

THE FREE MARKET IN HEALTH CARE; Why We Favor Choice Over Access

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



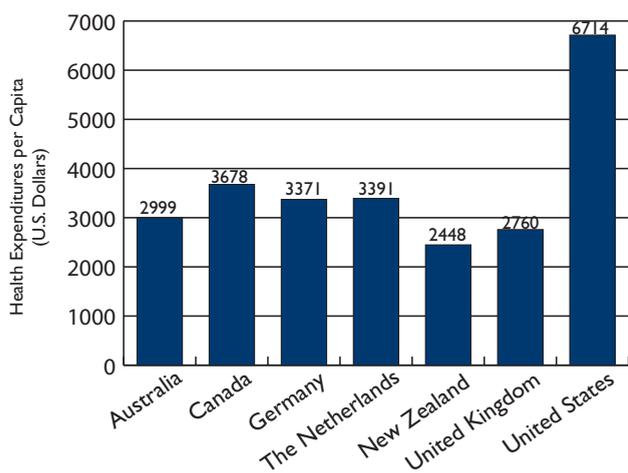
THE PROBLEM

The American system of health care is seriously ill and has been called “the most wasteful and least sustainable healthcare system in the world.”¹

The statistics are well known. About 17% of our gross domestic product, or nearly \$2.5 trillion per year now goes to health care, while other developed countries spend barely more than half as much per capita and have equivalent or better outcomes (Fig. 1a and 1b). Medicare and other government programs fund nearly half of health care costs, but the Medicare trust fund will run out of money within a decade or so, depending on whose figures are used.

At any given time, depending on the unemployment rate, 35 to 50 million Americans are without insurance, including almost 10 million children. Emergency departments are the main point of access to health care for large sectors of society. In 2007 President Bush somewhat callously declared that no one in America lacks health care because they can just go to an ER. True, ERs are the only part of the U.S. healthcare system required to treat all patients, regardless of whether they can pay, but hospitals aren't required to have an ER, and it's an obvious area to close if you are looking for savings. In an alarming

Fig. 1a



Slowing the Growth of Health Care Costs - Learning from International Experience, Karen Davis, N Engl J Med 2008 359: 1751-1755.

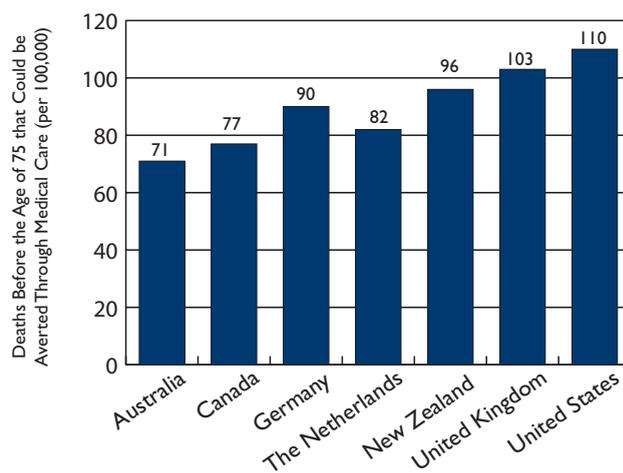
trend over the last 20 years, one quarter of hospitals in urban and suburban areas (which disproportionately serve large numbers of indigent patients) have closed their emergency rooms even while the number of ER visits rose 35%.²

For these and many other reasons, there is now nearly universal concurrence that our health care system needs reform. Yet, passage of the Patient Protection and Affordable Care Act of 2010 has only intensified the public debate about the changes we should make in health policy.

THE QUESTION

Many factors explain the inexorable rise in health care costs: technological advances, a growing population, increased access by previously underserved segments of society, the increased cost of drugs, etc. But those factors only raise costs; they do not explain why America persists in paying for health care in a manner that has amply demonstrated its inability to solve our triad of challenges—the need to restrain cost, maintain quality, and enhance access. Why do we keep making the same mistakes? Why do we keep paying for health care in such a clumsy, inefficient manner?

