



Transcript of podcast interview
with Arnold Relman, M.D. author
of *A Second Opinion: Rescuing
America's Healthcare*

Q: Two decades ago, you coined the term “medical industrial complex.” What did you mean by that?

A: I meant an organization of health care institutions and health insurance companies that were controlled largely by considerations of profit and were owned by investors. I meant that the healthcare system in this country was changing from a social service, which it had always been, to a profit-making industry.

Q: As healthcare is changing from a professional service into a marketplace for investors and investor-owned corporations, as you say in the book, what are some of the consequences of this commercialized care in terms of both costs and the quality of care?

A: The consequences have been enormous. First of all, costs have risen very rapidly, far more rapidly in the United States than elsewhere, and that's because industries naturally exist to grow, to expand their profits and maximize their income. So costs are higher in the United States because of the business overhead costs of these companies and also because they're driven to make more money.

Secondly, the primary concern of the medical-industrial complex being income generation, neglects what should be the basic purpose of a health care system, namely to take good care of all the people who need medical services. And those who can afford to pay for care get it in our present system, usually, but those who cannot, lose out. So the second consequence, after the increase in cost has been the increasing disparity of access to care. In this country we have almost 50 million people—approaching 50 million people—uninsured, at least another 25 or 30 million who are underinsured, and even those who have adequate insurance find that they may be pressed financially at times when they incur very high expenses. So it's an unfair system. You get what you pay for rather than what you need.

And thirdly, because the focus is mainly on income generation, the commitment to quality and to service is often forgotten. So in the United States we have vast differences in the quality of care. We know that many of the services that are provided routinely in other countries, other advanced countries, are not routinely provided in the United States. And judged by many measures, the quality of our healthcare system is only mediocre despite the fact that we spend much more than any other country.

Q: Now how would you address the argument made by Professor David M. Cutler of Harvard University, among others, that more money spent on health care will actually lead to better care?

A: That's purely theoretical, and it can be applied only in a few specific instances. The fact of the matter is that as a whole, this country spends almost twice as much on healthcare as the rest of the advanced industrialized world does, and by all the objective measures that we can apply, we are not getting healthcare that is of equal quality, and often our quality is less than the others. So it seems to me that on the face of it, Cutler's argument fails.

Q: *Managed care was seen by many for quite some time as the solution to rising prices. Why has it failed to curb them?*

A: Because managed care was based on the fallacious notion that administrators, business administrators, healthcare managers, knew how to make doctors practice more effectively and efficiently, and could exercise appropriate controls on the practice of medicine to achieve that end. Well, that's fallacious, that's false. The only people who can practice medicine effectively are physicians, and they have to be motivated. They have to be given the proper incentives and the proper opportunities to practice good medicine. Managed care emphasizes the business management, but it could not get into the problem of the medical management of patients very efficiently. So that managed care for a while controlled costs, after the failure of the Clinton plan in the early 90s, but the rising costs of medical services finally caught up with managed care, and there was also a rising chorus of discontent. Physicians were unhappy because they were constrained and controlled unreasonably in the way they could practice, and patients didn't like it because they could not follow their own choices and go to the doctors that they wanted and often could not get the services that their doctors recommended because the business manager said "No, that wasn't what we would allow." So after a while, managed care simply began to fall of its own weight, and by the turn of the century, of the 21st century, it was clear managed care was not the answer to our problem.

Q: *How has the movement to commercialization of care impacted doctors who are still in private practice?*

A: I think that it's made doctors much more concerned about their income. They have to compete with companies that provide medical services, they have to compete with other specialists. It has driven primary care, which is an absolutely essential basis for the delivery of good health care services, it has driven primary care almost out of business now.

Doctors can't make a living, can't practice the way they would like to practice as primary care physicians, and more and more attention is being paid to specialized services, to high technology services, for which large incomes can be generated. It's changing medicine into a business, it's reducing the personal contact between doctor and patient, and it is making both patient and doctors very unhappy. The fact of the matter is that healthcare is not a business, it cannot be conducted primarily for business objectives, and any time you try to make healthcare into a business, you end up with unhappy patients, unhappy doctors, and generally poor care.

