The Health Reform We Need & Are Not Getting

By Arnold Relman

Healthcare, Guaranteed: A Simple, Secure Solution for America
by Ezekiel J. Emanuel, with a foreword by Victor R. Fuchs
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President Obama has placed health care reform high on his domestic agenda. He believes that a better health care system is essential for the nation's economic recovery, so health reform "will not wait another year." However, he has made only general proposals for reform, leaving Congress to work out the details of the legislation. The Democratic-led Congress has already passed some limited health legislation and its leaders say that they will put a comprehensive reform bill on the President's desk before the end of this year.

Despite wide popular support for major reform, there will be powerful opposition. Most Republicans in Congress, allied with a small band of fiscally conservative "Blue Dog" Democrats, and most people in the for-profit health care industry will resist significant change. Many others with ideological objections to "big government" pay lip service to reform, but will balk at proposals that threaten private insurance. Compromises will be necessary, so it remains to be seen what legislation emerges and how effectively it addresses the basic problems of the US health system.

The central problem is its expense. Health care in the US is about twice as expensive per capita as in other developed countries—nearly 17 percent of US GDP in 2008—and its costs are rising faster. High costs partly account for another huge health care problem—nearly 50 million people are uninsured, and the number is rapidly increasing. Economists say that the main reason for high costs is the ever-expanding use of expensive kinds of diagnosis and treatment, such as new drugs, diagnostic tests, imaging methods, and surgical procedures. Physicians in most other advanced countries have access to virtually the same resources, but use them less.

This difference is partly explained by a higher proportion of specialists in the US, who rely more than primary care physicians on expensive technical procedures for their livelihood, and in general are much more highly paid than primary care physicians—one reason why primary care doctors are now in short supply. The American College of Physicians attributes much of the high cost of the US health system to its relative excess of well-paid specialists and lack of primary care doctors.

There are also much greater financial incentives in the US to use technology, since health insurers pay doctors and clinical facilities most of what they charge for such services. In most advanced countries with universal coverage, the government determines how medical expenses are reimbursed, and the income of health care providers from technical services is therefore more modest. Also, relatively more practicing physicians in those countries are paid salaries, and
relatively more hospitals (where most advanced technology is concentrated) are controlled by
government budgets. This limits the availability and use of expensive technology.

Another very important but often overlooked reason for greater health expenditures in the US is
that, more than in any other advanced country, large parts of the system are owned by investors. As
a result, the entire system behaves like a profit-driven industry, as I described two years ago in my
book *A Second Opinion*. The commercialization of our health system dates back only a few
decades, but its consequences are profound. Investors now own about 20 percent of nonpublic
general hospitals, almost all specialty hospitals, and most freestanding facilities for ambulatory
patients, such as walk-in clinics, imaging centers, and ambulatory surgical centers. These medical
care businesses, like other businesses, need profits to satisfy their investors, and for this purpose
they use marketing and advertising, directed at physicians and the general public.

To remain competitive, many not-for-profit hospitals promote their bottom line just like their for-
profit counterparts, vigorously advertising their facilities and services to the public. No other health
care system is as focused on generating income as ours, and in no other country is medical care
marketed and advertised so aggressively, as if it were just another commodity in trade. This
increases health costs, while hospitals concentrate on the delivery of profitable, rather than
effective, services. It also favors those who can pay over those who need medical care but can't
afford it.

The behavior of US physicians has been changed by the commercialization of medical care, and
this too has increased costs. US medical practice has traditionally relied on fee-for-service,
which has always given it some of the attributes and incentives of a business. However, the
American Medical Association (AMA) maintained for many years that medical practice was a
profession, not a business. The AMA's ethical guidelines therefore advised physicians to limit their
income to reasonable earnings from the care of patients, and to refrain from advertising and from
entering financial arrangements with drug and device manufacturers. Those restrictions were lifted
after the US Supreme Court decided in 1975 that lawyers, and by extension members of other
professions, including physicians, are engaged in interstate commerce and therefore must be subject
to antitrust law (from which they had largely been exempt).

