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## THE HEALTH OF NATIONS

I. In this past election season, our dysfunctional and extravagantly expensive health care system was pushed off the front pages by concerns about the candidates, the fight against terrorism, and the war in Iraq. And yet the health system's problems will not go away; sooner or later we will have to solve them or face disastrous consequences. Over the past four decades (starting just before the arrival of Medicare and Medicaid), both the system itself and ideas about how it should be reformed have changed a lot, but an equitable, efficient, and affordable arrangement still eludes us.

During the past four decades our health policies have failed to meet national needs because they have been heavily influenced by the delusion that medical care is essentially a business. This delusion stubbornly persists, and current proposals for a more "consumer-driven" health system are likely to make our predicament even worse. I wish to examine these proposals and to explain why I think they are fundamentally flawed. A different kind of approach could solve our problems, but it would mean a major reform of the entire system, not only the way it is financed and insured, but also how physicians are organized in practice and how they are paid. Since such a reform would threaten the financial interests of investors, insurers, and many vendors and providers of health services, the short-term political prospects for such reform are not very good. But I am convinced that a complete overhaul is inevitable, because in the long run nothing else is likely to work.

Let us begin by looking back. Just over four decades ago, in 1963, medical care in the United States consisted mostly of personal transactions between physicians and patients, which took place in patients' homes, doctors' offices, or not-for-profit hospitals and clinics. Only a few of these transactions involved expensive technology or highly specialized facilities, and primary-care physicians could spend the necessary time with their patients. Total expenditures for medical care were about 5 percent of the economy, and the government paid for less than a quarter of it. Health insurance purchased by individuals and insurance paid by employers for their employees accounted for a small part of the rest. Most of this insurance was of the "indemnity" type, that is, the insurance company paid the doctor and the hospital and charged the patient premiums that covered those bills, plus its modest overhead. Most patients were uninsured. They usually paid their bills directly out of pocket if they could, but there were far too many who simply could not afford the services that they needed. They had to rely on private charity or tax-supported institutions. Few observers thought the system was a "market" or an "industry," investors were not much interested in health care services, and hardly any economists or business leaders paid much attention to it.

In 1963, a seminal analysis of the medical care system as a market was published in the *American Economic Review* by the distinguished economist Kenneth J. Arrow. He argued that the medical care system was set apart from other markets by several special characteristics, including these: a

demand for service that was irregular and unpredictable, and was often associated with what he called an "assault on personal integrity" (because it tended to arise from serious illness or injury); a supply of services that did not simply respond to the desires of buyers, but was mainly shaped by the professional judgment of physicians about the medical needs of patients (Arrow pointed out that doctors differ from vendors of most other services because they are expected to place a primary concern for the patient's welfare above considerations of profit); a limitation on the entry of providers into the market, resulting from the high costs, the restrictions, and the exacting standards of medical education and professional licensure; a relative insensitivity to prices; and a near absence of price competition.

But perhaps the most important of Arrow's insights was the recognition of what he called the "uncertainty" inherent in medical services. By this he meant the great asymmetry of information between provider and buyer concerning the need for, and the probable consequences of, a medical service or a course of medical action. Since patients usually know little about the technical aspects of medicine and are often sick and frightened, they cannot independently choose their own medical services the way that consumers choose most services in the usual market. As a result, patients must trust physicians to choose what services they need, not just to provide the services. To protect the interests of patients in such circumstances, Arrow contended, society has had to rely on non-market mechanisms (such as professional educational requirements and state licensure) rather than on the discipline of the market and the choices of informed buyers.

Of course, another conclusion could have been drawn from Arrow's analysis (though he apparently did not draw it). It is that medical care is not really a "market" at all in the classical economic sense, and therefore that the basic theories of economics are not relevant to the discussion of the first principles of health care. But our society assumes that market economics applies to virtually all human activity involving the exchange of goods or services for money, and this dogma is rarely questioned. Most economists would acknowledge that medical care is an imperfect or idiosyncratic market, but still they believe that it is a market, and that it should therefore obey economic predictions.

