



Doctors as the Key to Health Care Reform

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Experts agree that sustainable health care reform requires reining in rising costs, but few people understand that the control of medical expenditures is largely in the hands of the medical

profession. Doctors, in consultation with their patients — not insurance companies, legislators, or government officials — make most of the decisions to use medical resources, thereby determining what the United States spends on medical care.

Most doctors are paid on a fee-for-service basis, which is a strong financial incentive for them to maximize the elective services they provide. This incentive, combined with the continued introduction of new and more expensive technology, is a major factor in driving up medical expenditures. The same incentive is attracting more and more young

doctors into specialties that command much higher fees — and therefore guarantee much greater income — than those earned by primary care practitioners. Primary care is rapidly becoming an endangered specialty; an important, but not the only, reason is its relatively low economic rewards.

A system like ours, which is grossly deficient in primary care physicians and dominated by specialists who are trained to use expensive tests and procedures, is inevitably costly, particularly when most specialists practice as independent small businesses, competing for patient referrals and

for income. Adjusting the fees paid by insurers, with increases for primary care and decreases for specialized procedures, or basing fees on the quality or outcome of care won't solve this problem, because specialists can easily control the volume and kinds of services they provide. Furthermore, competition doesn't lower prices in medical care as it does in other markets, because physicians usually choose the services to be provided and are paid largely by insurance — not by the consumers for whose business they would compete if this were an ordinary market.

To judge from the health care reform proposals getting serious attention in Washington, there is little evidence that lawmakers are aware of, or understand the significance of, these facts — or that, even if they did, they would

have the stomach for the major reforms needed to solve this problem.¹ Having surveyed all the current legislative proposals for slowing the continued inflation of costs, the Congressional Budget Office is not optimistic.

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Why should it be? We are not likely to control medical inflation unless the incentives in the traditional fee-for-service payment of doctors are eliminated, but nothing on the table in the health care reform debate even comes close to eliminating them. This fact explains why the private insurance and drug industries have so far been willing to support the Obama administration's reform proposals. These proposals would expand coverage and increase total health care expenditures, which means more income for insurers and drug manufacturers. Even after their promised help in reducing the increase in costs, these industries will make more money in the reformed system than they do now.

Massachusetts, often mentioned as a model for the nation, enacted legislation more than 3 years ago that achieved nearly universal insurance coverage but from the outset found itself struggling to keep up with rising costs. To control expenditures, a special state commission on health care payment has recommended the elimination of traditional fee-for-service payment.^{2,3} The commission envisions the creation of

new, as-yet-undefined medical management entities that it calls "accountable care organizations" (ACOs), which would organize physicians into multispecialty teams with strong primary care staffing. ACOs could include hos-

pitals, could be for-profit or not-for-profit, and would be expected to take risks only for their performance. Insurance carriers would continue to hold the insurance risk for their contracts with ACOs, and they would pay the latter on a per capita, risk-adjusted basis for comprehensive care. They would also use "pay for performance" as an incentive to promote quality and efficiency. The commission does not specify how physicians in ACOs would be paid, but a salary system is implied by the report's emphasis on the argument that Massachusetts cannot afford fee-for-service payment of its doctors if it wants to provide near-universal health insurance. Whether the commission's proposals will prove acceptable to stakeholders and, if so, whether they will ever be implemented remain to be seen.

As it moves to expand insurance coverage, the federal government will soon face the financial difficulty now confronting Massachusetts. However, I believe there is a much simpler national solution that would control costs by eliminating profit incentives and traditional fee-for-service payment while achieving

all the advantages of integrated practice. It would allow physicians and their patients to control medical care with less interference by insurers or government than the recommendations of the Massachusetts commission would probably require.

I have proposed a reformed health care system based on tax-supported, universal insurance, with medical care provided by a national network of community-based, private, not-for-profit, multispecialty, doctor-managed group practices.⁴ The insurance would pay for comprehensive care by the groups. Successful examples of multispecialty group practices already exist in our current health care system: the Mayo Clinic, the Cleveland Clinic, the Permanente Medical Group, the Geisinger Health System, the Marshfield Clinic, the Scott and White Clinic, the Billings Clinic, Denver Health, and many others. However, most of these groups are not prepaid for comprehensive care, and they bill many different payers for their services.

Groups in the system that I propose would pay their staff physicians a salary for doing what doctors ought to be doing: providing patients with the best, most cost-effective care, within the limits of a publicly determined budget. Physicians would not be influenced by the effects of each medical decision on their own income. The groups would enable primary care physicians and specialists to work together, without competition or turf warfare, but with compensation that would be acceptable to specialists and generalists alike.

Groups would compete for patients and for published ratings

of their quality — but not for income, because they would not be allowed to keep any net income. In addition, capital improvements would require approval, and groups would be held harmless for any losses due to adverse selection by patients with, or at high risk for, expensive conditions. Capitated prepayment of the groups would allow a central public agency to control the country's total medical expenditures. This agency would establish standards for group organization, administrative operations, and accountability but would leave individual medical care decisions where they belong — in the hands of physicians and pa-

tients. Private insurance plans and employers would have no role in this system.

Achieving reform of this kind would be a major task that would probably have to be carried out in stages. The opposition by vested interests and conservative ideologues would be fierce. To persuade lawmakers to act, the majority of the public, the medical profession, and the business community would have to unite in advocating this change. But without such a political awakening, I believe that the economic incentives and organization of medical care cannot be changed, and the current slide of the system toward bankruptcy will contin-

ue. That decline, however, might ultimately cause a disaster that would generate popular demand for real reform.

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Getting Past Denial — The High Cost of Health Care in the United States

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What seemed to be a golden opportunity to achieve badly needed health care reform now appears to be threatened. Many Americans believe that we simply cannot afford to cover the uninsured, since doing so would require taxes to be raised beyond the level the public can sustain. Others believe that we can slow spending growth only by rationing needed care. Neither option is attractive. Evidence regarding regional variations in spending and growth, however, points to a more hopeful alternative: we should be able to reorganize and improve care to eliminate wasteful and unnecessary services.¹

But not everyone is convinced. Some physicians, hospital administrators, and legislators appear to

have succumbed to a behavioral bias. They know that their patients are sick and that sick patients need more care than relatively healthy ones. They therefore conclude that the reason their hospital or region spends more is that their patients are sicker and poorer than those cared for by institutions in other regions. Given this reverse “Lake Wobegon” effect that renders all U.S. patients below average (in Garrison Keillor’s fictional town of Lake Wobegon “all the women are strong, all the men are good-looking, and all the children are above average”), they argue that any efforts to rein in costs will cause harm to the people we most want to protect.

And it's not hard to find examples of places where this expla-

nation might appear to make perfect sense: in Los Angeles, where Medicare spends \$10,810 per capita, a somewhat higher percentage of the population (15%) is at or below the poverty line than in Minneapolis (10%), which spends \$6,705 per capita.

This is too important a moment to allow physicians or policymakers to be confused by behavioral biases or distracted by one-off examples. Health is indeed the most important determinant of health care spending, but differences in health explain only a small part of the regional variations in spending.²

We illustrate by updating our earlier Dartmouth Atlas study² with 2004 and 2005 data from the Medicare Current Beneficiary