This decision had an enormous effect on the medical profession, but its consequences have
received relatively little public attention. Although the courts did not initiate the commercialization
of medicine, they certainly accelerated it and gave it legal justification. In 1980, after medical
organizations lost some costly antitrust trials, in which they were accused of such offenses as
limiting doctor fees or denying staff privileges, the AMA changed its ethical guidelines, declaring
medicine to be both a business and a profession. This lowered the AMA's barriers to the
commercialization of medical practice, allowing physicians to participate in any legal profit-making
business arrangement that did not harm patients.

Nearly a half-century ago, Stanford economics professor Kenneth Arrow, later a Nobel laureate,
convincingly argued that medical care cannot conform to market laws because patients are not
ordinary consumers and doctors are not ordinary vendors. He said that sick or injured patients
must rely on physicians in ways fundamentally different from the price-driven relation between
buyers and sellers in an ordinary market. This argument implied that, contrary to the assumptions
of antitrust law, market competition among physicians cannot be expected to lower medical prices.
And since physicians influence decisions to use medical services far more than patients do, the volume and types of services provided to patients—and hence total health costs—need to be controlled by forces other than the market, such as professional standards and government regulation. But Arrow's argument was largely ignored in the rush to exploit health care for commercial purposes that ensued after the passage of Medicare and Medicaid in 1965.

The effects of investor ownership on health costs are perhaps most evident in the US private insurance system, which covers about 170 million people under age sixty-five—most of them through employment-based private plans. The great majority of private health insurers today, such as Aetna and Cigna, are investor-owned businesses. Most of these were established just a few decades ago, when—as a result of the rapid expansion of employment-based insurance—huge amounts of money began to flow into health care, creating profitable opportunities for investors.

Profits and management expenses take at least 10 to 20 percent of the premiums charged by investor-owned plans, including the costs of selecting those they will insure, whereas the overhead costs of Medicare—a government-run insurance plan covering everyone sixty-five and older—are about 3 percent. When private insurance companies provide coverage for Medicare patients (as in the Medicare Advantage plans), they cost the US government about 13 percent more than standard Medicare coverage.

In comparison with public insurance, a much smaller fraction of private insurance premiums goes to the actual provision of care, and the cost of providing acceptable care for those under sixty-five is probably much higher than if the same population were covered by Medicare. The private US health insurance industry has revenues from premiums of at least $500 billion, so its business overhead and profits add many billions to the cost of health care. Furthermore, the overhead costs of physicians and hospitals, whose offices must deal with the red tape of multiple private insurance companies when billing and collecting for services, add substantially to the expense these insurers inflict on the US system.

When considered in the light of what has been said about health costs, the proposals now being debated in Washington seem to be missing the main target. They will expand insurance coverage in the short term, which is certainly needed, but they will create a system even less affordable than at present.

Consider, first, the health proposals made in late February by President Obama in his budget message (most of which were also part of his campaign platform). He stressed the need to cover the uninsured and reduce the costs of health insurance. He suggested that people should not be locked into their jobs just to secure health coverage, that they should have a choice of health plans and physicians, and should be able to keep their employment-based plans if they wished, but should have other options. To reduce costs he urged elimination of high administrative expenses, unnecessary tests and services, and other inefficiencies. He also advocated more use of electronic records and the development of data on the effectiveness of specific medical interventions. He expected that these measures would not only improve the reformed system but also help it to pay for itself and maintain "fiscal sustainability."

The coverage problem had already been partially addressed through the Recovery Act of 2009, signed by the President on February 17, which provides tax credits for the recently unemployed to
help them keep their health insurance. Coverage had been increased further by separate legislation reauthorizing the Children's Health Insurance Program (CHIP), which includes funds to insure an additional four million children under Medicaid—mainly children from poor families.

The Recovery Act also provides funds to improve the health care system and control costs. It authorizes $19 billion to support computerizing health records and about $1 billion for preventive public health programs (such as control of smoking and obesity), as well as community clinics and case management. As he said in his budget message, Obama believes that these initiatives will in the long run result in more efficient and less expensive care, although many people would remain uninsured. So beyond the already enacted measures, the President requested a reserve fund of more than $630 billion over ten years for health reform, most of which would expand and improve health insurance coverage.

