A Modest Proposal for Healthcare Reform

Lawrence I. Bonchek, M.D., F.A.C.C., F.A.C.S.
Editor in Chief

"Americans can be counted on to do the right thing... after they've tried all the alternatives."

Sir Winston Churchill

THE HEALTH CARE MORASS

In regard to health care in America, Winston Churchill would doubtless conclude that we are still a long way from doing the "right thing." Instead, we continue to try every possible system on some segment of the population, while adamantly refusing to try any particular system on everyone, i.e. as a national system of health care. Medicare and other government-sponsored programs are only available to defined populations; employer-sponsored health insurance is only available to specified employees; and vertically integrated systems such as Kaiser Permanente are concentrated in only a few regions of the country. Accountable Care Organizations are a more widespread step toward vertically integrated care, and I'll say more about them later, but first a few words about our current disarray.

No reasonable person would disagree with the assertion that our current system's patchwork of plans is less than ideal for almost everyone, and is simply unacceptable for many. Even at its best, health care in America is costly and inefficient; its quality varies strikingly among different institutions and regions; and access to care is spotty and shamefully dependent on ability to pay.

The facts are irrefutable. Our system of health care currently accounts for approximately 19 percent of the Gross Domestic Product (it was 17% when I wrote about this last summer[1]), even while it fails to insure 50 million Americans. Cost is growing 4-7%/year, while the GDP is only growing 2%/year or less. Medicare alone currently accounts for approximately 13% of total federal spending. We spend twice as much per capita on health care as Canada, the next most expensive developed country, without a significant increment in quality.

WHAT DRIVES THE RISE IN HEALTH CARE COSTS?

The factors responsible for the relentless rise in costs are well known; some are deplorable, others understandable. The indefensible causes alone provide blame enough to go around:

- Defensive medicine prompted by often meritless malpractice litigation: And though physicians focus on the cost of malpractice insurance, lower premiums would barely make a dent in this factor, as premium costs pale beside the cost of unnecessary tests and treatments done to prevent frivolous lawsuits. A "loser pays" system for attorney's fees (as in most of the developed world) would prevent frivolous suits but will never become law.
- End-of-life care that is often fruitless: 27% of Medicare's budget is spent in the last year of life, and 40% of that amount is spent in the last 30 days, according to the Medicare Payment Advisory Commission (MedPAC). Families would be less likely to insist—against medical advice—that "everything possible should be done" for their unresponsive loved one if they weren't so insulated from the actual cost of "everything."
- Unhealthy life styles: Obesity is a national disgrace, Type II diabetes is epidemic, smoking is hard to stamp out, most people don't exercise regularly if at all, etc., etc., etc. New York City required fast food restaurants to post their food's calorie content, after which studies revealed that the average customer ate still more calories!
- Unreasonable administrative costs: The private health insurance industry extracts administrative costs of almost 20 cents from every health care dollar. Exorbitant executive salaries, lavish office facilities, and inefficient administrative practices play a role even for non-profit companies, which can avoid showing a profit simply by increasing expenditures![2] By comparison, the administrative costs for Medicare and most large prepaid plans are no more than 6-8%.

These figures don't even consider the sums diverted from health care by for-profit health care providers. As one illustration, Forbes.com reported that last year the total compensation of Richard M Bracken, CEO of

HCA, was $5.76 million. That was a low year; his compensation over the past 5 years totaled $42.643 million.

- *Unwise choices for diagnosis and treatment* contribute substantially to the total cost of health care. Elsewhere in this issue Dr. Alan Peterson continues his discussion of the "Choosing Wisely" campaign of the American Board of Internal Medicine Foundation.[3]

A recent landmark report from the Institute of Medicine concluded that $750 billion is wasted annually on unnecessary services, inefficient delivery of care, excess administrative costs, inflated prices, prevention failures, and fraud.[4]

Regardless, the total cost of health care cannot fail to keep rising, because the most influential drivers of rising costs are unavoidable and entirely appropriate:

- technological advances;
- growth and aging of the population;
- improved access to care for previously underserved segments of society;
- effective and more costly new drugs.

The only sensible approach is to develop a system that addresses all the problems enumerated above, and also recognizes that the perverse incentives inherent in our fee-for-service system must be dealt with.

SHORTCOMINGS OF OUR CURRENT APPROACH

America has an unusual cultural attitude toward the right to health care. Universal public education is recognized as a social good even though it is not constitutionally guaranteed as a "right." Legal counsel is provided to everyone, at public expense if necessary. But though the right to "life" is enshrined in the Declaration of Independence along with liberty and the pursuit of happiness, America (alone among industrialized democracies) does not consider basic health care to be a fundamental right even though we all get sick sooner or later.

Of course the Declaration of Independence isn't the Constitution, but it still surprises me that this situation can persist as a matter of law. Isn't health care necessary to assure one's ability to live and pursue happiness? We seem wedded to an ideological bias that considers individual choice and the free market to have overriding advantages despite the demonstrable fact that in health care, competition and the free market do not lower prices.

The word "rationing" arouses political furor, but the stark reality is that we do ration, not by medical need, but by ability to pay. Of course we don't say this explicitly, but what else can you call it when we raise deductibles and co-payments, thus challenging patients to consume only the health care they can afford. If this were not true, why would the use of health care services decline during an economic recession? Our policies create the paradox that we abhor rationing by panels of physicians (inaccurately derided by politicians as "death panels"), but encourage rationing by consumers for themselves. Is that what we mean by health care "choice?"