Q: *Let me ask the same question in a slightly different way, looking at hospitals now. How has the growth of for-profit hospitals affected the hospitals that are still nonprofit?*

A: The distinction you have made between for-profit and not-for-profit hospitals is unfortunately increasingly disappearing. It used to be, at the beginning, 20 years ago, 30 years ago, when the for-profit hospitals first appeared on the scene, that there was a clear, measurable difference between the behavior of for-profit and not-for-profit hospitals. But as the market became more and more competitive, and as healthcare became more and more commercialized, the not-for-profit hospitals had to begin to act, to stay in the competition, just like the for-profit hospitals.

And now it is increasingly difficult to draw a distinction between the behaviors of the two types of hospitals. They're both focused far too much on the bottom line. They advertise, they market, they provide— they mainly emphasize the services that are profitable. They try to avoid as much as they can, legally, the services that are not profitable, and they charge as much as the traffic will bear. So the distinction is blurring, and that's because American healthcare has become a market, has become an industry. That's what's destroying the healthcare system in this country, making it unaffordable, and reducing its ability to serve the needs of patients.

Q: *Let's turn to solutions now. Let me start with a solution that you don't agree with, and let's talk about the idea of consumer-driven health care, as espoused by Regina Herzlinger of Harvard Business School and others. On the face of it, allowing people to make their own decisions about insurance and medical services seems like a good thing. But you clearly disagree. Could explain why such a system wouldn't work, either to control costs or improve the quality of care?*

A: In the first place, despite the fact that patients, some patients, can get a lot more information about the healthcare that they may need or want, through many, many new sources now, despite that fact, the basic fact remains that patients cannot be their own doctor. When you're sick, or injured, or you're frightened and you think you may be sick, you cannot be your own physician. You can't go to the Web and find out what to do and what services you need and what doctors to go to and whether you need an operation or not. You must depend on the services of some doctor that you trust. If you don't trust the doctor that you have, you've got to go to some other doctor.

So it's a delusion, it's a myth that informed patients can shop for their medical care the way you can shop for a new pair of shoes or a computer or a refrigerator using *Consumer Reports* and so on. I'm a very experienced physician. When I'm sick, I don't try to be my own doctor. I know the good doctors to go to and I seek the advice and help of a competent physician. And if I'm really sick and have to go to the hospital, there's no way that I can take care of myself. So the first thing that's wrong with consumer-directed healthcare is that consumers cannot really direct their own healthcare.

The second thing that's wrong with it is that it puts the burden of responsibility, the financial risk, on the patient's back. It says, if you're willing to take the risk and not go to see the doctor because of this complaint, or wait out to see whether your symptoms will go away, or not go for your annual checkup because it costs money, if you're willing to do that and you can save money, you can save money that way, but you do it at the risk of your own health. Now if you're well off, if you have enough money, you don't want to take that chance. You go to the doctor whenever you think you need to go to the doctor. And you'll ask for whatever, you'll be willing to get whatever services you need, because you have adequate insurance or you could pay out of pocket or whatever. But if you're poor, you can't. And therefore, consumer-directed healthcare makes poor people at risk, makes them take risks and cut corners that the well-to-do don't have to. So the second reason I object to it is that it's unfair. It's not only unrealistic, but it's unfair. It puts a burden on the poor person that the well-to-do does not have.

And the third reason I object to it is it doesn't really save much money in the end, because consumer-directed healthcare includes insurance for catastrophic illness, and that's where most of the costs are. So it maybe saves a little money on the margin for elective services, but if you're really sick, whether you like it or not, you're going to have to be taken care of by some sort of insurance system, public or private, and that's not going to save much money. So it's a bad deal all around. I'm happy to see that after the initial excitement and glamour of the idea, it's beginning to lose favor, and the people are not signing up in the millions and millions that was predicted.

Q: What is your proposed solution, then, and can you also discuss how we would pay for it?

