



## Developments in internal medicine

# A cautionary tale: the dysfunction of American health care<sup>☆</sup>

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### Abstract

Attempts to reform the US health care system in the 1980s and 1990s were inspired by the system's inability to adequately provide access, ensure quality, and restrain costs. In the era of managed care, after the Clinton administration's failed legislative effort at reform, access, quality, and costs are still problems, and medical professionals are increasingly dissatisfied. To aid understanding of why the system is now so dysfunctional, I have drawn upon discussions with thoughtful physicians about their direct experience. They raised important concerns not usually considered by health care reformers. Their central concern was about the abandonment of medicine's core values. They felt that health care has become dominated by large, bureaucratic organizations which may not honor these core values. Patients and physicians are often caught in conflicts between competing interests and demands. Those who work in health care may be subject to perverse incentives that discourage ethical practice. Health care leaders may be ill-informed, incompetent, self-interested, or even dishonest. Examples of attacks on the scientific basis of medicine have become more frequent. These worrying trends are not confined to the US. Physicians elsewhere should be skeptical of approaches to health care reform derived from the American model. European doctors should ensure the new health care initiatives do not undermine their core values or the best interests of their patients.

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### 1. Introduction

By the late 1980s and early 1990s reform of the US health care system seemed almost inevitable, inspired by gloomy accounts of the system's inability to provide adequate access to care, ensure quality, and restrain costs [1,2]. In 2002, however, well into the era of managed care, and after the Clinton administration's failed legislative attempt at health care reform, the American health care system seems increasingly dysfunctional. The problems of inadequate access, inadequate quality, and high cost re-

main. More people are uninsured [3]. The Institute of Medicine asserted that "quality problems are everywhere, affecting many patients" [4]. Despite managed care, health care costs have been rising steadily [5]. Meanwhile, physicians [6,7], and nurses [8] are increasingly dissatisfied.

It is, therefore, not surprising that reform is in the air again. There is risk, however, that reform efforts will break down into the left-wing versus right-wing, or big government versus big business polarities that dominated the discourse in the previous era of health care reform.

For example, on the big-government side, the Physicians for a National Health Plan campaigned for nationalized single payer health insurance in the late 1980s [9]. Its leaders had previously decried the evils of corporate interests in a Marxist analysis of health care [10]. In 2002, they are again promoting nationalized health insurance [11].

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On the big-business side, The Jackson Hole Group advocated managed competition [12], i.e., a health care system dominated by corporate managed care. The majority of this group's key members, dubbed Hillary Rodham Clinton's "brain trust on health reform," were corporate executives [13]. By the early 1990s, almost all the group's funding came from the managed care and insurance industry [14]. When the Clinton administration proposed adding a layer of government bureaucracy to managed competition, the Jackson Hole Group charged that the administration's proposal was a "grotesque" distortion of their original plan [15]. This year, a revived Jackson Hole Group will gather to again promote managed competition [16].

In search of a different, and hopefully less polarized approach to understanding why the American system is dysfunctional, I have informally consulted numerous colleagues. This process included in-depth discussions with a convenience sample of thoughtful physicians, 9 general internists, one internist/geriatrician, one internist/nephrologist, two family physicians, one psychiatrist and one pediatrician. These discussions identified a fundamental concern with the abandonment of the core values of medicine. They also identified five key areas of concern:

1. Domination of large, bureaucratic organizations which do not honor these core values;
2. conflicts between competing interests and demands;
3. perverse incentives;
4. ill-informed, incompetent, self-interested, or even corrupt leadership; and
5. attacks on the scientific basis of medicine.

These issues per se are not usually cited by others as causes of health care dysfunction, and there is little systematic discussion of them elsewhere. To justify their importance, I provide evidence, albeit often anecdotal, from available public sources, including the medical literature and news media.

## **2. Abandonment of core values**

The notion that physicians must hold dear a set of core values specific to the profession can be traced back at least to the Hippocratic oath (Greece, fifth century BC) [17]. Modern statements of core values include the American Medical Association's Principles of Medical Ethics [18], and the new physician charter proposed by the Medical Professionalism Project [19]. All these statements center around the requirement that the physician put the patient's interests first, and then require the physician to practice with honesty and integrity, to uphold the confidentiality of information about individual patients, and to be responsible for the education of new generations of physicians.