Arrow's paper attracted much attention from economists and social scientists, and it is generally acknowledged to have been a landmark in the early literature of health economics. It might have had more influence on health policy had not the whole system begun to change dramatically soon after his article was published. With the passage of Medicare and Medicaid legislation in 1965, large amounts of government money entered the health system through these insurance programs. Including the value of tax benefits, the government now pays for more than half of all health care costs. At the same time, funding through private insurance was also expanding greatly, due to the growth of employment-based health coverage that is tax-deductible by employers. The great majority of large- and medium-sized businesses began to offer their employees (and their families) medical insurance coverage as a tax-free fringe benefit. Today more than 160 million people are insured in this way, accounting for slightly less than half of all funding for health care.

In response to the business opportunities afforded by the abundant new supply of insurance

money, medical entrepreneurialism blossomed on a grand scale. Private investor-owned health care firms proliferated, including investor-owned hospitals, nursing homes, and ambulatory facilities. Many practicing physicians joined in this medical gold rush, and even many "not-for-profit" hospitals and ambulatory-care facilities became income-maximizers in what increasingly looked like a competitive "health care industry." This economic expansion-- this monetization--of health care in the 1960s and 1970s was also stimulated by a large increase in the number of doctors, both American-trained and foreign-trained, most of them specialists. There also occurred a great expansion of medical research and development, leading to expensive new treatments, devices, and drugs--which could be reimbursed by insurance on an item-by-item basis. New technology, new medical and surgical specialists, and piecemeal reimbursement by insurance were an explosive economic mixture that drove up health care expenditures and generated new opportunities for commercial gain.

Adding to the effects of these changes, the federal courts handed down a series of rulings that decided that the practice of the professions (including law and medicine) should not be exempted from the reach of antitrust law. Beginning in 1975 with a landmark ruling by the Supreme Court in *Goldfarb v. Virginia State Bar*, the courts applied antitrust law to professional practice. The effect of these rulings was to deter professional groups and associations from limiting competitive commercial activity by practitioners, which they had previously done through such time-honored measures as suggesting fair prices and banning advertising. The courts seemed to be saying that medical financial transactions were not different from ordinary commerce, and therefore attempts to limit market competition would violate antitrust laws. There was also the implication that competition in medical markets would serve consumer interests by moderating prices and improving quality, as it was supposed to do in other markets. These rulings cowed the American Medical Association and other professional societies, which thereafter carefully avoided any attempt to stem the commercialization of medical practice.

The result of all these economic and legal developments was to diminish the special aura of professionalism and social service that had traditionally surrounded the practice of medicine and kept it apart from commerce. Ignoring Arrow's wise argument that medical care was inherently different from most other markets and therefore required non-market mechanisms for its regulation, economists, health policy experts, and the courts began to think of it as simply a specialized form of business enterprise that was best left to market forces. And for this they could hardly be faulted. Health care had indeed begun to resemble a gigantic industry, and it was consuming a growing fraction of the national economy.

## II.

In 1980, in *The New England Journal of Medicine*, I described this changing face of American health care as the "new medical-industrial complex." The term was derived, of course, from the language that President Eisenhower had used ("military-industrial complex") when warning the nation, as he was retiring, about the growing influence of arms manufacturers over American political and economic policies. Referring to Arrow's analysis, I suggested that market-driven

health care would simply add to the explosion of medical expenditures and the growing problems of inequity and variable quality. I was also worried that this uncontrolled industrial transformation would undermine the professional values of physicians, which are surely an essential ingredient of any decent medical care system. Financial incentives were replacing the service ethic of doctors and hospitals, as the providers of care began to compete for market share and larger income. Yet competition on the basis of the price and quality of services--an essential characteristic of most free markets--was little in evidence, demonstrating again the truth of Arrow's argument that the medical care market was different.

