most important, central funding by the health agency would replace the multiple private insurance plans whose profits and overhead now exact such a heavy toll from payers. There is simply no evidence that these investor-owned insurers provide services remotely worth the huge sums they take out of insurance premiums before paying health care providers. The private, for-profit health insurance industry, which is a relatively new arrival on the scene, began to expand just a

couple of decades ago. They are, in my view, little more than middlemen in our health care system, and we would be much better off without them. Nevertheless, they will fight to maintain their position.

#### *Reorganized, Nonprofit Delivery System*

I stand with those who believe that a universal not-for-profit, single-payer should replace the private, for-profit insurance industry. But unlike most single-payer advocates, I do not believe that this reform will stem the rising costs of health care. As I've said, Medicare is a single-payer, and its burgeoning expenses prove my point. That is why my proposal also includes a reorganized delivery system based on nonprofit medical care institutions as well as prepaid, multi-specialty nonprofit group practices and salaried physicians. In every community, there would be an appropriate number of modest-sized, not-for-profit, prepaid, multi-specialty group practices that would, in effect, be small versions of group practices that now exist, such as the Mayo and Lahey Clinics. Patients could choose any group in their community and select any primary care physician in the group to manage their care. Groups would employ an approximately equal number of primary care physicians and specialists who would collaborate with each other and with other health care personnel in the group to provide appropriate and accountable care. Electronic records could become universally adopted by these groups, and technology assessment would be facilitated. Perverse economic incentives would be eliminated, because the groups would be nonprofit and would be protected by the central payer against any financial loss due to adverse selection by seriously and chronically ill patients. Groups would not be allowed to select their members, so anyone, regardless of medical condition, would be free to join a group so long as its capacity allowed for new members. These groups would be nonprofit institutions that did not have to worry about their bottom line, as all multi-specialty groups now must do.

All physicians would be salaried by their groups and the total physician share of each group's income would be limited to the approximate percentage of health expenditures currently received by U.S. doctors. Patients and physicians could choose between being

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fully in or out of the universal health plan; however, everyone would still pay the health care tax just as everyone now pays local property taxes that support public schools, even if they send their children to private school. Private health insurance would be permitted to cover only services that are not provided under the universal plan; these would be determined by the central health agency. The agency would not have to decide what services were provided under the health plan, but only what wouldn't be paid for. The physicians and the patients in each group would decide in each case what should be done, based on individual circumstance, patient preferences, and the best available medical evidence. The basic idea behind such groups would be to compensate physicians for their time and effort in providing optimal care for patients, without the perverse incentives inherent in a fee-for-service system.

#### *Can We Get There?*

Finally, I come to the question of whether such reform is feasible or just wishful thinking. I know that a major restructuring of the system would undoubtedly be a formidable task that is not likely to occur in the short run. Even if our next president were to favor major reform, opposition from vested interests in the private insurance, investor-owned health care, and pharmaceutical industries, coupled with strong resistance from market ideologues, would be too much to overcome right now. So I do not expect to see any major change in health care soon after the next election. In the long run, however, major reform is inevitable, although it may well be accomplished by step-wise legislation.

Sooner or later, business leaders in the non-health care sector of our economy will have had enough. Many of them have already said that health costs must be contained through

reform of the system. Opinion polls show that the growing army of U.S. citizens who are being financially threatened by rising health costs or are facing the terrifying prospect of major illness without insurance protection are coming to the same conclusion. And so will legislators who will begin to realize that rising health costs are destabilizing government budgets and preventing expenditures on other essential national needs. Legislators will also realize that they need votes and popular support even more than the financial support of the interests vested in health care.

Another reason I believe major reform is inevitable is that the attitude of the medical profession is changing. Heretofore steadfastly opposed to fundamental change in the health care system, physicians are now beginning to reconsider their position. A bare, but growing majority now believes that major reform is necessary, although the AMA has yet to change its traditional conservative position. Women will soon represent nearly half of all practicing physicians, and there is reason to believe most of them would be comfortable with a reformed delivery system based on group practice. But all physicians are coming to realize that present trends are compromising their professional independence and integrity. Without major reform, economic imperatives will continue to undermine professional values and eventually change medical practice into little more than a highly technical, highly paid business. This would not be in the public interest, nor would physicians like such a development.

In the last chapter of my book, I urge physicians to participate in developing a workable reformed system. The handwriting is on the wall, but it may take some time for our nation to realize that market-driven health care is not the solution. Within about five years, or at most a decade, we will be forced to abandon the present commercial health market in favor of a more socially oriented system. This time major health reform will not be denied. ■