

Understanding Health Insurance

**A Guide for Brokers, Administrators, Students
and Healthcare Practitioners**

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Healthcare Practitioners

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Preface

This book grew out of discussions I had with many health insurance brokers between 2007 and 2009.

I had been lecturing regularly to groups of experienced brokers. They typically understood their businesses well - underwriting, policy provisions and regulations. Their questions and comments typically reflected a high degree of policy knowledge and professionalism.

But I was struck by their lack of understanding about the context within which they worked. Though they knew a great deal about specific policies, they frequently knew very little about policy implications or the overall working of our health insurance system. They tended to see our health insurance system from a very parochial perspective.

Brokers, typically, take few courses in health insurance economics or policy analysis.

Yet their clients viewed them as having great expertise about the workings of our healthcare system. Their clients, and often the brokers themselves, equated knowledge about policies and regulations with knowledge about our health insurance system. These are, in my opinion, different fields of expertise.

I wrote this book to address this disparity. I describe various forms of health insurance - Consumer Driven, Managed Care, Single Payer, Medicare and others - and show how they function economically and systemically.

Hopefully health insurance brokers can use this book to complement their regulatory knowledge and policy expertise. Hopefully also, it will help them provide better advice to their clients.

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Introduction

This book describes our health insurance system with the aim of understanding why we spend so much on healthcare and what alternatives we have.

It also explains why excessive healthcare spending is bad both for our economy and for our health. In brief:

- Excessive healthcare spending deprives us of resources to invest in education, public transportation, environmental protection, new plants and equipment and other things vital to our economic health;
- Excessive medical spending can crowd out true health investments. Good health relies largely on good lifestyles, including appropriate nutrition, exercise, job satisfaction and similar components. Medicine can only correct unhealthy lifestyles to a point. We need to invest in *health*, not just medicine.

Too much medical spending is bad for us. We have alternatives. Will we embrace them?

Three Potential Healthcare Spending Futures

As I wrote this book, I considered that our healthcare spending trends can go in three possible directions in the future.

First, we can reform healthcare to make our system more efficient. I'm not terribly optimistic about this. We've tried to reform healthcare for years, but have never been able to rein in spending - this despite the best efforts of Presidents Nixon, Carter, Clinton, W. Bush and now Obama, plus myriad other state and federal cost control programs. Each meaningful spending control reform generates such vicious opposition that it ultimately fails.

Evidence of our historic cost control failures showed up in the 2009 healthcare inflation rate. Spending grew by 1% of GDP in 2009, the largest 1 year increase since 1960. The historic record is one reason why I'm pessimistic about our ability to reform our way to meaningful healthcare cost efficiencies.

I'm also pessimistic about efficiency improvements via reforms because we face a fundamental structural problem in our healthcare financing system, one rarely discussed in the popular literature. The problem: most of our healthcare spending goes to people with chronic medical problems - problems that last for many years. Yet we finance medical care with 1 year long, renewable health

insurance policies. Subscribers renew policies based largely on price. This puts extraordinary pressure on carriers and providers to maintain a short term cost control focus.

Effective chronic disease management, however, requires a long term focus for best results. Our short term policies incent carriers and providers the wrong way. This disconnect leads to higher than necessary long term costs.

We cut, for example, funding for podiatric visits by diabetics with no foot ailments, and then generate the highest foot amputation rates among developed countries. This situation plays out daily in our medical protocols with many different disease types.

Though healthcare system reform is a laudable goal, I don't see it leading to meaningful cost controls.

Second, we can continue to adjust to high healthcare inflation. I think this is probably our most likely scenario, as this is what we've done in the past. Every year, a little more of our budget goes to healthcare.

This is unhealthy for the reasons stated above.

In addition to those reasons, I worry about something else in this scenario. I worry that there is a tipping point - a point at which we simply cannot continue spending a greater percent of our budget on healthcare every year. I worry that when we reach this tipping point, we'll react with a series of bad healthcare spending decisions that result in more harm than necessary to us.

That raises the third potential healthcare spending future. **We could cut healthcare spending**, perhaps voluntarily (admittedly not likely) or under pressure from some future event or situation...a war, a recession, some natural calamity or even the normal business cycle.

Thus, I see three different potential futures:

- We could control healthcare spending through reforms, which I don't think will happen;
- We could allow healthcare spending to consume a larger and larger amount of our economy, which I think will probably happen; and/or
- We could hit a tipping point, with unforeseen and unknowable implications, which I fear might happen.

Gradual Trends vs. A Shock

As I consider these three alternative futures, I remember a story former Vice President Al Gore told frequently about global warming during the 2000

election campaign. It's the story of the frog in a pot of water, and I think it applies to healthcare spending: ¹

If you put a frog into a pot of cold water, he swims around happily. Then, if you very slowly raise the water temperature, the frog continues to swim, though slightly less energetically and happily over time, until the water temperature ultimately gets high enough to kill him.

Alternatively, if you put a frog into a pot of hot water, he will immediately jump right out.

(I don't advocate killing frogs and neither, to the best of my knowledge, did Gore.)

We may adjust ourselves to healthcare spending increases - like the first frog - and learn to live with them for awhile, so long as the annual increments are tolerable. We may not notice the heat rise so much, provided it doesn't rise too much at any one time.

A Boiling Pot

What happens if - instead of premiums rising slowly (slowly?) over time - we get hit with a sudden wallop?

Let's hypothesize a potential and uncomfortable future. Let's say our current healthcare reforms fail to control costs, which continue to rise faster than GDP.

Let's also assume - for the sake of making pessimistic assumptions - that our national debt holds steady, but that interest rates rise to their historic average rates, about 2 - 3x higher than in 2009.

Fast forward a decade or so. Healthcare consumes 22+% of GDP. Interest rates rise and - even if we cut our national debt - payments on our national debt consume 8+%. Together healthcare spending and debt service equal about a third of our economy.

Then we face a recession for some reason or other - war, fuel prices, normal economic cycling or something else. Our economy stagnates or shrinks. We need investment capital.

¹ I actually heard him tell this story at a campaign event at Chautauqua, New York in the summer of 1992.

Our bankers - the Finance Ministers in Shanghai, Riyadh, Tokyo and Frankfurt - demand that we reduce our healthcare spending as a condition of loaning us more money.²

What decisions will we make? Unlimited healthcare for some, but healthcare limitations for others? Healthcare limitations for all? More acute care and less preventive - or vice versa?

How do we think about these questions? How can we honor our traditional American values - equality, compassion, liberty, independence, justice etc - and set firm healthcare budgets?

We may be forced to address these questions. I don't know the answers. But I have some ideas. They'll come up in Parts 4 and 5.

I wrote this book to articulate the reasons why we spend excessively on healthcare and to present some alternatives. I'll discuss why we spend so much on healthcare, what types of reforms work, what types don't, and what health insurance brokers can do to help their clients.

I hope that this will help readers better understand our current situation, and better contribute to solutions.

² I can't detail the exact circumstances, but can imagine that some day we run out of money, due to high debt levels and profligate spending. It happened in California in 2009 and Greece in 2010. My concern is not the factors that lead to this catastrophe; it's about the kinds of healthcare financing decisions we might make in response.

Part 1:
The Cost Problem and Our Options

Chapter 1: The Cost Problem An Overview

We have a **huge** healthcare cost problem.

We currently devote about 17% of our total Gross Domestic Product (i.e. total economy) to healthcare. By comparison, Canadians spend about 10% of their GDP, Dutch about 9% and the British about 8%.

This means we spend about twice as much as other advanced, industrialized countries on healthcare.

This also means that we have less money available to spend on other important activities, like education, defense, food, housing, etc. than they do.

And it means that our international trading partners / competitors have lower production costs for their cars, computers, food and other goods and services...which can lead us to import more from them than they import from us.

All of this adds up to an economic mess. Here's the gory detail:

In round numbers, we spent about \$7800 per person on healthcare in 2007.³ We'll compare this to a group of developed countries that, combined, have about the same population as us.

2007 Per Capita Healthcare Spending in Select Countries And comparison with US spending

	<u>Per Capita</u>	<u>Ratio</u> (US over other country)
US	\$7800	
Australia	\$3200	2.4 (we spend 2.4x what Australia spent/person)
Canada	\$3900	2.0 (we spend 2x what Canada spent/person)
France	\$3600	2.2 (we spend 2.2x what France spent/person)
Germany	\$3600	2.2
Greece	\$2700	2.9
Netherlands	\$3850	2.0
Spain	\$2700	2.9
UK	\$3000	2.6

We averaged spending about **2.4 times** as much as these countries, per capita, on healthcare in 2007.

³ Data source: OECD Health Data 2009

Let's adopt an historical lens to review similar data to see if we're gaining or losing ground to them.

Our Spending History Compared to the Same Countries

Have we done better or worse than other countries over this time period?

1970 Per Capita Healthcare Spending in Select Countries

	<u>Per Capita</u>	<u>Ratio</u> (US over other country)
US	\$356	
Australia	\$207	1.7 (we spent 1.7x what Australia spent per capita)
Canada	\$301	1.2 (we spent 1.2x what Canada spent per capita)
France	\$194	1.8 (we spent 1.8x what France spent per capita)
Germany	\$269	1.3
Greece	\$161	2.2
Netherlands	\$300	1.2
Spain	\$ 95	3.7
UK	\$160	2.2

We averaged spending about **1.9 times** as much as these countries in 1970, less than in 2007.

Our relative position has worsened. The net effect of all our healthcare and payment reform attempts since 1970 (at least) has been increased healthcare spending compared to these countries.⁴

Where Were We in 1970?

In 1970 we spent about 7% of GDP on healthcare. That prompted many to call our then healthcare spending a crisis. Here's noted Stanford Medical School Professor Victor Fuchs in **1974**:

In recent years, almost every American family has become acutely aware of the soaring costs of medical care.⁵

⁴ Of course, this is a relatively small representation of countries, and perhaps including others would alter these ratios. However, in many ways, these countries are similar to us: advanced, industrialized economies with roughly comparable educational levels. Also, these countries were among the relative handful that had both the 1970 and 2007 data. For these reasons, I think these indicators are useful to consider.

⁵ Victor Fuchs, Who Shall Live, page 9

And here's Robert Finch, Secretary of Health, Education and Welfare under President Nixon, warning Congress in 1969 that high healthcare costs could lead to

A breakdown in the delivery of healthcare unless immediate concerted action is taken. ⁶

That was when healthcare spending hit 7% of GDP in 1970. Today we spend over 17%.

In other words, despite all the hand ringing, cost control programs and healthcare reforms of the past 40 years, our healthcare spending has far exceeded overall economic growth.

Healthcare Spending and Our Relative Standard of Living

Why is this spending increase a concern? Why do we care if we outspend these other countries on healthcare?

The short answer: because it threatens our relative standard of living.

In 2007, our productivity (as measured by GDP per capita) far exceeded any other country. Theoretically, this allowed us to enjoy higher living standards and wealth than other countries.

But if we subtract healthcare expenditures, our productivity and wealth advantages virtually vanish.

See below, the effect of excessive healthcare spending on our standard of living. Excluding healthcare spending, we have significantly more money available, per capita, than any country listed below.

But net of healthcare spending, we're about the same as other countries.

2007 Net GDP/Capita, Select Countries ⁷

<u>Country</u>	<u>GDP/capita</u>	<u>Healthcare Spending</u>	<u>Net GDP/capita</u>
US	\$43,700	\$7800	\$35,900
Australia	\$38,300	\$3200	\$35,100
Canada	\$39,000	\$3900	\$35,100
France	\$37,000	\$3600	\$33,400

⁶ Healthcare Warning, Congressional Quarterly Weekly Report, July 18, 1969, page 1271

⁷ GDP data from Economist, Pocket World in Figures, 2009, page 28

Germany	\$35,000	\$3600	\$31,400
Netherlands	\$40,400	\$3850	\$36,500
UK	\$37,800	\$3000	\$34,800

The obvious concern: as our healthcare spending ratios (compared to other countries) worsens, our standard of living may actually fall below these others.

Just for fun (fun?), let's project these numbers 13 years into the future - to 2020. We'll inflate everyone's GDP/capita at 3%, and everyone's healthcare spending at 8% - both quite reasonable assumptions.

2020 Net GDP/Capita, Select Countries

<u>Country</u>	<u>GDP/capita</u>	<u>Healthcare Spending</u>	<u>Net GDP/capita</u>
US	\$64,200	\$21,200	\$43,000
Australia	\$56,200	\$ 8,700	\$47,500
Canada	\$57,300	\$10,600	\$46,700
France	\$54,300	\$ 9,800	\$44,500
Germany	\$51,400	\$ 9,800	\$41,600
Netherlands	\$59,300	\$10,500	\$48,800
UK	\$55,500	\$ 8,200	\$47,300

Excessive healthcare spending takes us, in 2020, from the highest productivity (GDP/capita) to the second lowest net GDP/capita.

Or, in other words, if we continue to increase our healthcare spending at the same rate as these other countries, we'll have to generate far greater productivity gains than them to maintain our relative standard of living.

That's tough, especially since our excessive healthcare spending limits our ability to invest in future economic growth.

What have we purchased with all this healthcare spending?

Spending more than other countries on healthcare is not, in and of itself, necessarily a bad thing. If we outspend others but get better results, then this might be a good investment.

But if we outspend others and get poorer results, then we have invested badly.

Here are two easy-to-understand, standard measures of how well a healthcare system works: longevity at birth and infant mortality.

We'll first evaluate longevity as an indicator of healthcare system efficiency; we'll second review the infant mortality data.

Many commentators use longevity at birth as an indicator because it encompasses so much information:

- **Acute medical care system quality**, including the ability to get appropriate treatment when ill;
- **Preventive care system quality**, keeping people healthier, longer into their lives;
- **Chronic care system quality**, keeping people with chronic conditions healthier, longer into their lives;
- **Lifestyle quality**, including nutritional, fitness and stress levels;
- **Physical and environmental quality**, including housing quality, water quality, air quality, etc;
- **Educational levels**, as all data indicate that more highly educated people live longer in all countries.

Comparative Longevity Data And Longevity Gains

We'll provide comparative longevity data in two forms.

First, we'll compare longevity gains of various countries between 1970 and 2007 to gain an historical perspective: ⁸

Life Expectancy Gains 1970 - 2007: Life Expectancy at Birth

<u>Country</u>	<u>1970</u>	<u>2007</u>	<u>Gain</u>
US	70.9	78.4	7.5
Australia	70.8	81.4	10.6
Canada	72.0	80.9	8.9
France	72.2	81.0	8.8
Germany	70.6	80.0	9.4
Greece	72.0	79.5	7.5
Netherlands	73.7	80.2	6.5
Spain	72.0	81.0	9.0
UK	71.9	79.7	7.8

⁸ Life expectancy at birth, data from the OECD Health Data, downloaded in January, 2010. Some data estimated from 2006.

Most of these countries **gained more years of life** from 1970 - 2007 than we did, and ended up **living longer than us** in 2007.

In other words, as we **outspent** these countries on healthcare, they **outperformed** us in terms of this key healthcare system indicator.

Healthcare Spending and Longevity

Second, let's compare current healthcare spending to longevity in various countries. We'll use 2007 data, the most up-to-date currently available.⁹

Country	2007 Spending <u>per capita</u>	2007 Life Expectancy <u>at birth, years</u>
US	\$7800	78.4
Australia	\$3763	81.4
Canada	\$3895	80.9
France	\$3601	81.0
Germany	\$3588	80.0
Greece	\$2727	79.5
Netherlands	\$3837	80.2
Spain	\$2671	81.0
UK	\$2992	79.7

Clearly longevity is not a function of healthcare spending.

Infant Mortality Rates

Let's now review the infant mortality data. Remember when reviewing this, that infant mortality data summarizes a number of indicators, including:

- **Woman's health status**, including nutrition, fitness, mental health, etc. Infant mortality data also probably indicates something about woman's role in society and equality;
- **Quality of prenatal care**, including physician and nursing services;
- **Hospital operational efficiency**, including ability to bring appropriate technology to bear on a medical problem; and

⁹ OECD Health Data. The OECD uses Purchasing Power Parity, rather than official exchange rates, to compare international costs. According to PPP analysis, we only spent \$7300 per capita in 2007. Here, I used the more commonly accepted figure, since we pay in dollars and all other currencies are compared to dollars. Sorry about any methodological confusion.

- Many of the longevity factors listed above.

Here is comparative infant mortality data in 1970 and 2006 data (the latest available) from the OECD Health Data Book:

1970 and 2006 Infant Mortality Rates for Select Countries
(Deaths per 1000 live births)

<u>Country</u>	<u>1970 Rate</u>	<u>2006 Rate</u>	<u>Reduction</u>
US	20.0	6.9	13.1
Australia	17.9	4.7	13.2
Canada	18.8	5.4	13.4
France	18.2	3.8	14.4
Germany	22.5	3.8	18.7
Greece	29.5	3.7	25.9
Netherlands	12.7	4.1	8.6
Spain	28.1	3.8	24.3
UK	18.5	5.0	13.5

As in the longevity case, we have poorer infant mortality outcomes than many other countries that spend far less on healthcare than us.

We have also had fewer infant mortality gains than most of these countries, despite increasing our healthcare spending rate much more quickly than them over the past 30+ years.

The obvious conclusion from all this data (and there is much, much more, using many others indicators of healthcare system efficiency): we spend far too much on healthcare relative to our healthcare system quality.

Overspending on healthcare presents two main problems to us.

Two Problems Caused by Overspending on Healthcare

First, overspending on healthcare reduces the amount of money we could spend on other activities, such as national defense, education, environmental protection, housing, recreation, etc. We could, theoretically borrow to maintain our spending in all these arenas. But with our national debt approaching our annual GDP, this appears an unattractive option.

Absent borrowing, and without actual healthcare spending reductions, we'll need to cut spending in other important areas like defense, education etc to remain within our annual national budget and personal budgets.

Second, overspending on medical care reduces the amount of money we have available to spend on health care. We know, for example, that a healthy lifestyle - including good nutrition and exercise practices - can reduce medical costs, at least in the short term. Healthier lifestyles also lead to longer lives.

We also know various societal factors affect healthy lifestyles, including clean air, clean water, easy access to walking paths, good housing stock, good public transportation systems, etc.

Compare, for example, Ottawa Canada's (population 1 million) 105 miles of publicly maintained bike paths to Houston's (population 2 million) 20. Or see Quebec Province's \$88 million investment in 2700 miles of public bike paths during the 1990s. No American region did similarly...perhaps because we're overspending on medical, as opposed to health, care.

This type of investment differential helps explain why Canadians live longer than us, while spending less on medical care. (There are other factors, of course, also.)

We can reframe the problem of overspending on medical care as follows:

Does an extra \$100 billion spent on medical care make us healthier than \$10 billion for cleaner air, \$20 billion for better housing, \$30 billion for nicer public parks and \$40 billion for a better public transportation system?

The answer: probably not!

The evidence: countries that invest proportionally more in these types of activities - and less in medical care - generate better longevity and health outcomes.

What can we do to fix this problem? How can we rein in medical spending in favor of health spending? What are our options?

We'll answer those questions in ensuing chapters.

A note on terminology: in this book we will often use the terms 'healthcare', 'health insurance', 'access to medical care', 'access to healthcare' and 'medical care' interchangeably, even though they sometimes have different meanings.

Occasionally, we will differentiate healthcare from medical care.

Chapter 2 Some Background

Introduction

I often present the data from Chapter 1 to health insurance brokers in live lectures. I typically ask ‘How can you explain the fact that we spend far more than other countries on healthcare, but don’t live as long as them?’

One standard answer: we lead unhealthier lifestyles. By ‘lifestyle’ they mean diet and exercise. My students generally explain (patiently, which I always appreciate) that we’re less healthy than Europeans because of our poorer diet and lower exercise rates.

They also, sometimes, explain that we’re now more obese than we previously were, and that we exercise less today than we did years ago.

They may even quote data, like from US Department of Agriculture, showing that we consume 500 calories per day more today than we did in 1970 - about 2700 calories today compared to 2200 in 1970.¹⁰

Others may quote a recent study by the Centers for Disease Control and Prevention suggesting that three-quarters of healthcare spending goes to treat ‘preventable chronic diseases’ like diabetes, heart disease and hypertension - all linked to unhealthy lifestyles.¹¹

Heart disease treatments account for about 10% of our total healthcare spending. Coronary disease is the leading cause of death in America.

Other students may quote authors like Michael Pollan who quantify the medical costs of unhealthy lifestyles:

We’re spending \$147 billion to treat obesity, \$116 billion to treat diabetes, and hundreds of billions more to treat cardiovascular disease and the many types of cancer that have been linked to the so-called Western diet.¹²

Cancer is another leading healthcare cost driver and is the second leading cause of death in America.

¹⁰ Amber Waves, publication of the US Department of Agriculture, November 2005

¹¹ <http://www.cdc.gov/chronicdisease/overview/index.htm> . Heart disease and cancer are the two leading causes of death in America.

¹² Michael Pollan, Big Food vs. Big Insurance, New York Times, 9/9/09

Still other students may quote researchers like Kenneth Thorpe of Emory University's Rollins School of Public Health who suggests that about a third of our healthcare cost increases since 1990 are related to obesity.¹³

All these comments are correct. But they raise two critical questions:

- First, if lifestyle is more important to good health than medical care, why do we devote so much money to medical care? That's counterproductive - we're investing the wrong way;
- Second, what happened in the past few decades to decrease our ability to lead healthy lifestyles?

This chapter will focus on the second question. The rest of this book will focus on the first.

Let's briefly review some recent healthcare trends:

- In 1970, we spent about 7% of GDP on healthcare. Today we spent about 17%;
- Our obesity rates have about doubled since the 1970s. Today 130 million Americans are overweight and 60 million obese. Interestingly, the prevalence of obesity prior to the 1970s was a relative constant;¹⁴
- Our diabetes rates have skyrocketed since the 1970s, as have our diabetes treatment costs;
- Rates of coronary treatment, kidney dialysis, knee and hip replacements and bariatric surgery - all related to obesity - have also skyrocketed since the 1970s.

What happened since the 1970s to stimulate these trends? Are people correct who claim that we're less healthy now than we were in 1970? Are our lifestyles less healthy today?

We'll define lifestyle as a combination of diet and exercise. A healthy diet with plenty of exercise constitutes a healthy lifestyle; an unhealthy diet with insufficient amounts of exercise constitutes an unhealthy lifestyle. (Yes, there are other factors to consider. But these definitions take us quite a way toward understanding the impact of lifestyle of healthcare costs.)

¹³ Thorpe, et al, The Impact of Obesity on Rising Medical Spending, Health Affairs 10/20/2004,

¹⁴ http://obesity1.tempdomainname.com/subs/fastfacts/obesity_US.shtml

Let's first consider diet - the types and amounts of food we eat. I want to outline where our current unhealthy diets come from. I don't believe that we suddenly decided to eat badly. Instead, I think that various economic programs and government subsidies induce us to eat badly.

Of course, a discussion of the current American diet and of recent dietary trends is an enormous topic, one that could consume many books, each far longer than this. Rather than attempt a complete explanation of dietary trends, I will present here only a few themes. These are examples of how our current diets have evolved. There are many others.

My purpose is to show the relationship between our lifestyle and our healthcare system operation. If our dietary lifestyles lead to a high number of people needing heart treatments, then our healthcare system will respond by producing lots of cardiologists.

It follows, of course, that one way to address coronary treatment costs is to address the underlying lifestyle causes. That's far easier said than done.

Our Story Begins on the Farm

Our incredibly productive farmers generate phenomenal yields per acre today. Corn - one of our biggest crops - saw productivity increase from 72 bushels per acre in 1970 to 162 bushels in 2009.¹⁵ That's a tremendous amount to eat, and a tremendous amount available to feed livestock - that we also eat.

Corn is at the center of our lifestyle/diet story because corn has become so central to our food supply. We eat it, animals eat it, we use it as a sweetener and we use it in myriad processed foods. As corn prices fall, so also do beef, chicken, soda, breakfast cereal and other food prices. Corn prices tend to fall as we produce more of it.

Why do we produce so much of it, especially as the more of it we produce, the lower the price per bushel? It would seem more appropriate that, as the price of corn falls, some farmers switch to growing other, more profitable crops. But this doesn't happen.

A key reason for this is our extremely generous corn subsidy. The US government today subsidizes corn producers to the tune of about \$28 per acre - that's over and above whatever the farmer earns by selling corn on the open market.

So the corn farmer goes about his normal business, planting and harvesting corn, selling it at the highest possible price - and then gets a government

¹⁵ <http://www.econ.iastate.edu/outreach/agriculture/periodicals/chartbook/Chartbook2/Tables/Table10.pdf>

subsidy check. From 1995 - 2006, we spent over **\$56 billion** subsidizing corn. That's a pretty good incentive for American farmers to grow more corn.

It's actually a pretty weird incentive. Farmers grow as much corn as possible, to generate as much income as possible. That's just standard business economics. Then the government writes its checks. Farmers switch from cultivating other crops to cultivating corn. They switch conservation land to corn production land.

Absent the corn subsidy, some farmers would produce other products. But with the corn subsidy, these other products become less economically attractive. As a result, we generate mountains of corn.

We then need to find something to do with it.

Today, about 55% of our corn production becomes animal feed and 5% becomes food sweeteners, mostly high-fructose corn syrup or HFCS.

Animal Feed

These corn production subsidies make it cheaper for livestock farmers to use corn, rather than grass, as the primary feedstock for cattle, pigs and chickens. Two Tufts University researchers, Alicia Harvie and Timothy Wise, have calculated the value of our corn subsidy to livestock farmers over the 1997 - 2005 period (they included the soy subsidies in their calculations also, but soy is relatively unimportant): ¹⁶

Total Savings from Below-Cost Corn and Soy 1997 - 2005

Broilers	\$11.3 billion
Hogs	\$ 8.5 billion
Dairy	\$ 6.6 billion
Feed cattle	\$ 4.5 billion
Eggs	\$ 3.9 billion

Our corn subsidies decrease production costs of chickens, pigs, cattle and cows by quite a bit. By contrast, according to Barry Popkin a researcher at the University of North Carolina,

¹⁶ Harvie and Wise, Sweetening the Pot, Global Development and Environment Institute, Tufts University, Policy Brief, February, 2009.

We put maybe one-tenth of one percent of our dollars that we put into subsidizing and promoting foods through the Department of Agriculture into fruits and vegetables.¹⁷

Largely as a result of the corn subsidies, we produce and then eat, on average today, about 270 pounds of meat per American, per year, or about $\frac{3}{4}$ of a pound per person per day.¹⁸ That's a lot of meat.

But it's not a particularly good diet. Our government certainly doesn't think so. They publish Dietary Guidelines for Americans, suggesting what foods to eat, what foods to avoid and how much to eat for us to maintain good health. The 2005 Dietary Guidelines - the most recent available as of publication of this book - recommend a daily consumption of 5.5 ounces of meat *and beans*. That's less than a half of what we currently consume *just of meat*.¹⁹

The Dietary Guidelines are broken down into several sections: Food Groups to Encourage, Food Groups to Avoid, etc. Here's the entire list of food groups to encourage, not just a subsection. Note the deafening silence on meat:²⁰

FOOD GROUPS TO ENCOURAGE Key Recommendations

- Consume a sufficient amount of fruits and vegetables while staying within energy needs. Two cups of fruit and 2 1/2 cups of vegetables per day are recommended for a reference 2,000-calorie intake, with higher or lower amounts depending on the calorie level.
- Choose a variety of fruits and vegetables each day. In particular, select from all five vegetable subgroups (dark green, orange, legumes, starchy vegetables, and other vegetables) several times a week.

¹⁷ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1247588/>

¹⁸ This estimate comes from Elizabeth Kolbert, *Flesh of Your Flesh*, *New Yorker*, Nov 9, 2009. Other estimates are somewhat lower; Michael Pollan, for example, estimates that we only eat about 190 pounds per capita per year. See Pollan, *Farmer In Chief*, *New York Times*, October 12, 2008

¹⁹ Dietary Guidelines for Americans 2005, US Department of Agriculture, Table 1, page 10. The 2010 Dietary Guidelines were not available when this chapter was written.

²⁰ *Ibid.* page viii

- Consume 3 or more ounce-equivalents of whole-grain products per day, with the rest of the recommended grains coming from enriched or whole-grain products. In general, at least half the grains should come from whole grains.
- Consume 3 cups per day of fat-free or low-fat milk or equivalent milk products.

No meat, chicken or pork listed. I wonder why.

What's wrong with eating a little meat?

In reasonable quantities, eating meat is probably good for us. I'm not a nutritionist, but that seems the conclusion of numerous studies.

Eating large quantities of meat, though, seems bad for us. Indeed, a major 2005 study of food consumption patterns in 29,000 people concluded that those who ate the most meat were at the greatest risk of heart disease.²¹ Another study of 88,000 American nurses found that daily red meat eaters are far more likely to develop colon cancer than near vegetarians.²² High quantities of meat consumption correlates to heart disease and cancer - two of our healthcare cost drivers.

Physician Dean Ornish, a well known medical author, puts it this way:

This link between animal products and heart disease is now very well documented. It's no surprise that over half of all Americans develop heart disease, because the typical US diet puts almost everyone at risk.²³

Thus, according both to the scientists who study all this and the US government which issues nutritional guidelines, eating too much meat is bad for us.

Note how the government acts in contradictory ways on this issue. On one hand, the Department of Agriculture recommends that we consume more fruits, vegetables and grains - and less meat. On the other hand, the same department subsidizes meat production more heavily than fruit, vegetable or grain production.

²¹ American Journal of Epidemiology, February 2005

²² Walter Willett et. al, Nurses 1 and Health Professional's Follow Up

²³ <http://www.goveg.com/heartdisease.asp> .

The result, not surprisingly, is more meat consumption than is good for us. Even if too much meat is unhealthy, government subsidies make it cheap. Food production companies then make it tasty. ‘Cheap’ and ‘tasty’ have more behavioral impact than a government recommendation.

We’re beginning to understand where our poor lifestyles come from.

The Chicken Story

Some students in my classes hear this discussion, relate it to beef, and respond ‘We don’t eat beef. We only eat lean chicken breast in my house. So this discussion really doesn’t apply to me.’

Not quite.

We annually consume about 6.4 billion chickens in this country or about 20 chickens per American per year. That’s up from about 2.5 billion chickens consumed in 1970, or about 13 chickens per American per year - a per person consumption increase of about 50%.²⁴

Today’s chickens are larger than average 1970s chickens. The average 1970s chicken weighed 3.6 pounds. The average 2009 chicken weighted 5.6 pounds.²⁵ So today we eat about 50% more chickens than in 1970 and each chicken weighs about 50% more. That billion and a half dollar per year corn subsidy for chicken production certainly generates a lot of big chickens!

Chicken breast contains less fat than red meat on a per-unit basis. But it still contains over 20% fat as a percentage of calories.²⁶ And it contains about the same cholesterol levels as beef - about 25 mg per ounce.²⁷ So even though eating chicken breast might be slightly better for you than eating beef, it’s still not particularly good for you *in large quantities*. Eating twenty of the large 2009 sized chickens per American per year qualifies as eating large quantities, as compared to 13 of the 1970s sized birds.

The less healthy chicken parts include red meat and skin. These get consumed by *someone*. They tend to show up in chicken mystery meat - patties and nuggets for example.

²⁴ <http://www.epa.gov/oecaagct/ag101/poultrybackground.html>

²⁵ <http://dpicken.com/index.cfm?content=facts>

²⁶ <http://www.pcrm.org/magazine/GM00SpringSummer/GM00SpSum2.html>

²⁷ http://www.pcrm.org/health/prevmed/chol_heartdisease.html

Though you and your family claim only to eat ‘healthy’ chicken breast, I suspect that most people either eat too much of this, or consume the less healthy bits too, perhaps unknowingly.

Animal Consumption and Coronary Problems

Let’s put this into context. Here are the recommendations of the Physician’s Committee for Responsible Medicine, a group that helps the US government write its nutritional guidelines.²⁸

Many studies have shown the connection between cholesterol and heart problems.

Cholesterol is found in all foods that come from animals: red meat, poultry, fish, eggs, milk, cheese, yogurt, and every other meat and dairy product. Choosing lean cuts of meat is not enough; the cholesterol is mainly in the lean portion. Many people are surprised to learn that chicken contains as much cholesterol as beef.

No foods from plants contain cholesterol.

People can reduce their cholesterol levels dramatically by changing the foods they eat. Every time you reduce your cholesterol level by 1 percent, you reduce your risk of heart disease by 2 percent.

Consuming the various cholesterol generating foods at our 1970 level would lead to much lower rates of heart disease than consuming the same foods at our 2010 level. Using the Physician’s Committee factors, doubling our chicken consumption per capita since 1970 translates to a huge increase in our heart disease risk.

How much of an increase? About 6 million heart operations per year. We performed about **1.4 million cardiovascular operations and procedures in 1979**. This increased to about **7.2 million in 2006**.²⁹

Here’s another metric: In 2007 alone we had a **total of 80 million physician office visits, hospital emergency department visits and outpatient visits with**

²⁸ Ibid.

²⁹ Estimates come from American Heart Association. 2001 and 2010 heart and stroke statistical update.

a primary diagnosis of cardiovascular disease.³⁰ The 7+ million operations and procedures listed above are a subset of this.

We've so far traced a line from increases in corn subsidies to increases in meat consumption to increases in heart disease...which lead to huge increases in coronary treatments and related costs. But that's just part of our story.

High Fructose Corn Syrup

Let's return to our corn farm. We've discussed the 55% of our corn production that becomes animal feed. Now let's discuss the 5% that becomes High Fructose Corn Syrup.

HFCS has replaced sugar as the sweetener in many beverages and foods like breads, cereals, lunch meats, yogurts, soups and condiments, in part because it's cheaper.

Our annual consumption of HFCS has increased from 6 pounds per person in the 1970s to over 70 pounds by 2007.³¹ Harvie and Wise, the Tufts University researchers, estimate that corn production subsidies saved HFCS producers \$4 billion between 1986 and 2005. Soda bottlers, key consumers of HFCS, alone saved about \$100 million annually from this corn subsidy since the mid-1980s.³²

Perhaps as a result, according to Michael Pollan of the University of California at Berkeley:

Nearly 10% of all the calories Americans consume now come from corn sweeteners; the figure is 20% for many children...It's probably no coincidence that the wholesale switch to corn sweeteners in the 1980s marked the beginning of the epidemic of obesity and Type 2 diabetes in this country. Sweetness became so cheap that soft drink makers, rather than lower their prices, super-sized their serving portions and marketing budgets.³³

³⁰ http://www.americanheart.org/downloadable/heart/1265665152970DS-3241%20HeartStrokeUpdate_2010.pdf

³¹ Huff, Ill-conceived US Corn Subsidies Make Liquid Satan High Fructose Corn Syrup a Cheap Ingredient, Natural News, November 28, 2009. Harvie and Wise use a lower estimate, 43 pounds per person per year – still quite a lot! The US Food and Drug Administration estimates that total sweetener consumption – HFCS plus sugar – was 142 pounds per person in 2003, up over 20 pounds since the 1970s. See <http://www.ers.usda.gov/AmberWaves/November05/Findings/USFoodConsumption.htm>

³² Harvie and Wise, op. cit.

³³ Pollan, When a Crop Becomes King, New York Times, July 19, 2002

Here, then is a second reason that our lifestyles are less healthy today than in 1970: cheap, government subsidized sweeteners.

Researchers writing the in Archives of Internal Medicine in 2010, confirmed that the price of soda had fallen, in real terms, since 1990. As a result, soda consumption increased.³⁴

Interestingly, the researchers also found that a \$1.00 increase in the price of soda is associated with lower daily caloric consumption, lower weight and lower insulin resistance scores over time. Their conclusion: Policies aimed at increasing the price of soda may be effective mechanisms to steer US adults toward a more healthful diet and help reduce long-term weight gain or insulin levels over time.

This is exactly the opposite of our current corn subsidy program.

Consuming 70 pounds of high fructose corn syrup annually, for many years, can increase the body's resistance to insulin. That helps explain our current diabetes epidemic. (There are, of course, other factors causing diabetes.)

Remember the evolution: at the 1970s HFCS consumption average of 6 pounds per person per year, we had a minor diabetes problem. But at our current 70 pounds, we have a huge - and very costly - epidemic.

We could expand on our food consumption issues ad infinitum: there are other dietary causes of our current obesity, diabetes and coronary epidemics. Many of them are well known: high consumption rates of French Fries for example, making potatoes our most frequently consumed vegetable. Or high consumption rates of processed food. Or high salt consumption.

Or easy access to cheap, high calorie, high fat fast food. 'Economically, if you had just \$5 to maximize your calories, that's certainly a way to do it' according to Dr. Lauren Smith, medical director for the Massachusetts Department of Public Health.³⁵ Unhealthy but subsidized calories are cheaper than healthy but unsubsidized ones.

But this is a book about health insurance, not nutrition. My goal so far in this chapter: to suggest some reasons why and how our food consumption patterns have changed since the 1970s and to show how this has put more strain on our medical system. Understanding the impact of corn and corn subsidies helps in that process.

Now let's turn to the other part of 'diet and exercise' - the exercise bit.

³⁴ Duffrey, et. al, Food Price and Diet and Health Outcomes, Archives of Internal Medicine, March 8, 2010

³⁵ Boston Globe,, Kicking the Obesity Epidemic, March 10, 2010

Why We Exercise Less Than In 1970

Many factors affect our rate of daily exercise. Some examples:

- Availability of labor saving devices, such as cars;
- Increases in office-based jobs and decreases in manual labor-based jobs;
- Shifting from an agriculture/manufacturing based economy to a knowledge based economy.

These are all relevant. They all underscore the primary point in this chapter: that as our environment has changed since the 1970s, we have responded. One response to our changed environment is a decrease in daily exercise.

Let's use a description of our daily work day as an example.

Today we work longer than we did in the past. Madeleine Bunting claims in her book *Willing Slaves - How the Overwork Culture is Ruling Our Lives*, that the definition of 'full time work' grew from about 43 to 47 hours per week over the past couple decades. That's a decrease of almost 4 hours / week that we could have devoted to exercise or other health-oriented pursuits.

In addition to working longer, we're also commuting longer. Americans currently spend about an hour each commuting back and forth to work, according to the US Census Bureau.³⁶

Here's an example of commuting trends, from Chicago:³⁷

- In 1970, only 13% of Chicago commuters crossed county lines. By 2000 some 27% did, an increase of over 100%;
- Between 1990 and 2000, an additional 250,000 people in greater Chicago commuted more than 20 minutes each way to work.

That's a lot of people spending a lot more time driving now than in the past. They're also spending a lot less time engaged in healthier lifestyle pursuits. At best, commuting is a non-weight bearing activity. At worst, it's a stressful non-weight bearing activity that includes caffeine, HFCS, sugar, refined carbohydrate and fat consumption...along with, perhaps, a cigarette or two as well.

³⁶ <http://usgovinfo.about.com/od/censusandstatistics/a/commutetimes.htm>

³⁷ <http://www.berwyned.com/papers/co2cochgo.pdf>

Housing and Job Location Patterns

There's an interesting underlying demographic issue here. American metropolitan population and job densities are lower than many Canadian and European urban densities. Higher densities mean shorter commutes; lower densities mean longer commutes.

We've chosen, in this country, to buy bigger houses in spread-out suburbs; Canadians and Europeans have made different housing location decisions.

The largest Canadian cities, for example, average 76% higher population densities than the largest American cities. Similarly, job densities are 69% higher in Canada than America. The result: average trip lengths in Canada are about 60% of the average trip length in America.³⁸

This means Canadians spend less time stuck in traffic and more time engaged in healthier activities - like short, functional walking trips - than we do.

European population and job densities are higher even than Canada's. Some 20% of all Danish, and 32% of all Dutch, urban trips are by bicycle, for example. Transportation economists Pucher and Buechler summarize:

Most Western European countries dramatically shifted their urban transport policies in the 1970s to curb car travel and promote public transport and walking.

We, obviously, did not. Instead, we chose to subsidize long commutes, rather than curb car travel and promote public transportation like Europeans.

Tax Deductions That Lead to Long Commutes

Long commutes come, in part, from the deductibility of home mortgage interest in our income taxes. This effectively lowers home ownership prices and incents us to buy larger houses than we otherwise might purchase.

These larger homes are generally located in the suburbs which often have minimum lot size requirements. Lot size is a key variable determining house value, and thus the property tax rate. Property taxes are a main source of local government income. Property taxes are also income tax deductible.

The income tax deductibility of home mortgages and property taxes act as subsidies for us to purchase large homes on large lots. In 1970 our homes

³⁸ Pucher and Buechler, Transportation Policy 13 (2006)

averaged 1400 square feet. By 2004 they had grown to 2330 square feet.³⁹ Our suburban population growth rates mirrored this trend.

Here's the effect of lot size on commuting time:

If you commute past 100 homes on single acre lots, then you drive 100 linear acres (about 4 miles if square acres).

But if you commute past 100 homes on quarter acre lots, then you only drive 25 linear acres (about 1 mile if square acres).

And if you commute past 100 high density homes, then you may only drive 5 - about 1/5 of a mile if square acres).

Unsubsidized housing costs would be about 1/3 higher than our current subsidized (through the home mortgage and property tax deductions) housing costs, probably resulting in smaller homes, perhaps on smaller lots. We have apparently decided to use the government incentives to purchase the largest possible houses on large lots. That's why we commute so long.

The Government Subsidizes Our Drive Too!

We typically commute from our single acre lot to work by car, using below-world-prices for gas. This is effectively another government subsidy, for gas prices are primarily a function of taxes rather than the underlying fuel costs.

Here are sample gasoline prices per gallon in January, 2008:⁴⁰

<u>Country</u>	<u>Price per Gallon</u>
US	\$ 2.17
Netherlands	\$10.04
United Kingdom	\$ 9.31
Italy	\$ 9.13
France	\$ 8.77
Germany	\$ 8.72

By foregoing the taxes that would increase our gasoline prices to world levels, our government subsidizes long commutes.

³⁹ Data from the National Association of Home Builders

⁴⁰ <http://uk.reuters.com/article/idUKL1881342520080118>

Thus the government encourages us to buy large houses in the suburbs through the home mortgage and property tax deductions, which correlates to long commutes to work. The government then subsidizes automobile commutes by keeping the gas prices below the world average.

Note the divergent trends between us and other developed countries since the 1970s. We subsidized larger homes and longer commutes; they invested in public transportation and tried to curb excessive automobile commuting.

Lifestyle Context i: Coronary

The American Heart Association suggests that 9 easily measured and potentially modifiable risk factors account for over 90% of the risk of developing coronary disease.⁴¹ Heart disease accounts for almost 10% of our total healthcare spending.⁴²

The 9 risk factors:

- Cigarette smoking;
- Abnormal blood lipid (bad cholesterol) levels;
- Hypertension;
- Diabetes;
- Lack of physical exercise;
- Low daily fruit and vegetable consumption;
- Alcohol overconsumption;
- Psychological issues⁴³

We've shown, above, how our various government subsidies contribute to, rather than incent us against, several of these risk factors.

⁴¹ http://www.americanheart.org/downloadable/heart/1265665152970DS-3241%20HeartStrokeUpdate_2010.pdf

⁴² <http://www.ahrq.gov/research/ria19/ependria.pdf>

⁴³ http://www.americanheart.org/downloadable/heart/1265665152970DS-3241%20HeartStrokeUpdate_2010.pdf

Context ii: Snacking

As we work / commute longer (decreasing our food preparation time and energy), and as subsidies for unhealthy foods make them economically more attractive, Americans have snacked more.⁴⁴

More frequent snacking is associated with higher obesity levels. Over time, both our snacking rate and the size of each snack have increased. Today children consume almost 3 snacks per day, per capita, most commonly a salty snack (often corn based and thus subsidized) and a sweetened drink (also often subsidized). Fruit has consistently decreased as a snack.

Today kids up to age 18 receive about 27% of their calories from snacks. These tend to be low nutritional value, low fiber, high salt and high HFCS foods - exactly the foods that both the US Food Guidelines and the American Heart Association advise against.

But we eat them because they're quick, easy, cheap and satisfy our food cravings. They fit into our lifestyles.

Lifestyle = Diet and Exercise

What can we conclude about our lifestyles? First, I believe that people respond rationally to the incentives they face. In other words, when the government subsidizes something, we buy more of it.

Second, the pattern of governmental subsidizes of corn, mortgages, house lots and gasoline encourages us to eat badly and exercise too little. The costs of eating well and exercising sufficiently are *higher* than the costs of eating poorly and exercising insufficiently, in large part due to the presence of all these government subsidies.

I suppose the conclusion is this: you get what you pay for. As I have outlined above, the government pays us for poor-health choices.

The Challenge for Health Insurance

We accept government subsidies and encouragement that incent us to lead less healthy lifestyles today than we did 40 years ago. As a result, we're demonstrably less healthy - as measured by obesity, diabetes and heart disease - than we were 40 years ago.

⁴⁴ This discussion comes from Carmen Piernas, et al, Trends in Snacking Among US Children, Health Affairs, March 2010

We then turn to our healthcare system to make us healthier. This puts a tremendous burden on medicine. It has to undo all the harm that our lifestyle has created. This is extremely expensive.

We have, for example, more cardiologists per capita than any other country - largely because our population presents with so many coronary problems.

As healthcare costs rise, we then demand reforms to control prices.

This seems like a dog chasing its tail. We would apparently prefer to address healthcare system reforms rather than address these underlying lifestyle based issues. Perhaps we think it's easier. Perhaps we think it's quicker. We may even think it's cheaper.

But in any case, it's probably poorly targeted.

We've created a \$2.5 trillion healthcare monster that consumes an increasing percentage of our national resources. This is probably economically unsustainable. Much of it is unnecessary ('preventable' in academic parlance) through better lifestyle choices.

Since we've obviously decided not to address the underlying lifestyle issues - many of which are trending in the wrong direction - we need to reform our healthcare system to maintain some semblance of economic responsibility.

We only have a few reform alternatives available. We'll turn, in the next chapter, to a discussion of our healthcare reform options.

Chapter 3

Our Healthcare Cost Options: How Can We Reduce Healthcare Spending?

As in any economic activity, there are two basic ways to reduce spending: we can reduce demand for healthcare or we can increase the supply of healthcare services. Let's explore each briefly in turn.

Reduce demand for medical services

Demand for medical services has grown over time for several reasons:

First, as our population ages, as we become more obese and as we exercise less, we need more medical care;

Second, as our medical technologies improve, we can treat previously untreatable conditions; and

Third, insurance makes access to medical care relatively easy. Most healthcare reform activities over the past several years have aimed to insure more, not fewer Americans. Programs that simultaneously expand insurance coverage and reduce demand for medical care seem an oxymoron, if not a political impossibility.

Were healthcare a 'regular' product, then we would know how to reduce demand for it: we would raise healthcare prices. That's the traditional tool to reduce demand.

Increasing Prices Induces Some People to Change Their Behavior

When the government wants to reduce cigarette consumption, for example, it raises cigarette taxes, thus forcing smokers to pay more to continue their habit.

In economic terms, some smokers - at the margin - will change their behavior because of the price increase. A \$.01 price rise per cigarette, for example, may induce a small number of smokers to change their behavior.

These are people for whom smoking is a relatively unimportant activity. They find that the effort involved in quitting smoking is less than \$.01 per cigarette. (I don't know how to measure 'effort', but you get the idea.)

A \$.25 increase per cigarette would likely induce more people to quit, because more people would find that the effort involved in quitting falls somewhere between \$.01 and \$.25 per cigarette.

At a \$1.00 increase per cigarette, even more people would likely quit. At least, that's the theory.

But Not in Healthcare

This theory fails in healthcare. Yes, a rise in copayments and deductibles would certainly keep some people away from doctors. These are people with minor - or hypochondriacal - medical conditions. These are people in the 'gray area' between needing and not needing medical care.

Though perhaps a relatively large number of people, this group - from a cost point of view - is unimportant. The vast majority of our healthcare spending goes to really sick people with very expensive medical conditions. Here's the data: ⁴⁵

<u>% of the population</u>	<u>% of healthcare spending on them</u>
1%	24%
5%	49%
10%	64%
50%	97%

Ten percent of our population accounts for about 2/3 of all healthcare spending.

Fifty percent of us use about 3% of our medical resources. These are the people who might adjust their behavior as copayments and deductibles increase. But they have little impact on our national healthcare expenditures.

Unlike the cigarette case - where a modest price increase could induce a modest level of behavioral change - in healthcare, a modest price increase would generate virtually no savings at all. A \$1000 or \$2000 annual deductible trifles compared to the consequences of no medical care at all for really sick folks.

⁴⁵ Mark Stanton 'High Concentration of US Healthcare Expenditures' Agency for Healthcare Research and Quality, US Department of Health and Human Services, June 2006

People with major, acute medical problems - those who definitely need care - will still access it. They'll just pay more for it. Their choice is not between paying slightly more for care or doing without: it's between paying slightly more for care or dying (potentially).

Attempts to reduce our demand for health services appear non-starters. In fact, for the demographic, technological and financial factors listed above, demand for medical care is likely to increase in the future - exacerbating, not reducing our medical cost problems.

Increasing the Supply of Medical Services

In our capitalist economy, we normally respond to rising prices or increasing demand by expanding the supply of services. Thus, as our population ages and we continue to spend excessively on medical care, one potential cost control strategy involves increasing the number of medical care providers - hospitals, physicians, etc - for example, by building more hospitals and training more physicians.

This, however, seems unlikely to help us control healthcare costs, at least in the short run. Expanding the supply of hospitals would require a huge capital investment. So would training the required number of physicians, nurses and other professional staff. In the short run - which could take many, many years - we would need to spend more on healthcare, not less, to expand the supply of medical providers.

Expanding the supply of medical services, in addition, might have a negative long term effect on costs. Here's why: we've discovered, in medicine, a direct correlation between medical facility availability and medical facility usage. This is sometimes called 'supply induced demand' and sometimes also called Roemer's Law, after Professor Milton Roemer, the fellow who first discovered this in the 1950s. We'll refer to Roemer's Law several times in this book.

Roemer learned that the more hospital beds available in a region, the more people get admitted. His 'law' postulates that 'a hospital room built is a hospital room occupied', largely, though not entirely, due to our fee-for-service billing standards. Physicians, it seems, respond to the increased supply of hospital beds and related technologies by increased hospitalizations. Patients in the gray area between definitely needing hospitalization and definitely not needing become prime candidates for admission as facilities expand.

Other researchers - notably those at Dartmouth Medical School - have followed Roemer's lead and have found the same hospitalization usage patterns in multiple studies, over lengthy periods of time, in multiple locations.

This phenomenon of supply-induced demand is exacerbated by our constant upgrading of medical technology, which allows us to treat previously untreatable diseases. The more diseases we can treat - and the more hospital beds available for patients - the more patients get hospitalized.

Thus, in healthcare, unlike in most parts of our economy, expanding the supply of medical facilities will likely increase costs, both in the short and long term.

Improving Supply Efficiencies

As we discussed above, we currently outspend all other countries on medical care without generating better outcomes. This shows the inefficiency of our current system. We could - theoretically - improve our efficiencies and thus control our healthcare costs. We might even reduce spending without compromising care, given sufficient efficiency gains.

This appears, to most commentators, the best way to reduce healthcare costs. Indeed, this type of thinking has led at least one commentator (I don't remember who unfortunately) to quip that

Anyone can become a healthcare economist. Just say 'waste, fraud and abuse.'

A plethora of proposals to improve efficiencies already exists. Most focus on adjusting provider incentives and are quite well known: single payer, managed care, consumer driven, pay for performance, tiered networks, health savings accounts, global payments, etc. All share a common goal - improving healthcare systemic efficiency by better aligning costs and outcomes.

Unfortunately, improving supply efficiencies is far more difficult to do than to talk about. We've already tried to implement many of these programs, though always unsuccessfully from a cost control point of view. Here's a partial list:

Single payer healthcare - Medicare is currently on financial life support and threatens to bankrupt us; Obama's proposed Public Option met enormous political resistance;

Managed care - Nixon's HMO Law of 1973 failed to control medical costs; Clinton's healthcare reform effort of the early 1990s failed to get through Congress;

Consumer driven healthcare - Bush's Health Savings Accounts, introduced in 2003 have done little to stem healthcare inflation, probably for the reasons outlined above in the Demand Reduction section;

Tiered Networks, or Limited Network Plans - resoundingly unpopular with our population;

Pay for Performance - a set of standards and treatment protocols imposed on physicians by carriers and Medicare, primarily post 2000. Notable for their lack of effective cost controls, as evidenced by the inflation rate of 2009 - the highest one year rate since 1960.

No healthcare reform in the past 50 years has had sufficient impact on our supply efficiency to control medical costs. These have continued to rise faster than GDP growth, regardless the specific reform attempted.

In fact, the most recent data indicates that the rate of healthcare spending is increasing: 2009 showed the largest single-year increase since 1960.⁴⁶

Our recent track record of implementing healthcare cost reforms provides little reason to believe that future reforms will indeed, rein in costs.

A Key - Faulty? - Underlying Assumption

Note a key underlying assumption in all these efficiency-improvement reform ideas: that Americans can have all the medical care they want, from a wide choice of providers, at a reasonable cost, provided we reform the supply of medical care appropriately.

History has shown, unfortunately, that this assumption is faulty. **We never get an appropriately designed medical care system.** Politics, special interests, entrenched practices, government bureaucracy, opposing values and other factors always interfere. Every healthcare reform attempt has either left the cost inflation curve untouched, or has made it worse.

We'll present a short history of failed healthcare reforms in Part 4.

⁴⁶ Christopher Truffer, et al, Health Spending Projections Through 2019, Health Affairs, March 2010

Restricting the Supply of Medical Services to Control Costs

Let's revisit the assumption above - that Americans can get all the care they want at a reasonable cost, provided an appropriately designed system. But let's flip it around.

This time let's limit the supply of medical services to fit a budget. In other words, let's say we want to reduce healthcare costs by 2% over 10 years. What supply cuts would we need to make? What systemic changes would follow? What might our healthcare system look like?

This is sometimes called capitation, and has had a mixed history of successes.

Kaiser Permanente in California used capitation quite effectively in the 1950s and 60s. Among their results:

1. Kaiser hospitals in the 1950s reported 25% shorter stays than the US hospital average;
2. Kaiser's ratio of outpatient visits to hospital admissions was 50% higher than the US average in 1969;
3. In the 1960s, Kaiser was among the first to offer home nursing services as a substitute to expensive lengthy hospitalizations;
4. Through the 1970s and 80s, Kaiser continued to emphasize outpatient care, becoming one of the first institutions to offer freestanding surgery and emergency care facilities.⁴⁷

Kaiser Permanente innovated to maintain its medical care quality while working within tight budgetary constraints. In 1971, for example, Dr. Cecil Cutting, the executive director of the Kaiser Permanente Medical Group in northern California praised the effects of capitation, writing that the 'direct relationship of prepayment to providers become an incentive for the physician to develop economies in spending the medical dollar while maintaining quality'.⁴⁸

The US Veteran's Administration Healthcare System also uses capitation to control its spending. It generates excellent patient results while avoiding bottlenecks and inefficiencies. According to 2005 VHA data, 69% of patients are

⁴⁷ David Dranove, *The Economic Evolution of Managed Care*, page 40

⁴⁸ *Ibid*, page 39

seen by their physicians within 20 minutes of their scheduled appointment and 93% see specialists within 30 days of their desired appointment time.⁴⁹

Other examples of capitation - particularly from some so-called Managed Carriers in the late 1990s and early 2000s - were not so attractive. Michael Moore, in his muckraking film *Sicko* for example, described unsavory ways that carriers controlled their budgets. One particularly disturbing case in point: a patient harmed 2 fingers in an accident and needed medical care on both, but the carrier only allowed treatment on one for budgetary reasons.

The hope, of course, is that a capitated healthcare system will emulate Dr. Cutting's advice above - that capitation will incent physicians to develop economies in medical care provision - and not Michael Moore's.

A politically incorrect word for capitation is rationing.

What Does 'Rationing' Mean?

'Rationing' means restricting access to healthcare based on some criterion or other. Lots of rationing criteria already exist in our healthcare system. We use them every day. Here's a partial list:

- We sometimes ration healthcare based on price. Only those able to pay for health insurance, for example, may get treated. Those unable to afford insurance may be unable to access either the medical care they desire, or potentially any medical care at all.
- We sometimes ration based on referral requirements - more or less a fixture of Managed Care. The Primary Care Physician decides who gets what type of specialist care, and who gets denied care. The PCP's decision criteria may be unclear. Some PCPs may have a budgetary allotment, imposed on them by a carrier.
- Other PCPs may have financial incentives to ration care - the fewer patients they refer to specialists, the higher their compensation.
- Still other PCPs may have network restrictions - they may only be allowed to refer patients to 'in-network' providers. This rations healthcare services by network affiliation.

⁴⁹ Department of Veterans Affairs, Performance and Accountability Report FY 2005.

- Yet other PCPs may ration care based on geography. They may only be able to refer patients to in-state providers, not outstanding providers like the Cleveland Clinic, Texas Heart Institute or Mayo Clinic.
- Or PCPs may ration care based on their knowledge of available specialists. They may only know a handful of cardiologists so refer only to them. This handful may not be the ‘best’ cardiologists available, only the ‘best known’.
- Or your carrier may ration your care. You may only have access to certain medications on your carrier’s formulary. The decision on which drugs to include in the formulary may be based on price rather than patient results - thus effectively rationing medications by price.
- Or your care may be rationed by treatment type. Your carrier may not cover chiropractic care or physical therapy. You may face a price cap - perhaps an annual benefit maximum of \$1 million. Your carrier may not allow treatments that cost more than your treatment maximum. Or your carrier may only fund treatments that its medical director approves, with that approval criteria hidden from patient’s view.

None of these generate much popular criticism. Most of us consider these treatment restrictions as relatively minor hindrances. One cardiologist, for example, is pretty much as good as another, Connecticut hospitals are about as good as Maryland hospitals. One carrier’s formulary is about as good as another’s. Even with these restrictions, we can still choose our own doctor (more or less, typically within a very wide range of options) and still get all the care we need.

We Fear Rationing of Lifesaving Services

We fear, instead, rationing where we lose our ability to choose our medical provider and/or where someone denies us access to necessary care. We fear denial of lifesaving care for an elderly parent or young child. We fear that someone we love will cost too much and will die as a result of a rationing decision by some government entity.

Some of us may even cite examples from other countries. The British National Health Service, for example, rations care through the National

Institute for Clinical Excellence. Some Britons are denied treatment based on NICE's economic criteria, and some die as a result. The British press is full of stories about sympathetic folks who need lifesaving care but who cannot access it - because NICE said the care is insufficiently 'cost-effective'. These sympathetic people sometimes die as a result.

NICE and some other national healthcare rationing agencies limit healthcare based cost-effectiveness criteria. Let's introduce this concept as 'rationing by cost-effectiveness'.

Rationing By Cost Effectiveness

This is sometimes called rational rationing. It means that we use our healthcare resources most efficiently. We'll treat the most people and provide the most care within a budget.

Rational rationing is relatively easy to understand, though exceedingly hard to implement. Rationing by cost effectiveness simply means 'denying healthcare services where the treatment costs outweigh the patient benefits' - however these are measured.

Thus a hugely expensive treatment for a minor ailment - several thousand dollars, for example, to repair the oft-cited ingrown toenail - would be denied by some rationing board or other.

Or, a harder example, a million dollar medical intervention might be denied to an elder who likely has only a few months left to live.

Determining life expectancy, the value of a few more months of life for an elder, the value of pain reduction from a specified treatment or the pleasure gained from a successful medical treatment are hugely difficult things to measure. These are often emotional decisions. Many Americans simply reject the notion that we can measure these outcomes, and thus the entire notion of cost effective rationing. We'll discuss this in far more detail in Part 5.

By avoiding expensive, 'non-cost effective' interventions, we have more resources available for other, more cost effective treatments. **Rational rationing means more people get treated within the same healthcare budget.**

Rational rationing may be worth considering if we need to cut our healthcare spending. This could allocate medical care based on objective criteria such as return on investment, rather than subtle, unstated and hidden criteria.

Perhaps modern science and economics can help us cut our healthcare spending in a sensitive and appropriate way.

And - hey - all our other cost control attempts have already failed!

How Much Are We Willing to Pay to Avoid Rationing?

Americans typically abhor the idea of healthcare rationing. Our healthcare history has consistently showed that we - each individual healthcare consumer - want a great deal of freedom to make our own healthcare decisions. We want to decide which physician and hospital to use and which treatment we want.

We do not want to abdicate those decisions to anyone else - not an insurance carrier or the government.

Let's put some numbers to this. Annual family health insurance plans are approaching \$20,000/year in some states, and inflating at about 10% annually. So we're willing to pay about \$2000/family plan/year - typically split between the employee and employer - to maintain our value of 'easy access to provider of choice for unlimited care'.

We could, of course, purchase restriction-based plans far less expensively.

Are we willing to spend \$3000 - \$4000 - \$5000/year to maintain this value? How much are we willing to spend to maintain our 'access to provider of choice for unlimited treatment' value? At some point, if healthcare costs continue to grow at their historical rate, we may face a tipping point.

No one knows how we will react to that.

Summary of Part 1

1. We currently spend far more on healthcare, per capita, than any other country.

Our spending excesses have grown over time. In 1970, we spent about 1.9 times as much as most other advanced industrialized countries. In 2007, we spent about 2.4 times as much.

2. Our healthcare outcomes, as measured by average longevity and infant mortality, lag behind other countries.

In addition, we have *gained fewer years of life* between 1970 and today, than many other countries. According to the OECD data, for example, American life expectancies increased by about 7.5 years between 1970 and 2007, while Australians, Canadians, French, Germans and Spaniards all increased by at least 8 years. All these countries currently have greater life expectancies than we do.

3. There is no correlation between spending on healthcare and longevity, or spending on healthcare and infant mortality rates.

4. American infant mortality rates exceed that in most other advanced industrialized countries.

Our infant mortality gains since 1970 have lagged behind the gains in most other advanced countries.

5. Overspending on medical care causes two main problems. **First**, it reduces the amount of money available for other activities, like housing, education, transportation, defense, etc. **Second**, it reduces the amount of money available for healthcare - nutrition and exercise programs, for example - as opposed to medical care.

6. We can reduce healthcare spending either by reducing demand for medical care or expanding the supply of medical providers.

7. We cannot reduce demand for medical care because (a) our population is aging and (b) new medical technologies allow us to treat previously untreatable conditions. Thus demand for medical care will grow in the future, not shrink.

8. Increasing the number of hospitals and physicians will not solve our excess cost problem. Hospitals are expensive to build and physicians are expensive to train - so expanding the number of these will add to, not subtract from, cost.

Also, adding hospital beds will likely add to the number of patients admitted. This is sometimes called 'Roemer's Law' and sometimes called 'supply induced demand'. Studies have shown that **the more hospital beds available in a region, the higher the rate of patients admitted.**

9. Improving the efficiency of our medical providers will probably not cut costs either. We have a 40 year history of failed attempts to control healthcare spending. Yet we have tried virtually every conceivable cost control idea, from global payments to providers, to provider payment freezes, to consumer driven programs.

10. Rationing healthcare based on a 'cost-effectiveness' criterion may work to control healthcare spending, but Americans typically reject this approach to medical cost controls.