As expenditures on medical care continued to rise rapidly, the major payers (employers and government) began to resist. Employers revolted against the unpredictable and seemingly uncontrollable costs of the indemnity insurance that they were buying for their employees, and they demanded a different kind of coverage. In response, a new and largely investor-owned health insurance industry quickly appeared which contracted with employers to provide "managed-care" insurance plans, or HMOs. The plans controlled their payments for medical services (they called them "medical losses") by requiring beneficiaries to select a primary-care physician from among a panel of doctors under contract with the plan. These doctors had to approve referrals to specialists and had to get approval from the plan before admitting patients to the hospital. Primary-care physicians were usually paid on a per capita basis and could refer only to selected specialists who had agreed to accept the discounted fees negotiated by the plan. The expenditures and the referral patterns of the primary-care physicians were monitored by the plan, which used financial rewards and penalties to ensure compliance with its policies. Although the HMOs claimed these policies were primarily intended to improve the care of patients and to eliminate the risks and expense of unnecessary procedures, they were perceived by most physicians and patients as restrictions on care that were essentially designed for the benefit of the insurers and employers. And that perception was probably correct.

The government tried to control its costs by contracting with private HMO plans for many of its Medicaid beneficiaries, by encouraging Medicare beneficiaries to join HMOs, and by reducing its payments for services covered by Medicare. Physicians' fees were sharply discounted and based on a "relative value" scale. In a major change in its method of hospital payment, Medicare paid fixed sums related to the diagnosis and the type of treatment, rather than reimbursing for the individual items of service provided and the days of hospital care. Cost-controlling efforts by private and public insurers also included so-called "case management" and "disease management." Under these new approaches, nurses were employed to facilitate early discharges of patients from hospitals and to help ambulatory patients with chronic diseases avoid hospitalization through more careful compliance with therapeutic and preventive regimens. Like other aspects of "managed care," these programs were claimed to improve the effectiveness of treatment, but they also cut expenditures on hospital care.

During the mid-1990s, private managed-care insurance plans briefly succeeded in controlling the rise in the premiums charged to employers, while still making substantial profits for themselves. But there ensued a major backlash from employers, who resented the restrictions on their care

and their access to specialists, and this soon forced employers to abandon HMO plans in favor of so-called "PPO" plans that were more expensive but allowed beneficiaries greater choice of physicians and easier access to specialized care. At the same time, the financial pressure from new and more expensive technology was constantly increasing. The inevitable result was a resumption of cost increases for private insurers and an escalation in the premiums paid by employers. Government insurance also was affected by the increased use of technology, and, despite all efforts at control of payments to providers, Medicare expenditures per capita continued to rise almost as rapidly as expenditures in the private sector. Much of the new expensive technology (including drugs) was being used in outpatient settings, so restraints on hospital spending did not solve Medicare's problems.

In an increasingly profit-driven and entrepreneurial medical market, piecework payment for specialized outpatient services stimulated an even greater fragmentation of medical care and a greater use of individually billable items of outpatient technological service. Less attention was given to the continuity and the integration of care, and to preventive medicine. Decreased payments to primary-care physicians and increased pressure on them to see more patients reduced the time that they spent with each patient. As a consequence of all these developments, the quality of primary care suffered, and the difference between the quality of average medical care and the best medical care widened, even as per capita expenditures rose and the number of uninsured and underinsured patients increased. This quality "gap" was the subject of a major report in 2001 from the Institute of Medicine of the National Academy of Sciences, which described the many deficiencies in the way patients were being treated and suggested how their medical care could be improved. Unfortunately, the experts preparing the report were not asked to consider how the system itself might be restructured to facilitate the needed improvements.

And so we now live with a seriously defective medical care system, based more heavily on market incentives than the health care regime of any other country in the world. The commercial tone is set by investor-owned insurance companies (the major share of the private insurance market), investor-owned hospitals (about 15 percent of all community hospitals), and investor-owned ambulatory-care facilities and nursing homes (the great majority of both these markets). The behavior of many of the so-called "not-for-profit" health care facilities is not much different from that of their investor-owned competitors, because they have to survive in the same unforgiving marketplace, which is indifferent to the social values that originally motivated most health care institutions. As for American physicians, their attitude toward their profession has also been changed by the new medical marketplace. To a degree greater than anywhere else in the world, our doctors think of themselves as competitive businesspeople. As such, they own or invest in diagnostic and therapeutic facilities (including specialty hospitals), they form investor-owned medical groups, and they advertise their services to the public.

