

For-Profit Health Care: Expensive, Inefficient and Inequitable

A Presentation to the
Standing Senate Committee on Social Affairs, Science and Technology

by

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Mr. Chairman, Honorable Members of the Standing Senate Committee on Social Affairs, Science and Technology:

“No health care system in the industrialized world is as heavily commercialized as ours, and none is as expensive, inefficient, and inequitable -- or as unpopular.”

My name is Dr. Arnold S. Relman. I am Professor Emeritus of Medicine and of Social Medicine at the Harvard Medical School and former Editor-in-Chief of the New England Journal of Medicine. I have been asked by the Canadian Health Coalition to appear before you today to testify about the U. S. experience with private, for-profit health care.

I have been studying and writing about this subject for over two decades. In 1985 and 1986 I served on a committee established by the Institute of Medicine of the U. S. National Academy of Sciences to report on “For-Profit Enterprise in Health Care.” During my editorship and afterwards, the New England Journal of Medicine published many articles in this field and, since I retired from that post, my own writings have continued to focus on this topic. I am now at work on a book that surveys the present unhappy condition of the U. S. health care system, with particular attention to the role of private enterprise.

My conclusion from all of this study is that most of the current problems of the U. S. system – and they are numerous – result from the growing encroachment of private for-profit ownership and competitive markets on a sector of our economy that properly belongs in the public domain. No health care system in the industrialized world is as heavily commercialized as ours, and none is as expensive, inefficient, and inequitable -- or as unpopular. Indeed, just about the only parts of U. S. society happy with our current market-driven health care system are the owners and investors in the for-profit industries now living off the system.

The U. S. may be a world leader in medical science and technology, and its major medical centers may provide some of the best and most sophisticated care available anywhere, but taken as a whole, our health care system is failing and will need major reform very soon. We have tried private for-profit markets, first in hospitals, in ambulatory care facilities and services, and in nursing homes, and then more recently, in the ownership of insurance plans – and the experiment has failed. Private health care businesses have certainly not achieved the benefits touted by their advocates. In fact, there is now much evidence that private businesses delivering health care for profit have greatly increased the total cost of health care and damaged – not helped – their public and private nonprofit competitors.

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The U. S. experience enables students of health care policy to compare the performance of nonprofit and for-profit facilities as well as the performance of insurance systems, and the results are clear for all who want to examine the evidence. For-profit hospitals were much more expensive than their nonprofit counterparts when Medicare and private insurers simply reimbursed charges. That difference disappeared when the payers began to negotiate fixed prices, but there has never been any evidence that for-profit hospitals could provide similar services at lower prices than their nonprofit competitors. However, a recent study of Medicare per capita expenditures for all health services, including hospital care, found that they were much higher in regions served exclusively by for-profit hospitals than in regions where there were fewer or no for-profit hospitals.

There is no good evidence about the relative quality of hospital services in for-profit and nonprofit facilities, because such studies are difficult to do. Quality is easier to ensure in nursing homes and kidney dialysis centers. They are largely paid through fixed, negotiated prices by public insurance, and their products are more or less standardized. Studies that have looked at objective measures of quality of service show that public and private non-profit nursing and dialysis facilities provide significantly better and safer services to patients than their for-profit counterparts.

This shows that when you fix the price and the services so that there is no wiggle room, non-profits clearly provide better care.

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A little over a decade ago, for-profit investor-owned businesses took over the private insurance field, and now they cover more than half of our people – mainly through employers. More than a quarter of our population is covered by Medicare and Medicaid, which are largely financed by government. Comparisons of these private and public systems are instructive. The Medicare system has administrative costs of less than 3 percent, with all the remainder of expenditures going to physicians, hospitals and other providers. The private insurers, on the other hand, have corporate and administrative costs of 15 to 30 percent, and in addition outsource many other services they use to control costs by restricting the use of expensive resources. As a result, it can be estimated that only 50 to 60 percent of the premium dollar ends up with the providers, who themselves must pay additional administrative costs to deal with the regulations of the multiple insurers they must bill. And, while the private insurers at first held down premium prices by drastically cutting utilization, they have now run out of cost-cutting options and are meeting increasing resistance from providers and the public. Recently, premium prices of private for-profit insurers have again begun to increase at double-digit rates, more rapidly than the costs of Medicare and Medicaid.

A remarkable demonstration of the failure of the commercial, HMO insurance system was seen a few years ago when senior citizens covered by Medicare were encouraged to obtain their care from private, for-profit HMOs that would be paid by the government. It soon became obvious that the costs of care under the private system were much greater and that senior citizens were dissatisfied with the care they received. A wholesale exit of senior citizens from the private system ensued. They voted with their feet for the public system.

In short, the U. S. experience has shown that private markets and commercial competition have made things worse, not better, for our health care system. That could have been predicted, because health care is clearly a public concern and a personal right of all citizens.

By its very nature, it is fundamentally different from most other goods and services distributed in commercial markets. Markets simply are not designed to deal effectively with the delivery of medical care – which is a social function that needs to be addressed in the public sector.

We in the U. S. are belatedly learning this lesson and soon may be ready to try other options that will depend more on public action. Many of us south of the border have always believed that you Canadians had the right idea in deciding that the financing of health care is primarily a public responsibility. We still think you are right and that we ought to emulate you, rather than vice versa. I am surprised and disappointed in your Committee's Interim Report, which seems to favor policy options dependent on private market involvement in Canadian health care. Before making your final recommendations, I hope you will look more closely at the U. S. experience – which ought to convince most evidence-driven observers that markets can't solve public problems like health care – and in fact make them worse.

However, to make a publicly financed system work effectively, I believe both our countries need to begin reforming their medical care delivery systems. That is where we both ought to be looking for ways to optimize our use of resources and improve the quality of our health care.

I believe that splintering the delivery system into many different, highly specialized facilities, as has been proposed in both our countries, is not in general a sound option for improving quality and effectiveness. A much better approach would be to re-organize how physicians work together. Both our countries now depend largely on independent solo medical practitioners to provide ambulatory and hospital services on a fee-for-service basis. We should both begin to encourage physicians and other health care professionals to organize themselves into self-governing, multi-specialty and multi-disciplinary teams to deliver comprehensive care at prepaid, capitated rates.

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Physicians provide the best care when they work in teams, not as competitors. Furthermore, to discourage over service, they should be paid primarily for their time, and not on a piecework basis. That would reduce both fraud and the resources wasted on the processing of claims.

Finally, I want to say just a word about “consumer choice,” which is now being touted in the U. S., and I gather in Canada, too, by believers in the magic of the market as a mechanism for controlling costs and improving the quality of services. While there is much to be said for making more information available to people about their health care, it is a fundamental misconception to imagine that sick patients can or should behave like ordinary consumers in commercial transactions, selecting the services and prices they want. Health care is totally different from most goods and services, and that’s why we have medical insurance and why sick people need the professional and altruistic services of physicians and other providers.

I suspect most Canadians understand why health care is special and why it needs to be insured by a public system like the one you now have. I would be surprised if they want the fundamental fairness of their Medicare system to be changed by the introduction of market forces.

Thank you for your attention.

I will be glad to take your questions.