



It's Time for Fundamental Health Care Reform



By David J. Gibson, MD

To really do something about the dysfunctional health care system, we have to take aim at hospitals, insurance companies, drug firms and labor costs.

A CONSENSUS HAS BEEN REACHED. Cost trends in health care, now running six times the rate of inflation, are not sustainable. The facts overwhelmingly support this consensus.

- Medicare Trustees calculate the unfunded cash flow deficits for the next 75 years now stand at \$28 *trillion* (this figure includes the \$8.1 trillion in spending for the new prescription drug benefit). That is almost three times the current size of our entire economy.
- Medicaid is costing the states and the federal government more than \$300 billion a year. The growth of the program has outpaced state revenues and is now a larger component of total state spending than elementary and secondary education combined. This program alone is driving most of the states toward insolvency. Complicating the state's Medicaid problem, the federal government is indicating that it will likely lower the federal contribution to the program next year in its drive to reduce deficit spending.
- Health insurance premiums paid by U.S. workers have risen nearly three times faster than average earnings in the past four years. No other cost item has done more to impoverish the middle class.
- Over 44 million working Americans lack *any* form of health insurance.

As a result, we are hearing calls from across the political spectrum for "fundamental" change in health care.

What does "fundamental" mean? As defined by *Webster's Dictionary*, fundamental change involves re-establishing the innate or ingrained foundation of a system on which the entire infrastructure rests. For health care, this amounts to rebuilding the system to consume no more, and preferably less, of America's economic resources.

What we now have in America is a pricing structure for health care that is based upon the best funded payer's ability to pay (the employer and the government) rather than what patients and their families can ever afford. We also have an acuity based health care system that spends most of its resources in the last two weeks of life. In essence, we try to use medicine to defeat death. Of course, this does not work. Furthermore, both of the above represent an irrational basis on which to price and structure our health care system.

If we are going to examine fundamental changes, we must not confuse the terms fundamental with incremental. Getting something of value in return for concessions will not work. "Fundamental" reform requires focusing on the patient and his or her needs - not what benefits those making money in the current system.

The primary inflation drivers in health care include hospitals, pharmaceutical manufacturers, health insurance companies and the cost of labor. These are the areas where fundamental reform needs to begin in the industry. Reform outside the industry will be required as well but will not be examined in this article.

Hospitals

We need to revisit the outdated idea of isolating the sick and dying from the community. This concept originated in medieval times to protect society *from* the sick. This paradigm simply does not translate into the era of antibiotics.

For starters, it is a foreign concept. America's commitment to an individual's freedom makes it averse to custody. Furthermore, taking custody of an individual is the most costly and least productive of options for treating the sick and dying. Technology is driving health care to the ambulatory setting. Health care should plan for less dependence on institutional care in the future.

Transitioning from an inpatient, acuity-oriented system to an ambulatory-based system will require focusing upon these policy issues:

- **Deconstruct regional hospital oligopolies.** It was a major policy mistake, made by the federal courts over the objection of the Clinton Administration, to let hospitals coalesce into dominant regional corporations. More than half of the nation's hospitals belong to larger health-care systems. Recent studies demonstrate that consumers are disadvantaged in that these systems drive increased cost to the consumer.¹ Northern California is dominated by two of these systems (Sutter and CHW) and has some of the highest health care costs in the western United States as a direct result. These oligopolies should be dissolved.
- **Make rural hospital monopolies public utilities.** In communities with only one hospital (Marysville, Crescent City, etc.), the hospital should be regulated as a utility and managed as such. In a utility paradigm, the hospital would be required to get permission from the people it serves to set charges. These hospitals now prey on their local communities and destroy rural economies.
- **Prevent hospitals from expanding into the ambulatory market.** Over the past two decades, hospitals have used the most expensive resource in health care, their inpatient bed, to leverage contract advantages with managed care companies. In exchange for inpatient bed discounts, hospitals have been able to gain a dominant position in the delivery of ambulatory diagnostic and interventional services (outpatient surgery center and radiation units, etc.). They have brought their high overhead, monopolistic management style into this setting and stifled innovation while exacerbating the inflationary problem in health care. Hospitals should not be allowed to provide services in the ambulatory market. Furthermore, managed care companies should be prohibited from linking inpatient discounts with preferred outpatient diagnostic and interventional contracts.
- **Prohibit hospital-affiliated doctor groups.** Permitting hospitals to develop affiliated medical groups was also a public policy error. Affiliated groups align with the hospital in the latter's never-ending battle with health insurance companies. The cacophony of battle between Sutter and Blue Shield (representing CalPERS) speaks to this issue. A physician's loyalty represents a long term commitment to his or her patient and far transcends annual contract negotiations. Physicians should immediately disassociate their medical groups from hospitals.
- **Break up the Emergency Room monopoly.** Hospitals and ER medical groups have leveraged their contract position with third party payers so that professional fees for similar services are marked up by a factor of three over all other alternatives in the ambulatory setting. Furthermore, the hospital marks up supplies such as pharmaceuticals by a factor of ten or considerably more. Stacking the reimbursement system in such a distorted way makes the ER the only option after

