

---

## The market for health care: where is the patient?

ARNOLD S. RELMAN

---

In 1980 I wrote an article in the *New England Journal of Medicine* [1] in which I said that the most important new development in the US health care system was the recent, relatively unheralded rise of a huge new industry that supplied medical services for profit. Without attracting much public attention, investor-owned businesses had begun to take over large parts of a health system which until then had been largely community-based and not-for-profit. At that time the major components of this new industry were proprietary hospitals and nursing homes, diagnostic laboratories, home-care and emergency room services, and hemodialysis centers. In total, these businesses had already captured almost a quarter of all the revenues spent for personal health care and I predicted their rapid growth would soon make them not only a dominating force in our health care delivery system, but also a major influence on public policy.

There was an obvious analogy between this burgeoning, highly profitable new industry and the "military-industrial complex" that Dwight Eisenhower had warned about in his farewell address as President in 1961, so I called it the "new medical-industrial complex". As the significance of the commercial transformation of this country's health care system became increasingly apparent, this subject began to attract widening interest in the popular media and in the professional literature.

Paul Starr's 1982 landmark study of the social and economic development of medicine in America [2] was the first major scholarly work to take up this theme and put it in broad historical context. After devoting most of his book to the rise of the medical profession and its struggle for professional autonomy, Starr wrote a final chapter, entitled "The Coming of the Corporation", which described the new corporate transformation of the US health care system and its growing threat to the sovereignty of physicians. With remarkable prescience, he predicted that in the new corporate era, "Instead of public regulation, there will be private regulation, and instead of public planning, there will be private planning. Instead of public financing for prepaid plans. . . there will be corpo-

rate financing for private plans controlled by conglomerates whose interest will be determined by the rate of return on investments". This was written a decade before its author, as a leading figure in the Clinton health reform brain trust, was to experience at first-hand the power of the "medical-industrial complex" to control health care public policy. I will return to this subject shortly.

In 1986 the Institute of Medicine of the National Academy of Sciences released a major study of "For-Profit Enterprise in Health Care" [3]. Conducted by a committee of experts representing all sectors of the health care system, it focused primarily on the behavior of investor-owned acute care hospitals, and the growing influence of the for-profit market on the fiduciary role of physicians. The study found that investor-owned hospitals increased health care costs to payers, provided less charity care, and were not any more efficient than not-for-profit hospitals. No measurable differences in quality of care were found, but the committee emphasized the need for new and better measures of quality, and for more data on all these points. These questions have subsequently been extensively debated in the health care literature, and they continue to be. Representatives and supporters of the investor-owned hospital industry still insist there are no significant differences between for-profit and not-for-profit hospitals, except that the former pay taxes and the latter do not. In my judgment, however, the weight of the evidence in the peer-reviewed professional literature continues to support the original conclusions of the Institute of Medicine/National Academy of Sciences report. As I will mention later in this presentation, recent events also support the additional concerns expressed in that report about the effects of private health care markets on the viability of clinical research and educational programs in our academic medical centers.

Six years ago, in the Shattuck Lecture to the Massachusetts Medical Society [4], I reviewed what had happened to the "new medical-industrial complex" during the decade of the 1980s. I noted that the for-profit sector of our health care system had continued to grow rapidly, but mainly outside the hospital—in areas such as ambulatory surgery centers, imaging facilities, walk-in clinics, and health maintenance organizations (HMOs) and other types of managed care insurance plans. The number of

---

Brigham & Women's Hospital, 181 Longwood Ave., 5th Fl., Boston, MA 02115-5804. Fax 617/525-2186; e-mail arelman@rics.bwh.harvard.edu.

investor-owned hospitals had remained approximately constant during the decade, at ~1400—or slightly >25% of the nation's total. However, the commercial market's estimated share of our health care system had increased to about a third, due largely to the expansion of for-profit ambulatory facilities and services.

At the time, I was primarily concerned about the commercially driven rise in health care costs and the impact of a profit-seeking, competitive health system on community hospitals and the integrity of the medical profession. The anti-government, market-oriented political philosophy of the Reagan era had encouraged the privatization of health care, but the most powerful stimulus was the opportunity for large profits afforded by the virtually unlimited "cost plus" reimbursement policies of both the private and public insurance systems. Nevertheless, the dramatic events about to unfold during the next few years could not have been anticipated. What would happen in the decade of the '90s was nothing less than the transformation of the privately insured half of our health care system into an enormous commercial market for managed care and the progressive replacement of traditional doctor-patient relationships by a new, cost-oriented corporate control of medical practice.

