Dr. Business

By Arnold Relman

Health care remains one of the most intractable domestic problems facing the United States today. To compound the issue, there isn't even agreement on what health care really is, or what it ought to be. To most physicians, like me, it involves at its core a professional relationship between patients who are sick or injured and the physicians to whom they entrust their care. But to a business school professor, like Regina Herzlinger, it is a "service industry," the products of which ought to be selected by consumers (let's not call them "patients") in a competitive marketplace, on the basis of price, convenience, and quality.

Herzlinger, who teaches at Harvard University, is on one side of a profound debate about health care and the marketplace. Can the disciplines of the market be brought to bear to control medical costs while assuring access, choice, and quality—as they do in ordinary industries? Or is health care such a far cry from a free market to begin with that recourse to the marketplace only makes its problems worse?

The market view is currently ascendant. We have been witnessing a massive shift in the control and ownership of medical care to private, for-profit businesses. Most of the control is indirectly exercised through investor-owned, managed care insurance plans, but an increasing number of inpatient and outpatient medical facilities are also being acquired and managed by investor-owned corporations. These medical care businesses have become one of the largest sectors of the U.S. economy.

HEALTH SHOPPERS

Herzlinger's new book is a blueprint for transforming the health care system into a more explicitly consumer-driven market. As she sees it, buying medical care is like buying any other service or commodity the market economy offers. Smart shoppers, properly armed with information from the medical equivalent of Consumer Reports, should be able to seek out the vendors of the services they have decided they need and choose from among them based not only on price but on quality and convenience. Seeking to gain new customers, competing medical vendors would make every effort to provide a satisfactory product. If the market worked its usual magic, consumers would get what they wanted, efficient producers of medical services would be rewarded, prices would be kept down, and quality and innovation would be encouraged.

There are multiple problems with this general view. For one thing, most medical consumers are not free to shop around. In the age of managed care and medical underwriting, a patient with a serious illness who doesn't like her care is often simply stuck, because no other insurer will take her. For another, tens of millions of consumers cannot afford to buy health coverage. Further, most experienced physicians will question Herzlinger's breezy assertion that consumers of medical care are like consumers of other services who, given enough information, can shop for the services they desire.

People may be "consumers" when they are well and are shopping for elective or routine medical services, but they are "patients" when they get sick. Those with major illnesses or injuries do not and cannot shop around for what they want. They rarely know enough to choose their own treatment. They are dependent on professional help, and they rely on their physicians to provide it. Even very intelligent, well-informed people know better than to attempt self-diagnosis when they are in serious trouble.

There are few "consumers" or "smart shoppers" in hospital emergency rooms or intensive care units. Healthy economists and MBAs who talk about medical care as if it were just another business haven't yet learned that lesson.

It is fine to encourage people to become better-informed "health consumers" in the choices they make in their physicians and their treatments. But Herzlinger pushes the point beyond its logical limits. The essence of the relationship between a sick patient and a physician is trust by the patient in the competence and beneficence of the physician, and a commitment by the physician to meet his or her professional fiduciary obligations to the patient. There is nothing like that in the commercial transactions between customers and vendors that take place in service industries, even when the service is technical and beyond the understanding of most customers. "Caveat emptor" may be the watchword in commerce, but it cannot apply in medicine.

"FOCUSED FACTORIES"

Herzlinger offers another idea that conforms more to ordinary commerce than to medical care—single-service firms and facilities. She recommends that general care hospitals and large integrated managed care companies be replaced wherever possible by what she calls "focused factories," specialized facilities and clinics devoted to one particular disease or surgical procedure—like diabetes or asthma, or hernia repairs or open-heart surgery. She claims these "carve-out" organizations would provide care more efficiently and cheaply than the old-fashioned multipurpose hospitals and clinics, and she believes they would make shopping for health care more convenient for customers. As Herzlinger envisions the future, these "focused factories" would compete vigorously for customers and, through market forces, would transform health care into a more consumer-friendly and affordable system. This new era is almost at hand, she says, despite the resistance of stuffy old medical school professors (she names me as an example), who resent outside interference in their traditional domain.

But Herzlinger's vision of "focused factories" for medical care will be criticized not just by old professors but by most clinicians. They know that diseases are usually not compartmentalized and that the sicker the patient is, the more important it is to deal with him or her as a whole human being, rather than as an ailing body part or organ. Patients often have more than one disease or, even when they have only one disease, they often have complications involving several organ systems. They cannot be properly treated without considering the interrelations among the several parts and dealing with the whole person. Herzlinger briefly acknowledges this problem by suggesting that each "focused factory" should have on hand the specialists and facilities needed to manage the common complications of the disease upon which the institution is focused. But that simply integrates the care of one disease at the cost of fragmenting and duplicating the resources needed for the care of other diseases. Seriously ill patients are best treated by multispecialty teams of doctors, including primary care physicians and different kinds of specialists, and these teams should work together in one multipurpose inpatient facility.

While it may make sense to integrate care for particular problems within a general hospital, freestanding specialized institutions for single diseases or procedures are of dubious value, particularly when they separate inpatients from the hospital facilities they may need in unexpected emergencies. Every large hospital center has wings or floors that can function as "focused factories" for particular diseases, but they are still an integral part of a general hospital that can deal with any complication, whether or not it is based on the condition for which the patient first sought treatment. Narrowly specialized freestanding institutions are inherently risky for sick patients. This is not to say that no freestanding specialized facilities make clinical sense. Some kinds do, particularly those that treat relatively low-risk problems on an ambulatory basis. A few of the largest and most completely staffed cancer hospitals also can provide comprehensive care when it is needed. But if Professor Herzlinger means to suggest that most general care

hospitals should be broken up into physically separated and independently managed "focused factories," she doesn't understand the medical purposes of a general hospital.