The total cost of the health care system is now a staggering \$1.6 trillion. It consumes more than 15 percent of our economy, and the total is rising steadily at a rate of approximately 7 to 9 percent per year. Obviously, this rate of inflation is unsustainable. Neither the government nor private employers can keep up with rising health costs. Per capita, we spend one-third more on

medical care than the next closest country (Switzerland), and almost twice as much as the majority of other technically advanced Western countries. Yet as a consequence of our failure to provide affordable and good-quality medical care to so many of our citizens, we are not getting anywhere near our money's worth. Economists and vendors of new drugs and technologies may allege that the life-enhancing and life-extending benefits of many medical advances are good value for the money, but when the mediocre performance of our system as a whole (as judged by such measures as insurance coverage, life expectancy, and infant mortality) is compared with that of other advanced countries, which spend far less, it is an unpersuasive argument. Our best medical institutions and our most advanced technology lead the world in their sophistication, but we neglect the poor and the uninsured.

Our failure to address the glaring deficiencies and inequities in our health care system is nothing to be proud of. A growing number of people are losing their private health insurance. There are now more than 45 million Americans without coverage. Much of this is due to the loss of good jobs, but high costs are also a significant factor. The financial burdens of those who are insured increase steadily, as hard-pressed employers reduce covered benefits and increase the fraction of insurance costs being shifted to beneficiaries. Rising health costs are threatening the financial stability and competitiveness of many American businesses, and are discouraging the hiring of new full-time workers. The government is also shifting insurance costs to Medicare beneficiaries, as exemplified by the recent large increase in the premium charged for coverage of outpatient medical services and physicians' care ("Part B").

What really astonishes me is that so many conservative business and health policy experts continue to hold an unshakable faith in a market solution for our system's major problems. They believe that market forces have not been allowed to contain costs or to improve access and quality because of government regulation, and because of badly designed insurance that prevents consumers from playing an appropriate role. They think that the consumers of medical care in both public and private insurance systems have not had enough influence on the supply of services and have not been sufficiently involved in price negotiations with providers. These days the "free market" is held to be the solution to most social and economic problems, and it is commonly believed that in health care the most important missing ingredient of a free market is the traditional consumer who has the incentive and the ability to bargain for the desired price and quality of services. So it shouldn't be surprising that the idea for improving our health care system that is currently most popular is so-called "consumer-driven health care," or CDHC.

The term "consumer-driven health care" is used to mean a market for medical care in which patients, as the "consumers" of medical services, would have a lot more responsibility for choosing those services and would share more of the costs. In the most fully developed proposals, providers of medical care (physicians, hospitals, clinics, and so on) would compete for patients on the basis of quality, price, and convenience--not simply for market share, as they do now. Patients, like consumers in any service market, would have access to all the information they need to make their own health care choices. They would choose and own their insurance plans. They would select not only their health care providers, but also the particular medical

services they want. Since they would share more of the costs, they would have an incentive to make prudent choices and to demand higher quality. The net result, it is claimed, would be a better, less expensive health care system.

To achieve those goals, most proposals for CDHC include a high-deductible catastrophic insurance plan that is selected, purchased, and owned by individuals with the help of a tax-exempt contribution from their employer. This contribution is used to set up a "health savings account" (HSA), which is owned by the employee and can be used to pay the insurance premiums and to help defray the cost of the deductible. HSAs were created by a provision of the complicated and controversial Medicare Modernization Act that the Bush administration pushed through Congress at the end of 2003.

Under the new law, HSAs can be established by tax-free contributions from employers or individuals. The funds in an account can be invested but spent only on medical services. Unspent money is rolled over each year, as are any interest and investment earnings. HSAs are the property of consumers and stay with them if they change jobs. When the patient/consumer reaches the age of sixty-five, HSA savings can be withdrawn, tax-free, to pay out-of-pocket medical expenses not covered by Medicare, or they can be used for non-medical expenses, but with normal tax liability. Under this kind of plan, employers contribute to the health insurance expenses of employees, but make a defined financial contribution rather than pay for a medical insurance plan that provides a defined package of benefits. Consumers of health care get to "own" a piece of the system by using the employers' HSA contribution (possibly supplemented by their own funds) to purchase a high-deductible plan of their own choosing.