hours or on weekends. There is no incentive for physicians to create cost effective after hours alternatives. These disproportionate reimbursement structures should be eliminated.

- **Make hospitals participate in the safety net for the poor, or pay taxes.** Not-for-profit hospitals should rediscover their *only* mission — to care for the poor. Not-for-profits were not designed to compete in the for-profit market. Spending on a technology arms race and pouring money into advertising is a diversion from their fundamental mission. Complaints by non-profit corporations over their safety net responsibilities are unseemly.

Health insurance companies

Another health care player reporting record earnings is the health insurance industry. Underwriting health care is, at best, a minor peripheral activity for these companies. Most of their activity is focused upon intermediation of health care transactions. There are far more efficient alternatives in the market today.

Perhaps the most insidious effect of managed care has been the insurance company development of discounted provider networks. These networks now disadvantage the individual patient who pays cash. This disadvantage translates into a fiscally dangerous environment for the 44 million Americans without health insurance as they confront the health care system.

This discount structure is counterintuitive. No other sector of our economy marks up fees for cash customers. In addition, these networks reward the status quo, guarantee hospital hegemony and inhibit any incentive to innovate.

Health insurance companies have no other core competency outside these networks. Their adjudication of claims and financial intermediation of services use analog technology discarded by the financial services industry two decades ago. This outdated technology has inhibited the deployment of digital technology in health care.

Health insurance companies have utterly failed as intermediaries. On their watch, inflationary trends in the industry have been well above all other segments of the economy.

Eliminating insurers as intermediaries in health care would be a positive outcome in a new fundamentally restructured health care system.

Pharmaceutical companies

The core competency of pharmaceutical companies is not research, but marketing. The debate over stem cell research illustrates this. There is no ban on privately-funded stem cell research *anywhere* in America. There is a restriction on federal funding for some of its components.

If they chose to do so, pharmaceutical companies could devote unlimited amounts of basic research to stem cells. Of course, they have not done so in the past and will not in the future.

Dr. Marcia Angell, the former editor of the *New England Journal of Medicine*, has documented² that most of the current pharmaceutical breakthrough products on the market were developed from basic research funded by the National Institutes of Health in academic centers. Pharmaceutical companies then appropriated these publicly funded research efforts and brought products to the market under exclusive patent protections.

The marketing emphasis in pharmaceutical companies is evident by where they do invest their resources. Marketing expenditures of the drug industry have been estimated at \$12 billion to \$15 billion every year, or about \$8,000 to \$15,000 per physician. There are nearly 90,000 drug company salesmen in the United States, about one salesperson for

every 4.7 office-based physicians. A 2001 survey found that an estimated 92 percent of doctors received free drug samples from companies; 61 percent received meals, tickets to entertainment events, or free travel; and 12 percent received financial incentives to participate in clinical trials.³

It is now becoming evident that the pharmaceutical industry is morphing into an entirely new structure. This transition is traumatic for the pharmaceutical industry. As a result, there is great harm now being inflicted upon health care as old pharmaceutical companies resist change.

All the large manufacturers have business models built on delivering "block buster" products to the market. Block buster products target common health problems and are prescribed by generalist physicians.

Examples include: Proton Pump Inhibitors (PPI) for gastrointestinal ulceration; Selective Serotonin Re-uptake Inhibitors (SSRI) for depression; and HMG-CoA (3-hydroxy-3-methylglutaryl coenzyme A) reductase inhibitors or Statin products for hypercholesterolemia.

Most of these "low hanging fruit" products have been introduced to the market and either have, or soon will, lose patent protection. The current pipeline for new products is inadequate to sustain the pharmaceutical companies and investors are reacting. In late 1998, pharmaceutical stocks traded at 40 times their expected earnings for the following 12 months. Today, these stocks trade at less than 14 times their expected earnings, the cheapest level in eight years. It is clear that an era is passing. This situation is analogous to Pan American Airlines, which no longer flies chiefly because its business model did not translate into a fundamentally changed airline market.