Review Questions
Answers on next page

1. Which country spends the most on healthcare, per capita?
 - a. America
 - b. Canada
 - c. Britain
 - d. France

2. Which country has the lowest (poorest) life expectancy?
 - a. America
 - b. Canada
 - c. Britain
 - d. France

3. Which country has gained the fewest years of life since 1950?
 - a. America
 - b. Canada
 - c. Britain
 - d. France

4. Which country has the highest (poorest) infant mortality?
 - a. America
 - b. Canada
 - c. Britain
 - d. France

5. Which options exist to reduce healthcare spending?
 - a. Reduce demand for medical services or expand the supply of healthcare providers
 - b. Build more hospitals and train more doctors
 - c. Train more specialists and invest in better medical technologies
 - d. Expand our use of advanced radiological equipment and train more radiology technicians

Answers to Review Questions

Correct answers in bold

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Part 2:
**Understanding Employer Based Health
Insurance**

Chapter 4: History and Development of Employer Based Health Insurance

We, unlike any other country, base health insurance coverage on employment. If someone qualifies for employer based insurance, then he/she generally does not qualify for government funded coverage.

This is the exact opposite of most other countries. There, everyone gets government funded insurance and may supplement this with private, or employer funded insurance, depending on the country and circumstances, if they so desire.

Here, you can only qualify for government funded insurance if you are unable to get it privately. (As with all statements about health insurance, there are caveats and exceptions to this, but it covers the general case, for the majority of Americans.)

Employer based health insurance is aimed at working aged people, defined as non-poor and non-elderly. The elderly get Medicare. The poor get Medicaid.

Employer based insurance covers about half the US population. It reached its enrollment peak in 2000 with 164.4 million people insured. By 2004 enrollment had declined by 5 million or about 3%.⁵⁰

Where did employer based health insurance come from? How well does it work? What are its strengths and weaknesses?

This chapter provides some historical background about the development of our healthcare system. It helps explain why healthcare reform efforts aimed at improving systemic efficiency always fail.

How Employer Based Healthcare Started

(Editor's note: This section comes from an edited transcript of my lecture on Employer Based Health Insurance delivered at the Massachusetts Business Association in Braintree, Massachusetts on September 29, 2008)

The myth - or perhaps truth - is that it started in Dallas around 1929 as a reaction to the stock market crash and financial meltdown.⁵¹ The business problem for Baylor University Hospital in Dallas was that it didn't have enough money to pay its bills.

⁵⁰ Estimates by John Inglehart, Founding Editor of Health Affairs, 'Will Employer-Sponsored Health Insurance Endure?', Health Affairs Nov/Dec 2006

⁵¹ This suggestion comes from Richmond and Fein, The Healthcare Mess, page 30.

Prior to the stock market cash, hospitals raised funds in two ways. First they had paying customers who were billed for services rendered - a fairly modest percentage of the population because most people didn't have a lot of money. Second, the community chest, the charitable organizations - the wealthy would donate to the hospital because it was a good place to donate your extra money. Charity made you feel good and was good for the community.

But with the stock market crash, the wealthy didn't have as much money to donate, unemployment increased (reducing the number of patients able to pay), and the hospital faced a difficult financial landscape. So Baylor University Hospital made a deal with the Dallas School System. They said, "School system, you raise money from taxes. You always have money. Pay us \$.50 every other week, \$.25 a week, for each of your employees and when they get sick, they come to us and we'll take care of them." Employer based health insurance arrives.

A few comments about this.

First, it's a nice deal. It's a nice deal for the hospital because they stay in business. They don't have to worry about going out of business. They don't have to worry about turning people away as long as they get the numbers right (which apparently they did), \$.50 per employee every other week. That was the true cost. The school system payments protected the hospital's cash flow, so the hospital stayed in business.

Second, this was very efficient. The hospital signs one contract with one employer group and received back enough money to stay in business. Sweet. That's a pretty good incentive to look for more large employer groups.

Third, there was no prevention or provider choice, but theoretically the teachers and other employees of the school system were happy because they got medical care essentially for free.

Fourth, this was for hospitalization only. There was no outpatient doctor's coverage.

Fifth, community rating. The Dallas School System paid \$.50 per person every other week, regardless of individual medical status. There was no medical underwriting.

Sixth, there were no quality controls, no outcome based incentives, no holdbacks for poor hospital performance. Health insurance began simply to save the financial health of the hospital.

Vertical Integration - A Key Concept

In business terms, this is vertical integration. Those of you who have looked into managed care know what vertical integration means. It is the integration of finance and service provision in the same company to eliminate conflicts between providers and finance. In a truly vertically integrated healthcare system, physicians are paid on salary, not fee-for-service based on the number of treatments they provide.

The great advantage of vertical integration is that it eliminates many kinds of waste from the healthcare system by eliminating conflict between the payers (we call them insurance carriers) and providers (hospitals and physicians).

The conflict between finance and service provision results in higher prices. The conflict arises when finance and service provision are separate, independent companies. Providers always try to bill more to make more money. There is an incentive to provide more services and to bill more.

On the other hand, the finance people always try to pay less, and you always have a fight when finance and service provision are separate entities. The fight is over distribution of dollars, not over patient outcomes, because it's extremely hard to quantify outcomes as a basis for physician payment - we haven't yet even begun to address this issue, 80 years after the Baylor experiment. Physicians get paid to perform treatments, so the more treatments they provide the more they get paid. Physician economic incentives collide with carrier economic incentives.

But in a vertically integrated healthcare system, so goes the theory, where finance and service provision are in the same company, you eliminate these incentive conflicts and focus more on patient needs. At least, that's the theory.

One big problem with the vertical integration model: limited hospital or provider choice. As developed initially with Baylor University Hospital, the Dallas school system employees could only go to one hospital. This has advantages and disadvantages.

Vertically integrated healthcare systems have both advantages and disadvantages over non-vertically integrated systems:

Advantages:

1. Lower Costs
2. Reasonable medical care from a small number of 'in-network' providers

Disadvantage:

1. Little provider choice as few hospitals 'in-network'

The Baylor Hospital / Dallas School System deal worked so well that other hospitals soon copied it. Different hospitals looked for different large employers, offering the same kind of deal. Large manufacturers, etc, etc. And what problem begins to arise?

The Choice Problem

Consumers (school system employees or manufacturing workers, for example) wanted to choose among various hospitals. 'What do I know about Baylor University Hospital? I only know one thing. I know someone who went there and didn't get good treatment, so I want to go somewhere else.' Someone always knows of someone else who had a negative experience there. So you want to go somewhere else - consumers want choice.

Remember vertical integration, where finance and service provision are the same company? Once you introduce choice, then you have one group handling finance and another handling service provision. You have a split and then you immediately have the conflict that we just discussed. (A lot more on this coming up soon.)

But back to Dallas. The hospitals are cranking along with the employer based financing model. They're very happy. They're making money. And then Blue Shield comes along to provide financing for hospital care. Blue Shield offers a choice among hospitals. 'Dallas teachers' they might have said, 'you can sign up with Baylor University Hospital only, or for just a little more money, sign up with us and we'll give you the choice of many hospitals in Dallas. We contract with lots of hospitals. We have a large network.' Sounds pretty appealing, right?

Doctors looked at this and said, "Hey, we want in on this too." They organized Blue Cross so doctors could get paid because the same depression that was affecting all medical providers, both hospitals and physicians. Blue Cross for your doctor's bills and Blue Shield for your hospital bills. Both organized to protect provider incomes.

And both - conceptually, if not in real life - competed with vertically integrated hospitals, like Baylor University Hospital was at the beginning with the Dallas School System.

The Blues developed a couple of very clever ideas in the 1930s. First, from a marketing point of view, they offered this very attractive provider choice option. Very appealing to many consumers.

Second, they began searching for the healthiest subscribers. An interesting business idea: if they could find the healthiest people, they could offer lower priced policies and gain a competitive edge vs. their vertically integrated competitors signing up large employers at a fixed price per person.

Underwriting vs. Community Rating

The Blues figured that they would underwrite better than the competition so people would join them because their premiums would be a little bit lower. The community rating folks faced higher premiums because they took all employees.

Underwriting serves the economic interests of the carriers. It doesn't improve healthcare outcomes. It doesn't improve the healthcare system. It doesn't differentiate medical quality. It doesn't create patient value. It only makes one carrier lower cost than another carrier by having sick people pay more. The healthy pay less, the sick pay more.

Carriers gamble in their underwriting that their competition does a poorer job of running their business and monitoring their numbers, so they'll get stuck with all the sick people and go out of business.

This financing system has little to do with getting people healthy. That was not its intention. It was designed to protect physician and hospital income. That was the original Baylor idea. Then carriers came along to make a profit on consumer demand for choice. The demand for choice leads to the Split.

The Split and the Provider Payment Problem

Once you split finance from service provision, you have a wider consumer choice and it leads to conflict. But not necessarily healthier patients.

If you're the finance person, you're paying fee for service to me, the physician. I want to do as many treatments as I possibly can because the more treatments I do, the more you pay me.

As soon as you split finance and service provision there's an incentive on me, as a provider, to do more treatments. You're paying me by treatments, so I will do more treatments. You, on the other hand, want to limit the number of treatments. You want to look over my shoulder all the time and say, "No, you don't have to do that." I say, "Yes, I do have to do that." We fight all the

time. That's the conflict between healthcare payers and medical service providers.

Question:

So as opposed to the alternative?

SPEAKER:

Vertical integration, where we all work in the same company. I'm a physician on salary paid by you, the vertically integrated, combined hospital/financier.

Q:

Regardless of the procedures you do?

SPEAKER:

I get paid \$1000 a week or whatever it happens to be. I get paid the same amount every week. Once you split finance from service provision, then you have the conflict and you have an incentive on the part of providers to do more work. Remember that the only mechanism we found to pay providers in this 'split system' is fee for service, which leads to us paying two or three times more for healthcare than other countries. We'll get to the quality discussion later.

Q:

But aren't the finance people also powerful - don't you have a conflict in the other direction that they would do fewer procedures?

SPEAKER:

Not necessarily. A carrier with 8% market share has insufficient negotiating power to control prices of a provider that controls 60% of the beds. In that case, the finance people are not very powerful.

I suspect, though, that you're referring to a different issue - capitation. Your question may be 'can carriers develop economic incentives for providers to do less?'

That's a fairly complicated discussion. But the brief summary: the incentive to do less doesn't stand up very well because if you do less, you're going to get the patient back. You can do less - provide fewer medical services - to save costs in 2010, but you're going to get whacked in 2011 or 12 by returning patients. So you've got to be careful.

Q:

If you do less, you're going to get the patient back?

SPEAKER:

If you undertreat you're going to get the patient back.

Q:

Interesting.

Let's remember where we are. We're still in the 1930's and we're talking about the growth of the employer based system. Little cost control. We've developed the split between finance and service provision. Finance people will say, "You really don't need to do that procedure," and the service provider says, "Yes I do. Yes I do."

How Much Does A Procedure Cost?

How much does the financier pay the service provider? Hospital A has usually and customarily been charging \$10. Hospital B says 'We do this procedure better, so pay us \$11' and provides lots of reasons to justify the higher payment. Then Hospital C says 'Last year you paid us \$10, but this year we bought this expensive new equipment for the procedure, so now pay us \$11.50.'

There's a built-in provider economic incentive -- once you get the split -- under usual and customary to charge more and more. The incentive is even bigger when you're in a system of *cost plus*.

Cost plus reimbursement rewards the least efficient providers the most. The hospital with the most overhead, that buys the most expensive technologies (whether or not they're necessary), has the highest staffing ratios and the least efficient managerial operation gets paid the most. The 'plus' is a fixed percentage of cost. So cost plus is an incentive to become inefficient!

Once you get the split, you have all these incentives that are inflationary, few of which are related to quality. To reiterate the same point, all we've been discussing in this entire history of insurance -- and we haven't even gotten to World War II yet -- is protecting providers' incomes - the doctors and hospitals. That's why health insurance originated.

The Problem of Measurement in Fee for Service Medicine

There's a related problem in fee-for-service medicine - the problem of measurement. How well does a particular physician treat his/her patients? How well does a particular hospital perform certain surgical procedures? How well does a particular treatment work?

These are enormously difficult questions to answer. We do not even today have good measurement criteria or good data - and we had even poorer criteria and data in the 1930s. The data that we can measure might not be the most important. Remember that our healthcare goal is to extend life or improve life quality. We do not yet fully understand which treatments today will lead to longer lives in 30 or 40 years. Nor do we fully understand which treatment qualities will lead to long term life quality improvements.

We can only measure some aspects of medical treatments - surgical mortality rates, hospital infection rates, 30-day hospital readmission rates, for example. These may not always be the most significant outcome data, though they may be useful for some patients.

Whose interests are served by measuring or publicizing this information? Not the providers. They get paid fee-for-service for the *quantity* of medical care, not the *quality*. Publicizing outcome data may harm them economically. Thirty day hospital readmission rates may show that Hospital A provides poorer patient treatments than Hospital B. Or that Surgeon Z has a higher mortality rate than Surgeon X.

The risks of either inappropriate or unflattering outcome data becoming public were so great during the inception of our employer based system that providers fought against its release. The fee-for-service system suited their interests far better than any outcome based payment mechanism.

The fee-for-service / component payment structure suited their interests in a different way also. Not only could they make more money based on quantity rather than quality --- we've already discussed that.

Absent good data collection, each physician - responsible only for his/her specific tasks - can argue 'I did my job correctly. The fault lies elsewhere.' Physicians act as subcontractors, narrowly defining their individual tasks, rather than as general contractors responsible for the life of the patient. **This follows directly from payment systems that developed from the Split** between finance and service delivery.

Fee-for-service / component financing serves provider interests, is inflationary and expensive, and is not designed to improve patient health. It's only designed to reward providers. The Split between finance and service provision led us down this road.

The Impact of World War II

Let's continue with our historical / conceptual history of employer based health insurance.

During World War II, or perhaps as a function of it, more and more people got insured, most notably people in the military. They continued with insurance coverage after the war. In the relatively short post-war period we get lots more Americans covered for hospitalization insurance.

1942: 10 million hospital insurance / health insurance subscribers

1946: 32 million

1951: 77 million ⁵²

World War II plays an important role in our story for three main reasons.

First, the soldiers who received health coverage while in the military wanted to continue with it afterward. They saw the advantages of having health coverage. They married and wanted their families to receive coverage also. This created demand for health insurance.

Second, our wartime economy devoted significant resources to medical technology improvements. Perhaps most significant was the introduction of sulfa drugs to combat infections. These helped turn hospitals from infection breeding institutions into patient treatment and improvement centers. Other technological innovations followed. These improved the quality of medical care, or the supply.

Third, the Federal wartime wage and price freezes fostered the development of 'fringe benefits' such as health insurance. These reduced the cost of insurance to the individual consumer and further helped stimulate demand. It's a pretty interesting story just how these developed.

The government decided during the War to freeze wages and prices - to avoid domestic economic difficulties and help focus our economy on war production. Employers could not raise wages to attract new workers or to reward their best employees. The government controlled this aspect of employee compensation very tightly.

⁵² Richmond and Fein, op. cit. pages 30 - 38

But the government allowed employers to offer fringe benefits such as health insurance. This was how employers could attract new talent and retain their current employees. The concept of 'fringe' meant 'outside the normal compensation' and 'benefits' meant 'advantages of working here'. Employers couldn't simply raise wages - the traditional way of attracting labor - as that was illegal during the war. Fringe benefits were simply a mechanism to get around the wartime wage freeze.

As we grew in 9 years from having 10 million to 77 million insurance subscribers in this country, the health insurance industry developed and gained political power. It lobbied Congress for favorable legislation. It applied political pressure. It acted, in short, just like all other powerful industrial groups.

Tax Subsidies for Health Insurance

One successful lobbying effort resulted in passage, in 1953, of IRS regulations that exempted fringe benefits from income tax. These benefits became tax deductible to the employer but not income taxable to the employee and were **essentially a government subsidy for hospital care**, since that's what health insurance ultimately financed. The government stimulated sales of employer based health insurance by subsidizing the price.

To understand how this is a subsidy, let's look at both the employer and employee tax situations briefly. The employer buys a \$100 insurance policy for an employee, and, prior to the IRS regs, pays corporate income tax on the \$100 ---- let's say that was 50%. So the employer's total cost was \$150: \$100 for the policy and \$50 for the income tax on that \$100.

By making the payment tax deductible to the employer - that means by foregoing the corporate income tax on that \$100 - the government reduced the cost. Health insurance now only costs the employer \$50; the employer takes a 50% tax deduction on the \$100 payment. That's a big savings compared to the previous \$150 expense.

The employee received this \$100 employment benefit. Prior to the IRS regulatory change, he/she would have paid their marginal tax rate on this income --- let's say 30%. By making this tax free to the employee - that means by foregoing the personal income tax on the \$100 - the government contributed \$30. In other words, the government subsidized the employee who received health insurance by \$30.

An interesting note from the employee point of view. \$100 in benefits is more valuable than \$100 in salary. The \$100 in salary is taxable, so nets only \$70.

Here's a quick economic axiom: whenever you subsidize something, people buy more of it. If you subsidize milk, that reduces the price and people buy more. If you subsidize mortgages, people buy more expensive houses. And if you subsidize health insurance in an employer based model, employers provide more and employees get more.

This subsidy was so effective that the rate of Americans with hospital coverage skyrocketed. In the mid-1950s, about 45% of Americans had hospital insurance. By 1963, 77% had hospital coverage, and an additional 50% had some form of physician coverage.⁵³

The favorable tax treatment of fringe benefits led to healthcare inflation from higher *hospital* prices - because more people could afford to use hospitals.

Over this time period two strange incentives evolved in our healthcare marketplace: an excessive hospitalization incentive and an incentive to cover the unemployed. These two conditions merged in the late 1960s and 1970s. Their combined effect became clear by the 1980s as our health insurance costs skyrocketed and our employer based financing model became even more firmly entrenched.

Excessive Hospitalization Incentives

By the mid-1960s over three quarters of Americans had hospitalization insurance, paid for by employers and subsidized by the government. Hospitalizations became essentially free to patients, creating, in the words of Harvard Professors Richmond and Fein a 'not-so-subtle perverse incentive to hospitalize individuals.'

This was the case even for diagnostic tests that could have been performed on a less costly outpatient basis. Over time the hospital became all the more important and central to the delivery of healthcare services.

This increased the need for health insurance:

Since medical care became more costly, insurance became more useful (indeed, necessary). In turn, the presence of insurance helped

⁵³ Enthoven and Fuchs, 'Employment Based Health Insurance: Past, Present and Future' Health Affairs, Nov/Dec 2006

underwrite a buildup of resources and an upgrading of technology that added to costs and made insurance even more valuable.⁵⁴

Remember the incentives here.

- **Employees** liked the system because it appeared free to them;
- **Carriers** liked the system because the government subsidized their product (health insurance policies);
- **Hospitals** loved the system because they received patients and insurance payments - a wonderful recipe for making money.

Employers objected somewhat to this system, but not terribly strenuously. After all, the government was subsidizing their health insurance payments, so they felt the pain only partially.

Our healthcare system was hospital based - not really interested in preventive care (hospitals couldn't charge much for that); not really interested in public health (the field was only just developing); not really interested in outpatient or chronic care. Providers focused on hospital care because that's where the money was.

Hospital insurance stimulated the excess use of hospitals, which created more need for hospital insurance. Two byproducts:

- First, we used hospitals for almost all medical care, even if less expensive setting existed;
- Second, we developed fewer outpatient, home based, preventive or non-hospital types of medical care.

These two factors would become hugely important a few years later as our healthcare became increasingly expensive.

How Could Employers Afford Health Insurance Premiums after World War II?

There's an interesting underlying question here: how were employers able to make increasingly large health insurance premium payments for their employees post WWII while expanding their businesses? What set of circumstances allowed this system to develop? Why was the employer based system healthy and growing until the late 1900's, then in decline?

⁵⁴ Richmond and Fein, op. cit., pages 38 - 39

It turns out that for a number of years, this 40 year period more or less, many countries in the world were (a) recovering from World War II or (b) gaining independence and expanding their educational systems. They were not economic threats to the United States - countries like Japan, India, Korea, China, or Western Europe. We dominated economically.

Our big firms in particular were very profitable; they didn't have much foreign competition. They could afford to pay for employee healthcare. They could raise prices because nobody was competing with them to keep prices low. That's the trend that you see from World War II to about the 1980s. Big firms could set the standard and then small businesses filled in the holes. They had to compete for labor based on offering health insurance, and they could because the big firms were managing the world economy.

This allowed the U.S. to have an extra cushion of money available for healthcare benefits. Even though people complained, the economy could support the excess premiums. Regulated industries - for political and various other reasons - were able to pass on the cost because our economy was stronger than any other. Unions were strong. They could demand health insurance and the big firms could afford it.

The key factors that fostered employer based health insurance post World War II all changed in the 1980s and 1990s:

World Economy, 1945 - 1990 +/-

- Little foreign competition for American manufacturers;
- Japan and Western Europe needed time to rebuild;
- US manufacturers could keep prices high and afford health benefits

Importance of Large Firms, Regulated Industries and Unions

- GM, US Steel, ALCOA, etc - profitable with little foreign competition. Able to share profits with employees as benefits;
- Regulated industries (AT&T) - regulated monopolies were able to pass health insurance costs to consumers; they had little or no competition;
- Unions were relatively strong, could bargain effectively for benefits

All these conditions changed in the 1980s and 1990s!

So you have this nice system supporting the employer based health insurance idea during this 35 or 40 year period, all of which changed post 1980 or 1990. After that the trends changed and we could no longer afford the same benefit levels due to foreign competition and healthcare costs.

Our ability to generate excess profits, if you will, to afford for the employers to pay for healthcare starts to disintegrate as foreign competition gets going. From World War II until about 1980 or 1990 we could afford employer based health insurance and there was no significant political group that was lobbying or arguing against it.

Medicare and Medicaid Remove Potential Political Threats to Employer Based Insurance

One major potential political threat to our employer based health insurance system could have come from the unemployed - that significant percent of the population that is too old to work or unable to find full time work with benefits. This is potentially a very potent political force that could have lobbied in favor of single payer healthcare, universal coverage or something like that - like in other countries.

By introducing Medicare and Medicaid in the 1960s, this political force goes away. People are happy. They're not under pressure. They're not demanding universal coverage because they've got coverage. Where are politicians going to find a block of supporters who are going to argue for single payer systems, universal healthcare? They don't exist because Medicare and Medicaid took the potential block off the table.

Here is an estimate of the population size that these two entitlement programs satisfied. I'll use Medicare, because this covers the elderly who vote in particularly high numbers and in particularly important electoral states like Florida. This large voting bloc could have become a potent political force for universal coverage. Instead it became satisfied with Medicare.

Medicare Enrollment 1970 - 2000

<u>Year</u>	<u>Number Medicare Enrollees</u>	<u>% of US population</u>
1970	20 million	10%
1980	28 million	12%
1990	34 million	13.5%
2000	39 million	13.8%

Medicaid covers about the same population size.

The argument is that Medicare and Medicaid are key supporters of our employer based health insurance system. They allowed the system to grow and become entrenched nationally in the second half of the last century.

The employer based system reaches its peak of 165 million people in 2000 and then it starts to decline. Why did it decline? Because the international economic conditions changed. American firms could no longer pass on benefit costs to their customers.

At the same time, the hospital lobbies and related groups had done such a good job of protecting their constituencies that healthcare became hugely expensive. Healthcare grew from about 4% of US GDP in 1950 to 14% in 2000.

Lower cost alternatives to large general hospitals - freestanding outpatient clinics, for example - never took hold, presumably due to hospital lobbying efforts. Similarly, specialty hospitals - local diabetes clinics, for example - also failed to establish themselves, again presumably, for the same reasons.

By the end of the 1990s, we had developed a perfect storm for healthcare system financial catastrophe. Our healthcare costs - primarily hospitalizations due to the government subsidies of fringe benefits - rose far faster than GDP. Meanwhile, American businesses' abilities to pay for their employee's health coverage diminished in the face of foreign economic competition.

Let's turn, in the next section, to a review of the goals and incentives of all the players in our employer based melodrama. The players: Employers, Employees, Providers, Carriers and the Government.

Our purpose in this investigation: try to understand why reforming our employer based system always fails to control costs.

A secondary purpose: try to understand why, despite paying such high costs, we get such mediocre outcomes as measured by longevity, longevity gains over time, and infant mortality.

Chapter 5

Goals and Incentives with Employer Based Health Insurance

Different actors in our employer based melodrama operate under different goals and incentives. Unfortunately ‘promoting good health’ or ‘returning sick people to good health as quickly and efficiently as possible’ are not goals shared by many of these actors. As we’ll see, this has some strong negative effects on our healthcare system.

The key actors here are:

1. Employers
2. Employees
3. Providers
4. Carriers, and
5. Government regulators

Let’s look at the goals and incentives of each in turn.

But before we do that, let’s try to conceptualize the ideal healthcare system. This, it seems to me, would have three or four components.

- You’d have a lot of preventive care to keep people healthy and keep them out of the hospital because it’s cheaper than acute care and people live longer. Nutrition, weight control, exercise, other types of prevention;
- You would focus on chronic disease care because 70% of healthcare costs go to chronic disease care. You’d have regular monitoring, regular interactions with your doctors and you’d have teams. You would go into the clinic for diabetes and you would see a podiatric person and you’d see a psychologist, you would see a kidney doctor and you’d see a hematologist. You’d see lots of different specialists working together as a team to try to come up with a treatment plan for you, as opposed to what we have now in General Hospitals, which is hematology in the East Wing and podiatry on Floor C of the West Wing. You would have teams working together for the patient;
- You would have -- for acute care - high quality, good care, safe care, not necessarily the cheapest care;

- You would have rehab, coordinated with your acute and / or chronic care. A good hand-off from caregiver to caregiver.

This seems to be a picture of what a really good healthcare system would be. Remember that good health is cheaper than bad health. Getting a sick person healthier quicker is cheaper than having someone remain sick longer. So a system that keeps people healthy would be the least expensive system available. And when people get sick, we return them to good health quickly, not slowly. That would be an ideal care system.

Our ideal healthcare system would encompass these features:

- Good preventive care;
- Good chronic disease care;
- High quality, safe acute care;
- Good care coordination among care givers.

Now let's see how well the employer based healthcare system incents actors to emulate this ideal system. Let's see who - in an employer based financing system - has an economic interest in promoting this.

Employer Goals

Employers supply health insurance benefits for one primary reason: to attract and retain good employees. That's the reason employers started offering benefits during World War II and is still the primary reason for offering them today.

Employers do not, as an economic function of their business, aim to get people as healthy as they possibly can. They're interested in selling widgets and a mechanism to do that is to get good employees. If they didn't have to provide healthcare, they wouldn't. They want to make widgets. They make money selling widgets. That's why they're in business.

They have to trade off the quality of the health insurance they provide with investments in their firm's growth. If they invest too much in employee health they may harm the firm's financial health. For an employer, 'good enough' healthcare is good enough because they want to make widgets.

By contrast, a sick employee does not want 'good enough' healthcare. He / she wants 'excellent' healthcare. (More on this soon.)

'Good enough' healthcare in the 1980s and 1990s included some or all of the following:

- Provider network restrictions;
- Annual / lifetime benefit caps;
- Pre-existing or other medical condition exclusions;
- Strict specialist referral restrictions;
- Waiting periods;
- Other obstacles to medical treatment

These were designed to keep insurance premiums low so the firm's financial health remained strong; they were acceptable to employers.

Employers Like One Year Plans

Employers were also interested in short term healthcare commitments - generally 1 year, not multi-year renewable insurance policies. The employer could not predict the firm's financial health far into the future so wanted to avoid committing to long term liabilities. The employee census could change, business conditions could change, etc.

Remember that employers are the health insurance purchasing agents. If they are comfortable only with 1 year policy commitments, then that's what the carriers will sell.

But note the effect of 1 year policies: they focus carriers on short term cost control, not total disease cost control. Carriers compete for employer business by showing the lowest year-to-year premium increases.

Here's another economic axiom: in healthcare, short term cost control always leads to higher long term costs. Remember that 70% of our healthcare spending goes to people with chronic diseases. Short term cost control often means skimping on this year's preventive or maintenance treatments - resulting in higher costs in the future. Short term cost control is bad medicine.

Our business schools sometimes discuss business strategies for healthcare. There seems a general agreement that the way to generate the lowest healthcare costs is to focus on total disease costs, from diagnosis to treatment to rehabilitation. This is efficient ---- generating the best outcomes per dollar invested.⁵⁵

⁵⁵ For more on this, see Porter and Teisberg, 'Redefining Health Care: Creating Value-Based Competition on Results' or Regina Herzlinger 'Who Killed Healthcare: America's \$2 Trillion Medical Problem', both Harvard Business School professors, among many other books.

But calculating lowest total disease treatment costs include savings generated in the future - years 2+. This does not fit the employer's purchase criteria; they only care about costs in year 1. This leads to three unfortunate effects:

1. Higher total disease treatment costs;
2. Relatively mediocre outcomes, as evidenced by poor hospital safety records and high readmission rates;
3. A mind-numbingly confusing set of irrational cost control programs that neither control costs nor improve patient outcomes. (For more on #2 and #3, see the two Case Studies at the end of the next chapter.)

Employers like 1 year plans. They choose plans with the lowest year-to-year premium increases. This leads carriers to focus on short term cost controls that do not necessarily improve healthcare. Here are some inappropriate forms of short term cost controls that we accept:

- Failure to develop world class IT networks within and among providers;
- 'In network' hospital choice based on price, not quality;
- Over reliance on pharmaceutical companies for product testing;
- Underinvestment in infection control and patient safety;
- Rx formularies based on cost rather than long term results;
- Underinvestment in disease prevention;
- Restrictions on number of maintenance physician visits per day;
- Restrictions on number of specialist consultations per day

Fee for Service Cost Controls via Billing Codes

The mechanism adopted by most carriers in the 1970s and beyond was fee-for-service cost control via billing codes. We'll discuss some fee-for-service issues shortly. But I'd like to make a couple points about billing codes now.

New Jersey originally introduced codes called Diagnostic Related Groups to help control Medicaid costs in the 1970s. New Jersey hired Yale Medical School to develop the program, and the Yalies introduced 470 categories of medical DRGs. 470 seems like a lot, but may be a reasonable number of categories to control.

But by about 2005, this had grown to perhaps 20,000 + categories. This seems an unreasonable number of categories to control. Let's also remember a

key economic axiom: if you pay by categories, you get more categories. But you don't control spending. That's exactly what has happened to fee-for-service payments by billing code. Today we have both **more billing codes** and **more spending**.

Remember how we got here. Employers want to purchase 'good enough' healthcare for their employees, and are keenly interested in short term costs. This forces carriers to develop short term cost control mechanisms that simultaneously fail to control short term costs and lead to higher long term costs.

The employer goals don't closely relate to the ideal healthcare system that we just discussed. We're starting off on the wrong foot.

Employee Goals

Employees want excellent healthcare. When diagnosed with cancer, for example, they do not want to hear about cost control issues, or 1 year policy issues, or comparative health insurance premium increases. They want to get cured.

Employee goals do not coincide with employer's goals. Employees want the ideal healthcare system described above. Employers are satisfied with 'good enough' healthcare.

Employees want access to the 'best' hospitals, not just the 'in network'. They want access to the Cleveland Clinic for coronary problems, or Duke University Hospital for brain cancer, like Ted Kennedy - not just the local 'in-network' hospital.

They also want true prevention. Why is Weight Watchers an outside fee? Why must they pay for a personal trainer? Both of these lead to good health - and lower healthcare costs. Why must they pay out-of-pocket for them?

In effect, the employees ask 'Why must I wait until prevention fails before receiving medical care?' In economic terms this is inefficient: it adds cost without adding value. It does not keep them healthy --- which is the cheapest way to go. It does not get them healthy most quickly --- which is the most efficient way to go. Instead, it puts off expenses until next year, which serves the employers' short term interest.

Under our system, the employee is unable to exercise consumer sovereignty. They are unable to shop wisely because the employer has shopped for them. They are restricted. They can't go to the Cleveland Clinic easily because it's out-of-network. By eliminating hospital competition and consumer sovereignty, you eliminate the trend of Massachusetts' employees going to the Cleveland Clinic for care. (Or Nebraska employees, or Oklahoma employees.)

In short, the employer based system creates barriers to employee good health.

What might happen if employees went from state-to-state (i.e. out of network) to receive the best healthcare? **First**, they might get healthier less expensively and more quickly, which is economically efficient. **Second**, local hospitals might improve in the face of competition.

But employees - healthcare consumers - are not able to register their votes for excellent healthcare. They're restricted because the employer has restricted choice. Employees want the ideal healthcare system described above. But employer based health insurance stands in their way.

Carrier Goals

Carriers respond to employers because employers buy policies. Carriers compete on short term cost control, not on long term cost control, not on total disease cost controls, not on quality. Carriers do not reward excellence. They only reward short term cost control because they respond to employer purchasing criteria.

The carrier says to the employer "You want one year policies? We'll give one year policies. You don't mind out-of-network restrictions? We'll give you out-of-network restrictions."

What does the carrier try to do? Enroll healthy people to make more money. Put off expenses because maybe the diabetic subscriber will switch to another carrier next year before needing an amputation.

All this leads to crummy healthcare. We talked earlier about low quality and high costs, how we outspend all other countries on healthcare but have higher medical error rates (actually, we'll talk about that in a few minutes).

Then the government steps in to correct all this abusive short term cost control. Carriers have been trying to enroll only healthy people and to put off expenses to generate income. So the government passes regulations and coverage mandates to stop this private sector systemic abuse. The government puts a band-aid over the problems that shouldn't have existed in the first place, but they do exist because we have a fundamentally screwed up system.⁵⁶

We'll talk about the government's role in a few minutes. But for now, let's use this equation:

⁵⁶ I got the verbiage 'fundamentally screwed up' from a lecture by Harvard Business School's Michael Porter. See <http://www.hcp.med.harvard.edu/node/1975>

**Tension between carrier economic interests and healthcare system quality
= Government regulations to reduce short term cost control abuse.**

Provider Goals

Providers compete for carrier funding. Thus the carrier, not the patient, is the hospital's ultimate client!

Let's look at how hospitals act. They get involved in the Medical Arms Race. What's the Medical Arms Race? "Our competitor hospital just bought a brand new million dollar machine and they're getting more patients. So we need to buy the same brand new million dollar machine and then publicize it. We're not sure that it provides better patient value - better outcomes per dollar invested. But we compete for patients based on medical inputs not value for outcomes."

The Medical Arms Race describes competition among hospitals for physician referrals and patients. This is competition among General Hospitals, not Specialty Hospitals - why go to a Specialty Hospital if you don't know the outcomes? Input competition works to stifle the growth of Specialty Hospitals.

General Hospitals compete with each other by offering the latest in medical technologies and most modern facilities. This adds cost but doesn't always relate to better outcomes.

Two economists, James Robinson and Harold Luft discovered that hospitals with **more** competitors had **higher** costs than hospitals without competitors.⁵⁷ This is exactly the opposite of most other businesses that compete on outcomes, and results from our convoluted employer based payment system. When your competitor buys new equipment, then you must buy it also - but if you have no competitor, then you don't need to buy it. That's convoluted.

But this gets worse.

Robinson and Luft also found that these higher priced, competitive general hospitals sometimes had higher mortality rates (i.e. poorer outcomes) than non-competitive hospitals. Here's why, according Northwestern Professor David Dranove, an expert in these topics:⁵⁸

⁵⁷ J. Robinson and H. Luft 'The Impact of Hospital market Structure on Patient Volume, Average Length of Stay and the Cost of Care' Journal of Health Economics 4 (1985) 333:56

⁵⁸ David Dranove, 'The Economic Evolution of American Healthcare', Princeton University Press, 2000, page 47

Medical researchers have known for years about the volume-outcome relationship in medicine.

The 'volume outcome relationship' simply means that practice makes perfect. The more of a particular procedure a surgical team or hospital performs, the better the outcomes.

But when general hospitals compete for patients by offering the same services and the same technologies, each surgeon, surgical team and hospital may have less practice.

By spreading the same number of procedures over more hospitals and surgical teams, the medical arms race may reduce the amount of experience of each team - leading potentially to higher mortality rates.

Government Actions

The government enacts mandates to protect patients from abusive short term cost controls.

The government says to the carriers 'You have to cover these services.' The carriers respond 'We don't want to cover those services. It's going to raise premium prices.' The government then passes regulations and imposes mandates - in effect saying to the carriers 'Now you have to cover these services.'

Or the government says to providers 'We want you to act in this way' like having minimum nurse to patient ratios. The providers respond 'We don't want to act that way because it will drive up costs.' So the government passes regulations and mandates that force providers to act in certain ways.

But mandates don't seem to affect healthcare outcomes very much. We don't have data showing a relationship between mandates and longevity - but we do have data showing a relationship between mandates and costs. Massachusetts, for example, leads the way with healthcare mandates and Idaho lags far behind. Not surprisingly, Massachusetts' premiums are about double Idaho's.

Yet little credible public data exists showing that Mass residents live longer than Idaho residents - and I've looked!

I searched the US Statistical Abstract, the Kaiser Family Foundation website, the Idaho and Massachusetts websites and the National Center for Health Statistics website. No good comparable longevity data. I also looked at Iowa, New Jersey and several other states with varying levels of healthcare

mandates and premium price differences. No data upon which to base public policy.

I did find a chart on page 31 of a 150 page, 2 year old Massachusetts study showing Mass Longevity Increases over time, but nothing comparable for many other states. I wonder how many legislators or voters search that far?

Interestingly Massachusetts' greatest longevity increases occurred prior to about 1990, during a period of fewer mandated services. Perhaps this underscores Richmond and Fein's point that longevity gains come primarily from applying our knowledge of health promotion and disease prevention rather than from improved clinical care.⁵⁹

Remember that longevity is one of two healthcare outcomes - the other is improved life quality. Longevity is easy to measure; improved life quality very difficult. Credible data showing the latter is even less available.

Rather than affecting outcomes, mandates reflect the political power of the groups involved. Minimum nurse staffing ratios are sponsored by nurses groups; mental health coverage mandates are promoted by mental health professionals; alternative health coverage is pushed by acupuncturists, chiropractic is supported by chiropractors, etc.

There are virtually no credible outcome measures to prove that any of these increase longevity or improve patients' quality of life. But each lobbying group says it's important, and mandates generate jobs for members.

To be sure, many of these medical groups provide huge benefits to patients. Many do excellent work. I do not at all want to denigrate them. But I want to suggest that mandating medical services is expensive, and is largely a function of our employer based financing system and the split between finance and service provision. Many commentators think that provider payments based on outcomes would accomplish the same goal at a much lower cost. But that's the subject of a different lecture.

The downside of all this is that the more the government gets involved inappropriately - fixing problems that it shouldn't be fixing - the more we raise healthcare costs. I've seen estimates that mandates alone represent 10 - 12% of all healthcare costs in some states.

Our national rate of uninsured has risen along with our rate of mandates. Massachusetts has tried to stem this tide recently, but pays \$1billion+ in annual health insurance subsidies to low income / previously uninsured folks. This is probably unsustainable, especially during periods of economic downturn.

More mandates equal higher costs. Higher costs increase the need for health insurance but make it less affordable. This leads to more uninsured folks and

⁵⁹ Richmond and Fein, op. cit. page 92

more government subsidies. Yet there is no measurable impact of mandates on longevity or other patient outcomes.

Summary

Employer based healthcare financing harms all the parties involved:

- It harms **employers** by putting an unnecessary burden on them;
- It harms **employees** by reducing their healthcare options;
- It harms **carriers** by reducing their ability to provide high value products rather than just lowest cost products;
- It harms **providers** by reducing their ability to focus on excellence rather than cost.

Now let's turn to some systemic problems with the employer based financing structure.

Chapter 6

Problems with Employer Based Healthcare Financing

So far, we have discussed goals and incentives under the Employer Based model. Let's now look at some specific problems with this form of healthcare financing.

We'll look at 7 different problems:

1. Administrative Costs;
2. Coverage and Pricing Problems;
3. Price Structure;
4. Fee-for-Service Problems;
5. Labor Market Distortions;
6. Healthcare Market Distortions;
7. Demographics

Problem #1: Administrative Costs

Carriers generally charge around 10 or so percent of premium to cover their administration. Medicare, which is a single payer system, charges around 2%. CALPERS, the California public employee system, covers about 400,000 people with Kaiser Permanente for about a 0.5% administrative fee - that's half of one percent of premium. Other countries with single payer healthcare systems pay less for administration. So we're already at a financial disadvantage by going to the private sector to cover health insurance financially.

This high administrative cost puts our employers at a competitive disadvantage internationally, which really became noticeable in our economy from 1990 or so onward.

The problem with high administrative costs is it leads to higher premiums. That leads to higher demands for insurance subsidies. In a sense, we're always chasing our tail in this, which was fine as long as our economy was strong and we could set the world price. But when Korean steel manufacturers began undercutting American steel manufacturers' prices, we lost the margins to cover high administrative fees and the related high need for insurance subsidies and we began to run into trouble.

Problem #2: Coverage Problems

The second problem with employer based coverage is medical *continuity of treatment*. If you change your job, you may change your doctors or hospitals, which may lead to a change in your treatment.

The previous treatment might have been covered under your previous insurance, but is no longer covered under your new plan. Ditto for your medications. Or number of physical therapy, chiropractic, psychotherapy, etc. appointments. In other words, **your treatment plan may be a function of your job, not just your medical condition.**

This can have negative impacts on healthcare outcomes, especially for patients unable to advocate well for themselves.

The employer based model also leaves out various undesirable occupations, like taxi cab drivers, in states with weak coverage mandates. Taxi cab drivers happen to be poor risks: they need to work long hours to generate income, so skimp on preventive services. Then, when they get sick, they become very expensive patients. Private carriers don't like them.

Where do they go? They're employed. They make enough money so they don't qualify for Medicaid. They're too young for Medicare, but the carriers don't want to pick them up. So they get put into an expensive pool, perhaps (depending on the state) with poor coverage. This is a band-aid solution to a problem we shouldn't have in the first place because employer based health insurance doesn't make any fundamental economic sense.

Q:

So by groups you mean occupation?

SPEAKER:

Yes or medically undesirably underwritten folks. What do we call them? The 'undesirable, underwritten'? I don't know. People who are unable to get into the employer based system and don't qualify for Medicare or Medicaid end up getting whacked on price. It's sometimes called 'non-group' coverage, which is often poorer quality than 'group' or employer based coverage.

Problem #3: Price Structure

Price is a function of employer contribution plus employee contribution. The employer pays his/her bit ---- often 50 - 75% of premium, and the employee pays the rest.

But if you don't qualify for the employer based side of things then you end up paying 100%. You get whacked on price. You have to pay both the employer bit plus the employee bit.

If you lose your job, you go on COBRA. You get to keep your insurance - this is aimed at the Coverage Problem, above - but you have to pay 100% of premium. Actually about 102%, including additional administrative fees.

Alain Enthoven, of Stanford Business School writes, "Just when people need coverage the most, they're likely to have a hard time paying for it".⁶⁰ When the breadwinner dies, or becomes unable to work, or perhaps a marriage breaks up, then you get to pay 100% of your health insurance. 102% actually, which remember is priced at employer plus employee paying together. So if it's just the employee, you're in big trouble.

What happens if the employer reduces or eliminates coverage - either voluntarily or involuntarily (goes out of business). Remember why we have health insurance in the first place - so providers can get paid. Lots of employers group together through an insurance carrier and get discounts from hospitals. Volume discounts. The hospital may have a list price, but large carriers operating in the group market get 25 - 30 - 40% off of list.

Now your employer drops coverage, and you're responsible for 100% of the premium. You can't afford the same comprehensive, high quality coverage you previously had, so you get a lower benefit plan for a lower premium.

But the lower benefit plan - for which you pay 100% - may not have the market clout to negotiate the same discounts from your local hospital. After all, it's lower quality, and thus unattractive to many employers.

If you lose your job, you get a quadruple whammy:

- First**, you pay 100% of premium - extremely expensive;
- Second**, you probably lose your Section 125 tax deduction, a government subsidy for employer based coverage;
- Third**, you may switch to a lower cost carrier, which likely has poorer discounts from the local hospitals;
- Fourth**, you may switch to a lower benefit plan, thus generating more out-of-pocket costs...at a poorer hospital discount.

You'd better not get sick!

⁶⁰ Enthoven, op. cit.

Problem #4: Fee-for-Service Provider Financing

I raised the question earlier of whether employer based health insurance must, by definition, be based on a fee-for-service model. Though we've tried other types of employer based financing over the years - some capitation models, outgrowths of Kaiser Permanente, in the 1980s and 90s, for example - post-2000, we've relied primarily on fee-for-service formulas to pay providers.

Unfortunately, there are some huge problems with this payment mechanism. We've already touched on some of these. Let's explore others in more detail.

Fee for service is fragmented and uncoordinated. The incentive is to do more procedures - and more expensive procedures - because providers can bill more and make more money this way. So they buy expensive technologies and do expensive procedures to earn more money.

What this has to do with quality is a gray area, unclear, but the incentive is to overuse. Clive Killingsworth, the Chairman and CEO of Blue Cross Blue Shield of Massachusetts editorialized about this: ⁶¹

Years of research tell us that as much as 30% of all healthcare spending could be eliminated without reducing quality.

The reason:

Insurers like Blue Cross mostly pay for the quantity, not quality of the care patients receive. In other words, the more visits, tests and procedures a patient receives, the higher the payment. At the same time, we undervalue primary care, which can prevent and manage acute and chronic illness.

The cure, according to Killingsworth:

We must fundamentally change the way we pay for healthcare.

The classic is coronary artery bypass. Every hospital does coronary artery bypass because they can bill for it and can make a lot of money at it. So arguably we underuse preventive medicine for heart disease because providers can't make as much money doing this.

⁶¹ Boston Globe, 12/1/06 page A16 'Changing the cost of healthcare'. This section was added in December, 2008

The providers much prefer (economically) to bill and make money than to work with patients on exercise and nutrition routines. How much can you bill for consulting and advising patients on lifestyle? Much less than the \$40 - 50,000 or more for the artery bypass.

Remember that chronically ill folks represent about 70% of our medical costs. Chronic illnesses continue for a long time, not a short time. But our employer based, fee-for-service financing system focuses on specific interventions and short term cost controls.

We've already discussed some short term cost control issues. Brokers see the effects everyday - they present coverage alternatives to employers, and employers chose health plan based largely on premium price.

Remember that short term cost controls lead to higher long term costs. Your physician, under carrier pressure, says 'I know you have diabetes but I don't think you have to go to a podiatrist. You seem fine.'

If you cut enough podiatric preventive trips, you end up having to amputate someone's foot. You save \$100 every five or six months and then in four years we have the \$30,000 amputation. The carrier's theory, of course, is we're going to save \$100 this year and the diabetic will switch to another carrier next year. So they'll end up paying the \$30,000.

But this gets worse.

Here is a really insidious problem - under our fee-for-service financing system, providers who cause complications get paid more. There's a lot of data to show a correlation between 30 days post-surgical admissions and Medicare payments. You can argue causality or correlation, but the data is pretty clear.

30-day Hospital Readmission Rates and Medicare Payments ⁶²

NJ: \$8000 Medicare/capita; 18% readmission
NY: \$7600 Medicare/capita; 18% readmission
MA: \$7800 Medicare/capita; 19% readmission
LA: \$7700 Medicare/capita; 24% readmission
CA: \$7500 Medicare/capita; 18.5% readmission
MD: \$7500 Medicare/capita; 20.5% readmission

⁶² 'Aiming High: Toward a High Performance Value Based Health System', Cathy Schoen, Commonwealth Fund, lecture at Massachusetts Health Council, 4/7/08. The Medicare reimbursement and readmission rates were estimated from various slides.

Contrast this with data from the Maimonides Medical Center's Heart Failure Readmission Rates. The Maimonides people decided to try to reduce readmissions, even if this did not serve their own financial purposes.

Maimonides Medical Center Heart Failure Readmission Rates⁶³

1998: 21% readmitted
1999: 18%
2000: 7%
2001: 8%
2002: 3%
2003: 8%
2004: 8%
2005: 6%

The contrast between these charts shows some harmful effects of the fee-for-service incentives.

Let's summarize problems with fee-for-service medicine. All these problems flow directly from the split between healthcare financing and service delivery:

- Overuse of expensive treatments and procedures;
- Underuse of preventive medicine;
- Poor ongoing care for the chronically ill.

Providers get paid for volume, not quality. They want to see lots of people and perform lots of expensive treatments - lots of coronary artery bypass grafts. And perversely, they want to have lots of people come back within 30 days so they can treat them again because they got infected and they can make the most money in that.⁶⁴

Don't even ask about American infection rates or medical complications caused by lack of coordination among providers. Americans rank far too high on both scales, compared to other countries. For example, in a 2008 survey the Commonwealth Fund found that 1/3 of US patients reported medical errors, about double the rate from the Netherlands. 1/3 reported specialist

⁶³ *ibid.*

⁶⁴ Note that I'm not suggesting that individual providers try to infect patients so they can provide additional treatments. Instead I'm discussing the systemic economic incentives at play.

coordination problems, far higher than any other country.⁶⁵ And remember: *we pay much more for healthcare than anyone else.*

We discussed earlier The Split between healthcare finance and service delivery that developed after the initial Baylor University Hospital experience with the Dallas School System. That split led directly to fee-for-service billing and the related problems. We've been unable since the 1930s at least, to find a provider payment system that simultaneously satisfies consumer demands for choice and carrier requirements for provider accountability.

Problem #5: Labor Market Distortions

Some employees - perhaps 40% of chronically ill folks - chose jobs or remain in their jobs for the benefits.

The lack of health coverage is a disincentive for Americans to create new businesses. Some people don't start their own business or become an independent contractor. Remember that small business has always been our engine for economic growth. The employer-based financing system stifles the growth of small business.

John Goodman, a healthcare economist, estimates that among chronically ill workers the employer-based system reduced job mobility by 40%.⁶⁶

That has an effect on all of us. We're not getting employees who are the best at their jobs - who have high job satisfaction and related job performance. Instead too many employees are stuck in their jobs, unable to move, generating poorer outputs and potentially facing other problems. We get a poorer economic return from these employees.

That's simultaneously sad and economically inefficient.

Problem #6: Healthcare Market Distortions

The employer contribution has a negative impact on carriers' efforts to control healthcare costs.

Sounds contradictory, doesn't it? But let's go through the reasoning.

In this example, let's assume that an employer offers plans from two competing carriers and pays 75% of the premium.

⁶⁵ Commonwealth Fund study published as Health Affairs Web Exclusive, 11/13/08. See summary written by Steven Reinberg at HealthDay.com written 11/13/08

⁶⁶ Goodman, Employer Sponsored, Personal and Portable Health Insurance, Health Affairs, Nov/Dec 2006

The employee sees only 25% of any efficiency gains generated by carriers or providers, because the employee only pays 25% of the premium. (Actually only about 15% of the gains, assuming the employee is in the 40% combined state and federal tax bracket.)

In other words, if the carrier can reduce costs by \$1000/year, the employee only sees \$250 in savings - closer to \$150 after the tax benefits. To receive that \$150 savings, the employee might need to complete complicated paperwork, change physician or hospital, or agree to a different type of treatment. Probably too much effort for many employees.

But generating that \$150 employee savings also creates too much burden for the carrier; it's simply too difficult to cut \$1000 of cost. Stanford's Enthoven summarizes the problem of sizeable employer healthcare contributions:

They do not provide an incentive for employees to choose the economical alternative and it is not possible for the efficient systems [carriers] to gain market share by superior efficiency.⁶⁷

Unlike most sectors of our economy, there is no huge incentive on the part of insurance carriers to become more efficient. 'Let's reduce cost by 4%. We'll get more market share.' This doesn't work because of the employer contribution plus the tax incentives. Why would a carrier knock itself out to reduce cost? Cost reduction doesn't buy much.

So carriers compete on other factors: marketing, pizzazz, gym membership, network size. They don't compete on value because they can't win at that game. Instead, carriers say "We can get our share of the market as long as we've priced it where the competition prices it. Then we'll do some marketing." There's no great competitive incentive to cut costs and improve quality.

A similar situation occurs when only one carrier offers plans in a particular business. The employer is likely hesitant to switch the entire company - all the employees - to a different carrier for a small savings. That might create more employee problems than it solves. The carriers know this. So they keep prices in line with the competition, and provide the appropriate marketing pizzazz and gizmos, like network size and gym membership - neither of which apparently adds much to longevity.

Other sectors of our economy compete on value - a combination of price and outcomes. They compete by offering better products or lower priced products.

⁶⁷ Enthoven, op. cit.

But not healthcare --- largely, though not entirely, because of our employer based financial structure.

Problem #7: Demographics

The employed market is older than the US population in general, and aging faster. Aging alone accounted for about 7% of the premium cost increases between 2000 - 2004.

Future demographic trends for employer based healthcare look bad because of the elders moving through our population. That's the baby boomers. Population aging combined with rising premiums could reduce the interest on the part of young people to subsidize older people.

Remember that in health insurance the young subsidize the elderly. Unfortunately today and the near future, the *employed market is becoming older than the population in general*. It's also becoming wealthier.⁶⁸

This is beginning to create an untenable situation where a smaller population of younger, lower wage earners will pay increasingly high premiums to subsidize a larger population of elderly, higher wage earners. We don't know today how the young will react.

Patricia Keenan and her colleagues at Yale and Harvard studied the effects of our aging population on employer based health insurance. They estimate that age alone added an additional \$107 per capita to healthcare costs in the employer based market between 2000 - 2004.

Let's put this into context. Average per capita health expenditures grew from \$4790 in 2000 to \$6301 in 2004, an increase of \$1511.⁶⁹ Keenan's estimate of \$107 represents 7% of this increase, with the trend continuing.

This aging of our workforce is going to put increasing pressure on young people to subsidize old people's health coverage, which may not be politically palatable. The authors concluded:

Well before we see the much anticipated effects of the baby boom generation's retirement on Medicare and Social Security financing, population aging combined with rising premiums could place more pressure on an already strained employer based system.

⁶⁸ This discussion comes from Keenan, et al, "The 'Graying' of Group Health Insurance' Health Affairs, Nov/Dec 2006

⁶⁹ See Kaiser Family Foundation website KFF.org 'National Health Expenditures per Capita, 1990 – 2006

Conclusion to *Problems with Employer Based Health Insurance:* How Employers Try to Cope

Maybe the employer based model is on its wane. But it's in place today and many groups have an interest in maintaining it.

So let's discuss briefly what employers do to cope with this fundamentally unsound system.

First, cost sharing. That's a fancy way of saying 'make the employees - or the sick people - pay more.' It is not sustainable because we don't address the root causes of the problem. It's a band-aid that employees will only tolerate for a while. Then they start to rebel. They move out of state. They'll find some way to get out of it because they can't afford it.

The **second** thing employers are trying to do to improve this system - employee wellness programs. This currently seems a hot button.

Changing lifestyles is very difficult and we get the benefits 20 or 30 or 40 years in the future. We pay for the program now. It's not going to reduce our current health insurance costs. Maybe people will live longer, maybe they'll be healthier in the future, but somebody else will get the savings.

Wellness programs sound nice, but they're probably not going to have much effect on today's healthcare costs for a couple of reasons. Foremost, perhaps - it's very difficult to change people's lifestyles. It's hard for people to quit smoking, lose weight, eat better and exercise more. We're too busy. We have something important to do this evening. We'll start tomorrow.

The bottom line - if we don't quit smoking / lose weight / exercise today for our own health reasons, how will an employer's admonition help us? It may even make us uncomfortable working there, so we'll quit and find another job (so long as the benefits are comparable!)

But more fundamentally, the 'prevention will reduce healthcare costs' argument rests on a faulty assumption according to a couple of very clever economists, Bob Galvin of Yale and Suzanne Delbanco of the Leapfrog Group.⁷⁰

Let's say employers offer great wellness programs that actually work. They reduce the need for hospitalizations and hospitals practice wonderfully safe medicine so nobody gets readmitted within 30 days. In other words, let's assume we decrease demand for healthcare. Will that reduce healthcare costs? Will that save us money?

The answer put forward by these guys is No. No, it won't save us any money because doctors will stay in business. Hospitals will find ways to keep

⁷⁰ Robert Galvin and Suzanne Delbanco 'Between a Rock and a Hard Place: Understanding the Employer Mind-Set' Health Affairs, November / December, 2006

their beds full. They'll come up with new diseases. New technologies will develop to treat new (or old) problems. 40 years ago, how many people had sleep studies? None. We hadn't invented the technologies then. But today, lots of people go in for a sleep study.

According to Galvin and Delbanco, if we eliminate heart disease we're going to have a whole bunch of doctors treating other diseases. Galvin and Delbanco argue that healthcare is a super good in which the demand to live without pain and 'feel better' is continuous and robust. There are all kinds of life quality improvement procedures and treatments available to help people accomplish these goals.

Doctors and hospitals will find ways to maintain their income. This is kind of depressing because no matter what we do on the prevention side and the demand side, healthcare costs won't go down.

I'm not sure that this argument is completely correct. But I think it shows a problem with employer based health insurance. No matter what employers do, they won't be able to significantly lower their health insurance bills in the near term. They'll still face the same expense problems. They'll still have trouble competing with foreign firms.

Cost shifting and Wellness Programs won't save this flawed system. We'll need to look elsewhere for means to fix our healthcare financing structure.

Case Study: Impact of Short Term Cost Controls on US Medical Treatment Protocols

Foot Amputations

We annually amputate about 100,000 feet in this country, some 90% of which are deemed 'preventable' through better foot and medical care.⁷¹ In other words, we know how to prevent foot amputations, but we don't routinely implement that knowledge. Why?

The short answer, according to Dr. David Armstrong, a podiatrist and director of the Southern Arizona Limb Salvage Alliance, 'prevention doesn't pay.'

Some background: Diabetes is a primary cause of foot amputations. Over time, the disease weakens nerves, the immune system and circulation, allowing foot infections or inflammation to spread if not treated early enough. Some 15% of diabetics develop a foot ulcer. Ideally, patients and physicians would both prevent and identify foot ulcers before they become dangerous.

⁷¹ Much of this information comes from Steps Toward Saving Diabetic Feet, Roan, LA Times, 3/22/09

One method of foot ulcer identification involves monitoring the skin temperature with foot thermometers to detect skin heating, a sign of inflammation. Another method involves using scales equipped with lighted, magnified, mirrored surfaces that let diabetics check their weight and foot conditions frequently. Such measures can reduce diabetic's foot ulcer rates tenfold.

Unfortunately, in an effort to control short term costs, carriers typically underfund foot exams for diabetics without symptoms, special shoes, the foot mirror / scale or an appropriate thermometer - all of which cost far less than the \$25 - \$65,000 for a foot amputation (not including rehab costs or unnecessary patient suffering).

By contrast, Sweden uses these types of techniques and has achieved a 78% reduction in foot amputations, even as their diabetes rate has risen. Swedish physicians emphasize ulcer prevention and aggressive treatment to restore blood flow the feet, rather than amputation.

In the US, unfortunately, according to Dr. Armstrong, far too often, physicians don't see patients until they have a problem - which is often too late to save their feet.

In other words, wellness visits - a very inexpensive means to prevent amputations - are either not funded by insurance, or are too poorly funded to change patient and physician behavior. Amputations are, however, profitable for the service providers.

Our treatment protocols have developed based on this type of carrier funding. We are more expert at amputation than at prevention.

Below, we provide data on foot amputation rates in the US, UK and Spain. ⁷²

Lower Limb Amputation Rates:
Select Regions in US, UK and Spain
 Rates per 100,000 population

<u>US</u>		<u>UK, Spain</u>	
Average Male Rate:	24	Average Male Rate:	14
Average Female Rate:	15	Average Female Rate:	7
Lowest US County Studied, Male:	14	Lowest Region Rate, Male:	
Morris, NJ		Leicester UK: 7, Madrid 4	
Lowest US County Studied, Female:	10	Lowest Region Rates: Female:	
Bergen, NJ		Leicester, UK: 4, Madrid 0.5	

⁷² An International Comparison of Lower Extremity Amputation Rates, Ronald Renzi, et al, Annals of Vascular Surgery 2006, 20: 346 – 350. Data generated during the 1990s.

Note when reviewing this data: the researchers aimed at US counties and foreign regions that offered **above average** access to medical care, according to a variety of social-economic indicators. For example, the median household US income at the time of this study was \$42,000. The US counties included in this study averaged over \$50,000.

Leicester England and Madrid Spain enjoyed similar ‘above average’ health demographics. The researchers indicated that the Madrid data showing almost no female foot amputations is ‘well-documented...Ten years of study show a steadily decreasing trend in amputations.’

Note also that the researchers did not include VA foot amputation data. The VA generates about 10% of all US foot amputations, suggesting that the US numbers under-report our actual amputation rate, and thus the actual differences between us and the UK and Spain.

Unfortunately, it’s not really in any payers’ self-interest to fund these types of preventive services. Carriers and employers want to cut short term, ‘unnecessary’ costs, and providers find reimbursement rates for prevention unattractive.

Only employees (patients) want preventive services appropriately funded....but employees don’t get a voice in plan designs under the employer based financing system.

Case Study:
Impact of Short Term Cost Controls on US Medical Treatment Protocols
Open Heart Surgeries, 2001⁷³

The US rate for Open Heart Surgeries dwarfs that of other advanced, industrialized countries without, apparently, generating longevity gains.

<u>Country</u>	<u>Open Heart Surgeries</u> per 100,000 pop	<u>Longevity</u> at birth
US	223	77
UK	41	78
Germany	38	79
France	35	79
Canada	62	80
Australia	86	80

⁷³ The Open Heart Surgery data comes from Anderson and Hussey, ‘Comparing Health System Performance in OECD Countries’ Health Affairs 20 (3): 219:232. Average longevity at birth from the OECD Data Book.

This chart generates the following questions:

1. Are Americans actually sicker than others, or
2. Do our medical protocols simply differ from others?
3. Or both?

The answer: all of the above! Here's why (we discussed much of this in Chapters 2 and 4):

First, as Richmond and Fein explained in the last chapter, we use hospitals and advanced technology for far more medical treatments than others. Our health insurance history has funded hospital based treatments - including quicker embrace of technology, and training of proportionally far more specialists - more than in other countries.

Whereas the Briton might get a pat on the head from his General Practitioner (PCP), the American would more likely have an angiogram and/or other tests. The Briton would more likely see a General Practitioner in an office; the American would more likely see a specialist in a hospital.

The more extensive American use of specialists and hospital facilities generates more 'suspicious findings', for example, of artery plaque build-up. Unfortunately, according to Gina Kolata, the well known science reporter for the New York Times

Since most people who are middle-aged and older have arteriosclerosis [plaque build-up], the angiogram will more often than not show a narrowing.⁷⁴

A finding of plaque build-up leads medical professionals to do something - often an invasive coronary procedure, like stenting or a bypass.

Yet some 75 - 80% of the time the erupting plaque that caused a heart attack was not obstructing an artery, so would not have been stented or bypassed.⁷⁵ In other words, many of these open heart procedures accomplish very little.

Researchers at the Veteran's Health Administration - who have studied the effectiveness of preventive cardiac procedures - claim that the vast majority

⁷⁴ Gina Kolata, New Heart Studies Question the Value of Opening Arteries, New York Times 3/21/04

⁷⁵ Gina Kolata, New Heart Studies Question the Value of Opening Arteries, New York Times 3/21/04

are no more effective at preventing heart attacks than good medical management including lifestyle management and medication. ⁷⁶

Indeed, researchers estimate that about 14% of angioplasty procedures - some 170,000 annually - are 'inappropriate' meaning they should not have been performed. ⁷⁷ Another 500,000 are of 'questionable value' - not quite inappropriate, but probably not necessary either. ⁷⁸ Some 10% of CABG - Coronary Artery Bypass Grafts, more commonly known as bypass surgery - about 40,000 annually - were also 'inappropriate'. ⁷⁹

Thus we have a discrepancy: we try to control short term costs though we treat patients in the **most expensive settings** with the **most expensive technologies** and use the **most expensive interventions**...even if they don't work well. That's largely based on our insurance history, which led to the unique development of our hospital based treatment protocols.