Fig. 1b



THE ANSWER

The answer is not administrative, political, or technological; it is *cultural*. There are certain American cultural convictions that underlie our approach to the funding of health care.

a) Americans are raised with the belief that we are the richest country in the world, that we can afford whatever we need, and that our system of government, based on democratic capitalism, deserves most of the credit. With a few exceptions, such as municipal services, roads, the military, and the court system, we believe that free markets and the private sector are almost always and everywhere inherently more efficient than the government and the public sector. Consequently, we allow for-profit health insurers to retain a dominant role in health care. Similarly, in a development that would have baffled prior generations, investor-owned hospital chains have blossomed and generated huge profits for investors.

But experience has proven that market forces do not operate in the health care industry the way they do in the rest of consumer society. The free market works beautifully for health insurers, their executives, and their shareholders, but horribly for the rest of us. Just as competition among hospitals does not lower costs, competition among insurers does not result in lower premiums. In states where the for-profits have a significant presence, the surpluses rung up by the Blues average considerably higher than in states where the for-profits don't have as much market share.³

In 1993 the "medical loss ratio" (the ratio between health insurers' payments on claims and revenue from premiums) was 95 percent; i.e. insurers paid out 95 cents of every premium dollar to health care providers. Now, the average medical loss ratio for all insurers, regardless of their tax status, is close to 80 percent; administrative costs, including executive salaries, consume nearly 20% of every dollar.⁴ Some of the Blues are spending far less than the average; the medical loss ratio for the Texas Blues last year was just 64%. (Though comparisons with Medicare are difficult because of its different funding mechanism, even a heavily biased study funded by the insurance industry estimated that Medicare's expense ratio is a maximum of 6-8%.⁵)

b) An admirable American cultural characteristic is generosity of spirit, with its corollaries of volunteerism and a commitment to help those less fortunate. Most of us would likely agree that access to at least basic health care, particularly for children, should be

a universal human right. And most of us maintain this attitude even though our insurance premiums are increased to subsidize a system that also provides health care to those who cannot pay for it.

But subsidy by cost-shifting through inflated insurance premiums is an inefficient and expensive way to provide indigent care because insurance companies extract administrative costs from every premium dollar that passes through their hands. Second, since insurers pay only for care of the insured, the system provides an incentive for providers, particularly for-profit hospitals, to reduce services to the uninsured. This shifts most of the burden for indigent care onto the backs of the relatively few remaining urban public hospitals, and the large number of community hospitals like Lancaster General, for whom care of the entire community is part of their mission.

c) The American affinity for both volunteerism and the free market, and the resultant mix of for-profit and not-for-profit insurers and hospitals, is confusing to the public; many don't even know whether their local Blue is for-profit or not. To add to the confusion, many historically non-profit Blues have transformed into for-profit companies, after which their excess revenue may be distributed to investors. Last year, the five largest for-profit insurers (Aetna, CIGNA, Humana, UnitedHealth and WellPoint) had combined revenue surpluses of \$11.7 billion.³

WellPoint is the nation's largest insurer covering 35 million people through Blue Cross/Blue Shield plans in 14 states. For WellPoint and other health insurers the very concept of "profit" takes on new meaning, since paper "losses" can be generated if revenue surpluses are spent or paid out. In 2009 WellPoint raised CEO Angela Braly's compensation 51%, to \$13.1 million. Yet WellPoint reported that it had suffered a loss the previous year and asked for a 16.4% premium increase. Contributing to the "loss" were pay hikes for other top WellPoint executives, who took home between \$4.5 million and \$7.2 million each. Other ways of generating "losses" include, among others, building palatial offices or maintaining corporate jets. In 2009 BlueCross BlueShield of Tennessee moved into its new \$300 million, 950,000 square-foot headquarters overlooking the Tennessee River in Chattanooga. With such extravagances, it's no problem to minimize "profits" while announcing rate increases.