The President proposed to finance half of his health expenditures over the next ten years through increased taxes on the wealthy, and half through savings from improved medical care. He also proposed to save money by reducing excessive payments to private insurers who cover Medicare beneficiaries (Medicare Advantage plans); by reducing drug prices and encouraging the use of generics; and by curtailing fraudulent billing practices.

These objectives are laudable, but as many knowledgeable authorities—including the Congressional Budget Office—have pointed out, there is very little evidence that the President's initiatives would actually produce substantial savings. Whatever improvements these measures may make in the quality and efficiency of care—and they could well be significant—they are unlikely, over the next ten years, to generate the $300 billion in savings assumed by the President's budget. And even if such savings were to be realized, most health economists believe that universal coverage would cost over twice what Obama allocated in his budget, and that does not count the cost of medical inflation.

The President apparently wants to achieve nearly universal coverage now, hoping to deal with the cost problem later. That probably explains why he invited representatives of the health industry to the White House on May 11. According to the White House, the meeting was a "watershed" event that resulted in a pledge from industry officials to reduce costs by $2 trillion over the next decade. But leaders of the American Hospital Association and the private insurance industry told The New York Times a few days earlier that a specific amount of savings had not been promised, and that the savings would be more gradual. This episode is best described as part of the industry's strategy to appear supportive, more by words than action, hoping thereby to fend off legislation that would seriously threaten its interests. To facilitate passage of health reform, the President solicits the health industry's support, but he must know this will require making compromises with vested interests. He also must know that health care businesses cannot be much interested in reducing expenditures that are their income.

The President no longer insists that people under sixty-five whose income is too high for Medicaid should have the option of buying public insurance, although that was part of his campaign platform and Secretary of Health and Human Services Kathleen Sebelius says he still favors it. Representative Pete Stark, the California Democrat who chairs the House Ways and Means Health Subcommittee, strongly supports this idea. Such a public insurance option is strongly opposed by the private insurance industry and by some influential legislators like Iowa Republican
Senator Charles Grassley, who see it as unfair competition and the opening wedge of a move toward the ultimate replacement of private plans with a government-operated insurance system. The industry and its allies have so far been emphatic that they will not agree to a reform plan that offers the choice of public insurance.

A compromise has been suggested by Senator Charles Schumer in which the public insurance option is supported entirely by premiums and co-payments and administered by an independent agency enforcing the same rules that regulate the private plans. Whether this, or any other, version of the public option would satisfy industry's concerns is not clear. The private insurance industry has made clear its willingness to compromise on a proposal that subsidizes expanded coverage and improvements in medical care, provided that the legislation mandates private coverage for all those under sixty-five not already covered by a government program. The private insurance industry might even accept a requirement that private insurers offer insurance to all applicants without increasing premiums to those with preexisting illnesses, provided that insurers are allowed to set rates based on age and other demographic factors. The insurance industry's conciliatory public position may be concealing what will ultimately be its usual resistance to any policy threatening its current stranglehold on the under-sixty-five health insurance system. It will be interesting to see how these issues are resolved. As the May 11 meeting at the White House suggests, the administration does not want a direct confrontation with vested interests and probably will settle for arrangements the insurance industry suggests.

In seeking a consensus, Obama's health reform policies do not address the central causes of rising costs, and propose nothing likely to have much effect on them. He does not mention the ways that investor ownership and the fee-for-service payment system provide incentives for increasing costs. Nor do his policies recognize as a major problem the fragmented, entrepreneurial organization of a medical care system that is dominated by specialists and is deficient in primary care doctors. And yet reforms that do not address these problems cannot produce an affordable or sustainable system.

In many respects, Obama's proposals resemble the widely acclaimed reforms enacted three years ago under Governor Mitt Romney in Massachusetts. That initiative has achieved wider insurance coverage in the state but has not challenged the private insurers or made any changes in the delivery of medical care, which is among the most expensive in the country. Consequently, while federal funds from the Recovery Act may keep the Massachusetts plan alive for the time being, the state is now confronting cost problems that could bankrupt the entire program. Like Obama, Massachusetts lawmakers decided to begin by expanding coverage, apparently hoping to control costs later on.

