Sick Hospitals, Sick You: Healing America's Health Care Crisis

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Panelists:
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We all know that the health care system is in crisis and nobody's happy. Employers aren't happy, uninsured patients aren't happy, providers aren't happy. A few groups are happy—Medicare recipients, on average, and plastic surgeons who don't have to deal with the system because most patients that undergo cosmetic surgery pay out of pocket. The bottom line is we spend the most of any developed country but get the least for it. I'm going to read you a quote from a book by Malcolm Gladwell called The Moral Hazard Myth: "A country that displays an almost ruthless commitment to efficiency and performance in every aspect of its economy, a country that switched to Japanese cars the moment they were more reliable and to Chinese t-shirts the moment they were 5 cents cheaper, has loyally stuck with a healthcare system that leaves its citizenry pulling out their teeth with pliers."

Another way of saying it is that our health care system is making Model T Fords when really we should be making Toyotas—and we know how to make Toyotas. Expenditures in the US are $2.1 trillion and rising: about $7,000 per capita for health care. We spend 15 to 16 percent of our gross domestic product. How do we compare with other developed countries? Out of 19 countries we're No. 1 in spending. Finland, which is No. 19, spends $2,100 a year per capita on health care. You can say Finland's very different, but what about Great Britain? Great Britain spends $2,317.

Well, you say, we're spending more but we're better, it must be a great system. Life expectancy in the US increased by 7.6 years between 1960 and 2003, but that's much less than the increase of over 14 years in Japan or 8.0 years in Canada. We're below the OECD average of 78.3, which is 77.5. Infant mortality rates, although they've fallen in the US, are still below the average. But we can get up and cheer, we're No. 1 in obesity. We spend $150 billion a year on diabetes and we're creating the world's largest diabetes epidemic by allowing obesity to occur in our country. We're feeding those behaviors which drive costs up at the same time we're complaining about our ability to fund health care.

We spend nearly a $100 billion a year to provide uninsured residents with health care services, but the problem is that, of 1.4 million bankruptcies in the United States, half of them, according to a Harvard study, were due to medical bills, and more than three-quarters of those patients were insured at the start of their bankruptcy illness but lost it during the course of their illness. People with cancer had an average medical debt of $30,000. The uninsured are often the sickest, so bringing them into the system as Massachusetts is doing and California is attempting to do, is a way of then being able to emphasize the kind of preventative care that will prevent complications.

So, if we're paying more than any other country for health care, shouldn't we have everyone covered and the best results in the world? The answer is yes, but in order to do that we have to have the political will. So let me just talk about the three greatest myths about the health care system.
Panel Discussion

**Brown:** Dr. Brody argued for moving from a "non-system" to a system of coverage and of health care. How do we create this system? In that, what is the role of government? What is the role of the individual provider and the individual health care institution?

**Fielding:** The government is different levels, and at the local level we're even more disadvantaged than the community hospital system. The hospitals that are run by the county of Los Angeles have serious structural problems and they are probably worse than any other, and yet that's where a lot of people are getting their care. If you talk about strictly the financing part, I think you could make an argument for the government least setting the rules, just like the Treasury Department does now for how you buy mutual funds, or the kinds of disclosures that companies have to give in stock markets. Whether they're overbearing or not, there is an important government role.

I personally don't believe that government should be the primary provider of care, but it has to increasingly be part of setting rules. It doesn't make sense, for example, for your hospital to have to have 20 different sets of quality measures! all of which are somewhat different and incur huge expenses. We should get agreement on that.

But I think we have to be careful because the political winds are always to give more—and just like the political candidates who haven't talked about the "r" word [health care "rationing"] and how we're going to control cost. If we let the government decide on benefits without all the stakeholders being involved we'll wind up with the same problem Los Angeles County has, which is an incredible retiree health obligation that we don't know how we're going to meet. And we're not alone.