But **second** - as in the case of foot amputations above - we seriously underfund cardiac preventive care. As a result, Americans are less healthy than others, and more needing of acute medical care. ⁸⁰

We know the main causes of coronary trouble - poor diet and lack of exercise. We know that a diet rich in fat leads to high cholesterol levels, plaque build-up and a narrowing of arteries. We also know that a lack of exercise leads to poorer muscular strength, including a weaker heart muscle.

Yet we perpetually underfund both nutritional and exercise programs. Some results:

- Two thirds of Americans are overweight and half of them are obese; and ⁸¹
- 75% of Americans fail to meet the minimum government recommendations for daily exercise - 30 minutes of walking. ⁸²

⁷⁶ See Shannon Brownlee, *Overtreated*, page 99

⁷⁷ Schneider, et al, Racial Differences in Cardiac Revascularization Rates: Does 'Overuse' Explain Higher Rates among White Patients?, *Annals of Internal Medicine*, September 4, 2001, Volume 135, Issue 5, pages 328-337

⁷⁸ Brownlee, op cit. page 99

⁷⁹ Ibid.

⁸⁰ This discussion builds on the ideas presented in Chapter 2, particularly the discussion of lifestyle.

⁸¹ Estimates from *The Way We Eat Now*, Craig Lambert, *Harvard Magazine*, May-June 2004

⁸² See *The Deadliest Sin*, Jonathan Shaw, *Harvard Magazine*, March - April 2004

Here's a paraphrase of Harvard Magazine's analysis of exercise benefits for your cardio-vascular system:

Exercise helps prevent heart disease, stroke, diabetes and obesity. You'll grow new capillaries in your heart and improve your blood flow. Exercise will help you regulate your appetite and you'll probably find you prefer healthier foods. Your blood volume will increase.

Professor Frank Hu of the Harvard School of Public Health summarizes by suggesting that, though there is no magic pill for good health:

The single thing that comes close to a magic bullet, in terms of its strong and universal benefits, is exercise.⁸³

Yet Americans, over the past 20+ years, have exercised less and less. Among the reasons:

- An increasing number of women in the workforce, at jobs that require sitting for prolonged periods;
- Longer car commutes to work for both men and women, requiring less weight bearing exercise and more sitting (and stress?);
- Longer work days, allowing less time for organized exercise like gym attendance or after work sports activities.

A 2004 study published in the *Canadian Journal of Public Health* analyzed the 20 year trends of physical activity among Canadian and American adults. The conclusion: levels of physical activity decreased among Americans since about 1980, due largely to these workplace / demographic reasons.⁸⁴

Interestingly, levels of physical activity increased among Canadians during the same period. One key reason: Canadian urbanization rates, and urban job density rates, are much higher than American, allowing short walks in normal daily activity, including to and from work or public transportation.

⁸³ Ibid.

⁸⁴ Craig C.L., Russell S.J., Cameron C. and Bauman A., 'Twenty-year trends in physical activity among Canadian adults' *Canadian Journal of Public Health* 2004;95(1):59-63

As both the Canadian and American workforces expanded to include women, Canadian exercise rates increased, while American decreased.

We now have part of the answer to the question posed at the beginning of this section: Are Americans less healthy than others? The unfortunate answer: Yes. Canadians walk more - Americans drive more - in their normal daily routines. They are, consequently, healthier.

Interestingly, European urbanization rates and urban job density rates are even higher than Canadian. That helps explain why British, French and German rates of open heart surgery are lower than ours. They get more exercise and are less demanding of their healthcare systems to provide acute coronary care.

Our healthcare financing system, unfortunately, has not adjusted to these demographic changes. Carriers still do not invest appropriately in good health promoting programs, though they certainly give significant lip service. Some examples:

- Weight Watchers and other diet / nutritional type programs, are not typically funded by health insurance (unless the insured person is already ill);
- Gym memberships are often partially subsidized by insurance, but personal trainers are generally not.

Yet nutrition and exercise programs are precisely necessary to make up for the demographic changes and unhealthy lifestyles that most Americans currently enjoy.

In sum, we have more open heart surgeries than other countries because we are both less healthy than others, and because our healthcare system is designed to intervene rather than prevent.

Depressingly, none of these trends appear likely to change in the near term.

Conclusion

The incentive structure established by the employer based insurance model leads us to pay too much for the wrong kinds of treatments. Rather than investing in foot therapies or thermometers, we invest in foot amputations. Rather than investing in exercise programs, we invest in open heart surgeries.

The insurance cost problem is not primarily that some providers earn too much money or that others order unnecessary or duplicative tests. It is, rather, that we provide the wrong services to our population because we have institutionalized the wrong set of incentives.

There is, though, one healthcare system in this country that uses a different set of incentives: the VA. Let's compare it to our employer based system in the next chapter.

Chapter 7: The Veteran's Administration Healthcare System

The VHA is a single payer system that provides health coverage to veterans.

Some Background Comparisons: Quality

The VHA provides outstanding patient care:

- The New England Journal of Medicine published a 2003 study that used 11 quality measures to compare fee-for-service Medicare with VHA health facilities. The VHA was 'significantly better' on all 11 measures; ⁸⁵
- The Annals of Internal Medicine published similar results on a 2004 study that compared VHA facilities with commercial managed care systems in 7 measures of diabetes treatment; ⁸⁶
- The Rand Corporation concluded its 'Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample' by finding that the VHA outperforms all other sectors of American healthcare in 294 quality measures; ⁸⁷
- Medical Care in 2006 published a study comparing life expectancies of elderly patients in the VA to Medicare Advantage beneficiaries and concluded that Medicare Advantage mortality rates were 'significantly higher' than VHA; ⁸⁸
- The National Committee on Quality Assurance ranks health plans on performance measures such as high blood pressure management and

⁸⁵ New England Journal of Medicine, Effect of the Transformation of the Veterans Affairs Healthcare System on the Quality of Care, May 29, 2003. This and the next 5 notes appear in Longman's book Best Care Anywhere and his various articles.

⁸⁶ Annals of Internal Medicine, 2004

⁸⁷ Ibid.

⁸⁸ Risk adjusted mortality as an indicator of outcomes, Managed Care, 2005

adherence to protocols of evidence-based medicine. In the NCQA 2004 State of Health Quality report, the VHA outperformed all other medical systems including Johns Hopkins, the Mayo Clinic and Massachusetts General Hospital. 'In every single category, the veterans healthcare system outperformed the highest-rated non-VA hospitals' according to VHA researcher Phillip Longman.⁸⁹

According to 2005 VHA data, 69% of patients are seen by their physicians within 20 minutes of their scheduled appointment and 93% see specialists within 30 days of their desired appointment time.⁹⁰ As a result, the VA has outranked private-sector hospitals on patient satisfaction in the annual consumer survey conducted by the National Quality Research Center at the University of Michigan for the past 6 years.

Some Background Comparisons: Cost

Not only does the VHA offer better quality and customer satisfaction than commercial American healthcare, but it also costs less.

In 2004, the average American consumed \$6,280 of healthcare, but the VHA spent an average of only \$5,562 per patient.

From 1995 - 2004 the Medical Consumer Price index rose 39%; Medicare's cost per patient rose 40%; but the VHA's cost per patient rose only 0.8%. Between 1995 - 2003, the VA increased the number of patients treated on an annual basis by 75% (from 2.8 to 4.9 million) with only a 32% cumulative increase in its budget. While increasing patient treatments, it reduced its hospital and long term care beds from 92,000 to 53,000 and increased its outpatient clinics from 200 - 850.⁹¹

Remember that veterans in the VHA system are, as a group, older, sicker and poorer than the US population as a whole. They are more prone to mental illness, homelessness and substance abuse than average Americans. About half are over age 65. More than a third smoke. 20% have diabetes compared with 7% of US residents in general. On any chronic disease measure - Alzheimer's, cancer, congestive heart failure, sclerosis of the liver - a much higher percentage of veterans have it than do Americans in general.⁹² (Note that

⁸⁹ Longman, Best Care Anywhere, page 3

⁹⁰ Department of Veterans Affairs, Performance and Accountability Report FY 2005

⁹¹ Matthew Morgan, The VA Advantage, Healthcare Papers, 2005

⁹² Longman, op cit, page 6

some savings result from closing obsolete VA facilities and many VA enrollees get some benefits elsewhere. But the trend is clear.)

Jonathan Perlin, acting undersecretary for health summarized the VA experience: 'If we've proved anything...in the last 10 years, it is that quality is less expensive.'⁹³

The VHA is a huge organization, employing over 198,000 people, managing 154 hospitals and 875 clinics, and serving 5.4 million patients.⁹⁴ Interestingly, it also has a lifetime relationship with its patients so has incentives for investing in prevention and effective treatment, rather than simply billing for services rendered.

How does the VHA achieve these remarkable quality results with this frail population at lower costs than the private sector? It has two distinctive systemic features: its information technology system and its incentive structure.

VHA Information Technology: VistA

All VA facilities use a state of the art electronic medical records system. This compares to only about 20% of civilian hospitals that use similar quality system, according to BusinessWeek's estimate.

The VHA uses its own, internally designed information system called VistA. VistA is a bundle of over 20,000 software programs written primarily in the 1970s and 80s by individual VA physicians and other VA professionals, generally in their spare time. The system was not designed by IT consultants working with VA administrators; it was engineered as a 'bottom-up' system.

VistA is also 'open source' software, which allows registered users to improve or adjust programs as needed. This program has dramatically improved patient safety at the VA. It also improved diagnoses, the quality of care and our scientific understanding of the human body. And it helped physicians develop medical protocols based on hard data about what drugs and procedures work best over both the short and long term.⁹⁵

What can't VistA do as well as civilian IT systems? Bill! At least without adding code.

⁹³ Gilbert Gaul, Revamped Veteran's Health Care Now a Model, Washington Post, August 22, 2005

⁹⁴ The Best Medical Care in the US, BusinessWeek, July 17, 2006

⁹⁵ Longman, op cit, pages 22 -23

Quick History of VistA

In the 1960s, the VA Office of Data Management and Telecommunications software approval process had 17 steps and took about 3 years. It was main-frame based. But the mini-computer revolution of the 1970s took power from huge mainframes and put it in lower, more operational levels of the bureaucracy.

The VA data systems were so inefficient that physicians and VA employees began writing their own mini-computer based programs to solve their operational problems. The VA's Computer Assisted System Staff somewhat covertly coordinated this mini-computer effort and persuaded users to share a common, user-friendly, open source language.

By 1981 this underground effort was sufficiently widespread that the VA's Chief Medical Director, Dr. Donald Custis, looked favorably on it, as did the Reagan administration. They supported VistA development over the previous mainframe operations.

The VA faced a second IT problem in the 1970s and 80s that the US commercial healthcare system has not yet solved. VA beneficiaries could move from city to city or state to state easily, but still needed access to their medical records. VistA needed to coordinate records among all VA facilities and offer patient data to all VA physicians.

Thus the VHA faced a unique set of problems. It had a long term / lifetime relationship with its beneficiaries, so could amortize an IT or chronic disease management program investment over time. 'From a very early date, both VA doctors and administrators were far more likely than their private-sector counterparts to see the value of investing in information technology that could improve the practice of medicine' suggests Longman.⁹⁶

VistA keeps complete medical records of patients, including daily weight fluctuations, medications, blood pressure and other data. This is available to physicians - and increasingly patients - on laptops or PDAs. VistA allows viewers to graph data for easy viewing.

This availability of complete, easily accessible patient data allows the VA to manage patients particularly well:

- **Chronic disease management:** Oncologists, for example, can follow blood patient blood counts over time. Click a box and get a graph to see patient progress with a particular treatment.

⁹⁶ Longman, op. cit, page 32

‘In the field of oncology,’ according to Dr. Steven Krasnow of the Washington VA Medical Center, ‘following blood counts of patients over time is very important. And the ability to essentially click one box and show a graph of the patient’s individual blood count has been invaluable in maintaining patient safety and providing guidance to the clinician.’⁹⁷

- **Cancer screening:** The Baltimore VA reports a vast improvement in cancer screening rates. In 1990 rates of screening for breast and cervical cancer were 50 and 17%, respectively. By 2003 they were 88 and 87%. The computers drive this performance according to Dorothy Snow, acting chief of staff at the Baltimore VA hospital.⁹⁸
- **Prevent medical errors:** VistA eliminates handwritten physician scripts and the potential confusion between, for example, thioridazine and thiothixene. It also eliminates inappropriate Rx combinations as it keeps track of patient allergies and patient medications to eliminate contraindications.
- **Efficiency gains:** Easy access to all patient data on a physician’s laptop eliminates the need to run around the hospital retrieving medical records - X-rays from radiology, lab results from the basement, etc. One neurologist practicing at both Georgetown University Hospital and the Washington VA Medical Center reports that he can see as many patients in a few hours at the VA as he can all day at Georgetown.⁹⁹
- **Patient and family access to records:** Patients can access their own records from their home computer, or grant permission for someone else to so access. This allows a child in, say, Massachusetts to help a geriatric VA parent in Florida to take the right medications. And it allows patients to refill their own prescriptions electronically and track their personal health information such as blood pressure and blood sugar levels.

⁹⁷ Quoted in Longman, op. cit, page 36

⁹⁸ Gaul, op. cit

⁹⁹ Longman, op cit page 38

- **Scheduling:** VistA reminds patients to make appointments and to take their medications.
- **Measurable results:** The VA estimates that VistA has saved 6000 lives since introduction by improving rates of pneumonia vaccination; the vaccination rate went from 29% in 1995 to 94% in 2005. The results: 4000 fewer hospitalizations and a \$40 million annual savings.¹⁰⁰
- **Education and research gains:** VistA can review thousands of medical records quickly. This allows researchers to see treatment variations and results among diabetics, for example, by location, physician and treatment. This also allows for treatment protocols based on hard data, rather than, as is often the case, on factors such as where a doctor went to medical school or on highly variable local traditions of care.¹⁰¹

And this allows researchers to create the first national, risk-adjusted analysis of how patients fare after undergoing different types of surgery in different veterans hospitals. It shows which surgical teams, for example, have outstanding results and which need improvement. Civilian hospitals rarely, if even, have this kind of data.

- **Management tool:** VistA allows managers to ‘manage healthcare’. What percentage, for example, of VA patients by age (location?) get prostate screenings? How long do patients wait for an appointment? How often do medical errors occur and what are their patterns?
- **Safety:** The VA bar codes all medications and requires all patients to wear bar coded bracelets. The patient’s code includes name, types of medication required, dosage, name of nurse authorized to administer the medications and medication timing.

Before administering medication, the nurse scans the patient bracelet, his/her own bracelet and the medication bar code. This has virtually eliminated medication dispensing errors in the VA.

¹⁰⁰ BusinessWeek, op cit

¹⁰¹ Longman, op cit, page 40

The VA estimates that it prevented some 549,000 errors between 1994 and 2001.

This includes a 75% decrease in errors involving the wrong medication; 62% decrease in errors involving wrong dosage; 93% reduction in the wrong patient receiving medication and 70% reduction in number of times a nurse simply forgot - or was too busy to - give patients their meds. The net result: while some 3 - 8% of the nations prescriptions are filled incorrectly, the VA's prescription accuracy rate is greater than 99.997%.¹⁰²

'They've adopted a culture of patient safety and quality that is pervasive,' says Karen Davis, president of the Commonwealth Fund that studies healthcare issues.¹⁰³

- **Uniformity of care:** The VHA uses its extensive data base to determine appropriate care for each patient and monitors treatments by condition and location. Dorothy Snow, acting chief of staff at the VHA in Baltimore reviews weekly statistics on how her facility compares with on various measures. This helps maintain uniform practices and cost equalization throughout the VHA system.

Compare that efficiency to Medicare. Patients in their last 6 months of life at New York's Mount Sinai Medical Center received an average 53.9 doctors visits, while similar patients at Duke University Medical Center received only 20.9. Yet all those extra doctors' visits at Mount Sinai add no gains to life expectancy - just higher medical bills.¹⁰⁴

- **Efficiency:** BusinessWeek estimates that 96% of VA prescriptions and medical orders are entered electronically, compared to about 8% commercially. 'One out of five tests in a civilian hospital have to be repeated because the paper results are lost' according to Veterans

¹⁰² BusinessWeek, op cit

¹⁰³ BusinessWeek, op cit

¹⁰⁴ Longman, Best Care Anywhere, Washington Monthly, January/February 2005

Affairs Secretary R. James Nicholson. 'That's not happening in our hospitals.' Which may explain the high level of customer satisfaction.

Interestingly, acting undersecretary Perlin estimates that it costs the VA about \$87 per patient per year to operate electronic health records, 'roughly the equivalent of not repeating one blood test.'¹⁰⁵

With these excellent results from the VistA system, why don't commercial US hospitals - or Medicare - simply install it? There are several answers.

First, the economics of competitive commercial hospitals and insurance carriers can provide negative incentives for huge IT investments. World class IT has huge up-front costs that will negatively affect the hospital's cash flow or the carriers' premiums.

Remember that perhaps 20% of a carrier's current subscribers will switch to a different carrier next year. Why should a carrier raise its premiums to invest in these people, only to make them healthier for their competitor when they switch next year - for lower premiums?

Hospitals also fear - economically - that providing more efficient and effective treatment will reduce their occupancy rates, thus additionally harming cash flow.

Second, the US lags other countries in applying information technology to healthcare nationally.¹⁰⁶ Germany, for example, began investing in a national IT healthcare information network in the 1990s and spent \$1.88 billion or \$21 per capita on this by 2005. By contrast, the US has spent \$.43 per capita. Without the necessary massive national infrastructure, much of VistA's power is inapplicable.

Interestingly, many other countries have adopted VistA - including Finland, Germany, Nigeria, Mexico, India, Pakistan and Uganda.¹⁰⁷ There is even an Arabic language version up and running in Egypt.¹⁰⁸ Dr. Ian Reinecke of Australia's electronic medical records program - who has even recruited VA officials to work with him - says 'the US Veterans Health Administration is regarded as one of the best and most successful e-health systems in the world.'

¹⁰⁵ Gaul, op cit

¹⁰⁶ Longman, Best Care Anywhere, page 75

¹⁰⁷ Brown, et al, International Journal of Medical Informatics, 2003, referenced in Longman, page 76

¹⁰⁸ Longman, Washington Monthly

¹⁰⁹ But VHA officials reported in 2005 that they were unaware of any private healthcare system in the US using VistA - even though it's available for free on the internet. ¹¹⁰

VHA Incentive Structure

The VA's lifetime relationship with patients creates a different economic focus from the private sector's. For the VA, investing up-front in chronic disease control could mean huge future savings; for the private sector, investing in chronic disease control means huge short term costs.

Thus the VA has an incentive to invest in prevention and chronic disease management, whereas the private sector has incentives to bill fee-for-service excessively.

Kenneth Kizer, head of the VA under President Clinton, summarized this impact on pharmaceutical choice:

If you know you're going to have your patients for five years, ten years, 15 years or life, there are good economic and health reasons why you would want to use these more expensive drugs. ¹¹¹

Kizer suggests that you would make different decisions than if you only had the patient for a year or two. You might, for example, include different / more expensive drugs in your formulary.

The VA uses its VistA system to determine which drugs work best and then - unlike Medicare - negotiates with pharmaceutical companies.

Interestingly, the VA does not rely on pharmaceutical-funded research that may reflect private company incentives to show that 'new and more expensive' drugs are better than old. No other US hospital system has both this long term patient focus and objective medication results data to perform their own long term drug evaluations.

One result: VA patients pay, on average, 46% less than Medicare Part D enrollees for the same medications. ¹¹²

¹⁰⁹ Longman, Best Care Anywhere, page 76

¹¹⁰ Longman, Washington Monthly

¹¹¹ Longman, Best Care Anywhere, page 55

¹¹² BusinessWeek, op cit

Based on these outstanding results, should we consider expanding the VA to handle all healthcare for all Americans? Probably not, for several reasons.

First, the VA eligibility guidelines have been tightened since 1996. No longer do all veterans receive comprehensive medical services for life. Rather, new VA members only receive long-term medical services for ‘combat related’ problems.

This eligibility tightening corresponded with Medicare’s expansion into prescription drugs. There is an apparent political willingness to expand Medicare’s inefficient programs rather than the VA’s efficient ones. Perhaps this is due to Medicare’s allowance for Congressional meddling, or perhaps to other political pressures.

Second, veterans share special bonds together that non-veterans do not share. One reason the VHA works so well is its shared value relationship with its clients. This cultural connection has led Phillip Longman to conclude in his analysis of the VHA, that ‘it would not be a good idea to allow people who have no connection to the military to have access to VA hospitals’.¹¹³ Indeed, in 1992 when the then-VA secretary Edward Derwinski suggested allowing non-vets into 3 underused VHA hospitals, veterans groups forced his resignation.

Third, the VHA works well due to the combination of VistA and long term incentives. Altering the model to include a fee-for-service component, or including patients with 1-year insurance policies (not lifetime) would radically change this system.

Fourth, simply copying the VHA management structure and VistA onto the existing US commercial provider system runs into bureaucratic acceptance problems.

Healthcare system change generally requires a buy-in by system participants. As the VHA evolved, various provider groups bought in to the operation and allowed the process to continue. Absent this buy in (and often even with it) the VHA faced resistance due to its bureaucratic structure. Transplanting VHA processes and structures onto the private US carrier and provider system seems a managerial nightmare, if not impossibility.

And that begs the question of whether Congress would agree to stop meddling!

Fifth, much of the current VHA success has come from brilliant management, particularly under Kenneth Kizer. In contrast to Medicare for example, the VHA is an integrated delivery system with salaried physicians and

¹¹³ BusinessWeek, op cit

coordinated care. But ‘we were an integrated delivery system before and no one said we had an advantage’ then, claims undersecretary Perlin.¹¹⁴

It’s unclear that Kizer’s successors will be equally able. Dr. Dennis O’Leary, president of the Joint Commission on Accreditation of Healthcare Organizations warns that ‘the most common reason hospitals go into the tank is a change in leadership.’¹¹⁵ Since the VA is always affected by politics, this is an on-going concern he says.

And remember that reform movements end when administrators and bureaucrats take over. We have not yet, in the US government, found a mechanism for ensuring continued creativity and reform, but we have plenty of examples of calcified administration that blocks creative and reforming programs. Just look at the VHA’s initial response to VistA. It’s unclear that the VHA will continue to innovate and remain a healthcare leader in the future. It may - but there is no structural reason to believe that it will.

The VA is a very interesting healthcare system form. It shows the potential efficiency gains from having an integrated finance and service delivery system that incorporates long term incentives into its operation.

We, in our employer based system, have chosen not to integrate finance and service delivery together. We have also elected to use short term, rather than long term, insurance policies as the basis for our healthcare financing system. That leads to a number of systemic problems.

We’ll discuss them in the next section.

¹¹⁴ Gaul, op cit

¹¹⁵ BusinessWeek, op cit

Summary of Part 2

1. We are the only country that uses employer based health insurance as our primary form of coverage. We use public health insurance only for people unable to get employer based coverage.
2. Most employer based health insurance is not **vertically integrated**. Vertical integration means the insurer and providers belong to the same company. This eliminates conflict between providers (who want to get paid more) and insurers (who want to pay less), and may result in better patient care at lower prices.
3. American consumers value **choice of provider** extremely highly. This is a main reason why they object to vertical integration: vertically integrated companies offer a smaller provider network than most Americans would like.
4. The Split - between insurance companies and medical providers - resulted in more choice of provider. But it also resulted in higher healthcare inflation and many of the insurance practices we now take for granted, like medical underwriting.
5. World War II's wage and price freezes stimulated the development of 'fringe benefits', including hospital insurance, for employees. The IRS codified tax benefits for this in the 1950s.
6. Hospital insurance created incentives for excessive hospital use. The IRS tax benefits were essentially subsidies for hospital care.
7. The major economic factors that supported the growth of employer based health insurance all evaporated in the 1980s and 1990s. A key factor: during the 1950s and 60s, American manufacturers had little foreign competition, as European and Asian countries needed to rebuild after the War. American firms, thus, were profitable enough to provide health coverage to their employees.
8. Medicare and Medicaid eliminated political pressures to move toward single payer healthcare in this country. These two programs provided health coverage to people unable to get coverage from employers.
9. Employers are willing to settle for 'good enough healthcare' for their employees. The employer's trade-off: 'good enough healthcare' for 'good enough profits'. Good enough healthcare often included one or more of these:

- Provider network restrictions
- Annual / lifetime benefit caps
- Pre-existing or other medical condition exclusions
- Strict specialist referral restrictions
- Waiting periods
- Other obstacles to medical treatment

10. Employers like 1 year health plans. This puts providers and carriers under significant short term financial pressure, which is not always in the patient's best interests.

11. When carriers become too aggressive with their short term cost controls, the government steps in with healthcare mandates to protect patients.

12. Mandates often reflect the political power of some provider group, rather than the objective needs of patients.

13. Employer based health insurance is administratively quite expensive. Carrier overhead runs about 10% compared to Medicare's 2 or 3%.

14. Fee-for-service billing - a direct outgrowth of The Split between carriers and providers - results in more care, not better care.

15. Employers try to cope with the dysfunctionalities of this system by shifting costs to employees, in the form of higher copayments and deductibles and more premium cost sharing. None of these strategies will be effective in the long run.

16. One effect of having a short term cost control focus is a lack of preventive care. As a result, our treatment protocols focus on medical interventions later in the disease cycle than do protocols in other countries. We have, for example, a much higher rate of foot amputations in the US than do many European countries. We also perform more open heart surgeries.

Review Questions
Answers on next page

1. Which is the primary form of health insurance used in the US?
 - a. Employer based health insurance
 - b. Publicly financed health insurance
 - c. Medicare
 - d. Medicaid

2. How long is a typical health insurance policy?
 - a. 1 year
 - b. 2 years
 - c. 10 years
 - d. Lifetime

3. What was a major impact of World War II on US health insurance?
 - a. The development of fringe benefits due to the wartime wage and price freezes
 - b. The use of the word 'health insurance' in our common vocabulary
 - c. Expansion of the number of nurses available to treat patients
 - d. Growth in cancer research

4. When health insurance gets favorable tax treatment, who is the ultimate beneficiary?
 - a. Hospitals
 - b. Pharmaceuticals
 - c. Employees
 - d. Employers

5. What changed in the 1980s and 1990s to make employer based health insurance less viable than it had previously been?
 - a. European and Asian countries competed more vigorously with the US, thus reducing American company's abilities to set prices high enough to cover employee benefits
 - b. The dollar strengthened too much
 - c. The dollar weakened too much
 - d. American employees became significantly less healthy

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Correct answers in bold

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Part 3:

Our Health Insurance System

Chapter 8

Fee-for-Service Financing

Our employer based insurance system, combined with the Split between healthcare finance and service delivery, has led to fee-for-service payments to providers. We discussed the reasons for this at length in Chapter 4.

In this Chapter, we'll look at some effects of fee-for-service financing on our healthcare system. We'll discuss several systemic inefficiencies caused by fee-for-service financing.¹¹⁶

'Inefficiency' means that we pay too much for a particular outcome. This occurs in several ways:

- We may pay too much for a particular procedure, if, for example, similar quality is available elsewhere;
- We may generate preventable errors and then need to re-treat the same patient;
- We may have poor post-operative follow up, and then need to readmit someone;
- We may lose information between and among caretakers, requiring unnecessary retesting and retreating;
- We may provide unnecessary care due to poor diagnosis, for example, a false positive radiological reading;
- We may provide expensive care when less expensive, but equally effective, alternatives exist.

Inefficiencies arise in all phases of medical care: prevention, diagnosis, acute care, chronic care and rehab. The sum of all these inefficiencies is higher than necessary costs and poorer than optimal outcomes.

Healthcare System Inefficiencies: How Big a Problem?

Americans currently spend between \$500 and \$700 billion dollars annually on medical care that does nothing to improve our health.¹¹⁷ This is money spent on unnecessary tests, unnecessary treatments, excess treatments, excess

¹¹⁶ Portions of this chapter have appeared in Health Insurance Underwriter in 2009 and 2010. We thank HIU for permission to print here.

¹¹⁷ Shannon Brownlee, op cit, page 5

use of intensive care units, and the like. It is money that does not improve patient health or extend patient longevity.

These unnecessary medical interventions are certainly expensive and wasteful - but that's just one of the problems. A bigger problem, perhaps, is that systemic inefficiencies generate poor patient outcomes.

Here's a brief summary of how inefficient care - that often results in excess medical treatments - actually harm us:

- Radiological tests sometimes identify conditions that would never have bothered the patient had they never been found. 'There is a vast ocean of potentially diagnosed, but clinically meaningless cancers' according to Dr. James Talcott, Director of Outcomes Research at Massachusetts General Hospital. 'The more you [test] the more of those meaningless cancers you're going to find' and potentially treat unnecessarily. ¹¹⁸

Doctors annually perform an estimated 2 million biopsies on healthy women's breasts and male prostate glands as a result of 'false positives' (incorrect radiological readings that show cancer when it does not actually exist). In addition, some 500 women with no symptoms of cancer annually undergo unnecessary abdominal surgery due to false positives. These tests are stressful, painful and may lead to complications.

- Back surgery is overused as the treatment of choice for people in pain, even in the absence of conclusive evidence that surgery works. Surgery sometimes makes the pain worse.

Surgeons and hospitals apparently have an economic incentive to operate. Who objectively advises patients of these provider inducements...and that surgery is not always the best approach? Who advises them of their risks?

- Patients sometimes contract lethal infections while in the hospital for unnecessary or elective surgeries. In 2000, the Centers for Disease Control estimated that up to 90,000 people die annually from hospital acquired, preventable infections. How many died of preventable infections due to unnecessary hospitalizations...a third?;

¹¹⁸ Boston Globe, 'Scares Grow as Cancer Screening Rises' September 30, 2007, page A1, A20

- Up to another 98,000 Americans die annually from medical system errors, such as poor coordination among providers, according to the Institute of Medicine's 1999 study 'To Err is Human'. Again how many suffered medical systemic errors due to unnecessary hospitalizations?;
- Some 1.5 million Americans are 'sickened, injured or killed' annually due to medication errors, according to the Institute of Medicine's 2006 study 'Preventing Medical Errors'. In another report, the Institute estimates that patients receive, on average, 1 medication error per day that they stay in the hospital. A different study found that patients in intensive care receive, on average 2 errors per day. How many suffer these problems unnecessarily, due to unnecessary treatments or hospitalizations?

Medical Treatment Complications Present the Smaller Excess Treatment Problem

Dr. Atul Gawande of Harvard Medical School and the Harvard School of Public Health estimates that 97% of all medical treatments proceed as expected, and that only 3% have unintended / unexpected complications that harm patients.¹¹⁹ How big a problem is that?

In 2006, we performed about 72,000,000 ambulatory or inpatient procedures in this country, according to the Centers for Disease Control and Prevention.¹²⁰ If Dr. Gawande is right, then some 2+ million of these encountered systemic complications that harmed patients.

But this is just the tip of the 'healthcare systemic harm' iceberg. He limited his analysis to medical treatments where something actually went wrong.

He did not discuss unnecessary treatments that do no patient good. These may turn out 'well' but be unnecessary. Our epidemic of foot amputations may be one example here. Unnecessary heart surgeries may be another. We discussed both of these issues in the previous section.

¹¹⁹ Atul Gawande, interviewed by Charlie Rose on PBS, April 2, 2009. Dr. Gawande estimates that about 3% of all hospital admissions result in adverse complications.

¹²⁰ http://www.cdc.gov/nchs/data/hdasd/13_139t9.pdf

Three Effects of Unnecessary Care

First, regions of our country with more physicians have more medical procedures and higher medical costs. Among the most famous comparisons, Medicare recipients in Minneapolis cost about half as much as Medicare recipients in Miami without any indication of underlying health differences. (These people are all over 65 years old. There's no indication that sick people move to Miami, but healthy beneficiaries remain in Minneapolis.)

Researchers found that Medicare beneficiaries living in high spending areas were no healthier, no less disabled and had no lower mortality rates than people living in low spending areas.¹²¹ At best, more care accomplishes nothing positive. But this gets worse.

Second, surprisingly, beneficiaries in high spending areas were more likely to be undertreated than beneficiaries in low spending areas. This is, perhaps, a direct effect of having too many specialists and not enough generalists in high spending regions. Dartmouth researchers found, for example, that only 75% of heart attack patients in high spending areas had hospital discharge orders to take baby aspirin - the single most effective drug for reducing patient's risks of having a second heart attack.

By contrast, heart attack patients discharged from hospitals in low spending regions received baby aspirin orders 83% of the time.¹²²

Only 48% of patients in high spending regions received flu vaccinations, while 60% in low spending regions did.

Where did the excess spending go? The Dartmouth researchers discovered that

Differences in spending were explained almost entirely by greater frequency of physician visits, more frequent use of specialist consultations, more frequent tests and minor procedures, and greater use of the hospital and intensive care units...

We found no evidence to suggest that the pattern of practice observed in higher-spending regions led to improved survival, slower decline in functional status or improved satisfaction with care.¹²³

¹²¹ Fisher, op. cit.

¹²² *ibid.*

¹²³ Fischer, et al, The Implications of Regional Variations in Medicare Spending Part 2, *Annals of Internal Medicine* 2003:138, pages 292 - 293

Dartmouth's conclusion: hospitals that spent more were simultaneously overtreating patients (with specialists unnecessarily) and undertreating patients (with primary care) and generating no patient improvements.

But sometimes generating negative results.

Negative results? This is the third problem of excess treatment. Fisher and his Dartmouth colleagues found that patients who went to the most expensive hospitals had a 2 - 6% increased chance of dying, compared to patients who visited less expensive facilities. The reason, according to Fisher:

The most reasonable explanation for the higher mortality rate is that the additional medicine patients are getting in the high-cost regions is leading to harm.¹²⁴

The specific findings:

- An increase in medical spending per person was associated with a small increase in the risk for death;
- For every 10% increase in medical spending, the relative risk for death over 5 years increased;
- In none of the groups examined was a higher expenditure rate per capita associated with a statistically significantly lower mortality rate.

Note that Fisher and his team 'bent over backwards' to ensure that their cohorts of patients were equally sick. The generally accepted analysis of Fisher's study: there was no consistent medical difference among patients at the different hospitals.¹²⁵

What have we learned from all these Dartmouth - and other - studies? That regions with fewer specialists in relation to the population - and more primary care physicians - have better overall health. Fisher, in his major 2003 studies found both less undertreatment and lower mortality rates in hospital regions where there are more primary care physicians and fewer specialists.¹²⁶

¹²⁴ Fisher, quoted in Brownlee, op cit, page 50

¹²⁵ Brownlee, op. cit, page 320, note 50.

¹²⁶ Ibid, page 67

This is the big overtreatment problem. Remember how Dr. Gawande, above, noted that 97% of hospital treatments turn out well, so only about 3% are subject to error or mistreatment. As we suggested, that is the smaller overtreatment problem.

The big overtreatment problem is appropriateness - having the patient get the right care from the right specialist at the right time. That's another word for efficiency: getting the best patient outcomes at the lowest cost.

Seven Healthcare System Inefficiencies

Why do we have such inefficiencies in our healthcare system? I'll suggest seven major reasons, all arising from our fee-for-service financing model:

- Moral hazard
- Medical Arms Race
- Ineffective preventive and chronic care
- Treatment variation
- Poor safety
- Overuse of General Hospital
- High number of medically uninsured folks

Note that this is my own list and it is not necessarily exhaustive. These inefficiencies are often discussed in the healthcare literature, though other commentators sometimes use different labels for the same problems. My hope in presenting this particular list of healthcare problems is that it is useful to readers, rather than necessarily definitive.

Problem #1: Moral Hazard

'Moral hazard' identifies how consumer behavior changes when an insurance company pays: we have more doctor visits, tests and procedures than if we paid individually, out-of-pocket. We shop less wisely or aggressively using the insurance carriers' money than our own.

The moral hazard concept originated in the fire insurance industry when executives became concerned that people with 'poor moral character' might purchase policies and then burn down their own houses to collect the insurance proceeds.

Auto insurance carriers concern themselves with policyholders who intentionally cause auto accidents to gain insurance benefits.

And health carriers worry that people will have expensive, unnecessary medical tests and procedures.

Healthcare moral hazard is an elusive, difficult to grasp concept. Much like former US Supreme Court Justice Potter Stewart's description of pornography, it's hard to define but recognizable upon sight: it is healthcare system inefficiency.

Three Definitions of Healthcare System Inefficiency

First, healthcare efficiency means 'having the patient get all care that is worth at least what it costs, but get no care that is worth less than what it costs'.

Moral hazard is the opposite: patients may get care worth less (in terms of longevity gains or life quality improvements however measured) than the costs.

Second, healthcare efficiency means 'the treatment plan that your physician who is well versed in the current medical literature and knows your medical condition well, would approve absent any economic considerations.'

Moral hazard is the opposite - a treatment plan that includes economic considerations. A patient might think 'I don't know if I really need this test or procedure, but it's free (to me) so I might as well have it.' A provider might think, consciously or unconsciously 'I don't know if the patient really needs this test or procedure, but it's free (to them) and I can bill the insurance carrier, so I might as well do it.'

Third, healthcare efficiency means 'getting the maximum treatment benefit at the lowest cost.'

Moral hazard is the opposite - providers might recommend beneficial but costly treatments and ignore equally (or more) beneficial but less expensive remedies.

Provider Financial Interests

Under most US health insurance payment programs, providers receive fee-for-service payments. Physicians only get paid if they perform a service. Hospitals get paid only if they treat.

The physician or hospital has a financial interest to treat and earns the most by providing the most expensive treatment.

Meanwhile the patient has little or no financial interest in receiving low cost treatment or avoiding treatment altogether.

Roemer's Law

Economist Milton Roemer perhaps initially quantified this phenomenon in 1961.¹²⁷ He studied hospital admission behavior in an upstate New York community and developed Roemer's Law: that a hospital room built is a hospital room filled.

In 1957 this New York community had 1 general hospital with 139 beds that seemed to meet community needs with an average daily census of 108 - suggesting that the hospital was rarely full.

In 1958, the hospital moved to a new facility with 197 beds and the occupancy average increased to 137 (a 26% increase in 1 year) - *with no change in the overall community health and no other economic factors at work.*

<u>Year</u>	<u># Available Hospital Beds</u>	<u>Average Occupancy</u>	<u>Increase</u>
1957	139	108	
1958	197	137	26%

Roemer's only explanation: physicians responded to the increased supply of beds by admitting more patients.

He claims that 'the supply of hospital beds in a community or state is the major determinant of the hospital utilization.' Physicians and hospitals only get paid to treat, thus creating an economic inducement to treat, hospitalize, over-treat and over-hospitalize.

Dartmouth Medical School research

Dartmouth Medical School researchers followed Roemer's lead and studied economic effects of moral hazard in fee-for-service medicine.

They combed Medicare data on spending and longevity and learned, for example, that Medicare spends about twice as much per beneficiary in Miami as in Minneapolis - without achieving better outcomes.

Dr. Elliott Fisher, a highly respected Dartmouth researcher, summarizes the impact of moral hazard on US healthcare:¹²⁸

¹²⁷ Milton Roemer, Bed Supply and Hospital Utilization: A Natural Experiment, Hospitals, 35 (1961)

¹²⁸ Elliott Fisher, HealthCare in America: Is More Better? Annals of Internal Medicine, February, 2003. Fisher and colleagues compared regional Medicare spending differences and health outcomes. They found that while Medicare recipients living in high spending areas had more physician visits, more tests and more hospitalizations, they showed no evidence of lower death rates or better health status.

Up to about a third of medical care is devoted to services that do not provide any detectable benefit.

This is close to Roemer's discovery of a 26% increase in (unnecessary?) hospitalizations. Dr. Fisher also notes that increased levels of medical treatment sometimes lead to poorer outcomes (due to infections, physician errors, lack of attention to prevention, etc).

Case Study: Back surgery in Florida ¹²⁹ In 2001 Medicare paid for 6.9 back surgeries per 1000 enrollees in Fort Myers, Florida. But it only paid for 3.2 back surgeries per 1000 enrollees in Miami. The national average was about 4.5.

2001 Medicare Back Surgery Rates

Fort Myers, Florida	6.9/100,000 Medicare enrollees
Miami, Florida	3.2/100,000 Medicare enrollees
National Average	4.5/100,000 Medicare enrollees

Had Fort Myers operated at Miami's rate from 1992 - 2001, Medicare would have saved almost \$2 billion: 4,800 surgeries at an average \$40,000 each.

Why the discrepancy in back surgery rates for the same epidemiological population? 'It's highly improbable that Medicare retirees living in Fort Myers prefer back surgery two times as often as residents of Miami' suggests James Weinstein, Chairman of Dartmouth Medical School's Department of Orthopedic Surgery.

Rather, he looks at the 'surgical signature' of doctors --- idiosyncratic patterns in the likelihood of a doctor choosing to operate. The greater the scientific uncertainty in treatment options, he suggests, the more variations appear. And the more opportunity for moral hazard mischief.

In 2001, according to a study done by the American Academy of Orthopedic Surgeons, spine surgery accounted for more than half of all profits from orthopedic procedures in hospitals, but only 21% of the volume. Spine surgeries can be very profitable.

Surgeons at 3 hospitals owned by Lee Memorial Health System, a 'leading provider of healthcare in Southwest Florida' according to their website, performed 447 spine procedures on Medicare patients in 2004. Medicare

¹²⁹ This case study comes from the Washington Post, July 24, 2005, page A 12, When Geography Influences Treatment Options.

reimbursements to the 3 hospitals for spine operations grew by nearly 50% in the previous 5 years.

‘I can’t explain it’ said Lee Memorial’s chief medical officer when shown the back surgery rate statistics. He suggested that surgery is about the best medical intervention available for back pain.¹³⁰

But he noted that ‘if the only tool you have is a hammer, everything looks like a nail.’

Carrier reimbursement practices and hospital profitability goals, of course, may influence the perception that ‘everything looks like a nail’.

Dartmouth’s Weinstein disagrees. Dartmouth-Hitchcock Medical Center provides patients with education and options. ‘What we have found is that patients tend to make good decisions when presented with good information.’

As a result, in 2001 Dartmouth-Hitchcock, working with the same Medicare epidemiological population as Lee Memorial, performed back surgery on 2.3 Medicare patients per 1000 beneficiaries - 1/3 as much as Lee Memorial, and even less than Miami!

Who Wants to Cut Moral Hazard Waste... Providers? Patients? Carriers?

Why does our healthcare system allow all this waste? Commentators suggest that providers, carriers and consumers have separate sets of interests.

Providers

Providers get paid to treat, so have their financial interests tied to providing as much treatment as **justified**, not as little as **possible**.

Sick patients typically present with multiple problems (e.g. high blood pressure, coronary issues and pulmonary issues simultaneously) and thus complex diagnoses.

The responsible, reasonable and thorough physician examines all problems, evaluates all potential medical issues while diagnosing and presents all potential treatment plans when treating.

Are all diagnoses and treatments equally necessary? Unclear. If the patient paid out-of-pocket, would the physician and hospital services be more limited? Also unclear. But Roemer and the Dartmouth researchers seem to suggest, likely.

¹³⁰ Ibid.

Patients

Patients want as much treatment as possible. After all, they fear that their medical problem may be significant, and they have insurance to cover medical expenses.

Many studies have found that patients use medical services as long as the probable benefits outweigh their co-payment cost (often \$10-20).

This is classic moral hazard: the patient only pays a small percentage of treatment costs, so faces an artificial cost-benefit analysis.

Patients also have difficulty determining which physicians and hospitals provide the highest quality service as our medical system provides notoriously poor outcome data.

Absent Outcome Data, Patients Take Two Positions Simultaneously

First, they substitute physician trust and credentials for knowledge of physician quality. They trust, for example, a kind and responsive PCP as they cannot determine whether or not he/she is really 'good'.

They trust doctors at Massachusetts General Hospital (or the Cleveland Clinic, or the Mayo Clinic, or other) more than a local community hospital because 'Mass General is world class, many physicians went to Harvard and it's simply - obviously - better than the others' with no data to back up these claims. Mass General is more expensive than most other Boston area hospitals. But consumers don't care because they don't pay.

Second, consumers demand wide provider choice and few referral restrictions when choosing health insurance. This allows them to change providers should they so desire.

'It is a sad irony that 'choice of doctor' has become in most American's minds, the single greatest measure of the quality of any health care plan,' claims Phillip Longman, author of Best Care Anywhere, a study of the VA healthcare system.

Consumers demand this choice because they lack information about provider quality and treatment outcomes.

Carriers

Carriers want to satisfy their customers.

As consumers demand easier referrals and wider provider networks, the carriers comply. They determine the underlying medical costs, add their

overhead factor (generally about 10%) and provide the product that consumers demand.

HMOs - with referral restrictions that help reduce moral hazard waste - have lost market share to PPO/POS plans with few if any referral requirements.

Plan Type	Percent of US Health Insurance Policies by Year ¹³¹		
	<u>1996</u>	<u>2000</u>	<u>2005</u>
HMO	31%	29%	21%
PPO/POS Combined	42%	63%	76%

In addition, many HMO referral restrictions have diminished over time.

As these three parties - providers, consumers and carriers - all pursue their separate interests, moral hazard waste grows and our healthcare inflation roars...but healthcare results don't necessarily improve.

Conclusion

Controlling moral hazard waste can significantly reduce our healthcare expenses without reducing healthcare quality. We annually waste some \$500 - \$700 billion on unnecessary care, if Milton Roemer and the Dartmouth researchers are correct.

But we must control waste appropriately so acute and chronic patients get their necessary levels of service. Designing an appropriate healthcare finance system is fraught with difficulties.

We've tried dozens of control systems- including Prospective Payment Systems, DRGs, Utilization Review, Treatment Guidelines, Health Savings Accounts, Pay for Performance and others. None significantly reduce moral hazard systemic waste, at least not without compromising patient care.

Reducing our current levels of moral hazard induce waste is a laudable - though extremely difficult to achieve - goal. We've know about this problem since Roemer's Law was developed in the 1960s but, unfortunately, are no closer to a solution today than then.

Problem #2: The Medical Arms Race

The Medical Arms Race describes competition among hospitals for physician referrals and patients. Hospitals compete with each other by offering the latest

¹³¹ Kaiser Family Foundations, Trends and Indicators in the Changing Health Care Marketplace

in medical technologies and most modern facilities, often at great expense and sometimes without indications that the newest technologies significantly improve outcomes.

Why do Hospitals Compete Based on Treatment Inputs?

Physicians want to refer to the most up-to-date facility, patients want treatment at the 'best' hospitals, and malpractice lawsuits may be lost for failure to use the latest technologies. No one wants to use a hospital with old machines or old technologies - even if these work perfectly well.

When a new machine or technology becomes available, all hospitals in a competitive environment purchase it - for fear that if they don't and their competitors do, their referral sources will dry up and they'll go out of business.

Our fee-for-service or cost-plus insurance reimbursement formulas encourage this proliferation of costly medical technologies.

Under fee-for-service, as a hospital's costs increase, so can its fees (assuming it has the market clout to impose its fees on financiers). Under cost-plus reimbursement, the 'plus' calculation is generally a fixed percentage of 'cost'. So as a hospital's costs increase, so does its 'plus' reimbursement - and it makes more money.

Interestingly, hospitals do not compete on results - mortality rates by operation or by surgical team; 30 day readmission rates after surgery; post operative infection rates or similar. Rather they compete based on inputs - machinery, technology or staffing ratios, for example.

Healthcare Differs from Other Parts of Our Economy

This type of competition differentiates healthcare from other parts of our economy.

The auto industry, for example, competes on price and quality. We typically purchase a car knowing its miles per gallon and resale estimate - both outcome measures.

We typically care less about (or don't even know) the type of metal used in the engine or frame. Nor do we typically know about the brake line construction, the wheel bearing design or how the exhaust is fastened to the chassis. We only care how well these components work together and the outcome we can expect from our investment.

But the healthcare industry operates differently. It does not publish - and often does not even know - outcome measures of medical interventions. As a consequence, hospitals compete on inputs, using these as a proxy for quality.

Medical Arms Race First Discovered in the 1980s

The medical arms race was perhaps initially identified in 1985 when economists James Robinson and Harold Luft discovered that hospitals with **more** competitors had **higher** costs of care, staffing levels and high tech medical equipment than hospitals without competitors.¹³²

This is exactly the opposite of businesses that compete on results or outcomes.

Robinson and Luft also found, surprisingly, that these competitive hospitals sometimes had higher mortality rates (i.e. poorer outcomes) than non-competitive hospitals. Here's why:

Surgeons, surgical teams and hospitals with the most experience with a particular treatment get the best outcomes, and those with the least experience generate the highest mortality rates. In other words, practice makes perfect in medicine.

Healthcare commentators call this the 'volume-outcome relationship'; the higher the hospital's volume of a particular procedure, the better the patient outcomes.

If all hospitals in a competitive environment use the same technologies to perform the same treatments, there may be too few patients with a given condition for all hospitals to become expert.

In other words, the Medical Arms Race may reduce the amount of experience of each hospital or team - leading to poorer outcomes.¹³³

The Medical Arms Race forces American hospitals to invest huge amounts of money in (unnecessary?) technologies and perhaps increase mortality risks for patients...while tragically ignoring alternative treatment options.

A Second Version of the Medical Arms Race: Radiological Screening

There are many versions of the Medical Arms Race occurring in every US city every year. Here is a second example.

Hospitals invest in expensive new high tech screening tests designed to spot cancers early - often far more than they invest in nutrition and exercise

¹³² J. Robinson and H. Luft, the Impact of Hospital Market Structure on Patient Volume, Average Length of Stay and the Cost of Care, Journal of Health Economics 4 (1985): 333 - 56

¹³³ This conclusion is suggested by David Dranove, The Economic Evolution of American Healthcare, page 47

programs. Carriers reimburse well for these tests and investments; hospitals keep their patients coming and - theoretically - patients benefit.

Here's an indication of the size and growth of the radiological screening business (not all CT scans are related to cancer): ¹³⁴

<u>Year</u>	<u># CT scans performed</u>
2000	40 million
2004	65 million
2005	76 million
2010	100 million (estimate)

Two Screening Problems

First, the cost/cancer diagnosis is high - and the cost per marginal lifesaving diagnosis extremely high. A marginal lifesaving diagnosis is the problem that an existing technology would miss with negative patient outcomes, but a new technology finds with positive outcomes. Often the existing technologies would pick up the problem in time for treatment.

This raises a difficult resource allocation question. A new CT scanner may cost \$2 million. Would we save more lives by investing that \$2 million in dermatology, for example and keep using the existing scanner?

Second, these expensive new technologies lead to many false positives - results that indicate patients might have cancer when, in fact, they do not.

Patients consequently undergo stressful, expensive follow-up tests and procedures. Doctors annually perform some 2 million biopsies on healthy *female breasts* and *male prostate glands* as a result. In addition, more than 500 women with no symptoms of *ovarian cancer* underwent unnecessary abdominal surgery because tests wrongly indicated they had the disease. ¹³⁵

'There is a vast ocean of potentially diagnosed, but clinically meaningless cancers' according to Dr. James Talcott, director of the center for outcomes research at the cancer center at Massachusetts General Hospital. 'The more you [test] the more of those meaningless cancers you're going to find.'

And the more we're going to pay. Cost estimates for treating false positives in healthy female breasts alone range to \$70 billion over the next decade. ¹³⁶

¹³⁴ Shannon Brownlee, *Overtreated*, page 144

¹³⁵ Boston Globe, *Scares Grow as Cancer Screening Rises*, September 30, 2007 Page A1

¹³⁶ Natasha Singer, *In Push for Cancer Screening, Limited Benefit*, New York Times 7/17/2009 quoting David Newman, Director of Clinical Research at St. Luke's Roosevelt Hospital Center in Manhattan

In this version of the Medical Arms Race, we invest huge sums to gain a marginal diagnostic advantage, then more money to explore the false positives. Hospitals all compete to offer these 'newest, greatest' tests and keep their physician network referring.

Interestingly, the hospital can bill two or three times per test:

First, to perform the actual cancer screen;

Second, to explore the false positives, via surgery or otherwise; and perhaps

Third, to readmit the patient after surgical complications (we run that national 18% +/- readmission rate within 30 days of hospital discharge).

The tragedy: we could save more lives and improve more people's quality of life by investing in prevention and chronic disease treatment for the masses. But that's now how hospitals compete.

Conclusion

In the Medical Arms Race, hospitals compete based on treatment components - machinery, technologies, staffing ratios, etc - rather than on outcomes or cost.

This is extremely expensive and makes healthcare unlike most other businesses in our economy. Increasing medical component costs does not necessarily improve patient outcomes; it may, in fact, worsen them. This form of hospital competition is a huge problem for our healthcare system.

The Medical Arms Race: always more expensive; not always better outcomes.

Problem #3: Ineffective Chronic Disease and Preventive Care

Two Types of Medical Conditions

Medical conditions can usefully be divided into two types: 'chronic' and 'episodic.'

Chronic medical conditions are long-term, often presenting multiple, inter-related medical problems.

Diabetes is such a chronic condition, often caused by obesity, and requiring a coordinated team of specialists and technicians, including endocrinologists,

psychologists, podiatrists, nephrologists, nutritionists, educators and others for proper treatment.

The chronic condition is never ‘cured’ - the disease is only ‘controlled’, requiring an on-going, long-term effort.

Episodic conditions are one-off. Once treated and rehabilitated, the patient returns to good health without much need for on-going medical treatments. Episodic conditions and treatments include broken bones, illnesses such as pneumonia, and many coronary procedures.

Our fee-for-service provider payment system is primarily episodically based, with providers billing by DRG or a similar accounting system. The Institute of Medicine claims that today’s health system remains overly devoted to dealing with acute, episodic care.

The Majority of US Medical Problems Today are Chronic Disease-Based

Chronic disease treatment requires multiple healthcare interactions every year to ensure small but steady advances that can prolong life. Ranch Kimball, President of Boston’s Joslin Diabetes Center laments that

While [Massachusetts’] healthcare system is the best worldwide in helping acutely sick people, it is poorly organized to prevent chronic disease or to intervene early enough to prevent complications. ¹³⁷

More than half of all Americans have at least one chronic illness Kimball reports. The American Diabetes Association estimates the direct medical costs of diabetes in 2007 alone were \$116 billion, up from \$95 billion in 2002.

Perhaps 75% of today’s healthcare costs go to treating patients with chronic conditions, often a combination of obesity, hypertension, diabetes and depression. Emory University’s Professor Kenneth Thorpe suggests that obesity related (i.e. chronic) conditions alone may account for up to 1/3 of the total US healthcare cost increases over the past 15 years. ¹³⁸

¹³⁷ Ranch Kimball, The Chronic Cost of Chronic Disease, Boston Globe, 10/18/2007, page A13

¹³⁸ Kenneth Thorpe, presentation to the Massachusetts Healthcare Council, March 13, 2007 in Marlborough, Massachusetts

Case Study: Chronically Ill Patients Meet an Episodically Based Hospital Financing System

Here's a case study of Manhattan's Beth Israel Medical Center's diabetes center that illustrates the problems.¹³⁹

In March, 1999, Beth Israel opened its diabetes center, designed as a 'boot camps for diabetics...The center would teach them to check [blood sugar] levels, count calories and exercise with discipline, while undergoing prolonged monitoring by teams of specialists.' In other words, a moderately long-term, team approach to chronic disease treatment.

One patient, Ella H., a retired school administrator, compared Beth Israel to other preventive care.

The center was a totally different experience. What they did worked because they taught me how to deal with the disease, and then they forced me to do it in twice weekly, two-hour classes...compared to the average physician office visit lasting about 8 minutes. She attributed her 20-pound weight loss to those classes. 'I needed reminding.'

The program was 'an unqualified success' according to the New York Times. Within 5 months more than 60% of the center's patients had their blood sugar under control. Close to half had lost weight. Competing hospitals directed their diabetic patients to Beth Israel. Patient volumes grew by 20% monthly as success stories spread.

But Beth Israel lost money - \$1.1 million. And within 10 months the hospital decided to close its diabetes program. Why?

Carriers pay more for sickness procedures than wellness visits. There is little funding for 'reducing a patient's blood sugar level' or 'a daily reminder to exercise for 20 minutes every day' or 'checking a patient's weight as a reminder to eat better'. Insurers often balked at paying \$75 for diabetic's regular nutrition counseling, but regularly paid \$315 per kidney dialysis session - a byproduct of diabetes.

Insurers also often refuse to pay \$150 for a diabetic's regular preventive podiatric visits, but will pay \$30,000 for a foot amputation, apparently thinking that they will save \$150 this year and that you'll switch to another carrier before you need the amputation.

¹³⁹ This case study comes from Ian Urbina, In the Treatment of Diabetes, Success Often Does Not Pay, New York Times, January 11, 2006

And carriers paid only \$25 for an hour-long diabetes class. ‘That wasn’t even enough to pay for what it cost to have me do the paperwork to get the reimbursement’ according to Denise Rivera, the Center’s secretary.

The Beth Israel program scheduled patients for multiple physician and educator visits per day - for patient convenience and education reinforcement. But Medicaid only pays for 1 service per person per day.

So every time the hospital scheduled a diabetes education class and a specialist visit on the same day - in other words, worked in the patient’s best interests - it lost money.

Beth Israel learned the lesson that insurance carriers already knew. ‘The point is not to attract the most customers but rather the best...insurance executives usually think twice before bolstering their diabetes benefits, for fear they will attract the chronically ill,’ according to the New York Times.

Beth Israel closed its successful diabetes treatment program precisely because it was successful. More diabetics went untreated, suffered (preventable) blindness, limb loss, kidney failure or other problems, and the ultimate treatment costs continued to soar.

How Often Does Our Financing System Fail Chronically Ill Patients?

Boston’s Joslin Diabetes Center has taken an alternate financial approach.

Roughly 40% of Joslin’s diabetes care is not reimbursed by insurance. Joslin realizes that our episodic-based health insurance reimbursement formula fails patients (apparently about 40% of this time), so arranges outside, non-insurance funding to continue its patient based diabetes treatments.

Some Numbers

Let’s estimate the costs of poor disease prevention in this country, using coronary disease as an example.

In 2006, we performed about 1.3 million angioplasty procedures at an average of \$50,000 each, for an annual total cost of about \$60 billion. We also performed about 450,000 coronary artery bypass operations, costing \$100,000 each, for a total of about \$45 billion.

Thus the total 2006 costs just for for angioplasties and CABG exceeded \$100 billion. Yet lifestyle changes - a.k.a. good preventive medicine - could prevent

about 90% of all heart disease at a fraction the cost. That's the conclusion of a huge study, the INTERHEART study, published in 2004.¹⁴⁰

Here's the impact, as it appeared in the conservative Wall Street Journal:

The disease that accounts for more premature deaths and costs Americans more than any other illness is almost completely preventable.

The potential annual savings on coronary procedures alone approach \$90 billion...not to mention alleviating enormous suffering on the part of patients.

Expanding on this thesis, Journal columnists estimate that up to 95% of all US healthcare spending goes to treat diseases after they occur - yet 75% of these costs went to treat preventable or even reversible chronic diseases such as heart disease and diabetes.¹⁴¹

This is a huge misallocation of resources.

Annual Physicals: Prevention or Early Detection?

There is a second aspect of poor preventive care - the inefficacy of annual physicals.

Some 64 million Americans get their physical annually at a cost of almost \$8 billion. But researchers question the scientific justification of this. No major clinical organization supports annual physicals as a standard.¹⁴²

Listening to heart and lungs probably doesn't help unless the patient has symptoms; same for a complete annual blood count, urinalysis, EKG and X-ray.

The annual physical ritual, as currently practiced, has three drawbacks.

First, they waste expensive physician resources. 'If I'm spending 20 minutes or half an hour with you on an exam that's not necessary, that's 20 minutes I could be spending with one or two other patients who are ill,' says Dr. Robert Goldsizer, associate chief medical officer at Boston's Brigham and Women's Hospital. 'That's waste.'

Second, the 20 minute overview is insufficient for the physician to understand underlying patient issues and provide advice and support.

The patient may suffer from physical or emotional stresses that Marcus Welby-type physicians could address. Indeed, the annual physical is

¹⁴⁰ Cost and treatment volume estimates come from the Wall Street Journal, 1/9/2009, Alternative Medicine, by Chopra et al. The INTERHEART study by Yusef, et al. was published in the Lancet in 2004

¹⁴¹ Wall Street Journal, ibid.

¹⁴² Boston Globe, October 22, 2007, page C1

theoretically the time for patients and doctors to talk, develop trust and explore medical issues.

But 20 minutes is too short. Patients may need more time to open-up and divulge potentially embarrassing but important information; physicians may need more time to pursue discussions. The downside: a patient gets a good bill of health and feels praised by the physician - based on unnecessary tests - while the underlying issues remain untreated.

Note that the 20 minute time frame results from insurance carrier pressures that physicians see more patients per time period, rather than generate better results per patient. This runs exactly counter to the Institute of Medicine's 'Crossing the Quality Chasm' recommendations that defined medical care as a relationship, not just a visit.

Third, the annual physical functions more as early disease detection than disease prevention.

We know, for example, that regular exercise prevents far more diseases than an annual complete blood count. Yet at your physical, your caring physician only has time to say 'exercise more' - without detailing a specific program or designing an effective follow-up procedure.

Harvard Magazine presents this case compellingly, describing a wonder-drug: ¹⁴³

In the bottle before you is a pill, a marvel of modern medicine that will regulate gene transcription throughout your body, helping prevent heart disease, stroke, diabetes, obesity and 12 kinds of cancer - plus gallstones and diverticulitis. Expect the pill to improve your strength and balance as well as your blood lipid profile. Your bones will become stronger. You'll grow new capillaries in your heart, your skeletal muscles and your brain, improving blood flow and the delivery of oxygen and nutrients. Your attention span will increase. If you have arthritis, your symptoms will improve...You will test younger according to a variety of physiologic measures. Your blood volume will increase and you'll burn fats better. Even your immune system will be stimulated.

The only problem - there is no such pill. The prescription is exercise.

But the harried physician in your 20 minute physical can only prescribe an actual pill that accomplishes some of this - not manage an exercise program to address all of it. Remember the experience of Ella H., the retired school administrator working with Manhattan's Beth Israel diabetes program.

¹⁴³ Jonathan Shaw, The Deadliest Sin, Harvard Magazine, March-April 2004, page 36

Reinforcement, repetition and support worked; a one time admonition with Rx does not.

Conclusion

The underlying problem here: physicians get paid to intervene, not to prevent.

There is little funding for listening to patients or probing into their emotional / physical issues, being sympathetic and understanding, or helping them change unhealthy lifestyles.

There is little funding for providing excellent preventive care or maintaining wellness. Physicians do not get paid to monitor your exercise regime; they get paid to treat you after you and they fail to prevent illnesses.

This is a huge and depressing problem for our healthcare system to address.

Problem #4: Treatment Variation

Researchers have known about medical treatment variations for years.

An early study 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston' reported that rates of coronary artery bypass graft surgery were much higher in New Haven than Boston, but that rates of carotid endarterectomy here higher in Boston than New Haven.¹⁴⁴

Why would Yale trained physicians treat one way, while Harvard trained physicians another? If medicine is a science, they can't both be right.

Remember the Ft Myers and Miami back surgery example above. Back surgery rates per 100,000 Medicare beneficiaries in Florida varied between 6.9 in Ft. Myers and 3.2 in Miami.¹⁴⁵ Why would snowbirds in west Florida have twice as many back problems as snowbirds in east Florida? That doesn't make sense.

Actually, though that might not make any common or statistical sense, it may make financial sense. Had Ft Myers operated at Miami's rate from 1992 - 2001, it would have generated \$2 billion less in Medicare spending. That's a lot of jobs and provider incomes.

¹⁴⁴ J. Wennberg et al, Are Hospital Services Rationed in New Haven or Over-Utilized in Boston, Lancet 1 (1987) 1185:88

¹⁴⁵ Discussed above.