The assumption of the CDHC system is that such a plan would moderate health care inflation by encouraging patients to become more prudent consumers of elective and non-catastrophic health services, because they would be spending money they otherwise could invest in their savings account. It is also assumed that in competing for business, the providers of medical care would try to make their services more attractive to patients by improving quality and convenience, as well as by moderating their prices.

CDHC does not basically change the reimbursement of physicians, the itemized payment for outpatient technology, or the present mixed methods for hospital reimbursement. But some leading advocates of CDHC believe that to facilitate consumer choice in such a system, medical services should become more distinctly separated, specialized, and better identified. Much the way "boutique" stores in a shopping mall offer particular types of products in order to make it easier for shoppers to find what they want, hospitals and clinics would specialize in particular kinds of services for particular patients. Specialists, already the largest fraction of physicians, would become even more numerous, because consumers would be deciding for themselves what kinds of medical services they want, and they would need less advice from general physicians. No change in the organization or the provision of services by physicians would be mandated by law. Instead, market forces would be relied on to produce most of the desired changes in the delivery system.

Medical advertising would be encouraged in CDHC, including direct-to-consumer ads by pharmaceutical companies, physicians, and medical care facilities. To help medical customers evaluate the advertised goods and services and make their own decisions about their health care, the system would also rely heavily on making information easily available to patients through a wide variety of public and private sources, including websites, guidelines, popular books, and articles in the media. Some more educated and self-confident "consumers" might even consult medical journals and textbooks to decide about their health care needs. Proponents of CDHC believe that most patients, armed with the appropriate information, would know not only what insurance they want to buy, but also what care they want their physicians to provide--or they would at least be able to decide for themselves, except in some emergencies, whether to accept the medical advice given them by their physicians.

When combined with the financial incentives already described, this kind of "empowerment" of health care consumers, it is claimed, would allow market forces to work their magic, thereby solving most of the health system's problems. Some version of these ideas is part of virtually every proposal to change current arrangements for employment-based and individually purchased health insurance. Many CDHC plans have already been tried in the private sector, but without the tax benefits now provided in the new Medicare legislation. Despite the optimism and the enthusiasm of their proponents, it is too early to say whether any of these plans will prove generally popular, or even come close to meeting expectations.

There are compelling reasons, I think, to predict that they will not. For a start, high-deductible insurance is not likely to produce reductions in expenditures, except among low- and modest-income families, who would feel financial pressure to cut their doctor visits and their use of other medical services. There is good experimental evidence that high deductibles have such selective effects, which expose the most vulnerable patients to greater health risks. Higher-earning beneficiaries would not feel such pressure and would continue to use all medical services freely. Whatever reductions in total expenditures might occur would be achieved largely through reducing services to those with lower earnings. Adjusting the size of the deductible in approved plans to the income of the beneficiaries might ameliorate that injustice, but it would add to administrative costs and would be virtually impossible to do properly--given the difficulties in making fair assessments of financial need.

If people were allowed to select whatever insurance plan they wanted, the inequity would probably increase in another way. Healthy, young families would choose the least expensive plans with the highest allowable deductible, and those with health problems would be forced to choose plans with the lowest allowable deductibles but higher premiums. The premiums or the required co-payments of the latter plans would spiral upward because of the greater use of services by sicker beneficiaries, so it would become even harder for those with the greatest need for insurance to afford coverage. In this way, one of the most important values of insurance--the sharing of risks over a broad population base--would be lost. Adjusting the contribution of employer or government to the health status of the beneficiaries has been suggested as a means of avoiding this problem, but the relatively primitive state of the art of risk adjustment and the

difficulty in applying it to families make this solution unlikely. It also would add greatly to administrative costs.

Contrary to the claims of its advocates, CDHC would impede efforts to improve the quality of care. The improvements recommended by the Institute of Medicine in 2001 could not be implemented if medical consumers went shopping from provider to provider, looking for the desired services and acting to the best of their ability as their own primary-care physician. Neither could the Institute of Medicine's recommendations about quality be achieved if doctors and hospitals were expected to function as independent vendors do in ordinary markets, simply responding to the demands of consumers. The essential task of coordination and integration of services for each patient would be left to the patients themselves, and the uniform adoption of modern information technology would be impossible. A fully developed CDHC market would be chaotic, to say the least, and in such a system continuity of care would be virtually non-existent. It is hard to imagine such a system improving the quality or the efficiency of care. The problems with the quality of our current delivery system would probably worsen.