The two more modern statements also require the physician to commit to scientific medicine.

The new Physician Charter was developed because of concern that "the health care delivery systems in virtually all industrialized countries threaten the very nature and values of medical professionals" [19]. The physicians I consulted also felt that their core values are beset from all sides by many forces. These often may not be discrete, may act at multiple sites, and may interact.

## **3. Domination of large, bureaucratic organizations which do not honor the core values**

American health care is increasingly complex and is dominated by ever larger organizations. These include direct providers of care, such as various kinds of physician organizations, hospitals and academic health centers (AHC's), often assembled into larger health care systems, and the federal Department of Veterans' Affairs. Large corporations make most of the drugs and devices that these providers use. The insurance and/or managed care companies that pay for care on behalf of patients are so large that they dominate many urban markets [20]. Most of the funds that these organizations receive come, in turn, from patients' employers, often large corporations, sometimes aligned in consortia such as the Leapfrog Group, representing 90 organizations employing more than 28 million [21]. Medicare is the national single payer health insurance program for the elderly and disabled, while Medicaid, which insures some of the poor, is a joint national-state program. At the interfaces between employers, managed care organizations, and providers are also myriads of "fourth, fifth, sixth and any number of seventh and eighth parties . . . [including] health insurance brokers and consultants, . . . [and] out-sourced vendors of specialty medical insurers . . ." [22]. Other large organizations that influence health care include government regulatory agencies, independent accreditation organizations, and a variety of not-for-profit organizations.

These organizations are increasingly bureaucratic. As Kleinke put it in his acerbic account of the failures of modern American health care, "tens of thousands of well-meaning people work throughout the health care system, none of whom ever see a patient or deliver any actual medical care. They preside over an infinity of rules, regulations, forms, processes, contract outsourcing, financial brokering, benefit plan tinkering, analytical processes, incompatible data systems and dead forests of paperwork. Health care administration in America is a Tower of Babel that reaches to the moon . . ." [22].

Bureaucratic demands have grown complex and self-contradictory. For example, to bill Medicare, physicians theoretically need to know "more than 100 000 pages of rules that are so complex that the government's own contractors often cannot correctly advise physicians how to

accurately bill . . .” [23]. Yet physicians who make billing errors are threatened by the government’s sometimes heavy-handed attempts to enforce fraud and abuse laws [24].

Large organizations’ actions may conflict with physicians’ core values, and sometimes with their own stated mission. In *Time to Heal*, Ludmerer explained how academic health centers and medical schools betrayed their core values [25]. As Medicare began to pay for the care of patients who had previously received free care from teaching hospitals, this increased income lead academic health centers to focus less on academics and more on clinical practice, and then to depend on income from it. As costs rose, Medicare initiated stringent cost-containment efforts, and managed care replaced indemnity insurance. In response, “schools were content to go where the money was, doing whatever was asked of them along the way.” So “as market forces became stronger and more hostile, it was understood that academic health centers became more businesslike and adopted corporate strategies. Yet as they did, an extraordinary inversion occurred: they began to lose sight of their mission and *raison d’être*.”

#### **4. Conflicts between competing interests and demands**

Physicians and patients are frequently caught in conflicts between forces and organizations with opposing, albeit sometimes laudable aims. The goal of providing appropriate interventions that maximize benefits and minimize harms for the individual patient may be a casualty of the crossfire between those who push for less utilization and lower costs and those who push for more utilization and higher costs.

##### *4.1. Forces for less utilization*

Organizations which pay for health care, (even if it is with money ultimately derived from individuals, via deferred salary or taxes) demand decreased utilization and lower costs. For most young and middle-aged people, funds to pay for health care are channeled through employers who offer health care coverage as a benefit. Some have charged that employers’ main interest is cost containment [26]. Employers may drive managed care organizations to decrease utilization using strategies including gate-keeping, utilization review, financial disincentives for excess utilization and “slowing and controlling use of services and payment for services by impeding, inconveniencing, and confusing providers and consumers alike” [27]. Meanwhile, as Medicare costs rose, the government instituted cost-cutting measures ranging from the Diagnosis Rated Groups (DRG’s) of the 1980s, to cuts in reimbursement made by the Balanced Budget Act of 1997, which “disproportionately affected US teaching hospitals” [28].