Our question becomes: Did Ft Myers waste \$2 billion dollars on unnecessary surgeries...or were Miami Medicare beneficiaries underserved?

Or were the populations different?

To eliminate potential disease differences among populations (thus biasing their studies), researchers studied treatment variation patterns in Vermont - a small, demographically and epidemiologically homogeneous state. Among the findings:¹⁴⁶

- 70% of children under 16 years old in Morrisville had their tonsils removed, compared to only 7% of children under 16 in Middlebury;
- The rate of hysterectomies per 10,000 people ranged from 20 - 60 by region in Vermont, with no evidence of underlying epidemiological differences;
- Appendectomies and mastectomies varied threefold across the state, again without evidence of underlying disease differences;
- Varicose vein surgery varied fourfold.

Perhaps most surprisingly, tonsil removal rates ran 20% for kids under 15 in Waterbury vs. 70% in Stowe.

Why surprising? Waterbury and Stowe are next door to each other. They are socioeconomically similar. Researchers could find no significant demographic or epidemiological differences. Why the discrepant tonsillectomy rates?

It turns out that kids in Stowe visited one pediatric practice, while kids in Waterbury visited another. Physician orientation and practice protocols led to the discrepant medical treatments.

The Dartmouth Atlas of Health Care

Researchers from Dartmouth Medical School discovered other significant regional treatment variations which they publish in their Atlas.

Medicare spends, for example, far more in some regions than others on enrollees with the same age, socio-economic and health status. In 2006, for example, Medicare spent the following:¹⁴⁷

¹⁴⁶ Brownlee, Overtreated, page 25

¹⁴⁷ Dartmouth Institute Press Release, 2/26/09, Taming Wide Variations in Spending'. The Minneapolis figure came from the Dartmouth Institute's Interactive Map

\$16, 351 per beneficiary in Miami;
\$ 8, 331 per beneficiary in California
\$ 6, 705 per beneficiary in Minneapolis
\$ 5, 311 per beneficiary in Hawaii

This appears odd, since the populations are basically the same. Medicare's stipulated rates for medical procedures include only relatively minor cost of living differences - certainly not double or triple.

The spending differences, suggest the Dartmouth folks, were explained almost entirely by greater frequency of physician visits, more frequent use of specialist consultations, more frequent tests and minor procedures, and greater use of the hospital and intensive care units - not by underlying diseases.¹⁴⁸

But here's Dartmouth's surprising conclusion:

The higher spending did not result in better quality of care or survival following such serious conditions as a heart attack or hip fracture.¹⁴⁹

Even though residents of some regions received more care, they did not have lower mortality rates, better functional status or higher satisfaction with their medical care. Indeed, the Dartmouth folks suggest that:

If the US health care system mirrored the practice patterns of gold-standard healthcare systems such as the Mayo Clinic in Minnesota, Medicare could save tens of billions of dollars annually.¹⁵⁰

UCLA Medical, for example, uses 50% more beds and almost twice as many physician FTEs to manage similar patients as Mayo ... without any evidence that their patients receive better care.¹⁵¹

More care certainly means more provider income - but doesn't closely correlate to better patient outcomes.

¹⁴⁸ Elliott Fisher, et al, The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care, *Annals of Internal Medicine*, Feb 19, 2003

¹⁴⁹ Dartmouth Atlas Project Topic Brief, Healthcare Spending, Quality and Outcomes, 2/27/09

¹⁵⁰ Dartmouth Institute for Health Policy, Chronically Ill Patients Get More Care, Less Quality.

¹⁵¹ Ibid.

Treatment Variation Patterns

Treatment variation is the likelihood that a doctor will send a patient for one kind of treatment versus another. Note the national variations in some fairly common medical procedures:

Gall Bladder Removal.....	270% variation nationally
Hip Replacement.....	450% variation nationally
Intensive Care during last 6 months of life....	880% variation nationally
Back Surgery.....	500% variation nationally

These variations indicate huge healthcare system inefficiencies. Some patients are overtreated; others under. The potential economic costs of variation run billions.

Two Reasons Why There Are No National Treatment Standards

The interesting question: why are there no national treatment standards and protocols? After all, we have a huge amount of experience working with similar types of patients: hip replacement candidates, geriatrics, etc.

And we could save enormous resources by standardizing our protocols.

Commentators suggest two main reasons for the lack of national consensus on treatment.

First, politics and competing financial interests always seem relevant in discussions of medical routines.

Surgeons, according to many studies, tend to favor surgery; pharmaceutical companies like drug therapies.

In the 1990s some 30 commissions and 80 professional societies developed guidelines. By 1994 the AMA noted over 1600 sets of guidelines, often contradictory. Hospital guidelines said 'hospitalize'; carrier guidelines tended toward 'don't hospitalize'. Pharmaceutical companies recommended drugs; surgical suppliers recommended surgery.

Guidelines proposed by medical specialties supported the economic interests of those specialties. Each group believed that it contributed significantly to patient health, while opposing viewpoints, perhaps, did not. Each group embraced studies that showed its medical effectiveness.

Upton Sinclair, writing years ago about a different problem, summarized this issue:

It is difficult to get a man to understand something when his salary depends upon his not understanding it.

Second, medicine offers fertile ground for divergent schools of thought and approaches. In the absence of clear, objective outcome data, some physicians are aggressive, others conservative. The issue often revolves around where a physician received his/her medical training, and what set of experiences formed his/her medical judgment.

Underlying Issues and Assumptions

All this underscores a key problem in medicine: that it's a young and extremely complex science. There is enormous individuality and variability among patients and diagnoses.

We're still at an early stage of learning, innovating and discovering processes and treatment plans. We have, for many medical conditions, only identified **the easiest to quantify variables** - not necessarily the most important.

Many commentators worry that codification of treatment guidelines will stifle innovation. They worry that process compliance based only on the lowest common denominator of data will harm, rather than improve, our medical system.

People calling for national treatment protocols share a common assumption: that similar processes generate similar results in medicine.

This is questionable.

Significant data indicates that similar processes do not necessarily result in similar medical outcomes. Other factors such as physician / surgical team practice, patient rehab procedures and perhaps even physician personality may play more important roles.

If we codify processes without accounting for these other factors, we may do more harm than good.

Case Study: Hernia Surgery and Outcomes - Process or Experience? ¹⁵²

The Shouldice Hernia Hospital near Toronto, Canada performs more hernia operations than any other facility. It only performs hernia surgery. Its surgeons

¹⁵² This section is based on Atul Gawande, The Computer and the Hernia Factory and the Harvard Business School Case Study about the Shouldice Hernia Hospital

average about 700 hernia operations each annually, compared to the US average, for general surgeons, of perhaps a couple dozen.

Shouldice's techniques and hospital protocols are well known in the medical world. Hospitals throughout the US can copy their surgical techniques. Their business is the topic of a detailed Harvard Business School case study available to purchase on-line for less than \$10; it has sold over 250,000 copies.

Indeed, Shouldice is apparently happy to advise others on hernia treatment. I base this statement on the number of articles written about Shouldice and the apparent availability of Shouldice physicians to talk to reporters and other doctors.

Hernia surgery is measured by the 'failure rate' - or the percent of operations that need to be redone at a future date. The American failure rate runs about 5% according to several estimates.

The Shouldice failure rate is less than 1%, or more than 5 times better than the American average.

These are conservative estimates. Dr. Atul Gawande of Harvard Medical School indicated in a live lecture on 2/2/08 in Brookline, Massachusetts that the actual Shouldice failure rate is about 1/10 of 1%, or about 50 times better than the US average!

American hospitals have access to the Shouldice information, apparently often use the same surgical protocols, but consistently get poorer results. In this case, using the same surgical techniques can generate very different outcomes. This raises serious questions about the utility of national treatment protocols.

(There are many theories about why the discrepancy exists between Shouldice and US hospitals - physician practice, the post-operative treatment program, etc. The Harvard Business School case study discusses some of these issues in more detail.)

Case Study: Cystic Fibrosis Treatment and Outcomes ¹⁵³

Cystic fibrosis is a genetic disease that reduces the body's ability to manage chloride. This biochemical defect leads to thickened secretions throughout the body, including in the lungs. As thickened mucus fills and blocks airways, lung capacity decreases slowly until it disappears and the patient dies.

Thus protecting lung capacity is a key to CF patient longevity.

¹⁵³ This section is based on Atul Gawande, The Bell Curve

Unlike other fields of medicine, cystic fibrosis treatments are coordinated and monitored by a national organization, the Cystic Fibrosis Foundation.

The CF Foundation works like an idealized national treatment protocol program. All 117 ultraspecialized CF centers across the country undergo a rigorous certification process. They all follow the same, extremely detailed treatment guidelines. They all participate in research trials and all report their outcomes. CF specialists know each other; attend the same conferences and share knowledge and information regularly.

Cystic fibrosis successes led to significant longevity increases over the past 50 years. In 1966, average life expectancy for CF patients was 10 years. By 1972 it had increased to 18 years. By 2003 life expectancy had reached 33 years.

But these are average figures. The best US cystic fibrosis treatment center reported average life expectancy in 2003 of 47 years.

Equally interesting, average lung capacity for CF patients nationally in 2003 was about 75% of what it is for people without CF. But the best center reported lung function indistinguishable from the normal population.

The same CF treatment center achieved the top results on both longevity and lung capacity scales, year after year.

How can results vary so significantly when all centers follow the same protocols and treat patients with the same disease exactly the same ways? And how can some centers outperform - while others underperform - all the others year after year?

The answer appears to be that medicine is a combination of art and science. The mix of physician and patient personalities, mutual respect, commitment and shared struggles and other, non-quantifiable factors play important roles in the patient's progress.

Medicine is struggling with how to incorporate these factors into protocol advice; how much to encourage creativity and how much to require conformance.

Have we come full circle?

We seem to have. The treatment variations we noted at the beginning of this article indicate systemic quality problems. Some people are overtreated, others under, and others inappropriately. This poses a set of distinct harms to our medical and healthcare financing systems.

But requiring too much conformity to protocol also has drawbacks. Even if all physicians follow exactly the same protocols, we may still get discrepant outcomes, as with hernia operations or cystic fibrosis care.

In our quest to understand treatment variation, we need to understand which factors to quantify and which not.

We need to allow for individual differences - but not permit moral hazard or personal physician orientations to override good science.

We need to encourage innovation, but follow evidence based medicine.

These are huge and enormously complicated problems for our healthcare system to address. Unless we solve them, we will continue to waste resources on inappropriate interventions. We will continue to pay higher prices for poorer outcomes than we could have.

Problem #5: Relatively poor quality and safety

The U.S. healthcare delivery system does not provide consistent, high-quality medical care to all people, according to the Institute of Medicine.¹⁵⁴

Quality is the ability of our healthcare system to deliver desired outcomes. Here's some evidence supporting the IOM's claim:

Up to 98,000 people die annually from medical errors. These include diagnostic, treatment, preventive and systemic problems and are primarily system and process faults, not individual physician mistakes according to **To Err is Human**.

Another 90,000 people die annually due to almost entirely preventable hospital infections, according to the Centers for Disease Control and Prevention.¹⁵⁵

US chronic care is poorly coordinated, inefficient and unsafe, according to a 2008 study of 7500 chronic patients in the US, Australia, Canada, Germany, UK, Netherlands and New Zealand.¹⁵⁶ Some specific results:

- 1/3 of US patients encountered 'poorly coordinated care' - higher than any other country;
- 1/3 of US patients reported medical errors, about double that of the Netherlands;

¹⁵⁴ US Institute of Medicine, To Err is Human, 1999

¹⁵⁵ Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report 2000: 49

¹⁵⁶ Cathy Schoen, Aiming High, lecture at Massachusetts Healthcare Council, 4/7/08

- More US patients complained about ‘inefficient, unsafe, wasteful and poorly coordinated care’ than did patients in other countries.

Some 18% of US patients are readmitted within 30 days of hospital discharge. The main reason: poor post-discharge patient follow up. Too many patients failed to see their doctors as instructed in their discharge paperwork; too many failed to take medications as indicated; too many failed to follow the other discharge instructions.

And too many failed to have good post-operative care prescribed or available. The American Heart Association estimated that, in 2007, only about 14% of patients hospitalized for heart attacks accessed cardiac rehab facilities. And only 31% of patients discharged after bypass surgery did.¹⁵⁷

Yet attending a full 36 session post-discharge rehab reduced both death rates and subsequent heart attack rates significantly!

Many of these systemic, coordination and follow-up problems are fixable. Our question then becomes: *Why is our healthcare system unable to deliver better quality?*

The First Cause of Low Quality and Safety in US Healthcare: We Have No National Database of Citizen Health

Your primary care physician has some information; the hospital that performed your colonoscopy has other, your specialists have still more. Should you suddenly become ill, physicians may be unable to review your medical past - putting them at a diagnostic disadvantage and you at unnecessary risk.

Comparing financial information on gamblers in casinos with medical information on patients in emergency rooms¹⁵⁸

Let’s compare a Las Vegas gambler with an emergency room patient.

¹⁵⁷ See Kay Lazar, The Beat Goes On, Boston Globe, January 11, 2010, page G5

¹⁵⁸ This example and quoted discussion comes from Longman, Best Care Anywhere, pages 68 – 69. Longman attributes the gambler-emergency room comparison to J. D. Kleinke

A fellow walks into a Las Vegas casino - first time he's ever been there - buys some chips and starts gambling. He loses. He buys more chips, using various forms of plastic from his wallet. He keeps losing. He converts his checking and savings accounts into chips; he converts his retirement account into chips; he converts his home equity into chips - but keeps losing and then has a heart attack.

An ambulance takes him to the nearest hospital where the emergency room staff has no idea who he is. Is he allergic to certain medicines? Does he have a chronic condition? Is he on some medications that could possibly interact with coronary medications? Does he have a history of heart attacks?

The casino knew enough about this fellow to furnish him with chips without any financial risk - just by viewing some plastic cards and using current information technologies. It made a serious computer system investment because its business required it; absent this information, it would lose money or customers.

The hospital, on the other hand, knew nothing about him - even while trying to save his life. As Phillip Longman summarizes in *Best Care Anywhere*:

The casino, before it processed your credit cards or lent you money, used advanced but routine information technology to discover details about your life.

But when you arrive at the emergency room in pain, delirious or unconscious, the hospital is unable to access similar or necessary types of information about you, unless, according to Longman

It happens to be a veteran's hospital...outside of the VA, only a handful of hospitals have made the investment necessary to retrieve electronically [potentially lifesaving data]

American civilian hospitals have not yet found that developing world class IT is as essential to their businesses as the gambling industry has found IT development is to theirs.

**The Second Cause of Low Quality and Safety in US Healthcare:
Many Providers have Notoriously Inefficient, Non-networked, Information
Technology Systems**

Fewer than 20% of our nation's physicians use electronic medical records - even though such technology can help improve the quality and timeliness of

care. Experts, according to the New York Times, claim that ‘bringing patient records into the computer age...is crucial to improving care, reducing errors and containing costs in the American healthcare system’ ... in other words, to improving quality. ¹⁵⁹

Unfortunately, even those using electronic records report technological problems.

Some find their software programs buggy and inadequate. Others only have technologies that allow physicians to record notes and patient histories electronically - not to guard against adverse drug interactions, for example or allow electronic prescription ordering.

Absent the complete package, many still write their prescriptions by hand, potentially confusing Celexa, Celebrex and Cerebyx. ¹⁶⁰

The main barrier to improved provider IT? Initial cost, concern about the economic return on investment, and physician fears that the system will crash, leaving them with sick patients and no patient records.

Many American hospitals use rudimentary IT systems, far less robust than our banking or gambling industries.

Yet hospital professionals, including nurses, pharmacists, lab technicians, orderlies, specialists and others, need up-to-date, accurate information.

Absent such dynamic data, hospital patients experience, on average, 1 medication error such as receiving the wrong drug or wrong dosage, every day they stay in the hospital! ¹⁶¹

**The Third Cause of Low Quality and Safety in US Healthcare:
Competition based on treatment inputs - technology, staffing ratios, etc. -
rather than treatment outcomes**

We’re only at the very beginning stages of healthcare system measurement in this country. Input based competition does not always translate well into improved outcomes.

But input based competition leads providers to emphasize quantity over quality. Physicians are typically paid based on the number of patients seen or the number of operations performed, not on the outcomes of those activities.

If our payment system rewards quantity, then providers will rush more patients through their offices.

¹⁵⁹ New York Times, June 19, 2008 page C3

¹⁶⁰ This example comes from Longman, op cit, page 66

¹⁶¹ US Institute of Medicine, Preventing Medical Errors, 2007

But if our payment system rewarded quality, then providers might spend more time with each patient, maybe understand the underlying medical issues better and provide more appropriate - perhaps even less expensive - interventions.

Though we've tried for years, we are today not close to having an outcome based healthcare financing system.

The Fourth Cause of Low Quality and Safety in US Healthcare: Fee-for-service financing that pays more for sick than healthy people

Perversely and unfortunately, providers' financial incentives sometimes run counter to good health practices: having a modest post-operative infection rate, or post-discharge readmission rate, might be good for business.

Only in 2008 did Medicare begin to clamp down financially on providers with high post-operative infection rates. Prior, providers could bill Medicare twice for the same patient: the first time to treat the patient and the second time to treat the infection caused by the first treatment.

Perhaps as a result of Medicare's new program and other publicity, Boston's Beth Israel Deaconess Medical Center - a very well managed, Harvard Medical School affiliated hospital - announced in January of 2008

An ambitious quality-improvement effort aimed at eliminating within four years all harm to patients that it considers preventable, such as falls, infections caused by intravenous lines, and medication errors. ¹⁶²

Did our healthcare financing system actually allow preventable harm previously?

Many hospital safety problems are, and have been for years, solvable through implementation of advanced, high quality information systems. The US Veterans Administration, for example, has such a system and reports excellent safety results in a number of areas. ¹⁶³

Unfortunately, few private hospitals or insurance carriers have found that addressing safety through information systems is economically attractive.

Development of an efficient information technology system, or hospital-wide safety system, is expensive, requiring a long time to recoup the investment.

¹⁶² Boston Globe, Hospital aims to eliminate mistakes, January 17, 2008, page D1

¹⁶³ See Longman, op cit, for a detailed analysis

The first hospital that so develops will increase its overhead - and likely lose money, based on our billing code financing formula.

The first carrier to so develop will increase its overhead - but likely be unable to increase premiums sufficiently (without losing customers) to recoup the investment.

In short, the current US healthcare system provides little incentive for major investments in IT or safety.

**The Fifth Cause of Low Quality and Safety in US Healthcare:
Our healthcare culture sometimes mitigates against changes that will
improve patient safety**

This sounds odd - that hospital and medical culture is sometimes at odds with safety.

Atul Gawande, in his influential 2007 New Yorker article [The Checklist](#), compares and contrasts how airline pilots go through their pre-flight routine and how surgeons go through their pre-operative routine, or intensive care physicians check on patients.¹⁶⁴

Airline pilots have a detailed, written checklist with step-by-step checks for takeoff, flight, landing and taxiing. Even pilots who have flown the same plane from the same airport to the same destination hundreds of times must complete the same checklist of procedures every time. As a result of this (and, of course, multiple other air travel safety features) our airline safety record is very good.

Physicians, on the other hand, do not use checklists nearly as often. Indeed, physicians and hospital administrators often reject the notion that checklists can help in medicine. Why? There appear to be four main reasons:

- **First, physicians are sometimes offended by checklists.** They feel themselves highly trained and knowledgeable - above the need for such a mundane bureaucratic procedure. Their responsibility is to save lives, not comply with stupid regulations. A physician motto: Forget the paperwork - Save the patient;
- **Second, physicians sometimes claim that patient individuality precludes the utility of medical checklists.** Boeing 747s are all the same, they argue, making checklists relevant. But sick people present

¹⁶⁴ This case study and discussion comes from Atul Gawande, [The Checklist](#), New Yorkers, Dec 10, 2007

with multiple problems, needing specialized care. Lists would inhibit rather than enhance appropriate care under these circumstances;

- **Third, physicians and nurses are busy, constantly interrupted and can't focus on stupid forms.** In the midst of the constant interruptions and daily crises, they cannot stop to complete mindless forms;
- **Fourth, hospital administrators are concerned about keeping healthcare costs under control so do not have extra staff available to complete these forms.** Administrators try to keep administrative costs down. Under our billing cost financing system, administrators may see checklist forms as overhead they must absorb, rather than treatment for which they bill.

Thus hospital standard operating procedures and culture rarely include the types of checklists common in the airline industry.

In the 1990s, Israeli scientists published an engineering study of patient care in ICUs. They found that the average patient required 178 individual actions daily including inserting IV lines, inserting urinary catheters and giving medications. Each individual action posed some patient risk.

Remarkably, the Israelis discovered, doctors and nurses performed about 99% of these actions correctly and safely - but that still amounted to an *average of 2 errors per patient per day*.

This is approximately in line with IOM estimates of 1 medication error per patient per day from its 2007 publication Preventing Medical Errors. The Israelis studied only intensive care operations.

Could use of checklists reduce this?

Case Study: Checklists for Line Infections in Hospital ICUs

In this country, ICUs insert about 5 million lines into patients annually. Line infections occur in 80,000 people a year and are fatal between 5 and 28% of the time. (We're at a very early stage of data collection.) Those who survive line infections average 1 week longer in the hospital.

Avoiding line infections is potentially a big deal.

A Johns Hopkins critical-care specialist name Peter Pronovost decided to tackle these problems by using checklists in ICUs. He plotted the steps necessary for doctors to take to avoid infections when inserting lines, including

- Wash hands with soap;
- Clean the patient's skin with chlorhexidine antiseptic;
- Put sterile drapes over the entire patient;
- Wear a sterile mask, hat, gown and gloves;
- Put a sterile dressing over the catheter site once the line is in.

Astonishingly, in more than a third of patients, doctors skipped at least one step during the first month.

In the first year, the 10-day line infection rate went from 11% to zero. During the first 15 months the checklist prevented 43 infections, 8 deaths and \$2 million in costs.

Pronovost and Johns Hopkins then spread this checklist safety activity to Michigan in 2003, at the invitation of the Michigan Health and Hospital Association. After 3 years the Keystone Initiative published its results in the New England Journal of Medicine:

During the first 3 months, the infection rate in Michigan's ICUs decreased by 66%;

The typical ICU cut its quarterly infection rate from 2.7/1000 catheter days to zero;

During the first 18 months, hospitals saved an estimated \$175 million and more than 1500 lives.

These results are so astonishing that Atul Gawande claims

If someone found a new drug that could wipe out infections with anything remotely like the effectiveness of Pronovost's lists, there would be television ads with Robert Jarvik extolling its virtues, detail men offering free lunches to get doctors to make it part of their practice, government programs to research it, and competitors jumping in to make a newer, better version.

But that's not happening. Peter Pronovost explains why:

The fundamental problem with the quality of American medicine is that we've failed to view delivery of healthcare as a science.

The tasks of medical science fall into three buckets.

One is understanding disease biology. One is finding effective therapies. And one is insuring those therapies are delivered effectively.

That third bucket has been almost totally ignored by research funders, government and academia. It's viewed as the art of medicine. That's a mistake, a huge mistake.

We have a \$30 billion a year National Institutes of Health making phenomenal biological breakthroughs. But no comparable National Institute of Healthcare Delivery studying how best to incorporate those breakthroughs into daily practice.

Two frustrating follow-ups to the Michigan experience.

First, Pronovost estimates that it would only cost between \$2 and \$3 million to take the Michigan experience national. He estimates that it would take 2 years to implement. But the project hasn't started yet due to lack of interest. (Pronovost has, interestingly enough, already begun a national rollout of his checklists in Spain.)

Second, in November, 2007, the US Office for Human Research Protections shut down the Michigan program. Their reason: lacking appropriate informed consent from each patient and provider, the program violated scientific ethics regulations.¹⁶⁵ (Author note: No, I really don't understand this either.)

Three months later, the Office changed its position and allowed the Michigan hospitals to continue with Pronovost's program.¹⁶⁶

This is, perhaps, an appropriate commentary on our efforts to improve healthcare quality. We know that our provider's standard operating procedures produce poor quality outcomes. But attempts to change the environment face an astonishing array of hurdles.

Conclusion

Our healthcare system faces enormous quality and safety problems. These arise from a number of causes:

- Lack of a national health database;

¹⁶⁵ Atul Gawande, A Lifesaving Checklist, New York Times op-ed, December 30, 2007

¹⁶⁶ See Miller and Emanuel, Quality-Improvement Research and Informed Consent, New England Journal of Medicine, Feb 21, 2008, especially the note, top of page 765

- Poor hospital IT;
- Input, rather than outcome competition;
- Fee for service incentives; and
- Hospital cultural issues.

These are very, very difficult problems to address.

But we need to address them all to improve our healthcare system. This is a huge task, requiring a consensus among carriers, providers, patients, regulators and consumers, for no one group can improve quality and safety alone.

Can a desire to improve quality and safety supersede the various special interests? Stay tuned...

Problem #6: Inefficient General Hospitals

Many management experts claim that our general hospitals are high cost / low quality producers of health treatment; they provide their services inefficiently.

Harvard Business School's Regina Herzlinger claims that General Hospital fee increases are unrelated to patient demand or outcomes: ¹⁶⁷

In 2003 and 2004...hospital prices grew at least six times more than the growth in their utilization. There were no noticeable commensurate increases in quality.

Dartmouth researchers note that our hospital bed supply decreased by 13% from 1996 - 2006 --- while staffing increased by 6%. ¹⁶⁸

We want efficient healthcare providers to offer the best outcomes at the lowest prices. General hospitals, claim many, are the opposite.

General hospitals - facilities that treat all patients in a community for all medical problems, as opposed to specialty hospitals that focus on a specific set of medical problems - are 'clumsy and slow to innovate' according to Herzlinger. They are 'hard to manage, requiring a torrent of nourishing cash

¹⁶⁷ For a discussion of this, see Regina Herzlinger, Who Killed Healthcare, Chapter 3. This quote comes from page 61

¹⁶⁸ Dartmouth Institute Press Release, US Hospital Bed Supply Shrinks While Hospital Workforce Grows, 2009

flow to keep them alive and massive managerial efforts to keep them networked.’¹⁶⁹

The Institute of Medicine’s 1999 report *To Err is Human* noted the lack of coordination among care-givers as a fundamental healthcare system problem. The Institute seems to indicate that the huge size and complexity of today’s hospitals makes their efficient operation very difficult.

General hospitals pose three significant problems to our healthcare system:

- First**, they are generally high cost providers of medical care;
- Second**, they are sometimes poor quality care providers;
- Third**, they tend to be politically bad actors.

These problems combine to harm both patients and our overall healthcare system.

First Problem with General Hospitals: They are high cost providers

Hospitals use the business theory that horizontally integrated entities take advantage of economies of scale.

Horizontally integrated means that the hospital offers a large number of vaguely related services under the same administrative roof. Thus orthopedic surgeons, geriatric neurologists, child psychiatrists and OB/GYNs use the same billing, HR, payroll, laboratory, radiological, food and floor cleaning services.

Horizontally integrating many unrelated medical specialties does not decrease costs. The reason: There is little relationship between orthopedics and psychiatry, or obstetrics and otolaryngology. Physicians treat each patient separately and rarely work as integrated teams.

Direct treatment costs per patient decrease very little with hospital size; these are variable costs associated with each unique patient’s individual care. There are only some modest purchasing economies.

But the administrative costs of coordinating all these disparate, unique and often unrelated activities increases with size. That’s why, unlike other parts of our economy, hospitals regularly increase their prices despite the cost-reducing impact of many technological innovations.

The administrative size and complexity in horizontally integrated general hospitals puts tremendous patient occupancy pressure on the entire organization. Once a hospital purchases a new MRI unit (or robotic surgeon for

¹⁶⁹ Regina Herzlinger, *Market Driven Healthcare*, page 130

example), it tries to book that machine to capacity to cover its costs - and perhaps generate some additional income.

(This was made poignantly clear to me recently when a friend - a hospital staff physician - said during a routine office visit 'In this place, you sneeze, you get an MRI.')

Medicare understands so well that hospitals are high priced producers that it has codified pricing differences based on provider type in its payment schedule: Medicare pays hospital based dialysis facilities \$4 more per patient session, on average, than it pays free standing clinics, *even though the treatment protocols, equipment and procedures are exactly the same!*

This pricing difference was attributed by the Department of Health and Human Services to *overhead*, not *complexity or case mix*.¹⁷⁰

Second Problem with General Hospitals: They are often poor quality providers

General hospitals developed in the 19th century or prior, well before our current medical technology era.

Old hospitals had little or no differentiation among specialties, serving more as warehouses for all sick people rather than treatment facilities aimed at specific medical problems.

This physical and economic structure continues today even though technologies and specialties have evolved tremendously; general hospitals still provide all services to all patients.

But it is very difficult - if not impossible - for an organization to be excellent at all functions. A given hospital may provide outstanding orthopedic services but poor cardiac, or excellent neurologic but poor hemotologic. (In this sense, a general hospital is somewhat like a university, which may be outstanding at Medieval History but weak at Organic Chemistry.)

Why?

One reason for this difference may simply be organizational: the hospital administration may be more oriented toward or interested in one specialty than another.

A second reason may be financial: a hospital may focus more on procedures where it makes the most money or gets the most research grants.

And a third may relate to practice and experience. The hospital may simply attract too few patients with a specific medical problem to become excellent

¹⁷⁰ MedPac's 'Report to Congress: Issues in a Modernized Medicare Program' 2005 pages 88 and 89

at treating it. Lacking sufficient experience, that hospital may generate poor treatment outcomes.

The interesting question: why do some general hospitals engage in small numbers of highly complex procedures and then generate (apparently) poor outcomes?

One possible answer: patients arrive in emergencies and need immediate surgery. Perhaps time is critical and the patient has a better chance of good outcomes with surgery at a low volume hospital than he/she would have with a longer ambulance ride to a larger center. This may explain some of these procedures.

A potential alternative answer though: hospitals generate substantial revenues from complex procedures like CABG. Even a relatively small number of such patients can have a substantial impact on a small hospital's bottom line.

In other words, the general hospital - with its high overhead and constant occupancy pressure - may put its financial interests before the patient's medical interests.

Third Problem with General Hospitals: They may be bad political actors

Hospital mergers rarely decrease, but generally increase prices. Lots of evidence supports this and hospital administrators know it.¹⁷¹

Yet during the 6 year period between 1995 - 2001 some 900 hospital merger deals occurred on our base of 6100 hospitals. Some 2700 hospitals affiliated themselves with each other. Over the 25 year period 1970 - 2005 the total number of independent hospitals decreased by more than 20% due primarily to mergers.¹⁷²

Why do they merge, knowing the relatively poor financial results?

Commentators suggest that hospitals merged less to cut costs or improve patient care than to amass greater political and economic power.¹⁷³

¹⁷¹ For example, see Vogt and Town, How Has Hospital Consolidation Affected the Price and Quality of Hospital Cases? The Synthese Project, Robert Wood Johnson Foundation and Ranjan Krishnan, Market Restructuring and Pricing in the Hospital Industry, Journal of Health Economics 20, 2001, among many others

¹⁷² This data comes from Regina Herzlinger, Who Killed Healthcare, Chapter 3

¹⁷³ For a detailed discussion of this, see Michael Porter and Elizabeth Olmsted Teisberg, Redefining Healthcare, 2006, especially chapters 2 and 3

Here are some hospital domination examples resulting from mergers in the late 1990s and early 2000s: ¹⁷⁴

Cleveland had 2 hospital systems controlling 86% of its hospital beds;
Grand Rapids, Michigan had 1 system controlling 70%;
Richmond, Virginia had 3 systems controlling more than 80%;
El Paso, Texas had 2 systems controlling almost 80%;
Long Island, New York had 2 systems controlling more than 80%

This has several negative ramifications. We'll suggest two.

First, carriers lose their ability to influence hospital behavior. A carrier with 8 or 10% market share has little input into a hospital with 50 or 60%. The carrier's role is diminished to simply financing the hospital's activities; it loses any competitive counter-balancing role.

Merged hospitals can maintain their dominance by purchasing physician groups and limiting physician referral options.

One Massachusetts hospital group, for example, spent over \$100 million to purchase physician practices to act as 'feeders' for patient referrals. Carriers were unable to induce these physicians to refer to outside-the-group hospitals offering lower costs or better outcomes.

Second, elected government officials can become hostage to hospital interests. Local hospitals are major employers. Partners HealthCare, for example, with 50,000 employees, is the largest private employer in Massachusetts. The Mayo Clinic is Minnesota's largest private employer. The Cleveland Clinic is Ohio's second largest private employer. Similar situations exist in other states.

These hospital employees and their business allies - including physicians, hospital suppliers and similar - are often major local government campaign contributors. Voting against the hospital's interests may be politically difficult.

This plays out in local and state politics in several ways. The legislature may be unable to get enough votes to force hospitals to divulge prices or outcome data in useful or meaningful forms, thus making wise comparison shopping difficult for consumers.

Or hospital special interests may lobby for exceptions to government regulations.

Commentators also suggest that state and local governments sometimes erect barriers to keep competitors out, and to favor their local hospitals.

¹⁷⁴ Ibid, page 39

A common type of hospital protection is called a Certificate of Need. By 2005, some 35 states required state approval before a hospital, nursing home or other could build a new facility, expand or offer new services. These Certificates of Need were issued after a public hearing in which local hospitals discuss the 'need' for additional services.

'It is common for competitors to have much to say about whether a new facility is needed' according to healthcare commentators Michael Cannon and Michael Tanner, authors of 'Healthy Competition'. 'Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market'.¹⁷⁵

Especially if the market incumbent controls a majority of local hospital beds and is a major local employer.

Hypothetical Case Study: New Coronary Facility in a Certificate of Need State

Imagine, for example, that an entrepreneur wants to build a state-of-the-art CABG facility - perhaps as a joint venture with a well known, out of state hospital.

He sees a market opportunity: hospitals charge high prices for Coronary Artery Bypass Grafts. He thinks he can provide similar (or better) quality services at lower prices. But he needs to go through a public hearing to obtain a Certificate of Need.

How will the existing hospitals, all of which generate substantial income from CABG procedures, react to this potential loss of income and prestige? What will general hospitals advise local politicians who seek their input?

We can hypothesize: each local incumbent will show no 'need' for the new facility, and explain how they have sufficient capacity to satisfy any projected demand increase.

The likely result? No new CABG competitor to put price and quality pressure on the existing general hospital.

The Federal Trade Commission advises that 'states with Certificate of Need programs should reconsider whether these programs best service their citizen's healthcare needs'.¹⁷⁶

¹⁷⁵ Michael Tanner and Michael Cannon, *Healthy Competition*, page 137

¹⁷⁶ *Ibid.* page 138

Case Study of General Hospital Pricing Power: Partners HealthCare and Blue Cross Blue Shield of Massachusetts ¹⁷⁷

The Boston Globe reported (12/28/2008, page 1) on the May, 2000 pricing agreement between Blue Cross Blue Shield of Massachusetts and Partners HealthCare, owners of two huge internationally renowned Boston teaching hospitals - Massachusetts General and Brigham and Women's - among others.

This was, according to the Globe, a 'gentleman's agreement' - because a 'written agreement between the state's biggest hospital company and its biggest health insurer that would make insurance more expensive statewide might raise legal questions about anti-competitive behavior, according to officials directly involved in the talks.'

By terms of this gentleman's agreement, Blue Cross would increase their insurance payments to Partners by an extra \$193 million over three years - 'the biggest insurance payment increase since Massachusetts General and Brigham and Women's hospitals joined forces in 1993.'

In return, Partners would protect Blue Cross from price competition from other carriers. Partners would not allow other carriers to pay less than Blue Cross - and would even charge Blue Cross's competitors more, 'ensuring that all major insurers would face tens of millions in cost increases' according to the Globe.

Partners went so far as to tell Tufts Health Plan - the second or third largest carrier in Massachusetts at that time - that its coverage 'would no longer be accepted' unless Tufts increased its payments to Partners by an extra \$100 million over three years.

Tufts at first refused - apparently thinking this would raise premiums unnecessarily and put them at a competitive disadvantage - but fairly quickly agreed, fearing that they would go out of business without having Partners in their network.

Tufts change of mind took, according to the Globe, 'little more than a week' - a public 'humiliation' not lost on other carriers. Partners HealthCare, not the various carriers, held pricing power in Massachusetts.

Interestingly, though Massachusetts General Hospital and the Brigham merged in the early 1990s to become Partner's HealthCare, the two hospitals have 'rarely collaborated on clinical operations' according to the Globe, even though they're only about 4 miles apart. In fact, shortly after the merger, Mass General opened its own obstetrics unit to compete with the Brigham.

¹⁷⁷ This Case Study comes from the Boston Globe, Dec 28, 2008, page 1. All quotes come from this source.

Rather than have 'one superb major teaching hospital when this is all over' - the initial vision of Dr. J Robert Buchanan, the then head of Mass General - the two hospitals now compete and engage in, among other things, the Medical Arms Race between themselves.

Donald Berwick, the highly regarded head of the Institute for Healthcare Improvement in Cambridge Massachusetts, summarized this situation for the Globe:

When Partners HealthCare decides to expand...[my] prediction would be it will not add to the well-being of the population. It will add to cost.

Remember the genesis of this section. We want to learn why American healthcare costs are extraordinarily high while our outcomes - as measured by longevity or infant mortality - are only mediocre on international scales. Our reliance on inefficient general hospitals is a significant contributing factor.

General hospitals pose three significant problems for our healthcare system:

- They are high cost providers of medical care;
- They are sometimes poor quality providers of medical care; and
- They tend to be politically bad actors.

Can we reduce our reliance on general hospitals? Can we implement the Institute of Medicine's call for a 'sweeping redesign of our entire healthcare system'?

Can we have real competition between specialty and general hospitals? Can we generate better outcomes at lower costs?

Stay tuned.

Problem #7: High Number of Medically Uninsured Americans

We currently have about 45 million medically uninsured Americans. Many uninsured find themselves priced out of the medical insurance, as health insurance is so expensive. This follows from our discussion above of the inefficiencies in our current system. That's why I've left this issue to last. Presumably if our healthcare market was more efficient, insurance prices would be much lower and more people could afford insurance.

Most people understand the problems that having a large number of medically uninsured people causes. This is oft discussed in the popular literature, and why I'll limit this discussion to only two points.

First, the lack of health insurance leads directly to some 45,000 unnecessary deaths per year.¹⁷⁸ This is because the uninsured typically receive too little care and receive it too late.

Second, untreated illness and the related missed work and unnecessary deaths deprive us of some \$150 billion annually in lost productivity.¹⁷⁹

Insuring our entire population would reduce these twin scourges. Indeed, President Obama's healthcare reform package of 2010 focused largely on insuring a greater number of Americans. Our brief discussion here does not indicate that this is a small problem - only that it's already quite well known, and I wanted to focus on other, less frequently discussed systemic issues in this chapter.

Conclusion And Summary of Fee-for-Service Financing Problems

Our fee-for-service based healthcare financing system leads to extraordinary inefficiencies. Fee-for-service pays hospitals and physicians based on the quantity of their work, not the quality. The incentives are too *infrequently* aimed at improving patient outcomes and too frequently aimed at improving provider's bottom lines.

As a result, according to Harvard School of Public Health Professor Meredith Rosenthal:

In our current healthcare financing system, successes are the triumph of will over the environment.¹⁸⁰

Let's tie this analysis of our inefficient healthcare financing system to our previous discussions of both lifestyle (from Chapter 2) and hospital development (from Chapters 4 - 6):

Today Americans present as an increasingly overweight and under-exercised population with high levels of coronary disease and diabetes. This leads to high medical treatment costs;

¹⁷⁸ American Journal of Public Health, December 2009

¹⁷⁹ Boston Globe, Bilmes and Day, November 7, 2009, page A11

¹⁸⁰ Massachusetts Healthcare Council Annual Convention, 4/7/08, lecture entitled The Road to Affordability

We incent healthcare providers inappropriately, paying them for acute care quantity rather than long term patient improvements;

We treat people in the most expensive settings, due to the historical development of our general hospital based healthcare system.

Is it any wonder that we face a huge healthcare financing crisis?

The argument that I've put forward, starting in Chapter 2 and ending here, suggests why I'm so pessimistic about the prospects of controlling healthcare cost inflation by improving our healthcare system efficiency. Indeed, I've suggested that, over time, most costs are trending in the wrong direction. I've tried to articulate the reasons for this.

Not all commentators agree. Many suggest that we can restructure our health insurance system to - simultaneously - control costs and improve outcomes. Proposals abound, ranging from abolishing private insurance to abolishing public insurance. Some call for an increasingly deregulated healthcare system, others for an increasing regulated one. Some people want to eliminate employer based health insurance, others to mandate that all employers insure their employees.

We'll discuss a number of these ideas in upcoming chapters.

But next, I'd like to evaluate one particular proposal, commonly known as Medicare for All. The Medicare-for-All enthusiasts see Medicare as the best available healthcare system for us. We'll turn, in the next chapter, to an analysis of it and discuss whether or not Medicare should be the basis of a national healthcare system.

Chapter 9

A Word About Medicare

Medicare is our public health insurance program for elderly and disabled Americans. It consists of Part A - Hospital Insurance, Part B - Medical Insurance, Part C - Medicare Advantage Plans, and Part D - Prescription Coverage. We'll combine all these together in this discussion and refer to them all as 'Medicare'.

Medicare By The Numbers

Medicare started in 1966 with an initial enrollment of 19 million people. It has grown to include about 45 million by 2008.¹⁸¹

Since inception, its costs have grown about 14x the rate of inflation. Here we compare the 2001 and 2008 Medicare costs and enrollment:

	<u>2001</u>	<u>2008</u>	<u>% Change</u>
Enrollment	34 million	45 million	32%
Costs	\$240 billion	\$468 billion	95%

Medicare's financial position has worsened over this 7 year period. Here's a summary of Medicare's position from the 2002 Annual Report of the Board of Trustees:

- In the short range, the financial status of the Health Insurance Trust Fund is favorable;
- The Health Insurance Trust Fund meets the Trustee's test of short-range financial adequacy.

By 2009 this had changed. The Trustees reported in 2009:

- The Health Insurance Trust Fund is not adequately financed over the next 10 years;
- The Health Insurance Trust Fund does not meet the short-range test of financial adequacy;
- The Health Insurance Trust Fund is projected to be exhausted in 2017.

¹⁸¹ <http://www.cms.hhs.gov/MedicareEnRpts/Downloads/HISMI08.pdf>

In short, Medicare's financial position is precarious. It takes in too little money and spends far too much.

Of course, as we have already argued in this book, healthcare spending increases alone tell only part of the medical care story. If we spend a lot, but get outstanding results, then we have invested well. It may make sense, under those conditions, to divert money from other activities to get higher returns in Medicare.

But if we spend a lot and get mediocre results, then we have invested poorly. In that case, it does not make sense to divert funds from other activities. Instead, perhaps we should cut Medicare spending and divert those funds elsewhere, since we could get higher returns from other healthcare investments.

Which is it - spending a lot, but getting outstanding outcomes (in which case, we should probably spend even more)? Or overspending and getting mediocre outcomes (in which case we should consider cutting spending to divert funds to other parts of our healthcare system)?

One reasonable measurement compares US longevity at age 65 to other country's longevity at the same age. We already have established - in Part 1 of this book - that we spend more than others on medical care. Let's compare our life expectancies from age 65 on to other countries.

1970 and 2006 Life Expectancy At Age 65, Males in Select Countries ¹⁸²

<u>Country</u>	<u>L.E. 1970</u>	<u>L.E. 2006</u>	<u>Years Gained</u>
US	13.1	17.4	4.3
UK	12.0	17.4	5.4
Spain	13.3	17.9	4.6
Portugal	12.2	16.6	4.4
Italy	13.3	17.9	4.6
Greece	13.9	17.4	3.5
Germany	11.9	17.4	5.5
Canada	13.6	18.2	4.6
Belgium	13.6	17.0	3.4
Australia	11.9	18.3	6.4
Austria	11.7	17.2	5.5

The female data shows the same general situation.

¹⁸² OECD Health Data, 2009

We're about in the middle of the pack for outcomes. But we're the cost leader. Not good. What's going on?

First, Medicare hemorrhages money.¹⁸³ Between 2004 and 2005, for example, Medicare expenditures grew by \$35 billion or 11% - more than 3 times the 3.4% Consumer Price Index - while enrollment grew by a slim 1.4%.¹⁸⁴

One critic, Professor Richard Epstein from the University of Chicago Law School, claims that it 'encourages all beneficiaries to consume as much healthcare as possible - but always at the expense of others.'¹⁸⁵ It is well documented that Medicare beneficiaries will undertake treatment as long as the value of that care is more than the copayment for which they are responsible. Copayments are often \$0. This artificial cost-benefit analysis encourages excess use.¹⁸⁶

Michael Porter of Harvard Business School, claims Medicare is a 'dysfunctional healthcare system'¹⁸⁷ with a 'stupid reimbursement structure.'¹⁸⁸ Total 1990 Medicare hospital expenditures were more than 6 times higher than originally forecast in 1965, just 25 years before.

Since its inception, Medicare spending has grown more than 14 times the rate of inflation. In a decade or so according to some estimates, spending will top half a trillion dollars annually and consume nearly a fourth of the Federal budget.

There are few, if any incentives to control medical treatment costs prudently. Providers, especially in high retiree / important electoral vote states like Florida, often live off of Medicare.

Politicians have no incentives to tackle Medicare funding and cost control problems, for any change that leaves the elderly worse off will lead to ballot box reprisals from a large, vocal and politically active segment of society. And providers have little incentive to control costs through, for example, cheaper

¹⁸³ David Hyman, Medicare Meets Mephistopheles, CATO Institute, 2006

¹⁸⁴ Medicare Enrollees: 1980 – 2005. US Centers for Medicare and Medicaid Services, cms.hhs.gov/researchers

¹⁸⁵ Hyman, op. cit

¹⁸⁶ Thomas Healy, Senior Fellow at Harvard's Kennedy School of Government, Boston Globe, June 9, 2007, page A11

¹⁸⁷ Jerry Krause, Saving Medicare, Annals of Family Medicine, May 2006, pages 274 - 275

¹⁸⁸ Michael Porter, MIT Health Information Technology Symposium, 7/19/2006, www.icvclients.com

treatment alternatives, for their self interest runs counter...a classic case of moral hazard.

Even beyond moral hazard problems, outright Medicare fraud runs billions annually. Dara Corrigan, Acting Principal Deputy Inspector General, testified to the House Budget Committee on July 9, 2003 that ‘improper payments under Medicare’s fee-for-service system totaled an estimated \$13.3 billion during 2002.’

One improper payment example: Medicare paid up to \$92 million between 2000 - 2008 for medical equipment prescribed by dead doctors; it honored some 500,000 claims written by docs who were deceased at the time the prescription was written.¹⁸⁹

By 2009, Medicare fraud had grown to about \$60 billion annually, according to testimony by Attorney General Eric Holder. That’s about 12% of total Medicare spending! Medicare fraud is ‘totally out of control’ according to Louis Saccoccio, health of the National Health Care Anti-Fraud Association.¹⁹⁰

The US General Accounting Office claims that there has been only limited progress in bringing fiscal discipline to Medicare. Medicare spends just 15/100ths of 1% of funding to oversee and improve patient care and to assure provider compliance with its 100,000+ pages of regulations.¹⁹¹

Second, Medicare exhibits little quality control. Dartmouth Medical School researchers estimate that 20% of Medicare expenditures go to procedures that provide no benefit in terms of longevity gain or improved quality of life and \$1 or every \$3 is wasted on unnecessary or inappropriate care.¹⁹²

Indeed, the Dartmouth estimates may actually be low! That was a 2001 estimate. Today, Medicare’s waste factor may be 50%!

¹⁸⁹ Christopher Lee, Billings Used Dead Doctor’s Names, Washington Post July 9, 2008, page A13

¹⁹⁰ Brad Heath, Little Progress Seen Against Health Insurance Fraud, USA Today, January 28, 2010

¹⁹¹ Gilbert Gaul, Bad Practices Net Hospitals More Money, Washington Post, July 24, 2003, Page A1. Gaul writes that for every \$1000 that Medicare pays to providers, it invests just \$1 or \$2 to oversee and improve patient care.

¹⁹² Jonnathan Skinner, et al, The Efficiency of Medicare, NBER Working Paper 8395, National Bureau of Economic Research, 2001

Case Study of Treatment Variation: McAllen vs El Paso, Texas

Here's a quick case study comparing Medicare spending and practices in McAllen and El Paso, Texas, using 2006 Medicare spending data: ¹⁹³

<u>McAllen</u>	<u>El Paso</u>
\$14,900 Medicare/person	\$7,500 Medicare / person
\$40,000 average household income	\$36,000 household income
27% poverty rate	27% poverty rate
80% Hispanic	77% Hispanic

Both cities had similar rates of smoking, obesity and diabetes. Both had similarly equipped medical facilities. McAllen had, in 2006, lower than the US average rates of smoking, cardiovascular disease, asthma, HIV, cancer, infant mortality and injury.

In 1992, both McAllen and El Paso were at the Medicare national spending average per person.

Yet by 2006, McAllen spent twice as much per capita as El Paso. Interestingly, no data shows McAllen patients do better than El Paso patients or end up healthier. But they did have, per capita:

- 50% more specialist visits than El Paso;
- 20% more abdominal ultrasounds;
- 30% more bone density studies;
- 60% more stress tests with echocardiography;
- 200% more nerve-conduction studies to diagnose carpal-tunnel syndrome;
- 550% more urine-flow studies to diagnose prostate troubles;
- 2 - 3 x more pacemakers, implantable defibrillators, cardiac bypass operations and coronary artery stents

How can this be? We'll look at Medicare from 3 vantage points: local conditions, quality control, and government meddling.

¹⁹³ This section comes from Atul Gawande, The Cost Connundrum, New Yorker, June 1, 2009

Local Conditions Causing Treatment Variation i: Resources

Researchers have long known that a greater availability of medical resources leads to more medical spending. That's a long way of restating Roemer's Law which we've already discussed.

Dartmouth researchers quantified this supply induced demand phenomenon by dividing the US into 10 deciles according to healthcare spending, and then labeling the deciles as high spending or low spending regions. Here's a summary of their data, using 2003 Medicare data:

Regional Comparisons per 1000 Medicare Beneficiaries ¹⁹⁴		
<u>Item</u>	<u>High Spending Region</u>	<u>Low Spending Region</u>
Hospital Beds	3.2	2.4
Physicians:		
Specialists	78	57
Sub specialists	44	27
Surgeons	56	44
GPs / Family practitioners	27	36

High spending regions had more facilities and more specialists than low spending regions. Dartmouth did not note any significant discrepancies in outcomes as measured by longevity, mortality rates or patient satisfaction.

Indeed, according to noted Dartmouth researcher Elliott Fisher:

We found no evidence that the pattern of practice observed in higher spending regions led to improved survival, slower decline in functional status or improved satisfaction with care. ¹⁹⁵

Our question becomes: Do specialists go to regions with more sick people? If so, that would explain similar outcomes. If not, then the availability of more specialists apparently does not add value to our healthcare system. Which is it?

Here's the conclusion of an analysis of specialist location decisions by researchers Baicker and Chandra, published in Health Affairs in 2004: ¹⁹⁶

¹⁹⁴ Maggie Mahar, Money Driven Healthcare, page 170

¹⁹⁵ Elliot Fisher, Implications of Regional Variations in Medicare Spending, 2003

¹⁹⁶ Baicker and Chandra, Medical Spending, the Physician Workforce and Beneficiaries Quality of Care, Health Affairs, April 7, 2004

Researchers have found that underlying population risks does not seem to drive the presence of specialists...

Specialists decide where to locate themselves based on factors besides population risks - cost of living, weather, availability of world class hospitals and similar considerations. Specialists then use the available resources to treat patients - apparently often unnecessarily.

Unnecessarily? Let's provide the full quote from Baicker and Chandra's Health Affairs article:

Researchers have found that underlying population risk does not seem to drive the presence of specialists and that outcomes are not improved by increased access to these specialists.

Dartmouth Medical School's John Wennberg gives an interesting explanation of this process.¹⁹⁷ There is no clear rulebook for dealing with chronically ill patients, he says. When should an elderly cancer patient who also suffers from congestive heart disease be admitted to hospital either for treatment or observation? How ill must a patient be for a physician to prescribe home health care? How often should a patient suffering from congestive heart failure be seen by a cardiologist - every 2 months? Every 3 months? Every 4 months?

Wennberg suggests that the physician 'will sort it out based on how sick an individual patient is and how many openings he has in his schedule. Specialists tend to fill their appointment books to capacity' (emphasis my own) making it easy to see how increasing the supply of specialists would mean patients will see their physicians more often.

In addition, the greater availability of medical resources may allow specialists to game the system. Atul Gawande, in his insightful New Yorker article 'The Cost Connundrum' suggests, for example, that some specialists want referral fees from local hospitals, under the guise of a 'medical directorship' that pays a few thousand dollars per month. Note the local effects:

1. The specialist generates additional income not tied to Medicare's fee schedule;
2. The hospital has higher expenses, especially if it has lots of 'medical directors', so is under more pressure to admit more patients and to perform more procedures on those patients

¹⁹⁷ This analysis comes from Mahar, op. cit page 172

(This helps explain why Medicare is unable to reduce its costs by lowering its payment schedule. Specialists can sidestep the pricing constraints by becoming medical directors - and leave it to the hospital to perform more procedures.)

Local Conditions Causing Treatment Variation ii: Part C

Medicare sometimes contracts directly with providers and pays fee-for-service. Other times Medicare contracts with an HMO and pays a flat fee/member. Medicare calculates that fee, in part, on fee-for-service costs per patient in that region.

The result: HMOs located where patients use more services receive higher payments/member than HMOs in lower cost regions. WellCare, a Miami HMO, received \$11,823 per Medicare member in 2003; HealthPartners in Minneapolis received \$7,851.

Yet HealthPartners outperformed WellCare on 13 of 14 Medicare quality measures such as percent of enrollees getting flu shots or colorectal exams.¹⁹⁸ Medicare does not tie payments to quality. ***So over the average lifetime of a Medicare patient, low quality Miami Medicare beneficiaries receive about a \$50,000 subsidy from high quality Minneapolis Medicare recipients!***

Local Conditions Causing Treatment Variations iii: Moral Hazard

Patients are complicit in this Miami Medicare extravaganza.¹⁹⁹ Doctor visits, according to Gina Kolata of the New York Times

have become a social activity...Many patients have 8, 10 or 12 specialists and visit one or more of them most days of the week. They bring their spouses and plan their days around their appointments, going out to eat or shopping while they are in the area. They know what they want; they choose specialists for every body part. And every visit, every procedure is covered by Medicare...Boca Raton, researchers agree, is a case study of what happens when people are given free rein to have all the medical care they could imagine.

¹⁹⁸ Gaul, op. cit

¹⁹⁹ Gina Kolata, Patients in Florida Are Lining Up for All That Medicare Covers, New York Times, September 13, 2003, page A1. Quotes in this section come from this article.

How do patients find appropriate specialists? Leon B., age 83 tells us: 'You get recommendations at the clubhouse, at the swimming pool. You go to a restaurant here and 9 out of 10 times, before the meal is over, you hear people talking about a doctor.'

The traditional Medicare fee-for-service system acts like a PPO, with no Primary Care referrals needed. Apparently Miami residents think clubhouse friends and swimming pool companions have equal diagnostic and referral credibility as technically trained primary care physicians.

Providers see this excessive patient demand - patients want lots of tests and specialists, they refer themselves to specialists and they ask for and get far more medical attention than many doctors think is reasonable or advisable. The Medicare card is 'like a gold card that lets you go to any doctor you want' claims Dr. C., a Boca Raton internist. 'I see it every day.'

But Dr. C sounds a cautionary note, worrying that Primary Care Physicians cannot perform their gate-keeping function properly. 'When there's no control on utilization, (physicians take) the path of least resistance. If a patient says 'My shoulder hurts, I want an MRI, I want to see a shoulder specialist,' the path of least resistance is to send them off. You have nothing to gain by refusing.'

In other words, moral hazard rules in Miami. Patients demand service, providers bill and Medicare pays - about double per capita compared to Minneapolis for approximately the same epidemiological population, with no obvious longevity or life quality improvements. Medicare is unable to control itself; Miami Medicare subscribers self-diagnose and self-refer, apparently at whim. Everyone, it seems, takes advantage of the fact that 'Medicare pays.'

Does More Care Equal Better Health?

Unfortunately, patients in Dartmouth's High Spending Regions don't exhibit better health. After studying patient hospital utilization, costs and outcomes, they concluded

Residents of high-spending regions received 60 percent more care but did not have lower mortality rates, better functional status or higher satisfaction.²⁰⁰

²⁰⁰ Fisher, et al, The Implications of Regional Variations in Medicare Spending Part 2, Annals of Internal Medicine 138 (2003) page 288

More money simply resulted in more physician visits, specialist consultations, tests and greater use of hospital and intensive care facilities, with no better though sometimes slightly worse outcomes.

Slightly worse? The most expensive regions had a 2 - 6% increased mortality rate! Dartmouth's Eliot Fisher concluded his major 2003 study of Medicare by suggesting

For every 10% increase in spending, the relative risk of death in 5 years increased.²⁰¹

This is counter-intuitive. More care should lead to lower, not higher, mortality rates. How can this be? Fisher explains:

The most reasonable explanation for the higher mortality rate is that the additional medicine patients are getting in the high cost regions is leading to harm.²⁰²

More care leads to more risk of complications, more patient fatigue and more chance of physician error. More is not better. In healthcare - above a certain level - more is worse.

Yet Medicare, for all its manuals, regulations, research and cost controls, fails to articulate this to physicians and beneficiaries.

This is a tragedy in the making.

Quality Controls

Medicare controls quality through a complex system of accreditation and oversight contractors.²⁰³ It spends over \$600 million annually on quality controls:

- Over \$100 million for hospital accreditation;
- Over \$250 million to state regulators to investigate complaints and inspect healthcare facilities;

²⁰¹ Fisher, Implications of Regional Variations in Medicare Spending, Part 2, 2003

²⁰² Shannon Brownlee, Overtreated, page 50

²⁰³ Information on this section, including the discussion of QIOs, state regulators and the Florida hospital case study comes from the Washington Post analysis of Medicare that ran July 24 - 26, 2005

- Nearly \$300 million annually to private groups in each state called Quality Improvement Organizations that work closely with hospitals to improve care

The 1965 Medicare legislation contained language that delegated hospital quality evaluation to the Joint Commission on the Accreditation of Healthcare Organizations. This nonprofit receives over \$100 million annually to accredit Medicare providers. Interestingly, its mission is to help hospitals and other facilities meet Medicare standards, not to relegate or punish them; it has no sanctioning powers.

The Joint Commission on the Accreditation of Healthcare Organizations also owns Joint Commission Resources, a for-profit subsidiary that advises hospitals how to pass accreditation reviews. About 99% of the hospitals reviewed by the Joint Commission win accreditation. And Joint Commission Resources, which bills hospitals for its advice, paid its parent over \$10 million between 2000 and 2003 in management fees.

Some state regulators claim that the Joint Commission and similar groups are too closely aligned with the health facilities they review. Nelson Sabatini, Maryland's health commissioner for example, called this system 'a fraud' with poor oversight. 'The fundamental structure of the joint commission doesn't make sense. It's one big built-in conflict, and the fact that Medicare allows it is appalling.' Medicare spot-checks the Joint Commission's work: in 2003 it reviewed 1% of all hospital accreditation surveys.

But Medicare officials say they are required by law to use the joint commission's congressionally mandated accreditation system, virtually whatever the quality, due to 1965 legislation. The Medicare statute explicitly specifies that any provider who meets the entry requirements is entitled to participate in Medicare and that patients are free to choose any provider who will have them, regardless of quality.²⁰⁴ Indeed, the first two sentences of the original Medicare statute state:

Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person. Any individual entitled to insurance

²⁰⁴ Hyman, op cit, page 54

benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him with services.

(See next section on Government Meddling for more.)

Quality Improvement Organizations

Fifty-three **Quality Improvement Organizations (QIOs)** receive almost \$300 million annually from Medicare to measure quality, work with hospitals and doctors to improve care and investigate patient complaints. By law, QIOs operate in secrecy with little oversight or accountability and generally prefer to cooperate with hospitals, rather than sanction them. ‘One of the problems with QIOs is that they are reluctant to do anything that ruins their relationships with providers’ according to Robert A. Berenson, a Medicare official in the Clinton administration.

How well do QIOs work? In 2003 and 2004, they received a total of about 3,100 patient complaints - about 1 for every 14,000 Medicare beneficiaries, indicating perhaps that 99.993% of Medicare beneficiaries were satisfied. (Really?) They sanctioned about 1 doctor each year in the early 2000s.

QIO executives claim they are hamstrung by Medicare’s decades-old rules that place a premium on secrecy. They are even prohibited from publicly naming the hospitals they work with unless the facilities agree. (Few do.) This prohibition likely reflects the political power of organized medicine that wants to protect its members, and the campaign contributions of healthcare providers to congressional candidates.

Medicare officials audit QIOs but declined a Washington Post request for audit copies, and did not respond to Freedom of Information requests for that information during the 17 months prior to the Post writing its Medicare analysis in 2005.

State regulators also receive Medicare money to monitor hospital quality, but often to little effect, again likely reflecting provider political power.

Medicare and State Regulators

Here’s a brief case study of a 200+ bed hospital near Miami that illustrates this issue.²⁰⁵

²⁰⁵ This case study comes from the Washington Post series on Medicare, July 24 – 26, 2005

In the 1990s, this hospital performed over 1,000 open heart procedures annually. State regulators received complaints about the high rate of patient infections in 1999 but dismissed them. Public lawsuits forced the state to reconsider in 2002 - 3 years later.

State inspectors in 2002 found 'massive post operative infections' in the heart unit. They reviewed records of 24 heart patients and found that 13 - that's 54%! - developed serious infections after their surgical procedures. (Note that Medicare pays for infection treatment also - even if performed at the same hospital - creating a potential provider conflict of interest regarding infection reduction.)

The state notified Medicare, which subsequently informed the hospital that it was 'out of compliance' with Medicare requirements and conditions posed an 'immediate jeopardy to patient's health and safety.' Medicare threatened to remove the hospital from its program.

Medicare never delivered on this threat. The hospital filed a 'plan of correction' and Medicare backed-off its threat. Medicare rarely expels hospitals from its program, even the dangerous ones.

State regulators fined the hospital \$323,800 but reduced this to \$95,000 to avoid a lengthy process. The hospital did not acknowledge any wrongdoing.

After suffering a short-term drop-off in business, the hospital is once again busy. It touts its heart program as among the nation's best. We have no information on results of its plan of correction because neither Medicare nor the State of Florida (nor any other credible organization) releases audited outcome data.

But Miami Medicare costs are still among the highest in the country - regardless of the results.

Government Meddling

The US Congress seems comfortable micromanaging Medicare.

This is due in part to Medicare's origins and structure. When created in 1965, the government needed support from providers and provider organizations. They consequently agreed on an open-ended, fee-for-service payment system that could only be changed by act of Congress. As Medicare prices rose (along with raising fears about tax hikes to pay for entitlements), Congress changed from a 'usual and customary' to Prospective Payment System based on Diagnostic Related Groups for hospitals (1983) and physicians (1992).

These administrative pricing mechanisms allow providers to use their political clout to lobby for special treatment. Why is this? According to former CMS administrator Bruce Vladeck 'Medicare cannot deliver services to its

beneficiaries without providers and because providers are major sources of campaign contributions in every congressional district.’²⁰⁶

Medicare compensates providers for their medical inputs (procedures performed or time spent with patients) rather than on their outcomes (hospitals with higher post-operative infection rates, for example, getting paid less), with predictable results.²⁰⁷

We’ll explore how this works with the Congressionally mandated End-Stage Renal Disease program.²⁰⁸

ESRDP

Medicare funds almost all US kidney dialysis through the End Stage Renal Disease Program (ESRDP), a huge program totaling \$24 billion in 2007 - almost 6% of all Medicare spending.