For the industry's highly paid executives, it hardly seems to matter whether they work for a non-profit

or a for-profit insurer. Non-profit Massachusetts Blue Cross gave former CEO Cleve Killingsworth an \$11.3 million platinum parachute, after having already given \$16.4 million to predecessor Willam Van Faasen.⁶

There is the additional paradox that—as I pointed out in the last issue of *JLGH*⁷—increased publicity about executive compensation has propelled, not restrained it, because when executives find out what others are making, they want as much or more. When the Pennsylvania Insurance Department reviewed 2007 CEO compensation packages at Highmark (\$3.6 million) and Independence Blue Cross (\$2.6 million), it declared—with no sense of irony—that they were “reasonable” because they were “in line with other Blue Cross plans nationwide and with major nonprofit health systems.” Of course they were. That’s precisely the problem!

d) It is yet another counterproductive aspect of our system that health insurance is usually tied to employment, which makes changing jobs hazardous to one’s health, particularly if one has a dreaded “*pre-existing condition*.”⁸ This linkage paradoxically interferes with an unfettered free market; it impairs the efficient distribution of labor because workers are reluctant to change jobs or relocate lest they lose health insurance.

THE PROPOSED SOLUTIONS (AND WHY THEY WON’T WORK)

Attempts to “control” health care costs with methods available in the private sector are disingenuous because they do not acknowledge that the only way to control escalating costs is to pay providers less, to ration care, or to stifle technology, which is the main driver of increased costs. The only reason costs aren’t rising even faster in the U.S. is because we keep paying physicians less, and we ration by ability to pay. It is no coincidence that insurers have posted record profits since the recession began. Payouts by insurers have plunged as demand for health care has fallen. The recession has impelled millions of struggling workers to self-ration by postponing necessary care. Meanwhile insurance premiums continue their inexorable rise.⁹

Because it is politically impossible to construct a solution that would marginalize (let alone eliminate) free market mechanisms, the 2010 Patient Protection and Affordable Care Act keeps private health insurance as the dominant mechanism of funding. As many wags have noted, it could easily have been called the Health Insurance Industry Protection Act. Worse, the Health and Human Services Department is allowing many states to phase in already lenient rules that

stipulate a medical loss ratio of only 80%. Even so, states can request an adjustment if they determine “that immediately implementing the new limits would drive insurers out of the state and disrupt consumers’ access to care.” Unashamed, New Hampshire asked to set the ratio at a mere 70 percent for the next three years. In response, HHS approved a gradual transition of 72 percent this year, 75 percent in 2012, and the federally mandated threshold of 80% only in 2013.¹⁰ Apparently it did not occur to the New Hampshire legislature that any insurer that is currently sucking more than 30% out of every dollar it touched should be run out of the state, not accommodated.

Since technological advances are such a major contributor to the rise in costs, attempts have been made to maximize the value of technology by eliminating ineffective technology, and limiting “indiscriminate” use of effective technology. But it is hard to decide what is ineffective or not cost-effective even if “safe and effective;” it is nearly impossible to decide what constitutes “indiscriminate” use of technology. The British National Health Service has done so with some success by creating the National Institute for Health and Clinical Excellence (NICE), which uses scientific evidence to weigh the cost and benefits of treatment and to get the best value for NHS expenditures, yet even in their culture of government health care NICE has aroused debate.

Americans love technology, and since we are the “richest country in the world,” we are not yet ready to accept restraints on the use of costly tests or treatments. Hospitals with no real need for robots often buy them merely to keep competitive and to be perceived as on the cutting edge. We compound the problem by separating people from the cost of technology, so they can choose it without financial pain. Restrictions on the use of new technology are viewed as rationing.

Entities that attempt to restrain the use of technology have limited influence. The California Technology Assessment Forum (CTAF),¹¹ an independent body developed and funded by the insurance industry to provide credible, evidence-based information about new and emerging medical technologies, has no teeth. It issues thoughtful, carefully considered assessments but has no enforcement powers.