##### *4.2. Forces for more utilization*

For-profit corporations that provide health care often push to increase utilization and costs. For example, the operator of free-standing walk-in clinics pressured physician-employees to increase utilization, regardless of clinical justification [29]. Furthermore, a federal investigation targeted a large, for-profit hospital chain because of its “upcoding” policy which exaggerated the severity and complexity of patients’ problems to justify charging Medicare higher fees [30].

The threat of malpractice litigation is another impetus for increased utilization. Jury verdicts in malpractice cases are soaring [31], although defensive medicine meant to reduce the risk of litigation may reduce quality of care [32] and be unscientific and costly [33].

Spending on direct to consumer advertising, which may cause patients to pressure physicians for expensive drugs [34], tripled in the three years after it was legalized [35]. Entrepreneurs, including physicians, have also been marketing high-technology screening tests directly to consumers [36,37].

Well-intentioned special interest groups may push physicians to address problems that traditionally had been beyond the scope of medical practice, thus leading to increased utilization and costs. For example, physicians have been urged to screen patients for victimization by dating violence [38] and men who might be at risk for committing violence [39], to address domestic violence as a chronic problem [40], and to inquire about childrens’ exposure to violent animated movies [41].

Efforts to expand the scope of practice may lead to “unfunded mandates,” i.e., demands to perform tasks in the absence of payment for them. For example, the government requires hospitals to treat illegal aliens [42], and physicians to provide translators for patients who cannot speak English [43], but does not pay for these services. An accrediting organization required hospitals to decrease house-staff working hours, but did not pay for others to do the work these limits would preclude them from doing [44].

#### **5. Perverse incentives**

Physicians, especially primary care physicians, are often exposed to incentives that conflict with professional values. “Market driven health care creates conflicts that threaten medical professionalism” [45]. Managed care organizations, in particular, provided strong incentives to do less for patients, but at the risk of making physicians into “double agents,” whose “financial incentives are no longer clearly aligned with providing services, but may turn on holding services to some minimum level” [46]. Most primary care physicians feel pressure from managed care to limit referrals and see more patients [47], and thus

are concerned about conflicts of interest and failure to regard the patient's interests as paramount [48]. Managed care organizations may employ a "strategy of giving with one hand while taking away with the other, of offering consumers comprehensive benefits while restricting access through utilization review, [which] obfuscates the workings of the system, undermines trust between patients and physicians, and has infuriated everyone involved" [49]. Particularly notorious, and now generally outlawed, were managed care's "gag rules," which "prohibited physicians from frankly discussing all treatment options, covered or uncovered, expensive or inexpensive, that could be of benefit to the patient" [50], leading to "an unethical abridgement of the physician–patient relationship" [51].

Ironically, managed care has never successfully controlled the costs of high-technology care, such as coronary revascularization. For example, managed care did not dampen enthusiasm for or reduce the price of cardiac stents, small devices fashioned of metal alloy that resemble springs found in a ball-point pens, yet which cost about \$1500 in 1998 [52]. Similarly, managed care has not restrained the generous compensation given the invasive cardiologists who implant such stents. Their median income rose from \$326 537 in 1997 [53] to \$340 010 in 1999 [54]. Nor has managed care dampened the salary prospects of cardiothoracic surgeons who perform coronary-artery bypass grafting. Salaries of senior surgeons in academic health centers now average \$475 800, and may exceed \$1 million [55]. In contrast, although primary care was originally promoted as a way to decrease costs and increase access under managed care [56], primary care physicians' pay has declined and life-styles have worsened, while the popularity of primary care training has declined [57]. Finally, whatever ability managed care had to control costs seems to be waning. For example, in California, a state with heavy penetration of managed care, hospital costs are now rising at 25% yearly [58].

Medicare's quest to decrease costs also generated its own set of perverse incentives. Proposed Medicare fee cuts may decrease access to primary care services as physicians refuse to accept new Medicare patients [59]. Meanwhile, shrinking Medicare payments to hospitals for graduate medical education remain based on a formula unrelated to training program design, or educational expenditures or outcomes [60].

## **6. Ill-informed, incompetent, self-interested, or even corrupt leadership**

Recently, public confidence in the leaders of large American institutions has been shaken. For example, a series of scandals involving large American corporations such as Enron, Global Crossing, and Worldcom, run by "morally challenged executives," per Senator John

McCain [61], arose out of a culture of "infectious greed," per Federal Reserve Chairman Alan Greenspan [62].