Some history: In 1973 Congress passed the ESRDP to provide federal support for most patients with end-stage renal disease. Prior to this, the new technology of kidney dialysis was too expensive for most people even with medical insurance. In 1965, for example fewer than 150 people were dialyzed nationally even though tens of thousands were medically qualified.

Congress decided not only to cover costs, but also to stipulate protocols, standards, national reimbursement rates, frequency of dialysis, approved types of testing, etc. This made Congress both the financier and medical decision-maker. Neither patients nor providers could deviate from the Congressional cookbook formula. The only patient choice: treatment site.

In the early 2000s, dialysis cost about \$65,000 per person per year. If patients have private insurance, the carrier pays for 33 months of treatment and then Medicare pays, regardless of patient age. Medicare accounts for about 90% of ESRDP payments and covers about 300,000 patients.

Does this program work well? While expenditures more than tripled from \$5.1 billion in 1991 to \$18.4 billion in 2004, the death rates in the first year of dialysis for end-stage renal disease patients remained about the same from 1993 - 2004, as did hospital admissions and lengths of stay. Despite great medical knowledge increases and treatment improvements.

²⁰⁶ Bruce Vladeck, The Political Economy of Medicare, Health Affairs, 19 (1999) page 22

²⁰⁷ Hyman, op cit, page 31

²⁰⁸ This section comes from Regina Herzlinger, Who Killed Healthcare, Chapter 5. Data and examples come from this source.

This is much as one would expect, since all ESRDP treatment variables were mandated, bureaucratically codified and resistant to change regardless of medical technology improvements. It's also a testament to the political power of ESRDP providers and the bureaucratic ability of administrators to stifle innovation.

'All too many patients did not receive the preventive care that could slow the progression of their diseases' according to Harvard Business School's Regina Herzlinger, for the Congressionally approved treatment did not pay for prevention, only cookie-cutter treatment. 'Because providers must follow Congress's recipe, kidney disease victims...can die prematurely, injured by the shortage of the testing and health promoting services they need and the excessive drugs they received,' for the Congressionally mandated treatment consisted of drug therapy for all patients.

In other words, we likely pay too much for the wrong kind of care. ESRDP treatment pricing does not include prevention, testing or wellness activities that could have mitigated progression of the other diseases that frequently accompany kidney disease. Diabetes, for example, is a key cause of kidney failure.

Who benefits from ESRDP? According to Herzlinger, 'the businesspeople who understood the care and feeding of our Congress earned millions.' That includes drug suppliers and dialysis center owners who were able to lobby Medicare and get their products included in the protocols.

One publicly traded company owns a quarter of all dialysis centers in the US. It spent about \$1 million on federal lobbying during the first half of 2006. The Los Angeles Times says this million led to an annual \$100 million increase in Medicare payments to dialysis providers.²⁰⁹

The biotechnology firm that manufactures epoetin (epo), the drug primarily used for people on dialysis, spent \$5.7 million on lobbying in 2005. Perhaps related to this, Congress, through Medicare authorizations, set the target range for hematocrit - a measure of oxygen-carrying red blood cells that is directly impacted by epo.

Hematocrit target levels were raised over time from 30% to 33% and finally to 36% in 2006. According to Harvard's Herzlinger, 'one powerful senator personally requested that the Medicare administrators increase the upper end level of the hematocrit...he chaired the subcommittee that supervises the budget for Medicare.' This increased spending on epo by about \$500 million

²⁰⁹ Herzlinger refers to Tom Hamburger and Walter F. Roche Jr, Congress Closes with a Park-filled Flourish: Dialysis Industry, Other interests that Donated to Lawmakers Get Lavish End of Session Breaks, Los Angeles Times, December 21, 2006, page A1

annually, for a 3% increase in hematocrit requires up to a 50% increase in epo dosage.²¹⁰

Herzlinger suggests, unfortunately, that ‘patients assigned to higher hematocrit target levels do not show discernable improvements in survival, hospitalization or cardiac outcomes.’

Congress also mandated that dialysis treatment in hospitals receive \$4 more than in stand-alone clinics, per treatment, due to the higher hospital cost structure. But Medicare notes that treatments and outcomes are the same in hospitals and clinics. This amounts to a taxpayer subsidy for hospital inefficiency and is, perhaps, related to the \$17 million that hospitals and related organizations spent on lobbying and contributions in 2004.

Herzlinger summarizes the ESRDP program that results from Congressional meddling and program micro-management. Although diabetes is a key cause of kidney failure and many dialysis patients are also diabetic, fewer than half

had good results for diabetes or the important tests for the heart diseases that typically accompany diabetes, and two-thirds had excessive levels of protein in their urine, a dangerous sign of the lack of efficacy of the dialysis.

Use of Epo increased. Congress favored it in the cost-plus payment formula it chose for drugs, so gave the manufacturer a virtual monopoly by granting it a special designation ‘orphan drug’. This prohibits similar drugs from going through the government clearance process for 7 years and grants a 50% tax credit on clinical trials, among other advantages.

Medicare codification, mandates, orphan drug designations and micromanagement of ESRDP inhibited alternative treatments from being developed. Whether or not all this government involvement with this Medicare program improved patient experiences is far from clear.

Medicare’s Financial Situation

Is Medicare financially solvent and thus a well-functioning healthcare system? What is Medicare’s underlying financial / actuarial situation?

Medicare was designed in 1960s when we had about 4.5 working employees paying into the system for each beneficiary taking money out. It was originally designed as ‘pay-as-you-go’ - designed to receive tax money annually from

²¹⁰ Herzlinger refers to Dennis Cotter, Trnalating Epoetin Research into Practice, Health Affairs, Vol 25, no 5

employee-based taxes but not fully capitalized based on expected payout rates.

That was not an unreasonable financing structure given the political realities of the 1960s and anticipated future systemic demands.

Today, however, there are only about 4 workers paying in for each beneficiary taking out, and each beneficiary is taking out far more than anticipated in 1965. According to Medicare's trustees, by 2030 there will be only 2.4 payers vs. beneficiary, making 'pay as you go' financially perilous even if payout rates per beneficiary buck their historical trend and do not increase.

But remember the history: lifetime geriatric spending has increased 11 fold, inflation adjusted, for 65+ year olds for from 1960 to 2000. ('Inflation adjusted' means that \$1 in 1960 = \$1 in 2000.) Here's the data:

In 1960, the average American consumed an inflation adjusted \$11,500 from age 65 until death;

In 2000, the average American consumed an inflation adjusted \$147,000 from age 65 until death.²¹¹

(I once presented this information to a class that included a former banker. I asked if he would lend to a client who presented like Medicare. His shocked response: 'absolutely not!')

Medicare's current unfunded liabilities are about \$70 trillion. That's the difference between the amount that Medicare will take in from employment taxes, and the amount that Medicare will pay out to beneficiaries.

This is unbelievable. We are saddling our children and grandchildren with huge financial obligations - for no good reason. We're way overspending on Medicare, but we're generating mediocre results. Our Medicare beneficiaries aren't living longer than elders in other countries. They just get more (unnecessary) medical care.

And we're forcing future generations to pay those bills.

But here's the really frightening bit: with healthcare spending holding down our future economic growth, we'll be less competitive internationally. Our future growth rates will likely be lower than other countries - and lower than optimal to pay this debt back. US job formation may be low - because employers will (a) have more difficulty expanding their businesses in a slow

²¹¹ David Culter, The Value of Medical Spending in the United States 1960 – 2000, New England Journal of Medicine, 2006

economy and (b) because the burden of health insurance - and Medicare taxes - looms so large.

We'll likely end up with higher unemployment. That means fewer employees paying Medicare payroll taxes. All the while, our Medicare bill continues to grow....

Conclusion

Perhaps the Medicare story makes my initial point concretely. Our healthcare costs are burying us. We're facing an \$70 trillion unfunded liability in Medicare. Note that \$70 trillion is about 5 times our annual GDP.

We've tried - unsuccessfully - to reform Medicare multiple times. We never get it right. Medicare's costs continue to rise, regardless our attempts to reign them in.

Some people have suggested that we need radical changes to our healthcare financing system. Some advocate single payer healthcare - astonishingly (to me) arguing for Medicare for All. Others claim that only Consumer Driven Healthcare can save us. Still others want to implement true Managed Care, sometimes called co-ops.

Can any of these forms of health insurance save our healthcare system?

We'll turn in Part 4, to a discussion of health insurance forms --- and of reforms.

Summary of Part 3:

1. We have a slew of systemic inefficiencies in our healthcare system that waste some \$500 - \$700 billion annually.
2. The primary cause of this systemic waste is our **fee for service financing system** that pay providers based on quantity of patients seen, rather than quality of services provided. Indeed, in our fee for service financing system, we generate very poor outcome data so have difficulty paying for quality.
3. The 7 main systemic problems discussed here include:
 - High rate of medically uninsured people
 - The uninsured receive care later and die younger
 - Moral hazard
 - We shop less wisely using the carrier's money than our own
 - Medical Arms Race
 - Payment for treatment inputs, not outcomes
 - Ineffective chronic and preventive care
 - 75% of costs go to chronically ill people, but we pay by acute care codes
 - Treatment variation
 - Some patients receive more care, less care or different care than others for the same medical condition
 - Relatively poor quality and safety
 - Medical care is often poorly coordinated, inefficient and unsafe
 - Overuse of general hospitals
 - General hospitals are expensive and often poorly organized to provide efficient medical care
4. Medicare covers about 45 million elders at a cost of about \$500 billion. It is inefficient and is going broke. Despite its huge costs, American life expectancies at age 65 are about the same as many other countries that spend far less on their elder care.

Review Questions
Answers on next page

1. What is healthcare system efficiency?
 - a. Getting the best outcomes for a given investment
 - b. Paying the least amount for medical care
 - c. Getting the best medical care available, regardless the price
 - d. Getting the least cost medical care available

2. How efficient is our healthcare system?
 - a. Quite inefficient, since we annually waste some \$500 - \$700 on unnecessary medical care
 - b. Quite efficient, since we waste very little money on unnecessary medical care
 - c. More efficient than most other countries, based on the fact that we spend less than them, but live longer
 - d. About as efficient as most public services

3. Which problem is the most important to solve in our healthcare system:
 - * Having a high number of medically uninsured;
 - * Moral hazard;
 - * Treatment variation
 - * Poor quality and safety
 - a. Having a high number of medically uninsured
 - b. Moral hazard
 - c. Treatment variation
 - d. They are all equally important

4. Why might we **NOT** want to expand Medicare to cover all Americans?
 - a. Because Medicare is poorly financed and is going broke
 - b. Because Medicare's organization is uniquely applicable to the elderly
 - c. Because Medicare's protocols are uniquely applicable to the elderly
 - d. Because Medicare is already too large to be truly effective in treating patients

Review Questions
Correct answers in bold

1. What is healthcare system efficiency?
 - a. **Getting the best outcomes for a given investment**
 - b. Paying the least amount for medical care
 - c. Getting the best medical care available, regardless the price
 - d. Getting the least cost medical care available

2. How efficient is our healthcare system?
 - a. **Quite inefficient, since we annually waste some \$500 - \$700 on unnecessary medical care**
 - b. Quite efficient, since we waste very little money on unnecessary medical care
 - c. More efficient than most other countries, based on the fact that we spend less than them, but live longer
 - d. About as efficient as most public services

3. Which problem is the most important to solve in our healthcare system:
 - * Having a high number of medically uninsured;
 - * Moral hazard;
 - * Treatment variation
 - * Poor quality and safety
 - a. Having a high number of medically uninsured
 - b. Moral hazard
 - c. Treatment variation
 - d. **They are all equally important**

4. Why might we **NOT** want to expand Medicare to cover all Americans?
 - a. **Because Medicare is poorly financed and is going broke**
 - b. Because Medicare's organization is uniquely applicable to the elderly
 - c. Because Medicare's protocols are uniquely applicable to the elderly
 - d. Because Medicare is already too large to be truly effective in treating patients

Part 4: Insurance Forms and Reforms

Chapter 10: Health Insurance Forms

I would take almost any system - from Medicare-for-all to a private insurance voucher system - over the one we have now.

Atul Gawande, New York Times, 5/31/07

Health insurance form describes the relationship between healthcare system users (patients), funders (insurance carriers) and service providers (physicians and hospitals). The clear goal of any health insurance form, or reform: make our system more efficient - i.e. generate the best possible patient outcomes per dollar spent.

Where Does A Healthcare System Come From?

A healthcare system is embedded in the culture, history and values of a particular society. That's why the British system, with various access and payment restrictions for example, can work in Britain. Or why the Canadian system, which includes lengthy waits for various specialist procedures, can satisfy Canadians.

Similarly, the French system grew out of a particular, unique French social evolution, the German out of their history, etc. Absent, for example, Otto von Bismarck's contribution to German historical development, the German healthcare system may have developed very differently. But Bismarck made his contributions, and the German system evolved - differently from the French or Italian.

Interestingly, each different healthcare system typically enjoys strong support from its constituents. Surveys consistently show that Britons generally like their National Health Service and Canadians like their medicare.

Surveys also typically show that people in one country are suspect of the healthcare system in another. Americans typically object to the socialized medicine practiced in Britain, just as the British typically object to the private, non-guaranteed healthcare system in America. Canadians often shake their heads in wonder over our need to pay for medical care - they get it for free. Americans respond with equal skepticism at a Canadian system that prohibits private medical options.

People, it seems, are comfortable with the system that they have, know and understand - and uncomfortable with systems that differ significantly.

Not only did each healthcare system develop organically from its own social roots, but each system rests on the epidemiology of the specific population it

serves. Thus, for example, the Canadian system has fewer open heart surgical demands than our system, so is organized differently. Similarly, Japanese women have far lower rates of ovarian cancer than American women, so their healthcare system is designed to accommodate that.

We'll suggest that a healthcare system reflects the social values of a country, and evolves over time within the framework of that country.

Social Bases of the American Healthcare System

The various American healthcare reform debates seem to rest on our *lack* of shared values about the type of health insurance we desire. Some Americans prefer single payer healthcare, others managed care and still others consumer driven healthcare.

People sometimes seem to place their healthcare system preference on an almost metaphysical pedestal. Anecdotally, I've heard multiple consumer driven / market based healthcare supporters, for example, claim that the Obama public insurance option is a threat not only to our healthcare system, *but also to our entire way of life*. 'I'm worried' a prominent and influential broker once told me, 'about what this means for America.'

I've also heard some single payer proponents claim that that the healthcare deregulations embedded in consumer driven healthcare proposals may destroy the 'fabric of our country'.

People supporting different types of healthcare in this country sometimes see alternatives not only as *inappropriate*, but also as *evil and destructive*. 'If my proposal wins,' people sometimes seem to think, 'then American can continue as we know it. But if my opponents win, then our future prosperity, and even liberty, will be put in jeopardy.'

That's a very strong position to take about health insurance form! Why do we take it?

Our healthcare reform debates are, I think, really debates about underlying societal values.

This chapter will explore those values.

Social Values as a Basis of Health Insurance Form

Healthcare as a Right

Some people, and some countries, define access to healthcare as a **right**, much like access to national defense, primary education, clean air and clean water. They see provision of healthcare as a governmental responsibility, like

education and defense. The British would, by and large, accept this point of view.

People holding this position sometimes argue that we all need health insurance, just like we all need national defense and primary education. Just like defense and education are provided to all for free - funded, of course, by taxpayers - so healthcare should be also.

This broad argument strikes me as fallacious. Yes, we all need defense, education and healthcare. But we also need food, clothing, housing and transportation. None of these are typically provided by the government, unless, of course, you are poor and they are unaffordable to you.

Yet there seems to be something special about healthcare that differentiates it from food, clothing and housing. The healthcare-is-a-right folks might argue that everyone needs exactly the same kind of health insurance, unlike food and clothing. The reason: people buy health insurance when they're healthy, before they know what illnesses they will get, and thus before they know what kinds of treatment they will need. As such, everyone needs to purchase the same coverage for everything.

Since everyone needs the same coverage according to these folks, it becomes a small step to argue that we should all receive it from the government, tax-paying and equality comprising key aspects of being 'American'. This then morphs into the healthcare-is-a-right conclusion.

Healthcare provision, thus, differs from food, housing or transportation provision. We prefer different kinds of food and choose to live in different types of houses. These are completely rational decisions. As such, they are inappropriate for 'one size fits all' provision by the government.

According to the healthcare-is-a-right crowd, healthcare is a 'one size fits all' product that we all need. Healthcare is a unique product in this regard. As such, it should be provided by the government, equally to all.

Or so goes that argument.

Healthcare as a Product

Other people see access to healthcare as a **privilege** or a **consumer good** - available to those able to pay for it - much like owning an automobile, a house or a tennis racquet. They see provision of healthcare as primarily a private sector responsibility. Many Americans, including for example, both the Nixon and George W. Bush administrations, would probably accept this position.

This group would see provision of healthcare more like that of food, clothing, housing and transportation. People could purchase more or less

healthcare according to their tastes, preferences and ability to pay - just like they buy different kinds of food, clothing and houses.

According to this group, people could buy catastrophic health insurance, buy coverage with or without prescription drug coverage, buy long term care insurance, buy coverage from a narrow provider network, or buy concierge healthcare services. They could - completely rationally - purchase different benefit packages at different times of their life.

The healthcare-is-a-privilege crowd would not see healthcare as a public good. Instead, they would say that consumers can understand enough about it, and about their own needs, to make wise purchases.

Our Uncomfortable Blending of These Two Positions

Our health insurance history described in Chapter 4 shows an uncomfortable combination of both points of view. We developed health insurance initially as a private sector function (a privilege), to protect the cash flow of private sector hospitals. Initially health insurance was available only to those able to pay for it.

Later, we granted free healthcare as a right to certain groups in our society - the military, for example during World War II, and the elderly in Medicare.

We also blended the two ideas - right and privilege - to insure the poor through Medicaid. These people have a right to health insurance - funded by the government - but need to pay a portion of the cost according to their income. Massachusetts, for example, uses this type of formula in at least one of its Medicaid programs, the Insurance Partnership.

We've had a disagreement about the right vs. privilege question at least since Baylor University Hospital first contracted with the Dallas school system to provide health insurance to employees.

Both Sides Agree on Wide Choice of Provider

We have more agreement on another social value that underlies our health insurance system - the importance of provider choice. The Split, described in Chapter 4, indicates that Americans value choice of provider very highly. We want the ability to choose our own physician and we object to health insurance forms that restrict this choice. This value seems common to both the 'healthcare is a privilege' and the 'healthcare is a right' crowds.

Translating Social Values into Insurance Policies

Let's translate these various social value positions into actual health insurance policy forms and actual health insurance reform proposals.

To do this, I propose categorizing health insurance and reform proposals according to the answers to 2 fundamental questions, both of which reflect the values discussed above:

Question 1: Is healthcare like, or not like, other goods and services in our economy? and

Question 2: Is competition good or bad in healthcare?

The way you answer these questions likely reflects the way you see the 'right vs. privilege' argument.

Let's explore these questions in more detail.

Question #1:

Is healthcare like, or not like, other goods and services?

Can we shop for healthcare like we shop for tennis racquets, cars or houses? Or must we all obtain exactly the same coverage?

There is no clear, objective answer. People answer these questions differently - almost as a matter of metaphysical belief. The healthcare-is-a-privilege crowd believes that individual consumers simply need the right **price** and **outcome** information to make wise and informed healthcare purchasing decisions. They think that this information can be made available to consumers.

Regina Herzlinger, from Harvard Business School and a strong healthcare-is-a-privilege proponent, is very strong on this point. The fact that we currently do not have quality price and outcome information, she says, is a minor issue. Comparing the current state of healthcare treatment information to the 1930's state of financial information in this country, she claims that 'when the federal government required disclosure, they got it.'²¹² All we need, in her opinion, is a strong federal commitment to publishing audited price and outcome information. After that, our marketplace can take over.

People holding this set of beliefs tend to favor **consumer driven healthcare**.

²¹² Regina Herzlinger, Who Killed Healthcare, page 234

Alternatively, the healthcare-is-a-right folks think that purchasing healthcare is fundamentally different from purchasing other consumer goods. They may think that purchasing different insurance packages, or specific medical services, is inappropriate for most consumers. **First**, most of us lack the technical training to make wise and informed medical decisions. **Second**, the healthcare-is-a-right folks ask why we should make important medical decisions when we're sick and probably frightened; we don't shop for other products under these circumstances. This is an inappropriate time to shop. **Third**, patients are generally poor self-diagnosticians. They are emotionally involved and lack the necessary medical training.

They may also disagree with Herzlinger and think that generating actual medical price and outcome data is extremely difficult, if not impossible. We don't, even today for example, have publically available prices for most treatments at most hospitals. The lack of federal requirement for this is only one reason. There are a host of others - confidentiality, anti-collusion laws, competitive business practices, data collection problems, etc.

Quantifying benefits from medical procedures, for example, is extremely difficult. Note the difficulty surrounding measuring the benefits of a specific therapy for a particular disease in a patient suffering from multiple chronic conditions, like scleroderma, Parkinson's Disease, diabetes, asthma and anxiety. Remember that some 75% of all healthcare spending goes to people with chronic diseases. We have not yet begun, in this country, to quantify benefits of most treatments - a necessary step for wise healthcare shopping.

Thus, the healthcare-is-a-right folks would argue, we cannot treat healthcare like other goods and services. We cannot generate sufficiently good cost and benefit data for people to make rational purchasing decisions. Even if we could, this is an inappropriate venue for comparison shopping.

People thinking that healthcare purchasing is essentially different from purchasing other goods and services tend to favor **managed care or single payer healthcare**.

There is no national consensus, and great minds differ on the answer to our Question #1.

Question #2: Is competition good or bad in healthcare?

Some people think that competition among carriers, physicians and hospitals will improve our healthcare system - just as it improved our cars, computers etc.

Other people think that competition *per se* is not the critical variable, but that **certain kinds** of competition are necessary to improve our healthcare system.

In general, people who think that competition among carriers and providers will improve our system favor **consumer driven healthcare** or **managed care**.

Others disagree. They claim that physicians should focus exclusively on treating their patients, and should not think about marketing, business issues or competitive demands. Indeed, according to advocates of this position, competition may **harm** our healthcare system, by eroding professional values and standards and by forcing providers to think about inappropriate issues, like their business practices. This group would tend to favor **single payer healthcare**.

Of course, there are variations within each system. I've tried, here, to outline the basic positions of single payer, managed care and consumer driven proponents.

Comparisons

Here's the matrix defining the 3 basic forms of health insurance:

Consumer Driven

Healthcare is like other goods and services;

Competition among providers is good and will improve our system

Managed Care

Healthcare is not like other goods and services;

'Managed Competition' among Managed Care Organizations is good and will improve our system

Single Payer

Healthcare is not like other goods and services;

Provider competition is bad and will harm our healthcare system

There's also a fourth type of healthcare system - the system we have today: fee-for-service financing based on billing code. The specific fees are based on negotiations between carriers and providers, and tend to reflect relative bargaining power more than any fundamental value structure or outcome goals.

Fee-for-service financing grew directly out of the Split described in Chapter 4, and has been around for 60+ years. Many think that fee-for-service is a fundamental problem with our healthcare system. Indeed, we articulated many of these reasons in Chapter 8.

We have no national consensus on which form of health insurance is best for us, and which will improve on our current fee-for-service mess.²¹³ If we had a national consensus, then healthcare reform would become significantly easier.

²¹³ 'Mess' as in the title of Richmond and Fein's classic work, The Healthcare Mess.

We'll describe, below, each form of health insurance. As we do this, try to focus on which form you think leads to the best cost control mechanisms, and which can provide the best patient outcomes.

Understanding Consumer Driven Healthcare

People who think that purchasing healthcare services is the **same** as purchasing other services, and that **competition among carriers and providers is good**, tend to favor consumer driven healthcare.

Consumer driven proponents want less governmental regulation of our healthcare system so consumers can have more freedom of choice. The theory: when consumers shop among a wide variety of options, they will demand better quality at lower prices, thus improving the value of our healthcare system. Consumer choice and competition among providers are the keys to improving our healthcare system.

Since - according to these folks - healthcare purchasing is fundamentally the same as tennis racquet purchasing, then the same, relatively low level of government regulation should apply. More governmental involvement will reduce both **the ability of consumers to choose** and **the amount of competition among providers**. In sum, more government regulation will make the system worse in their view.

Consumer Driven Healthcare is defined by Herzlinger, perhaps its key academic proponent, as:

The restructuring of our healthcare delivery system around the needs of human beings, not around the needs of the status quo...high deductibles [don't] represent consumer driven healthcare. That's ridiculous. Consumer markets have lots of choice.²¹⁴

When consumers apply pressure on an industry, whether it's retailing or banking, cars or computers, it invariably produces a surge of innovation that increases productivity, reduces prices, improves quality and expands choices. The essential problem with the healthcare industry is that it has been shielded from consumer control - by employers, insurers and the government...

Entrepreneurs will respond to the unleashing of consumer demands with clearly differentiated products featuring various combinations of

²¹⁴ Sean Silverthorne, Is Healthcare Making You Better – or Dead?, Harvard Business School Working Knowledge, June 4, 2007

benefits, levels of insurance coverage, payment systems for providers, lengths of policies and sources of information. The competition among the new products, in turn, will control costs while improving the overall quality of coverage and care...

Under consumer driven healthcare, enrollees can tailor health insurance policies to their specific needs - e.g. insurance for long term care and drugs; easy access to integrated teams that specialize in treating chronic diseases and disability; pre-tax savings accounts for uninsured healthcare needs, such as hearing aids and support in modifying lifestyles; and 'bonus' long term policies that reward those who switch to healthy lifestyles.²¹⁵

Understanding Managed Care

People who think that purchasing healthcare services is **different** from purchasing other services, but that, among healthcare providers, **competition is good**, tend to favor managed care.

Managed care proponents think that individual consumers **cannot** choose wisely among healthcare professionals for several reasons:

1. Consumers cannot determine which specific physician or hospital is best for their particular medical needs;
2. Consumers generally purchase medical services when they are ill and upset or frightened. This is a poor time to comparison shop;
3. The appropriate unit of measure is not really the individual physician or hospital, but the **medical team** - consisting of diagnosticians, therapists, acute care specialists, rehab professionals and others who must work together to achieve the best patient outcomes. An outstanding surgeon working with a poor rehab team may generate poor results.

As a result, managed care proponents want to organize our healthcare system so that each physician, nurse and hospital belongs to only one managed

²¹⁵ Regina Herzlinger, Are Consumers the Cure for Broken Health Insurance?, Harvard Business School Working Knowledge, August 5, 2002

care organization. This will foster good medical care integration within that organization.

According to the theory, managed care organizations include both the insurance function and healthcare treatment function in the same company - i.e. the Vertical Integration we discussed in Chapter 4.

In a true managed care society we would no longer have separate health insurance carriers, independent physicians, independent general hospitals and fee-for-service billing. Instead, we would have large organizations that integrate finance and treatment functions for the good of the subscriber / patient.

Consumers in a true managed care society would not purchase insurance from one company (Blue Cross, for example) and then get medical care from another (the Cleveland Clinic, for example). They would belong, rather, to a company that's hypothetically called *The Managed Care Organization that Integrates Finance and Medical Service Provision Together*.

Each physician and hospital would belong to only one such managed care company. Each health insurer would affiliate with only a specific set of providers. Consumers could purchase insurance from only one company, and could get medical care only from the providers affiliated with that company.

Patients would also need a Primary Care Physician referral to access a specialist. The PCP sits at the center of information flows. He/she knows the patient, the available specialists and the best provider teams so can provide the best advice. Patients alone are unable to choose the best specialist and team for their particular needs.

In the ideal model, managed care organizations compete with each other to provide the best value to subscribers. Competition among managed care organizations is called 'managed competition'.

The goal of managed competition, according to Stanford Business School Professor Alain Enthoven, perhaps our foremost managed care proponent, is 'to divide providers in each community into competing economic units and to use market forces to motivate them to develop efficient delivery systems.'²¹⁶ Only through competition can the health plans that do the best job of improving quality, cutting costs and satisfying patients be rewarded. Competition occurs at the level of integrated financing and delivery plans, not at the individual provider level.

Thus managed care advocates walk a fine line when answering our 2 fundamental questions.

²¹⁶ Enthoven, History and Principles of Managed Care, Health Affairs, 1993

They believe that purchasing healthcare differs from purchasing most goods and services in our society, so individuals should not buy their own medical services. But they also believe that competition is necessary to improve our healthcare systemic performance.

They walk that fine line, but not always very successfully.

Understanding Single Payer Healthcare

People who believe that purchasing healthcare is **different** from purchasing other services and that among healthcare providers, **competition is bad**, tend to prefer single payer healthcare.

Some single payer folks think that healthcare is a right, not a product, so is not even appropriate for economic analysis. Thus it's intrinsically different from other types of products and services in our economy. Arnold Relman of the Harvard School of Public Health seems to take this position, suggesting that 'medical care is not really a 'market' at all in the classical economic sense and therefore ... the basic theories of economics are not relevant to the discussion of ... healthcare.²¹⁷

Others believe that individual consumers cannot shop wisely for healthcare, for roughly the same reasons as articulated by the Managed Care folks above:

- Patients cannot adequately diagnose their own medical problems - so cannot shop wisely for solutions;
- Patients cannot measure treatment costs or outcomes - especially for long term, chronic treatments - so cannot shop wisely.

Unlike the Managed Care advocates, however, Single Payer proponents do not generally believe that competition among providers is a good thing. Their reason: Physicians should focus entirely on their patients, and should not allow business considerations to cloud their thinking. Provider competition, they believe, decreases physician care quality.

Here's Relman again, lamenting the impact of business competition and consumerism on our healthcare system:

To a degree greater than anywhere else in the world, our doctors think of themselves as competitive business people...a real solution to our problems will not be found until the public, the medical profession and

²¹⁷ See Arnold Relman, Medicine and the Free Market, New Republic, March 7, 2005

the government reject the prevailing delusion that healthcare is best left to market forces...we need to depend on non-market mechanisms to make our healthcare system work properly.²¹⁸

These 'non-market mechanisms' would include educational requirements and professional licensure standards, among others.

Thus Single Payer proponents believe that purchasing healthcare differs from purchasing other services and that competition among healthcare providers is bad for patients.

Single payer proponents further argue that having a national health insurance single payer will generate various other patient benefits. Among those benefits:

- Universal coverage;
- A more equitable healthcare system, which treats everyone alike;
- More uniform treatments, to avoid a situation where some Americans get access to excellent care, while others get only mediocre;
- Lower cost healthcare, since the single payer will not need to pay for marketing, underwriting or other expensive private insurance functions, and providers will not need to pay for expensive administration to manage their billing function.

Proponents of these 3 forms of health insurance - Consumer Driven, Managed Care and Single Payer - all believe that the other forms are inferior. They criticize each other enthusiastically.

Let's look, in the next chapter, at the various standard criticisms.

²¹⁸ Ibid.

Chapter 11

What Proponents Say About Each Other

What Consumer Driven folks say about the other forms of health insurance

Consumer driven healthcare proponents object to fee-for-service insurance.

Fee-for-service financing pays for treatment inputs, not outcomes. This presents two major problems for our healthcare system:

First, fee-for-service financing is highly inflationary. It offers hospitals incentives to perform the most possible treatment, not the least. It further incents providers to perform the most expensive treatments, not the least. This is unlike any typical consumer product. Fee-for-service financing produces far more expensive than necessary medical care.

Second, fee-for-service financing offers little, if any, data collection resources to inform carriers or providers which treatments generate which results. Fee-for-service financing leads to fragmented services, with specialists rarely working as teams.

Yet good patient outcomes rely on all medical team members working together. If outcomes are good, which team members played the key roles? If outcomes are bad, which messed up - or did poor team coordination lead to poor outcomes? Only with this knowledge can we improve our healthcare system. The fee-for-service model does not generate the data to tell us.

As a result of this fragmentation, fee-for-service generates relatively mediocre results. It offers few incentives for providers to invest in prevention, safety or efficiency. It is inappropriate for chronic disease care.

Consumer driven proponents claim that allowing shoppers to choose medical services based on price and outcomes would simultaneously improve outcomes and reduce prices. This follows from the answers to our 2 questions above. They believe that purchasing healthcare is essentially like purchasing other goods and services, and that competition is a good thing.

Consumer driven folks object to single payer healthcare.

Under single payer financing, one entity - often the government - defines the medical services to be covered and then pays for them.

Consumer driven opponents object to the 'top down' nature of government run programs. 'Top down' means that the government decides what types of coverage are available, what services are covered, and the terms and conditions of access. 'Bottom up' policies, favored by CDHC fans, are

stimulated by consumer demand, and may come in a wide variety of types of policies, plans, services, terms and conditions.

CDHC proponents believe that bottom up policies most accurately reflect the demand for healthcare services, are more innovative, and respond more quickly to consumer demand and new treatment options. 'Top down' programs can too easily become politicized by special interests - to the potential harm of patients. Only consumers can save our healthcare system from special interest domination.

Consumer driven healthcare folks object to managed care.

Consumer driven advocates claim that managed care is another 'top down' healthcare system with policies, programs, terms and conditions imposed on subscribers.

Harvard's Herzlinger, for example, claims that managed care programs are designed by well-meaning but misguided academics who believe that they know more about your healthcare than you do. These academics do not trust consumers to make wise and informed healthcare decisions. They seek to reduce consumer healthcare choices through network or policy coverage limitations, and by various types of referral requirements.

CDHC fans reject these ideas.

Consumer driven proponents also claim that managed care's requirement of integrated financial and medical service functions in the same company - i.e. vertical integration - is impossible to implement in the real world. They cite a large library of business school studies to support this.

What Managed Care folks say about the other forms of health insurance

Managed Care theorists walk that fine line when they answer our Questions #1 and #2. They need to show why buying healthcare differs from buying other goods in our society, but that competition among providers will improve our system.

Managed care folks object to fee-for-service insurance

Stanford's Enthoven sees 10 major problems with fee-for-service health insurance:²¹⁹

²¹⁹ Alain C. Enthoven 'Why Managed Care Has Failed to Contain Health Costs' Health Affairs, Fall 1993.

- Fee-for-service creates an adversarial relationship between doctors and payers;
- Fee-for-service has little accountability - poor data collection and provider motivations for economy;
- Fee-for-service 'free choice of provider' leaves patients to make remarkably poorly informed choices;
- Fee-for-service generates excess hospital capacity, high tech equipment and open-heart surgeries;
- Fee-for-service generated an excess supply of specialists;
- Fee-for-service misallocates resources, as no incentive to use the least costly settings for treatment;
- Fee-for-service has no capacity to plan care processes from diagnosis to treatment to rehabilitation;
- Fee-for-service has led to a dangerous proliferation of facilities for complex and costly procedures without the volumes necessary to maintain good outcomes;
- Fee-for-service cannot practice total quality management due to lack of service integration;
- Fee-for-service cannot organize the rational use of technology

Only systems that manage healthcare can emphasize prevention, early diagnosis and effective chronic disease management.

Managed care folks object to single payer healthcare

They claim that single payer financing eliminates competition from healthcare to the detriment of the entire system. Only through competition, they believe, can we simultaneously reduce healthcare costs and improve outcomes.

As evidence, managed care advocates might refer to this recent comparative cost data:

Per Capita Healthcare Spending Increases, 2000 - 2007 ²²⁰

Australia	48%
Canada	54%
France	41%
Germany	34%
Greece	88%
Spain	73%
UK	63%
US	54%

Absent appropriate competition, single payer systems were no better at containing healthcare spending than we were.

Managed Care Folks Object to Consumer Driven Healthcare

Under CDHC, individual consumers make their own decisions about their healthcare.

Managed care theorists object to this idea. They believe that healthcare is fundamentally unlike other goods and services in our economy, and that consumers are unable to shop wisely for health services for reasons of information availability, risk and price.

Consumers, according to managed care advocates, cannot access good information about important aspects of our healthcare system. They cannot self-diagnose nor determine which specialists are 'better' than others. They can't determine which treatment is most appropriate, which hospital is best for a specific ailment, or which providers offer the best value.

Managed Care proponents think that consumers need a guide or gatekeeper to advise them how best to use our healthcare system. In the managed care vocabulary, the advisor is the Primary Care Physician.

The PCP knows both the patient and the available resources, so can design a treatment plan that uniquely fits each individual patient. This key component is lacking in Consumer Driven Healthcare plans, according to the Managed Care folks.

²²⁰ OECD Health Data

What Single Payer Folks Say about the Other Forms of Health Insurance

Single payer proponents object to consumer driven healthcare, claiming that purchasing healthcare differs from purchasing other goods and services. Single payer advocates typically define healthcare as a right, much like primary education. As such, it fits outside our typical market based economy.

Market economics, in other words, are inappropriate in healthcare.

Single payer proponents object to managed care, though specific reasons vary according to the specific single payer advocate.

Some object to the narrow provider networks offered by managed carriers. Others object to payment of premiums based on some sort of risk analysis by the managed carrier. This follows from the 'healthcare is a right' argument.

Still others object to attempts to measure outcomes, fearing that any outcome measurement would negatively influence providers' behavior. Providers trying to maximize their outcome rankings might accept only healthier patients or specialize in certain types of treatments to make themselves look good on comparative scales. (By analogy, we hear stories about colleges that jockey their statistics to look good on comparative scales.)

Thus, single payer proponents typically think, competition among providers is a bad thing for our healthcare system.²²¹

Consensus is Key, Not Specific Form

Who's right?

They all are!

Any of these 3 forms of health insurance - consumer driven, managed care or single payer - could work reasonably well...***if we had consensus.***

This is a radically different position from most healthcare commentators.

I'm suggesting that the solution to our healthcare problems rests with our ability to generate consensus about the answers to Questions 1 and 2.

This position contrasts with most commentators. Healthcare 'experts' typically define our healthcare system problems in some way or other, and then provide solutions based on their definition of the problem.

We take a different approach in this book, suggesting that our lack of consensus is the real stumbling block to healthcare system improvement.

²²¹ Single payer healthcare comes in various flavors. Some flavors, as those articulated by Professor Relman above, oppose competition. Others embrace some forms of competition. I tried to present a general summary here, fully acknowledging that the general does not fit every specific

A typical commentator, for example, may claim that the fundamental problems with our healthcare system are the 7 problems we discussed in Chapter 8, or any of the list below (choose as many as you like):

- Too many specialists;
- A financing system that rewards quantity of medical procedures rather than the quality of care provided;
- Inappropriate competition;
- Poor coordination of medical treatments;
- Over-use of general hospitals;
- Short term, rather than long term, insurance plans;
- Too much attention to the bottom line;
- Too much business focus;
- A lousy tort system;
- Too much carrier involvement;
- Too few real preventive services;
- Poor chronic disease care;
- Poor hospital safety;
- Etc, etc, etc

While these - and other problems - may be real, I don't think they provide a basis for healthcare reforms.

Instead, it's the value and context within which we put that problem that's key.

Let's use 'poor hospital safety' as an example.

If we believe that purchasing healthcare is like purchasing other goods and services in our economy (more or less that healthcare is a privilege), then the solution to poor hospital safety comes from various market mechanisms. We could, for example, publish outcome data to shine a light on poor performers. Once this information becomes publicly known, then market will force the hospital to solve its safety problems, for fear of losing patients and going out of business.

The Consumer Driven and Managed Care folks would approve of this solution.

On the other hand, if we believe that purchasing healthcare is not like purchasing other goods and services (more or less that healthcare is a right), then simply publicizing outcome data is an inappropriate solution. We need something else - government regulations, more mandates, more investment or

a different administrative structure. Healthcare regulations would be more like primary education regulations.

The Single Payer folks would applaud this.

Let's compare this situation to our primary education system. Occasionally a public school system is threatened by the state with a loss of accreditation. The school system rarely actually loses its accreditation. Teachers rarely get fired en mass. Administrators may get 'reassigned' but rarely lose their jobs. In other words, the school system doesn't go out of business. Instead, the state steps in to fix the problem.

So, apparently, would single payer folks address the problem of poor hospital safety. A very different approach from the market approach supported by managed care and consumer driven folks.

Thus, **the solution to our hospital safety problem depends on our answers to Questions 1 and 2:**

- #1: Is healthcare like or dislike other goods and services? And**
- #2: Is competition good or bad in healthcare?**

Either solution, above - market or regulatory - can improve hospital safety.

But both, together, may cause more problems than they solve. That's why we need consensus for any meaningful healthcare reform!

Let's expand on this example. If a clear majority of Americans answered our Questions 1 and 2 the same way, we could move forward with real healthcare reform - fairly easily. **Any** of these forms of health insurance would probably provide better outcomes at lower costs than today.

But **all** these forms together, conflicting with each other in our healthcare system, will probably not improve our system. These types of health insurance offer different provider incentives and set different treatment priorities. For example:

Managed care systems, working within tight budgets, emphasize preventive services but may reject some patients for certain types of acute care; but

Consumer driven systems may not emphasize prevention as much, but would give patients access to a wider range of acute services.

Or

Managed care advocates think that having a small network of providers who work together will generate the best patient outcomes at the lowest possible price; but

Consumer driven advocates want consumers to have the widest possible provider network, so people can have the most possible choices.

Or note the conflict between investing in the most efficient providers, and the least:

Market based systems (consumer driven or managed care) reward the most efficient providers the most, because they generate the best patient outcomes at the lowest cost; but

Single payer systems may invest disproportionately more in poorer quality providers so they raise their service levels, thus equalizing healthcare service quality to us all.

And note the conflict between consumer driven and single payer attempts to improve hospital efficiencies:

Consumer driven folks who think buying healthcare is like buying other goods and services want fewer hospital regulations. They see excessive regulations as hampering the hospital's ability to innovate, and thus improve efficiencies; but

Single payer folks who think buying healthcare is *not* like buying other goods and services and want more hospital regulations, to protect patients and to define efficiency.

A piecemeal approach to healthcare reform - a bit of consumerism, a bit a managed care and a bit of single payer - will not work. These different forms of health insurance rest on very different assumptions.

That's why our healthcare reforms over the past 40 years have all failed.

If we shared a consensus that healthcare is like other goods and services, and that competition is good, then we could design market based reforms to improve our system. We know how to design these - we've designed lots of market based regulatory systems in this country.

Alternatively, if we shared a consensus that healthcare is not like other goods and services, and that competition is bad, then we could design non-market reforms to improve our system. We know how to design these also.

But designing a combination of both market-based and non-market based reforms leads to mis-targeted regulations, confusion, contradiction and inefficiencies, like we see in our healthcare system today.

If We All Agreed... The Evidence That Any Form of Health Insurance Can Work

My students often challenge this thesis - that any form of health insurance could work better than what we have now, provided we have consensus. 'No,' they sometimes say, 'consumer driven healthcare is much better than single payer.' And then they proceed, typically, to talk about Canadian or British waiting lists for certain types of medical procedures, or other restrictions.

Other students - particularly the left-leaning ones - claim the opposite, typically arguing 'Our private sector based healthcare system has huge administrative costs. Only a single payer system can save us' and then show Medicare's 2% overhead, compared to private carrier's 10%. The 8% difference in a \$2.5 trillion healthcare economy is about \$150 billion per year.

Or they claim that Britain and Canada - single payer systems - spend about 60% as much on healthcare as we do, while generating slightly better longevity and infant mortality statistics. A prima facie case, they claim, for single payer healthcare.

They're both right! That's why I think consensus is more important than actual policy type.

The evidence in favor of single payer healthcare is very strong, for example. The British or Canadian data from Chapter 1 show quite clearly that both generate better outcomes than we do, while spending far less on healthcare.

How do they do this? They have designed a regulatory environment around the concept that healthcare is different from other goods and services. They could do this because they share a national consensus, more or less, about this definition of health insurance.

Most surveys show that the British and Canadians (and French and Germans and other single payer systems) are generally satisfied with their healthcare systems. The interesting thing about these surveys - they have shown high levels of support for the national healthcare system in each country for many years. In essence, each system has evolved within its own national value structure. This is what I call consensus.

On the other hand, the evidence for managed care is also very strong, though presented differently. Stanford's Enthoven and his managed care buddies - a very bright and articulate crew - argue persuasively that the Kaiser Permanente experience, the Mayo Clinic experience and other such managed care organizations are the ideal that we should emulate nationally.

They typically present reams of data and analysis showing why Kaiser Permanente and the Mayo Clinic, among others, generate better outcomes than the US average - at a lower price.²²²

Hillary Clinton found these arguments sufficiently persuasive to attempt an entire national healthcare reform based on them in the 1990s. Clinton's reforms, of course, ultimately failed and have been ridiculed as HillaryCare ever since.

It is interesting to note, however, that most Americans actually liked her proposals - including the Wall Street Journal! Here's former Harvard University President Derek Bok explaining the results of a Wall Street Journal - NBC News poll that the Journal published in 1994. The Journal's article title: 'Many Don't Realize It's The Clinton Plan They Like':

The article reported the results of a Journal-NBC poll asking respondents their reaction to a health plan that contained all the features of the Clinton proposal without revealing that it was the President's plan. Respondents were also invited to evaluate the four other plans under consideration in Congress, again without identifying the sponsor of the plan to the readers. When the results were tabulated, 76 percent saw 'some' or 'a great deal' of appeal in the Clinton proposal, a much more favorable response than that given to any of the other plans.

This result occurred at the very time that other polls were reporting a majority of Americans opposing the Clinton Plan.²²³

At the time of the WSJ-NBC News poll, only about 37% of the American public actually supported the 'Clinton Plan'. But when the various contending healthcare plan options were presented to them - blindly, without identifying the sponsors - Hillary's plan emerged as most popular!

²²² See, for example, Enthoven and Tollen, *Toward a 21st Century Health System*, Jossey-Bass, 2004. Jan Gregoire Coombs makes some similar points, though less stridently, in *The Rise and Fall of HMOs*, University of Wisconsin Press, 2005.

²²³ Derek Bok, *The Great Health Care Debate of 1993 - 94*, www.upenn.edu/pnc/ptbok/html

Our point: it was the Clinton's *lack of ability to build consensus*, rather than the actual managed care plan itself, that spelled defeat.

And our consumer driven friends also present a compelling case that they're right, though they generally argue this from the bottom - up. 'Look at all the evidence,' they say, 'of providers who respond to consumer demand' and then provide case studies of Shouldice Hernia Hospital, the Texas Heart Institute or similar, showing outstanding results at relatively low costs.²²⁴

'Just imagine,' they continue, 'how great our healthcare system could be if we harness the innovative and competitive energies of American entrepreneurs to fix our healthcare system. The problem is that regulators get in the way. Henry Ford couldn't have developed cars, or Bill Gates software, if regulators had been involved every step of the way.'

They're right too! That's why I believe that any of these insurance types can work - provided we agree to use it.

But if we continue to lack consensus and engage in partial solutions, then our reform efforts will continue to fail.

Can We Generate Consensus About Whether Healthcare is a Right or a Product?

Probably not, if the Great Healthcare Debate of 2009 /2010 is any indication. The proponents of each form are pretty entrenched. President Obama had to compromise, compromise and compromise to get anything passed in the Senate.

I think this lack of consensus flows directly from the different social values that underlie each health insurance position. Consumer driven proponents think that the additional government involvement necessary for single payer healthcare, will make our system worse. They believe that the best thing they can do for America is to stop movement toward single payer healthcare. Additional governmental involvement and regulations are anathema to them, because they believe that buying healthcare is like buying other goods and services.

Single payer proponents completely disagree. They think that deregulating health insurance, as proposed by the consumer driven folks, will generate harm to Americans. They fear attempts to treat healthcare like other goods and services, because they believe healthcare provision is a right.

²²⁴ See for example, the Harvard Business School Case Study, Shouldice Ltd, or Cooley and Adams, Package Pricing at the Texas Heart Institute, in Herzlinger, Consumer Driven Healthcare, Jossey-Bass, 2004

There appears little room for compromise among these positions. That which consumer driven proponents see as ‘good’, single payer proponents see as ‘bad’. And that which single payer proponents see as ‘good’, consumer driven proponents see as ‘bad’. These are deeply held values.

Generating consensus among these virtual polar opposites is very difficult. Absent consensus, the chance of real healthcare cost reform seems slim.

We’ll turn in the next chapter to the tension caused in our healthcare system by the lack of consensus. And we’ll look at why reforms have consistently failed to control costs and improve our healthcare outcomes.

Chapter 12

A Brief History of Health Insurance Reform

Those who cannot learn from history are doomed to repeat it.
George Santayana

We learn from history that we learn nothing from history.
George Bernard Shaw

Some Failed Reforms Since 1970

Let's turn now to some actual healthcare system reforms. Note as we go through this: carriers and Medicare attempted time and time again to control healthcare costs by limiting payments to providers. The apparent justification: by paying less per procedure, we'll save money.

Yet time and time again providers found a way around the payment limitations. Physicians and hospitals found remarkably creative ways to maintain their incomes. They either did more procedures on the same patient, saw more patients in the same amount of time, or played games with the financing system. In all cases, the result of healthcare reform was healthcare cost inflation that exceeded the GDP growth rate.

We'll **first** discuss two overt cost control reforms - New York State's Prospective Payment System and New Jersey's introduction of Diagnostic Related Group (DRG) pricing.

We'll, **second**, review some failed quality control reforms. (Remember our thesis from Chapter 1: one mechanism to control healthcare costs is to improve healthcare system efficiency. The various quality improvement programs aimed to do this.)

Lyndon Johnson's Great Society programs of the 1960s set the stage for tremendous healthcare cost inflation. Medicare and Medicaid extended health insurance to a huge number of additional Americans without increasing the supply of providers nearly as much. By the early 1970s, we had more people, with more health insurance money, chasing roughly the same number of providers - a recipe for rampant inflation.

In response, we tried a slew of non-market cost control and quality improvement programs. Northwestern University Professor David Dranove summarizes the effect of all these: they ‘utterly failed on all accounts’.²²⁵

Hospital Cost Control Programs

New York State developed the first rate setting program in 1970. New York State was under particular Medicaid cost pressure, as it had a particularly large Medicaid eligible population. Medicaid, remember, is funded jointly by the Feds and each state. New York officials worried that continued Medicaid inflation might require politically unpopular tax increases. Hence their motivation to control costs.

The New York legislature tried to cap Medicaid hospital payments. Interestingly, they included private health insurance carriers in their program to avoid hospital cost shifting - in other words, billing Medicaid sometimes and private carriers other times for the same patient, as a means of avoiding the intended cost controls.

The New York State Prospective Rate Setting System established a flat fee per patient per day. The fee was set at the beginning of each year so hospitals could budget and plan, and was approximately equal to the average cost per patient per day the previous year with an inflation factor and regional cost variations applied.

New York officials figured that the patient population would be about the same each year - about the same number of births, broken legs, heart attacks, etc - so on average hospitals would receive the same patient mix year after year. By paying hospitals per patient per day, Medicaid regulators figured they could control healthcare inflation without decreasing the quality of patient care.

What an odd cost control mechanism for people who think that buying healthcare is essentially like buying other goods and services!

But what an innovative cost control mechanism for people who think that buying healthcare is essentially different from buying other goods and services.

The regulator’s assumptions proved incorrect. Unfortunately for them and the NYS tax payers, hospitals quickly learned how to game the Prospective Payment System. Since hospitals received the same reimbursement from Medicaid for all patients, they earned more by admitting the healthy and denying care to the sick. Hospital competition quickly switched from providing

²²⁵ David Dranove, *The Economic Evolution of Managed Care*, page viii¹

excellent service to all patients, to reducing service to expensive patients. Not a good solution.

But this was a rational solution for hospitals working within this regulatory environment.

New Jersey, just down the road, observed the experience in New York and sought to improve on New York's model by devising its own Prospective Payment System in the late 1970s.

New Jersey modified New York's calculation of average cost/patient/day by introducing some 470 Diagnosis Related Groups (DRGs). This system, designed by Yale Medical School, divided patient costs into diagnostic categories. Cancer surgery now received a higher reimbursement than a simple overnight observation; brain surgery more than an hour of physical therapy. New Jersey hoped to deny hospitals the ability to game the system as hospitals had in New York.

Again, regulators did not want market forces to set prices. Instead, under the New Jersey plan, hospitals would only receive payment deemed 'appropriate' by regulators for medical treatments.

Patients, interestingly under this system, would also receive 'appropriate' care but no more, in an attempt to control potential moral hazard-based overbilling incentives.

Medical cost inflation would, as a result, be controlled, at least in theory. Medicare took the New Jersey system national in the mid-1980s.

How did hospitals respond? Many shifted to more outpatient surgeries - not necessarily a bad thing. In 1984 some 28% of all community hospital surgeries were outpatient; by 1996 that percentage had increased to 59%. That's the good news.

But there was also some bad news. Some hospitals simply focused on DRG management. They hired DRG experts to help 'up-classify' patients to receive higher reimbursements. They began 'dumping' expensive patients who exceeded their DRG reimbursements by transferring them to other hospitals - presumably with less sophisticated admissions procedures.

Some hospitals practiced 'skimming', by admitting only potentially profitable patients. Still others 'unbundled' their services, requiring patients to make more hospital visits at higher reimbursements, often with no additional health benefits. Hospitals, in other words, figured out how to game the DRG reimbursement system just as hospitals had in New York State.

The moral of the story: attempting to use non-market regulations in a competitive market fail. Regulators defined healthcare as being different from other economic activities, but hospitals still had to bill and follow most

principles of competitive business. The clash between these two approaches led to the failure of both of these cost control reforms.

Hospital Quality Control Programs

Just as Diagnosis Related Groups were aimed at controlling hospital costs, so various measures were introduced in the 1970s to improve hospital quality. These aimed primarily at ensuring that patients received appropriate, high quality hospitalization and care, and exhibited the same incentive clashes and failures as the cost control reforms discussed above.

The first Professional Standard Review Organizations (PSROs) began in 1972. These were established by the Social Security Amendments of 1972 to 'promote the effective, efficient, and economical delivery of health care services of proper quality for which payments may be made.'²²⁶ PSROs were local physician organizations designed to monitor the necessity, appropriateness and quality of hospital care. PSROs established standards of care for a wide range of diseases, with a goal of treatment practice uniformity - rather like guilds.

These organizations were quite ineffective. Local physicians, it turned out, were generally reluctant to judge or punish their colleagues. PSROs created dilemmas for physicians who observed questionable quality or potentially excessive treatment in others. Should they report on physicians who unnecessarily bring patients into the hospital - but increase everyone's income? Should they be team players? Or should they fight other physicians and hospital administrators and create political or professional problems for themselves?

Most physicians decided their interests - financial and professional - lay in getting along with their colleagues rather than reporting on them. Hence PSROs failed to have much impact on US medical quality. Another non-market reform falls to market based incentives.

Regulators grasped this problem and modified the PSRO concept when creating the next quality control mechanism, the **Professional Review Organization (PRO)** in 1983. These were private companies, initially contracted by Medicaid. PROs were designed to assure the necessity and appropriateness of Medicaid services by reviewing hospital records for evidence of the upcoding, dumping or unbundling of services that we discussed above with Diagnostic Related Groups.

²²⁶ CBO Testimony: Statement of Robert D. Reischauer, Deputy Director, Congressional Budget Office before the Subcommittee on Oversight, Committee on Ways and Means, US House of Representatives, June 27, 1979

PROs established elaborate guidelines and enforcement protocols, again focusing on physicians and hospitals working in a particular locale.

For example, a PRO might establish a goal of only allowing X number of treatments for a specific medical problem - perhaps allowing 1 coronary bypass graft annually for every 50,000 people. Once it set the goal, the PRO would define medically appropriate procedures to achieve it. Hospitals that performed more than the target number of procedures, or who didn't follow the criteria, might have their Medicare reimbursement requests denied.²²⁷

Unfortunately, the process of developing guidelines introduced an even bigger problem - startling variations in medical practice across seemingly similar communities.²²⁸ A famous early study 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston' reported that rates of certain procedures including coronary artery bypass graft surgery were much higher in New Haven than Boston, but rates of other procedures such as carotid endarterectomy were higher in Boston than New Haven.

Studies such as this suggested the PRO focus was too narrow and that the real hospital quality problem involved treatment variations. These put patients at risk, for some were under-treated while others were over-treated.

Once regulators and our medical community realized that treatment variation was a huge healthcare systemic problem, the question arose about how to address it. The decision in the 1990s was to continue the non-market approach - measuring and controlling treatment inputs like costs, types of procedures, second opinions, etc. Thus we maintained the same mind-set from the early 1970s. We still used non-market regulations to control the business of healthcare production. The clash between these two approaches to healthcare continued.

One such post-PRO program was development of **Treatment Guidelines**. These had a goal of standardizing medical treatments to control both quality and costs. Treatment guidelines typically provide the medical staff with detailed day-by-day instructions for testing, nursing, surgery, rehabilitation and discharge planning. Guidelines also provide a systemized method of ordering tests.

²²⁷ This discussion comes from David Dranove, *What's Your Life Worth?*, Prentice-Hall, 2003, Chapter 4, especially pages 70 - 71

²²⁸ Dranove, *ibid*, pages 78 – 79. For more information on treatment variation see also J. Wennberg, et al 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston' *Lancet* 1, 1987, Shannon Brownlee, *Overtreated*, especially Chapter 1 and Maggie Mahar, *Money Driven Medicine*, 2006, especially Chapter 5

Unfortunately, contradictory treatment guidelines proliferated. By 1994 the AMA reported over 1600 sets of guidelines designed by potentially competing special interests. Hospital guidelines sometimes said ‘treat’ (presumably to increase hospital occupancy) while carrier guidelines said ‘don’t treat’ (presumably to control costs). Some guidelines were developed by pharmaceuticals and recommended drug therapy; others by surgical supply manufacturers and recommended surgery. Hospital bureaucracies and physicians often resisted the imposition of guidelines, figuring they knew best how to treat their own patients.

Utilization Review

PROs and Treatment Guidelines evolved into **Utilization Review** requirements. Private UR companies would approve or reject physician requests for permission to treat according to a specific treatment plan. The goal: weed out inefficient and ineffective treatments - not a bad goal.

Unfortunately, the entire Utilization Review process became mired in two irreconcilable conflicts.

First was the conflict between the physician dealing with an individual patient, and the reviewer providing advice about patients ‘in general’. Seen in a regulatory light, this question can become ‘it is more important to deal with the idiosyncrasies of an individual patient or to remain within the budget?’²²⁹

What an odd question to ask, for those who consider healthcare to be like other goods and services. ‘Of course you consider the patient first - that’s what doctors are paid to do.’

But those who consider healthcare different from other goods and services might respond, ‘there are always individual differences. If we consider them all, then we’ll never have meaningful budgets, and never have meaningful healthcare cost controls.’

Who’s right and who’s wrong? It depends on how you see healthcare!

The second irreconcilable problem with Utilization Review concerns the conflicting financial incentives. UR firms make money by denying services - that’s how they justify their existence. But physicians make money by treating patients - that’s how they get paid. UR proponents say physicians ignore costs; physicians claim that UR firms adhere too strongly to the bottom line.

This is a huge conflict. How did it get resolved?

By the mid-late 1990s, physicians learned that if they argued strenuously enough and long enough, they could get what they wanted - thus gutting the

²²⁹ Dranove, *ibid*, page 71

raison d'être of the entire Utilization Review exercise. Ultimately, UR companies approved about 99 of physician request, eviscerating the cost control effectiveness of the entire process.

Utilization review practices ultimately died away due to these problems. The actual date of death: November, 1999 when United Healthcare eliminated its UR requirement. Other carriers followed.

Pay for Performance - the Last Gasp of Non-Market Controls?

With the demise of Utilization Review and the abject failure of all the previous cost control programs, carriers attempted in the early 2000s, one last non-market regulatory program. Carriers decided to pay hospitals and physicians for their performance - hence the name, Pay for Performance.

Carriers justified this 'new' non-market control program in two ways. First, by about 2000, the various Dartmouth (and other) studies convinced them that some Americans were receiving too little care while others received too much, or inappropriate care. Treatment variation began to be perceived as a significant problem.

Second, carriers learned that preventable medical errors were also a significant problem that they needed to address. The publication of *To Err Is Human* by the US Institute of Medicine in 1999 brought this issue alive to carriers. This report indicated that up to 98,000 Americans died annually from preventable hospital errors. Other reports by Dartmouth Medical School and the Rand Corporation (among others), confirmed that we often received inappropriate and even dangerous medical care from our healthcare system.

Carriers understood that poor quality medical care almost always raises costs through inefficiency, prolonging the length of treatment time and requiring remedial treatments to correct errors. Hence their desire to pay only for good physician and hospital performance.

Unfortunately, these programs, like all the previous non-market reforms, are not based on generating good patient outcomes. Rather, they aimed at compelling providers to comply with certain, specified treatment processes. We note, briefly, 4 problems with this approach - any one of which would have doomed this cost control effort to failure:²³⁰

1. Pay for performance incentives may not be large enough to shift physician behavior, especially if the incentive to provide *better* care conflicts with the incentive to provide *more* care;

²³⁰ This list comes from Porter, op cit, pages 86 - 87

2. **Process similarity** does not always equal **results similarity**. Our case studies of hernia treatments and cystic fibrosis, previously discussed, make this point painfully clearly, for example. This may suggest that treatments for certain types of disease such as chronic conditions should consider the impact of physician personality or the emotional relationship between physician and patient, in addition to quantifiable medical interventions. Pay for Performance guidelines do not account for personality or emotion, even though they may be keys to generating good outcomes;

3. Pay incentives tied to process compliance may inhibit innovation, especially if certain stipulated required processes become codified as administrative and bureaucratic requirements;

4. The stipulated processes may codify only those processes upon which the medical community has reached consensus. These may not be the most important processes, but rather the ‘lowest-common denominator starting point’ in Michael Porter’s words. There may be many other relevant processes to consider also, but ones we have not yet identified. As a result, pay for specified process compliance runs the real risk of harming, rather than helping, patients.

Again, a non-market reform ultimately failed. Healthcare costs, post 2000, continued to rise far faster than overall inflation. Our treatment variation rates continued to astonish commentators and our healthcare outcomes continued to lag behind other countries - and lag behind our desired goals.

What’s the moral of this story? Absent national consensus about whether healthcare is like or dislike other goods and services, we’ll continue to spin our regulatory wheels. We’ll design inappropriate regulations. We’ll fail to control healthcare spending and inflation.

And we’ll fail to improve our healthcare system.

Case Study: Nixon’s HMO Act of 1973

We’ll review Nixon’s HMO Law of 1973 to show how our lack of consensus about whether healthcare is like or dislike other goods and services weakens healthcare reform movements. Nixon tried to implement one clear idea in 1973, but the implementation process so changed the reform as to make it virtually meaningless.

Nixon used Kaiser Permanente as the basis of his HMO Act of 1973, because KP was the largest and most successful of the HMO models. This was a private sector solution to our then-healthcare problems. As such, it satisfied Republicans, for it kept healthcare in the private sector. But it also satisfied Democrats because it expanded benefits and included community rating provisions.

Nixon had felt pressure to do something to control rising healthcare costs.²³¹ National healthcare expenditures almost tripled from \$27 billion in 1960 to \$73 billion in 1970, creating economic and political problems. Robert Finch, then Secretary of Health, Education and Welfare warned Congress in 1969 that ‘the nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector’.

Political Pressures

Politicians and special interest groups lobbied the Nixon administration to overhaul our healthcare system, though from many different points of view. The Special Committee on Aging wanted Congress to extend Medicare and Medicaid programs to the entire population. The 1969 National Governor’s Conference endorsed New York Governor Nelson Rockefeller’s (one of Nixon’s key rivals for the Republican nomination in 1968) plan for national health insurance. Massachusetts Senator Ted Kennedy and the United Auto Workers led the prestigious Committee of 100 for National Health Insurance in drafting it’s own universal healthcare plan.