Five congressional committees, two in the Senate and three in the House, are working on health care proposals, but to judge from the advice they are getting and from comments in the media by members of these committees, the resulting legislation is unlikely to go beyond the expanded coverage and the marginal improvements in the existing medical care delivery system proposed by Obama. Max Baucus, Democrat from Montana, chairman of the influential Senate Finance Committee, released a white paper last November outlining a reform plan largely resembling the President's. There is little evidence in this document of a strong determination to challenge the private insurance plans with a competing public plan, or to make basic changes in the organization and funding of medical practice. Timid legislative tinkering with the current medical care system
and a focus on increasing coverage, rather than major reform, are not going to control costs or make much difference in the quality of care.

This is one of the main conclusions of Ezekiel Emanuel's recent book, *Healthcare, Guaranteed*. Although its views stand apart from the current consensus, it will get attention from Washington's policymakers, not least because the author, a physician with clinical training, is the older brother of Rahm Emanuel, Obama's chief of staff. He is also chair of the Department of Bioethics at the National Institutes of Health and the medical adviser to Peter Orszag at the Office of Management and Budget.

Emanuel shares many of the criticisms of the current system that I have put forward here, including the problems of private insurance and fragmented, fee-for-service medical care. However, he says nothing about the role of investors and commercial behavior in creating these problems, and none of his suggested reforms addresses the lack of primary care doctors. Still, to his credit, he proposes comprehensive reforms in all parts of the system, arguing that incremental changes like those advocated by Obama and Baucus will be ineffective.

Emanuel proposes, first, that everyone be issued a government certificate guaranteeing access to a broad range of health care services, which would be provided through certified, competing private health insurance plans. These plans would be paid by a government agency, with premiums adjusted for the degree of risk estimated for each patient. The plans would be required to accept everyone regardless of preexisting medical conditions. They would then organize integrated teams of physicians and other health professionals to provide the guaranteed care. Hospitals, selected by the doctors and their patients, would be reimbursed by the plans. Employment-based insurance would disappear, to be replaced by increased wages for employees. Medicaid would also end and Medicare would be gradually phased out, to be replaced by membership in the new national system. Individuals would be free to buy alternative or supplemental services at their own expense, but these costs would not be tax-deductible.

Emanuel's proposed system would be funded by a dedicated, VAT-type of consumption tax, the rate to be set by Congress. The amount collected would in effect limit total federal expenditures on health. Costs would also be moderated by a more rational use of expensive technology, based on the recommendations and research findings of a federally supported Institute for Technology Outcomes and Assessment. A National Health Board would oversee the operation of the entire system, monitor and report on the performance of the plans, and determine the risk-adjusted per capita payments to them.

Apart from the question of its political chances, how should this proposal be judged? In my view it has much to commend it, but is seriously flawed by its dependence on competing, for-profit private insurance plans to reorganize and manage the medical care delivery system, and to determine the reimbursement of physicians and hospitals. It recalls the "managed care" era of the 1990s, when, in an effort to control costs and maximize profits, the HMOs restricted access to specialists and hospitals and regulated physicians' use of technical procedures, causing many patients and physicians to rebel against them. As that experience has shown, insurers should not make decisions about the use of medical resources, whether the insurers are private or public. Such decisions should be left to physicians and their patients—provided, of course, that there is appropriate accountability, and public mechanisms are in place for controlling total expenditures and the prices.
paid for services.

Emanuel is right in wanting to reform the present insurance system, but he is mistaken in thinking that it should be replaced by regulated competition among private, for-profit insurers. The experience of the last few decades with such insurers—Medicare Advantage plans are a case in point—shows that they add costs without commensurate benefit. Private, investor-owned insurance plans are a failed experiment and should be phased out or marginalized.