Meanwhile, the domination of health care by large organizations has granted disproportionate power to their leaders. This has multiplied the potential negative effects of the actions of the fraction of these leaders who are ill-informed, incompetent, self-interested, and, at worst, dishonest.

There is little systematic data about the background, experience, and skills of leaders of large health care organizations. Ludmerer, however, argued that leaders of academic health centers are increasingly unlikely to have direct experience in health care. Instead, "hospital administrators increasingly had M.B.A degrees . . . assumed business titles . . . , demanded and received corporate levels of compensation, and retained hordes of management consultants," who usually did not have health care backgrounds either. Encouraged by them, "medical school and hospital officials approached academic medical centers much as if those institutions were making cars or breakfast cereals. They applied the same management strategies to medical centers that were widely being used in other 'industries'" [25]. Kleinke charged that members of hospitals' boards of trustees exhibited "virulent ignorance and abdication of responsibility . . . —which typify what I have personally encountered among hospital board members across the country—[which] are at enormous odds with the complexity of running today's hospital" [22].

Although not yet subject of systematic investigation, there have been anecdotal reports of self-interest and dishonesty afflicting leaders of health care organizations. For example, managers at a southern hospital were convicted of stealing from it, and six years later its president was fired for making an improper payment to a company connected to members of its board of trustees [63]. A mid-Atlantic teaching hospital paid more than \$8 million to businesses in which two of its board of trustees had a financial interest, while a majority of its board members did business with the hospital [64].

Major conflicts of interest also have affected leadership of non-profit organizations that seek to influence specific aspects of health care. For example, the American Heart Association advocated alteplase for stroke as part of its "brain attack" campaign, after receiving millions from Genentech, the drug's manufacturer [65]. The American Medical Association endorsed Sunbeam products without evaluating them in exchange for royalties, leading to the resignations of three of its top administrators [66].

The "merger mania" of the 1980s and 1990s generated striking examples of deficient leadership of managed care organizations and hospitals. Kassirer had warned that "decisions about mergers, acquisitions, and vertical integrations in health care are largely in the hands of an oligarchy of executives who are reacting to the vicissitudes of the marketplace" [67]. These organizations seemed to

repeatedly reward their leaders for increasing massive failures.

A particularly flagrant example was that of a Mid-Atlantic not-for-profit health care system that encompassed 14 hospitals. During its early years, its CEO declared “the synergies that develop through our new relationship . . . should prove to be of great benefit to patients, referring physicians and insurers” [68]. While top executives touted its financial strength [69], and 77 managers’ salaries exceeded \$200 000 a year, debt was soaring. The CEO continued to assert that the merged entity’s “financial position remains very strong” [70], and ordered premature repayment of at \$89 million loan to a bank whose leaders included five members of his Board of Trustees [71]. Nonetheless, the system went bankrupt. Managers faced lawsuits under the RICO [Racketeering Influenced and Corrupt Organizations] law [72]. Its former CEO was just sentenced to up to 23 months in jail for misapplication of entrusted property [73].

## 7. Attacks on the scientific basis of medicine

Most physicians believe that medicine should be based on science. Evidence based medicine, (EBM) “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” [74], is a refinement of this view. Meanwhile, the scientific basis of medicine is under increasingly severe attack.

The integrity of medical research has been violated by the deliberate suppression of its results. The frequency of successful suppression of research, is, by definition, unknown. In one survey, however, 20% of life-sciences faculty admitted delaying publication substantially, and about 6% did so to slow dissemination of undesired results [75]. There have been anonymous reports of cases “of articles whose publication was stopped or whose content was altered by the funding company” [76], and instances in which research results were attacked because they “ran counter to financial interests and strong beliefs” [77].

Two striking examples of attempted suppression of research have been widely reported, and are used as case studies for research ethics training [78]. In both, corporations tried to prevent medical school researchers from publishing undesirable results, while the researchers’ own hospitals and schools added obstacles to publication. While both researchers finally published their work [79,80], one’s career was seriously set back, and the other lost his research and clinical program and finally his job [81].