**Plested:** If you're going to provide something you must set limits, and that's what government doesn't want to do. They want to shift the limit setting to physicians and hospitals and it just doesn't work. It isn't going to work because one is a rules-based system and one is an ethics-based system. Financing is key for the public portion of this new system and they have to set the limits. When you come to me as a doctor, I can say "these are the things that are available." This one I may choose as best for you, but it isn't covered by your insurer. These are your options, I think this is the best. If you pay for yourself and you say, I want the one you think is the very best, fine. But the government's got to say, we can't cover everything. They've got to admit that instead of saying we'll cover everybody. You know, "if you're sick go to the emergency room." And then guess who gets stuck paying the bill?

**Surowitz:** The government is already involved in financing. The vast majority of hospital care is either for Medicare for the...
Panel Discussion (continued)

aged or Medi-Cal for the poor, so they’re already there in terms of the financing arm as well as that quality component. If we don’t get our acts together as both hospitals and doctors, the government will intercede in both. People expect more from us as it relates to quality, and if we don’t assert ourselves it will be done for us by the government.

Brown: Aren’t we now in the situation where we have a system in which every payer is able to set their own limits, their own payment rules? Isn’t most of that bureaucracy really rated to the billing process that we have when we have a hospital? The standard example is Cedars-Sinai, with how many staff in the billing department? In the hundreds, I would suspect. Compared to an equally large and prestigious hospital in Canada, University of Toronto Hospital, which I believe has a billing department of half a dozen staff. The reason for that is in Canada there is a totally unified payment system. In the United States we don’t have anything even approximating it, not even a figment of anybody’s imagination. So, given that, is there a role for government in forcing the different parties in the system to come together and setting rules that would apply to the public sector and the private sector alike?

Surowitz: I think on the quality issues, without a doubt. The government needs to take a role in that arena. If we break out the Medicare population and the Medicaid population you’re left with the private insurance population, the working folks in this country. I think we’re going to need somebody to say these are the rules. In the long run it’s going to have to be focused not just on the quality component but it’s got to be focused on cost.

Plested: The quality issue is a professional imperative and not a government imperative. I just don’t think the government has the core competence to do this job.

The question is, should we have only one type of care offer in the United States? That’s what they have in Canada and what Richard says is right. It’s a lot cheaper, but the Supreme Court of Canada said last year that the free Canadian healthcare system is a virtual monopoly which causes untold pain, suffering and death to the citizens of Canada. The biggest revolution in Canada today is the growth of a separate private system where people are allowed to purchase a different type of insurance on the private side in addition to the public side. I strongly believe that you must have a public and a private system and there will be different costs involved.

Fielding: I think as the richest nation in the world we can afford to provide health care for everybody. It’s a disgrace that we have 46 million people who are uninsured, that’s not what we stand for as a nation. We need better treatment for our national schizophrenia, because on one hand we’re a market-based economy, and on the other hand you don’t have the things that make a perfect market. The consumer is not the patient in many cases, it’s the doctor. That means you’re not going to have the kind of market you have when you go out to buy a car. I think to try and have competition on that basis doesn’t make a lot of sense and probably adds a lot of cost. That’s a place where the government and private stakeholders need to agree on a set of rules. But I would still make room for different organizational structures, like Kaiser, because that’s a different way of thinking about how you organize and deliver care.

Brown: Most European countries have some model in which the government does play a strong role and the role varies tremendously. In some, like the United Kingdom, the government actually runs the health care system, the delivery system. They hire many of the doctors, they provide all the salaries to those doctors, they pay all the bills in the system. In others, there’s largely private health insurance that provides the financing, and there are many models in between. In Germany, quasigovernmental health plans now become more privatized. In France, there are largely private health plans that operate under very strict government and charter regulations so that they are quasi-public. But what is common across all of them is that the government plays a role in setting the upper limits on how much money is going to be spent, and they bring the different parties together—the doctors, the hospitals, the employers, labor, and other groups—and force them to come up with a system of dividing money up that those entities can all live with. How do we make these decisions about where our national health resources are going to be invested to produce the most health for the dollars?