Washington State’s Health Technology Assessment Committee, created by a 2006 law with bipartisan support, has authority to determine which medical devices and procedures Washington will cover for state employees, Medicaid patients, and injured workers—about 750,000 people in all. But it too has trouble depriving

the ill and disabled of access to appealing interventions.¹² *The Wall Street Journal* called Washington State's process a harbinger of limitation of choice, and used the same brush to tar the federal health care reform bill, which includes efforts to compare the effectiveness of different therapies. Until now, Washington's technology committee has ruled on 21 devices or procedures, rejecting coverage for about half of them, including upright positional MRI, pediatric bariatric surgery, virtual colonoscopy, discography, arthroscopic knee surgery, implantable infusion pumps, vagal nerve stimulation for depression, electrical nerve stimulation, calcium scoring, and spinal cord stimulators. The decisions made so far are expected to save the state \$31.8 million annually.

SUMMARY: CHOICE OVER ACCESS

To return to my initial assertion, control of health care costs will require not simply a change in technology, but a change in culture. In 1893, in a paper entitled "The Significance of the Frontier in American History," Frederick Jackson Turner described Americans as a rugged, self-made race of men, forged in adversity through the pioneering experience, reborn and purified into a breed unique on earth.¹³ The term "rugged individualism" as a defining characteristic of the American sense of exceptionalism was born.

Rugged individualism is a belief in the importance of the individual and in the virtue of self-reliance and personal independence, with corollaries of personal liberty and free competition that have implications for the ordering of social and economic affairs. In health care, it has led Americans to a persistent emphasis on *choice over access*, a fundamental cultural preference that makes us tolerate, even praise, our unwieldy, costly, and inefficient system of health care in which 50 million people lack health insurance. Conversely, Canada, Britain, and most other Western countries have systems that restrain choice in favor of universal access. Gallop surveys in 2005 conducted in the United States, Canada, and Britain found that slightly more than half of those surveyed in all three countries described their own healthcare systems as "excellent" or "good." (Over the three years from 2003-2005, the ratings in Canada remained essentially unchanged, while the percentage rose from 49% to 55% in Britain and fell from 60% to 53% in the United States.¹⁴)

Choice over access, in practical terms, means that we would rather choose which physician we will wait three months to see, than have the Federal Government

arrange an appointment for us tomorrow. One particularly dramatic and expensive example of the pre-eminence of individual choice is the treatment of end-stage renal disease, for which the federal government since 1972 has provided nearly free care to almost all patients with renal failure regardless of their age or ability to pay. At that time it was expected that fewer than 40 patients per million would need dialysis, and that most of those patients would be healthy—except for their failed kidneys—and under age 54. Dialysis would return them to productive lives.

Now that same law allows elderly patients with other medical problems to choose to continue with dialysis though for many it does not even prolong life but simply increases the chances they will die in the hospital rather than at home.¹⁵ Patients may choose to remain on dialysis against the advice of their physicians. End-stage renal disease will cost the nation an estimated \$40 billion to \$50 billion this year.

At long last, we are seeing increasing attention to cost considerations in the evaluation of expensive therapies. *The Cost Implications of the Rapid Adoption of Newer Technologies for Treating Prostate Cancer* were assessed by a study in the *Journal of Clinical Oncology*. The lead author Paul Nguyen, MD, a radiation oncologist at the Dana-Farber/Brigham and Women's Cancer Center, pointed out that society must decide how to spend limited resources and called for more comparative effectiveness research.

The story of Provenge may be a harbinger of this new attitude. The FDA approved Provenge in April 2010 as a unique immunotherapy for prostate cancer though it costs \$93,000 and gave incurable patients an average increase in survival of four months. In most cases Medicare automatically covers approved drugs because *Medicare is legally prohibited from considering price when deciding whether to pay for a new treatment*. But it was not until nearly one year later, in March, 2011, that Medicare said it would pay the cost of Provenge. Medicare's prolonged review of Provenge was exceptional and was doubtless based on cost-benefit considerations. Financial analysts estimate Provenge could have \$1 billion in sales next year. Is this the best use of such a sum? Are we as a society prepared to answer such a question?