In 1992, Bill Clinton was elected on a platform prominently featuring his pledge to seek health care reform legislation that would contain rising costs, provide universal coverage, and protect and promote the quality of services. The story of the development of Clinton's gigantic and complex Health Security Plan in 1993, and its subsequent slow death in 1994, has been told many times. The plan was killed primarily by a divided and suspicious Congress, which Clinton could not control, but the powerful co-conspirators were an intractably hostile health insurance industry allied with many other vested interests in the "new medical-industrial complex". Perhaps the most incisive and illuminating account of these events is to be found in a recent book by Harvard Professor Theda Skocpol, *Boomerang* [5].

The Clinton plan was based on competing managed care plans, which his advisors believed should be the keystone of a new health care system. They did not believe, however, that an unregulated managed care market could achieve the desired objectives of cost control, universal coverage, and quality assurance, so their plan included an elaborate system of regional and national controls to reach these ends. More than anything else, it was the fear of these government controls that motivated the opposition to the Clinton initiative.

As I had noted in 1991 [4], managed care insurance plans were already a part of the rapidly growing for-profit health care market in the 1980s. By the time the Clinton administration was ready to introduce its Health Security bill, investor-owned plans had captured the lion's share of the private insurance market. It was clear to many observers that the Clinton proposal would simply extend the hegemony of the private market. Of course, the adminis-

tration's bill did not rule out participation by not-for-profit managed care plans—indeed, its designers said they hoped good plans with all types of ownership would flourish. However, the proposed legislation had no provisions to encourage not-for-profit plans, except those in underserved areas. Without government help, most not-for-profit plans stood little chance of competing with the well-financed investor-owned plans already in the market, or with the new ones springing up all around the country.

In any case, the political demise of the Clinton plan left a vacuum into which the for-profit managed care companies expanded with almost explosive speed. Employers, desperate to control the rising costs of their employees' health benefits, had rejected the old indemnity-style insurance and were now demanding prepaid capitated rates from insurers willing to accept the risk of providing less-expensive health care at a fixed price. These new managed care insurers, in turn, signed contracts with physicians and hospitals, giving the companies enough control over expenses to guarantee them a good profit even while they met the demands of employers for lowered premiums. In many parts of the country, an oversupply of hospital beds and physicians, coupled with the ability to direct large numbers of insured employees to the providers with whom they chose to do business, gave the managed care companies considerable bargaining leverage and the power to control the style of physicians' practices.

The general principle of prepaid health care, as exemplified by such well-established not-for-profit organizations as Kaiser-Permanente in California, Group Health of Puget Sound, HIP in New York City, and the Harvard Community Health Plan in Boston, had been around for several decades, but the new managed care companies were quite different. Although based on the same principle of combining insurance and health care delivery functions, these new managed care businesses were investor-owned and driven primarily to generate financial gains for their owners. They were managed by business people responsible to investors, unlike the older organizations that were managed by physicians who felt a primary responsibility to their patients. Most of the physicians in the older organizations were on full-time salaries; that is to say, these earlier organizations were group- or staff-model HMOs. By contrast, the new companies were mainly IPA (independent physician associations)-model HMOs, or PPOs (preferred provider organizations). In these newer types of managed care plans, physicians contract with the management to take care of a certain number of patients (or, "covered lives", in the currently fashionable lingo) on a capitated, or negotiated fee-for-service basis. To keep health care expenditures down (and thereby maximize the portion of the premium retained by the company), these contracts usually include financial incentives for physicians to restrict the use of specialists and diagnostic tests, and to cut down on hospitalizations. Contracts or company rules also control

patients' access to physicians and the time physicians spend with patients, and physicians are often required to get prior approval for elective hospital admissions and for expensive tests, procedures, or consultations.

As business ventures, the new managed care companies have been hugely successful. By squeezing payments to providers, and by controlling the availability of services, they save enough money to offer competitively low premium prices to employers and yet retain a large fraction of the premium for their own generous corporate expenses and profits. In less than a decade, the new managed care companies have captured the major share of the employment-based private health insurance market. In addition, they provide growing coverage for Medicare and Medicaid patients through contracts with government. About half the US population is now enrolled in some form of managed care plan, and the great majority of these plans are investor-owned corporations. It is a dynamic market that must currently generate nearly \$200 000 000 in gross revenues.