Failure of universities to champion the academic freedom of their clinical researchers may stem from their abandonment of their own academic core value of free enquiry. There is abundant evidence that universities may restrict expression and limit academic freedom [82]. In The

Shadow University, Kors and Silvergate charged that “universities have become the enemy of a free society” [83]. Universities have punished faculty and students who raised unpopular viewpoints. Such cases include a professor fired for an academic argument against some aspects of feminism; one whose research was shut down after making academic arguments against racial quotas and “race-norming” test results [83]; and one charged with sexual harassment because he used a sexual analogy in a letter to a newspaper opposing gun control [84]. Many examples of students and faculty punished for saying or writing unpopular things appear on the website of the Foundation for Individual Rights in Education (<http://www.thefire.org>).

Postmodernism, which has “increasing reach and power within the [American] university” [85], has provided the erstwhile intellectual rationale for suppressing academic freedom. Postmodernism is “an attempt to question the fundamental philosophical and political premises of the West. It argues that many of the concepts we take for granted—including truth, morality, and objectivity—are culturally ‘constructed’” [86]. To postmodernists, truth is just what the powerful say is true [87]. This facilitates a slippery slope argument for the suppression of free speech and academic freedom. For example, in his aptly named book, *There’s No Such Thing as Free Speech, and It’s a Good Thing, Too*, the well-known postmodernist Stanley Fish, Dean of the College of Liberal Arts and Sciences at the University of Illinois, argued “some form of speech is always being restricted, . . . someone is always going to be restricted next, and it is your job to make sure that the someone is not you.” Finally “the only question is the political one of which speech is going to be chilled” [88].

Postmodernism is also a direct threat to the integrity of medical research. Medical postmodernists, believing that truth is politically defined, deride widely accepted standards for research methodology as political constructs. For example, Berkwits charged “the preeminence of clinical epidemiologic research in medicine derives not from its ability to reveal the truth about clinical phenomena, but from an agreement within the medical community for a variety of reasons that it will grant greater authority to statistical expressions of evidence over others” [89]. Postmodernists argued that clinical trials became pre-eminent not because they are less susceptible to selection bias than are observational studies, but because they somehow gained more political support than did other methods, e.g., “in a self-authenticating manner, the double-blind RCT became the instrument to prove its own self-created value system” [90].

Although basic scientists have fiercely repelled postmodernist attacks in the “science wars” [91], the postmodern viewpoint has received a warmer reception from medical researchers. There is a vocal postmodernist faction in medical qualitative research [92–94]. Postmodern arguments also underlie some of the current enthusiasm for

alternative medicine. For example, Kaptchuk and Eisenberg, the editors of a prominent published series on alternative medicine, asserted the “old cultural war of a dominant culture versus heretical rebellion in politics and religion as well as medicine has begun to transform into a recognition of postmodern multiple narratives” [95].

## 8. Conclusions

Physicians around the world should be wary of catching the American malady, health care dysfunction, and skeptical of promoting approaches derived from the current American health care system. All health care systems should provide access to high quality care at an affordable cost. They should also support the physicians’ traditional core values, particularly that the needs of the individual patient must come first. Incentives must align with these core values, and conflicts about the delivery of health care must be resolved in line with them. Health care leaders must be honest, competent and actually understand health care as well as business principles. Medical schools and universities must re-affirm their support for scholarly work in the spirit of free enquiry, and reject the politicization and cynical nihilism of postmodernism.

Medicine’s core values are not just threatened in the US. British physicians, warned of government actions that may deprofessionalize them [96], are increasingly dissatisfied [97]. Such discontent is global [98]. Managed care is spreading in Latin America [99]. Europe may be on the brink of direct-to-consumer advertising [100]. Canada has endured a major incident of attempted suppression of medical research [101]. Postmodern “anti-realism” affects qualitative research from the UK [94]. Australian postmodernists fear evidence based medicine “becoming an oppressive or totalising discourse (as envisaged [sic] by Foucault) in the clinical context”. [102].

Some principles suggested by my overview of US health care system dysfunction may be useful in that and other countries. Re-stating the core values that most physicians support may be helpful, but physicians must press health care organizations to act in accord with these values. This may require that some health care organizations be re-organized or even taken apart, and others be better regulated. Meanwhile, European doctors must ensure future initiatives do not undermine their core values or the best interests of their patients.

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