I do not mean to suggest that a more consumer-oriented system would not be in many respects desirable and possible. For years critics have been saying that the traditional medical care system is too paternalistic and not sufficiently focused on making care more convenient and responsive to patients. They are right. There are many ways physicians could help patients better understand their own health needs and participate more in their own care. Doctors should undoubtedly pay more attention to patients and less to their own convenience. They should also ensure that medical decisions are based on fully informed consent by patients whenever possible. But all this is quite different from what the most zealous proponents of CDHC are urging. They seem to be saying that patients can and should play a sovereign role in selecting their own care, and that physicians should assume the role of mere providers of the services requested by consumers.

The CDHC plans that are now being advocated by believers in the magic of markets shift to patients not only a large part of the responsibility for being their own doctors, but also the burden of paying more of the cost--and that burden would be heaviest on the poorest and sickest of our citizens. This is surely a denial of the ethical principle underlying universal coverage and the sharing of costs. But the major payers, government and employers, are no longer willing or able to shoulder health care's rising costs, and so they are promoting CDHC. They may justify their views by arguing that it makes sense to shift more of the costs to patients because patients are in the best position to put the brakes on health cost inflation. This might be a reasonable argument if medical care were like other services in other markets--but it is not.

For all these reasons, then, "consumer-driven" plans are unrealistic and unfair, and they are not likely to be politically viable in the long run. There is some understandable support for the idea that individuals should be more responsible for the cost of elective or optional medical services, but most people believe that the availability of needed services should not depend on ability to pay. We are a wealthy society, and decency requires that we make equitable arrangements to

ensure at least minimally adequate health care for all--a goal that is beyond the scope of market forces.

These arguments notwithstanding, CDHC plans of one kind or another are now firmly embedded in current thinking about health policy and will surely be more widely tested. A notable sign of this trend, and a clear depiction of the way CDHC will fracture the social values of health insurance, is the recent announcement by the Kaiser Permanente HMO plan that it will be offering its members the choice of a high-deductible, low-premium plan tied to an HSA. Explaining this decision, a Kaiser spokesman said, "If all we offer at Kaiser is comprehensive coverage, then all of the sick people go to Kaiser and everyone else goes to the other plans."

So strong is the current belief in market-based plans such as CDHC, and so powerful are the economic interests profiting from the commercialization of our health care system, that it will take considerable time--at least, I would guess, until the end of this decade or beyond--before a major change in the direction of national health policy becomes feasible. The start of substantial reform will probably have to wait for CDHC to play itself out, just as investor-owned "managed care" did in the last decade. I expect the system to become so dysfunctional, and costs to become so onerous, that the availability of services to the poor will decline even more, the number of uninsured and underinsured will continue to grow, and the inequity between the care of the rich and the poor will reach scandalous proportions. At that juncture, public opinion will probably demand that health care move from market control to some form of government protection and guaranteed benefits. Major reform of our entire health care system might then become a politically realistic option.

Another critical requirement for major change will be the recognition by a majority of physicians that their professionalism is being eroded by the commercial transformation of medical care. Doctors will have to understand that in the long run they cannot thrive as a profession in a market-driven system. They will have to be willing to practice under less entrepreneurial arrangements that are more compatible with the moral and scientific standards upon which medicine has traditionally been based. And they will need to stand with the public in opposing those who have been exploiting the health care system for private gain, and who have added so much to its overhead, administrative costs, inefficiency, and inequity without adding anything nearly commensurate in value.

#### IV.

Then that time comes, we should be prepared to replace a failed market-based system with a better one that can deliver the health care we need. What kind of system might that be? The question cannot be confidently answered in any detail before the market-based system has run its course, and before there has been some preliminary experience with non-market-based models--perhaps at first in a few states. Still, a few general principles and objectives can be proposed now, based on what we have learned from our experience during the past four decades and on what we know about the essential nature of medical care.

