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SCHROEDER LECTURE

REFORMING THE U.S. HEALTH CARE SYSTEM: WHAT THE LEGAL & MEDICAL PROFESSIONS NEED TO KNOW*

Arnold S. Relman†

Good afternoon, everyone. It is a great honor to be here on this occasion. I appreciate that I am the first physician in this distinguished series of speakers. So I have an obligation to say things that will be of interest to you and meaningful to your profession, as well as to mine.

Today I am going to talk about the American health care system. It is not really a system. It is a dysfunctional, disordered, and chaotic series of arrangements for the financing and delivery of health care, which we call a system. First, I will talk about it from a historical point of view: how it got to be what it is now. Then I am going to tell you why I call it dysfunctional and chaotic, why it is totally inadequate, and why it has to change. I do not know whether it will be in my lifetime or not, but it has to change. And then I will give you my own interpretation of the contending forces that are now trying to shape the future of American health care, and end up with my own vision of where we ought to be and why we ought to be there.

First of all, let me say a word about health care systems in general. They have several parts and when you think about how to change them, you must be very careful to think of all the parts. All the parts are interconnected, but sometimes people have a special fi-

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nancial interest in one part of the system and act as if there were only that one part when, in reality, *everything* is important. The first part has to do with funding. Health care costs money. If it did not cost money, I would have nothing to talk about and we would not have a problem, but it costs a lot of money. And one important part of the system is figuring out where the funding should come from and finding an arrangement that is equitable and affordable.

The second thing about our health care system is that unlike most other parts of our economy, it requires some form of insurance. Medical care is the kind of service that sometimes is so expensive that virtually none of us can afford it. Moreover, if something really bad happens to you and you need the services of the health care system, you cannot postpone the expense. So the only sensible thing to do is to insure yourself against those costs, just the way you would insure yourself against the costs of having your house burn down. Not many of us could personally afford the economic consequences of having our house burn down, so we have fire insurance.

Another important part of the health care system has to do with the actual delivery of care. First of all, there are the health care professionals, the physicians, the dentists, the nurses, and all the other technical people who provide health care services. And then there are the facilities, the institutions, hospitals, clinics, and nursing homes where the care is provided. Finally, you have the tools and the equipment, the drugs, and the medical supplies needed to deliver medical care. How are the providers and suppliers of these necessary services and goods to be paid; and should they be regulated?

Together, all of these elements comprise a health care system, and how well they work together determines the success of the system. In 1963, a professor of economics at Stanford by the name of Kenneth Arrow took a look at the U.S. health care "market." He wanted to see whether health care really is a market in the classical sense. And he concluded that it was quite different from the kinds of markets economists are familiar with.

In the American Economic Review in 1963 Arrow wrote an analysis of health care markets, which was the first theoretical study of the economics of health care. And it was in part for this work that he later won the Nobel Prize. He was a very smart man, but he approached health care with the kind of innocence that children sometimes have when they approach a subject they know nothing about. Arrow looked at the health care market and concluded that it was not like any other market known in economics.

First, Arrow said, there is no way to anticipate the demand for health care, but it is often urgent. And he said when you need health care you sometimes need it so badly that you cannot act like a con-

sumer. You are sick, you are scared, you may be incapacitated, and you cannot be a consumer choosing a product that you may or may not want to buy at a price that you may or may not want to pay. The supply is not determined by what people want, it is determined by the medical care they need. Nowadays with direct to consumer advertising, we all may think we need Viagra and Claritin, and we may want them, but we only get them if they are prescribed by our physician. For the most part, the supply is determined by the medical needs of the patient and this is not judged by the patient. Patients say to their physician in effect, I am sick or injured, and worried. I do not know what is wrong or how to heal myself, but that is why I need you. A sick or injured patient is not an independent economic agent, shopping around for what he or she needs.

Second, Arrow recognized that entry into the medical "market" is limited by professional licensure, and the time and expense required to complete medical education. This restriction on entry, of course, is an essential protection. *Caveat emptor* will not protect your life when you need medical care. You have to trust the competence of your physician, and this is protected by the limitations on entry of "suppliers" into the market.

Another point that Arrow made was that price sensitivity is very low in health care. When you are sick you do not worry about price. God forbid that tomorrow morning, one of you should wake up with blinding headaches, and you consult a neurologist who examines you. He does a CAT scan or MRI and says, "You have a brain tumor and it must be removed or you will die." You do not say, "Well, how much is that going to cost me? What I want, since I am strapped this year and I have got kids in college, is a cut-rate, stripped of all frills, basic neurosurgical procedure. The cheapest you can give me. I do not want to buy a surgical Mercedes, I want a Hyundai." You do not say that. You want the best possible treatment and price doesn't control the decision to have the operation.

Arrow's most insightful perception about the health care "market" was what he called the "asymmetry of information" between provider and buyer. In most markets, if you do not know what product you want to buy, you can find out. You can go to a publication from a consumers' union, or you can ask people, you can read the ads, you can take a test drive, and if you still do not know, there are many other ways to find out. In health care it is very difficult for you to have an equivalent amount of information about your medical condition or your doctor. You have got to depend heavily on the doctor's opinions and advice, and that asymmetry makes it impossible for ordinary market forces to work.