MEDICAL GENTRIFICATION

Having devoted most of her book to extolling the virtues of "market-driven" health care, Herzlinger spends only one chapter at the end on how to change the current private health insurance system to establish the market she envisions. Ironically, Herzlinger's market system is heavily dependent on government. She recognizes, quite correctly, that the present system of managed care does not allow the consumers of medical services to make their own choices with their own money. She is opposed to employers holding the money and making most of the choices of managed care plans for their employees. I share that view.

What she proposes, therefore, is a "tax-neutral," government-regulated transfer of health benefit funds from employers to employees ("based on the employee's health characteristics"), and a government requirement that em ployees use these funds to purchase a catastrophic health insurance policy to pay for all expenses beyond "what they can reasonably afford to pay out of their pockets." Government would also "assure the quality and availability of information about health care providers; and it would prosecute consumer and provider fraud." Large deductibles would encourage employees to shop carefully for their initial medical services each year because they would be spending their own money. Beyond that initial outlay, they would be comprehensively insured by policies they would choose themselves, using the funds paid to them by their employers.

Herzlinger gives only sketchy outlines of how her "consumer-controlled health insurance system" might work, and leaves many important questions unanswered. Many of these questions are probably unanswerable. For example, how would government carry out all the complicated regulatory functions she lists? How would it adjust transfers according to the "health status" of an employee and his or her family? Risk adjustment for health status is not developed enough to ensure fair payment of this kind for coverage of an individual employee, let alone a family. How would government discourage low-income employees from delaying necessary care simply to avoid out-of-pocket expenses? And, once the deductible had been exceeded, what would prevent employees who chose an indemnity type of plan from overusing the insurance benefits and driving up premium costs? In short, Herzlinger fails to explain how the wide-open insurance market she advocates could be expected to work without extensive cost and quality controls by government that would inevitably constrain free choice by consumers. She cites the Federal Employees Health Benefits Program (FEHBP) as a model of what informed consumer choice can achieve, but she neglects to mention that the majority of the choices offered to federal employees (after careful screening by the government) are managed care plans—to which she is opposed.

Professor Herzlinger's book is unpersuasive largely because the consumer-driven market she envisions simply isn't compatible with the realities of medical care. Her proposal for reform also falls short because it doesn't deal with the whole health care system. Not surprisingly, given her profession, she focuses on the part of the system that is funded through employment-based insurance (by now, almost entirely under managed care). The other part, including Medicare and Medicaid and thegrowing army of the uninsured, is barely mentioned. This omission means that the book is mostly about medical services for the relatively young, healthy, educated, and employed members of society—like the author herself. Herzlinger's book is therefore not a proposal for general health care reform. It is instead a call for a kind of medical "gentrification"—a reconfiguration of the system to make it more accessible and convenient for those able to shop for what they want, and able to pay for it out of pocket.

Despite its obvious limitations, Herzlinger's book will probably appeal to the growing number of free-market enthusiasts who are becoming uncomfortable with the restraints and aberrations of the present

managed care market. Managed care, in one form or another, may be the only viable alternative to the fee-for-service, indemnity-insured system it is replacing, but its present configuration is certainly not consumer-friendly. Furthermore, managed care plans have an inherent conflict of interest with the employees they are supposed to be serving. The less medical care a plan provides, the more of the premium the plan gets to keep. It is easy to understand why a backlash against managed care is growing so rapidly. Herzlinger's book will add strength to that protest, although it offers little in the way of practical solutions to the problem.

HEALTH Vs. WEALTH

The best current book about managed care is George Anders's Health Against Wealth. The author, a Wall Street Journal medical reporter, tells the story of "HMOs and the Breakdown of Medical Trust." He describes how physicians, unable to contain rising health care costs, lost control of the medical care system to a rapidly expanding managed care industry. That industry, increasingly owned by for-profit corporations, acts as a middleman between employers and the providers of health care. Employers have negotiated lower premiums with the HMOs, but the latter have drastically reduced payments to providers, thereby assuring high profits to themselves. The winners in this new system are the employers and the HMOs. The losers are the providers and the employees.

Managed care is often described as a "market" solution to the problem of health care costs, but it isn't much like the consumer-oriented market Herzlinger advocates. As Anders explains, the "market" in managed care is largely limited to the negotiations between employers and the managed care plans they choose for their employees. The real consumers of health care, employees, have little or no choice of plan, limited choice of physician, and—unless they want to pay the costs of seeking care outside their plan—virtually no opportunity to shop for the services they think they need.

Anders illustrates all of these limitations and predicts that the system will inevitably change. He is probably right. What will replace it is not at all clear at the moment. Anders suggests the next phase may be direct negotiation of managed care contracts between employers and the providers of medical care (physician groups and hospitals), thus bypassing the HMO companies. That would be an improvement over the present system, but it would still not allow the consumers of care to choose their own providers. Why should employers decide which doctors and hospitals their employees can use? Herzlinger is right in her objection to that arrangement, although the rest of her proposal for a consumer-driven, price-competitive market for medical care is unconvincing.

Both books make clear how far we still are from an equitable and workable health care system. To solve the manifold problems of health care in America, we will have to develop a system that deals with economic and medical realities while moving the responsibility for ownership back into the community and putting the reins of management in the hands of those who deliver and receive the care. Before we can reach that goal, we will have to accept the notion of health care as a social good rather than an economic commodity. What the public and the medical profession are learning from their current unhappy experience with commercialized medical care is that the free market cannot by itself produce the system we need. Sooner or later, we will realize that more regulation and new policies are required. What then happens will depend on how strongly physicians, patients, and not-for-profit community health care institutions press for real reform.

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