The logical alternative would be a universal insurance plan administered by the government and funded by taxes—some sort of "single-payer" arrangement, which would eliminate paying for the profits and administrative expenses of private insurance middlemen. Emanuel admits that a single-payer system would save a lot of money, probably at least $120 billion per year, but he fears single-payer plans, and argues against them. He says that they do little or nothing to improve the quality or efficiency of care, while exposing the system to the risks of government meddling, rationing, and unpredictable financial support.

The obvious response to those criticisms is that single-payer plans concern the method of insurance and not the delivery of medical care. Medicare, for example, is a single-payer system in which medical care is privately delivered, with a minimum of government interference. The medical care delivery system could be reformed and reorganized to control costs and improve quality while still being funded through a single payer plan.

That solution, in fact, is one that I proposed two years ago in *A Second Opinion*. It would include a single public payer that guaranteed comprehensive health care for all, funded by a progressive tax whose proceeds would be dedicated to medical care. This insurance and funding plan would be combined with a delivery system, overseen by a public agency but managed entirely on a not-for-profit basis by privately organized doctors and hospitals. The delivery of care and the use of health resources would be the responsibility of organized multispecialty groups of salaried physicians and other health professionals, which would include adequate numbers of primary care doctors.

Multispecialty group practice with salaried physicians has many advantages for the delivery of low-cost, high-quality care, in which the different medical services needed by a patient are effectively integrated. Evidence for these advantages, as well as the problems faced by group practice in the current system, are thoroughly discussed in a book edited by Alain C. Enthoven and Laura A. Tollen. Despite the problems, a few large multispecialty groups have managed to thrive—for example, the Mayo Clinic, Kaiser-Permanente, Marshfield, Geisinger, Scott-White, and Lahey. Patients at these groups are covered by a variety of insurance plans, public and private. They receive high-quality care by integrated teams of physicians, primary care doctors, and specialists, who are paid mainly by salaries.

The Mayo Clinic, for example, has been very successful as a large, private, not-for-profit, self-governing organization, in which the participating physicians elect medical leaders who set professional standards, hire and fire staff, and determine salaries. I envision a system that would encourage the development of many smaller community-based group practices of this kind, and would help them survive, with subsidies if needed. These groups would be certified by a new central health agency, which would set guidelines for salaries and administrative policies.
As in Emanuel's plan, total costs would be limited by the amount of money collected through a health tax, but I favor a progressive, income-related tax rather than a VAT. Decisions on the use of available resources would be the responsibility of physicians, who would be helped, but not controlled, by clinical guidelines and assessments of technology. Hospitals and other facilities would be not-for-profit and would be paid through the central health agency, but the choice of these facilities would be a private decision made by doctors and their patients.

Congressman John Conyers of Michigan has introduced a single-payer proposal (HR 676) that would provide universal health care through a Medicare-like public insurance system with private, nonprofit providers. Although his bill now has many cosponsors in the House, it remains held up in committee and is unlikely to be part of any legislation emerging from the 111th Congress. A single-payer system, despite its many advantages over the present insurance system, and despite its growing public acceptance, is clearly "off the table" in current legislative discussions. At the start of the public hearing of the Senate Finance Committee on May 5 and 12, Senator Baucus insisted that he was "open" to all views; but among the twenty-eight invited witnesses, no single-payer advocate was allowed to testify. In fact, Baucus has repeatedly said that the legislative debate would not consider a single-payer option.

Neither my proposal, nor Emanuel's, nor Conyers's, nor any other plan that starts with the elimination of private employment-based insurance and depends largely on public funding stands much of a chance of being enacted now. It would be too great a change, and it would threaten insurance companies and other powerful vested interests that influence Congress. The same is true of any major reorganization of medical care that phases out fee-for-service practice in favor of nonprofit multispecialty groups of salaried physicians and dampens the commercial fire that has converted US medical care into an ever-expanding profit-seeking industry.

As bad as they already are, things will have to get still worse before major reform becomes politically possible. The legislation likely to emerge from this Congress will not control—and will probably even exacerbate—the inflation of costs. But sometime in the not-too-distant future, health expenditures will become intolerable and fundamental change will at last be accepted as the only way to avoid disaster. When that time arrives, the opportunity to enact real health reform will finally be at hand.

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Notes