Arrow concluded that health care cannot be regulated by the ordinary mechanisms of the free market. You have to depend on non-market mechanisms. Professional licensure, certification, medical ethics, law, trust between patient and doctor, all of these things regulate the market, not the give and take between supply and demand." Arrow published that article in 1963. Economists read it and thought about it. A few of us doctors who could understand what he had to say agreed with him and his conclusion. We recognized that if we want to regulate health care in the interest of the public, we cannot depend on the mechanisms of the market; we have to depend on other means.

Unfortunately Arrow's insight was quickly overshadowed by subsequent events and largely ignored. In 1965, Lyndon Johnson finally persuaded the medical profession to accept government insurance. He said he was not going to socialize medicine; he was not going to put government in charge of the practice of medicine. All he said the government asked of the profession was the assurance that they would charge Medicare and Medicaid beneficiaries the same fees they would charge anybody else. And, of course, government would need assurance that the doctors really did provide the services they billed for. And in 1966 Medicare and Medicaid went into effect and it was the beginning of the commercial expansion and exploitation of health care. Eli Ginzberg, professor of Economics at Columbia, and a very astute observer, used the term "monetization." He said it was the monetization of health care through public insurance, Medicare and Medicaid, and then later through private insurance, that transformed U.S. health care from a social service to an industry. Employers were adding health care insurance as part of salary fringe benefits for their workers. There were wage and price controls at the time, and the only way that the workers could get their demands for increased rewards was through benefits, and health care was one of them. So it was the rapid expansion of public and private insurance that fed vast amounts of new money into the system.

And during the same period, we saw an enormous expansion of specialization in medicine and the development of new technology. This caused more money being devoted to expensive, specialized services. And all of this attracted investment in the health care system that never existed before. Beginning in the late 1960s and early 1970s, investor-owned hospital chains appeared, followed by investor-owned clinics, diagnostic centers, nursing homes, and so forth.

At the same time the courts decided that the so-called learned professions, were not that much different from businesses in their economic behavior. Therefore, the reach of the Sherman Antitrust Act and all the other antitrust legislation extended to the professions. In

Goldfarb v. Virginia State Bar,[1] the Supreme Court said the Sherman Act applies to lawyers and, by implication, other professions as well. But the Court had some reservations about the scope of its opinion. For instance, Chief Justice Burger in a footnote to his opinions said he was not quite sure he wanted to go all the way and say that the learned professions were not different from ordinary business,[2] and we might want to revisit this. But he voted with the majority. And, in any event, antitrust law began to be applied to the practice of law and to the practice of medicine, and that had a powerful effect on changing our health care system into something resembling a "market."

In those early days, most insurance companies were not interested in health care. They insured property and life and so on, but they later began to see that with all this money now being spent on health care, there was a new market that promised new revenues and big profits. So insurance companies rushed into that market, went public and became investor owned managed care plans.

Investors in vast numbers began to put their money into health care: hospitals, insurance plans, nursing homes, and all sorts of ambulatory clinics. Even physicians began to invest in hospitals and clinics in which they practiced.

Now, when medical care becomes a business, certain things follow. Think about this: businesses must grow if they are going to succeed. Growth is imperative. That means you must get people to spend more and more money on health care. Therefore, the growth imperative is going to drive expenditures on health care way up. Also, when business begins to provide medical insurance and medical care, there are large overhead, management, and outsourcing expenses. Health care businesses employ brokers, lawyers, marketing experts, business consultants, information technology people and so on. With each added person, overhead goes up and up and health insurance premiums do the same.

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[1] 421 U.S. 773 (1975).

[2] Berger stated:

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today.

Id. at 788 n.17.

The growth imperative resulted in a sharp increase in the rate at which health care expenses increased. Health care expenditures began to increase at ten to twelve percent per year, due in large part to the overhead, management, outsourcing and administrative expenses of a business-run medical care system. My best guess is that at least a third of what we now spend on health care as a nation goes to support the overhead and management expenses of a medical care delivery system that is heavily commercialized.

Furthermore, another imperative of business as it grows is to segment the market. That is what they teach students at the Harvard Business School: divide your market and do what you can do best and most profitably, and leave the rest to others. Piecework, rather than integrated health care, becomes the name of the game. And what was a holistic approach to health care now becomes fragmented and scattered. There is no single, overall responsibility for the patient. The profession of medicine started out with the idea that its primary responsibility was to serve patients, not to make money. It is not that way any longer, as income, market share and promotion of services begin to be at least as important as taking the best care of patients.

When I graduated from medical school, very few of my classmates thought they would get rich. Most thought they would drive a Ford or a Buick, own a house, be able to educate their kids, be economically comfortable, but not rich. The purpose of medicine was to be the best possible doctor you could be. But that has changed. Nowadays, far too many graduates think of their profession primarily as a business. They think about the money they are going to make. And while they want to be competent physicians and not harm patients, it is the money that is ultimately important.