Another instance of questionable strategy is the attempt to improve the overall quality of health care by assuming that if the public has more information, they will be able to make informed choices. Of course more public information is a good thing, but selecting a high quality provider of health care isn't the same as buying a washing machine. It requires the ability to gather and comprehend complex medical information, which the lay public generally lacks. The reports of the Pennsylvania Health Care Cost Containment Council (PHC4) probably have had some beneficial overall effects on cost and quality in certain defined areas, but they appear to have had little measurable effect on consumer choice. As the NEJM reported, "The [Pennsylvania] Consumer Guide to Coronary Artery Bypass Graft Surgery has limited credibility among cardiovascular specialists. It has little influence on referral recommendations."[5] An unintended consequence is that it may lead some surgeons to refuse high risk patients whose poor outcomes could adversely affect the surgeon's ranking.

In sum, if the publication of costs and outcomes has beneficial effects, I suspect its greatest benefit comes from informing the referrals made by primary care physicians, and not from directly affecting the public's choices.

Another deplorable result of giving the public more information is the growth of advertising by health care providers. Following are two recent advertisements by a major medical referral center in national publications:

"We can do very sophisticated operations with great precision. We help people get better faster and do it in a safe manner." *("Better and faster" than what?)*

"Stats that matter: The most robotically-assisted valve surgeries in the country with a 100% success rate." *(What is a "100% success rate" for valve surgery?)*

Self promotional advertising by health care providers diverts still more resources from actual health care.

IS THERE ANY REASONABLE SOLUTION?

Attempts to reduce the overall cost of health care while retaining the current system of multiple-payers and fee-for-service would require reduction or elimination of the perverse incentives that encourage overutilization. Attempts to do so have included bundling of payments, use of global fees, and establishment of medical homes to enhance coordination of care and reduce Emergency Department visits and hospital admissions, but the task is formidable and I believe these efforts must fail. Resourceful providers who have grown accustomed to the current system will resist efforts to restrain their use of services that have a chance of benefitting their patients.

For the same reasons, "Medicare for all" would be exorbitantly expensive in the current fee-for-service model, and the Affordable Care Act will likely have unintended benefits for insurance companies because the public insurance option that would have restrained premiums was gutted from the final bill.

I believe the only long-term solution will involve vertical integration of care with an employment model for physicians, and some form of accountable care that transfers risk to providers. As recently as 10 years ago such a suggestion might have been summarily dismissed, but it is tenable today. Accountable Care Organizations are springing up everywhere as a means of accomplishing just these objectives but they are not necessarily based on seamless vertical integration, and some merely patch together entities that already exist in a particular locale.

Fortunately, there already is a highly successful example of an efficient, high quality, vertically integrated, employment-model, managed health care system. Kaiser Permanente is the largest non-profit health system in the country, with over 9 million subscribers, and has proven its effectiveness in California, Oregon and Hawaii for decades, though it has had mixed success in some other regions where it only operates outpatient facilities but not its own hospitals. The system comprises three distinct entities: the Kaiser Foundation Health Plan and its regional operating subsidiaries; Kaiser Foundation Hospitals; and the autonomous regional Permanente Medical Groups.

Since the regional Permanente Medical Groups are organized as for-profit entities, the Permanente Federation was developed as a separate entity that focuses on standardizing patient care and performance across regions. The size of the Kaiser system provides an unequalled opportunity for exchange and analysis of medical data, and Kaiser spent over $6 billion to initiate the Epic system of electronic medical records, after an unsuccessful and expensive attempt to create its own system. Kaiser physicians publish large numbers of studies in peer reviewed journals.

Kaiser's regional entities are federally qualified health maintenance organizations. As the largest and most successful managed care plan in the country, some believe that then-President Richard Nixon had Kaiser Permanente in mind when he signed the Health Maintenance Organization Act of 1973.

That our current system is untenable is beyond debate. The only question is what will succeed it. The appeal of the Kaiser approach as the model for a national system is that it does not involve the government and it eliminates fee-for-service, while the conditions, terms, and standards of clinical practice remain under the control of contracted but legally independent regional medical groups.

Though similar efforts to integrate vertically are being initiated at the community level, they lack the inherent cooperativeness and the national scope of the Kaiser system. Even so, as Tom Beeman, CEO of Lancaster General Health has indicated, local providers on the front lines cannot sit idly by without preparing for the inevitable changes that will be required in the health care system.[6] Hospitals and physicians must combine to align incentives. These efforts may take the form of contractual affiliations or outright employment, which is no longer anathema, but rather is increasingly sought after by physicians as a desirable option.

REFERENCES

1. Bonchek, LI. The free market in health care; why we favor choice over access. J Lanc Gen Hosp. 2011. 2:33-38
2. Bonchek, LI. Where have all the dollars gone; or, why can't we afford universal health care. J Lanc Gen Hosp. 2007. 1:4-7.
3. Peterson, AS. Choosing wisely. J Lanc Gen Hosp. 2012. 3: 92-96
4. Institute of Medicine Report, Sept. 6, 2012. Best care at lower cost: the path to continuously learning health care in America
5. Schneider, EC, Epstein, AM. Influence of cardiac-surgery performance reports on referral practices and access to care—a survey of cardiovascular specialists. N Engl J Med.1996; 335:251-256
6. Beeman, TE. Changes in health care are inevitable. J Lanc Gen Hosp. 2012. 2:36