First, since we cannot rely on the free play of markets to control costs or guarantee universal coverage, we should establish a tax-supported national budget for the delivery of a defined and comprehensive set of essential services to all citizens at a price we can afford. Employers should pay an appropriate part of the tax for their employees. These services should include both acute and long-term care, and they should be exclusively reimbursed through a single-payer national insurance plan, with other elective and non-essential services paid out of pocket or through privately purchased insurance. No services covered by the national plan should also be covered by private insurance plans, but the latter could insure services, such as "aesthetic" plastic surgery and private hospital rooms, that would not be covered by the national plan. There should be no billing by providers and no piecework payment in the single-payer plan, thus eliminating the huge business costs and the colossal hassle of the present billing and payment systems in multiple public and private insurance plans.

Second, not-for-profit, prepaid multi-specialty groups of physicians should provide all necessary medical care on the approved list of insured services. The physicians in the groups should be paid salaries from a pool of money that would be a defined percentage of the total patient income received by the group from the central payer. The groups should be privately managed but publicly accountable for the quality of their services, and they should be expected to use standardized information technology that could be integrated into a national data system. They should be indemnified against losses due to adverse selection or other costs beyond their control, assisted with start-up and technology expenses, and exempted from antitrust restrictions. They should compete for patients on the basis of the quality of their services. All groups should be open to all citizens, although the number of members for a given-sized group should be regulated to ensure an appropriate ratio of doctors to patients.

Third, patients should be free to choose their own physician group and to switch membership at specified intervals, but everyone must be included in the national plan and belong to a group--including politicians. (Lawmakers are unlikely to neglect the needs of a health care system that provides care for themselves and their families.) Physicians should be free to join any group that wanted them and to change their affiliation, but they should not provide services outside the national system that are covered by the latter.

Fourth, all health care facilities (whether privately or publicly owned) that provide services covered by the central insurance plan should be not-for-profit, and should compete on the basis of national quality standards for patients referred by the physicians in the medical practice groups. Facilities should be paid, and monitored for their performance, by the central plan. They should have no financial alliances with the physicians or the management of the medical groups. Teaching facilities should be separately funded by the national plan and be paid for their extra costs, including education. Budgets in all facilities should include salaries for full- and part-time clinicians providing essential services.

Fifth, the health care system should be overseen by a National Health Care Agency, which should be a public-private hybrid resembling the Federal Reserve System. It should be

independently responsible for managing its budget and establishing administrative policy, but should report to a congressional oversight committee and to the public. It is essential that the plan be sufficiently independent of congressional and administration management to be protected from political manipulation and annual budgetary struggles.

Much of this skeletal outline would have to be fleshed out later and would undoubtedly be modified with the benefit of further experience. But these five general proposals can explain how this kind of reform could solve the major problems now besetting the market-based hodgepodge that is our present health care system.

Uncontrollable costs are the primary problem in our present system, from which most of the other problems result. The reforms proposed here effectively control costs through a national budget cap that could be adjusted annually or biennially in conformity with national need and our ability and willingness to pay. The plan would remove many of the current generators of costs, such as high business overhead, billing and collecting, profit incentives, piecework payment, and the entrepreneurial drive of income-maximizing providers. In the reformed system, physicians, with the consent of their patients, would largely control the use of resources and facilities and would have no financial incentive to either over- or under-use them. Doctors would be paid salaries by their own group managers for their time and effort in delivering the best care for the money available.

A much higher proportion of health care funds would be expended on patient care instead of on overhead, profits, and unnecessary business-related functions. From studies of these burdens on the current system, the net savings can conservatively be estimated as at least one-third of total present health expenditure. That would be more than enough to pay for coverage of the uninsured, for improving the quality of care, and for the added expenses of teaching hospitals. What many people do not understand is that our present cost problem represents not a lack of funds but a misuse of the funds that we already spend. Moreover, the inflation in the current system is due mainly to increasing business overhead and to the unregulated use of new drugs and new technology, driven by business incentives. The proposed new system would eliminate most of those incentives and cause physicians to be much more rigorous in applying professional standards to the use of resources.