There are a lot of things wrong with the system, but everything can be boiled down to money. When business incentives dominate the system, and when most payment is on a piecework basis, there is inexorable pressure to provide more services for those who are adequately insured or can pay out of pocket. As Arrow saw so clearly, the physicians control the demand, so expenditures inevitably rise. Those who are not insured adequately, or are uninsured, are marginalized and underserved. Government and business employers, who pay most of the costs of insurance, are pressed so hard that they are forced to reduce insurance benefits, reduce the number of beneficiaries and add to the numbers of uninsured. Attempts by government and private insurers to cut costs by reducing prices simply lead to increased volume and complexity of services, as doctors and hospitals attempt to maintain their income.

In an effort to control costs, the Bush administration is promoting a new initiative called "consumer-directed health care." The idea is

that consumers should play more of a role, that health care should be directed by consumers. The Bush administration likes to put it in grandiose terms. They say it is the "ownership society." People should own their own health care plan, be in charge of their health care, and decide what they want to pay. And when they have to pay more of the cost of their care, they will have some stake in the care being more efficient. People will not ask for too much health care and costs will be controlled.

And so the way to make all this work is to encourage people to buy low premium, high deductible plans, which put the consumer at greater risk. In addition, the government or your employer sets up a health savings account, which is like an IRA. You can use the account to help pay your deductible health care costs. And if you do not spend it, the account rolls over and accumulates tax-free. This is a great deal for well-to-do, healthy people. They end up with a big tax-free IRA. But if you are poor and need medical care, you face the choice of spending your account or not getting the care you need.

"Empowering" the patient, as promoted by the Bush Administration, really means giving the patient responsibility for paying. This idea fits in with a currently popular philosophy: If you are rich, you can do pretty well, but if you are poor and sick, God help you.

"Consumer-directed health care" is very popular with conservative politicians and business people, but it isn't fair and it won't produce much savings in the long run. It isn't fair because it puts the greatest financial pressure on those with limited income to hold back on services, and it won't save very much because most health care costs are incurred by the big-ticket, expensive items that will be covered by catastrophic insurance.

With that in mind here is what I predict: "consumer-directed health care" will play itself out over the next five to ten years, by which time it will become perfectly clear it has not worked. Medicare will be going broke, government will be accumulating vast deficits, and private business will not be able to afford the costs of health care for its employees. We will have to try something else that will control costs without denying access to necessary care for all.

Well, then, what *will* work? Here is my idea. We need a single efficient insurance system instead of all the multiple insurance systems and multiple transactional costs of billing and collecting. We need one insurance system and it should be funded from some sort of earmarked tax base to which employers contribute appropriately. I do not think employers ought to be taken off the hook and told they do not have to pay for their employees' health insurance. Employers should pay part of the cost of a single insurance system. Such a system, which would have minimal administrative overhead, should save

tens of billions of dollars. There would be no billing costs because the insurance plan would pay for specified comprehensive care, on a capitated basis.

Right now, for the most part, what we have is insurance that covers benefits paid on a piecework basis. We should change to a system where the care is guaranteed and it is paid up front, per capita. Now, many people who are in favor of a single payer system want to stop there. They say that will save a lot of money. That is true, but it will not adequately control cost inflation. As long as you have the providers of health care being paid on a piecework basis, the incentives to do more and to use more technology—to promote the use of services, whether they are needed or not—will still be there.

You need to have a capitated, prepaid delivery system and the doctors have to be paid, not on a piecework basis, but by salaries. Furthermore, they have to practice together. They have to work together the way they do in the Mayo Clinic, or in the Kaiser Health Plan, or in the Health Care Cooperative of Puget Sound (Seattle), or in the Harvard Vanguard Health Plan of Boston. Physicians need to work in groups to provide the best possible care for a given prepaid premium.

What about hospitals? I think we should convert to a fully not-for-profit system of health facilities. We should not allow any new investor-owned facilities and should gradually buy out the existing ones, turning most of them over to private non-profit community-based trustees. I do not favor establishment of more government-owned or managed medical facilities. Private, not-for-profit ownership and management should be the model and there should be regulated competition among them for physician-directed patient referrals.

In Canada there is a single-payer universal insurance system, which operates very efficiently, but is not sufficiently funded. This has recently led to pressure for adding private insurance plans to the system. But if Canada spent nearly as much money per capita, on its health care as we do, it would probably have the finest system in the world without breaching the solidarity of its public, single-payer system. Our problem is not that we don't spend enough money. It is the system that needs reforming. With a better system of insurance and medical care delivery, we could provide excellent care for all our people—without spending much more money.

All that we need is the political will to make the necessary changes. This will be resisted by the vested interests in U.S. health care businesses. The tide will probably not turn until the rest of U.S. business (which pays for health care), along with the public and the medical profession, finally realize that there is no viable option to a major restructuring of our health care system. It will be difficult, and

slow in coming, but I believe it is inevitable. Our present arrangements cannot survive much longer, although things may have to get much worse before there will be enough popular support for the necessary changes.