Makena, a synthetic progesterone given as a weekly injection to women at high risk of pre-term delivery, has been made cheaply for years in compounding pharmacies for \$10-\$20/dose. To standardize quality, the FDA recently granted KV Pharmaceuticals exclusive approval to

sell the drug. KV then announced a price of \$1,500/dose and sent a letter to compounding pharmacies telling them the FDA would enforce the company's exclusive right to make the drug.¹⁷ This restriction would have forced cash-depleted state Medicaid programs to either stop paying for the drug or cut other benefits.

Soon thereafter the FDA made an unusual announcement: "In order to support access to this important drug, at this time and under this unique situation, FDA does not intend to take enforcement action against pharmacies that compound hydroxyprogesterone caproate (generic Makena) based on a valid prescription . . ."¹⁸ Hopefully this suggests that the pharmaceutical industry is losing some of its vaunted political clout, and the reality of cost has poked its nose under the tent.

PROBLEMS CREATED BY THE SUPREMACY OF CHOICE

In a system where society pays for some or most of the cost of care, and the patient is usually distanced from concern for the expense, can we continue to let the individual's right to choose override society's interest in the choice?

There are several problems with an approach that prioritizes *choice over access*:

1) Patients often lack sufficient information to make an informed choice:

a) It is not paternalistic or condescending to assert that patients often do not understand, or cannot obtain, the necessary scientific evidence for choosing among alternative approaches. In some cases the evidence is not even available, or the scientific community disagrees about its meaning. Lacking the medical education and experience necessary to apply objective but necessarily intuitive judgment to the weighing of risks and benefits, the patient cannot make the best informed choice.

b) It is difficult for patients to judge among alternative providers, despite Health Grades and similar online databases, which usually charge for often sketchy information. Further, a provider's reputation is often based on intangibles, and choices are often guided by emotion rather than reason.

2) Many patients lack proper *access* to the health care system. The allocation of resources to expensive modalities such as those discussed above, rather than to ensuring basic care for all, is a choice that society has made by default, if not by design. Now that most of us recognize that we cannot afford to do everything,

we will have to reconsider the choices about *choice and access* we have made as a society.

3) The availability of choice is often just the illusion of choice.

Each year the Commonwealth Fund awards one-year fellowships to an international group of mid-career professionals to study health care in the U.S. One of the 2006-07 fellows from Britain, Vidhya Alakeson, blogged about their experiences obtaining health care in our system.¹⁹ She offers fascinating insights about the illusion of choice, but I can only provide an excerpt here, and I urge you to read both installments of the blog:

"We found that choice was typically accompanied by a level of bureaucracy and micromanagement that belied the rhetoric of market efficiency. At every stage, our choices were strictly governed by which providers were "in" our health plan's network, which medications were on the formulary, and which procedures required preauthorization. Strictly speaking, preauthorization was the physician's responsibility, but the financial risk of not checking fell on us. The bureaucratic burden of choice not only created uncertainty about coverage, despite being comprehensively insured, but also . . . imposed both financial and time costs.

To date there has been little . . . to suggest that greater choice has increased our sense of control. More often than not we found we were making choices to knit together different providers and fragmented parts of the system to guarantee access and continuity of care. Frequently we had to choose between different options, even when the choices offered were of little value to us, and often with little information to support informed decision making. Rather than giving us a sense of greater control, these forced choices served only to create a sense of uncertainty."

The author describes calling 25 family physicians on her insurer's list of approved providers before finding one that was taking new patients. She proposes instead a system of self-directed care that I do not have room to discuss now, but perhaps will return to in another issue of the *Journal*.

SUMMARY

Our system of health care is costly, inefficient, and cumbersome to access. We accept these flaws because the system is consistent with our cultural bias of *rugged individualism* that considers individual choice as an absolute good. However, even this characteristic of our system is often merely an illusion. (Most of

this *Journal's* readers are physicians who know how to access the system, and which choices to make, so we are not acutely sensitive to the problems faced by lay consumers of health care who must gain access and make choices.)