Even Nixon’s own assistant Secretary of Health, Education and Welfare, Lewis Butler, wrote that ‘ultimately some kind of national health insurance should be enacted.’ And Dr. Vernon Wilson, Nixon’s chief of Health Service and Mental Health Administration at HEW said that Kennedy’s plan ‘was a well-conceived, comprehensive approach to solving the nation’s health delivery problems.’

Nixon’s problem: he had to do something, but he couldn’t support a Democratic healthcare plan sponsored by one of his chief rivals, Ted Kennedy. Nor could support a Republican plan sponsored by another political rival, Nelson Rockefeller - especially a plan that potentially harmed the physicians, hospitals and insurance carriers that supported Nixon politically. He had to develop his own plan.

Dr. Paul Ellwood Jr, sometimes called the father of the HMO came to Nixon’s rescue in 1970. Ellwood recommended a prepaid healthcare system

²³¹ Much of this section comes from Jan Gregoire Coombs, *The Rise and Fall of HMOs*, 2006, Chapter 2

that would motivate doctors and hospitals to control costs and keep patients healthy. Assistant Secretary Butler (see above) supported Ellwood's ideas because they fit with the Republican philosophy of support for free markets and competition to reduce costs. Butler also believed that these HMOs would be inexpensive to implement, optional and self regulating. Many conservative politicians and organizations agreed with the HMO idea because it was flexible, inexpensive, encouraged private investment in profit-making organizations and imposed few mandates or regulations. Nixon's new HEW Secretary, Elliot Richardson predicted in 1970 some 450 HMOs by the end of fiscal 1973 and 1700 by end 1976.

The Republican HMO plan faced opposition from both the left and right between 1970 - 1973. Kennedy and the Left consistently fought for higher levels of guaranteed benefits, community rating, open enrollment periods and significant Federal grants and loans to help HMOs proliferate. Richardson, the AMA and the Right wanted only basic levels of guaranteed benefits, less government funding and individual underwriting. Richardson in particular, feared that community rating would put HMOs at a competitive disadvantage compared to indemnity coverage that routinely rejected people with significant medical needs.

The AMA in particular, lobbied enthusiastically against the HMO idea. Dr. Malcolm Todd, for example, chair of the Physician's Committee to Reelect the President claimed 'We used all the force we could bring to bear against this legislation. As a result, there has been some backtracking on the part of the White House, [which] directed the [HEW] Secretary to slow down this thing.'

The AMA, a key political supporter of Nixon, opposed vertical integration - the integration of healthcare finance and service delivery in the same company. It feared that physicians - i.e. AMA members - would lose control over their incomes. They wanted fee-for-service medicine to continue.

As a result of these competing pressures and Nixon's determination to implement his own plan (i.e. not Kennedy's or Rockefeller's), the HMO Act of 1973 was not a particularly close copy of the Kaiser Permanente model. Indeed, the changes to KP's model doomed the entire effort for three main reasons:

First, under Nixon's law, HMO meant simply 'prepayment' - not vertical integration. Healthcare delivery and healthcare finance were separate functions handled by separate companies. This satisfied independent insurance carriers, physician groups and general hospitals - all parts of Nixon's political base. But the key integration feature that made Kaiser-Permanente so successful was lost in the legislation.

Why did carriers, physician groups and general hospitals dislike vertical integration? The short answer: they wanted to compete for revenues with each other.

Carriers hoped to dominate the marketplace and dictate economic terms to providers. *The American Medical Association* wanted its members to remain free from carrier or hospital meddling so they could protect their incomes. *Hospitals* wanted to determine patient lengths of stay to protect their own cash flow.

None of these groups trusted the others or the government to protect their interests.

Second, Nixon's law called for a loose physician structure, in which practitioners could opt in or out of any HMO. Again, this satisfied the insurance, physician and hospital groups. But it was the opposite of KP's tight structure in which physicians were fully integrated into both the hospital and financial system. The loose physician structure meant that providers had no particular loyalty to any specific HMO. Another key feature of KP was lost.

Third, Nixon's law allowed providers to bill insurance carriers on a fee-for-service basis. Yet Kaiser-Permanente had used a capitated financial structure to motivate providers to control costs. Absent capitation, much of the underlying financial advantage disappeared.

Results of Nixon's Healthcare Reform

'The HMO Act of 1973 clearly inhibited HMO development' claims Jan Coombs in *The Rise and Fall of HMOs*. Some 124 HMOs developed from 1970 - 1974, but only 40 developed from 1974 - 1978. Also, the enticement of public funding was insufficient to overcome federal legislative and regulatory requirements, so many HMOs turned to Wall Street financing and state approvals. In 1981, 88% of HMOs were nonprofit; by 1986 this had fallen to 41%.

Nixon's act legitimized HMOs and managed care, but so drastically altered the Kaiser Permanente model that insurers and providers had to develop new organizational forms. No longer did managed care equal Kaiser Permanente's closely integrated finance and service provision model. Instead three different types of managed care appeared in the marketplace.

Staff model managed care looked most like KP. Under a staff model, physicians were paid salaries by the integrated carrier/provider, which generally also owned its own hospitals. This allowed the carrier the greatest amount of cost and quality control over providers. Staff models are the most expensive to establish, take the longest time to get up and running, and offer

subscribers the most limited networks of providers. They are generally the least attractive model to consumers for this reason.

Group model HMOs look like the original version of Kaiser Permanente. Here a carrier and provider group have mutually exclusive contracts. Carriers still exert cost and quality controls, though perhaps to a lesser degree. Quicker to establish than staff model HMOs, the limited network is still relatively unappealing to consumers.

Independent Practice Associations or Network Models offer the widest provider networks and the least carrier cost and quality control. The American Medical Association favored this form of managed care after Nixon's law - because it allowed AMA members the best opportunity for financial gain.

With IPAs, multiple carriers contract with any willing provider and carriers have the least amount of input and control. This managed care form also has the highest degree of consumer satisfaction as it generally offers the largest provider network and the least restrictions. Some commentators wonder if IPAs are really managed care at all, or instead simply fee-for-service / indemnity healthcare with a price list.

Post Nixon, HMOs grew because managed care premiums were lower than the alternative, indemnity coverage. As a result:

By 1980, 9 million Americans enrolled in HMOs;
By 1990, 33 million enrolled;
By 2000, 60 million enrolled.

However, the majority of subscribers entered IPA or network models:

<u>Date</u>	<u>Group and Staff Market Share</u> ²³²	
	<u># of subscribers</u>	<u>% of all HMO subs</u>
1980	7.4 million	81%
1990	13.1 million	39%
2002	7.5 million	10%

Was the US moving toward true managed care or something else? The answer: we still had fee-for-service healthcare, but in managed care clothing. The **words** we used to describe healthcare had changed, but the **fundamentals** of our healthcare system had not.

²³² Gitterman, et al, Rise and Fall of a Kaiser Permanente Expansion Region, Milbank Quarterly, 2003

This led Alain Enthoven to exclaim in his famous 1993 article *Why Managed Care Has Failed to Contain Health Costs* - some 20 years after Nixon's Law - that true managed care had never been tried nationally in the US.

The net result of Nixon's 1973 healthcare reforms: higher healthcare costs.

Case Study: The Clinton Healthcare Plan

Bill Clinton had campaigned for President on four healthcare platforms:²³³

- To provide healthcare coverage for all Americans;
- To slow runaway medical care cost inflation;
- To minimize governmental intrusion; and
- To avoid harming most special interest groups.

He delegated responsibility for the specific healthcare plan design to his wife, Hillary. She introduced her plan in mid-September 1993. Note how the implementation process derailed her plan.

Note also how our lack of consensus about healthcare being like or dislike other goods and services allowed political considerations to trump healthcare efficiency considerations.

Basis of Clinton's Plan

The plan itself was broad, ambitious and founded in Enthoven's theories. It would set up one or more large 'healthcare purchasing alliances' in each region. These would restructure the health insurance market by serving as the group purchaser for people not on Medicare, including small and medium sized employers. Large companies with 5000+ employees could act as their own purchaser.

These alliances would manage competition among plans and carriers, along the lines that Enthoven envisioned. They would - theoretically - offer people their choice of health plans and would provide them with competitive information about costs, services and quality. As envisioned by the authors, consumers would have a minimum of 3 plan options, varying by cost-sharing, out of network restrictions and specific services covered (above the mandated minimums). The alliances' responsibilities would include maintaining

²³³ Much of this discussion comes from Schroeder, The Clinton Healthcare Plan, *Annals of Internal Medicine*, November 1, 1993

competition among plan options so those that operated most efficiently would get rewarded in the marketplace.

The Clinton Plan would require carriers to offer a comprehensive minimum set of benefits including hospital and office care, clinical prevention services, hospice care and home health and long term care. By 2001 it would add mental health and substance abuse services.

The entire healthcare distribution operation would be run by a complex administration including a National Health Board responsible for oversight, budgets and national quality. States would also have responsibility for establishing risk-adjustment procedures, monitoring carrier fiscal stability and monitoring the quality of local care. This combined state and federal administrative effort was deemed necessary to ensure two things:

- That our healthcare system would function well both during and after the transition to the Clinton Plan; and
- That Enthoven's dual theories of managed care and managed competition would be made operational.

Hillary Clinton presented her 1000+ page healthcare plan in 1993. For about a year proponents and opponents discussed, debated, analyzed and considered her healthcare plan for America. Articles appeared in learned journals; interest groups spent over \$100 million lobbying and campaigning for or against it. Ultimately, in 1994, Congress voted the plan down.

Why HillaryCare Failed

The interesting question from this story is 'why'. Why did the American people - and ultimately Congress - reject Hillary's plan?

Public opinion polling during this period highlighted contradictory and confusing indicators. The American public apparently liked the ideas - while disliking the Clinton plan. Understanding how this can be helps explain the fundamental problem with establishing true managed care in the US.

The Wall Street Journal reported in 1994 that 'Many Don't Realize It's the Clinton Plan They Like'. The article summarized results of a WSJ-NBC news poll asking people their reaction to a health plan that contained the same features as the Clinton plan but without revealing that it actually was the President's. Some 76% found 'some' or 'a great deal' of appeal in Clinton's plan - even while indicating in other polls their opposition to 'the Clinton Healthcare Plan'.

How can people actually like the plans' features while opposing the plan itself? According to former Harvard University President Derek Bok, there are two answers:²³⁴

First, Americans distrust government imposed solutions to problems;
Second, special interests (intentionally or otherwise) play on popular fears with targeted marketing campaigns.

Bok reports that polls taken during the 1993 - 1994 healthcare debate showed that 80% of the population believed healthcare costs would rise more than the Clintons claimed, including 54% who thought costs would rise 'much more'. Similarly although only 25% of Americans said that they understood what a health alliance actually was, 65% assumed that the President's plan would lead to more bureaucracy. Perhaps the Clintons marketed their plan poorly. But perhaps also, popular distrust of government made their marketing task impossible.

Plan opponents understood this popular sentiment and played on it. The over \$100 million spent to lobby the public for or against healthcare reform, according to Bok, 'seemed designed less to inform than to arouse latent fears and anxieties'. He reports on an infamous Harry and Louise TV commercial paid for by the Health Insurance Association of America:

'This plan forces us to buy our insurance through those new mandatory government health alliances,' complained a prototypical wife, Louise...
'Run by tens of thousands of new bureaucrats,' added husband Harry.
'Having choices we don't like is not choice at all,' replied Louise. 'They choose, we lose,' both concluded with evident disapproval.

The University of Pennsylvania's Annenberg School of Communications found that 59% of all TV ads on healthcare reform were misleading, with most attacking rather than advocating one position or the other. Opponents said the Clinton plan was 'involuntary euthanasia' that deprived families of their choice of a doctor. Proponents claimed that 'unless the Clinton plan is passed, millions of Americans will have no access to healthcare.' Fearmongering on both sides led less to education and compromise than to rejection amidst a climate of fear and mistrust.

234 Much of this discussion comes from Derek Bok, 'The Great Health Care Debate of 1993 - 1994' available at www.upenn.edu/pnc/ptbok/html

This shows the fundamental problem with the Clinton healthcare plan - the same problem that has plagued every other government attempt to reform healthcare. Government designed, top-down solutions imposed on Americans fail due to the lack of buy-in by participants. Americans, it appears, do not want to be told what kind of healthcare to purchase.

Top-down solutions attempt to impose the values of some group - Stanford academics, Washington liberals, Texas conservatives or whomever - on the rest of Americans. It matters less that the healthcare plan is good or bad; what matters is that it is imposed. Americans need time to evolve solutions to our healthcare problems, to feel comfortable with and to embrace healthcare reform. This is not, as in the Clinton case, a 12 - 15 month process. It is a process in which Americans gain positive experiences necessary to 'buy-in'. (Remember that it took years and years for Garfield to develop the Kaiser-Permanente operation.)

Absent this buy-in, we will, apparently, reject a health plan we like (according to the Wall Street Journal polling data) simply because it is imposed on us.

In short, any attempt to implement reform healthcare need focus at least as strongly on the acceptance process as on the plan itself. At least that appears the major lesson of this story. And popular acceptance is likely a multi-year, long term process.

The Clinton Administration ultimately failed to pass its huge healthcare reform plan. American culture and politics intervened, and for the second time in 20 years an attempt to take Kaiser Permanente national failed. That political debacle led to another 15+ years of fee-for-service healthcare that deviated from the 'true' managed care model, with economic and quality results that harmed Americans.

Chapter 13

Why Healthcare Reforms Always Fail to Control Costs

We have a 40+ year history of healthcare system reform, and a 40+ year history of reform failures to control costs. Derek Bok suggested in the last chapter that special interest power always plays a role in healthcare reform efforts. While this is undoubtedly true, I think that our lack of consensus about the definition of our health insurance problem also plays a fundamental role in healthcare reform failures.

Harvard Business School Professor Michael Porter explains:

With the wrong diagnosis, the attempts to treat the system have addressed the wrong issues or offered piecemeal, ultimately ineffective solutions aimed at symptoms rather than causes.²³⁵

In our terms, reforms failed because we lack consensus about the appropriate form of health insurance and whether healthcare is like or not like other goods and services in our economy.

Consensus, rather than a specific form or policy, is key here. With consensus we can address root causes with a unified, consistent approach. Without consensus, we use contradictory tools to reform healthcare - always, ultimately, unsuccessfully. *Contradictory regulations and administrative tools lead to confusion, inefficiencies and failure.*

This chapter will look at our history of failed healthcare reforms in two ways:

First, we'll look at how our lack of consensus has led to inappropriate, dysfunctional and ultimately very expensive competition among healthcare actors - carriers, providers and employers;

Second, we'll look at several specific failed healthcare reforms that were tried in the last century and see why they failed.

Consensus is Key

Consensus, rather than **specific form of health insurance**, is the key to appropriate reform and appropriate cost controls.

²³⁵ Porter and Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006, page 71

We need consensus about the answers to our 2 key questions to generate real healthcare reform and systemic improvement. Our 2 key questions:

- Is healthcare like, or not like, other goods and services in our economy?
- Is competition among carriers and providers a good or bad thing for our healthcare system?

There are no right or wrong answers. The important issue is that we agree about the answers.

In other words, **it matters less if we use managed care, consumer driven or single payer healthcare.** Any of these may work, at least much better than our current system.

Let's state this differently. If we all agreed that healthcare is like other goods and services, then we could employ market-based reform. We know how to do these pretty well. We use market-based tools to influence markets for lots of consumer products, ranging from sports equipment to food products, from home construction to automobile manufacturing, and from computer retailing to computer servicing.

In all these cases, we have seen quality improve while prices fall, especially adjusting for inflation. Also, by and large, consumer protections work pretty well in these fields. Most cars are safely manufactured and most houses don't fall down.

We have, in short, lots of history and experience regulating market-based goods and services. It's not much of a leap to assume that we could generate roughly similar results in healthcare - **provided we all agree to treat healthcare like a regular market product.**

Alternatively, we also know how to design non-market services pretty well. The Army, for example, is a non-market service; the standard supply-and-demand / competitive pricing functions don't apply. Instead, we have one buyer - the US government. It sets the standards, sets the 'price', designs the required training, etc. The Army is, in other words, a single payer system.

By and large, the Army functions pretty well. In competitive situations (we commonly call these 'wars'), our Army generally wins. Yes, we may spend more per soldier than the competition - but in return, we win. In business terms, we get relatively good value - outstanding results, even for a high price - with the Army.

This single payer system works pretty well, and has done so for many years.

We have many other examples of non-market services providing good value. Other parts of our military, for example. The National Parks Service. The IRS,

which generates a very healthy return on its investment in the form of additional revenues for the US Treasury - though most of us dislike this function quite enthusiastically. The National Transportation and Safety Administration, which regulates transportation safety.

We have, in other words, a pretty good track record for providing both **market** and **non-market** goods and services in this country.

But in healthcare, we blur the distinction. We often regulate healthcare as though it's a non-market service and then expect market based competition to prevail. This confusion leads to the gross healthcare systemic inefficiencies that we discussed in previous chapters, and to inappropriate competition.

Our Lack of Consensus Leads to Dysfunctional, Fragmented and Expensive Competition

Harvard Business School's Michael Porter, along with his colleague Elizabeth Teisberg, have written the Big Book About Healthcare, 400+ pages, titled **Redefining Healthcare**. Chapter 2 provides a litany of competitive dyfunctionalities. We'll use some of Porter and Teisberg's categories to articulate why we have expensive, fragmented, inappropriate and dysfunctional forms of healthcare competition. (Though we'll use some of Porter and Teisberg's *categories*, we won't necessarily use their *arguments*, as we seek to make a fundamentally different point.)

Note when reading this: Porter is a business school professor, primarily interested in improving healthcare value. This he defines as getting the best outcomes per dollar spent.

Porter and Teisberg think that purchasing healthcare is like purchasing other goods and services in our economy, and that the laws of economics and business should apply to healthcare.

They see as dysfunctional many healthcare regulations because these are designed to treat healthcare purchasing as different from purchasing other goods and services in our economy. **The clash between appropriate business strategies to promote patient value, and inappropriate regulations to control competition, comes through quite clearly.**

Dysfunctional Competition in the Wrong Geographic Market

We know that some hospitals provide better value than others. The Cleveland Clinic, for example, is nationally recognized as an outstanding cardiac center, and the Mayo Clinic wins accolades for its patient care. Both provide outstanding patient value - excellent outcomes at moderate prices.

From Porter's point of view, we could increase overall American patient value by allowing more patients to access these, and similar, outstanding medical facilities.

But regulations often prohibit people insured in one state from getting treatment in another state, at least, without paying hefty 'out of network' costs (essentially fines). A Massachusetts small group employee, for example, who has Massachusetts based health insurance, must pay this fine - in the form of out-of-network costs - to access the Cleveland Clinics' outstanding care.

This makes no sense. We don't do this in other economic arenas. We are not restricted from purchasing cars made in other states, or computers, or food, or clothing. That's one reason why we have a history of quality improvements and cost reductions in these products.

But in healthcare, we charge patients **more** to get better care - meaning often quicker and cheaper care.

What would happen if, for example, Massachusetts insureds could use out of state facilities without these extra charges? The short answer: it would be a win-win for the carrier, employer and employee:

- The carrier would save money;
- The employer would thus have reduced premiums;
- The employee would save money and - as an added bonus - receive better care.

The only losers - perhaps - are the Massachusetts providers who lose a patient to an out-of-state competitor. (I say lose 'perhaps' because competitive pressures from out-of-state providers might actually improve the value at Massachusetts hospitals, so they will get more insureds from other states than they lose. Inter-state competition might reward them with more patients.)

This type of geographic restriction may make no sense to people who believe that purchasing healthcare is the same as purchasing other goods and services.

But it may make perfect sense to folks who believe that purchasing healthcare is different from purchasing other goods and services. These people may see the state as a protector of its citizens.

Massachusetts, for example, may have significantly more stringent licensing requirements than some other states. As such, it's the Massachusetts state regulator's responsibility to dissuade its citizens from leaving the state to receive - potentially - inferior care. Yes, some people may not be able to

access the Cleveland Clinic. But they are protected from receiving shoddy care in lots of other states.

Regulators, thus, may restrict people from getting the **upside** of out-of-state providers, but they also save people from getting the **downside** - shoddy treatment. That, apparently, is the justification.

Are they right? Are they wrong? The answer depends on how you define healthcare. If it's like other goods and services, then the regulators interfere with market competition to the detriment of us all. But if it's unlike other goods and services, then regulators provide a valuable function.

Regulators think that purchasing healthcare is different from purchasing other goods and services, so they regulate accordingly.

Whether or not we agree with them, we all pay the price in the form of higher costs than any other advanced industrialized country.

Dysfunctional Competition over the Wrong Time Horizon

We know that most diseases, especially the chronic ones, last longer than 1 year. Lupus, multiple sclerosis and cystic fibrosis, for example, last a lifetime. Yet we finance healthcare treatments with one year health insurance policies.

These policies, underwritten by different carriers, may have different provider networks, different drug formularies and different approval criteria for various medical treatments. A patient may need to change physician, hospital, medications and treatment protocol when the employer decides to change plan.

Conceivably some patients may need to change provider, medication and treatment protocol annually. This makes no medical treatment sense - people with chronic conditions need, above all, continuity of care. This allows the treaters to monitor progress, tweak protocols as necessary and take a long term view of patient improvement.

But short term health insurance policies - i.e. 1 year plans - incent carriers and providers to seek quick hits, like eliminating certain expensive drugs or failing to invest in world-class hospital IT systems. This can be counter-productive: a patient responding to one drug may develop problems when that drug is discontinued due to a formulary difference.

Some drugs may, for example, be more expensive in the short term but reduce long term costs significantly. The VA has found this sometimes to be true. Our 1 year policy horizon and associated restrictions, however, may dissuade physicians from using the better / lower-long-term cost medication. The patient may receive sub-optimal care and the total disease treatment costs may ultimately increase.

Yet we allow, and indeed require, 1 year long insurance policies because of our weird employer based funding system. Employers, loath to take on appreciating long term liabilities, balk at committing to longer term insurance policies.

This short term funding mechanism treats healthcare purchasing as **different from** other goods and services. Your employer doesn't buy your food or auto insurance, for example. We don't subject other products designed for long term use - like automobiles - to the same short term financial review. Imagine if we purchased cars using the same 1 year time horizon as we use when purchasing healthcare!

The historical quirks that led to our employer based insurance system have generated many regulations that protect employers from potentially harmful financial obligations...sometimes to the detriment of patients, and often to the detriment of employer's own long term financial interests.

In the meantime, we choose our health insurance policies based largely on premium price. We shop for health insurance like we shop for other goods and services. But we finance healthcare very differently, using this artificially imposed 1 year time horizon.

Thus we have a financing system absurdly designed to treat healthcare purchases as **different** from other goods and services, while we try to apply routine business practices to medical treatments - restricting costs to remain within a budget, for example. This is a huge disconnect.

Dysfunctional Competition over the Wrong Unit of Measure

We currently shop for providers, when we shop at all, seeking the 'best' doctor, the 'best' surgeon or the 'best' hospital. We typically have no clear definition of 'best'.

Some people define the best hospital as the name hospital, the research facility associated with a famous university. Some define the best doctor as the head of a department or research institute, or a graduate of a famous medical school. Others define the best surgeon as the one most frequently recommended by other doctors.

None of these definitions, typically, includes a quantification of outcomes, as in 'Dr. Smith is the best surgeon because 97% of his patients fully recover within 30 days'. We typically lack this data.

But there's a more insidious underlying issue here. Dr. Smith is but one component of a large team that provides care to a patient. The team consists of diagnosticians, nurses, pre-op professionals, surgeons, assistants, post-op professionals, rehab professionals, IT specialists, therapists, psychologists, etc.

Good patient outcomes require the entire team to work together as a well oiled machine for a failure of any one component may doom the patient.

In other words, the appropriate unit of measure for medical care is the medical condition itself - not the individual surgeon or hospital. A great surgeon with a poor rehab team may generate poor results.

A specific hospital may be outstanding at orthopedic care, but lousy at cardiac. Or the hospital may be outstanding at certain surgical procedures but poor at chronic care. Or have a poor IT system that fails to follow patients post-discharge, leading to a high readmission rate. Or perhaps have poor post-op patient counseling that fails to prevent self destructive behavior.

A brilliant surgeon with a poor post-discharge team may generate outcomes as poor as those from a crummy surgeon with an excellent post-discharge team.

We need cost and outcome information **by medical condition** for competing hospitals in order to make wise purchasing decisions. We also need this information to make wise healthcare reform decisions. Yet this information is virtually nonexistent.

The costs and value of each individual treatment component cannot be assessed in isolation, as each component is but a part of the larger team effort. Our attempts to control a portion of the treatment costs - surgical costs, for example, or rehab therapy costs - backfire as a result.

Healthcare reforms that consider any unit of measure other than the specific medical condition will almost certainly also fail.

Dysfunctional Competition to Amass Wealth

Our various medical care providers - primary care physicians, specialists, hospitals, diagnosticians, allied medical professionals, etc - all share a client who is not their patient. Their real client: the insurance carrier who pays the bills!

I have no doubt that medical care professionals would each, personally, like to help their patient's get better. Many went into the profession to help people.

But I equally have no doubt that medical professionals also seek to maximize their incomes, as do all rational business people in a capitalist environment. In the healthcare field, we call this 'supply induced demand'. It correlates with moral hazard - the healthcare problem we discussed in Chapter 8. Here's how it works:

Physicians know that someone besides the patient - i.e. an insurer - will ultimately pay the bill. The physician also knows the criteria that each insurer

uses to approve payments. It's a simple step - and probably unconscious for most medical professionals - then, to design a treatment plan that generates the highest payments.

Take this process one step further. Each hospital has an economic self interest in providing the most reimbursable treatment to each patient. Providers also have economic interests in not referring that patient out. This would mean that another provider benefits economically.

Providers - both specialists and hospitals - compete to provide the most care to each patient and refrain from referring patients to other providers. Again, probably not even consciously.

Now add one more step. Providers assemble themselves in networks, often affiliated with hospital systems. When referrals are necessary, they refer 'in-network'. Not to the 'best' specialist or, necessarily, to the cheapest. Instead, to an in-network affiliate, to keep the carrier's payments within their group. Compensation, bonuses, etc may rest on physicians' abilities to keep patients in-network.

And add a final step. Provider groups negotiate rates against carriers. The carriers want to pay less; the providers want to earn more. The larger and more powerful the provider group, the higher the rates.

Rates become a function of negotiating power, not of outcomes, not of efficiency, and not of patient satisfaction.

Providers thus compete with carriers and with each other to amass wealth. Whether or not patients get good treatment or enjoy good outcomes becomes a side issue in the compensation competition.

Hospitals typically do not support their claim for higher payments with data showing that their 30-day readmission rate is lower than another's. Nor do they show that their diabetic patients reduce their blood sugar levels more in a given time period. They generally don't argue that they should get paid more because their treatment quality is better.

Instead, they threaten not to accept a carrier's payment schedule. Here's Rick Weisblatt, Senior Vice President for Health Services at Harvard Pilgrim Health Care in Massachusetts, describing how geographically isolated hospitals (for example, on an island) negotiate fees. They use their geographic monopoly

To leverage higher reimbursement. The employers in that community generally want that hospital in the network. And the hospitals are not shy about threatening termination [of the carrier's contract]²³⁶

²³⁶ Kowalczyk, Insurer details its unequal payments, Boston Globe March 16, 2010, page A1

The competition is to amass wealth, not provide better value.

Healthcare competition is like competition in other arena where the parties negotiate fees and prices to maximize their wealth. But it is different from other goods and services which compete on value - in our case, cost per patient outcome.

Instead, in healthcare, the parties compete simply via power relationships.

Dysfunctional Competition over the Wrong Hospital Strategies

Most American hospitals are General Hospitals, providing all medical services from ER to cancer treatment to open heart surgery, to all patients in a geographic area. These broadline general hospitals compete with each other.

Yet numerous studies have demonstrated that specialty hospitals - orthopedic, cardiac, etc - generate better outcomes at lower prices. The literature is full of case studies of this.²³⁷

Indeed, Harvard Business School Professor Regina Herzlinger - who has taught accounting to budding MBAs for years - claims bluntly:

Specialty hospitals generally provide better, cheaper healthcare than the everything-for-everybody general hospital.²³⁸

General hospitals, rather than competing with specialty hospitals on value (best outcomes per dollar spent) instead obtain political redress.

Some states - about 35 currently - have Certificate of Need regulations on the books. CON laws restrict hospital expansion or construction unless the hospitals can demonstrate a 'need' for the additional services to government regulators - at a public hearing. A new specialty hospital looking to enter a market must similarly face this requirement.

Imagine the hearing. I, for example, want to open Gary's Coronary Hospital, perhaps in conjunction with an out-of-state hospital (or even, heaven forbid, a foreign hospital). I think I can provide better value - better outcomes at lower costs - than the current hospitals in my region. I'm willing to invest my money in this venture.

I make my proposal at the public hearing. 'Why,' I wonder, 'do I need to convince regulators about the validity of my proposal? I wouldn't have to go

²³⁷ See, for example Harvard Business School's Case Study on Shouldice Hernia Hospital and Cooley's article on the Texas Heart Institute, op cit.

²³⁸ Regina Herzlinger, Who Killed Healthcare?, McGraw-Hill, 2007, page 4

through this if I wanted to open or expand a shoe store. Or if I was a university president and wanted to expand my business school or chemistry department. I'm looking for the same tax treatment as the university, but I have a far more difficult regulatory hurdle to overcome.'

After I outline my business plan, the local incumbents speak in turn. They all explain to the regulators that there is no 'need' for my new coronary facility. They all, it turns out, have sufficient capacity to cover all the cases that I'm hoping to get. They try to convince regulators that there is no need for my services.

I, in this case, see purchasing healthcare as like purchasing other goods and services. I'll invest my money and take my chances. If I'm wrong about the need for my service, I'll fail and go out of business. I'm willing to take that risk.

But the regulators see purchasing healthcare as different from most other economic activities. They perceive a need to avoid wasting resources - potential tax losses from another non-profit entity, perhaps. They may want to avoid generating excess expensive medical capacity, so seek to protect hospitals from themselves. They may want to prohibit me from 'cherry-picking' profitable services from existing broadline general hospitals, using the totally fallacious argument that hospitals need the profitable patients to subsidize the unprofitable ones.²³⁹

Regulators may also perceive a need to protect the local incumbents, perhaps on the theory that 'they do such good work' for the local community - even if this raises medical costs to state inhabitants. In Michael Porter's terms, CON laws serve to

Protect local incumbents from competition that could drive improvements in the diagnosis and treatment of specific medical conditions.²⁴⁰

Hospital systems tend to be very large local employers, often the largest or second largest in a local market. Physician and hospital campaign contributions are also generally quite significant, especially at the local level. One wonders

²³⁹ Services would not be unprofitable if hospitals organized themselves better and negotiated more appropriately with insurance carriers and the government. Regina Herzlinger is particularly clear on these points in her books **Market Driven Healthcare** and **Who Killed Healthcare?**

²⁴⁰ Porter, op cit, page 79

the impact of this electoral and campaign contribution clout in the Certificate of Need decisions.

This situation played out at the national level in, for example, the Medicare Modernization Law of 2003. That Law prohibited establishment of new specialty hospitals for 18 months. Congress passed a second 6-month ban in 2005.

Now that's a good way to stifle competition!

Note the tension between those who see healthcare as like, and unlike, other economic activities. Contrast the regulations governing private hospital expansion with the regulations governing private college expansion. A private college (also generally a non-profit, like a hospital) can open a new department or expand an existing one without receiving state permission. But a hospital cannot....to our cost disadvantage.

Dysfunctional Competition Based on the Wrong Information

Wise shoppers need quality information - both price and outcomes - about the products they're considering. Neither is available in healthcare.

Contrast the purchase of a tennis racquet with the purchase of any medical service, even one as simple as an MRI.

You can comparison shop for tennis racquets. You can determine price, weight, color, string tension, hand grip size and construction material. You might even - depending on where you purchase - hit a few balls with it. You can get all this information about a product that costs a couple hundred dollars and plays a minor or inconsequential role in most people's lives.

Contrast this with available medical provider information. We'll use an MRI example, because this is a relatively straight-forward, discrete test.

You can't determine the MRI price - it's a function of carrier discounts, which in turn are a product of power negotiations. You can't determine radiologist quality. You can't learn how many misdiagnoses have been generated from this facility - either false positives or false negatives. You can't determine if this particular machine is the most current incarnation of MRI. You can't even learn how many people with your medical condition have used this radiological facility.

In short, you can't learn anything about this procedure's cost or quality, even though it may have life impacting consequences for you.

Not only is this type of quality information unavailable to shoppers, but it's also typically unavailable to physicians. Indeed, according to Porter, 'most physicians lack any objective evidence of whether their results are average,

above average or below average...they generally lack information on their own efficiency.’²⁴¹

Imagine lacking quality feedback about your own competence and outcomes in other profession! Porter goes even further:

The information that is available - health plan overviews, subscriber satisfaction surveys, and reputation surveys...has modest value. Much more relevant is information about...results.²⁴²

The hospital rankings currently available, in, for example, US News and World Report or Money magazine ‘fall far short of the types of information really needed to support comparisons of value’.²⁴³

This differs, of course, from auto, food or other product information.

Why is medical information so unavailable? One short answer: government regulators treat healthcare differently from the way they treat providers of other goods and services. They don’t require it.

We require auto manufacturers to publish lots of information about their products, including crash test ratings. But not hospitals. Why?

Some claim that hospital lobbies are too powerful. This seems an unsatisfactory answer, for the auto industry also has lobbyists, is also powerful and would probably be delighted to avoid publicizing crash test ratings and other comparative information that might cast them in a poor light. Ditto for the food industry.

Instead, I think, regulators see medical service provision as essentially different from provision of other goods and services, and thus subject to a different set of rules. They allow medical providers to withhold comparative information from the public, apparently with the justification that ordinary people would not be able to understand this data. (OK, political pressures and lobbying are a consideration here also.)

Interestingly, regulators have no problem mandating certain kinds of services for sick people - minimum nursing staffing ratios, for example, or mental health parity. They do this because they believe that the market alone will not provide adequate services to sick people. They typically regulate based on political influences - the nurses lobby, for example, demanding certain

²⁴¹ Ibid, page 54

²⁴² Ibid.

²⁴³ Ibid.

minimum staffing rates - rather than on rigorous, extensive studies comparing various nurse-to-patient ratios and patient outcomes.

But regulators balk at requiring price and outcome transparency. They require it for autos, but not for healthcare. They require it for food products, but not for healthcare. They require it for financial services, but not for healthcare. They even require it, more or less, for life, homeowners and auto insurance - but not for healthcare.

The best way to understand these discrepancies? Understand that many regulators see healthcare as essentially different from other goods and services.

This conflict - between regulations based on one set of assumptions, and competition based on another - leads to dysfunctional competition that raises medical service prices without simultaneously improving patient outcomes.

Porter and Teisberg note several other kinds of inappropriate and dysfunctional competition in the healthcare arena. We've presented enough above to make our underlying point: our lack of consensus about whether healthcare is like or not like other goods and services leads to a poor regulatory framework and dysfunctional, costly competition.

Our Lack of Consensus Is Expensive

As our medical providers compete for business in this poorly regulated, dysfunctional marketplace, we have more and more people administering our healthcare. In 2006, for example, we had some 470,000 health insurance employees - that's 1 for every 2 physicians!²⁴⁴

These numbers don't include the number of hospital and physician office employees who coordinate with these insurance employees. Surveys find that both doctors and nurses spend between one-third and one-half of their time on paperwork and that health insurance administration alone is a staggering 30% of all healthcare spending.²⁴⁵

Why are these costs so astonishingly high? Because we lack a consensus on whether healthcare is like or dislike other goods and services. As a result, we have an overly complicated, confused and often internally contradictory regulatory and administrative system.

We could reduce administrative costs, complications and confusion if we all agreed that healthcare is like other goods and services - or dislike.

²⁴⁴ David Goldhill, What Washington Doesn't Get About Healthcare, Atlantic, September, 2009, page 42

²⁴⁵ Porter, op. cit, page 29

If, for example, we let the market alone dictate healthcare system evolution, then we could eliminate many mandates and healthcare access restrictions, referral costs and requirements and inappropriate geographical competition. We could probably eliminate the expensive and inappropriate medical arms race by focusing on outcomes per dollar.

Alternatively, if we agreed that healthcare is a government function - not a market function - then we could eliminate many of our current costly types of provider competition, like individual underwriting and pre-existing condition exclusions and network restrictions. We could also eliminate the massive private insurance overheads that serve no useful economic function in a public healthcare system.

But since we lack consensus, we have the worst of both worlds. We have expensive private insurance overhead. We have expensive provider overheads whose only function is to deal with the various insurance carriers and complications. Yet we don't have the benefits of true market competition that would lower costs and improve outcomes.

Indeed, our current convoluted healthcare billing system is so complex and confusing that carrier and provider *billing offices themselves* often cannot understand the process. Errors and double billing abound.²⁴⁶ Partially as a result, insurers find reasons to reject up to 30% of all the bills they receive from physicians and hospitals²⁴⁷ - leading to more administrative time and expense to straighten all this out.

Our lack of consensus about how to treat healthcare - is it like or dislike other goods and services? - is hugely expensive for all of us.

²⁴⁶ See Porter, op. cit, page 63

²⁴⁷ Estimate from Atul Gawande, Better, page 118

Summary of Part 4

1. There are three basic forms of health insurance: single payer, managed care and consumer driven healthcare.

2. In single payer healthcare, one entity - generally the government - finances all medical care for all people.

The great advantage of single payer healthcare is that it covers everyone and can provide long term financial incentives to keep people healthy. The great disadvantage of single payer healthcare is that it is generally slow to innovate and often allocates medical resources poorly.

3. In managed care, the same corporate entity handles both the financial function and the medical service provision function. This is called vertical integration.

The great advantage of vertical integration is that it avoids a conflict between financiers - who want to pay less for medical care - and physicians - who want to earn more.

Managed carriers compete to provide the most efficient care.

The great disadvantage of managed care is that it is impossible to implement in the US today.

4. In consumer driven healthcare, each consumer can purchase his/her own benefit package from competing carriers. Consumer driven healthcare treats medical care just like other goods and services in our economy.

The great advantage of consumer driven healthcare is that it forces healthcare financiers and providers to respond to consumer demands. This, theoretically, will make healthcare more convenient and efficient.

The great disadvantage of consumer driven healthcare is that it doesn't actually exist anywhere, so we don't know how to implement it.

5. Healthcare reforms always fail because we do not have consensus about what form of healthcare we want in this country. We differ over the answers to 2 fundamental questions:

- Is healthcare like or dislike other goods and services in our economy?
- Is competition good or bad in healthcare?

6. We currently have dysfunctional competition among health insurers and providers in many areas, including the following:

- Wrong geographic market - states
- Wrong time horizons - one year policies
- Wrong unit of measure - surgeon vs. medical condition
- Wrong goals - wealth creation vs. patient outcomes
- Wrong hospital strategies - general vs. specialty
- Wrong information - need results data, not customer satisfaction surveys

7. Nixon passed major healthcare reform in 1973, but his political compromises transformed the essence of managed care and ultimately failed to control healthcare costs and improve outcomes.

8. Clinton failed to pass major healthcare reform in 1993 by handling the political process poorly. Even though a majority of Americans actually liked reforms proposed, they opposed this government attempt to overhaul our healthcare system.

Review Questions
Answers on next page

1. What is the essence of managed care?
 - a. Vertical integration
 - b. Horizontal integration
 - c. Draconian cost controls
 - d. Benefit limitations

2. Is fee-for-service financing good or bad? Why?
 - a. Bad, because this incents physicians to perform more procedures, not better procedures
 - b. Bad, because it is extremely difficult to determine appropriate fees
 - c. Good, because this rewards physicians appropriately
 - d. Good, because specialists earn more than generalists

3. What is one potential advantage of single payer financing employer based financing?
 - a. Single payer financing can use long term incentives to provide cost effective care, while employer based financing focuses on short term cost controls
 - b. Single payer financing generally uses better medical technologies
 - c. Hospitals in single payer systems are generally better
 - d. Physician training in single payer systems is generally better

4. What does 'dysfunctional competition over the wrong geographic area' mean?
 - a. State based provider networks
 - b. National provider networks
 - c. International provider networks
 - d. Condition based provider networks

5. What was the major cause of Clinton's healthcare reform failure?
 - a. Poor marketing
 - b. Poor plan design
 - c. Excessive healthcare mandates
 - d. Excessive health insurance subsidies

Review Questions
Correct answers in bold

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Part 5:
Expanding the Supply and Allocating by
QALY

Chapter 14

Expanding the Supply Of Healthcare Providers

Let's quickly review our thesis so far:

1. US healthcare costs are too high, and are growing too quickly for our economy to sustain without creating major difficulties for Americans;
2. We can only get costs under control by altering the **demand** for healthcare or the **supply** of healthcare services;
3. We cannot reduce demand due to demographic and technological reasons. Demand for healthcare will increase for the foreseeable future (however long that actually is);
4. We probably **cannot improve our supply efficiencies** much due to our lack of consensus about whether healthcare is like or not like other goods and services and the power of healthcare special interests. We discussed why healthcare reforms always fail to control costs in previous chapters.

Therefore, we only have two options left to control our healthcare costs. We can **expand the supply of medical services**, or **restrict access to medical treatment**. We'll discuss supply expansion in this chapter, and access restrictions in the next.

Expanding the Domestic Supply of Medical Services Won't Work

We discussed this option in Part 1. It's a non-starter as a cost control mechanism. We'll restate the reasons why here:

Expanding the supply of hospitals - even if politically possible - would require a huge capital investment. So would training the required number of physicians, nurses and other professional staff. In the short run - which could take many, many years - we would need to spend more on healthcare, not less, to expand the supply of medical providers.

Expanding the supply of medical services, in addition, might have a negative long term effect on costs - Roemer's Law again. Physicians respond to the increased supply of hospital beds and related technologies by increased hospitalizations. Patients in the 'gray area' between definitely needing

hospitalization and definitely not needing become prime candidates for admission as facilities expand.

Thus, in healthcare - unlike in most parts of our economy - expanding the domestic supply of medical facilities will likely increase costs, both in the short and long term. Not a practical solution to our current problem of high healthcare costs.

Finding a New Supply of Medical Services Overseas

The Medical Tourism business - a fancy name for using overseas hospitals - has grown dramatically in the past decade or so. Time magazine estimates that in 2006 some 150,000 Americans went overseas for medical treatments. That increased, in 2007, to 750,000. Deloitte, the accounting and consulting firm, projects upwards of 1.6 million US patients going overseas by 2012, with ‘sustainable annual growth of 35%’ after that.²⁴⁸

It’s easy to understand why some Americans look to overseas hospitals for their medical care: **it’s much cheaper!** These price comparisons come from BusinessWeek in 2008:²⁴⁹

Procedure	Estimated Costs			
	US	Singapore	Thailand	India
Heart Bypass	\$130,000	\$18,500	\$11,000	\$10,000
Valve Replacement	\$160,000	\$12,500	\$10,000	\$ 9,000
Angioplasty	\$ 57,000	\$13,000	\$13,000	\$11,000
Hip Replacement	\$ 43,000	\$12,000	\$12,000	\$ 9,000
Hysterectomy	\$ 20,000	\$ 6,000	\$ 4,500	\$ 3,000
Knee Replacement	\$ 40,000	\$13,000	\$10,000	\$ 8,500
Spinal Fusion	\$ 62,000	\$ 9,000	\$ 7,000	\$ 5,500

Add a few thousand for transportation and the picture doesn’t change much: these countries provide great savings to Americans for non-emergency, acute medical procedures.

Let’s review some case studies to understand the enormous potential that Medical Tourism offers our healthcare system.

²⁴⁸ Deloitte, Medical Tourism: Update and Implications, 2009

²⁴⁹ Businessweek.com 11/12/2008

Case Study: Wayne King's Back Surgery Gleneagles Medical Centre in Penang, Malaysia

Wayne King, a 35 year old Sacramento, California resident, had severe back pain. He couldn't stand for more than 25 minutes, which impacted his entire quality of life.²⁵⁰

His back pain was caused by 2 collapsed lumbar disks. Doctors recommended a two-level disk replacement.

King's insurance carrier, however, refused to cover the \$105,000 procedure, saying it was still experimental. They suggested a different kind of surgery, which King's doctor discouraged.

King appealed the carrier's denial - to no avail. He then changed jobs so he could try again with a different carrier. Again, no success.

His only hope - an overseas hospital offering the procedure at a price he could afford. He chose Gleneagles Medical Centre in Penang, Malaysia. Dr. K Parameshwaran, an orthopedic and spinal surgeon performed the two-level disk replacement recommended by King's own physician.

King stayed in the hospital for 4 days. He was walking by the second day post-surgery. The outcome, he says, 'was fantastic, just life-changing...I'm able to stand and walk and get out on the bike again...I'm happy - and it's not medicated happy.'

The price? Including travel expenses, surgery, hospital stay and two weeks in a five-star hotel: \$27,000. About a quarter of the US cost.

Case Study: Byron Bonnewell's Heart Surgery Bumrungrad Hospital, Bangkok, Thailand

Byron Bonnewell owned a campground in Shreveport, Louisiana. In 2004, he had a heart attack, and his doctor told him he needed surgery.²⁵¹ Lacking insurance, Bonnewell decided to pass on the surgery for cost reasons. He didn't have the necessary \$100,000 and figured 'I'd rather die with a little bit of money in my pocket than live poor.'

He stumbled on a BusinessWeek article about Bumrungrad Hospital in Bangkok, then did some Internet research - and learned that the required quintuple bypass surgery would cost \$12,000: 'I made an appointment, and away I went to Thailand.'

²⁵⁰ Booming Trend is Standard Operating Procedure, Janet Fullwood, Miami Herald, Nov 2, 2008

²⁵¹ 60 Minutes, CBS, September 4, 2005

He chose his cardiologist, Dr. Chad Wanishawad, after reading on the hospital's website that he used to practice at the National Institute of Health in Maryland. 'Every doctor that I saw there has practiced in the United States.'

He was operated on three days after arriving at the hospital, and was home 2 weeks later. 'I wish I had found them sooner.'

Bonnewell raved about the care and the nursing staff:

I found it so strange in Thailand, because they were all registered nurses. Being in a hospital in the United States, we see all kinds of orderlies, all kinds of aids, maybe one RN on duty on the whole floor of the hospital.

In Thailand, I bet I had eight RNs just on my section of the floor alone. First- class care.

Case Study: Wayne Steinard's Heart Surgery Devki Devi Heart & Vascular Institute, India

Wayne Steinard, a 59 year old general contractor from Winter Haven, Florida, had a clogged coronary artery. He needed surgery to unclog the artery and probably also to insert a stent. But Steinard - too rich for Medicaid and too poor for insurance - didn't have the \$60,000 necessary to self-fund his treatment.²⁵²

He flew, instead, to India for treatment at Max Healthcare's Devki Devi Heart & Vascular Institute.

Upon arrival, things took an almost immediate bad turn. His initial heart scan showed the artery was 90% blocked, and that the stent was out of the question. 'Your father is going to need a double bypass, and he needs it immediately,' surgeon Pradeep Chandra told Steinard's daughter Beth Keigans, who accompanied him to India.

Steinard was blunt about his options: either immediate bypass surgery far from home or a fatal heart attack shortly after returning to Florida. He chose the surgery.

It was successful, at a total hospital cost of \$6,650...about 10% of the American hospital cost. 'I'll be telling everyone I know to come here if they need surgery' he said. 'It's not just the price. They've made everything so easy for us.'

²⁵² Outsourcing Your Heart, Time Magazine, May 21, 2006

His daughter Beth, meanwhile, raved about the plush hospital suite and the superb staff. Outstanding patient services at a fraction of the US cost.

Case Study: Mark and Lily Pierce's Cosmetic Surgery Malaysia

Mark and Lily Pierce used a 3rd party Medical Tourism intermediary to arrange their cosmetic surgery trip to Malaysia in 2007. The Pierces had an array of his-and-her cosmetic procedures.²⁵³

'The #1 reason to go out of the country is cost,' said Mark. 'What we had done would have cost \$80,000 to \$100,000 here, There, it was \$20,000 for both of us - including a three-week stay in a five-star hotel, airfare, five days in the hospital for Lily and two for me.'

Their Medical Tourism trip packager, MedRetreat, made all the arrangements. 'When we showed up they had a car pick us up at the airport. An American couple met us at the hotel, gave us a cell phone, set us up with Skype, told us where to eat and who to see. We even had a video conference with my dad. It really didn't seem like we were half a world away.'

The Pierces would do it again. 'I'd recommend it in a heartbeat,' said Mark. 'In fact, I want a hair transplant. I got a quote of \$10,000 in Thailand. Over here it would cost me \$50,000 at least.'

Patrick Marsek of MedRetreat listed some of the most popular international procedures: 'Cosmetic surgery is most in demand, followed by orthopedic surgery, gynecological surgery and simple coronary procedures. Medical travel is fueled by the least risky procedures that provide the highest amount of savings for patients.'

Case Study: Howard Staab's Heart Surgery Escorts Heart Institute, New Delhi, India

Howard Staab, a 53 year old carpenter in North Carolina in apparently excellent health, had exercised daily for years, mainly swimming before work. At a routine physical in 2004, his doctor diagnosed a severe case of a flailing mitral valve with severe mitral regurgitation - requiring surgery as soon as possible.²⁵⁴

²⁵³ Booming Trend is Standard Operating Procedure, MiamiHerald, November 2, 2008

²⁵⁴ See www.howardsheart.com

Lacking health insurance, Howard checked prices at his local hospital, Durham Regional. Their cost estimate: \$100,000, with half up front - just for the hospital. Adding the additional payments to the surgeon, the cardiologist, the anesthesiologist, the radiologist, the pathologist, the pharmacy and any others, Howard's total cost could run about \$200,000. Unaffordable.

As an alternative, he went to Escorts Heart Institute in New Delhi, India. His partner, Maggi, kept a diary of their experiences. Some highlights:

September 17, 2004 - Dr. Trehan from Escorts called us at home and confirmed Howard's details.

September 25 - Escorts staff met Howard and Maggi at the airport, breezed them through customs and drove them to the hospital.

They were taken to their private room which was stocked with baskets of fruit and cookies. Maggi felt like Howard was being treated like royalty. Doctors and nurses performed a battery of tests, including an EKG, and echocardiogram, an ultrasound and a catheterization.

September 28 & 30 - Howard had two surgeries. Doctors initially repaired his valve, then watched his progress for 2 days. They were dissatisfied with the results, so replaced the valve two days later. According to Maggi's journal, 'although we did not expect two surgeries, they always go for the repair first, and then replacement if the repair is not the best solution.' [I don't know enough about coronary medical technology to comment. GF]

October 2 - Howard was in the ICU, receiving 'exquisite care'. He was still on oxygen but his lines and catheters were removed one by one and he sat up, ate Indian food and drank tea. He had very little discomfort.

October 4 - Howard left the ICU and returned to his hospital room. He went for a short walk that evening.

October 5 - Howard had his bandages removed and went for 6 walks along his corridor.

October 11 - Howard was discharged. He moved to the Centrum Hotel, within walking distance of Escorts Heart Institute, to continue his recovery.

The hospital discharge was delayed a few days because Howard's recovery was not as smooth as the doctors had hoped. He had developed temporary vision problems which were addressed with a neurological consultation, a CT scan (which was normal), an ophthalmology consultation and an eye exam. He received a heparin drip to prevent any clots. His vision returned fairly quickly, but he remained for observation until today.

The Centrum Hotel staff supplied food and support as Howard strengthened.

October 15 - Final checkup with Dr. Trehan. Howard gained strength and planned to become a tourist during his final few days in India.

October 24 - Return home to North Carolina. The return was delayed slightly for tourism / social reasons.

November 12 - Howard's case was picked-up by Dr. Henke, a cardiologist in North Carolina, who prescribed some blood thinners and followed his recovery progress. Howard returned to work with a light schedule of paperwork.

Postscript - Howard recovered fully. He returned to work full time, 'climbing ladders, framing houses, and digging footings - and even eating pizza' according to Maggi.

The total cost of this Indian adventure, including transportation, acute care and recovery at the Centrum Hotel - about \$10,000, which Maggi charged on her credit card.

Anecdotal stories like these abound. You can google 'medical tourism' and find them yourself. But we wonder if they're typical stories or abnormalities. Are they unique stories? How good is the typical care overseas? How good are the hospitals?

Medical Care Quality Overseas

Let's let Harvard Business School's Herzlinger introduce us to Bumrungrad Hospital in Thailand.²⁵⁵ We'll revisit that hospital later in this chapter. I'll paraphrase Herzlinger:

The beautiful hospital entrance - spacious, airy, sparkling clean - resembled a fancy hotel lobby. Upon entry, I felt pampered and elegant, with an attentive, first class staff ready to serve me.

Everything was done quickly and efficiently. An administrator handed me an up-to-date copy of my medical records - including a diagnosis of my condition by an Ivy-League trained doctor - and a treatment schedule.

No waits, no unresponsive staff, no plastic furniture, no blaring televisions. Compare that to the experience in a crowded, uncomfortable American hospital emergency room or waiting room.

Time Magazine refers to Bumrungrad as 'the marble-floored mecca of the medical trade that - with its liveried bellhops, fountains and restaurants - resembles a grand hotel more than a clinic.'²⁵⁶

Josef Woodman, author of Patients Beyond Borders summarizes the international quality situation:²⁵⁷

The key behind contemporary medical travel is the build-out of high-quality international hospitals mostly in Southeast Asia and India...the best have very high standards. They're competing with or engaging in partnerships with the Mayo Clinics, the Johns Hopkinses, the Harvards.

A look at India

We'll look at some specific hospitals since there are not yet reliable generalized databases by country. We'll look first at some **Indian hospitals** due

²⁵⁵ Herzlinger, Who Killed Healthcare, pages 85 - 86

²⁵⁶ Outsourcing Your Heart, op cit

²⁵⁷ Booming Trend is Standard Operating Procedure, Miami Herald, op.cit.

to the relatively easy availability of good data...and also to the astonishing quality.

Harvard Business School Professor Tarun Khanna, author of the HBS Case Study 'Apollo Hospitals - First World Healthcare at Emerging Market Prices' described private healthcare in India:

Often better care - by which I mean technologically first-rate care with far greater 'customer service' and accessibility - is available in parts of India than in my neighborhood in Boston. ²⁵⁸

Professor Khanna continues

India is rising because there's just a ton of very well-trained doctors just like there is a ton of well-trained engineers. Over the decades, many engineers have relocated to Silicon Valley, but for doctors it remains the case that barriers to entering the US medical profession are still large...

The same depth pool of engineering and mathematical talent for software, offshoring and outsourcing is there for medicine, too. In the 1950s and 60s, the Indian government invested a lot in tertiary education. By now there is at least a small handful of medical institutes that are really first-rate, and the doctors they produce are extremely well trained...

India has a unique competitive advantage as a result of this deep pool of technical knowledge.

Some specific Indian hospitals:

Apollo Hospitals, a group of 33 hospitals primarily in India, has performed over 50,000 heart operations with a success rate of 98.5%. ²⁵⁹ In 2004, Apollo's hospital in Chennai did all its cardiac surgeries using the 'beating heart technique', with a success rate of 99.5%, a result only surpassed, anywhere in the world, by the Mayo Clinic. Some 95% of the 6,000 kidney transplants at Apollo facilities were successful.

²⁵⁸ Harvard Business School Working Knowledge, The Rise of Medical Tourism, Dec 17, 2007

²⁵⁹ The Apollo data comes from **Apollo Hospitals – First World Care at Emerging-Market Prices**, a Harvard Business School Case Study written in 2005.

Apollo also had an 87% success rate with its 138 bone marrow transplants.

Apollo's cardiac surgeons earned, in 2004, about \$300,000 each, compared to a median American cardiac surgeon wage at that time of \$417,000. Yet Apollo treatment costs were far lower than American:

Treatment Price Comparisons, 2004
As reported in the Harvard Business School Case

<u>Procedure</u>	<u>US Price</u>	<u>Apollo Price</u>
Liver Transplant	\$300,000	\$45,000
Cardiac Surgery	\$ 25,000	\$ 6,000
Orthopedic Surgery	\$ 20,000	\$ 4,500
Bone Marrow Transplants	\$250,000	\$30,000

One reason for the dramatically lower costs, despite only modestly lower surgeon salaries - far higher equipment utilization rates and more hospital specialization. (See below for a discussion of the impact of higher utilization and specialization.)

Narayana Hrudayalaya Hospital in Bangalore, India, has 1,000 beds, compared to a US average of 160.²⁶⁰ The 42 cardiac surgeons performed 3,174 cardiac bypass surgeries in 2008, more than double the Cleveland Clinic's. Surgeons operated on 2,777 pediatric patients, more than double the 1,026 performed at Boston's Children's Hospital.

Narayana charges about \$2,000 for open-heart surgery compared to US hospitals that charge \$20,000 - \$100,000 depending on the complexity. It uses economies of scale to drive down prices and improve outcomes - just like Henry Ford did a century ago when he introduced mass-production based automobile manufacturing plants in Detroit.

'What healthcare needs,' according to Dr. Devi Shetty, Narayana's founder, 'is process innovation, not product innovation...Japanese companies reinvented the process of making cars [a couple decades ago]. That's what we're doing in healthcare.' Perhaps as a result, Narayana reports a 1.4% mortality rate within 30 days of coronary artery bypass surgery, compared to a US average of 1.9%. [I don't know how they generate these statistics, nor how valid they are. GF]

Here's a way to understand their process innovations: Narayana surgeons perform more surgeries per capita annually, than do American surgeons. That

²⁶⁰ Data on the Narayana hospital chain comes from the Wall Street Journal, The Henry Ford of Heart Surgery, Nov 25, 2009

gives each surgeon, and each surgical team, more practice and reduces surgical and systemic errors.

Narayana surgeons perform 2 or 3 surgeries per day, 6 days per week. They typically work 60 - 70 hours per week.

American surgeons typically perform 1 or 2 surgeries per day, 5 days per week, operating fewer than 60 hours.²⁶¹

This volume difference has two dramatic consequences. First, since practice makes perfect in medicine, the increased surgical volume leads to better patient outcomes. A key reason: handoffs between pre-op, surgery, post-op and rehab are more routine, with paperwork patterns and information flows more regularized. Each component of the treatment team knows exactly what to do and what to expect from others. High surgical volumes keep this well-oiled machine working efficiently.

By contrast, a general hospital that does coronary, urinary, orthopedic, kidney and other kinds of surgery has less experience with each specific treatment type. Medical professionals may work on multiple types of treatments, leading to less of a 'well oiled machine' and more idiosyncratic patient requirements and differences. Paperwork and information flows also become less routine and more individualized - leading, potentially, to more handoff and follow-up problems.

Second, the increased daily volume leads to higher equipment utilization rates and thus lower equipment costs per procedure. Simply put, performing more procedures in the same room with the same equipment lowers the per patient costs.

Interestingly, Narayana plans to expand its hospital network. It currently owns a 1,400 bed cancer hospital and a 320 bed eye hospital. Over the next five years, it plans to expand its Indian hospital bed total to 30,000, up from about 3,000 today. And it plans to build a 2,000 bed facility in the Cayman Islands, about an hour's plane ride from Miami, to service Americans who lack appropriate health coverage.

Now that's an interesting idea - compete with high price American hospitals right in our backyard!

Escorts Heart Institute in New Delhi is part of Fortis Healthcare. Howard Staab received his care here.

Escorts annually performs over 4,000 heart surgeries. That compares favorably to the Cleveland Clinic, a US leader, with about 1500. Remember the importance of practice in medicine. The more frequently you perform a

²⁶¹ Ibid.

procedure, the more routine it becomes, and the better the integration of medical team - doctors, nurses, pre-op, surgery, post-op, rehab, etc. Better team integration leads to better handoffs among team members - and better outcomes.

Escort's mortality rate is about 0.8%, well below the developed world average of 1.2%. The 0.3% infection rate compares to a world average of 1%.²⁶²

Escorts holds the world record of carrying out over 80,000 angiographies, 17,000 angioplasties and 43,000 cardiac surgeries in the past 15 years. It introduced the innovative technique of minimally invasive and robotic surgery and as state-of-the-art infrastructure.

Let's take a closer look, below, at 'the Escorts Experience' for international patients.

The experience starts on their website, www.ehirc.com, with a convenient **International Patients** drop down tab on their Home Page. Escorts first identifies its areas of expertise, so international visitors can ascertain whether or not Escorts has the services they need:

- Cardiac Bypass Surgery
- Minimally Invasive / Robotic Surgery
- Interventional Cardiology
- Non-invasive Cardiology
- Pediatric Cardiology

Second, Escorts provides summary statistical data, including:

- **Size:** 332 beds, 9 operating rooms, 5 cath labs, etc
- **Experience:** over 114,000 angiographies, over 27,000 angioplasties, over 65,000 cardiac surgical procedures
- **Outcomes:** 99.6% success rate of cardiac procedures; less than 0.3% infection rate (which American hospitals provide this data on their websites?)

Third, Escorts lists the additional / non-medical services that it provides to international patients:

- Visa assistance

²⁶² This data comes from **Promoting Healthcare Tourism in India**, written in 2007, available from Harvard Business School.

- Lodging arrangements
- Information needs (city maps, Escorts information, ways to forward patient information to relatives back home), and, perhaps most interesting from a customer service point of view
- Value Added Services, including
 - * Dedicated Patient Care Coordinators to assist the Patient and the Patient's Family / attendant
 - * Travel/ticketing arrangements for patients and relatives
 - * Specialized cuisine for health, cultural or preference reasons
 - * Airport pick-up
 - * Local travel needs for the patient's relatives
 - * Foreign exchange
 - * All finance-related matters in one office
 - * (I wonder which American hospitals offer these services in an easy-to-access manner to their foreign patients.)

Fourth, Escorts lists the insurance carriers with whom they have partnerships, including AETNA and CIGNA as of December, 2009.

Hospitals in India are more often **specialty hospitals** than are hospitals in America. Apollo owns a number of different specialty hospitals. Narayana owns, in addition to the Hrudayalaya hospital, a 1,400 bed cancer hospital and a 320 bed eye hospital. Aravind, the world's largest eye-hospital chain performing some 285,000 surgeries annually, is based in Madurai.

Most American hospitals, on the other hand, are general hospitals.

Look, briefly, at the impact of specialization on **Lifespring Hospitals** - a chain of small maternity hospitals around Hyderabad. These no-frills hospitals charge \$40 for normal deliveries attended by a private doctor and about \$140 for Caesarean.²⁶³

Lifespring focuses on efficiency and consistency. Their operating rooms deliver 3 - 4 babies per day and crucially, according to the *Economist*, 'get better results as a result of high volumes and specialization.'

And information technology. The *Economist* estimates that fewer than 20% of American medical offices use world class IT systems, while nearly 60% of Indian hospitals do. Here's the import:

Instead of grafting technology onto existing, inefficient processes as often happens in America, Indian providers build their model around it.

²⁶³ Healthcare in India; Lessons from a frugal innovator, *Economist*, April 16, 2009

Apollo's integrated approach to IT has enabled the chain to increase efficiency while cutting medical errors and labor. Electronic Health Records and drug records zip between hospitals, clinics and pharmacies ... Apollo is already selling its expertise to American hospitals.²⁶⁴

American Affiliations

As the Indian hospital sector has grown and matured, the landscape has become dominated by several large chains. These have affiliated with major American facilities. They have also received - or are in the process of receiving - approvals from various American regulatory groups including the Joint Commission - that's the group that accredits US hospitals to receive Medicare payments.