This enormous managed care market is only a part of the total health services economy that is now in the for-profit sector. To estimate the total size of that economy, the premiums paid to investor-owned managed care companies must be pooled with the premiums paid to investor-owned indemnity insurance plans (which is still a sizeable market) and with the direct, itemized payments by government programs and self-paying patients to the thousands of investor-owned facilities and services.

In sum, the "new medical-industrial complex", defined to include the entire range of businesses concerned with the delivery of health services, probably now accounts for at least 50% of total national expenditures on personal health care. It is undoubtedly the most powerful element shaping our health care system today. No significant reform can be expected in the future without regulation of the market forces now dominant in that system. As long as Americans accept the notion, despite all the evidence to the contrary [6], that markets in health care are just like markets in other parts of our economy, and as long as those with a vested interest in the "new medical-industrial complex" can exert a decisive influence over health care legislation, major reform seems unlikely. That, at least, seems to be the common wisdom among students of health care policy.

I do not accept that "wisdom". In the final part of this commentary, I would like to offer a different perspective on the future of health care markets in this country. I believe the present configuration of our health care system cannot last much longer. It is in an unstable state because it has not shown itself capable of meeting the fundamental health care needs of our people. Indeed, the evidence seems to indicate that private profit-oriented markets will not, and cannot, do the job. I base these conclusions on the following argument, which can be only briefly outlined here.

The first point is that in our country, as in other advanced and relatively wealthy democratic societies, the most important element in the medical care system is the relation between patient and physician—and that fact is not likely to change. But, in our present market-oriented system, neither patients nor physicians are very satisfied. Indeed, there are growing and widespread signs of their deep discontent. The current unhappiness of physicians with the expanding corporate control of their profession is so evident that it seems hardly debatable. In >50 years as a physician, I have never before seen the widespread discontent and restiveness that I now find among the medical profession all over the country. This is not a subject for discussion here, but there is no doubt that physicians are increasingly resisting corporate control and are attempting to reassert their traditional role in the doctor-patient relationship. Cynics interpret this as little more than economic self-defense—and so it may be, at least in part. But something more fundamental and important is at work here, and I believe physicians, along with patients, will ultimately force a loosening of the present corporate stranglehold on health care delivery.

The dissatisfaction of patients with the kind of corporate managed care they now receive might seem to be more debatable. After all, membership in managed care plans continues to rise rapidly, turnover rates in employment-based plans are low, and the results of questionnaires usually indicate that ~90% of members in these plans are satisfied with their care. But remember that most employees are under strong financial pressures from their employers to join a managed care plan and are usually given only one or two plans to choose from. They have few other practical options. As for the apparently high rate of member satisfaction, that means very little when it is understood that <10% of members in the usual employment-based plan are likely to have a serious illness or injury in any given year and thus require more than routine or preventive care. If even half of those with serious problems were to be deeply dissatisfied with their care, a questionnaire directed at the total membership would hardly be affected. Only if a questionnaire were focused on the seriously ill (and if it were administered and reported by independent third parties) would the results be a good measure of patient satisfaction.

In the absence of reliable questionnaire data on satisfaction, turnover rates among Medicare beneficiaries in managed care plans are more revealing. The proportion of enrollees likely to be ill at any given time is much higher among the elderly than among the members of an employment-based plan, and, since Medicare beneficiaries are free to leave at the end of any month and return to the open-ended fee-for-service system, disenrollment rates are a good measure of their dissatisfaction with managed care. According to the Government Accounting Office, annual disenrollment rates were 12–37% in metropolitan Miami and 4–42% percent in Los Angeles, where a third

of all current Medicare managed care enrollees live. And in another study, 27% of Medicare enrollees in managed care plans said they would not recommend their plan to family or friends with serious or chronic health care problems [7]. The popular backlash against managed care in general, the plethora of unhappy anecdotes in the media, and the growing legislative reaction to widely perceived problems with the patient care provided by managed care companies can hardly be ignored. All of this has been well described in a recent book on the managed care industry by one of the senior reporters at the *Wall Street Journal* [8]. I believe the message is clear; it has been received by the managed care industry and they are worried. A manifestation of that worry is the recent announcement by the industry's major trade association (the American Association of Health Plans) of a new initiative called "Putting Patients First" [9].

Even Professor Regina Herzlinger, of the Harvard Business School, a well-known champion of the corporate transformation of health care, is unhappy with the plight of patients in the new managed care environment. Because she considers medical care to be "America's largest service industry", patients are "consumers" in her lexicon, and she wants these "consumers" to have much more power to select their own services than the present employment-based system of managed care allows. In a recent book [10] she argues for the dismantling of that system and the transfer of funds from employers to patients, to enable the latter to shop for their medical needs in a competitive, more-consumer-oriented marketplace. I happen to believe that her proposed solution is unworkable and unrealistic, but I certainly agree with her opinion that the present system puts patients (or "consumers") in a fundamentally unacceptable position, which will sooner or later have to be changed.