Since the resources available for health care will not remain forever unlimited, we will soon have to make choices as a society that will outweigh the patient's choices. Doing so will require not a change in technology, but a change in culture.

IN THIS ISSUE

This issue contains a wealth of diverse and hopefully interesting information. In a typically comprehensive and authoritative article, Joseph Kontra, M.D. reviews the The Epidemic of Hyper-virulent *Clostridium difficile* Infection. Leigh Shuman, M.D. provides an insider's insights into the changes in radiology that have vastly altered the amount of data that must be processed, stored, and made available for review, and how this task is being handled by new Picture Archiving and Communication Systems

(PACS). Charles Rodenberger, M.D. updates his earlier discussion of home hemodialysis, and how it is becoming more widely used. In a complementary article, Steven Woratyla, M.D. provides a vascular surgeon's discussion of the problems obtaining and maintaining vascular access for dialysis. (Easy and uncomplicated access is a particularly stringent requirement for home hemodialysis.) Regular columnist Alan Peterson, M.D. discusses two particular illnesses (asthma and leukemia) that are increased in children exposed to the exhaust pollutants generated by heavy traffic. Dr. Kontra's article uses "old dogs" metaphorically in the title. Drs. Nepps and Stewart, and Mr. Bruckno used dogs literally in assessing the utility of animal assisted therapy in an in-patient mental health population. And in an article entitled Perinatal Palliative Care, Carolanne B. Hauck, M.A., B.C.C., Staff Chaplain at Lancaster General Women and Babies Hospital, discusses the extensive and coordinated support mechanisms that have been developed there for parents of neonates with a poor medical prognosis.

Enjoy!

Note: The opinions expressed in this column are mine alone. The Journal's sponsor, Lancaster General Hospital, does not review or approve these editorials.

REFERENCES

- Gawande A, The cost conundrum, *The New Yorker*, June 1, 2009.
- Hsia RY, Kellerman AL, Shen Y. Factors Associated With Closures of Emergency Departments in the United States.
- JAMA. 2011; 305(19):1978-1985.
- Potter W. <http://www.pnhp.org/news/2011/may/blue-cross-blue-shield-getting-richer-like-corporate-insurers>.
- Potter W. *Deadly Spin. An insurance company insider speaks out on how corporate PR is killing health care and deceiving Americans.* Bloomsbury Press. 2010.
- Matthews M. 2006. Medicare's hidden administrative costs: a comparison of Medicare and the private sector http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf
- Jackson DZ. No wonder health costs are so high. *Boston Globe*. March 5, 2011
- Bonchek LI. Conflicts of interest and the absence of shame when the price is right. *J Lanc Gen Hosp*. 2011; 6:1-3
- Health coverage still tough to get for individuals. <http://www.reuters.com/article/2011/03/16/us-usa-healthcare-survey-idUSTRE72F11X20110316>
- <http://thehill.com/blogs/healthwatch/health-reform-implementation/161209-hhs-grants-healthcare-waivers-to-nevada-new-hampshire>
- www.catf.org
- <http://www.nytimes.com/2011/03/22/business/22care.html>
- http://en.wikipedia.org/wiki/Frontier_Thesis
- <http://www.gallup.com/poll/20821/Americans-Canadians-Britons-Similarly-Rate-Their-Healthcare-Systems.aspx>
- Kurella M, Covinsky KE, Collins AJ, et al. Octogenarians and nonagenarians starting dialysis in the United States. *Ann Int Med*. 2007; 145: 177-183.
- http://news.yahoo.com/s/ap/20110310/ap_on_he_me/us_med_premature_birth_drug
- <http://www.webmd.com/baby/news/20110330/fda-generic-makena-ok>
- Nguyen PL, Gu X, Lipsitz SR, et al. Cost Implications of the Rapid Adoption of Newer Technologies for Treating Prostate Cancer. *J Clin Oncol*. 2011; 29: 1517-1524
- <http://healthaffairs.org/blog/author/alakeson/>