Fortis Healthcare, for example, which owns Escorts Heart Institute and some 40 other hospitals, has a partnership arrangement with Partners Healthcare System;

Wockhardt, which owns specialty facilities in Mumbai, Bangalore and other Indian cities, has partnered with Harvard Medical International;

Birla Heart and Research Center has partnered with the Cleveland Clinic Foundation.²⁶⁵

Let's make 2 summary points about Indian hospitals that cater to international patients. **First**, they often offer world class treatments, services and outcomes. **Second**, they may offer an excellent way to expand our supply of hospitals and thus help control our medical costs. Expand the supply overseas and prices come down domestically - at least, that's the theory. It worked for cars and computers...

Is India the Only Option?

Not according to Ruben Toral, CEO of Medeguide, a Medical Tourism consulting firm:²⁶⁶

²⁶⁴ Ibid.

²⁶⁵ These partnership arrangements are listed in Promoting Healthcare Tourism in India, op cit.

²⁶⁶ VoANews.com, Health Tourism Increasingly Popular in Asia, December 22, 2009

You will pay for Singapore but you absolutely know what you will be getting. If you want absolute guarantees, you go to Singapore. If you want absolute price, you go to India. Thailand and Malaysia right now represent the value plays - good quality, great service, good product.

All these countries have seen a rise in international patients. **Thailand's** foreign patient volume grew from about 1 million in 2003 to 1.26 million in 2005. **Singapore** had about 375,000 in 2005 and is targeting 1 million by 2012. **Malaysia** had an increase of about 25% between 2000 and 2001 and served perhaps 100,000 in 2003.²⁶⁷

Thailand

Bangkok's Bumrungrad Hospital alone, for example, treated over 30,000 Americans in 2007. It has an outstanding reputation for high quality care at modest prices. It's certified by the Joint Commission. Over 200 of its physicians are Board Certified in the US.

Bumrungrad is a complete medical campus comprised of

- A 554 bed tertiary care hospital using state-of-the-art technologies;
- A huge outpatient clinic, home to 30 specialty centers;
- 125 hotel rooms and apartments for foreign patients and their families;
- Restaurants, shops and other services.

The main building opened in 1997. The 22 story outpatient building nearby opened in 2008. All buildings meet US hospital fire and safety standards.

The hospital annually treats over 1.2 million people on an in- or out-patient basis. Some 430,000 are foreigners, including those 30,000 Americans. It advertises its Top 10 Procedures for International Patient Value:

- Coronary artery bypass graft
- Balloon angioplasty
- Hip replacement
- Knee replacement
- Microdisectomy

²⁶⁷ Data from Promoting Healthcare Tourism in India, op. cit.

- Comprehensive check-up
- Spinal fusion
- Gastric bypass
- Prostate surgery
- Facelift

Bumrungrad lists prices for these and many other procedures on its website, www.bumrungrad.com/realcost . It lists both a la carte and package prices in an easy-to-read format. (Interestingly, while writing this chapter, I looked at websites for 2 prominent Boston area teaching hospitals and was unable to find similar data.)

Use Bumrungrad as another example of the type of hospital currently available to Americans willing to travel.

Singapore

Singapore presents an interesting case. It's very small, with a total land area of only 275 square miles - about the size of Greater Boston. Its population is about 4.5 million. Yet it has 19 major hospitals, including 5 large public hospitals and a dozen private, often catering to foreigners. Medical Tourism is big business in Singapore.

Parkway Health operates about a dozen hospitals in Asia, including 4 in Singapore .

- East Shore Hospital is a 123 room acute care general hospital, undergoing interior renovations that will be completed in 2010.
- Gleneagles Hospital is a 380 bed tertiary care hospital that was accredited by the Joint Commission in 2006.
- Mount Elizabeth Hospital, also accredited by the Joint Commission, performs the largest number of cardiac surgeries and neurosurgeries in a private facility in the region.
- Parkway Novena Hospital, opening in 2010, with 314 beds and 200 physician offices, all located in the center of Singapore's medical hub. Presumably this expansion is aimed at the foreign clientele, as Singapore's population is not growing significantly.

About 35 - 40% of patients at these 4 hospitals come from overseas.

What's the Trend?

The Economist, a well-respected international business and economics weekly, notes a trend:

Several decades ago very few hospitals in poor countries could claim to offer the highest quality of healthcare. Today there are dozens of hospitals around the world that meet the stringent requirements for accreditation by the respected Joint Commission International ... gaining the commission's seal of approval has become a price of entry into the serious market for global medical travel.²⁶⁸

In 2005, there were just 76 Joint Commission accredited hospitals overseas. By 2009, there were more than 220.

Some hard headed business people, healthcare economists and medical commentators claim that foreign hospitals sometimes offer *even better quality* than American hospitals:²⁶⁹

International hospitals may even leapfrog over their American counterparts. The best of the bunch are being created from the ground up, without the burden of old buildings and equipment, politicized unions and other baggage that weights down American hospitals.

When Bumrungrad looked for information technology to run its operations a decade ago, it found that vendors were so wrapped up in the arcane and fragmented ways in which rich-country firms do business that they couldn't manage to design a complete computer system from scratch...

So Bangkok's Bumrungrad designed its own, which proved superior to that offered by American hospital IT firms. How, you may ask, do we know it's superior? Because Microsoft ultimately took it over, and used it as a basis for its own international health IT efforts - based, as a result, in Bangkok!²⁷⁰

²⁶⁸ Operating Profit, Economist, August 14, 2008

²⁶⁹ Ibid.

²⁷⁰ Ibid

The AMA Gets On Board

The American Medical Association has decided to join this Medical Tourism trend. Remember that the AMA exists to protect physician interests. It apparently sees Medical Tourism as a potential threat to its members' livelihoods, so it wants to try to control the process, noting in 2007

It is possible that the effects of medical tourism could soon be felt by the grassroots physician....Major payers and employers may soon follow in the footsteps of individuals and self insured firms now leading the charge overseas [and] could exert significant downward pressure on US fees in the coming decades.²⁷¹

The American Medical Association Governing Council recommended that the following resolution its 2007 Annual Meeting (we'll paraphrase for brevity):²⁷²

1. That the AMA work with the National Association of Insurance Commissioners and other interested parties to examine the international liability issues involved in Medical Tourism;
2. That the AMA work with the Joint Commission among others to develop policy in the area of international quality;
3. That the AMA consider development of a separate CPT code for the post- operative care of surgical patients treated overseas;
4. That the AMA develop model State legislation for companies that facilitate medical tourism, including in the area of HIPAA-compliant records transfer and patient's rights to legal recourse.

Interestingly, the AMA Governing Council noted in its report that

As has happened in the automobile industry, it is conceivable that in the future, Americans will chose international providers of medical care not only for cost reasons, but also on the basis of side-by-side quality comparisons.

²⁷¹ AMA-OMSS June 2007, Report B: Medical Travel Outside the US

²⁷² Ibid.

An Orbitz or Expedia for healthcare ... is a real possibility ... and we'll see the importance of the brand continue to grow....this is a natural development of Americans becoming savvier healthcare shoppers ... when Americans realized more LASIK was being done in Toronto at a lower price, then began heading north for that procedure.

What is different now is that as our financial exposure grows,we're more inclined to shop for and create our own value equations for a broader spectrum of health services.

Market forces, the AMA suggests, including 1) price sensitivity, 2) competition on quality, 3) customer service and 4) convenience may accelerate growth in the medical tourism movement in the future.

The AMA apparently sees increased Medical Tourism as inevitable, so wants to help mold appropriate policies, rather than simply try to obstruct evolution.

Coordination and Legal Problems

Critics of Medical Tourism typically point to problems involving treatment coordination between American and overseas physicians, and legal / financial problems in the event that treatment goes badly.

The coordination problems occur most frequently during the rehab phase of treatment, after the American has left the foreign country.

Remember, for example, our friend Howard Staab - the North Carolina carpenter who had the valve procedures at Escorts Heart Institute in New Delhi. His American cardiologist prescribed a blood thinner, Coumadin, shortly after Howard returned from India. This raises some potentially troubling questions:

- Why didn't Escorts prescribe or provide the Coumadin?
- Did Escorts release Howard too quickly?
- Was the American cardiologist being overly conservative?, and, perhaps most fundamental of all
- How good was the communication between Howard's Indian physicians and his American cardiologist?

In Howard's case, the American physicians were able to diagnose and treat his post-operative condition.

But reports exist of other American patients who develop infections or other post-operative problems only after returning to this country.

One such patient was Texas resident Maggie Terry who went to a small hospital in northern Mexico for a tummy tuck that ultimately became severely infected, requiring plastic surgery in this country to treat the problem. Terry's summary of her Mexican medical experience: 'I wish I had never done it.'²⁷³

Terry's case highlights two major problems: the treatment coordination problem and the legal / financial problem. In most cases, Americans have no legal access to redress overseas if the treatment goes badly.

We don't know exactly how the medical and legal systems will deal with these types of problems. I would suggest, though, that the economics of medical tourism are so compelling that the medical and legal systems will be forced to develop solutions. Perhaps improved communications technologies will allow physicians in America and overseas to discuss patients together. Perhaps the American physician can even observe the foreign procedure and interact with foreign nurses.

And perhaps the legal systems of various countries will develop mechanisms for dealing with the various tort and malpractice issues.

What the Future May Hold

Potential Implications for US Hospitals

Some commentators suggest that as more Americans travel overseas for their medical care, this will put pressure on American hospitals to lower their prices. Indeed Narayana's proposed hospital in the Cayman Islands may have this effect on some Florida providers.

There's nothing like good old competition to force providers to lower their prices!

Potential Implications for Self-Insured Companies

Self insured companies can, perhaps, reap the greatest financial benefits from Medical Tourism. Each dollar they save in medical costs falls right to their bottom lines.

Hannaford Brothers, an operator of 160 supermarkets in New England and New York, tried to take advantage of foreign savings. In January, 2008, they

²⁷³ Los Angeles Times, Ticket to Treatment: A guide for Americans seeking affordable medical treatment abroad, November 1, 2008

began offering employees who needed knee or hip replacements, the option of having treatment in Singapore.²⁷⁴

In return for using the Singapore facility, Hannaford would waive all deductibles and copayments and pay transportation costs for the employee and significant other to go to Singapore.

As of November, 2008 - 11 months after the program rolled out - no one had taken Hannaford up on this offer. The reason, according to Peter Hayes, the company's director of associate health and wellness, was mainly blind luck: no employees needed these services during this time period.

Hayes is somewhat skeptical about this program, in part because of resistance from local American healthcare providers: 'We've had some orthopedic groups say if you do this, we are not going to take care of you when you come back.'

But Hayes notes an interesting side effect of announcing this program. One US company contacted him and offered to provide Hannaford employees with comparably priced services in this country. So Hannaford ended the first year of this program with two new options for employees: treatment in Singapore or treatment from other hospitals in the US.

Perhaps the pricing impact of low foreign hospital costs has already hit US providers.

Implications for Carriers

The various American health insurers are trying to understand the medical tourism trend and respond appropriately. Some, including a few Blue Cross affiliates, have developed their own international hospital networks.

Blue Cross of South Carolina, for example, already includes Bumrungrad Hospital in its network - along with 3 hospitals in Singapore and medical centers in Ireland, Turkey and Costa Rica. All are accredited by the Joint Commission.

David Boucher, the assistant vice president of healthcare services at BCBSSC explains why:²⁷⁵

We are selling a high number of high deductible health plans - with deductibles from \$2,000 to \$10,000. Customers are saying 'We want to shift more of a percentage of care onto employees; we want our employees to think there is no free lunch.'

²⁷⁴ BusinessWeek, Hannaford's Medical Tourism Experiment, November 9, 2008

²⁷⁵ BusinessWeek, Medical Travel is Going to Be Part of the Solution, March 17, 2008

More and more of our group execs have said, 'I've seen something about this. Tell me about that.'

Boucher and BCBSSC see a growing market to support medical travel over the next 10 - 20 years:

Here in the US you have the 'Silver Tsunami.' In 2008, 365 Americans an hour turn 62. Over half are selecting early Social Security and many do not have employer-sponsored medical plans. The number turning 62 goes to 1,400 an hour by 2010 and the numbers continue to stack up until the peak year of 2017.

This leads to a perfect storm: increasing demand with a static or constricting supply of domestic providers.

We think that over the long term, medical travel is going to be part of the solution. It may not be the only solution, but it's going to be part of it.

Blue Cross Blue Shield of South Carolina is currently developing an overseas hospital network.

Today we have seven hospitals in the network. We see a potential of probably 10 to 12. We are talking to hospitals in India right now. And we're looking at South Korea.

All this, of course, in an attempt to keep premiums reasonable in the face of inflating American hospital prices.

Conclusion

Clearly Medical Tourism is an activity that will grow in the future. Equally clearly it is part of - not all of - the solution to our healthcare cost problem. The new hospitals in India, Thailand, Singapore, Korea and other countries will add to our supply of medical providers and have some impact on healthcare pricing.

Indeed, if the Blue Cross Blue Shield of South Carolina experience becomes typical, American carriers will include some overseas hospitals in their networks.

In economic terms, this is called 'outsourcing overseas'. We already do this with telephone call centers and various manufacturing processes. Medical procedures are a next step.

Elective acute treatments seem most appropriate for this international outsourcing. These are relatively short term interventions designed to address a specific medical problem - replace a heart valve, for example, or fuse two spinal disks. Commentators sometimes call these 'episodic treatments'. The patient has a problem, receives care and recovers completely (hopefully). Then the care ends.

Unfortunately, some 70+% of US healthcare costs go to people with chronic conditions. Chronic - as opposed to episodic - conditions are never completely resolved. Chronic conditions include diabetes, Crohn's disease, cystic fibrosis, multiple sclerosis, some cancers, Parkinson's and other lifelong medical problems. Chronic patients need regular, on-going care to control - not resolve - their medical problems.

Chronic interventions are typically frequent and inexpensive such as regular nutritional counseling, podiatric visits for diabetics or physical therapy for stroke victims. A one hour weekly or monthly session, costing \$100 or so, is probably inappropriate to outsource overseas. (We'll see how communications technologies develop in the future - they may negate the last sentence.)

Perhaps we should look at medical tourism as analogous to outsourcing of our manufacturing processes. We, in the US, often retain certain parts of the manufacturing process - product design, software writing or marketing, for example. But we outsource other, more labor intensive functions.

Perhaps we should see Medical Tourism as outsourcing the acute care function, while we retain the diagnostic and chronic care responsibilities. This would allow physicians to specialize: American doctors could manage their patient's care while foreign surgeons focus on expensive, acute procedures.

If this prognosis is correct - and who knows, in 2010? - then the impact of medical tourism on our healthcare system could be profound. We would need many more Primary Care Physicians to act as 'patient managers' and perhaps fewer surgeons and specialists. Those functions could be fulfilled more efficiently by foreign doctors.

Reducing our high percentage of expensive specialists, and increasing our current low percentage of less expensive generalists could certainly help control healthcare costs.

But Medical Tourism is still in its infancy. The number of Americans going overseas for care remains in the low single-digits as a percent of all American patients. This trend will take time to develop, perhaps decades.

Remember the function that Medical Tourism fills: expanding the supply of healthcare providers. We can forecast only a modest supply increase from international outsourcing over the next decade or so, given the infancy of this industry - and thus only a modest impact on our healthcare costs as a result. We can still expect our healthcare inflation to outpace GDP growth, and healthcare to consume an ever-increasing amount of our total economy.

Thus we need to explore other cost control mechanisms. We've already ruled out two of these:

- Reducing demand, in Part 1 and at the beginning of this Chapter; and
- Improving our supply efficiencies, in Part 4

We'll need to look for cost savings elsewhere. In the next chapter, we'll look at mechanisms to restrict our domestic supply of medical services as a means of controlling costs. That's the only option we have not yet discussed.

And it may be the most fruitful option of all.

Chapter 15: Allocating Healthcare Resources by QALY

We turn in this chapter to the final mechanism aimed at controlling healthcare costs: constricting the supply of healthcare services. This is exactly the opposite of what we discussed in the last chapter - expanding the supply. Let's quickly review the progress of our argument and of this book.

First, we showed that our healthcare costs are far higher than healthcare costs in other countries;

Second, we outlined the only mechanisms available to control costs: **reduce demand** or **alter the supply**. We explained why a demand reduction strategy will not work;

Third, we showed why **expanding the domestic supply of healthcare services will not reduce costs**, but will, in fact, increase them;

Fourth, we showed why **attempts to improve the efficiency of our healthcare providers always fail**, and why this strategy will not reduce healthcare spending;

Fifth, we discussed expanding the supply of healthcare providers by accessing hospitals overseas, and explained why this strategy will work, but also why it is only part of the solution.

In this chapter we'll look at mechanisms to reduce access to medical care in this country. The theory is that by limiting access, we'll reduce our overall healthcare expenditures.

This is not a 'demand reduction' strategy. Instead, it's a 'supply restriction' strategy.

Interestingly, this approach sidesteps the 'healthcare is a right' vs. 'healthcare is a privilege' argument. We can reasonably limit the amount of healthcare under either.

We already do this in other parts of our economy. We limit, for example, many aspects of primary education (a 'right') by local school budgets. Some classes have 30 students, others only 18. Some schools offer many electives, others only a few. Some offer Spanish, French, Chinese, German, Arabic and Russian as foreign languages, others only Spanish. Some schools have a

marching band, a dance band, an orchestra and a chamber music group, others only one band.

We also limit labor forces (hiring workers being a 'privilege' for a business owner and labor being a relatively free and private market). We limit the number of H2B visas annually, thus restricting the number of workers available. Seasonal businesses, for example, those located on Cape Cod, Massachusetts, regularly complain that they can't staff all the positions they have.

Thus, we can realistically limit access to medical care under either the 'right' or 'privilege' point of view.

Our Point of Departure

Here's the underlying question in this chapter: how can we cut healthcare spending if, for some reason, we must? Here's, again, our hypothetical from the Introduction:

We fail to reduce the rate of healthcare inflation over the next 10 or so years. In 2020, our healthcare spending consumes 22+% of GDP.

At the same time, interest rates rise from their 2009 levels, so the interest on our national debt consumes 8+% of GDP. Thus healthcare plus debt service equal about a third of our GDP.

Then some economic calamity strikes - perhaps a war, an oil supply problem, a depression or even a normal economic slowdown. The federal government needs to borrow money.

Our bankers in Frankfurt, Shanghai and Tokyo demand healthcare spending decreases as a condition of lending us money.

How do we think about this? What's our criterion for spending reductions? What's our criterion for limiting medical care?

How We Currently Limit Access to Medical Care

We already, in this country, limit the number of medical treatments. We use a maze of complex, hidden and subjective criteria as the justification for treatment limitations. Here's a partial list:

- We restrict access to care by rationing health insurance **based on price**. This is known as rationing based on people's ability-to-pay. This restricts medical service access to some 45 million Americans;

Here's some specific data on access limitations due to non-existent or inadequate health insurance:

In Texas, some 25% of residents lack health insurance. Even those with health insurance often have inadequate policies. As a result, some 44% have never had colorectal cancer screening and 25% of women over 50 years old have not had a mammogram in the past 2 years, according to data presented by the US Department of Health and Human Services. Only 62% of Texas women had prenatal care during their first trimester of pregnancy in 2006. This compares to the national average of 83%.²⁷⁶

- Carriers typically limit access to specific medications by developing a **drug formulary**. A patient needing a non-formulary medication may be denied access and forced to pay out-of-pocket, perhaps large sums of money;
- Carriers sometimes **deny specific treatments**, as was the case for Wayne King in the last chapter - the fellow who needed a two-level disc replacement ;
- State regulations often **restrict access** to out-of-state providers. Patients insured in Massachusetts, for example, may be unable to access the brain surgeons in North Carolina who operated on Senator Ted Kennedy, perhaps to their detriment ;
- Access to physicians is often limited by their **availability**. In Massachusetts, for example, most primary care physicians have full caseloads, and relatively few are accepting new patients as of 2010. We regularly hear people complain of difficulties finding any PCP, let alone their PCP of choice;

²⁷⁶ Health Insurance Reform, the Case for Change, US Department of Health and Human Services, report released Nov 23, 2009.

- Access to surgeons or specialists is often restricted by their **calendars or caseloads**. The most highly respected surgeons at the most famous hospitals often have a several month backlog of patients, while the newer, younger, less well established surgeons may have shorter backlogs;
- Access to specialists is often limited by your **PCP's referrals**. The PCP, or 'gatekeeper' may close, rather than open, certain gates for certain patients;
- Access to specialists is often **limited by network**. Physicians who contract with certain carriers or hospitals may not be available to patients who contract with other carriers or hospitals;
- Many Americans, even those medically insured, go without care due to **cost**. A 2006 Commonwealth Care study found that 54% of American adults with chronic illnesses reported not filling a prescription, not visiting a doctor when sick or not getting the recommended care due to cost.

Thus we have a myriad of treatment restrictions. The key concern about these restrictions is not about their **existence** - for they certainly exist - but about their **rationality**.

Few Americans would support 'irrational' treatment restrictions. We would not support, for example, treatment restrictions based on race, sex, religion, hair color, national origin or similar. These seem unrelated to medical care and poor bases for care access decisions. Restricting medical care based on these criteria runs against our national sense of equality, fairness or justice.

On the other hand, we do support restrictions like those above that use geography and physician contracts, or drug formularies as the criteria. These seem to apply to all of us equally and are, in some sense, fair.

We don't object strenuously to our lack of access to Hospital A if it's not in the network we choose. Nor do we object strenuously to our lack of access to Duke Medical Center or the Cleveland Clinic if they are out-of-state providers. Or to our lack of access to Drug B if it's not on our carrier's formulary. We typically use another provider, or choose another drug.

Interestingly, none of the restrictions above - network contracting or formulary for example - are based on expected patient outcomes. Instead they are based entirely on cost.

When we are denied access, the carrier does not say ‘we deny access because that provider generates poorer outcomes or has higher inpatient infection rates than other providers.’ Nor do they say ‘that medication gets poorer results than others on our formulary.’ Rather they say ‘that provider is not in our network’ or ‘that drug costs too much.’

Note that ‘not in our network’ is fundamentally a cost excuse. If that provider accepted the carrier’s payment schedule, then it would be in-network.

This discussion of medical care access restrictions underlies a fundamental issue when considering the question that we’re trying to answer: How can we restrict access to medical care while maintaining our national values of fairness, equality and justice?

I assume that if we need to cut medical spending - perhaps under pressure from our foreign bankers - we would want to do so compassionately and rationally.

Capitation: Irrational Restrictions Based Solely on Cost

Waiting is widely associated with publicly funded healthcare systems: it indicates the absence of costly excess capacity.

Paul McDonald, ‘Waiting List and Waiting Times for Healthcare in Canada’, Health Canada Summary Report, 1998

Capitation means limiting medical spending to a specific amount, say \$1 million per person or \$1 trillion for an entire country. In a capitated healthcare system, you only have that much money to spend. There’s no more available until the next budgetary cycle once you’ve spent to your limit.

Many publicly funded healthcare systems capitate their healthcare spending. Canada is one such example. The Canadians set national and provincial annual budgets that cannot be exceeded. Typically the healthcare budget is more a function of resource availability than demand for healthcare. Demand for healthcare, as we discussed in Part 1, always exceeds supply.

One result of strict healthcare budgeting, or capitation: waiting lists for medical care. Waiting lists indicate an excess demand for a particular medical service. That’s the opposite way of saying that capitated systems restrict the supply of medical services.

Some Canadian Capitation Issues

The waiting list problem is notorious in, for example, Canada. Remember that these waits exist because the Canadians have decided to restrict the supply of medical services. In other words, ***they have decided that they get a higher economic return on other investments than they would get by funding healthcare at higher levels.***

Stated differently, the Canadians have decided that *waiting for medical care* generates a higher economic return than getting *easy access to medical care*. (If they thought that easy access to medical care generated a higher return than waiting for care, they would fund medical care more generously.) Here are some examples:

- In 2000, the median wait for radiation oncology was 9 weeks. Note that this delay may give a tumor time to metastasize;²⁷⁷
- In 2001, Canadians waited an average 150 days for an MRI scan; Americans waited 3;
- In 2000 - 2001, 27% of Canadians needing non-emergency surgery waited more than 4 months compared to 5% of Americans²⁷⁸

How did Canadians respond to these long waits for certain medical services? Post 2000, the government increased healthcare funding and established national wait benchmarks:

- Hip or knee replacements within 26 weeks,
- Radiation therapy for cancer within 4 weeks,
- Surgery to remove cataracts within 16 weeks for high risk patients, and
- Cardiac bypass treatments within 2 - 26 weeks, depending on severity.

The Canadian Broadcasting Corporation reported in November 2006 the following 'Waiting List Report Card' grades:²⁷⁹

²⁷⁷ Walker and Wilson, *Waiting Your Turn: Hospital Waiting Lists in Canada*, page 37

²⁷⁸ Schoen, et al, *Comparison of Healthcare System Views and Experience in Five Nations*, Commonwealth Fund Issue Brief, 2002

²⁷⁹ CBC, *Waiting List Report Card*, November 2006

<u>Condition</u>	<u>Waiting List Grade</u>
Diagnostic Imaging	F (< 50% within benchmark)
Joint Replacement	C (60 - 69% within benchmark)
Sight Restoration	C (60 - 69% within benchmark)
Cardiac Care (Bypass)	C (60 - 69% within benchmark)

By 2007 or so, Canadian waiting periods for medical care were long, even according to their own goals. **BUT** they controlled their healthcare spending.

Capitation, Medical Conditions and Treatments

Capitation keeps healthcare costs within a specified budget. Capitation alone is a brutal cost control mechanism. It doesn't necessarily target patients according to need or severity. It doesn't necessarily get the greatest 'bang for a buck'.

The Canadians, for example, control the number of radiological scans by the number and location of MRI machines, not on the basis of a case-by-case review of patient conditions.

Canadians and other capitated healthcare systems control costs by imposing arbitrary limits - on, for example, the number of specialists and the number of modern technology units (CT scanners and MRI units, for example). In general, they make access to the most expensive services the most difficult, thus maintaining their budget.

By limiting access to the most expensive procedures, capitated healthcare systems tend to focus on needs of the relatively healthy while denying medical care to the very ill. They tend, under the influence of those notorious waiting lists, to allocate resources on a 'first come, first served' basis, often filling hospital beds with chronic patients while acute patients wait for care.²⁸⁰

Capitation has some attractions, primarily cost control. And some disadvantages, primarily poorly targeted controls.

Capitation and Primary Care

The various actors in a capitated healthcare system - physicians and hospitals - generally organize themselves relatively efficiently, given the budgetary constraints. One noteworthy difference between our system and capitated systems: the distribution of primary care physicians vs. specialists.

²⁸⁰ The ideas in the last 3 paragraphs come from Goodman, et al, Lives at Risk, pages 5 – 8.

In the early 2000s, less than 20% of American physicians engaged in general or family medicine - the rest specialized. This compared to:

- Canada, where slightly over half of all physicians were GPs;
- New Zealand, where nearly half were;
- Australia, where almost 65% were.²⁸¹

Primary care physicians earn less than specialists and, thus, cost our healthcare system less. Having an excess of primary care physicians is far less expensive than having an excess of specialists.

On the other hand, **having more primary care physicians correlates to better longevity outcomes.** We discussed this in Chapter 8.

Remember Dartmouth’s 10 deciles - their division of the country into high and low spending regions. One key difference between the most expensive regions and the least expensive regions was the distribution of specialists and PCPs.

The high spending regions had more specialists and subspecialists than the low spending regions.

	<u>Physicians/ 1000 Medicare beneficiaries</u> ²⁸²	
	High Spending Regions	Low Spending Regions
– Specialists	78	57
– Sub specialists	44	27
– Surgeons	56	44
– GPs/family practitioners	27	36

Outcomes as measured by longevity and patient satisfaction, were higher in the low spending regions. The most expensive regions had a 2 - 6% increased mortality rate. Researcher Elliot Fisher found that for every 10% increase in spending, the relative risk of death in 5 years went up, not down.

This is perhaps due to patient fatigue, more chance for physician error or more chance for systemic error. Having an excess of specialists turns Roemer’s Law upside-down. His Law now becomes ‘a hospital bed built is a hospital bed

²⁸¹ Ibid, page 117

²⁸² Mahar, Money Driven Healthcare, page 170

occupied with an increased mortality risk to the patient’ or ‘a specialist hired is a specialist fully employed with increased mortality risk to the patient’.

Having more specialists leads to more expensive care and slightly poorer outcomes. Exactly the situation we described in Part 1 of this book. The US spends more for healthcare than other countries, in part because we have so many specialists. But other countries live longer, in part because they have proportionally more primary care physicians.²⁸³

Capitation that limits the number of specialists by the budgetary process may actually result in better medical care. This is exactly the opposite of what we might expect!

Capitation and Lifestyle

We have already discussed how capitation limits medical care funding. This limits the number of specialists and correlates with both lower medical costs and better patient outcomes.

Capitated healthcare correlates, also, with healthier lifestyles. We’ve previously touched on the reason: by limiting medical spending, we have more money available for true health spending.

Limiting healthcare spending in this country to, say 50% above the average of most western European countries would reduce our spending to about 13% of GDP on medical care, not the current 17%. That 4% difference is about \$550 billion per year. That’s a tremendous amount to spend on health generating activities. Here’s a partial list of potential activities:

- Stronger clean air programs would reduce the number of asthmatic problems;
- More walking and biking paths would induce more daily exercise;
- Better public transportation would reduce car commuting stress and air pollution, potentially also reducing commuting times, and - as an added benefit - stimulate more walking between transportation modes (numerous studies have suggested a high correlation between increased public transportation use and increased daily exercise)²⁸⁴ ;
- Better funding for obesity, nutrition, exercise and similar programs.

²⁸³ Yes, other factors are at work here also. But this is a fairly astonishing correlation.

²⁸⁴ See, for example, John Pucher and Ralph Buechler, ‘Why Canadians Cycle More Than Americans’ *Transportation Policy* 13 (2006) 265-279.

In short, we could use all that extra money to invest in disease prevention programs, rather than wasting money treating medical conditions that we had failed to prevent. Victor Fuchs of Stanford Medical School summarized this situation succinctly long ago, in the 1970s:

It is the patient rather than the physician who has the major influence on his health.²⁸⁵

We've known for years that lifestyle, not medical care, is the major determinant of our health. Yet we fund medical care excessively and cut funding for healthy lifestyle supports. At best, this doesn't help people live healthy lifestyles; at worst, it inhibits them.

How important is medical care in determining our overall level of health? Here's former US Senate Majority Leader Bill Frist in 2009:

Health is not health services. Health is behavior, it's genetics, it's socio-economic status, it's disparity, it's environment. **Health services has about a 15 - 20% impact.**²⁸⁶

Frist, a cardiologist, is clearly a healthcare expert. He's also clearly frustrated that we're missing the point on our healthcare investment in this country.

That missing point was articulated almost 20 years ago by Boston University Professor George Annas:

We are doing more and more for fewer and fewer people, at higher and higher cost, for less and less benefit.²⁸⁷

We knew that 20 years ago, if not before. Yet we've continued to invest in specialists and medical technology that benefit a few of us, not the lifestyle improvements that actually generate the bulk of healthcare improvements.

David Goldhill, in a brilliant 2009 Atlantic Monthly article, nicely updated Fuch's and Annas' comments and put them into today's context. Goldhill suggests that our medical technology advances have been so outstanding over the past few decades that

²⁸⁵ Victor R. Fuchs, *Who Shall Live: Health, Economics and Social Choice*, 1974

²⁸⁶ CNBC Meeting of the Minds, July 2009. Emphasis added.

²⁸⁷ George Annas, et al, *American Health Law*, page 293

Nutrition, exercise, education, emotional security, our natural environment and public safety may now be more important than care in producing further advances in longevity.²⁸⁸

Capitation is one mechanism to bring medical spending in line with its relative importance. But capitation alone is not enough.

Problems with Capitation Based Solely on Cost

Limiting medical treatments based on cost alone creates a myriad of problems. We tried this form of healthcare cost control in the late 1990s under the guise of Managed Care, and Americans rejected it quite enthusiastically - for three main reasons:

First, carriers could deny treatment arbitrarily. Their incredibly complicated approval processes might allow one person care, while denying another with the same condition the necessary treatment. We actually had cases where our clients would call a carrier to ask if a specific treatment was covered, only to learn that *'yes it is, but this is only a preliminary opinion. We will make the final decision upon receipt of the documentation and the bill'* - whatever all that means!

Additionally, someone insured by Carrier A might get a particular type of care, while someone insured by Carrier B might be denied.

Or Medicare in a high-priced state might deny a treatment that Medicare in a low-cost state might approve.

Though perhaps cost effective, this arbitrariness runs against our notions of fairness and equality.

Second, denying treatment based solely on cost seems un-American. This kind of denial treats access to expensive, lifesaving medical care as a game of chance. People needing cheap treatments would receive them, but people needing expensive care would be declined. 'But for the grace of God go I' we might think, as we avoid that medical condition that costs too much to treat. Healthcare access should make sense, not be a result of randomness or luck;

Third, denying treatment without considering the benefits is a poorly targeted strategy. There were no objections raised, for example, when Senator Kennedy underwent expensive brain surgery. Rather, most people (even his political opponents) expressed the hope that his surgery would be successful.

²⁸⁸ Goldhill, How American Healthcare Killed My Father, Atlantic Monthly, September, 2009

Similarly, we do not protest when low birth-weight babies receive expensive, lifesaving medical care. Or when people receive expensive, but successful cancer treatment. We typically applaud the technologies that save these people's lives.

Most Americans (in my experience) do not object to expensive, beneficial care. We only object to wasteful care. Waste is not only a function only of cost - it's also function of outcomes.

What is Healthcare Waste?

Waste is a relationship between costs and outcomes - the opposite of value which we discussed earlier in this book. We defined value as 'best outcomes for a given cost.' Waste, on the other hand, is 'spending too much for a given medical benefit.'

Capitation - alone - doesn't eliminate waste. It just cuts costs.

Spending thousands of dollars to save a low birth-weight baby seems appropriate, but spending thousands on medical care for a broken arm seems wasteful. Spending thousands to save someone from cancer seems right, but spending equal thousands for a minor routine procedure seems wasteful. What's the difference?

In the 'appropriate' examples above, the benefits seem to exceed the costs. In the 'wasteful' example, the costs seem to exceed the benefits.

Let's refine our definition of waste: 'medical care where the costs exceed the benefits.' Combining waste reduction with capitation may take us to a positive healthcare cost control strategy.

But we first must identify waste. To do this, we need to compare medical costs with expected patient benefits.

Determining medical costs, though difficult, is the easy part of this process. We can find the hospital bill, the surgeon's bill, the rehab therapist's bills, the pharmaceutical bills, etc. We can add these up and arrive at the costs for a given medical procedure. Though there are several accounting issues here, we can come up with a pretty good cost number, pretty quickly. This is the easy part.²⁸⁹

The hard part is valuing benefits.

²⁸⁹ This is often termed 'transparency' and is the focus of many so-called Consumer Driven programs. We've been attempting to make medical costs more transparent, at least since W. Bush's introduction of Health Savings Accounts in late 2003. I'm not sure we've made much progress publicizing costs, nor do I expect that establishing true cost transparency is an easy task. But I assume that we can generate and publicize relatively good pricing data. That's why I say this is the easy part of this program.

Valuing Healthcare Benefits

Medical treatments only generate two types of benefits: we can live longer or we can live better (reduced pain, happier, etc).

Living longer is fairly easy to measure. This is an objective calculation. We provided charts and statistics on longevity in Part 1.

Living better is much more difficult to measure. This is a subjective calculation and differs greatly among individuals. Living better may mean living in less pain, living with a more positive outlook, living with increased physical mobility, or simply feeling better.

Living better often leads to living longer. Indeed, it's difficult to see how - on a national scale - feeling better, living in less pain, with greater mobility and a more positive outlook on life will lead to decreased longevity. We would expect just the opposite.

Thus for simplicity reasons, let's consider longevity gains as our primary medical benefit. This is clearly a shorthand and very rough calculation, but it may help us identify valuable vs. wasteful medical procedures. Let's define wasteful as procedures where the cost exceeds the longevity gain, fully understanding that some treatments aim primarily at life quality improvements, such as pain reduction.

Valuing Longevity: What's a Year Worth?

We next need to determine a value of longevity in order to compare healthcare costs and benefits.

This is the hard part. This generates considerable upset. People seem to fear that miscalculating the value of their longevity gains may potentially deprive them of necessary, lifesaving care. But we need to value longevity gains in order to determine which procedures are wasteful and which are valuable.

People fear that calculating benefits inappropriately may lead to death panels of some sort, deciding who shall live and who shall not. They fear that codifying a method for determining the value of longevity gains will legitimize denial of life saving treatments and will result in death sentences for expensive patients.

These concerns may be - and probably are - emotionally valid. But they are not useful or constructive if we want to control our healthcare spending. Instead, if we wish to control our healthcare spending, we should aim our healthcare expenditures at 'valuable' rather than 'wasteful' treatments.

If we spend too much on the wasteful treatments, we may not have enough money to invest in valuable ones. That could deny medical care to some very needy people. From the so-called 'death panel' point of view, we're damned if we do and damned if we don't:

If we ignore any cost-benefit analysis, then we may waste healthcare resources, run out of money and then deny valuable treatments to some people;

If we accept cost-benefit analysis, then we may deny healthcare resources to others.

But in the latter case, we would deny wasteful treatments.

That's why we need to quantify longevity. That will help us target valuable treatments and reduce wasteful ones.

We Already Make These Decisions - Implicitly - Everyday!

We already make life and death decisions based on costs and benefits every day. We already have many definitions of 'valuable' and 'wasteful' investments codified in our regulatory agencies. Many government manuals define when to invest in lifesaving activities and when not to invest. We use these manuals daily at the local, state and federal levels.

And nobody objects.

One example: transportation codes that define when to install a stop light at an intersection.

What's More Expensive: A Stop Light Installed or a Life Saved?

The US Manual on Uniform Traffic Control Devices (MUTCD) defines when to install a traffic light. It lists several criteria, including:

- Crash experience that exceeds 5 right-angle and cross traffic turn collisions in a 12 month period.

MUTCD does not recommend installation of a traffic light in areas that only experience 2 or 3 accidents per year. That accident volume is too low to justify the cost of installing a stop light.

In other words, **the value of the lives saved by the stop light are deemed lower than the cost of light installation.** ²⁹⁰ We have the beginning of our calculation of the value of longevity - one version of valuing life.

Let's look at another traffic example. We learned, during the 1970s oil embargo, that lowering the speed limit on superhighways saved lives.

In the 1970s, the federal government mandated a 55 mile per hour national speed limit, down from the previous 65 miles per hour, to reduce gas consumption. As a byproduct of this speed reduction, we noted a reduction in the loss of life on superhighways - about 3000 per year.

If reducing the speed to 55 saved lives, why not reduce the national speed limit to 50. Or 45. Or 40. These actions would certainly save lives.

The reason: such a speed reduction would raise costs of domestic shipping and travel too much, so we stayed at 55 during the oil crisis, then many states raised the speed limit back to 65 - knowing full well that more people would die as a result.

In other words, **the lives saved by lowering our national speed limit were worth less than the costs of slower interstate travel.**

We're starting to see who is a death panel - the US Department of Transportation! They're apparently willing to let some people die for the sake of travel efficiency and cost controls - the very things rationing aims to accomplish in healthcare.

Curbs along the sides of all streets would save lives. Street lights on all roads that stay on all night would save lives. Wider roads would save lives. Lower speed limits would save lives. More stop lights would save lives. There are lots of road safety improvements that would save lives.

But we choose not to make some of these safety investments because we perceive that the value of lives saved is less than the cost of the safety investment. At least, that economic position underlies MUTCD's advice.

No one calls the US Department of Transportation a death panel. Yet these regulations serve the same function as healthcare rationing. Both eliminate wasteful procedures, defined as procedures where the costs exceed the patient benefits.

What's the difference?

Healthcare rationing decisions seem more personal and individual than traffic safety regulations. Traffic planners do not decide that Mary Smith will have an accident or will avoid one. But some healthcare rationing panel may

²⁹⁰ We could state this as 'the value of the lives saved or the pain reduced by the stop light are lower than the costs of light installation'. That would be more accurate. But I'm trying to present the concept here, so will focus on the simplest concept, that of longevity gain.

decide that Mary's specific treatment is wasteful, so will deny her access to a lifesaving procedure.

Immediacy and individuality, rather than the lifesaving decision itself, sets transportation regulation and healthcare regulation apart. Both activities achieve the same result - a certain number of lives saved at a certain price. The distinction between the two is patently irrational.

It's as irrational as limiting healthcare access based on geography, provider controls and cost-based drug formularies - all things we do today.

How Do We Determine What a Life is Worth?

Transportation planners value life implicitly: they don't enunciate the value or even the criteria for arriving at a value for life.

Why does MUTCD suggest a stop light for 5 or more accidents / year --- not 2? Or 3? Or even 1? What's their underlying decision criteria?

The MUTCD folks know the cost of installing a stop light. It was about \$500,000 in 2009. They also know, statistically, how many right-angle and cross traffic turn collisions result in death. They valued the potential longevity gains from reducing traffic accidents against this cost.

But they valued the longevity gains implicitly, not explicitly.

Healthcare planners don't have this luxury - they need to determine an actual value for life. Once they determine this, they can value a year of life and then compare medical costs with benefits.

Healthcare planners can use several different methods to calculate the value of longevity, or of life.

The US Government Calculation

Based on the September 11 victim's compensation

One method uses expected future earnings to determine value. The US government used this method to determine compensation for victims of the September 11 attacks in New York City.²⁹¹

The government divided victim compensation into two different categories, an economic and non-economic. They did this because it seemed unfair to pay people entirely based on their expected future earnings - stock broker's beneficiaries would receive vastly more than floor cleaners, for example. Yet all victims died in equal circumstances and all are equal before the law. Hence the non-economic category.

²⁹¹ This discussion comes from David Dranove, What's Your Life Worth, chapter 8

The government stipulated the non-economic value at \$250,000 per person. The economic category averaged about \$1.6 million due to the large number of young professionals who perished. This is the value of victim's projected future earnings discounted back to September 11, 2001.

According to this methodology, had the September 11 attacks been on a warehouse instead of a financial center, the average compensation would have been lower.

There's something unsavory about this technique for determining the value of life. If we use an average projected earnings value, some - the high wage earners - might complain about subsidizing low earners. If we don't use average values, the low earners complain about receiving too little.

Some wonder why one 25 year old husband and father should have a value of each additional life year any less than another 25 year old with no family, but who makes more money.

The basic flaw in the future earnings technique is that it treats people differently. This seems unfair. We'd prefer a technique that treats everyone the same - that's more in keeping with our national values of equality, fairness and justice.

The law treats us all the same - young and old, rich and poor. Our healthcare system, many suggest, should similarly treat us all the same.

Willingness to Pay

Healthcare analysts have a second method for valuing life - a Willingness to Pay (WTP) technique.²⁹²

Analysts look at what Americans are willing to pay for various life-saving devices such as car air bags. They then look at the total value of air bag consumption and compare it to the number of lives saved by air bags. This determines a value per life saved. Since driving, automobile accidents and air bag expenditures affect a wide cross section of our population, this methodology may approximate an average American's values.

Air bags are now standard in new cars. When they were an optional purchase in the 1970s, they cost about \$300 each. Some people purchased and others did not.

Studies showed that air bags save the life of 1 driver in 10,000. Paying \$300 to save 1 life in 10,000 is the equivalent of paying \$3 million for each life saved. This air bag example indicates that, based on our consumption decisions for this lifesaving product, we, as a society, value each life at about \$3 million.

²⁹² This is explained in detail in David Cutler, *Your Money Or Your Life*, Chapter 2

Interestingly, this \$3 million life value based on air bag consumption is relatively consistent with conclusions from consumption studies of other life saving devices such as home fire alarms, home carbon dioxide detectors or boat life preservers. Economists who have used this methodology have concluded that - based on our consumption patterns - we value our remaining years between \$3 and \$7 million, with \$5 million as an approximate average.

We say 'remaining years' as today's consumption decisions will affect our future years, rather than our total life years. (Buying an air bag today will have no affect on your previous life.) The US average life expectancy is about 80 years and our average age almost 40, so the average US consumer has about 40 years more to live.

Dividing the 'about \$5 million' value of additional life by the 'about 40 years' more to live indicates that most Americans value each additional remaining life-year at about \$125,000. This is somewhere in the ballpark of the figure most analysts use. To be generous and conservative, many analysts use \$150,000 as the value for each additional life year.²⁹³

Rational Rationing

We now have a basis to determine healthcare waste. Procedures that cost more than \$150,000 and are expected to prolong someone's life less than a year are wasteful: they cost more than the patient benefits.

Similarly, procedures that cost more than \$300,000 but will likely prolong someone's life less than 2 years are also wasteful.

On the other hand, procedures that cost less than \$150,000 and are expected to prolong someone's life a year or more are valuable.

Remember when considering value and waste: we always have excess demand for healthcare services. In the event that we cannot provide all treatment to all people, this criterion can help us decide who to treat. It can help us provide valuable, rather than wasteful, treatments.

Life Years and Quality Adjusted Life Years

As healthcare analysts considered the value of life years, they tried to tailor their calculations to the needs of individual patients.

²⁹³ Cutler estimated about \$100,000 used in 2004. See Cutler, op cit, page 16. David Dranove used a slightly higher figure, \$150,000, as the value of each life year in 2003. See Dranove, op. cit. page 155.

- Some asked, for example, if an additional life year for someone in pain is worth the same as a life year for someone in good health.
- Others wondered if extending a depressing life is worth the same as extending a happy life.

Some medical interventions keep people alive but in pain, others extend a depressing life, and still others extend an only partially fulfilling life. Economists try to measure **Quality Adjusted Life Years (QALYs)** - to measure health quality combined with longevity.

This term was first coined in the 1970s and has stimulated an entire branch of medical economics that measures QALYs under different circumstances. Basically QALYs assign values ranging from 0 (dead) to 1 (perfect health): values closer to 0 indicate poorer health, and closer to 1 indicate better health.

Medical economists then rank healthcare interventions by QALY, with the lowest cost/QALY being the most efficient intervention. These are notoriously difficult calculations to make, are at best crude measurements and are based on trade-offs that most people prefer not to consider.

However, if medical resources are constrained and we want to allocate treatment based on value, then some sort of calculation like QALY seems appropriate.

In other words, if we must borrow money at some future date, and our bankers in Frankfurt, Tokyo and Shanghai insist that we cut healthcare spending, QALYs may point us in a useful direction.

Oxford University's ETHOX Center agrees with this position. In spite of the quantitative and methodological problems, the medical ethicists at Ethox claim that

QALY theory is the most thoroughly worked approach to cost effectiveness analysis²⁹⁴

in the healthcare field. The Ethox Centre is a world leader in bioethics and is affiliated with Oxford's Department of Public Health.

QALY theory is far from perfect. But according to Ethox and many others, it's better than the alternatives...if we really need to cut medical spending.

²⁹⁴ Cost-effectiveness analysis (CEA) and QALY theory, ETHOX, University of Oxford, www.ethox.org.uk

Researchers have tried to rank medical procedures by QALY to determine which generate the greatest value and which the least. Here's one such, non-definitive ranking list. We provide this for illustration purposes only:²⁹⁵

<u>Condition or Treatment</u>	<u>Cost per QALY</u>
Erectile Dysfunction	\$6,400/QALY
Physician Counseling for Smoking	\$7,200/QALY
Total Hip Replacement	\$9,900/QALY
Gastric Bypass Surgery	\$20,000/QALY
Osteoporosis Treatment	\$38,000/QALY
Left Ventricular Assist Device	\$900,000/QALY

Other researchers have developed similar lists.

The point about these rankings: they provide a rational basis for approving or rejecting a specific medical treatment. Installing a left ventricular assist device in someone with a life expectancy of less than 1 year becomes wasteful; but installing it in someone with a life expectancy of 10 years becomes valuable.

Remember the situation we're discussing. We're imaging a case where we need to hold our healthcare expenditures to a tight budget. We're no longer able to provide all medical care to all people, as that exceeds our healthcare budget.

Allocating treatment according to this 'cost per QALY' calculation is a rational way to allocate medical resources when we operate under severe budgetary constraints.

Three Problems with QALYs

Supporters of using QALYs generally claim that we ration healthcare all-the-time, but that use of QALYs simply makes these subjective, implicit decisions into rational, explicit ones. This may be true. QALY use, however, may be only a useful but not sufficient decision criterion.

Consider, **first, the case of chronic disease.** How much longevity gain can we measure from each of a diabetic's various maintenance visits - to nutritionists, podiatrists, etc? The short answer: we can't measure on a per visit basis.

This certainly doesn't mean 'don't treat'. Instead, it indicates that we need to consider aggregate treatment costs - perhaps annual - rather than unit costs.

²⁹⁵ See Wisconsin Public Health and Health Policy Institute, 5/26/05, unpublished paper by Gold, et al

That gives us a budgetary starting point. Identifying total annual disease costs that exceed \$150,000 indicates that we're being wasteful and need to treat that patient differently.

The point about QALY calculations is to help us identify cost effective vs. cost ineffective treatments - not to give knee jerk treatment rejection decisions.

Second, consider the case of an expensive patient - a child with cerebral palsy, for example, or someone needing expensive open-heart surgery. We know that these people will be more expensive to treat than, say, 1000 healthy folks.

Should we deny all expensive treatments if our medical resources are constrained? That seems too brutally efficient. By that logic we should not treat anyone, for that would reduce healthcare costs to 0.

Should we use the University of Wisconsin chart as justification to treat everyone with erectile dysfunction problems but no one with left ventricular problems? Clearly not. Our healthcare system exists to treat sick people.

QALY measurements do not, all alone, help us differentiate modest gains to a large number of people vs. great gains to a small number.

This is an extremely difficult problem. Remember that a relatively small number of people consume the vast majority of our healthcare resources. Here's the approximate breakdown - using data we introduced in Part 1: ²⁹⁶

<u>% of the population</u>	<u>% of healthcare spending on them</u>
1%	24%
5%	49%
10%	64%
50%	97%

QALY calculations can help us allocate resources, to some extent, by highlighting valuable vs. wasteful treatments. But we must avoid the trap of only treating relatively inexpensive, healthy people. That's, again, why QALYs are a useful but not sufficient decision criterion.

Third, we should understand that QALY calculations are only clinical guidelines, not dictates. 'Guidelines' are designed to cater to the aggregate of society but not necessarily to individuals. The British healthcare rationing board NICE (the National Institute for Clinical Excellence) makes this point very clearly:

²⁹⁶ Mark Stanton 'High Concentration of US Healthcare Expenditures' Agency for Healthcare Research and Quality, US Department of Health and Human Services, June 2006

NICE has always indicated that health professionals, when exercising their clinical judgment, should take its guidance fully into account; but that it does not override their responsibility for making appropriate decisions in the circumstances of the individual patient. This principle is important because **even the best clinical guideline is unlikely to be able to accommodate more than around 80% of patients for whom it has been developed.**²⁹⁷

How severe are these 3 problems? Are they insurmountable? Should we reject QALY theory because it doesn't answer all questions, completely and clearly, for all medical treatments and for all people?

The answer, I think, depends on how tightly constrained our budget is. If the budget is very firm and severe, we may need to rely significantly on QALY calculations as we have no better objective mechanism currently available. In other words, using this imperfect allocation mechanism is probably better than using no objective allocation mechanism at all and allocating medical resources entirely subjectively, based only on cost and whim.

But that's only if our resources are severely constrained.

If resources are less constrained, so we have more latitude to consider individual issues and cases, then we should use QALY calculations as only one of several allocation considerations. The more financial latitude we have, the greater the role for subjective and idiosyncratic considerations.

In other words, we should rely on QALY calculations less if we have more money available; and rely on them more if we have less.

(These ideas, of course, leave out political and economic power relationships among patients, providers and carriers. If healthcare resources are severely constrained, I would expect the rich and powerful to have easier access to medical care than the poor and unempowered. This seems always the case, regardless the specific allocation system. But this is a poor basis for public healthcare policy.)

Reforming Healthcare: Better Incentives or QALYs?

This discussion of QALYs marks a significant shift in thinking about healthcare reform and healthcare system efficiency.

Most previous reform attempts have tried to eliminate waste by altering provider financial incentives. We've discussed these already in Part 4. Over the

²⁹⁷ NICE's response to Learning from Bristol, 2002, bold added

past 40 years, we've tried high deductibles, low deductibles, single payer, pay for performance, DRGs and many other payment reforms. All tried to incent providers to treat patients most efficiently, though none did a particularly good job of defining efficiency.

All failed to rein in medical costs. None included the objective cost-benefit type analysis that QALYs offer. None, in other words, gave providers a measurement tool to decide which treatments are valuable and which are wasteful.

QALY analysis represents a new way of thinking. They offer a tool to define valuable and wasteful treatments. They're the first reform attempt that includes expected longevity gains as part of their decision criteria.

This paradigm shift may prove useful if we're serious about reducing unnecessary healthcare spending.

Tentative Conclusion

We've identified capitation and rationing as a potential avenue to allocate healthcare spending appropriately. We've suggested some reasons why rationing healthcare may actually improve people's health. And we've suggested QALYs are a measurement unit to help us identify valuable vs. wasteful treatments.

Are these complete answers to our healthcare cost problems? Of course not. Our healthcare system is far too complicated and the resource allocation questions far too difficult. Nevertheless, according to Peter Neumann and Dan Greenberg in the September 2009 Health Affairs:

QALYs provide an imperfect but nonetheless useful proxy as a measure of value in healthcare...despite controversies, QALYs can serve as a useful benchmark in informing decisions ²⁹⁸

As I think about capitation, rationing and QALYs, I am struck with two concluding thoughts.

First, applying these ideas sensitively and thoughtfully can help us control our healthcare costs while we maintain our national values of compassion, generosity and equality. But applying concepts like rationing and QALYs mechanically can harm people and harm our society.

²⁹⁸ Neumann and Greenberg, Is the United States Ready for Qalys?, Health Affairs, September / October 2009, page 1370

We cannot quantify sensitivity. That's the art of cost control - some combination of wisdom, maturity and compassion.

It's not only the art of medical cost control, but it's also the art of generating good public policy. To some extent, it's the same issue that Robert Kennedy wrestled with during the Cuban Missile Crisis in 1962 - when to rely on objective data and when to rely on wisdom, maturity and compassion.²⁹⁹

I thought about Kennedy's dilemma while writing this chapter. It seems oddly relevant. Here's his story:

President Kennedy and his brother Bobby had all the available data and military analysis at his fingertips during the Cuban missile crisis. But they had to apply maturity and wisdom to put the facts into context. Here are Bobby's words. As you read them, consider the position of the physician, hospital or healthcare rationing agency in this country when faced with a difficult QALY case:

I could not accept the idea that the United States would rain bombs on Cuba, killing thousands and thousands of civilians in a surprise attack...

I argued that, whatever validity the military and political arguments were for an attack...America's traditions and history would not permit such a course of action...if we were to maintain our moral position at home and around the globe.

[My position] had as its essence our heritage and our ideals and these we must not destroy.

I think the same can be said about applying rationing rules to our healthcare system. If we apply them ruthlessly, we'll make bad decisions. If we ignore them, we'll also make bad decisions. So we need to implement our 'value' calculations sensitively, with proper regard to our values.

Second, I am reminded of a story from my graduate days at Harvard. In class one day we discussed some theory or other designed to solve a social or economic problem. (I don't remember the theory or the problem.) In the face of student skepticism, the professor told this story:

A fellow walked through a secluded area, fell into a deep hole and shouted 'help, help.'

²⁹⁹ See Robert Kennedy's *The Thirteen Days*, reproduced at www.wwnorton.com/college/history/ralph/workbook/ralprs37.htm

Many, many hours later, a lone passerby heard these cries, rushed to his aid and offered the only thing available: a thin branch. The fellow in the hole figured the branch would not support his weight and told his potential savior to find something better.

To which the passerby responded: 'that's all I have.'

The fellow thought about this for awhile, then asked, 'Is anyone else up there?'

Rationing healthcare by QALY is like the thin branch. It may not solve our healthcare cost problems...but it may be the best objective solution we have.

I suppose we should end this chapter with a philosophical question: is it better to use a flawed tool like QALYs to allocate our healthcare resources, or to use no explicit tool at all?

My answer: in a period of unlimited resources, we can allocate healthcare goodies any way we want. Everyone can have as much as they want, because we have plenty available.

But in a period of resource constraint - as, for example, if we're squeezed by our bankers to cut healthcare spending - then using an objective tool is better than using no tool at all.

Even if that tool is as flawed as QALYs.

Summary of Part 5

1. We can increase our supply of healthcare providers by using overseas hospitals.
2. Foreign hospitals, especially in many so-called developing countries, offer outstanding care at a fraction of the cost in this country.
3. Most people use overseas hospitals for routine acute procedures, like hip replacements or coronary procedures.
4. Overseas medical facilities are probably less appropriate for on-going, chronic patients. These represent about 70% of all our healthcare spending.
5. As the use of foreign hospitals increases, we will need to address various financial, legal and continuity of care issues. These are currently significant problems.
6. Medical tourism is only a partial solution to our healthcare cost problems.
7. Capitation, or healthcare rationing, is another mechanism of controlling healthcare costs. Capitation means limiting funding for medical care. Rationing means allocating care based on some criteria.
8. We already ration medical care in a number of subjective, implicit ways. 'Rational rationing' makes explicit our form of medical resource allocation.
9. We can differentiate 'valuable' from 'wasteful' medical treatments by comparing costs and benefits. We have defined valuable treatments as those where the benefits exceed the cost, and wasteful as those where the costs exceed the benefits.
10. One mechanism for measuring healthcare benefits is quantifying the value of a year of life. Currently, many economists estimate that each additional year of life is worth about \$150,000. This value can be adjusted for the quality of life involved. The net calculation is a QALY, or Quality Adjusted Life Year.
12. Valuable procedures are those costing less than \$150,000 that extend life for at least 1 year. Wasteful procedures cost more than \$150,000 and extend life less than 1 year.

13. QALY calculations are far from perfect, but appear the best rational tool for differentiating valuable from wasteful medical procedures. Advocates of QALY calculations advise using them with care, and tempering them with sensitivity, wisdom and good judgement.

Review Questions
Answers on next page

1. How do medical treatment costs in India compare to medical treatment costs in America?
 - a. Indian costs are about 10% of American costs
 - b. Procedures in India cost about twice as much as similar treatments in America
 - c. It depends on the treatment. Coronary care, for example is far more expensive in India
 - d. It depends on international currency fluctuations. In the past 5 years, care has gone from more expensive in India to less expensive in India as the US dollar has fallen compared to the rupee

2. What are the two most important variables in determining medical treatment quality?
 - a. Provider experience with a particular treatment and the quality of the provider's information technology system
 - b. Level of nursing care and level of medical technology available in a hospital
 - c. Age of the medical technology and the training of the physicians
 - d. Average work experience of the nursing staff and the level of technology available to patients

3. From an information technology point of view, how do the best foreign hospitals compare to most American hospitals?
 - a. The foreign hospitals often have better IT systems than do American hospitals
 - b. Foreign hospital IT systems are rarely the equal of most American hospitals
 - c. Foreign hospitals invest primarily in medical technology, not information technology, so have, at best, rudimentary systems
 - d. Most American community hospitals have better IT systems than do most American teaching hospitals

4. What do we call healthcare rationing by price only?
 - a. Capitation
 - b. Cost effectiveness analysis
 - c. QALY

Review Questions
Correct answers in bold

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Part 6: The Broker's Role

Chapter 16

What Responsibilities Does the Broker Have?

What can a broker do to protect his/her clients from paying high health insurance costs? What responsibilities does the broker have to protect his/her clients?

This chapter will review some broker ethical issues that relate to healthcare costs, and perhaps define the broker's responsibilities very differently from the traditional roles.

Broker Policy Disclosure Responsibilities

Brokers have several legal and ethical disclosure responsibilities when they present a policy.

First, they must honestly explain policy terms. Second, they cannot leave out important information. Third, they must honestly quote the price.

But do they also have a fourth ethical requirement - to disclose policy implications, such as likely medical outcomes, medical risks and unnecessary costs? Should the broker provide clients with data about treatment practices and medical outcomes?

The knowledgeable broker knows that we sometimes overuse our medical system. Above a certain level of care, however, researchers suggest that:

There is just no evidence that doing more helps. At best you do the same, and in some cases you actually do worse [due to infections, errors, patient fatigue, etc] ³⁰⁰

Indeed, researchers have discovered that patients in some regions regularly receive excessive and unnecessary care - and have higher mortality rates! The reason:

The additional medicine patients are getting in the high-cost regions is leading to harm. ³⁰¹

³⁰⁰ Jonathan Skinner, John E. Wennberg, How Much is Enough", NBER Working Paper 6513, 1998

³⁰¹ Fischer, et al, The Implications of Regional Variations in Medicare Spending Part 2, Annals of Internal Medicine 2003:138, pages 292 - 293

Should the broker - the 'benefits advisor' - provide warnings to clients? Does the broker have an ethical responsibility to educate clients?

What ethical disclosure responsibilities does the broker have?

Education, Not Advocacy

This is an education book, not an advocacy exercise. Our goal: to stimulate broker's thinking. We hope this chapter will help you consider your own ethical standards.

I will outline in this chapter a very activist ethical position based on our interpretation of Biblical sales ethics - specifically the story of Abraham's first commercial transaction, the purchase of a burial plot for his wife.

I do not advocate any particular religion - or any religion for that matter. I base this chapter on the Bible because it has served as the ethical basis of western civilization for thousands of years. Living according to Biblical teachings is generally synonymous in our society with living ethically.

Not all brokers will agree with this analysis. Many will disagree. Some will think that the interpretation of Abraham's purchase is flawed. Others will argue that the Bible is not relevant to today's health insurance market. Still others will argue that we set an unrealistically high ethical standard for health insurance brokers.

Regardless of whether you agree with our activist position or not, I hope that you will consider the ethical issues discussed in this chapter, and that you will be a better broker as a result.

Summary of the Problem From Your Client's Point of View

Excessive and unnecessary medical care raises costs and poses risks to your clients. Here are two examples:

Unnecessary prostate surgery. A 2009 study of prostate cancer screening found that PSA tests identified approximately 48 times as many benign tumors as cancerous. In other words, only about 1 of 49 men who had prostate treatment actually suffered from life threatening prostate cancer.³⁰²

Patients receiving the prostate cancer diagnosis commonly received an invasive, expensive treatment. This caused two problems:

³⁰² Stephen Smith, Benefits of Screening Questioned, Boston Globe 3/19/09

First, they cost more than men who did not; and

Second, all the men who received treatment, including those who had unnecessary surgery, risked incontinence and impotence, both byproducts of the surgery. Indeed one study indicated that the majority of men were impotent and still wearing adult diapers a year after their prostatectomy.³⁰³

Here we have an example of our healthcare system generating higher costs for poorer outcomes - at least for the 48 men who received unnecessary treatment.

Negative appendectomies. Appendicitis is common but sometimes difficult to diagnose. Research shows that about 15% of our 250,000 annual appendectomies are inappropriate; the patients don't actually have appendicitis. In other words, surgeons removed a healthy organ (a 'negative appendectomy') in response to abdominal pain.³⁰⁴

In women of reproductive age, some 25% of appendectomies are negative. Other conditions, including burst ovarian cysts, intestinal blockages, constipation or menstrual cramps can appear as a swollen appendix.

The concerns: first, unnecessary surgery is expensive. Second, it puts patients at risk. Remember some medical risk data. The Institute of Medicine estimates that 1.5 million patients are annually sickened, injured or killed due to medication errors and that hospital patients average 1 medication error for every day that they stay in the hospital.³⁰⁵ Plus infection risks, surgical risks, unnecessary organ removal, etc.