Our present medical care system lacks the structure and incentives to improve the quality of care. A not-for-profit system of salaried physicians, who work together in groups that have no financial incentive to do more or less than is medically appropriate, who compete with other medical groups only on the basis of quality and their attractiveness to patients, and whose results are publicly accountable, could be expected to deliver the kind of health care we need. The quality of care would also be improved by a system of competing not-for-profit facilities that are held to national standards.

As for access and equity, the plan outlined here would guarantee universal coverage for all essential services and would allow employers and individuals to share in the costs through an earmarked and graduated tax. The government would be expected to pay the costs of today's

uninsured, as well as the contributions it now makes to government insurance programs. Given the large savings expected in this system, the change in net costs to government should be minimal.

The insurance part of this plan is in fact a "single-payer" system, but most other proposals for a single-payer system lack any plan for changing the delivery of health care, and it is usually assumed that merely changing to a single payer would solve the cost problem. In fact, it would not. While it is true that a single-payer system would achieve substantial savings by eliminating much unnecessary overhead, that alone would not control the inflationary effect of new technology and new drugs, piecework payment, and competition for market share among income-maximizing physicians, hospitals, and ambulatory-clinic facilities. A delivery system that is a competitive commercial market cannot possibly control expenditures. Inevitably, such a market tends to grow as it seeks ever-improving income and incurs ever-greater overhead costs.

Medicare is a case in point. It is essentially a single-payer system for the elderly. Its insurance plan operates far more efficiently than most private plans, but it is nevertheless facing a cost crisis because it must pay for services from an expanding commercialized medical marketplace. That crisis will surely be exacerbated when the Medicare Modernization Act begins to be fully implemented in 2006. The failure of Medicare to control its medical expenditures tells us that no real reform of our health care system is likely to succeed unless we change the way medical care is provided, as well as the insurance system. We need to reform the way doctors are organized to practice and the way they are paid. We also need to eliminate private investors from the ownership of medical care facilities. In short, we need to remove commercial incentives not only from our health insurance system, but also from our medical care delivery system.

V.

Any major health care reform must have the support of a large majority of the physicians who deliver our medical care. The Clinton administration learned this to its sorrow when in 1993 it proposed a sweeping reform of the health care funding and insurance systems (based on "managed competition" among private insurance plans) without first consulting with the medical profession. Within a year, the proposal died in Congress without ever even coming to a vote. Although the most important reason for the failure of the Clinton initiative probably was the strong resistance from powerful vested interests in the health insurance industry and the investor-owned businesses concerned with the delivery of medical care, opposition from organized medicine also played a major role. The Clinton administration failed to explain this bewilderingly complex proposal not only to the public but also to the medical profession, which was never asked to help with the drafting of the proposal and was largely ignorant of the plan until it was made public. Not surprisingly, when the plan was announced a majority of physicians were ready to believe the mendacious claims of lobbyists and advertisers who insisted that it was just another version of "socialized medicine." (Remember the "Harry and Louise" ads?) A more collegial approach to the profession might have gained enough support to produce a much different result. Also, if the Clinton administration had done a better job of taking its case

to the public, it would have had a much better chance of success.

Since that time, there have been no proposals for major health care reform by either political party. Proposals have been confined to incremental expansions of government support for an unchanged medical care delivery system, as advanced by John Kerry, or to greater dependence on market forces in the private sector, as favored by the Bush administration. None of these approaches is likely to work because they do not deal with the whole system--the insurance and the delivery sides. But even more importantly, they do not address the basic problem with our health care system, that is, increasing domination by commercial forces, leading to uncontrollable costs and unacceptable inequities. The Bush administration and its allies in the health policy community seem blind to this problem and appear determined to press ahead with their version of CDHC. It will almost certainly fail.

A real solution to our crisis will not be found until the public, the medical profession, and the government reject the prevailing delusion that health care is best left to market forces. Kenneth Arrow had it right in 1963 when he said that we need to depend on "non-market" mechanisms to make our health care system work properly. Once it is acknowledged that the market is inherently unable to deliver the kind of health care system we need, we can begin to develop the "nonmarket" arrangements for the system we want. This time the medical profession and the public it is supposed to serve will have to be involved in the effort. It will be difficult, but it will not be impossible.

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