A: My proposal is that you basically eliminate indemnity insurance entirely. That is to say, you eliminate any kind of insurance system that pays on a piecemeal basis, that pays doctors and hospitals for individual services. And certainly that you eliminate paying doctors on a fee-for-service basis. I think that healthcare should be prepaid. I think that everybody in this country, every citizen of this country, rich, poor, young, old, is entitled to a certain basic level of healthcare that would be paid for by some central fund. I'll come back in a moment to how that's financed. So that there ought not to be insurance, just a guarantee of decent, basic healthcare for everybody.

Now the delivery of that healthcare has got to be put in the hands of groups of doctors because doctor groups are much more efficient, much more accountable, much more effective than solo practitioners. If you want to save the primary care health system, if you want to keep primary care doctors, family physicians, general practitioners, general internists and pediatricians in business, you have to make them part of an organization. They can't survive on their own in competition with the specialists. So you have to have a delivery system that's a multi-specialty group practice.

In every community there should be small versions of the Lahey Clinic or the Mayo Clinic, or Kaiser: small, multi-specialty group practices in which physicians are paid salaries. I believe that fee-for-service is an anachronism. It worked very well when I was a young doctor, up until recently, but fee-for-service now is a bad idea, doesn't work very well. And doctors should be paid salaries, and those salaries should be fixed in total by some regulation. That is to say, the total amount of money that goes to doctors as income should be some fixed percentage of the total amount of money we spend on healthcare. And I think that it's adequate now, and it should stay about the same. Roughly, before doctors' expenses, around 20 percent.

How doctors are paid, how much goes to a surgeon versus how much goes to a primary care doctor — that should be determined by the physician management of the group. The group should be not-for-profit, they should be guaranteed against adverse selection, and they should be open to all comers, and there should be many of them so that patients can choose which group practice they want to join.

Hospitals, I think, could be paid from the central payer, the way they are, say, in Canada, but I rather think it would be better if the healthcare system allowed the physician groups to pay the hospitals for the services that they provide to the patients of the individual groups. In that way, the hospitals would be competing for the income from these groups and they would be held to, in terms of the quality, they'd be judged in terms of the quality, by the people who best know the quality, namely, the physicians who refer their patients.

How do we fund it? I think the fairest way to do that is through a progressive income-related, earmarked healthcare tax that applies to everyone according to their ability to pay. Those who can't afford to pay would not have

to pay, and it should be earmarked in the sense that it would not compete with the rest of the national budget. Where would the money come from? The money would come from all the money that's now being spent on healthcare. We don't need more money. There's enough money being spent on healthcare. What we need is a better system

Q: Under this proposed system then, how could we ensure people aren't wasting money on unnecessary care, and on the flip side, that needed care isn't being withheld?

A: Well, this is a responsibility of the medical profession. There's no way that you can expect to get good care if the medical profession isn't committed to providing it. There's no way that you can regulate the medical profession to make sure that only needed care is given. You have to depend on the professional competence and integrity of the medical profession. But in the present system, the economic incentives don't allow doctors to behave that way. The economic incentives in the present system force doctors to behave like independent business people who are out to maximize their income and protect their interest.

If you had a not-for-profit system in which doctors are paid salaries, and worked together with other doctors, no competition among doctors, they'd be working as teams together the way they do at the Lahey Clinic or the Mayo Clinic, the primary care doctors and the specialists all working together as teams, patients being able to select their own primary care doctor as they wish.

Q: In your book, you also admit that some of these changes might not go over so well with all of your colleagues, especially the switch from a fee-for-service model to a salary model. What do you think are the most compelling arguments to motivate your colleagues to buy in to this new system?

A: I try to make clear in my book that the objective that I've just described to you is going to be one that will be achieved gradually in steps. It's not going to happen overnight, and it's not going to be easy. I think we're going to need a lot more experience and a lot more time to get there. But I think we are getting there. Physicians are changing.