Another reason I believe private markets will not continue to dominate our health care system is that they have not been shown to add anything of lasting value to the system. True, they have at least temporarily halted the rapid rise in the costs of premiums paid by employers, and they have forced health care providers to confront the excesses and inefficiencies formerly so rampant in the delivery system. But at best, those are one-time achievements. There already are signs that the basic forces underlying the earlier inflation of premium rates are still there, and that prices are starting up again. Furthermore, at least part of the control of prices was at the cost of reduced coverage, greater out-of-pocket expenditures by enrollees, and unsustainable reductions in payments to hospitals and physicians.

Corporate managed care plans are extracting a large bounty from the health care system in terms of high corporate overhead and profits—often amounting to 15–25% of the premium dollar. Not-for-profit plans generally have much lower overhead costs. At a time of increasing constraints on health care resources and a growing inability of the system to provide adequate coverage for all, it

seems to me doubtful that we will much longer tolerate the commercial exploitation of our health care system. And I believe this will become even more problematic as the public comes to learn that the managers of investor-owned health care businesses are not smarter than their not-for-profit counterparts. Not-for-profit health care facilities have by now learned whatever business lessons their investor-owned competitors had to teach. There is simply no evidence that not-for-profit health care institutions and managed care plans are inherently less efficient than the for-profits. Why, then, should we continue to pay the latter a bounty?

Yet another reason I believe the present system cannot last is that competitive commercial markets inevitably neglect the essential social, scientific, and educational infrastructure of our health care system. In fact, investor-owned health care companies thrive on this neglect. In addition to the profit and overhead bounty they extract from health care revenues, they add an additional financial burden on the private and public not-for-profit sectors of the system by avoiding the costs of socially necessary but unprofitable community health services and by failing to pay their share of the costs of clinical research and graduate medical education. They argue that they contribute through their taxes, but of course we know that corporate income taxes are not all they are claimed to be, and in any case they make little or no contribution to the uncovered costs of free community health care, clinical research, and graduate medical education. No health care system lacking adequate and equitable support for these vital functions can last very long.

There is a final, and critical, reason for my conviction that our present market-based system cannot long survive. Markets may be efficient ways of distributing goods and services to those who can afford them, but they are quite indifferent to the needs of the poor and underprivileged. Clinton and his health advisors insisted in 1992 and 1993 that any new plan had to provide universal coverage. They were keenly aware of the growing deficiencies in the existing insurance hodge-podge. Since the defeat of the Clinton plan, the army of uninsured and underinsured has grown steadily larger. Patchwork efforts to expand coverage of children and to help some citizens ineligible by virtue of "pre-existing conditions" or loss of jobs will do little to change the basic problem. We clearly need a different approach to health insurance and, just as clearly, we cannot depend on free markets to point the way.

For all these reasons, I believe we are witnessing a temporary and transitional phase in the history of our health care system. It is too early to predict in any detail what the system will look like in the first or second decade of the next century when the dust finally settles. I feel safe in saying, however, that it will be much different from the one we have now, and that government regulation will play a larger role.

### References

1. Reiman AS. The new medical-industrial complex. *N Engl J Med* 1980;303:963-70.
2. Starr P. The social transformation of American medicine. New York: Basic Books, 1982.
3. Institute of Medicine, National Academy of Sciences. For-profit enterprise in health care. Washington, DC: National Academy Press, 1986.
4. Reiman AS. Shattuck lecture. The health care industry: where is it taking us? *N Engl J Med* 1991;325:854-9.
5. Skocpol T. Boomerang. Clinton's health security effort and the turn against government in US politics. New York: WW Norton, 1996.
6. Kuttner R. Everything for sale. The virtues and limits of markets. New York: Alfred A Knopf, 1997.
7. Angell M. Fixing medicare. *N Engl J Med* 1997;337:192-5.
8. Anders G. Health against wealth. HMOs and the breakdown of medical trust. Boston: Houghton Mifflin, 1996.
9. Kassirer JP. Managing managed care's tarnished image. *N Engl J Med* 1997;337:338-9.
10. Herzlinger R. Market-driven health care. Reading, MA: Addison-Wesley, 1997.