These multinational pharmaceutical companies are now consolidating while they compensate for their pipeline deficiencies by marketing "me too" products. They are also modifying previously introduced products that are losing patent protection with minor molecular modifications.

This strategy isn't working.

In reality, these companies are failing because they lost their ability to innovate. Over the next decade, most of these old companies will either disappear or morph into delivering high-margin, lifestyle-enhancing drugs such as Viagra or Propecia to the market.

The truly innovative new products coming to market are being developed by small new companies that generate "orphan" drugs. These products serve only a small number of patients and are generally prescribed by specialists. Most of the biologic-produced products, such as Remicade, Enbrel and Humira, fit into this category. All of the genetic targeted and derived products will as well. Block buster business models will not deliver these new products at affordable prices.

The sooner these older block buster-based companies give way to new companies with new business models, the better it will be for health care. Society has entrusted physicians with the exclusive responsibility for prescribing, and it is incumbent upon us to not allow these older companies to inflict further damage on America's health care system as they fail.

Any physician prescribing a brand product over a generic without head-to-head proof of its superiority, documented in a national peer-reviewed journal, is doing a disservice to his or her patients and to America's health care system.

Cost of labor in health care

Resonating through all of these issues is the reality that the cost of labor in health care is too high.

Before the advent of third-party payers, America's health care system relied on the patient and his or her family to pay their health care bills. There was no inflation problem in health care when the patient paid the bill. Consumers policed costs far more effectively than have third parties under the current system.

Paul Starr in his book, *The Social Transformation of American Medicine*, documents that doctors throughout American history have traditionally had meager incomes. In fact, doctor incomes were roughly commensurate with a school teacher prior to the advent of third-party payment. The rest of the labor components in the system were structured proportionately.

As America's health care financing system moves away from first dollar coverage and toward higher front-end payments by patients, most families cannot afford a labor cost structure that is out of line with the society it seeks to serve.

So, how do we realign the labor cost structure in health care? We should start with professional licensure laws. These laws provide one of the primary supports for today's bloated labor cost structure in health care.

Professional licensure was originally developed to protect the patient. It no longer serves that purpose. Licensure now insulates labor in health care from competition and inhibits innovation. This is featherbedding at the expense of the patient. It restricts the availability of culturally and ethnically suited support for the patients in our evolving society.

Today, the only real purpose of license defined scope-of-practice is to raise money for politicians. Each year doctors fight with dentists before the Legislature over how far into the neck the latter can treat. The same goes for doctors and podiatrists — how far up the lower leg can the latter go? Defining clinical competence through the political process is nonsense.

It is no secret that the Legislature holds annual "juice sessions" to exploit these inter-professional conflicts and thereby raise campaign money. This is obscene. The process serves no useful purpose and should be stopped.

In short, the entire purpose of licensure and scope-of-practice needs a thorough re-evaluation from the perspective of what is good for the patient rather than what serves the interests of the labor force in health care.

Conclusion

It is time to get serious about "fundamentally" reforming health care. Not doing so will only perpetuate our self-created culture of delusion. The established inflationary trends are not sustainable, and our society has no alternative but to reform its health care system.

We can no longer perpetuate an acuity-based system whose foundation is built upon outdated custodial institutions. We can no longer permit health insurance contracts to warp the incentives in health care and stifle innovation. We dare not let failing pharmaceutical companies inflict further damage, and we cannot accomplish any of this without bringing health care's labor cost structure into line with the rest of our economy.

The critical question is, will physicians play a leading role in the coming reform process or will they remain one of the special interests that resist the process?

Continuing to whine about the need for more money is a non-starter. We live in an era where health care must co-exist with the rest of America's economy.

We need to devolve America's health care system into a less complex and costly structure that patients and their families can understand and actually pay for. In reality, there is no choice. Without truly *fundamental* reforms, our economy cannot sustain the inflationary juggernaut we have unleashed.

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1. Health Affairs, Vol 24, Issue 1, 213-219.
2. "The Truth About the Drug Companies;" M. Angell; Random House; ISBN 0-375-50846-5
3. Doctors and Drug Companies; David Blumenthal; NEJM; Volume 351:1885-1890; Number 18.
<http://content.nejm.org/cgi/content/extract/351/18/1885>

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