Unfortunately, patient outcomes do not necessarily improve with the added expense and risk; negative appendectomies do not address the patient's underlying problem. So even after the surgery, physicians need to determine the source of the patient's pain. The negative appendectomy accomplished nothing - except adding cost and patient risk.

Does the broker have an educational, advisory role toward his / her clients in these cases? If so, what is it?

³⁰³ Shannon Brownlee, *Overtreated*, Bloomsbury Press 2008, page 202

³⁰⁴ *ibid*, page 151

³⁰⁵ Institute of Medicine, *Preventing Medical Errors*, 2007

**Demand for Health Services:
Americans want all the medical care available.**

In the 1990s, carriers restricted access to medical care as part of their cost containment programs. Patients needed referrals - which were not always accepted by the carrier. Carriers limited access to expensive specialists, limited the number of physician visits / condition, or limited the types of medications covered.

The American public perceived this as an attempt to improve carriers' financial positions rather than to improve patient outcomes - and objected to these inappropriate restrictions.

One result: today's insurance policies allow easier, even unfettered (in the case of many PPO or POS type plans) access to the hospital or specialist of choice. Post-2000, many carriers have acquiesced to consumer demands for easier access to care. Today many insured Americans can get access to all the medical care available.

This clearly added costs. But does it improve patient outcomes?

Who advises people NOT to receive medical care?

In our healthcare financing system, physicians are paid to treat. They have a financial incentive to intervene, for they generally do not get paid unless they do something to the patient. Many studies have shown that surgeons tend to recommend surgery - far more than non-surgeons do - and sometimes more than patients need. (We are not ascribing any base motives to doctors. We simply note the economic incentives.)

But no one in our healthcare system is paid to advise consumers against getting medical care. By contrast, physicians who get paid fee-for-service for treating patients have an economic interest in providing as much care as possible. Who balances their economic interests? The health insurance broker?

Some possible results: 48 out of 49 'inappropriate' prostate treatments, or 15% - 25% negative appendectomies. The providers earned money; the patients did not get healthier - but did risk complications.

Our medical system does not pay anyone to disagree with the physician. By analogy, our legal system requires both a prosecution and defense attorney to question witnesses. That way neither has too much power.

In our medical system, however, patients only get one point of view ---from providers who have a certain set of economic incentives. We do not pay anyone to oppose the provider's point of view.

Carriers might play that role - but the managed care experience of the 1990s has turned popular opinion against trusting carriers too much.

Second opinions might fulfill the role...but probably do not. Physicians in the same group practice, hospital or region tend to treat patients with similar protocols, and disagree far less than perhaps they should. Also, physicians may have informal - perhaps even unconscious - motivations to support each other.

That leaves the broker. Should the broker advise clients of potential risks of easy availability of medical care? How much should the broker inform clients about systemic abuses? In sum...

What ethical disclosure responsibilities does the broker have to protect his/her client from expensive, unnecessary / excess treatments and the related potential medical harm?

Overview of Disclosure Ethics

The Biblical View of Business Ethics: ‘Do not do unto others as you would not like done to yourself’ and ‘Love thy neighbor as yourself’ are two fundamental ethical dictates of Judeo-Christian religions.³⁰⁶ We - Americans coming from Judeo-Christian traditions and teaching - believe that we have responsibilities to treat others as we would want them to treat us.

Ethical business considerations fall into two separate categories.³⁰⁷ **First**, business ethics regulates conduct in direct contact situations, such as with employees, clients or suppliers. These commonly fall into standard categories including employee relations, honest representation and truth in advertising.

These types of ethical issues have an immediacy or personal effect: lying to a customer may induce that person to buy the wrong product. Shading the truth may persuade a client to purchase a policy that benefits the broker inappropriately. In both cases, the only party harmed is the party in direct contact with the unethical broker.

Second, business ethics involves social responsibility. These ethical issues consider how much all of us must take responsibility for society as a whole. Ethical social behavior, for example, includes helping to control our healthcare spending.

³⁰⁶ Christians typically phrase this in the positive as ‘Do unto others as you would have them do unto you’, while the Jews phrase this in the negative as ‘Do not do unto others as you would not have them do unto you.’ Either version works for our purposes.

³⁰⁷ This discussion comes from www.besr.org/DCPage.aspx?PageID=199

This chapter will discuss both, as they both relate to the broker's role in helping to reign in healthcare spending.

Unequal Knowledge about our Healthcare System

What does 'unequal knowledge about the healthcare system' mean?

Brokers typically know a great deal more about our healthcare system than do their clients. Among the areas of broker expertise:

- Underwriting guidelines
- Provider cost data (at least rough and crude measures)
- Outcome data (again, rough and crude measures)
- Treatment complication data (assuming a well informed broker)

We will explore the broker's ethical responsibilities to share all available information with their clients.

In developing our overall position on the ethics of disclosure, we will rely primarily on the Torah. Why?

The Torah also known as the beginning of the Old Testament or Five Books of Moses, has served as the moral and ethical foundation of our Judeo-Christian western civilization for thousands of years.

Virtually all the great historical ethicists and philosophers had a deep understanding of the Torah's teachings. These permeate our shared views of right and wrong, morals and ethics, and have done so for a very long time.

Some Judeo - Christian Business Ethical Positions on Disclosure: Abraham's first purchase

In the first commercial transaction in the Torah or Old Testament, Abraham laid down the 'full disclosure' commercial principle.³⁰⁸

The story of Abraham purchasing a burial plot for his wife Sarah is instructive from our ethical viewpoint. The haggling over land takes five steps in Genesis 23: 3 - 20:

³⁰⁸ This genesis of this discussion comes from www.torah.org Business Ethics: The Challenge of Wealth, *Parchas Chayei Sarah, Parchas Metzora, Parshas Shoftim and Responsa-Vayigash*

Step 1: Abraham explains what he needs in vague terms - a burial plot for his wife. He does not stipulate where or exactly what kind of burial plot;

Step 2: The sellers offer 'the choicest of our burial places';

Step 3: Abraham considers this (perhaps even goes on a guided tour of choice burial places) then asks for 'the cave of Machpelah...which is at the end of [the sellers] field', and offers to pay 'full price';

Step 4: The sellers confirm that they have exactly what Abraham wants 'the field and cave that is in it';

Step 5: The buyer and seller ultimately agree on the land and price and transact the purchase in public 'in the presence of the sons of Heth, before all who went in at the gate of his city'.

Note the similarity with health insurance policy sales:

Step 1: the Buyer explains what he/she needs in vague terms - a policy to cover my family's medical needs, perhaps with some specific issues in mind;

Step 2: the Broker says 'we have many quality plans available' and explains them;

Step 3: the Buyer considers several options, then stipulates what he/she wants;

Step 4: the Broker confirms that a specified policy contains the desired benefits;

Step 5: the Buyer enrolls by signing a contract.

It was clear from Abraham's negotiations that he had the opportunity to view the land and cave prior to purchasing. The seller had helped him learn about the land, pointing out the choicest burial place. Indeed, the seller may even have warranted the land: 'none of us will withhold from you his burial place', thereby confirming that this was, in fact, burial property.

The seller apparently understood that Abraham - 'a foreigner and a visitor' - did not know all details about local burial plots. The seller therefore helped Abraham learn everything that he needed to know so he could make a wise, informed purchase.

There was no ambiguity about the land, the location or the use. No confusion about exactly what Abraham bought...because the seller provided such a thorough and detailed education.

The story of Abraham's burial plot purchase shows that the seller has an ethical responsibility to educate the buyer about the product. Abraham was a

foreigner, needing advice about local burial procedures and options, which plot to purchase, etc. The seller provided that education.

The Biblical message: sellers who educate buyers are ethical. This begins the Biblical ethical tradition of full disclosure.

‘Let the Buyer Beware’ is Unethical

The lesson about this transaction? That in the Torah there is no concept of ‘let the buyer beware’. The seller taught Abraham everything he needed to know about local burial plots, made very clear to Abraham exactly what he was buying and made his declarations publicly.

Thus, according to the Torah, the principle of ‘let the buyer beware’ is unethical.

‘Let the buyer beware’ assumes that all parties to a commercial transaction have the same information regarding price, quality, use, location, comparative markets, etc, etc. This was clearly not true for Abraham, the ‘foreigner and visitor’. The seller could have taken advantage of his lack of knowledge to swindle him - but did not. The seller educated the buyer. This is the ethical business lesson of Genesis 23: 3 - 20.

‘Let the buyer beware’ also assumes that all parties have equal abilities to understand the information available. In the Biblical case, Abraham was only able to understand the intricacies of burial plots after being educated by the seller. Is this concept still valid today? Can ‘let the buyer beware’ serve as a valid basis for commercial transactions?

The answer is no. Traditional Torah ethics remain valid today - for two main reasons.

First, sellers and buyers rarely have exactly the same information. The seller generally knows his / her products far better than the buyer. The simple reason: the seller deals in this market - for this product - far more frequently than does the typical buyer.

This was clearly the case for Abraham, whose expertise did not include detailed knowledge of local burial plots. It’s also the case in our industry, where the health insurance broker regularly reads industry information provided by carriers and regulators, for example, while the buyer only purchases health insurance one time per year.

Second, in the real world, sellers can understand their product information far better than the buyer can. This is primarily because the health insurance broker has studied healthcare issues in far greater depth than the typical buyer. Even if the buyer has access to information, he / she often lacks the background and context in which to place that information.

Again, this is similar to Abraham's situation. He was a merchant, with expertise in his own arena - not in burial plots. He was not in a strong position to understand burial plot issues without additional education.

Our clients are similar to Abraham. They are accountants, schoolteachers, fishermen or others, with expertise in their own fields, not healthcare. Lacking the broker's healthcare education and background, they are less able to understand healthcare details and issues than the broker.

Thus for these two reasons - that the broker has better access to product information and a better ability to understand that information - today's health insurance salesperson has an ethical responsibility to educate the client. Just like Abraham's burial plot seller.

Do Your Fellow A Favor

The Torah builds on this concept and goes even further. Halakha or Jewish law forbids the seller from hiding product flaws, and even from creating a false impression. This is covered in the Jewish legal concept of 'mekach taut' or faulty sale. According to this doctrine, the seller is obligated to make full disclosure of any defect in the goods or services sold.

To quote Rabbi Dr. Meir Tamari, an expert on business ethics, 'even where the seller was ignorant of the flaw, the sale may be cancelled' as the buyer cannot be forced to accept a discount as compensation for the defect.³⁰⁹ Thus, the broker who claims 'I didn't know that the policy contained that' has no ethical defense: Jewish law makes the seller responsible to understand fully all the implications of each health insurance policy.

Rabbi Tamari goes even further in a discussion of Parshas Shoftim when he quotes the Rabbis that 'he who does not *do his fellow a favor*, is not of the sons of Abraham' for 'we force one to act contrary to the selfishness of Sodom'.

Now the seller has an even greater ethical burden. Not only must he / she educate the buyer and make full disclosure, but the seller must *do his fellow a favor* and highlight problems with the health insurance policy that may occur - i.e. the broker should protect the client from potential harm due to policy implications.

Why would Jewish law --- which later became Judeo-Christian ethics - place such a burden on sellers?

There appears some thinking that these burdens ultimately work to the advantage of the seller. If all sellers act ethically as described above, then it

³⁰⁹ ibid. Responsa-Vayigash

becomes very easy to sell products to buyers. The reason: buyers would have a very high degree of confidence in the seller's representations.

Business Ethics = Business Efficiency

The Torah equates business ethics with business efficiency. Its ethical standards are really instructions for successful businesspeople.

This approach follows directly from the two fundamental ethical dictates of Judeo-Christian religions described above: 'Do not do unto others as you would not like done to yourself' and 'Love thy neighbor as yourself'.

Effectively, this means sellers should put their long term financial interests ahead of short term profit goals and give clients excellent advice.

In doing this, the Torah advises us to *put business long term financial interests ahead of short term profit goals*.

If everyone followed the Torah's teachings, in other words, we would have a very well functioning business economy. The Torah can be seen as a manual for how to prosper in business. We'll read its various ethical teachings in this light.

Ethical sellers - i.e. those who follow the Torah's teachings - would not have to prove their honesty or credibility. They could concentrate, instead, on selling products. This is very efficient: sellers could focus on their income generating activities (i.e. sales) rather than spending time explaining or justifying their personal ethical standards, or establishing personal credibility. They would thus generate higher incomes.

Abraham's burial plot sellers, apparently, had this credibility, as there is no mention of him searching for other plot sellers. He did not shop around for a 'better deal'. He was - apparently - satisfied with his seller's ethical positions and chose to do business with him.

The religious laws outlined above ultimately work to the seller's advantage.

Efficiency and Health Insurance Sales

Let's apply this standard to health insurance brokers. If we all *do our clients a favor* and warn them about risks of healthcare systemic abuse and excess, then we may help control healthcare inflation. Some studies, most notably from Dartmouth Medical School researchers, suggest that up to 1/3 of all US healthcare provides no discernable benefits to patients.³¹⁰ (We'll return

³¹⁰ Dr. Elliott Fisher, Healthcare in America: Is More Better?, Annals of Internal Medicine, February 2003

to this point several more times in this course.) By ***doing our clients a favor***, we may serve the interests of our entire economy by reducing healthcare costs.

Brokers can 'do your fellow a favor' by, for example, advising clients about systemic abuses, may reduce overall healthcare costs. This addresses considerations listed under the second type of business ethics - social responsibility - described above.

In short, we do well for our clients and do well for our country by doing our clients a favor. We also, according to the Torah, do well for ourselves as brokers by adhering to this ethical standard.

Whose Interests Should the Broker Protect?

This ethical disclosure standard seems to require brokers to act against physician and hospital financial interests by describing policy implications. Providers, under our fee-for-service financing arrangements, have an economic incentive to treat, and often to overtreat - by Dartmouth Medical School researcher's estimates, up to a third of the time. Brokers, under this standard, have the burden of countering these physician economic incentives.

Seen in this light, the Torah's teachings may set up a conflict in our healthcare economy. Let's look at the gray area, in which a subscriber may or may not need treatment, and discuss the economic incentives facing each party. (Ethical discussions always focus on gray areas, as these are the difficult cases. There's no ethical dilemma in an easy or obvious case.)

Providers - physicians and hospitals - have an economic interest in treating and make the most money by providing the most treatment. The lens through which they view the patient may - consciously or unconsciously - include their own financial self interest. 'Patients of this type', they may think, 'often improve with treatment.' When in doubt, our economic system may motivate providers to treat.

Patients with health insurance have little or no *economic* incentive to avoid treatment. They purchased insurance exactly for this situation. They have no (or little, depending on their policy type) out of pocket cost associated with treatment. Even a \$500 or \$1000 inpatient deductible pales in comparison to a potentially life saving treatment, or to treatment that eliminates a chronic pain.

Many patients are in the gray area between definitely needing treatment and definitely not needing. Providers have an economic incentive to treat in the gray area. Patients with insurance have no economic incentive to avoid treatment. This is an uneven playing field and sets up ethical issues for the broker.

In addition, patients who are sick or in pain are often scared and want to trust someone who offers relief. The reassuring physician who counsels ‘I have treated many patients like you successfully’ provides exactly the advice that the patient wants to hear.

Thus, our systematic incentives may induce unnecessary treatment for patients in the gray area. The providers gain, but the patient doesn’t pay.

Who Wins and Who Loses in the Gray Area?

This seems, at first cut, a win-win situation. The provider wins - gets paid. The patient wins - gets better. Even if the patient doesn’t improve much, he/she didn’t pay much. No harm, no foul.

Except for two problems. **First**, in the US, a great deal of care generates ‘no discernable benefit’ according to data provided by researchers at Dartmouth Medical School. Our ‘win-win’ situation, according to the Dartmouth folks, becomes ‘providers win, patients get nothing’ up to about a third of the time.

Those odds might be attractive to patients if medical treatments were risk-free; if we never had treatment complications, then reasonable and rational patients might decide that a 67% chance of improvement is good enough. They might discount the risk of ‘no discernable benefit’ and agree with their physician’s advice to receive treatment.

Unfortunately, however, medical treatments are never risk-free. This is the **second** problem. There are always significant complication risks. Here are two examples. We’ll discuss many more in future chapters:

- Medical errors occur, on average, twice per day for every person in Intensive Care; ³¹¹
- Up to 40% of hospital deaths occur in patients who are not hospitalized for end-of-life issues. ³¹²

Our ‘win-win’ situation has deteriorated. Providers win - they get paid. Patients may not win - and apparently do not - up to a third of the time. But the patients accept all the risk.

³¹¹ Atul Gawande, The Checklist, The New Yorker, December 10, 2007

³¹² Data from Dr. David Pryor, Medical Director of Ascension Health, lecture given 4/7/08 to the Massachusetts Healthcare Council in Waltham, Massachusetts

This is not the business efficiency envisioned in the Torah's ethical discussions. This is very inefficient and unethical: one group in our society (providers) wins with every transaction while another (patients) loses a significant percent of the time.

The Broker's Education Responsibility

What group in our society can counter the providers? Who can give warnings to patients about risk? Who can give unbiased advice to patients about when to trust providers and when not to? Who can act - in Biblical terms - like Abraham's burial plot seller?

We will argue in this course that the broker has these responsibilities. This is a wider definition of broker duties than is currently common in our industry. But it is the definition that follows from the ethical standards discussed in the Torah.

Here's the core of our argument. The knowledgeable, well educated, professional broker understands both the provider's financial incentives and the patient's risks better than does his/her client.

As a result, the broker has an ethical obligation to advise clients about these.

Here are some medical treatment risks:

- Medication errors, that occur, on average, once per day for every person hospitalized;³¹³
- Medical errors, that occur, on average, twice per day for every person in Intensive Care;³¹⁴
- Death - up to 98,000 people die annually due to medical systemic errors;³¹⁵
- Death - 90,000 people die annually from hospital acquired infections;³¹⁶
- Death - some 126,000 people die annually from failure to observe evidence-based medicine;³¹⁷

³¹³ Institute of Medicine, Preventing Medical Errors, op. cit

³¹⁴ Atul Gawande, The Checklist, The New Yorker, December 10, 2007

³¹⁵ Institute of Medicine, To Err is Human, 1999

³¹⁶ Centers for Disease Control and Prevention, 'Morbidity and Mortality Weekly Report 2000';49:149-53

- Death - up to 40% of hospital deaths occur in patients who are not hospitalized for end-of-life issues; ³¹⁸
- Wrong side surgery occurs in 1 out of every 15,000 patients; ³¹⁹
- Excess expense - up to 1/3 of US medical care generates 'no discernable benefit'; ³²⁰
- Unnecessary tests and treatments may lead to 30,000 deaths each year; ³²¹
- 1 in 10 Massachusetts community hospital patients suffered 'serious and avoidable medication mistakes' in the early 2000s, leading to 4 extra days in the hospital. 'Serious errors' included the patient receiving a drug when his / her personal medical files recommended against, or drug doses that exacerbated a medical condition. ³²²

Here are some treatment variation risks:

- Prostate testing vs prostate mortality: Between 1987 - 1997, men in Seattle were 5x more likely to get a PSA test than men in Connecticut, and 5x more likely to undergo prostate removal surgery. But there was almost NO DIFFERENCE in death rates from prostate cancer... except that the Seattle men were SLIGHTLY MORE LIKELY to die of prostate cancer than Connecticut men, perhaps due to the increased rates of treatment.³²³ The men in Seattle were also more likely to suffer impotence and incontinence as a result of the unnecessary surgery;

³¹⁷ RAND Corporation, First National Report Card on Quality in Health Care in America, page 4.

³¹⁸ Data from Dr. David Pryor, Medical Director of Ascension Health, lecture given 4/7/08 to the Massachusetts Healthcare Council in Waltham, Massachusetts

³¹⁹ Institute of Medicine, Preventing Medical Errors, 2007

³²⁰ Dr. Elliott Fisher, Healthcare in America: Is More Better?, Annals of Internal Medicine, February 2003

³²¹ Shannon Brownlee, op cit. page 6

³²² Boston Globe 2/14/08, page A9. This conclusion was drawn largely from a PricewaterhouseCoopers financial analysis of Massachusetts community hospitals

³²³ ibid page 201.

- Who you see is what you'll get. Dr. Richard Deyo, a back expert at the University of Washington, discovered that people with back pain received very different treatments - depending on which medical specialist they visited. Rheumatologists tended to give blood tests - to look for rare immunologist disorders. Neurologists looked for nerve damage. Surgeons ordered MRIs and CT scans to check on bones and soft tissues. In other words, **specialists treated according to their expertise, more than according to patient need;**³²⁴
- Conclusions from the Back Pain Patient Outcomes Assessment Team: 'There is no evidence that spinal fusion is superior to other surgical procedures for common degenerative spine conditions. Patients who undergo spinal fusion have more complications, longer hospital stays and higher hospital charges than do patients undergoing other types of back surgery.' These conclusions were published by the Back Pain Patient Outcomes Assessment Team in 1994. Yet the rate of fusion surgeries tripled between 1997 and 2007. One possible reason - it's quite lucrative;³²⁵
- Surgical rates vary geographically. Gall bladder removal rates vary up to 270% comparing 1 US region to another; hip replacement rates vary up to 450%, intensive care hospitalization rates during the last 6 months of life vary 880%. Doctors in Santa Barbara are 5x more likely to recommend back surgery than doctors in Bronx, New York;³²⁶
- Medicare beneficiaries in Fort Myers Florida were twice as likely to have back surgery (6.9 surgeries per 100K beneficiaries) than Medicare beneficiaries living 3 hours away in Miami (3.2 surgeries per 100K beneficiaries). There was no evidence of epidemiological differences - people with bad backs don't flock to Fort Myers, while people with strong backs go to Miami. The question: between 1992 - 2001, did Fort Myers perform 4800 unnecessary back surgeries, at a cost of \$2 billion - and put these people at increased risk for complications?³²⁷

³²⁴ Shannon Brownlee, Newtnered, Washington Monthly, October 2007

³²⁵ www.ahrq.gov/CLINIC/medtep/backpain.htm . The rate data from ibid

³²⁶ See Dartmouth Atlas of Healthcare

³²⁷ Washington Post, When Geography Influences Treatment Options, July 24, 2005, page A12

We could go on and on. But this list provides an indication of the magnitude of medical risks. Clearly, these risks are worth taking for people who absolutely need medical care.

But these risks are excessive for folks who don't need care - those who undergo unnecessary treatments.

Is it enough simply to describe the health insurance policy in detail?

Such a description would include a discussion of copayments and deductibles, pre-existing condition exclusions if any, available providers, prescription drug coverage, price etc and then show alternative products and describe them.

Though this may satisfy some customers, it does not satisfy the Torah's ethical requirement.

The broker also has an ethical responsibility to describe policy implications and healthcare systemic problems that may harm the customer.

How Much Should Brokers Disclose?

The question posed by Rabbi Tamari in *Parchas Shoftim* above, in the discussion of *do the fellow a favor* remains: **How much should a seller disclose about a product to a customer?**

Tamari starts with the religious doctrine of *Mekach Taut* or faulty sale, discussed above. That's the doctrine requiring full disclosure of any defect in the goods or services sold, and a cancellation of the sale due to product defects *even if the seller was ignorant of the flaw at the time of sale*.

It is unclear from Genesis 23 exactly how much information Abraham's burial plot seller provided. He apparently provided a great deal, and probably all that was necessary in that circumstance. But we get into a gray area when applying the lessons of Genesis to more complicated transactions, like health insurance policy sales.

Is it a 'product defect', for example, if one type of health insurance policy - say, a PPO - leads to unnecessary care more often than another type - say an HMO? The answer: we don't know. The Torah seems vague on the issue of 'how much information must the seller provide'.

That's why the Rabbis expanded their discussion to include *do the fellow a favor*. Now we have the ethical tools to address this question.

Different Types of Health Insurance Policies May Lead to Different Types of Treatment

Some policies promote excess treatment implicitly, by offering large provider networks and allowing easy access to specialists and easy referrals. This can feed into the provider's economic incentive to treat. Other policies are more restrictive in terms of network size, ease of access and ease of referrals.

Health insurance policies with larger networks and fewer restrictions implicitly induce more unnecessary care and may cost more and ultimately cause more patient harm than more restrictive policies.

The broker is not 'ignorant of this flaw' and has an ethical obligation to 'do the fellow a favor' by explaining this to clients. This follows directly from Biblical teachings.

Brokers should advise clients about risks of unnecessary care from certain types of health insurance policies.

How much of this information should the broker tell the client? When - if ever - should the broker advise a client against policies with large provider networks and few referral restrictions?

Conventional wisdom says this is not the broker's responsibility - that medical decisions should be made between the doctor and patient. The broker's traditional role is limited to providing healthcare financing - insurance coverage - and then stepping back. Brokers should have no role in medical decisions: the broker is not a trained medical professional, does not know the current medical technologies, does not know which surgeons are good and which poor, etc. The broker's role should be limited to selling insurance policies honestly.

Conventional wisdom may be wrong. The broker may have an ethical responsibility to 'do his fellow a favor'. Here's why:

Our fee-for-service healthcare finance system pays medical providers based on the number of treatments they perform, not on the quality or applicability of those treatments. Physicians and hospitals have an economic incentive to provide as much treatment as possible, not as little. The more tests and procedures they perform, the more they will get paid.

Our healthcare financing system does not have any counterweight to the provider's incentives to provide excess medical care. Physicians can too easily use their knowledge and prestige - at a time when the patient is sick or frightened - for their own financial gain.

The patient rarely wants less care - after all, he / she has purchased insurance that pays all, or almost all, medical costs. It is too easy for the

patient to acquiesce to the physician's advice ---- advice that serves the financial interests of the physician. (Of course physicians also provide good medical care. That is given. But ethical discussions take place at the boundaries, not the center, of normal activities.)

Excess and unnecessary treatments can cause harm. We touched on some indicators of this, above.

The broker has an ethical responsibility to advise clients about these risks.

Conclusion

The Torah apparently reasons that a knowledgeable broker is not 'ignorant of the flaw' of overtreatment and has an affirmative ethical responsibility to 'do the fellow a favor' and advise against the costs and risks of overtreatment.

What do you think? Should brokers warn clients about the risks of overtreatment? If you were a client, what would you want your broker to advise you?

Chapter 17: Excess Treatment Costs and Harms: Coronary Problems at Centers of Excellence

Do Hospital Financial Interests Always Coincide with Patient Health Interests?

‘I sometimes just shake my head at the American system, where the financial intent is almost cleverly designed to create mischief. For administrators, it creates a conflict of interest when they’re trying to deliver the numbers at the same time that doctors are saying the hospital is doing too much cardiac surgery.’ Princeton Health Economics Professor Uwe Reinhardt ³²⁸

Hospitals need to earn money - to expand, to pay investors, to attract top talent, to keep current with technologies, and for many other reasons. In our fee-for-service financing system, hospitals are financially induced to invest in the most profitable procedures; like all income generating enterprises, they seek the best margins. And they invest to gain the greatest return on investment --- that’s called capitalism.

Hospitals know that, based on Medicare and other insurance payment systems, the following services are most profitable so they invest the most in these: ³²⁹

- Cardiology
- Neurosurgery
- Orthopedics
- High end imaging (CT scans and MRI)
- Bariatric surgery
- Cancer

Far less profitable - indeed, often unprofitable - services include:

- Psychiatric wards

³²⁸ Quoted from Kurt Eichenwald ‘Operating Profits: Mining Medicare – How One Hospital Benefited from Questionable Surgery’ New York Times, August 12, 2003.

³²⁹ This list and subsequent discussion comes from Brownlee, op cit. page 82

- Emergency medicine
- Medical wards dealing with chronically ill patients

One study of California emergency rooms indicated that hospitals lost an average of \$84 per patient who was seen but not admitted. (That seems a pretty good financial incentive to admit.)

Cardiac surgery is particularly profitable. A 2002 MedPAC study indicated that hospitals made an average profit of \$9600 per bypass patient. Heart valve replacements generated about a 60% profit margin. Hospitals earned about \$20,000 per angioplasty, about 40% of which was profit.³³⁰

On the other hand, treating heart attack patients with medication generates about an 11% operating loss per patient. Where would the smart hospital administrator invest?

Remember that hospitals earn money by treating patients. The more treatment they provide - and the longer the treatment takes - the more money they'll make.

Duke University Medical Center Does It Right - But Loses Money

Duke University Medical Center learned this lesson the hard way in 1995. They had implemented an aggressive coronary patient service system to ensure that patients followed all appropriate procedures. Nutritionists checked on patients nutrition programs, nurses verified that patients took the right medications, doctors designed new and improved procedures.

Annual treatment costs per patient declined by almost 40%. As Harvard Business School Professor Regina Herzlinger summarizes:

Duke's new model achieved these cost reductions by improving participants' health status - hospital admissions and lengths of stay dropped.³³¹

The net result? As the number of coronary admissions fell and patients spent less time in the hospital, Duke lost money.

³³⁰ See Liz Kowalczyk, Small Hospitals Battle for Right to Do Angioplasties, Boston Globe, Feb 13, 2005 and Richard Lange, et al, Use and Overuse of Angiography and Revascularization, New England Journal of Medicine 338, no. 25 (1998) pages 1838-39

³³¹ Regina Herzlinger, Who Killed Healthcare?, McGraw-Hill 2007, page 78

Terry Langbaum, a senior financial officer at Johns Hopkins Medical Center in Baltimore, explains how a hospital views various medical treatments. (Note that cochlear implants were not profitable at the time of this quote due to carrier reimbursement practices, but cancer treatments were):

Would we want to grow the cochlear implant program? No. Are we going to advertise it? No. But we make money taking care of [cancer patients]. Are we trying to grow those programs? Yes.³³²

So they advertise their wonderful cancer programs. The hospital investment criteria: servicing its bottom line.

Let's summarize to this point: hospitals and physicians have an economic incentive to treat. They have no economic incentive to avoid treating. So a patient who presents in the gray area, between needing treatment or not, may receive unnecessary care - which may lead to the complications.

Further, the hospital makes more money with certain types of treatments than others - so has an economic incentive to recommend those treatments. Hospitals make more money from angioplasties than from medication treatments, so have an economic incentive to promote the former. Hospital administrators and physicians typically know this.

The patient, meanwhile, doesn't know all this, but trusts his / her physician to work in the patient's best interests. Is this trust always warranted?

Let's consider what happens when the hospital bottom line contradicts patient needs.

Cardiac 'Centers of Excellence' May Not Always Serve Your Clients Best

Cardiac catheterization involves inserting a wire through the patient's femoral artery into the heart. These are often done during a heart attack - on about 800,000 patients annually.

Sometimes catheterization is done electively or preventively - on about 1.2 million of us annually. Cardiologists perform these procedures on patients suffering from shortness of breath, stable angina or similar....or on patients who appear to have plaque built up in their arteries. Cardiologists may perform angioplasties - insertion of a balloon that inflates and crushes plaque against an artery wall. They also sometimes insert stents to keep the artery open.

About 14% of these angioplasty procedures - some 170,000 annually - are 'inappropriate' meaning they should not have been performed.³³³ Another

³³² Brownlee, op cit. page 86

500,000 are of 'questionable value' - not quite inappropriate, but probably not necessary either. ³³⁴ Some 10% of CABG - Coronary Artery Bypass Grafts, more commonly known as bypass surgery - about 40,000 annually - were also 'inappropriate'.

These procedures carry a mortality risk, estimated at about 1 - 2% of bypass surgeries...or potentially 14,000 annual deaths due to unnecessary CABG surgeries annually!

Though the rate of these preventive procedures has skyrocketed over the past 15 or so years, our rate of heart attacks has not decreased.

The reason: heart attacks are caused when a plaque bursts, forming a clot that blocks blood flow to the heart. Some 75 - 80% of the time the erupting plaque was not obstructing an artery, so would not have been stented (or bypassed). Heart attack patients may have hundreds of these vulnerable plaques - which would, theoretically, require hundreds of angioplasties and stents. That's why cholesterol controlling medications often generate better outcomes. ³³⁵

But here's what happens in hospitals, according to Dr. David Hills, an interventional cardiologist in Dallas:

If you're an invasive cardiologist and Joe Smith, the local internist, is sending you patients, and if you tell them they don't need the procedure, pretty soon Joe Smith doesn't send patients anymore. Sometimes you can talk yourself into doing it even though in your heart of hearts you don't think it's right. ³³⁶

So a patient with a vague complaint gets a scan - which indicates a plaque build-up or artery narrowing - and gets referred to a cardiologist. The cardiologist performs the angiogram and, sure enough, confirms the scan findings. Unfortunately, according to Gina Kolata, the well known science reporter for the New York Times

³³³ Schneider, et al, Racial Differences in Cardiac Revascularization Rates: Does 'Overuse' Explain Higher Rates among White Patients?, Annals of Internal Medicine, September 4, 2001, Volume 135, Issue 5, pages 328-337

³³⁴ Brownlee, op cit. page 99

³³⁵ Gina Kolata, New Heart Studies Question the Value of Opening Arteries, New York Times 3/21/04

³³⁶ ibid

Since most people who are middle-aged and older have arteriosclerosis [plaque build-up], the angiogram will more often than not show a narrowing. Inevitably, the patient gets a stent.³³⁷

Or, depending on perceived severity or physician disposition, a bypass.

This mirrors Dr Talcott from Massachusetts General Hospital (above) who claimed ‘the more you test, the more you find’.

Patients too often want the highest technology treatments and question cardiologists who defer or refuse to treat. In our society - too often - they simply go elsewhere.

But the general data discussed above hides two significant other patient risks.

The first risk: hospitals performing low volumes of these procedures have higher mortality rates than hospitals performing high volumes. The American College of Cardiology and American Heart Association, for example recommend that hospitals perform a minimum of 400 angioplasty procedures annually to maintain the highest level of quality. Several studies have shown that patients have more complications at hospitals performing fewer than 200 procedures annually, with mortality rates increasing as volumes decreased.³³⁸

Similar data indicates that CABG procedures performed at low volume hospitals generates higher mortality rates. Indeed, the Leapfrog Group - odd name for a good research group - recommends a 450 minimum number of CABG procedures annually per hospital to keep mortality rates low.

Many US hospitals do far fewer than Leapfrog’s minimum. Some do as few as 1 CABG per week. You can look up some of your local hospitals on the Leapfrog Group website, www.Leapfroggroup.org . As you do this research, ask yourself how much of this information you should share with your clients. Should you ‘do your fellow a favor’? Or just keep quiet and let the doctors advise? What would you want your broker to tell you?

The second risk: geography. A detailed 1990s study led by Eric Topol of Scripps Clinic in California, indicated that cardiac treatment rates differed by region.³³⁹ Patients were least likely to get angioplasty or CABG in New England or California, but most likely to get these treatments in the central part of our

³³⁷ ibid

³³⁸ See Magid, et al, Relation Between Hospital Primary Angioplasty Volume and Mortality...’ JAMA, Vol 284, 2000, pages 3131-3138

³³⁹ This section comes from Brownlee, pages 107 - 109

country - Texas, Oklahoma or Louisiana for example. Treatment variations were unrelated to underlying health differences.

But treatments correlated almost perfectly to locations of cardiac catheterization labs --- often called 'Centers of Excellence'. (New England was the only exception to this rule.)

In other words the more catheterization labs available in a region - i.e. the more Centers of Excellence - the more frequently patients underwent invasive cardiac treatments. Cath labs are special facilities designed for invasive heart procedures.

But there is no difference in coronary mortality rates among regions with more cath labs than with fewer! The providers got paid, but the patients took on all the risk.

Though these procedures doesn't necessarily help the patient, they certainly benefit the cardiologist and hospital. In 2006, Medicare paid the physician about \$1800 to catheterize a patient, plus \$800 for the first stent insertion and about \$200 more for every additional stent.³⁴⁰ The hospital received additional fees, often a very profitable \$20,000.³⁴¹

What's a Center of Excellence?

We have no clinical definition of Center of Excellence. No minimum number of procedures, minimum number of cardiologists, required technologies, minimum mortality rates, etc. We have precious little meaningful outcome data by hospital, by surgical team, by procedure, etc.

So here's what a cardiac 'Center of Excellence' means. A hospital invests in high technology coronary facilities - cath labs - which it calls a 'Center of Excellence' and advertises as state-of-the-art. Perhaps it recruits cardiologists to attract referrals also. These are exploratory facilities, designed to perform preventive procedures if / when they discover dangerous levels of plaque in patients.

But most middle aged patients have artherosclerosis - it's a normal part of aging. So as the Center of Excellence performs more scans and angiographies, it sees more plaque in patients, then advises more invasive procedures.

Center of Excellence is a marketing, not a clinical term. Hospitals performing low volumes of angioplasties or CABG may advertise themselves as 'Excellent' to attract patients. Why not? It attracts patients.

³⁴⁰ Brownlee, op cit.

³⁴¹ Kowalczyk, op. cit.

Here's what a Center of Excellence is not (generally). A facility that advises and monitors patients on lifestyle changes necessary to reduce their risks of coronary problems and keep them out of the hospital. A facility that uses medication first and invasive cardiac technologies only if medication fails. A facility that integrates lifestyle (diet and exercise) with medication over a long time period to reduce the risks of heart failure. In short, a facility like Duke Medical School in the 1990s that actually reduced the need for coronary care.

Instead of this, 'Center of Excellence' too often means 'Center of Profit' for the hospital. The Center's method of generating profits: failure to prevent heart attacks via diet, exercise or patient lifestyle change - and then use of the most profitable interventions on the patient.

The hospital's financial interest may diverge from the patient's good health interests.

How does the ethical broker approach these issues?

The ethical, informed broker understands three conflicting consumer trends:

First, the trend of consumers to demand easier access to specialists from carriers with wider provider networks;

Second, in the absence of clear, understandable outcome data, the trend for consumers to equate provider name recognition with medical quality (i.e. teaching hospitals affiliated with prominent universities are often perceived as better than community hospitals);

Third, the trend for consumers in PPO or POS types of plans to overuse cardiac services - generally testing services - often to their detriment.

Let's remember the ethical basis of this chapter: that the ethical broker is not 'ignorant of the flaw' and should 'do the fellow a favor'. In our case, that means advise clients of the risks associated with these three trends.

Remember the policy sales landscape: consumers look to their physician for medical advice. The physician functions under a set of financial incentives that may run counter to the consumer's best interests. The broker is the only party that can advise consumers how much to trust their physician.

Brokers can present their clients with the following types of information:

- Number of angioplasties performed by each in-network hospital annually, as reported by the hospital;
- Number of CABG performed by each in-network hospital annually, as reported by the hospital;
- Number of procedures reported by the Leapfrog Group, along with Leapfrog's recommendations for minimum number of procedures annually;
- Rate of 30 day readmissions for cardiac treatments;
- Success rates of angioplasty compared to medication treatments (note: if a hospital cannot provide this data, include it in your report. Shows your clients how responsive the hospital is.)
- Number of cardiac treatments by cardiologist annually

Providing this information to your clients, along with the standard policy terms, restrictions and premium prices, will comply with the Torah's ethical dictates. The reason: you have 'done the fellow a favor'. You have helped your client understand relevant issues about choosing a cardiologist, a hospital and a treatment protocol.

By actively educating our clients about cardiac treatments, procedures and incentives, the ethical broker avoids exploitation through silence.

The ethical broker educates him / herself about cardiac procedures and treatments and stays up-to-date with treatment trends and data. He / she then provides this data to clients and helps them make informed choices. That's what the Torah recommends.

Do you agree? Should the broker use his / her knowledge about our healthcare system to help his or her client?

Or should the broker simply develop a spreadsheet of policies, provider networks and costs, and then let the client make all decisions?

Chapter 18: Are Teaching Hospitals Always Best?

a.k.a. What should an ethical broker respond when the client says 'I want treatment at a famous university-affiliated teaching hospital'

Health insurance premiums are outrageously expensive today - and will be even more expensive tomorrow.

One way to reduce premium costs: limited network plans. These often exclude the most famous - and most expensive - teaching hospitals. Clients often perceive access to these as necessary, and perceive policies that reduce access as inferior.

Carriers understand this. Sometimes they offer policies with narrow networks - without access to the famous local teaching hospitals - at a substantial discount. Most Americans, traditionally, have chosen the wider-access policies, even at the higher cost.

Is this always a wise decision? What advice should the broker offer? Does the broker have an ethical responsibility to advise clients one way or the other?

This section will look at these types of decisions. We'll *first* discuss why purchasing health insurance (healthcare) is fundamentally different from purchasing other goods and services. This difference places ethical responsibilities on health insurance brokers that other salespeople - for other products - do not share.

Second, we'll look at some special and specific operational issues involving teaching hospitals. We'll look at **technologies available at teaching hospitals** compared to community hospitals to determine which provide better patient outcomes.

We'll then look at **the impact of teaching on patient care** - specifically at the role of residents in treatment. We'll show how the teaching function may actually harm patients.

Third, we'll look at how **the constant upgrading of technology may increase patient mortality**. Teaching hospitals often pride themselves on offering the newest and greatest available technologies. This may not always be a good thing for patients.

Why buying healthcare differs from buying cars

Buying healthcare is fundamentally different from buying other goods and services in our economy ---- cars, tennis racquets or tuna fish, for example.

When we purchase these types of products, we know a great deal about the product's quality. A Lexus vs a Subaru. Solid white tuna vs chunk light. But we don't have this information in healthcare.

As we go through this discussion, consider the ethical implications for health insurance brokers. As a general rule, people selling other goods and services have a lower ethical bar. The reason: consumers have easier access to information about other goods and services than they do about healthcare.

Thus the Torah's requirement that we 'do our fellow a favor' is far more important in the health insurance field than in other markets.

The role and availability of critical information in healthcare

We typically know a great deal about a car, for example, before we purchase it. We know the color, condition and style --- all pretty obviously --- and can decide if we like them.

We also know various safety and economic indicators about the car. We know - or can very easily learn - the crash test rating, the estimated resale value and operating costs - miles / gallon, manufacturer's warranty, etc.

We can get this information not only about the car we're considering purchasing, but also about other vehicles, so we can choose among cars based on various quality measures.

We - Americans - are used to comparison shopping for goods and services. We do it for almost all goods and services that we purchase. But we cannot comparison shop for healthcare like we shop for other products. We cannot shop for medical quality because we rarely know it. We often use hospital name and university affiliation as proxies for hospital quality.

We typically don't choose a provider based on comfort or style --- medical services are not promoted based on any type of customer service model developed by other industries. (Would that it was...we might have better healthcare.)

We typically don't choose a provider based on quality data for this very rarely exists in healthcare. Sample hospital quality questions:

- What is the 30 day readmission rate per surgical team, for each type of operation performed in a specific hospital?
- What is the patient infection rate in competing hospitals ... or on various floors of a hospital...or by various procedures?
- What is the mortality rate / failure rate by surgical team, for a specific procedure?

Even when choosing a primary care physician, we rarely shop wisely. Ask yourself about your PCP:

- Is he / she aggressive, perhaps referring unnecessarily to specialists? Or conservative, suggesting we watch and wait before referring? Which approach is 'better' - i.e. generates the best results? Which suits your personality better?
- When referring, does your PCP prefer aggressive specialists who operate as quickly as possible ---- or conservative specialists who understand surgical risks and operate only as a last resort?
- Do the specialists that your PCP recommends test appropriately? Do they overtest, perhaps letting their financial interests (consciously or unconsciously) influence their judgement?
- Does your PCP prescribe medications over the phone, without seeing you? Is this good --- by getting you treatment without an unnecessary trip to the doctor? Or bad, by prescribing medications without seeing you - and perhaps missing something critical?

Most typically, our clients tell brokers that they trust their PCP. When questioned, however [we do this in live lectures] few could answer any of these questions. The reason: the data don't exist.

So in healthcare, we use proxy information for quality - including reputation and name brand. 'University affiliated teaching hospital' sounds more impressive than 'local community hospital'. We apparently believe that the smartest or 'best' physicians have university affiliations. They're more current on the literature it would seem, more fluent with cutting edge research and better able to treat our medical problems.

In our insurance brokerage business, we regularly hear from clients who demand access to the famous Boston area teaching hospitals...but virtually never from clients who demand access to a particular local community hospital.

Our client's underlying assumption: the teaching hospitals are better, so will provider better care and better outcomes.

Let's evaluate these assumptions, and then ask what ethical responsibilities the broker has to disclose information to clients.

We'll look at three issues that university affiliated teaching hospitals face and then pose the disclosure / ethical questions to brokers.

Three Unique Issues that Teaching Hospitals Face

Issue 1: Levels of technology available at teaching hospitals may not correlate with better outcomes.

Most healthcare commentators recognize that new surgical techniques and medical treatments are generally introduced at teaching hospitals. The reason: these hospitals have closer / easier access to medical researchers and are in the best position to try experimental types of treatments.

These new and improved treatments often save lives, particularly for patients presenting with rare or difficult to diagnose / treat conditions. But they may not be the best places for routine, preventive or chronic care.

Here's the problem: we lack evidence that teaching hospitals generate better outcomes for routine procedures than do community hospitals. Indeed, teaching hospitals may be more focused on teaching and research than routine procedures, and may not perform the volume of routine treatments necessary to achieve excellence.

They may be better as back up, for acute cases with unique problems, rather than as facilities for routine care or non-controversial treatments.

The critical variable that affects outcomes is **hospital experience with a particular treatment** - not level of technology available. Studies have shown that hospitals with newer technologies but less experience generate poorer outcomes than hospitals with less robust technologies and more experience.

A case in point: number of Coronary Artery Bypass Graft procedures performed by various hospitals. The Leapfrog Group lists the number of these procedures performed by various hospitals annually. See discussion above.

Note the almost perfect correlation between results and number of CABG procedures performed. Hospitals performing more than about 300 procedures almost uniformly produce 'above average results', while hospitals performing fewer than 100 procedures almost all report 'below average results' or 'results data unavailable'...regardless the technologies available.

Patient outcomes are generally more a function of physician/hospital experience with a procedure than of the level of medical technology available. Hospitals with the same technologies may generate discrepant outcomes, as in the care of Heart Transplant procedures (below).

A second case in point: mortality rates from heart transplants. Many if not most in the early 2000s took place in teaching hospitals. But mortality rates varied greatly depending on frequency of treatment. Here's the data:

Heart Transplant Mortality Rates ³⁴²

	Number of heart transplants performed annually in each facility surveyed	
	<u>Less than 18 transplants annually</u>	<u>More than 50 transplants annually</u>
Total number of facilities surveyed	63	6
Approx annual # of transplants performed in these facilities	630	425
% of facilities with 1 yr patient survival rate average less than 80%	52%	0%

Experience matters.

But this gets worse. Remember the Duke University Medical Center discussion above. Duke learned that providing good preventive and follow up care reduced the number of patients and length of patient stays --- and reduced hospital income. Good healthcare for patients was bad financial care for the hospital.

Other university affiliated teaching hospitals may have learned from Duke. What have they learned? There are two potential lessons. First, that good preventive and outpatient care keeps people healthier and out of the hospital. Second, that such care reduces hospital income.

The lesson from Duke may be: follow the traditional hospital business model more closely. Treat sicker patients for longer to improve hospital finances. Invest more in technology - and less in prevention and patient follow up - and make more money.

Which Duke lesson did your local hospital learn? The first - that better care improves patient lives - so it improves care? Or the second - that better care harms hospital cash flow - and invests accordingly?

The ethical broker should check two important variables before advising clients to use famous local hospitals. First, the broker should determine treatment volumes. Start with the Leapfrog Group website and proceed from there.

Second, the broker should determine the level of patient services. Check the average length of patient stays and compare this data to national averages.

³⁴² Porter and Teisberg, Redefining Healthcare, Harvard Business School Press, 2006, page 50. Data from 2001. Some estimates by GF.

Also check the rate of hospital readmissions and compare that to national averages.

(Some people argue that increased readmission levels indicate that teaching hospitals serve sicker patients. This may be true - though objective data is very difficult to obtain. If true, however, it simply makes our point: that teaching hospitals specialize in difficult cases, not routine. It may make much more sense to use community hospitals for routine care.)

There are many other variables to consider before determining that a particular hospital is 'outstanding'. The *Economist*, for example, in its major April 2009 report on Healthcare and Technology, claims that the quality of the hospital's information technology system is critical. The *Economist* argued that a top-notch hospital IT system, combined with specialization and high volumes, can outperform low volume hospitals that have mediocre IT systems but outstanding medical technologies.³⁴³

Only after doing your homework, can an ethical broker advise patients which local teaching hospitals actually justify their reputations...and justify the higher prices they tend to charge carriers.

Issue 2: Teaching Hospitals Use Interns and Residents.

Atul Gawande's brilliant essay 'Education of a Knife' describes the role that residents play in teaching hospitals.³⁴⁴

Gawande wrote this deeply personal article about his first weeks as a surgical resident. He describes the difficulty the first time he inserted a line into a patient's vena cava. He missed on his first two attempts - fortunately, not collapsing a lung or lacerating a blood vessel - but fumbling around, hurting the patient, and ultimately allowing a more experienced physician fix the problem.

Gawande continues, and describes his second line insertion - unfortunately, no more successful than his first. This time he missed several times, the patient's chest turned black and blue, and she ended up with a hemotoma --- all from the surgical resident's mistakes.

It took until the third patient for Gawande to insert a line correctly - 'I still have no idea what I did differently that day.' But several weeks later he thought back over the first 100 lines that he inserted:

³⁴³ 'Lessons from a Frugal Innovator' *Economist*, April 18, 2009, page 67

³⁴⁴ Atul Gawande, *Education of a Knife, Complications*, Picador, 2002

I am by no means infallible. Certainly, I have had my fair share of what we prefer to call 'adverse events'. I punctured a patient's lung, for example...

While learning the trade, resident surgeons 'assist' in surgery. Though the attending physician directs the surgery

To say I just assisted remains a kind of subterfuge. I wasn't merely an extra pair of hands...I was there to practice.

What happens when a resident's need for practice and experience affects surgery? Gawande describes reconnecting a colon during residency.

It turns out that there are two ways to reconnect a colon. You can staple the ends together or sew them. Stapling is swifter and easier

But the attending suggested I hand-sew the ends - not because it was better for the patient but because I had done it few times before.

Gawande continues:

My stitching was...imprecise. [I put] stitches too far apart.

The attending surgeon made him put in extra stitches so the connection would not leak.

Certainly the patient's right to the best possible care always supercedes the training needs of young doctors. But we also need to train young surgeons. Having young surgeons practice under the watchful eye of the attending is clearly necessary.

But remember our ethical disclosure question: when should brokers advise their clients to use famous teaching hospitals?

Gawande himself helps answer that question. His then infant son needed cardiac surgery followed by ongoing treatment from a pediatric cardiologist. Gawande knew all the hospital's cardiologists. Which did he choose? He had several options.

One option was the physician who correctly diagnosed his son's condition - the fellow who put in the most time caring for his son, coordinated his son's care, visited his son every day to check up and answer questions. Did Gawande chose this fellow?

No - that was a resident. Instead, Gawande chose the hospital's associate cardiologist in chief. The reason: she had more experience. As he says

I know this was not fair...But I was not torn about the decision...Given a choice, I will always choose the best care I can for [my child]. How can anybody be expected to do otherwise?

He fell back, perhaps, on the experience of others in his position. One in a similar position was a health policy expert, important in the hospital hierarchy. Gawande one day noticed a picture of a young baby in the expert's office. 'Did you let a resident deliver the baby?' Gawande asked.

'No. We didn't even allow residents in the room.'

Hospital data probably shows that residents did not work on the most famous, celebrity patients - though this information is undoubtedly not available to the general public.

Issue 3: Learning New Technologies

Here's another hidden truth about our healthcare system. Physicians get frighteningly little training in the use of new technologies. New technologies and treatments emerge constantly, and physicians - somehow - are expected to master these.

Let's let Atul Gawande lead us through this discussion also. ³⁴⁵

'Three quarters of what I do today I never learned in residency' says his father, a urologist. Working alone, miles from others in his specialty, he had to learn to put in penile prostheses, to perform microsurgery, to reverse vasectomies, to implant artificial urinary sphincters, to use shock-wave lithotripters, electronhydraulic lithotripters, laser lithotripters and dozens of other techniques and technologies. Only some of these were related to things he had studied in medical school.

Many of today's technologies were not even imaginable when our current crop of surgeons was in medical school.

To learn a new treatment or technology, typically surgeons take a one or two day course offered by the equipment manufacturer. They may participate in or watch an operation. 'See one, do one, teach one' goes the surgical training mantra - so surgeons had better be quick studies.

³⁴⁵ ibid

After observing an operation they go home. Sometimes they watch an educational video. Sometimes they read additional articles. Then - maybe before they're comfortable and feel ready? - they operate on a real person.

Unquestionably, the first 'guinea pig' faces risks that later patients do not. How much risk?

This question was addressed in the British Medical Journal in 2000, in an article entitled 'Scientific, ethical and logistical considerations in introducing a new operation: a retrospective cohort study from paediatric cardiac surgery'. This article summarized Great Ormond Street Hospital's (London) experience introducing a new surgical technique to repair infant heart defects.³⁴⁶

Researchers studied the mortality rates from 325 heart operations using the (older) Senning technique, and 100 operations using a new arterial switch technique that offered various longevity benefits. Both procedures were extremely complex.

The operative mortality rate using Senning was about 6%. But the operative mortality rate using the new procedure was 25% for the first hundred patients. In other words, **nineteen additional infants died so surgeons could develop familiarity with the new techniques and procedures!**

The British Medical Journal summarized its findings:

If early risk alone had been considered, the arterial switch operation (which had a higher early mortality when first introduced) might have been abandoned.

Once surgeons gained familiarity with the new technique, the mortality rate dropped - only 5 infants died during the next 100 operations.

Why change treatments in the first place?

This study shows that the theoretical rationale based on life expectancy projections used to justify the change from a Senning to a switch policy has been corroborated by the outcomes obtained so far in practice.

Corroborated perhaps for the survivors - but would the 19 additional dead infants (or their families) agree?

How does this relate to teaching hospitals and to the ethical responsibilities brokers have to their clients?

³⁴⁶ Bull, et al 'Scientific, ethical and logistical considerations in introducing a new operation: a retrospective cohort study from paediatric cardiac surgery, British Medical Journal 2000; 320: 1168 – 1173 (29 April). See also Gawande, *ibid*, pages 27 and 28.

Brokers, we have argued, have a responsibility to inform their clients of medical risks. Here, clearly, they should inform clients that hospitals that keep current on technologies and treatment techniques pose certain risks - specifically the risks that surgeons will have insufficient practice or familiarity with the new treatment. Some clients may suffer accordingly.

Ethical brokers, however, can mitigate this risk by learning about hospital procedures.

Hospitals purchase new technologies for several reasons. Sometimes they purchase to keep up with their competitors - for marketing and referral reasons. (I once spoke with a noted Boston area surgeon who complained that his hospital had just purchased a new robotic type surgical machine for \$1 million. 'It doesn't do a better job than me - but the hospital across town just bought one, so we had to.' I wondered about his learning curve on this new machine.)

This is sometimes called the Medical Arms Race - hospitals purchase the newest available technologies to avoid falling behind in the competitive physician referral business.

Sometimes also hospitals may purchase to keep current with new technological developments.

And sometimes hospitals may actually perform the longevity benefit analysis discussed in the British Medical Journal above.

The ethical broker should learn which purchase criterion their local teaching hospital uses and advise clients accordingly. In the third case above - where the hospital purchased new technologies based on expected longevity gains - a slight increased operating mortality risk may be justified, so long, of course, as the client understands this.

The mortality risk increase is clearly NOT justified when a hospital purchases new equipment simply to participate in the Medical Arms Race - i.e. to enhance it's own position in the market.

Which criterion does your local teaching hospital use? How will you - an ethical broker - obtain the necessary information to advise clients? What will you advise clients who insist on having the local teaching hospital in-network?

Do you agree? What ethical position would you take as a broker?

If you were a client - what ethical position would you want your broker to take toward you?

Conclusion: How Should a Broker Proceed?

*British think death is inevitable; Canadians think death is preventable; and Americans think death is optional.*³⁴⁷

Shannon Brownlee summarizes an underpinning of our overuse of medicine in *Overtreated*:³⁴⁸

Our relentless search for wellness through medicine has created a kind of therapeutic imperative, the urge to treat every complaint, every deviation from the norm, as a medical condition.

If we test or intervene with every new development along our normal aging process, we'll abuse our medical system --- and likely generate more unnecessary and counterproductive care, and perhaps higher mortality rates.

We've come to believe that if a test can be performed, it should be performed... [almost] regardless of whether the intervention will improve the patient's sense of wellbeing.

Remember Dr. Talcott's observation from Chapter 8:

There is a vast ocean of potentially diagnosed, but clinically meaningless cancers...The more you [test and scan] the more of those meaningless cancers you're going to find [and potentially treat unnecessarily].

Dr. Talcott was the Director of Outcomes Research at Massachusetts General Hospital. He's the fellow who measures the utility of all these tests and scans against patient gains.

Just because a medical test exists doesn't mean we need to embrace it. Or the fact that a treatment is available isn't always a good reason to use it.

Maybe an old French proverb got it right: the physician's job is 'to cure sometimes; to relieve often; to comfort, always.'

³⁴⁷ I don't know the origin of this expression. I first heard it from John Kingsdale, Director of the Massachusetts Healthcare Connector, at a speech at the Boston Harvard Club sponsored by the Pioneer Institute of 1/15/09.

³⁴⁸ Brownlee, op cit, page 206. Same source for the next quote and the French proverb.

The ethical, sensitive broker understands this and helps clients accordingly. Clearly no broker can keep current on all healthcare literature and advise clients on all healthcare decisions. That's beyond any human's capabilities and outside the broker's core expertise.

But, as we have argued in this course, the ethical broker has a responsibility to advise clients not only on policy details but also on likely treatment outcomes, and to help clients chose policies that improve chances of treatment successes.

We have outlined some issues in this course. Many, many more exist.

Hopefully, we have pointed brokers in the right direction, both for ethical advising and for their own future research.

But in this concluding chapter we'd like to offer some general advice for how best to *do your fellow a favor*:³⁴⁹

1. Educate yourself about our healthcare system.

The ethical broker has a responsibility to 'do your fellow a favor'. The more you know about our healthcare system, the better you can help your clients.

Today's bookstores are full of insightful and useful books about healthcare. Some that we have found particularly useful (also quite engaging and easy to read):

Overtreated, by Shannon Brownlee;
Complications, by Atul Gawande;
Better, by Atul Gawande;
Best Care Anywhere, by Phillip Longman;
Should I Be Tested for Cancer?, by H. Gilbert Welch;
Know Your Chances, by Steven Woloshin, et al

Here's typical feedback from our students who have read these books: they contain fascinating and very useful information. Ethical brokers use that information their normal professional work.

2. Help your clients understand the importance and utility of their primary care doctor. Help them find primary care doctors with whom they can communicate easily.

³⁴⁹ Some of this advice comes from the Afterward of *Overtreated*. See Brownlee, op cit pages 308 - 310

The PCP is your client's link to our entire healthcare system. A good PCP will advise your clients in ways appropriate to them: perhaps treating illnesses aggressively for aggressive patients, and conservatively for more conservative folks.

Too many of us consider specialists the 'really important doctors' who we use for major medical issues, and relegate PCPs to the less important, more minor medical activities like prescription refills and annual physicals.

Remind your clients to rely on their PCP's advice. The PCP is the medical professional responsible for your 'whole' client, not just for his or her kidneys, heart or blood system. The various Dartmouth Medical School studies showed that the more people rely on their PCP's advice, the better their mortality outcomes.

3. Help your clients ask questions. Help them remember that doctors are guides to medicine, not gods to be believed unquestioningly.

Here, for example, are 5 questions they should ask about screening tests such as PSA tests or calcium screening tests that look for buildup in the coronary arteries:

- How good is the evidence that this screening test will reduce my risk of dying?
- Is the test itself dangerous?
- Could the test lead to my being treated unnecessarily?
- Does the treatment I might face have side effects?
- Can I make lifestyle changes - diet, exercise, stress reduction, etc - to reduce the risk of getting the disease?

Sometimes patients are intimidated by specialists; sometimes awed by specialists; or sometimes tongue-tied in front of specialists. Encourage your clients to ask good questions and to enlist the help of their PCP in this process.

Medicine is still a young science, constantly evolving. We often know less than we think we know. Honest physicians will approach your client in this light.

4. Help your clients use the web appropriately. One of the best online resources is the Agency for Healthcare Research and Quality at www.ahrq.gov. The Consumer Health section provides information about a wide range of conditions and treatments. Also see the US Preventive Services Task Force on the same website. The USPSTF consists of experts who regularly assess the scientific evidence underlying many medical tests and treatments.

These information sources are more conservative than many practicing physicians. Perhaps their information can help your clients formulate questions to ask their medical providers.

5. Explore overseas options. Remember that many overseas hospitals provide excellent services at a fraction of US costs. The savings, especially for self-insured clients, may be extremely attractive.
6. Remind your clients that physicians and hospitals have an economic incentive to treat, and generally earn the most by providing the most treatment. Help your clients understand that medicine is a business as well as a 'helping profession'.

Encourage your clients to ask about alternative treatments - maybe less aggressive or less invasive, maybe from a different kind of specialist, maybe from a different geographic region. Each of these changes can affect your client's treatment and outcome.

Help your clients to have the courage to advocate for themselves and to protect their own interests, for in the end, all healthcare decisions are ultimately their own.

We have, in the Judeo-Christian tradition, thousands of years of ethical business experience. Hopefully some of the ideas in this course will help today's health insurance brokers continue that tradition.

Summary of Part 6

1. Brokers have an ethical responsibility to advise their clients about potential harm caused by medical care.
2. Among the medical risks that patients' face: systemic error that kills up to 98,000 people per year.
3. Providers have an economic incentive to treat patients in the gray area between definitely needs care and definitely not needing care. Patients with insurance have no economic incentive to avoid unnecessary care. But patients take all the risks.
4. Hospitals prefer some treatments to others, because hospitals generate more income from some treatments than others. In general hospitals lose money on emergency care, psychiatric care and medical wards, but make money on radiology, coronary, bariatric surgery and cancer treatments.
5. High technology preventive coronary treatments like angioplasty are no more effective than medical management and lifestyle change in helping patients avoid a heart attack. But hospitals make money on angioplasty and lost money on medical management, so prefer the more expensive forms of treatment.
6. Many patients prefer care at famous, university affiliated teaching hospitals, because they assume that university affiliation indicates better quality. There is no objective data to support this belief. Indeed, there is some evidence that teaching hospitals may provide inferior patient care when, for example, residents perform their first surgeries.

Review Questions
Answers on next page

1. The Torah suggests that brokers should 'do their fellow a favor'. What does this mean for a health insurance broker?
 - a. Brokers should advise their clients both that providers have an economic incentive to treat and that treatments are not risk free
 - b. Brokers should offer to help sick people pay their monthly health insurance premiums
 - c. Brokers should offer to drive their clients to and from medical appointments. This is not only 'doing your fellow a favor' but is also excellent customer service
 - d. Brokers should offer medical advice

2. What does the ethical concept of 'full disclosure' mean?
 - a. The broker has a responsibility to disclose everything he / she knows about a policy, including policy implications
 - b. The broker should read the insurance policy to the client to ensure that the client understands every detail
 - c. Professional brokers should get law degrees, so they completely understand all aspects of insurance law
 - d. Full disclosure, according to the Torah, is limited to answering the clients' questions completely, but not providing additional information as this may confuse the client

3. Does having the best medical technology available ensure the best patient outcomes?
 - a. No. Physician experience is more important than technology
 - b. No. Physicians often take years to learn new technologies, so many patients prefer using 'tried and true' machines, rather than the latest 'newfangled notion'
 - c. Yes. Technology has been shown to be the key and most critical variable in determining good patient outcomes
 - d. Yes, but mainly in coronary and cancer treatment. The level of technology does not matter as much in orthopedic or psychiatric care

Review Questions
Correct answers in bold

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