First of all, pretty soon half of all practicing physicians are going to be women. That's going to make an enormous difference in the attitude of doctors towards how they see their profession. Women, I think, when they become a major force in the practice of medicine, will be more interested than the average man is in working in groups for salaries, because it's more compatible with a woman's view of how she wants to spend her professional life. So I think you're going to have fewer entrepreneurial types in medicine than heretofore, and that's going to make a big difference.

Secondly, physicians, particularly the young physicians, are beginning to see the consequences of the medical-industrial complex. I've been talking about this, I've been advocating these positions that I've just outlined to you, for a long time, for decades now, and I've spoken to medical groups all over the country. I get a clear sense that attitudes are changing. Polls show that an increasing percentage of physicians now believe that we need major changes in the healthcare system. That's a big change. Organized medicine, so called, the AMA, namely, is much slower and more conservative, but it represents a minority of physicians now, and the AMA position I don't think is one that is going to be supported by the great majority of practicing physicians. So I think doctors are changing in their attitude. They're beginning to see the facts, think about the alternatives.

I try to make it clear in my last chapter in the book, in which I address to my colleagues in medicine. And I say you're going to have to make a choice pretty soon. You're either going to be working for corporations or working for the government, unless you as a profession decide to step up, help design a better system in which professional values and doctor-patient relationships are at the core. And you have to take responsibility, you have to be willing to work for a salary, you have to be much more transparent in what you do, and you have to work collegially together, not competitively, but collegially, with your colleagues, but that's the only way we can preserve our professional values.

Q: Two more questions. Let's look at two places that have started to make reforms and where they've done the right thing and where they haven't gone far enough. The first one is Canada, which has been used both as an example of why we should support a call for public, universal health care, and as an example of why we shouldn't.

A: I devote a chapter of my book to Canada because Canada, unlike other advanced countries that have a national health system, started out fairly recently in the same place that we were. In the 1950s and early 1960s, the Canadian healthcare system was very much like our own. Then a series of laws were passed at the federal level and in each of the provinces, which changed the system dramatically. And at that point, Canadian Medicare took over, and as a result, everybody in Canada was guaranteed basic healthcare. Not for all services, but basic healthcare. Seventy-five to 80 percent of the health care costs were taken care of by combined support from the federal government and each

province. Healthcare costs, which up until then were rising at the same rate as in the United States, stopped rising as rapidly, and over the next 20 or 30 years, since the Canadian Medicare was passed, Canadian healthcare costs have been much less than American.

Now the price that they've had to pay for that is that the provinces in essence control the availability of resources. The provinces pay for the hospitals and the provinces also pay for medical education and the training of specialists, and they've limited the facilities that are available for specialized services, and that in some instances has resulted in waiting lists, in waits for specialized services. Not for emergency services, but for elective services.

Canadians are wondering whether some little mixture of private enterprise in the system wouldn't be a good idea. I think, my own idea is, if they spent a little more money on the public system, they wouldn't need private enterprise. Canadians are still spending only about 60 percent as much on healthcare as we are. If they spent 80 percent as much as we do, or 85 percent as much as we do, they'd have the best healthcare system in the world, and there wouldn't be any waiting lists, there wouldn't be any waits for elective, specialized services. I think that would be the best answer.

Q: Let's move a little closer to home now. Massachusetts has recently enacted major health care reforms. Do these reforms move us in the right direction?

A: I think the Massachusetts plan was a great idea. There's no question that we want to have the uninsured covered, and Massachusetts has gone a long way to do that. And I think Massachusetts ought to be proud of the fact that it is covering a considerable percentage, but not all, of those who are uninsured. That's a great achievement.

The problem is, the costs haven't been controlled, and costs are rising very rapidly in this state, as they are elsewhere in the country, and it remains to be seen whether the plan is going to survive because of the high costs. That, it seems to me, simply supports my argument, that if you want to have a viable healthcare system, you have to not only deal with the insurance part, with the payment side of it, which Massachusetts is doing, but also you have to deal with the delivery side, which Massachusetts isn't doing, and which nobody can do unless you change the organization and the payment for healthcare providers.