Fielding: Well, we’re not doing it now. That’s for sure. Tobacco is still the No. 1 preventable cause of death. If we spent a very small percentage of that extra 1 percent or reduced it, if we simply spent a couple hundred million dollars a year, which is chicken feed, or let’s be grandiose and say a billion dollars a year, we could reduce the smoking rate dramatically. We still have over a million smokers in Los Angeles County alone and we don’t have the resources to do the things that have been shown to be effective. We know what to do but all the money’s going into health care. What about overweight and obesity? One out of three kids born today is going to wind up with diabetes at some time in their life if we continue to have this epidemic of overweight and obesity and yet we’re spending very little. This is not going to be solved just clinically. We’re going to need to do a lot of things to try and change how we eat. More physical activity, which we could get if we weren’t sitting here sitting next to each other. We have to think more broadly about what determines health. We might decide we should put $100 billion into the public education system so we didn’t have so many people who are functionally illiterate, which is sapping our national productivity as well as adversely impacting health. The perception of how to think about health is really the major constraint and needs a reconceptualization.
Governor Schwarzenegger for taking the lead. The difficulty, of course, comes with what should be covered, and there the political system comes in.

**Myth 3:** Myth No.3 is that the patient is a consumer. He isn’t, really. We all talk about consumer-driven health care, and more information for patients is a great idea. Patients with a mammogram and a diagnosis of breast cancer come to their doctor today with a lot of information from the Internet. That’s terrific, I think most physicians appreciate it. But promoting health care consumption the same way we promote laundry detergent is a bad idea. First of all, health care consumers are not payers—they’re not paying the bill. So I’m sending you to the wine store and you can buy all that imported French wine because you’re not going to pay for it, and I’m not going to pay for it, somebody else is going to pay for it. The doctors and the consumers have no vested interest in managing patient health care expenditures.

In my view the worst offender is direct-to-consumer advertising, both by pharmaceuticals and health care providers as well, because there’s no way of providing information that runs counter to what you see. And since the patients are not paying the bills themselves, you lose the ability to find an efficient way to purchase health care.

The question is, what can we do? We have to get everyone in the insurance pool, we ought to be funding more for public health, we should emphasize and reward quality, we need to float prices for providers as well as suppliers because you can’t have a system where one side is capped and the other isn’t. We should eliminate DTC advertising, and one thing I didn’t talk about is reforming the medical justice system.

Do we have the political will? If you listen to everybody in Washington all the candidates are going to be talking about it. It’s going to be very interesting to see how specific they want to get about the things they’re going to do and not going to do. I think the recipe is to treat health care not as a product, but as a benefit provided all citizens. More is not necessarily better. We’re spending a lot but we’re not getting what we should be getting for the amount that we’re spending.

We need to learn one thing that we’ve been missing over and over, which is that we have been emphasizing cost rather than quality. Toyota showed us many years ago that if you emphasize quality, overall you drive down cost. But if you emphasize cost, quality does not go up.◆

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—WILLIAM R. BRODY, MD

**Q&A:**

Q. Is there anything individual Americans can do to help promote some of the reforms that you are suggesting?

**Dr. Brody:** I never saw students smoking on campus. I saw more students overweight, tremendously overweight. Alcohol is another huge issue on college campuses. If you had students begin a grassroots movement to promote healthy behaviors it would make an extraordinary impact 20 to 60 years down the line when those people then develop chronic ailments resulting from diabetes, chronic obstructive lung disease to lung cancer and so forth. Those are really public health and behavioral issues. So the extent to which students could get involved in creating that kind of movement, it would be very profound.

Q. There’s been news recently about Wal-Mart entering the care delivery business. How’s that going to change the delivery of care?

**Dr. Brody:** Well, one thing I’m in favor of, but not all my physician colleagues are, is the ‘minute clinic’—providing very cost-effective and convenient ways of delivering routine care. What the minute clinics do are provide a nurse practitioner within a CVS or Target store, and Wal-Mart has their own. If you have a common ailment, sore throat being one, you can go in and have a throat culture. They’re less costly than going to a physician, it’s faster and it’s done under strict protocol so the care is very standardized.

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